Board of Directors Meeting
501 Comfort Place, Conference Room A, Mishawaka
November 20, 2019
7:15 a.m.

BOARD BRIEFING BOOK

Table of Contents

Agenda 2

Consent Agenda 4

- Minutes of 08/21/19 5
- Patient Care Policies 11
- QI Committee Minutes 09/17/19 58

President's Report 64

- Average Daily Census Charts 81
- Monthly Dashboard Summary 87
- Volunteer Newsletters September-November 2019 88
- Committees of the Board of Directors 106
- Attachments to President's Report 107

Compliance Committee Minutes 08/22/19 144

Nominations 147

CHAPTER ONE

AGENDA

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

A G E N D A

1. **Consent Agenda** – Mary Newbold (10 minutes)
   a) Approval of August 21, 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)* – 09/17/19 Minutes are included in your board packet. Carol Walker is available to answer questions.

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

3. **Finance Committee** *(action)* – Tricia Luck (15 minutes)
   A. 2020 Flex Spending Account Limit
   B. YTD October 2019 Financial Statements
   C. 2020 Budget

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

5. **Nominating Committee** *(action)* – Mary Newbold (5 minutes)

6. **Board Education** *(information)* – Karl Holderman and Mike Wargo (10 Minutes) "Current and Future Planning for Milton Adult Day Services in Roseland and Care Connections at Milton Village at that location, fundraising already received, funds that will be needed, and the collaboration between CHC, HF, Alzheimer's and Dementia Services of Northern Indiana and REAL Services"

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

8. **Board Member Recognition** – Mary Newbold (5 Minutes)

Next meeting February 19, 2020
# # #

CHAPTER TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
August 21, 2019

Members Present:	Amy Kuhar Mauro, Carol Walker, Jennifer Ewing, Jennifer Houin, Jesse Hsieh, Mark Wobbe, Mary Newbold, Suzie Weirick, Tim Portolese, Wendell Walsh
Absent:	Andy Murray, Ann Firth, Tricia Luck
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. • Introduced Jennifer Ewing as the new Vice Chair.	
2. Minutes	• A motion was made to accept the minutes of the 05/15/19 meeting as presented. The motion was accepted unanimously.	A. Mauro motioned T. Portolese seconded
3. Policies	• A motion was made to accept the revised policies as presented. The motion was accepted unanimously.	A. Mauro motioned T. Portolese seconded
4. QI Committee	• The minutes of the 05/21/19 Quality Improvement Committee Meeting are in the board packet to give updates on CHC's quality indicators and reporting programs.	
5. President's Report	• Census – We have been at record levels for some time now. We set an all-time record one day census in June of 453. The ADC is up 5% from a year ago. YTD ADC 415 and the breakeven is 383. Home health census is up 89%. We serve about 11 home health patients a day. We are looking for any patterns on referrals to see why we've had such a large increase. Generally patients start in home health and then change to hospice. Also it could be that our admission department is doing a better job getting people into our programs. Through July referrals are up 2.5%. Both IPUs have been very busy, especially in July. Occupancy was about the highest we've ever seen. We have been working very hard the past couple of years to recover patients in ECFs. The We Honor Veterans vet to vet cafes programming has been very beneficial in this regard. July ECF ADC was 146 and YTD 136. • Medical staffing – We have two new nurse practitioners that were former CHC nurses that became NPs. A new doctor started Monday. One of our contracted	

Topic	Discussion	Action
	doctors is retiring at the end of the month and Dr. Gifford, our chief medical officer, is retiring at the end of the year. Pacific Companies recruitment agency has been the worst agency we've ever worked with. We are interviewing another doctor today from North Carolina. • Clinical Staffing – We are in much better than a couple months ago. We have openings for an Elkhart IPU Coordinator, weekend triage nurse, and a La Porte case manager. We have a number of staff on FMLA. • La Porte Office – We hope to be able to move into the new La Porte office in about four weeks. We are still waiting for some furniture, and IT has some minor things to install. • South Bend move to Mishawaka – This will probably take place the first week in October. Raclin House staff will move in mid-November and we will host a ribbon cutting ceremony before patients arrive. • The Fiscal Year 2020 Hospice wage index final rule was issued on 07/31/19. It announces a 2.6% increase in hospice rates, but sequestration takes 2% out of it. CMS dramatically increased the rate for Respite and GIP and reduced Routine level of care so it is budget neutral. The one in five hospice programs have their own inpatient unit are ecstatic, but those that do very little Respite or GIP are upset. If the new rates had been in place at the beginning of 2019, it would have been $475,000 in additional revenue and annually $950,000. The new rates begin 10/01/19 for CMS fiscal year 2020. • REAL Services, with our assistance, received grants from two foundations totaling $1.25M to assist in repurposing our South Bend office to become Milton Village adult day services and offices for Alzheimer's and Dementia Services of Northern Indiana (ADSNI). The grants are from the Community Foundation of St. Joseph County and the Leighton Foundation. This is not public knowledge. We have identified some additional foundations and donors to help create something state of the art for Alzheimer's and Dementia patients. We are bringing in consultants from the Netherlands that are experts in this area to make recommendations. ADSNI will be a tenant in one part of the building. The architects are working on the plans for it. • A couple of CHC staff will be giving two presentations at the NHPCO clinical conference in November. One is on our pediatric training program and the other is	

Topic	Discussion	Action
	on our HeartWize and BreatheEazy programs. • On July 9th the OIG released two negative reports about hospices Copies of the reports are in the board packet and began to tell states to write more hospice deficiencies before these reports were published. A lot of it is a rehash of very old incidents. The House Ways and Means Committee said CMS should do something about hospices. On June 11 we had two surveyors come to the South Bend office to investigate four complaints. Two of the complaints were found to be unsubstantiated and two substantiated. The home health surveyor made three visits with two of our nurses and an aide, and our staff did an excellent job. • When the ISDH receives a complaint, they have to investigate every phone call even if it seems ludicrous. Three of the four complaint calls came from outside Indiana from family members. We think the link between the OIG reports and ISDH surveys are not a coincidence. We have never been through something like this. Reports are published on the ISDH website, but they are hard to find. • We can't remember a time when an agency was decertified from the Medicare program. It has been published that CMS may be hoping to get civil monetary penalties like they do with nursing homes. Carol W. said anyone can complain about anything and it gets this type of response and takes a lot of staff time. The patients and families we are dealing with in health care have escalated tremendously what staff have to put up with and are exposed to. We do have liability insurance for medical malpractice. Staff knows they can make visits with two staff members like a nurse and social worker or can ask for a police escort. Occasionally we have to discharge a patient for cause. • We encourage you to read the article in the board packet by hospice CEOs speaking out on hospice audits and what it means to the industry. It is one of the best collection of the issues hospices are facing and why there are so many independent hospice CEO job openings and why many are retiring early. • Elleah Tooker, HF Community Education Coordinator, is one of the first four people in the nation to be NHPCO "MyHospice" ambassadors.	
6. Finance Committee	• The Finance Committee met last Friday. A quorum as not present, but those in attendance reviewed the financial statements and recommend they be presented to the Board for approval. • YTD through July we have served 1,390 patients, which is slightly below a year	

Topic	Discussion	Action
	ago. YTD ADC is 415 compared to 396 a year ago. The breakeven is 381. YTD operating revenue is $13.2M, total revenue $15.7M, total expenses $11.7M, net gain $4M, net without beneficial interest $1.7M. On the one hand some physician positions have not been filled, but on the flip side receivables are up because we don't have enough physicians to fill out the Medicare paperwork. This is an example of how we can do well in keeping expenses low, but it has some effect on the revenue side. The increase in census is also a part of that. • A motion was made to approve the July 2019 YTD financial statements as presented. The motion was accepted unanimously.	J. Hsieh motioned J. Ewing seconded
7. Hospice Foundation Update	• The Crossroads Campaign ended 06/30/19 and raised $12.8M. This does not include some additional grants that have been secured, like the previously mentioned ones for the remodeling of the Sunnybrook property and programs for Milton Adult Day Services and Alzheimer's and Dementia Services of Northern Indiana. This is being done in conjunction with REAL Services. There are four other asks out there from two more foundations, a bank fund, and a charitable trust. We anticipate the cost of remodeling and new programming to be about $3.5M. We would like to begin work at the end of the year once the South Bend staff has moved to Mishawaka. This is a fundraising "initiative," not a campaign. Thank you to Tim Portolese for his diligent efforts to bring a $500,000 grant from a major donor in Elkhart County to help finish up the Crossroads Campaign. • The 2019 Helping Hands Award Dinner honoring Catherine Hiler was the highest grossing dinner in its history with $401,000, and the highest net of $334,000. • Events – 06/04 was the Elkhart Garden of Remembrance and Renewal event. 120 people attended the Journeys in Healing art auction on 07/24. A number of organizations in the community continue to do third party events for us. The Michiana Sodbusters raised $8,200 on May 25-26. This is the largest amount they ever raised for us. Over 15 years they have raised $92,000. Old National Bank did a Friday jeans event and we were the sole beneficiary of that event. Tom's Car Care in South Bend held its Lube-a-Thon on 07/26. This is the 14th year for this event and all proceeds come to CHC. This year they raised $4,000. Bike Michiana for Hospice and the Walk for Hospice are on 09/08 at the Mishawaka campus. The annual Veterans' Tribute Ceremony will be on 10/15. • Level 5 We Honor Veterans – The WHV program was created by NHPCO and the	

Topic	Discussion	Action
	VA. It is based on staff training on the special end of life needs of veterans. Up until February there were only four levels, which we achieved. Now they created a Level 5 and we are seeking that too. That is an annual level that we will have to maintain. • PCAU partnership – The biennial conference is September 5-6 in Kampala, Uganda. This year Annette Deguch, bereavement counselor, will be doing a presentation on yoga and mindfulness, and Kristiana Donahue, volunteer recruitment and training coordinator, will be doing a presentation on volunteer program essentials. They were selected by the scientific committee planning the conference. Then they will come back and talk about their experiences at a staff meeting. • Road to Hope has 58 children enrolled. PCAU is also hosting an intern, Kat Kostolansky, a University of Notre Dame student who is spending seven weeks in Uganda supporting the Road to Hope program. • The Mulago School of Nursing and Midwifery diploma program kicked off this year. This is an extension of what we had been doing for nine years through the International Hospice and Palliative Care Association (IHPCA). Between 2010 and 2018 we provided funding for 62 students to receive their diploma. Through this new training program, we can support scholarships for up to 30 students per year instead of 6 or 8. 15 started in February and 15 in August. • We have been working with PCAU for several years advocating with the Ministry of Health on the mHealth Project. It is now being implemented in 20 facilities across the country. • Education – Our Center for Education and Advance Care Planning hosted its second panel discussion on 06/18 and approximately 25 people attended—the highest so far. We are working with Beacon and St. Joseph Health System to provide Hospice Foundation of America (HFA) webinars at their locations and continuing education credits. We are able to do this with a gift from the Vera Z. Dwyer Trust for community education. We are also involved in national outreach through Elleah Tooker, our Community Education Coordinator, and taking the "MyHospice" program on the road to some facilities. • IU School of Medicine (IUSM) – The IUSM has several activities going on. Dr. Bunmi Okalami is the new Vera Z. Dwyer Bicentennial Chair of Palliative Care at	

Topic	Discussion	Action
	the Vera Z. Dwyer College of Health Sciences at IU South Bend. We will be meeting with her to share ideas about palliative care certification courses to be developed. Dr. Areeba Jawed has been named the recipient of this year's Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. She is scheduled to rotate through CHC 09/22 – 10/05. IU Talk will be held on 10/11. We have 12 seats for this one-day workshop at our Mishawaka office. It will provide 6.25 CMEs at no charge, although there is a $25 registration fee. • Honoring Choices Indiana-North Central – So far we have trained 20 facilitators. We have created a new brochure. Michael White is attending training in LaCrosse WI to become an Honoring Choices instructor. • We plan to hold the ribbon cutting ceremony and open house for the Ernestine M. Raclin House in November. • Global Partners in Care – See the President's Report in the board packet for the full GPIC report.	
8. Board Education	• Nancy DeMaegd, director of Milton Adult Day Services, gave an overview of their services for adults in a community environment. They are a community based agency that provides respite time for caregivers. They accept Medicaid, VA, and private pay. About 37 clients are enrolled, but about 16-17 are there each day. They are excited about expanding their programs in their new building and getting more clients next year.	
Adjournment	• The meeting adjourned at 8:35 a.m.	Next meeting 11/20

Prepared by Becky Kizer for approval by the Board of Directors on 11/20/19.

Jennifer Houin, Secretary

Becky Kizer, Recording Secretary

Center for Hospice Care

VERIFICATION OF TERMINAL ILLNESS

Section: Compliance, Patient Care Policies　　Category: Hospice, Compliance　　

PURPOSE: To verify that the patient has a terminal illness.

POLICY: The Medical Director/Hospice Physician and patient's attending physician (if applicable) sign a written statement certifying that the patient's prognosis is six months or less if the terminal illness follows its normal course. This prognosis is substantiated based on physical findings.

PROCEDURE:

1. The "Certification of Terminal Illness" form specifies that the patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.
2. The certification of the patient's terminal illness is based on the physician's clinical judgment regarding the normal course of the patient's illness.
3. Clinical information (which may be provided verbally) and other documentation that supports the patient's medical prognosis and the physician's certification of terminal illness is included in the patient's medical record and documented as part of the hospice's eligibility assessment.
4. If the Medical Director/Hospice Physician and the patient's attending physician do not sign the "Certification of Terminal Illness" form within two days of the start of care (by the end of the third day), a verbal certification is obtained from both physicians within the two days and is documented in the patient's medical record. The RN may take a verbal certification of terminal illness from the patient's physician.
5. The signed "Certification of Terminal Illness" form is available in the patient's medical record prior to submitting claims for payment.
6. The Medical Director/Hospice Physician may consider the following information when making his/her certification decision:
   - Diagnosis of the terminal condition of the patient
   - Other health conditions, whether related or unrelated to the terminal condition
   - current clinically relevant information supporting all diagnoses and objective and subjective medical findings
   - Current medications and treatment orders, and
   - Information about the medical management of any of the patient's conditions unrelated to the terminal illness

RISK AREAS: Admitting patients to hospice care that are not terminally ill.

Effective Date: 09/00	Revised Date: 08/19~~05/11~~	Board Approved: 08/17/11
Reviewed Date: 01/18		Signature Date: 08/17/11

Signature: ____________ President/CEO

Center for Hospice Care

PATIENT ADMISSION

Section: Patient Care Policies   Category: Hospice

PURPOSE: To ensure appropriate admission to hospice services.

SCOPE OF PRACTICE: Registered Nurse.

POLICY: Patients admitted to hospice services will be certified by their attending physician to have a limited life expectancy of six months or less if the disease follows its normal course.

PROCEDURE: Obtain completed patient folder.

Review the ~~Pre-Assessment~~Pre-admission consents to verify completion.

Complete LCD. Review clinical data at time of referral to verify that patient is appropriate for services.

The plan of care must be established by the Interdisciplinary Team (IDT), attending physician, and the Medical Director/Hospice Physician prior to providing care.

Coordinate with the patient/primary caregiver (PCG) to plan a visit.

Contact patient/primary caregiver to set appointment to complete the initial assessment and all other necessary information.

- Respond to any questions that may have arisen since ~~pre-assessment~~pre-admission
- Review information and literature given at the ~~pre-assessment~~pre-admission and discuss agency services

Complete an initial Nursing Assessment.

- Verify all needed equipment has been delivered and no further needs.
- Education on hospice services, medications and DME.

Make any necessary referrals.

Contact physician's office after initial nursing visit is completed to include:

- Relay admission status
- Verify any needed medication changes
- Review plan of care
- Document~~Record~~ any changes made and/or contact with physician

~~Evaluate the need for a Hospice Aide/CNA and let the scheduler know of patient's needs.~~

- ~~According to plan of care~~
- ~~Per physician direction~~

~~If not already completed, complete the Plan of Care appropriate to the patient's payor. Listed below are additional forms needed for each insurance type.~~

~~1. Hospice Medicare Benefit~~

- ~~Fill in patient name and admission date on Physician Certification/ Recertification of Terminal Illness, QA form.~~
- ~~Hospice Medicare Benefit patients must have a written certification of terminal illness within two calendar days after the benefit period begins. If written certification cannot be obtained within two days, obtain a verbal certification and follow it with a written certification. This must be obtained prior to a claim being submitted for payment.~~
- ~~The initial certification of terminal illness must be obtained by both the Medical Director/Hospice Physician and the patient's attending physician. If these are one and the same, the physician will sign both places on the certification of terminal illness.~~
- ~~The Medical Director/Hospice Physician must sign all recertifications.~~
- ~~See Hospice Medicare Benefit/Medicaid Hospice Benefit.~~

2. Medicaid Hospice Benefit (MHB)

- Patient/PCG need to sign Medicaid Election form if not already completed.
- RN needs to complete the Nursing section of the Medicaid Plan of Care and complete Word document to determine medically predictable life expectancy. RN needs to forward complete packet to the Billing Department.

Support services will contact the patient/family within 48 hours of admission to offer services and to develop the Psychosocial and Spiritual plan of care

- Psychosocial and spiritual care assessments will be completed and placed in the patient folder within one week
- The visit(s) will be documented

~~Miscellaneous Forms:~~

- ~~Provide a Pre-Poured Medication Profile for patients and/or primary caregivers who wish or require a written schedule of the medications.~~
- ~~Use the Pre-Poured Medication Profile when pre-pouring patient medications.~~

Leave the Family/Facility Handbook in the patient's home and inform the patient and family to keep all Agency-related information in it.

Email admission information to the appropriate admit team and triage.

Consents to be Signed at Admission

	Hospice Medicare	Hospice Medicaid	Hospice Commercial (includes VA)	~~Hoosier Connect~~ Replacement Programs	Hospice Self-Pay
~~Receipt of Notice of Privacy Practices~~	~~X~~	~~X~~	~~X~~	~~X~~	~~X~~
General Consent and Release of Information	X	X	X	X	X
Notice of Election of Hospice Benefit	X		X	X	X
Medicaid Hospice Election		X		X	X
Commercial Insurance Verification			X	X	
Fee Assessment Worksheet			X	X	

REGULATION: 42 CFR 418.104 – Clinical Record

PURPOSE: The agency must obtain certification of terminal illness for every patient meeting the criteria as listed below.

POLICY: A certification of terminal illness will be obtained on patients who qualify for the Hospice Medicare or Medicaid program. The certification must specify that the individual's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.

PROCEDURE: The agency will obtain written confirmation of terminal illness for each of the certification periods: for the initial 90 day period, the subsequent 90 day period, and each of the following 60 day unlimited periods.

Each physician certification should coincide with the start of the new benefit period.

The initial Admission certification must be signed by the Medical Director/Hospice Physician and the beneficiary's attending physician (if there is one).

Initial Admission Certification: If written certification cannot be obtained within two calendar days after the benefit period begins--verbal certification may be obtained. If a verbal certification is obtained, clearly document this in the patient's medical record.

~~The verbal certification must be obtained from both the hospice Medical Director/Hospice Physician and the attending physician if a written certification cannot be obtained within two calendar days.~~

Contents of the Certification

1. Certification will be based on the attending physician and Medical Director/Hospice Physician's clinical judgment regarding the normal course of patient's illness.

2. It must specify the patient's prognosis is six months or less if the terminal illness runs its natural course.

3. Clinical information and documentation must support this prognosis, accompany the certification and be present in the patient's medical record.

4. Initially this information can be given verbally, but must be subsequently documented in the medical record and be included as part of the eligibility assessment.

Signature: President/CEO

5. The physician must include a brief narrative explaining critical findings that support a life expectancy of six months or less. This may be part of the certification document, or as an addendum to the certification document.
    - The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the clinical record or if applicable, examination of the patient.
    - The narrative must reflect the patient's individual circumstances, no check boxes or use of standing language.
    - Narratives associated with the third benefit period and subsequent certifications must include language that a face to face encounter supports life expectancy of six months or less.
    - If a nurse practitioner or non-certifying physician performed the face to face encounter, the narrative composed by the certifying physician shall contain language indicating that clinical findings of that encounter were provided and used in determining continued eligibility for hospice.
6. All certifications and recertifications must be signed and dated by the physician(s) and must include the benefit period dates to which the certification applies.
7. Certification may be completed up to 15 days prior to the start of the eligibility period.

CHAPLAIN SERVICES

REGULATION: 42 CFR Part 418.64(d)(3) – Core Services

PURPOSE: To ensure Chaplain services are available to hospice patients/ families/primary caregiver (PCG).

POLICY: To meet the spiritual needs of patients/caregivers in a manner consistent with their beliefs and desires and in accordance with the patient's plan of care.

PROCEDURE: A Chaplain is assigned to each patient/caregiver and participates as a member of the Interdisciplinary Team (IDT) in the development and implementation of the patient's plan of care.

The Chaplain visits the patient/caregiver and/or arranges for other supportive ~~clergy to~~ visits based on the wishes of the patient/caregiver.

The comprehensive assessment of the patient includes a spiritual assessment conducted by the Chaplain to evaluate the patient/caregiver's spiritual needs and identify appropriate spiritual problems, interventions, and goals for the patient's plan of care.

The Chaplain provides services to the patient/caregiver in accordance with the plan of care. Visit frequencies, specified in the plan of care, are determined based on the individualized needs and wishes of the patient/caregiver.

Chaplain services may include, but are not limited to:

- ~~Providing~~Completing an assessment of the patient's and family's spiritual needs.
- Work with other staff in the development of the plan of care.
- Provide spiritual counseling to meet needs in accordance with the patient's/family's acceptance of services and in a manner consistent with patient/family beliefs and desires.
- Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of their ability.
- Inform~~Advise~~ patient and family of ~~service.~~the scope of chaplain services.
- ~~Administering requested sacraments or contacting local clergy to do so.~~
- ~~Praying with patient/caregiver as appropriate and if requested.~~
- Provide or make arrangements for requested spiritual rituals or practices.
- Conducting family meetings as desired.
- Assisting with the planning or conducting of memorial services or funeral services.
- Serving as a spiritual resource to members of the IDT.

Signature: _[signature]_ President/CEO

The Chaplain reassesses the patient and family needs every 14 days at the IDT meeting~~, and the plan of care is updated~~. The plan of care is reviewed and updated as needed.

The Chaplain documents all care provided in the patient's medical record.

If the patient/caregiver refuses chaplain services, no visits are required and the refusal is documented in the patient's record. The assigned Chaplain continues to offer support to the IDT in its care of the patient and to monitor the caregiver's evolving spiritual needs.

REGULATION: 42 CFR Part 418.64(d)(1) – Core Services, Bereavement Counseling

PURPOSE: To provide Bereavement Services before and after the death of hospice patients, as well as to members of the local community who were not associated with the Agency.

POLICY:

1. The Agency's Bereavement Program is a natural component of the hospice program, a program which supports patient and family before, during and after the death of a patient.

2. The assessment of patient and family bereavement needs are incorporated into the patient's comprehensive assessment and plan of care.

3. Members of the hospice team and volunteers addressing bereavement concerns will support patients and families during the phase of anticipatory grief focusing on issues related to grief, loss, and adjustment.

4. Bereavement services are available to the family and other individuals in the bereavement plan of care for a period up to 13 months following the death of the patient.

5. Bereavement counselors are available to individuals of the local community who are in need of bereavement services.

6. Service to bereaved will include mailings, supportive phone calls, individual and family counseling, and support groups offered at regular intervals for adults and children.

7. Services to bereaved are provided by or under supervision of a qualified individual with experience in grief and loss counseling.

Effective Date: 02/94	Revised Date: 09/19~~02/14~~	Board Approved: 04/16/14
Reviewed Date: 05/16		Signature Date: 04/16/14

Signature: President/CEO

BEREAVEMENT SERVICES for EMPLOYEES

REGULATION: 42 CFR Part 418.64(d)(1) – Core Services, Bereavement Counseling

PURPOSE: To assure that all ~~newly hired~~ employees at Center for Hospice Care (CHC) have an opportunity to identify any grief issues they may be experiencing.

POLICY: To assure that employees are able to recognize the grief process that they could experience during their employment at CHC and have knowledge of the resources available to staff on the grief process.

PROCEDURE:

1. ~~This will be accomplished through the e~~Employees will hav~~eing~~ the opportunity to contact a Bereavement Counselor at any time ~~before or after their 90 day probationary period.~~for written materials on the grief process and grief reactions.

~~2.~~3.Employees will be encouraged to contact a bereavement counselor to help them identify their ~~staff's~~ own feelings related to the deaths of the patients they have cared for.

3. Promote communication with caregivers on the grief process.

~~4. To have a knowledge of resources available to staff on the grief process.~~

~~5.~~4.The bereavement counselor can also assist staff in to recognize ~~staff's~~ whether their grief reactions may be a result of personal experience and loss of a loved one.

