Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
February 20, 2019
7:15 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
February 20, 2019
7:15 a.m.

A G E N D A

1. **Welcome and Board Member Introductions –** Mary Newbold (5 Minutes)

2. **Consent Agenda** – Mary Newbold (8 minutes)
   A. Approval of November 28, 2018 Board Meeting Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.
   C. QI Committee Meeting Minutes *(information)* -- included in your board packet. Carol Walker is available to answer questions.

3. **President's Report** *(information)* - Mark Murray (15 minutes)
   A. 2019 – 2021 Strategic Plan for CHC/HF/GPIC (*action*)

4. **Finance Committee** *(action)* – Tricia Luck (15 minutes)
   A. December 2018 Year End Pre-Audited Financial Statements

5. **Hospice Foundation Update** *(information)* – Wendell Walsh (12 minutes)

6. **Board Education** *(information)* **–** "2018: The Year in Review" – Mark Murray (17 Minutes)

7. **Chairman's Report** – Mary Newbold (3 minutes)

Next meeting May 15, 2019

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
November 28, 2018

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:15 a.m.	
2. Consent Agenda	• The minutes of the 08/15/18 meeting were reviewed. The Medication Disposal policy has been pulled for further revision and will be brought back to the February Board meeting. • Patient Care Policies – Discharge Criteria (revised), Death Procedure (revised), Standing Orders (revised), Alerts in the Electronic Medical Record (new), Home Health Quality Assessment Performance Improvement (QAPI) Plan (new). • QI Committee Minutes 08/28/18 • Revised Bylaws – The Bylaws are reviewed every three years, and 2018 was the year they were due for review. Minor changes were made such as adding Porter County, Immediate Past Chair of the Foundation Board of Directors, changing chairman to chair, and deletion of the Professional Advisory Group which was a home health requirement that was done away with in the updated Home Health Conditions of Participation. • A motion was made to accept the minutes of the 08/15/18 meeting, revised and new patient care policies, QI Committee minutes, and revised Bylaws as presented. The motion was accepted unanimously.	C. Walker motioned J. Ewing seconded
3. President's Report	• The ADC has been going down since July; however, the YTD ADC is up a little from last year. Part of the issue was the admission department went back under the clinical department at the end of July. We thought this was temporary due to hiring and orientation of new staff, but we were mistaken. As of 11/16, admissions is back under Marketing. October had 113 new admissions and the break even is 147 for the budget. We don't spend all of budgeted expenses every year. October	

Topic	Discussion	Action
	referrals were 194 compared to 214 a year ago, a 9% decrease. October conversion rate was 57% compared to 68% a year ago, an 11% decrease. YTD referrals are up by 7 patients. Original admissions are down 1.69%. YTD conversion rate was 71.67% compared to 73.98% a year ago. We had a 12% increase in patients dying before admission, and a 25% increase non-admit referrals from hospitals compared to last year. Both IPUs have been very busy recently, but with very short lengths of stay. Referrals to the IPUs have been very high. We are still projecting to serve over 2,000 patients this year. • Optum Hospice Pharmacy drug costs per patient day was $3.71 in September, compared to $8.00 a couple of years ago. Optum says CHC is in the top four best demonstrated practice models nationally. • Every February we review the status of the previous year's annual CHC goals and introduce new ones for the coming year. The current strategic plan ends at the conclusion of 2018. We will present a final report in February and introduce the new three-year strategic plan. We have had feedback from some board that they are not sure what is happening with our strategic plan. We do give an update annually on its status. This is one of the questions on the board self-evaluation survey too. • The fiscal year 2019 Hospice Medicare reimbursement rate doesn't consider the Congressional sequestration 2%, which has been in effect since about 2011 and will continue for the next few years. When CMS says we're getting a 1.5% increase, we're actually getting a negative increase because of the sequestration. When NHPCO and HAN brings this up to CMS and call it a cut, they say it's not a cut but merely a reduction is in the amount you would have received . Total Assets at the end of October were $54.M, an increase of just over $5.6M from a year ago. At the end of October we were over budget on operating revenue by nearly $300,000 and below budget on expenses by just over $1.8M. We don't always spend what we budget for expenses. • The annual memorial service on 11/18 had its second highest attendance in the past five years. 665 people participated at three locations in South Bend, Elkhart and Plymouth. We received a lot of positive feedback. Everyone received a candle in memory of their loved one. • Denis Kidde, International Programs Coordinator, became a U.S. citizen on 11/20.	

Topic	Discussion	Action
	He has been with us six years coming from Uganda. • Wendell W. commented that the decision to move admissions to clinical away from marketing was quickly reversed because management recognized something was not working and responded immediately.	
4. Finance Committee	• 2019 Flex Spending Limit – This is pre-tax dollars an employee can use for qualified medical expenses. They have access to those funds immediately. The IRS allows up to a $2,000 limit. The Finance Committee recommends keeping the limit at $2,000 for 2019. A motion was made to keep the flex spending limit at $2,000. The motion was accepted unanimously. • 2018 Retirement Plan Audit – Back around 2010 the IRS determined 403b plans needed to more closely mirror 401k's and have to have an independent audit. There is not a lot under our control as far as the plan, because they are individually owned and directed accounts. We have one provider that administers the plan, but there are four other legacy providers. The audit was the last from David Culp & Company. There were no deficiencies or findings, and they gave an unmodified opinion. A motion was made to approve the 2018 Retirement Plan Audit as presented. The motion was accepted unanimously. • YTD October Financial Statements – Operating revenue $18.6M, beneficial interest in affiliates loss (-$1.5M) mainly due to loss in investments, total revenue $17.4M, total expenses $16.4M, net gain $1M, net without beneficial interest $2.6M. This compares favorably to last year's net without beneficial interest at this time of $1.6M. A motion was made to accept the financial statements as presented. The motion was accepted unanimously. • 2019 Budget – The Travel line item is for staff to see patients. Education includes staff travel to conferences and the NHERT, public awareness, social media, webinars, newsletters, etc. The Education budget is $142,500, which 0.6% of the overall budget. One function of Mary Lou Foley, accounting coordinator, is to make travel arrangements for staff attending conferences. The employee fills out an expense report and must attach receipts to be reimbursed. Expense reports must be submitted within 45 days. The ups and downs of the ADC can make projecting a budget difficult. The ADC and the number of patient days drive the census. In 2018 we are projecting an ADC of 393 and had budgeted 398. In 2019 with the new IPU and medical staff building, we are projecting an ADC of 400, a 1.9%	J. Houin motioned M. Newbold seconded A. Mauro motioned T. Luck seconded C. Walker motioned M. Newbold seconded

Topic	Discussion	Action
	increase. Total overall revenue $23.8M, total expenses $22M, net gain $1.8M, beneficial interest in Foundation $1M, and net without beneficial interest $831,000. A motion was made to accept the 2019 Budget as presented. The motion was accepted unanimously.	J. Houin motioned M. Newbold seconded
5. Hospice Foundation Update	• Through October 31 the Capital Campaign has raised $11.2M of our $10M goal. The Campaign continues through June 2019. We have a couple of underfunded priorities: $1.3M of $5M goal for Raclin House. We received a challenge matching grant for the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. About $582,000 remains on the $1M challenge. We don't have to reach it by June to take advantage of the grant, but we would like to. The grant is a five year commitment made to us, so we still about 2.5 years to meet that. • Annual Appeal – The appeal will focus on the remaining underfunded priorities of the Crossroads Campaign. The main areas are Raclin House, Camp Evergreen Endowment, Sr. Carmel Sallows Helping Hands Fund, and the Vera Z. Dwyer matching grant. • Okuyamba Fest celebrated our ten year partnership with PCAU. About 175 people attended the event. The Bike and Walk for Hospice were combined and held at the Mishawaka Campus for the first time. By combining the two events we had a higher net gain than the previous three years when the events were separate. The 10th anniversary celebration of the Elkhart Campus was held in August, and the IPU was rededicated as Esther's House. The Veterans Tribune Ceremony was held 10/16 and the memorial was rededicated as the Robert J. Hiler, Jr. Veterans Memorial. • The recipient of the 35th Helping Hands Award will be Catherine Hiler. The event will be held on 05/01/19 at the Hilton Garden Inn. • Center for Education and Advance Care Planning – Refer to the President's Report for specific information. • Honoring Choices Indiana-North Central – We have fully engaged that program and have hired a part-time coordinator. See the President's Report for specific information. • PCAU – One thing we are doing is building a relationship with Bethel College. We now have an intern who is creating the framework for a program focused on developing entrepreneurial skills for our older Road to Hope students that are	

Topic	Discussion	Action
	moving out of that program to jobs. See the President's Report for more information on GPIC projects. • Construction Update – Things going well. They will start putting up dry wall soon. Most of the windows have been installed. We are on target to complete construction on the medical staff building in early summer, and on Raclin House in the fall. After going through a series of meetings with the Mishawaka Common Council, we have received approval to vacate Madison and Pine Streets up to the alley. We will maintain the street and added additional public parking spaces that the neighbors can use. The council said they appreciate working with CHC, and that we helped jump start what has happened in the community with our initial investment several years ago.	
6. Nominating Committee	• Jennifer Ewing has agreed to serve a second term. As an example of how the role of a board member can be really significant, Jen was able to help Rose Kiwanuka, National Coordinator for PCAU, get a needed medical test while she was here. • New candidates – Mark Wobbe from Gibson Insurance and Andy Murray from Lippert Components. Both attended the Finance Committee meeting on 11/16 as guests and have agreed to serve. • The 2019 Board officers will be: Chair – Mary Newbold, Vice Chair – Carol Walker, Treasurer – Tricia Luck, Secretary – Jennifer Houin, Immediate Past Chair – Wendell Walsh, Hospice Foundation Immediate Past Chair – Amy Kuhar Mauro. • A list of committees is in the board packet. We invite each board member to consider what committee they would like to be involved with in 2019. Contact a member of the executive committee if you are interested in serving on a committee. In the coming weeks the executive committee will go through process of doing the CEO's annual evaluation. We invite board members to submit any input to an executive committee member as part of the process. • A motion was made to accept the nominations as presented. The motion was accepted unanimously.	C. Walker motioned A. Mauro seconded
7. Board Education	• Craig Harrell, Director of Marketing & Access, reviewed the Admissions Department, responsiveness, and opportunities. YTD 2018 we have had 1,952 referrals compared to 1,945 a year ago. We started strong in January until we took a dip in September. As of 10/31/18 YTD we had 1,399 admissions compared to	

Topic	Discussion	Action
	1,439 a year ago. Our goal is 147 admissions per month. Same/next day referral to admission goal is 58% and YTD we are at 52.74% compared to 57.54% a year ago. Our conversion rate goal is 75% and YTD we are at 71.67% compared to 73.98% a year ago. Nationally anything above 70% is considered very good. We had moved the admission nurses under the ADON and DON in July due to changes in personnel. That has been reversed. • Non-Admits – Those beyond 24 hours are primarily the family's request because they are waiting for family from out of town or the patient wants to see the doctor one last time before making that decision. Competition is surviving on what falls through our fingers. Staffing has been an issue. When someone leaves, it takes time to replace, orientate, and train a new employee which can take months. Some of the newer nurses don't have their conversion rate where needed, so we will have them mentored by a long-term admission nurse and give them further training. • We are struggling with a 42% increase in losing patients to going to a Medicare A covered bed in a facility. There was a 77% increase in patients going to a Medicare A bed through a hospital referral this year compared to last. We have also seen an increase in the patient/family/POA refusing services. Part of that we think is staff not having the proper response for an objection from a family, so we will be providing additional training for our staff. DBA was up 11.5% from a year ago. There was a 25% increase in DBAs from hospital referrals. Our goal in 2019 is to let families know they can contact us and not wait for a doctor referral and work with families further upstream to make those decisions. We have also seen an increase in "went with another agency." The majority of those referrals are through the hospitals. • We continue to monitor non-admits daily. 233 previously non-admits have been converted to admissions in 2018. We have openings for a weekend admission nurse and two weekday nurses. Carol W. commented hospitals are trying to decrease their lengths of stay. If we had additional nurses, would our response time be faster which would be a positive for the hospital's length of stay and patients getting the care they need quickly? Yes. We have also taken on the responsibility of having a nurse start the admission process at hospital and following up if they go to the IPU to complete the admission.	

Topic	Discussion	Action
8. Chairman's Report	• The Board Self-Evaluation Survey is in the board packet. Please complete it and return it in the provided envelope by 12/31/18.	
9. Recognition	• Anna Milligan is leaving board at the end of the year and was given a plaque in recognition of her five years on the Board. This is Corey Cressy's last Board meeting as Hospice Foundation Immediate Past Chair. He was given plaque in recognition of his ten years serving the CHC and Foundation Boards. This is Wendell Walsh's last meeting as Chair and he was given a clock in recognition of his two years as CHC Board Chair.	
Adjournment	• The meeting adjourned at 8:40 a.m.	Next meeting 02/20

Prepared by Becky Kizer for approval by the Board of Directors on 02/20/19.

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Carol Walker, Secretary Becky Kizer, Recording Secretary

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)~~(a) Alerts should be added the same day they are identified.
   ~~(c)~~(b) 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

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

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

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

PROCEDURE:

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

2. Admitting nurse will order appropriate Care Kit, according to Attachment A, under order sets in Cerner.
   (a) Admitting nurse will explain Care Kit to family and what to do with it when it arrives.
   (b) Admitting nurse should obtain a local supply of Morphine/Lorazepam if there is the potential patient may become symptomatic before Care Kit arrives.
   (c) If patient has an allergy to any of the medications in the carekit, the admission nurse will contact the medical staff for substitution.

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

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

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

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

Center for Hospice Care

ECF: ELDER JUSTICE ACT REPORTING

Section: Patient Care, Compliance Category: Hospice, Hospice Compliance Page: 1 of 1

REGULATION: Patient Protection and Affordable Care Act – Section 1150B

PURPOSE: To identify Agency staff reporting responsibility under the Elder Justice Act.

POLICY: Center for Hospice Care staff will report known or reasonable suspicions of crimes against residents of Skilled Nursing Facilities (SNF) that the Agency is contracted with to provide hospice services. These crimes may include, but are not limited to, abuse, neglect, theft, and/or fraud.

PROCEDURE:

1. Reasonable suspicion of a crime against a resident of a contracted SNF, will be reported to the Indiana State Department of Health (ISDH) by email, fax, or telephone, and to the County Sheriff's office of the county the SNF is located in. The contact numbers for the county sheriff offices are posted at each Agency location ~~in the employee break room~~ and on the Agency staff website.

   ISDH Email: incidents@isdh.in.gov
   Fax: 317-233-7494
   Complaint/incident report line: 1-800-246-8909

   Elkhart County Sheriff: 574-891-2300
   Fulton County Sheriff: 574-223-2819
   Kosciusko County Sheriff: 574-267-5667
   LaGrange County Sheriff: 260-463-7491
   LaPorte County Sheriff: 219-326-7700
   Marshall County Sheriff: 574-936-3187
   Porter County Sheriff: 219-477-3000
   St. Joseph County Sheriff: 574-245-6500
   Starke County Sheriff: 574-772-3771

2. Reasonable suspicion of a crime resulting in serious bodily injury will be reported immediately to the above agencies. The reporting will occur no later than two hours after forming the suspicion.

3. Reasonable suspicion of a crime not related to serious bodily injury will be reported to the above agencies within 24 hours after forming the suspicion.

4. Report all reasonable suspicion of crimes to your supervisor and the Skilled Nursing Facility administrator immediately.

REFERENCE: A copy of the Elder Justice Act can be found on the staff website under Files, Policies.

Effective Date: 10/11	Revised Date: 12/18~~06/15~~	Board Approved: 12/16/15
Reviewed Date: 01/18		Signature Date: 12/16/15

Signature: President/CEO

PURPOSE: To ensure appropriate supply of medications from the Inpatient Unit (IPU) to transition patient to home.

PROCEDURE:

1. All medications brought from home are the property of the patient. These medications should be sent home with the patient. If the medication is discontinued and the patient is no longer taking it, these medications should still be sent home unless the family requests that the medication be disposed of.
   - Document the name of the person who is requesting disposal of medications.
   - If any medications are forgotten, a family member should be contacted to pick it up, if possible, otherwise send to patient via courier service.
   - No CHC staff may transport any medications.

2. All medications delivered by CHC's contracted pharmacy and labeled with the patient's name and instructions for use may go home with the patient.

3. Any medications taken from the Emergency Drug Kit (EDK) that are not labeled by a pharmacist and should be discarded per CHC policy. Medications from the EDK are never to be sent home with the patient.
   - Atropine drops are not part of the EDK. If the patient has atropine drops, they may take it home if it is labeled with the patient's name and directions.

4. If the patient is not on any injectable medications when they leave the IPU, all injectable medications should be discarded per CHC policy regardless of whether they came from the EDK or CHC's contracted pharmacy.

5. If the patient leaves the IPU with injectable medications ordered and labeled for home use, educate the family on the use of the SQ/PICC/VAD site and how to give the medications.
   - Instruct the caregiver on the proper steps for giving an injectable medication.
   - If the patient is going home with an injectable medication, a sharps container should be sent with them.
   - Educate the caregiver that all needles and syringes are single use only.
   - Document this education thoroughly in your narrative note, including the name of the person educated, exactly what they were educated on, and their understanding of the education.
   - Email triage and the case manager of the SQ or IV medications and family's understanding.

Signature:  President/CEO

6. All patients should be sent home with a minimum four (4) day supply of all ordered medications.
   - If a patient does not have a four day supply of medication, IPU staff should order more from CHC's contracted pharmacy to ensure the patient does not run out of medications before the next scheduled visit.
   - Medications should be ordered from CHC's contracted pharmacy as soon as potential discharge date is known.
   - CHC's contracted pharmacy will deliver up to a four-day supply to the IPU to send home with the patient.

7. A seven (7) day supply of medications can be ordered to be delivered to the patient's home after the patient leaves the IPU.
   - Change patient's address in the EMR from IPU to their home address.
   - After this is completed, a call can be placed to CHC's contracted pharmacy to order the medications.
   - If unable to order from the IPU, coordinate with triage and/or the patient's case manager to make sure the patient gets an adequate supply of medications delivered to their home.
   - CHC's contracted pharmacy's policy is that all medication orders must be received by 6:00PM for next-day delivery Monday through Friday, or 2-3 day delivery time Saturday, Sunday, and holidays.

8. Complete the "Inpatient Unit Discharge Instructions" sheet (attachment A).
   - Page 1 transcribe from the MAR or doctor's orders the scheduled medications, as well as the name of the patient's case manager, social worker, and chaplain.
   - Page 2 transcribe the PRN medications with specific instructions including last dose given.
   - Give the form to a family member if possible, and provide an opportunity for them to ask questions.

9. If a patient is going to an ECF, contact the ECF regarding sending medications with patient.
   - If medications cannot be sent to the ECF, follow CHC policy on disposal.
   - If medications can be sent to the ECF, document in patient's chart medications that were sent with the patient.
   - Complete the IPU to ECF orders form (attachment B) and send with patient.

Center for Hospice Care

INPATIENT UNIT – WEEKLY IDT MEETING DRAFT

Section: Patient Care Policies Category: Hospice

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

PURPOSE: The Agency will use an interdisciplinary approach to assess the ongoing medical, physical, social, emotional, and spiritual needs of the Inpatient Unit (IPU) patient and family.

PROCEDURE:

1. The Agency will have an Interdisciplinary Team (IDT) that includes the following persons:
   - Doctor of Medicine or Osteopathy
   - Registered Nurse
   - Social Worker
   - Pastoral or Other Counselor
2. No member of the IDT shall be a family member or related to a family member of the patient.
3. Participation of team members will be reflected in the documentation.
4. The IDT will meet weekly to discuss General Inpatient (GIP) level of care patients. Discussion will include:
   - Patient/Family Goals
   - Appropriateness of Level of Care (LOC)
   - Plan of Care
   - Discharge Plans
5. The IPU nurse will complete an IDT note in the patient summary weekly including the above information and whether the patient remains appropriate for GIP Level of Care.
6. Any Respite patients that social work identifies any discharge issues will be discussed during the weekly IDT meeting. Documentation of the discussion will be done in the patient summary by the social worker.

Effective Date: 01/19	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

Signature: President/CEO

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

Members Present:	Alice Wolff, Amber Jay, Bethany Lighthart, Carol Walker, Chrissy Madlem, Craig Harrell, Deb Daus, Greg Gifford, Holly Farmer, Karen Hudson, Lisa Bryan, Mark Murray, Rebecca Fear, Tammy Huyvaert, Becky Kizer
Absent:	Connie Haines, Dave Haley, Jennifer Ewing, Larry Rice, Sue Morgan, Terri Lawton

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. • Introduced Bethany Lighthart, new Social Work Coordinator.	
2. Minutes	• The minutes of the 08/28/18 meeting were approved by consensus.	
3. Hospice Quality Reporting Program	• Hospice Compare Website – Data from the CAHPS and HIS is publicly reported on this website. The data is updated quarterly and the most recent is for 10/01/15 – 09/30/17. One question on the HIS is patient/caregiver was asked about treatment preferences. CHC scored 100% and the national average was 98.7%. Another question is patient/caregiver was asked about their beliefs and values. CHC scored 98.3% and the national average was 94.9%. • HIS – Comprehensive Pain Assessment. Our lowest score was 69.2% for patients who got a timely and thorough pain assessment when pain was identified as a problem. The national average was 83.4%. We originally didn't know we needed to capture at least five of seven elements, because that was not initially explained to providers. We didn't discover this until we attended a webinar last year. We were not the only hospice with this issue. This year we started a double-check system to make sure the data matches and that five of the seven elements are being captured. Our scores have improved to 97-100%. • CASPER – Quality Measures Report. The newest reported measure is the Hospice Comprehensive Admission Assessment. This is an "all or none" measure. The hospice must perform all seven HIS care processes to receive credit. This measure sets a higher bar for performance, so most providers may see a lower score than they currently have on their individual HIS measures. We are currently at 93.2% and the national average is 86%. We will talk to IT about why the numbers are now showing in Cerner.	

