Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

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

BOARD BRIEFING BOOK

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Center for Hospice Care
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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
May 15, 2019
7:15 a.m.

A G E N D A

1. **Consent Agenda** (10 minutes) – Mary Newbold (10 minutes)
   A. Approval of February 20, 2019 Board Meeting Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.
   C. QI Committee *(information)* – Minutes from the 02/26/19 meeting are included in your board packet. Carol Walker is available to answer questions.

2. **President's Report** *(information)* - Mark Murray (20 minutes)

3. **Finance Committee** *(action)* – Tricia Luck (20 minutes)
   A. 2018 Combined Audit
   B. Year to Date 2019 Financial Statements

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

5. **Board Education *(information)* –** "CHC Diversity Initiatives" – Barb King, Professional Relations Liaison and member of NHPCO's Diversity Committee (10 minutes)

6. **Chair's Report** – Mary Newbold (3 minutes)

Next meeting August 21, 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
February 20, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:15 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 11/28/18 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned J. Hsieh seconded
3. Policies	• The following policies were presented: Alerts in the Electronic Medical Record (revised), Care Kits (revised), ECF: Elder Justice Act Reporting (revised), Inpatient Unit – Patient Transfer from IPU to Home: Medications (new), Inpatient Unit – Weekly IDT Meeting (new). • A motion was made to accept the new and revised policies as presented. The motion was accepted unanimously.	W. Walsh motioned T. Luck seconded
4. QI Committee	• The minutes of the 11/27/18 QI Committee meeting are in the board packet. Staff have been preparing for a Home Health survey since October.	
5. President's Report	• The ADC for January was 378, and so far February is 392. Both Inpatient Units (IPU) combined had 15 patients last Friday, and today one IPU has no patients. Turnover has been very quick. A lower ADC and longer LOS than reverse would be of more benefit to us. A longer length of stay is the key to everything. The most expensive period of time is at the beginning and end of care. We need a longer middle LOS to benefit from it. We had longer lengths of stay in 2018, which made a huge difference for us. • We signed an agreement with the Elkhart Clinic for an associate hospice physician, which is Dr. Ahsanul Haque. He has already referred 11 patients to us in the first 22 days, and staff enjoys working with him. Jesse H. suggested we will make more progress with hospitals and clinics if we go to the doctors instead of	

Topic	Discussion	Action
	administrators and show how we can help with their work flow. Doctors would like one CHC physician they can just call. Jen E. said when looking at referrals in the hospital system, the direct provider to provider relationship is what could be extremely helpful to CHC. The hospitalists need to know they contact the CHC doctors directly. Jesse H. added we need to more aggressively pursue that strategy by going to the head of the hospitalists or chair of internal medicine at the South Bend Clinic. If the doctors feel the relationship is valuable, then they will go to their administrators and tell them they want this relationship, and administration will follow. We should include the Directors of Nursing as well. • December medication costs per patient day were $3.84, which is the lowest it has ever been. Years ago we were at $11-$12. Our medical staff is very good at controlling drug costs. • Physician Recruitment – Several doctors have contacted us through our ad on the AAHPM (American Academy of Hospice and Palliative Medicine) website. One is coming next week for an interview. We have hired a physician that starts in September after she finishes her degree. We are down a couple of physicians. We have not had to use a recruitment agency. • Some CHC staff are participating on national committees for NHPCO. Rebecca Fear is on quality and standards committee, Tammy Huyvaert is on education, and Barb King is on diversity. Barb will be presenting at the NHPC conference in April on diversity, and she is also CHC's diversity officer. A lot of this began when Edo Banach, NHPCO CEO was here and encouraged staff to get involved on a committee. • We have updated our "Top 10 reasons for CHC" elevator speech cards to aid board members when talking about CHC in the community. One of the roles of board members is to be ambassadors for CHC. If you want additional cards, please contact Becky Kizer. • MedPAC is suggesting to Congress a -2% cut to hospice rates for fiscal year 2020, which begins October 2019. Congress doesn't have to pay attention to their recommendations. For-profits are running a 15-16% profit margin and nonprofits 2.5-5%. MedPAC is saying the overall profit margin is 10.1%, which they say is too much. Congress cannot pass a law just based on the tax status of an organization. This will be a major focus for Capitol Hill Day in April during the	

Topic	Discussion	Action
	NHPCO conference. • As part of our 990 tax form, board members are request to sign the Conflict of Interest form annually. Please return the signed forms to Becky K. • In 2018 we had agency 107 goals, and 82% were met or are in process and carried over to 2019. In 2019 we have 92 goals. All goals are tied to the Strategic Plans. Also in the board packet is the 2019-2021 Strategic Plan. All of the members of the Hospice Executive Roundtable (NHERT) shared copies of their strategic plans, and they are pretty much all over the place. We had talked about making our annual goals our strategic plan, because it is so hard in health care to plan for three years. However, the executive committee said they would still like a three year plan. We are proposing an additional member of the leadership team in the role of Director of Strategic Initiatives. As the organization has grown and is taking on new things, it would help the other administrators so they are not stretched as they are now. This will be the first addition to the leadership team in a long time. • A motion was made to accept the 2019-2021 Strategic Plan as presented. The motion was accepted unanimously. • The admission nurses were moved from the clinical side of the agency back under marketing, and it has been beneficial. They had been moved under admissions several years ago, but due to staffing issues we were having at the time, it was decided to try moving them under the nursing department. However, we discovered that department doesn't have the immediacy to admit new patients as we do in admissions, so they were moved back. Medical issues still fall under nursing.	W. Walsh motioned J. Ewing seconded
6. Finance Committee	• As we were preparing for the Finance Committee meeting last Friday, we decided it would be a good opportunity to review beneficial interest in affiliate, how it works, and how it is reflected on our books. The entities that make up CHC include the Hospice Foundation (HF), GPIC, and Milton Adult Day Services. GPIC is a separate 501c3 entity and the Hospice Foundation is its sole corporate member. The Hospice Foundation is also a separate 501c3 entity and is a Type II Supporting Organization and its finances roll up into CHC's balance sheet and income statement. Milton is a separate LLC, and CHC is the sole member which the IRS calls a disregarded entity. Milton is considered a program of CHC. GPIC is an asset or investment of the Hospice Foundation, and the Hospice Foundation	

Topic	Discussion	Action
	is an asset or investment of CHC. These assets will increase or decrease in value from month to month. • 2018 year end pre-audited financial statements were reviewed. Patients served were 2,045, which is down 2.2% from 2017 and down 3.6% from budget. On 01/01/2018 we carried forward 371 patients and on 01/01/2019 we also carried forward 371 patients. ADC was 393, up 2.4% from 2017 and down 1.1% from budget. Breakeven is 383. The breakeven in 2019 is 381. Operating revenue was $22.1M, up 5.5% from 2017 and up 1% where budgeted to be. Total expenses were $20.1M, up 2.1% from 2017 and down 1.8% from budget. Overall net gain was $62,000, net without beneficial interest in affiliate $2.5M. • A motion was made to accept the 2018 pre-audited financial statements as presented. The motion was accepted unanimously.	T. Portolese motioned J. Houin seconded
7. Hospice Foundation Update	• The Crossroads Campaign goal is $10M and we've raised $11.5M through the end of 2018. The campaign runs through June, and we still have some underfunded priorities. We need to raise an additional $800,000 for the Ernestine M. Raclin House and $550,000 for the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine endowment match. Fundraising for our annual giving campaigns over the last nine years has remained fairly steady. • Next week Mark M., Chris T., Mike W. and Catherine Hiler will be going to Florida to meet with some donors and host a donor event. This is the third year we will be doing this. • The value of charity care relative to annual giving is used for discounted patient care 59%, bereavement counseling 21%, unreimbursed patient care 12%, and community services 8%. Over 3,000 people used our bereavement program throughout the year. About 25% are community bereaved. About 65% of our counselors' time is with community bereaved, because they have not had that time with hospice to better prepare for a death. We should share with this information with the community about our bereavement services as another differentiator for us. Under the Hospice Medicare Benefit we are required to offer bereavement services for up to 13 months following the death. • The Center for Education and Advance Care Planning has a new website. There is information in the President's Report on how to access its website. It has three main areas of focus – community education, professional education, and student	

Topic	Discussion	Action
	learning. One of the things we are doing is offering webinars from the Hospice Foundation of America (HFA) to various professionals in the community. CHC staff can participate in this webinars at no cost. • Honoring Choices Indiana-North Central – We are starting to work with organizations in St. Joseph, Elkhart, and Marshall Counties with plans to go into LaPorte. We hired a part-time person to coordinate the program through money raised by the consortium. We are in the process of getting ready to train facilitators who will then be certified to sit with someone and help them develop written advance directives. Beacon, SJRMC, and Goshen are some of the organizations providing funding. Training will take place a couple times a year and we will also get instructors trained at facilities so they can train their own facilitators. • GPIC – We presently have 41 partnerships that we are working with on a daily basis. We have a new GPIC website. It talks about partnerships, education, research and collaborations. Staff will be attending three conferences this year. In September will be attending and presenting at the biennial PCAU conference and we will also be recruiting new partnerships. Usually a couple of CHC employees attend and do presentations. They will submit abstracts to their scientific committee who will make selections. Staff will also attend the APCA conference and recruit new African partners as well. See the President's Report for more information. • Mishawaka Campus – The clinical staff building should be done in June, and the Ernestine M. Raclin House around October. • The HF will be saving $30,000 by switching its database software from Raiser's Edge to Bloomerang.	
8. Board Education	• 2018 Year in Review – The number of patients served was down slightly from 2017, but it was the fifth year in a row we served over 2,000 patients. This still keeps us in the top 3% in the country. The ADC was 394, which is up 2.42% from 2017. Total referrals were up 1.7%. The conversion rate was nearly the same. Anything over 70% is considered good and we were 72%. Same/next day admits decreased from 59% to 52%. Over half of our admissions are done the same day we receive the referral. DBAs increased from 6.8% to 7.6%. The percentage of patients/POA refusing admission increased from 2.9% to 4.1% due in part to the inability for some people to make the decision on their own to begin hospice care.	

Topic	Discussion	Action
	The average hospice patient lives 27 days longer than a patient with the same diagnosis that didn't receive hospice care. People are not having the conversation about end of life care, which is one of the reasons why we have Honoring Choices Indiana-NC and the Center for Education and Advance Care Planning to help make having those conversations easier. Hospital referrals increased to 46.5%. Physician referrals increased to 88 days from 77 days. We are trying to spend more time with our customers that give us referrals with longer lengths of stay. The median LOS for admitted physician referrals increased from 26 days to 37 days. • We have 28 competitors in our service area. 68% of hospices in the country and 70% in Indiana are for-profit. Deaths in seven days or less following an admission was 42%. Again this is due to late referrals or patients/families not being able to make a decision. Over 52% of patients served had COPD, lung, heart, or dementia. In 1990 it was primarily cancer and AIDS. The Hospice was 76 days and the Hospice Medicare Benefit (HMB) LOS was 83 days, a 1.4% increase. Hospice per diem days were up 5%. We had 179 DBAs or 7.6% of referrals. Referrals to CHC were down 5% from a year ago. 46% of referrals were from hospitals, 27% from patient/family, 16% physicians, 7% facilities, and 3% other. • The Inpatient Units (IPU) served 627 patients, down 3% from 2017. The Elkhart IPU was closed 3.5 weeks in August due to staffing issues. No one did not receive the level of care they needed during that time. If they needed inpatient care, they were seen at EGH under our contract. Health care continues to have staffing issues in our community as do other industries. Hospitals can use contracted agencies and hire a nurse to work a shift, but hospices are not allowed to do that under the HMB. All core services—nurse, aide, counselor, social worker, dietician—must be provided by a W2 employee. The Elkhart IPU is now fully staffed and the South Bend IPU has an opening for a coordinator. We have a couple of home care nurse positions open, and we always have openings for CNAs. Three employees are also on FMLA. Jesse H. suggested working more to support IUSB and Ivy Tech with their nursing and CNA programs. More hospitals are opening or expanding in the community, so there will be even a greater need for clinical staff. • Bereavement served 3,132 clients. 20% were from the community. 74% were hospice and 6% were families of DBA patients. Bereavement staff did a total of nearly 4,000 individual/family counseling sessions. 32% were with hospice clients	

Topic	Discussion	Action
	and 66% with community clients. • On the Press Ganey family satisfaction survey (CAHPS) there are two questions we pay a lot of attention to: (1) Did you have a positive experience with CHC, and (2) Would you recommend CHC to others. 97.3% said they had a positive experience, and 96.9% said they would recommend us to others. • Functional expenses – 84% program services, 14% management & general, 2.3% fundraising.	
Adjournment	• The meeting adjourned at 8:25 a.m.	Next meeting 05/15

Prepared by Becky Kizer for approval by the Board of Directors on 11/28/19.

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Jennifer Houin, Secretary Becky Kizer, Recording Secretary

REGULATION: 42 CFR 418.52 – Patient's Rights
42 CFR 418.54 – Initial and Comprehensive Assessment
42 CFR 418.56 – Care Planning

PURPOSE: To ensure a uniform and consistent process for: integumentary assessment, documentation, skin care, related comfort measures, and wound care.

POLICY: All patients will have an initial and ongoing comprehensive assessment of the integumentary system. The Agency focus will be on prevention of skin breakdown and palliative wound care. Comfort is of primary importance and may supersede prevention and wound care for individuals who are actively dying. The plan of care will be individualized ensuring consistency with the patient/family goals and wishes.

PROCEDURE:

1. Braden Scale for predicting pressure sore risk will be completed at the initial assessment, at recertification, and when there is a change in the patient's level of mobility.

2. Skin integrity will be assessed at the initial assessment and~~,~~ at each 14 day - comprehensive assessment by an RN. Assessments may be done~~, and~~ more frequently by an RN/LPN if the patient's condition warrants~~. during assessments.~~ Assessment details will be noted in the integumentary section of the Cerner visit document.

~~3. Prevention of skin breakdown will include the following:~~
~~a) Initiating prevention measures such as skin emollients, offloading techniques/ supplies/DME, incontinence products, and barrier lotions/creams.~~
~~b) Educating patients, families and caregivers on skin breakdown risk factors and prevention and promotion of healthy skin.~~
~~c) Dietary consult as directed by the IDT.~~

3. Wounds will be assessed at a minimum of every seven days by an RN and measurement documented in EMR.

4. Reference agency formulary for wound care.

5. Wound care interventions will be provided per physician's order utilizing Agency wound care formulary or according to superseding specific physician orders.

Signature: President/CEO

6. Prevention of skin breakdown will include the following:
   a) Initiating prevention measures such as skin emollients, offloading techniques/ supplies/DME, incontinence products, and barrier lotions/creams.
   b) Educating patients, families and caregivers on skin breakdown risk factors and prevention and promotion of healthy skin.
   c) Dietary consult as directed by the IDT.

7. Symptom management goals for palliative wound care may include, but are not limited to the following:
   a) Preventing deterioration and stabilizing the wound
   b) Promoting a clean and protected wound environment
   c) Minimizing infections, trauma or complications to surrounding tissue
   d) Managing pain, drainage, odor, bleeding or itching associated with the wound
   e) Minimizing frequency of dressing changes

8. Skin and wound care teaching to patient, family and caregivers can include, but is not limited to:
   a) Elimination of risk factors
   b) Symptom control measures
   c) Wound care
   d) Infection control measures
   e) Symptoms/conditions to report to Agency for skilled assessment

9. Plan of care will be updated as appropriate.

REGULATION: 42 CFR 418.52 – Patient Rights
42 CFR 418.56 – Care Planning

PURPOSE: To facilitate the safe, efficient, patient focused transfusion of blood products in the home or Inpatient Unit setting.

SCOPE OF PRACTICE: Registered Nurse

POLICY: The Agency will provide blood product transfusions to patients 18 years or older for the management of symptoms associated with anemia, by physician order, to meet the patient and family goals, as approved by the Interdisciplinary Team (IDT). These transfusions can occur in the patient's home or in the patient's preferred Inpatient Unit.

PROCEDURE:

1. The IDT will meet to discuss patient symptoms which may benefit from blood product transfusion.

2. Once the IDT has agreed to include a blood transfusion in the patient's plan of care, obtain a physician order from the patient's attending physician for a blood draw and blood transfusion.
   - The IDT will determine the most appropriate location for patient during transfusion with consideration to the following:
     a) Patient Safety
     b) Symptom Management
     c) Patient's ability to transport and coverage of transportation
   - Plymouth patients – the IDT will determine if patient is to go to SJRMC-Plymouth for transfusion instead of one of the Inpatient Units (IPUs).
   - The IDT will determine GIP Level of Care (LOC) or Continuous Care for continuous transfusion monitoring and potential symptom management.

3. Notify the South Bend Medical Foundation (SBMF) client services about the impending blood transfusion and fax the physician order to 574-234-3983, or 888-950-7263. A nurse trained in phlebotomy will do a blood draw on the patient for ABO and Rh compatibility and place an identification band on the patient.

4. Arrange for equipment from St. Joseph Infusion Center for home or Inpatient Unit delivery. Equipment will include IV pole, blood administration tubing, saline solution, IV start kits, two vials of Lasix 20 mg, and an adult anaphylaxis kit.

5. Establish IV access for the blood transfusion.

6. Once the blood product is ready for pickup at SBMF Blood Bank, an Agency RN will pick up the blood. The RN obtaining the blood product from SBMF will read, complete and sign the Home Blood Transfusion Consent by Guardian, Representative, or Other Person (form 920614).
   - If patient going to the Inpatient Unit, arrange transportation once the SBMF has notified blood is ready for pickup.

7. The unit of blood must be verified by two nurses~~RNs~~.
   - If transfusion occurs in the patient's home, a second nurse will go to the home when the blood is ready to do verification.
   - Identify the patient and compare the donor blood type, and blood bank sticker number with the patient's blood type, and blood bank sticker number on the patient's wrist band.
   - Obtain signed transfusion consent from the patient or legal guardian (Attachment A).

8. The blood transfusion should be initiated within 30 minutes of removing the bag from the controlled environment.

9. Obtain base line vital signs, including blood pressure, heart rate, respirations, and temperature. If the patient's temperature is above 100 F (37.8 C), notify the physician for any new orders before initiating the transfusion.

10. Have the patient void or empty urinary drainage collection container. If a transfusion reaction occurs, urine specimen obtained must be recent and preferably taken after transfusion is initiated to assess for presence of red blood cells from a hemolytic reaction.

11. Assemble all necessary equipment. Perform hand hygiene and apply gloves. Use aseptic technique.

12. Open blood administration set and prime the tubing with NS 0.9%, completely filling filter with saline. Maintain sterility of system and close lower clamp.

13. Gently invert the bag of blood two to three times.

14. Attach blood product to IV administration set by inserting spike of Y tubing located next to NS 0.9% tubing. Close normal saline-primed blood administration tubing directly to client's IV site.

15. Open lower clamp and regulate blood infusion to allow only 2ml/min. to infuse in the initial 15 minutes. Remain with the patient for the first 15 minutes of the transfusion.

16. Remove and discard gloves. Perform hand hygiene.

17. Obtain vital signs 5 minutes after the blood transfusion begins. Repeat vital signs in 15 minutes, 30 minutes, and then every 60 minutes until the blood has infused. If there is no change in the patient's condition, increase the infusion rate as tolerated, per physician order. Monitor the patient closely during the transfusion. Record all vital signs in the medical record. Assess for:

    - Fever with or without chills, defined as 2 degrees F (1 degree C) increase in temperature associated with the transfusion
    - Shaking chills with or without fever
    - Pain at infusion site or in chest, abdomen, or flank
    - Blood pressure changes, usually acute (either hypotension or hypertension)
    - Respiratory distress, including dyspnea, tachypnea, or hypoxemia
    - Skin changes, including flushing, itching urticarial or localized or generalized edema
    - Nausea with or without vomiting
    - Circulatory shock in combination with fever, severe chills, hypotension and high-output cardiac failure. This is suggestive of acute sepsis, but may also accompany an acute hemolytic transfusion reaction. Circulatory collapse without fever and chills may be the most prominent finding in anaphylaxis.
    - Urine color changes

18. If a transfusion reaction occurs, stop the transfusion immediately and refer to the Blood Transfusion Reaction instruction sheet (see attached).

19. When the blood bag is empty, clamp blood tubing, unclamp and run saline until tubing is clear. No saline should be added to packed cells.

20. Take vital signs post transfusion.

21. Record blood transfusion in the Cerner medical record. Clinical documentation will include blood identification numbers, blood type and Rh factor, the time given, volume and type of component given, patient condition and identity of person who discontinued the transfusion. Maintain a copy of the SBMF Record of Blood Issued for the patient's medical record.

22. In the event additional units are needed, obtain additional units from SBMF as outlined in #5 above and repeat steps #10 through #21. Dispose of blood bag(s) and tubing in a double red biohazard bag. Place the double red bagged blood bag(s) and tubing in the biohazard waste box at the Agency office.

23. Blood tubing should be changed after two (2) consecutive units. Flush tubing with 0.9% saline between units.

24. Instructions will be given to blood recipients after the transfusion, so they may be aware of any effects that may occur after the transfusion. Verbal patient and family education will include information contained in the Instructions to Blood Recipients handout (see attached).

25. Gloves are to be worn anytime employees may come in contact with blood products.

26. When blood transfusion is complete:
    - For Continuous Care, a doctor's order is needed to discontinue.
    - For discharge from the IPU, an IDT must be held to transfer back to Routine LOC and for coverage of transportation.

REGULATION: 42 CFR 418.110 – Hospices that provide inpatient care directly
Title 410 IAC 7-24 Retail Food Establishment Sanitation Requirements

PURPOSE: To establish Dining Room/Kitchen use guidelines.