Effective Date: 06/16	Revised Date: 09/19	Board Approved: 10/19/16
Reviewed Date:		Signature Date: 10/19/16

Signature: [signature] President/CEO

REGULATION: 42 CFR Part 418.64(d)(1) – Core Services, Bereavement Counseling

POLICY: CHC patients and significant family members and caregivers are assessed for bereavement needs.

PROCEDURE:

1. During the comprehensive assessment of the patient, information is obtained related to anticipated bereavement needs of the patient's family, caregivers and significant others.

2. Throughout the course of the patient's care, members of the interdisciplinary team reassess, document, and address the anticipatory mourning needs of the patient's family, caregivers and significant others.

3. Bereavement risk factors and needs of family members, caregivers, and significant others are identified during contact following the death of the patient and documented. The Bereavement Coordinator in collaboration with other team members ensures this process.

4. For ~~E~~each person designated to receive bereavement services, their risk level ~~is categorized according to level of risk~~ for complicated grief reactions is assessed, and bereavement services/interventions are~~is~~ offered ~~appropriate interventions~~ according to the identified risk level~~need~~.

5. The interventions offered all hospice bereaved are:
   - Condolence card acknowledging the death.
   - Initial phone call within 3 to 4 weeks of the patient's death, unless interdisciplinary team requests earlier contact, with the offer of continued periodic supportive phone calls for up to 13 months.
   - Invitations for individual counseling, bereavement groups, and memorial services.
   - Bereavement related mailings following the death of the patient at 1, 3, 5, 7, and 10 months, a card acknowledging it has been a year at ~~and 13~~ 12 months, a mailing at the holidays, and a final letter and bereavement survey at 13 months. ~~following the death of the patient, along with a holiday mailing.~~
   - Additional information regarding community resources, bereavement literature and, if necessary, referral to professional assistance if needed.

6. If the needs of the bereaved are beyond the scope of the service provided by CHC, referrals are made to appropriate community resources or practitioners.

Effective Date: 11/08 | Revised Date: 09/19~~02/14~~ | Board Approved: 04/16/14
Reviewed Date: 05/16 | Signature Date: 04/16/14

Signature: President/CEO

Center for Hospice Care

BEREAVEMENT PLAN OF CARE

REGULATION: 42 CFR Part 418.64(d)(1) – Core Services, Bereavement Counseling

POLICY: A bereavement plan of care is developed for identified family members and other involved individuals after the patient's death.

PROCEDURE:

1. During the initial bereavement assessment, the Interdisciplinary Team (IDT) identifies family members, caregivers, or significant others who may be significantly impacted by the patient's death. The initial bereavement assessment is updated during IDT meetings throughout the course of the patient's care.
2. The Bereavement Department/Coordinator is notified of all deaths and the plan of care is initiated following the patient's death. Information from the initial bereavement assessment is considered in the bereavement plan of care.
3. The bereavement plan of care reflects the assessed needs of the bereaved and notes the kind of bereavement services to be offered.
4. The Bereavement Coordinator ensures that the bereavement plan of care is followed for thirteen (13) months following the patient's death, appropriate to the level of need assessed.
5. Bereavement services listed in a client's bereavement plan of care may include, but are not limited to: bereavement groups and individual counseling, mailings and/or telephone contact.
6. Support groups, community education, and/or additional bereavement services are provided on an as needed basis.
7. Memorial Services are offered annually at multiple locations throughout the service area.~~at office locations are offered annually.~~

Effective Date: 11/08	Revised Date: 09/19~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 09/14		Signature Date: 10/19/16

Signature: [signature] President/CEO

BEREAVEMENT – TRACKING AND EVALUATION

REGULATION: 42 CFR Part 418.64(d)(1) – Core Services, Bereavement Counseling

POLICY: CHC monitors the patient's family, caregiver and/or significant others receiving bereavement care for thirteen (13) months following the death of the patient.

PROCEDURE:

1. A bereavement file is initiated at the time of the patient's death for each designated bereaved that contains documentation related to all bereavement services, interventions, and support provided~~ to the patient's family, caregiver and/or significant other(s)~~.

2. ~~A~~ Bereavement Counselors and~~or~~ Bereavement Volunteers document~~s~~ all contacts with a~~the~~ bereaved.

4. At least one or two telephone calls are attempted~~s~~ ~~are made~~ to reach the designated bereaved ~~family member, caregiver, significant other~~ of the deceased patient during the first month following the death. If the designated bereaved are not reached and they do not return the call, ~~no one can be reached, a "No Answer"~~ a letter is sent (when their address has been gathered) offering condolences, indicating phone calls have been made, mentioning bereavement services, and - informing the bereaved they will receive the mailing program.~~that attempts have been made to be in contact.~~ The office number is included in case they want more information or want to opt out of the mailing program.

5. Family members, caregivers, and significant others of the hospice's patient have the right to refuse bereavement services and support at any time.

6. A survey of hospice bereavement services is sent at 13 months following the death of the patient to all bereaved receiving the mailing program. ~~The evaluation of the hospice's bereavement services is conducted twice: in a survey sent approximately three months following the death of the patient, and at the end of the bereavement services.~~

7. Data obtained from returned bereavement surveys/questionnaires is used to improve the bereavement services offered by CHC.

Effective Date: 11/08	Revised Date: 09/19	Board Approved: 11/05/08
Reviewed Date: 05/16		Signature Date: 11/05/08

Signature: [signature] President/CEO

Center for Hospice Care

VOLUNTEER SERVICES

Section: Patient Care Policies Category: Hospice

REGULATION: 42 CFR 418.78 – Volunteers

PURPOSE: To ensure the utilization of trained volunteers in administrative, ~~or~~ direct patient care, or bereavement support roles.

POLICY:

1. The hospice program will routinely utilize volunteers in its provision of care and services.

2. Volunteers will provide direct patient/family care functions and bereavement support after the patient's death.

3. Volunteers will be involved in ancillary, office, ~~bereavement~~ and fundraising activities.

4. Professional volunteers providing professional service will meet all standards associated with their specialty area. Required licensure or registration is maintained by the staff person responsible for the discipline of the professional volunteer.

Effective Date: 02/94	Revised Date: 09/19~~05/05~~	Board Approved: 05/17/05
Reviewed Date: 05/16		Signature Date: 05/17/05

Signature: [signature] President/CEO

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: CHC makes a consistent and concerted effort to recruit qualified, appropriate and competent people willing to volunteer their services to the hospice program. Volunteers are selected regardless of race, color, national origin, ancestry, age, sex, religious creed, sexual orientation, or disability.

POLICY:

1. The Volunteer Recruitment and Training Coordinator is responsible for the recruitment of new volunteers through the Agency's service area, identifies recruitment opportunities, and follows through with a plan of action. Volunteers are recruited for the following opportunities:
   (a) Level One:
   - Office Volunteers
   - Bereavement Volunteers
   - Tuck-In Callers
   - Community Relations
   - Special Projects

   (b) Level Two:
   - Extended Care Facility Volunteers
   - Specialty Areas Volunteers
   - 11th Hour Volunteers
   - Complementary Alternative Medicine ~~Comfort Care~~ (CAM) Volunteers
   - Life Bio
   - We Honor Veterans
   - Hospitality Program Volunteers
   - Pet Peace of Mind Program Volunteers

   (c) Level Two Plus:
   - Companion Visit Volunteers
   - Inpatient Unit Volunteers
   - Home Visit Volunteers
   - Pediatric Program Volunteers

   (d) Level Three:
   - ~~Patient Care~~ Home Visit Volunteers
   - Inpatient Unit Volunteers
   - Pediatric Program Volunteers

2. Prior to a scheduled volunteer training program, press releases are sent to various area publications and/or other venues either by mail or e-mail.

3. The Volunteer Recruitment Coordinator, as well as ~~A~~all staff members are ~~aware of their roles in the recruitment of volunteers and~~ to actively seek to promote the Agency's volunteer opportunities as they speak formally and informally to family members, friends, ~~places of worship and~~ community groups, clubs and organizations.

4. Family members and other caregivers of the hospice's patients are encouraged to wait at least a year after the patient's death before serving as a patient care volunteer. However, this is reviewed on a case by case basis.

5. All efforts to recruit hospice volunteers are documented and maintained by the Volunteer Recruitment and Training Coordinator.

Effective Date: 11/08	Revised Date: 09/19~~06/16~~	Board Approved: 10/19/16
Reviewed Date: 09/14		Signature Date: 10/19/16

Signature: [signature] President/CEO

VOLUNTEERS – ORIENTATION, TRAINING, AND SUPERVISION

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: To provide appropriate orientation and training prior to placement as a volunteer.

POLICY: Volunteers will provide at least 5% of the total of both travel time and patient care hours of all paid employees and contract staff. Volunteers will be used in defined roles under supervision of a designated Agency employee after they have received proper orientation and training.

Plan for orientation and training:

- All individuals are interviewed before training for purposes of screening and to determine the volunteer's interests and skills.

- Two reference checks are obtained, as well as a limited criminal history check on all potential volunteers.

- Volunteers who have any opportunity for patient contact will have a signed statement from their physician that they are free from communicable disease and will comply with any Agency drug screening policies.

- New patient care volunteers are required to have an initial two-step testing method of the Mantoux TB Test and an annual test thereafter. Office volunteers that provide services in buildings that have a Inpatient Unit must also have an initial two-step Mantoux TB Test, followed by an annual TB Test.

- A training program is prepared by the Volunteer Recruitment and Training Coordinator and is presented throughout the year. The program consists of, but is not limited to:
  - Their duties and responsibilities
  - The persons to whom they report
  - The person(s) to contact if they need assistance and instructions regarding the performance of their duties and responsibilities
  - Hospice goals, services and philosophy
  - Confidentiality and protection of the patient's and family's rights
  - Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death and bereavement
  - Procedures to be followed in an emergency, or following the death of the patient
  - Guidance related specifically to individual responsibilities

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- Volunteers will receive and sign copies of the~~ir~~ position description related to their specific volunteer duties and be given a copy of the CHC~~a~~ Volunteer Policies Manual.

- An orientation check list will be completed by the volunteer for specific duties he/she may be asked to perform and is placed in the personnel file.

- All forms are to be ~~The~~ signed and dated and ~~orientation checklist~~ will be maintained in the volunteer's personnel file~~record~~.

- Volunteers are directly supervised by the Volunteer Coordinator at the office to which they are primarily assigned.

- Volunteers are evaluated annually.

- Volunteers will participate in annual inservices, skills validation, OIG check, and a TB test depending upon his/her level of service and/or service role.

Effective Date: 02/94	Revised Date: 09/19 ~~06/16~~	Board Approved: 10/19/16
Reviewed Date: 09/14		Signature Date: 10/19/16

Signature: [signature] President/CEO

REGULATION: 42 CFR Part 418.78 – Volunteers

PURPOSE: All volunteers are required to provide timely, accurate and appropriate documentation of any patient-related contact.

POLICY:

1. Hospice patient care volunteers use the Patient Care Volunteer Report/Time Sheet for documentation of any and all contact with hospice patients and their caregivers, including visits and telephone calls.

2. Volunteers Coordinators are required to ~~keep a~~ supply volunteers with time sheet forms and envelopes ~~of forms available~~ for their use.

3. Upon completion of a patient/caregiver visit or phone contact, the volunteer completes the Patient Care Volunteer Report/Time Sheet and brings or mails the completed documentation to the Volunteer Coordinator.

4. All volunteer documentation is submitted following~~within three days of~~ the patient contact for incorporation into the patient's medical record.

5. The Volunteer Coordinator reads and approves all Patient Care Volunteer Report/ Time Sheets and follows up with the volunteer ~~or patient/caregiver as needed.~~ for any necessary corrections. The Volunteer Coordinator may also contact the patient/caregiver for follow up.

Effective Date: 11/08 Reviewed Date: 05/16	Revised Date: 09/19 ~~09/12~~	Board Approved: 10/17/12 Signature Date: 10/17/12

Signature: [signature] President/CEO

Center for Hospice Care

COMPLEMENTARY ALTERNATIVE MEDICINES (CAM) PROCEDURES

Section: Patient Care Policies Category: Hospice

PURPOSE: To ensure access to complementary care for patients interested in the use of non-pharmacologic interventions for comfort.

POLICY: Agency recognizes that patients may choose to use complementary non-pharmacologic interventions along with traditional interventions to obtain comfort physically, emotionally, and/or spiritually.

PROCEDURE: **Referral**

1. When a patient requests CAM, a modality is identified and then approved at an IDT meeting. The case manager will document this in the patient's plan of care. That documentation will generate a physician order, which QA prints and sends to the physician for his or her signature.

2. The case manager will verify a signed physician's order has been received and placed in the patient's chart.

3. Staff will document a patient's request for CAM by completing a CHC Volunteer Request Referral. The request~~referral~~ can be completed by any care team member. The date of the IDT meeting and the date of the signed physician order must be documented on the request~~referral~~ in order for the request~~referral~~ to be processed.

4. The Volunteer Coordinator (VC) will determine volunteer availability and document~~notify the IDT~~ the assignment details in the patient's electronic medical record (EMR) when a volunteer has been assigned. The VC will give a copy of pertinent patient information to the assigned volunteer. The VC will document the processing of the CAM request~~referral~~.

5. The VC will maintain a wait list for CAM services when necessary.

Consent:

1. A Complementary Comfort Care Consent form is to be signed by the patient or their representative before a practitioner begins a session. In the event the patient is unable to sign the consent, the VC will obtain a signature from the patient's Power of Attorney or Health Care Representative.

2. The consent form will be placed in the patient chart under Miscellaneous. If the patient resides in an extended care facility or group home, a copy of the consent form and physician's order will be placed in the facility's patient chart.

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Volunteers:

1. Volunteers will be trained in their modality according to the required standards of CHC. Volunteers will also complete required practice hours.

2. Caring Touch Volunteers will be required to complete annual skills validation training.

3. Massage Therapists are required to hold certification from accredited massage schools and hold appropriate state issued licenses.

4. The VC will instruct the assigned volunteer to document observations and CAM service provided on the Volunteer Report and Time Sheet. Documentation will be completed timely and accurately and submitted to the VC following~~within three days of~~ the visit. CHC support staff will scan the ~~place~~ Volunteer Report and Time Sheet~~s~~ into the patient chart under IDT notes.

TRIAGE ON CALL SERVICES

REGULATION: 42 CFR 418.100(c)(2) – Organization and Administration of Services

PURPOSE: To ensure quality care of patients - 24 hours a day, 7 days a week.

POLICY: Patients have access to hospice services 24 hours a day, seven days a week by calling the Agency telephone number.

PROCEDURE:

1. Patients/caregivers receive written information at the time of admission regarding how and when to access care during, and after, normal business hours.
2. A Triage Nurse determines emergency needs requiring a patient/caregiver visit. Psychosocial and/or spiritual needs may be referred to the social worker, chaplain or bereavement coordinator.
3. The Triage Nurse provides follow-up appropriate to each call. Activities may include:
   - Calling the patient/family/caregiver
   - Arranging a visit to the patient if necessary
   - Obtaining physician orders as needed
   - Arranging for other services as needed
   - Arranging for changes in the level of care as needed
   - Obtaining medications, equipment and/or supplies as needed
   - Taking referrals for service, and/or
   - Taking messages for Agency personnel
   - Contacting Agency volunteers as needed on weekends, evenings and holidays.
4. All interactions that occur outside of normal business hours are recorded in an email report and in individual patient electronic medical records (EMR).
5. The Triage and Emergency Visit Nurse communicate information (e.g., changes in the plan of care, status updates, deaths, referrals, admissions, etc.) to the Interdisciplinary Team (IDT) via secure messaging in the EMR.
6. IDT members notify the Triage Nurse each day to provide patient status updates and plan of care revisions in order to ensure continuity of care.
7. Non-emergency patient visits when indicated normally occur within three hours from the time the need is identified, or as agreed upon by the Agency and patient/ caregiver.
8. When clinically indicated, emergency visits are made as soon as able.

Effective Date: 01/06	Revised Date: 07/19~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 04/14		Signature Date: 10/19/16

Signature: [signature] President/CEO

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

PURPOSE: To insure that respite care is available for Hospice Medicare Benefit (HMB) and Medicaid Hospice Benefit (MHB) patients.

POLICY: Respite care is available for up to five consecutive days and may be repeated within a certification period. This accommodates the family or primary caregiver by providing a rest from the physical and emotional strain of caring for the patient.

Inpatient Unit is first choice for respite care if the patient's plan of care requires this type of intervention.

Agency will use contracted area hospitals or Medicare/Medicaid contracted nursing ~~specified intermediate care~~ facilities for respite care according to the guidelines of their individual contracts. RN coverage must be available to provide direct patient care 24 hrs. a day.

If contracted facilities are ~~Bremen Hospital is~~ being used as a Respite stay when special circumstances warrant and supporting documentation explains the request is valid, contact the Director of Nursing (or designee) for use of a bed.

- Inform Director of Nursing (DON) of it being a Respite Level of Care.
- The DON will obtain a physician to assume care for that patient while he/she is a patient~~at Bremen Hospital~~.
- Fax to the DON a current face sheet, medication sheet, and plan of care.
- When confirmed by the DON, notify the patient's attending physician.
- Instruct the patient/primary caregiver to take all medications, inclusive of Care Kit or Seizure Paks and DME equipment.

Document patient and family's choice and acceptance of the location offered in utilizing either inpatient unit, contracted facilities, or their choice in delaying Respite stay.

Effective Date: 02/94	Revised Date: 11/19~~01/06~~	Board Approved: 01/17/06
Reviewed Date: 05/16		Signature Date: 01/17/06

Signature: [signature] President/CEO

REGULATION: 42 CFR 418.104 – Clinical Record

PURPOSE: To ensure a timely, accurate written record of the patient/family encounter, care, and coordination of contacts and services provided by the Agency.

POLICY: A medical record is established and maintained for every patient receiving care and services from the Agency. The record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

PROCEDURE:

1. Entries are made in the medical record for all services provided. Services provided directly and through contracted providers will be entered in a standardized format and are legible, clear and complete, and signed and dated by the person providing the services.

2. Only authorized individuals are allowed to make entries in patient medical records and all signatures are authenticated with name and title or a secured computer entry by a unique identifier to ensure the author is who he/she claims to be.
   - Authentication must include date and time that an event occurred, not the time the documentation was entered into the record.

3. Each patient's medical record includes, at a minimum, the following:
   - Identification data, including contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s).
   - Referral information and pertinent medical history.
   - Contact information for the primary care physician or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency.
   - The initial plan of care, updated plans of care, comprehensive assessment, comprehensive assessment, and updated comprehensive assessments, clinical notes.
   - Signed copies of the General Consent form and election statement.
   - Documentation of all interventions including medications, symptom management, treatment and services, and responses to those interventions.
   - Goals and patient's progress toward achieving them.
   - Outcome measure data elements.
   - Physician certification and recertification statements.
   - Signed physician orders.
   - Copies of advance directives (if applicable).
   - Patient/family understanding of the Plan of Care.

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4. Access to patient medical records is restricted to members of the Interdisciplinary Team (IDT) and employees who require such access to perform their jobs effectively.

5. A patient's entire medical record may only be used or disclosed in accordance with the Agency's policies and procedures related to uses and disclosures of protected health information.

6. The Agency has a zero tolerance policy for falsification of medical records.

7. The medical record contains a discharge summary, and medical records of discharged patients are completed upon discharge from the Agency.

8. When an error is made in the medical record, it may only be corrected by drawing a single line through the error with the initials of the individual making the correction. Correction liquid or tape, erasure, or obliteration of the error by multiple cross-outs and/or write-overs is not allowed. An addendum to the electronic medical record may be made, but never changed, using the date of the addendum in a memo attached to the date of the contact being addended.

9. Electronic medical records are safeguarded against loss or destruction by a backup process of the Agency's computer server each day.

10. Medical records are retained and protected for ten (10)~~seven (7)~~ years from the last date of service~~after the death or discharge of a patient~~.

11. Records of any patient who is a minor will be maintained for five (5)~~three (3)~~ years after the person's 18th birthday or until the age of 23~~21~~ years.

12. Records in the field offices will be maintained after discharge for a period of one year and/or up to the time of the next survey. Following this time period, the medical record will be sent to the South Bend office for incorporation into the Agency's official record and/or transferred to permanent storage.

13. If the record is not on site in the records room, it will be stored at Two Men and a Truck, 903 S Main Street, South Bend. The Executive Office Manager will maintain an inventory of records stored off site and the date when the records can be pulled and destroyed. The date and list of the records destroyed will be maintained permanently in the Two Men and a Truck file.

14. Documents that no longer serve a purpose will be placed in a certified document destruction bin for shredding by the contracted Agency vendor~~, or shredded~~.

15. In the event that Center for Hospice Care closes, medical records will continue to be stored at Two Men and a Truck.

Effective Date: 12/08	Revised Date: 07/19 ~~04/18~~	Board Approved: 05/16/18
Reviewed Date: 05/16		Signature Date: 05/16/18

Signature: President/CEO

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

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

PROCEDURE:

1. Upon notification of the death, advise the caller that a staff person will be in route to the residence of the patient.
2. If the patient was at a facility, CHC staff will go to that facility and work with the Extended Care Facility (ECF) staff to coordinate efforts to follow the routine for a death of a patient in their facility.
3. Contact the patient's attending physician and inform him/her of the patient's death and determine who is to sign the death certificate.
4. Ask the primary caregiver if there are any other physicians they would like notified.
5. Prepare the patient's body for transfer by removing catheters, bathing, redressing, etc. If patient resides in an ECF, only the nurse may do the above.
6. Check patient for personal affects (rings, watches, etc.) and document items and recipients of said items.
7. If patient has implanted pump, call their physician so it can be shut off.
8. If patient has defibrillator, take magnet to deactivate. We must have a physician's order prior to this procedure. Return the magnet to the office and clean per protocol. Location of magnet: South Bend—triage desk, Plymouth—nurses' room, Elkhart—chart/documentation room and the nurse's station in Inpatient Unit, La Porte - office.
9. Assess whether the family or other appropriate caregivers wish to be a part in any way in the post mortem care.

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10. Attend to the family, friends, and ECF staff (if applicable) and explain that bereavement services are available to anyone in the family and contact will be made to the family member identified by the patient care team. If a family member at the death visit asks to be contacted by bereavement, CHC staff will gather complete name, address and phone number.

11. Be sensitive to public locations (Inpatient Unit) when a body is being removed, and offer an explanation that the funeral home representative is arriving soon and they may want to move to another location.

12. If the death is unexpected or there is suspected foul play, notify ~~the police~~nursing leadership and appropriate administrator.

13. After permission is obtained from the family, notify the funeral home as designated by the family for transport of the patient's body. Inform the funeral home who will be signing the death certificate.

14. For Inpatient Unit (IPU) patients: Place wristband on the patient with patient's name and date of birth written on it. When the funeral home arrives, the funeral home director should verify they are the correct funeral home and verify the correct patient name before releasing the body. If there is no funeral home identified and family cannot be reached, will not make a decision, or there is no family to make a decision:
    - Call social worker to work with the family or identified person.
    - Notify the IPU Coordinator or nurse leadership on call if the social worker is unable to resolve in a timely manner.

15. Contact all appropriate agencies, DME, contracted pharmacy, volunteer, contracted providers (~~IV~~CADD pump provider, therapies, etc.), private duty providers, etc., of the patient's death.

16. Complete a Death/Discharge Note in Patient Note and transfer note to patient note summary. Include where death occurred, date and time of death, and that all agencies listed on #14 above were contacted. If death occurs in an ECF, document this information in the facility chart also.

17. Enter the patient's name, attending staff, funeral home, and date of death into the Secure Messaging.

18. Staff will notify the triage nurse of all patient discharges or deaths. The nurse making the death visit with discharge in Cerner. This is inclusive of all shifts and agency locations.

19. See policy for Medication Disposal for disposal of medications. Medical disposal must be documented in this note.

20. Known coroner cases are handled per individual case. At the time of death, notify nursing leadership and medical staff prior to notifying the coroner.

~~20.~~21. If at the time of admission the patient is identified as a coroner case, place in patient Alerts.

Effective Date: 05/94	Revised Date: 07/19~~08/18~~	Board Approved: 11/28/18
Reviewed Date: 09/14		Signature Date: 11/28/18

Signature: President/CEO

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

PURPOSE: The agency will use an interdisciplinary approach to assessing the medical, physical, social, emotional, and spiritual initial and ongoing needs of the patient and family to determine the best placement for patient.

POLICY: **GIP for New Admissions**

- Admissions will set up conference call from their iPhone. (See CHC knowledge base for directions).
- GIP patients should have an MD (on call if available), rounding Nurse Practitioner, Inpatient Unit (IPU) RN, Social Worker, and Admission RN for all IDT's.
- If IPU nurse too busy to participate in IDT at requested time:
  - The IPU nurse will ask the coordinator, if she is not available then the ADON during business hours.
  - If after business hours, staff member requesting the IDT will conference in the nurse leader on call.
- Staff facilitating GIP transfer should mutually decide with IPU best time for transfer.
- GIP patients should go to the IPU of family choice, if there is a reason to divert to the other IPU, the coordinator or nurse leadership on call should be included in the decision.
- Communicable disease form will be completed by Admission RN.
- Admissions will complete IDT note.