Topic	Discussion	Action
4. Hospice Performance Improvement	• Education & Training – We offer NHPCO webinars twice a month that focus on quality and clinical topics. There is an education topic presented at the monthly CNAs meeting and bimonthly all staff meetings. Edo Banach, President/CEO of NHPCO did a hospice industry update to all staff in July. In August we reviewed the summary of the recent OIG report on Hospice, reviewed the results of our recent Hospice Survey, and provided annual HIPAA education. In September we did a Veterans Tribute and We Honor Veterans update, staff from PCAU was here and visited each of our offices, staff delivered the Introduction to Hospice & Palliative Care course to students at Notre Dame, we did emergency preparedness education, the annual infection control and Blood Borne pathogens education, and a presentation working with the LGBTQ community. • Quality Monitoring – We monitor high risk, low frequency events. One of these was tissue donation with the Indiana Donor Network. We had two patients we managed for tissue donation. We continue to provide education to staff on tissue donation. Information is also in the Family Handbook. We don't bring tissue donation up until the family does, and then we will help with getting them in contact with the Indiana Donor Network. Another area we are monitoring is palliative extubation and how well we deliver it. Most of them this year took place at the Elkhart IPU. Staff did an excellent job documenting and educating families on what to expect. The IPU always makes sure a second nurse is there so one nurse can be with the patient and another nurse cares for the other patients in the IPU.	
5. Hospice Patient Safety Monitors	• Patient Safety – We monitor falls to see where they took place to make sure it was reported, were there any injuries, and that a risk assessment was done. If a patient has repeated falls, we look to see what we've put in place and what education was done to minimize falls. Falls mainly occur in the home and ECF between the bed and bathroom. We are still working on the numbers to determine the volume of falls per patient day and will report that at the next meeting. We continue to look for trends and ways to reduce falls.	
6. Hospice Quality Indicators	• Live Discharges – The Health Information Management (HIM) Committee is monitoring live discharges. Examples of patient initiated discharges include revocation and transfers (change in designated hospice). Hospice initiated includes no longer terminally ill, leaves the service area, or cause. Compared to the national average, our percentage of live discharges is low. On average 10% of all of our discharges are live.	

Topic	Discussion	Action
	YTD through September we had 1,307 total discharges, and 143 were live. Of those, 17% didn't meet eligibility requirements, 46% revoked, 23% left our service area, 10% transferred to another hospice, and 4% were for cause. We noticed an increase in discharge for cause. There have been five so far this year—most of them for drug diversion or misuse. Another was due to violence toward staff. • Revocations – We identified some challenges including with new staff, staff documenting the patient is seeking aggressive treatment instead of curative treatment or documenting that the patient needs to revoke which could be construed as the agency pressuring the patient into revocation. Staff has been educated to also call the nursing leadership on call to inform them of a revocation, and signing and returning revocation paperwork timely and gets to Billing. Rebecca F. and Bethany L. are working on joint education with nurses and social workers. We have updated and also created new reference materials that will be a part of the education. The HIM Committee will review revocations monthly. We track if patients that revoked come back to us and how soon, and we did notice a trend of patients coming back to us in a relatively short amount of time. Admissions would like to know about revocations so they can follow up on those patients. Deb D. reviews the reason for discharge daily. • Infection Control – We did our annual Blood Borne pathogens inservice for all staff, a trunk fair in September where we look at the medical supplies stored in staffs' vehicles and nursing bags, reviewed infection control in the home with social workers and chaplains, and gave staff a flu vaccine.	
7. Hospice Specialty Programs	• HeartWize and BreatheEazy – Our goal is to provide optimal care to help keep the patient at home. We track them to see if they return to us after a hospitalization. A lot of it reflects trust. New patients still are more likely to call 911, but those on service longer call us first. We have to be sure we are documenting why patients make the choices they do, otherwise it might look like the patient revoked because we didn't want to pay for the treatment. The OIG is monitoring this. We updated our Cardio-Pulmonary boot camp to include case studies, admission criteria, and focus on teaching and training patients and families. We also increased focus on prevention of patients seeking treatment in an ER or hospitalization. 20 nurses completed the C-P boot camp course in 2018, and we received positive feedback from staff that participated.	
8. Home Health QAPI Programs	• Admissions – We began tracking home health admissions in 2016 as a quality indicator to ensure the needed elements were present. This is a joint effort between Admissions	

Topic	Discussion	Action
	and QA. Areas we are tracking include making sure face-to-face visits are completed within mandated time frames, a skilled need is identified, homebound status is documented appropriately, and the OASIS documentation is sent for co-signature by the attending physician. From 05/01/18 – 10/22/18 we had 77 home health referrals and 42 admissions. Not eligible or declined admission was 35. 18 patients changed from home health to hospice, and 5 died under home health. The majority of home health referrals come from MHO. We do follow up on patients that were not admitted. We understand the need to educate doctors to let us make the determination whether the patient qualifies for services. • New Home Health Conditions of Participation were published. As a result we wrote a new Quality Assessment Performance Improvement Plan (QAPI) policy for home health, similar to the one in hospice. • Infection Control – We did all staff education on Blood Borne pathogens and infection control, monitored medical supplies stored in staff vehicles and nursing bags, reviewed infection control in the home by social work and chaplains, and gave flu vaccines to staff. • Falls – We monitor falls to see where they took place to make sure it was reported, were there any injuries, and that a risk assessment was done. There was one fall in the third quarter and five in October (2 home, 3 ECF). All of the falls were reported, not observed, and no injuries were sustained. If a patient has repeated falls, we look to see what we've put in place and what education was done to minimize the risk of falls. We are still working on the numbers to determine the volume of falls per patient day and will report that at the next meeting. • Survey Readiness – We are due for a home health survey at any time, so we conducted mock surveys with staff. We created resource binders for each office on what to do when the surveyor arrives. PCCs did ride along visits with their staff. In 2019 we are planning QAPI projects and are due to review the home health patient care policies again.	
Adjournment	• The meeting adjourned at 8:50 a.m.	Next meeting 02/26

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
February 20, 2018
(*Report posted to Secure Board Website on February 14, 2019)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from November 29, 2018 – February 19, 2019. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

Between Christmas Day 2018 and New Year's Day 2019 we had 35 deaths in just seven days. This is not really that unusual as we have seen for decades patients "hang on" to make it through the holidays. This phenomenon is experienced at many hospice programs nationwide. We typically start out the New Year with a much lower census. 2019 is not an exception. However, census has continued to build throughout the month of February and we've been as high as 396 on a single day. At the time of this writing the average daily census for February is 392, bringing the year-to-date up to 382 from January's 378. Our breakeven census for budget purposes assuming a predictable, budgeted payor case-mix is 381. While busy, both inpatient units have seen very short lengths of stay, perhaps the lowest in history due to very late referrals, primarily from hospitals. Historically, about 50% of all patients in our inpatient units are direct referrals from area hospitals and hospitals now rank #1 out of all general referral sources. On 2/13 both units were at capacity with seven patients each. Overall, sadly, 45% of all admissions in January were deceased in seven days or less.

January 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	511	511	524	-2.48%
Original Admissions	142	142	155	-8.39%
ADC Hospice	350.00	350.00	360.19	-2.83%
ADC Home Health	27.68	27.68	19.71	40.44%
ADC CHC Total	377.68	377.68	379.90	-0.58%

CHC HOSPICE INPATIENT UNITS

January 2018	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
SB House Pts Served	40	40	29	37.93%
SB House ALOS	4.23	4.23	5.07	-16.57%
SB House Occupancy	77.88%	77.88%	67. 74%	14.97%
Elk House Pts Served	23	23	28	-17.86%
Elk House ALOS	3.65	3.65	4.46	-18.16%
Elk House Occupancy	38.71%	38.71%	57.60%	-32.80%

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2018 Jan	**2019** Feb	**2019** Mar	**2019** Apr	**2019** May	**2019** June	**2019** July	**2019** Aug	**2019** Sept	**2018** Oct	**2018** Nov	**2018** Dec
S.B.:	190									190	190	198
Ply:	74									83	78	75
Elk:	92									83	89	96
Lap:	14									16	16	14
SBH:	5									6	5	4
EKH:	3									4	5	3
Total:	378									382	382	390

PATIENTS IN FACILITIES

Of the 511 patients served in January 2019, 159 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in January 2019 was 129.

FINANCES

Karl Holderman, CFO, reports the year-to-date December 2018 Financials will be posted to the Board website on Friday morning, February 15th following Finance Committee approval. For informational purposes, we are pleased to present the unapproved 2018 year-end financials on the next page. Hard copies will be available at the board meeting.

On 12/31/18, at the HF, intermediate investments totaled $4,588,365. Long term investments totaled $18,477,065. The combined total assets of all organizations, including GPIC, on December 31, 2018 totaled $54,098,519MM, an increase of $4,224,737 from year-end 2017.

Year-to-date investments showed a loss of -$1,009,227. From a budget standpoint, CHC alone was over budget on operating revenue by $150,690 and under budget on operating expenses by $1,788,275.

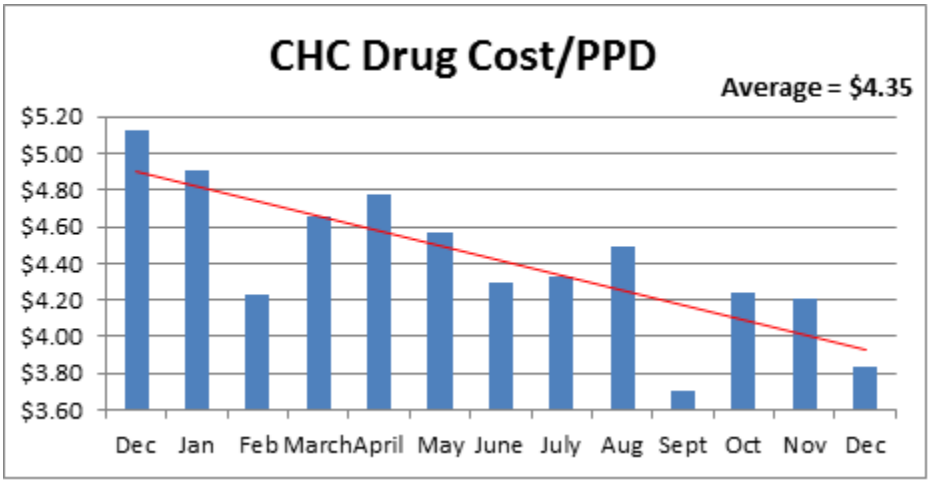
Non-Audited, Unapproved, Year to Date December 2018 Financials

December 2018 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	22,191,456			**22,191,456**
MADS Revenue	439,230			**439,230**
Development Income		1,312,675		**1,312,675**
Partnership Grants			476,322	**476,322**
Investment Income (Net)		(1,099,227)		**(1,099,227)**
Interest & Other	66,462	(4,237)	39,277	**101,502**
Beneficial Interest in Affiliate	(2,528,850)	1,166		
Total Revenue	**20,168,298**	**210,377**	**515,599**	**23,421,958**
Total Expenses	**20,105,834**	**2,739,227**	**514,433**	**23,359,494**
Net Gain	**62,464**	**(2,528,850)**	**1,166**	**62,464**
Net w/o Beneficial Interest	*2,591,314*	*(2,530,016)*		
Net w/o Investments				***1,161,691***

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

CHC's total drug cost per patient day for the last 13 months as reported to us by our drug vendor, Optum continues to trend down. Our average drug cost per patient day for 2018 was $4.35 Per Patient Day (PPD). The declining cost trend line seen below shows significant progress made during the year. December of 2018 had a cost of $3.84 PPD. Optum has reported we are their #4 best performer nationally for economical drug utilization. This puts us in the top 1.4% of their client hospices when comparing economical drug prescribing. Optum provides drugs nationally to 84,000 hospice patients daily and they have 285 clients. To be in their top four performing clients on a national basis is a great honor and is testimony as to how well our medical staff is performing on cost savings as measured by this metric.



We signed a contract with the Elkhart Medical Clinic, which took effect on January 15, 2019. It allows for Dr. Ahansul Haque, MD to provide services to CHC as a CHC hospice physician, which includes taking call, conducting Interdisciplinary Team meetings, being available for calls up to a half-time as a hospice physician, and completing patient documentation. In the 22 days following the initiation of this contract, we have admitted 11 patients from the Elkhart Clinic. Our hopes are that this relationship continues to be mutually beneficial.

CHC Chief Medical Officer, Gregory Gifford, MD, JD, and CHC Hospice Physician, George Drake both passed their Board recertification exams in Hospice and Palliative Medicine. They took the exams in December and just recently learned the results.

Sandra Roland, M.D., a former Interventional Radiologist at St. Joseph Medical Center in Mishawaka, has just started doing face-to-face visits for us on a contract basis.

Larry Rice, M.Div., M.B.A., our Chaplain Coordinator, has been promoted to the position of Director of Support Services. Reporting to him will be our Social Work Coordinator, our Bereavement Coordinator, and the Chaplains.

Karissa Misner, D.O., M.P.T., has signed a contract to begin working with us full-time on September 3, 2019. Over this year she is completing her Hospice and Palliative Medicine Fellowship training at a program in Macon, Georgia.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

The Nursing Goals for 2019 have been established. They are reviewed, and progress is updated monthly at the Nursing Leadership Meeting. All 2018 Nursing Goals have been met except for "Preceptor Program is to be revised and updated." This goal will continue into 2019.

During October and November Flu shots were offered to all CHC staff. A total of 183 Flu shots were administered and all employees with direct patient contact received the immunization.

Kathy Kloss, RN MS Clinical Education Coordinator, Abby Eicher RN Case Manager, and Julie Kos RN Emergency/Visit Nurse Passed the Certified Hospice and Palliative Care exam (CHPN) in December. The exam focused specifically on hospice and palliative care nursing concepts.

All the clinical RN's and LPN's completed a 10-module course End of Life Nursing Education Consortium (ELNEC) which focuses on end of life care for the pediatric patient.

Rebecca Fear RN CHPN, Coordinator of Quality and Medical Records, has been appointed to the NHPCO (National Hospice Palliative Care Organization) as a member of the Quality and Standards Committee. Tammy Huyvaert RN, MS Assistant Director of Nursing, has been appointed to the NHPCO Professional Education Committee Education Programs. The interest in committee participation was largely based upon the enthusiastic response staff had to NHPCO Pres/CEO Edo Banach's visit to CHC this past July.

Southwestern Michigan College has signed a contract with CHC for a clinical site for their Senior RN students. This began last month.

A Skills Fair was held in November for all RN's and LPN's to maintain a current competency of their clinical skills; there was 100% completion.

We believe we continue to be "survey" ready in preparation for Indiana State Department of Health Home survey for home health license and Medicare recertification. 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 in South Bend, Elkhart and Plymouth.

The Nursing Department is continuing to evaluate the Triage Program and to improve on the process related to the response to calls. Two areas of improvement will be the incoming phone calls will rotate as they come into triage allowing the families/patients not to wait or be on hold. We have identified high call volume times and will be allocating staff to the high-volume times adjusting their work hours. The changes have resulted in additional phone coverage from 3:00pm until 8:00 pm where we receive a higher volume of calls. The additional coverage was a result of realigning present triage positions without adding additional staff.

Quality Improvement year-to-date summary:

- Medication orders—new tracking and notifications to the nurses and Patient Care Coordinators (PCCs)
- Care Planning Monitors
- Supervisory Visits—monitoring by PCC's with individual Plans of Care
- Live Discharge data review
- Specialty Programs data review
- ECF documentation and Chart set up
- HIS measures: Interdisciplinary Visits at the end-of -life

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, for our two separate 501(c)3 organization, Hospice Foundation (HF), and Global Partners in Care (GPIC) presents this update for informational purposes to the CHC Board…

;Fund Raising Comparative Summary

Through December 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	1,173,928.93
December	1,665,645.96	1,757,042.51	2,018,630.54	2,730,551.86	$1,635,368.33

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	94,053.07
December	193,065.45	161,519.80	138,328.11	286,687.74	191,211.72
Total	**1,033,125.99**	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**	**1,134,560.06**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in November & December 2018 and January 2019 included implementation of the Crossroads Campaign Final Year Plan, the principal goals of which are to: (1) raise an additional $1.3 million in capital funding; (2) surpass the Annual Giving aggregate goal of the campaign; and (3) raise the remaining $550,000 of the $1,000,000 Vera Z. Dwyer Charitable Trust's matching gift challenge.

As we move through the final months of our comprehensive campaign, now in its 55th month (7/1/14 thru 1/31/19), cash, pledges and documented bequests now total $11,580,844. Because of cultivation efforts from a member of our Campaign Cabinet, we have a verbal commitment for an

unrestricted gift of $500,000. We anticipate a signed pledge form soon and have scheduled a follow up meeting with this donor to discuss naming opportunities and other details. Our annual donor stewardship and cultivation efforts in Florida take place from February 25 to 28. We are scheduling individual meetings along with hosting an event at the Naples home of friends of Campaign Cabinet member Denny Beville.

Planned Giving

Estate gifts since the last report totaled $25,850. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients.

Annual Giving

Our Annual Appeal, which was mailed in late November, is focused on securing gifts for the remaining underfunded priorities of the Crossroads Campaign. The annual appeal mailing list was subdivided with the same brochure going to everyone, but with different letters. One letter went to the small subset of donors who have already made a significant campaign gift, and another to the rest of our annual appeal list. So far, the annual appeal is performing in a similar level as compared with recent years.

Special Events & Projects

There are several special events on the horizon, including the 35th Helping Hands Award Dinner on May 1, 2019 honoring Catherine Hiler. The Dinner Committee Chairs are Stephanie & Todd Schurz and Kurt Janowsky. Planning for the event is going very well. A reception will be held for this year's Vera Z. Dwyer Fellow on for April 10.

HF completed its donor base conversion from Raiser's Edge to Bloomerang in November. As with any conversion, adjusting to the new system has presented several challenges and opportunities. That said, the ease of use and cost savings will make the switch to Bloomerang well worth the temporary pain of the conversion. We're saving about $30,000 a year or 67% by this switch.

PCAU

The Uganda Ministry of Education recently approved the Advanced Diploma in Palliative Care Nursing which will be offered at the Mulago School of Nursing and Midwifery. This program will replace the course at Hospice Africa Uganda (HAU) that has provided palliative care training for nurses and clinical officers who then return to their districts to provide palliative care. This program is unique because it will develop a cadre of specialized nurses capable of assessing and managing pain and symptoms as well as suffering caused by serious chronic illnesses. It is tailored to the knowledge and skills gap of the nurses, as identified in the communities where palliative care will be provided. These nurses will prescribe medications to relieve pain and other symptoms. It also draws from the wide experiences and technical expertise of current palliative care practitioners, as well as best practices in the country. Due to significant efficiencies offered by the government-supported Mulago program, the funding levels historically provided by HF will go much further. Instead of supporting eight students annually, comparable funding levels will now be sufficient to support 30 students per year in the new program. The first cohort of students were interviewed at the end of January and classes will begin mid-February. The first cohort will include 15 HF-

supported students; a second cohort of 15 HF-supported students will enter the program in July. In addition to providing student funding, HF also assisted in supporting training of program tutors last fall. The Palliative Care Association of Uganda (PCAU) will continue to provide oversight and support for the program as needed, as well as working with the five clinical placement training sites.

The mHealth surveillance system to collect accurate, timely data on palliative care throughout Uganda continues to progress. Activities in process include training of new participants at Gulu Regional Referral Hospital, meetings with the Ministry of Health to discuss the integration of the palliative care data into ministry data systems, and coordination with the palliative care technical working group on the development of palliative care register and national indicators.

Planning is underway for The Uganda Cancer & Palliative Care Conference which will take place in Kampala September 5-6. The theme will be "Towards Universal Health Coverage." As in previous years, CHC staff members will be encouraged to submit abstracts for consideration by the conference's scientific committee. The committee will select two employees to present at the conference as part of the bi-annual CHC/PCAU staff exchange program. In addition, some HF team members will also be presenting at the conference and participating in various meetings related to the many initiatives currently in process and some under development.

Road to Hope Program

Our international volunteer and former employee, Roberta Spencer, traveled to Uganda at the end of January to work with PCAU staff preparing for/holding the 2nd annual empowerment retreat for older students. The retreat was attended by 21 Road to Hope program students who were divided into two groups: those who attended last year and those who attended for the first time. The theme for the Level 2 group was: *I know Who I Am – I Can*. The theme for the Level 1 Group was the same as last year: *I Know Who I Am – I'm Special*. Their scheduled sessions were like those from last year: self-awareness, self-esteem, coping with emotions, finances, making good friends and peer resistance. The returning students were on a different track of learning: decision making, goal setting and achievement, self-expression and communication, positive sexuality, time keeping/ management, and money matters. Late afternoons were for games; evenings for a movie, talent show and personal sharing.

Roberta reported that the older students know the meaning of "being sponsored," know the names of their sponsors and struggle to find the words to express their appreciation and thanks. They had many questions about their sponsors. And although some sponsors have written letters about themselves and their families, the students wanted to know more: what type of job do they have, do they have children/grandchildren, are they married, do they have a house, are they happy, has Roberta met them and talked with them, how do we get sponsors, where do we get money if no one sponsors a child, etc. Their main question is: Why would someone spend money to support a child they don't know and have never met?

To maximize financial and staff efficiencies, the camp for younger students was held later in the same week.

We've been approached by Clay United Methodist Church to share information about the Road to Hope program with members of their congregation. To begin the dialogue, we will hold a screening

of the award-winning, *Road to Hope* documentary film on Thursday, March 21st at the Clay Church Firehouse Campus.

Education

The Center for Education & Advance Care Planning (CEACP) hosted the inaugural "Cupcakes to Die for" event in early December. This event aimed to bring together area professionals and organizations that work in fields relating to end-of-life issues. Through this event the CEACP was able to spark interest among multiple organizations for this event to be brought to their businesses. CEACP, and Primrose Retirement community will be working together to bring "Cupcakes to Die for" to their residents and families on February 19th.

In collaboration with the Hospice Foundation of America (HFA), we will be hosting a series of public webinars, which will offer continuing education (CE) credits for area professionals. We're bringing a comprehensive webinar package to employees through HFA and the National Hospice and Palliative Care Organization (NHPCO). The webinar offerings are being shown during both the live showing times as well as in the evenings to ensure their availability to all who are interested, both internally and externally. Detailed information may be found on the new Center for Education & Advance Care Planning website, along with information on end-of-life education and issues: www.educate4endoflife.org.