POLICY: The dining room is for use by the patients, families, and friends of patients of the Inpatient Unit. Patient meals are prepared for the patients by the staff and volunteers, and occasionally by friends or family of the patients.

~~Staff may also use the dining room.~~

Snacks or meals may be warmed in the microwave by staff, patients and family, or friends of the resident.

The prep kitchen will be used only by ~~Inpatient Unit~~ staff for patient-only food. Family or friends may use the prep kitchen only after instruction by staff on proper procedures and only for patient food preparation.

The Registered Dietician will review and approve the meal plans.

PROCEDURE:

1. Three meals daily (breakfast, lunch, dinner) are prepared by or ordered by the ~~Inpatient Unit~~ staff for patients. Snacks and small meals may also be prepared by the staff as required to meet the needs of each patient. Patients with special dietary needs will be referred to the dietitian. There are no set meal times. ~~Anytime a patient is hungry food will be provided.~~ Food will be provided on an as requested basis by patients.

2. Staff or volunteers will cover food to prevent contamination during transportation.

3. Food items placed in cupboards and the family room refrigerator by staff and friends or family of the patients will be in room-assigned containers with the date displayed on the food container.

4. The cupboard and refrigerator will be checked on a regular basis by staff or volunteers to remove items approaching expiration. ~~, and to monitor the refrigerator temperature. Expired items will be discarded, as will items not removed upon discharge.~~

5. All refrigerators with patient food will have weekly temperature checks in compliance with State Board of Health regulations.

6. Refrigerators with patient food may not be used for family or friends food.

7. Expired items will be discarded. Food prepared at home will be discarded after five (5) days, as will items not removed upon discharge.

~~4.~~8. Staff is responsible for cleaning all areas used for food preparation and~~,~~ consumption.~~, and personal meal breaks.~~

PURPOSE: To provide guidance on when to call non-emergent Emergency Medical Services (EMS).

POLICY: Center for Hospice Care (CHC) will utilize non-emergent EMS for lift help after all other avenues of help for the patient have been attempted or the safety of the patient is at risk.

PROCEDURE:

1. CHC staff should make every effort to find family/friends to help with moving or lifting patients before calling non-emergent EMS.

2. Non-emergent EMS should be called if an attempt to obtain help from family/ friends is unsuccessful:
   a. When patient has fallen and the family/caregiver has no one to help get the patient off the floor.
   b. When patient needs to be moved from a regular bed to a hospital bed.

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

Signature: President/CEO

REGULATION: 42 CFR 418.52 – Patient rights

PURPOSE: To ensure appropriate patient care for those patients in Inpatient Unit who are known to be infested with parasites.

POLICY: Any patient admitted for care at the Agency's inpatient units who are known or discovered to be infested with parasites will receive care in a manner to cure the infestation and protect other patients from the spread of the parasites.

PROCEDURE:

1. Social work/case manager will ~~I~~instruct the patient/family that the patient's personal items will be limited to clothing necessary to transport the patient to Inpatient Unit.

2. The Inpatient Unit RN is to notify Maintenance and the Inpatient Unit Coordinator via email of the patient's arrival (see Infestations Procedure Steps).

3. Inspect medications from home. If any evidence of parasites, double bag and order new medications for the patient.

4. When the patient arrives to Inpatient Unit escort the patient to their room (or upon discovery of an infestation). Place all personal items in a double bag and have the family take the items home with them. If no family is present, double bag patient clothing in purple~~clear~~ plastic bags, securing each bag tightly at the top and place the bag in the closet in the patient's room. ~~Clear bags are utilized to allow visualization of bed bugs and lice~~.

5. All linen used for patient care will be double bagged and placed in a hamper inside the patient's room, until it is picked up by the approved laundry service. ~~In Elkhart, the double bagged linen will be thrown away in the dumpster~~.

6. Consult the Medical Director/Hospice Physician to obtain an order for the appropriate product to use in the treatment of lice and scabies.

7. Personal protective equipment, i.e., gown, gloves and shoe covers, will be worn by all staff, volunteers, and family entering the patient's room. Long hair will be confined, so as to not hang over patient or family. The PPE will be removed at the patient room door prior to leaving the room.

8. The patient will receive a bed bath/shower appropriate for the patient's condition in their room with products appropriate to treat the parasite. Following the bath, the patient will be clothed in hospital gowns only (no clothes from home).

9. Following the prescribed medical treatment for the parasite, patients will be assessed for reoccurrence of the infestation every shift.

10. Follow the appropriate process for room preparation, decontamination, and proper handling of linen for patients with infestations (see Infestations Procedure Step).

11. Upon the discovery of a parasite infestation, report to your supervisor and Maintenance immediately and complete an incident report..

12. If a patient is discovered to be infested with scabies or lice after their admission into Inpatient Unit, any exposed personnel will be treated with appropriate medications according to physician instructions.

13. In any event of a suspected exposure outbreak, Human Resources will be notified to identify staff and volunteers potentially affected.

REFERENCES

Center for Disease Control and Prevention, Resources for Health Professionals – Institutional Settings
Cornell University, Guidelines for Prevention and Management of Bed Bugs in Shelters and Group Living Facilities

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

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

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

Medications are the property of the patient and are not the property of the Agency. Agency nurses may only educate the POA/Responsible Party on proper handling and disposal of medications. Education regarding proper medication disposal will be documented in the medical record by Agency staff in compliance with state and federal requirements. Agency staff shall not perform medication destruction and disposal.

On admission, the POA/Responsible Party will be given printed instructions in the patient/family handbook on proper non-scheduled classification drug disposal methods, as well as locations of authorized collection receptacles. Agency staff will offer to assist the family with disposal of medications.

PROCEDURE:

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

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

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

b. Count all scheduled narcotics and document on disposal form. Agency nurse and family will sign the form after disposal. The form will be uploaded to the patient's chart.

~~b.~~

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

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

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

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

5. **Long Term Care / Hospital Setting**: When the patient resides in long term care or in the inpatient hospital setting, Agency staff will follow the policies of the facility for disposing of patient medications.

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

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

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

ATTACHMENT: Inpatient Unit Medication Disposal Form

Center for Hospice Care
QI Committee Meeting Minutes
February 26, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. • New members Crystal Leiler, Elkhart IPU Coordinator, and Kim Geese, Elkhart Patient Care Coordinator, were introduced.	
2. Minutes	• The minutes of the 11/27/18 meeting were approved by consensus.	
3. HQRP	• The Hospice Quality Reporting Program consists of the CAHPS and HIS. The Hospice Compare Website data is refreshed quarterly. The most recent update is for 04/01/17 – 03/31/18. CMS has taken all seven of the measures and created one composite measure. Our score was 88.2% compared to the national average of 84.2%. When the scores are broken down to the seven measures, all of our scores were above the national average. Education is ongoing with all staff. • HIS measures the number of visits made when death is imminent. In May we introduced the "Enhanced Care" email to notify the team to increase their visits and contacts with the patient and family. There is no national benchmark published on this yet. Short lengths of stay may also affect these scores. NHPCO is working on a best practices guide, and Rebecca F. serves on that committee.	
4. 2019 Quality Reporting Calendar	• We have created a Quality Reporting Calendar for 2019 to monitor when each quality indicator will be reported. A recap will be done at the end of the year. Wound care is one of the areas of improvement we want to make based on the hospice survey last year. We will be reporting on wounds on a routine basis. We partnered with McKesson to create a formulary for wound care education. • A motion was made to accept the 2019 Quality Reporting Calendar as presented. The motion was accepted unanimously.	T. Huyvaert motioned A. Wolf seconded
5. Hospice	• We have created a calendar of the education and training we plan to do in 2019. In 2018	

Topic	Discussion	Action
Performance Improvement	100% of nurses participated in skills validation. We always do a review of infusions and CADD Pumps. We also did education on drains, wounds and urinary catheters. The education is done at each office. Some will be joint education with nurses, social workers, and chaplains. • Pediatric ELNEC – In 2018, 62 nurses and 12 social workers were trained on Pediatric ELNEC. Terri L. and Rebecca F. are the trainers. We also have 10 CHPN RNs and 3 ACHPN nurse practitioners. The QA/Medical Records Coordinator is a Certified Professional in Healthcare Quality, three of our physicians are certified through AAHPM, and one physician is certified as a Hospice Medical Director. Our goal for 2019 is to have five additional nurses achieve their CHPN. • Every year we purchase the NHPCO webinar package presented twice a month. This year also purchased webinars through the Hospice Foundation of America (HFA). Both offer CEs. We have posted a flyer with the dates and topics of each webinar, so staff can decide which ones apply to them. We also purchase webinars on a case by case basis from Hospice & Home Care through IHPCO based on the subject of the webinar. This year we purchased a webinar series on OASIS and Home Health CoPs. We also send coordinators to the NHPCO management and leadership training. We have an intensive volunteer training program, and Kathy Kloss, Clinical Education Coordinator, helps teach portions of it. • In 2019 we will purchase a learning management system to use as a clearinghouse for education, materials, tracking of education activities, etc. We are working on a new orientation program for all employees, and created a task force to work on that so we can meet the CoPs and best practices. • Blood Transfusions Policy – This is a high risk, low volume event. We did a couple transfusions recently. One was an ALF patient and the facility didn't want the transfusion to take place at the facility, so we brought the patient to the IPU. During this event, we realized we needed to update our policy to make sure it captures the correct level of care, and that two nurses check the blood prior to administration. One of the nurses can be an LPN.	
6. Patient Safety Monitors	• We look at three areas: falls, medication errors, and adverse events, and their contributing factors. We recently participated in a conference call with IAHHC on drug diversion. We have policies and procedures in place to follow when we know of drug diversion in the home. It is handled on a case by case basis. Dr. Gifford, Dave, Sue,	

Topic	Discussion	Action
	and/or Tammy are always involved in those IDTs. In 2018 we did staff education on how to properly complete the incident report form, and we will be repeating that education in June. We are also looking at education resources through NHPCO. We will report on all of the 2018 data at the next meeting.	
7. Quality Indicators	• We look at quality indicators created externally and internally. One is live discharges. Historically 9-11% of our discharges are live. In 2018 we had 1,665 discharges and of those, 181 were live or 11%. Of the 181, 14% were didn't meet eligibility, 52% revoked, 20% left service area, 13% transferred or change of designated hospice, and 3% for cause. For cause are usually 1-3 patients annually. • Revocations – We have identified some new challenges, such as new staff, documenting appropriately (still seeing "seeking aggressive treatment)," not holding an IDT, not calling the nursing leadership on call to inform them of a revocation, and not signing and returning the revocation paperwork timely. Patient needs to be made aware of their option to choose to revoke. In 2018 the most vulnerable time for patients is within the first 25 days after admission. 41% revoked within the first 25 days, and 48% were related to symptoms. 50% of these patients were readmitted fairly quickly. IDT note documentation was 90%. • Live discharge education – We held joint education with nurses and social workers in January, and created new reference and education materials. QA monitors the data monthly and reports at the HIM Committee and QI Committee. • Infection Control – In 2018 we monitored influenza reports, needle sticks, infection surveillance reports, and did education according to our infection control plan. In 2019 we are planning training topics for care staff, and review and update our infection control policies and Exposure Control Plan. We will add additional education as needed. A motion was made to accept the 2019 infection control activities plan as presented. The motion was accepted unanimously. • Quality indicators for chaplains, social work, and bereavement – The chaplains and social workers are updating their care plans, profiles in Cerner, and IDT note standards. Bereavement are reviewing their care plans to make sure the requested bereavement services are identified, along with the frequency of service. They have created a new admission packet tailored to the type of death, and are working on improving counseling support for veterans by having counselors complete additional training and education.	S. Morgan motioned G. Gifford seconded

Topic	Discussion	Action
8. Specialty Programs	• In 2018 BreatheEazy had 255 patients. One patient had an ER visit and 10 had hospitalizations. Of the 11 that sought treatment, six returned to CHC following treatment. Three of those six died within seven days of returning to hospice care. • HeartWize had 313 patients. Three had ER visits and three had hospitalizations. Of the six that sought treatment, three returned to CHC for services, and of those, one died within one month. It is often the family, not the patient that calls 911.	
9. Home Health QAPI	• Some Home Health CoPs changed in 2018. We created a Home Health QAPI policy, which is nearly identical to the hospice QAPI policy. We are still waiting for a home health survey. In 2019 we plan to educate staff on the difference between hospice and home health. There is an increase in Medicare Replacements, which will require increased monitoring by QA and Billing, because each one wants something different. We are updating our therapy monitoring and creating a different mechanism for that. We are always looking at high risk areas and adverse events. • A motion was made to accept the 2019 Home Health QAPI activities. The motion was accepted unanimously.	A. Wolff motioned T. Huyvaert seconded
Adjournment	• The meeting adjourned at 8:55 a.m.	Next meeting 05/21

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
May 15, 2018
(*Report posted to Secure Board Website on May 9, 2019)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from February 20 – May 15, 2019. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

As of 4/30/19 referrals to CHC are up 6% compared to same time last year. The year to date (YTD) average daily census is at 401 on May 9th for the first time in history. April's average daily census (ADC) of 420 was an all-time agency record for monthly ADC. This compares to 2018's ADC for the entire year of 394. The previous one-month record ADC was 415 in in September of 2015. Single day census records were broken on 4/18 and 4/19 as census hit 431. The May 2019 census, at the time of this writing (5/9/19), is currently at 426 and YTD is at 401. These are the highest census levels we have ever experienced in the more than 39 years of the agency. Our two inpatient units (IPUs) should be much more utilized than they are, and we will be addressing this shortly. Compared to other non-profit hospice agencies our size, we have a very low level of the General Inpatient level of care. Additionally, occupancy at the South Bend IPU YTD is down 3% from last year, while the Elkhart IPU occupancy is up 3%. Due primarily to very late referrals from hospitals, deaths in seven days or less YTD is running 44%. This is up from 42% YTD April 2018.

April 2019	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	548	974	961	1.35%
Original Admissions	160	605	593	2.02%
ADC Hospice	384.770	367.88	370.15	-0.61%
ADC Home Health	35.17	31.20	16.47	89.44%
ADC CHC Total	419.94	399.08	386.62	3.22%

CHC HOSPICE INPATIENT UNITS

April 2019	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
SB House Pts Served	39	129	121	6.61%
SB House ALOS	3.72	4.68	5.12	-8.59%
SB House Occupancy	69.05%	71.90%	73.81%	-2.59%
Elk House Pts Served	31	101	96	5.21%
Elk House ALOS	4.81	4.85	4.93	-1.62%
Elk House Occupancy	70.95%	58.33%	56.31%	3.59%

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2019 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	197	204	217						190	190	198
Ply:	74	77	79	77						83	78	75
Elk:	92	94	94	96						83	89	96
Lap:	14	18	18	20						16	16	14
SBH:	5	5	5	5						6	5	4
EKH:	3	4	5	5						4	5	3
Total:	378	394	405	420						382	382	390

PATIENTS IN FACILITIES

Of the 548 patients served in April 2019, 150 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in April 2019 was 131 and year to date was 133.

FINANCES

Karl Holderman, CFO, reports the year-to-date April 2019 Financials will be posted to the Board website on Friday morning, May 10th following Finance Committee approval. For informational purposes, we are pleased to present the unapproved March 2019 year-end financials on the next page.

On 3/31/19, at the HF, intermediate investments totaled $4,643,896. Long term investments totaled $20,247,107. The combined total assets of all organizations, including GPIC, on March 31, 2019 totaled $57,666,957, an increase of $7,380,887 from March 2018.

Year-to-date investments as of 3/31/19 showed a gain of $1,855,572. From a budget standpoint, CHC alone was under budget on operating revenue by $71,394 and under budget on operating expenses by $647,014.

Year to Date March 2019 Financials

March 2019 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	5,250,390			**5,250,390**
MADS Revenue	84,457			**84,457**
Development Income		355,027		**355,027**
Partnership Grants			112,899	**112,899**
Investment Income (Net)		1,855,572		**1,855,572**
Interest & Other	8,511	17,125	607	**26,243**
Beneficial Interest in Affiliate	1,546,480	(20,770)		
Total Revenue	**6,889,838**	**2,206,954**	**113,506**	**7,684,588**
Total Expenses	**4,755,349**	**660,474**	**134,276**	**5,550,099**
Net Gain	**2,134,489**	**1,546,480**	**(20,770)**	**2,134,489**
Net w/o Beneficial Interest	*588,009*	*1,567,250*		
Net w/o Investments				***278,917***

2018 CONSOLIDATED FINANCIAL AUDIT AND STATEMENTS

The 2018 audited financial statements are on the Board Agenda. They are scheduled to be reviewed by the Finance Committee on Friday May 10th at an extended in-person Finance Committee meeting with the auditors from Kruggel Lawton CPAs. The audited financials will be posted to the board website on Friday morning 5/10/19 following the Finance Committee meeting for those wishing to review the materials prior to Wednesday's board meeting. Hard copies of the 2018 audited financial statements by Kruggel Lawton CPAs will be distributed to all board members at the Wednesday board meeting. We do note that we have new auditors, new eyes, and a few new issues and recommendations which will be discussed at the board meeting. We will also have restated 2018 financial statements which have resulted in an increase to the bottom line of more than $372,000 due to a *new to us* interpretation of accruing matching funds as they come in prior to raising the entire match. Details at the board meeting.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

The physician who had signed an employment agreement to begin working with us fulltime on September 3, 2019, called to inform us that she would not be coming due to personal matters. We are continuing our physician recruitment activities through Pacific Companies, a national physician recruitment firm. Another candidate from the Seattle area, and board certified in Hospice and Palliative Medicine was considering coming here but has decided to relocate to Columbus Ohio. Her husband has a Ph.D. in Finance and was interested in a position with the University of Notre Dame. He apparently will be joining the faculty at Ohio State University. A former Interventional Radiologist at St. Joseph Medical Center in Mishawaka, had started doing face-to-face visits for us, but will no longer be performing those on a contracted basis after demanding a 300% increase in the fee.

The contract we signed with the Elkhart Medical Clinic, effective on January 15, 2019, has been operating very well. It allows for Dr. Ahansul Haque, M.D. to provide services to our hospice and includes his taking call, conducting Interdisciplinary Team meetings, being available for calls up to a half-time as a hospice physician, and completing patient documentation. We are approaching the South Bend Clinic to investigate whether there also may be similar interest in such an arrangement.

Our Total Drug Cost Per Patient Day, as reported to us by our drug vendor Optum, continues to decline from a 12-month average of $4.35 to an average of $4.29. March 2019 Total Drug Cost Per Patient Day performance was $4.19. This is outstanding performance in comparison to our peers and places us near the top performing hospices in Optum's book of business which is now over 100,000 daily hospice patients.

Construction of the new LaPorte branch office building continues. It should be ready for occupancy in about a month.

Our Nurse Educator will be taking part in active shooter training soon, which is sponsored by the District 2 Healthcare Coalition. This is a course which will be widely attended by other area healthcare facilities. The Nurse Educator will then educate the rest of our staff on active shooter training.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

Kari Kendricks RN has joined CHC as the South Bend Inpatient Patient Unit Coordinator. She previously worked for the Franciscan Hospice in Michigan City. Julie Kos RN has been promoted to the South Bend Patient Care Coordinator she has been a Triage/Visit Nurse for the past year at CHC. Brittney Wisler, RN passed her CHPN (Certificate in Hospice and Palliative Nursing). Abby Eicher RN passed her CHPPN (Certificate of Hospice and Palliative Pediatric Nursing). The exam focused specifically on hospice and palliative care nursing concepts.

The following Education Programs were held for Nurses since the last board meeting:

- Skin and wound care resources and references were updated and reviewed.
- The CADD pumps (medication administration pump) were reviewed with competency validation completed.
- Alick's Home Medical reviewed the various methods of oxygen administration.
- A preceptor class was held for six nurses who will now orient, educate and mentor new nurses to CHC.

We continue to be "survey" ready in preparation for Indiana State Department of Health's Home Health Survey. 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 Indiana State Department of Health visited the South Bend Inpatient Unit on April 22 to conduct a Retail Food Establishment survey and there were no deficiencies.

The Nursing Department is continuing to evaluate the Triage Program and to improve on the process related to the response to calls. All the triage calls are now going to South Bend with the expectation of the move to Mishawaka and having one call center. 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 when we receive a higher volume of calls. The additional coverage was a result of realigning present triage positions without adding additional staff.

Around quality, we are pleased to report that the most recent results of the HIS (Hospice Item Set) required submissions to CMS, CHC exceeded all the national standards across the board. A copy of this report is included as an attachment to this report.

The Specialty Program Committee where the BreatheEazy, HeartWize, and DementiaCare programs have been established and monitored for many years will now be included in the Quality Committee. The Specialty Committee will no longer meet. The data review will occur at the Quality Committee. The DementiaCare portion will be a Quality Assurance Team which will allow the program to be reviewed and include the Milton Adult Day Services employees for their expertise on dementia.