Transfers of Current Patients

- CM/Visit nurse will set up conference call from their iPhone.
- Transfer patients should have an MD (on call for the IPU if available), rounding NP, Case Manager/Visit Nurse, IPU RN, and Social Worker for all IDT's.
- If IPU nurse too busy to participate in IDT at requested time:
  - The IPU nurse will ask the coordinator, if she is not available then the ADON during business hours.
  - If after business hours, staff member requesting the IDT will conference in the nurse leader on call.
- Staff facilitating GIP transfer should mutually decide with IPU best time for transfer.
- GIP transfer patients should go to the IPU of family choice, if there is a reason to divert to the other IPU, the coordinator or nurse leadership on call should be included in the decision.
- Communicable disease form will be completed by CM/Visit nurse.
- CM/Visit nurse will complete IDT note.

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Respite

- Case Manager/Social Worker will set up conference call from their iPhone.
- If CM is unable to be on the call, CM should call IPU RN with report on patient.
- Respite patients IDT's are done within 24 hours of requested date.
  - Social work ~~W~~ should call unit day of transfer to confirm bed availability.
- Respite patients should have included in their IDT: MD, SW, CM/VN, IPU staff, and Coordinator, if Coordinator not available, nurse leadership on call.
- Social Work is responsible for entering respite information in the Outlook calendar titled "IPU Respite Reservations."~~both IPU green books.~~
- The IPU coordinator or nurse leadership on call can divert to the other IPU or delay transfer of respite patient if the respite patient will occupy the last bed at that IPU.
- All respite patients will have a fee assessment completed by Social Work either before transfer or within 24 hours of transfer~~same day as transfer~~.
- TB tests and Communicable disease questionnaire will be completed prior to transfer to IPU. TB tests are valid for 1 year.
- Social Work will complete IDT note.

Effective Date: 03/01/18 Reviewed Date:	Revised Date: 07/19	Board Approved: 05/16/18 Signature Date: 05/16/18

Signature: [signature] President/CEO

Center for Hospice Care

INPATIENT UNIT – RESPITE PATIENT CARE

Section: Patient Care Policies   Category: Hospice   Page: 1 of 3

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 if they choose not to go to the other IPU, they may be given the choice of delaying respite stay. Medicare contracted facility may only be used if both IPUs are full. ~~or utilizing contracted facilities.~~

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.
- On the date the 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~~IPU staff member will complete the CHC Respite Stay Questionnaire profile before arrival to the IPU.
    - If family is requesting same day respite and there is no time for IPU staff to complete the questionnaire, Social Work will complete it with the family.

- 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.

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- 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
  - 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 family upon arrival to 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.

INPATIENT UNIT – MEDICATION ADMINISTRATION

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

PURPOSE: To ensure the safe management of all ~~provide safety and consistency in the delivery of~~ medications and biologicals related to the care of the hospice patient residing in - ~~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.~~ All medications and biologicals will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care. These medications and biologicals will be reviewed by a licensed pharmacist through Agency contracted pharmacy for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse, and appropriateness of drug, dose, and duration of treatment.

PROCEDURE:

1. Medication Orders

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

b) The RN/LPN 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, or LPN under the supervision of the RN on duty, 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/LPN 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) Each time a medication is changed or added, the entire profile is reviewed for drug to drug interactions, drug-disease state contraindications, drug-allergy interactions, therapeutic duplication, drug therapy associated with laboratory testing, clinical abuse/misuse, and appropriateness of drug, dose, and duration of treatment

e) 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 <u>second dose</u> is held due to one of these reasons.
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 <u>first dose</u> that this is identified as an issue.

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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.

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

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.

INITIAL ASSESSMENT OF PATIENT, FAMILY, ~~PRIMARY~~ CAREGIVER

PURPOSE: To ensure needs are met in a manner consistent with the symptoms and wishes of the patient and family.

SCOPE OF SERVICE: Registered Nurse

POLICY: An initial assessment is done to determine the critical information necessary to treat the patient/family's immediate care needs and will be conducted by a Registered Nurse within 48 hours of the receipt of the attending physician order to determine appropriateness for service.

The nurse will gather the following baseline data at the time of admission:

- Health history.
- Physical assessment of patient.
- Assessment of patient's skilled need
- Consult with the attending physician for orders to treat the patient's immediate physical, psychosocial, and emotional status related to the skilled need and related conditions.
- Instruct in actions, side effects, contraindications, and efficacy of current regime, examine any additional medications (prescribed or over-the-counter) which the patient may be taking, and to report this information to the attending physician.
- Based on the patient's needs and findings from the initial assessment, the Admission nurse~~case manager~~ coordinates disciplines that must participate in the comprehensive assessment of the patient within five (5) days of the patient's election of home health services.
- The Social Worker is responsible for assessing the psychosocial needs of the patient, family /primary caregiver.

Effective Date: 12/94	Revised Date: 07/19 ~~03/17~~	Board Approved: 06/28/17
Reviewed Date: 09/14		Signature Date: 06/28/17

Signature: [signature] President/CEO

REGULATION: 42 CFR 484.60 – Plan of Care

PURPOSE: The home health agency (HHA) must provide a written individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by the attending physician acting within the scope of his or her state license.

POLICY: The interdisciplinary team (IDT Team) is responsible for formulating the patient/ PCG care plan; this formulation occurs after the initial assessment by the team members, and occurs with the collaboration of these team members, patient and family. The IDT Team will be notified prior to the initiation of patient care.

The IDT Team works together in contributing information, identifying of patient/ family problems, and planning appropriate responses to patient and family needs inclusive of goals and interventions.

PROCEDURE:

1. A registered nurse will conduct the initial physical assessment of each patient and contact members of the IDT to initiate the care plan.
2. Care plan will include an assessment of patient/family/ PCG needs including medical, nursing, functional psycho-social~~ and spiritual issues~~.
3. Care plans shall be reviewed and updated every 60 days for all patients and as needed as changes occur.
4. An updated Plan of Treatment will be sent to the physician every certification period, and progress notes will be sent every two weeks.
5. Upon signing the plan of Treatment, the physician is confirming he/she has seen the summaries in addition to the care plan.
6. Review of the patient's plan of care, inclusive of changes, occur as needed in addition to a review routinely~~every two weeks~~ at the IDT Care Conference (weekly IDTs)~~Supervisory Meeting~~.

Effective Date: 12/95	Revised Date: 07/19~~04/18~~	Board Approved: 05/16/18
Reviewed Date: 03/17		Signature Date: 05/16/18

Signature: [signature] President/CEO

PHYSICIAN AND CARE TEAM ~~IDT~~ REVIEW OF PLAN OF CARE

REGULATION: 42 CFR 484.18(b) – Periodic Review of Plan of Care

PURPOSE: To ensure an accurate, timely review and update of the patient's plan of care by the ~~interdisciplinary team and~~ attending physician and Agency personnel as often as the severity of the patient's condition requires.

POLICY: A written summary report of the plan of care for each patient shall be sent to the physician at least every sixty (60) days.

PROCEDURE: The case manager will review each patient's plan of care no less than every 60 days, or as the patient's condition warrants. The nurse will complete a nursing summary in the patient's medical record based on the review. These summaries will be printed by the QA Department and sent to the attending physician via fax or mail.

Verbal communication will be given to the physician and documented accordingly in the patient's record indicating the condition of the patient, the plan of care, and that the physician was notified as frequently as the patient's conditions warrant.

The total plan of care is reviewed by the attending physician and Agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same Agency during the 60 day episode. Agency staff promptly alert the physician to any changes that suggest a need to alter the plan of care.

Effective Date: 08/04	Revised Date: 07/19~~03/17~~	Board Approved: 06/28/17
Reviewed Date: 03/13		Signature Date: 06/28/17

Signature: [signature] President/CEO

REGULATION: 42 CFR 484.18(a) – Plan of Care

PURPOSE: Following the initial assessment of the patient, a written plan of treatment is individually developed to ensure that the care provided to an individual is in accordance with the plan.

POLICY: The Plan of Treatment is formulated at the time of the initial nursing visit in consultation with the attending physician and is the responsibility of the case manager.

The physician(s) responsible for the patient's medical care must sign the Plan of Treatment, and remains in charge of the patient's care. (See exception in Medical Supervision Policy). This physician receives and must sign within fourteen (14) days this Plan of Treatment and return it to the Agency office. A full signature is required; rubber stamp and initials are not acceptable.

The Plan of Treatment contains the following information:

- Patient name and identifying information
- Provider name and identifying information
- Allergies
- Nurse's signature and date of verbal order
- Date agency received Plan of Treatment
- Physician certification of need
- Diagnosis, mental status, and prognosis
- Functional limitations, rehabilitation potential, and discharge plan
- Types of service required to meet the PT/PCG goals
- Nutritional requirements
- Activities permitted
- Medications and treatments
- Safety measures and equipment required
- Frequency of visits and services for each discipline
- DME and supplies
- Penalty statement

An updated Plan of Treatment is mailed to the physician(s) for signature at least every 60 days.

Patient Summaries are faxed or mailed ~~every fourteen (14) days~~routinely following Care Conferences (weekly IDT) to update the attending physician on the patient's condition.

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Interim orders, verbal or telephone, are mailed to the patient's attending physician(s) when written, and to be signed and returned to the Agency within fourteen (14) days.

Physician is to designate PCG or designee to administer patient's medication if patient is unable to do so.

Effective Date: 03/96	Revised Date: 07/19~~03/09~~	Board Approved: 04/15/09
Reviewed Date: 03/17		Signature Date: 04/15/09

Signature: President/CEO

Center for Hospice Care

OASIS COMPLETION

Section: Patient Care Policies Category: Home Health

REGULATION: 42 CFR 484.20 – Reporting OASIS Information

PURPOSE: To provide a consistent procedure for the completion and submission of OASIS.

POLICY: Agency will collect OASIS data elements and electronically submit them to the state of Indiana within the mandated time frames for Home Health Medicare (HHM) and Medicaid Home Health patients.

A completed OASIS will be submitted to the CMS system for all Medicare and Medicaid patients, and patients utilizing any federally funded health plan options that are part of the Medicare program (e.g., Medicare Advantage plans). An OASIS must also be submitted for Medicaid patients receiving services subject to the Medicare Conditions of Participation as determined by the state. Exceptions to the transmittal requirements are:

- Under age 18
- Receiving maternity services
- Receiving housekeeping or chore services only
- Receiving only personal care services
- Patients for whom Medicare or Medicaid insurance is not billed

PROCEDURE:

1. A privacy statement will be obtained for OASIS on admission.
2. A Registered Nurse will make a visit to collect data elements (exceptions would be discharge or transfer).
3. The data elements are reviewed for appropriate and correct responses by a Quality Assurance Nurse.
4. The data elements are locked and an electronic file is created with submission to the Indiana State Department of Health within 30 days following the completion date.

Effective Date: 11/02	Revised Date: 08/19~~05/06~~	Board Approved: 05/16/06
Reviewed Date: 03/17		Signature Date: 05/16/06

Signature: [signature] President/CEO

Center for Hospice Care

PHYSICIAN NOTIFICATION OF MISSED SCHEDULED VISIT

Section: Patient Care Policies Category: Home Health Page: 1 of 1

REGULATION: 42 CFR 484.18(a) – Plan of Care

PURPOSE: To comply with state and federal regulations. The attending physician will be notified if the number of visits varies from the patient's plan of care.

POLICY: Each discipline is responsible for notifying the physician by fax or phone of visits that are not within the visit strings as designated on the plan of care. The Patient Care Coordinator will be responsible for the Home Health Aide visits.

PROCEDURE:

1. Notify the physician when the visit frequency is not met as ordered.
2. Document notification in a demographics memo, phone contact, or scheduling calendar in the EMR.
3. Staff must document why the visit was missed in the EMR~~patient chart~~.
4. Any questions or problems regarding scheduled visits or physician notification of visits should be forwarded to the Patient Care Coordinator.

Effective Date: 07/93	Revised Date: 07/19~~04/18~~	Board Approved: 05/16/18
Reviewed Date: 03/13		Signature Date: 05/16/18

Signature: President/CEO

REGULATION: 42 CFR 484.52(b) – Clinical Record Review

PURPOSE: To ensure all patient medical records are reviewed for compliance with state and federal guidelines, and established Agency policies.

POLICY: Designated employees will audit patient medical records on a monthly basis. Identified results will be reported to the Quality Improvement Committee on a quarterly basis. There will be at least one committee member to represent each scope of service provided each quarter.

PROCEDURE:

1. Medical records will be reviewed monthly by designated employees from the Quality Assurance (QA) department. Portions of the medical record related to therapies will also be reviewed by individuals trained in the therapy specialty.

~~2. Each person completing a review of the medical record will utilize the QA Chart Review form and the Documentation Audit form.~~

~~3~~2. Routine ~~Monthly~~ medical record reviews will be reported to the managers of each Interdisciplinary Team (IDT) discipline.

34. Results of the medical record reviews will be analyzed and reported at the ~~audits will be reviewed and approved at the quarterly~~ Quality Improvement Committee meetings, which includes at least one member of the Agency Board of Directors.

Effective Date: 01/15	Revised Date: 07/19	Board Approved: 02/18/15
Reviewed Date: 03/17		Signature Date: 02/18/15

Signature: [signature] President/CEO

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

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

PROCEDURE:

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

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

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

4. Prepare the patient's body for transfer by removing catheters, bathing, redressing, etc.

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

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

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

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

~~9. Attend to the family and friends and explain that bereavement services are available to anyone in the family, and contact will be made to the family member identified by the patient care team. If a family member at the death visit asks to be contacted by bereavement, CHC staff will gather complete name, address and phone number.~~

~~10.~~9. Be sensitive when a body is being removed and offer an explanation that the funeral home representative is arriving soon and they may want to move to another location.

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~~11.~~10. If the death is unexpected or there is suspected foul play, notify nursing leadership and appropriate administrator~~the police~~.

~~12.~~11. After permission is obtained from the family, notify the funeral home as designated by the family for transport of the patient's body. Inform the funeral home who will be signing the death certificate.

~~13.~~12. Contact all appropriate agencies, DME, contracted pharmacy service, contracted providers (CADD pump provider~~IV~~, therapies, etc.), private duty providers, etc., of the patient's death.

~~14.~~13. Complete a Death/Discharge Note in Patient Note and transfer note to patient note summary. Include where death occurred, date and time of death, and that all agencies in listed on #14 above were contacted.

15. Enter the patient's name, attending staff, funeral home, and date of death into the Secure Messaging.

16. ~~16.~~ Staff will notify the triage nurse of all patient discharges or deaths. The nurse making the death visit will discharge in the computer. This is inclusive of all shifts and agency locations.

17. Known coroner cases are handled per individual case. At the time of death, notify nursing leadership and medical staff prior to notifying the coroner.

18. If at the time of admission the patient is identified as a coroner case, place in patient Alerts.

Effective Date: 05/94 Reviewed Date: 03/13	Revised Date: 07/19~~03/17~~	Board Approved: 06/28/17 Signature Date: 06/28/17

Signature: [signature] President/CEO

Center for Hospice Care
QI Committee Meeting Minutes
September 17, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m. • Natalie Barnes was introduced as the new QA/Medical Records Coordinator.	
2. Minutes	• A motion was made to accept the minutes of the 05/21/19 meeting as presented. The motion was accepted unanimously.	T. Huyvaert motioned C. Harrell seconded
3. HQRP	• Hospice Conditions of Participation 418.58 state, "The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program." There are 14 areas we should be monitoring, but we are not limited to just these 14 areas. The CoPs show the complexity of the organization and that we need to monitor all areas of the agency. • Hospice Compare Website – Anyone can look up our organization to see how we compare to other hospices nationally. The biggest gap in our CAHPS scores for 10/01/16 – 09/30/18 were help for pain and symptoms (CHC 72%, national 75%), and training family to care for patient (CHC 74%, national 75%). All of our HIS scores for the same time period were above the national average. • CHC's scores for the Enhanced Care HIS measures for this time period were above the national average. Visits from an RN, physician, nurse practitioner, or physician assistant in the last three days of life CHC score was 88% and national 82.3%. An assessment of all seven HIS quality measures at the beginning of hospice care CHC score was 94.1% and national 86.4%. This measure will no longer be recorded on the Hospice Compare website, but we will continue to monitor it. CMS is having trouble measuring this off of the HIS reports. It is staying, but for a while they will not report on it. We found some discrepancies in our own data, so we will continue to measure it.	
4. Hospice QAPI Programs	• CHC's specialty programs are HeartWize, BreatheEazy, and Dementia Care. We discontinued the specialty programs committee and will now report on these programs	

Topic	Discussion	Action
	to the QI Committee. In order to find a way to measure the success of the dementia care program, we are creating a QAPI with a goal to provide patients and families with excellent end of life experiences for dementia patients and related cognitive impairment diagnosis by providing specialized interdisciplinary presence and interventions. We are also working with Patti Piechocki from the Alzheimer's & Dementia Services of Northern Indiana to develop a certification program for our nurses and aides on dementia care. Kathy Kloss will chair that program. • In the second quarter of 2019, HeartWize averaged 116 patients a month in the program. Three patients sought treatment at a hospital and two for symptom management. In April 1.8% were hospitalized related to cardiac symptoms, 1.7% in May, and 0.8% in June. • BreatheEazy averaged 80 patients in the second quarter in the program. Eight sought treatment, five for symptom management. In April, 6.4% were hospitalized related to pulmonary symptoms, 6.1% in May and 3.8% in June. We are looking at the process from admission to make sure we are doing education and include triage in that to make sure we are responding to calls appropriately.	
5. Hospice Quality Indicators	• Live Discharges – Patients initiate "revocations" and "transfers" live discharges, and agencies initiate "no longer terminally ill", "for cause", and "left service area" live dicharges. Comparing NHPCO 2017 data to CHC to the first half of 2019, CHC total deaths 88.6%, nationally 82.9%. Our percentage is above the national average, which indicates we are meeting the guidelines for eligibility for hospice services. Live discharges CHC 11.4%, nationally 17.1%. Revocations CHC 7.1%, nationally 6.5%. Transfers CHC 0.8%, nationally 2.1%. Moved out of service area CHC 1.9%, nationally 1.4%. No longer terminally ill CHC 1.2%, nationally 6.7%. Discharged for cause CHC 0.4%, nationally 0.3%. • The Live Discharges QAPI is looking closely at revocations. 58% of patients that revoke do so within the first 25 days of being on service. Approximately 50% of those who revoke return within days. Our HeartWize and BreatheEazy patients are frequently the ones who seek to revoke services. Six revocations were for drain placements. On 08/01 we started using a revocation cue card to guide nurses in documenting of live discharges. • We did education to social work, chaplains, bereavement, and admissions on documentation standards. We had 98% compliance.	

Topic	Discussion	Action
	• Chaplains – Care plans and summary note standards were updated and we continue to monitor for compliance. 100% of all new admissions are being monitored for initial assessment compliance. We had 223 new admissions from 07/24 – 09/11 and only one fell outside the five day assessment compliance. We also started peer reviews of charts to verify the information is accurate. We are also reviewing the chaplain policies to make sure they are accurate and in line with the CoPs. • Social Work – We created a new documentation profile and updated documentation standards. In February we started new visit/contact standards. We are monitoring the initial social work assessments and Respite stays to make sure the documentation is accurate. We also reviewed the social work policies. • Bereavement – We are reviewing all of the bereavement policies. We are creating a monitoring tool to make sure we are compliant. Counselors attended Tier One and Tier Two Star Behavioral Health Providers (SBHP) Veterans training. Some have also attended Tier Three trainings, and those that have not, will attend as able given the training schedules and locations. We are working on consistency in documentation of individual and family counseling sessions. • Education Topics – Sue M. did education for all disciplines at each office in June and July on documentation do's and don'ts, cutting and pasting, certification criteria, NHPCO standards, HIPAA, legal considerations, consumer concerns, and incident reporting. 98% of staff participated. We did education in April was onboarding training and CHPN study groups. In May we did Hospice 101 to the Mishawaka EMS. In June we did active shooter training at EGH, level three volunteer skills validation, and onboarding training. • Patient Safety – YTD we had 107 adverse events outside of falls. There were 6 medication delivery events, 7 drug diversion events, 8 medication errors, 12 wounds, and 17 general medication events. When a patient is admitted to the IPU from a hospital, we are recording if the patient comes to us with a pressure ulcer or other adverse event. Falls – We always see an increase in falls in the summer, because patients are going outside. The top reasons for falls are: #1 weakness, #2 cognition, #3 dementia.	
6. Home Health QAPI Programs	• The new Home Health CoPs went into effect 01/01/2018. QAPI activities for 2019 included OASIS and Home Health CoPs training for QA staff, nurses, admissions, and Billing. We reviewed and updated home health policies. As a result of the home health	

Topic	Discussion	Action
	survey, we reviewed our policy when a patient is admitted to the hospital. Nurses were educated on our home health program. We increased monitoring for Medicare replacement insurance companies by QA and Billing. We are monitoring therapy visits to make sure we have their documentation, OASIS, and adverse events. • Home Health Compare Website – We do not need to participate because the percentage of home health patients we serve falls below the threshold at least through 2021. Karl Holderman tracks and submits these numbers annually. • Patient Safety – No adverse events YTD outside of falls. Census has increased in home health, so we've seen an increase in the number of falls. Hospitalizations – We are taking a serious look at our policies when a home health patient goes to the hospital. We put the patient on hold, but we have no standard how long to do that.	
7. ISDH Survey Follow Up	• In May two surveyors arrived to investigate four hospice complaints. One complaint was related to Respite care, one to wounds, and the other two were unsubstantiated. We had ten days to submit a plan of correction. ISDH did not accept our first and second plans, but did accept the third. That occurred on Monday and then the surveyor returned on Friday after having told us it would be 42 days before she followed up. She was also investigating a new complaint. The day before the hospice surveyor returned, another surveyor showed up for our home health survey that was due in October 2018. So we had two surveys going on at the same time. Thank you to our QA Department and other staff that broke into teams for hospice and home health to work on the surveys. • We continue to monitor the areas of concern identified in the survey. Social work and chaplain initial assessments within five days of admission – 100% compliance in July. Separate hospice and home health IDTs – 100% compliance in July and August. 14 day reviews are not required for home health, but we have decided we will do them because the majority of those patients are palliative care and will eventually move to hospice. • Medications in the IPU – 100% compliance for August through 09/10/19 for nine Respite patients. • Respite – We continue to monitor that we are offering patients and families additional locations if both IPUs are full. 100% compliance. • Wounds – Compliance in May was 68%, June 69%, July 74%. We are monitoring care	

Topic	Discussion	Action
	plans for skin and wound care and doing peer reviews. The PCCs are responsible to review the wound care plans, potential or actual wounds, interventions, and that wounds are measured at least every seven days. Wounds are reviewed at every IDT and care plans updated concurrently. We are also monitoring which nurses are in compliance and which are not and talking to them one on one if they need further education. Performance improvement plans will be done for staff that is not in compliance. May had 184 patients with actual/potential wounds, June 324, and July 323. Some PCCs are having their nurses review their own charts and correct them, which has been a great learning experience for them. We have created tools to monitor compliance. We are looking at adding a certified wound care nurse and are working on a job description. • We have created a tracking method for identified survey tags that includes our plan, what we are monitoring, and our actions to be in compliance. Social work and chaplains assessment occurring within five days of admission – 99% compliance in July and as of last week 100% compliance. Separating Hospice and Home Health IDTs – 100% compliance. Respite patients in the IPU medication reconciliation – 100% compliance for nine Respite patients. • We are also tracking other areas we identified during the hospice survey process that we need to improve upon. One is the MobileCare device the aides use for documentation. When they have connection issues, they use paper flow sheets. We realized the form in Cerner doesn't match the paper form, so we are working on that. We are monitoring Home Health OASIS. The surveyor insisted we need to do an OASIS for patients with commercial insurance, but we showed her the CoPs that said it was not required. We are also looking at PRN orders, because there must be a specific reason for it. • Home Health survey – The only thing we were cited for was not having a copy of the urine drug screening in all employee files. We offered to print copies while the surveyor was here, but she didn't want to wait. We received the survey letter on 09/12 and have 30 days to submit our plan of correction.	
8. Other Business	• Jennifer E. commended staff for doing a great job correcting identified problems quickly. • QI Committee evaluation – Annually we need to evaluate this committee. We could do it via a written survey. The membership of the committee has changed. Kim G. is	

Topic	Discussion	Action
	representing nursing, Tammy H. the IPUs, and Deb D. admissions. If you want the handouts ahead of time, we can make those available to you. The only thing not on the report is volunteer services and medical staff. We will start reporting on volunteer hours in the future.	
Adjournment	• The meeting adjourned at 8:45 a.m.	Next meeting 11/19

CHAPTER THREE

PRESIDENT'S REPORT

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

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from August 22 – November 20, 2019. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

Census has continued to be at all time record levels. At the end of October we were at a 419 average daily census for the year, the highest in our history. October alone was at 428. Our federal fiscal year rates for 2020 went into effect on October 1 which should be positive for our financials with our significant increases in our daily reimbursement for general inpatient (GIP) and respite levels of care. Rates in South Bend increased 35% for GIP, 157% for respite and in Elkhart rates increased 43% and 160% respectively. Overall referrals to CHC year to date are up slightly a 0.022%. The percentage of patients dying before admission is up slightly from same time last year at 7.42% compared to 7.22% last year. 47% of all patients this year have been admitted the same day the referral was received or the next day. Inpatient units census has been very choppy with some very short lengths of stay and numerous patients not surviving 24 hours. We can be nearly full one day and have one or no patients the next day.

