Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
August 21, 2019
7:15 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING

Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
August 21, 2019
7:15 a.m.

A G E N D A

1. **Consent Agenda** – Mary Newbold (10 minutes)
   A. Approval of May 15, 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 05/21/19 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 (12 minutes)
   A. Year to Date 2019 Financial Statements

4. **Hospice Foundation Update** *(information)* – Wendell Walsh (20 minutes)

5. **Board Education** *(information)* **–** "Milton Adult Day Services Update" – Nancy DeMaegd, Director, Milton Adult Day Services (10 Minutes)

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

Next meeting November 20, 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
May 15, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:15 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 02/20/19 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned T. Portolese seconded
3. Policies	• A motion was made to accept the new and revised policies as presented. The motion was accepted unanimously.	C. Walker motioned J. Hsieh seconded
4. QI Committee	• The minutes of the 02/28/19 QI Committee Meeting are in the board packet to give updates on our quality indicators and reporting programs.	
5. President's Report	• We are experiencing record high census. So far May ADC is 428 and we hit an all-time census high of 436 on 05/09. YTD ADC is 402. The budgeted ADC is 400. Referrals are up 6% from a year ago. • Our agreement with the Elkhart Clinic has gone very well. YTD we have had 25 referrals from Dr. Haque and 13 from other clinic physicians. Dr. Haque is also a part-time hospice physician with us and is involved in IDTs and approving admissions. We've heard a lot of positive feedback about him from staff. • The PEPPER report comes out annually and covers several areas as a tip off for potential problems with fraud and abuse. The report compares a hospice's data to national, jurisdiction, and state statistics. If a hospice's scores are at 80% compared to their peers, they may have a problem. Our percentages have always been very low and even lower in the past 12 months. • Doctor recruitment – We continue to attempt to recruit physicians. We had a couple of doctors that were very interested and one signed a contract and was going to start in August, but she changed her mind.	

Topic	Discussion	Action
	• La Porte staff will probably be able to move into the new location in July. South Bend staff will also be moving to Mishawaka in July. • Congratulations to Sue M. and our nursing staff for our great scores on the HIS quality measures report. All of our scores in seven quality measures were above the national average in the most recent report. • 2018 Audit – We had new auditors this year from Kruggel Lawton CPAs. The auditors had three potential concerns that were discussed at the Finance Committee meeting. • Indiana ranked #2 in the country in contacting legislatures to support the Rural Access to Hospice Act. Jackie Walorski was one of the main co-sponsors in the House. • Hospice Managed Care – The CMS Office of Innovation is planning to do a demo in 2021 on hospice managed care carve-in. We believe managed care companies would steer people to hospice sooner than people would do on their own Right now hospice is the only Medicare provider carved out. MedPAC has been interested in getting everyone on the same page for a long time. CMS is promising to keep the Hospice Medicare Benefit intact and not let managed care carve it up. • CMS has proposed new Hospice rates for fiscal year 2020 that would go into effect 10/01/19. They have proposed a cut in the Routine rate, and an increase in Respite, and GIP rates. CMS is finally realizing that Respite is just as expensive as GIP. If these new rates had been in place for all of 2018, we would have had an increase in revenue of $835,000. So we will be promoting Respite in our units for families as much as possible. • Jay Cushman of Health Pivots ran a report regarding the use of DME and oxygen as a predictive indicator of mortality. 67% of patients who received a hospital bed died within 180 days. We will share this information in our physician newsletter. We will also talk to Alick's Home Medical about being able to make referrals to us as well.	
6. Finance Committee	• The Finance Committee reviewed the 2018 audit and YTD financial statements last Friday with the auditors from Kruggel Lawton. The financial statements of CHC and its affiliates were presented fairly and the changes in their net assets and cash flows for the year were in accordance with accounting principles. The auditors expressed an unmodified opinion on the consolidated statements.	

Topic	Discussion	Action
	Reminder that this report is confidential. • This was a combined audit of CHC, Hospice Foundation (HF), and GPIC. The auditors had two areas of concern and one material misstatement. The material misstatement was on the HF books regarding a matching grant from the Vera Z. Dwyer Trust in late 2016. Generally the way matching grants are set up and structured, the money will not be recognized as a receivable until we reach the goal. So as we were raising money throughout 2017 and 2018, we had not been recognizing it as revenue. In reviewing this particular agreement with the Dwyer Trust, the auditors said it was worded in such a way that the barrier didn't exist in that we don't have to reach the $1M goal before they would provide a match. So any money we raise up to the $1M match, we are obligated to record it as revenue. The money raised in 2017 and 2018 was $372,000. So, even though very positive to the 2018 bottom line, this is considered a material misstatement. That adjustment was made to the 2018 financial statements for the HF, which affects the CHC books through the beneficial interest in the HF. • A potential issue of concern was with CHC's payroll. We operate 24/7 365 days and pay staff accordingly. We have various shift differentials, on call, weekend, etc. and over 80 different time codes. In addition, we have an internal productivity report for management purposes. The key driver of the report is the manual time sheets. A manual system increases the potential for human error. The auditors found some discrepancies when they tracked some time sheets through the payroll system. This is something we were aware of, and we have a plan in place to put together a panel of staff from different disciplines to look at ways to streamline the process for payroll and the productivity report. At the time we converted to the new EMR in 2010, we were still doing paper charting. Now the EMR is the official record and we are no longer doing paper charting. We are past due to update our payroll system and will look at upgrading it in the next 12-24 months. Suzie W. said Elkhart County is looking at automating employee management systems, and Karl H. is welcome to sit in on their webinar. • The other potential issue was the recognition of contractual adjustments with third party payers. The way we had been doing it is we would book the revenue, and then when we were paid if we didn't get paid in full, at that point we would recognize the contractual adjustment. The new ASU states if we reasonably know and can project what the contractual adjustment is, we should put that adjustment	

Topic	Discussion	Action
	in place at the time we generate the receivable so when we receive the actual payment, there will be less settlement. • When we put in the new rates in the fourth quarter 2018, there was a typo so claims were generated with the incorrect amount. Medicare will pay the correct amount regardless of what we bill. The overall effect on the books was about $15,000 for 2018. We put new procedures in place to double check the input of new rates. This only affected Medicare. • A motion was made to accept the 2018 Audit as presented. The motion was accepted unanimously. • A motion was made to accept the adjusted 2018 post-audit financial statements as presented. The motion was accepted unanimously. • 2019 YTD financial statements – The number of patients served and ADC through April was just under 400. May has surpassed that. The budget ADC is 400. Total operating revenue YTD $7.2M, MADS $118,000, interest income $13,000, beneficial interest in affiliates $2M, total revenue $9.3M, total expenses $6.4M, net gain $2.8M, net without beneficial interest in affiliates $865,000. Compared to the budget YTD operating revenue was $18,000 over budget, total revenue $1.8M over budget, total expenses $805,000 under budget, net gain $2.6M over budget, net without beneficial interest in affiliates $786,000 over budget. With the census growing as it is, we will probably bypass the budgeted ADC. • A motion was made to accept the 2019 YTD financial statements as presented. The motion was accepted unanimously.	S. Weirick motioned A. Mauro seconded T. Portolese motioned M. Newbold seconded S. Weirick motioned W. Walsh seconded
7. Hospice Foundation Update	• The Helping Hands Award Dinner honoring Catherine Hiler was the second highest grossing in its history with $400,000 thanks to the efforts of the dinner committee headed by Kurt Janowsky and Todd & Stephanie Schurz. • Through the end of April, our five-year $10MM Capital Campaign has raised $12.1MM. We received a $500,000 gift that we had been working on thanks to Tim Portolese. The campaign ends June 30th. There are still a couple of major gifts out there. Chris T. and Mike W. met with a potential major donor yesterday, so we expect by the time the campaign is over we will have over $13MM. We still have a couple of underfunded priorities: $800,000 for the Ernestine M. Raclin House and $495,000 for the Vera Z. Dwyer matching grant. We have also seen price increases in construction, some as a result of the new tariffs. Electronics have gone	

Topic	Discussion	Action
	up from 10% to 25%. We are trying to buy more U.S. products, but they are still more expensive even after the tariffs. We anticipate finishing the patient care staff building in July and Raclin House in October. • We are in the process of wrapping up the Annual Appeal at the end of May. To date it has raised $100,000. Then we will start the Friends of Hospice appeal. It will focus on wrapping up the capital campaign and raising money for the After Images art counseling program and Camp Evergreen. It should hit mailboxes around Memorial Day. • The Center for Education & Advance Care Planning has been very active this last quarter. We continue to host events including in LaPorte and Porter Counties on end of life planning panel discussions. Elleah T. was asked by NHPCO to be an ambassador for its "My Hospice" campaign and was given a scholarship to attend Capitol Hill Day last month. She is one of four ambassadors across the country. • Honoring Choices Indiana-North Central recently hosted its first facilitator training for over 20 people. We are working with Saint Joseph Health System, Beacon, Goshen, REAL Services, and faith-based organizations to get facilitators trained at each location. Four CHC employees are certified as facilitators. Individuals are trained to have one on one conversations with people to help them develop their advance care plans. We will have another certification program this fall and also have some of people trained as certified trainers. • The most recent issue of Crossroads celebrates the 10th anniversary of the Hospice Foundation. We officially started in 2007, but started activities in 2008. • The list of upcoming Hospice Foundation events is in the board packet. We encourage board members to attend. This is a good way to see hands on what we do and meet people. • GPIC is in the process of doing work with our partners and developing new partnerships. We have 42 GPIC partners. Dr. Paul Mmbando from Tanzania visited us. He has eight GPIC partners in the palliative care program of the Evangelical Lutheran Church of Tanzania. Lacey Ahern had time to meet with Dr. Eddie Mwebesa from Uganda and Dr. Christian Ntizimira from Rwanda at the CUGH conference in Chicago in March to discuss networking opportunities. • We continue to be involved in a number of research projects. We are working with Bluegrass Care Navigators in Lexington, KY and with APCA to develop the next	

Topic	Discussion	Action
	generation of palliative care leaders. An intern from Oxford is working with APCA on a project, and we have a student from Notre Dame working with us as a GPIC office intern. We are working on the next round of APCA scholarships for nurses and social workers. We will be sponsoring five nurses and four social workers. GPIC was also involved in presenting at the NHPCO conference and a GPIC advisory council meeting in April, and presented the GPIC award to Hospice of the Western Reserve in Cleveland, OH. The award will be presented to their African partner, Helderberg Hospice, at the APCA conference in September. • Carol W. commented in regards to professional education, that there is a misunderstanding in the hospitals between professionals as well as family members between Do Not Resuscitate (DNR) and Do Not Treat (DNT). Also that palliative care coming in earlier is equated to giving up and end of life. They don't understand the whole spectrum from here to there. Mike W. said that is what we face when talking to families and professionals, and the Center for Education & Advance Care Planning is trying to address those issues with the "Death by Chocolate" events. Mike W. will talk to Cyndy S. and Elleah T. to incorporate this information. This is an issue CHC deals with all the time.	
8. Board Education	• Barb King, Diversity Officer and Professional Relations Liaison, gave a presentation on diversity initiatives. Barb K. has also been a member of the NHPCO Diversity & Advisory Committee for three years, and gave a presentation at the NHPCO conference in April. The committee is working on a diversity and inclusion program model.	
Adjournment	• The meeting adjourned at 8:30 a.m.	Next meeting 08/21

Prepared by Becky Kizer for approval by the Board of Directors on August 21, 2019.

Jennifer Houin, Secretary

Becky Kizer, Recording Secretary

REGULATION: 42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To provide safety and consistency in the delivery of medication for all patients in the Inpatient Unit (IPU).

POLICY: Nursing personnel shall ensure safe and effective administration of medications. Medications will be administered by an RN to patients as ordered by a physician or nurse practitioner. RNs may administer medications via oral, sublingual, topical, rectal, subcutaneous, intramuscular, intradermal, intravenous, or inhalant routes.

PROCEDURE:

1. Medication Orders

a) A physician or nurse practitioner shall write all orders for medications on a physician order form.

b) The RN or specially trained IPU staff member will enter medication orders into the Electronic Medical Record (EMR). All orders entered in the EMR shall be double-checked by an RN to ensure accuracy and completeness of orders. Noting orders include reviewing physician written order and EMR orders are identical. Documentation of this verification will be noted on the physician order form to include "noted" along with the date and the RN's signature.

c) An RN may take a Verbal or Telephone order from a prescribing practitioner. These orders will be transcribed on a physician order form and shall be read back to the ordering practitioner for confirmation of accuracy.
   i. Documentation of this order will include the prescriber's name, read back and verified (RB&V) and the RNs signature.
   ii. Medication order components shall include the name of the medication, the dose, the route, and the frequency. If a PRN medication is written, the indication shall also be included.
   iii. The RN shall check for allergies at the time of the verbal/telephone order.
   iv. The practitioner must confirm order's accuracy and sign printed medication order within 72 hours.

d) Ordering medications from the pharmacy will be done by the RN for medications. All medication orders are to be faxed to the contracted pharmacy. Order (either covered or non-covered) will be identified.
   i. The contracted pharmacy will profile all orders, but only send the medications requested.

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

2. Medication Administration:

a) Medication administration will be consistent with the 5 Rights: patient, medication, dose, time and route. To confirm the 5 Rights, the medication is checked against the MAR prior to administration.

b) Verify the medication selection matches the order, the label and that the patient is not allergic to the medication.

c) Confirm the medication is being administered at the proper time, in the prescribed dose and by the correct route.

d) Aseptic technique and proper hand washing procedures shall be followed prior to medication preparation and administration. Verify that the medication is stable based on visual inspection for particulates, discoloration and that the medication has not expired.

e) Instruct the patient or family on appropriate medication action and potential side effects, resolving any concerns about the medication with the patient, family or prescriber.

f) Nursing personnel will monitor patients on an ongoing basis for medication effectiveness and adverse reactions. If any reaction occurs, the nurse will contact the physician immediately. Document all medications administered, the patient's response to medication and any physician communication.

g) The nurse will call the physician/NP if a patient refuses a scheduled medication or a scheduled medication is held due to a change in mentation, after a second dose is held due to one of these reasons.

~~f)~~h) If a patient's mentation changes to the point the nurse's assessment is they cannot safely swallow an oral medication (scheduled or PRN), the nurse must call the physician/NP after the first dose that this is identified as an issue.

~~g)~~i) Medication should be administered within 60 minutes before or after the scheduled time. A comment must be entered any time medication is given outside the 120-minute administration window.

~~h)~~j) Standardized medication times are specified for administration of **routine medications.**

Standard Medication Times:

Once Daily – 0900
BID – 0900, 2100
TID – 0800,1400,2000
QID – 0700, 1200, 1700, 2200

Q4H - 0400, 0800, 1200, 1600, 2000, 2400
Q6H – 0600, 1200, 1800, 2400
Q8H – 0600, 1400, 2200
HS- 2200
Every Evening – 1800
Before Meals – 0730, 1130, 1630

~~i)~~k) Document **PRN Medications** effectiveness for all PRN medications within one hour after administration. If a PRN medication is administered immediately prior to the end of the shift, the off going nurse shall notify the oncoming nurse of the need for PRN effectiveness assessment and it will be the oncoming nurse's duty to document the PRN effectiveness. If the PRN medication being given is the same medication as a scheduled medication the following should be done:

i. PRN after scheduled: A PRN narcotic dose can be given **15-20 minutes after a scheduled IV or SQ does, and 30-40 minutes after a scheduled SL or PO dose.**
ii. Scheduled after PRN: A scheduled dose should not be given sooner than one hour after a PRN dose unless that PRN dose has not begun to relieve the patient's pain, in which case a CHC MD/NP should be contacted and asked to reconsider that medication's dosing.

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

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

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

Before a patient is scheduled for Respite stay:

- Case Manager/Visit nurse will complete a TB test and the Communicable Disease form before transfer. Exception on TB test will only be made for emergency respites or documented allergies to solution.
  - Emergency Respites are defined as:
    - Caregiver illness/injury and cannot physically care for patient
    - Loss of utilities or sudden unsafe home condition
    - Other as determined by administration
- As soon as the family has made the request for respite, the Social Worker will enter all respites on the public calendar labeled IPU Respite Reservations~~fill out the IPU Request List form at both IPUs~~.
- On the date patient/caregiver is requesting to start respite, the social worker will add the following:
  - Under Subject:
    - Patient Name
    - Date entered into calendar
    - Length of stay
  - Under Location:
    - Preferred location
  - Under the body:
    - If TB test done
    - Diagnosis
    - Anything that would be pertinent to the stay
  - Social worker will complete the CHC Respite Stay Questionnaire profile before arrival to the IPU.

- An IDT will be scheduled within 24 hours of start of Respite by the Social Worker.
  - Respites that will begin on Sunday or Monday may be IDT'd on Friday in order to include the patient care team.
- The Case Manager will be included in the IDT to ensure all needed information is shared with IPU staff.

Day of Respite:

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

Admission to IPU:

- Upon arrival the patient and the caregiver, if present, will be oriented to the IPU including the following:
  - Inventory of patient belongings
  - ~~Questionnaire on patient preferences will be completed by the RN~~
  -
  - Copy of questionnaire will be kept in CNA book for reference
- RN will call family prior to admission to complete
- Questionnaire will be utilized for the patient plan of care while in the IPU
  - Family preference on who to call first if there is more then one family member
- Home medications will be reconciled with the family upon arrival to the IPU. If the family does not accompany the patient, the RN will call the family to discuss.

Daily Care while in the IPU:

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

Transfer from Respite Back to Home:

- Social Work will coordinate transfer time and transportation.
- IPU nurse will call the Case Manager with an update on the patient.
- Medications and belongings will be packed and made ready for transportation.
  - Belongings will be double checked against the inventory sheet to make sure all of the patient's belongings are returned with the patient.
- IPU Patient Discharge Instructions (Attachment A) will be completed and accompany medications home.
  - Dosages will be written in mg and # tablets or mL.
- If the family is not present at the discharge from the IPU, the IPU nurse will call the family with an update and to educate on any medication changes during ~~on~~ the patient's respite stay.

REGULATION: IC 29-2-16.1 – Uniform Anatomical Gift Act (UAGA)

PURPOSE: To ensure patient's rights for tissue, eye, or whole body donation is honored.

POLICY: Agency personnel will ensure that a patient who has requested tissue, eye, or whole body donation's decision is honored according to the self-determination act under the UAGA law.

PROCEDURE:

1. **Determination**
   a. Family/patient/caregiver notifies staff that patients has made decision to be a donor
   b. Social Work will be notified via secure message regarding decision
   c. Note will be added to Alerts titled Donation

2. Post Death (tissue/eye donation):
   a. CHC staff will not discuss specifics of donation regarding what can be donated or how it is done.
   b. Within 1 hour of pronouncement of death, Nurse/Social Work will call the Indiana Donor Hotline at **800-356-7757.**
   c. Nurse/SW will have patient name, birthdate, and past medical history available for donation specialist.
   d. Nurse/SW will have available name of legal next of kin/HCR and a number they can be reached at within the next 4 hours or early am(if middle of night.)
   e. Do not release body to funeral home until okay given from Indiana Donor Network.

3. Care of the Body
   a. Place pillow under head
   b. Gently tape eyelids closed
   c. Fill 2 gloves with ice and place gently over eyes
   d. Keep body as cool as possible

4. Whole Body Donation
   a. Patient or family must have completed a Bequeathal form before death
   b. Call Indiana University School Of Medicine after pronouncement at **317-274-7450**
   c. Rule outs for whole body donation through IU School of Medicine. IU School of Medicine should still be called, but patients must have an alternative listed for funeral plans.
      - Maximum height of 6ft and maximum weight of 200 pounds. For every inch below 6ft, subtract 10 pounds from maximum weight.

- All infectious our contagious diseases.
- Any unhealed wounds or incisions. This includes any incisions that still have sutures or staples.
- Any amputations.
- Any tubes or bags, including ostomies and feeding tubes.

Effective Date: 07/17	Revised Date: 05/19-	Board Approved:
Reviewed Date:		Signature Date:

REGULATION: 42 CFR 418.58(c) – Quality assessment and performance improvement

PURPOSE: To provide a systematic format for documentation of unusual incidents.

POLICY: An Incident Report is completed by any employee/volunteer who performs, discovers, witnesses, or becomes aware of circumstances suggest or confirm an event.

- An event is defined as any happening not consistent with the routine operation of an organization or the routine care of the patient that has potential litigious aspect or may compromise patient care.
- The incident report provides a prompt and accurate account of an event, and provides a method for discovery and investigation of causes for notification of the insurance carrier, and data for evaluation and prevention of incidents.
- Incident reports are not used for disciplinary actions or punitive measures and should be objective, factual, and completed in a non-accusatory manner.

PROCEDURE: Document detailed information on the Incident Report form within 24 hours of the incident.

- Patient related incidents will be forwarded to the Director of Nursing for follow-up after all required signatures are obtained.
- Patient related incidents will be reported immediately to the coordinator or nursing leadership on call under the following circumstances:
  - Police or fire department is involved
  - Safety of patient or staff is at risk
  - Injury to staff related to patient care
  - Serious adverse drug event
  - Building alarm is activated
- The coordinator or nursing leadership on call will make the determination to call the DON and/or COO.
- Employee/volunteer related incidents will be forwarded to the Director of Human Resources after all required signatures are obtained.

FOLLOW-UP: The Director of Nursing will review and evaluate all incident reports as a part of the quality assurance process.

The President/CEO and Vice-President/COO will:

- Review all incident reports and give priority to all reports involving serious injury or potential litigation.

Signature:  President/CEO

- Initiate appropriate investigation into each event which may include, but not be limited to:
    - discussion with the personnel involved,
    - the person's supervisor, the attending physician,
    - if indicated, the patient.
- All discussion is documented and the insurance carrier is notified as needed.

PURPOSE: To establish an Agency protocol when using a CADD Pump for symptom control that provides safe and accurate use of the pump while providing good symptom management.

POLICY: Agency nurses will go to the patient location, verify the order, confirm pump setting, provide patient and caregiver teaching, and start the CADD Pump according to designated settings and route.

PROCEDURE:

Initiating the Pump

1. After the order is received, verify by repeating the order to the physician. Fax a copy of the order to the infusion pharmacy and call the pharmacy.
2. Confirm that the medication and pump has arrived at the patient's home before your arrival. Upon arrival, identify your patient and review the order with a second licensed professional in person or by phone. Check the pump settings against the order. Follow protocol for correct route, IV, port, SQ, and update the care plan.
3. Start the pump according to CADD Quick Reference Card for Clinicians. Confirm that the pump is running and locked prior to leaving the patient's location.

