Center for Hospice Care

choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
February 19, 2020
7:15 a.m.

BOARD BRIEFING BOOK

Table of Contents

CHAPTER
ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING

Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
February 19, 2020
7:15 a.m.

AGENDA

1. **Welcome and Board Member Introductions –** Mary Newbold (7 Minutes)

2. **Consent Agenda** – Mary Newbold (8 minutes)
   - A. Approval of November 20, 2019 Board Meeting Minutes *(action)*
   - B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.

3. **President's Report** *(information)* - Mark Murray (10 minutes)

4. **Finance Committee** *(action)* – Tricia Luck (15 minutes)
   - A. December 2019 Year End Pre-Audited Financial Statements

5. **Hospice Foundation Update** *(information)* – Wendell Walsh (15 minutes)

6. **Board Education** *(information)* – “2019: The Year in Review” – Mark Murray (15 Minutes)

7. **Chair’s Report** – Mary Newbold (5 minutes)

Next meeting May 20, 2020

# # #

1-800-HOSPICE ♦ cfhcare.org

111 Sunnybrook Court
South Bend, IN 46637
(574) 243-3100
Fax: (574) 243-3134

112 S. Center St., Suite C
Plymouth, IN 46563
(574) 935-4511
Fax: (574) 935-4589

22579 Old US 20 East
Elkhart, IN 46516
(574) 264-3321
Fax: (574) 264-5892

286 W Johnson Rd, Ste. B
La Porte, IN 46350
(219) 575-7930
Fax: (219) 476-3965

Administration & Foundation
Life Transition Center
501 Comfort Place
Mishawaka, IN 46545
(574) 277-4100
Fax: (574) 822-4876

PAGE - 3

CHAPTER
TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
November 20, 2019

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

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:15 a.m.	
2. Raclin Dedication	• The ribbon cutting and dedication of the Ernestine M. Raclin House was held last evening. We had 185 RSVPs plus additional people attend. This could be the largest event like this held on our campus. The project was ten years in the making. Mayor Dave Wood spoke about gratitude on behalf of the City of Mishawaka, and that this development helped spur things on in this city. We had good media coverage too.	
3. Minutes	• A motion was made to accept the minutes of the 08/21/18 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned T. Luck seconded
4. Policies	• The revised hospice and home health policies were reviewed. The revisions reflect changes in regulations and practices. Complementary Alternative Medicine (CAM) is defined as a certified massage therapist. We do not do aromatherapy due to open flames. The IPUs are the first choice for respite care. If the units are full, then we will use contracted area hospitals or nursing homes. The plan of care is the care plan by each discipline. The plan of treatment is written at the time of the initial nursing assessment and is sent to the physician responsible for the patient's medical care for his/her signature. These are two different things. • A motion was made to accept the revised policies as presented. The motion was accepted unanimously.	W. Walsh motioned T. Luck seconded
5. QI Committee	• Carol W. reported on the QI Committee meetings from 09/17/19 and 11/19/19. The committee approved a new QAPI related to pediatric care. We have seen an increase in pediatric admissions. NHPCO's report from 2017 shows the national average of	

Topic	Discussion	Action
	revocations was 6.5% and CHC YTD 2019 through September was 7.5%. We focused a lot on patient/family education. Our HeartWize and BreatheEazy programs are well supported and we've had great outcomes to help keep those revocations down. CHC's live discharges through September 2019 were 12.3% compared to the national average of 17.1% in 2017. • Some of the follow up from the ISDH survey was in relation to social work and chaplain assessment within five days of admission. We are now at 99% compliance. We are also working on medication reconciliation in the IPUs, and the last three chart audits had 100% compliance. One month was 71% related to a specific employee and we have worked with her on this. We are also focusing on wounds. If a patient is actively dying, it is difficult to manage wounds, because the patient's systems are shutting down and their food intake is down. Wound care compliance in May was 68% and in October was 95%.	
6. President's Report	• ADC continues to be at all-time record highs in the history of the organization. Through 11/19 the ADC was 426, and YTD through October 419, a 6% increase. The breakeven ADC for budget is 383.Referrals are up 2.2%. The census in ECFs continues to recover dramatically. October ECF ADC was 154 and YTD 141 compared to 129 in January. We are doing several veteran events at facilities and also our Partners in Care program. One thing we noticed last year when we visited facilities was the lack of communication. Our staff was not letting them know when they were in the building. We created Partners in Care to bring our staff assigned to that facility to interact with their staff and build those relationships. • Staffing – Dr. Karissa Misner is now here, and we have some potential new doctors in the pipeline. Dr. Nicole Sharilla from OSU medical center is considering joining us in six months when she completes her Master's Degree in ethics. Dr. Tom Browne is a family practitioner in Knox who is considering transitioning to hospice. We will be interviewing him next week. We have four full-time nurse practitioners. One left in June to go to Indianapolis and then decided to return. Our CMO Dr. Gifford is retiring at the end of the year. A contracted medical director who worked up to 24 hours/week retired, so we are still understaffed with doctors. So we may see an increase in Receivables again due to outstanding certs/recerts. • Congratulations to Dave Haley in renewing our Optum contract for five years with no price increase. That includes DeliverCareRx. The price of drugs may go up or	