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 March 2019, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous five years:

	2014	2015	2016	2017	2018	2019
January	51,685.37	82,400.05	65,460.71	46,552.99	37,015.96	62,707.48
February	109,724.36	150,006.82	101,643.17	199,939.17	93,912.90	113,771.80
March	176,641,04	257,463.89	178,212.01	282,326.61	220,485.17	369,862.26
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	2019
January	51,685.37	57,971.60	52,156.98	31,552.99	37,015.96	51,082.36
February	43,038.99	67,572.77	36,182.46	35,125.58	56,896.94	45,621.02
March	66,916.68	107,457.07	73,667.84	79,387.44	113,969.42	254,547.16
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**	**351,250.54**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in February, March and April 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 $500,000 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 57th month (7/1/14 thru 3/31/19), cash and documented pledges now total $11,879,795. Because of cultivation efforts from a member of our Campaign Cabinet, we have a verbal commitment for an unrestricted gift of $500,000. We await a signed pledge form. A follow up meeting with this donor to discuss naming opportunities and other details was cancelled and we are in the process of rescheduling it. Our annual donor stewardship and cultivation efforts in Florida took place from February 25 to March 1. Individual meetings with donors took place in St. Petersburg and Naples. A donor event at the Naples home of friends of Campaign Cabinet member Denny Beville took

place on February 27. It is developing into our most productive Florida fundraising event since we began conducting these events in 2017. Because of our Florida events and meetings, to date, we've received about $75,000 in gifts

Recent campaign related meetings include those with the Judd Leighton Foundation, Indiana Trust and the Community Foundation of St. Joseph County. We are working with REAL Services to procure a grant from the Community Foundation to support Milton Adult Day Services. If we receive grant funding, then we expect to launch a fundraising initiative in cooperation with Alzheimer's and Dementia Services of Northern Indiana to advance a new programming initiative that will benefit Milton Adult Day Services clients.

A reception to introduce our second Vera Z. Dwyer Fellow in Hospice and Palliative Medicine, Dr. Gregory Pelc, took place on April 10. It was well attended and generated additional awareness about the Dwyer Fellowship and the remaining Dwyer Trust matching dollars that we're working to procure.

Annual Giving

We are currently finalizing our 2019 Friends of Hospice appeal, to be mailed late May. It will focus on a "Crossroads" theme to help us finish the campaign as strongly as possible. The Annual Appeal, which officially ends May 31, has raised $98,926.38 to date.

Special Events & Projects

Clay United Methodist Church hosted a special screening of our *Road to Hope* film documentary to raise awareness of the program and to generate long-term interest in supporting the program. A new child sponsors came from this event.

The 35th Helping Hands Award Dinner held on May 1, 2019 honoring Catherine Hiler was a success. The Dinner Committee Chairs were Stephanie & Todd Schurz and Kurt Janowsky. The dinner is on track to be our second most profitable in history.

On June 4, we will host our annual Gardens of Remembrance and Renewal event on our Elkhart campus – giving family members a chance to honor their deceased loved ones with a commemorative brick, plaque or tree.

The Hospice Foundation is also busy planning for our second "Journeys in Healing" art auction to benefit our *After Images* program. The 11th Bike Michiana for Hospice and 34th Walk for Hospice will take place on Sept. 8 and will once again begin and end on our Mishawaka Campus.

Palliative Care Association of Uganda

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. Training in this system is also part of the new advanced diploma program described below.

The first cohort of 15 students has entered the Advanced Diploma in Palliative Care Nursing program at the Mulago School of Nursing and Midwifery. This program replaces the Hospice Africa Uganda (HAU) course that has provided palliative care training for nurses and clinical officers who then return to their districts to provide palliative care. It is unique because it is developing a cadre of specialized nurses capable of assessing and managing pain and symptoms as well as suffering caused by serious chronic illnesses. Due to significant efficiencies offered by the government-supported Mulago program, the funding supplied by CHC will stretch far beyond the eight students we were able to support through the HAU program to 30 full or partial scholarship students per year in the new course (another cohort will be added in July). Some students will pay their own tuition for the program while others will receive partial or full scholarships. As the program moves forward, PCAU will provide oversight and support for the program as needed, as well as working with the five clinical placement training sites.

Abstracts for The Uganda Cancer & Palliative Care Conference, which will take place in Kampala September 5-6, will be due on June 1st. The theme will be "Towards Universal Health Coverage." As in previous years, CHC staff 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 CHC/PCAU staff exchange.

Road to Hope Program

We continue to work with Rise Up and Bethel College student Keenan Boyce to develop entrepreneurship support for students graduating from the Road to Hope program. Using materials supplied by Rise Up and Keenan, we conducted validation interviews with two student graduates as well as two local entrepreneurs to learn more about the challenges they face as small business employees/owners. Their answers will inform the materials we develop going forward.

Education

The Center for Education & Advance Care Planning hosted our second on-campus "Death by Chocolate" on March 5th, with a Mardi Gras theme. Although a deep freeze impacted attendance at the event, it did result in an appointment to discuss advance care planning with a husband/wife who attended. We also took both "Cupcakes to Die for" and "Death by Chocolate" on the road by presenting them at area retirement/extended care facilities in Mishawaka and Valparaiso.

Our first South Bend End-of-life Planning Panel Discussion was held on Thursday, March 28th at the Pfeil Innovation Center with approximately 30 people in attendance. The six panelists discussed their roles in end-of-life planning and offered advice on how to prepare to speak with trusted advisors on this topic.

We continue to host webinars for the public through the Hospice Foundation of America (HFA). These webinars offer continuing education (CE) credits for area professionals in social work and counseling.

NHPCO's grassroots campaign, MyHospice Campaign was launched at the Leadership and Advocacy Conference in April. Elleah Tooker, HF Community Education Coordinator, was given a scholarship to attend the conference and participate in advocacy education and meetings at the

conference. She, along with Lacey Ahern and Craig Harrell, were part of the contingency that made visits to Indiana lawmakers on Capitol Hill in Washington, DC.

Honoring Choices® Indiana – North Central hosted a First Steps Facilitator Certification training for facilitators on March 7th and 13th. Four CHC/HF employees were certified as facilitators, along with HC board members, REAL Services staff and representatives from each of the funding health systems. Kristiana Donahue, Cyndy Searfoss, Elleah Tooker and Sr. Eileen Wrobleski are now able to work with healthy adults to complete their advance directives.

Mishawaka Campus

We're moving into the final phase of construction on the Clinical Staff Building and anticipate completion in early summer 2019. Great progress is being made on construction of our new 12-bed inpatient facility, the *Ernestine M. Raclin House*. Framing is complete and interior build-out is well underway. We continue to anticipate construction completion in Fall 2019. 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 complete. The home has been listed with Tim Murray of Coldwell Banker at an asking price of $379,900. Several showings and open houses have taken place with strong interest expressed by three parties.

GLOBAL PARTNERS IN CARE UDPATE (GPIC)

Funding Opportunities

We have a graduate of the M.S. in Global Health Program at the University of Notre Dame who has been volunteering time to help us sort through and prioritize potential funding opportunities for GPIC. We have shortlisted approximately ten possibilities that we are beginning to follow up with now. We are beginning to engage Chris Taelman in these conversations as well. In addition to identifying and securing grant funding, we continue to work with existing partners to hopefully increase their contributions and we are focusing on developing new partnerships. We have not yet developed a strategy for individual donor giving but are beginning to develop this as we work toward financial sustainability.

Partnerships

We persisted in communicating with the few remaining partnerships of uncertain status. By February, we confirmed the lack of activity and interest from several of them and went ahead in formally dissolving all uncertain or confirmed dissolved partnerships. This leaves us with 42 partnerships. This includes the new/transitioned partnership between Hospice Delaware and NAPCare (the Nepalese Association of Palliative Care). Both organizations have completed new

applications and an introductory call to launch the partnership will take place in May. Nepal remains the only country outside of Africa where we have a partnership.

Dr. Paul Mmbando, palliative care coordinator for the Evangelical Lutheran Church of Tanzania (ELCT), visited GPIC headquarters April 9 – 11th. We currently have eight partnerships with ELCT palliative care programs and several more have applied. This was a wonderful visit to foster our relationship with Dr. Mmbando. He interacted with many CHC and HF staff during his visit and we discussed strategies for advancing our collaboration with ELCT. He also attended the reception for the latest Dwyer Fellow in Palliative Medicine.

In February, Northwestern Medicine DeKalb Hospice (Illinois) hosted its 8th annual fundraiser for its South African partner, Knysna Sedgefield Hospice. The fundraiser, "Transformation through Rhythm," was a concert featuring percussion music by the DeKalb High School Percussion Ensemble, Northern Illinois University Percussion Ensemble, and Harambee African Percussion Ensemble. About 300 people attended the event, raising over $1,500 to support the work of Knysna Sedgefield Hospice. Denis Kidde, International Programs Coordinator, for HF attended on behalf of GPIC and was able to congratulate the partners and share a bit more about GPIC during the program. GPIC also provided the partners support ahead of and after the event. This was a demonstration of an added value GPIC can provide partners in their fundraising efforts.

Several of our partners are planning exchange visits this year. We will work closely with all partners to support them as they plan and hope we will get great stories and photos from these visits. This list may not be comprehensive, but upcoming exchange visits we are currently aware of include: Helderberg Hospice (South Africa) will visit the Hospice of the Western Reserve (Ohio) in June; we expect to plan a visit to Ohio during this time so we can acknowledge the Global Partnership Award while they are together; Hospice Wits (South Africa) will visit Empath Health/Suncoast Hospice (Florida) in May; Our Lady's Hospice (Kenya) was planning to visit Caring Circle (Michigan) in May – however, both staff from Our Lady's Hospice were denied visas. We are working with the partners to rewrite letters, prepare for interviews, and address the concerns of the US embassy in Nairobi. This visit will be delayed until June or July; St. Luke's Hospice (Malawi) is planning to visit Hospice of Northwest Ohio sometime in the fall; and Palliative Care and Support Trust (Malawi) is planning to visit Hospice of Kankakee Valley (Illinois) in the fall. This may coincide with the NHPCO Interdisciplinary Conference in Orlando, FL.

On April 24th, we held an informational webinar with Together for Short Lives, a UK member organization for pediatric-focused palliative care organizations in the UK. The goal is to raise awareness of our Partnership Program and recruit members to join us as partners or collaborators. This opportunity was made possible through our Advisory Council member, Stephen Connor, PhD, Pres/CEO of the World Hospice and Palliative Care Association.

We made many connections at the NHPCO Leadership & Advocacy Conference in mid-April and are in early stages of follow up with new potential partner leads.

Research and Education

We continue to work closely with African Palliative Care Association (APCA) and University of Alberta (UofA) to advance the project. The UofA faculty member has submitted a partnership grant application to the Social Sciences and Humanities Research Council of Canada to pilot this project, focusing on the development of the partnership with GPIC and APCA. UofA researchers and a representative of APCA will travel to Ghana with a group of masters-level students in May to do some preliminary work for the project. GPIC has been regularly meeting with the student group this semester and has been instrumental in facilitating this collaboration.

Since late last year, we have been in touch with University of Kansas Medical Center (KUMC) researchers who are implementing a telehospice project in rural Kansas with one of our partners, Hospice Services Inc. of Northwest Kansas. Researchers joined a Hospice Services team on their exchange visit to Tanzania in January to explore possibilities of adapting their work in that setting. It was a wonderful visit, conversations are ongoing, and the project discussions are moving forward with KUMC, Hospice Services, and the Evangelical Lutheran Church of Tanzania (ELCT).

Bluegrass Care Navigators in Lexington, KY and APCA are still keen on developing an initiative to establish Palliative Care Leadership Centers in Africa. Our Advisory Council has begun to have deeper conversation on the need for leadership training among palliative care professionals in Africa. This may emerge as an area where GPIC can make a significant contribution with our partners. We will continue to advance discussion on launching a project during the next few months.

Internships, Scholarships, and University Collaborations

University of Oxford, Blavatnik School of Government has one student to be placed with APCA again this year. Details are being finalized, but the plan is to have Nadeen Ibrahim focus on supporting APCA's development of policy language on palliative care and universal health coverage. We had another student from Oxford very interested in working with us and had preliminarily hoped to place him with ELCT. He was unable to accept our offer of internship because it was not funded. University of Notre Dame intern, Carmen Alvarez, has been a GPIC office intern. This position continues to provide valuable support to the staff.

This year, APCA UK joined GPIC in supporting the African Palliative Care Education Scholarship Fund for Nurses and Social Workers fund so that more scholarships will be available. APCA intends to award five nursing scholarships and four social work scholarships. APCA is currently reviewing applications for the scholarships.

Lacey Ahern, GPIC Program Director, attended the Consortium of Universities for Global Health (CUGH) conference in Chicago March 7-10, 2019. This presented an opportunity to network with universities to begin exploring possible collaborations. We had time to meet and visit with Dr. Christian Ntizimira from Rwanda and Dr. Eddie Mwebesa from Uganda. Following the conference, Dr. Mwebesa traveled to Indiana to visit GPIC and discuss possible collaboration. His two programs of Hospice Africa Uganda have applied for partnership.

Global Collaboration

GPIC was well represented at the NHPCO Leadership and Advocacy Conference – Washington, DC April 13-15 with an exhibit booth, luncheon and as a faculty collaborator with Center for Hospice Care presenting a workshop session for conference attendees. We also held a meeting of our Advisory Council during the conference. Half of our existing US partner organizations were represented at this conference – some were the contact persons with whom we work closely and many we were meeting for the first time. We had great interaction with most of them and used the opportunity to meet with them in person to deepen our relationships with them. We had good traffic at the booth and expect to recruit some US partners from contacts made during this conference. We are actively following up with them now. We also made some important contacts for other areas of collaboration – including the American Academy of Hospice and Palliative Medicine (AAHMP) and Simione Healthcare Consulting. This Advisory Council meeting was a wonderful opportunity to meet face-to-face with several members of this group. We were also honored to have FHSSA/GPIC founder, Dr. Bernice Catherine Harper, join the meeting. She is pleased with where GPIC is now. During the luncheon, we presented the Global Partnership Award to representatives from Hospice of The Western Reserve (located in Cleveland, OH) who won the award with their partner, Helderberg Hospice (located in Somerset West, South Africa). Dr. Harper also attended this lunch. Mike Wargo, Cyndy Searfoss and Lacey Ahern presented a very well-attended workshop entitled "Strategies to Successfully Engage Your Community and Staff." We shared the experience of CHC, the HF and GPIC in this interactive workshop. There were approximately 100 attendees. Tim Wolfer of Wolfer Productions in Baltimore, MD, and Director of Photography on our Road to Hope documentary, captured quite a bit of video – both b-roll and interviews – from the above events. We plan to use this footage for promotional videos, fundraising campaigns, raising awareness of GPIC, etc.

GPIC remains actively engaged in planning for the 6th International African Palliative Care Conference – Kigali, Rwanda September 17-20. We expect to host either a luncheon or workshop during the conference that is targeted at our partners but open to anyone (details are still being planned with APCA). We encouraged our partners to submit abstracts and we hope that many of our partners – both US and those from Africa – will be in attendance. GPIC is represented on two conference committees: Cyndy is on the Communications and Publicity Committee and Lacey is on the Scientific Committee.

COMMUNICATIONS, MARKETING, AND ACCESS

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

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In February and March our four Professional Relations Liaisons completed 775 visits to current and potential referral sources within our service area.

In 2019 we're once again targeting referral sources that tend to result in longer lengths of stay such as patients with COPD, CHF and Alzheimer's/Dementia. All of these can be addressed in CHC's specialized programs such as HeartWize and BreatheEazy. HeartWize and BreatheEazy have a 99% rate of keeping a patient from visiting the ER and a 98% and 97% rate of reducing hospitalization readmissions respectfully. Because of this focus in 2018, CHC was able to attain a 14% increase in ALOS of physician admitted patients in 2018.

Access

Our Admissions Department has done an outstanding job surpassing the monthly admissions goal for the first quarter of 2019. Our staff is continually looking for ways to improve efficiency and have been working with the clinical team on projects to quickly address admissions to the Inpatient Units from the hospitals. We also review daily the reasons there may be a delay in admissions for a patient. The first reason continues to be DBA (Death Before Admission). After that reasons vary including "Patient/Family/POA Refused", "Admitted to Nursing Home Med A" and "Went with Another Agency". We're finding it more common with one of our referral sources to "broadcast" referrals to multiple agencies. This often results in confusion to the patient and family who are then forced to answer multiple calls from multiple hospice agencies at a time when they are most venerable. The families are understandably very upset at the inconvenience that is forced upon them, often when their time is precious and limited.

Website

During the months of February and March, CHC's website hosted 5,395 new users, which is statistically the same over the same period as last year. The overall number of users to our website also remained the same. We continue to update our site to make it a resource for patients and families in need of hospice. A goal this year is to update and condense our website with the same branding as the Hospice Foundation and to target the potential patient or family members.

Social Media

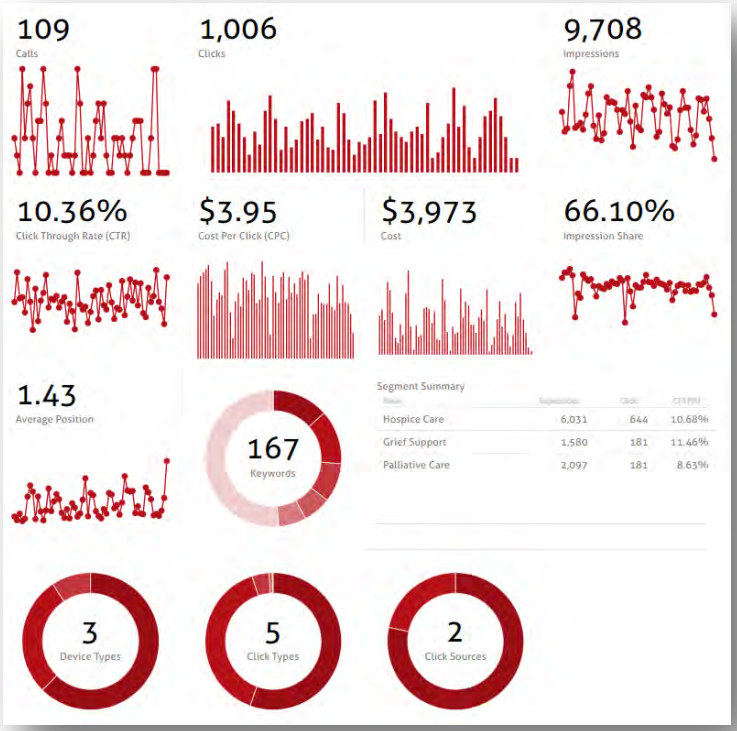
Facebook (Center4Hospice)

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. CHC reached 68,082 people for the period of February thru March, and had 7,478 reactions, comments and shares. Our leading post was of CHC announcing our Pet Peace of Mind program. Pet Peace of Mind is a program that enriches the quality of life and well-being of hospice and palliative care patients by providing a support network to help care for the pets they love. In addition, we raised money to help offset the cost of our volunteer training materials associated with the program. This single post reached over 7,400 people, created 675 reactions and was shared 338 times. Our second most viewed post focused on our need for Pet Visitors program which reached over 4,400. We also continue to share content through Twitter, Instagram and LinkedIn.

Digital Overview

The following digital report represents activity from February and March of 2019. The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of

February - March it generated 109 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 10.36%.



CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are six clinical policies on the agenda for approval. Five are existing policies that have been updated to reflect current practice or changes in regulations. The only new policy covers when staff should call non-emergent emergency medical services for lift help when a patient has fallen.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MET IN MAY

The National Hospice Executive Roundtable (NHERT) met at member program Transitions LifeCare in Raleigh, NC May 5 - 7. Besides individual NHERT program member updates, we had guest speakers: Lori Taylor, Blue Cross Blue Shield of North Carolina, present their views about community based palliative care and value-based payment; Glenn Kauthhold, president of GKollaboration, presented an update on the NHERT Fundraising/Development group; and Dr. Adam Wolk (Alignment) amd Dr. Laura Patel (Transitions LifeCare) who presented on the Transitions LifeCare, Humana and Alignment Health partnership. We also discussed inpatient unit trends for size, growth, occupancy and mixed use along with touring the units at Transitions LifeCare who have done a marvelous job at keeping the units filled under the General Inpatient

Level of Care. Finally, the hospice Medicare Advantage Carve-in conversation continued from our last meeting.

The NHERT now is comprised of the CEOs form 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

CMS PROPOSES RATE CUT TO MEDICARE HOSPICE AND OTHER CHANGES

On Friday, April 19, 2019, the Federal Register posted the public inspection copy of the FY2020 Hospice Wage Index proposed rule. CMS proposes to rebase and increase the continuous home care, inpatient respite and general inpatient levels of care, as the average cost per day of care is greater than the reimbursement. CMS proposes to reduce the routine home care rate by -2.71% to allow the rates for the other levels of care to be adjusted in a budget neutral manner. CMS proposes to use the current year of hospital wage index values, rather than a one-year lag, to compute the hospice wage index. CMS proposes an addendum to the hospice election statement that would allow the patient and/or their representative to more fully understand what the hospice would cover under the Medicare hospice benefit. The proposed rule has a significant discussion on hospice determination of relatedness and how an addendum could provide full disclosure on what the hospice covers as part of the benefit. CMS requests information on the interaction of the Medicare hospice benefit and alternative delivery models, including ACOs, MA plans and others. Finally, there is a discussion on hospice quality reporting with updates on quality measures and measure status, as well as possible options for publicly available data to be posted on Hospice Compare. A 14-page explanation from NHPCO is included as an attachment to this report.

As an attachment to this report, I have included an article from the National Law Review, "CMS Proposes to Force Hospices to Specify Unrelated Treatments, that does a very nice job of outlining the problems for hospices when required to provide patients information on unrelated medications and treatments and the potential pitfalls of having to do this within 48 hours of a hospice admission. I have also included an article from Hospice News entitled, "Hospices Lose Money Under 2020 Rule."