NHPCO began a grassroots initiative called the MyHospice Campaign during the latter half of 2018. The Community Education Coordinator at CEACP has represented the Hospice Foundation through strategic planning meetings each month to determine how best to bring hospice discussions to the forefront of legislators' minds. The CHC Pres/CEO has also been serving on the overall Advisory Council, composed of Hospice Action Network board members, for this national campaign for the last two years.

The Trusted Advisor Panel Discussion series begins this February after weather postponed the first discussion in January. The panel will include local trusted advisors who will discuss their experiences and answer questions on end-of-life issues. They will provide expert commentary on topics such as funeral planning, estate planning, real estate and insurance planning. The first discussion will be held in Elkhart on February 28th at The Lerner.

Honoring Choices® Indiana – North Central will host First Steps Facilitator Certification training for 24 participants on March 7th and 13th. Three CHC/HF employees will receive training, along with HC board members, REAL Services staff and representatives from each of the funding health systems (Goshen, Beacon and St. Joseph Health Systems). Once certified these facilitators will be able to work with healthy adults to complete their advance directives.

HF Chief Development Officer, Chris Taelman, will be participating in the Healthcare Foundation of La Porte's 2019 Nonprofit Leadership Academy. The foundation is providing the academy to nonprofit leaders at no charge –except for the cost of lunch. It is being conducted through Indiana University's Executive Education Department at the School of Public and Environmental Affairs. Chris will be traveling to La Porte to participate in the program for two days each month beginning from February through June.

Mishawaka Campus

Construction continues at the Clinical Staff Building and drywall is nearly complete; painting and tile installation is underway. 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*. The building is now completely enclosed and interior work is well underway. We 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.

Residential Housing

Construction on the first of two Helman Sechrist-designed homes is nearly complete. The home has been listed on the MLS with an asking price of $379,900.

GLOBAL PARTNERS IN CARE UDPATE (GPIC)

GPIC activities for 2019 will center around three main goals: 1.) Develop our programs in a collaborative way that enhances access to palliative care worldwide. We will focus activities in three main areas: a.) Research and Education – build relationships with universities to expand engagement in research and opportunities for learning; b.) Global Collaboration – elevate GPIC on the international stage through collaborative endeavors and building relationships with other key players; c.) Partnership Program – continue to develop and provide enhanced support to our current partners and establish new partnerships around the globe. 2.) Effectively communicate GPIC branding and raise the profile of GPIC internationally. We will primarily focus on our communication and reporting of GPIC work to raise awareness of and build support for our work. 3.) Establish financial and operational sustainability for GPIC. Working from a financial sustainability plan, we will focus the identified key areas to establish sustainable financial support for GPIC. We will also develop a three-year strategic plan by the end of 2019.

Website update

The new GPIC website is live. It contains new and improved content, but also reflects the branding scheme of the Hospice Foundation. We are still adding more partnership stories, but we did not want this to hold up the launch of the new site.

Financial Sustainability

The Financial Sustainability Task Force met in November 2018. This group provided guidance on our strategy and activities to grow GPIC financially. We have outlined a fundraising plan for 2019 which will focus on: increasing partnership revenue, securing grant funding, and increasing

individual donor giving. In 2018, GPIC expenditures were less than expected and income was more than expected. We expect to continue this trend in 2019 and have GPIC at minimum breaking even or hopefully, achieving a positive net gain.

Partnerships

We spent much of 2018 following up with each partner and despite our persistence there were a handful who never responded to our emails, phone calls or other attempts to connect with them. These US partners were sent a letter in December stating that their partnership would be dissolved if we didn't hear from them by end of year. We have moved ahead dissolving these and are contacting both US and international partners. This leaves us with 40 partnerships. Unfortunately, those dissolved includes the remaining partnerships we had in Nepal and India. We are actively working with folks in Nepal to establish new collaborations there and we believe we will quickly establish a new partnership between the US partner, who wants to continue working in Nepal, and the national association. On February 24th, Northwest Medicine DeKalb Hospice will hold its annual fundraiser for partner Knysna Sedgefield Hospice in South Africa. We have offered some support in planning and at least one GPIC staff member will be in attendance.

Partnership Surveys

In January, we sent an annual partnership survey to all current partners to capture data and stories on our partners. We expect to gather useful information that will help us measure the impact of our partnerships. Our response rate is currently below 20% right now so we are actively following up with partners to respond.

Potential Partners

We currently have 11 international applications and are actively looking for a good match. We have ten organizations (in the US, UK, and Australia) with which we are pursuing conversations about joining our Partnership Program.

Global Partnership Award

2018 Awardee: Helderberg Hospice (located in Somerset West, South Africa), and Hospice of the Western Reserve (located in Cleveland, OH) are the recipients of the 2018 Global Partnership Award. The award will be presented during the National Hospice and Palliative Care Organization's annual Leadership and Advocacy Conference on April 15th, 2019. The winner was selected based on a scoring process that we adapted from what has been used in previous years by NHPCO. Each partnership was interviewed during a Zoom call to share more about their partnership. Two Advisory Council members conducted the interviews, scored and provided feedback.

Research and Education

We are in conversation with Bluegrass Care Navigators (Lexington, KY whose CEO is a member of the National Hospice Executive Roundtable) and the African Palliative Care Association (APCA) to develop an initiative to establish Palliative Care Leadership Centers in Africa. Both partners are very excited about piloting this initiative.

In collaboration with the APCA, we are supporting a research project at the University of Alberta and will act as collaborators on this. The primary investigator is submitting a grant request to the Social Sciences and Humanities Research Council of Canada to pilot this project.

Internships

We have a new GPIC office intern. Carmen Alvarez is a junior at the University of Notre Dame studying biology and psychology. She will spend 8-10 hours a week with us supporting GPIC work in general. She will likely help us with US partner recruitment, developing resources for partners and support our work with APCA. She has some experience in fundraising, so we may have her help with that as well. In addition, we are interviewing potential interns to work with partners internationally and are currently interviewing two Oxford students, one of which will likely be placed with APCA.

Global Collaboration and Conferences

The Consortium of Universities for Global Health conference will be held March 8-10, 2019 in Chicago and will be a great opportunity for GPIC to network with this group of universities, as well as colleagues from Uganda and Rwanda who are presenting at the conference. We will have meetings with various university contacts to discuss collaboration (possibly through research or internships) as well as possible engagement with our partnership program.

The 6th International African Palliative Care Conference will be held September 17-20, 2019 in Kigali, Rwanda. We continue to work with APCA in planning the partnership track for this conference. We also intend to host a day-long preconference workshop for GPIC partners and are currently developing a proposal to seek funding to support this workshop. Cyndy Searfoss and Lacey Ahern are both representing GPIC on conference committees. Cyndy is on the Communication/Publicity Committee and Lacey is a member of the Scientific Committees.

NHPCO Leadership and Advocacy Conference

GPIC will hold a lunch meeting for GPIC partners and other interested individuals who may be interested in becoming a partner. The Global Partnership Award will be presented at that time. In addition to attending conference sessions, our team will have an exhibit booth to recruit new U.S. partners and will hold our annual in-person advisory council meeting. Mike Wargo, Cyndy Searfoss and Lacey Ahern will also be presenting a conference session entitled 'Strategies to Successfully Engage Your Community and Your Staff".

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for November, December and January.

Referral, Professional, & Community Outreach

Our Professional Relations Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In November through January our four Professional Relations Liaisons completed 1,362 visits to current and potential referral sources within our service area. They accomplished 385, 506 and 471 in November - January respectively.

Distribution of our upcoming webinars that CHC will be hosting for staff and community professionals has been met with enthusiasm. These 24 webinars will be split between our Mishawaka and Elkhart Campuses throughout the year and will allow professionals to acquire much needed Continuing Education Units for the minimal cost of $5. This is being coordinated in conjunction with our Center for Education & Advance Care Planning. A complete list of all webinars for 2019 is included as an attachment to this report. All board members are invited to attend, if they would like, to experience any subject matter of interest.

Access

In November we moved our Admissions Nursing Team from beneath clinical back to Marketing & Access. Almost immediately we saw an increase in admissions for the final months of 2018. We're continuing to grow our team and have hired an additional two nurses, one due to demand and another to replace one that was dismissed by our organization. Once these two new CHC RNs complete orientation and another is released from medical restrictions, we should be at a nearly full staff, with the last position to be filled being our Power Weekend Nurse.

Our Professional Relations Liaisons have been trained to conduct family meetings and how to sign consents. This training has already benefited our patients by beginning the admissions process sooner when Referral Specialists' schedules have been full due to previously scheduled meetings.

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 197,995 people for the November - January, and had 11,885 reactions, comments and shares. In January we surpassed 4,000 Facebook followers!

Our leading post was of CHC patient Bryan Czarnecki who was a huge Garth Brooks fan. To his disappointment, he became too ill to attend the recent concert at Notre Dame. However, Elkhart Police Patrolman Jay Peterson caught the attention of Garth recently with his in-car cover of "All Day Long". He was gracious enough to visit "Esther's House" and perform a few songs for Bryan and some of his family and friends and reached over 7,100 people. Our second most viewed post focused on the hospice team and reached 5,304 individuals. We also continue to share content through Twitter, Instagram and LinkedIn.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of November - January it generated 200 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 2.42% and we continue to be extraordinarily high at 10.7%.

MILTON ADULT DAY SERVICES UPDATE

CHC subleases space for Milton Adult Day Services (MADS) at 922 East Colfax, South Bend and shares a building with Alzheimer's and Dementia Services of Northern Indiana (ADSNI). ADSNI is owned by REAL Services. The building is owned by Beacon Health System. Our plan for some time has been to move the Roseland staff to the new Mishawaka clinical staff building in mid-summer, move the Roseland inpatient unit to the new Raclin House in October / late fall, begin needed remodeling of the Roseland facility for MADS and for ADSNI who may rent or purchase their portion of the building from CHC who own the property free and clear. Renovations and repurposing is necessary due to adult day regulations regarding space, bathrooms, etc. In November, REAL Services received a letter from Beacon indicating their intent to liquidate the East Colfax property. An appraisal was performed which we believe is much higher than the actual value of the building which needs a great deal of repairs and has a moisture issue. The appraiser did not see the building and simply used local comparables. REAL explained our situation and desire to stay until early 2020. Beacon responded by saying, "At this point in time, we do not feel it would be feasible to extend this lease through the end of 2019. We are currently reviewing our options to discontinue our relationship with Alzheimer's Services of Northern Indiana at the above referenced address." We are assuming that the property may be purchased by the South Bend Clinic which is across the street. They have already purchased a church and another parking lot close to MADS. CHC/HF are in the process of attempting to set up a meeting with the Beacon CEO and REAL is attempting to set a meeting with the new CEO of the South Bend Clinic to see if they are planning on buying it and we could rent from them until early 2020. Additionally, we have already begun looking at other available properties should we have to temporarily move prior to early 2020.

CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are five policies on the agenda for board approval. Three have just minor revisions for accuracy of all counties in our service area and to provide clarifications. They are:
-- Alerts in the Electronic Medical Record
-- Care Kits
-- ECF: Elder Justice Act Reporting

The two new policies are:
-- Inpatient Unit – Patient Transfer from IPU to Home Medications
-- Inpatient Unit – Weekly IDT Meeting
These are intended to improve patient care via scheduled communications and insure appropriate education of patients and family members on medications that may leave the inpatient unit and go home with the patient at the end of their stay in the unit.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MET IN JANUARY

The National Hospice Executive Roundtable met at member program, as we do each January, at the home town of our consultant, Peter Benjamin of The Huntington Consulting Group. Topics included program updates, and an entire day regarding positioning for the potential Medicare Hospice Managed Care carve-in and looking at the challenges and future of hospice care in America. We had two in-person guests, Jay Cushman, founder and President of HealthPivots DataLab in Portland, OR which is a premier analytics solution that provides critical data about the competitive landscape for health systems, hospices, home care agencies and skilled nursing facilities. Decision makers, leaders and analysts utilize HealthPivots DataLab, a web-based analytics platform, to assess agency progress, identify or align with partners, benchmark performance against competitors and leaders in the field, and support data-driven planning. CHC is a client. Jay has been a consultant in the healthcare field for the past 40 years with deep expertise in the post-acute sector. Since 1985, Jay has provided management consulting and health planning services, as well as expert testimony on the planning and regulation of health services. Jay was an early adopter of planning and analytics, developing custom software to exploit extensive health databases. The other guest was Lougie Anderson, MS and PhD in computer science, who is the CTO at HealthPivots. Lougie's role is to oversee the overall technology direction of HealthPivots. She is a thirty-six-year veteran of the computer industry with an extensive background in architecting and implementing complex, highly secure, distributed enterprise systems based upon her history of original research in the Internet, Object Technology, Database Design and Agile Management.

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

2018 ANNUAL GOALS RESULTS

Included in your packet is a copy of the final status for the 107 individual goals for 2017. The number of goals for 2018, at 107, was the highest ever and possibly a little too ambitious. Final status is broken down into four categories: "Met" means that the goal was achieved; "In Process" means the goal was started, but not yet completed during calendar year 2018 and likely carried over

to 2019; "Not Doing" means after evaluating the goal we decided that for whatever reason we were not going to do the project; and "Not Met" means that we simply didn't get to that goal at all or external factors made the goal no longer realistic. Results for 2018 are as follows:

Total Number of Published Goals = 107

Met = 71 (66%)
In Process = 17 (16%)
Not Met = 13 (12%)
Not Doing = 6 (6%)

For 2018, 78% of the 107 individual goals were either completed or were in the process of being completed at the end of the year. We are delighted to answer specific questions on any of the goals and their status at the end of the year.

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

2019 GOALS

Included in your packet are the 2019 Goals for Center for Hospice Care, Hospice Foundation, and Global Partners in Care. Like we have done every year for the past 19 years, we have placed individual goals under the traditional headings which match the four overarching goals of the Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with ideas and concepts from what line staff and middle management staff believes we should accomplish as a leading hospice organization which allows us to improve and enhance our agency and the care we deliver. For 2019, we have 92 individual goals.

2016-2018 STRATEGIC PLAN FINAL REPORT AND 2019-2021 STRATEGIC PLAN

Included in this board packet, for review purposes, is the 2016 – 2018 Strategic Plan, the Final Status Update of that plan in a significantly shorter presentation style, and the 2019 – 2021 Strategic Plan. The board has formerly approved the Strategic Plans in the past and it is my hope they will again. It should be noted that this newest strategic plan for 2019 -2021 contains items for the Hospice Foundation and Global Partners in Care. Those boards also are on the CHC Board and it seems more expeditious and manageable to present one plan for all three entities than three separate plans. I am happy to answer any questions and will be briefly covering the new plan as part of my President's Report at the board meeting.

BOARD COMMITTEE SERVICE OPPORTUNITIES

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

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 distributed hard copies of the bi-annual Board of Directors Self Evaluation along with a postage page return envelope. We asked in writing and at the meeting that all board members would remember that this is a Board Self-Evaluation requesting opinions 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. We indicated at the meeting that aggregate results would be included in the February 2019 board meeting packet. They are enclosed as an attachment to this report.

2018 BEREAVEMENT STATICS

- Of the total bereaved clients served (2,992), 22.0% are community, 70.7% are hospice and 7.3% are deaths before admissions (DBA)/other (other = bereaved of patients who discharged alive and then died).
- The Bereavement Department is averaging 143 deaths per month (including DBA/Other deaths).
- The Bereavement Department is averaging 156 identified bereaved per month (including DBA/Other bereaved).
- There were 20,963 contacts made to bereaved by mail and phone.
- The total of new bereaved admitted during 2018 = 2,424 (averaging 606 a quarter).
- Of the total individual/family counseling sessions (4,217) 2.5% were sessions with DBA/Other clients, 31.1% were sessions with hospice clients and 66.4% were sessions with community clients.
- Of the total group counseling sessions (3,549) 2.8% were sessions with DBA/Other Clients, 42.8% were sessions with hospice clients, 54.4% were sessions with community clients.
- Of the total Art Counseling Clients (38), 31.6% are hospice and 68.4% are community.
- 18% of the DBA/Other client population utilized more services than the mailing program.
- 27.7% of the hospice bereaved population utilized more services than the mailing program.

- The Annual Memorial Service had a total of 665 participants attending at our 3 locations. This is the fourth largest attendance since available records beginning in 2005.

- The Bereavement Department did 58 presentations in the community and for staff on a variety of grief and loss topics.

- A total of 41 individuals attended the 25th Annual Camp Evergreen in 2018. The weekend camp served 24 teen and youth campers with the help of 28 volunteers. The addition of a Family Workshop in the fall received positive feedback. In addition to the 9 youth that attended, the workshop requires a parent or other adult to attend with their campers and 7 parents and 1 aunt attended. Since 1994, the running total of campers that attended camp is 1,006 in addition to the 8 parents/adults that were served for the first time in 2018. Over 25 years, camp has served 944 individual (non-duplicated) campers and 8 parents/adults utilizing 582 staff and volunteers.

- Over the past 5 years, the bereavement department has served 3,052 bereaved on average each year (2014=3,037; 2015 = 3,100; 2016 = 3,001; 2017 = 3,132; 2018 = 2,992).

2018 VOLUNTEER SERVICES STATISTICS

Medicare hospice is the only provider required by federal statute to have a volunteer component. Like the required bereavement services for 13 months for family members, there is no reimbursement for the recruitment, training, annual education, or vaccinations for any of CHC's volunteers. We are required to provide a minimum of 5% direct patient care hours from volunteers when compared to direct patient care hours of paid, professional staff. Total volunteer hours of all types were down 2% from last year. CHC has always met the 5% minimum and the percentage to direct patient care hours came in at 7% for CHC for calendar year 2018. Below is the summary of 2018 Volunteer Hours compared to the previous year. While we have a wide variety of volunteer functions, only direct patient care hours are factored in the percentage calculation for Medicare. All hours are shown below and shared with the volunteers at the annual Volunteer Recognition coming up this year on April 9th.

Year To Date Volunteer Hours

As of December 31, 2018

Sort	Dedcription	Hours '18	Hours '17
1	Hospice House (Total)	3,186.38	3,791.60
1	Patient Phone Call	30.75	7.30
1	Patient Visit	5,376.28	5,343.18
2	Community Education		34.58
2	Community Relations	714.72	917.25
2	Training and Education	789.83	1,135.75
3	Bereavement Camp	1,056.80	990.55
3	Bereavement Groups	196.70	241.25
3	Bereavement Phone Call	115.75	200.87
3	Bereavement Visit	1.67	26.75
3	Bereavement Letter / Note	2.55	8.97

4	Bereavement Memorial Service	36.00	53.00
4	Fundraising	185.50	114.35
5	Administrative and General	3,704.11	3,088.55
5	Deliveries	93.58	108.58
5	Funeral Home	8.92	18.67
6	Veteran Program	47.88	79.80
7	Board Committees	67.28	69.17
7	Board of Directors	52.50	90.25
	Total Hours	**15,667.20**	**16,320.42**
	Total Miles	**49,760.00**	**51,636.00**
	Total Savings (2018)	**$407,224.77**	**$415,145.70**
	Valued at $24.69 / Hour and $0.41 / Mile		

1) Patient Care 2) Community Relations 3) Bereavement 4) Fundraising 5) Administrative & General 6) Veteran Program 7) Board of Directors

MedPAC SUGGESTS TWO PERCENT CUT TO HOSPICE IN FEDERAL FY 2020

The Medicare Payment Advisory Commission is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105-33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare. MedPAC releases reports to Congress several times a year and there is usually a chapter on Medicare hospice and always a recommendation on hospice payments for the next federal fiscal year. The most recent meeting took place in December 2018 and at that meeting concerns were raised about payment rates and providers with higher volumes of long stays continuing to have larger margins, particularly for-profits and it was noted that for-profit hospice margins are 16.8% and nonprofit hospice margins are 2.7%. They are projection an overall 2019 Medicare margin of 10.1%, which includes for-profits that comprise nearly 70% of all programs. The Chairman's draft recommendation was a 2% reduction for hospice reimbursement in federal FY 2020. This is effectively a 4% cut to hospice reimbursement beginning in October of this year because we are still dealing with the Congressional Sequester, which has cut 2% off all Medicare provider reimbursement since 2013. It should be noted that MedPAC can only make recommendations to Congress. Congress does not have to act on any of MedPACs recommendations, and frequently they do not. This topic of a negative percentage update will be a major push ("talking point") for the Hospice Action Network and our Hill Day on April 17th. In the past, MedPAC may have recommended a "0%" update, but many of us cannot remember a time where they suggested reducing hospice payments for a federal fiscal year.

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2019. This is the same statement used in previous years. It is signed each year by every member of the board of directors to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

OUT AND ABOUT

I attended the National Hospice Executive Roundtable meeting in Miami, FL on January 6 -8.

Several staff attended the annual Martin Luther King, Jr. breakfast at Century Center where CHC had a table on January 21.

I attended the Hospice Action Network and NHPCO Issues Session meetings in Phoenix, AZ on January 23-24.

I chaired the Board of Directors meeting for the Indiana Hospice and Palliative Care Organization on February 7th.

Several staff attended the annual Salute to Business luncheon on February 12 presented by the South Bend Regional Chamber of Commerce. CHC/HF had a table to hear Indiana Governor Eric Holcomb.

For the fourth time in as many years, I presented a lecture at the Mendoza College of Business at the University of Notre Dame on February 14 on "End-of-Life Care in America" for Dr. Jesse Hsieh's MBA class, "Innovations in Healthcare Transformations."

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

Dave Haley's Census Charts

Karl Holderman's Monthly dashboard summaries

2018 Goals Final Report

2019 Goals

Current Strategic Plan 2016-2018

Current Strategic Plan Status Update document

2019 – 2021 Strategic Plan

Conflict of Interest Policy Statement

Volunteer Newsletters for November, December, and January

Board Committee Service Opportunities

2018 Board Self-Evaluation Survey Results

Email thank you for student bereavement groups at Penn High School

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date December 2018 CHC Financials

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

2019 Board Roster

2019 CHC/HF Webinars

2019 HF Events Schedule

List of Board Committees

Perinatal Palliative Care brochure

Common Abbreviations (always handed out at board meetings)

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, May 15, 2019 at 7:15 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org .