Topic	Discussion	Action
	down, but the fee to deliver them will not increase. • The new La Porte office is now operational. South Bend staff moved to Mishawaka in October. • We finally had our home health survey. It is supposed to happen every three years and our last one was in 2015. The only problem found was we didn't have copies of pre-employment drug tests in the HR files. Apparently the state law changed a few years ago, but we didn't know it. We offered to print them and put them in the files, but the surveyor didn't want to wait. Our plan of correction was accepted by ISDH. • A few weeks ago at Cerner's national conference they announced that they will stop supporting HomeWorks and RoadNotes, our electronic medical record we have had in place since November of 2010, as of 12/31/20. So we are in the process of looking for a new EMR. Cerner is recommending Brightree and they will do a demo with us. We will interview some other vendors too. • The reception for the Vera Z. Dwyer Fellow at the IU School of Medicine is tomorrow evening at Notre Dame. • CHC staff presented at two sessions at the NHPCO clinical conference recently in Orlando, FL. Sue M. was a presenter on HeartWize and BreatheEazy, and Kathy Kloss, Clinical Staff Educator, did a session on our ELNEC program. We are submitting presentations for the April NHPCO conference to be held in Washington, DC. • The OIG report came out this summer that was negative towards hospice care. Legislature followed up on that with a Senate bill that would require state deficiency reports be posted on the Hospice Compare Website. If the bill goes through, it probably won't happen until 2021. We are discussing going to Indianapolis to go through the informal dispute process on the condition level deficiency we received on the complaint survey. We are still discussing this. • CHC, the Hospice Foundation, and GPIC combined have assets over $66M. We met with 1st Source Bank to discuss whether to continue with our line of credit, and arbitrage the difference between what we're receiving in investments and what we're paying in interest on the line, and we decided we would. We are a major business in the Michiana area, and 1st Source said they have very few clients in Michiana that are larger than us.	
7. Finance	• The Finance Committee met Friday and went over three action items.	

Topic	Discussion	Action
Committee	• Flex Spending Account limit – Every year CHC offers this benefit to staff. The limit has to be set every year, and $2,000 seems to work well for us. A motion was made to set the Flex Spending Account limit at $2,000 for 2020. The motion was accepted unanimously. • YTD October 31, 2019 financial statements – YTD we have served 1,785 patients, a slight increase from a year ago. It is slightly under budget. ADC was 395 year ago, and we budgeted 400. YTD through October the ADC is 419. YTD operating revenue YTD $19.2M, total revenue $22.3M, total expenses $17.2M, net gain $5.1M, net without beneficial interest $2.3M. A motion was made to accept the YTD October 31, 2019 financial statements as presented. The motion was accepted unanimously. • 2020 Budget – We look at the current ADC and project it out for the rest of the year. We are projecting the ADC going into 2020 will be 425 and that we will serve 2,152 patients. Operating revenue $24.5M, and total revenue $25.6M. One challenge when we brought the South Bend staff to Mishawaka was the internal distribution and reallocation of expenses. We are projecting total expenses in 2020 of $23.8M, net gain $1.8M, net without beneficial interest $1.1M. We budgeted money for the new electronic medical record. This will be one of the significant changes going forward. In 2010 it was a capital expenditure when we purchased Cerner software—we had a $600,000 outlay. Going forward it will be a cloud based product, so instead of a onetime large capital outlay, we will probably be looking at an enhanced support subscription program. We do have money in the budget for equipment. We budgeted $405,000, which may be a little aggressive.. We are projecting a 1.5% increase for 2020. We will also be opening a new IPU, which usually leads to a spike in residential home care census. The census in La Porte and Porter Counties is relatively untapped. A motion was made to accept the 2020 budget as presented. The motion was accepted unanimously.	W. Walsh motioned S. Weirick seconded T. Portolese motioned J. Ewing seconded M. Newbold motioned J. Houin seconded
8. Hospice Foundation Update	• The total for the Capital Campaign continues to rise even though the campaign has been technically over since June 30th. We have five open prospects in the pipeline and three more are pending. To date we have raised $13.5M for a $10M campaign. What has also helped is we are very close to being able to match the Vera Z. Dwyer $1M challenge grant. We have an outstanding ask for that part and someone has said if we don't get it, we could use their gift towards the match. Once that is done, we	