LATEST PEPPER REPORT SHOWS CHC BELOW CHC'S ALREADY LOW SCORES (LIKE GOLF = DESIRED) IN NEARLY EVERY CATEGORY

The Government Accountability Office has designated Medicare as a program at high risk for fraud, waste and abuse. Medicare spending for hospice care has increased dramatically in recent years. The Medicare Hospice Benefit has been identified as vulnerable to abuse; in 1999 the Office of Inspector General (OIG) encouraged hospices to develop and implement a compliance program to protect their operations from fraud and abuse. As part of a compliance program, a hospice should conduct regular audits to ensure charges for Medicare services are correctly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can help guide the hospice's auditing and monitoring activities. National hospice claims data were analyzed to identify areas within the hospice benefit which could be at risk for improper Medicare payment. These areas are referred to as "target areas." PEPPER is a data report that contains a single hospice's claims data statistics (obtained from the UB-04 claims submitted to the Medicare Administrative Contractor (MAC)) for these target areas. Each hospice receives a PEPPER, which contains statistics for these target areas, regardless of whether the hospice's data are of concern. The report shows how a hospice's data compares to national, jurisdiction and state statistics. Data in PEPPER are presented in tabular form, as well as in graphs that depict the hospice's target area percentages over time. All the data tables, graphs and reports in PEPPER were designed to assist the hospice in identifying potentially improper payments. PEPPER is developed and distributed by the RELI Group, along with its partners TMF Health Quality Institute and CGS, under contract with the Centers for Medicare & Medicaid Services (CMS). CHC's most recent annual report, April 2019, is included as an attachment to this report.

THANKS TO CHC, WALORSKI REINTRODUCES "RURAL ACCESS TO HOSPICE ACT"

I am happy to announce that the Rural Access to Hospice Act was reintroduced in the US House of Representatives on 5/8/19 by Congressman Ron Kind (D-WI) and Congresswoman Jackie Walorski (R-IN). It had been reintroduced in the Senate last month by Senators Jeanne Shaheen (D-NH) and Shelley Moore Capito (R-WV). Now that it is fully reintroduced in both chambers, it is imperative that Members of Congress hear from you. We have reason to believe that a rural health package is being discussed in Congress, and we need to show that the Rural Access to Hospice Act has wide bipartisan grassroots support to bolster our argument to include this bill in the package. I have attached a brief one-page summary about the Rural Access to Hospice Act. As a board member of the Hospice Action Network (HAN), I will likely be sending you an email link for you to complete and send your personal support on this important issue. My thanks to HF staff member, Elleah Tooker, who is one of six people nationwide chosen by NHPCO/HAN to serve as a "Hospice Ambassador" on behalf of HAN.

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.

BOARD EDUCATION SECTION

I am very pleased that Barb King will be presenting on CHC's various diversity initiatives at the next board meeting. Barb currently serves as CHC's diversity officer and has been instrumental in providing and arranging education for staff regarding a wide variety of diversity issues. Barb is also currently serving on the National Hospice and Palliative Care Organization's (NHPCO) national Diversity Committee. In mid-April, at the NHPCO national Leadership and Advocacy conference, with other members of the NHPCO Diversity Committee, she presented a concurrent session entitled, "Let's Get Uncomfortable…Diversity, A Kaleidoscope of Care." The session was very well attended and very well received.

OUT AND ABOUT

Mike Wargo, Chris Taelman, and I went to Tampa and Clearwater, FL for donor meetings the week of February 25th.

I attended the NHPCO board issues session and Hospice Action Network board meeting and various other activities as well as the Leadership and Advocacy Conference in Washington, DC from 4/13 -17. Sue Morgan RN Director of Nursing, Lisa Bryan RN Patient Care Coordinator and Alice Wolff Patient Care Coordinator attended the NHPCO Leadership and Advocacy Council in April. Mike Wargo, Denis Kidde, Lacey Ahern, Cyndy Searfoss also attended portions of this meeting to exhibit and present educational sessions on behalf of GPIC. Several other staff attended the conference as well.

Mike Wargo, Chris Taelman, Craig Harrell and I attended the "Age of Excellence Awards" luncheon for REAL Services on April 23rd. CHC was an underwriter.

I attended the National Hospice Executive Roundtable meeting in Raleigh, NC May 5 – 7.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

PEPPER Report

Volunteer Newsletter for April and May 2019.

Board Committee Opportunity Sheet

Upcoming Events Calendar that all Board Members are Invited to Attend

Latest HIS Quality Measures Report for CHC

National Law Review article, "CMS Proposes to Force Hospices to Specify Unrelated Treatments"

Hospice News article, "Hospices Lose Money Under 2020 Proposed Rule"

Thank you email from John Adams High School for our student bereavement group

LaPorte County Life piece on our Helping Hands Award Dinner honoring Catherine Hiler

One-sheet regarding the Rural Access to Hospice Act

Compliance Committee Minutes 02/28/2019

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date April 2019 CHC Financials.

2018 Audited Financial Statements

2019 CHC/HF Webinars

2019 HF Events Schedule

Common Abbreviations (always handed out at board meetings)

CHC "By the Numbers" one-sheet handout

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, August 21, 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 .

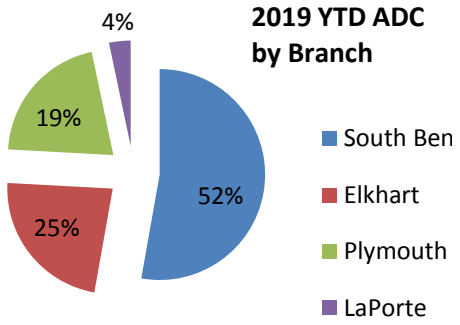
# # #

Center for Hospice Care

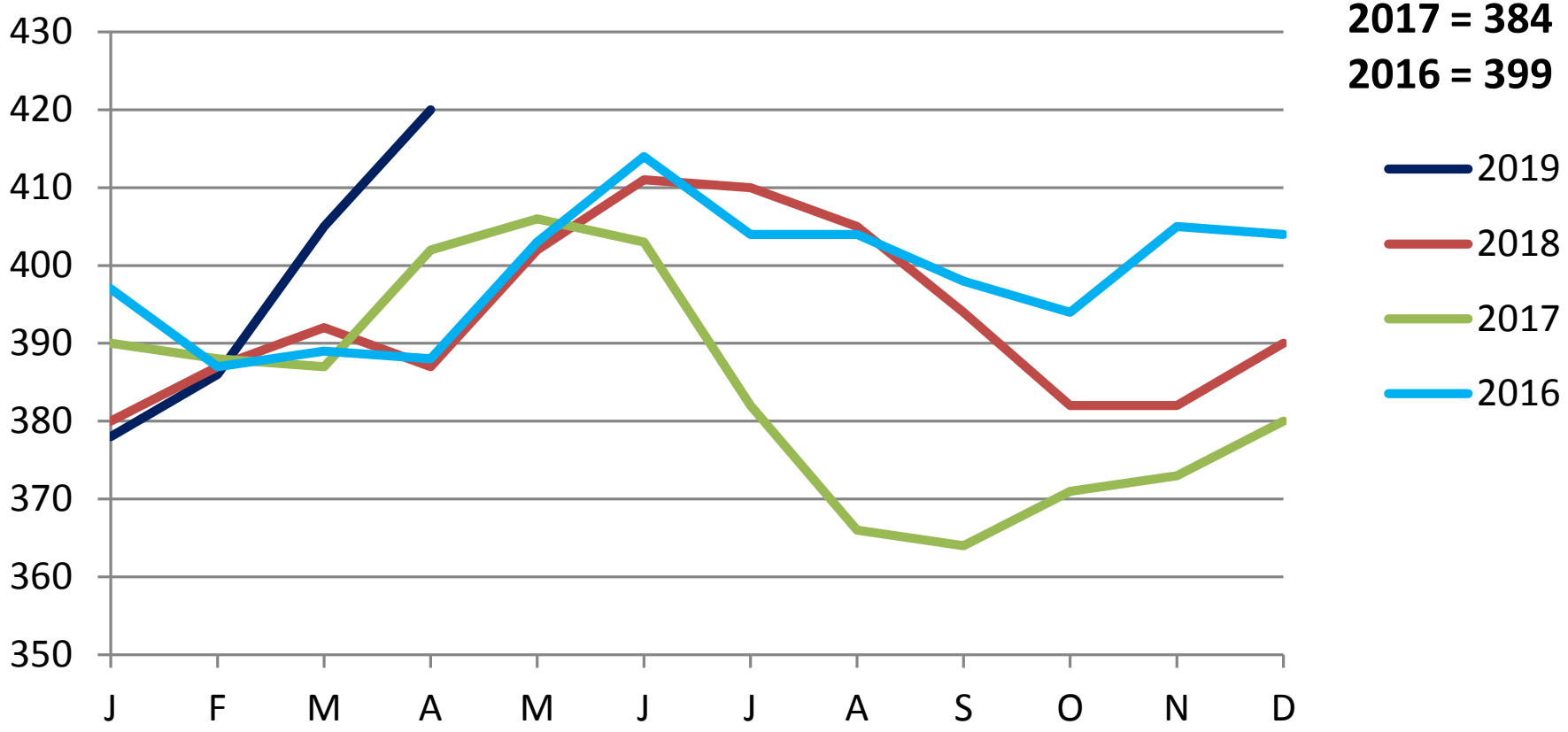
2019 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

	All	South Bend	Elkhart	Plymouth	LaPorte
J	378	195	95	74	14
F	394	202	98	77	18
M	405	209	99	79	18
A	420	222	101	77	20
M					
J					
J					
A					
S					
O					
N					
D					
2019 YTD Totals	1597	828	393	307	70
2019 YTD ADC	**399**	**207**	**98**	**77**	**17**
2018 YTD ADC	387	214	93	69	7
YTD Change 2018 to 2019	12	-7	5	8	10
YTD % Change 2018 to 2019	**3.2%**	**-3.3%**	**5.6%**	**11.2%**	**NA**

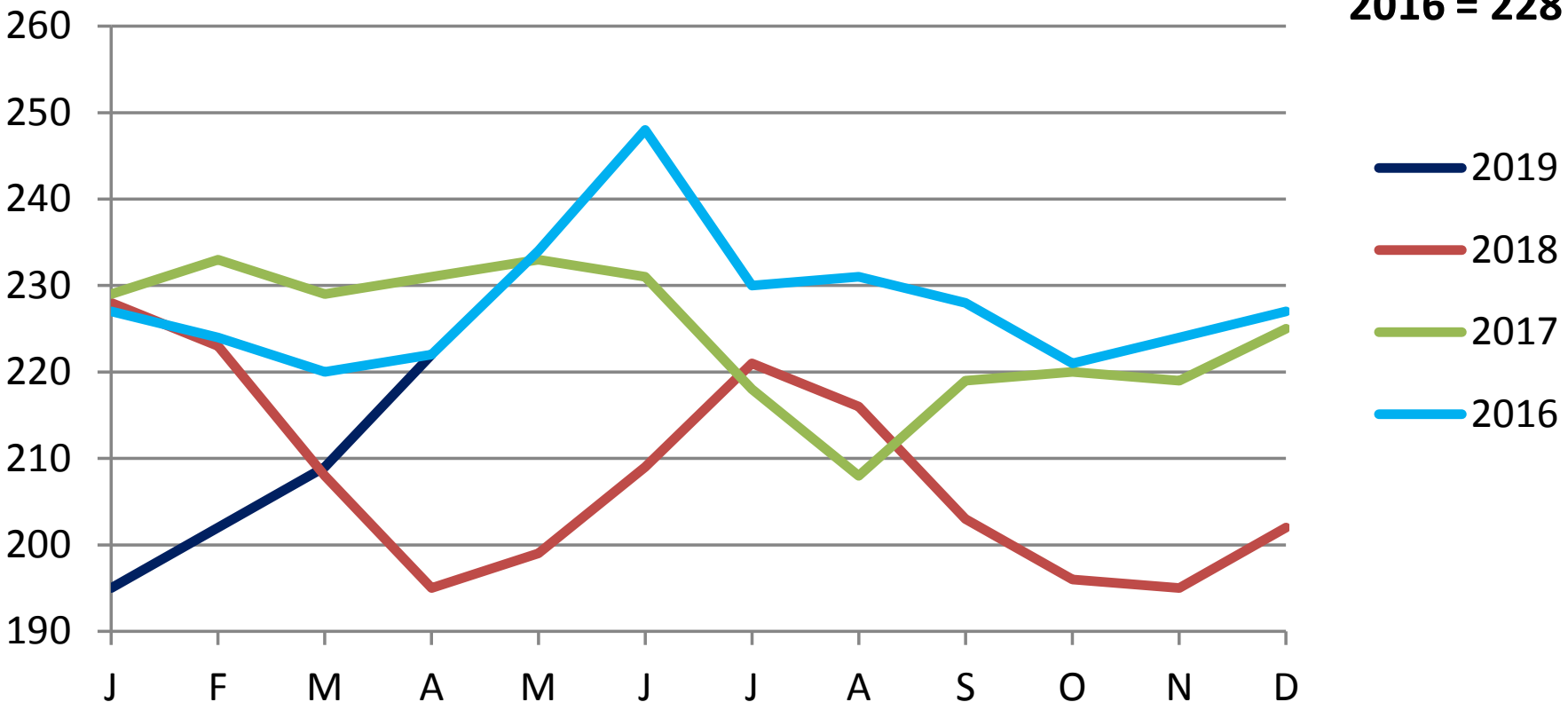


Center for Hospice Care
Total Average Daily Census (ADC)



South Bend
Average Daily Census

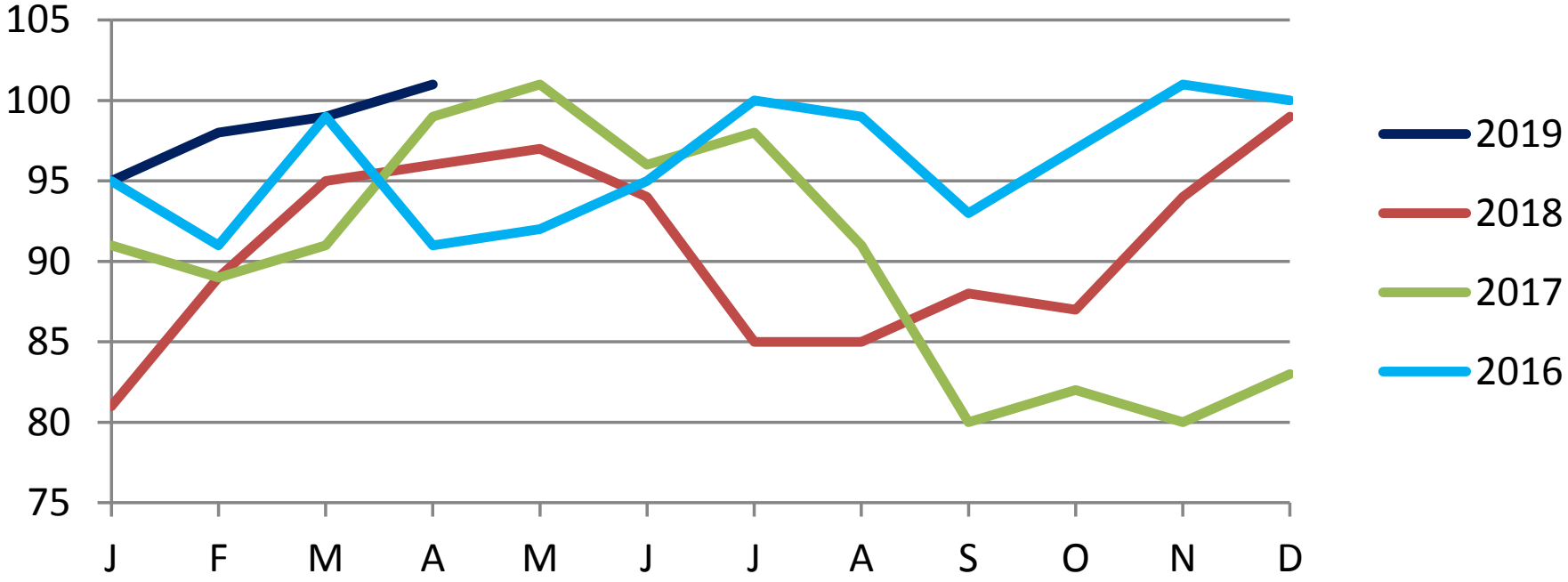
ADC
YTD 2019 = 207
2018 = 208
2017 = 225
2016 = 228



Elkhart
Average Daily Census

ADC

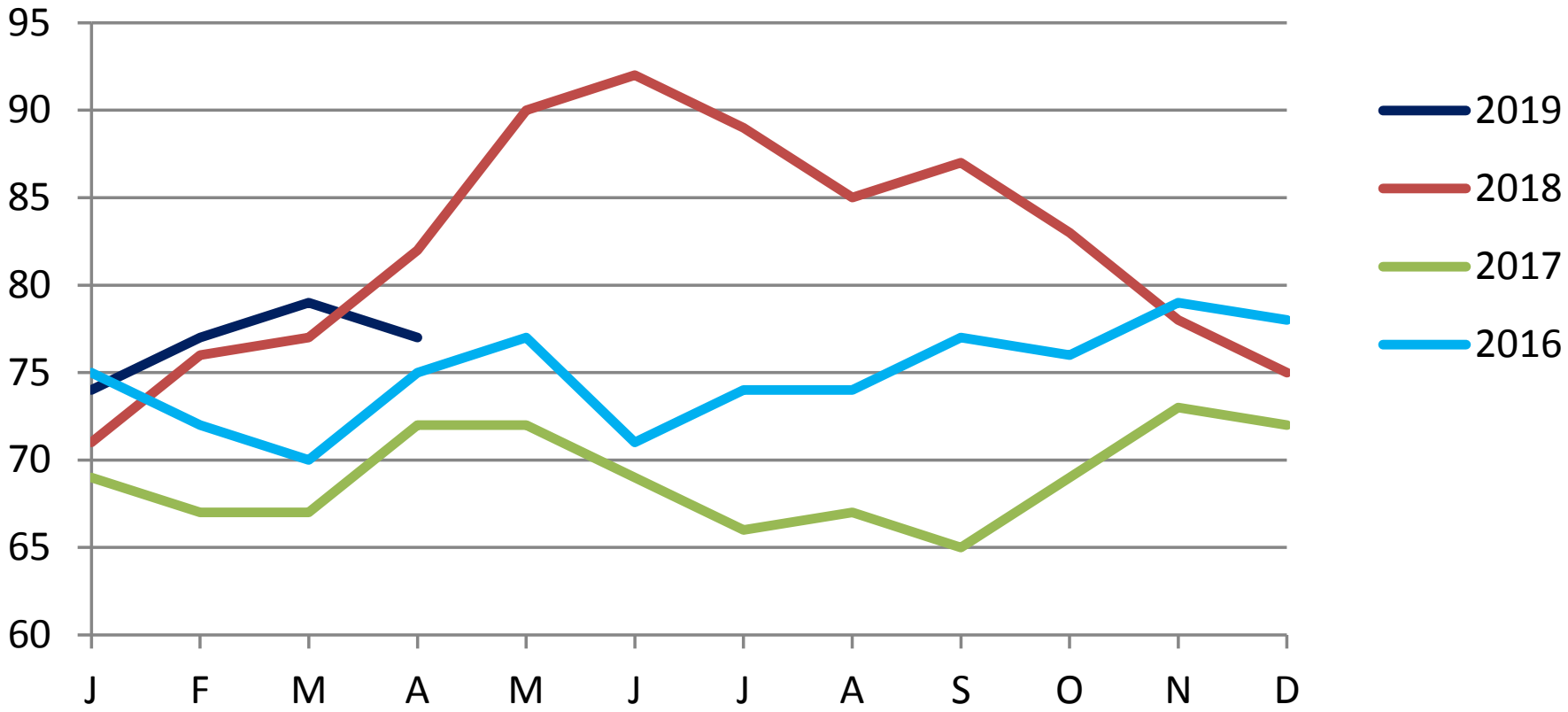
YTD 2019 = 98
2018 = 91
2017 = 90
2016 = 96