# # #

Center for Hospice Care

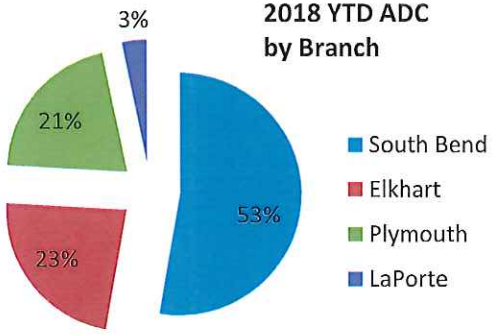
2018 YTD Average Daily Census (ADC)

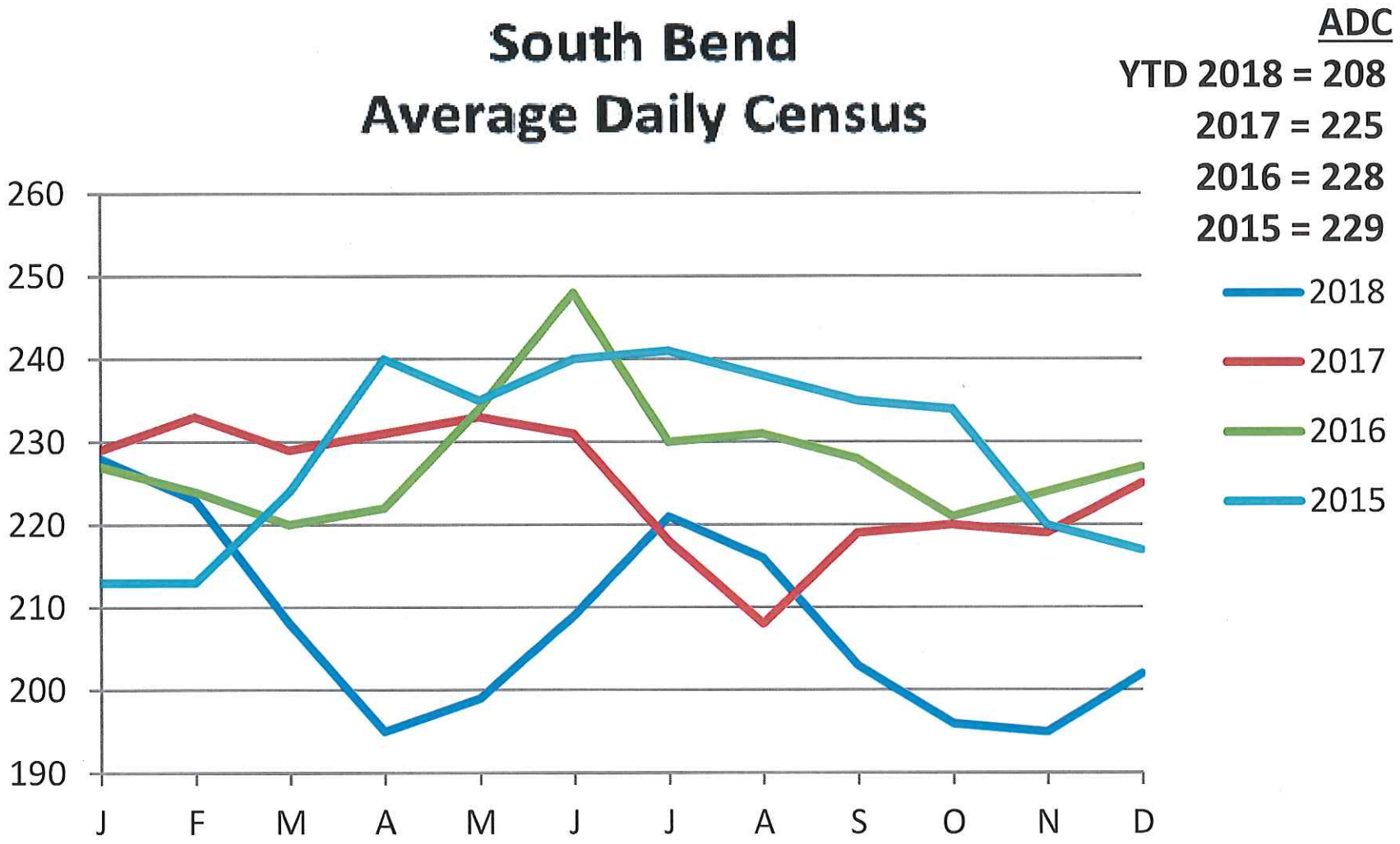
(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth	LaPorte
J	380	228	81	71	0
F	387	223	89	76	0
M	392	208	95	77	12
A	387	195	96	82	15
M	402	199	97	90	16
J	411	209	94	92	16
J	410	221	85	89	15
A	405	216	85	85	19
S	394	203	88	87	17
O	382	196	87	83	16
N	382	195	94	78	16
D	390	202	99	75	14
2018 YTD Totals	4722	2495	1090	985	156
2018 YTD ADC	**394**	**208**	**91**	**82**	**13**
2017 YTD ADC	384	225	90	69	0
YTD Change 2017 to 2018	10	-17	1	13	13
YTD % Change 2017 to 2018	**2.5%**	**-7.6%**	**0.9%**	**19.0%**	**NA**

2018 ADC by Branch

South Benc	53%
Elkhart	23%
Plymouth	21%
LaPorte	3%
All	100%




South Bend
Average Daily Census
ADC
YTD 2018 = 208
2017 = 225
2016 = 228
2015 = 229
2018
2017
2016
2015
260
250
240
230
220
210
200
190
J
F
M
A
M
J
J
A
S
O
N
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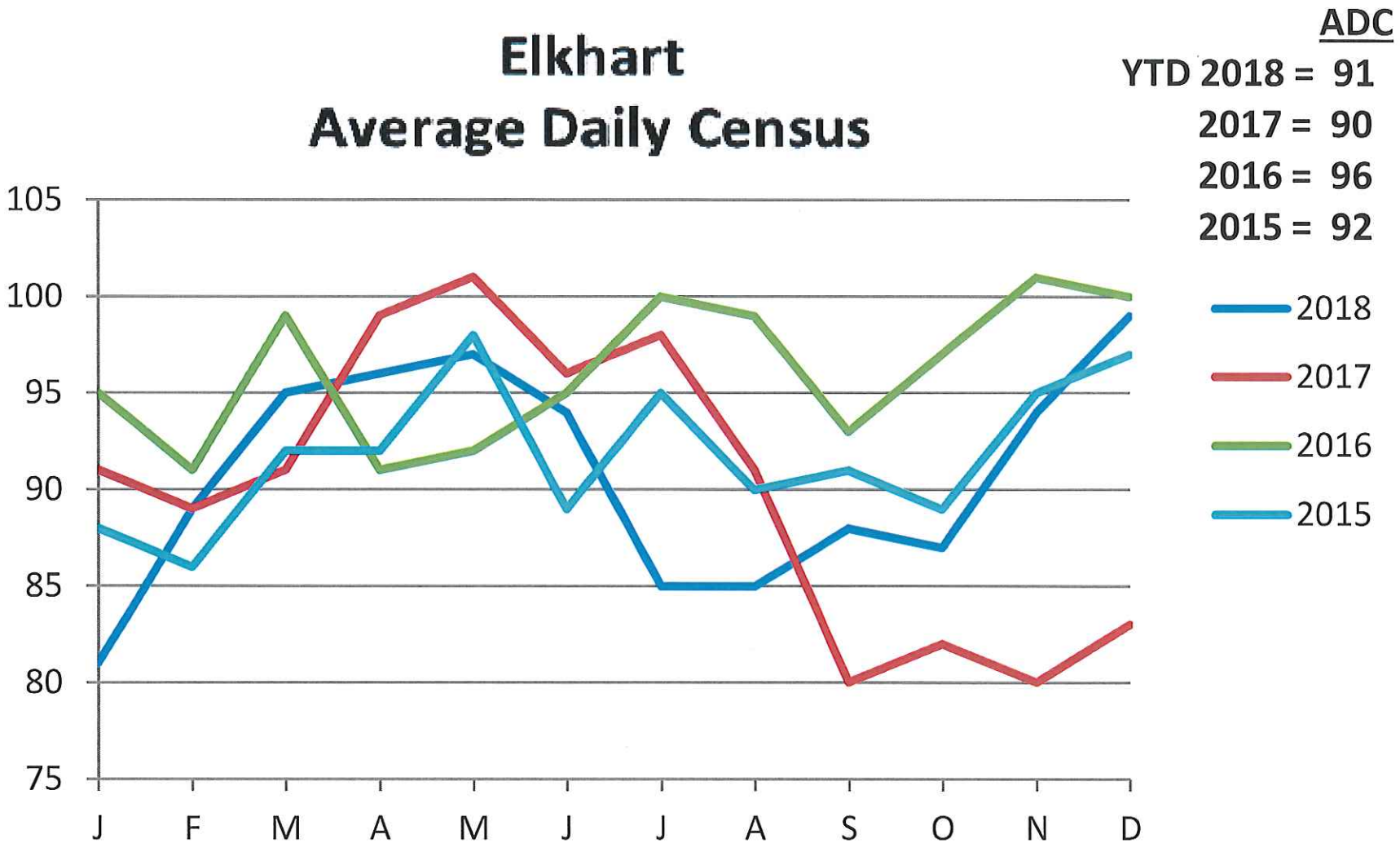
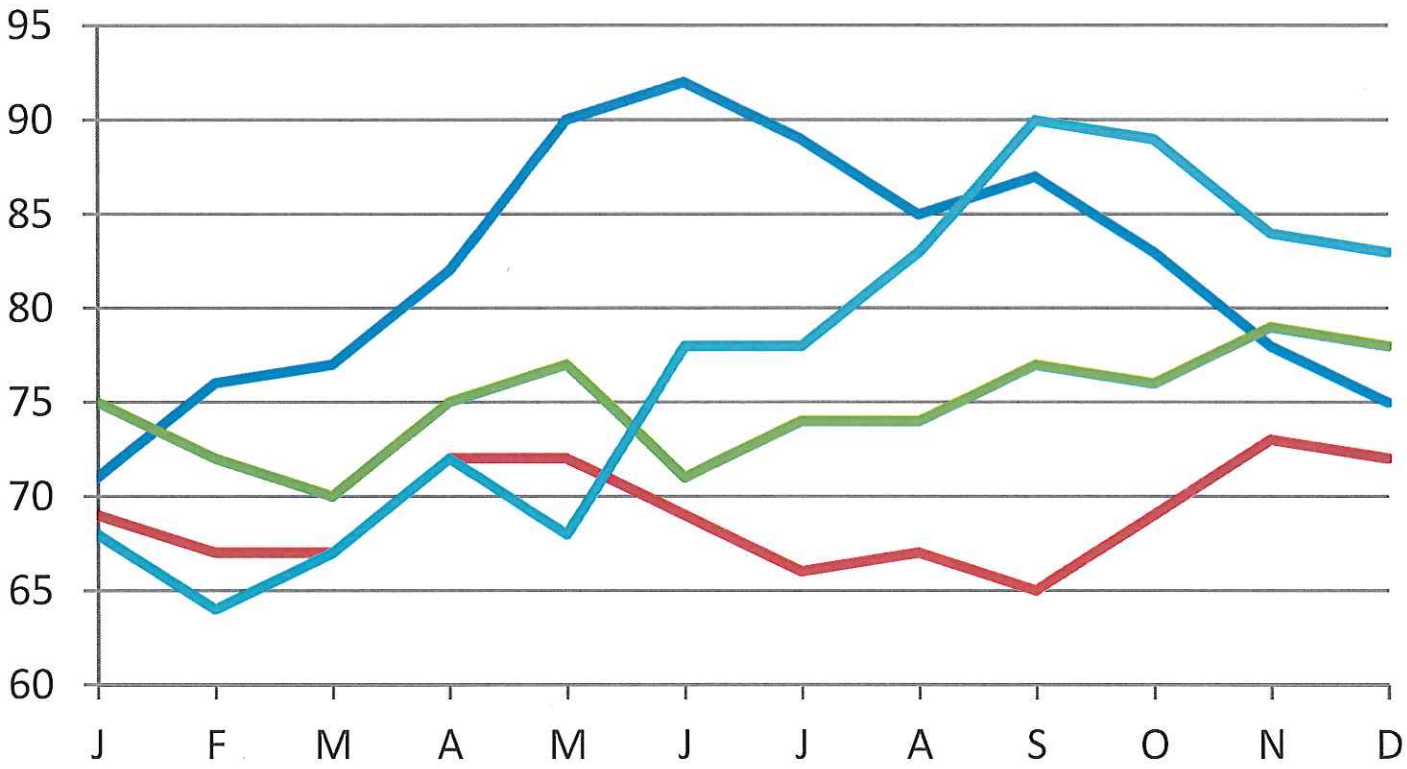
Elkhart
Average Daily Census



Plymouth
Average Daily Census



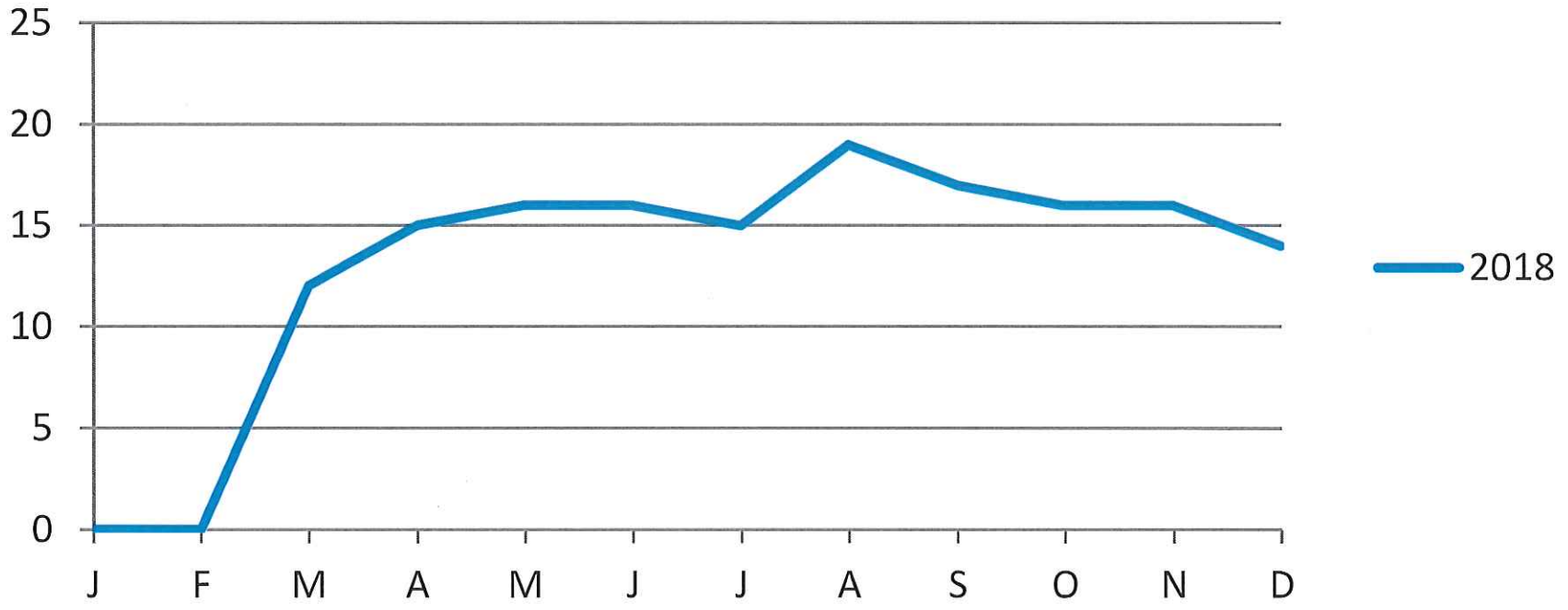
ADC

YTD 2018 = 82
2017 = 69
2016 = 75
2015 = 77

2018
2017
2016
2015

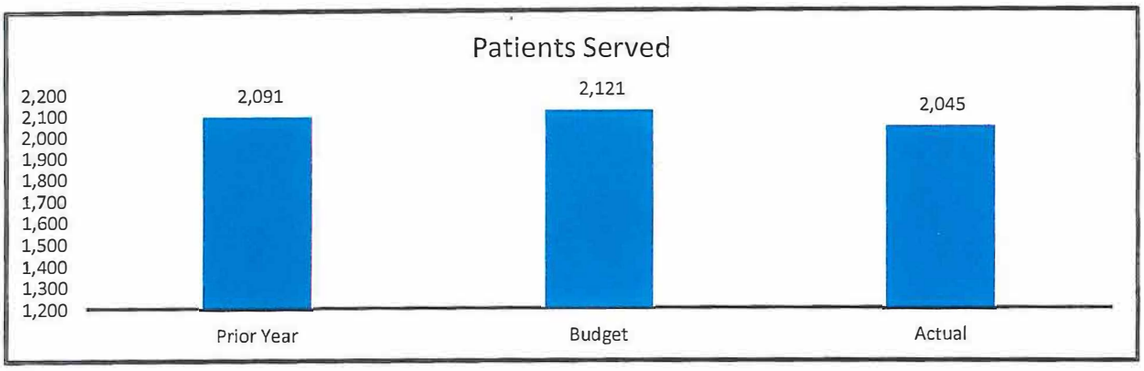
LaPorte
Average Daily Census

ADC
YTD 2018 = 13
2017 = 0

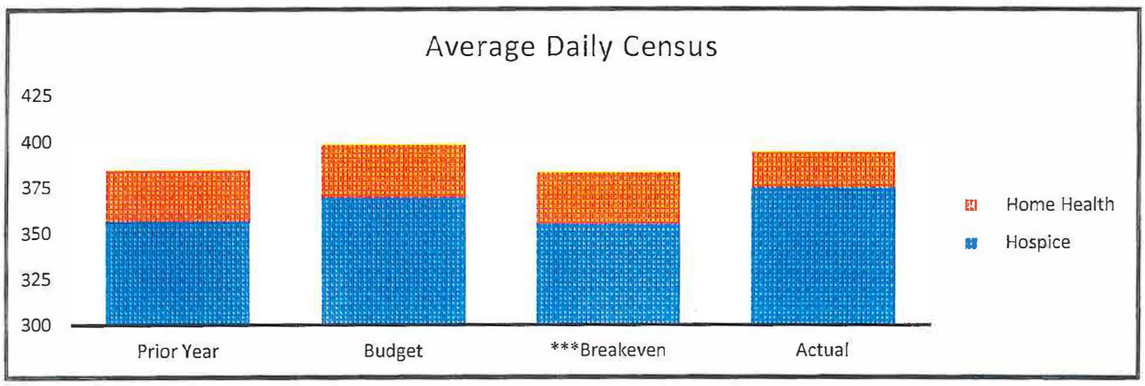


Center for Hospice Care
December 2018 Summary

	Prior Year	Budget	Actual
Patients Served	**2,091**	**2,121**	**2,045**

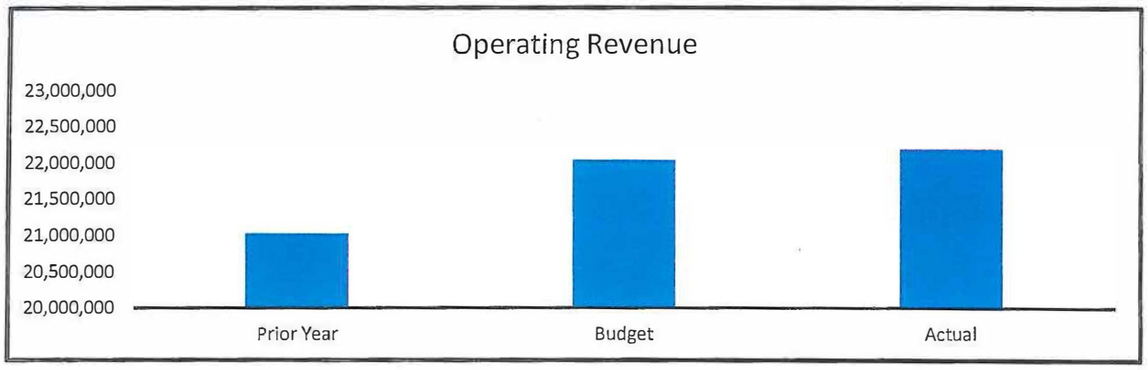


Average Daily Census	**Prior Year**	**Budget**	***Breakeven**	**Actual**
Hospice	356.34	369.00	354.98	374.88
Home Health	27.98	29.00	27.90	18.74
Total Average Daily Census	**384.32**	**398.00**	**382.88**	**393.62**

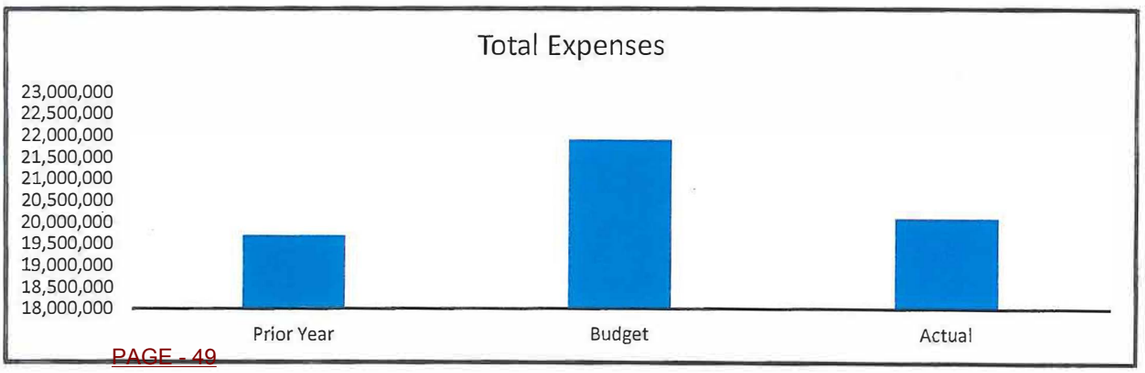


*** *Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	**21,024,411**	**22,040,766**	**22,191,456**



	Prior Year	Budget	Actual
Total Expenses	**19,688,050**	**21,894,110**	**20,105,834**



Center for Hospice Care

Goals for Calendar Year 2018

Updated 01/28/19

Goal A: Enhance Patient Care

Category	Status	Goal
Administration	In Process	1. Develop a specific pediatric palliative care program along with the marketing materials to support it with an emphasis on CHC clinical staff having been trained in the ELNEC Pediatric Palliative Care education modules.
	Not Doing	2. Begin customization and implementation of the "Every Person. Every Time" model of patient care.
	Met	3. Formally offer to bring an FTE in-house to coordinate the efforts of Honoring Choices Indiana-North Central on End-of-Life Wishes.
	Met	4. Adopt the PPS scale (or another approach to predictive analysis) to determine at admissions which patients have the greatest chances of expiring in seven days or less, and increase the immediate scheduling of the number of RN and social work visits to those patients.
	Not Met	5. Begin to quietly market the availability of private pay room and board residential care in Hospice House with a two week up front and refundable daily fee based upon the average area nursing home daily rate.
	Met	6. Develop a dashboard for the CHC Board of Directors.
	Not Met	7. Establish a CHC new orientation program including all departments in conjunction with Nursing, Human Resources, Hospice Foundation, and Administration.
	In Process	8. Develop a community-based palliative care program.
Admissions	Not Met	1. Increase same day/next day referral admissions to 58%.
	Met	2. Increase admission representative PA to Admission conversion rate to 70%.
	Met	3. Continue tracking palliative care consults and patients that admit by location of consultation, number of days between consult and hospice admission.
	Met	4. Have 100% of admission nurses working on or complete the Pediatric ELNEC.
	Met	5. Have 75% of admission nurses either have their CHPN or working towards it. This is going to be a house-wide initiative for the education—all nurses are to have their CHPN within two years of working at CHC.
	Met	6. PA to admission conversion rate to 75% for nurses.
	Met	7. Medication charting compliance to 97%.
	Met	8. Begin tracking PA to admission time, as well as continue to track referral to PA time tracking.
	Met	9. Start tracking live discharges, reason for discharge, and if the patient gets readmitted.