Cassette Change

1. When the reservoir volume has less than a 24 hour supply, consider changing the cassette depending on availability of the medication. Notify the pharmacy that you are starting the new cassette.
2. Verify current order with a second licensed professional by phone. Check cassette against that order. Review pump settings. Change cassette according to instructions in "Quick Reference Card for Clinicians."
3. Change site if indicated by site appearance or protocol.
4. Confirm that pump is locked and running before leaving the patient location.
5. Dispose of any unused medication per agency policy.

Changing the Settings

1. Verify new order by repeating it back to the physician. Fax a copy to the infusion pharmacy.
2. Make any changes according to the instructions in "Quick Reference Card for Clinicians." Verify the new setting with a second nurse by phone. Start the medication as ordered.
3. Verify that the pump is locked before leaving the patient location.

Discontinuing the Pump

1. Verify the discontinuation order.
2. Notify the infusion pharmacy of the discontinued order. Fax the order.
3. Discontinue site per protocol.
4. Dispose of unused medication per protocol (see medication disposal policy).
5. Return pump to the triage area for pick up.

CADD Pump Keys

1. Each office will have a spare key kept:
   - South Bend IPU medication room
   - Elkhart IPU medication room
   - Plymouth medication refrigerator
   - La Porte medication refrigerator
2. CADD pump keys must be picked up and returned to the office the same day.
3. CADD pump keys must be signed out and in (see attachment A).
4. Lost keys will be reported immediately to coordinator and an incident report completed.

Center for Hospice Care
QI Committee Meeting Minutes
May 21, 2019

Members Present:	Carol Walker, Craig Harrell, Dave Haley, Dr. Greg Gifford, Holly Farmer, Kim Geese, Larry Rice, Mark Murray, Rebecca Fear, Sue Morgan, Tammy Huyvaert, Becky Kizer
Absent:	Bethany Lighthart, Deb Daus, Jennifer Ewing

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 02/26/19 meeting as presented. The motion was accepted unanimously.	T. Huyvaert motioned C. Walker seconded
3. Committee Changes	• We looked at membership on the QI Committee and decided there were a lot of individuals, especially from nursing. So we decided to have one nurse representative, which will be Kim G. She will also sit on the HIM Committee so there is a good flow of information, and also report at the nursing leadership meetings. If there is a new PCC, we will have them sit in on a meeting as part of their orientation so they get an idea of what is presented.	
4. HQRP	• Hospice Quality Reporting Program – For the period of 04/01/16 – 03/31/18 our CAHPS scores were a little lower than the national average in help for pain and symptoms. CHC's score was 73% and national 75%. All of our other scores were the same or above the national average. The QAPI is looking at why our score dropped in this area.	
5. Visits at End of Life (HIS)	• CHC's score was 88% and national 87% in patients got timely and thorough pain assessment when pain was identified as a problem. We recently changed how the data is collected. At admission, the nurse will document all seven areas of the HIS and then QA will review the documentation, extract the data, and then submit the HIS. Our score for 04/01/16 – 03/31/18 for patients got timely treatment for shortness of breath was 99% compared to national 95.8%, which ties into our BreatheEazy program. CHC's composite score for all seven measures was 88.2% compared to national 84.2%. This is great data for our liaisons to share with referral sources. NHPCO is working to provide resources and tools for agencies to put together performance improvement plans or anything else to help improve their scores.	

Topic	Discussion	Action
	• Another measure through the HIS is visits when death is imminent, especially measure 2 that patients receive at least two visits from a social worker, chaplain, LPN, or Aide in the last seven days of life. We've had a QAPI working on this for a year, and want to create some new actions surrounding this measure. We started Enhanced Care email alerts to the care team so they know a patient is imminently dying and need to increase visits to meet the patient's needs. We have the raw data on the number of deaths and visits, but there are no national benchmarks yet. CMS started the Service Intensity Add-On (SIA) payments for the beginning and end of care, but it has made no difference in the number of visits. The SIA only applies to nursing and social work and pays $40.00. We want to create our own benchmarking data and do outcome measures based upon the results. Sometimes families say they don't want more visits at the end of life. • NHPCO has created a resource tool, "Management of Imminent Death in Hospice Care." We want to restart this QAPI using NHPCO's tool, look at our own numbers and create internal benchmarks. The QAPI will go through the HIM Committee and give updates to the QI Committee. This could tie into the CAHPS for help with symptoms. The QI Committee approved rebooting this QAPI by consensus.	
6. Specialty Programs Committee	• The Specialty Program Committee developed the HeartWize, BreatheEazy and Dementia programs. At its last meeting, the committee decided HeartWize and BreatheEazy are now hardwired, so they would disband the committee. We will continue to report on these programs to the QI Committee. • We have a proposal for a new QAPI on Dementia Care. We have the expertise of Milton ADS to help us with this. We have had difficulties in the past in measuring success, so we want to look at this in the near future. • Rebecca F. offers a facilitator course for anyone interested in being on a QAPI or heading a QAPI. • The QI Committee approved the Dementia Care QAPI by consensus.	
7. Wound & Skin Care	• Staff is educated on wound and skin care during orientation and ongoing. We work with a Wound & Ostomy Certified Nurse at McKesson and also review our policies to ensure we meet the Wound Ostomy & Continence Nurses Society standards of practice. Carol W. said specialty mattresses can get pricey. SJRMC purchased a mapping product which measures different surfaces. One thing they found in a mattress	

Topic	Discussion	Action
	they have on most med-surg beds is that something as simple as a waffle overlay greatly reduces pressure points versus a specialty bed. They looked at whether they really need waffle overlay and found they are still better care and less expensive to use. • We have palliative skin and wound care interventions and best practices. With our patients, some outcome may not always be feasible to heal the wound, but we can prevent pain, discomfort, and infection. We have a good partnership with McKesson, and other tools like "At a Glance" for wound assessments and we also have measuring guides. • Renee S. in QA will review the care plans and documentation to make sure the plan of care and orders are being followed. She will give feedback to the PCCs so they know where education and performance improvement is needed.	
8. Adverse Events	• We formally report patient falls and med errors every six months, so we will have information to report at the next meeting. We will also break it out by home health and hospice. We of course do look at all adverse events and effect appropriate changes in real time.	
9. Live Discharges & Revocations	• There are five areas of live discharges: revocation, change of designated hospice, no longer terminal, cause, leaves service area. National data from 2014 showed 16.7% of all discharges in hospice were live. CHC in 2018 11% were live, which has been pretty steady the past few years. The HIM Committee is focusing on revocations. YTD 37 patients have revoked. We recommend restarting the Revocation QAPI to look at this in greater detail. 50% of patients that revoked were within the first 25 days of service, and nearly 50% of those return to CHC services. QA looks at all discharges daily and Laura T. in QA looks at live discharges monthly. • We noticed four of the revocations in March and April were patients in the BreatheEazy and HeartWize programs. Staff may not be 100% on board about live discharges and revocations, even though they were educated on it in January. We need to be more proactive with families too. We'll also look whether it would have been better if CHC just paid for the treatment and kept the patient on our program. Sometimes patients revoked and went to the hospital for something not related to the terminal diagnosis, so they didn't have to revoke. Did we offer all resources like the IPU or Continuous Care so the patient didn't have to go to an acute care setting. • Discharge for cause is related more to safety in the home. We go to great lengths to	

Topic	Discussion	Action
	care for patient, but when it becomes a safety issue for staff or we cannot find the patient to care for them, we have to discharge them. • The QI Committee approved restarting the Revocation QAPI.	
10. Infection Control: TB	• Every year we have planned infection control activities and will add additional activities as needs arise. Annually we do TB screening for staff and volunteers. Indiana changed its requirement, but we chose to continue screening all of our employees as we have a congregate setting and serve a very vulnerable patient population. So far 97% of staff has completed the TB screening, and volunteers will be screened in June. Patients are also screened prior to entry into IPU through the use of a TB questionnaire. We also educate staff on TB every year. Annually we review Indiana statistics to help us assess our risk in our nine county service area. Tammy H. is on the District 2 emergency preparedness group. We also screen employees and volunteers when they start with CHC and recommend any boosters for vaccines per the CDC guidelines.	
11. Documentation	• Social Work and Chaplain have updated their profiles so their notes are more succinct and accurate. The new profiles now have the information we want in there and we eliminated any redundancy. There is a section on anxiety and sadness which ties into the CAHPS. Eventually Bethany L. will pull that data to show that we are educating on anxiety and sadness. The chaplains updated their profile a year ago and removed things they were no longer using and updated their care plans to include more inclusive language. We are also doing peer reviews. • Bereavement – When NHPCO put out new guidelines, Holly F. reviewed bereavement documentation to make sure we are still on track. In their team meetings this year, Holly F. is selecting one of the guidelines to focus on to make sure we are consistent. We are also looking at creating bereavement admission packets for different types of deaths.	
12. Other Business	• In June we will be doing interdisciplinary education on documentation do's and don'ts at each office. We will review the NHPCO standards, certification criteria, HIPAA, legal considerations, consumer concerns, incident reporting, and more. Bereavement staff and admission representatives will be included. • We prioritized the QAPIs approved today. The committee decided to do Revocations first, then Imminent Death, and then Dementia care.	
13. Home Health	• Activities planned for 2019 include update training on Home Health OASIS and CoPs.	

Topic	Discussion	Action
Updates	Several staff will be attending the Palmetto GBA Regulatory & Reimbursement conference on June 4 -5 in Indianapolis, including QA, admissions, and billing. One day is just for home health. • We are still waiting for our home health survey. We have created guidebooks for each office so staff knows what to do when the surveyor arrives. • With the changes in staffing in the QA Department, Rebecca F. has reassigned duties. QA reviews therapy documentation to make sure everything is accurate, orders are in place, etc. Maryjanet S. puts a report together weekly. • We will be reviewing home health policies and procedures in the next quarter.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 08/27

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
August 21, 201
(*Report posted to Secure Board Website on August 15, 2019)*

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from May 16 – August 21, 2019. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

Through the end of July, referrals to CHC are up 2.4% from same time in 2018. The percentage of referred patients who die before admission (DBA) is at 7.81% compared to 7.02% at the same time last year. Most DBAs are hospital referrals. The numbers of patients served at 7/31/19 and the number of original admissions is statistically about even at just six patients less in both categories. Part of the reason for the increase in average daily census is the 86% increase in home health patients which, if they continue to qualify, generally have a longer length of stay. While the percentage increase is substantial, we are talking about 14 patients per day on average compared to last year. Both inpatient units (IPU) have been busy, particularly in July, with Elkhart's occupancy level at 90% and the South Bend at 82%. CHC hit an all-time high single day census record of 453 on June 13, 2019.

July 2019	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	539	1,390	1,396	-0.43%
Original Admissions	135	1,022	1,028	-0.58%
ADC Hospice	406.35	383.75	378.76	1.32%
ADC Home Health	32.35	31.34	16.88	85.66%
ADC CHC Total	438.70	415.09	395.64	4.92%

CHC HOSPICE INPATIENT UNITS

July 2019	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
SB House Pts Served	34	211	216	-2.31%
SB House ALOS	5.21	5.00	5.13	-2.53%
SB House Occupancy	81.57%	71.16%	74.60%	-4.61%
Elk House Pts Served	33	182	181	0.55%
Elk House ALOS	5.91	5.15	4.49	14.70%
Elk House Occupancy	89.86%	63.14%	54.72%	15.39%

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	221	228	234			190	190	198
Ply: 105	74	77	79	77	74	76	67			83	78	75
Elk:	92	94	94	96	101	105	105			83	89	96
Lap:	14	18	18	20	24	23	21			16	16	14
SBH:	5	5	5	5	4	5	6			6	5	4
EKH:	3	4	5	5	4	4	6			4	5	3
Total:	378	394	405	420	428	441	439			382	382	390

PATIENTS IN FACILITIES

Of the 539 patients served in July 2019, 169 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in July 2019 was 146 and year to date it was 136. We continue to make progress on rebuilding our census in extended care facilities as we have expended a great deal of effort to enhance our relationships with nursing homes and assisted living facilities. The Vet-to-Vet programming through our We Honor Veterans partnership is very beneficial in this regard. We have also formed new friendships with facilities in LaPorte County.

FINANCES

Karl Holderman, CFO, reports the year-to-date July 2019 Financials will be posted to the Board website on Friday morning, August 16th following Finance Committee approval. For informational purposes, we are pleased to present the unapproved June 2019 year-end financials on the next page.

On 6/30/19, at the HF, intermediate investments totaled $4,729,420. Long term investments totaled $20,939,964. The combined total assets of all organizations, including GPIC, on June 30, 2019 totaled $61,265,067, an increase of $10,186,606, or 17%, or from June 2018.

Year-to-date investments as of 6/30/19 showed a gain of $2,633,953. From a year-to-date budget standpoint at 6/30/19, CHC alone was over budget on operating revenue by $115,291, over budget on total revenue by $2,247,263, and under budget on operating expenses by $1,008,949.

Year to Date June 2019 Financials

June 2019 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	11,112,036			**11,112,036**
MADS Revenue	178,016			**178,016**
Development Income		1,276,390		**1,276,390**
Partnership Grants			209,372	**209,372**
Investment Income (Net)		2,633,953		**2,633,953**
Interest & Other	15,111	33,769	22,560	**71,440**
Beneficial Interest in Affiliate	2,397,621	(12,748)		
Total Revenue	**13,702,784**	**3,931,364**	**231,932**	**15,481,207**
Total Expenses	**9,931,372**	**1,533,743**	**244,680**	**11,709,795**
Net Gain	**3,771,412**	**2,397,621**	**(12,748)**	**3,771,412**
Net w/o Beneficial Interest	*1,373,791*	*2,410,369*		
Net w/o Investments				***1,137,459***

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Gregory Gifford, M.D., JD, our Chief Medical Officer, has announced his retirement to begin in December 2019. George Drake, M.D., who has been working for us up to 24 hours a week, has announced his retirement and his last day will be August 30. Karissa Misner, D.O., M.P.T., will be starting on August 19, 2019. She, her husband (a pediatrician), and her children have already relocated to the area and we are looking forward to her addition to the medical staff. She has just finished her Fellowship training in Hospice and Palliative Medicine at a program in Macon, Georgia. Gayle Waldenmaier, ACNP-BC, ACHPN, one of our nurse practitioners, has resigned to relocate to Indianapolis. Ann Mueller, an RN and new nurse practitioner graduate, started on July 22 working for us in the capacity of a nurse practitioner. She has been a long-time employee of ours as an RN. Amy Fish, an RN and new nurse practitioner graduate, started in August working for us in the capacity of nurse practitioner doing face-to-face visits. She also has been a long-time employee of ours as an RN. We are currently recruiting for another physician and another nurse practitioner to assist with the record level of patient care we have been experiencing.

On July 23 Gregory Gifford, M.D., JD, our Chief Medical Officer, and Dave met with Kelly Macken-Marble, the new CEO of the South Bend Medical Clinic, to introduce ourselves and explore the possibilities of developing an arrangement similar to the one we presently enjoy with the Elkhart Medical Clinic. This is an arrangement where the clinic would provide a part-time physician to work as a contracted agent with our organization to provide care to our patients. The initial meeting went well, and she said she would speak to her medical staff and get back with us.

Our Total Pharmacy Drug Cost Per Patient Day, as reported to us by our drug vendor Optum, continues to perform well. We are told we are one of the top performers in the Optum national book of business.

Construction of the new LaPorte branch office building is complete except for installation of IT and audio-visual equipment. We are awaiting delivery of furniture on order. Due to internal issues on our end, the order itself was delayed.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

Natalie Barnes RN will be joining CHC on August 13, 2019 as the QA/Medical Records Coordinator; she was a Case Manager at CHC, relocated and is returning to the area. Rachel Bridegroom RN passed her CHPN (Certificate in Hospice and Palliative Nursing). The exam focuses specifically on hospice and palliative care nursing concepts. CHC now has 11 nurses certified with their CHPN.

Sue Morgan RN, DON, and Kathy Kloss, Clinical Educator, will be presenting at the NHPCO Clinical Conference in November in Orlando, FL. Two concurrent presentation proposals from CHC were accepted among the hundreds submitted. They are, *"How to Develop an ELNEC (End of Life Nursing Consortium) Program for your Clinical Staff"* and *"QAPI Success—End Stage Cardiopulmonary Program."*

One education program held for clinical staff included the "Do's and Don'ts of Documentation" presented in June and July for all nurses, social workers, chaplains, bereavement counselors and admissions representatives. The program was a competency on documentation in which 122 employees attended. Learning objectives included: Using NHPCO's Hospice Standards of Practice into our own individual professional practice; identify and discuss effective documentation strategies to meet regulatory and legal requirements; apply concepts of accurate and concise documentation into ones professional practice; identify the purpose of incident reports and consumer concerns; and the need to identify patient documentation requirements for patient level of care changes and live discharges.

The Indiana State Department of Health (ISDH) conducted a Federal Complaint Survey from May 30, 2019 until June11, 2019. Two surveyors were here for portions of nine days. There were four complaints which were investigated, one of which we strongly suspect went back over a year. These took place due to calls to the ISDH consumer "Hotline." We received the letter on July 10, 2019 requesting a follow up plan of correction to resolve the noted deficiencies related to the CMS Conditions of Participations. Of the four complaints it was determined that two were substantiated

with findings and two were unsubstantiated, lack of enough evidence, and with no findings. Our plan of correction was submitted to the Indiana State Department of Health within the short number of days allowed. It has been returned twice asking for additional information. This additional information request was not included in any of the correspondence originally received. Each time, we were given five days to produce the additional information that seemingly came out of nowhere. The areas which were identified by the surveyors as deficient were: wound and skin care, social work and chaplain visits not being completed in the five-day time frame after admission, respite level of care bed availability, the use of medications in the inpatient unit, and the required interdisciplinary care team meetings every 14 days which included home health patients. The reasons we have always included home health patients at these meetings were for enhanced care planning and continuity of care. We had been doing this over the last 39 years and it has never been an issue in any survey. We have now been instructed not to do this because chaplains and bereavement counselors have nothing to do with the care of home health patients and if these staff are in the room when these patients are being discussed it's a potential HIPAA violation and we were cited for not protecting patient privacy. This deficiency, as well as others, had nothing to do with the complaints. It was simply noticed during their visit. We changed our practice immediately. Because of privacy protections of the complainants, we do not know which pieces of investigation topics were related to which complaints, nor do we know exactly what was investigated related to the complaints and what was completed and cited unrelated to the original complaints. Documentation review included at least 60% more charts than were related to the complaints. This is hypothetically supposed to protect the identity of the complainant and throw us off. We also discovered through contacts in Indianapolis that have friends at the ISDH, that three of the four complaints originated outside of Indiana. Our survey took place within weeks after all states were notified by the OIG to write more hospice deficiencies. The OIG released two reports publicly after the states had been contacted. The OIG reports are topics that follow later in this President's Report and are included as attachments to this report. Our first two Plans of Correction were deemed by the ISDH as "unacceptable." After sending in three Plans of Corrections over many weeks and receiving a form letter threat by the Centers for Medicare and Medicaid Services in Chicago to basically shut us down, we received notification by letter from the ISDH on August 13th that they had accepted our third Plan of Correction on August 12th. The letter indicated they would let CMS in Chicago know that we had filed an acceptable Plan of Correction. We expect to get a resurvey to insure we are doing what we have promised to do sometime in September or October.

HOSPICE FOUNDATION VP / COO UPDATE

Mike Wargo, VP/COO, for our two separates 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 July 2019, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous three years:

Year to Date Total Revenue (Cumulative)

	2016	2017	2018	2019
January	65,460.71	46,552.99	37,015.96	62,707.48
February	101,643.17	199,939.17	93,912.90	113,771.80
March	178,212.01	282,326.61	220,485.17	369,862.26
April	341,637.10	431,871.55	310,093.61	565,568.94
May	579,888.08	574,854.27	505,075.65	663,483.70
June	710,175.32	1,066,118.11	633,102.69	850,496.19
July	1,072,579.84	1,277,609.56	767,397.15	918,087.39
August	1,205,050.76	1,346,219.26	868,232.25	
September	1,297.009.78	1,466,460.27	994,301.35	
October	1,421,110.26	1,593,668.39	1,074,820.86	
November	1,494,702.09	2,443,869.12	1,173,928.93	
December	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)

	2016	2017	2018	2019
January	52,156.98	31,552.99	37,015.96	51,082.36
February	36,182.46	35,125.58	56,896.94	45,621.02
March	73,667.84	79,387.44	113,969.42	254,547.16
April	163,425.09	149,569.94	87,978.18	194,857.93
May	93,318.98	142,982.72	182,601.92	97,864.76
June	127,315.24	146,200.17	46,947.92	69,026.39
July	52,394.52	61,505.45	64,243.53	67,591.20
August	97,470.92	63,593.03	61,803.98	
September	92,459.02	120,261.01	117,984.73	
October	71,323.54	127,208.12	79,852.69	
November	66,490.16	75,809.56	94,053.07	
December	138,328.11	286,687.74	191,211.72	
Total	**1,064,532.86**	**1,319,883.75**	**1,134,560.06**	**780,590.82**

Cornerstones for Living: The Crossroads Campaign

Campaign-related work in May, June and July 2019 focused on implementation of closing out campaign solicitations based upon on the Crossroads Campaign Final Year Plan. The Crossroads Campaign ended chronologically on June 30, 2019. We continue to work on closing large gifts from a few select donors, who have indicated that they intend to participate. Our 6/30/19 campaign total is $12,835,737, surpassing our total 5-year campaign goal of $10 million by 28%. Based upon interaction with prospective donors during the final weeks of the campaign, this number will increase through the remainder of 2019. On May 7, Tim Portolese joined us in hosting Kim Welch for a campus tour and meeting. Based upon cultivation and solicitation efforts led by Tim prior to the May 7 meeting, Kim and Scott Welch pledged $500,000 to the Crossroads Campaign. They selected CHC's Life Transition Center as the area to be named in their honor. Their gift is

significant since it is the largest received during the Crossroads Campaign from an Elkhart area donor, and it is helping us in our efforts to procure gifts from other Elkhart philanthropists.

Planned Giving

Estate gifts since the last report totaled $3,189. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients. Based upon recent correspondence, we anticipate receiving a minimum of $30,000 in planned gifts within the next 30 days. One additional large bequest is in the process of being administered and we expect to receive a distribution from the estate within the next 90 days.

Annual Giving

The 2019 Friends of Hospice appeal reached donors at the end of May and its focus on promoting campaign participation in the final weeks is producing results. The Annual Appeal, which officially ended on May 31, generated a total of $98,638.

Special Events & Projects

Following is a summary of HF events during the months of May, June and July:

Helping Hands Award Dinner (May 1):

- Highest grossing dinner ever in its 35-year history at **$404,239.**
- Highest netting event ever at **$334,209.**
- Over 500 people in attendance.
- Outstanding networking and interaction with dinner chairs, Stephanie and Todd Schurz and Kurt Janowsky.
- Positive feedback about honoring long-standing CHC/HF volunteer, board member and Campaign Cabinet Chair – Catherine Hiler.