Plymouth
Average Daily Census

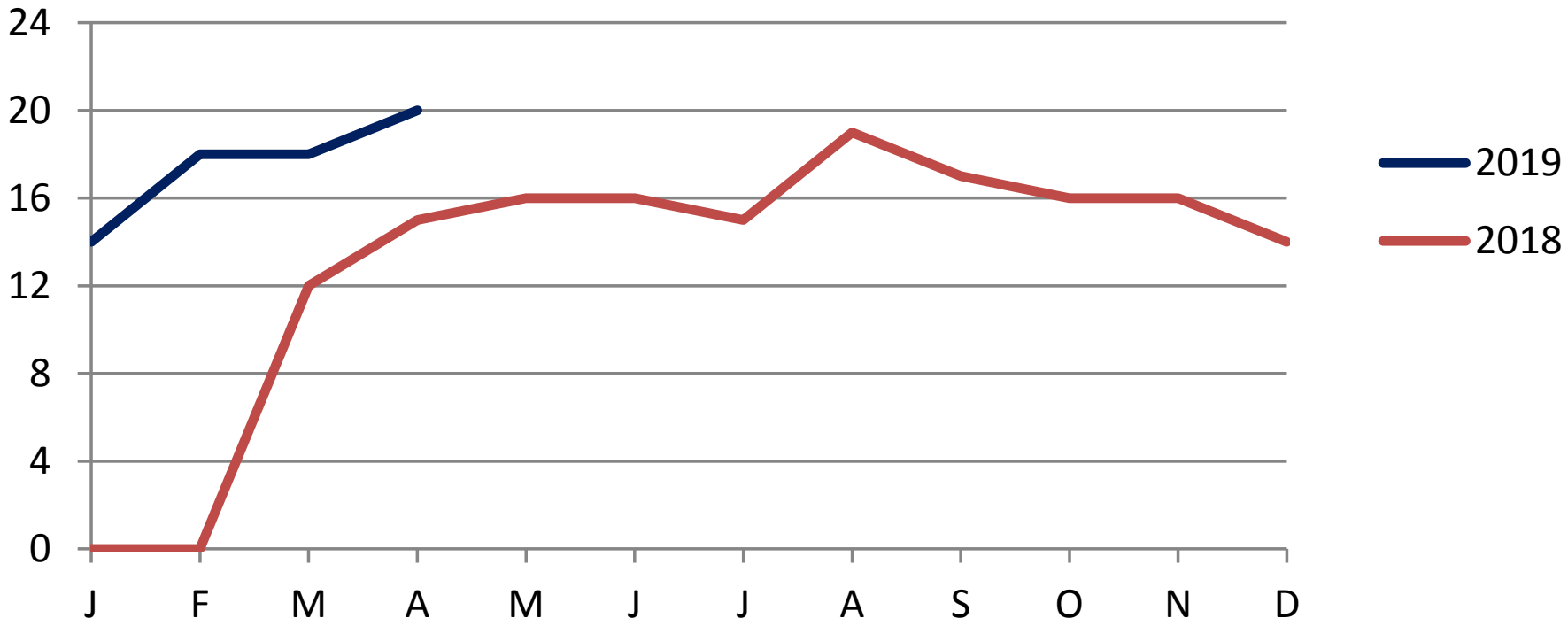
ADC

YTD 2019 = 77
2018 = 82
2017 = 69
2016 = 75



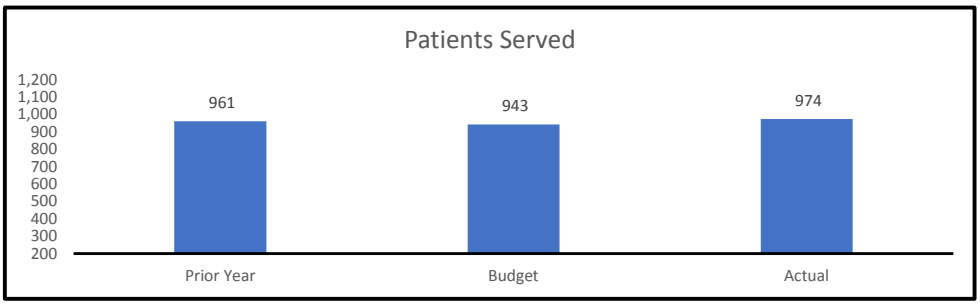
LaPorte
Average Daily Census

ADC
YTD 2019 = 18
2018 = 13

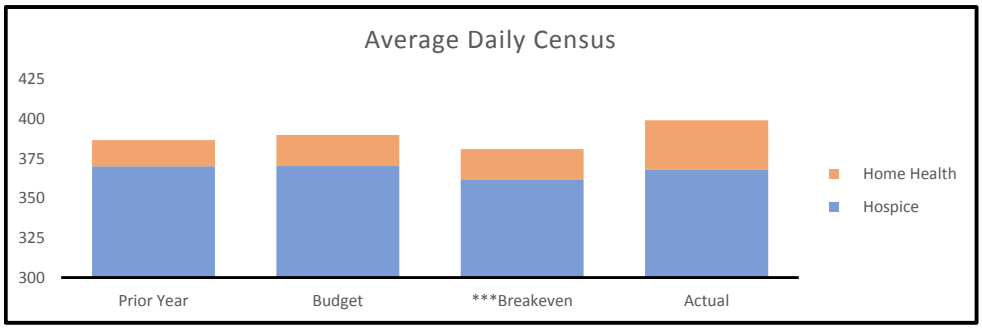


Center for Hospice Care
April 2019 Summary

	Prior Year	Budget	Actual
Patients Served	**961**	**943**	**974**

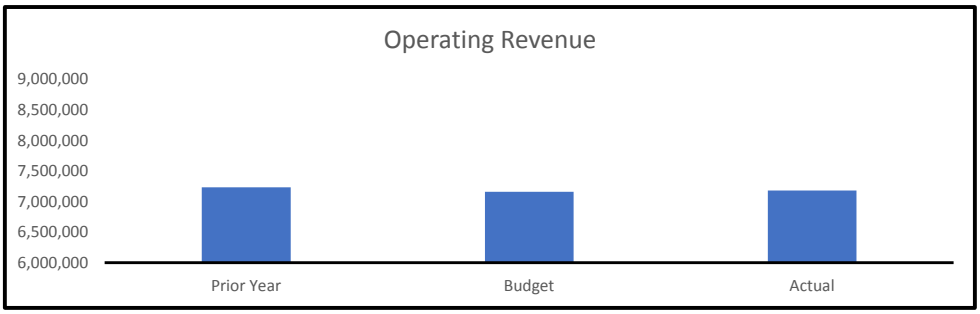


Average Daily Census	**Prior Year**	**Budget**	*****Breakeven**	**Actual**
Hospice	370.15	370.36	361.93	367.88
Home Health	16.47	19.49	19.05	31.20
Total Average Daily Census	**386.62**	**389.85**	**380.98**	**399.08**

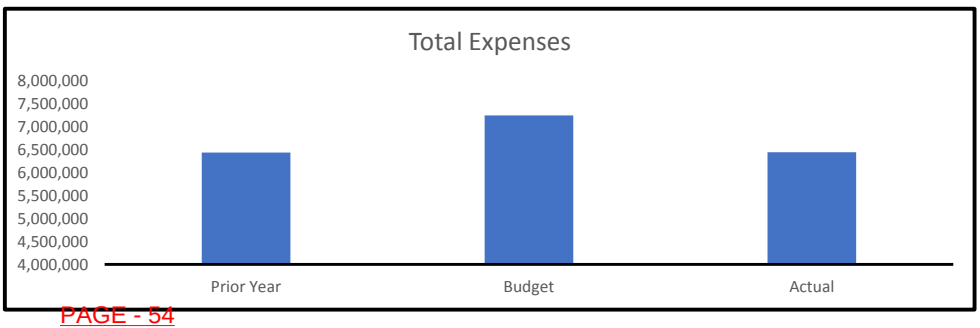


**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	**7,230,864**	**7,161,230**	**7,178,776**



	Prior Year	Budget	Actual
Total Expenses	**6,438,568**	**7,249,334**	**6,443,654**



Purpose of Hospice
Program for Evaluating Payment Patterns Electronic Report

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151501, Center for Hospice and Palliative Care Inc, The
Most Recent Three Federal Fiscal Years Through Q4FY18

The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is an educational tool which supports CMS' efforts to protect the Medicare Trust Fund. PEPPER summarizes a provider's Medicare claims data for services in areas that have been identified as at high risk for improper payments.

Please refer to the Hospice PEPPER User's Guide at https://pepper.cbrpepper.org for guidance using the report. The statistics are summarized and reported as three 12-month time periods based on the federal fiscal year which begins October 1 and ends September 30. If you need assistance, please visit https://pepper.cbrpepper.org and click on the "Help/Contact Us" tab.

This is HSPC PEPPER version Q4FY18
Jurisdiction: JM Palmetto GBA (11001)

PEPPER is developed under contract with the Centers for Medicare & Medicaid Services (CMS), by RELI Group, along with its partners TMF Health Quality Institute and CGS.

Hospice Target Area	Hospice Target Area Definition
Live Disch	N: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown)), excluding: a. beneficiary transfers (patient discharge status code 50 or 51) b. beneficiary revocations (occurrence code 42) c. beneficiaries discharged for cause (condition code H2) d. beneficiaries who moved out of the service area (condition code 52) D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
Live Disch Rev	N: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown)), with occurrence code 42 D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
Live Disch LOS 61-179	N: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown)), with a length of stay (LOS) of 61-179 days D: count of all beneficiary episodes discharged alive by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
Long LOS	N: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice) D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
CHC in ALF	N: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (revenue code = "0652") were provided while the beneficiary resided in an Assisted Living Facility (HCPCS code = "Q5002") D: count of all beneficiary episodes ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = "Q5002") for any portion of the episode
RHC in ALF	N: count of Routine Home Care days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = Q5002) D: count of all Routine Home Care days (revenue code = 0651) provided by the hospice on claims ending in the report period
RHC in NF	N: count of Routine Home Care days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a nursing facility (HCPCS code = Q5003) D: count of all Routine Home Care days (revenue code = 0651) provided by the hospice on claims ending in the report period
RHC in SNF	N: count of Routine Home Care days (revenue code = 0651) provided on claims ending in the report period that indicate the beneficiary resided in a skilled nursing facility (HCPCS code = Q5004) D: count of all Routine Home Care days (revenue code = 0651) provided by the hospice on claims ending in the report period
Single Diag	N: count of claims ending in the report period that have only one diagnosis coded D: count of all claims ending in the report period with one or more diagnoses coded

Hospice Target Area	Hospice Target Area Definition
No GIP or CHC	N: count of beneficiary episodes ending in the report period that had no amount of general inpatient care (revenue code = 0656) or continuous home care (revenue code = 0652) D: count of all beneficiary episodes discharged (by death or alive) by the hospice during the report period (obtained by considering all claims billed for a beneficiary by that hospice)
Long GIP	N: count of GIP stays within episodes ending in the report period with a length greater than five consecutive days D: count of all GIP stays within episodes ending in the report period, identified as 1+consecutive days of revenue code 0656

Compare Targets Report, Four Quarters Ending Q4 FY 2018

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The Compare Targets Report displays statistics for target areas that have reportable data (11+ target count) in the most recent time period. Percentiles indicate how a hospice's target area percent compares to the target area percents for all hospices in the respective comparison group. For example, if a hospice's national percentile (see below) is 80.0, 80% of the hospices in the nation have a lower percent value than that hospice. The hospice's state percentile (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target area indicate that the hospice may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Target Count	Percent	Hospice National %ile	Hospice Jurisdict. %ile	Hospice State %ile	Sum of Payments
Live Discharges Not Terminally Ill	Proportion of beneficiary episodes discharged alive, excluding patient discharge status code 50 or 51 (discharged/transferred to a hospice), excluding occurrence code 42 (beneficiary revokes), excluding condition code H2 (beneficiary discharged for cause) or 52 (beneficiary moves out of service area), to all discharges	61	4.3%	15.9	17.5	32.7	$1,522,880
Live Discharges Revocations	Proportion of beneficiary episodes discharged alive with occurrence code 42 (beneficiary revokes), to all discharges	32	2.3%	7.3	6.0	9.8	$475,860
Live Discharges LOS 61-179	Proportion of beneficiary episodes discharged alive with LOS 61-179 days, to all live discharges	26	23.6%	16.1	20.7	27.3	$438,672
Long LOS	Proportion of beneficiary episodes discharged (by death or alive) whose combined days of service at the hospice is greater than 180 days, to total number of beneficiary episodes discharged (by death or alive)	183	12.9%	35.0	32.2	38.7	$11,414,485
Routine Home Care in Assisted Living Facility	Proportion of Routine Home Care days (revenue code 0651) provided on claims that indicate the beneficiary resided in an assisted living facility (HCPCS code Q5002), to count of all Routine Home Care days (revenue code 0651) provided by the hospice	12,433	10.4%	32.5	40.3	50.8	Not Calculated
Routine Home Care in Nursing Facility	Proportion of Routine Home Care days (revenue code 0651) provided on claims that indicate the beneficiary resided in a nursing facility (HCPCS code Q5003), to count of all Routine Home Care days (revenue code 0651) provided by the hospice	25,775	21.6%	51.8	49.6	25.4	Not Calculated
Claims w/ Single Diagnosis Coded	Proportion of claims that have only one diagnosis coded, to all claims	197	3.6%	23.3	26.9	58.3	Not Calculated

Note: State and/or jurisdiction %iles are not reported when there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

Worksheet: Compare
File: 151501_11001_HSPCPEPP_Q4FY18_Center_for_Hosp

Compare Targets Report, Four Quarters Ending Q4 FY 2018

151501, Center for Hospice and Palliative Care Inc, The

The Compare Targets Report displays statistics for target areas that have reportable data (11+ target count) in the most recent time period. Percentiles indicate how a hospice's target area percent compares to the target area percents for all hospices in the respective comparison group. For example, if a hospice's national percentile (see below) is 80.0, 80% of the hospices in the nation have a lower percent value than that hospice. The hospice's state percentile (if displayed) and the Medicare Administrative Contractor (MAC) jurisdiction percentile values should be interpreted in the same manner. Percentiles at or above the 80th percentile for any target area indicate that the hospice may be at a higher risk for improper Medicare payments. The greater the percentile value, in particular the national and/or jurisdiction percentile, the greater consideration should be given to that target area.

Target	Description	Target Count	Percent	Hospice National %ile	Hospice Jurisdict. %ile	Hospice State %ile	Sum of Payments
No GIP or CHC	Proportion of episodes that had no general inpatient care (revenue code 0656) or continuous home care (revenue code 0652), to all episodes	912	64.4%	13.0	18.0	14.6	$13,635,858
Long GIP Stays	Proportion of GIP stays > 5 consecutive days, to all GIP stays (1+ consecutive days of revenue code 0656)	139	26.7%	50.9	43.9	62.5	Not Calculated

Note: State and/or jurisdiction %iles are not reported when there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

Worksheet: Compare
File: 151501_11001_HSPCPEPP_Q4FY18_Center_for_Hosp

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Live Discharges No Longer Terminally Ill

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile

YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	4.4%	3.8%	4.3%
Target Count Numerator: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown), excluding beneficiary transfers (patient discharge status code 50 or 51), beneficiary revocations (occurrence code 42), beneficiaries discharged for cause (condition code H2) and beneficiaries who moved out of the service area (condition code 52)	65	55	61
Denominator Count (see Definitions worksheet for complete definition)	1,461	1,451	1,416
Target (Numerator) Average Length of Stay	194.6	211.8	177.4
Denominator Average Length of Stay	79.7	80.6	80.6
Target (Numerator) Average Payment	$28,930	$30,297	$24,965
Target (Numerator) Sum of Payments	$1,880,460	$1,666,319	$1,522,880

*Data not available when numerator count less than 11

COMPARATIVE DATA			
Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.			
National 80th Percentile	15.3%	14.4%	14.2%
Jurisdiction 80th Percentile	16.0%	13.8%	13.3%
State 80th Percentile	11.6%	10.4%	9.8%

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

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Live Discharges-Revocations

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile

YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	2.8%	2.6%	2.3%
Target Count (Numerator: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown)), with occurrence code "42"	41	38	32
Denominator Count (see Definitions worksheet for complete definition)	1,461	1,451	1,416
Target (Numerator) Average Length of Stay	131.8	79.9	96.1
Denominator Average Length of Stay	79.7	80.6	80.6
Target (Numerator) Average Payment	$20,654	$12,559	$14,871
Target (Numerator) Sum of Payments	$846,802	$477,232	$475,860

*Data not available when numerator count less than 11

COMPARATIVE DATA			
	National 80th Percentile	13.4%	13.8%	14.1%
	Jurisdiction 80th Percentile	12.9%	12.6%	11.9%
	State 80th Percentile	6.8%	7.3%	6.2%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. A high percentage of live discharges for beneficiary revocations could indicate improper beneficiary revocations are occurring. The hospice should review instances where occurrence code "42" is applied to ensure that the revocation was initiated by the beneficiary (not by the hospice) and that the revocation was not initiated to avoid costly patient care.

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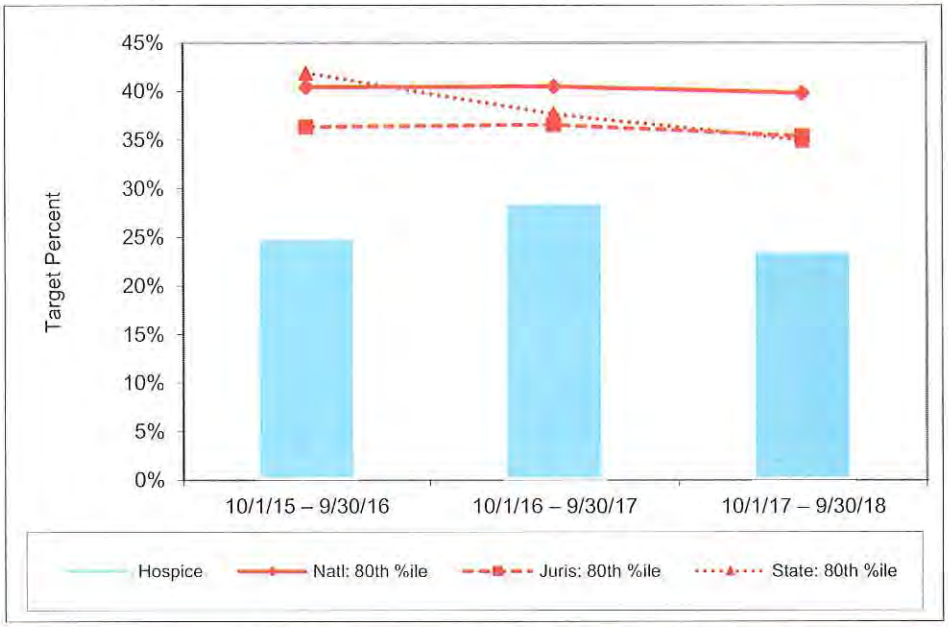
Live Discharges with LOS 61-179 Days

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	25.0%	28.7%	23.6%
Target Count (Numerator: count of beneficiary episodes who were discharged alive by the hospice (patient discharge status code not equal to "40" (expired at home), "41" (expired in a medical facility) or "42" (expired place unknown)), with a length of stay (LOS) of 61-179 days	30	29	26
Denominator Count (see Definitions worksheet for complete definition)	120	101	110
Target (Numerator) Average Length of Stay	118.7	122.5	115.9
Denominator Average Length of Stay	180.2	152.9	153.4
Target (Numerator) Average Payment	$17,864	$18,435	$16,872
Target (Numerator) Sum of Payments	$535,919	$534,611	$438,672

*Data not available when numerator count less than 11

COMPARATIVE DATA			
	National 80th Percentile	40.5%	40.5%	39.8%
	Jurisdiction 80th Percentile	36.4%	36.6%	35.4%
	State 80th Percentile	41.9%	37.7%	35.0%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for beneficiaries discharged alive to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy. Beginning October 1, 2015 (fiscal year 2016), hospice payments for RHC will decrease beginning on day 61. Beginning with FY2016, a high percentage of live discharges with a LOS 61-179 days could indicate that financial incentives are impacting patient care decisions.

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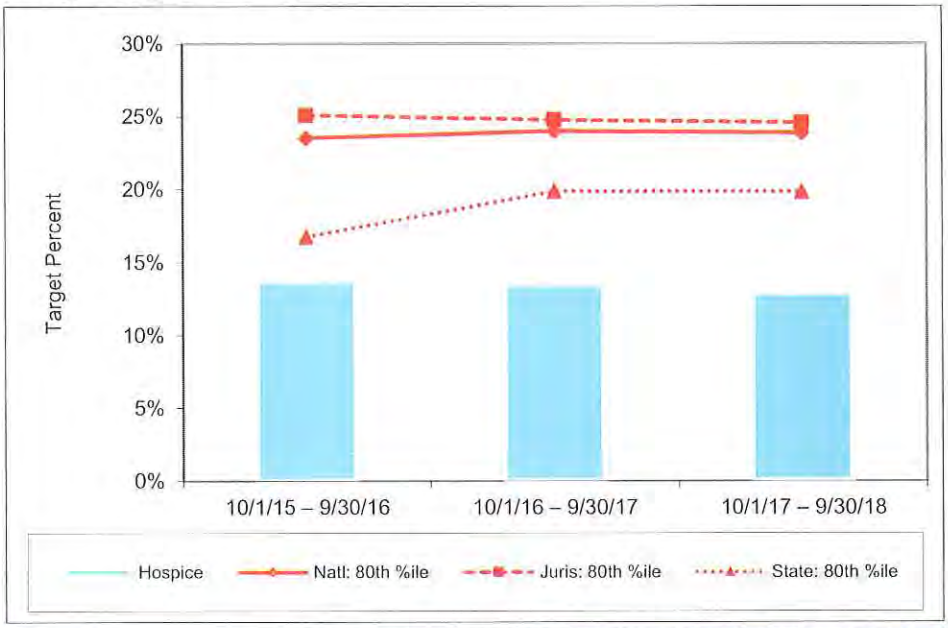
Long Length of Stay

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	13.8%	13.5%	12.9%
Target Count (Numerator: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period whose combined days of service at the hospice is greater than 180 days (obtained by considering all claims billed for a beneficiary by that hospice)	201	196	183
Denominator Count (see Definitions worksheet for complete definition)	1,461	1,451	1,416
Target (Numerator) Average Length of Stay	396.2	419.1	433.5
Denominator Average Length of Stay	79.7	80.6	80.6
Target (Numerator) Average Payment	$58,500	$59,840	$62,374
Target (Numerator) Sum of Payments	$11,758,572	$11,728,649	$11,414,485

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	23.5%	24.0%	23.9%
Jurisdiction 80th Percentile	25.1%	24.8%	24.6%
State 80th Percentile	16.8%	19.9%	19.8%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries are being enrolled in the Medicare Hospice Benefit who do not meet the hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit when they meet eligibility criteria. Medical record documentation should be reviewed for a sample of beneficiaries with long lengths of stay to determine if enrollment in the hospice benefit was appropriate and in accordance with Medicare policy.