Goals for Calendar Year 2018

Updated 01/28/19

Category	Status	Goal
	Met	10. Evaluate admission process in order to help increase efficiency.
Volunteers	Met	1. Complete revision of the Volunteer Department Policies and Procedures Manual.
	Met	2. Explore the use of electronic time sheets.
	Met	3. Expand recruitment efforts to include Spanish speaking volunteers.
	Met	4. Continue focus on acquiring home visit patient care volunteers.
	In Process	5. Pursue new volunteer opportunities, i.e., Peace of Mind – Celebration.
	Met	6. Offer volunteer orientation to current volunteers to refresh skills and rejuvenate.
	In Process	7. Develop new training options for current volunteers, i.e., communication and Dementia classes.
	Not Doing	8. Offer targeted orientation classes for specific groups, i.e., veterans, hair dressers, teens.
	Met	9. Recruitment, training, and placement of La Porte area volunteers.
Nursing	In Process	1. Establish a revised Nurse Preceptor Program.
	Met	2. Design and implement education, resources, and tools on Live Discharges for all staff.
	Met	3. Create and implement Home Health Quality Improvement Projects.
	Met	4. Establish a program for educational resources and trainings for nurses seeking CHPN Certification.
	Met	5. Identify strategies for ongoing clinical education and competency assessment for all nurses and nurse aides.
	Met	6. Identify and implement other clinical education programs and courses.
Bereavement	Met	1. Implement addition of basic grief information provided by CHC Bereavement staff on the grief support page of the CHC website.
	Met	2. Continue to improve bereavement counseling support for Veterans by having bereavement counselors complete the Tier One, Tier Two, and Tier Three Star Behavioral Health Providers Trainings.
	Met	3. Utilize a satisfaction survey for individual and family counseling clients.
Social Work	Not Doing	1. Explore possible risk stratification and assessment for patient problems related to caregiving.
	Met	2. Improve quality of care for veterans by having all social workers who have been employed for at least one year as of 01/01/17 complete the Star Behavioral Health Providers Tier One Veterans Training.
	Met	3. All social workers will complete Pediatric ELNEC training in hospice care.
	Met	4. Veteran pinnings will be attended by social workers assigned to patients and social workers will

Category	Status	Goal
		encourage other staff to attend.
Chaplains	Not Met	1. Each Chaplain will organize and conduct four hospice educational presentations for local ministerial-type associations or faith communities.
	Met	2. Develop an educational training plan for other CHC disciplines to increase awareness of the scope of spiritual care for hospice patients and families.
	Met	3. Evaluate the ongoing effectiveness of the Spiritual Comfort Measure (SCM) and Spiritual Health Assessment (SHA) by Chaplains for CHC patients and their primary caregivers.
	Not Doing	4. Advertise and implement a Clinical Pastoral Education (CPE) program through the HealthCare Chaplaincy Network (HCCN) at CHC.
Medical Directors	Met	1. Assist in recruitment of one or two more HPM physicians.
	Met	2. Assist in recruitment of more MD, DO, and NPs to assist with face-to-face visits.
	Not Met	3. Complete original COTIs within seven calendar days.
	Not Met	4. Decrease the backlog of COTIs to less than two months.
	Not Met	5. Assist in development of Hospital 30-day Readmission Reduction program.
	Not Met	6. Assist in development of High-Cost Insureds Home Care program.

Goal B: Position for Future Growth

Category	Status	Goal
Mishawaka Campus & Regional Expansion	Met	1. Begin construction on Clinical Staff Building.
	Met	2. Begin construction on Ernestine M. Raclin House.
	Met	3. Acquire final Madison Street home.
	In Process	4. Construct first Cedar Street home to be sold (two-story).
	Met	5. Complete rezoning and Mishawaka Campus replat as needed.
	Met	6. Work with City of Mishawaka in an effort to vacate Madison and Pine Streets.
Global Partners in Care	Met	1. Develop a five year pro forma.
	In Process	2. Identify external sources of funding.
	In Process	3. Release five-year Strategic Plan.
	Met	4. Develop a plan to recruit U.S. partners.
	Met	5. Launch new partner application process.
	Met	6. Develop new partnership materials.
	Met	7. Establish at least one new university relationship.
	Met	8. Establish student internship with GPIC.
	Met	9. Establish relationship with at least one other AAHPM Fellowship program to facilitate four-week rotations with collaborative GPIC partners in Sub-Saharan Africa.
PCAU	Met	1. Facilitate Biennial PCAU Exchange Visit.
	Met	2. Review and revise Road to Hope sponsorship guidelines.
	Met	3. Identify funding sources for next phase of mHealth project.
	In Process	4. Obtain distribution for Road to Hope documentary.
	In Process	5. Publish 10-year PCAU Report.
Education	Met	1. Hire Education Coordinator.
	Not Met	2. Certify at least two Hospice Foundation staff members as facilitators and integrate Honoring Choices Indiana-North Central into community education curriculum.
	In Process	3. Leverage the Leighton Foundation challenge grant for palliative care to support CHC's palliative care priorities.

Category	Status	Goal
	Not Doing	4. Develop online video education series about end-of-life planning using various local area professionals.
	Met	5. Work with IU South Bend to establish Palliative Care Certification Program.
	Met	6. Develop branded recruiting materials to market the Vera Z. Dwyer Fellowship to area physicians.
	Met	7. Bring IUSM-Indianapolis' IU Talk to the region.
	In Process	8. Develop an internship program with IUSM-South Bend.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship	Met	1. Develop a ROI methodology to determine financial success of fundraising events.
	Met	2. Develop a Raclin House brochure for use in fundraising activities.
	Met	3. Pursue Healthcare Foundation of LaPorte County opportunities.
	Not Doing	4. Launch campaign to build fund at Community Foundation of Elkhart County to $1MM.
	Met	5. Initiate a targeted Physician component to support the Crossroads Campaign.
	In Process	6. Kamm Society roll out.
	Met	7. Host two donor events in Florida.
	Met	8. Host Dwyer Fellowship event to publicly announce the gift and challenge grant.
	In Process	9. Raise remaining $850,000 to complete Dwyer match for HPM Fellowship.
	In Process	10. Complete $5MM Crossroads Campaign capital fundraising goal.
	Met	11. Begin working to secure funding to create and endow CHC's Community Diversity Outreach positions.
	Met	12. Host an event to celebrate the 10th Anniversary of the Elkhart Campus.
	Met	13. Host an event in honor of Camp Evergreen's 25th Anniversary.
	Met	14. Rededicate the Veteran's Memorial as the Robert E. Hiler, Jr., Veteran's Memorial.
	Met	15. Groundbreaking ceremony and reception for the Ernestine M. Raclin House.

Goal D: Continue Building Brand Identification

Category	Status	Goal
HF Marketing	Met	1. Introduce new Hospice Foundation website.
	In Process	2. Develop a comprehensive PR and communication plan for the Hospice Foundation.
	In Process	3. Complete Hospice Foundation branding documents.
CHC Marketing	Met	1. Increase market share in the following counties (all settings): Elkhart 38%, LaPorte 9%, Marshall 58%, St. Joseph 54%.
	Not Met	2. Increase referrals by 5%.
	Met	3. Focus on non-cancer physicians and illnesses to increase the MLOS by 7% (MLOS of 14 days) utilizing statistics and data from HeartWize, BreatheEasy, Dementia Program, Pain Assessment, Response Time.
	Met	4. Conduct customer service training for intake department and admission representatives.
	Met	5. Re-emphasize WHV and actively recruit community partners.
	In Process	6. Convert CHC and MADS websites to Wordpress with branding similar to FoundationForHospice.org.
	Not Met	7. Increase ECF admissions by 5%.
	In Process	8. Help establish and promote Pet Peace of Mind.
	Met	9. Create marketing materials for MADS.
	Met	10. Incorporate Marketing component into existing orientation for new employees.
	Met	11. Develop standard responses for common objections, i.e., *Every Patient Every Time.*

Center for Hospice Care

Goals for Calendar Year 2019

Updated 02/11/19

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Review all commercial insurance plans for current rates, assignability, and discounts. 2. Review all job descriptions to insure they are accurate for current practices, particularly as the organization has grown and added new entities with overlapping staff. 3. Begin the process of redomesticating GPIC from New York to Indiana. 4. Begin the repurpose of 111 Sunnybrook for Milton Adult Day Services.
Admissions		1. Increase same day referral/admissions to 55%. 2. Increase admission RN PA to Admission conversion rate to 72%. 3. Ensure 100% of admission nurses complete Pediatric ELNEC. 4. Have 75% of Admission RNs complete or are working to complete CHPN. 5. Maintain admission medication charting compliance 97% or greater. 6. Continue tracking PA to Admission time, as well as continue to track referral to PA time tracking. 7. Continue tracking live discharges, reasons for discharge, and readmission rate. 8. Implement training sessions quarterly to educate Admission Representatives and RNs to overcome barriers to admissions. 9. Update intake form to improve triage at referral level.
Volunteers		1. Pursue new volunteer opportunities – Pet Peace of Mind. 2. Expand volunteer services provided to veteran patients and families – Level 5 Partners Activities. 3. Recruitment, training, and placement of LaPorte area volunteers. 4. Create targeted orientation classes for online module: veterans, hair dressers, pet visitor, etc. 5. Develop a minimum of one training option for current volunteers for online module. 6. Continue to evaluate and refine the annual skills validation process for Level 3 volunteers.
Nursing		1. Establish Nurse Preceptor Program. 2. Identify strategies to promote improved wound assessments and documentation.

Goals for Calendar Year 2019

Updated 02/11/19

Category	Status	Goal
		3. Identify strategies and tools to improve and streamline the IDT process through all branches. 4. Design and implement a "Hospice Language" to ensure all staff are presenting, responding, and training families and caregivers in a similar fashion. 5. Establish a CHC new orientation program, including all departments. 6. Review and update policies and procedures for Hospice and Home Health. 7. Increase CHPN certification by five registered nurses. 8. Open the 12-bed Mishawaka Inpatient Unit. 9. Review and implement an Action Plan to address the 2018 Employee Satisfaction Survey related to nursing strengths and weaknesses.
Bereavement		1. Create an admission packet tailored to the type of death/who died for new bereaved counseling clients, including general grief information, grief services booklet, online resources, booklists, etc. 2. Continue to improve bereavement counseling support for Veterans by having current bereavement counselors complete Tier Two and Tier Three Star Behavioral Health Providers Training, and have any newly hired bereavement counselors complete Tier One as trainings are available. 3. Explore providing group bereavement services to young adults, 18 to 24 years old.
Social Work		1. Create and implement an educational training plan to increase awareness of cultural competencies. 2. Create and implement a training plan for social workers and RNs to increase awareness of abuse and neglect. 3. Identify strategies for ongoing assessment for anticipatory grief with patients and families. 4. Identify and implement an assessment tool for anxiety and stress for patients and families.
Chaplains		1. Update the Chaplain Care plan template in Cerner. 2. Look into the possibility of hosting local ministerial association meetings at the Mishawaka Campus and Elkhart office. 3. Provide education to nursing, including IPU staff, social work, and bereavement departments via team meetings regarding the chaplain's scope of practice. 4. Host a Trauma Informed Care Seminar with Chaplain Gregg Fry from Oaklawn Psychiatric Center for patient care staff.
Medical Directors		1. Assist in recruitment of one more HPM physician. 2. Assist in recruitment of additional MD/DO/NPs to offload face-to-face visits.

Category	Status	Goal
		3. Complete original COTIs within 19 days on average. 4. Fully implement the relationship with the Elkhart Clinic. 5. Increase Palliative Care program at the Center for Palliative Care clinic. 6. Establish professional relationship with Dr. John Mulder's Grand Rapids Hospice and Palliative Medicine Fellowship program with opportunity for Fellow rotations at CHC.

Goal B: Position for Future Growth

Category	Status	Goal
Administration		1. Perform cost-benefit analysis to determine best options for Mishawaka Campus security and implement. 2. Revise Mishawaka Campus policies and procedures manual. 3. HF staff cross-functional training and organizational development program.
Mishawaka Campus & Regional Expansion		1. Construct first Cedar Street home to be sold (two-story). 2. Design Mishawka Campus landscaping master plan. 3. Complete construction on Clinical Staff Building. 4. Design and begin construction on new Milton facility. 5. Complete construction on Ernestine M. Raclin House. 6. Successfully transition Roseland staff and operations to Mishawaka Campus. 7. Campaign Celebration/Ribbon-Cutting.
Global Partners in Care		1. Release five-year Strategic Plan. 2. Identify external sources of funding.
PCAU		1. Review and revise Road to Hope sponsorship guidelines. 2. Publish 10-year PCAU report. 3. Devise a strategy for Road to Hope Fund's long-term sustainability. 4. Revise Road to Hope Fund website. 5. Work with PCAU to finalize establishment of a DCPC program at Mulago School of Nursing and Midwifery.

Category	Status	Goal
Education		1. Roll-out new Center for Education and Advance Care Planning website. 2. Develop branded recruiting materials to market the Vera Z. Dwyer Fellowship to area physicians. 3. Certify at least two HF staff members as facilitators and integrate Honoring Choices Indiana-NC into community education curriculum. 4. Investigate opportunities to use Okuyamba and Road to Hope for educational and fundraising purposes (called "Distribution" in 2018 goals). 5. Work with IUSM-SB to develop plan to incorporate Hospice and Palliative Care education in the curriculum. 6. Develop a medical student internship program with IUSM-SB. 7. Work closely with HCIN-NC board to develop fundraising strategies, marketing plan, and implementation of facilitator training throughout the community. 8. Work with IU South Bend to hire an endowed chair in Palliative Care and begin implementation of Palliative Care Certification Program. 9. Leverage the Leighton Foundation challenge grant for palliative care to support CHC's palliative care priorities.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship		1. Raise remaining $1.3M Crossroads Campaign capital fundraising goal. 2. Wrap-up Volunteer portion of the Crossroads Campaign. 3. Complete targeted Physician component to support Crossroads Campaign. 4. Kamm Society Rollout. 5. Post-Campaign Fundraising Plan. 6. Pursue HC Foundation of LaPorte County opportunities. 7. Raise remaining $600,000 to complete Dwyer match for HPM Fellowship. 8. Develop and initiate a Milton Adult Day Care fundraising plan. 9. Optimize Bloomerang for online fundraising. 10. Optimize Bloomerang for donor email campaigns.

Goal D: Continue Building Brand Identification

Category	Status	Goal
HF Marketing		1. Complete Hospice Foundation branding documents. 2. Develop revised social media strategy. 3. Develop a comprehensive PR and communications plan for HF.
CHC Marketing		1. Attain Level 5 of the We Honor Veterans program: (a) Recruit Community Partners (b) Incorporate Vietnam War Commemoration into WHV events. 2. Focus on ERs as hospice referral sources. 3. Create materials that focus on Home Health in SNFs. 4. Increase referrals by 5% (2,460). 5. Convert CHC and MADS websites to WordPress with branding like FoundationForHospice.org: (a) Focus on current most visited pages. (b) Make user friendly. 6. Increase ECF admissions by 5%. 7. Help establish and promote Pet Peace of Mind. 8. Create virtual tours of Esther's House and Raclin House.

The Envisioned Future

Center for Hospice Care
Hospice Foundation

Strategic Plan (2016 - 2018)

Overview

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

Envisioned Future

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

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

CHC will continue to have four overarching goals:

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

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

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

Strategic Priorities 2016 -2018:

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

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

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

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

5. Optimize engagement of diverse and underserved consumers.

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

Strategic Priorities: Plans and Objectives

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

2016 - 2018 Plans and Objectives

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

Strategic Plans:

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

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

Strategic Plans:

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

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

Strategic Plans:

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

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

Strategic Plans:

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

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

Strategic Plans:

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

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

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

Strategic Plans:

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

Respectfully submitted,

Mark M Murray
President / CEO

Center for Hospice Care
Hospice Foundation

February 2016

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Center for Hospice Care / Hospice Foundation

Strategic Plan 2016 – 2018

FINAL UPDATE

From Mark Murray, President/CE
February 2019

The Strategic Plan for 2016 – 2018 was approved by the CHC Board in February of 2016. The Plan has six specific Strategic Priorities, with each having multiple suggested plans to achieve the priorities over the course of three years. For space saving purposes, these suggested plans are not reproduced below. For clarity and review purposes, the 2016 – 2018 plan is attached immediately before this document.

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

Under the banner of Center for Education and Advance Care Planning, which is a component of the Hospice Foundation, we are working with many key stakeholders such as Saint Joseph Health System, Beacon Health System, members of the various faith communities, physicians, IU South Bend, IUSM – South Bend and the University of Notre Dame to help create a community culture that talks openly about health care choices, including end of life, and respects/honors those choices. This group has been meeting for several years to get this initiative going. CHC has been at the table for some time now and several staff members have served on various committees and sub-committees during that time. Two staff members currently serve as members of the steering committee. The consortium has adopted the name Honoring Choices™ Indiana - North Central (HCINC) and is operating as a d/b/a of our Hospice Foundation. The organization is housed in the Foundation offices. Honoring Choices is a national initiative committed to promoting and sustaining advance care planning (ACP) to ensure individuals' future health care preferences are discussed, documented, and honored. It is currently a 13-state network that shares information, resources, and best practices. Indiana has chosen this model to educate citizens statewide about end-of-life issues. Several organizations throughout Indiana have joined together to accelerate awareness, systems changes, and policy related to ACP. HCINC is charged with delivering quality ACP education in North Central Indiana. Much progress has been made during the past year, including hiring a part-time coordinator, whose salary is funded by contributions from the three main health systems serving Elkhart and St. Joseph County and other various stakeholders who will have the opportunity to underwrite the programming. By early 2019 we will have CHC/HF staff members who are trained in completing advance directives. In addition, we will have staff who will also be able to train facilitators through HCINC which will work in tandem with our Center for Education and Advance Care Planning to facilitate similar objectives. We are beginning this work in St. Joseph, Elkhart and Marshall counties with an eye toward expansion into the other counties in

which CHC operates. We will begin by training facilitators throughout the community who will work directly with individuals to assist them in completing advance directives. The Center for Education and Advance Care Planning website was recently launched and includes information targeted at three primary audiences: the community, trusted advisors and clinical professionals. We are currently offering several programs developed by the Hospice Foundation of America that provides continuing education units for social workers, counselors (particularly around bereavement), spiritual care providers, nurses and other clinical staff. We began offering these CEU-awarding courses in 2017 and this effort was expanded in 2018 through collaborative efforts with IU South Bend to include offerings for trusted advisors. We are also working with the IU School of Medicine to offer a program called "IU Talk," which provides physicians a facilitative environment in which to practice high-yield skills to better navigate difficult conversations around end-of-life issues with their patients. Permanent funding for this critical skills training was provided through a gift from the Vera Z. Dwyer Charitable Trust. The first offering took place in Fall 2018. Our plan is to offer this training on an annual basis.

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

This was to be originally accomplished through the customization and implementation of "Every Patient, Every Time" which was originally developed by National Hospice Executive Roundtable (NHERT) member, Hospice of Northwest Ohio, based in Toledo. A previous Administration Annual Goal was "Begin customization and implementation of the 'Every Patient. Every Time' model of patient care." I first became familiar with "Every Patient. Every Time" in mid-2015 while visiting Hospice of Northwest Ohio (HNWO) during a NHERT meeting. They had just finished developing the program and were very proud of it. At the time it seemed like a good plan for CHC to customize and implement. Since that time HNWO found the tool to be too unwieldy, greatly increase new staff onboarding time, and they have abandoned the project altogether. The staff there who originally put it in place are no longer employed by the hospice. In the last few years, CHC has been customizing some of the more useful concepts by adopting a much simpler but effective program based upon Susan Balfour, RN's trademarked program entitled "The Shape of the Visit." The intent is to assist hospice staff with creating a more effective and efficient patient visit while providing less variability from staff person to staff person. The hallmarks are 1.) Focus and Intention, 2.) Respect of Boundaries, 3.) Involvement of other disciplines, and 4.) Organizational skills. This leads to excellent management of patient and family needs, thorough and timely patient/family teaching, regular involvement of other disciplines in the care, and high visit productivity. It is designed to have visits go from an isolated, unconnected event to an intentionally designed interaction understood to be part of the continuum of care. In the Admissions Department specifically, we've taken the most common objections a patient or family may have for entry into our program and constructed standardized answers. These were modeled from our current Admissions Nurses who consistently have the highest patient conversion rates. Likewise, with the Referral Specialists, the tendency had been to provide way too much information over the phone rather than scheduling an in-person visit. Now, they're focused on listening to specific needs and match those services which would quickly benefit the patient and caregiver, schedule the meeting and be done. Our programming is

then described in more detail by the Admissions Nurse or Representative at the time of the in-person appointment. We also review each patient that is delayed or denied eligibility by our medical staff to insure all options are exhausted before the patient is deemed 'Not Eligible'. In this sense, the goal remains, 'Every Patient. Every Time." We plan on continuing to develop this project in 2019 and have a goal of designing and developing a common "Hospice Language" to ensure all staff are presenting, responding, and training families and caregivers in a similar fashion.