South Bend Sodbusters MudBog (May 25, 26)

- Special year because our long-time supporter and MudBog participant "Big Rob" passed away in our care prior to the event, and this motivated participants to make the event even more successful.
- Organizers created a special fundraiser that sold t-shirts, and all the proceeds of the t-shirt sale came to CHC.
- Donations from the event totaled $8,200 (largest amount ever).
- Total raised through the 15th consecutive year for this 3rd party event: $92,140.

Elkhart Gardens of Remembrance & Renewal (June 4)

- A very good turnout for the event.
- Unsolicited donations at the event came from guests (who had not previously purchased any memorial items) because they were so moved by the program, and they left the 2019 event motivated to purchase memorial items for the 2020 event.

Journeys in Healing: (July 24)

- 120 people in attendance.
- 11 pieces of artwork sold.
- Gross Revenue is **$7,592.34** as of August 2 (we continue to sell prints, so this could increase).
- Excellent donor relations/communications/networking event.
- Article w/ photo gallery: https://valpo.life/article/journeys-in-healing-art-auction-raises-money-for-art-counseling-program-at-center-for-hospice-care/ and also included

Lube-A-Thon: (July 26)

- 14th year – continuing to build our relationship with Tom's Car Care Center & Zmyslo family.
- 109 vehicles were serviced that day.
- We received a total of **$3,915.15** from oil changes, car washes and donations.
- Media coverage of this event exceeded expectations.

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.

Partnership with the Palliative Care Association of Uganda (PCAU)

PCAU is hosting its 8th biennial Palliative Care Conference, working for the second time with the Uganda Cancer Institute. The conference will include rich content on cancer treatment and palliative care; it be held at Kampala Serena Hotel from Sept 5th – 6th, 2019. This year's theme is "Toward Universal Health Coverage." Mike Wargo, Denis Kidde, HF International Programming Representative, and Lacey Ahern, Manager of International Programs, will be moderating or chairing sessions during the conference. We will once again combine our partnership exchange visit with this conference. Two CHC staff submitted abstracts for the conference and both were accepted. Annette Deguch, CHC Bereavement Counselor, will present *Yoga and Mindfulness: A more Holistic Palliative Care Approach*, and, Kristiana Donahue, Volunteer Recruitment & Training Coordinator will present *Volunteer Program Essentials*. The CHC staff will spend the week following the conference working with PCAU colleagues to see first-hand how hospice and palliative care are delivered in Uganda. They will share their experiences with staff and other stakeholders after they return. PCAU is also currently hosting Kat Kostolansky, a University of Notre Dame student who is spending seven weeks in Uganda supporting the Road to Hope Program. She is helping us investigate peer programs to make recommendations for best practices in child sponsorship programs. While in Uganda, Kat is also helping PCAU establish better documentation on the children.

Road to Hope (RTH)

Currently there are 58 children on the program. Of these, eight are unsponsored. Of the 50 sponsored children, 27 are sponsored by CHC staff. Children are in their second trimester, which runs from May 27 – Aug 23. This year, nine children on the program are in candidate classes, meaning they will take national exams at the end of the year to advance to the next level (i.e., from primary to secondary school to vocation institution and/or to university). The candidate classes are primary seven and senior four. There are seven RTH children in primary seven and two in senior four. Sadly, the program experienced the death of another child. Annet Nakaye passed away in her

sleep May 10, 2019. She was a special needs child who in 2013 was abandoned by her parents in a garage. PCAU immediately enrolled her on the RTH program. She was enrolled in a L'Arche school and seemed to be doing well. Financial sustainability and fundraising are key priorities for the program this year. Eventually, we would like to establish an endowment for the program, but at least for the next several years, we will need to raise a minimum of $50,000 to keep the program at status quo. We have developed a plan focused on increasing fundraising, grants, and child sponsorship. Our current child sponsorship amount is $450 a year. Due to increases in administrative costs and school tuition, moving children to better schools, and some additional costs to support the children's welfare, this amount no longer actually covers the actual average amount spent. We are in process of establishing a revised amount, which we anticipate will be closer to $550 annually. We are developing a plan to help sponsors understand this increase and how we will move forward in bridging the gap in amounts.

Advanced Diploma in Palliative Care Nursing (ADPCN)

The first cohort of 15 students on this course at the Mulago School of Nursing and Midwifery started studies in February of 2019; the second intake was in July. With this new training program CHC/HF now supports scholarships for up to 30 students per year, which greatly increase the impact of our financial support. Between 2010 and 2018, CHC/HF funded scholarships for 62 students to receive their DCPC through the International Hospice and Palliative Care Association (IHPCA) which is housed at Hospice Africa Uganda.

mHealth Project

This project, now in its 5th year, continues to make progress integrating essential data with the Ministry of Health which is crucial to its sustainability. The scale up to 10 new facilities took place in April/May and the project is now being implemented in 20 facilities across the country. All participants will gather at the PCAU conference for a workshop with PCAU and CHC/HF during our upcoming visit.

Education and Collaborative Partnerships

The Center for Education and Advance Care Planning hosted our second panel discussion in Mishawaka on June 18th. Attendance was the highest so far, with approximately 25 people in attendance. We used WFRN to promote the panel discussions; Elleah Tooker, community education coordinator, and one of our panelists spoke on air as well. We will be expanding these discussions to LaPorte as well as continuing in Mishawaka, South Bend and Elkhart during the latter half of the year. We are now working with both Beacon and Saint Joseph Health Systems to provide Hospice Foundation of America webinars at their locations. The first one was held at Memorial Hospital on June 25th. The Saint Joseph Hospital series will take place in August, September, October, and November. Thanks to the Vera Z. Dwyer Charitable Trust we can provide these webinars to our own employees as well as community members. Staff members can receive continuing education credits at no cost. The credits are available to non-staff attendees for $5. Trail Creek Place Assisted Living and Memory Care Community has scheduled a customized "Death by Chocolate" event on August 7th at their facility. The goal of this seminar is to normalize the conversation about end-of-life and to talk to community members about advance care directives.

National Outreach

Our involvement with *MyHospice*, a nationwide initiative of the Hospice Action Network (HAN), has continued to grow. *My Hospice* is a campaign to reinforce the value of the Medicare hospice benefit among policy and healthcare decision makers to foster a policy environment that will support patient access to high quality, comprehensive hospice and palliative care. As part of our efforts, we anticipate hosting a roundtable event on campus. Elleah Tooker, HF Community Education Coordinator, and our ambassador for the *MyHospice* program, spoke with Sen. Todd Young's representatives about the legislative initiatives currently under consideration in the House of Representatives as well as other legislative priorities, as the representatives toured our Mishawaka campus. Elleah's MyHospice Ambassador spotlight has been completed and will be posted on the HAN website in the upcoming weeks.

IU School of Medicine Activities

Cyndy Searfoss, Director of Education and Collaborative Partnerships, Elleah Tooker and Lacey Ahern recently met with members of the IU School of Medicine – South Bend staff to discuss research/medical education projects for medical students and other possible collaborations. We will be meeting with Bunmi Okalami, MD, MBA, FAAP, the new Vera Z. Dwyer Bicentennial Chair of Palliative Care at the Vera Z. Dwyer College of Health Sciences at IU South Bend in August to share ideas about palliative care certification courses to be developed, as well as provide an overview of our relationships with IU South Bend and the IU School of Medicine. We will once again host IU Talk on the Mishawaka Campus on October 11th. This one-day workshop facilitated be physicians from the IU School of Medicine – Indianapolis, teaches clinicians the communication skills they need to talk effectively with patients about serious illness and end-of-life issues. This year's workshop will provide 6.25 CMEs at no charge to the participants (although there is a $25 registration fee). The workshop is limited to 12 participants. Areeba Jawed, MD, has been named the recipient of this year's Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. Dr. Jawed begins her Fellowship with IUSM Palliative Medicine on August 12, 2019 and is scheduled to rotate thru Center for Hospice Care from 9/22 thru 10/5.

Mishawaka Campus Construction Updates

Construction is nearly complete on the Clinical Staff Building. Punch List items are being completed by DJ Construction and various subcontractors. Most furnishings are now in place. Installation of audiovisual equipment, security cameras, access control system and the IT infrastructure are all currently in process. We anticipate moving staff from Roseland to the new building in September. Since the last board meeting, we've made great progress on construction of our new 12-bed inpatient facility, the Ernestine M. Raclin House. Interior walls are up and electrical and plumbing rough-in work continues. Much of the exterior work on the building structure is complete. Final grading and landscaping work are in process. Construction on the new residential house on Cedar Street is complete. The home is listed with Tim Murray, from Coldwell Banker. You may see the MLS# 201903324 listed house at http://www.michianahomesandland.com/property/201903324/

GLOBAL PARTNERS IN CARE

Goals

In June, the team reviewed our 2019 operational plan and reflected on progress, discussed necessary adjustments to some activities, and affirmed our goal to develop a three-year strategic plan for the period 2020-2023. Overall, we are on track to meet many of our goals and have made great progress in deepening relationships with our current partnerships. We are working closely with Chris Taelman, Hospice Foundation Chief Development Officer to advance fundraising. We started the year with ambitious goals and continue to work on cultivating relationships with various organizations to bring them into the Partnership Program. We will revisit our strategy on new partner recruitment and expect to have at least two new partnerships in 2019. In June we finalized the partnership between Delaware Hospice and NAPCare. This is a key foundation for our work to grow in Nepal. Once we begin engaging more, it may make sense to reach out to the Asia Pacific Palliative Care Network for collaboration. We all agree that our goals for growth and engagement in Nepal are still on target and we need to advance planning to really ramp this up in 2020.

Current Partnerships

We currently have 41 partnerships. This includes the new partnership between Hospice Delaware and the NAPCare. Many of our partners have been engaging more with us – reaffirming the value that GPIC offers partnerships. Several have increased their financial commitments to their international partners. Our Advisory Council has played a big role in growing several of these partnerships as well. Caris Healthcare, after 12 years of partnership with Hospice Ethiopia, has closed their foundation and therefore is ending their partnership. They are a for-profit hospice. In doing so, they sent $73,000 as their final gift to Hospice Ethiopia (HE). Lacey and Cyndy are working with Ephrem Abathun at HE to help him explore possibilities to leverage more support with this gift. As previously reported, Snowline Hospice has stepped up to support HE on a going-forward basis. We have received word that The Denver Hospice and Selian Hospice will no longer operate under GPIC after the end of this year. The Denver Hospice will be replaced by an independent partnership committee that will send funding to Selian through a Lutheran missionary organization.

Partner Events

Several exchange visits are still planned for this year. Upcoming exchange visits about which we are aware include Helderberg Hospice (South Africa) will visit the Hospice of the Western Reserve (Ohio) in November; this was rescheduled due to a health emergency. We plan to visit Ohio during this time so we can acknowledge their receipt of the 2019 Global Partnership Award while they are together. St. Luke's Hospice (Malawi) is planning to visit Hospice of Northwest Ohio in Toledo in October/November. Umodzi Children's Palliative Care Unit (part of the Palliative Care Support and Trust in Malawi) is planning to visit Hospice of Kankakee Valley (Illinois) in the fall. Our Lady's Hospice (Kenya) was planning to visit Caring Circle (Michigan) – however, both staff members from Our Lady's Hospice were denied visas. We worked with the partners to rewrite letters, prepare for interviews, and address the concerns of the US embassy in Nairobi. Unfortunately, they were still denied visas.

Potential Partners

Stephen Connor, PhD, Executive Director of Worldwide Hospice Palliative Care Alliance (WHPCA) and GPIC Advisory Council member, has been very supportive in helping us cultivate relationships and look for potential partners. 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. One UK organization wants to explore officially partnering with a hospice organization in China with whom they have a connection. While we are still sorting through some logistics of bringing this partnership fully into our program, we are supporting them with the guidance we normally would provide in twinning two organizations. WHPCA has been working in Armenia and Stephen connected us with a hospice organization in Armenia. We are exploring the possibility of partnering them with an organization in the US. While expansion to Armenia was not on our radar, this is a good opportunity to explore and possibly grow our programs more outside of Africa. At Stephen's recommendation, we were contacted by Ken Ross, President of the Elizabeth Kübler-Ross Foundation seeking collaboration on their initiatives in Latin America. We are working to set up a Zoom call to learn more. We are also in early conversation with national chain hospice and home health corporation Amedysis (through our Advisory Council member, Lori Williams) about establishing a partnership. They seem very interested and we are considering partnering them in Kenya or Nepal. Our engagement at this past April's NHPCO Leadership & Advocacy Conference has not yet resulted in any concrete partnerships. However, we continue to engage with those who expressed interest and will also revisit our recruitment strategy for future conferences.

Disaster Response Fund

Through the good work of John Mastrojohn, GPIC Advisory Council member and former Executive VP of NHPCO, NHPCO donated $10,000 to GPIC to start a disaster response fund. This was immediately matched by another local donor on staff at GPIC. The initiative was launched in response to the devastating Cyclone Idai and subsequent flooding that hit southern Africa in March/April (followed by Cyclone Kenneth). We were able to quickly send $500 to those affected partners and will match up to another $500 of what their US partner donates. We have partners in Zimbabwe and Malawi and many of the patients they serve were hit hard by the cyclones. Working with Karl Holderman, GPIC CFO, we have established an investment policy and a small investment fund with Vanguard.

Research and Education

We continue to stay engaged in many research collaborations. The university and organizational partners are very supportive of our role as a collaborator on these projects.

Understanding the Challenges of the Ageing Population in Ghana -- In May, Eve Namisango, Research Director at APCA, met with the University of Alberta researcher and students in Ghana to advance the project with local collaborators. The University of Alberta received a small partnership development grant through the Social Sciences Research Council of Canada to advance the project. GPIC is listed as a partner on the grant. There are no funds coming to us for this, but we expect this small grant to set us up to apply for future, larger grants that may bring some small income for our involvement in the project.

Telehospice to Enhance Palliative Care in Tanzania -- Following a successful visit to Tanzania earlier this year, University of Kansas Medical Center (KUMC) researchers are working with us and ELCT to develop a concept note to pilot a project with a few of our partners in Tanzania. This may be an ideal site to involve a GPIC intern in the coming year.

Palliative Care Leadership Center Project -- Conversations and planning are moving forward with Bluegrass Care Navigators (Lexington, KY) and APCA on this initiative. At our previous Advisory Council meeting, we discussed the need for leadership training among palliative care professionals in Africa. This project seeks to help address that. A representative from Bluegrass Care Navigators, Anne Monroe, will attend the APCA conference with us in September to learn more about palliative care in the African context. We are currently working with APCA to maximize this visit to advance the project.

University Collaborations

Following the Consortium of Universities for Global Health (CUGH) conference in March, Lacey and Jim Cleary (GPIC Advisory Council) were part of a group to propose a formal working group on palliative care within CUGH. The proposal was accepted, and the group held their first call in June. There is still conversation as to the appropriate role for this group and we are encouraging collaboration and engagement with the larger global palliative care community as the principal role of this working group. Lacey, in her role as an adjunct faculty member at Notre Dame, is serving as co-vice chair for the committee.

Scholarships

African Palliative Care Education Scholarship Fund for Nurses and Social Workers
Scholarships for this year were awarded in July to six recipients from Kenya, Malawi, Uganda and Zimbabwe. At least one recipient is from a GPIC partner in Malawi (Nkhoma Hospital). All scholarships this year will be for nurses as no qualified social work applications were received. We will work with APCA to determine a targeted recruitment strategy for social workers next year.

Upcoming International Conference

GPIC remains actively engaged in planning and will co-host a pre-conference workshop with APCA on partnerships and collaboration at the 6th International African Palliative Care Conference – Kigali, Rwanda September 17-20. We are also giving a 90-minute workshop during the conference on partnerships and resource mobilization. We will involve our partners who will be at the conference in helping to facilitate this workshop. We continue to support APCA behind the scenes thru membership on both the Scientific and Communications committees. Cyndy, Denis, and Lacey will be in attendance. The team will also be traveling in the region to visit additional partners. In addition to Rwanda, Cyndy will visit Malawi and Uganda (travel dates: 9/12-10/5); Lacey and Denis will visit Uganda.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for April through July.

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 April through July our three Professional Relations Liaisons completed 1,346 visits to current and potential referral sources within our service area. They accomplished 334, 357, 333 and 322 visits in April thru July respectively. Our newest Professional Liaison, Toni Foyer, began in mid-July and lives in Valparaiso. She will be responsible for both LaPorte and Porter counties replacing Melanie Marshall once she completes her orientation.

In May, Peter Ashley transferred from Director of Communication for the Hospice Foundation to become the newly created Community & Engagement Liaison. This position will be responsible for contacting non-professional referral sources and educating the community specifically to the services offered by Center for Hospice Care. This includes, but not limited to, businesses, faith communities and veteran organizations. One of the 2019 corporate goals of CHC is to attain the newly created Level 5 of the We Honor Veterans program. This will entail ongoing interactions and acknowledgments of veterans and veteran organizations each year. A large part of the contacts will take place through our Vet-to-Vet cafes, seven which we have accomplished along with six scheduled at the time of this writing. We are also participating in the two traveling Vietnam Memorial Walls that will be in Plymouth and South Bend in September.

Access

Our Referral Specialist took 3,459 phone calls between April and July. We also set agency census records in April, May and June. On June 13th Center for Hospice Care set an all-time agency record of 453. Also, in June our agency attained an average daily census of 441, which was a record for a single month.

The number one reason for patients not admitting continues to be death before admission with 67% of those referrals coming from hospitals, which is understandable since the patients that are at a hospital are there usually due to a crisis. The second highest reason for non-admits is due to the patient going with another agency, 69% of those also being from hospitals. Our same or next day admissions (within 24 hours) are currently at 46.45% with many of those outside the first 24 hours being due to family requests, patients wanting to keep a scheduled a physician appointment, etc. Although our referrals are down slightly compared to this time in 2018 (-.006%), we're continuing to aggressively pursue patients in all settings. Part of the increase in census is due to the number of Home Health patients we're seeing, nearly double over 2018.

Website

We're currently in the process of updating our website with the same branding as the Hospice Foundation with the intention of informing potential patient or family member and generating the phone call for help. Part of the new look will include field staff and actual CHC patients (with permissions and signed releases), which may take a little longer than purchasing stock photos, but we feel it's essential to show the authenticity of our work. Also planning to be included will be virtual tours of both the Ernestine M. Raclin House and Esther's House in Elkhart.

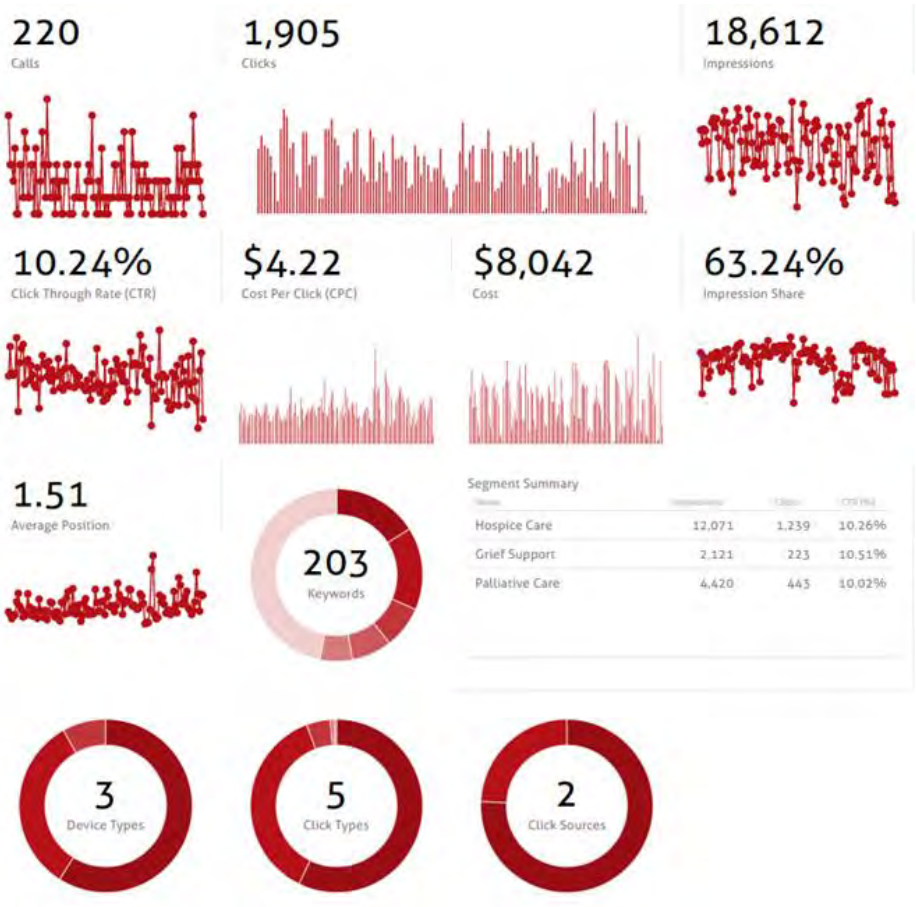
Social Media

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 136,422 people for the period of April thru July, and had 17,583 reactions, comments and shares. Our leading post was of our video posted on May 23rd, "You're entitled to choose the hospice program you want." It was viewed for 2,242 minutes by 4,300 people. It also received 105 comments or engagement. The second most viewed posting was on June 25th explaining that CHC is a community-based, not-for-profit organization offering hospice, home health, grief counseling and community education. It was viewed 3,873 times and garnered 552 engagements.

Digital Overview

The following digital report represents activity from April through July 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 220 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 10.24%.



CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are no new policies on the agenda. There are five clinical policies that have been updated for current practice. They are:

- IPU Medication Administration
- Respite Care in the IPU
- Anatomical Donation
- Incident Reporting
- CADD Pump Procedure

Sue Morgan, DON, will be available to answer any questions.