Topic	Discussion	Action
	will receive a $1M check from the Dwyer Trust that will go towards an endowment. • A couple of estate bequests came in since the last board meeting for a total of over $563,000. The St. Joe Valley Street Rods raised $11,500 this year selling coupons for Barnaby's pizza. Over the years this group has donated $125,450. We will have a naming opportunity for them on our campus. • Education – We are working in a lot of different areas. See the President's Report for more details. We are doing grief and advance care planning, community education, and collaborating with St. Joseph Health System to do a series of webinars. We are making an effort to keep our name out there in the community. • International – Staff participated in the PCAU biennial conference September 5-6. This year Annette Deguch and Kristiana Donahue did presentations, and then shadowed PCAU staff the following week. At the conference gala we were presented with an award from the Ugandan Minister of Health. We had an opportunity to visit the Mulago School of Nursing and Midwifery. When we did scholarships with Hospice Africa Uganda, we could only sponsor eight students at a time. Now we can sponsor 30 because the government has taken over the training program. 27 students are currently in training. GPIC has 40 U.S. partners with 40 organizations in 13 different countries, and have four new U.S. prospects. Staff attended the APCA conference in September. We did a one day workshop on international partnerships. Three or four members of the GPIC advisory council also attended. We are working on research projects with the University of Alberta, the University of Kansas Medical Center, and Notre Dame. • The clinical staff building is now occupied. We held a series of orientation with staff about the Mishawaka campus building and grounds. The move went very smoothly. • The Raclin House dedication was last night. DJ Construction and Office Interiors did a lot of work over the past few days to get the building ready for the ceremony. There are still some behind the scenes things that need to be done. We are working hard to get everything done shortly after the first of the year. Then we'll turn our attention to the Roseland facility and developing it for Milton Adult Day Services. . • Tim P. reported he is working on an initiative to fund an endowment for the IPU's dog. An area was built for a service dog at Raclin House. He is estimating $50,000 to purchase, train, and set up an endowment for food and health care for the dog. He has raised $5,000 already. Of all of the National Hospice Executive Roundtable	