October 2019	Current Month	Year to Date	Prior Year to Date	Percent Change
Patients Served	523	1,785	1,761	1.36%
Original Admissions	144	1,418	1,393	1.79%
ADC Hospice	400.29	389.07	377.83	2.97%
ADC Home Health	27.90	29.76	11.28	72.22%
ADC CHC Total	428.19	418.83	395.11	6.00%

CHC HOSPICE INPATIENT UNITS

October 2019	Current Month	Year to Date	Prior Year to Date	Percent Change
SB House Pts Served	31	300	298	0.67%
SB House ALOS	3.81	5.10	5.28	-3.41%
SB House Occupancy	54.38%	71.90%	73.87%	-2.67%
Elk House Pts Served	23	236	228	3.51%
Elk House ALOS	3.96	5.24	4.49	16.70%
Elk House Occupancy	41.94%	58.08%	48.12%	20.70%

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	2019 Oct	2019 Nov	*2018* Dec
S.B.:	190	197	204	217	221	228	234	231	224	230		198
Ply:	74	77	79	77	74	76	67	66	69	68		75
Elk:	92	94	94	96	101	105	105	107	111	111		96
Lap:	14	18	18	20	24	23	21	15	13	12		14
SBH:	5	5	5	5	4	5	6	6	5	4		4
EKH:	3	4	5	5	4	4	6	4	3	3		3
Total:	378	394	405	420	428	441	439	429	425	428		390

PATIENTS IN FACILITIES

Of the 523 patients served in October 2019, 185 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in October 2019 was 156 and year to date it was 141.

FINANCES

Karl Holderman, CFO, reports the year-to-date October 2019 Financials will be posted to the Board website on Friday morning, November 15th following Finance Committee approval. For informational purposes, we are pleased to present the unapproved September 2019 year-end financials on the next page.

On 9/30/19, at the HF, intermediate investments totaled $4,773,919. Long term investments totaled $21,026,957. The combined total assets of all organizations, including GPIC, on September 30, 2019 totaled $64,246,186, an increase of $10,158,271, or almost 19%, from September 2018.

Year-to-date investments as of 9/30/19 showed a gain of $2,766,446. From a year-to-date budget standpoint at 9/30/19, CHC alone was over budget on operating revenue by $463,681, over budget on total revenue by $2,002,144, and under budget on operating expenses by $1,248,907.

Year to Date September 2019 Financials

September 2019 Year to Date Summary	**Center for Hospice Care**	**Hospice Foundation**	**GPIC**	**Combined**
CHC Operating Income	17,177,661			**17,177,661**
MADS Revenue	271,907			**271,907**
Development Income		1,512,513		**1,512,513**
Partnership Grants			391,223	**391,223**
Investment Income (Net)		2,765,446		**2,765,446**
Interest & Other	25,138	49,654	23,854	**98,646**
Beneficial Interest in Affiliate	2,062,089	(11,291)		
Total Revenue	**19,536,795**	**4,316,322**	**415,077**	**22,217,396**
Total Expenses	**15,245,747**	**2,254,233**	**426,368**	**17,926,348**
Net Gain	**4,291,048**	**2,062,089**	**(11,291)**	**4,291,048**
Net w/o Beneficial Interest	*2,228,959*	*2,073,380*		
Net w/o Investments				***1,525,602***

2020 CHC BUDGET ON THE AGENDA FOR NOVEMBER MEETING

The Finance Committee also reviewed and is expected to approve the 2020 CHC Budget at their meeting on November 15th. CHC's budget alone is over $26 million dollars for next year. To continue business into the new year, it is very important that we have a quorum at our next board meeting. Please plan to attend the board meeting on Wednesday, November 20.

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Karissa Misner, D.O., M.P.T., joined our medical staff on August 19. She finished her Fellowship training in Hospice and Palliative Medicine at a program in Macon, Georgia this summer. Additionally, she is Board Certified in Rehabilitative Medicine. Nicole Shirilla, MD, who is Board Certified in both Family Medicine and in Hospice and Palliative Medicine, and currently a Clinical Assistant Professor at the Ohio State University College of Medicine in Columbus, Ohio, interviewed for a vacancy we have on our medical staff. A job offer was extended to her and we are awaiting her response. Her availability is in approximately six months.

We currently have an opening for another physician to assist with the growth in the level of patients we have been experiencing. We have started employing internet geofencing in our physician recruitment activities. Geofencing is social media targeting of prospective physicians in certain geographic areas with ads notifying them of physician opportunities with CHC. The ads allow physicians to click to our web site and message us indicating their interest and to provide us with their contact information.

We have had several physician Fellows and medical students rotate through our agency for training in the last several months. Collin Bowman, MD, will rotate through from November 17 to November 27. He will be the Vera Z. Dwyer Fellow in Hospice and Palliative Medicine and will be so recognized at a reception at the IU School of Medicine on November 21.

Dave Haley recently negotiated a five-year contract extension with our drug vendor, Optum, involving no increase in Optum charges during that time period. We continue to be one of the top performers in the Optum national book of business.

Our new LaPorte branch office building construction is complete and fully functional. Staff have moved and we are up and running.

The clinical offices located at Roseland have relocated to the Mishawaka campus and are now operating out of this campus. The South Bend inpatient unit remains there and will move upon completion of the Ernestine M. Raclin House.

Our annual Bereavement Memorial Services are scheduled for November 24. They will be held at the Kroc Center in South Bend at 2 pm, Trinity Church on Jackson in Elkhart at 2 pm, and at Christos in Plymouth at 4 pm. Board members are welcome to attend any of these services.

DIRECTOR OF NURSING UPDATE

Sue Morgan, DON, reports…

Sue Morgan RN Director of Nursing and Kathy Kloss RN Clinical Educator presented at the NHPCO Clinical Conference on November 5 and 6, 2019. Two concurrent presentations have been accepted, "How to Develop an ELNEC (End of Life Nursing Consortium) Program for your Clinical Staff" and "QAPI Success—End Stage Cardio Pulmonary Program."

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

- The "Do's and Don'ts of Documentation" was presented in August for all nurses, social workers, chaplains, bereavement and admissions representatives. The program included a competency on documentation in which 122 employees attended.
- Wound Care Self Learning Packets
- Cardiac Pulmonary Boot Camp
- Preceptor Class
- Trunk and Treat fair, all nurses traded out supplies in their automobiles
- Infection Control and Bag Technique Self Learning Packet

The Nursing department and Volunteer Department are working collaboratively to develop an improved Volunteer Training Program.

On October 22, 2019 the Office of the Attorney General conducted an investigation based on the previous issues identified from the State Hospice Survey related to Medication Management. The inspector reviewed record documentation and interviewed the Director of Nursing and Assistant Director of Nursing in the care of the patient and medication management. We have not received any official notification from the outcome of the investigation.

The Indiana State Department of Health conducted a Home Health Survey August 20, 21, 24 and 25. There was one area of non-compliance identified related to drug screening results available in employee human resource records. This was immediately corrected. The plan of correction was submitted on September 1, 2019 and final letter of compliance was received on September 12, 2019.

In the area of Quality Improvement, the HIS (Hospice Item Set) required submission to CMS we exceeded all the national standards.

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

	2015	2016	2017	2018	2019
January	82,400.05	65,460.71	46,552.99	37,015.96	62,707.48
February	150,006.82	101,643.17	199,939.17	93,912.90	113,771.80
March	257,463.89	178,212.01	282,326.61	220,485.17	369,862.26
April	419,610.76	341,637.10	431,871.55	310,093.61	565,568.94
May	635,004.26	579,888.08	574,854.27	505,075.65	663,483.70
June	794,780.62	710,175.32	1,066,118.11	633,102.69	850,496.19
July	956,351.88	1,072,579.84	1,277,609.56	767,397.15	918,451.53
August	1,042,958.42	1,205,050.76	1,346,219.26	868,232.25	1,018,532.22
September	1,267,659.12	1,297.009.78	1,466,460.27	994,301.35	1,122,498.94
October	1,321,352.39	1,421,110.26	1,593,668.39	1,074,820.86	1,778,379.29
Nov	1,469,386.01	1,494,702.09	2,443,869.12	1,173,928.93	
December	1,757,042.51	2,018,630.54	2,730,551.86	$1,635,368.33	

Year-to-Date Monthly Revenue

(less major campaigns, bequests and significant one-time major gifts)

	2015	2016	2017	2018	2019
January	57,971.60	52,156.98	31,552.99	37,015.96	51,082.36
February	67,572.77	36,182.46	35,125.58	56,896.94	45,621.02
March	107,457.07	73,667.84	79,387.44	113,969.42	254,547.16
April	162,146.87	163,425.09	149,569.94	87,978.18	194,857.93
May	160,178.34	93,318.98	142,982.72	182,601.92	97,864.76
June	159,776.36	127,315.24	146,200.17	46,947.92	69,026.39
July	93,586.27	52,394.52	61,505.45	64,243.53	67,591.20
August	86,606.54	97,470.92	63,593.03	61,803.98	54,739.37
September	99,931.45	92,459.02	120,261.01	117,984.73	68,812.68
October	53,693.27	71,323.54	127,208.12	79,852.69	50,019.27
November	46,870.62	66,490.16	75,809.56	94,053.07	
December	161,519.80	138,328.11	286,687.74	191,211.72	
Total	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**	**1,134,560.06**	**954,162.14**

Cornerstones for Living: The Crossroads Campaign

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%. Since our last report, the addition of campaign gifts solicited prior to 6/30/19 and received since that date resulted in a revised campaign total of $13,494,090.

Planned Giving

Estate gifts since the last report totaled $562,860. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients. One large significant bequest that's been in the works since March 2019 is from the estate of Raymond A. Wiley totaling $449,414. Center for Hospice Care provided care to members of Raymond Wiley's family.

Annual Giving

Our 2019 annual appeal mailing is being developed and will be sent out by the end of November.

Special Events & Projects

Events in August, September and October are summarized in the following: Members of the St. Joe Valley Street Rods visited CHC's Campus on August 23rd and presented us with a donation of $11,500 to increase this group's total giving to $125,450. The 11th Bike Michiana for Hospice and 34th Walk for Hospice took place on September 8th. As we've experienced with the Walk over the years, we are now seeing a similar decline in participation among cyclists. Participation figures over the past four years are as follows: 2016:1,015, 2017:875, 2018:400, 2019:253. This information leads us to the conclusion that these events have likely run their course. The amount of

work and effort expended by both staff and volunteers to produce these events far outweighs the return on investment. HF staff is working with the volunteer leaders of both events to evaluate future revenue potential and sustainability as 3rd Party events in which HF staff would have a very limited role beyond participation on the day of the event. Hospice Foundation's annual Veterans Tribute Ceremony took place at the Captain Robert J. Hiler Jr. Veterans Memorial on October 15. We hosted more than 100 veterans and guests. Our featured speaker was retired USAF Chief Master Sergeant Scott Brewer. He is currently Senior Vice President of Government Affairs and Community Relations and Security with the Pokagon Band and Four Winds Casinos.

Palliative Care Association of Uganda (PCAU)

Staff from Center for Hospice Care (CHC) and the Hospice Foundation (HF) were part of the International Conference on Cancer and Palliative Care in Kampala, Uganda September 5 and 6. More than 300 attendees from 13 countries shared innovative, evidence-based research and projects as well as best practices to improve cancer and palliative care throughout the region. This is the second time the conference has been held jointly by the Palliative Care Association of Uganda (PCAU) and the Uganda Cancer Institute. During the conference, CHC was recognized as a key partner in the development of palliative care in Uganda over the past ten years. Mike Wargo accepted the award for "outstanding contributions through funding PCAU to extend palliative care services throughout Uganda" from Uganda's Minister of Health, The Honorable Dr. Jane Ruth Aceng. Other CHC and HF staff participated in the conference. Kristiana Donahue, CHC volunteer recruitment coordinator, presented a session on "Volunteer Program Essentials." Annette Deguch, CHC bereavement counselor, gave an interactive session on "Yoga and Mindfulness: A more holistic palliative care approach." Both were well received. Lacey Ahern, HF international program manager, moderated a workshop on digital health and palliative care with an official from the Uganda Ministry of Health. HF has been working with PCAU on a digital health/mHealth palliative care surveillance project to improve the evidence base for palliative care programming and policy. Denis Kidde, HF international program coordinator, co-chaired a breakout session on service delivery and was part of the overall conference organizing committee. The conference was part of an exchange visit for CHC and HF staff to Uganda. While in Uganda, CHC and HF personnel also spent time with PCAU staff on several of the joint projects the partnership supports. The team participated in high level meetings with Uganda government officials at Ministry of Health, Ministry of Education and Sports, and Uganda Police. These meetings gave the team an opportunity to interface with government officials and better understand the dynamics that exist at the national level as PCAU champions its vision and mission. They visited children on the Road to Hope program. Staff was able to visit some children at home and meet their guardians. The staff also visited a couple of the schools our children attend. Staff visited PCAU member organizations. This offered an opportunity for our staff to meet palliative care patients and experience service delivery. These visits helped our staff understand the challenges health care workers face in the office and on home visits. We visited Mulago School of Nursing and Midwifery where a new palliative care training program for nurses was launched by PCAU (with support from HF/CHC) earlier this year. These visits are very important learning and sharing opportunities and really help deepen the partnership. Connecting in person is vital to building strong relationships, and they offer CHC staff a way to be more directly involved in the partnership.

Road to Hope (RTH)

We recently completed a careful evaluation of RTH program costs and programming with the goal of developing a financial sustainability plan for the program. After assessing actual costs for supporting the children, we have concluded that overall sponsorship costs are higher than established previously. This has occurred for a variety of reasons. These include the fact that some costs have increased because PCAU is enrolling children in schools better equipped to handle the social/emotional needs of these extremely vulnerable children. We are communicating this change with sponsors individually and welcome them to continue giving at current levels if they cannot increase their sponsorship amount. We are also working on an overall fundraising strategy to identify other sources of funding to support the children and the program.

PCAU Intern

Kat Kostolansky, a junior at the University of Notre Dame, completed a very successful internship with PCAU supporting the Road to Hope program. Given the significant growth in the program since it started seven years ago, Kat worked closely with the PCAU team to develop frameworks, documentation and tracking of the children in the program. This organization and structure will help us advance the program.

Advanced Diploma in Palliative Care Nursing (ADCPCN)

The second intake of July 2019 saw 12 students admitted for this course at Mulago School of Nursing and Midwifery. In the inaugural year of the program, a total of 27 students are being sponsored. While the financial investment has remained relatively constant over the years, the number of supported nurses has quadrupled over that which we experienced when all the training was done at the Institute of Hospice and Palliative Care in Africa from 2010 – 2018.

mHealth Project

As noted above, the project hosted a digital health workshop at the PCAU conference. The objective was to bring together key stakeholders in the full scale up of the mHealth palliative care surveillance project. Participants discussed successes and challenges as well as the best way to move forward integrating the project into the Ministry of Health informatics. The Head of the Division of Health Information-Ministry of Health (MOH) was a guest speaker and discussed possible integration of the mHealth surveillance system with government data systems. PCAU is actively working on this integration with the MOH.

Partnership Report

The CHC/PCAU 10th anniversary partnership report has been published. This document reflects on the successes of this partnership from 2008 – 2018. Copies were taken to Uganda for the conference to be shared with stakeholders; PCAU also has additional copies to share as they deem appropriate. Their input was invaluable in preparing the report.

Education and Collaborative Partnerships

On World Hospice and Palliative Care Day, October 13th, the Center for Education & Advance Care Planning, along with Harper Cancer Research Center, Global Partners in Care and the Eck Institute for Global Health worked with DeBartolo Performing Arts Center to screen "The Farewell." This highly rated comedy-drama focuses on cultural dialogues and traditions surrounding end-of-life conversations. Following the film Mike Wargo, Cyndy Searfoss, Lacey Ahern and Yutong Liu (an ND graduate who was also a PCAU intern) participated in a panel discussion and fielded questions from audience members. The film was sold out and approximately 40 people stayed for the panel discussion. Collaborative initiatives like this allow our community to learn about topics like end-of-life conversations to a world view on palliative care.

Health System Collaborations

As part of our professional education mission we continue to offer webinars to area health systems. The Center for Education & Advance Care Planning hosted a series of webinars at St. Joseph Health System Mishawaka Medical Center. These webinars offer CE credits through the Hospice Foundation of America and have been made available to CHC staff as well as other community professionals. This year we offered these webinars three times a month at our Mishawaka and Elkhart Campuses to ensure that the vast majority of employees had the opportunity to attend.

Education

In what has become an annual event, the Center for Education & Advance Care Planning also hosted the National Alliance for Grieving Children's (NAGC) webinar on campus on November 8th. This event was made available to the general public and offered CE credits through NAGC. The clinician education workshop, IU Talk, was held on October 11th in collaboration with the IU School of Medicine. Faculty for the workshop were Dr. Lyle Fettig and Dr. Rafael Rosario. Attendees were led through simulated conversations about end-of-life care and were exposed to new skills through those mock-conversations. This program was offered with CME credits for the first time as well. We continue to be involved in NHPCO's grassroots campaign, MyHospice. We anticipate that we will host Indiana legislators from our service area on campus next year. Our ambassador, Elleah Tooker, flew to Washington, DC on September 16-18th to meet with Indiana legislators and discuss NHPCO priorities. The trip was all expense paid by a national underwriter who happens to be our former pharmacy vendor. Part of our development of these relationships also gives us an opportunity to highlight our own programs and campus development. In addition, Elleah used our collaboration with the IU School of Medicine on the Hospice and Palliative Medicine Fellowship/IU Talk (funded by the Vera Z. Dwyer Trust) to highlight how donors, hospice organizations and universities can work together on palliative care education and provision. In addition, we are working with NHPCO and the MyHospice program to create content for World Hospice and Palliative Care Month (November). This includes highlighting the Ernestine M. Raclin House as well as thanking legislators for helping to pass PCHETA in the House, one of NHPCO's high priority bills. As part of our community end-of-life education initiatives we continue to offer a variety of programs to community organizations. Since August, we have hosted four events off campus. Atria Eastlake Terrace scheduled a customized "Cupcakes to Die for" on August 22nd at their facility for residents and guests. Elkhart Meadows hosted an advance care directives conversation on September 25th. On October 2nd we held a "Death by Chocolate" at Golden Living; on October 9th, Grand Emerald hosted a DBC as well. The goal of these events is

to normalize the conversation about end-of-life and to talk to community members about advance care directives. Part of our work with Honoring Choices Indiana – North Central (HCIN-NC) is helping facilitate the completion of advance care directives. Elleah, who completed Respecting Choices® First Steps facilitation certification, worked with Sr. Eileen Wrobleski to assist residents at Oakhaven in Bremen. In addition, one of our HCIN-NC volunteers, retired palliative care nurse Michael White, was recently certified as an Honoring Choices instructor. This now offers us the opportunity to conduct facilitator training without the need to bring in an instructor from outside the area.

Facilities

Construction is complete on the Clinical Staff Building with a few open punch list items yet to be addressed by DJ Construction and various subcontractors. Roseland staff was oriented and moved into the new building during the week of September 30th. Construction is very nearly complete at our new 12-bed inpatient facility, the Ernestine M. Raclin House. We anticipate the building being turned over to us by DJ Construction on November 13th. Furniture is scheduled for installation on November 14th and 15th with a ribbon-cutting/dedication event to take place on November 19th. Following that event, work will begin on completing punch list items and installation will begin on the data, AV and telephone systems. Finishing touches should be complete by year-end with full occupancy soon thereafter. The Cedar Street residential home is under contract at a purchase price of $384,900. The Buyers need to sell their home in Virginia before setting a closing date. In addition to the Mishawaka Campus, the Hospice Foundation has assumed responsibility for maintenance of all HF-owned facilities (Elkhart and Roseland) as well as those leased by CHC (Plymouth and La Porte). We're currently working with Jeff Helman and Brad Sechrist on plans to remodel and transform the Roseland facility into the new home for Milton Adult Day Services.

GLOBAL PARTNERS IN CARE

We have begun our end-of-year assessment which we will share in January. In the meantime, below are on the key areas identified during our mid-year review:

- Fundraising: We are making progress in this area. We recently received a $10,000 grant from the Ronald W. Naito MD Foundation to support our Partnership Program. We continue to work closely with Chris Taelman to advance this area. In addition, GPIC is now included as an area of focus for the larger HF fundraising strategy, which is being guided by Dan Reagan, who was our consultant for the Crossroads Campaign.

- Recruiting US partners: This was a focus of the grant (above) and will be a high priority activity for 2020. To date in 2019 we have established one new partnership (Delaware Hospice and NAPCare) and there are three more potential partnerships we are hopeful will launch in the next several months.

- Nepal: Further developing our engagement in Nepal and the region will be a focal area in 2020.

Partnerships

We currently have 40 partnerships. Caris Healthcare recently ended their 12-year partnership with Hospice Ethiopia (who is already re-partnered with Snowline Hospice and that is going very well). Dekalb Hospice / Northwestern Medicine ended their partnership with Knysna Sedgefield Hospice in South Africa. This was a well-established partnership, but the US partner was bought by JourneyCare, a large hospice / palliative care organization that was not interested in continuing the partnership. 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 as well. Our Advisory Council has played a big role in growing several of these partnerships. We are in conversation with a few potential new US partners. We hope to launch a partnership between the Missouri Hospice and Palliative Care Association (MHPCA) and Kenya Hospices and Palliative Care Association (KEHPCA) very soon. Amedysis is interested in partnering and we are working with GPIC Advisory Council member, Lori Williams, on establishing this partnership. Her leadership team is supportive, and we have identified a hospice in Kenya to partner them with. We are waiting on the green light from Lori to get this one set. Hospice of Acadiana reached out to us with interest in establishing a partnership. They are the largest not-for-profit hospice in Louisiana. We have had a few follow up conversations and are hopeful we can establish a partnership in the next few months. We are setting up a conversation with World Hospice and Palliative Care Association to discuss how we might expand our partnership model in the UK.

Research and Education

We continue to stay engaged in the following research collaborations. The university and organizational partners are very supportive of our role as a collaborator on these projects. One project is Understanding the Challenges of the Aging Population in Ghana. GPIC remains in partnership with the University of Alberta and APCA on this project. We are currently writing another grant application to the Social Sciences Research Council of Canada to advance the project. This is for a large Partnership Development Grant. APCA will play a key role in this grant. We have continued to advance planning for a pilot project with University of Kansas Medical Center (KUMC) and ELCT and have also brought University of Notre Dame (UND) into the project. We will have a master's student from UND who will work closely with KUMC and ELCT to help pilot the project in 2020.

Palliative Care Leadership Center Project

Anne Monroe, a representative from Bluegrass Care Navigators, attended the APCA conference with us in September. This was a great opportunity for her to learn more about palliative care in the African context to help us advance the project. We were able to have a meeting with a majority of APCA staff to brainstorm with Anne which led to three possible areas of focus for launching the project with APCA:

- Streamlining strategic planning / organizational support resources for national associations (and other members);
- Palliative Care Standards / Guidelines revision for African context;
- Study on costing of palliative care – needed for policy development.

University Collaborations

The Palliative Care working group of the Consortium of Universities for Global Health (CUGH) submitted a proposal for a panel discussion at the CUGH 2020 conference. APCA and WHPCA were invited as part of the panel. It was, however, not accepted and the working group is discussing the best way to move forward with continuing the discussion at the conference. Lacey, in her role as an adjunct faculty member at Notre Dame, was awarded a small partnership development grant along with Uganda Martyrs University from CUGH. This builds on existing work between UND, PCAU and the Center for Hospice Care / Hospice Foundation on collecting palliative care data in Uganda. While not directly a GPIC project, this may give us more opportunity to raise our profile and possibly open doors for additional funding.

COMMUNICATIONS, MARKETING, AND ACCESS

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

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities in an effort to build relationships and generate referrals. During August through October our four Professional Relations Liaisons completed 1,486 visits to current and potential referral sources within our service area. They accomplished 529, 455, and 502 visits in August thru October respectively.