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

Thanks to the generosity of the Judd Leighton Foundation, we completed the build-out of our new Center for Palliative Care outpatient clinic on CHC's Mishawaka Campus in 2016. Once completed, we hosted an open house for medical providers, community leaders and centers of influence so they could see the facility and learn about our program. During the past two years we've made great strides in fostering ongoing collaborative relationships with other organizations interested in palliative care services, including area hospitals and physician offices. In addition, we have developed a series of educational materials and targeted communications designed to raise awareness of the palliative care services that we are now able to offer to the community. Because of the Leighton challenge grant, we have been able to generate additional funds to assist us in getting our palliative care program off the ground. We are currently working on developing a formal business plan and beginning to identify future potential funding sources to make the Center for Palliative Care self-sustaining in the future. As part of this effort, we are testing various market approaches to heightening awareness of the need for palliative care services. An internal "Palliative Care Summit" was held on February 7, 2018 with key CHC staffers to kick-off development of a Community-Based Palliative Care program. CHC has also become members of the national Center to Advance Palliative Care and has access to their resources. Additional resources are available to CHC as members of NHPCO, The Advisory Board Company, the NHERT, and HealthPivots LLC. Through the new educational arm of the Hospice Foundation, palliative care educational materials, video, and website materials are in development. We are working on the development of a specific pediatric palliative care program, which will include marketing materials emphasizing that CHC's clinical staff have been trained in the End-of-Life Nursing Education Consortium's Pediatric Palliative Care education modules. We've also developed a brochure and webpage content for our Perinatal Palliative Care Services. In addition, we are working closely with IU South Bend to establish a Palliative Care Certification Program.

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

Over the last two years, we have been able to deepen our relationships with higher education institutions such as IU South Bend, Indiana University School of Medicine, the University of Notre

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

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

One of the goals of our Cornerstones for Living: The Crossroads Campaign is to secure endowment funding to establish a fulltime staff position for Diversity and Community Outreach. We will continue to work on identifying funding sources throughout the remainder of the campaign. In the meantime, during 2016: CHC attended the African American Women Breast Cancer Awareness Conference in Michigan; attended the HIV Conference at Logan Center; and updated our Spanish Family Handbook and forms. During 2017: CHC attended the Monthly Diversity Committee Teleconference with the National Hospice and Palliative Care Organization; sponsored lunch and provided a presentation about advance directives at the Martin Luther King Center; met with Cherri Peat, Director of Community Outreach for the South Bend Mayor's office discussing diversity and inclusions; met with Christina Brooks, the Diversity and Inclusion Officer for the City of South Bend; attended the Human Rights Awareness Workshop and Luncheon at Century Center; attended NHPCO Management Leadership Conference in Washington, DC and attended a lunch meeting with the national Diversity Committee; arranged a meeting with key Staff and Cory Gathright, Director of the Interdenominational Ministerial Alliance of St. Joseph County discussing more ways of outreach; sponsored lunch at the Martin Luther King Center where CHC social work staff did presentation about caregiver tips on self-care; sponsored lunch at the Martin Luther King Center where a CHC RN presented to attendees about recent experience on losing her mother, being a care-giver, and battling cancer herself; had Eric Ivory, the Diversity Manager for Kem Krest in

Elkhart, speak to all employees at an All Staff meeting regarding Diversity and Inclusion; and CHC staff attended the Diversity and Inclusion Seminar in Westville at Purdue University Northwest that was presented by Human Resource Association and Greater LaPorte Chamber. CHC has: annually sponsored a table and attended the MLK Breakfast at Century Center. CHC has participated in a six-week "Diversity Dialogue" with the Near Northwest Neighborhood members which was facilitated by staff from the University of Notre Dame staff and the City of South Bend to discuss experiences and ways to better communicate and relate. We arranged for Diversity and Competency training with CHC staff by the LGBT Resource Center of St. Joseph County and had a presenter from La Casa de Amistad to come in-house to discuss barriers regarding hospice with the Hispanic community. As to seeking funding opportunities to reach new populations, we are continually seeking new funding / grant opportunities to grow our capacity to reach new populations and have been successful in obtaining multiple grants, including $500,000 from the Leighton Foundation to fund our expanding palliative care program, $500,000 from the Asante Foundation to fund a new inpatient unit to meet growing future demand, $1.75 Million from the Vera Z. Dwyer Trust to expand our community education initiatives as well as hospice and palliative medicine fellowship training to educate our future workforce and $1 Million from Ernie Raclin to establish the Ernestine M. Raclin House on our Mishawaka Campus. Finally, we are proud that CHC's internal diversity officer, Barb King, has been appointed the national "Diversity Advisory Council" for the National Hospice and Palliative Care Organization and will be presenting a session at the national Leadership and Advocacy Conference in April 2019 entitled "Let's Get Uncomfortable...Diversity, A Kaleidoscope of Care." with the intent of raising awareness of subconscious bias, how it influences care delivery, and how it can be overcome leading to a culturally sensitive and inclusive patient experience.

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

When a CHC employee observes a co-worker, who is exemplifying CHC's core values (Compassion, Dignity, Innovation, Integrity, Quality, Service & Stewardship) that creates a memorable experience for a patient, family, volunteer, vendor or partner, that person can be recognized. The WOW card, available for completion on the staff website / Intranet is the instrument that does that. The card is then submitted. Those that are outstanding are recognized and the WOW is read at bi-monthly All Staff meetings. Both the recipients and submitters receive a certificate to be redeemed for CHC logo wear. To receive a WOW, staff must differentiate themselves, which means do something a little unconventional and innovative. They must do something that's beyond their job description. And whatever they do must have an emotional impact on the receiver. Center for Hospice Care is not an average hospice, our service is not average, and we don't want our employees to be average. We expect every employee to deliver WOW. And they are recognized by their peers for doing so. Whether internally with co-workers or externally with our customers and partners, delivering WOW results in word of mouth. Our philosophy at CHC is to WOW with service and experience. We seek to WOW our patients, their families, our co-workers, our vendors & our partners. A 2018 Goal was "Establish a CHC new orientation program including all departments in conjunction with Nursing, Human Resources, Hospice Foundation, and Administration" and while this has begun, the project will be carried over into 2019. Other

engagement practices include recognition of staff who are promoted from within. They are prominently featured in the published Weekly Announcements. New staff at all offices are introduced at the bi-monthly All Staff meetings with a warm welcome and applause. CHC also allows staff and their family members to enjoy the Mishawaka 4th of July fireworks display on the private, gated south lawn of the Mishawaka Campus. They appreciate the private parking and clean rest rooms. Several times over the last three years we have also hosted CHC night at the South Bend Cubs for staff and their families to enjoy. In December, CHC hosts "Donuts with Santa" on an early Saturday morning. All CHC staff, their families, children, grandchildren are invited to attend. Donuts, juice, pictures with Santa, games, and crafts are all part of the festivities.

# # #

Preparing for Things to Come

Center for Hospice Care
Hospice Foundation
Global Partners in Care

Strategic Plan (2019 - 2021)

Overview

Incorporated as a not-for-profit on June 16, 1978 under the name Hospice of St. Joseph County, Inc., the first patient was admitted in January 1980. Today, and 37,007 patients later, Center for Hospice Care (CHC) is a premier, nationally recognized, and award-winning agency dedicated to improving the quality of living through hospice, home health, grief counseling, adult day services, and community education. With care offices in South Bend, Plymouth, La Porte, and Elkhart, CHC serves St. Joseph, Marshall, Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Porter and Starke Counties in northern Indiana. Caring exclusively for persons with life-limiting illnesses and their families / caregivers, the corporation also operates two Medicare certified seven-bed inpatient units at its South Bend and Elkhart locations. The agency also operates a community bereavement facility called the Life Transition Center, Administrative and Foundation offices, an outpatient clinic called Center for Palliative Care all located at its expanding Mishawaka Campus, as well as Center for Adult Day Services, LLC which operates Milton Adult Day Services in South Bend. In 2018, CHC had an average daily census of nearly 400 patients and expects to serve over 2,000 patients during calendar year 2019 for the sixth consecutive year. CHC is licensed as both a hospice and a home health agency by the Indiana State Department of Health. CHC is also Medicare Certified for both hospice and home health care. CHC is a member of the National Hospice and Palliative Care Organization (NHPCO), the National Association for Home and Hospice Care, The Advisory Board Company, the Center to Advance Palliative Care, the Indiana Hospice and Palliative Care Organization, the Indiana Association for Home and Hospice Care, and is a four-star We

Honor Veterans approved provider in collaboration with the Veterans Administration and NHPCO. Development / fundraising activities to benefit CHC are provided by a separate 501(c)(3) corporation -- an IRS Type II Supporting Foundation -- known simply as Hospice Foundation (HF). Global Partners in Care (GPIC), another 501(c)(3) entity is operated by the HF. 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 around the globe. To promote community education regarding advance directives, HF operates the Center for Education and Advance Care Planning, as well as Honoring Choices Indiana – North Central. Together, CHC / HF / GPIC have a professional staff of 228 and about 500 volunteers.

Preparing for Things to Come

As we prepare for the year 2021 and beyond, we are taking steps to create a future that will provide a seamless delivery model from referral through bereavement with the goal of providing the right care at the right time.

CHC will continue to have four overarching goals:

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

CHC's Annual Goals will continue to be categorized under these headings. The CHC board receives each year's annual goals at the first meeting of every year, along with the results of the previous year's annual goals.

For the next three years, we have identified specific Strategic Priorities. These priorities have been developed to provide direction and expectations to the Boards and Staff throughout 2019-2021. Besides CHC, these strategic initiatives include plans for both Hospice Foundation (HF) and Global Partners in Care (GPIC). The members of the CHC Executive Committee are also the entire board of directors for HF and GPIC. This meets the IRS requirements for overlap of the HF as a Type II supporting foundation where the supporting entity must be controlled by the supported entity. For continuity purposes and to provide a single document for reference purposes, several HF and GPIC strategic priorities are included in this strategic plan. The order of content below should not be interpreted as one being more significant than the others, because items are not listed in any order of importance.

Strategic Priorities 2019 - 2021:

1. Investigate CHC becoming an accredited hospice agency through one of the available accrediting entities in preparation for the continued increase in Medicaid and Medicare Managed Care payors and their probable accreditation requirements.

2.) Develop a marketing plan for private pay room and board for CHC's inpatients units.

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

4.) Redomesticate Global Partners in Care from the State of New York to Indiana.

5.) Begin preparing for the likely and eventual carve-in of the Medicare Hospice Benefit for Managed Care payors by developing a pre-carve-in relationship with them now that encourages earlier referrals based upon Medicare claims data that proves a savings to them.

6.) Consider developing a new position tentatively titled "Director of Strategic Initiatives."

7.) Continue expanding CHC/HF's role to be perceived 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.

8.) Prepare for a massive caregiver shortage for certified nursing assistants / hospice aides and the accompanying challenges that may affect hospice and home health care.

Strategic Priorities 2019 - 2021

1.) Investigate CHC becoming an accredited hospice agency through one of the available accrediting entities in preparation for the increase in Medicaid and Medicare Managed Care and their accreditation requirements.

Strategic Plans:

- In 2015, 31% of Medicare beneficiaries were enrolled in a Medicare Advantage Plan, although enrollment rates vary greatly by state and locale. This is up from 19% in 2007. Once a beneficiary elects to receive hospice care, the hospice is responsible for all medical care related to the beneficiary's terminal prognosis—their primary diagnosis and related conditions—as well as coordinating unrelated care. Currently, Medicare Advantage Plans do not cover hospice care. When an individual with Medicare Advantage coverage decides to elect the Medicare Hospice Benefit, he or she typically disenrolls from the MA plan, and can then select any Medicare-certified hospice, without any network restrictions. All Medicare-covered services a beneficiary receives while in hospice care are covered by fee-for-service Medicare. This includes any Medicare-covered services for conditions unrelated to the terminal prognosis. If the beneficiary's Medicare Advantage Plan includes additional services not covered under fee-for-service Medicare (such as vision and dental benefits) and the patient does not disenroll from the Medicare Advantage Plan, the MA Plan will continue to cover those additional services.

- The Medicare Payment Advisory Commission's (MedPAC) March 2014 Report recommended that Medicare Advantage (MA) plans assume both the clinical management of and financial responsibility for the hospice benefit. This proposal is rooted in an effort to promote coordination of care management between MA plans and hospices. In December 2015, the Senate Finance Committee's Chronic Care Working Group (CCWG) released a similar proposal.

- In January 2019, the Center for Medicare and Medicaid Services (CMS) announced a coming demonstration of the hospice Medicare carve-in. CMS' Center for Medicare and Medicaid Innovation (CMMI) announced enhancements to Medicare Advantage for plans who wish to participate in the Value Based Insurance Delivery (VBID) model. The model is designed to reduce Medicare program expenditures, enhance the quality of care for Medicare beneficiaries, including dual-eligible beneficiaries, and improve the coordination and efficiency of health care service delivery. The VBID model is voluntary and not every plan will apply for the VBID model. There are 13 now in 10 states. As we think about the VBID model for the future, the scope is unknown, and it will likely not be every MA plan.

- In 2020, the VBID model will be available to all 50 states and territories and includes Services that can be offered by MA plans for the 2020 plan year. Medicare Advantage (MA) plans will be allowed to: target additional benefits to enrollees of an MA plan, including services that are based on the enrollee's chronic condition, socioeconomic status or both; offer benefits not primarily related to health care, such as palliative care or transportation; increase access to telehealth services by allowing plans to use access to telehealth services instead of in-person visits, as long as an in-person option remains timely, coordinated approaches to wellness and health care planning, including advance care planning is a required component

- Beginning in the 2021 plan year, the VBID model will also test allowing Medicare Advantage plans to offer Medicare's hospice benefit. CMS states, "This change is designed to increase access to hospice services and facilitate better coordination between patients' hospice providers and their other clinicians." The addition of these services, including the Medicare hospice benefit, is voluntary for the MA plan. MA plans in all 50 states and territories may apply for the VBID model by 2020. The model is also available to all Special Needs Plans and Regional PPOs in all states and territories.

- CMS reports that the percent of Medicare beneficiaries enrolled in MA plans is increasing. The Kaiser Family Foundation reports that at the end of 2018, 34% of beneficiaries were enrolled and this number is increasing. The current Administration is clearly interested in expanding MA. This is a direction that will likely continue and CHC needs to be prepared. It is highly unlikely that an MA plan will want to contract with a hospice provider that is not accredited by the Joint Commission, Community Health Accreditation Program, or some other accrediting organization. CHC should investigate accreditation and plan for this eventual requirement and the associated additional costs.

2.) Develop a marketing plan for private pay room and board for CHC's inpatient units.

Strategic Plans:

- With the number of total beds increasing 36% at CHC to 19 by the end of 2019, the increased scrutiny of the General Inpatient Level of Care (GIP), concerns by the Office of Inspector General regarding GIP utilization, and the decrease in utilization of GIP nationally, CHC should develop a plan to market its bed availability for private pay room and board. Currently, CMS Region V Chicago is taking a stance that only patients enrolled in hospice may be cared for in a hospice inpatient unit. However, state laws are changing allowing non-hospice enrolled palliative care patients to be cared for in a hospice inpatient unit. We expect eventually CMS will agree. Through the Indiana Hospice and Palliative Care Organization, we plan to introduce legislation to allow this in Indiana. We have legislators interested along with various groups that have been meeting to expand palliative care, including the Indiana Palliative Care and Quality of Life Advisory Council (IPCQLC). IPCQLC is funded by a grant from the Indiana State Department of Health through a bill that passed the Indiana Legislature. Under IPCQLC, I participated on the Access to Palliative Care Workgroup. Within IPCQLC's Three-Year Report, published in December 2018, one of the five recommendations from the access workgroup is, "Explore the possibility of permitting hospices to offer palliative care to non-terminal patients or inpatient hospices to offer non-terminal inpatient palliative care." I pushed hard for this. Our workgroup discussions, final recommendations, and expected outcomes were included in the report.

- In the meantime, CHC should develop a marketing plan for private pay room and board for hospice patients whose family members need a longer than Medicare allowed break from caregiving, or are going on vacation, etc. Custodial care is not covered by Medicare and this would not be a covered service and we would not offer a sliding fee scale for this private pay option. Other hospice programs have been doing this for some time, including Ft. Wayne, IN, Toledo, OH, and others. Generally, they accept a two-week credit card payment up front and should not all days be used, funds for unused days are refunded. CHC's current room and board charge is $325 a day and has been based upon research for private pay nursing home room and board. This is still less than many local hotels charge on a Notre Dame home game weekend and they do not provide 24/7 nursing care, unlimited food, and many other amenities.

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

Strategic Plans:

- Define, initiate, and market a community-based palliative care program and product that requires a palliative consult to increase utilization of the outpatient clinic Center for Palliative Care.

- Continue to look for and engage ongoing collaborative relationships with other organizations interested in palliative care services.

- Develop and implement a comprehensive educational program for area physicians to increase their knowledge about hospice and palliative care.

- Develop, implement, and market a genuine pediatric palliative care program that includes pediatric End-of-Life Nursing Education Consortium trained CHC staff.

- Consider development of a six-week Care Transitions program product to sell to health systems that would follow hospital discharges for patients with Congestive Heart Failure or Chronic Obstructive Pulmonary Disease that includes a RN visit during weeks 1 - 4, telephone check on week five, and an RN visit on week six. The goal is to reduce repeat emergency department visits within the 30-day hospital readmission penalty period and to screen appropriate patients for hospice earlier. Models of such programs are available from our Lexington, KY based fellow member program in the National Hospice Executive Roundtable. This would be performed under CHC's home health license.

4.) Redomesticate Global Partners in Care from the State of New York to Indiana.

Strategic Plans:

- Global Partners in Care (GPIC) was created in 1999 and incorporated in New York state as the Foundation for Hospices in sub-Saharan Africa following a professional seminar tour of hospices in Zimbabwe and South Africa by US hospice leaders. These leaders witnessed the impact the HIV/AIDS pandemic had on hospice leaders and their programs. The limited number of hospices that did exist were adapting to the needs of those living with HIV/AIDS. With minimal access to pain medication and very few hospice programs, healthcare systems and community members alike were overwhelmed. The Foundation for Hospices in sub-Saharan Africa (later known as FHSSA) was formed to mobilize a response to help support Africa's hospice and palliative care programs' ability to provide compassionate care. The focus of the organization was to partner US hospice and palliative care providers with those in sub-Saharan Africa. In 2004, FHSSA came under the auspices of the US-based National Hospice and Palliative Care Organization (NHPCO). For 10 years, FHSSA successfully facilitated partnerships across many states and countries in sub-Saharan Africa. In 2014, based on input from leaders of US-based hospice organizations, NHPCO decided to build on the proven model of partnership previously established and extend the organization's reach. Still fully committed to the existing partnerships in Africa, the organization expanded to other regions of the world. To reflect the new global aspect of the organization, the name was changed to Global Partners in Care. In 2017, Global Partners in Care became an affiliate of the Mishawaka, IN-based Hospice Foundation, the supporting foundation for Center for Hospice Care (CHC). CHC and their partner, the Palliative Care Association of Uganda (PCAU), have been one of Global Partners in Care's most successful

partnerships since being partnered in 2008. Hospice Foundation has used the knowledge gained through their experiences as a global partner to build new partnership frameworks and help other partners strengthen their relationships.

- New York state is a difficult state for nonprofits. The transfer of GPIC from NHPCO to HF was made even more difficult because of the New York State Attorney General's Office. GPIC, HF, and CHC have no dealings with the State of New York and desire to have all its entities incorporated in Indiana.

- However, as a New York not-for-profit corporation, GPIC cannot simply redomesticate to Indiana as an Indiana nonprofit corporation, as the New York Not-for-Profit Law does not permit it. However, the Not-for-Profit Law does allow GPIC to merge into a new corporation, referred to here as "Newco," an Indiana nonprofit corporation, which would allow GPIC to exit the state of New York with the new Indiana nonprofit corporation being the surviving entity in the merger. The full process for such a merger includes the formation of Newco in Indiana, achieving tax-exempt status with the IRS for Newco, and the filing of the necessary merger documents in New York and Indiana. Although the full process will likely take some time, the process will be beneficial since GPIC's sole member, The Foundation for the Center for Hospice and Palliative Care, Inc., is an Indiana nonprofit corporation, and all GPIC's business operations and activities will be based in Indiana. Additionally, merging GPIC into an Indiana Newco would eliminate any future requirements for GPIC to register with the New York Attorney General's Charities Bureau and the New York Department of State, eliminating future business filings that are time consuming and expensive. Doing so will also allow us to keep GPIC separate from Center for Hospice Care and the Hospice Foundation.

- Once again, this work would take some time and involve the expense of the formation and tax-exempt qualification of a new nonprofit corporation, but I believe the result will substantially outweigh the ongoing administrative costs and other burdens in connection with maintaining and operating a New York not-for-profit corporation. In addition, we can prepare the Articles of Incorporation and By-Laws for a new Indiana nonprofit corporation to mirror those of Center for Hospice Care and the Foundation (rather than going through the likely agony of New York Department of State approval for amendments to the existing Certificate of Incorporation). Currently, the GPIC bylaws are the same as when the entity was under control of NHPCO. I have purposefully delayed changing them because this process could be implemented when GPIC came to Indiana.

5.) Begin preparing for the likely and eventual carve-in of the Medicare Hospice Benefit for Managed Care payors by developing pre-carve-in relationships that encourages earlier referrals using Medicare claims data that proves a savings to them.