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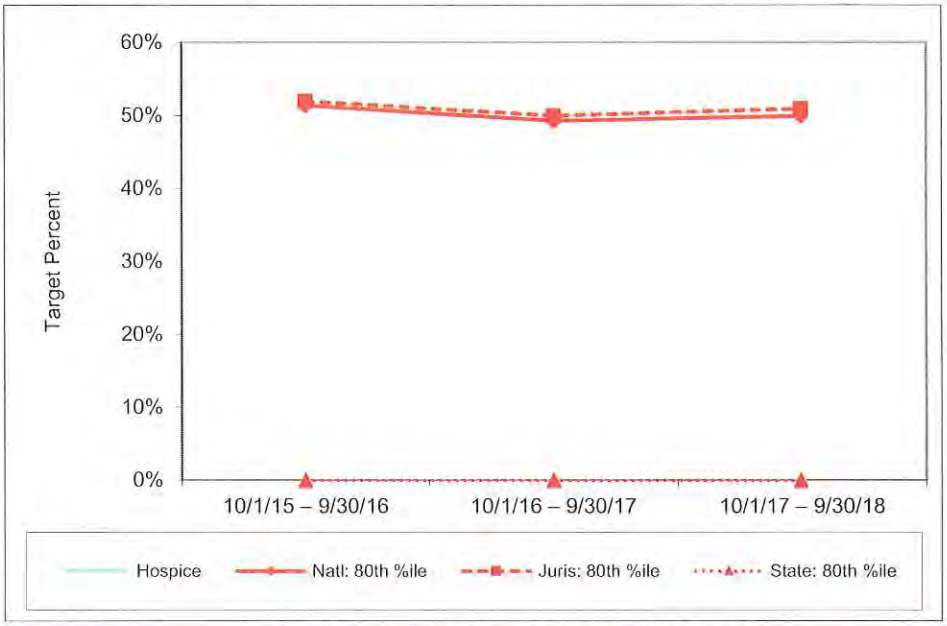
Continuous Home Care Provided in an Assisted Living Facility

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	*	*	*
Target Count (Numerator: count of beneficiary episodes discharged (by death or alive) by the hospice during the report period where at least eight hours of Continuous Home Care (revenue code = "0652") were provided while the beneficiary resided in an Assisted Living Facility (HCPCS code = "Q5002")			
Denominator Count (see Definitions worksheet for complete definition)			
Target (Numerator) Average Length of Stay			
Denominator Average Length of Stay			
Target (Numerator) Average Payment			
Target (Numerator) Sum of Payments			

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	51.4%	49.3%	50.0%
Jurisdiction 80th Percentile	52.0%	50.0%	51.0%
State 80th Percentile	0.0%	0.0%	0.0%

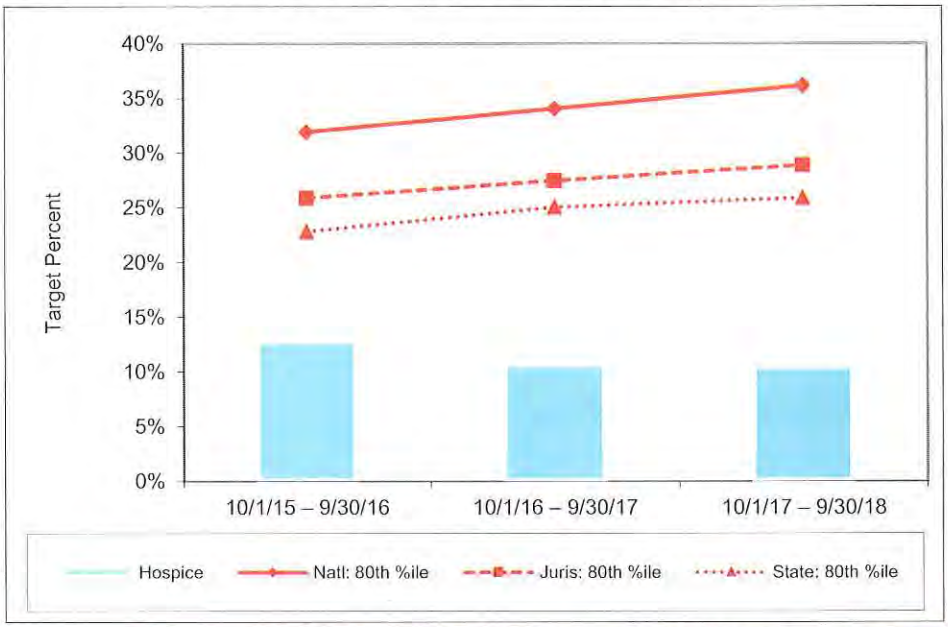
Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries who reside in an ALF are being enrolled in the Medicare Hospice Benefit when they may not meet hospice eligibility criteria, or that the hospice is providing a higher level of hospice service than is necessary to beneficiaries who reside in an ALF. The hospice should review documentation to ensure that beneficiaries are enrolled in the hospice benefit appropriately, that the level of hospice service is appropriate and in accordance with Medicare policy, and that the number of hours of CHC billed are supported by documentation in the medical record.

Routine Home Care Provided in an Assisted Living Facility

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	12.8%	10.7%	10.4%
Target Count (Numerator: count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in an assisted living facility (HCPCS code = "Q5002")	15,486	12,633	12,433
Denominator Count (see Definitions worksheet for complete definition)	121,078	118,487	119,424

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	31.9%	34.1%	36.2%
Jurisdiction 80th Percentile	25.9%	27.5%	28.9%
State 80th Percentile	22.8%	25.1%	25.9%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries who reside in an ALF are being enrolled in the Medicare Hospice Benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.

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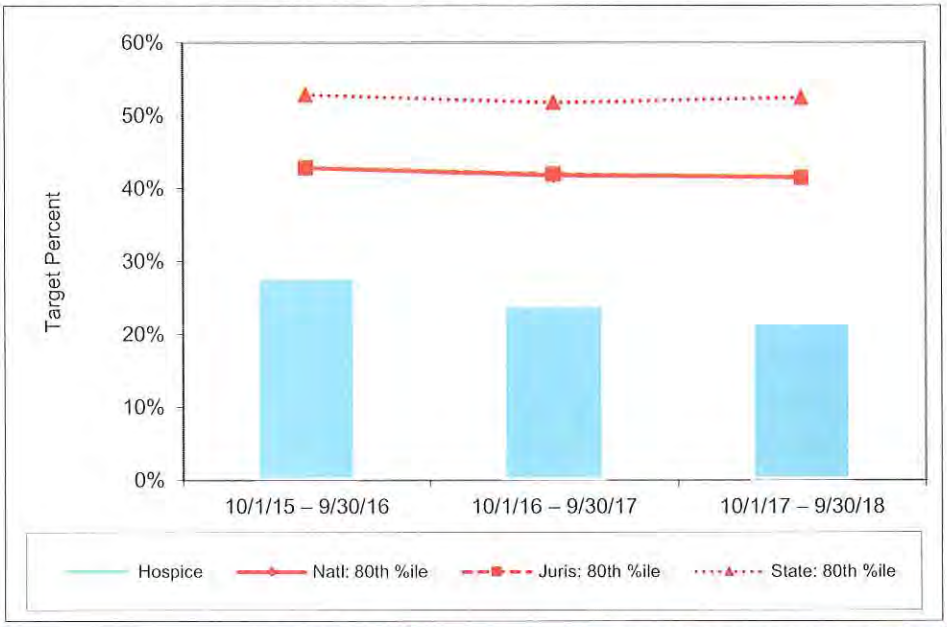
Routine Home Care Provided in a Nursing Facility

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	27.9%	24.0%	21.6%
Target Count (Numerator: count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in a nursing facility (HCPCS code = "Q5003")	33,816	28,462	25,775
Denominator Count (see Definitions worksheet for complete definition)	121,078	118,487	119,424

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	42.9%	41.8%	41.6%
Jurisdiction 80th Percentile	42.9%	42.0%	41.5%
State 80th Percentile	52.9%	51.8%	52.5%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries who reside in a nursing facility are being enrolled in the Medicare Hospice Benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.

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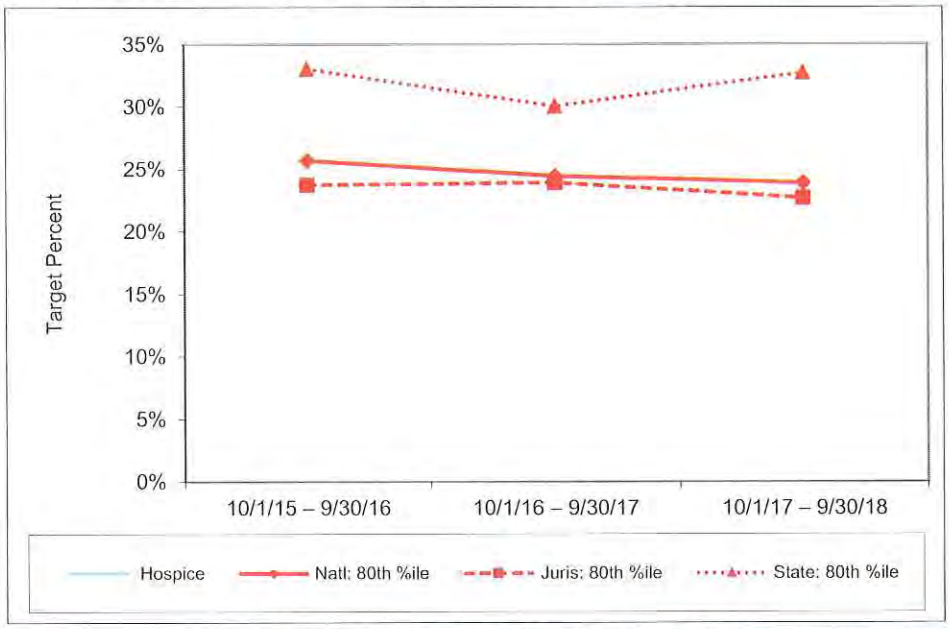
Routine Home Care Provided in a Skilled Nursing Facility

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	*	*	*
Target Count (Numerator: count of Routine Home Care days (revenue code = "0651") provided on claims ending in the report period that indicate the beneficiary resided in a skilled nursing facility (HCPCS code = "Q5004")			
Denominator Count (see Definitions worksheet for complete definition)			

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	25.7%	24.5%	23.9%
Jurisdiction 80th Percentile	23.8%	23.9%	22.7%
State 80th Percentile	33.0%	30.1%	32.7%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that beneficiaries who reside in a skilled nursing facility are being enrolled in the Medicare Hospice Benefit when they may not meet hospice eligibility criteria. The hospice should review Medicare hospice eligibility criteria and admissions procedures to ensure that beneficiaries are enrolled in the hospice benefit appropriately. Medical record documentation should be reviewed to determine if enrollment in the hospice benefit and services provided are appropriate and in accordance with Medicare policy.

Hospice PEPPER
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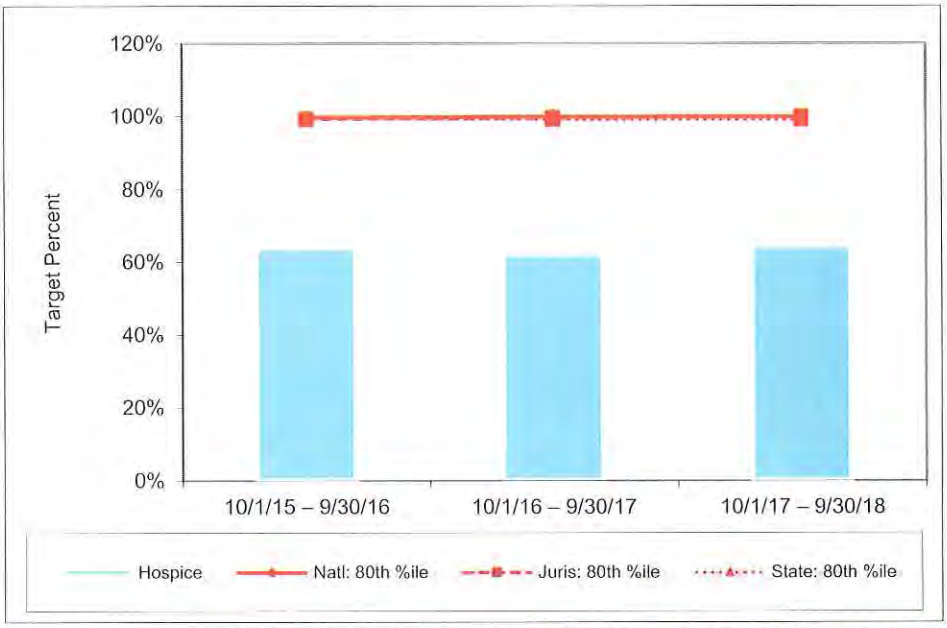
No General Inpatient Care or Continuous Home Care

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	64.0%	62.2%	64.4%
Target Count (Numerator: count of beneficiary episodes ending in the report period that had no amount of general inpatient care (revenue code = "0656") or continuous home care (revenue code = "0652")	935	903	912
Denominator Count (see Definitions worksheet for complete definition)	1,461	1,451	1,416
Target (Numerator) Average Length of Stay	96.0	98.1	99.6
Denominator Average Length of Stay	79.7	80.6	80.6
Target (Numerator) Average Payment	$14,238	$14,560	$14,952
Target (Numerator) Sum of Payments	$13,312,737	$13,148,061	$13,635,858

*Data not available when numerator count less than 11

COMPARATIVE DATA			
	National 80th Percentile	99.8%	100.0%	100.0%
	Jurisdiction 80th Percentile	99.4%	99.7%	100.0%
	State 80th Percentile	99.4%	99.3%	99.2%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that the hospice is not providing the full spectrum of services as required by the Medicare program. A sample of records for beneficiaries that did not receive GIP or CHC should be reviewed. The hospice should ensure that processes are in place to assess when beneficiaries need GIP and/or CHC, and that the hospice is able to provide these services.

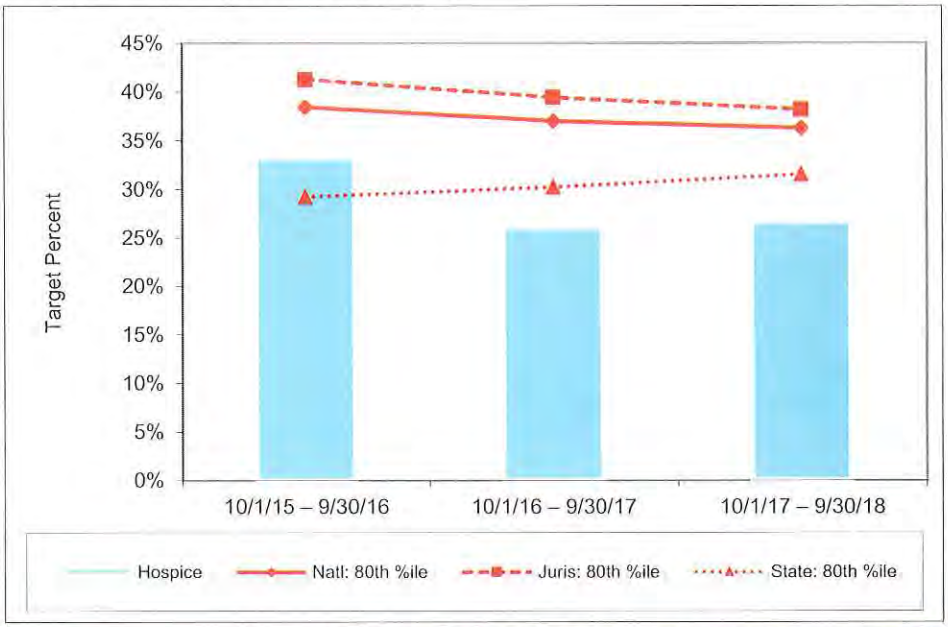
Hospice PEPPER
151501, Center for Hospice and Palliative Care Inc, The

Visit PEPPERresources
Link to Definitions Worksheet

Long General Inpatient Care Stays

Need to audit? When reviewing this information, you may want to consider auditing a sample of records if you identify:

- Increasing Target Percents over time resulting in greater risk of improper Medicare payments
- Your Target Percent (first row in the table below) is above the national 80th percentile



YOUR HOSPICE	10/1/15 – 9/30/16	10/1/16 – 9/30/17	10/1/17 – 9/30/18
Target Area Percent	33.3%	26.1%	26.7%
Target Count (Numerator: count of GIP stays within episodes ending in the report period with a length greater than five consecutive days	182	146	139
Denominator Count (see Definitions worksheet for complete definition)	547	560	521

*Data not available when numerator count less than 11

COMPARATIVE DATA			
National 80th Percentile	38.5%	37.0%	36.3%
Jurisdiction 80th Percentile	41.3%	39.5%	38.2%
State 80th Percentile	29.3%	30.3%	31.6%

Note: State and/or jurisdiction percentiles are zero if there are fewer than 11 providers with reportable data for the target area in the state and/or jurisdiction.

SUGGESTED INTERVENTIONS WHEN ABOVE 80th PERCENTILE: This could indicate that the hospice is initiating GIP services when not indicated/necessary. A sample of records for beneficiaries that had long GIP stays should be reviewed to determine if GIP was provided in the appropriate setting and was appropriately used for pain control or acute/chronic symptom management that could not be addressed in other settings.

Hospice PEPPER

Visit PEPPERresources

151501 Center for Hospice and Palliative Care Inc, The

Hospice Top Terminal CCS Diagnosis Categories, Most Recent Fiscal Year

Terminal Clinical Classification System (CCS) Diagnosis Category	Total Decedents for Each Category	Proportion of Decedents for Each Category to Total Decedents	Hospice Average Length of Stay for Category
Cancer	414	31.7%	45.2
Circulatory or heart disease	231	17.7%	91.6
Stroke	162	12.4%	82.8
Respiratory disease	140	10.7%	70.5
Dementia	130	10.0%	179.4
Top Terminal CCS Categories	1,077	82.5%	80.3
All CCS Categories	1,306		74.5

Note: This report is limited to the top terminal CCS diagnosis categories for which there are a total of at least 11 decedents during the most recent fiscal year. The terminal CCS diagnosis categories are: Cancer (CCS categories 11-47), Circulatory or heart disease (CCS categories 96-108 and 114-121), Dementia (CCS category 653), Respiratory disease (CCS categories 127-134), and Stroke (CCS categories 109-113). The principal ICD-10 diagnosis code from the final claim was collapsed into a general category using Clinical Classification System (CCS) software. More information on CCS can be found at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Average length of stay is calculated by dividing the total number of days decedents received services from the hospice by the total number of decedents with the terminal CCS diagnosis category(ies) that received services from the hospice.

Hospice PEPPER
Hospices for JM Palmetto GBA (11001)

Visit PEPPERresources

Jurisdiction Top Terminal CCS Diagnosis Categories, Most Recent Fiscal Year

Terminal Clinical Classification System (CCS) Diagnosis Category	Total Decedents for Each Category	Proportion of Decedents for Each Category to Total Decedents	Jurisdict. Average Length of Stay for Category	National Average Length of Stay for Category
Cancer	155,511	28.7%	46.0	45.9
Circulatory or heart disease	95,186	17.6%	75.4	72.5
Dementia	83,488	15.4%	118.9	107.7
Respiratory disease	65,129	12.0%	65.2	64.2
Stroke	56,154	10.4%	78.0	71.2
Top Terminal CCS Categories Jurisdiction-wide	455,468	84.0%	72.2	68.4
All CCS Categories Jurisdiction-wide	541,929		69.5	66.0

Note: The terminal CCS diagnosis categories are: Cancer (CCS categories 11-47), Circulatory or heart disease (CCS categories 96-108 and 114-121), Dementia (CCS category 653), Respiratory disease (CCS categories 127-134), and Stroke (CCS categories 109-113). The principal ICD-10 diagnosis code from the final claim was collapsed into a general category using Clinical Classification System (CCS) software. More information on CCS can be found at http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Average length of stay is calculated by dividing the total number of days decedents received services from the hospice by the total number of decedents with the terminal CCS diagnosis category(ies) that received services from the hospice.

Hospice PEPPER

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151501, Center for Hospice and Palliative Care Inc, The

Hospice Live Discharges by Type, Three Fiscal Years

Type of Live Discharge	Total Episodes	Proportion of Live Discharge Episodes	Hospice Average Length of Stay
No longer terminally ill	181	54.8%	194.0
Revocation	111	33.6%	103.7
Beneficiary transfer	38	11.5%	191.7
All Live Discharges	330	7.6%*	163.4

Note: Live discharges are identified as discharges where the patient discharge status code is not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown). This report is limited to displaying the types of live discharges for which there were a total of at least 11 occurrences during the three fiscal years. Average length of stay is calculated by dividing the total number of days beneficiaries received services from the hospice by the total number of that type of live discharge.
*Proportion of all episodes ending by death or alive

Note: Categories will display if they had at least 11 episodes in the most recent three fiscal years.

Hospice PEPPER

Visit PEPPERresources

Hospices for JM Palmetto GBA (11001)

Jurisdiction Live Discharges by Type, Three Fiscal Years

Type of Live Discharge	Total Episodes	Proportion of Live Discharge Episodes	Jurisdict. Average Length of Stay	National Average Length of Stay
No longer terminally ill	115,966	43.4%	232.1	224.2
Revocation	87,458	32.7%	115.6	109.7
Beneficiary transfer	43,317	16.2%	147.8	134.0
Moved out of service area	16,181	6.1%	125.3	114.3
Discharged for cause	4,321	1.6%	157.5	159.5
All Live Discharges Jurisdiction-wide	267,243	14.6%*	172.6	165.9

Note: Live discharges are identified as discharges where the patient discharge status code is not equal to 40 (expired at home), 41 (expired in a medical facility) or 42 (expired place unknown). Average length of stay is calculated by dividing the total number of days beneficiaries received services from the hospice by the total number of that type of live discharge.

*Proportion of all episodes ending by death or alive

April 2019

Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

What is the Center for Palliative Care?

What is the Center for Palliative Care?

The Center for Palliative Care (CPC) is a state-of-the-art, freestanding clinic located in Mishawaka. If a patient has decided to pursue aggressive or life-extending treatment for a progressive or incurable illness and wants pain management or symptom control, the CPC may be a suitable choice.