Peter Ashley, who joined us in May from the Hospice Foundation as the newly created Community Relations and Engagement Liaison has accepted a position with Hanover College as their Vice President of Communications & Marketing. His focus since May has been two-fold; to lead CHC in attaining We Honor Veterans Level 5 before the end of the year and to update our website to reflect the sites overseen by the Foundation, which Peter spearheaded. Our Professional and Community Liaisons have hosted 30 Vet-to-Vet Cafes in both institutional and public settings. These cafes are designed to offer veterans an opportunity to interact with other vets and allows CHC to thank and honor them for their service. We will be searching for a replacement for Peter that will oversee non-medical referral sources such as veteran groups, community organizations, faith communities and chambers of commerce.

Access

Due to a change in our phone system, we are temporarily unable to track the total number of incoming calls to our Admission Referral Specialists. In October we surpassed the number of original admissions for the YTD as compared to 2018, with 1.79% increase. The average daily census (ADC) in hospice has increased 2.97% while home health has increased 72.22% for an overall increase of 6%. We've also seen an increase in the number of our patients in facilities (Extended Care Facilities, Assisted Living Facilities and Group Homes) of over 22% compared with the same time last year. The number one reason for patients not admitting continues to be death before admission over 70% 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, 65% of those also being from hospitals.

Website

Our new website is due to launch in the next few weeks. In the meantime, the number of new overall users has increased 27.95% over the same period last year, while the new users have increased 30.3% for the same time. Also increasing was the number of sessions at 17.51%. One of the additions to our new website will be a virtual tour of the new Ernestine M. Raclin House. This virtual tour will allow patients and family members to view the different areas available to them should they have the need. It also will allow the community to view it without intruding on the privacy of patients. If successful, we will be adding Esther's House in the future as well.

Social Media

Facebook (Center4Hospice)
Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook as a means to communicate information and events. CHC reached 107,259 people for the period of August-October, and had 6,574 reactions, comments and shares. Our leading post was on September 16th: Overview /Center for Hospice Care. It pointed out how scary the phone call to hospice can be and provided first names of our Referral Specialists. It reached nearly 4,000 people and generated 413 reactions, comments and shares. The second most viewed posting was on August 29th and explained that CHC offers both hospice and palliative care and the difference between the two. It reached 3,840 people and generated 348 reactions, comments and shares, as well as 92 post clicks. We currently have over 4,200 Facebook followers.

Digital Overview

Digital report represents activity from August through October of 2019. The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of August-October it generated 159 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 3.79 % and we continue to be high at 8.99%.

CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are numerous home health and hospice patient care policies on the agenda at attached to this board packet. There are too many to list individually. These policies are reviewed every three years and many have been updated to reflect those reviews as well as more accurately mirror current practices and changes in federal / state rules and regulations. There are no new policies and the majority of changes are not significant. Sue Morgan, DON, will be on hand to answer questions you might have.

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MET IN OCTOBER

The National Hospice Executive Roundtable met at member program The Empath Health in Clearwater, FL. Topics included program updates, positioning for the potential Medicare Hospice

Managed Care carve out, software for advance directives Additionally, we toured one of the Empath Health campuses and saw their HIV/AIDS programming. The program, with eight separate entities and eight separate boards of directors, has an average daily census of 1,300 hospice/home health/palliative care patients and 325 PACE clients. It is the largest non-profit hospice program in America. It should be noted that Florida is a certificate of need state most hospice programs in the state have no competitors.

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

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

A twelfth participate will be joining in January. Dian Backoff is Executive Director of Catholic Hospice in Miami Lakes and Fort Lauderdale, FL.

BOARD COMMITTEE SERVICE OPPORTUNITIES

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

ELECTION OF NEW BOARD MEMBERS; RECOGNITION OF MEMBERS GOING OFF

We will be electing new board members at this meeting. There is a short bio statement on Roland Chamblee, Jr. and Kurt Janowsky attached to this report. We will also be thanking Carol Walker and Tim Portolese for their six years of service to the CHC board.

BOARD EDUCATION SECTION

The board education section will be an update on Milton Adult Day Services, the repurposing of the Roseland facility for both Milton and the Caregivers Connection at Milton Village to be operated by Alzheimer's and Dementia Services of Northern Indiana, the recent visit from the dementia care

experts, Vivium Group, from the Netherlands November 5 – 8, grants we have received so far, future fundraising needs and our collaborative efforts with REAL Services on this project. Karl Holderman will be covering programming as CHC's lead on Milton and Mike Wargo will be covering fundraising, Helman-Sechrist Architecture, and the timeline for completion.

OUT AND ABOUT

I attended the National Hospice Executive Roundtable meeting October 6-8 in Clearwater, FL

I attended Hospice Action Network and NHPCO Issues session meetings in Orlando FL on November 2-3.

Several staff, including Sue Morgan, attended the NHPCO Interdisciplinary Team conference in Orlando, FL November 4-6.

Several staff, including Craig Harrell and Mike Wargo attended the annual Medicine Ball for the Indiana University School of Medicine on November 9th.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

Volunteer Newsletter for August, September and October 2019.

Board Committee Opportunity Sheet

Hospice News article, "Senators Introduce Bill on Hospice Quality, Transparency"

NHPCO News Release regarding bipartisan legislation to enhance oversight of hospice

Hospice News article, "MA Carve-in May Hurt Quality"

Press release, "Center for Hospice Care Honors Veterans during 'The Wall that Heals' Event"

VALPOLIFE.COM story, "Improving the Quality of Living at Center for Hospice Care"

VerywellHealth article, "How For-Profit Hospices Compare to Nonprofit Hospices"

Disrupt News article, Adult Day Industry Trending Toward For-Profit

WSBT-TV news story of "Local Veterans have 'Vet-to-Vet Café' sessions once a month to talk

Internal Medicare Compliance Committee Minutes of 08/22/19

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

Year to Date October 2019 CHC Financials.

2020 CHC Budget

Common Abbreviations (always handed out at board meetings)

NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, February 19, 2020 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 .

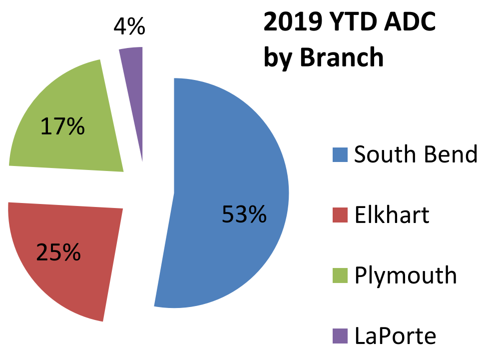
# # #

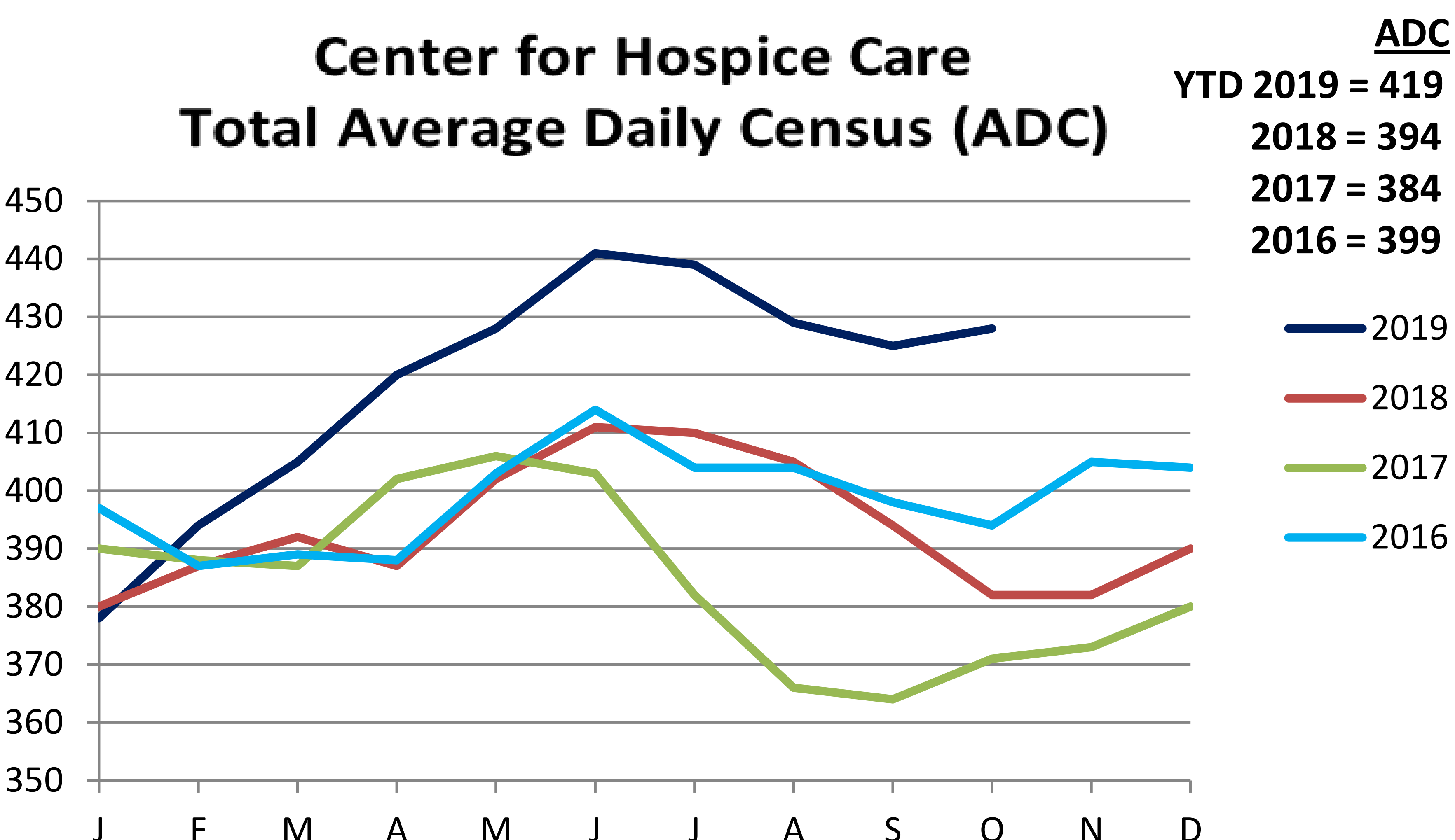
Center for Hospice Care

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	429	237	111	66	15
S	425	229	114	69	13
O	428	234	114	68	12
N					
D					
2019 YTD Totals	4187	2226	1057	727	178
2019 YTD ADC	**419**	**223**	**106**	**73**	**18**
2018 YTD ADC	395	210	89	83	13
YTD Change 2018 to 2019	24	13	17	-10	NA
YTD % Change 2018 to 2019	**6.0%**	**6.0%**	**18.8%**	**-12.4%**	**NA**




Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2019 = 419
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

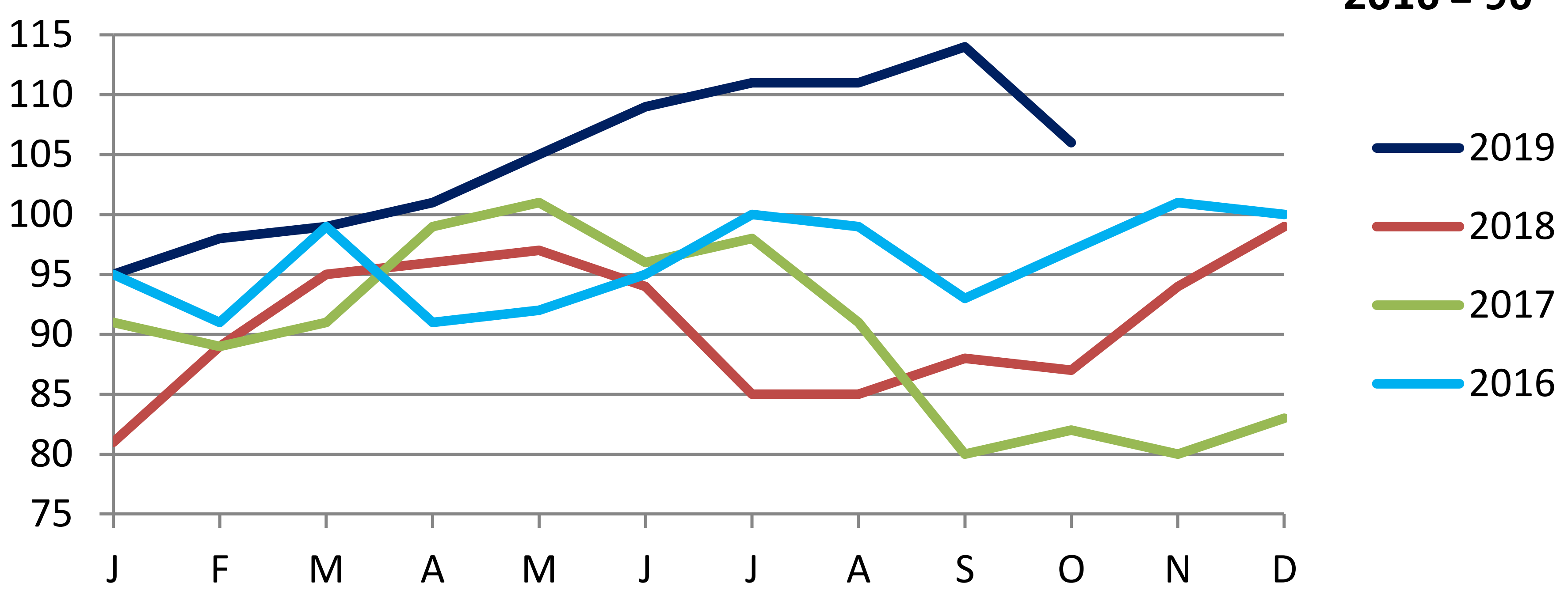
South Bend
Average Daily Census

YTD 2019 = 223
2018 = 208
2017 = 225
2016 = 228

260
250
240
230
220
210
200
190

J F M A M J J A S O N D

2019
2018
2017
2016


Elkhart
Average Daily Census
ADC
YTD 2019 =105
2018 = 91
2017 = 90
2016 = 96
115
110
105
100
95
90
85
80
75
J
F
M
A
M
J
J
A
S
O
N
D
2019
2018
2017
2016

ADC

2018 = 82

2017 = 69

2016 = 75

Plymouth
Average Daily Census

95
90
85
80
75
70
65
60

J F M A M J J A S O N D

2019
2018
2017
2016

ADC

YTD 2019 = 18

2018 = 13

28
24
20
16
12
8
4
0

J F M A M J J A S O N D

2019
2018

Center for Hospice Care
October 31, 2019

	Prior Year	Budget	Actual
Patients Served	1,761	1,788	1,785

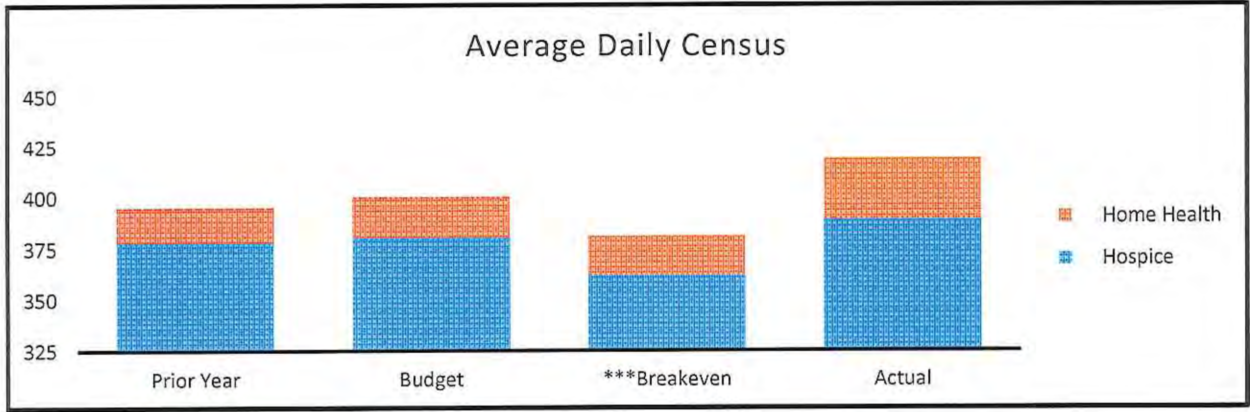
Patients Served

2,000
1,900
1,800
1,700
1,600
1,500
1,400
1,300
1,200
1,100
1,000

1,761
1,788
1,785

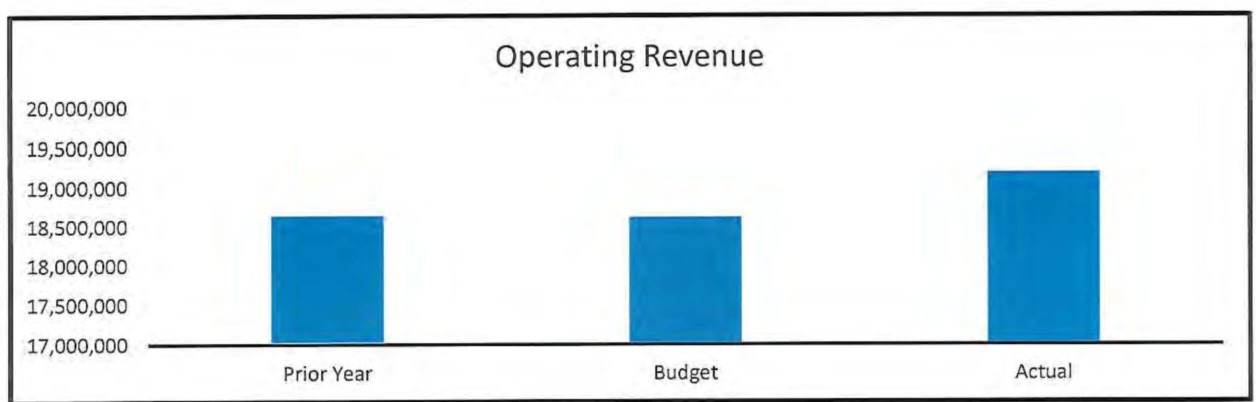
Prior Year
Budget
Actual

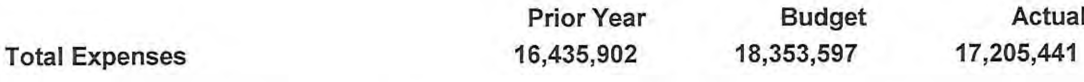
Average Daily Census	**Prior Year**	**Budget**	*****Breakeven**	**Actual**
Hospice	377.83	380.09	361.93	389.07
Home Health	17.28	20.00	19.05	29.76
Total Average Daily Census	**395.11**	**400.09**	**380.98**	**418.83**



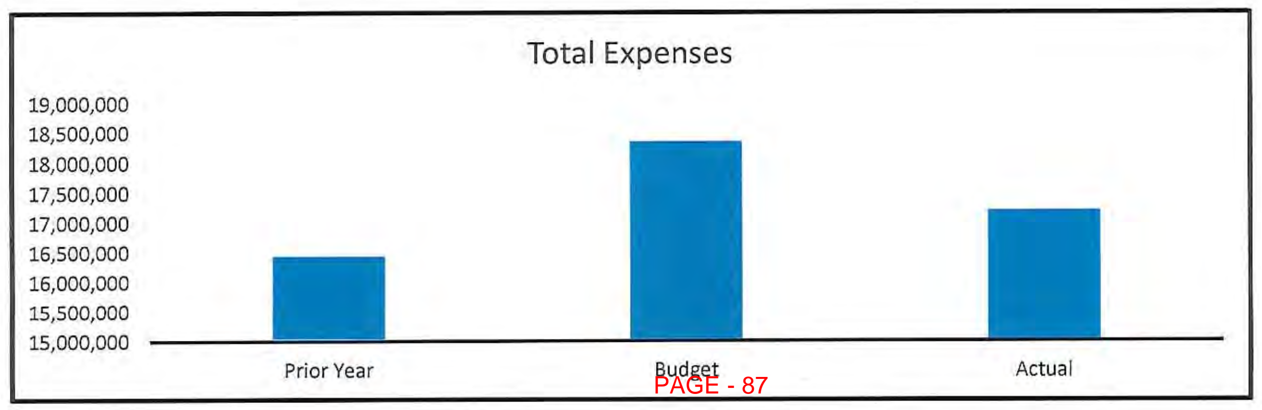
**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	18,638,126	18,618,418	19,188,147





	Prior Year	Budget	Actual
Total Expenses	16,435,902	18,353,597	17,205,441



September 2019
Volunteer Newsletter

Compassionate Support:
Perinatal & Pediatric Palliative Care

By Kristiana Donahue

When I went in for my 20-week ultrasound, our family was full of excitement and anticipation. We made predictions on whether we were going to have a boy or a girl. What we didn't expect was the news we received. Our little girl had problems, and the prognosis we received was grim. I was silent as the shock of the news absorbed every ounce of me. I continued to carry our daughter amidst all the uncertainty, and I found myself dreading each ultrasound visit.

Many of the lessons I learned along that difficult journey have been used in my role as the Volunteer Recruitment and Training Coordinator at Center for Hospice Care. There is a Perinatal and Pediatric Committee that meets regularly to make sure we are providing the best support for families that are walking similar paths. Having a well-prepared and compassionate support network makes a difference. There wasn't much I could do to change my daughter's circumstances, but I found that such a network allowed me to ask my questions and to cry. It also equipped me and my husband to have hard conversations with each other and our other children. I have held hope in one hand and dismal realities in the other. I have fallen exhausted after hours of sitting bedside in the NICU. And while my story may not be everyone else's story, we may share experiences. Please know that at Center for Hospice Care, you will be supported by a compassionate and empathetic team of individuals.

Center for Hospice Care provides perinatal and pediatric palliative care. Perinatal palliative care is compassionate support for parents and families who find out during pregnancy that their baby has a potentially life-limiting condition. Care focuses around the needs of the family in a holistic nature. This support is provided from the time of diagnosis throughout the baby's life. Perinatal palliative care helps parents embrace whatever time they have with their child and make it meaningful, memorable and family-focused. Pediatric palliative care provides quality of life for the child and support for the family. Children within our care can continue to receive treatment for their disease, and also benefit from palliative care, which focuses on quality of life.

Sarah Sieh, Social Worker

As a social worker, I seek to support our families in many ways. I create a safe space in which to share. I want to hear the family's journey and the child's story, to allow the family to share anything that may be hard for others to hear…. I provide support to siblings, and I listen to the parent's worries, hopes and fears. We discover ways to cope. I am a sounding board for families and loved ones as they make hard decisions.

Story continued on Page 6

Inside this issue:

Welcome new Plymouth VC	2
Birthdays	2
Mark Your Calendars	2
In Loving Memory	2
Volunteer Spotlight: Larry Milanese	3
Welcome to the Team	4
Volunteer Needs	4
Welcome New Volunteers	4
10 Years of Partnership	5
Training Reminder: Families at Death	5
Comments from Our Families	5
Compassionate Support, Continued	6

Mark Your Calendars

11th Annual Bike Michiana for Hospice & 34th Annual Walk for Hospice

September 8, 2019

https://foundationforhospice.org/events/

Volunteer "Bring a Friend" Brunch

September 11, 2019

9:30am at the Plymouth CHC office

Do you know any Veterans or Musicians that might want to join our team?

Get to know our Plymouth Volunteer Team!

NEW Volunteer Orientation

Tuesdays & Thursdays,

October 1, 3, 8, 2019

9:00am-Noon

October 10, 2019

9:00am-3:00pm

Mishawaka Campus

Contact Kristiana Donahue, Volunteer Recruitment and Training Coordinator, at donahuek@cfhcare.org if you have questions.

Birthdays

9/7
Mary Perron

9/8
Mary Adams

9/8
Barbara Adcock

9/10
Molly Hepperle

9/11
Kathleen Hojnacki

9/12
Becky Donahue

9/12
Nancy Whipple

9/14
Cheryl Barker

9/16
Sharon Leamon

9/16
Max Rarick

9/18
Emma Mazurek

9/21
Judith Atkinson

9/22
Wayne Fisher

9/22
Jim Rahilly

9/23
Lino Rodriguez

9/24
Sylvia Ford

Welcome New Plymouth VC

We are excited to welcome Kim Morrison who recently started as the new volunteer coordinator in Plymouth.

Hello! I am Kim Morrison and I am very excited to be a part of Center for Hospice Care!

I've been married to my husband, Jamey, for 27 years. We both grew up in Plymouth, but moved to Culver about 15 years ago. Jamey is a Supervisor at Summit Manufacturing in Bremen. We have two amazing daughters. Mandy is 21, and is a Junior at Goshen College, where she is majoring in Accounting, and minoring in Music (Flute). Sarah is 19, and is a Freshman, majoring in Nursing, minoring in American Sign Language, and playing on the Goshen College Volleyball team.