Strategic Plans:

- As mentioned previously, the hospice carve-out under Medicare is highly likely to go away at some point within the next three to five years. CHC should begin to develop relationships with Medicare Managed Care (MA) payors in this pre-carve-in world. We need to be developing the answers to the following questions: 1.) The Data: what do we need to know about our market? 2.) When it comes to short term/long term Value Propositions: what might we offer? 3.) Understanding "competitive offers": who is the "competition" and what do they "offer"? We need to discover how CHC might approach an overall plan for understanding our MA market and begin to contemplate a strategy of who to approach with what value proposition(s).

- We need to learn and become fluent in MA market penetration trends (local/state MA as % of Medicare beneficiaries). We need to know MA enrollment by plan – identifying the "big players" (and knowing if they are State wide or more regional/local). We need to know our data: % MA, % share by county (trend/reason), % share of inpatient, LOS, referral sources, level of care mix – currently because of the carve-out we have no way of tracking this in our EMR and will have to develop work arounds. We need to develop MA account profiles and "relationship maps" with perhaps the top three MA payor players in our market. These account profiles would include Ownership/headquarters; Enrollment/trends; Financial performance; including Medical Loss Ratio, days per thousand, any reported metrics; Quality data, star ratings; and discover if there are related commercial, Medicaid plans, third party administrator platforms and other lines of business. We need to understand MA/commercial/Medicaid plan overlap. And we need to understand our current contracting "situation" and review all commercial insurance contracts for current rates, assignability, and discounts. Through subscriptions to companies like HealthPivots, we currently have access to the Medicare data we need, but it will take time to put it all together. We believe that MA payors will be interested in contracting with non-profit hospice programs primarily from a cost perspective. Because non-profits generally have much shorter lengths of stay than for-profits that cherry pick nursing home patients with Alzheimer's, heart and lung diseases, which have the longest lengths of stay, the aggregate costs of non-profit hospice programs are lower. We can acquire the data, and it's provable and defendable. We need to show MA plans the data that proves they would save money by steering their current hospice-eligible patients to hospice care much earlier than they are. We can have this conversation now, before the carve-in becomes a part of our world.

- CHC needs to take advantage of all opportunities including the previously mentioned CMMI demonstration of a Medicare hospice carve-in for MA plans in 2021, leading to opportunities for CHC to build relationships with MA plans serving our area. There may be contracting options for palliative care as well as being a contracted hospice provider. There may even be opportunities to expand our developing community based palliative care program through new referral sources, like the MA plans, in the coming years. CHC should investigate and take advantage of all opportunities that may become available due to this demonstration.

6.) Consider developing a new position tentatively titled "Director of Strategic Initiatives."

Strategic Plans:

- I'm considering a new position, tentatively entitled, Director of Strategic Initiatives. This position may become an addition to the Administrative Team. If it does, it would be the first addition since I added the VP/COO position in 2006, replacing myself as VP/COO after waiting nine years following President/CEO appointment in 1997. We have many items we would like to accomplish over the next three years, but time and freedom is a precious commodity for our Administrative 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. Essential functions under consideration may include, but are 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 monitor 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.

7.) Continue expanding CHC/HF's role to be recognized as the principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the ongoing design of what end-of-life care looks like in our community.

Strategic Plans:

- Deepen relationships with key stakeholders throughout the community to implement initiatives that will facilitate effective end-of-life planning and care.

- Through the new Center for Education and Advance Care Planning, deliver creative, engaging programming to educate community members about the importance of advance care planning and entice them to access expert assistance from trained individuals.

- Through Honoring Choices Indiana – North Central, train facilitators at hospitals, medical providers, extended care facilities and faith communities to assist people in completing advance directives.

8.) Prepare for a massive caregiver shortage for certified nursing assistants / hospice aides and the accompanying challenges that may affect hospice and home health care.

Strategic Plans:

- A January 2019 report from the Paraprofessional Healthcare Institute (PHI) notes data from the Bureau of Labor Statistics (BLS) indicating that the direct care workforce will grow more than any single occupation in the country, adding the greatest number of new jobs in 38 of the 50 states, from 2016 to 2026. In fact, the direct care workforce will be

larger than any single occupation in 21 states in 2026, growing faster than registered nurses and fast food workers combined – the two jobs ranked second and third for net job growth, according to the BLS. California alone is poised to add almost 275,000 direct care workers by 2026, with New York adding over 190,000 and Texas over 126,000 in that time.

- However, the BLS also calculates that 3.6 million workers will leave the direct care workforce, 2.8 million will leave the direct care workforce for other jobs, and 1.4 million new positions will be created to meet rising demand. We saw this happen in our CNAs in 2018 as many of them left to go to work in the RV factories in Elkhart during that boom. Adding that up means the BLS is projecting 7.8 million direct care job openings in the decade from 2016 to 2026.

- CHC should consider following the recommendations from PHI and begin plans over the next few years to consider expanding the labor pool for this workforce through education campaigns that elevate the profile of direct care workers; through targeted recruitment of new populations (including men, younger workers, and older workers); and through partnerships with community institutions such as schools, churches, and workforce development agencies. Generally, the hospice care workforce is overwhelmingly female and CHC may need to attract far more male workers to keep up with demand. CHC will need to consider large-scale and long-term investments to recruit new workers and reduce turnover within this workforce to ensure that our vulnerable patients and families can access proper supportive hospice services in the coming years.

Respectfully submitted,

Mark M Murray
President / CEO

February 2019

Center for Hospice Care
Hospice Foundation
Global Partners in Care

# # #

Center for Hospice Care

Conflict of Interest Policy

Article 1

Purpose

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

Article II

Definitions

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

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

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

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

Article III

Procedures

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

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

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

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

Article IV
Records of Proceedings

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

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

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

Article VI

Annual Statements

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

Article VII

Periodic Reviews

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

Article VIII

Use of Outside Experts

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

_____ _____

Signature **Date**

_____

Print Name

2010

November 2018
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Getting Through the Holidays

The holidays are hard for many. Grief doesn't pause. Here is a brief article to keep in mind when working with patients and families...or maybe even for yourself.

The following guidelines are shared in the hope that they will be helpful to you in thinking about and planning for the holidays and other special family times throughout the year. They were prepared by Shirley Melin of The Compassionate Friends, Fox Valley Chapter, Aurora, Illinois with some additions from the Montgomery, Alabama Chapter and from the booklet, Handling the Holidays, edited by Bruce Conley, a funeral director in Elburn, Illinois and a member of the Advisory Board of the Fox Valley Chapter. We are most grateful to all of these people for sharing with us.

Know When Your Holidays Are

- Holidays are not just Easter, July 4th, Thanksgiving, Hanukah or New Year's.
- Holidays are those times when family and friends get together for fun. It may or may not be associated with one of the traditional days of celebration.
- Mark on your calendar the months during which your family's holidays occur.
- Begin early to plan your coping strategies.

Be Intentional About How You Plan Your Holiday

Together as a family, examine the events and tasks of the celebration and ask the following:

- Do we really enjoy this?
- Is it done out of habit, free choice or obligation?
- Is this a task that can be shared?
- Would the holiday be the same without it?

Decide What You Can Handle Comfortably

- Whether or not you are open to talk about your loved one.

Continued on Page 6

Inside this issue:

Mark Your Calendars

Skills Validation Make-Up

Tuesday, December 11, 2018

By appointment only

Mishawaka Campus

This is only for volunteers who did not complete skills validation in June.

Elkhart 1st Annual Cookie Exchange

Tuesday, December 18, 2018

3:00-4:30pm

Elkhart Campus

You may bring 3 dozen cookies to exchange. If you don't wish to bake, just come and socialize. Coffee, tea and water will be provided.

Welcome to the Team

Wendy Callahan
South Bend IPU RN

Elisabeth Hazen
Elkhart RN

Roger Knapp, Jr.
Elkhart IPU CNA

Wendolyn Lovelady-Davidson
Elkhart IPU CNA

Denise Robles
Plymouth LPN

Shanda Stevens
Plymouth Triage/Visit RN

Sr. Eileen Wrobleski
Honoring Choices Coordinator

Birthdays

12/1
Barbara Zimlich

12/2
Sarah Nerenberg

12/2
Richard Schweizer

12/3
Kate Siupinski

12/5
Leslie Eid

12/6
Alfred Levy

12/9
Blanche Sailor

12/10
Pius Skarich

12/11
Mary Kay Ferry

12/14
Norah Ray

12/15
Michael Seraphin

12/16
Norma Diedrich

12/16
Allan Weidman

12/19
Fallon Coody

12/20
Marjorie Fink

12/24
Sr. Julia Huelskamp

12/25
Carolyn Bennett

12/25
Catherine Bly

12/30
Carole Moats

Volunteer Spotlight

Larry Kajzer, South Bend

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

I started working with Center for Hospice Care in 2009. At that time I did home visits. I did that until 2013.

In 2012, I started the veteran pinning ceremonies. I still am active to this day.

Why do you volunteer with CHC?

I am a military veteran serving from 1967-1969. I served in Korea 68-69.

I am very aware of all who served as well as those still serving to help make this the great country that it is today. That is why I take an active role in thanking them for their sacrifice.

I am also visiting veterans that have been admitted to Saint Joseph Hospital under the program Hover.

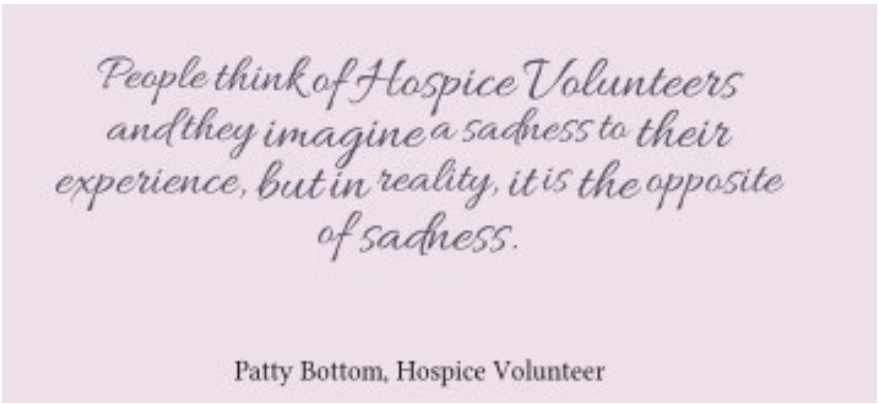
There is no greater feeling than helping those in need. That is why I volunteer at CHC.

What do you like to do in your spare time?

I am also an usher at ND football games and have been for 38 Years. I love 60's music and attend as many concerts as I can with my wife, Karen.

Tell us a little about your family.

Karen and I have been married 48 years and have two grown boys and one special grand daughter, Fritzie.



"Larry is such a nice guy! He has done patient care, companion visits and now veteran pinnings. He is so devoted to the veterans and loves that connection. We are fortunate to have him on our CHC team!"

Debra Mayfield,

South Bend Volunteer Coordinator

Volunteer Needs

Elkhart-Area Activity Volunteers

A couple ECFs (Millers Merry Manor in Wakarusa and Valley View in Elkhart) have requested regular volunteer assistance for activities (bingo, reading or special events). This is a fun opportunity and a way to spread the word about CHC and the work we do.

If you're interested, please contact Marlane Huber for more details.

Training Tips & Reminders

Winter Driving Tips

Following is a suggested list of items to keep in your car during winter driving:

- Flashlights with extra batteries
- First aid kit with pocket knife, scissors
- Necessary medications
- Several blankets or a sleeping bag
- Plastic bags (for sanitation)
- Matches in waterproof container
- Extra set of mittens, socks, cap
- Sack of sand for generating traction under wheels
- Shovel, small tools, booster cables, windshield scraper
- Flares or reflective triangle
- Dried fruit, nuts, high-energy bars, hard candy, bottled water

If trapped in a car during a blizzard:

Stay in the car. Do not leave the car to search for assistance unless help is visible within 100 yards. You may become disoriented and lost in blowing and drifting snow.

Display a trouble sign. Hang a brightly colored cloth on the radio antenna and raise the hood.

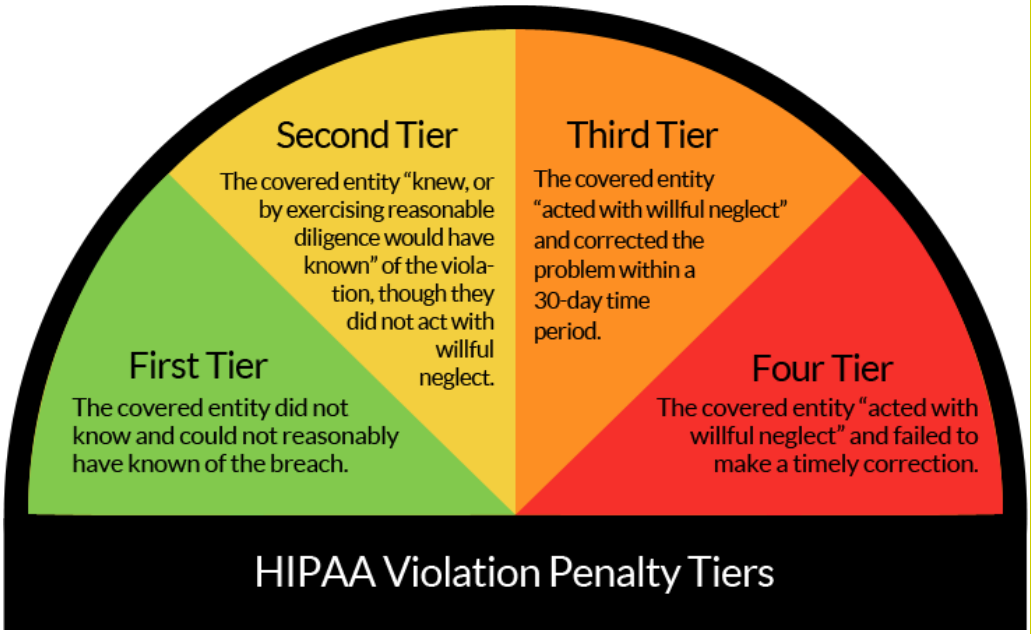
Occasionally run engine to keep warm. Turn on the car's engine for about 10 minutes each hour. Run the heater when the car is running. Also, turn on the car's dome light when the car is running.

Beware of carbon monoxide poisoning. Keep the exhaust pipe clear of snow, and open a downwind window slightly for ventilation.

Watch for signs of frostbite and hypothermia. Do minor exercises to keep up circulation. Clap hands and move arms and legs occasionally. Try not to stay in one position for too long. If more than one person is in the car, take turns sleeping. For warmth, huddle together. Use newspapers, maps, and even the removable car mats for added insulation.

Avoid overexertion. Cold weather puts an added strain on the heart. Unaccustomed exercise such as shoveling snow or pushing a car can bring on a heart attack or make other medical conditions worse. Be aware of symptoms of dehydration.

HIPAA Information



Comments from Our Families

- It's a useful service for all who have experienced a loss. CHC is a wonderful organization to have.
- Our family is singing the praises for the Elkhart CHC. From the facilities to the caring staff, we were impressed with the quality.
- Everyone that came into my home was compassionate and caring. Encouraged me that I was doing the right thing for my husband. Thank you all.
- It was a blessing experience. I thank you all so very much from the bottom of my heart. God bless you and for each of you for what you do to help our loved ones. Thank you.
- CHC was very helpful in our time of need. Everyone was wonderful and very caring to not only our family member, but also to us.

Continued from Page 1

- Whether or not you feel able to send holiday cards this year.
- Whether or not you can handle the responsibility of the family dinner, holiday parties, etc. or if you wish to have someone else take over some of the traditions this year.
- Whether or not you stay home for the holidays or choose a different environment.
- Whether or not you want to shop in the stores, from catalogs, on the internet, buy gift cards or send money. Shopping in the stores will be easier if you make a list out ahead of time and then it is ready for one of the "good days" when it comes along.

Don't Be Afraid to Make Changes

- Making changes can make things less painful.
- Decorate less, let the children take over decorating, invite friends in to help or don't decorate at all.
- Open presents the night before the holiday instead of in the morning.
- Have dinner at a different time and/or change the seating arrangement.
- Burn a special candle to quietly include your absent loved one.

Our Greatest Comfort May Be in Doing Something for Others

- Giving a gift in memory of your loved one to a charity.
- Adopting a needy family for the holidays.
- Inviting a guest, that might otherwise be alone, to share in the festivities.
- Volunteering to work at your local center for the homeless.

Evaluate Your Coping Plans

- Do your plans isolate you from those who love and support you best?
- Do your plans allow for meaningful expression and celebration of what the particular holiday means to you?
- Do you have flexibility built into your plans so if the gathering becomes difficult you have a plan for coping while there or leaving?

Let Your Plans and Limits Be Known

- Discuss with family and friends any intended changes. Be prepared for resistance to changes if family and friends are grieving differently.
- Share with friends and family how you plan to approach the holidays and how they can best help you.

Don't Be Afraid to Have Fun

- Enjoyment, laughter and pleasure are not experiences in which you abandon your loved one.
- You have not forgotten your loved one and do not love them less if you enjoy yourself.
- You need not feel guilty over experiencing enjoyment.
- Give yourself and others permission to celebrate and take pleasure in the holiday.

Remember To:

- Take one day at a time.
- Be realistic. Recognize that we need to set limits and do those things which are meaningful to ourselves and our families.
- Know that whatever you choose to do this year, you may decide to handle differently next year. Growth and change go hand in hand.
- Don't forget that comforting discovery that many bereaved have confirmed: The realization that when the special day occurs, it is usually not as bad as we imagined.
- As you seek to make special plans, remember to make them firm enough to support you, but flexible enough to leave you some freedom.
- Most importantly, take time in your plans to love and let yourself be loved – for this is the real gift of the holiday season.

December 2018
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Making Blankets to Honor a Friend

What better way to honor a friend than to give to others? That's exactly what CHC volunteer, Jean Lucas, and her church family did.

Carol Dugan was a vital member of our Focus Sunday School class at Trinity UM Church. She died August 10, 2018. She had asked that as a memorial to her we should do an act of kindness for someone.

I had been given information about the blankets previously and thought this would be the perfect way for our class to do as she had asked, especially if we would do it together. The class was enthusiastic about the project so on an October Sunday following our class, we met together and made 15 blankets. We had a wonderful time of fellowship and remembrance as we worked on these blankets of "kindness."

Carol would have blessed us with one of her favorite prayers: ***The Lord bless you and keep you. May the Lord make his face to shine upon you and be gracious to you. May the Lord lift up the light of his countenance upon you and give you peace now and forever. Amen***

Inside this issue:

Mark Your Calendars

NEW Volunteer Training
Tuesdays and Thursdays
February 19, 21, 26, 2019
9:00am-12:00pm
February 28, 2019
9:00am-3:00pm
501 Comfort Place
Mishawaka, IN
Contact Kristiana Donahue at donahuek@cfhcare.org for more information.

In Loving Memory

Our condolences and heart-felt sympathies go out to the following CHC volunteers and families.

Chrystal Snow-Schmatz, Elkhart
Husband, Mike Schmatz,
December 15, 2018

Sr. Julia Huelskamp, Plymouth
CHC Volunteer,
October 28, 2018

Welcome to the Team

Lady Viviana Avery-Baron
South Bend RN

Kathy Kirsits
Mishawaka Receptionist

Crystal Leiler
Elkhart IPU Coordinator

Jackie Lubarsky
Elkhart IPU RN

Ceres Soutto
South Bend RN

Birthdays

1/5
Lisa Melin
1/5
Norman Woolet
1/6
Douglas Jaques
1/7
Lynn Blessing
1/8
Kathy Walsh
1/15
Thomas Wroble
1/17
Suzanne Gilliland
1/17
Pam Weinland
1/20
Joshua Jantzi
1/20
Linda Strain
1/21
David Ricchiute
1/22
Linda McFarland
1/24
Frieda Cultice
1/27
Chrystal Snow-Schmatz
1/28
Steven Listenberger
1/29
Sharon Jennings
1/29
Barbara Reasor
1/31
William Blum

Volunteer Spotlight

Linda McFarland, South Bend

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

I help make bereavement calls. I can even do this while we snowbird for the winter months down in Florida. I also help out with the computer during the interdisciplinary team meetings. I have done home visits as well.

I started volunteering with Center for Hospice Care in 2012.

Why do you volunteer with CHC?

I love lifting people up. I saw first-hand how Center for Hospice Care helped my dad. It was a truly rough time when my mom was dying from terminal cancer. I thought I would like to be part of an organization that has everyone's best interest at heart!

What is your favorite food and why?

I like Eckrich smoked sausage sliced on top of mac-n-cheese topped off with ketchup. This is a great comfort food and reminds me of my mom who loved ketchup on almost everything!

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

I would love to go see the Aurora Borealis (Northern Lights). This just fascinates me.

Favorite movie and why?

Sleepless in Seattle. A little comedy, a little romance, a little suspense, and a little mystery. Just a good clean fun movie.

What is your favorite quote?

Only one life twill soon be past, only what`s done for Christ will last!

Tell us a little bit about your family.

My dad was a WWII veteran. He was a Marine Medic. He was proud of his service and was a fine example of a man, and a dad. Mom was a marvelous stay-at-home mom. She was a great cook, seamstress and blessing to my two brothers, my older sister and myself. I was and still am blessed because of the faith they had in God and love they had for each other.

"Linda is a quiet, compassionate volunteer who currently serves in the South Bend CHC Office when she is not wintering in Florida. She assists with IDT meetings, Tuck-in calls and Bereavement calls. The staff respect her and appreciate the skill and professionalism she displays in her service."

Debra Mayfield,

South Bend Volunteer Coordinator

Volunteer Needs

Community Relations Volunteer, Elkhart Valley View ECF on Mishawaka Road in Elkhart would like a CHC volunteer to assist residents when playing BINGO on

Mondays,
10:00-11:00am
Wednesdays,
1:30-2:30pm
Saturdays,
10:00-11:00am

This role is called "Community Relations." It is a way to support the work at our local ECFs to enhance the quality of living for those who reside there.

Contact Marlane Huber at (574) 970-0401.

Training Opportunity

Level III Training for Current Volunteers

We have successfully completed our first year of skills validation. Next year we will be scheduling individual appointment slots to make sure it runs smoothly. This worked out well for the make up session.

During skills validation we identified a handful of CHC volunteers who really needed to complete the Level III training again. Some volunteers completed their initial training many years ago and training has changed quite a bit since then.

Because of this, we are offering a Level III class for current volunteers. This class will just be the "hands-on" portion of the volunteer training. We will have a hospital bed and "patient" to practice our skills on.