FY2020 HOSPICE WAGE INDEX FINAL RULE

On July 31, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1714-F) that intended to better align the hospice payment rates with the costs of providing care. This final rule updates the hospice payment rates, wage index, and cap amount for fiscal year FY2020. The final rule announces a 2.6% increase in hospice rates. The increases are used solely to rebase the rates for Continuous Home Care (CHC), Inpatient Respite Care (IRC), and General Inpatient Care (GIP). The RHC rates are reduced by -2.72% to accommodate the rebasing for the other three levels of care. The rates for Routine Home Care (RHC), at both the high (first 60 days) and low tier (61+ days), are a reduction of $1.75 per day from the original FY2019 RHC high tier rate, and a reduction of $0.49 from the original FY2019 RHC payment rates for the low tier rate. This is strictly the national rates. Due to wage index calculations that vary across the country, the actual rates vary. This rule finalizes rebasing of the continuous home care (CHC), general inpatient care (GIP), and the inpatient respite care (IRC) per diem payment rates in a budget-neutral manner through a small reduction to the routine home care (RHC) rates to more accurately align Medicare payments with the costs of providing care. Additionally, this rule finalizes modifications to the election statement by requiring hospices, upon request, to furnish an election statement addendum effective beginning in FY2021. (The draft rule wanted this to begin October 1, less than two months from now, which would have been impossible and additionally wanted patients to receive the information within 48 hours – another impossibility. We have a year to get ready and will have five days to get the addendum to the patients.) The addendum will list those items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, increasing coverage transparency for beneficiaries under a hospice election. Finally, CMS will continue its work to modernize and strengthen Medicare operations through the Hospice Quality Reporting Program (HQRP). The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments per patient made to a hospice annually. The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The rates must be budget neutral so the routine home care rates (about 97% of all patient days were cut in order to increase the CHC, GIP, and IRC rates. Because CHC has its own inpatients units, the new rates are expected to positively affect our revenue. For example, the GIP rate for South Bend will go from its current rate of $718.52 to $973.46 and IRC will go from its current $168.25 to

$432.29. We have four sets of rates of for each level of care including RHC for the first 60 days and 61+ days in addition to the service intensity add-on of about $55.00 an hour calculated in 15-minute increments for visits by nurses and social workers in the last seven days of life. Rates are based on St. Joseph, Elkhart, and LaPorte as core-based statistical areas with our other six counties falling under the Indiana Rural rates. For additional information, I have attached two articles for your information at the end of this report – "CMS Final Rule Rebases Payment Rates, Changes Election Statement," and, "CMS Final Rule Could Lead to More Hospice Audits." For specifically, the new FY 2020 rates applied to our YTD 6/30/19 per diem days based upon our current average levels of care would result in additional revenue of $478, 676. Annualized it would be an additional $937,352 in revenue.

GRANTS FROM TWO FOUNDATIONS FOR $1.25 MILLION TO ASSIST WITH REPURPOSING CHC SOUTH BEND OFFICE INTO "MILTON VILLAGE"

Our partnership with REAL Services to enhance Milton Adult Day Services (MADS) recently received a nice boost from the Community Foundation of St. Joseph County (CFSJC) and the Judd Leighton Foundation. As we've been working on plans to establish a new home for MADS through the renovation of CHC's Roseland facility at 111 Sunnybrook Ct, we learned about a funding opportunity from the CFSJC, known as the "2019 Senior Living Initiative." As we learned more about this initiative, it became apparent that partnering with REAL Services to apply for these funds was the most practical approach. We believed this new funding could enhance programming provided by MADS and Alzheimer's and Dementia Services of Northern Indiana (ADSNI), while aligning with our plans to renovate and repurpose our Roseland facility for MADS and ADSNI's Institute for Excellence in Memory Care. We made it through several application processes as they narrowed down the potential grantees and were invited to present our proposal on 6/13. A total of $1.5 million was available and we asked for all of it in our proposal. A concept for ADSNI and MADS was a "Care Connections at Milton Village" which would be a state-of-the-art adult day care center and more. It would be a comprehensive resource for older adults beyond adult day care. The concepts of Milton Village focus on in-depth Life Story collections, development of multiple socialization clubs and activities based upon needs. Programming would therefore evolve and change to meet the needs of clientele as they pass through the Village. A significant number of local entities and resources have indicated their desire to participate as consultants (Catholic Charities, the History Museum, etc.). Consultants will help develop scenic and reminiscent surroundings, advise on staff and volunteer training as well as caregiver education, which will allow not only staff, but caregivers to use and understand the surroundings and how person-centered program development will bring the sense of identity, purpose and scalability back into their loved ones lives. This project also focuses on the needs of caregivers and those affected by dementia. We received word in early July that that the CFSJC board of directors approved a grant in response to our Senior Living RFP in the amount of $750,000.00 to REAL Services, Inc. for the "Care Connections Center at Milton Village." The application for this grant was a collaborative effort between REAL and CHC doing business as MADS. Due to CHC's Crossroads Campaign, CHC was downplayed, and MADS took the spotlight. While we were certainly participants and presenters at the grants committee, we purposefully and strategically allowed REAL Services to take the lead on this. Additionally, we have been notified by REAL that the Leighton Foundation has pledged a grant in the amount of $500,000 for this project. Please note this is currently confidential and we are not allowed by the CFJSC to say anything about the grant at this time. They will release this news as their news, on their terms, when they decide to do so, probably

sometime this month. We have continued to work with REAL in answering follow-up questions from the CFSJC but have accepted their grant by the deadline which was 7/31/19. We need additional funding to fully realize our vision and we have identified some additional foundations and individual donors that we will contact regarding this initiative. Not a "campaign," but an "initiative."

TWO NEGATIVE OIG REPORTS ON HOSPICE, NEGATIVE MEDIA COVERAGE, AND US HOUSE OF REPRESENTATIVES CALL FOR CMS TO INCREASE SCRUTINY OF HOSPICES

On July 9th, the Department of Health and Human Services Office of Inspector General released two reports which found that from 2012 through 2016, most U.S. hospices that participated in Medicare had one or more deficiencies in the quality of care they provided to their patients. Some Medicare beneficiaries were seriously harmed when hospices provided poor care or failed to act in cases of abuse. OIG made several recommendations in both reports to strengthen safeguards to protect Medicare hospice beneficiaries from harm and to ensure hospices are held accountable for deficiencies in their programs. The reports were titled, "Hospice Deficiencies Pose Risks to Medicare Beneficiaries" which can be found here: https://oig.hhs.gov/oei/reports/oei-02-17-00020.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00020 . and" Safeguards Must Be Strengthened To Protect Medicare Hospice Beneficiaries From Harm" which can be found here https://oig.hhs.gov/oei/reports/oei-02-17-00021.asp?utm_source=mmpage&utm_medium=web&utm_campaign=OEI-02-17-00021 Much of the information in the reports were several years old and previously covered and publicized in the media. As an attachment to this report is the NHCPO Regulatory Alert which summarizes these two reports by OIG. The reports were covered in the mainstream media by nbcnews.com and The Washington Post. The post article, which is also an attachment to this report, was the most over the top of all coverage. The article was titled, "Hospices Go Unpunished for Reported Maggots and Uncontrolled Pain, watchdog Finds." The Washington Post has a long history of assailing the hospice industry and several years ago published a long series of articles detailing horrific hospice beneficiary experiences. As a result of these public articles, the House Ways and Means Committee leaders formally asked CMS how it plans to improve oversight of hospices. As an attachment to this report, I have included an Inside Washington Publishers release on this topic, as well as the letter from the House W&M Committee to Seema Verma, CMS Administrator. As stated earlier, the states were aware of the OIG report prior to their release. We believe this may have had something to do with our very long recent survey which resulted in a 61-page deficiency report.

CMS AUDITS OF HOSPICE PROGRAMS CONTINUE TO INCREASE, CAUSE INORDINATE AMOUNT OF STAFF TIME AND SERIOUS CASH FLOW PROBLEMS FOR MANY HOSPICES -- CEOs SPEAK OUT

I encourage you to read the Hospice News article "Confessions of a Hospice CEO: CMS Audits May Kill Us" which is attached to this report. It is one of the best summations of the numerous challenges due to ongoing and continued audits facing hospices in America while we continue to have vague rules and a lack of directives. Hospice CEOs were interviewed anonymously, and their comments are entirely accurate on what many of us our feeling and likely why hospice CEOs are leaving the industry altogether or retiring early.

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 "Special Committees" section which is open to all board members.

BOARD EDUCATION SECTION

Nancy DeMaegd, RN, Director, Milton Adult Day Services will provide the board education section at our next meeting. She will cover services and the amazing amount of innovative and creative activities that our MADS clients enjoy Monday through Friday.

OUT AND ABOUT

Mike Wargo and I attended the annual President's Community Leaders Breakfast at the Dahnke Family Ballroom at the University of Notre Dame on June 4th.

CHC staff members Karl Holderman, Dave Haley, Mike Stack, Mike Wargo, Jim Wiskotoni, Becky Kizer, Dan Zelmer and I attended the South Bend Cubs Hall of Fame luncheon which benefited Memorial Children's Hospital on June18th.

CHC and HF staff including Cyndy Searfoss, Peter Ashley, Mike Wargo, Chris Taelman and I attended Saint Mary's College "Down the Avenue" dinner. Sister Carmel, our 2018 Helping Hands Award recipient was one of the honorees. I was honored to be one of three participants in the testimonial video presented at the event.

CHC was a major sponsor of Mishawaka's Kamm Island Fest on July 17th.

I chaired the Indiana Hospice and Palliative Care Association's Board of Directors meeting based in Indianapolis on August 1st.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

Board Committee Opportunity Sheet

Hospice News article, "CMS Final Rule Rebases Payment Rates, Changes Election Statement"

Hospice News article, "CMS Final Rule Could Lead to More Hospice Audits"

NHPCO Regulatory Alert, "Two Reports Released by OIG

Washington Post article, "Hospices Go Unpunished for Reported Maggots and Uncontrolled Pain, Watchdog Finds"

Inside CMS article, "Ways & Means Asks CMS for Plan to Up Hospice Deficiency Oversight"

Letter from House Committee on Ways and Means to CMS Administrator re: Office of Inspector General Reports on Medicare hospice deficiencies

Hospice News article, "Confessions of a Hospice CEO: CMS Audits May Kill Us"

ValpoLife article, "Center for Hospice Care has a Message: 'We are Here for Everyone'"

June, July and August CHC Volunteer Newsletters

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date July 2019 CHC Financials.

2019 CHC/HF Webinars Schedule

2019 HF Events Schedule that all Board Members are Invited to Attend

Common Abbreviations (always handed out at board meetings)

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, November 20, 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 .

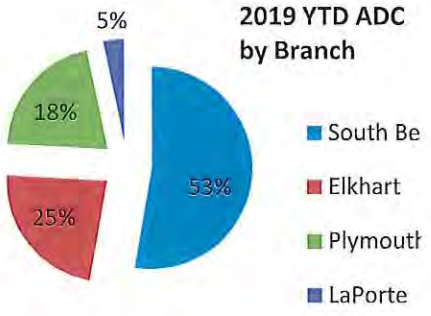
# # #

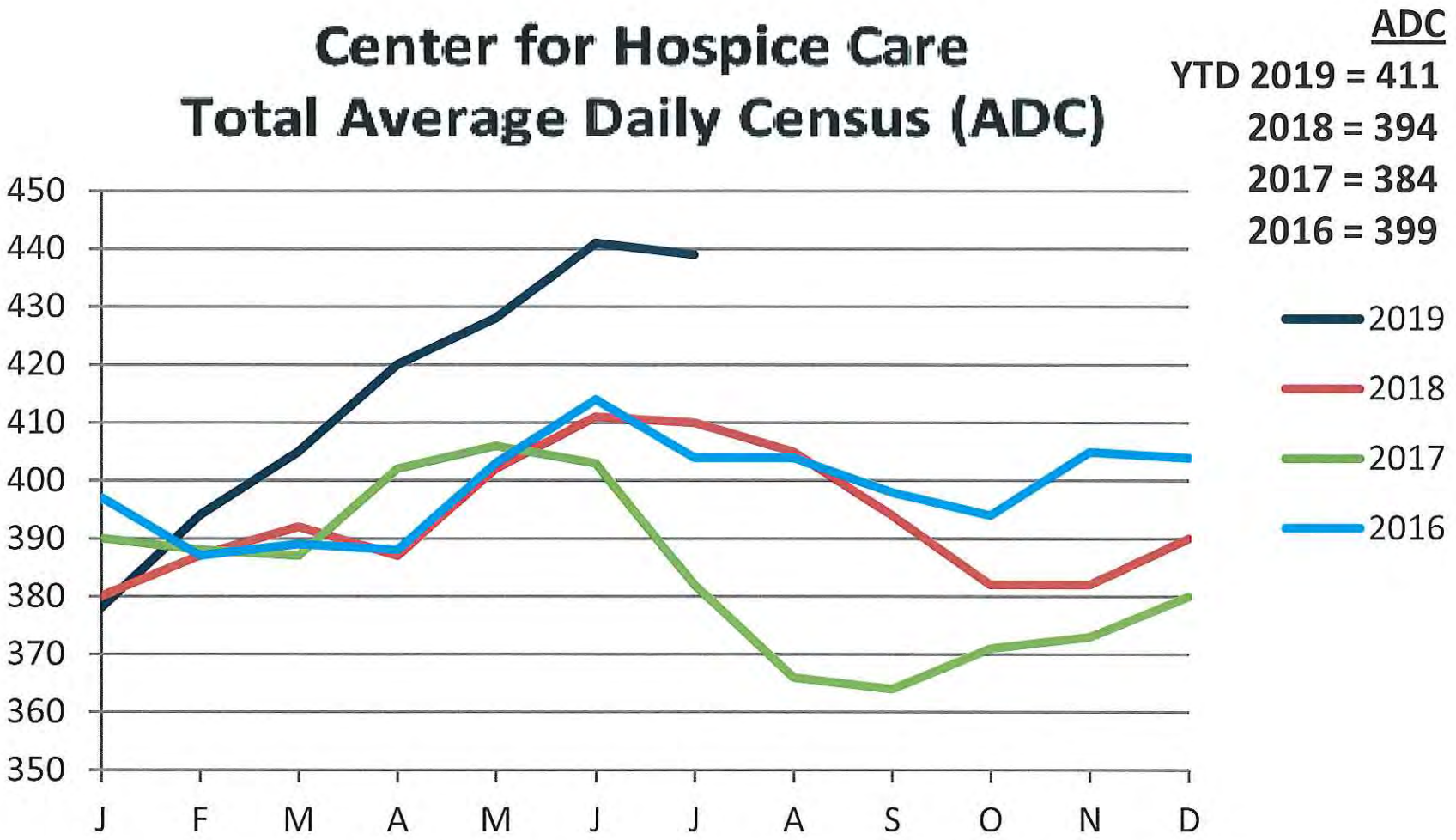
Center for Hospice Care

2019 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

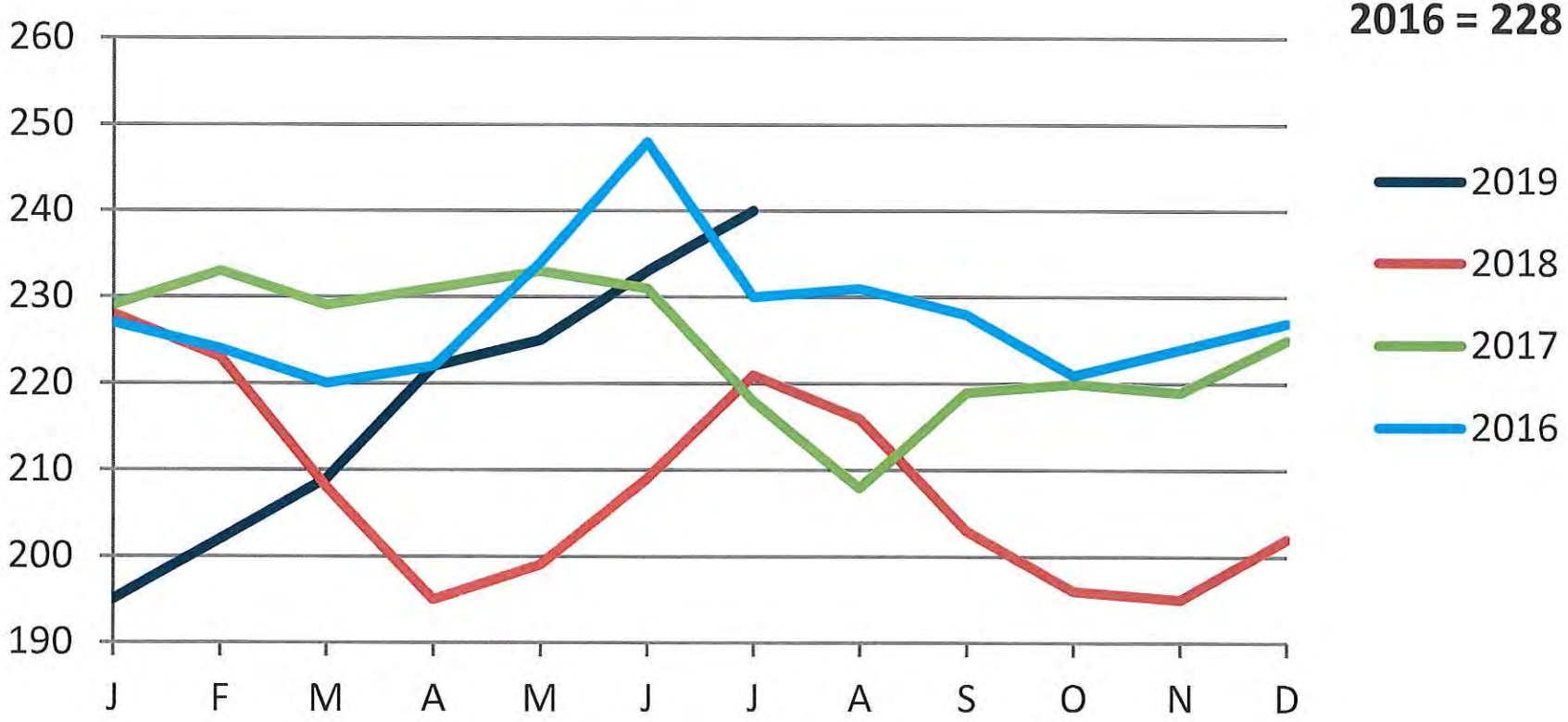
	All	South Bend	Elkhart	Plymouth	LaPorte
J	378	195	95	74	14
F	394	202	98	77	18
M	405	209	99	79	18
A	420	222	101	77	20
M	428	225	105	74	24
J	441	233	109	76	23
J	439	240	111	67	21
A					
S					
O					
N					
D					
2019 YTD Totals	2905	1526	718	524	138
2019 YTD ADC	**415**	**218**	**103**	**75**	**20**
2018 YTD ADC	396	212	91	82	11
YTD Change 2018 to 2019	19	6	12	-7	NA
YTD % Change 2018 to 2019	**4.8%**	**2.8%**	**12.7%**	**-8.7%**	**NA**




Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2019 = 411
2018 = 394
2017 = 384
2016 = 399
450
440
430
420
410
400
390
380
370
360
350
J
F
M
A
M
J
J
A
S
O
N
D
2019
2018
2017
2016

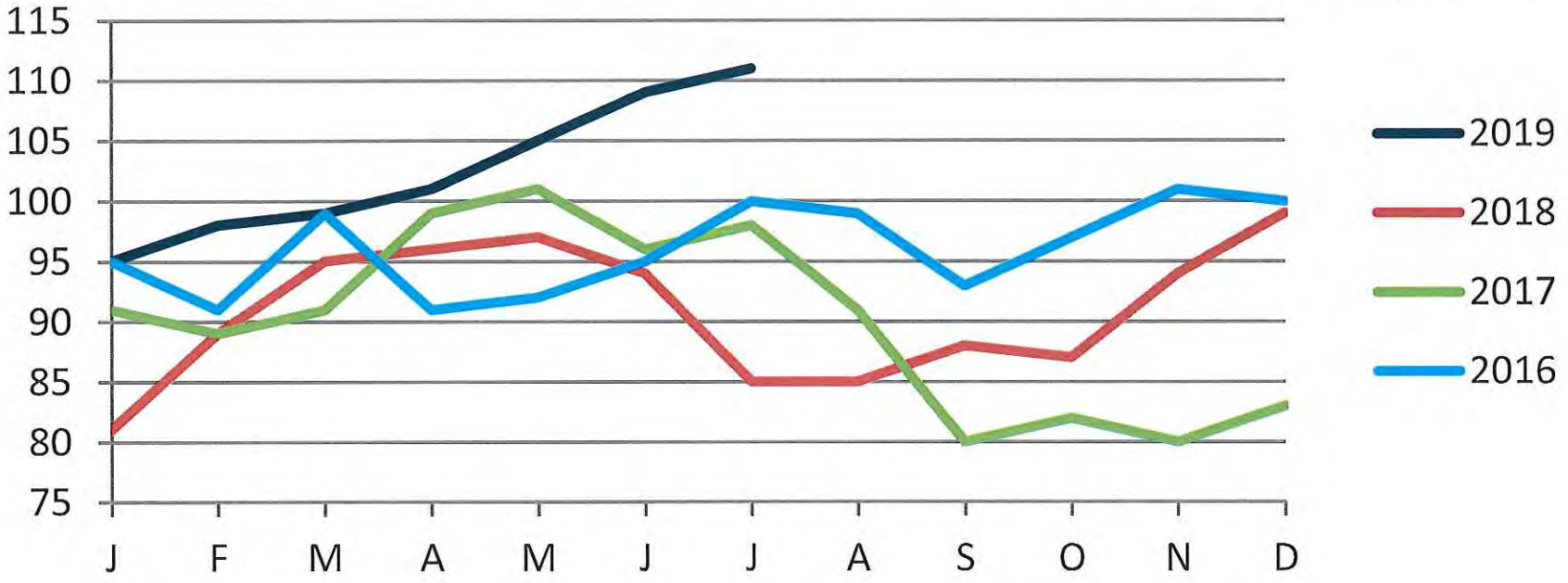
South Bend
Average Daily Census

ADC
YTD 2019 = 218
2018 = 208
2017 = 225
2016 = 228



Elkhart
Average Daily Census

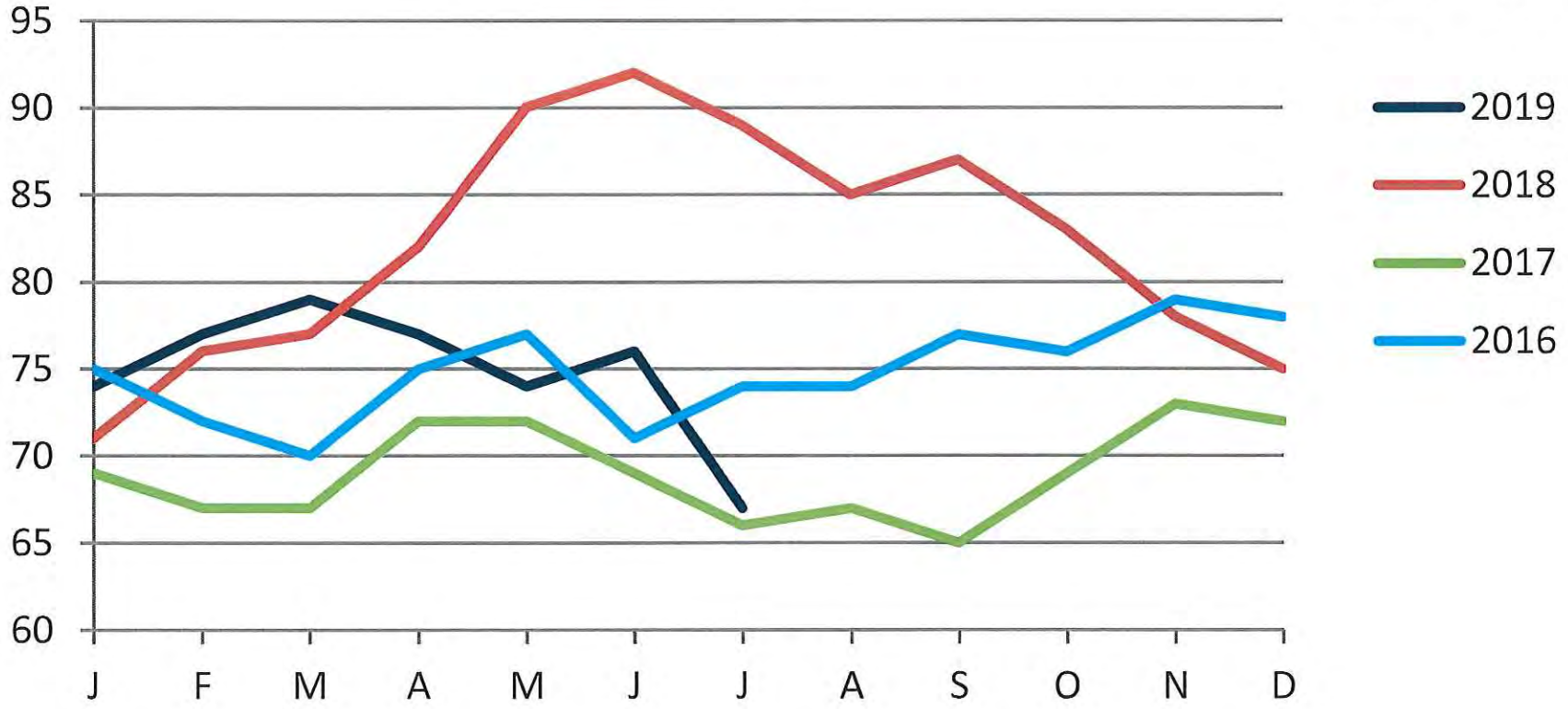
ADC
YTD 2019 =103
2018 = 91
2017 = 90
2016 = 96