I graduated from Goshen College in 1993 with a Bachelor's Degree in Music Education. I spent 18 years teaching Elementary Music, but had to leave teaching after having a temporal lobectomy. I've spent the last few years volunteering throughout the community. I enjoy directing the Marshall County Melody Makers, singing at the Wild Rose Moon, and attending my daughters' concerts and games.

I am very excited to be the Volunteer Coordinator at such a wonderful organization!

Volunteer Spotlight
Larry Milanese, Elkhart

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

I have been a volunteer with CHC since November 2014. I spend time with patients.

Why do you volunteer with CHC?

To get to know people and about their lives. I get to learn about their strengths, and sometimes weaknesses, in difficult circumstances. Having some experience with illness and having spent time in a nursing home,
I sometimes have a somewhat different perspective on what folks are going through. It is very interesting and fulfilling getting to know people and spending time with them.

What is your favorite food and why?

Eggs Benedict. My wife has the best recipe ever.

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

Italy, because of the art and it's a romantic country. All my grandparents are from Northern Italy.

What is your favorite quote?

"God is in charge of my life, I am in charge of my attitude."

Favorite movie?

Romantic comedy, musicals and Disney

Favorite book and why?

Westerns by Louis L'Amour. We have been able to spend considerable time on horseback in the Rockies riding and rounding up cattle. We like to "play cowboy".

Favorite music?

I like many kinds of music but easy listening most, both vocal and instrumental. My favorite song of all time is "I don't mind being alone if I'm alone with you" by the Mills Brothers.

Where are you from originally?

Elkhart all my life except for time in the military.

What do you like to do in your spare time?

Nothing is better than doing anything with Ethel.

Tell me a bit about your family.

Married 52+ years. We have four sons and are expecting our 10th grandchild in August. Best of all is that they all live in this area.

What talents/hobbies do you enjoy?

I am addicted to travel. We have been blessed to have traveled quite a bit. I also enjoy woodworking and being outdoors as much as possible. I occasionally still do some advertising drawings on the computer.

"Larry has been a volunteer with CHC since November 2014. He has a very compassionate heart. We are very fortunate to have him as part of our volunteer team!"

Marlane Huber,

Elkhart Volunteer Coordinator

Welcome to the Team

Stacey Annoreno-O'Brien
South Bend IPU RN

Natalie Barnes
QA/Medical Records Coordinator

Melissa Burpee
Triage RN

Jennifer Hall
Triage RN

Dr. Karissa Misner
Hospice Physician

Glenna St. Julien
Plymouth RN

In Loving Memory

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

Norah Ray, South Bend

Brother, Fred Toth,

August 15, 2019

Volunteer Needs

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.

Vietnam Traveling Wall, Plymouth

Friday, Sept. 13- 3pm-7pm

Staff a table and tent, hand out veteran booklet and Vietnam vet pins as appropriate. Help set up and tear down.

Estimated volunteers needed: 2-4

Contact Kim Morrison if interested.

Pet Visitors

We don't have many pet visitor volunteers at this time. We would love to add more pet visit volunteers to our team. Pets must be certified through a reputable company, such as Pet Partners or Therapy Dogs International.

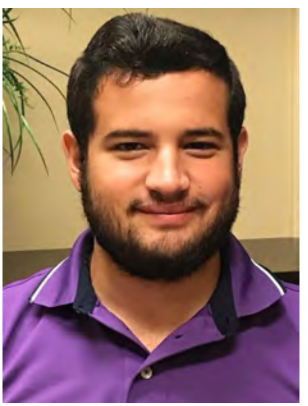
Specialty Volunteers

Plymouth specifically mentioned needing specialty volunteers, such as people willing to do handyman services.

Please notify Kim Morrison if you might be interested.

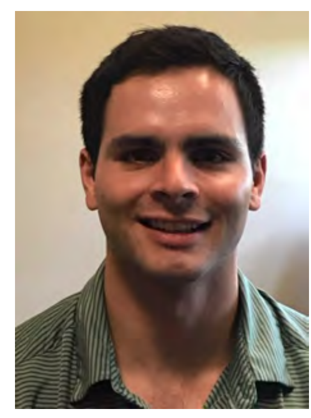
Welcome New Volunteers

Help us welcome these new volunteers who finished their training this month. Please introduce yourself to these volunteers as they begin their service with CHC.



Evan Curl
LaPorte

Wayne Fisher
South Bend



John Huber
South Bend

10 Years of Partnership

On September 2nd, Kristiana Donahue, Volunteer Recruitment and Training Coordinator along with Annette Deguch, Bereavement Counselor will be traveling to Uganda to present at the joint PCAU—Uganda Cancer Institute conference next week. They will be joining Mike Wargo, COO, Hospice Foundation, Lacey Ahern, Manager of International Programs, Denis Kidde, International Program Coordinator and Cyndy Searfoss, Director of Collaborative Partnerships as they all celebrate the 10 year partnership of CHC and PCAU (Palliative Care Association of Uganda). Following the two day conference, we will be joining PCAU staff to travel to different locations and learn more about their work across Uganda.

If you are interested in keeping up with their adventures, be sure to watch for updates on the CHC Facebook page:

https://www.facebook.com/Center4Hospice/

Training Reminder

Families at Death

- Losses are different among family members although the same person died.
- Individual differences among family members as to how they will grieve may be present.
- Problems of competing needs may arise.
- Differing expressions of grief may be present.
- Past hurtful family relations may surface.
- Closeness of family members can be both beneficial and detrimental.
- Problems arising from protection such as lack of communication and overprotection.
- Expression of emotions may be very varied.
- Strong emotions may be present.
- Family arguments may erupt.

Comments from Our Families

- When mamma was sick and was at Hospice House, everyone there was also very nice. Mamma loved them and called them her very good friend. I would say yes to that too.
- I believe the hospice care my brother received helped him pass on as peacefully as possible. I would strongly recommend them in the future.
- Thank you so much for your support in this most difficult year of grief. I particularly appreciated the periodic newsletter that fit my progression through the year in a very timely manner.
- .Our family is very grateful for everything our Hospice team did for us and our family members. They are true super heroes.

Kathy Eash, Nurse Practitioner

I am part of the medical team, composed of a physician and two nurse practitioners, who care for our pediatric patients' medical needs. I often work directly with the physicians and can perform developmental exams and also manage any new conditions that may arise. Many times office visits can be avoided with the involvement of the CHC team. The pediatric team has more than 30 years of experience working in the pediatric field.

Abby Eicher, RN Case Manager

Families get to know me well as I set a schedule with them and make visits to the home. My goal is to make sure the child is comfortable, and I will assess this each time I come. I will communicate with the child's doctor or nurse practitioner to address any issues. I order supplies and medications. I want to make sure the family is comfortable caring for their child at home, so I can provide any education needed to make sure they feel equipped to do so. I will support the parents and family in any way I can and I'm available 24/7 for any question or concern. I am a Certified Hospice and Palliative Pediatric Care Nurse and have a passion to give these children the best quality of life we can.

Holly Farmer, Bereavement Counselor

I am a counselor that works with our perinatal palliative care families. I meet families where they are, offer support and I listen as they share their understanding of what is happening with their baby or babies. I will meet with them during their pregnancy to listen to their concerns, their fears, their sadness and at times their intense sorrow about their baby's diagnosis. We can talk about the birth plan, looking at their different options, and we can talk about how to tell others about what is happening. Providing education on how to talk about the baby's illness with siblings is another role of the counselor. When the family wants to create memories, I will encourage them to do so during the pregnancy and then offer ideas for how to do this when needed. Once their baby is born, I can provide support as needed during their baby's life. After their baby dies, our support continues. We provide individual, family and group counseling for those families grieving the death of their baby or babies.

Kristiana Donahue, Volunteer Recruitment and Training Coordinator

I work with our volunteers to equip them for their role supporting families. We have a designated team of volunteers who have a passion for working with our pediatric patients and their families. Volunteers can support families in many ways, from being with the child while parents take a much-needed nap, to doing some light housework, to even walking the dog. Volunteers provide a listening ear, and can help with memory making items and activities. Volunteers are an extension of the Center for Hospice Care team as well as an extension of our own community. I know how important it was for our family to have individuals to walk with us on our journey. Our volunteers are willing to walk with our families on theirs.

Arlin Cochran, Chaplain

As a Chaplain, I care for the spiritual needs of our families. Spiritual care focuses on what is most important to the family and the child. I'm here to journey with the family as they find hope and meaning beyond their child's illness. I am clinically and theologically trained and know that listening is the first step in learning from the child and the family. Genuinely hearing their spiritual needs allows me to help them work through their pain so they can find true peace within the context of their own belief system.

Pediatric Volunteers

We have a recently formed group of volunteers who want to work with our pediatric patients. We need volunteers open to do any of the following: home visits, scrapbooks, photography sessions and possibly more. If you're interested in being a pediatric volunteer, please let your volunteer coordinator know.

October 2019

Volunteer Newsletter

A Ugandan Album: Snapshots of CHC's Exchange Visit

The 2nd Uganda Conference on Cancer and Palliative Care

CHC staff, Annette Deguch and Kristiana Donahue, presented at the Uganda Conference on Cancer and Palliative Care in September. Annette shared about yoga and it's physical benefits for grieving individuals. Kristiana presented on essential tenants for an effective volunteer program. Hospice Foundation staff Lacey Ahern, Mike Wargo and Denis Kidde, chaired sessions and were an integral part of support for the international conference. CHC received an award for its vital 10-year partnership with the Palliative Care Association of Uganda (PCAU).

Kawempe Home Care

Kawempe is a partner organization of PCAU. Kawempe provides free medical care to disadvantaged people living with HIV/AIDS, TB and/or cancer. They have a children's hostel for pediatric patients receiving cancer treatments at the Uganda Cancer Institute. They also empower their clients through an income-generating program. They do such wonderful work to care for those in need. Annette, pictured above, led the Kawempe staff in morning yoga. Staff begin each day with a prayer and announcements.

Pictured above is a client working on a sewing project as part of Kawempe's income-generating program. You can shop for their beautiful items online: https://kawempehomecare.org/shop

Story continued on Page 6

Inside this issue:

Welcome new Volunteers	2
Birthdays	2
Mark Your Calendars	2
We're Moving In!	2
Volunteer Spotlight: Jim Rahilly	3
Welcome to the Team	4
Volunteer Needs	4
Staying HIPAA Compliant	4
Training Reminder: Documentation	5
Comments from Our Families	5
A Ugandan Album, Continued	6

Mark Your Calendars

NEW Volunteer Orientation

Tuesdays & Thursdays,
October 1, 3, 8, 2019
9:00am-Noon
October 10, 2019
9:00am-3:00pm
Mishawaka Campus

Welcome New Volunteers

Help us welcome these new volunteers who finished their training this month. Please introduce yourself to these volunteers as they begin their service with CHC.

Faythe Lawson
South Bend

Birthdays

10/1
Ann Baucus
10/2
Noreen Buczek
10/2
Sue Ermeti
10/8
Kathryn Bowyer
10/8
Reilley Knott
10/11
Don Zimlich
10/13
Joan Hunt
10/15
Charles Lynn
10/15
Carolyn Tihen
10/18
Hugh O'Donnell
10/21
Margaret Cunningham
10/21
Ted Stanley
10/25
Janice Berger
10/27
Cindy Ward
10/30
Sharon Marshall
10/30
Kay Swett
10/31
Donna Kooy
10/31
Robert Putnam

We're Moving In!

We are very excited that the time has come for our South Bend staff to move to the brand new clinical building in Mishawaka the first week of October. VC, Debra Mayfield, will be in the Mishawaka office in the HR wing (this is not located in the new building). Please be patient with staff during this transition, as it can take a few days to get settled.

The South Bend location will still house our IPU staff and patients. If you are an IPU volunteer, you will still be reporting to the South Bend IPU for a little while longer. We will keep you posted on the projected timeline for our IPU move. We are very excited about the move and look forward to the opening of the Raclin House soon!

Volunteer Spotlight
Jim Rahilly, South Bend

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

I joined CHC training in 2005 and just completed 14 years. I have done home visitations for a number of years, 11th Hour (to assist between the hours of midnight and 6:00am) and also the inpatient care unit (Sunday evenings 4:00-7:00pm).

Why do you volunteer with CHC?

I am retired, single and have time on my hands, which I use for service and ministry. It is my life and my calling at this time. I enjoy what I do! I feel qualified for it with the yearly CHC training and my past experiences.

Tell us a bit about your volunteer background.

I like to volunteer because it has to do with my background as a part of my youth group in my home town, an altar boy at church and watching my parents volunteer in various ways. I was involved in youth programs both in Kenya and Uganda. I was trained by St. John Ambulance (a British-based First Aid/Nursing program) as a volunteer brigade member. I was trained in first aid and called upon to use these skills at national celebrations, at horse races, at the Pope's visits to Kenya, at the State House and other public events. I rose in rank first as a division officer, then City Corps Superintendent and finally as Area Secretary. I was appointed to the national board of the brigade and became one of the officers preparing and judging First Aid competitions. Later I was trained by a group of nurses from England in home nursing skills. I, along with three other Kenyans, prepared and published the first Kenyan First Aid Manual.

When I returned to the USA in 1984 for a 5 month course at Notre Dame, I volunteered in the ER at St. Joseph Hospital on Friday evenings. I returned from Africa in 1996 and again began volunteering with Scout Troup 505, Audubon Society, Friends of Bendix Woods and Spicer Lake. After retiring I added Friends of Potato Creek, usher at the Morris Theater, tour guide at the Studebaker Museum, services in Loretto Church at Saint Mary's College, Local Chapter 270 AARP Board, Gardens at the Trinity Tower (where I live) and Center for Hospice Care. Over the years I've received various awards for volunteer service.

Where are you from originally?

I'm a New Yorker by birth. I was born in Oyster Bay, Long Island (home of Teddy Roosevelt), in 1937, second of five children. I went to St. Dominic's grade school and stayed in Long Island for high school. I went to the University of Notre Dame as a seminarian and graduated in 1960. I completed my studies at Holy Cross College in Washington DC in 1964.

"Jim's passion for people and gentle personality make him a great fit for the hospice population. His long term dedication CHC has truly helped this agency fulfill it's mission to improve the quality of life for those we serve!"

Debra Mayfield,

South Bend Volunteer Coordinator

Welcome to the Team

Nadia Beavers

South Bend CNA

James Cervantes

Elkhart Maintenance Technician

Chris Donahue

Maintenance Coordinator

Janet Harrell

Triage RN

Van Malcolm

Elkhart Case Manager RN

Duane Rowley

IT Service Desk Technician

Judy Salmon

South Bend IPU RN

Stephanie Ufkin

Nurse Practitioner

Sarah Young

PRN Referral Specialist

Volunteer Needs

Elkhart Office

- Home Visit Volunteers
- Hospitality Volunteers
- Hair Stylist/Barbers
- Massage Therapists
- Inpatient Unit Volunteers

Seeking at least one volunteer in these areas: Nappanee, Middlebury, Shipshewana and Goshen

South Bend Office

- Home Visit Volunteers
- Hair Stylist/Barbers
- Pet Visitors

Plymouth Office

- Home Visit Volunteers
- Extended Care Facility Volunteers
- Office Volunteers

LaPorte Office

- Home Visit Volunteers

Additional Volunteer Needs for Entire Service Area

- Spanish-speaking Volunteers
- Willingness to travel across service areas

STAYING HIPAA COMPLIANT

when using social media

What can healthcare providers do to help ensure HIPAA privacy and security rules are adhered to when posting online?

Here are five tips to avoid disclosing PHI when using social media.

NEVER POST ABOUT PATIENTS

It's extremely difficult to anonymize patients - even the subtlest identifier could land you and your practice in a lot of trouble.

ONLY USE SECURE MESSAGING

Only discuss or exchange patient information using HIPAA-secure messaging platforms.

EDUCATE YOURSELF AND OTHERS

Staff should always be trained and kept up to date with HIPAA compliance best practices and company social media policies.

DON'T MIX WORK AND PERSONAL LIFE

Healthcare professionals should keep their personal and professional lives separate. Interacting with a patient online could result in PHI inadvertently being exchanged in the public domain.

WHEN IN DOUBT, DON'T POST

People can make mistakes in the heat of the moment. Always take a minute, read the post back to yourself, and consider the potential consequences before hitting the 'post' button

Training Reminder

Documentation Reminders

Whether you are documenting in a chart in the ECF or on a time sheet, please remember the following:

- Use only black ink
- This is a legal medical document.
- For the IDT Flowsheet in an ECF, do not leave any open lines. Draw a line to fill in a partial line.
- Be clear & concise in documentation section; state facts only.
- Document only what you see and do - **NOT WHAT YOU THINK OR BELIEVE.**
- If an error is made, cross out with one line and initial next to error, then write correct information.
- Avoid the following words in documentation:

  -Appeared

  -Seemed

  -Looks or Looked

  -Think or Thought

  -Feel or Felt

  -More than

  -Less than

  -As usual
- Remember that the time sheet can only include what the patient said or did and what the volunteer observed.
- If you notice changes from each visit, you cannot write those comparisons on the time sheet. Volunteers can call staff and discuss these changes with staff.
- **Avoid** the following:

  -Providing any judgments, thoughts, assessments or feelings.

  -Using "White Out" or scratching out words.

  -Making comparisons about the patient.

  For example: *The patient slept more today than last week*

Contact your volunteer coordinator if you have any questions or need assistance with proper documentation.

Comments from Our Families

- When mamma was sick and was at Hospice House, everyone there was also very nice. Mamma loved them and called them her very good friend.
- I believe the hospice care my brother received helped him pass on as peacefully as possible. I would strongly recommend them in the future.
- Thank you so much for your support in this most difficult year of grief. I particularly appreciated the periodic newsletter that fit my progression through the year in a very timely manner.
- Our family is very grateful for everything our Hospice team did for us and our family members. They are true super heroes.

Road to Hope

Road to Hope is a documentary film that explores the unique challenges of orphaned children after caring for their dying parents in poverty-stricken areas of Sub-Saharan Africa.

The Road to Hope program was created to provide support for these children by enabling donors to sponsor a child for one year for only $550. This sponsorship covers costs associated with clothing, education, and healthcare needs.

Denis Kidde (pictured left) laughs with a current Road to Hope child as we visited him at his boarding school in Jinja. Mike and Rose stand next to Stephen (pictured right), who is a resident physician at a hospital in Kampala and the first Road to Hope graduate. He is a wonderful role model to the many other children on the program.

Hospice Jinja

Hospice Jinja is another partner organization of PCAU and was founded in August 2005 by a small group of local volunteers, who saw the need for a palliative care service for patients with advanced cancer and HIV/AIDS. The service is coordinated from its center in Jinja, capital of the Bosoga region, which has a population of 4.5 million. The hospice team visits and networks with the 5 hospitals in the region and also visits outreach clinics near remote villages. Many of the patients they serve live in remote areas and have very limited resources. Many of their staff do home visits which take multiple days to complete because they are so remote. We were able to go with staff on a couple home visits to see the challenges they face and the wonderful work they do to provide compassionate palliative care.

Mulago Training School for Nurses and Midwives

Mulago School of Nursing and Midwifery is a public training institution owned by the Ugandan Government under the Ministry of Education and Sports. Pictured below is the current class that is participating in a Palliative Care Certification program. This certification program takes a year to complete and each student is a current nurse looking to further their education so they can provide palliative care in their home areas. This is a very important program as Uganda desperately needs more healthcare workers specialized in palliative care to expand the accessibility. We were able to greet the class and hear some students share why they are in the class. One student said that she wants to better learn how to provide palliative care so she can return home (which is in a remote part of Uganda) and better care for those in need in her own community.

November 2019

Volunteer Newsletter

Annual Skills Validation: What is it? Why do we do it?

Inside this issue:

Welcome to the Team	2
Birthdays	2
In Loving Memory	2
Are you in a Group?	2
Volunteer Spotlight: Susan Danielson	3
Training Tips & Reminders	4
Volunteer Opportunities	4
Welcome New Volunteers	5
Comments from Our Families	5
Annual Skills Validation Continued	6

What is Annual Skills Validation and why do we do it?

We are very fortunate to have a volunteer program that trains its volunteers to provide hands-on care to our patients. Because of this level of training, volunteers are truly able to provide quite a bit of care during a respite visit in the home setting and they can assist our staff in the inpatient care units.

CHC volunteers know that each assignment is quite unique. Even though volunteers are trained to provide care in the home, some patients' families may or may not take them up on it and it may be only occasional that a volunteer will actually need to change a brief or perform another hands-on skill. As your CHC volunteer department, we want to make sure that we provide you with not only the best volunteer orientation, but the best continued training and skills development. Annual skills validation ensures that volunteers are always equipped to perform skills. We want the families to be confident in the volunteer and we want the volunteer to be confident in themselves.

Who needs to complete Annual Skills Validation?

It's a matter of training level. Level 3 volunteers have been trained on how to perform hands-on skills, such as brief changes, transfers, positioning in the bed and more. Level 2 Plus, a

Continued on page 6

In Loving Memory

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

Bill Singler, South Bend
Wife, Carol Singler
Monday, October 28, 2019

Welcome to the Team

Lori Hight
Admission Scheduling Assistant

Kashawna Marshall
South Bend CNA

Birthdays

11/1
Nancy DeMaegd
11/5
Ingrid Hirte
11/7
Martha Jones
11/7
Kristie Sherburn
11/8
Susan Danielson
11/8
Karen Goodnough
11/8
Mary Murphy
11/10
Ruth Anne Gray
11/10
Kathleen Griffin
11/11
Rebecca Lanning
11/17
Jenny Cowsert
11/18
Nancy Jackson
11/20
Karen McCormick
11/22
Elizabeth Basket
11/22
Bill Singler
11/23
Kathy Fuchs
11/23
Diane Huwaldt
11/25
Jennifer Lutz
11/25
Nellie Vels
11/29
Phyllis Hong
11/30
Phyllis Hutton Bowser

Are you in a Group?

Research shows that many people who regularly volunteer are involved in more than one organization or group. Are you involved in your church or religious organization? Are you involved in a civic group or community of some sort? To help recruit more volunteers across our service-area, we are open and willing to speak to many groups. It works best when our own CHC volunteers are already part of a group. Members of the group know and trust you. When we come to speak, you are welcome to share a few informal words. Consider asking your church or religious group, civic group or organization if they would like a speaker at their meeting or event. If you get a favorable reply, please contact Kristiana Donahue who will follow up.

Thank you for helping us spread the word!

Volunteer Spotlight

Susan Danielson, Plymouth

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

I am an office volunteer in the Plymouth office. I have been volunteering since early Spring 2015.

Why do you volunteer with CHC?

I volunteer with CHC because of the wonderful organization that they are and because it is the right "fit" for me. When I worked full time and was raising my daughter I didn't feel like I had the time for any outside volunteer work. When I retired it was always something I wanted to do to "give back", but it had to be the right "fit". I looked at other organizations for volunteering, but it just wasn't right. I had prior knowledge of CHC when my older sister died from cancer, so I knew of CHC and the wonderful help they are to patients and families. I found out later that they were looking for office volunteers so it all just came together.

What is your favorite food?

My favorite food is SHRIMP! Growing up in Culver there were few restaurants back in "my day". Friday nights most adults would congregate to the Corner Tavern which was well known for their fish, chicken, or shrimp. My dad would often bring us home fried shrimp dinners. Thus my love of shrimp began. Needless to say one of my favorite restaurants is Red Lobster!

What is your favorite quote?

I do have a favorite quote, although many. My daughter passed away three years ago and this one means the most.

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

Favorite movie?

Favorite movie still has to be "Dirty Dancing". Love the music, love the story line, and of course the dancing. I used to love to dance! So all these things put together in one movie makes it easy to watch over and over.

"Susan is a dedicated, dependable volunteer, and we are so fortunate to have her as part of our team at the Plymouth office!"

Kim Morrison,

Plymouth Volunteer Coordinator

Volunteer Needs

While we are always looking for Home Visit Volunteers across the area, we also have a need for the following:

South Bend

- Hairdresser
- Barbers
- Pet Visitors

Elkhart

- Hairdressers
- Barbers

Plymouth

- Hairdressers
- Barbers
- Veteran Volunteers
- Office
- Hospitality
- Tuck-In

LaPorte

- Any opportunity

Training Tips & Reminders

We Honor Veterans Training

As you know, Center for Hospice Care is a proud Level Four Partner in the "We Honor Veterans Program" – a collaboration between the National Hospice and Palliative Care Association and the Department of Veterans Affairs. This program helps ensure that veterans receive the best possible and most appropriate end-of-life care possible.

Until recently, Level Four was the highest level of partnership. "We Honor Veterans" created a Level Five partnership to continue to encourage partner organizations to increase veterans' outreach and programs.

Center for Hospice Care is determined to achieve the Level Five designation, and that requires all volunteers to participate in training specific to veterans. The following training must be completed by all volunteers.