Kristiana Donahue, Volunteer Recruitment and Training Coordinator, has a list of volunteers who expressed the desire to complete this training. Those individuals have been notified. However, this training is open to any CHC volunteer who would like a refresher course.

January 22, 2018
9:00am-12:00pm
Mishawaka Campus

If you would like to attend this course, please contact Kristiana Donahue at donahuek@cfhcare.org or (574) 286-1198 to RSVP.

Training Tips & Reminders

Frostbite and Hypothermia

Frostbite is a severe reaction to cold exposure that can permanently damage its victims. A loss of feeling and a white or pale appearance in fingers, toes, or nose and ear lobes are symptoms of frostbite. Hypothermia is a condition brought on when the body temperature drops to less than 90 degrees Fahrenheit. Symptoms of hypothermia include uncontrollable shivering, slow speech, memory lapses, frequent stumbling, drowsiness, and exhaustion.

If frostbite or hypothermia is suspected, begin warming the person slowly and seek immediate medical assistance. Warm the person's trunk first. Use your own body heat to help. Arms and legs should be warmed last because stimulation of the limbs can drive blood toward the heart and lead to heart failure. Put person in dry clothing and wrap their entire body in a blanket.

Never give a frostbite or hypothermia victim something with caffeine in it (like coffee or tea) or alcohol. Caffeine, a stimulant, can cause the heart to beat faster and hasten the effects the cold has on the body. Alcohol, a depressant, can slow the heart and also hasten the ill effects of cold body temperatures.

Severe Weather Procedures—Inpatient Unit

The scheduled incoming volunteer is responsible for notifying the inpatient unit staff currently on duty of anticipated safe arrival time.

The inpatient unit staff currently on duty will proceed in providing staffing for patient care until scheduled staff or other relief staff arrives.

The St. Joseph County Emergency Management (235-9234) and Elkhart County Emergency Management (535-6590) will place inpatient unit on a list for staff pick-up and take-home only if there is a severe blizzard or declared disaster. The response will depend on placement on the assistance list and available 4x4 vehicles. Marshall County – contact the city or county police department.

Comments from Our Families

- Thank you to the staff for the support and care given to entire family during this difficult time.
- Hospice helped me the most when I called in several times with questions. They were a big help. Could not have done it without them. Thank you.
- Thank you for your wonderful mailings and warm and caring classes. Don't know what I'd have done without you.

Season of Giving
Blankets for Hospice

We have been completely in awe of our community. Blankets for Hospice really started about 3 years ago as a way to make sure all Camp Evergreen campers were able to receive a fleece blanket. Boy has it grown!

Today our storage spaces are full of blankets to give not only to our Camp Evergreen campers, but also to our patients and families! Hardly a month goes by where we don't have blankets coming through our doors.

Here are a few pictures of groups within just the last few weeks that have gotten together to make blankets for us! There are many more groups that provide blankets and don't send pictures.

IUSB and St. Joseph High School are pictured on this page. Just today, we picked up 30 blankets from Schmucker Middle School where the Junior National Honor Society donated to us their 2nd year in a row!

Top Left: Jeanette McKew, CHC volunteer, has worked at St. Joseph High School for years. This group of St. Joseph students made blankets for CHC as part of their service to the community.

Top two pictures: Molly Fox and other members of an honors class at IUSB did a group volunteer project as part of their course. Out of a list of agencies they picked CHC and presented us with a great pile of beautiful blankets!

January 2019
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Adventures with Pete

By: Kristiana Donahue

"Kenneth is my dad's name," Pete shared with me when I met him. Though his name is also Kenneth, he said it's too formal for him. Pete suits him well. At 87 years old, his appetite for adventure and jokes is just as plentiful as ever, which is what led this Center for Hospice Care (CHC) patient to take a ride on a Harley just a few months ago.

"I had a motor scooter when I was a kid," Pete said. It was the scooter that ignited his desire for a motorcycle. Eventually, when he was grown and had the money for it, he got his wish. "The first motorcycle I had was a full-size old Harley. When I got it, it ran on only one cylinder. I got it fixed and repainted it. It was a stick shift." The adventures began.

He has taken long distance rides on a motorcycle, but also in a 1929 Model A Ford Roadster. "I put 135,000 miles on that car," Pete said. "We went as far as Key West in Florida, clear up the east coast, into upper Michigan, Canada, all over Colorado and down to Mexico." Though it may not be the fastest, most convenient or even most comfortable ride, there is an adventurer's heart at the core. "It's very special," Pete said. "It's an experience."

Long distance rides in a Model A attract attention, and in some ways, brings people together. "We didn't drive the Interstates," Pete explained. "We hit the backroads. We hit all the little towns. The local people would see us and come out. Shoot the breeze with us." One of his favorite rides was to Leadville, Colorado, the highest city in the United States at 10,200 feet. With an oxygen making machine in the rumble seat to help with altitude sickness, they were warmly welcomed at this little city. "They cleared Main Street and made arrangements for us to park along it. There were a ton of people that came to see old cars that high in the mountains."

For the past 27 years, his wife Jeanne has been his partner in

Continued on page 6

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February 28, 2019
9:00am-3:00pm
501 Comfort Place
Mishawaka, IN
Contact Kristiana Donahue at donahuek@cfhcare.org for more information.

Volunteer Recognition Luncheon
Tuesday, April 9, 2019
11:30am-1:00pm
The Brick
1145 Northside Blvd.
South Bend, IN
RSVP by March 13, 2019 by calling (574) 277-4100.

Welcome to the Team

Stacey Bryant
South Bend IPU RN

Liz Siebenthal
South Bend IPU RN

Lisa Larson
Admissions RN

Heather Stoddard
Elkhart IPU PRN RN

In Loving Memory

Our condolences and heartfelt sympathies go out to the following CHC volunteers and families.

Sharon Jennings, South Bend
Son, Brian Jennings, Sr.,
December 31, 2018

Birthdays

2/13
Janet Gruwell
2/13
Carl Mayfield
2/13
Joyce Metzler-Smith
2/15
Marlane Huber
2/15
Ann Hughes
2/20
Robert Evans
2/20
Anila Mondabaugh
2/21
Kathleen Bowlby
2/21
Mary Jane Lawson
2/23
Larry Brucker
2/23
Martha Lewallen
2/24
Elizabeth Kreskai
2/24
Sage Santana
2/27
Cynthia Lewis

Volunteer Spotlight

Noreen Buczek, South Bend

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

I am currently a volunteer for the in-patient care unit in Roseland, IN. I have also been a part of the team to cut hair for our outpatient requests and spent many years with the bereavement team. I completed my volunteer training on February 18 , 2004 with Jackie Boynton as Volunteer Resources Coordinator.

Why do you volunteer with CHC?

This is a special calling and I have been gifted with skills to assist our loving patients, family members and dear friends in time of need. I truly believe that all individuals have a place on earth and in their time of need, I can provide: respect, compassion, dignity, a caring hand, an understanding heart and a listening ear. It is about our patients, their families and dear friends. How can I make a difference?

Favorite movie and why?

It's a Wonderful Life I like what it means, the message it sends to all, the faith we have and share and how we all can make a difference.

Favorite music and why?

Big Band Music—like Glenn Miller. It was an easier place and time. It used many different instruments. It was upbeat and the singing was great. It's also easy to dance to. I love it!

What talents/hobbies do you enjoy?

I enjoy horseback riding, gardening and quality time with family. I twirled baton for over 15 years. I was in the band in high school and drum and bugle core. My favorite events were the fire baton, 2 or 3 batons, hoop, flag, strut, duets and team competition.

"Noreen has a sincere love for people. Even with a rigorous work schedule she makes time to serve in the South Bend IPU. Her eagerness to serve and encourage others is valued by patients, families and staff alike."

Debra Mayfield,

South Bend Volunteer Coordinator

Volunteer Needs

Our volunteer needs are changing every day. There is a new way you can check on the ever changing needs: our website!

Check it out:

http://www.cfhcare.org/volunteer/forvolunteers/current-volunteer-opportunities/

Level 2 Plus

Just recently we created a new level of training to allow volunteers to do home visits without requiring the personal care component. Level 2 Plus volunteers can assist with some tasks, like adjusting a pillow or offering a drink, but will not change briefs or assist a patient to the commode.

While we still need Level 3 volunteers and want our current Level 3 volunteers to continue, this allows volunteers who can no longer do certain tasks due to health issues or new volunteers who may be initially intimidated with personal care, an option to continue serving in the homes.

Training Tips & Reminders

Ongoing Training Opportunities

It is our goal to make sure that we are preparing each new volunteer for their CHC volunteer journey. It is also our goal to make sure we continue to equip our volunteers with the tools they need to be successful, confident and well-versed. Our annual in-service provides one tool to make sure that we not only meet the regulations, but also bring you topics to enrich your volunteering.

Some of you went through the initial orientation many years ago. And we thank you for sticking with us for so long! Training has morphed and changed over the years and looks quite different from 20 years ago. Below are some opportunities you can take advantage of for continued training:

Attend a New Volunteer Orientation Class

When we announce our New Volunteer Training in these newsletters, please know that you are welcome to attend these. If you would simply like a refresher and see what the new training is like, please attend. If interested, contact Kristiana Donahue, Volunteer Recruitment and Training Coordinator.

Do the New Volunteer Online Training

We have a newly created online training program that allows our volunteers to get the classroom content all in the comfort of their own homes. This allows us to bring on more volunteers—and frankly, online training is the way of today! If you would like to check it out, let Kristiana Donahue know.

Additional Online Courses—Coming Soon!

To enhance our ongoing training, we have goals to develop new online courses designed especially for our current volunteers. Whether it is learning about techniques with our dementia patients, to activities to enhance your visit to spiritual care—we want to develop an online library where you can pick and choose topics that interest you. Watch for it soon.

Kristiana Donahue, Volunteer Recruitment & Training Coordinator
donahuek@cfhcare.org | (574) 286-1198

Each 1 Recruit 1

Over the past nearly 40 years, Center for Hospice Care has grown tremendously. We now cover 9 counties in Northern Indiana. Because of this large territory, we are needing more volunteers than ever. We also need help recruiting volunteers. That is why I want to introduce Each 1 Recruit 1.

It may seem daunting to find a group of volunteers willing to do what you do as a hospice volunteer. I understand! But what if we just recruited one person this year? Just one? If each of our volunteers recruited just one new volunteer—we'd be busting at the seams. So I want to make that our goal this year—Each 1 Recruit 1.

Here's where it gets a little tricky. There are some locations and opportunities that we have a higher need for than others. As I recruit new volunteers, I share with them where our needs are. Right now we aren't needing new Bereavement Callers or Life Bio volunteers, just for an example.

Keep the following in mind:

Elkhart, Plymouth and LaPorte

South Bend (or St. Joseph County) does the best with self-recruiting. It is the largest area and we've been here awhile—it makes sense. We always take new volunteers in South Bend. **But our new classes are significantly hurting for Elkhart and Plymouth volunteers**. LaPorte will soon have 3 trained volunteers, which will be fine for now. Hopefully as that area grows, so will our volunteers in that area.

Patient Home Visitors

Know that we always have a need, across the board, for Patient Home Visitors. With our newly created Level 2 Plus, we are able to place volunteers in homes without requiring personal care assistance. While we still need Level 3 volunteers who are willing and able to change a brief or assist a patient to the commode, not all home visit volunteers have to do that.

Comments from Our Families

- I deeply appreciate CHC. You were enormous support for my husband. The nurses and aides were so kind and gentle, as was the chaplain, and followed by counseling. These are all incredibly caring individuals who make CHC the wonderful organization that it is. I am truly grateful to you all!
- I appreciate everything hospice did to help us be able to be with him during his last days. They were wonderful and I have already recommended them to others.

"I put 135,000 miles on that car (1929 Model A Ford Roadster). We went as far as Key West in Florida, clear up the east coast, into upper Michigan, Canada, all over Colorado and down to Mexico. It's very special, it's an experience."

his adventures. Their unorthodox wedding announcement was perfectly suited for them. At the time, they had a stone house by the river, inclusive of an antique shop. Picture a hog roast with 350 people in attendance along with an array of old cars strewn out along their front lawn. After their joyous announcement, Pete had another surprise for his bride. "A scruffy looking guy with a big, long beard taps me on the shoulder and says, 'You need to come with me,'" Jeanne remembered. Though hesitant, she followed him. "He surprised me with a hot air balloon! We went straight up over our house and you could see all the people watching us…it was awesome."

Pete has kept it interesting. Only three weeks after knee surgery, Pete needed to get to the hardware store. Jeanne was working. He didn't want to walk. He got out his little dirt bike, put on a jacket and decided to make his way to the store. "I forgot to put the kickstand up," Pete recalled, while I cringed. "I leaned over a little to put the kickstand up. I jammed my toe and shoved my leg backward. I went off the driveway and just missed a tree." Though he wasn't going very fast, he had a fleeting thought that this wasn't a good idea. But it was fleeting. He fired the bike back up and finished his trip, much to the surprise of the guys at the hardware store, who knew of his recent surgery. Jeanne shook her head in dismay as Pete recalled the memory, however she smiled. "I've had a fun life," Pete said, his eyes gleaming mischievously.

Kidney failure and other issues have slowed him down a bit. He started hospice with CHC and the care has proven beneficial for him and his wife. "With hospice care, we don't have to haul him around to all of these appointments and put him in the hospital," Jeanne shared. "It has just been wonderful. We are very happy and pleased."

Health may have slowed Pete down a bit, but it can't keep him down.

A few months ago, while at an office visit at Michiana VIP LLC, MD, he was talking to Jami McDonald, Director. "Pete came into an office visit one day and we were talking about my bike," Jami said. "This may have been when he realized that I rode a bike. As bikers we naturally share stories of riding. Pete shared his story with me about how he used to ride and how much he loved it. I proceeded to do all the normal stuff that I do for an office visit and right before I left the exam room to get the doctor Pete asked me, 'Will you give me a ride on your bike some time, its on my list?' I said, 'Absolutely, I will.' From there we planned it for his next visit."

Some may be questioning at this point if taking a risky motorcycle ride may be the best idea. BJ Miller is a palliative care specialist at Zen Hospice in San Francisco. He did a TED Talk about "What Matters Most at the End of Life." He shared a story about another adventurer, like Pete. Here's what he said, "Loss is one thing, but regret, quite another. Frank has always been an adventurer—he looks like something out of a Norman Rockwell painting—and no fan of regret. So it wasn't surprising when he came into clinic one day, saying he wanted to raft down the Colorado River. Was this a good idea? With all the risks to his safety and his health, some would say no. Many did, but he went for it, while he still could. It was a glorious, marvelous trip: freezing water, blistering dry heat, scorpions, snakes, wildlife howling off the flaming walls of the Grand Canyon—all the glorious side of the world beyond our control. Frank's decision, while maybe dramatic, is exactly the kind so many of us would make, if we only had the support to figure out what is best for ourselves over time."

Life is about risks. Risks in all things: love, choices, jobs, family and sometimes...the thrill of a motorcycle ride. Indiana cooperated, providing gloriously blue skies and sunshine. Pete was able to ride so fast his hat flew off. "She did a nice job," Pete said of Jami. "She didn't drive 30 mph, probably 50-55mph where she could." And on the way back to the office, they found the hat again. The reality is, while Pete can still get on the motorcycle, we need to support him in his decision to do so. It's Pete's life...and Pete loves adventure!

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.

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.

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, and the Walk/Bike for Hospice Committee.

Center for Hospice Care

BOARD OF DIRECTORS SELF-EVALUATION

2018 Survey Results

5 = Very Good 4 = Good 3 = Average 2 = Fair 1 = Poor

10 out of 13 people responded. Number of Responses for each rating is listed in the box along with Average Score.

#	Question	Very Good	Good	Average	Fair	Avg. Score 2018	Avg. Score 2016	Avg. Score 2014
1	Board has full and common understanding of the roles and responsibilities of a Board.	4	5	1		**4.3**	**4.7**	**4.3**
2	Board members understand the organization's mission and its products / programs.	7	3			**4.7**	**4.8**	**4.8**
3	Structural pattern is clear (Board, officers, committees, administrative team, staff).	5	5			**4.5**	**4.7**	**4.6**
4	Board has clear goals and actions resulting from relevant and realistic strategic planning.	5	4		1	**3.9**	**4.2**	**4.5**
5	Board attends to policy-related decisions, which effectively guide operational activities of staff.	8	1	1		**4.7**	**4.7**	**4.7**
6	Board receives regular reports on finances, budgets, products, program performance, and other important matters.	10				**5.0**	**5.0**	**5.0**
7	Board effectively represents the organization to the community.	5	4			**4.1**	**4.7**	**4.5**
8	Board meetings facilitate focus and progress on important organizational matters.	8	1	1		**4.7**	**4.7**	**4.6**
9	Board regularly monitors and evaluates progress toward strategic goals and products / program performance.	5	4	1		**4.4**	**4.4**	**4.5**

#	Question	Very Good	Good	Average	Fair	Avg. Score 2018	Avg. Score 2016	Avg. Score 2014
10	Each member of the Board feels involved and interested in the Board's work.	3	4	3		**4.0**	**4.2**	**4.3**
11	All necessary skills, stakeholders, and diversity are represented on the Board.	3	5	2		**4.1**	**4.2**	**4.3**

Ratings by percent of responses:

Rating	2018	2016	2014
Very Good	58%	65%	66%
Good	33%	28%	29%
Average	8%	6%	5%
Fair	1%	1%	0

Participation Rate

2018	77%
2016	69%
2014	60%

Please list three to five points on which you believe the Board should focus its attention in the next year. Be as specific as possible in identifying these points.

1. Clearly delineate the Palliative Care Service strategic and operational goals.
2. Continue the educational process for Board members related to the various departments and associated activities.
3. Enumerate plan of action for improving metrics that are not a goal (i.e., number of days/hours in Hospice care or death before seen).
4. Observation – I sit on the MADS Advisory Committee. No one knows why I am there—neither do I except for my interest in elder care. My take away is there is great opportunity here to both increase MADS daily census and CHC's referrals. There is opportunity to help people and families who need us. This is a CHC Board committee, but the contact needs attention, especially with the move to Roseland in 2020.
5. I am probably too "new" to say this, but I think the Board asks too little of its "regular" members and too much of its "Executive" members. Maybe this could be discussed.
6. Tremendous growth and expansion activities until completion in 2020(?), MADS, Global Partners, Mishawaka Campus. What's the end game? What does success look like in all of these areas including the La Porte expansion?
7. Raising public awareness and understanding of CHC.
8. Continued oversight.
9. Continued education and understanding of the hospice field in order to be advocates and to provide educated oversight.
10. Increase in ADC.

11. Continued development of liaisons in each community we serve to help increase ADC.
12. Expense management.
13. Board engagement.
14. Continued oversight of CHC finances.
15. Continued oversight of CHC policies.
16. Attend events, including openings of new buildings, and bring friends—help make these events a "splash."
17. Be as educated as possible about what CHC does, so as to better inform others in the community.
18. Continue to focus on increasing admissions and market share.
19. Continue good strides we are making in regards to strategic plan. Update when necessary, usually every meeting.
20. Continue focus on accounts receivables.
21. Look at adding 1-2 Board members with more diversity. I would like to see a physician and perhaps a lawyer (another!), banker.
22. Keep pushing Board members to review Board packet materials before meeting. Encourage Board members to attend Hospice events. Perhaps this would raise awareness on their part. Also more commitment.
23. Strategic plan regarding consistent staffing. We are a dysfunctional organization when we have to close facilities due to staffing.
24. How to maintain and enhance existing services…new services.
25. Update Strategic Plan.
26. I think this Board is extremely thorough in all areas.

How would you improve the Board's effectiveness?

1. Meetings are very efficient and effective. Identify other committees or specific activities to which Board members can commit.
2. As a rookie member of the Board, I feel like I am just getting my feet on the ground. My initial impression is that the CHC is managed by a very adept and skilled team led by Mark. This organization is larger and encompasses more than I imagined. There appears to be good balance between the Board and the management team—a clear understanding of who does what. I read the Board packet, but it seems a bit cumbersome. I'm sure it takes a great deal of time to prepare that level of detailed reporting. Hopefully, Directors take the time to read it. So, four meetings in, the Board appears to efficiently and effectively perform its role. Over the course of this year, there has not been much, if any, opportunity for strategic counsel or input. There are probably times when that is more critical. Wendell sets a very high bar as Board chair. His level of understanding and engagement in CHC operations is mighty impressive. He covers the gaps!
3. I feel the Board is effectively executing its role.
4. Increasing involvement by Board members. Think reduced meetings lends to a less engaged and therefore less effective Board.
5. More active participation by a few more Board members during our meetings.
6. Better attendance by Board members at CHC/HF events.
7. Director's report are very complete and helpful. This is the only Board I am on; however, where Board member participation in meetings is minimal. The information presented at meetings is helpful, necessary, and appreciated, but Board meetings are not set up to engage

Board members. Therefore, the Board has minimal opportunity to be effective. Unfortunately, I don't have any suggestions to turn this critique into an opportunity just yet.

8. Promoting more Board participation at meetings and on committees. The better they know the organization, the more a Board member can participate.
9. Move back to six meetings a year. It is my feeling that we have become a less engaged board in the past year.
10. After speaking with board colleagues, most members feel that we are unengaged…and have been. Possibly we should examine a new structure that asks board members to sit on committees (or require them to do so).

Please identify any Board-level performance gaps and recommended solutions.

1. Sorry to be redundant, but I feel the Board is fulfilling its role.
2. Participation in various Hospice events. Phone call asking for their participation I believe would increase participation.
3. As mentioned, reminders to read materials before meetings. Crucial on a consent Board!
4. With Wendell terming off the Board (or I believe he is), we should look for a new Board member who is tied to law. These are areas we should have represented: law, finance, marketing, human resources, business/business structure, medicine, community engagement, other.

Mark Murray

From: Madeline Watkins <mwatkins@phm.k12.in.us>
Sent: Friday, December 14, 2018 1:35 PM
To: Mark Murray
Subject: Thank you from Penn High School

Thanks again for providing your Grief/Loss Support group services to Penn High School for another year! Hope you have a great holiday season!

--
Maddi Watkins
Freshman Academy Counselor
Penn High School
mwatkins@phm.k12.in.us
Phone: 574-254-2842