Although Center for Hospice Care (CHC) has been offering palliative care for many years, our free-standing facility opened in September of 2016.

Who is a typical palliative care patient?

Palliative care is provided primarily for patients with advanced progressive illness who are continuing to pursue curative, life prolonging treatments. The goal of palliative care is to enhance the prevention or relief of a patient's distress.

This goal is accomplished by performing frequent assessment and treatment of their pain, as well as other physical, psychological and spiritual needs. Palliative care is a "quality add-on" to a patient's regular medical care and does not replace it. We will work closely with the patient's current physician to monitor the patient's progress while attempting to decrease the number of recurring hospitalizations.

Patients of any age who are facing an advanced progressive illness are eligible for a palliative care consult. Such a consultation includes patients who are receiving curative treatments, chemotherapy, radiation or dialysis. A patient need not be in the last stages of illness to be

Continued on Page 6

Inside this issue:

Mark Your Calendars

Volunteer Recognition Luncheon

Tuesday, April 9, 2019

11:30am-1:00pm

The Brick

1145 Northside Blvd.

South Bend, IN

Mandatory Annual In-service

Tuesday, June 4, 2019

More details to follow.

Welcome to the Team

Antoinette Waite

South Bend RN

Welcome New Volunteers

Welcome to these new volunteers who recently completed orientation!

Ruth Ann Gardner

Elkhart

Anthony Williams

South Bend

Birthdays

4/2
Pat Lawton

4/5
Sara VonGunten

4/7
Victoria Banowsky

4/7
Patrick Kuzan

4/9
Steve Bussmann

4/10
Stephen Dinehart

4/10
Susan Fron

4/12
Beth Davis

4/13
Linda Williams

4/15
Linda Wruble

4/20
Paul Go

4/25
Jan Atwood

4/25
Larry Kajzer

4/25
Marlene Taylor

4/26
Jeanette McKew

4/27
Rebecca Kauffman

4/27
Sandra Marietta

4/29
Jean Lucas

4/29
Joan Pauley

Camp Evergreen Volunteers

2019 Schedule and Location

Camp Evergreen Weekend will take place May 31st to June 2nd at Camp Eberhart in Three Rivers, MI. Free transportation to and from camp will be provided at designated pick up sites. Campers and volunteers stay overnight in a secure and comfortable lodge. A licensed nurse will be at camp at all times. It is for youth and teens ages 10 to 17 (18 years old if they are a senior in high school).

Camp Evergreen Family Workshop will take place on Saturday, September 21st at the Center for Hospice Care Mishawaka office. It is for youth ages 6 to 12 and a parent/guardian.

Volunteers Needed

Volunteers are needed to be adult buddies for each youth camper and for small groups of teen campers. We also need adult volunteers to assist with the general activities of camp. Center for Hospice Care trains all volunteers and offers support throughout the camp weekend and during the family workshop. ***Volunteers must be 18 years of age or older.***

To request a volunteer or camper application packet, please call 574-255-1064 or toll free at 1-800-413-9083, or email us at evergreen@cfhcare.org.

Volunteer Spotlight
Ish Welch, Camp Evergreen

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

My name is Elishia, but I am better known as "Ish." I volunteer for Camp Evergreen every year. My 1st year was in 2008 I believe, and have volunteered every year with the exception of 2015 when my mom got married (how dare she, haha). I have always volunteered for the teen camp.

Why do you volunteer with CHC?

I volunteered at Camp Evergreen the first year after hearing some speakers in a class I was taking in college. I have always worked with youth in one form or another, and thought this would be great since I too experienced loss in my life. I lost my grandpa and best friend in the same month my sophomore year in high school.

What do you like to do in your spare time?

In my spare time I love being outdoors. I love hiking and kayaking and take my golden doodle, Finn, with me wherever I go. I am a youth leader at my church and have been involved with kids ministry/ youth ministry for over 10 years!

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

If I could go anywhere in the world, I would love to go to Israel and walk where Jesus walked, pray where Jesus prayed, and get baptized in the Jordan River.

Favorite music and why?

At the moment I would say my favorite musician would be Jason Gray. But I love any worship and praise music such as Elevation Warship, Hillsong, For King and Country, etc. I feel it draws me closer to God, I forget everything around me and just consume myself with the Lord.

Favorite things to do?

I love sports and am a huge White Sox fan, which is really rare in this area. I freeze every year and attend opening day. I'm a former season ticket holder but still manage to go to at least 10 games every year. Right now my 5 year old nephew is playing Upward basketball so my Saturday's consist of cheering on the Little Kangaroos. I also love Notre Dame Football, Go Irish!

Favorite book and why?

My favorite book is the Bible. Aside from the birth, death, and resurrection of Jesus, my favorite people are King David, Queen Esther, and Daniel. I read my Bible daily and love the messages, lessons, and grace throughout it. I love how Esther stood up for what was right even though it could have killed her and how Daniel refused to bow down when everyone else was. How Jesus walked on earth and loved everyone. I love how time after time, God used people who seemed the least qualified to do His work.

"Ish has been a dedicated Camp Evergreen volunteer for several years. She provides a caring and supportive presence for grieving youth and teens."

Kim Mathews,

Camp Evergreen Director

Each 1 Recruit 1

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.

Check it out:

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

Training Tips & Reminders

Decreased Appetite at the End of Life

One of the most misunderstood and difficult things for families to deal with is a patient's lack of appetite or in many cases, no appetite.

As changes begin to take place within the patient's body, the hunger and need for food lessens greatly. Nothing tastes good, cravings come and go, liquids are frequently preferred to solids. This does not mean that eating should not be encouraged, but the patient's limitations and choices should be respected. The following suggestions may be helpful:

- Honor the patient's request for certain types of food and do not be discouraged if they only eat a small portion.
- Serve food in small portions on small plates so as not to overwhelm the patient.
- Frequent small meals and snacks may be tolerated better than the traditional "three meals a day."
- Concentrate on food or liquids higher in calories if less is being eaten.
- Monitor the patient's eating routine to determine if there is a particular time of day when eating is best.
- Serve food in a comfortable and relaxing atmosphere.

As an illness and weakness progress, eating usually decreases. The body begins to shut down the functions of eating and digestion to conserve energy. This is not an uncomfortable process. Forcing a patient to eat may cause physical discomfort and distress. This may be evident through signs of the patient coughing, choking, nausea, or vomiting. Notify the hospice nurse to discuss these concerns and for further instructions.

It will also become evident in the last stages of a patient's illness that the need for fluids also decreases. We continue to stress that this is part of the natural process of dying. As fluids lessen, there may actually be relief from some uncomfortable physical symptoms. There will be:

Less fluid in the throat and lungs to reduce coughing and congestion

Decreased stomach fluids that may reduce episodes of vomiting

Less need for urination

Swelling may decrease, lessening feelings of pressure and tightness

When fluids are reduced, the concentration of natural chemical elements in the body changes. This can reduce sensation in the central nervous system, and the patient may feel less distress. A patient's comfort and dignity will always be our priority. We will consult and work with the physician and family to meet the patient's needs. Staff is always available to talk with the family about their feelings, especially regarding difficult issues.

Comments from Our Families

- Thank you for the assistance you provided before and after my mother's transition: contacting my children's schools, helping me move her from the hospital to home, providing the bed and other equipment and procedures, contacting the mortuary, and being there when mom transitioned. Although I did not take advantage of the counseling services, it was comforting to know they were available.

- We did not have hospice services for very long, but we were very appreciative of the time we did have. Thank you all.

eligible.

Because palliative care is offered in addition to the care they are currently receiving, nothing needs to be discontinued to qualify for a visit to the CPC.

How does the referral process work? Who can refer?

Tell your doctor, nurse or healthcare provider that you want Palliative Care. You may also call our Admissions Department at 574-243-3125. Because a referral must be made by the patient's attending physician, we will gladly contact them on your behalf.

Once the referral and pertinent medical information have been received from the patient's attending physician, an appointment is scheduled with the patient. It is at this initial appointment when goals and desires are discussed.

Recommendations regarding medication and support care are then made to the attending physician.

What kinds of treatment are provided? What can the staff at the CPC help patients with?

Because a CPC consultation is for addressing patient symptoms, treatment suggestions will vary based on the nature of the symptoms. Relief from general pain, upper and lower intestinal pain, shortness of breath, anxiety and worry, and any other upsetting or noxious symptoms will be addressed. Also discussed are medication options along with concomitant benefits and risks. Non-medication treatment options such as acupuncture, acupressure, massage or caring touch therapy, herbal therapy, aromatherapy, pet therapy, music therapy and others, are also presented as appropriate.

What are the benefits of receiving palliative care?

Palliative care improves the quality of life for patients by alleviating symptoms and stress while focusing more on the whole person. CPC staff specialize in providing comfort, clarity, choice and connection as they:

- Make the patient comfortable by alleviating both anxiety and physical symptoms such as pain, nausea, loss of appetite and sleep issues
- Support coordinated care in partnership with the patient's physician
- Allow time for communication with patients and family members so they can better understand the illness and care options
- Help reduce stress within the family unit Consider all needs; medical, physical, emotional and spiritual
- Alleviate suffering and bring comfort and peace

The CPC physicians help to reduce frequent office visits, emergency department visits, as well as hospital readmissions.

CPC also provides ongoing education and discussions with patients and families regarding end-of-life care goals.

How does palliative care differ from other methods of pain management?

Most medical care focuses on diagnosing, curing, or prolonging life which may actually result in worsening pain and other symptoms. CPC nurse practitioners and physicians concentrate solely on symptom relief and patient comfort.

How does it differ from other methods of pain management?

All other parts of total medical care have to do with diagnosing, curing, or prolonging life, and all of these are very capable of inflicting and worsening pain and other symptoms while being done. The diagnosing, curing, and prolonging doctors concentrate on those activities.

Palliative Care NPs and physicians concentrate solely on symptom relief.

Who pays for CPC services?

Palliative care is covered by Medicare/Medicaid and most private insurance.

What are the hours?

Center for Palliative Care consultations are available by appointment between 9 AM and 4 PM, Monday – Friday.

May 2019

Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

2019 Volunteer Appreciation

On April 9, 2019 a roomful of CHC volunteers joined staff, board members and the volunteer team to recognize the wonderful work our volunteers provide to our families, patients and the community each year.

CHC President and CEO, Mark Murray, shared an annual report. He said that our volunteers give thousands of hours annually equating to about 8 full time employees who never get sick or take a day off!

This year's John E. Krueger, MD Hospice Caring Award went to Kay Swett. Kay has served in ten different capacities in her five years as a CHC volunteer. This amounts to about 850 hours of service to patients and their families!

Kay Swett, 2019 John E. Krueger, MD Hospice Caring Award recipient and Marlane Huber, Elkhart Volunteer Coordinator.

Being a former CNA, she is a perfect fit for her service at the Inpatient Unit.

She does everything and anything needed there including providing care for patients, sitting with them as an 11th Hour Volunteer, cleaning the facility and its rooms, checking on and assisting family members, doing laundry and grocery shopping and yes, getting coffee and tea for the staff! She is a born caregiver and has been ready, willing and able to do whatever is needed to help CHC run smoothly. In addition to her work at the IPU, Kay serves at our reception desk, she makes weekly Tuck-In Program calls to patients and/or their caregivers, she serves on our Volunteer Recruitment Committee, provides 1:1 companionship for patients, does one-time home visits to patients and more. Kay is a true gem. Her work ethic and compassionate care are second to none.

She keeps going like the Energizer Bunny and has no intention of slowing down!

The Brick, generously donated to us by Corey & Pat Cressy, was jam-packed with our wonderful CHC volunteers!

Story continued on Page 6

Inside this issue:

Mark Your Calendars

Mandatory Annual In-service

Tuesday, June 4, 2019

Details in this newsletter

NEW Volunteer Orientation

Mondays & Wednesdays

June 17, 19 & 24, 2019

9:00am-12:00pm

Wednesday

June 26, 2019

9:00am-3:00pm

501 Comfort Place

Mishawaka, IN

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

Mandatory Annual Skills Validation for Level III Volunteers

Monday, July 8, 2019

Tuesday, July 9, 2019

Wednesday, July 10, 2019

Details in this newsletter

Birthdays

5/1
Ilene New

5/2
Miriam Orendorf

5/4
Anthony Williams

5/7
Mary Kerby

5/8
Noah Hochstetler

5/10
Kathleen Gaspar

5/11
Allen Falls

5/11
Julie Mann

5/12
Bill Probst

5/14
Ruben Ottenwalder

5/15
Linda Rothrock Jurus

5/17
Janet Van De Veire

5/23
Pat Goeller

5/23
Cindy Kilgore

5/24
Betty Kay Eley

5/25
Loretta Blowers

5/25
Linda Ward

5/29
Sarah Wargo

5/30
Megan McCabe

Welcome to the Team

Tami Brinks
Elkhart PRN CNA

Kristen Holt
Elkhart RN Case Manager

Candice George
Billing & Coding Verification Representative

Iris Pitts
South Bend IPU CNA

Pet Peace of Mind

Coming soon!

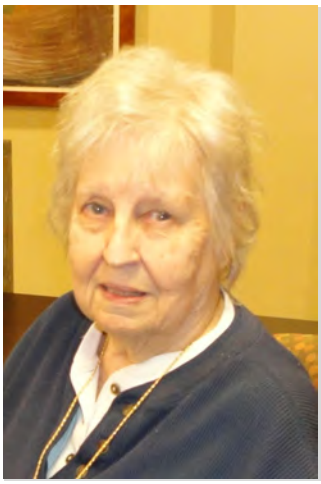
We have just started the process of becoming a Pet Peace of Mind partner. Pet Peace of Mind's mission is to enrich the quality of life and well-being of hospice and palliative care patients by providing a national support network to help care for the pets they love. This will involve some new volunteer opportunities!

For all you animal-lovers, this may be a great new way to serve our patients. If you are interested, let your volunteer coordinator know. We are in the early stages, so keep your eyes peeled for updates.

Pet Peace of Mind®
Keeping Pets & People Together Through Life's Transitions

Volunteer Spotlight

Connie Nyerges, South Bend



This year, at the Volunteer Recognition luncheon, Connie Nyerges received her service award for 35 years of volunteering with Center for Hospice Care. We are so fortunate to have such dedicated volunteers. Connie definitely embodies long term dedication to our agency, and for that we thank her. In this month's volunteer spotlight, Connie shares her story of volunteerism at Center for Hospice Care. Thank you, Connie! We appreciate all that you've done and all that you continue to do.

CHC Staff & Volunteers

One day in 1983, I was visiting my uncle in the nursing home, when a social worker from Memorial was visiting his roommate and telling him about hospice. That struck my interest. I guess she noticed and was glad to tell me about it and what it was all about. She was telling me about the volunteer services. Needless to say she didn't have to say much more. She had me sold on the idea, since my kids were grown. She gave me the info I needed and away she went.

When I started volunteering for Center for Hospice Care they had a few rooms in the Angela Building. There was 1 receptionist and 2 nurses/home health aides.

They eventually moved to a house on Cedar Street where they had more room. Then they moved to the JMS Building on the lower level and then to Sunnybrook in Roseland.

I did a lot of home visits for years: all ages, babies on up. I met a few patients I had known long ago who were now in Hospice House. We had some laughs about old memories. I learned a lot about death and dying and the different stages you go through. Every patient was different. Some were angry and some happy.

I volunteered at Hospice House for about 13 years after doing some volunteer things in offices. I then moved on to the Life Transitions Center, or the Bereavement Department. I took a leave of absence in 2010 after the death of my son. When I came back to volunteer, I decided to stay in the Bereavement Department.

I was honored to receive the Krueger Award in 1998. I was the 4th person to receive this award.

The most striking impact has been the realization that as a stranger I was allowed to enter the most personal corner of a person's life. We didn't remain strangers for long.

I feel very fortunate to have been a part of the Center for Hospice Care team for 36 years.

"Connie's outstanding dedication to CHC and it's mission is an inspiration to us all! Her work has truly improved the quality of living for countless patients and families over the years. Connie will insist that SHE is the one who has been blessed through her many hospice experiences."

Debra Mayfield,

South Bend Volunteer Coordinator

Level 2 Plus Online Training Now Available

Last year we incorporated a new level of volunteer—Level 2 Plus. While many volunteers enjoy volunteering in the home and IPU settings, some volunteers may not be able to perform some of the skills of Level III. Skills such as transfers or brief changes may not be possible for some volunteers. A Level II Plus volunteer is able to volunteer in the home or IPU and can help with care such as oral/mouth care, feeding and stand by assistance for patients who are independent with walking.

The Level 2 Plus training is now available via online training format. We understand that many volunteers may not have computer access at home. Stay tuned for more details on upcoming training opportunities for Level 2 Plus.

If you have any questions, please contact Kristiana Donahue at donahuek@cfhcare.org.

Annual In-Service

Mandatory Annual In-service

Tuesday, June 4, 2019

501 Comfort Place Mishawaka, IN

Morning Session

9:00-9:45am—Registration, TB Tests, Breakfast

9:45-11:30am—In-Service

11:40am-12:00pm—Inpatient Unit (formerly Hospice House) In-service

Evening Session

5:30-6:15pm—Registration, TB Tests, Dinner

6:15-8:00pm—In-Service

8:10-8:30pm—Inpatient Unit (formerly Hospice House) In-service

Plymouth Satellite Location

9:00-9:45am—Registration, TB Tests, Breakfast

9:45-11:30am—In-service

Plymouth Public Library

Call 277-4100 to reserve your spot today!

Volunteer Needs

Tuck-In Callers—LaPorte Area

We are in need of volunteers to do Tuck-In calls on Thursdays. We currently are in need of these volunteers in the LaPorte area.

Patient Home Visitors—All Areas

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

Annual Skills Validation

What is Level III and why do we do skills validation?

Level III volunteers have gone through all three levels of training. They have been trained to adjust patients in bed, safely transfer patients, do brief changes and even bed baths. We realize that just because volunteers have been trained on these skills doesn't mean that they utilize them all the time. That is why we have established skills validation, where we can verify that volunteers still know how to perform these skills. If they have become rusty on skills, this is the time where we can re-teach them. This assures that volunteers can be confident in performing these skills and we are vigilant in keeping volunteers up to date and trained.

Who needs to do the Annual Skills Validation?

- **Level III Home Visit Volunteers**—any volunteer who is providing the personal care skills or has been trained to provide the personal care skills (whether you've utilized the skills or not) should attend the Annual Skills Validation. **One exception**—any Level III Home Visit Volunteer who has been trained in 2019 (including the class of current volunteers who did training in January 2019) do NOT need to attend the Annual Skills Validation this summer. They will need to attend the Annual Skills Validation in 2020. Please contact your Volunteer Coordinator with any questions.
- **Level III Inpatient Care Unit Volunteers**—any volunteer who is providing the personal care skills or has been trained to provide the personal care skills (whether you've utilized the skills or not) will be skills validated with Kathy Kloss, Clinical Staff Educator, within the IPU setting. You do NOT need to attend the Annual Skills Validation day, but will complete skills validation at the IPU.

Volunteers who need to do Annual Skills Validation will be receiving an invite via mail and/or email.

When and where is the Annual Skills Validation?

- **Elkhart Campus**—July 8, 2019 from 9:00am-1:00pm
- **Mishawaka Campus**—July 9, 2019 from 8:00am-2:00pm and 3:00-6:00pm
- **Plymouth Public Library**—July 10, 2019 from 9:30am-Noon

Do I need reservations and how long will it last?

- Yes, you will need to call to reserve your spot. Validations are scheduled time slots. Two volunteers can be scheduled per time slot. Validations are scheduled for 30 minute increments. We will do our best to accommodate your schedule.
- Call 277-4100 to reserve your spot.

Comments from Our Families

- The patient in room 3 of the IPU wanted me to let you know that she is appreciative of the blanket she was given. She loves it and wants the volunteers who made them to know. Thanks.

  -Sarah Contreras, IPU RN

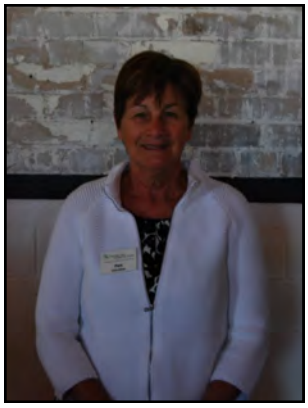
- The hospice center in Elkhart is the best. The care that everyone showed my mother and our family in her last days was incredible. I can't say enough good things about them. We were truly blessed.

- I like knowing that I have an option to call for support even down the road. Thank you!

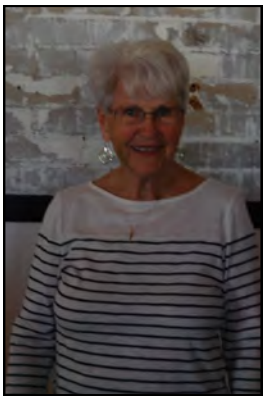
Choices to make the most of life...

2019

Service Awards



10 Year Service Award:
Pamela Jentz



25 Year Service Award:
Norma Diedrich

10 Years

Pamela Jentz
Linda Wruble
Thomas Wruble

25 Years

Norma Diedrich

15 Year Service Awards (left to right):
Phyllis Hong, Nellie Vels, Ilene New

15 Years

Phyllis Hong
Ilene New
Nellie Vels

20 Years

Bernard Randall

5 Year Service Awards (left to right): Mary Adams, Betty Kay Eley, Joan Hunt, Sylvia Ford, Sarah Wargo, Grace Munene, Donald Neely, Kristie Sherburn, Kay Swett

5 Years

Mary Adams
Carol Barbour
Betty Kay Eley
Sylvia Ford
Joan Hunt
Nancy Jackson
Grace Munene
Donald Neely
Annetta Russell
Kristie Sherburn
Kay Swett
Sarah Wargo

35 Year Service Award:
Connie Nyerges and Debra Mayfield, SB Volunteer Coordinator

35 Years

Connie Nyerges

thank you!