Volunteers

Review the NHPCO Standards of Practice for Hospice Programs (2019)

View the videos:

- 15 Things Veterans Want You to Know https://player.vimeo.com/video/226368040 (17:16)
- A Tribute to Vietnam Veterans https://youtu.be/aVeBtnfAxP8 (4:48)
- View the webinar https://www.wehonorveterans.org/moral-injury-vietnam-veterans-webinar (1:28:45)

To help CHC be able to file for our Level Five this year, volunteers should complete the training by Friday, November 22nd, 2019.

We will also be providing screenings for those who would prefer to come into one of our offices.

Elkhart Campus

Friday, November 1, 2019, 1:00-3:30pm

Friday, November 8, 2019, 10:00am-12:30pm

RSVP to Marlane Huber at (574) 970-0401 or huberm@cfhcare.org by 10/30/19.

Mishawaka Campus

Wednesday, November 6, 2019, 1:00-3:30pm

Friday, November 15, 2019, 9:30am-12:00pm

RSVP to Debra Mayfield at (574) 243-3127 or mayfieldd@cfhcare.org by 11/4/19.

Plymouth Campus

Wednesday, November 6, 2019, 9:30-12:00pm

RSVP to Kim Morrison at (574) 243-2411 or morrisonk@cfhcare.org by 11/4/19.

Welcome New Volunteers

Help us welcome these new volunteers who finished their training this month. Please introduce yourself to these volunteers as they begin their service with CHC.

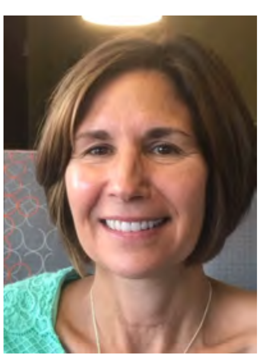
Left to Right

Dennis Thornton
Plymouth

Kathleen Matuszak
South Bend

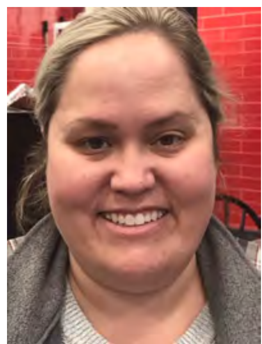
Marti Skrzeszewski
South Bend

Steven Madar
South Bend



Lana Zeltwanger
South Bend

Cathy Schiff
South Bend



Carmen Sheets
Elkhart

Left to Right

John Couri
South Bend

Kate Brown
South Bend

Comments from Our Families

- Everyone involved in my mother's care were awesome. The nurse and chaplain made the transition better understood. I thank all of you truly from my heart.
- The nurse was really "there" for us. She always took time to talk and answer questions. She was an invaluable resource during a difficult time. Thank you.
- Our nurse was very kind and compassionate to my mom and very understanding to me. Always took time to listen to me and got what I needed to take care of my mom. Never appeared to rush in and out.
- Your team by far was exceptional. I would not have been able to care for him at home without them. The kindness of the team exceeded anything I could have asked you. Thank you for your love and support.

Continued from page 1

newer level for CHC volunteers, allows volunteers to help with mouth care and feeding; however, they are not trained to provide the other hands-on skills. A Level 2 Plus volunteer needs to review mouth care and feeding skills annually, which can be done at home with online training. We also provide opportunities to view the video at screening events. Level 3 volunteers, those who are home visit volunteers or IPU volunteers, need to complete the annual skills validation once a year. Last year we offered it in July and scheduled appointments. This worked quite well and we were able to complete validations within a 30 minute time slot. If there are any skills that need retaught, we have the time to do so.

New Changes in 2020

While Annual Skills Validation is still relatively new, we have been working on developing it and making it the most efficient system.

Two Skills Validation Days

We will be coordinating two skills validation days a year: one in January and one in the summer. For snowbirds, you can keep an eye out for the summer date. For those who plan summer vacations, you can come to the one in January.

For those of you who completed the skills validation day last summer, you have the option to attend the one in January or the one in the summer. You just need to complete one of them a year to meet your requirements.

We will be having all of the skills validation days at the Mishawaka location. We have a permanent and beautiful room in the new clinical building! This houses all the supplies that we use for skills validation. Our volunteers also get a chance to see our beautiful new building!

New Videos for Review

We are working on a new set of training videos that we hope to be available in 2020. These videos will be available for your review at your convenience, probably on our You Tube channel. When a volunteer receives a new assignment and learns that the patient may need some hands-on skills, the volunteer can review any of the videos that might prepare them for that patient. We hope that this will become a very valuable resource for our volunteers.

Current IPU Volunteers

Our first plan for IPU volunteers was to validate them during the IPU shift. We tried that this past year and it isn't working as well as we had hoped. It is quite demanding logistically. Therefore, moving forward we are asking our IPU volunteers to take part in one of the upcoming skills validation days. Some of the IPU volunteers have already been validated this past year; however, some have not.

During the Annual Skills Validation Day this past summer, I heard many positive remarks from the volunteers completing it. Many thought that it was quite helpful and reassuring to them. This is exactly what it is meant to do.

If you have any questions, please either contact your Volunteer Coordinator, or Kristiana Donahue, Volunteer Recruitment and Training Coordinator at donahuek@cfhcare.org.

Bi-Annual Skills Validation Day

Tuesday, January 14, 2020

Location: Mishawaka Campus

Time Slots: 30 minute time slots

Time slots begin at 8:00am

Last one at 5:30pm

Lunch from 1:00-1:30pm

To schedule your time slot, call or email Kristiana Donahue at

donahuek@cfhcare.org

Or (574) 286-1198

Summer Skills Validation Day

More Information to Come

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.

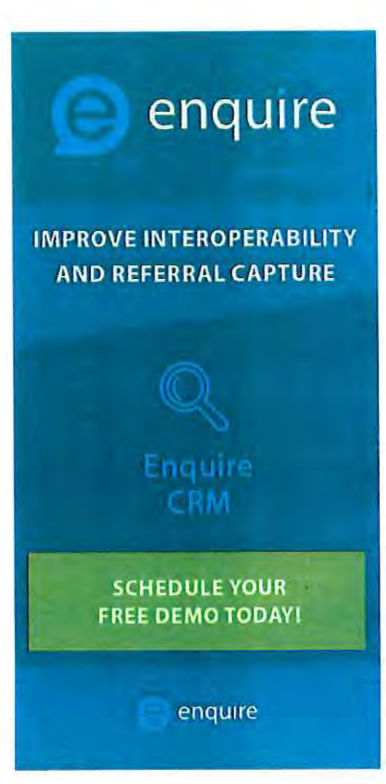
Bylaws Committee
The Bylaws Committee shall consist of the Executive Committee of the Corporation and other appointees by the Chair of the Board of Directors in such numbers as they deem necessary. It shall have the responsibility of reviewing the Corporation's Bylaws at least once every three years.

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.



LEGISLATION

Senators Introduce Bill on Hospice Quality, Transparency

By **Jim Parker** | November 7, 2019

forcal35

U.S. Senators Rob Portman (R-Ohio) and Ben Cardin (D-Md.) have introduced a new bill, the Hospice Care Improvement Act, in response to the July reports on hospice quality from the Office of the Inspector General (OIG) at the Department of Health and Human Services (HHS).

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If enacted, the legislation would implement new rules for oversight and transparency, including public reporting of hospice survey results, providing education to hospices and surveyors related to quality issues, and establishing penalties for providers that have a track record of poor quality or instances of abuse or neglect. The penalties would be comparable to those applied to other health care settings, such as nursing homes and home health care providers.

"The findings from the HHS OIG report on hospice care abuse across our country are deeply upsetting and unacceptable," Portman said in a statement. "A hospice patient should live out their final days with comfort and dignity, and their families should have the peace of mind knowing their loved ones are receiving the best care. This legislation will provide the oversight needed for hospices and give patients and their families the transparency and accountability they deserve."

LEGISLATION

Senators Introduce Bill on Hospice Quality, Transparency

November 7, 2019

EXECUTIVE PERSPECTIVES

Hospice Physician Timothy Ihrig: MA Carve-in May Hurt Quality

November 7, 2019

SPONSORED

Voices: Jim McDevitt, President, Trella Health [Sponsored]

November 6, 2019

ADVERTISEMENT

Reps. Jimmy Panetta (D-Calif.) and Tom Reed (R-N.Y.) are introducing a similar bill in the House.

The first OIG report indicated that about 20% of hospices surveyed by regulators or accreditors between 2012 and 2016 had a condition-level deficiency that posed a serious safety risk. A second report discussed 12 examples of those deficiencies in-depth. OIG examined state agency and accreditor survey findings as well as complaint data from 2012 through 2016. Regulators and accreditors surveyed nearly all hospice providers in the nation during those years.

Hospice industry organizations spoke in favor of the bill, the sponsors of which sought input from the field during development.

"We greatly appreciate and applaud the work undertaken by [Portman and Cardin] in developing the Hospice Care Improvement Act of 2019, which is designed to refine the hospice survey process, improve compliance, and increase transparency," the National Association for Home Care & Hospice indicated to Hospice News in an email. "NAHC is

particularly appreciative that Senators Portman and Cardin actively sought input from the hospice community and from other stakeholders in this process."

The bill would also require the U.S. Centers for Medicare & Medicaid Services (CMS) to provide training to state and local survey agencies, approved accreditation agencies, and hospice programs on a regular basis as changes to regulations, guidelines, and policies governing hospice program operations are implemented and used in standard surveys.

"[The National Hospice & Palliative Care Organization (NHPCO)] supports the reasonable policies outlined in the bipartisan bill introduced by [Portman and Cardin], which focuses on implementing new safeguards and strengthening existing ones in order to protect patients facing serious illness at the end of life," said NHPCO President and CEO Edo Banach. "NHPCO supports regulations that promote accountability and safety and is eager to work with lawmakers to develop reasonable policies and enforcement mechanisms that promote program integrity."

Among the significant changes in the bill, related to transparency, is the public

reporting of survey results, not only CMS and state agency findings, but those of accreditors such as The Joint Commission, which are currently kept confidential.

Industry experts generally support this move but are urging CMS to take steps to make the arcane reports understandable to patients and families.

"We want to be sure that the data that is made public is done so in a way that makes sense to consumers. So we talked a lot with the senators' offices, and we've also talked to CMS about how to make it public," said Mollie Gurian, director of hospice, palliative, and home health policy for LeadingAge, who also expressed support for the bill. "If they're just sort of thrown up with a link with no explanation that can be confusing for consumers. But we think that if certain data points are taken out of the accreditation reports or survey reports, and explained in a way that makes sense for consumers as to why they should care about it, that's something that that could be that could be positive."

Companies featured in this article:

LeadingAge, National Association for Home Care and Hospice, National Hospice and Palliative Care Organization

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.

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Mark Murray

From: Jon Radulovic <jradulovic@nhpco.org>
Sent: Friday, November 8, 2019 2:49 PM
To: NHPCO Board of Directors; 2019 Hospice Action Network Board
Cc: Edo Banach; Hannah Yang Moore; Judi Lund Person; Mark Slobodien
Subject: FW: ** Policy Alert: Program Integrity Legislation
Attachments: S2807_Policy_Alert.pdf

EXTERNAL EMAIL: Do not click any links or open any attachments unless you trust the sender and know the content is safe.

Board,
Many of you have likely received the Policy Alert today about the program integrity legislation. I'm sending the summary again and the full alert is attached for your convenience. Please reach out to Mark or Judi with specific questions.

I wanted to make sure you saw it today. Great to see many of you this past week.

Thanks,
Jon R

NHPCO is Supportive of Policies in Bipartisan Legislation to Enhance Oversight of Hospice Care

November 8, 2019

Summary

On November 7, 2019, Senators Rob Portman (R-OH) and Ben Cardin (D-MD) introduced **S. 2807**, a bipartisan bill entitled the Hospice Care Improvement Act of 2019, specifically written to address the concerns identified by the HHS Office of Inspector General about hospice survey deficiencies and patient harm. NHPCO supports many of the policies in the bill as it closely tracks NHPCO's recommended Hospice Program Integrity Initiatives. Thank you to the Legislative, Regulatory, and Quality Committees for their work on vetting and approving many of the program integrity measures that were included in this legislation. NHPCO will continue to engage with the sponsors of the legislation and hope to further refine the legislation to include enhanced access to hospice.

OIG Reports and Program Integrity: In July 2019, the HHS Office of the Inspector General (OIG) issued two reports that outlined deficiencies with CMS monitoring of hospice and examples of poor care. The reports attracted a great deal of negative attention from policy makers, were featured on NPR and the NBC nightly news and caused some members of Congress to say that "we have to do something about hospice." The "do something" could have meant public hearings on hospice, a Congressional investigation or worse, definitely not the publicity that the hospice community would want.

NHPCO staff immediately began dialogue with the relevant Congressional committee staff – on the House side, the House Ways and Means Committee and on the Senate side, the Senate Finance Committee. The "do something" discussion evolved into creating a hospice program integrity bill that would address some of the issues identified for CMS by the OIG. Discussions with both the OIG and CMS identified key areas where legislative action could be helpful in addressing hospice program integrity issues.

Discussions with NHPCO Regulatory, Legislative Affairs and Quality and Standards Committees: Shortly after the OIG reports were published, NHPCO engaged the Regulatory, Legislative Affairs, and Quality and Standards Committees to discuss hospice program integrity issues identified by the OIG. NHPCO staff shared discussions with policymakers, House and Senate committee staff, the OIG and CMS with the three NHPCO committees to continue the dialogue and to identify a series of program integrity initiatives that would address the concerns noted in the OIG reports. Each committee voted on each of the program integrity initiatives and only those who were approved by all three committees were included in the final NHPCO Program Integrity Initiative document. NHPCO staff shared the Program Integrity Initiative document in discussions with legislative champions and the Administration to craft draft legislation that would balance the need for smart, targeted oversight and education without imposing excessive regulatory burden.

Alternative sanctions: Discussions with both OIG and Congress centered around their desire to identify alternative sanctions for hospice, named as an issue by the OIG. Alternative sanctions for hospice are not currently available and must be authorized in statute for CMS to take any action for a hospice provider's deficiencies, short of decertification. The alternative sanctions listed in the bill mirror those for home health, without the additional civil monetary penalties sanction. The most serious of the alternative sanctions, partial or full suspension of payments for all new admissions, is a

very serious alternative sanction and could be used when the survey deficiencies identified have implications for significant patient harm. There is a provision in the bill, however, that gives the Secretary discretion to add other alternative sanctions. The addition of alternative sanctions gives CMS and surveyors options to use in correcting survey deficiencies short of decertification. More detail on the specific alternative sanctions can be found on page 4 of this Alert or on page 3, Section 3 of the bill (**S. 2807**).

The complete Policy Alert is attached and available on the NHPCO website,
https://www.nhpco.org/regulatory-and-quality/regulatory/updates/

Download the text of the bill, S 2807. At the moment, no grassroots advocacy is needed, but watch for additional communication about this bill in the coming days.
If you have any questions about this bill, please reach out to Mark Slobodien, Director of Legislative Affairs, at MSlobodien@nhpco.org or Judi Lund Person, Vice President, Regulatory and Compliance at jlundperson@nhpco.org

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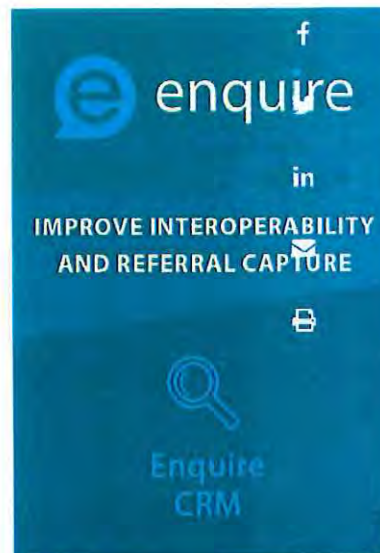

EXECUTIVE PERSPECTIVES

Hospice Physician Timothy Ihrig: MA Carve-in May Hurt Quality

By **Jim Parker** | November 7, 2019

Timothy Ihrig

Hospice and palliative care physician Timothy Ihrig, M.D., is chief medical officer of Crossroads Hospice and has served in that role since 2018. He speaks nationally on policy, clinical and economic issues that impact hospice and palliative care providers and their patients.

Crossroads provides hospice and palliative care to approximately 1 million patients annually in Georgia, Missouri, Oklahoma, Pennsylvania, Ohio, Tennessee, and Kansas. The organization's average daily census is 2,400, 74% of which are hospice patients.

The Center to Advance Palliative Care has endorsed Ihrig as a clinician-educator, and he consults with palliative care providers nationwide and internationally. In his TED Talk, "What We Can Do to Die Well," Ihrig advocates for physicians to focus on patients' quality of life, in accordance with the patient's goals and wishes, rather than fixing their attention on clinical interventions.

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Hospice Physician Timothy Ihrig: MA Carve-in May Hurt Quality

November 7, 2019

EXECUTIVE PERSPECTIVES

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Hospice News spoke with Ihrig at the National Hospice & Palliative Care Organization Interdisciplinary Conference in Orlando, Fla.

What are some of the societal, technological and policy factors that could be shaping the future of hospice and palliative care going forward?

I think the greatest challenge to hospice is the evolution of hospital systems and their desire to mitigate their downside, downstream financial risk.

With the advent of [Accountable Care Organizations (ACOs)] 10-plus years ago, and the growth and expansion of risk-based contracting in the hospital space and the hospital system space, we see that [the U.S. Centers for Medicare & Medicaid Services (CMS)], and other payers are actually putting teeth into reimbursement and penalties from a financial perspective if systems aren't delivering positive outcomes.

Positive outcomes are not truly defined, unfortunately, as what's sacred to you, and what aligns with your goals of care, having led with true informed consent, because that doesn't happen — positive outcomes are really are the systems decreasing the overall spend per capita expenditure for this segment of the population. If they're not, then they're held accountable from a decreased reimbursement or financial penalties.

Hospice is the first to be on the chopping block, usually, historically. We see it again when it's time to ask, "Where are we going to squeeze money from turnip?" Let's go to hospice, because the word is very consternating to many of the political pundits and the society at large. So how do we squeeze money out of that sector? We continue to see that over the last few

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October 23, 2019

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October 11, 2019

years hospice is being held to a standard different than the rest of the system.

Back in 2013, and 2014, in an attempt to stomp out quote-unquote fraud, you saw this with the [U.S. Department of Health and Human Services Office of the Inspector General and the Department of Justice] jumping in. We've seen so many hospices go belly up, because there is a methodology that is not valid for evaluating the care that's being delivered, and people are held accountable to outrageous, non-relevant fines. Small hospices with an average daily census of 70 or 80, are being fined as much as $40 million.

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When we look upstream of that, there's no system that's being held accountable for quote-unquote fraud. If you have an end-stage diseases that are actively dying and they still offer support to potentiate majorly invasive, expensive procedures that absolutely will not change the outcome. There's a double standard from a from an oversight perspective.

I think that's a big threat to hospice.

Back to the ACO health care systems, what we're seeing is they are wanting to own attributable lives from birth to death. And so if they have the means, and many think that they do, of providing end-of-life care outside of the hospice Medicare insurance benefit, they're going to try to promote that because they don't want to be held accountable to the regulatory issues that hospice has in place.

That's concerning to me as a provider. It's concerning to me from an organizational perspective as well.

What are your thoughts on the Medicare Advantage hospice carve-in is planned for 2021?

I have seen no details, and that's frightening. Who's sitting at that table? I can speculate that it's not a lot of hospice providers or physicians. Rather, if you follow the money stream, it's probably a lot of your big [Medicare Advantage] plans.

And so the threat is, what is the quality of care going to be? That's fundamentally my greatest concern. How do we hold people accountable for the highest level of care, for

understanding that the last few chapters of life and end-of-life care is very different than then your linear algorithmic formula that systems potentiate of doing things to people?

CMS says it's going to provide access to a lot more individuals. Access is one thing, how do we ensure quality? That that is yet to be determined.

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How do we ensure timely referrals? How do we ensure that — if it's consistent with somebody's goals of care — that they can have a transition to a hospice level of care that day without a prior authorization?

The system of medicine is such that, for the most part, people are transitioning to hospice at the very bottom of the ninth inning. So with the Medicare Advantage carve-in, who is going to regulate timeliness of referrals, appropriateness of care, oversight of care, and what is the payment methodology? It's a perspective of let's make money, and that precedes the notion of patient first. So that's a grave concern.

And I challenge some of the larger academies who have taken the position that it is going to improve and increase access to hospice. Again, that's not enough. There has to be some accountability. Access to poor care is still poor care.

Similar question, what do you see happening in the palliative care space?

It's being influenced more and more by organizations feeling the financial pinch of accountability through CMS and payers for the advanced illness population and still just 1% to 3% of their attributable lives. But there's about 1% to 3% of the health care systems' attributable lives that are costing them money.

What we've seen the spring of this year is two distinct reimbursement models [the Primary Care First and the Seriously Ill Population models], and obviously that's tethered to the policy at some level to promote care outside of the hospital, non-acute care, so community-based home care, and one is to incentivize, financially, primary care providers. [Primary Care First-general option] is really similar to the medical home model, and then the [Seriously Ill Population model] is to potentiate palliative care.

My concern with that is: You have a system that's broken, period, for this population, for the advanced illness population. It does not work. And regardless of where you deliver that care, it's still the same process and method of delivering care that fails this population.

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Even if we take it to the home, it's still the wrong care. We have a system that potentiates doing things to people based on disease and ability and not based on physiologic realities or true patient choice. Patients aren't told the truth. If you have widely metastatic disease and the mean life expectancy is "X," people aren't privy to that. So the system is stealing choice from people.

I see that to mitigate costs there are these incentives in the non-acute space. Is it going to be a game changer? Empathically, I would say no, because you're just giving the same care at a different location. We are not changing the narrative. We're not moving it upstream to offer realities and choice beyond the bottom of the ninth inning. So it's going to be very, very interesting over the next 18 to 24 months.

How might hospice and palliative care change with the advent of value-based payment models such as the Medicare Advantage carve-in and the Primary Cares Initiative?

I think hospices generally are very passive, and some of the larger academies have suggested that they remain so and absorb whatever changes come their way. I think is antithetical to what we need to do. We need to take a stand and demand to sit at the table. We need to hold ourselves accountable for being relevant.

Particularly now, when there's so much focus on end-of-life care and those individuals that cost a lot of money; that's the perception from the systems. But, emphatically, the elderly and the ill — and that's generally who we're talking about — don't cost money because they're elderly and ill. They cost money because of what systems do to them.

So you have the aggregate per capita reduction in expenditures for all ACOs; about a year-and-a-half ago was 1.25%. That's laughable. And I challenge all those institutions: How much money did you spend to create processes within a system that has repeatedly failed? And how many tens of thousands of

hours were spent to achieve a 1.25% reduction in expenditure across this population?

Again, the narrative from most of the academies and the systems is that we're trying to say care for people at the end of life. If they really wanted to care for them, we would change the structure and the process and operationalizing how they actually understand that which is done to them, either to potentially increase life expectancy or increase life quality, and it really is the thing that that cost them financially.

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So it's not about health care reform. We need to reform how we care. The institution is flawed with respect to care in general, but specifically in the population we deal with, served by palliative and hospice.

The electric light was not invented by improving candles, but everybody's still working in wax. That's the biggest challenge I see. We are never going to be successful in caring for people — and thus mitigating that financial risk — if we continue to act in the same manner we have the last 30 years.

Companies featured in this article:

Crossroads Hospice and Palliative, National Hospice and Palliative Care Organization

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 Honors Veterans during "The Wall that Heals" Event

Photos: The replica of the Vietnam War Memorial and the ceremony honoring veterans hosted by Center for Hospice Care.

Center for Hospice Care (Southbend, Indiana) was honored to be able to take part when "The Wall that Heals" – traveling replica of the Vietnam War Memorial – came to South Bend. Hosted at the St. Joseph Cemetery, "The Wall that Heals" was on display Sept. 19-22. Center for Hospice Care hosted a tent during the Hometown Heroes celebration on Saturday, Sept. 21. Center for Hospice Care staff and volunteers were able to present dozens of veterans with commemorative pins while thanking them for their service.

"Participating in this event was a deeply moving experience for our organization," said Peter Ashley, community relations liaison. "Many of the veterans had never been properly thanked for their service. Being able to present Vietnam Vets with pins and say 'thank you' made a difference to those Vets."

Center for Hospice Care is proud to be part of the "We Honor Veterans" program, a collaboration between the Department of Veterans Affairs and the National Hospice and Palliative Care Organization. Its purpose is to raise awareness among veterans of the end-of-life services and benefits available to them.

"One out of four dying Americans today is a veteran," noted Mark Murray, CHC President/CEO. "Our goal is to address their end-of-life needs, to serve them as they have served us."