Topic	Discussion	Action
	members that have IPUs, and they all do, we are the only one that doesn't have a service / therapy dog.	
9. Nominations	• The new CHC Board candidates are Roland Chamblee and Kurt Janowsky. Their bios are in the board packet. A motion was made to accept the nomination of the two new CHC Board members as presented. The motion was accepted unanimously. • The 2020 CHC Board officers will be: Chair – Mary Newbold, Vice Chair – Jennifer Ewing, Treasurer – Tricia Luck, Secretary – Jennifer Houin, Immediate Past Chair – Wendell Walsh, Hospice Foundation Immediate Past Chair – Amy Kuhar Mauro. A motion was made to accept the Board officers as presented. The motion was accepted unanimously.	J. Ewing motioned J. Houin seconded T. Portolese motioned M. Wobbe seconded
10. Board Education	• Milton Adult Day Services – A presentation was done on the future plans for Milton Adult Day Services in Roseland and Care Connections at Milton Village, the fundraising already received, what additional funds will be needed, and the collaboration between CHC, the Hospice Foundation, Alzheimer's & Dementia Services of Northern Indiana (ADSNI), and REAL Services. We have been involved with MADS since 2016. We met with people from Vivium Group, a consulting firm from the Netherlands, to discuss how to translate their residential model to a day care model. Currently REAL Services leases a building on Colfax, and the tenants include Milton ADS, Care Connections, ADSNI, and the Institute for Excellence in Memory Care. After the transition, tenants would be leasing space from us. The architects from Helman-Sechrist attended the Vivium planning meetings. They are very enthusiastic about the project. REAL Services received a $750,000 grant from the Community Foundation of St. Joseph County to jump start the project. We used some of that money to bring Vivium here. They also received a $500,000 grant and will receive that money at the tail end of the project. We are estimating a cost of $3.5-$5M. One foundation said when we get to $2.7M, they would give us the remaining $500,000. That would leave a gap of about $2M, so we are having conversations with a number of different foundations and individuals. We have $500,000 asks out to two foundations, and are in the process of working on some $250,000 grants. Milton's census is now around 20, and we are targeting 50 for the new building. The History Museum will be one of the partners and also the St. Joseph Library.	
11. Chairman's	• The list of Board committees is in the packet. If anyone would like to serve on a	

Topic	Discussion	Action
Report	committee, let Mark M. or Mary N. know. • Board members recognition – Tim P. and Carol W. finished serving their second terms. Carol W. has agreed to continue on the QI Committee. • Board meeting frequency – Mary N. was approached by some board members about moving the number of meetings back to six a year instead of four. This organization run so smoothly that board involvement is not as needed as much as some boards. Maybe we could go to five meetings a year. Board attendance has been higher since we went to four meetings. Four meetings lacks the engagement, which is why serving on a committee is extremely important. Reach out to Mary N. of your area of expertise or what you want to learn more about. It was decided to keep the meetings at 7:15 a.m. New board member orientation is held in January, and the first board meeting is in February so we can do the year in review. The Board would like to keep the last meeting of the year in November instead of December. • A motion was made to have the Executive Committee set the number of board meetings. The motion was accepted unanimously. They will meet in early January and make a decision. • In the board packet is the list of 2020 Hospice Foundation Events and PCAU ten year report.	W. Walsh motioned S. Weirick seconded
Adjournment	• The meeting adjourned at 8:45 a.m.	Next meeting 02/19

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

Jennifer Houin, Secretary

Becky Kizer, Recording Secretary

Center for Hospice Care

AICDs: ARTICULATION OF IMPLANTED CARDIOVERTER/DEFIBRILLATORS

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

PURPOSE: The articulation of:

- The management of patients with implanted cardioverter/defibrillators
- The circumstances under which *Center for Hospice Care* and its employees will deactivate an implanted cardioverter/defibrillator
- The method for deactivation~~doing so~~.

POLICY:

1. At the time of admission of a patient with an implanted cardioverter/defibrillator , the admitting nurse will inquire~~determine~~ whether or not the device is active and will record that information in the CHC Admission Outline~~Start of Care form~~. If the device is active, and the patient and/or his/her surrogate wishes to have the device deactivated, the admitting nurse will seek an order allowing the staff to deactivate the device immediately ~~emergently,~~ using a magnet.~~, at the request of the patient or his/her surrogate.~~

2. Elective inactivation of the device can be performed by the patient's cardiologist in their office.

3. Ultimate responsibility for following up on the order to use the magnet and on the magnet's location will fall to the case manager.

4. In circumstances where a patient or designee clearly wish the ~~emergent~~ deactivation of an implanted cardioverter/defibrillator, as determined by appropriate counseling and discussion, the Registered Nurse will inactivate the defibrillator by the application of a magnet over the device generator until such time as the patient
   - Elects to resume the use of the device
   - Has the device turned off by reprogramming of the device
   - Dies

5. An Alert will be placed in the record, so all staff are aware the magnet is present in the home.

6. Responsibility for the retrieval and cleaning of the magnet lies with the person who performs the death visit.

PROCEDURE: **Admission:**

Admissions staff will query each patient about the presence of a cardioverter/ defibrillator regardless of admission diagnosis

1. In patients who have such a device implanted, it will be determined whether or not the device is active.

Signature: President/CEO

2. In the event the device is active, upon patient and/or surrogate request, an order permitting the ~~emergency~~ deactivation of the device with a magnet ~~upon patient/surrogate request~~ will be sought from the attending physician.