Plymouth
Average Daily Census

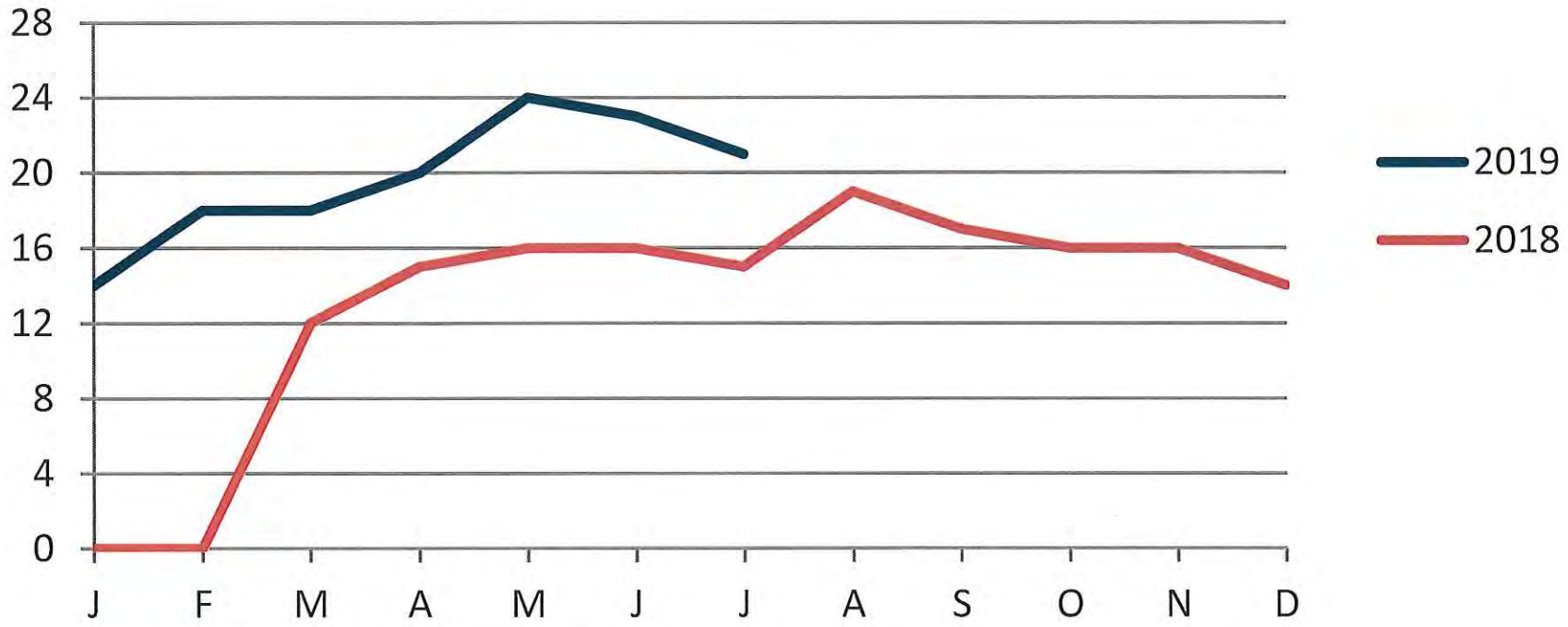
ADC

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



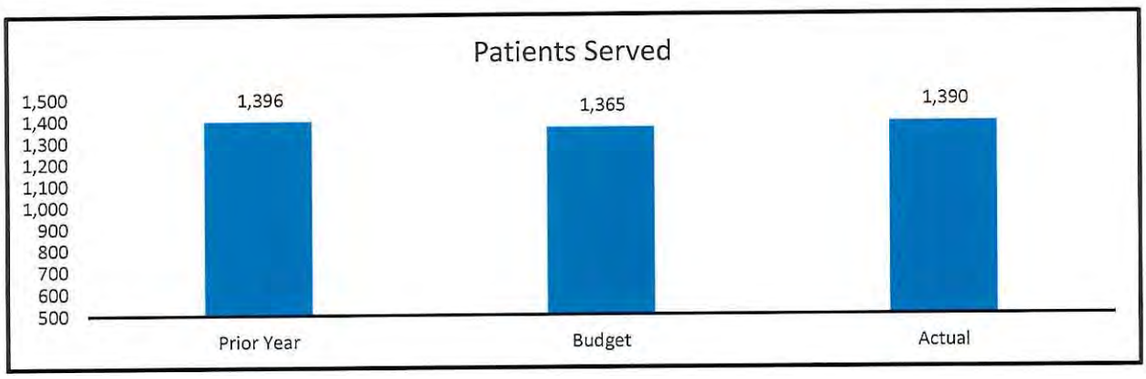
LaPorte
Average Daily Census

ADC
YTD 2019 = 20
2018 = 13

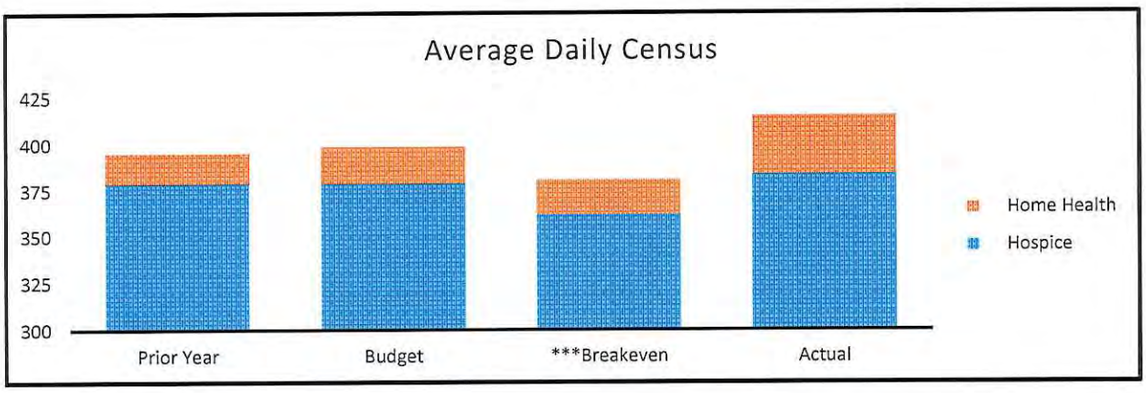


Center for Hospice Care
July 2019 Summary

	Prior Year	Budget	Actual
Patients Served	**1,396**	**1,365**	**1,390**

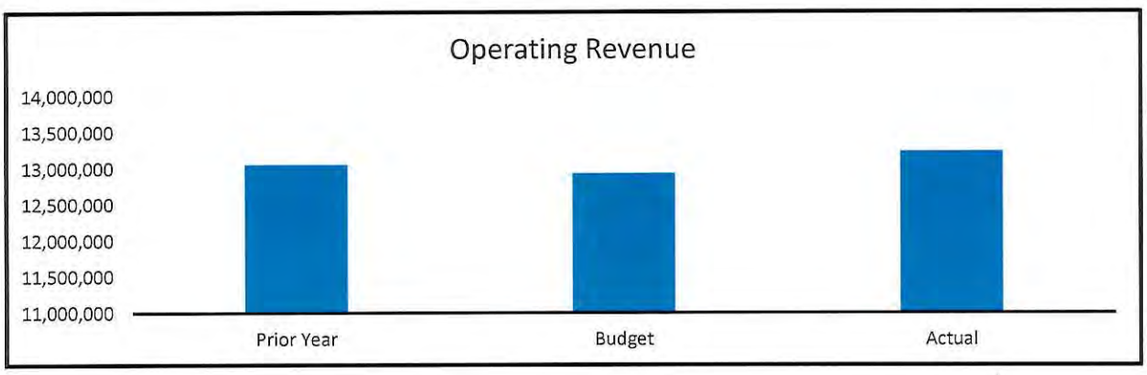


Average Daily Census	**Prior Year**	**Budget**	***Breakeven**	**Actual**
Hospice	378.76	378.75	361.93	383.75
Home Health	16.88	19.93	19.05	31.34
Total Average Daily Census	**395.64**	**398.68**	**380.98**	**415.09**

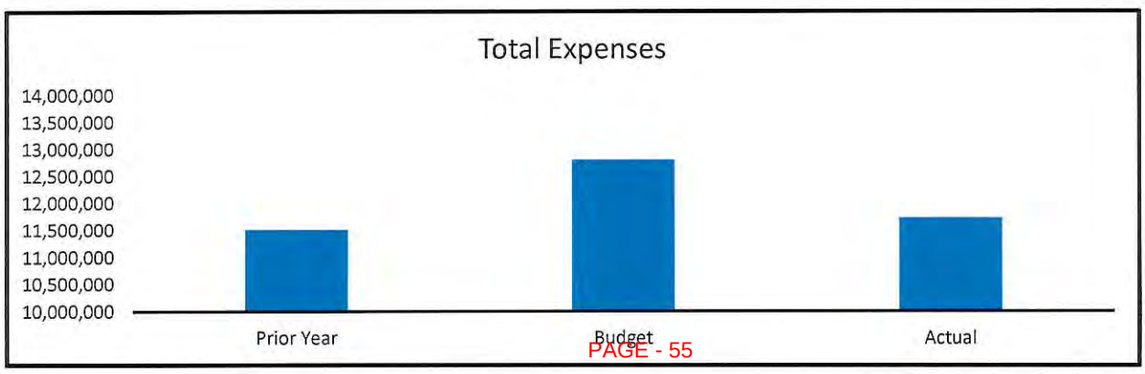


**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	**13,062,612**	**12,937,952**	**13,239,218**



	Prior Year	Budget	Actual
Total Expenses	**11,514,428**	**12,811,774**	**11,734,134**



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.

REGULATION

CMS Final Rule Rebases Payment Rates, Changes Election Statement

By **Jim Parker** | August 1, 2019

Geralt-Pixabay

Share

The U.S. Centers for Medicare & Medicaid Services (CMS) has rebased payment rates for the four levels of hospice care in a final rule for Fiscal Year 2020. Among other provisions the rule includes a new requirement that hospices provide an addendum to election statements that would detail care, treatment and services the patient would receive that are covered outside the Medicare Hospice Benefit. The rule becomes effective Oct. 1.

The U.S. Centers for Medicare & Medicaid Services (CMS) proposed the rule in late April, calling for a 2.7% cut in routine home care payments and a corresponding 2.7% increase in payments for continuous home care, general inpatient care, and inpatient respite care. Prior to this rebasing, payment rates for those levels of care amounted to less than the cost of providing those types of care.

According to the Affordable Care Act, Medicare payment increases must be budget neutral, requiring CMS to compensate for any increases with comparable cuts in other areas. CMS

Related Stories

REGULATION

CMS Final Rule Rebases Payment Rates, Changes Election Statement

August 1, 2019

LEGISLATION

based the update on a market basket increase of 3.2 percent, less a 0.5 percent multifactor productivity adjustment.

Hospice industry organizations were reticent to accept the rebasing, particularly the cut to the routine home care rate. Routine home care comprises 97.6% of all hospice care, with the three levels of care that received increases representing a much smaller volume of patients.

"We are gravely concerned about the impact the proposed reduction in the [routine home care] rate will have on care, as well as the message the increased reimbursement for the other levels of care sends to providers," the National Hospice and Palliative Care Organization (NHPCO) commented on the rule when it was proposed. "NHPCO is concerned that the substantially increased rates for the other levels of care could drive provider behavior away from [routine home care] and toward the higher levels of care. This is not in keeping with the wishes of patients and families or the original intent of the Medicare hospice benefit. The reduction in the [routine home care] rate will be especially difficult for smaller hospices and those in rural areas, which do not have economies of scale and where the cost of personnel and drugs are increasing."

Despite the drop in routine home care payments, executives at large hospice companies voiced few concerns about the payment levels when the rule was first proposed, though smaller organizations could be adversely affected.

"While the majority of our hospice revenues fall under the [routine home care] category, the impact to LHC Group is slightly positive according to the CMS impact file," said Don Stelly, president and chief operating officer for LHC Group (NASDAQ: LHCG) in a first quarter earnings conference call.

New Senate Caucus to Focus on Palliative Care

July 31, 2019

REGULATION

Confessions of a Hospice CEO: CMS Audits May Kill Us

July 30, 2019

"As a reminder, hospice currently makes up 10.3% of our total revenue."

Hospice and home health provider Amedisys Inc. (NASDAQ: AMED) estimated that the cuts, if made final, could have a 1% impact on 2020 revenue. In line with the industry, most of the hospice care Amedisys provides is at the routine home care level. Nevertheless, CEO Paul Kusserow said the move would be positive for the industry at large.

"A positive update for hospice payments is a positive move for our industry as we see expanded use of the Medicare Hospice Benefit," Kusserow said in the company's Q1 earnings call. "All of this is positive for Medicare beneficiaries and Amedisys."

Also in the final rule was a provision requiring hospices to provide an election statement addendum listing the rationales for items, drugs, and services that the hospice has determined to be unrelated to the terminal illness and related conditions to the patient or patient's representative, as well as any other providers caring for the patient, and to Medicare contractors. Submission of that document will become a condition for payment.

This requirement could prove problematic for hospices due to the complexity of determining which services pertain to the terminal diagnosis and which do not, as well as the work time that such an addendum would require.

"The downside is the significance of the workload that it will take to do that. There is already in place a requirement that patients be notified of services that won't be covered under the hospice benefit," said Melinda Gaboury, CEO of consulting firm Healthcare Provider Solutions Inc., speaking at the National Association for Home Care & Hospice Financial Management Conference earlier this month. "Giving them this level of detail, explaining why services would be covered in language the patient or patient's representative can understand, is very labor intensive. [CMS] is not providing a form for this. Each hospice will have to create its own addendum for each patient, and they have to be very careful that it contains all of the information that CMS would require under the rule."

Companies featured in this article:

Amedisys, Healthcare Provider Solutions, LHC Group, National Association for Home Care and Hospice, National Partnership for Hospice Innovation

Jim Parker

Jim Parker is a subculture of one. Swashbuckling feats of high adventure bring a joyful tear to his salty eye. A Chicago-based journalist who has covered health care and public policy since 2000, his personal interests include fire performance, the culinary arts, literature, and general geekery.

REGULATION

CMS Final Rule Could Lead to More Hospice Audits

By **Jim Parker** | August 2, 2019

S. Keeze-pixabay

The U.S. Centers for Medicare & Medicaid Services (CMS) issued its annual final rule for hospice payments in Fiscal Year 2020, including a payment rebasing that raises rates 2.7% for three higher-acuity levels of care and cuts routine home care by a corresponding 2.7%. With regulatory scrutiny on the rise, some hospice providers are concerned that increased audits associated with utilization of more expensive care could be an unintended consequence.

CMS raised payments for general inpatient care, continuous home care and inpatient respite care. Combined, these levels of care account for only 2% of days of hospice care in the United States, with the remaining 98% being routine home care. Prior to this rebasing, payment rates for those levels of care amounted to less than the cost of providing those types of care.

In recent years, regulators have increasingly targeted hospices for audits because of issues like live discharges, documentation errors and longer than average lengths of stay, particularly in the higher acuity care levels.

Related Stories

REGULATION

CMS Final Rule Could Lead to More Hospice Audits

August 2, 2019

EXECUTIVE PERSPECTIVES

"One of the challenges in my mind is now CMS increasing your reimbursement for respite care, continuous home care, and general inpatient care, which is needed. But in GIP care, they are doing more audits," said Clevis Parker, M.D., chief medical officer of Nathan Adelson Hospice told Hospice News. "So it's like they're saying, 'We are going to pay you more to take care of patients in your inpatient facilities, but by the way we are going to be doing more audits on the more expensive levels of care.' So it feels like a set up. 'Come get it, but gotcha, now we are going to take that money back.'"

Many hospice leaders seem conflicted about the changes, praising the rate increases as necessary but furrowing their brows over the cuts for services that represent the lion's share of their business. While margins for large for-profit hospices can better accommodate these changes, the 2.7% cut for routine home care is close to the average margin for nonprofits, according to the Medicare Payment Advisory Commission. For some, increasing utilization of higher acuity care might be necessary to ensure stable margins.

Organizations that operate their own inpatient facilities are most likely benefit from the raises.

"We have two inpatient centers, one within the walls of a hospital and one that is freestanding. This increase in the reimbursement better reflects the costs of providing that care," Mary Ann Boccolini, president and CEO of Samaritan Healthcare & Hospice told Hospice News. "For us I think it will work. The 2.7 is a cut, but I think with general inpatient care increase it will balance out for us."

The final rule also included a requirement that hospices provide an election statement addendum to the patient, listing

Humana Senior VP: Hospice MA Payment Should Support Quality Care

August 1, 2019

REGULATION Share

CMS Final Rule Rebases Payment Rates, Changes Election Statement

August 1, 2019

the rationales for items, drugs, and services that the hospice has determined to be unrelated to the terminal illness. Submission of that document to CMS will become a condition for payment.

Hospice organizations have expressed concerns about the workload associated with this requirement , as well as the complexity of determining which services pertain to the terminal diagnosis and which do not.Advocacy groups, including the National Hospice & Palliative Care Organization (NHPCO) and the National Association for Home Care & Hospice (NAHC), opposed the requirement.

"We took a pretty hard line on the addendum, thinking it was really going to be a lot of extra paperwork. We are concerned about that, but we also want to make sure that patients and families have all the necessary information and that hospices are paying for things that are their responsibility," Judi Lund Person, vice president, regulatory and compliance for NHPCO, told Hospice News. "The best news for us is that CMS did give a one year delay in implementation, because it will be a challenge for software vendors to get up to speed and it will be a challenge for vendors, and it will be challenge for hospices to get their processes in place."

NAHC released a statement citing stakeholder concerns about the payment rebasing, for which the organization advocated a gradual phase-in over a number of years rather than making the rates immediately effective. NAHC also saw value in the one-year implementation period for the election statement requirement.

"We are encouraged that CMS recognizes the need to allow for additional time so that logistical and operational issues associated with the election statement and addendum requirements can be addressed," NAHC President Bill Dombi said in the statement. "We look forward to working closely with CMS over the next year to limit the level of burden that these new requirements imppose on hospice caregiving staff."

Companies featured in this article:

Nathan Adelson Hospice, National Association for Home Care and Hospice, National Hospice and Palliative Care Organization, Samaritan Healthcare & Hospice

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Jim Parker

Jim Parker is a subculture of one. Swashbuckling feats of high adventure bring a joyful tear to his salty eye. A Chicago-based journalist who has covered health care and public policy since 2000, his personal interests include fire performance, the culinary arts, literature, and general geekery.

NHPCO
Leading Person-Centered Care

NHPCO Regulatory Alert

Two Reports Released by OIG

To: NHPCO Provider Members
From: NHPCO Regulatory Team
Date: July 9, 2019

Summary at a Glance

On Tuesday, July 9, 2019, the Health and Human Services Office of Inspector General (OIG) released two reports on hospice care, one focused on deficiencies identified in hospice surveys and one focused on a sample of serious harm to hospice beneficiaries and identified vulnerabilities. The OIG's key takeaway – "The majority of hospices had at least one deficiency in the quality of care they provide. It is essential that CMS take action to hold hospices accountable and protect beneficiaries and the program." A summary of both reports is below.

OIG Report #1

Hospice Deficiencies Pose Risks to Medicare Beneficiaries (OEI-02-17-00020)

This report provides a first-time look at hospice deficiencies nation-wide in that it includes both hospices that were surveyed by State agencies and those surveyed by accrediting organizations. This report is the first in a two-part series, both released today, July 9, 2019. The companion report, *Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm*, addresses beneficiary harm in depth.

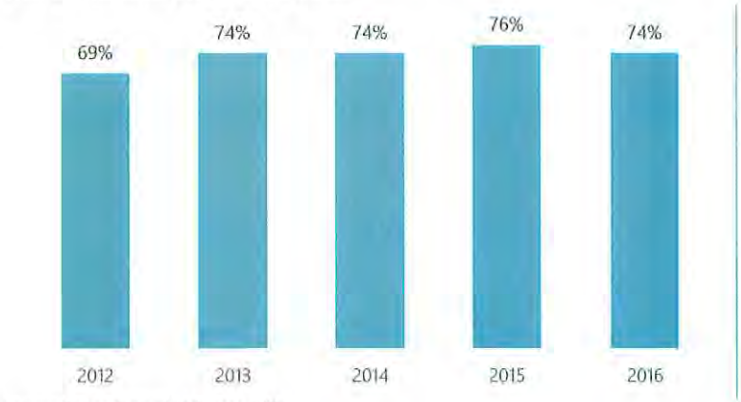
How the OIG did the Report

In total, 4,563 of the 4,799 hospices (95 percent) that provided care to Medicare beneficiaries were surveyed from 2012 through 2016.