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.

2019 Hospice Foundation Event Schedule

Event	Date	Location
Vera Z. Dwyer Fellow Reception	4/10/19 (Wed)	Mishawaka Campus
35th Helping Hands Award Dinner	5/1/19 (Wed)	Hilton Garden Inn
Gardens of Remembrance & Renewal	6/4/19 (Tue)	Elkhart Campus
Journeys in Healing Art Auction	7/24/19 (Wed)	Mishawaka Campus
Bike Michiana / Walk for Hospice	9/8/19 (Sun)	Mishawaka Campus
Veterans Tribute Ceremony	10/15/19 (Tue)	Mishawaka Campus
Ribbon-Cutting, Campaign Celebration	TBD (Fall)	Mishawaka Campus

Hospice Provider Preview Report

HIS Quality Measures Data Collection: 07/01/17 to 06/30/18

Hospice Quality Measure	Number of eligible patients pt.'s	Center for Hospice Care	National Rate
NQF # 1641 Treatment Preferences	1601	100%	99%
NQF # 1641 Beliefs/Values	1601	98.6%	96.2%
NQF # 1634 Pain Screening	1601	98.1%	96.2%
NQF # 1637 Pain Assessment	881	92.3%	89.2%
NQF # 1639 Dyspnea Screening	1601	98.6%	98.1%
NQF # 1638 Dyspnea Treatment	961	99.1%	96.1%
NQF # 1617 Bowel Regimen	414	98.8%	94%
NQF # 3235 Hospice Comprehensive Assessment	1478	91.3%	85.3%

03/29/19—report run date

Published on *The National Law Review* (http://www.natlawreview.com)

CMS Proposes To Force Hospices to Specify Unrelated Treatments

Article By:
Brian M. Daucher

In its FY 2020 proposed hospice update, CMS proposes two changes of significant interest to providers:

- Shifting $500 million of reimbursement from routine to enhanced care levels; and
- Requiring providers to notify patients in writing of treatments that will be deemed "unrelated" to the terminal illness (and therefore still covered by Medicare separately).

Given that both of these topics deserve significant attention, we will address them in separate posts. This first post covers the notice of unrelated treatments.

In recent years, CMS has claimed that "virtually all" treatment (drugs or services) a terminally ill patient requires should be deemed "related" to the terminal illness. CMS has claimed that Part D insurers, for instance, have covered millions of dollars of medications for admitted hospice patients that should have been paid for by hospices.

If treatment is related to the terminal illness, and palliative not curative, the hospice must provide it as part of the hospice benefit. If, however, treatment is related, but curative in nature, then by electing hospice, the patient waives such treatment. By contrast, if certain treatment (such as diabetes medications for a cancer patient) is deemed unrelated to the terminal illness, then a patient can obtain such treatment through the regular Medicare benefit while on hospice.

CMS notes that patients can be surprised that some treatments are not covered by hospice. In the name of "patient rights," CMS proposes to require hospices to advise new patients of the right to receive written notice (called an addendum to the notice of election) specifying any treatments that hospice believes are "unrelated" to the terminal illness and that, therefore, will not be covered under the hospice benefit.

The real purposes of this proposal appears to be three-fold: to decrease Medicare expense for "unrelated" drugs and services; to require hospices to broadly enforce a patient's waiver of right to "curative" treatments (perhaps in turn deterring some use of hospice); and, finally, to set up strong audit rights for CMS against hospices.

If requested by a patient, the proposed addendum will need to include a "written clinical explanation" in plain language detailing what treatments will be deemed unrelated and why.

CMS proposes to require this addendum to be delivered within *48 hours* of request on admission or *immediately* if requested during the course of treatment. Both proposed timelines are unrealistic.

Patients elect hospice, doctors certify eligibility, and only then does the IDG, within *5 business days*, make a comprehensive assessment of patient needs. The *48-hour* rule would dramatically compress admission workflow and force hospices to recognize, *almost instantly*, any unrelated treatments.

CMS proposes to make both the provision of notice of right to receive the addendum and, if requested, the provision of a satisfactory addendum, *conditions of payment*. When framed as conditions of payment, it sets up the right for CMS and its auditors to deny all reimbursement (or recover all reimbursement in a post-payment audit) if the requirements are unmet.

CMS has not promised to limit such audit denials/recoveries (what we call "forfeitures" in civil law) to cases where there is actual harm to the patient (surprised that some treatment is unrelated) or harm to Medicare (where Medicare actually incurs treatment expense outside of hospice for a patient on the benefit). Although the issue of incremental expense to Medicare is relatively rare, the audit rights on this point could be applied to all patient claims.

CMS' proposal is not without irony when framed as a "patient's rights" issue: If certain treatment is deemed *unrelated*, patients have an unequivocal right to receive such treatment, at their election, under regular Medicare. By contrast, if certain treatments are deemed *related*, and curative not palliative in nature, then patients electing hospice may not be able to receive such treatment at all. In one sense, this proposal will force hospices to play the bad guy: deny hospice patients certain treatments, even if arguably unrelated to the terminal illness. For CMS to suggest that this is, then, a patient rights issues is a bit misleading.

Although framed as optional at the patient's request (i.e., don't blame CMS for this), in practical terms, providers may be better served to regard this addendum, if adopted, as mandatory.

Consider: If a hospice offers to provide an addendum of unrelated treatments, will a patient or patient representative ever refuse? And, if one does refuse, how will the hospice document that fact so as to avoid audit risk on that question? This author's advice may be to provide the addendum to all patients (and abandon the CMS ruse of patient choice in the matter).

Given that the vast majority of patients have no "unrelated" treatments, by providing an addendum that says just that in most cases, hospices will mitigate audit risk. If there is a patient with an unrelated condition, such as a lung cancer patient with a broken leg, then by providing the addendum, the hospice will protect itself against specific audit risk on that claim. If the addendum is not provided in such a case, CMS auditors might try to put all expense on the hospice.

Of course, by creating a set of addenda with lists of unrelated conditions and treatments, a hospice thereby exposes itself to audit risk as well. CMS may demand to see all such addenda; and, reviewing them, CMS, or its auditor, may decide that it disagrees with a hospice's approach to certain treatments. CMS may then regard certain addenda as "deficient" and demand refunds for that foot fault alone.

As with the basic conundrum of hospice eligibility (is a patient with a particular set of conditions likely to pass away in six months or less?), CMS could itself set up National Coverage Determinations specifying what is related or unrelated to certain terminal diagnoses. CMS refuses to take up the task. Instead, CMS leaves this second thorny question to the judgment of each hospice. Given its choice to burden providers with this assessment, CMS should accord deference to such determinations; however, that is unlikely (*de novo* review seems more likely).

Any way you look at it, this proposal will cabin more patient expense and impose more risk on hospices.

Hospices, and those that would advocate for them, should comment on this proposed rule asking CMS:

- To consider whether the true extent of expense from and occurrence of "unrelated" treatments justifies a general requirement like this (as a percentage of the hospice program and as a percentage of the number of patients receiving hospice);
- To include a more honest assessment of the regulatory burden this addendum will put on hospices. (MedPAC and CMS bemoan the growth of for-profit hospice providers, but ever-increasing regulatory burdens and audit risks can in fact only be met by well-organized institutional providers (and not stand alone non-profits));
- To provide *reasonable* time for providers to complete the addendum. 48 hours after election is not enough time for a hospice to identify all unrelated treatments; and, a hospice certainly cannot provide such an addendum immediately during the course of service. 7 calendar days would be a minimum amount of time to allow in either case. CMS has identified no exigency requiring a more immediate turn around;
- To promise not to use the addenda requirement to deny reimbursement *unless* there is a nexus between the violation and identifiable harm either to the patient (very unlikely) or to Medicare (unlikely as well). If there is no harm, there should be no potential forfeiture of reimbursement;
- To acknowledge that, given that CMS is leaving the determination of unrelated treatments to the discretion of providers, CMS will defer to hospice judgments on these matters, unless *clearly erroneous*; and
- To confirm that hospices may revise the addendum, without penalty or presumption, as circumstances require (for instance, when they learn new information about a patient or when a patient's condition changes). Hospices are not omniscient; CMS should acknowledge this fact.

A copy of the FY 2020 Hospice Wage Index, including these proposed changes, may be found here.

Comments on this proposed change must be submitted to CMS by June 18, 2019 (methods detailed in the proposed rule).

Hospices Lose Money Under 2020 Proposed Rule

By Jim Parker | April 23, 2019April 23, 2019

Despite rate increases for some care levels, hospices would lose a dollar per patient, per day of routine home care under the U.S. Centers for Medicare & Medicaid Services (CMS) Fiscal Year 2020 proposed rule.

The agency has proposed a 2.7 percent cut in payments to hospice providers for routine home care. Corresponding 2.7 percent rate increases for continuous home care, inpatient hospice care, and inpatient respite care will not offset the reductions due to low volumes, according to analysis by the National Hospice and Palliative Care Organization (NHPCO).

For example, continuous home care represents approximately 0.2 percent of all hospice care days. General inpatient care has a 1.7 percent utilization rate, the highest among those three levels of care.

Routine home care represents 97.6 percent of all hospice care days.

"The cuts are about a dollar a day. The blow seems a little bit easier, because it doesn't seem like that big of a drop," Judi Lund Person, vice president of Regulatory and Compliance for NHPCO, told Hospice News. "But if you have a hundred patients and each of them is with you for 25 days, all of a sudden it turns into big money."

If the rule becomes final, the per diem routine home care rate would fall to $195.65 per patient in FY 2020, down from the 2019 rate of $196.21.

The cuts were spurred by an Affordable Care Act requirement that the Secretary of Health and Human Services must make Medicare payment adjustments budget neutral. Because rates for the other three levels of care went up, the rate for routine home care had to come down. The agency decided to raise rates for those levels because the cost of providing them was higher than the reimbursement.

The cost of providing 24 hours of general inpatient care is $1,363.00, for example, but the current reimbursement rate is $997.00.

"CMS is rebasing rates for these three levels of care to align the costs with the reimbursement," Lund Person said.

The low reimbursement rates caused serious problems for the three services that received increases. For instance, many hospitals would be reluctant to contract a hospice for general inpatient care if costs were exceeding reimbursements.

The NHPCO released a statement that raised objections to the cuts.

"The vast majority of care provided by hospices across the country is delivered at the Routine Home Care level," said NHPCO President Edo Banach in the statement. "Reducing payment for the highest utilized level of care will hurt hospice organizations and their ability to provide care to persons and families facing serious and life-limiting illness."

Despite these concerns, the news was not unwelcome for some in the industry. Organizations that provide more of the three care levels that received increases felt encouraged.

"Our programs provide more of the other levels of care, especially general inpatient care, because many of them operate their own inpatient units" said Mollie Gurian, chief strategy officer for the National Partnership for Hospice Innovation, told Hospice News. "We were excited to see CMS recognize that the costs of providing that care were not covered. We will have to see how that tempers against the routine home care cuts."

Mark Murray

From: Mark Geissler <mgeissler@sbcsc.k12.in.us>
Sent: Friday, May 03, 2019 9:18 AM
To: Annette Deguch
Cc: Mark Murray; James Seitz
Subject: Thank You

Annette,

Thank you for conducting the Grief Group at Adams High School. I know the students who were a part of the group benefitted from the experience. We very much appreciate that Hospice provides this important service in our community and hope that our partnership can continue.

Sincerely,
Mark Geissler

--
Mark Geissler LCSW
School Social Worker
John Adams High School
Phone: (574)-393-5326
Fax: (574)-283-7699

LaPorteCountyLife.com

Catherine Hiler receives Center for Hospice Care and Hospice Foundation Helping Hands Award

Written by Mandy Haack on May 3, 2019

Dedicated community leader and generous philanthropist Catherine Hiler is a true community servant and supporter of Center for Hospice Care (CHC) and the Hospice Foundation, so it was only fitting that she was celebrated on the evening of May 1 among more than 500 attendees at the organization's biggest event of the year, the Helping Hands Award Dinner.

"Catherine has been a huge part of Center for Hospice Care and Hospice Foundation for 16 years," said Peter Ashley, Director of Communications and Annual Giving for the Hospice Foundation. "She has been an incredible force for good when it comes to Center for Hospice Care."

Click here for more photos!

This is the 35th year for the Helping Hands Award, which honors a deserving recipient who has significantly given back to their community. The theme for this year's dinner was "An Irish Blessing," celebrating Hiler's Irish roots.

"The award honors people who have been actively engaged in the community over a long period of time, not just with Center for Hospice Care," Ashley said. "It is truly a community award, for people who have made a significant impact."

Hiler was on The Stanley Clark School board of trustees and a parent representative on the John Adams High School committee that established the International Baccalaureate magnet program. She has served on the Center for Hospice Care board as a volunteer member, and currently chairs CHC's five-year fundraising campaign, "Cornerstones for Living: The Crossroads Campaign," which concludes June 30, 2019. She also has received the Individual Philanthropist of the Year Award from the Association of Fundraising Professionals.

Proceeds from the Helping Hands Awards gala support a variety of programs at CHC, including bereavement programs, charity and unreimbursed care, as well as support for two significant current projects on CHC's Mishawaka campus: a 12-bed inpatient care facility, and a clinical staff building for nurses and other employees.

"I think Catherine is very deserving," said Sister Carmel Marie Sallows C.S.C., the 2018 Helping Hands award recipient. "She is very humble. She's put so many hours in for Center for Hospice Care, and she sets a wonderful example of serving others."

Hiler explained that her 16 years of supporting CHC started with her experience in a Virginia hospice care center alongside a friend.

"My friend Susie was diagnosed with liver cancer and would only have a short time to live," Hiler recalled. "I visited her in Virginia Hospice House where she was receiving medical care to keep her comfortable."

"The care she was receiving made all the difference for her family and friends. It allowed them not to worry about her care, and focus on the time they had together," she said.

Shortly before Susie passed away, her grandson was determined to make sure she was at his wedding. The hospice care center and her grandson made it possible for Susie to attend an onsite ceremony.

This was one of the many moments that inspired Hiler to serve her local community by supporting CHC.

"It's been an honor and a privilege for me to work with the wonderful and competent Center for Hospice Care and Hospice Foundation staff," Hiler said.

"Most of you have had your hospice moments and you appreciate the impact that hospice care has on individuals and families. Hospice care brings the joy during an incredible time of sadness."

For more information about CHC and the Hospice Foundation visit cfhcare.org and foundationforhospice.org.

Hospice Action Network
1731 King Street · Suite 400
Alexandria, VA · 22314
703·837·1500
www.hospiceactionnetwork.org

WHO WE ARE

The National Hospice and Palliative Care Organization (NHPCO) is the largest membership organization representing hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice programs that care for the majority of hospice patients in the US. NHPCO is committed to improving end-of-life care and expanding access to hospice so that individuals and families facing serious illness, death, and grief will experience the best care that humankind can offer.

Rural Access to Hospice Act (HR 2594/ S.1190)

Background

Hospice is a person-centered model that works to meet the unique needs of patients and families facing serious illness at the end of life. One way to increase access to hospice is to address a statutory barrier related to payment for services through Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC), also known as Community Health Centers. RHCs and FQHCs were created in 1977 and 1991, respectively, as a response to a shortage of physicians serving Medicare patients in disadvantaged communities and parts of rural America. They are a part of the healthcare "safety net" and provide primary care to over 27 million Americans.[i] For many people, RHCs and FQHCs are their only source for primary care.

RHCs/FQHCs and Hospice

Despite recent growth in hospice utilization, traditionally underserved minority and rural communities continue to lag behind more suburban affluent communities in hospice access and utilization. The goal of the Rural Access to Hospice Act, along with other legislative and regulatory initiatives, is to help close this gap in access and utilization of hospice care.

One reason for this disparity in utilization of hospice is a statutory barrier that inhibits access to hospice in communities served by RHCs and FQHCs. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician. The attending physician collaborates with the hospice in the development of the care plan and is kept informed of the patient's care. Typically, the attending physician is reimbursed for these services under Medicare Part B. Unfortunately, RHCs and FQHCs do not bill Medicare under Part B; they are paid a fixed, all-inclusive payment for all services provided to Medicare beneficiaries. Due to a statutory oversight, hospice is not included under this all-inclusive payment.

This oversight keeps patients who may have been receiving services from their same primary care physician serve, some for over 20 years, from choosing that physician as their hospice attending physician. Needless to say, this loss of a trusted provider at a critical time poses a huge burden to patients and their families. The National Advisory Committee on Rural Health and Human Services notes that when rural patients discover that their primary care provider is unable to serve as their attending physician, patients choose to dis-enroll from hospice, or not to enroll at all.[ii] The Medicare Hospice Benefit guarantees the patient the right to choose their own physician, however current law prohibits patients of RHCs and FQHCs from exercising that right.

The Solution

Skilled nursing facilities (SNFs) faced a similar prohibition from RHC physicians providing services to SNF residents until 2003, when Congress passed legislation that allowed RHC and FQHC physicians to bill Medicare separately for their services in a SNF. The Rural Access to Hospice Act takes a similar approach and would allow RHCs and FQHCs to receive payment for serving as the hospice attending physician. NHPCO urges all members of Congress to pass this common-sense legislation to ensure that terminally ill beneficiaries in underserved and rural communities can access the hospice benefit and the attending physician of their choice.

The Rural Access to Hospice Act was reintroduced in the Senate by Senators Shelley Moore Capito (R-WV) and Jeanne Shaheen (D-NH) and in the House by Congressman Ron Kind (D-WI) and Congresswoman Jackie Walorski (R-IN).

To contact your Members of Congress about this legislation, please visit http://hospiceactionnetwork.org/get-informed/supported-legislation/ruralact/#/31.

For more information on this legislation, contact NHPCO's Hospice Action Network Team at info@nhpcohan.org.

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[i] National Association of Community Health Centers. About Our Health Centers: http://www.nachc.org/about-our-health-centers/
[ii] HRSA. Office of Rural Health Policy. National Advisory Committee on Rural Health and Human Services Policy. "Rural Implications of Changes to the Medicare Hospice Benefit." August 2013. http://www.hrsa.gov/advisorycommittees/rural/publications/nacrhhshospicebrief.pdf.

Center for Hospice Care
Compliance Committee Meeting Minutes
February 28, 2019

Members Present:	Craig Harrell, Dave Haley, Karl Holderman, Mark Murray, Sue Morgan, Tammy Huyvaert, Vicki Gnoth, Becky Kizer
Absent:	Dr. Greg Gifford

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 3:00 p.m.	
2. Minutes	• The minutes of the 08/30/18 meeting were approved by consensus.	
3. Follow-Up	• At the August meeting we discussed Patients' Rights and "Pearls for Providers: How to ensure that patients' rights are honored." This would be a good guideline to focus on and share with staff. Sue M. will review it at the March staff meeting.	
4. Comprehensive Assessment	• The August 2018 Hospice Compliance Newsletter had an article on Hospice CoPs: The Comprehensive Assessment. It is one of the most common condition-level deficiencies uncovered on hospice accreditation surveys. It is best practice to get all the disciplines out to the home in five days sharing their input and working together. There are eight factors in the assessment. Are we specifically addressing all eight? One of the challenges is the EMR. It takes 3-4 hours to do the initial and the comprehensive assessments no matter how much we have tried to cut down on that time. Tammy has worked on making the comprehensive visit assessment more user-friendly. It includes boxes for psychosocial needs and prompts the nurse to notify the social worker for that issue. There is also a prompt to notify the chaplain if a spiritual care issue is identified. The article says it is the nurse's job to sell the other services to the patient/ family. Usually families don't turn down their initial assessment, but they may for any follow up contacts. We could ask Rebecca Fear if she could run a report to see if we are meeting the five days' requirement. Since we made the change from using the title spiritual care to chaplain, we haven't really noticed that it has made any difference to families.	
5. Interdisciplinary Group	• In the September 2018 Hospice Compliance Newsletter is an article on Hospice CoPs: The Interdisciplinary Group. CMS has recommended color coding the plan of care to	

Topic	Discussion	Action
	highlight active problems, interventions and outcomes, as well as avoiding repetitive usage of standardized phrases or comments. That would help cut down on cutting and pasting. We have a goal this year for nursing, social work and chaplains to develop strategies and tools to improve and streamline the IDT process.	
6. Revocations	• CMS is concerned that patients are revoking for something the hospice should have paid for, especially if the patient returns in a short period of time. Our number of revocations didn't increase in 2018 compared to 2017. Staff needs to be sure to document that the patient chose to pursue curative, not aggressive, treatment. Patients have the right to come back for hospice services if they want to. CMS is concerned how quickly these turn arounds are happening, especially in some programs. It is probably happening more frequently with for-profits than not-for-profits. At the QI Committee meeting this week, Rebecca reported 48% of our revocations come back within 25 days or less. It is also very tough on admissions, because it is like starting over with a new admission. Sue reviewed appropriate documentation with staff in January and will repeat it in June.	
7. Compliance Inservice	• It was suggested that we put something in the April weekly announcements asking staff if they have any compliance issues that they would like to learn more about. The committee could review the responses at their next meeting in August and provide feedback to staff at the September staff meeting.	
8. Other Business	• We are still waiting for our home health survey. It was due in October. • At the August compliance committee meeting we will review the compliance plans for hospice and home health, so come prepared with any revisions or additions. The policies can be found on the staff website under Files, Policies.	
Adjournment	• The meeting adjourned at 3:25 p.m.	Next meeting TBA in August