Center for Hospice Care has achieved the Level 4 designation, in the "We Honor Veterans" Partner program. As a Level 4 partner, Center for Hospice Care integrates veteran-specific content into staff and volunteer orientation and education.

Center for Hospice Care is also proud to be an official Vietnam War Commemorative Partner with the Department of Defense. This partnership is focused on ensuring that all Vietnam vets and their families are properly acknowledged and thanked for their service and sacrifice.

About Center for Hospice Care

Established in 1978, Center for Hospice Care is an independent, community-based, not-for- profit organization, improving the quality of living through hospice and palliative care, grief counseling, and community education. With offices in South Bend, Plymouth, Elkhart, La Porte and Mishawaka, CHC serves Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Marshall, Porter, St. Joseph and Starke counties in Northern Indiana.

Improving the Quality of Living at Center for Hospice Care

By: Center for Hospice Care Last Updated: August 27, 2019

Center for Hospice Care's DNA is intertwined with the community. We exist because of the vision and collaboration of community members and organizations that helped launch us. That memory is part of what fuels our commitment to improve the quality of living in the community.

It's part of the reason we collaborate with and support other organizations to serve the community. There are more than 40 local not-for-profits we partner with regularly – along with countless others we support throughout the year. This support ranges from hosting community events, offering the use of our conference spaces, and supporting fundraising events hosted by our partners.

We are humbled that our impact has been recognized throughout the community with several special awards.

2010 Not-For-Profit of the Year Award – Greater Elkhart Chamber of Commerce

The Business Recognition Council of the Greater Elkhart Chamber of Commerce named Center for Hospice Care as the recipient of its 2010 Non-Profit of the Year Award.

The formal presentation of this award took place during the Chamber's annual meeting, which drew over 400 attendees.

2011 Business of the Year Award – REAL Services, Inc.

REAL Services honored CHC with the Business of the Year Award at their Age of Excellence Awards Luncheon in 2011. The Age of Excellence Awards celebrate unsung heroes in REAL Services' six-county service area who give of themselves to care for elderly and low-income individuals.

2014 Economic Impact Award – St. Joseph County Chamber of Commerce

CHC was chosen for the Economic Impact Award at the 2014 "Salute to Business." The award recognizes a company's strategic vision and its sustainable capital investment in the St. Joseph County economy.

2015 Juxta Crucem Award – Holy Cross College

Holy Cross College honored CHC with the Juxta Crucem Award at their inaugural "Through the Eyes of Faith" gala. The evening featured presentations about Center for Hospice Care's then-recent trips to Uganda where Holy Cross students and faculty were hosted by CHC's partner organizations.

PARTNER ORGANIZATIONS

- A Rosie Place
- Alcohol & Addictions Recovery Center
- Alzheimer's & Dementia Services
- Association of Fundraising Professionals Michiana Chapter
- Bashor Children's Home
- Bike the Bend
- Bike to Work Week
- Casie Center
- Community Foundation of Elkhart County
- Community Foundation of Marshall County
- Community Foundation of St. Joseph County
- Community Hospital of Bremen

- Economic Development Corp. of Elkhart County
- Elkhart Chamber of Commerce
- Foundation of St. Joseph Health System
- Goshen Hospital & Healthcare Foundation
- Holy Cross College
- Holy Cross Mission Center
- IU School of Medicine
- Junior League of South Bend
- Kelly Cares Foundation
- LOGAN
- National Hospice Foundation
- Oaklawn Foundation
- REAL Services
- River Bend Cancer Services
- Ruthmere Museum
- Ryan's Place
- South Bend Alumni Association
- South Bend Civic Theatre
- South Bend Heritage
- St. Mary's College
- St. Pius X Catholic Church
- Studebaker National Museum
- The History Museum
- Unity Foundation of La Porte County
- Vineyard Church
- Wellfield Botanic Gardens
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How For-Profit Hospices Compare to Nonprofit Hospices

Why patient characteristics differ between the two hospice types

By Angela Morrow, RN

Updated July 07, 2019

Research published in the Journal of the American Medical Association (JAMA) has found key differences in the patient populations of for-profit hospice agencies compared to their nonprofit counterparts. Primarily, patients at for-profit hospices tend to have lower care needs and stay in hospices longer than those at non-profit hospice agencies.

Get the facts on the differences and similarities between for-profit and nonprofit hospice agencies with this analysis.

The Growth of For-Profit Hospice Agencies

The for-profit hospice sector has increased substantially in the 21st century. The number of for-profit agencies doubled from 2000 to 2007 while the number of non-profit hospice agencies has remained the same.

Although it's promising that the number of hospice agencies is increasing overall, it raises concerns that for-profit hospice agencies have significantly higher profit margins than non-profit hospices. A JAMA study looked at the differences in patient population and practices of for-profit and non-profit agencies to better understand why the discrepancy in profits was so great.

Medicare Hospice Reimbursement

Medicare reimbursement pays for 84 percent of patients in hospice care. Medicare reimburses hospice agencies for hospice care at a per-diem rate, meaning every

patient receives the same amount of reimbursement per day despite their diagnosis or individual care needs.

This reimbursement system may be creating incentives for hospice agencies to select patients with fewer care needs and longer hospice stays. By doing so, for-profit agencies may be conserving money by providing less intensive care and increasing profits by selecting patients who will live longer.

For-Profit Hospices Have More Dementia Patients

For the JAMA study, researchers used data from the 2007 National Home and Hospice Care Survey, with a nationally representative sample of 4,705 patients discharged from hospice.

Comparing data from for-profit hospices and non-profit hospices revealed that both diagnosis and location of care varied by profit status. Compared with nonprofit hospices, for-profit hospices had a lower proportion of patients with cancer (48.4 percent vs. 34.1 percent) and higher proportions of patients with dementia (8.4 percent vs. 17.2 percent) and other diagnoses (43.2 percent vs. 48.7 percent).

The data also indicated that approximately two-thirds of patients in for-profit hospices had dementia and other non-cancer diagnoses, whereas only about half of patients in nonprofit hospices had these diagnoses.

Cancer patients have a fairly predictable life expectancy and course of treatment. By the time cancer patients enter hospice care most have exhausted all other treatments and are close to death. End-stage cancer patients also tend to need more expensive care with intensive pain and symptom management.

Dementia patients (and other patients with less predictable diagnoses) tend to live longer than cancer patients with less costly care. These patients are more profitable because they accrue the Medicare hospice per diem rate daily with little out-of-pocket expense.

Location of Care and Length of Stay

Compared with nonprofit hospices, for-profit hospices had a higher proportion of patients residing in nursing homes and a lower proportion residing at home. Patients who reside in nursing homes often cost hospice agencies less money in the long run.

Nursing homes have around-the-clock nursing care that handle many situations that home patients would require a hospice visit for. For-profit hospice agencies also tend

to do a very good job of marketing at nursing homes to achieve an "in" with the nursing home staff and increase referral rates.

The JAMA study found that compared to patients with cancer, those with dementia or other diagnoses had fewer visits per day from nurses and social workers. This makes sense because cancer patients typically have more severe symptoms that require more frequent monitoring. Because hospice agencies are paid daily rates per patient, for-profit hospices may benefit financially by selecting patients who will need fewer nursing visits.

The hospice length of stay (LOS) is the number of days a patient is on hospice care before discharge or death. According to researchers, the median (midpoint) LOS was four days longer in for-profit hospices as compared with nonprofit hospices (20 days vs. 16 days, or 26.2 percent longer LOS).

Compared with patients in nonprofit hospices, patients in for-profit hospices were more likely to have stays longer than 365 days (2.8 percent vs. 6.9 percent) and were less likely to have stays less than seven days (34.3 percent vs. 28.1 percent).

Implication of Research Findings

JAMA researchers said the study findings have important policy implications and that nonprofit hospices are at a distinct disadvantage in terms of patient population.

"Patient selection of this nature leaves nonprofit hospice agencies disproportionately caring for the most costly patients—those with cancer and those tending to begin hospice very late in their course of illness; as a result, those hospices serving the neediest patients may face difficult financial obstacles to providing appropriate care in this fixed per-diem payment system."

These findings could, and should, prompt discussion about payment reform in the Medicare Hospice Benefit. Hospice is a growing industry, especially in the for-profit sector, and more research is needed to fully understand the correlation between profit status and patient/caregiver experiences at the end of life.

Article Sources

- Wachterman MW, Marcantonio ER, Davis RB, McCarthy EP. Association of Hospice Agency Profit Status With Patient Diagnosis, Location of Care, and Length of Stay. *JAMA*. 2011;305 (5):472–479. doi:10.1001/jama.2011.70

INNOVATION

Adult Day Industry Trending Toward For-Profit Status, 2020 Boom

By Robert Holly | October 23, 2019

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Prior to 2014, there were only a few thousand adult day centers operating throughout the United States. Today,

there are likely over 10,000 centers in existence, each one trying to make a lasting mark in an extremely fragmented industry.

Founded in 1991, Tennessee-based Centennial Adultcare Center is among that group. The medical-model adult day provider is led by CEO William Zagorski, who says big things are in store for the space in months and years to come.

Home Health Care News recently caught up with Zagorski during the latest installment of its podcast, Disrupt.

Among topics of conversation, the CEO outlined industry challenges and explained how at-home care providers will play a critical role in adult day's future. Zagorski – a member of the National Adult Day Services Association's board of directors – also discussed how the adult day model is becoming increasingly for-profit.

Highlights from HHCN's conversation with Zagorski are below, edited for length and clarity. Subscribe to Disrupt via Apple Podcasts, Google Play Music, SoundCloud or your favorite podcast app.

HHCN: Can you tell me a little bit about your company? What does American Senior Care Centers do?

Zagorski: American Senior Care Centers is our corporate name. We operate as Centennial Adultcare Center. We have three medical-model adult day health care facilities in the central Tennessee area. We also operate non-

medical in-home care services and transportation services, all of which are under our Centennial Adultcare Center brand.

But that medical model of adult day is our primary focus. We serve Individuals 18 and over — of all acuity ranges. That means all diagnoses, all physical and cognitive conditions. There are very few individuals who we have not been able to help over the years.

We're the largest comprehensive, medical-model adult day health care facility in Tennessee.

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It's not often we've had adult day providers on Disrupt. I think you're actually the first, so congratulations on that!

Happy to be the first! Adult day health care is certainly a newer, lesser-known part of the continuum of care, so I'm happy to talk about it.

How did you first get into the space and, ultimately, into the CEO role?

It's a long story that takes lots of meandering paths.

My parents started our company back in 1991. One of the main inspiring factors was a grandmother who had been diagnosed with Alzheimer's, who then moved from Chicago to Nashville to live with us.

She attended a social-model adult day program in Nashville for a number of years. But as soon as her acuity rose to where she could no longer attend the social programs, there was nowhere for her to go. So we set up shop as the first medical-model adult day health care provider in Tennessee. We were one of the only providers able to assist individuals with advanced dementia, you know, progressing to the point of wandering, incontinence and other issues.

That's the genesis of our company. I was younger when that company opened and did not plan on staying in Tennessee. My personal history is mired in scientific research; I spent a number of years in cancer research, then in molecular genetics as my primary academic research through the late 90s and early 2000s.

I came back to our company in 2011. We've increased our daily attendance by double since. I opened our second location in 2015. And then our third location in late 2017.

Our in-home care agency has been in progress for a number of years as well, though there's been some growth and retraction.

We talk all the time on HHCN about how the home care and home health industries are booming. What's going on in the adult day center space on a macro level?

Adult day mirrors the same growth trends that we're seeing in home health and home care. The driving factor is individuals want to remain living at home.

Historically, adult day has existed throughout the United States for decades. It took off in the late 70s and 80s, mostly on the East Coast and West Coast. It has been a little bit slower to grow through the Midwest — and even slower in the South.

But it continues to grow overall, ramping up over the past five years. In fact, today, there are probably close to 10,000 adult day centers in the U.S., which is up almost 50% from 2014.

One of the factors inhibiting growth is the fact there's no federal model or federal definition of what adult day care is. It's regulated differently from state to state, with some states being more permissive for social-model or medical-model services.

As of 2016, slightly over 50% of the adult day centers throughout the country are in the for-profit space as opposed to the nonprofit world. That's been a big switch compared to the past.

There has also been a divergence between the social model of adult day services and the medical model. There has been a social stigma around this industry, so

we try to be consistent with terms for what different players are doing. The common nomenclature is to use "adult day services" for the social model, then "adult day health care" for the medical model.

What are some other headwinds in the space? You mentioned a lack of a federal model, which seems like it could be difficult in terms of stability.

Yeah. Very much so. I mean, the different regulation from state to state is so significant. Just look at the state-to-state variation on licensure and certification. There are a dozen or so states that still have no type of licensure status. There's still a few where it's like the Wild West. Of course, there are also Medicaid issues. There are lower reimbursement states or the Medicaid-prohibitive states, usually in the Deep South or in lower-income, lower-population areas in the North.

And when it comes to access to care, since adult day is a lesser-known model and varies from place to place, nobody really knows what adult day really is. They don't know whether it's adult day services or adult day health care, whether adult day is part of the continuum of care or separate.

There's a lot of confusion and lack of knowledge.

Can this be a profitable space for operators?

It certainly can be a profitable space. And I think that's really reflected by the for-profit side of the industry doubling in recent years. But it's hard to define what the margins are because reimbursement models differ so

much. And there's a lot of providers that only operate in a Medicaid space. There's some providers that only operate in a private-pay space. Some people work with the VA.

We've been a for-profit company for the better part of 30 years, and it's been profitable over that time for sure, but it varies. The fact is that you're in a conglomerate setting where your staffing levels are slightly lower, so you're able to do things that are slightly lower in terms of expense rate.

It's difficult to answer on the margins. A ballpark answer, you know, they're somewhere, probably between 1% and 40%.

What competitive advantages do adult day centers have over home health or home care agencies?

We're able to staff at a slightly lower level than the one-on-one care that's needed for home care.

In the adult day setting, most states are in the six-to-one or eight-to-one suggested or mandatory ratios. Most organizations run in the four-to-one or six-to-one ratios. Another advantage is service availability, being able to provide services without interruption. Centers can be staffed with three to six employees at any given time.

Cost is certainly a competitive advantage. The average cost of adult day is $72 a day — and that's usually for six to 10 hours of care. In Tennessee, most of the companies we work with are open for eight to 11 hours per day.

Some of them are even open on weekends. So being able to provide services for 10 hours at $72 a day is certainly a competitive advantage.

Medical oversight in the adult day health care industry is continuing to progress, and most centers have registered nurses on staff ... to provide ongoing medical oversight as well as medication assistance and management of vitals.

Many centers are truly interdisciplinary, with masters-level social workers, registered dietitians, RNs, LPNs, recreational therapists. Many programs bring in pet therapist, music therapist, art therapist ... so the ability to provide comprehensive therapeutic services in a conglomerate setting provide some unique advantages and a social situation. Not to mention the social determinants of health we're avoiding — avoiding geriatric depression and combating loneliness.

Why is it important for adult day centers and home-based care providers to work together?

Adult day health care is great, but it can't do it all. Centers can't be open all the time. They can't do everything. It is essential for individual providers or larger companies to be able to associate with home-based care providers and wraparound services, including transportation.

If you take in-home services, transportation services, adult day health care and everything else, you put it all together, it's still so much less expensive than most assisted living or skilled nursing facilities.

What's the M&A and investment landscape like in the adult day space?

I think there's significant, increasing interest. But from an M&A standpoint, adult day does have those real challenges I talked about. Additionally, the largest provider of adult day services has about 112 locations throughout the U.S. — and that's less than 1% of market share. So that fragmentation is a downside for those looking for a large investment opportunity. Still, that means the industry is ripe for consolidation.

Many adult day centers throughout the United States are still in the first round of ownership and are privately owned — probably family-owned. Many of us are aging and looking for exits.

What's next for you and your company in terms of future plans and growth? Any plans to move outside of Tennessee?

There are lots of plans. We've grown slowly over time and have opened two additional centers in the last four years. We plan to continue growing when opportunities present themselves. There's room for expansion in Tennessee. There's only about 40 providers throughout the entire state, and there's room for about double that.

I've also had the pleasure of working as the president of the Tennessee Association of Adult Day Services, as well as working with the National Adult Day Services Association, where we have pretty significant policy efforts.

Disrupt

Centennial Adultcare Center CEO...

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Companies featured in this article:

Centennial Adultcare Center

Robert Holly

When Robert's not covering the latest in home health care news, you can likely find him rooting for the White Sox or roaming his neighborhood streets playing Pokemon Go. Before joining HHCN, Robert covered everything from big agribusiness to the hottest tech startups.

You May Also Like

Local veterans have 'Vet-to-Vet Cafe' sessions once a month to talk struggles, successes

by Katlin Connin, WSBT 22 Reporter
Wednesday, October 30th 2019

WSBT 22

Veterans Day is just around the corner, a time for us all to remember the service men and women in our life.

The Center for Hospice Care says it's trying to remember those veterans year-round. We got to chat with some of those veterans at their "Vet-to-Vet Cafe" on Wednesday.

They live at Southfield Village in South Bend and are looked after by staff from the Center for Hospice Care.

The Vet-to-Vet Cafe is part of a partnership with the VA called "We Honor Veterans."

It's a chance for these guys to talk about their common experience and be supported, but these chats also help staff at Southfield take better care of their veterans.

Letters from home, new military technology, and life after service -- those were just a few of the things these guys talked about today at their monthly Vet-to-Vet Cafe.

But these men didn't always speak so freely.

John Lindley -- a World War II Army veteran -- talked to us about what it was like when he came home.

"They were interested, I think, but they didn't want to know all the details," said Lindley. "I didn't think it would do them any good to know."

Dwight Handschu -- a Korean War Army veteran -- says when vets get together, it doesn't have to be that way.

"When you get with the guys who have been in the service, you have a branding, I guess," said Handschu. "You know what they're talking about."

"[I] know that they were away from home and doing something that they never expected to ever do," said Lindley.

Chats like this don't just help vets. Peter Ashley with the Center for Hospice Care says they also help his staff understand what specific needs and expectations veterans may have.

"It also gives us a great chance to thank them for their service in a way that's... when they can still appreciate that thank you," said Ashley.

And these chats are also more than just thanking these vets and honoring their service-- it's also about camaraderie.

"Yeah, that's a good word for it," said Handschu.

Many of these veterans are getting pretty old; Lindley is 102.

These vets talked to us about the pain they all feel when one of their friends passes away, but they get a chance to honor their friends with a "walkout."

The veterans in the vet-to-vet cafe walk out of Southfield Village with the casket, do a quick service and say goodbye.

Center for Hospice Care
Compliance Committee Meeting Minutes
August 22, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 3:00 p.m.	
2. Minutes	• The minutes of the 02/28/19 meeting were approved by consensus.	
3. Review of Home Health Compliance Plan	• Page 8, Program Elements Outline – Add "national and" to state criminal history check. • Page 9, Code of Conduct – In the second paragraph change Department of Health and Human Services to OIG. Instead of listing where the compliance box is physically located at each office, make it more generic. Staff will be educated on where it is located at their office. • Page 22, Informed Consent – Added updates from the change in Indiana law in July 2018 spelling out who can give consent for health care and in what order of priority. • Page 30, Destruction of Clinical Records – Deleted this policy, because that information has been added to the "Medical Record" policy. • Page 32, Ability to Pay – In the third paragraph, delete first sentence and change to "Patient/family will be requested to complete a Fee Assessment Worksheet." It should be a part of the admission process. • Page 33, Fee Agreement – Add "In absence of a complete form, the patient/family will be billed at 100% applicable rates."	
4. Review of Hospice Compliance Plan	• Page 9, Program Elements Outline – Add "national and" to state criminal history check. • Page 20, Code of Conduct – In the second paragraph change Department of Health and Human Services to OIG. Instead of listing where the compliance box is physically located at each office, make it more generic. Staff will be educated on where it is located. • Page 27, Elder Justice Act Reporting – Added the phone numbers for the sheriff office	

Topic	Discussion	Action
	in each county in our service area. • Page 28, Destruction of Clinical Records – Deleted this policy, because that information has been added to the "Medical Record" policy. • Page 36, Informed Consent – Added updates from the change in Indiana law in July 2018 spelling out who can give consent for health care and in what order of priority. • Page 39, Revocation – Added "Verbal revocations are not acceptable." • Page 44, Fee Agreement – Add "In absence of a complete form, the patient/family will be billed at 100% applicable rates." Also add "The social worker will complete a Fee Assessment Worksheet for any patient entering the Inpatient Unit." • Page 46, Ability to Pay –In the third paragraph, delete first sentence and change to "Patient/family will be requested to complete a Fee Assessment Worksheet." It should be a part of the admission process.	
5. OIG Reports	• The NHPCO Regulatory Alert from July 9 on "Two Reports Released by OIG" was reviewed. Vicki G. noted on page 4 under 5c failure to provide needed services; failed to provide needed volunteer services to several beneficiaries. One beneficiary waited eight months for volunteer services. She will share this information with the volunteer coordinators so they are aware of the seriousness of this and what the OIG expects. We do show the surveyor proof of our efforts to recruit volunteers. Sue M. said when we reviewed the quality reports for the QI Committee she noticed we don't report on volunteers. She will get with Vicki G. and Karl H. to look at what information should be included in the report. • One of the surveyors insisted if our initial order says a social work visit weekly, if the patient refuses a visit we have to get a cancellation order from the doctor. A surveyor also said we need to do OASIS for commercial insurance patients. We showed her the regs that say commercial insurance patients are exempt from OASIS. • Sue M. has a list of items she needs to follow up on after the surveys. As an agency, we need to decide what we are going to do going forward and what areas we can ignore.	
6. 2019 Compliance Inservice	• The annual compliance inservice is usually done at the September staff meeting. We could review the OIG reports and surveys and educate staff on the seriousness of it all. Mark M. could do it. The climate is completely different now. The years of going 6-15 years without a deficiency are over. Audits are also increasing dramatically and what they are asking for is incredible. He can include the article of comments from hospice	

Topic	Discussion	Action
	CEOs on what the future looks like. Documentation so important and staff reporting any complaints they hear up the chain of command so we can respond appropriately.	
Adjournment	• The meeting adjourned at 3:30 p.m.	Next meeting in Feb. 2019 TBD

CHAPTER FOUR

NOMINATIONS

2019 Nominations to the Board of Directors
First three-year term to commence in January 2020

Roland W. Chamblee, Jr.

Attorney

A lifelong resident of St. Joseph County, Roland W. Chamblee Jr obtained his law degree from the University of Notre Dame Law School in 1977. He received his bachelor's degree from Notre Dame in 1973. Roland was appointed magistrate of the St. Joseph County Circuit Court in 1989. He became a judge of the St. Joseph Superior Court in 1990 and served until 2013. During his tenure on the Superior Court, he co-founded and presided over the St. Joseph County Drug Court and spent the past 15 years presiding exclusively over felony cases. Upon retirement from the Bench, attorney Roland W. Chamblee Jr returned to the practice of law and now practices criminal defense in both federal and state courts in St. Joseph and surrounding counties.

Kurt Janowsky

Navarre Hospitality Group

1981 Kurt Janowsky was graduating from Adams High School in South Bend, but he'd already been introduced to the foodservice industry. At 14 Kurt took a job as a dishwasher at a local pancake house to help support his mother and siblings. At 15 he was a cook at the popular Moonraker restaurant in downtown South Bend. At 17, after High School, Kurt became an apprentice chef at Boca West Club and Resort in Boca Raton, Florida where he developed is love for higher culinary taste. Returning to South Bend at 18, he became the executive chef at Knollwood Country Club, the youngest chef in Club Corporation's (the company that owned Knollwood) history. At 20 years old, using a credit card for a cash advance down payment, Kurt purchased his first restaurant. The Loft, a favorite upscale restaurant in downtown South Bend, was Kurt's first business and the year was 1983. He wasn't old enough to drink, but owned one of South Bend's most popular restaurant and bar! Kurt's passion for quality food and service grew as he started a partnership with Bruce and Pat Tassell, who owned The Ice House restaurant, in 1985. It was a partnership that would last for over 30 years. Together with the Tassells, Kurt purchased The Matterhorn in 1988, opened Baxter's in Elkhart in 1989, then joined them as a partner in operating The Emporium in downtown South Bend in 1995. Today, Kurt's vision has lead to almost 20 upscale restaurants and bars in the Michiana area including a catering company and exclusive venues such as Palais Royale at Morris Civic Theatre, Crystal Ballroom at The Lerner in Elkhart, and many others. The chicy Café Navarre in downtown South Bend and AAA's Four Diamond Award

winning restaurant Artisan in downtown Elkhart are Kurt's flagship fine dining restaurants.

Slate of 2020 Officers

Mary Newbold, Chair
Jennifer Ewing, Vice-Chair
Tricia Luck, Treasurer
Jennifer Houin, Secretary
Wendell Walsh, Immediate Past Chair
Amy Kuhar Mauro, Hospice Foundation Immediate Past Chair