Twenty percent of hospices had serious (condition-level) deficiencies in quality of care.

Twenty percent (903 of 4,563) of hospices surveyed from 2012 through 2016 had at least one serious deficiency—a condition-level deficiency—which means that the hospice's capacity to furnish adequate care was substantially limited, or the health and safety of beneficiaries were in jeopardy. The number of hospices with these deficiencies nearly quadrupled from 2012 to 2015—going from 74 to 292—but the percentage did decrease slightly in 2016.

Exhibit 1: The percentage of surveyed hospices that had a deficiency was consistently high each year.



Source: OIG analysis of CMS data, 2018.

Immediate jeopardy: 28 hospices had at least 1 Immediate Jeopardy issue during the 5-year period. When a hospice is cited with immediate jeopardy, it means that the hospice did not meet one or more requirements that caused, or is likely to cause, serious injury, harm, impairment, or death to a beneficiary.

What OIG Found

Hospices are reviewed onsite by surveyors from either State agencies or accrediting organizations. From 2012 through 2016, nearly all hospices that provided care to Medicare beneficiaries were surveyed. Summary data includes:

1. **Poor care planning**
    a. **Services called for in the care plan were not provided:** Many hospices with care planning deficiencies **failed to ensure that they provided the services called for in the care plans** that they established. For example, one hospice did not provide nurse visits for two consecutive weeks despite a beneficiary's care plan ordering weekly nurse visits. Also, for at least 5 weeks, the nurse did not follow the care plan to assess the beneficiary's gastrostomy tube site or colostomy stoma at each visit.
    b. **Care plans not individualized:** Hospices also **failed to ensure that the care plans were appropriately individualized.** For example, one hospice did not address the needs of a beneficiary with dysphagia who had to be fed very slowly with small bites due to frequent choking.

2. **Hospice aide training and management**
    a. 53% of the hospices surveyed in the 5 years had **deficiencies related to hospice aide and homemaker services.**
    b. Many of these hospices failed to ensure that **hospice aides were supervised or given patient-specific care instructions**. In one example, a hospice nurse did not perform the required supervisory visits to assess the aide services.
    c. Some of these hospices **did not ensure that hospice aides were competent to provide care**. For example, one hospice failed to ensure that three of four aides had the appropriate skills in toileting and transfer techniques to provide care to beneficiaries.

3. **Beneficiary assessment**
    a. 42% of the hospices surveyed in the 5 years had **deficiencies related to patient assessments**. The care provided to a beneficiary is dictated by the hospice's assessment of the beneficiary. Without timely or thorough assessments, beneficiary and family needs may be overlooked or inadequately addressed.
    b. **Key content in the comprehensive assessments missed**:
        i. In one example, the hospice did not review beneficiaries' drug profiles to monitor medication effectiveness or check for possible side effects during updates to comprehensive assessments.
        ii. In some cases, hospices failed to assess the beneficiaries' history of pain.
    c. Hospices also **failed to update assessments within the required timeframe.** Comprehensive assessments must be conducted at least every 15 days, or as frequently as the patient's condition requires. In one example, three beneficiaries were each in hospice care for more than 5 months and the hospice did not update their assessments during that entire time.

4. **Vetting of staff**
    a. Some hospices **did not complete criminal background checks of staff,** while other hospices did not update employee credentials. When hospices fail to ensure that staff are qualified, they put the safety of beneficiaries at risk.
    b. Another hospice failed to ensure that 34 of its 35 **employees who provided care had updated credentials in accordance with State and local laws.** Eighteen employees were not screened for abuse and neglect prior to working at the facility and three did not have required professional licensure.

5. **Failure to provide needed services**
    a. A hospice did not ensure that a **beneficiary's pain was assessed and managed in a timely manner.** Although the beneficiary was given medication to treat the pain, the pain continued to escalate, and several days passed before the beneficiary was reassessed.
    b. Another hospice **did not measure for several weeks a beneficiary's Stage IV pressure ulcer—the most severe type—despite having a policy stating that wounds were to be**

measured weekly at minimum. In addition, the hospice did not follow the physician's orders to treat the wound.

c. Another hospice **failed to provide needed volunteer services to several beneficiaries**. All hospices are required to use volunteers. These volunteers provide services to beneficiaries who need them. The services include spending time with beneficiaries and assisting with daily activities. One beneficiary waited about 8 months for volunteer services.

Summary of Complaint Data

1. **Complaints:** From 2012 through 2016, 1,574 hospices had at least one complaint, and 741 had multiple complaints. One hospice in Florida had a total of 70 complaints in the 5-year period. One hospice in Texas had 12 complaints in 2016 alone. The OIG states that "Numerous complaints against the same hospice raise concerns that it may have systemic problems."
2. **Severe complaints:** In total, 1,143 severe complaints were filed against hospices during the 5-year timeframe, and 35 percent of these complaints were substantiated.
3. **Poor performers:** 313 hospices identified as poor performers, 18% of all hospices surveyed in 2016. Among poor performers, all had at least one serious deficiency or one substantiated severe complaint in 2016. 88% (275 hospices) had a history of other violations, including one other deficiency or substantiated complaint. About half of these hospices had deficiencies or substantiated complaints in multiple years.

OIG Recommendations

Centers for Medicare & Medicaid Services (CMS) should implement existing Office of Inspector General (OIG) recommendations to strengthen the survey process, establish additional enforcement remedies, and provide more information to beneficiaries and their caregivers.

The OIG also makes several new recommendations: CMS should

(1) expand the deficiency data that accrediting organizations report to CMS and use these data to strengthen its oversight of hospices;
(2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices;
(3) include on Hospice Compare the survey reports from State agencies;
(4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained;
(5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries; and
(6) increase oversight of hospices with a history of serious deficiencies.

CMS either concurred or partially concurred with all the recommendations *except* the third.

OIG Report #2

Safeguards Must Be Strengthened to Protect Medicare Hospice Beneficiaries from Harm (OEI-02-17-00021)

The OIG has issued this report featuring 12 cases of harm to beneficiaries receiving hospice care. We examined each case to identify vulnerabilities that could have led to the harm and to determine how such harm could be prevented in the future. Some instances of harm resulted from hospices providing poor care to beneficiaries and some resulted from abuse by caregivers or others and the hospice failing to take action.

The OIG states: "These cases identify areas where there are vulnerabilities in the Centers for Medicare & Medicaid Services efforts to prevent and address harm. These vulnerabilities include:

- insufficient reporting requirements for hospices
- limited reporting requirements for surveyors
- barriers that beneficiaries and caregivers face in making complaints."

They also report that the hospices featured in this report did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm and hospices' plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

Findings

1. **Poor care provided by the hospice:** including pressure ulcers resulting in gangrene and a leg amputation, maggots around a feeding tube, and prescribed respiratory therapy services not provided by the hospice.
2. **Abuse by caregivers or others where the hospice failed to take action:** including sexual assault, theft of medications by a neighbor, or abuse by a family member not recognized or reported by the hospice.
3. **Barriers to patient/caregiver reporting:** including instances where the hospice mismanaged the family's grievance over poor pain control for their family member.
4. **State surveyor cannot cite immediate jeopardy when it is warranted:** including providing essential pain medication or addressing patient in pain and vomiting blood for several days.
5. **Hospice plan of correction not designed to address underlying issues.** Plans of correction are generally addressing specific circumstances identified during a survey rather than underlying problems.
6. **CMS cannot impose penalties—other than terminating hospices—to hold hospices accountable for harming beneficiaries.** There are no penalties available to CMS and its surveyors except termination of the Medicare certification, even when beneficiaries are harmed or at significant risk.

Recommendations from the OIG to CMS

1. **Existing recommendation:**
   CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance. To effectively protect beneficiaries from harm, CMS must have enforcement tools.
2. **New Recommendations to strengthen safeguards to protect Medicare hospice beneficiaries from harm:**
   CMS should
   a. strengthen requirements for hospices to report abuse, neglect, and other harm;
      i. Specifically, CMS should strengthen the hospice Condition of Participation related to the reporting of abuse, neglect, and other harm. The revised CoP should require hospices to report suspected harm—regardless of perpetrator—to CMS, and law enforcement if appropriate, within short timeframes.
   b. ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm;
   c. strengthen guidance for surveyors to report crimes to local law enforcement;
   d. monitor surveyors' use of immediate jeopardy citations; and
   e. improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

CMS Response

CMS concurred with the first four new recommendations listed above. For the last recommendation to improve the process for beneficiaries and caregivers to make complaints, CMS partially concurred and stated that it will investigate ways to improve the process "within regulatory constraints and with available resources."

-###-

NHPCO Public Response

NHPCO issued a public response offering key message points from President and CEO Edo Banach. Find the full public response on the NHPCO website.

Questions

Members with questions should email regulatory@nhpco.org.

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Hospices go unpunished for reported maggots and uncontrolled pain, watchdog finds

Christopher Rowland

A state inspector in Missouri documented the grim details: a deep, poorly treated pressure wound on the patient's tailbone, apparent pain that caused grimacing and — in a crisis requiring a trip to the emergency room — a "maggot infestation" where the feeding tube entered his abdomen.

The official cited Vitas Healthcare, the nation's largest hospice chain, for putting the patient in "immediate jeopardy," the most severe category of

violation. The inspector found that Vitas staffers had skipped home visits and failed to assess the amount of pain the patient endured.

The case is among the most severe of a dozen examples of patient suffering cited in a strongly worded inspector-general report on the hospice industry released Tuesday. The report takes Medicare to task for what it describes as weak oversight and enforcement of the growing ranks of hospice providers and recommends stronger safeguards "to protect Medicare hospice beneficiaries from harm."

[Terminal neglect: How some hospices fail the dying]

The report, by the Office of Inspector General for the Department of Health and Human Services, withheld information about the individual hospice providers and the states where the examples of harm occurred. Vitas Healthcare, which did not comment on the case, is not named in the inspector general's report. The Washington Post identified the 2016 Missouri case by reviewing state inspection records and matching them to the specific circumstances described by the inspector general.

According to the Missouri inspection documents, the patient had been living at home under hospice care for more than 18 months when the discovery of "maggots around the opening of his wound" triggered an urgent call by the family in the middle of the night.

The patient was taken to a hospital for removal of the pests and stayed there for two days. One reason the patient was in hospice care was to avoid unnecessary pain and trauma associated with hospitalizations, the Missouri report said. In a "plan of correction" included in the Missouri documents, Vitas neither disputed nor agreed with the state inspector's findings. It outlined steps it would take to improve supervision and assessment of patients.

Other dire cases listed by the inspector general included a patient whose pressure ulcers developed gangrene, resulting in an amputation; a patient whose injuries from an apparent sexual assault were missed and discovered only at a hospital; and another who did not receive appropriate medication and died in pain.

[As Trump fumes, his team struggles to lower prescription drug costs]

Despite the seriousness of the harm, the hospices in each of the dozen cases did not face serious consequences — largely because Medicare has few disciplinary tools at its disposal, the inspector general said.

"When hospices do not fulfill their obligations, there can be real human costs," Nancy Harrison, deputy regional HHS inspector general, said in an interview. Medicare, she said, "needs to hold hospices accountable."

While the report describes a poorly regulated hospice system, it also found that Medicare gives consumers limited options to screen for quality on their own or lodge complaints.

A Post investigation in 2014 documented patient hazards and industry financial abuses. Although improvements have been made since then — including the national Hospice Compare consumer website launched in 2017 — the gaps in enforcement and quality appear large, according to the report.

Medicare pays for most hospice care in the United States, with billings reaching $18 billion in 2017, double the amount a decade ago. The number of hospices has risen to around 4,500.

But Medicare's oversight of hospice is not as strong as its oversight of nursing homes.

[When should I start thinking about hospice care for myself or a loved one?]

The frequency of hospice inspections by state or private accreditation agencies increased from once every six years to once every three years in 2018. About 300 hospice providers, or nearly 20 percent of all hospices inspected in 2016, had a serious deficiency or a substantiated severe complaint, making them "poor performers," the report said.

There are few requirements for hospice companies to alert Medicare when they detect violations. And when problems are discovered, Medicare has limited tools to discipline providers for neglecting or harming patients, even in cases of "immediate jeopardy."

Other than removing them from the Medicare program, a step that is very rarely taken, Medicare has no ability to levy fines or other sanctions on poorly performing hospice providers, the report said.

It also found fault with Medicare's Web portal, Hospice Compare, which is supposed to help patients and families shop for hospice providers based on quality and other metrics. But Hospice Compare does not list hospice provider deficiencies or state inspection results.

"We live in a time when we don't even think about going to a restaurant without checking its reviews. Why do we demand less from hospices?" Harrison said. "The information is already collected. We just need to make that extra step and make it publicly available in a way that patients can understand."

The Missouri case provides an example of the gap. A Post review showed that someone checking Hospice Compare would see that the Vitas Healthcare office in St. Louis responsible for the patient with a maggot infestation has a 96.4 percent quality rating, 11 percentage points above the

national average. Nothing is mentioned about the "immediate jeopardy" finding or other serious deficiencies cited by inspectors.

The Centers for Medicare and Medicaid Services (CMS), which is in charge of Medicare, said it has taken steps to improve Hospice Compare, including adding information from consumer surveys.

It said it is prohibited by law from posting inspection reports by private accreditation agencies and has told the inspector general previously that it would be "misleading" to post state inspection reports alone. CMS has asked Congress in its budget for authority to post accreditation agency reports.

"CMS has zero tolerance for abuse and mistreatment of any patient, and CMS requires that every Medicare-certified hospice meet basic federal health and safety standards to keep patients safe," the agency said in response to the inspector general's report. It called the inspector general's individual findings of patient harm a "selective sample" of cases found between 2012 and 2016.

In the example of the maggots in the patient's feeding tube, the local Vitas Healthcare provider was put on a track to be terminated as a Medicare provider, but it corrected its deficiencies before that step was taken, CMS said.

"CMS does not have the statutory authority to impose remedies, such as fines, on hospices," the agency said. "Additionally, CMS cannot close any facility."

The hospice industry trade group in Washington, the National Hospice and Palliative Care Organization, which had not seen the report as of Monday, said it supports accountability and transparency in hospice. It pointed out

that it supportedincreasing oversight, including raising in inspection frequency to once every three years. "However, NHPCO continues to stress that outliers in the field do not adequately reflect the vast majority of hospice care provision in the U.S.," Edo Banach, the organization's president, said in a statement.

Congress told Medicare to begin reimbursing for hospice in 1982. Since then, the practice ofhospice has steadily become mainstream, routinely serving patients with dementia and other ailments of the elderly, and has attracted for-profit investment and chain ownership.

"At the first meetings of our national hospice organization, we were nearly all women, mostly volunteers working on making our communities better," said Joanne Lynn, a hospice physician and director of the program to improve elder care at Altarum, a nonprofit health-care consulting organization. "Once Medicare started paying for hospice, it was more men in suits, and the focus shifted to administration and sustainable financing."

Most hospice care continues to be delivered at home or in a nursing home, with routine visits by nurses and aides, but companies also run inpatient hospice facilities. The focus remains the same: comfort and palliative care, including pain medications, in a patient's final months of life.

[Underperforming: New York nonprofit struggles to recover transplantable organs]

To qualify for hospice coverage under Medicare, a patient must be terminally ill with a prognosis of living less than six months. But as increased numbers of patients with Alzheimer's disease and other forms of dementia enter hospice, many are living far longer than six months. Their Medicare coverage continues.

"You increasingly have diagnoses of dementia, patients who are dying at home, but their life expectancy is extremely difficult to estimate," said Melissa D. Aldridge, a professor of geriatrics and palliative medicine at the Icahn School of Medicine at Mount Sinai, in New York.

Meanwhile, Medicare pays providers the same amount for each day a patient is in hospice — around $200 each day for the first 60 days and about $150 each day after 60 days — without regard to how much care is provided.

"They're paying for a day of hospice with no accountability for what was done on that day. How is Medicare going to oversee that?" Aldridge said. She estimated two-thirds of providers are now for-profit, "with a payment mechanism that is completely opaque as to what is being done."

While Hospice Compare does not list any documented problems at hospices, Missouri and Alabama are examples of two states that list complaints and link to full inspection reports.

"We want to be as transparent as we can," said Dean A. Linneman, director of regulation and licensure for Missouri's Department of Health and Senior Services. "The intent is for families seeking a good place for their relatives to view reports, and it's not too far-fetched to believe that is a good learning tool for others in the industry."

Ways & Means Asks CMS For Plan To Up Hospice Deficiency Oversight

Inside CMS

August 1, 2019

Length: 549 words

Body

By Chelsea Cirruzzo July 30, 2019 at 3:52 PM House Ways & Means Committee leaders asked CMS to detail how it plans to improve its oversight of ***hospices***, including by collecting better quality information, as recommended by the HHS Office of Inspector General.

The recommendations were part of two reports released by OIG earlier this month that found over 80% of ***hospices*** providing care for Medicare beneficiaries between 2012 and 2016 had at least one deficiency, including inadequate patient assessment and poor care management. The reports also found that CMS lacked strict reporting and enforcement requirements, resulting in cases not being properly reported and investigated. The reports also detailed cases of beneficiary harm, including one where maggots had infested a beneficiary's feeding tube insertion site, which OIG attributed to poor care management.

Ways & Means Chair Richard Neal (D-MA) and ranking Republican Kevin Brady (TX) call the reports chilling in a joint letter to CMS on Tuesday (July 30). They ask the agency to lay out its plan to tackle OIG's recommendations.

CMS had agreed earlier this month to increase oversight of ***hospice*** facilities and work to make ***hospice*** quality information more accessible on ***Hospice*** Compare, including by using deficiency data from accrediting organizations in its oversight and increasing a focus on ***hospices*** with serious deficiencies. Additionally, CMS agreed to update protocols and training for ***hospices*** and state survey agencies that observe abuse and neglect. However, CMS did not agree to place state survey agency data on ***Hospice*** Compare.

In their letter, Neal and Brady ask CMS to describe the metrics of the deficiency data the agency says it will receive from accrediting organizations as well as how it will ensure such data are provided in a timely and reliable manner.

Additionally, the lawmakers ask CMS for its plans to rectify patterns of abuse and neglect, as well as its specific plans to tackle the underreporting of abuse. They also ask for the educational materials CMS said it will provide to ***hospice*** staff on identifying and reporting abuse.

In its reports, OIG also recommended CMS streamline and standardize online reporting mechanisms for caregivers and beneficiaries, to which CMS responded that it would instead look into updating the ***hospice*** handbook. Neal and Brady ask CMS to explain why it only partially agreed with this recommendation and whether it plans to make standardized complaint forms for caregivers and beneficiaries.

The lawmakers also ask CMS to clarify the outcome measures it intends to include in quality reporting and how else it plans to improve quality reporting, whether removing or altering measures, and how long it will take to put the changes in place.

Additionally, Neal and Brady ask how specifically CMS will increase oversight of ***hospices*** with a history of serious deficiencies and how the agency will define ***hospices*** with serious deficiencies.

Finally, since the OIG report only goes as far back as 2016, the lawmakers ask CMS for data on ***hospices*** identified to have serious decencies in the past three years.

Neal and Brady ask CMS to respond within 14 days. CMS told Inside Health Policy that it has received the letter and is reviewing it. -- Chelsea Cirruzzo (*ccirruzzo@iwpnews.com*)

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U.S. House of Representatives
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July 30, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, DC 20201

Re: Office of Inspector General Reports on Medicare hospice deficiencies

Dear Administrator Verma:

Hospice enrollees are some of Medicare's most vulnerable beneficiaries and deserve the level of care the program has always promised – one that respects the dignity of patients at the end of life and provides the type of individualized plan of care both patients and their families rightly expect. Earlier this month, the Department of Health and Human Services Office of Inspector General (HHS OIG) released two reports that identified significant deficiencies in the quality of care delivered to Medicare hospice enrollees.[1,2] These two HHS OIG reports, and the larger body of work HHS OIG has developed over the last decade-and-a-half, reveal a pattern of deficient care that must be resolved. Accordingly, we write to request information about how the agency is addressing the urgent concerns HHS OIG raised.

Over the last two decades, the Medicare hospice program has changed dramatically – from one that had previously focused on a limited set of primarily cancer patients to a program representing $17 billion in Medicare spending in 2017 and caring for 1.5 million patients with a variety of chronic conditions. Such diseases include Alzheimer's disease, chronic heart failure, chronic obstructive pulmonary disease, and Parkinson's disease.[3] From 2000 to 2012 the number of hospice providers increased by nearly 65 percent, with the majority of facilities operating

[1] OEI-02-17-00020
[2] OEI-02-17-00021
[3] http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0

under for-profit status by 2017.[4,5] While these shifts on their own are not cause for concern, patient outcomes over this time period are.

According to OIG's two recent studies, 87 percent of hospices had at least one care deficiency between 2012 and 2016. Twenty percent (903 out of 4,563 hospices surveyed) had at least one serious deficiency, meaning that the health and safety of a beneficiary were in jeopardy or the hospice was limited in its capacity to deliver adequate care.[6] In some states, nearly every hospice that OIG surveyed had at least one deficiency during that five-year period. These reports provided chilling details of individual cases where hospices did not treat beneficiary wounds – resulting in gangrene and limb amputation.[7] In another case, the OIG described a hospice that had allowed maggots to develop around the feeding tube of a patient.[8]

These findings are alarming and demand attention. OIG reiterated four recommendations from its prior work on hospice care, while outlining several new recommendations for the agency. We request that the Centers for Medicare & Medicaid Services (CMS) immediately address each of these and provide us with the following information:

1. CMS concurred with OIG's recommendation that CMS expand the deficiency data accrediting organizations report to CMS.
    a. Please describe the types of metrics CMS plans to collect, the rationale for collection of those data elements, and the timeline for such collection.
    b. Please explain how CMS plans to ensure such reporting occurs in a timely and *reliable* manner.

2. In June 2019, HHS OIG released a broader report exploring how Medicare data could be better used to identify instances of potential abuse or neglect across various settings of care.[9] HHS OIG discovered a pattern of underreporting that may be reflective of the need to improve oversight of abuse and neglect across settings of care.
    a. Please describe CMS's plans to rectify patterns of care deficiency, including patient neglect or abuse, as well as the underreporting to law enforcement. Specifically, per OIG's recommendation in its hospice reports, how will CMS strengthen requirements for reporting of abuse, neglect, and other harm among hospices? How does CMS plan to monitor and enforce this reporting to ensure there is effective tracking of resident harm?
    b. CMS concurred with OIG's recommendation that CMS ensure hospices are educating their staff to recognize signs of abuse, neglect, and other harm. We request that you provide us with the educational materials provided to hospices, as well as a clear plan for oversight of information dissemination.

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[4] http://www.medpac.gov/docs/default-source/reports/mar2015_entirereport_revised.pdf
[5] http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0
[6] OEI-02-17-00020, Appendix C, pages 28-29
[7] OEI-02-17-00021, page 6
[8] *Id.*
[9] https://oig.hhs.gov/oas/reports/region1/11700513.pdf

c. CMS concurred with OIG's recommendation that it strengthen guidance for surveyors to report suspected crimes to law enforcement. Please describe how CMS will encourage and educate patients and hospice staff to recognize and report suspected abuse specifically to law enforcement.
d. Please describe specifically how CMS plans to improve the channels of communication between CMS and law enforcement.

3. In response to OIG's recommendation that CMS "improve and make user-friendly the process for beneficiaries and caregivers to make complaints," CMS stated that it only partially concurs with the recommendation.
    a. Please explain the reasoning and specific regulatory and resource constraints that you believe would hinder the agency from fully concurring with and carrying out the OIG recommendation, including examples where appropriate.
    b. Is CMS considering creating standardized complaint forms? If not, please explain why.

4. In its March 2019 report, the Medicare Payment Advisory Commission (MedPAC) reported that the seven hospice process quality measures are mostly "topped out," or no longer provide meaningful distinctions in quality. In 2017, the aggregate average of these measures was 86.0 percent – a relatively high level of quality which appears disconnected from the information the OIG presented in these two reports.[10] Furthermore, MedPAC has indicated outcomes measures, including a live discharge measure, merit further exploration.
    a. Please describe CMS's plans for managing already topped-out hospice process measures.
    b. Please describe CMS's short- and long-term plans to improve quality measurement in hospice by incorporating outcome measures. More specifically, which outcome measures is CMS considering; which current measures would CMS consider eliminating; what are the standards for consideration; and what is the timeline for any such changes to hospice quality measures?

5. CMS concurred with the OIG recommendation that it should "increase oversight of hospices with a history of serious deficiencies."
    a. Please describe how CMS plans to increase its oversight of hospices with a history of serious deficiencies, as well as a timeline for doing so.
    b. Please describe how Quality Improvement Organizations (QIOs), including Quality Innovation Network (QIN) QIOs, will play a role in improving hospice care. If QIOs will not play a role, please explain why.
    c. Is CMS considering implementing a Special Focus Facility (SFF) Program for hospice, similar to that which exists for nursing homes with a history of serious quality issues? If not, please explain why.
    d. Please describe how CMS plans to define a "history of serious deficiencies" and the rationale for that definition. Which hospices would this additional oversight capture?

[10] http://medpac.gov/docs/default-source/reports/mar19_medpac_entirereport_sec.pdf?sfvrsn=0

e. OIG identified 313 hospices as "poor performers" based on their having had "at least one serious deficiency or one substantiated severe complaint in 2016." Please provide the three most recent years of data on hospices with serious deficiencies (and the reasons for those deficiencies).

We must ensure that the Medicare hospice program is not only reliable but also one that effectively supports both patients and families managing this difficult stage in life. Beneficiaries must be equipped with helpful information to make informed choices about their hospice care, and we must identify and root out bad actors that may be putting seniors in harm's way. We appreciate your commitment to providing quality care to American seniors, and we look forward to working with you to make necessary improvements to hospice care.

We appreciate your prompt attention to this matter and are eager to work with you to improve the quality of care for Medicare beneficiaries nearing the end of life. Given the urgency of these concerns, we request that you provide a written response within 14 days. If you have questions, please contact Amy Hall or Rachel Dolin of the Ways and Means Health Subcommittee majority staff at 202-225-3625 and Stephanie Parks or Carla DiBlasio at 202-225-4021 with the minority staff.

Sincerely,

Richard E. Neal
Chairman
Committee on Ways and Means

Kevin Brady
Ranking Member
Committee on Ways and Means

REGULATION

Confessions of a Hospice CEO: CMS Audits May Kill Us

By **Jim Parker** | July 30, 2019

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Hospices are under increasing levels of regulatory scrutiny from the U.S. Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health & Human Services Inspector General's Office (OIG), particularly in the form of audits, and many hospice leaders are expressing frustration with the associated costs and workload.

Hospice News' Confessions interviews give hospice and palliative care professionals a space to sound off on the pressing issues that affect their businesses and patients. This piece has been condensed and edited for clarity, as well as to protect the anonymity of today's subject.

Leading drivers of CMS audits are issues such as live discharges, utilization of the four levels of hospice care covered under the Medicare Hospice Benefit, and lengths of stay beyond six months. In addition to audits, a number of organizations have found themselves in court proceedings, accused of knowingly filing fraudulent claims.

OIG recently released a report indicating that about 20% of hospices surveyed by regulators or accreditors between 2012

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and 2016 had a deficiency that posed a serious safety risk; a second OIG report detailed 12 extreme examples of those deficiencies. The reports called on CMS to step up their enforcement efforts in the hospice industry.

These reports followed another OIG report published last year outlining vulnerabilities in the Medicare hospice program, which also called for CMS to step up enforcement.

Hospice News recently spoke with one hospice CEO about the OIG reports and the rising scrutiny hospices face.

What are some of the concerns that hospice leaders have about the current regulatory environment?

Regulators consider live discharges, levels of care and lengths of stay beyond six months to be red flags that can trigger an audit, often alleging that the hospice provider knowingly submitted claims under the Medicare Hospice Benefit for someone who was not expected to die within six months.

Certainly, this may happen, but there is a widely held belief [among hospice professionals] that this position may be more about the ability to "Monday Morning Quarterback" prognosis, than any deliberate erroneous prognostication. Research validates the inability of practitioners to accurately predict death.

The Hospice Medicare Benefit statute states that only physicians are allowed to certify a patient as terminally ill and eligible for hospice. However, every day audits are conducted by nurses who are reviewing charts determining whether a patient was "terminally ill enough" to be covered by the Hospice Benefit.

Hospice, Home Health Yield Highest Multiples in Health Care M&A Deals

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REGULATION

CMS Rule Would Allow PAs to Serve as Attending Hospice Physicians

July 30, 2019

Do you think there are ways for regulators to make enforcement systems more equitable?

There are some things they could do from a regulatory perspective. To me if they don't like the benefit, redesign it. They created it. It's also old, and it is out of touch with the changing demographics and the conditions of our patients and their needs. It needs to be redesigned but there isn't any energy to do that.

The benefit wasn't so much poorly designed as it has had too many loopholes that need to be filled up as the industry grew.

For example, general inpatient care [GIP] was never designed to be done in a nursing home by concept. Expanding it to nursing homes was understandable, because the level of care expected is defined by statute as being the level of care provided in a skilled nursing bed day. It's a skilled nursing level of care, and so it made sense that it could be offered in a contracted manner with a skilled nursing facility.

The regulations are very specific in what that care would have to entail if it were delivered in a skilled nursing facility, but no one surveys to it. The states don't survey to it. CMS doesn't survey to it. So, we have hospices coming into these facilities and doing what I call "drive-by hospice." They hardly ever see the patient, and they are getting paid the same amount per day as a hospice that is running its own inpatient facility. Why not pay for it at the skilled nursing rate? That will put the kabosh on a lot of inappropriate GIP billing.

And instead of the constant audits, why not have the surveyors who are already coming in review some of these questions of eligibility. Make the surveys more complete. They come in and they talk to patients; they review charts; they look at our policies. They could do the work of these auditors. They are looking at the charts; they can see whether the patient is terminally ill.

This is one of the notions that has been suggested by the OIG.

If hospices are doing a bad job, go shut them down and stop using data mining to penalize the rest of the providers. CMS knows who these providers are. They have their provider

numbers. It's not a secret. The data are there; 10% of providers are way out of line in terms of practice. This is where the focus must be, and — much as the report suggests — CMS needs to use the "teeth" they have to get those providers to change or close.

As a hospice leader, what was your initial response to the new OIG reports?

My first response was to email a colleague and say, "Why the heck are they picking on us?" [Incidents described in the report] were one-time occurrences repeated for effect as if they are widespread.

We have had two deficiency-free surveys in the last five years and have some of the highest quality scores. We have been subjected to capricious auditing, holding up our cash to the point of financial jeopardy, only to find years later that we should have been paid for all the claims that they have held. The costs to the organization to fight these audits have been almost equal to the cash held.

If you talk to the people who are actually doing these audits, they feel they are doing "God's work." Unfortunately, there is a huge gap between what appears on the surface to be a major problem and what the major problems actually are. The result of their work appears to be putting good hospices out of business while the ones that are creating the problems are making 20% to 30% margins, and their stockholders are getting wealthy.

After [decades] in hospice care, I am exhausted and depressed about the unraveled state of the social reform movement called "hospice" that I was a part of almost 40 years ago, now pared down to a "scaled" hospice industry lacking commitment to the internationally held core values and principles of hospice volunteerism, family focus, grief care and helping people live well until they die.

The current [regulatory] concerns are not unjustified. However, in many ways CMS is responsible due to the current lack of clarity of regulations related to eligibility and levels of care. I believe the benefit was genius when created, but as years have passed patient's diagnoses changed and the motive for profit became prolific, clarity has become more paramount.

Can you say more about that? What needs to be clarified?

I believe that if CMS identified which services must be covered, and hospices were paid appropriately to provide those services, the hospice benefit would have more integrity. I think that looking at the information in terms of what the benefit pays for, and what the costs are for hospices to provide those things, could really help sustain the benefit.

CMS allows each hospice to determine which services should be covered under the hospice benefit. This is left over from 1984 when there were only about 200 hospices in America, half of them in rural areas. CMS didn't want to put them out of business before they even got started, and so there was a lot of latitude in terms of what you could cover and not cover.

In hospice, and I say this categorically, we could say that we don't believe in IVs for hospice patients, that we don't believe in blood transfusions, that we don't believe in surgery. You can't be on hospice and have radiation. We don't believe in emergency care, and so on. I can just choose what we are not going to pay for and then [patients and families] would have to pay for it out of pocket or revoke the hospice benefit and go back to Medicare Part A.

This happens every day in America, even with something as simple as a hospital bed. There are some hospices that have a policy that you cannot have a hospital bed unless you pay for it privately or unless you are bedridden — not considering that it's easier to care for you in a hospital bed — and Medicare has allowed for that.

Instead of having a prescribed set of services they leave it up to the providers, and then they complain about it. I don't have much sympathy for it because I feel like policy makers are looking in all the wrong places to do right, and that's a frustration to me. There is an economist, Harold Miller, who stated in an address that capitation only works with altruism. I believe that is particularly pertinent to the state of affairs with hospice.

How has the increased scrutiny affected your organization in particular?

We were just notified that we were going to have another audit. After I saw the hospice deficiencies report, I noted that 95% of the hospices in our state who have been surveyed had at least one deficiency for the past five years of surveys. Our hospice has had none. I'm unclear why this hospice has the majority of challenges with audit.

It seems like they want to do the easy thing– data mine and look for aberrancies — and then write the story based on data and not information. If you look at our data that they mine, it says that we have 19% of patients in hospice for more than 180 days on our [Program for Evaluating Payment Patterns Electronic Report]. CMS has arbitrarily decided that 20% is bad; so we must be doing something fraudulent; so we must be audited.

We have an average of 6 to 7 days of acute care in our hospice facility that provides intensive palliative care, staffed daily with a medical provider and a 1:4 nursing ratio. The report says that more than five days average stay is "bad"— based on "average" industry experience.

[Earlier this year] we had four-months of cash reserves, and that has been reduced to 19 days because of auditing, and we haven't done anything wrong. If the auditing continues, our only choice may be to redesign care to make it less expensive. We raise more $2 million annually from the communities we serve to meet the budget of our comprehensive hospice program. These programs transform the experience of illness and grief for thousands every year.

Placing a program in jeopardy that actually saves Medicare money seems unusual. Our region has some of the lowest Medicare overall costs in the last two years of life. It is the model of hospice practiced here that makes that happen. I truly believe that if we are driven to be more conventional– cover less, staff less, respond less in order to stay in business not only will our community suffer, but ultimately Medicare costs will escalate.

Know someone who'd want the opportunity to speak freely about the current state of hospice — or want to sit down yourself? Reach out to jparker@agingmedia.com for consideration.

Jim Parker

Jim Parker is a subculture of one. Swashbuckling feats of high adventure bring a joyful tear to his salty eye. A Chicago-based journalist who has covered health care and public policy since 2000, his personal interests include fire performance, the culinary arts, literature, and general geekery.

CENTER FOR HOSPICE CARE HAS A MESSAGE: "WE ARE HERE FOR EVERYONE"

By: Center for Hospice Care
Last Updated: July 17, 2019

Hospice care is about improving the quality of living by focusing on both the patient and the family's overall health (emotional, spiritual and physical) through interdisciplinary care, reducing stress, and providing caregiver assistance. This type of quality care is available to everyone eligible within our nine-county service area – regardless of their ability to pay.

Lack of awareness and misconceptions about hospice care can prevent people from contacting us in their time of need. Center for Hospice Care (CHC) is determined to build awareness and to dismantle misconceptions so we can serve more families.

The National Hospice and Palliative Care Organization's (NHPCO) Facts and Figures 2017 Edition, shares some disturbing statistics about who receives hospice services nationally. In 2017, the vast majority of those receiving hospice services through Medicare were Caucasian, which is consistent with other years. Race is not the only factor in determining who seeks hospice care. Religious affiliation, sexual orientation or identity, and differing cultural practices are also contributing factors.

CHC wants to ensure people know that hospice care is for everyone in need of compassionate care. Barb King, CHC's diversity officer, has been examining our efforts to outreach to all communities, particularly those underserved.

"I have been looking at how CHC can become more educated about other communities, and their unique needs," King said. "The greatest way

to have an impact in your community is when you're empathetic with people and demonstrate an understanding of their perspective and circumstances."

The goal of this outreach is to show all communities, that we are here to help. We support both families and patients.

"I think our number one barrier is fear," King explained. "There is fear that there is going to be a cost, or fear that I'm going to let hospice staff into my house and they are going to take over."

The reality is that the pressures of caring for loved ones with chronic health issues without support leads to more stress in the long run. The stress they are trying to avoid by not contacting CHC actually results in additional hardship for the patients and families. How do we help potential patients and their families understand that CHC is here for them?

"I believe that we must first be friendly and show that we care. I open my door for someone who cares for me, not just trying to sell me something. I need to know they genuinely care about what I think and what I want. That's our goal," said King. "Our first step is equipping the staff that goes into the home. The most powerful ally we have is positive word of mouth from the people we serve. That is a great way to break barriers."

Hospice care is about respecting the unique needs and wants of the individual. The goal is to compassionately support families and patients in any way possible.

"Part of diversity and inclusion is learning that we all have our own beliefs," King said. "My job is not to come into your household, as a caregiver, and change your beliefs, or make sure ours match. My job is to give you the best end-of-life care possible. My job is to help that transition be better by improving the quality of living. My personal beliefs stay at home."

Living life to the fullest and dying on our own terms, with dignity and comfort, are common end-of-life wishes. Hospice and palliative care help provide this experience. Invite us in. Let us help. We are here for everyone.

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

We Are Here for Everyone

Center for Hospice Care (CHC) regularly receives feedback from our patients and their families that the care we have provided is immeasurably appreciated. Hospice care is about improving the quality of living by focusing on the patient and family's overall health (emotional, spiritual and physical) through interdisciplinary care, reducing stress and providing caregiver assistance.

This type of quality care is available to everyone eligible within our nine-county service area – regardless of their ability to pay. So why doesn't everyone in need of hospice care call CHC and receive the benefits of our care? Lack of awareness and misconceptions about hospice care can prevent people from contacting us in their time of need. CHC is determined to build awareness and to dismantle misconceptions, so we can serve more families.

Patient Race*

In 2016 a substantial majority of Medicare hospice patients were Caucasian.

TABLE 2. PERCENTAGE OF PATIENTS BY RACE*

Race	Percentage
Caucasian	86.5 %
African American	8.3 %
Hispanic	2.1 %
Asian	1.2 %
Other	1.0 %
Native American	0.4 %
Unknown	0.4 %

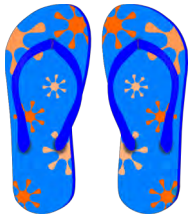
** Categories correspond to those used by CMS in the Hospice Limited Data Set*

The National Hospice and Palliative Care Organization's (NHPCO) Facts and Figures 2017 Edition, shares some disturbing statics about who receives hospice services nationally.

In 2017, the vast majority of those receiving hospice services through Medicare were Caucasian, which is consistent with other years. Race is not the only factor in determining who seeks hospice care. Religious affiliation, sexual orientation or identity, and differing cultural practices are also contributing factors. CHC wants to ensure people know that hospice care is for everyone in need of compassionate care.

Barb King, CHC's diversity officer, has been

Story continued on Page 6



Inside this issue:

Mark Your Calendars

Mandatory Annual In-service

Tuesday, June 4, 2019

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

6/2	6/7	6/13
Sandra Houghton	Vera Tiani	Sandra Casey
6/2	6/8	6/16
Carol MacLean	Grace Munene	Marlene Ogorek
6/3	6/9	6/17
Marilyn Kay	Erin Norton	Margaret Hartlage
6/4	6/9	6/17
Mary Reber	Sandra Ringenberg	Connie Nyerges
6/4	6/9	6/19
Vicki Skodras	Monet Woolfolk	Carolyn Becker
6/6	6/10	6/19
Linda Benwell	David Laux	Kate Crane
6/7	6/12	6/30
Lawrence Milanese	Jean Verteramo	Keith Johnson

Welcome to the Team

Rachel Lockwood
Elkhart IPU CNA

Shelly Pajor
Admissions RN

Jasmine Mayberry
Elkhart 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
Kristie Sherburn, Elkhart

What volunteer work do you do with CHC?

I volunteer once a week at the Elkhart office. I get the tuck-in forms ready and cover the front desk while the receptionist goes to lunch. I started my volunteering for CHC in South Bend. At that time I ran the computer during the IDT meetings.

How long have you been a volunteer with CHC?

I have been a volunteer now for 5 years.

What volunteer work do you do with CHC?

My husband passed away on 11/30/2011, and I would still be lost if it were not for the wonderful bereavement counselors and support groups at CHC. The reason I now volunteer is my way of giving back for all they have done for me.

Favorite movie and why?

My favorite movie of all time has always been *Gone With the Wind.* I saw it for the first time when I was 12 and it really made an impression on me.

What do you like to do with your spare time?

I am in a senior glee club called The Silvertones. We have one concert per semester and also perform at other venues like retirement centers, and am currently working hard at reading music.

What talents/hobbies do you enjoy?

I love sewing projects and making my own greeting cards. My other **love** is dancing. My husband and I go dancing every Friday night. I guess music is and always has been a theme in my life.

"Kristie has been a part of our CHC Elkhart Team since 2013.

She is perfect in her role as a reception Volunteer. Her calm demeanor is truly helpful to those on the other end of the telephone line.

Kristie also assists with our Tuck-In Program and makes sure all our paperwork is ready to go on Thursdays.

She brings a smile, wisdom and warmth to us every week and we love working with her!"

Marlane Huber,

Elkhart Volunteer Coordinator

Level 2 Plus Online Training Now Available

Last year we incorporated a new level for volunteers—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 2 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.

Weather Safety

Tornado Danger Signs

- **Dark, often greenish sky.** Sometimes one or more clouds turns greenish (a phenomenon caused by hail) indicating a tornado may develop.
- **Wall Cloud**. This is an isolated lowering of the base of a thunderstorm. The wall cloud is particularly suspect if it is rotating.
- **Large Hail.** Tornadoes are spawned from powerful thunderstorms and the most powerful thunderstorms produce large hail. Tornadoes frequently emerge from near the hail-producing portion of the storm.
- **Cloud of Debris**. An approaching cloud of debris can mark the location of a tornado even if a funnel is not visible.
- **Funnel Cloud**. A visible rotating extension of the cloud base is a sign that a tornado may develop.
- **Roaring Noise**. The high winds of a tornado can cause a roar that is often compared with the sound of a freight train.
- **Tornadoes may occur near the trailing edge of a thunderstorm and be quite visible**. It is not uncommon to see clear, sunlit skies behind a tornado. They may also be embedded in rain and not visible at all.

What to do in a Patient's Home

If you are in a **patient's residence** and a tornado threatens, go to the lowest level possible—preferably a basement, along with the patient **if the patient is mobile. If the patient is not mobile, move the patient away from any windows, close the drapes and/or blinds and lightly cover the patient with a sheet or light blanket for protection.**

Once on the lowest level, go to the middle of the room away from windows, into a bathroom or hallway or room closet if possible. The safest place to be in is a basement. If this is not an option, seek shelter in an interior room on the lowest level. Putting as many walls as you can between you and the outside will provide additional protection. If possible, get under something sturdy to provide protection against falling objects. Protect your head and neck from falling or flying objects, since these areas are more easily injured than other parts of the body.

If you are **in a car or in a mobile home**, seek shelter in a nearby sturdy building. If this is not possible, lie flat in a low-lying area where wind and debris will blow above you.

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 nurses were the greatest, plus the wonderful person that played games and talked about general interests with my husband. They were well matched.
- I appreciated all of the communications after my mother passed away. I live out of town and could not attend any events. Everyone was and has been so wonderful and my entire family appreciates all that you have done for us. Thank you for what you do.
- We just want to greatly thank you all for everything you did to care for mom. She could be a handful, but she always made it clear that you all took great care and I know I would not have done this without you.

Story continued from Page 1

examining our efforts to outreach to all communities, particularly those underserved. “I have been looking at how CHC can become more educated about other communities, and their unique needs,” King said. “The greatest way to have an impact in your community is when you’re empathetic with people and demonstrate understanding of their perspective and circumstances.”

The goal of this outreach is to show all communities, that we are here to help. We support families. We support patients. “I think our number one barrier is fear,” King explained. “There is fear that there is going to be a cost, or fear that I’m going to let hospice staff into my house and they are going to take over.” The fact is these fears are not grounded in the reality of the experiences our patients and families have with CHC. And the reality is that the pressures of caring for loved ones with chronic health issues without support leads to more stress in the long run. The stress they are trying to avoid by not contacting CHC actually results in additional hardship for the patients and families.

How do we help potential patients and their families understand that CHC is here for them? “I believe that we must first be friendly and show that we care. I open my door for someone who cares for me, not just trying to sell me something. I need to know they genuinely care about what I think and what I want. That’s our goal,” said King. “Our first step is equipping the staff that goes into the home. The most powerful ally we have is positive word of mouth from the people we serve. That is a great way to break barriers.”

Another message we need to share with all the communities we serve is that we respect everyone’s right to their own beliefs. CHC’s job isn’t to align our patients’ beliefs with our own – far from it. Hospice care is about respecting the unique needs and wants of the individual. Our job is to compassionately support families and patients in any way we can. “Part of diversity and inclusion is learning that we all have our own beliefs,” King said. “My job is not to come into your household, as a caregiver, and change your beliefs, or make sure ours match. My job is to give you the best end-of-life care possible. My job is to help that transition be better by improving the quality of living. My personal beliefs stay at home.”

When we take the time to talk with each other, we appreciate our differences and often realize we have more in common than we thought. Wanting to live to the fullest and die on our own terms, with dignity and comfort, are common end-of-life wishes. Hospice and palliative care help provide this experience, and it is something accessible to anyone in need. It is the promise CHC has made from its inception: no one eligible for hospice care will be turned away, regardless of their ability to pay. We should just say ‘regardless’. Invite us in. Let us help. We are here for everyone.

July 2019
Volunteer Newsletter

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

Portrait of a Beautiful Life

In memory of Thomas Yoder, 7/31/32-4/6/19

By: Kristiana Donahue

Thomas Yoder has always had an artistic eye. Whether painting portraits or growing flowers - he found his calling and passion among beautiful things. But some experiences in life aren't as pretty - and cancer is one of them. A few months ago, Tom's doctor delivered the difficult news that his cancer had spread and was throughout his body, including his bones and joints. "Talk about a bombshell when he told me," Tom said. He had always been active and healthy, and definitely not appearing the 87-years old that he is. One thing Tom has already learned is to take each day as it comes. "I grow into this," he said. "Like something is new every day. You don't really know what to expect exactly." And that's when his Center for Hospice Care nurse reassured him, "We want you to have a good quality of life—to do the things you love and spend time with the people you love." And that is Tom's goal, each and every day.

Tom and Beth Yoder in their home.

Tom grew up in Middlebury, where he was a meat cutter at his family's grocery store on Main Street. By the late 1970's, Tom was managing Everett's Grocery Store in Goshen. He was a single dad with two daughters and a son. He couldn't help notice an attractive frequent customer who had two sons and one daughter, and was also single. Recently, Tom and Beth celebrated their 44th wedding anniversary. Their "Brady Bunch" family remained in the Goshen area where Tom started to discover and pursue his many artistic talents.

Tom had wanted to try his hand at painting and had a few pieces he showed to Martin Stevens, an Elkhart Art League teacher. Martin said that Tom should do more of it, and so he did – for 12 years. Tom entered art competitions where he won best of show, and even judged a few shows. "I started doing commission portraits," Tom said. "I probably did 40 to 50 of them in the Middlebury area." Even though that was quite a few years ago, many of the paintings have recently resurfaced. One by one, Beth brought pictures into their

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By appointment

In Loving Memory

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

David Laux, South Bend

Brother-in-Law,

Rick Tremblay

Monday, June 17, 2019

Tracey Eagleton, South Bend

Mother-in-Law,

Hazel Farrell

Saturday, February 9, 2019

Father, Don Wilson

Thursday, February 21, 2019

Birthdays

7/2
Erik Chalman

7/2
Casey Kasper

7/5
Joni Kanzler

7/6
Dan Shuppert

7/11
Gianna Haller

7/12
Jeanne Steiner

7/15
Carolyn Peterson

7/16
Hubert Kuzmich

7/18
Kathy Davis

7/23
Cornelia Langheinrich

7/26
Sandra Maichen

7/28
Paul Alwine

7/30
Gene DeMorrow

7/30
Nettie Russell

7/31
Leah Ramanujan

Welcome to the Team

Catlyn Borders
Elkhart RN

Erika Grayson
South Bend LPN

Tamera Phillips
South Bend IPU RN

Michelle Rawson
South Bend IPU CNA

Wyatt Smith
Elkhart Chaplain

Ron Wilson
South Bend Case Manager RN

Jennifer Woods
Commercial Billing Representative

We Thank You

It takes a lot of volunteer hours and donations to make our Hospitality Volunteer opportunity possible. We have many volunteers who may not volunteer regularly with patients or in our offices, but they provide us with blankets so that we can continue this wonderful volunteer opportunity to our patients and families.

We want to extend a hearty THANK YOU to

Maria Moleski

who has made many blankets for CHC in honor and memory of her mother,

Betty Deisler-Smith

and in honor and memory of her son, an Army Reservist,

Ben Moleski.

Thank you Maria! Our patients, families and staff appreciate your generosity.

Volunteer Spotlight

Cindy Proffitt, South Bend

What volunteer work do you do with CHC?

I provide Level III Certified Volunteer care at the inpatient care unit in Roseland, IN. I'm also a member of the Volunteer Recruiting and Training Committee, and a Bereavement Volunteer.

How long have you been a volunteer with CHC?

I've been a volunteer since 2016.

Why do you volunteer with CHC?

I believe that hospice care is a calling, and that those who can answer the call should do all they can to support patients and their families, as well as the committed CHC employees. My grandmother was able to die in her home because of the dedication and commitment of hospice in-home care providers. I'm grateful that she could choose the type of care she wanted in the final months of her life.

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

My life travel goal is to visit all seven continents; I've visited Europe, Asia, and Africa so far, and look forward to next visiting South America, Australia, and Antarctica.

What is your favorite quote?

"Sometimes you will never know the value of a moment until it becomes a memory."

Dr. Seuss

What is your favorite food and why?

I love Ethiopian food -- the spices are amazing.

Favorite book and why?

I enjoy everything written by Parker Palmer. He has a beautiful spirit, insightful wisdom, and a plain-spoken writing style.

What do you like to do in your spare time?

I like being creative and crafty, crocheting, making t-shirt quilts, and painting, as well as cooking and gardening. A few years ago, I made a drum and enjoy playing it in drumming circles.

"Cindy is a hard worker who has a full time job but still makes time to volunteer at our SB IPU. She has a heart for hospice and assists with recruiting new volunteers and getting the word out about CHC to the community. Cindy is great to have on the team!"

Debra Mayfield,

South Bend Volunteer Coordinator

Each 1 Recruit 1

Over the past nearly 40 years, Center for Hospice Care has grown tremendously. Over the past month or so we've seen a great increase in numbers. While it's encouraging to see the growth, our challenge is an ever growing need for volunteers. We are needing more volunteers than ever. We need your help recruiting volunteers. That is why I want to remind you about Each 1 Recruit 1.

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

If you have anyone interested have them contact Kristiana Donahue at donahuek@cfhcare.org.

Welcome New Volunteers

These new volunteers just finished volunteer training on June 26th! We appreciate their dedication to the process of becoming new volunteers. If you see them out and about, take a moment to welcome them to the CHC family!

Back row (left to right): Clarence Ha, Kassidy Ekdahl, Marne Austin, Peg Stutzman, Terry Trimmer and Richard Keen. Middle row (left to right): Jennifer Stanley, Julie Schlundt and Darlene Trapp. Front row (left to right): Lisa Svelmoe and Connie Fisher.

Ongoing Volunteer Needs

Home Visit Volunteer
This is our most requested volunteer opportunity (and our ongoing biggest need). These volunteers provide companionship to patients who live in their homes and respite for their caregivers.

Hospitality Volunteer
Make short visits to offer a friendly smile and deliver a small care package.

Extended Care Facility Volunteer
Provide companionship, socialization or assist with activities for patients residing in nursing homes or assisted living facilities.

Inpatient Unit Volunteer
Provide support to patients and families, as well as our staff, in one of our two seven-bed inpatient facilities. (South Bend and Elkhart)

Training Reminder

Healthy Boundaries

I may be exceeding my boundaries when:

- I lose objectivity
- I feel like I am responsible for their well-being
- I feel the need to save, cure, rescue
- I feel I know what is best for the family
- I start giving advice
- Patient/family problems are becoming too dependent on me
- I feel under stress in the situation
- I do more talking than listening
- I visit the patient/family outside of scheduled time
- I'm doing things which I am not comfortable talking about
- I give or accept cash or gifts of considerable monetary value
- I am doing things I don't want to do
- I address issues outside of my discipline or role
- I share personal concerns or work concerns with clients

Preparation/Practice

- Have clear self boundaries, know yourself and your comfort level
- Be aware of your role – you are not a friend, family member or medical person. You are a trained volunteer who reaches out to individuals in a supportive and caring way.
- Set boundaries such as time, purpose, etc., prior to or at the beginning of the visit.
- Always be respectful. Don't seem too familiar with telling emotional stories and jokes.
- Limit involvement of personal feelings and emotions.
- Realize that sometimes a volunteer assignment may end for other reasons besides death (i.e. patient decline, family request, ECF staff request, CHC staff request, patient discharge, etc.) Know that this happens on occasion and may have nothing to do with anything the volunteer has done.

Good questions to ask ourselves:

Why am I here?

Whose needs are being met?

Is this part of the care plan?

Comments from Our Families

- Our hospice nurse was absolutely fantastic. She helped us every step of the way with the care of our loved one and in receiving specialized diet, medicine, wound services while our loved one was in the nursing home through her passing. The booklet that hospice sent me describing the end of life stages was extremely helpful. The nurse's communication with us every week was spot on and helped us prepare for a final visit before our loved one passed away. Highest regards for her professionalism and experience in this role as hospice nurse.

- All of the hospice team were wonderful. I have told many people and our doctor how great they were with him and me. Thank you so much.

living and dining room - still-life paintings and portraits, lovingly painted years ago. "My brother's daughter posted a painting on Facebook the other day," Tom said. "She said, 'You painted this picture of me when I was a young girl." He wasn't sure until he looked closely at the painting and realized that it was one of his. Another family in Middlebury commissioned Tom to paint portraits of their kids many years back. Members of that family have been taking pictures of those paintings to show Tom.

Although painting lasted for years, Tom's creative pursuits found a new direction. Everett's Grocery Store sold more than groceries, it also had a garden center. When Tom was ready to retire from a different job, a friend at Everett's told him they were looking for someone to manage the garden center. Because Tom had always liked flowers and had dabbled with gardening while in Middlebury, he decided to try it. "We had a little makeshift garden center that didn't amount to a whole lot. I think they did about $60,000-$70,000 in business a year," Tom shared. "When I took it over, it started increasing. We moved the garden center across the street to a nicer facility and built a new building and added a greenhouse." Tom had big plans. "A couple years later I talked the owner into putting in another greenhouse and business was really starting to boom," Tom said. "The last three years we were open we were doing over a quarter of a million dollars worth of business each year. We sold a lot of flowers."

When the garden center closed, Tom realized he didn't want to buy and start up something new. However, another friend approached him regarding a new artistic endeavor—one that incorporated his love of gardening. "Goshen News is looking for someone to write a gardening column," Tom shared. He had never written anything like that, but he drafted what he thought would make a good gardening column. "I took it in and met with the publisher and editor. I explained that I wrote this as a kind of introduction. They read it and said they would make it my first column." That was in 2009. His first column began, "Well folks, here it goes, my first attempt at writing a column. No, I'm not a journalism major, nor do I have a degree in horticulture, but I do have a love for flowers." With those words Tom grew a faithful following and had binders brimming with newspaper columns—all expertly organized by date. Tom was writing the column up until Christmas 2018. "I quit when I got my cancer," he said.

One of Tom's award-winning paintings.

It's evident that Tom takes great pride in the beautiful things that filled the room where we sat. He's taken great joy in the work he's been involved in over his lifetime. As people approach him with copies of portraits he's painted or comments about his popular newspaper column, Tom realizes how impactful his work has been on people around him. With Center for Hospice Care helping improve his quality of life, Tom has been able to enjoy these precious moments and to continue to share his talents with the new people he meets.

August 2019
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

The night we hung up on hospice

By Joan Wickersham
Globe Columnist,
July 25, 2019,
2:44 p.m.

In the middle of the night, in Florida, sitting up with a gravely ill family member who had wanted to die at home, we became worried about how hard it was getting for him to breathe. It was painful to listen to — was it painful for him? We'd been giving him morphine for several days under a hospice protocol, but was there anything more we could or should be doing? We never got the chance to fully ask these questions. When we called the 24-hour hospice number, the person who answered the phone said, sharply, "Wait — you're giving him how much morphine? Who told you to give him that much?"

We explained that a hospice nurse had come out to the house earlier in the day and written new orders to increase the dosage, after speaking in our presence to a doctor over the phone.

"Who was this nurse?" the hospice person asked.

We gave her the nurse's first name, which was all we could remember.

"I don't know anybody by that name," she said, still in the same sharp tone. "And I don't see these orders written anywhere on the chart."

It was midnight. We were at home with a dying person, and the hospice staffer seemed to be suggesting that we were screwing up, giving him way too much morphine, on the orders of some rogue hospice worker whom she'd never heard of.

We stayed on the phone with her for several more minutes. We kept repeating the instructions we

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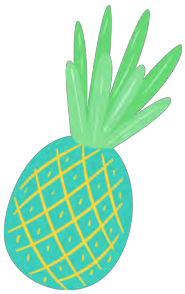

Inside this issue:

Mark Your Calendars

11th Annual Bike Michiana for Hospice

September 8, 2019

The 11th Annual Bike Michiana for Hospice will begin and end at the Center for Hospice Care Mishawaka Campus at Central Park.

For more information on how to register, visit the Foundation's website at

https://foundationforhospice.org/events/

34th Annual Walk for Hospice

September 8, 2019

The 34th Annual Walk for Hospice will begin and end at the Center for Hospice Care Mishawaka Campus at Central Park.

For more information visit the Foundation's website at

https://foundationforhospice.org/events/

Birthdays

8/1
John Guyse

8/10
Kathy Schlegelmilch

8/11
Linda Meeks

8/11
Donald Neely

8/12
Sarah Klinedinst

8/14
David Simons

8/18
Sue Collins

8/20
Diane Hogsett

8/20
Ruth Yoder

8/22
Doris Shea

8/23
Tracey Eagleton

8/23
Kassidy Ekdahl

8/23
Patricia Osborne

8/25
Sr. Carmel Marie Sallows

8/30
Paul Piller

8/31
John Dendiu

8/31
Ginny Russell

Welcome to the Team

Melissa Foster
Plymouth CNA

Toni Foyer
LaPorte Professional Relations Liaison

Ronda Isley
Elkhart IPU RN

August Jones
South Bend CAN

LeAnn Kane
South Bend Triage RN

Katenda Kanema
South Bend RN

Krista Maclellan
LaPorte Volunteer Coordinator

Sheri Mason
Elkhart RN

Stacie Meyers
South Bend Triage RN

Marcia Miller
Admissions RN

Kim Morrison
Plymouth Volunteer Coordinator

Rianna Smith
South Bend CNA

Kim Snyder
Admissions RN

Volunteer Spotlight

Carolyn Tihen, South Bend

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

I do patient care volunteering and I've been with CHC for 4 years this fall.

Why do you volunteer with CHC?

I believe in the mission of Center for Hospice Care and I want to give back in memory of my mom and dad.

What is your favorite food and why?

I love ice cream. It just tastes good. Vanilla, peanut butter and coffee are my favorites in that order.

What is your favorite quote?

"Peace Begins With A Smile," Sister Theresa

What is your favorite movie?

Scent of a Woman I like Al Pacino. I have seen all of his movies.

Favorite book and why?

I don't have one favorite book. I have a favorite author – Mary Higgins Clark. I really enjoy all of her books. They are easy to read and easy to get into.

Favorite music/band and why?

I love Keith Urban. I really like most types of country and western music. Although some of the stories the songs tell make me sad.

What do you like to do with your spare time?

I like to workout. I work with a personal trainer. It helps with the aches and pains of getting older and also helps with my mobility. My favorite workout is to walk. I enjoy walking outside and also on the treadmill indoors.

Where are you from originally?

South Bend. I live in my birth home.

What talents or hobbies do you enjoy?

I like to be active and I don't like to sit for long periods of time so I don't have any hobbies unless you consider walking a hobby. I love to walk!

"Carolyn is tiny in size but big on commitment! She always puts patients and families first in her service at CHC. Carolyn rarely misses a shift at the inpatient care unit and is an amazing part of the team."

Debra Mayfield,

South Bend Volunteer Coordinator

Each 1 Recruit 1

Over the past nearly 40 years, Center for Hospice Care has grown tremendously. Over the past month or so we've seen a great increase in numbers. While it's encouraging to see the growth, our challenge is an ever growing need for volunteers. We are needing more volunteers than ever. We need your help recruiting volunteers. That is why I want to remind you about Each 1 Recruit 1.

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

If you have anyone interested have them contact Kristiana Donahue at donahuek@cfhcare.org.

Volunteer Needs

Current Need
Hair Stylists/Barbers
We are in need of some good hair stylists/barbers. They would need to be available to make home visits for our patients. Currently these requests are remaining unmet. Please spread the word.

Home Visit Volunteer
This is our most requested volunteer opportunity (and our ongoing biggest need). These volunteers provide companionship to patients who live in their homes and respite for their caregivers.

Hospitality Volunteer
Make short visits to offer a friendly smile and deliver a small care package.

Extended Care Facility Volunteer
Provide companionship, socialization or assist with activities for patients residing in nursing homes or assisted living facilities.

Inpatient Unit Volunteer
Provide support to patients and families, as well as our staff, in one of our two seven-bed inpatient facilities. (South Bend and Elkhart)

Honoring Choices

Honoring Choices® Indiana – North Central is a not-for-profit organization whose mission is to proactively engage people in our community in conversations with the loved ones and medical providers about their goal for quality of life and advance care planning. Honoring Choices® Indiana – North Central is part of a 13-state network that shares information, resources, and best practices.

The partners that comprise Honoring Choices® Indiana – North Central include hospitals, health systems, community groups, employers, educators, social service organizations and faith communities. Their vision is that everyone in our service area receives care that honors their personal values and goals in catastrophic or end-of-life care.

The service area served by Honoring Choices® Indiana – North Central includes Elkhart, Marshall and St. Joseph counties. Its role is to provide education, tools and resources to assist people with advance care planning. Through the three-county service area there are certified facilitators available to educate and facilitate discussion and guidance to individuals and families who wish to develop an advance care plan, complete advance directives and designate a health care representative.

Honoring Choices® Indiana – North Central is a 501 (c)(3) organization and does not charge for its services. It relies on donations to support its work.

To learn more or schedule an appointment with a certified ACP facilitator contact Honoring Choices® Indiana – North Central at 574.243.2058 or WrobleskiE@hci-nc.org

Training Reminder

Pronounced Physical Changes Prior to Death

Surge of Energy

The patient may suddenly seem a bit stronger. This may be apparent through an increase in alertness, or clearer speech, or some intake of food and/or liquids. The patient may even wish to sit up for a short period of time to visit. Many explain this "new energy" as being a spiritual energy that has arrived for the transition that is about to take place. For some, this "spiritual energy" is used for a time of physical expression before moving on. Respond to the patient's wishes. He or she will know what they can or cannot do.

Restlessness

This may increase shortly before death due to a lack of oxygen in the blood. It is sometimes called **"terminal restlessness**". If the patient is uncomfortable, contact the Triage nurse.

Congestion

Oral secretions may increase and collect in the back of the patient's throat. This is often referred to as a **"death rattle**". This symptom is a result of pooled secretions that the patient is too weak to clear. The noise comes from the passage of air through these secretions, and is generally much more troublesome to families than to the patient. Elevate the head of the bed with pillows or raise the hospital bed to make breathing easier. Repositioning the patient in bed may be helpful.

Body Circulation

The patient's circulation continues to decrease. The hands and feet may become purplish in color. The knees, ankles, and elbows may appear blotchy—this is commonly referred to as **mottling.** Provide touch and presence.

Breathing Changes

The patient's breathing patterns change from time to time. It can become irregular, with periods of no breathing for 10-30 seconds. These periods are referred to as **"apnea".** This symptom is very common and indicative of a decrease in circulation and buildup in body waste products. Respiration may increase and then again decrease, presenting **no discomfort to the patient**. Allow the patient to continue to rest if the patient is comfortable. Raise the head of the bed if the patient breathes more easily this way, or offer to change their position.

Comments from Our Families

- Wish our entire hospice team could be cloned. Our world needs to be populated by more kind, upbeat, competent, loving care individuals. They are the best and very much appreciated.

- I thought your services were just right. My husband was doing everything you said he would do. Even before you came to us, he was eating and sleeping as you said he would. It was like he was on track with you all the way. I am thankful you came into our lives. He passed away with no pain, and we were happy for that. Bless you all!

- On behalf of my entire family, we would like to extend our deepest thanks and appreciation to all staff and volunteers. This community is so lucky to have you all a part of it. Thank you again. Your work does not go unnoticed.

had been given, and she kept saying that she had no record of the nurse, the visit, or the instructions. Finally, feeling that we were wasting our energy and getting nowhere, we hung up on her.

The dying man's breathing — even with the morphine, even with the Ativan — continued to be labored and wet. We moistened his lips, took turns sitting with him, listened. At 4 a.m. he died.

I was furious at hospice. "Hospice," I say, as if the entire hospice system, the entire concept, the premise and the promise, were at fault. In fact, our family has had two deeply good experiences with hospice in the past, and the care we'd been receiving from this particular team — employees of a reputable nonprofit hospice provider — had been excellent up until that night.

Now, several months later, I think I understand better what happened during that phone call. The staffer's "You're giving him how much morphine?" didn't mean she thought we were giving him too much, it meant that the dosage we were giving didn't tally with the most recent paperwork she had in front of her. The problem was clerical, not medical; but she was too wrapped up in procedure to see that, and we were too frightened and confused to understand it.

But isn't help with fear and confusion part of what you need from hospice? You're alone with a dying person in the middle of the night, alone with a box full of powerful medicine and some instructions about when and how to administer it. You feel like you're in way, way over your head.

We knew that what we were doing was OK. Two different nurses had told us, at different times in the last couple of days, what the maximum morphine dosage was, and we were still within that allowable maximum. We weren't looking for medical advice. We were looking for help sorting out whether the dying person was in a pain that we could do something about, or whether what we were seeing was the inevitable process of dying, and the pain was ours, the inescapable pain of watching death and being unable to stop it.

Thinking back on that conversation, I wish we'd gotten a different person when we called hospice that night. I wish that instead of someone who met our panic with panic, and made us scared, in an already scary moment, that what we were doing wasn't right, we'd reached someone who could have helped us navigate the moment we were in. I wish she'd had the training and compassion and imagination to say, "OK, listen, I don't have the paperwork in front of me, but that's something for me to sort out later. Tell me more about what's going on right now. What exactly is it that you have questions about? And how can I help?"

https://www.bostonglobe.com/opinion/2019/07/25/the-night-hung-hospice/A63kg8QedT8FWYOg1SGkcJ/story.html?et_rid=1744101053&s_campaign=todaysheadlines:newsletter

What exactly is it that you have questions about? And how can I help?