3. In the event that the order above is not obtained at the time of admission, it will be pursued by the case manager.

Candidacy:

In order for a patient to be a candidate for deactivation of the ardioverter/defibrillator:

1. The patient must have a Do Not Resuscitate order in place
2. The patient/designee must be counseled that the likely result of deactivating the device may be the death of the patient from arrhythmia
3. Where possible, conflict among family members as to this issue should be resolved

Procedure:

1. Where elective deactivation is considered, arrangement will be made with the patient's cardiologist or electrophysiologist to inactivate the device by reprogramming it.
2. Where ~~emergent~~ deactivation is desired, the nurse will:
    a. Place an appropriate magnet over the device generator and secured there by whatever means is most comfortable for the patient. The magnet will deactivate the device only so long as it is in place, and so must be left in place until it is no longer necessary to deactivate the device.
    b. Notify the triage nurse of the placement of the magnet
    c. Document the placement of the magnet in a Secure Message, as well as in a patient note.
    d. Place an asterisk in parentheses [(*)] following the text of the order permitting its placement
3. When the patient no longer requires the magnet, the magnet will be returned to its appropriate branch and cleaned with soap and water, then wiped down with 10% bleach solution.
4. Recovery and cleaning of the magnet will be the responsibility of the patient's case manager.
5. Magnets are located at each branch office, at a location to be determined by the Patient Care Coordinator.

Effective Date: 09/06	Revised Date: 11/19~~05/16~~	Board Approved: 10/19/16
Reviewed Date: 07/19		Signature Date: 10/19/16

Signature: President/CEO

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
February 19, 2020
(Report posted to Secure Board Website on February 11, 2020)

This meeting takes place in Conference Room A at the Mishawaka Campus at 7:15 AM. This report includes event information from November 21, 2019 – February 18, 2020. The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

CENSUS

Average daily census (ADC) ended 2019 at record levels for the year. ADC was 420 for the calendar year. This has remarkably continued into 2020, which is very unusual at the beginning of a calendar year. January ADC was 431, another all-time agency record. Through February 18, ADC is 445. Year-to-date on 2/18/2020 was 435. Both inpatient units have recently been very busy, but census in each unit has been choppy. On 2/10/2020, we had 17 patients in a total of 14 beds at the two Inpatient Units (IPU). However, the census changes rapidly and we may have many empty beds the next day or within 24 hours. The January 2020 number of IPU patients in South Bend is even with 2019 while the Elkhart IPU is up 57%. There is no explanation. Historically, we usually begin each year slowly and build up throughout the year, frequently peaking in early fall. Again, this census is very unusual for this time of year.

January 2020	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	599	599	511	17.22%
Original Admissions	180	180	142	26.76%
ADC Hospice	396.58	396.58	350.00	13.31%
ADC Home Health	34.84	34.84	27.68	25.87%
ADC CHC Total	431.42	431.42	377.68	14.23%

CHC HOSPICE INPATIENT UNITS

January 2020	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
SB House Pts Served	40	40	40	0.00%
SB House ALOS	3.10	3.10	4.23	-26.71%
SB House Occupancy	57.14%	57.14%	77.88%	-26.63%
Elk House Pts Served	36	36	23	55.52%
Elk House ALOS	3.44	3.44	3.65	-5.75%
Elk House Occupancy	57.14%	57.14%	38.71%	47.61%

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2020 Jan	**2020** Feb	**2020** Mar	**2020** Apr	**2019** May	**2019** June	**2019** July	**2019** Aug	**2019** Sept	**2019** Oct	**2019** Nov	**2019** Dec
S.B.:	220				221	228	234	231	224	230	230	225
Ply:	70				74	76	67	66	69	68	65	71
Elk:	120				101	105	105	107	111	111	107	114
Lap:	14				24	23	21	15	13	12	13	12
SBH:	4				4	5	6	6	5	4	6	5
EKH:	4				4	4	6	4	3	3	4	4
Total:	431				428	441	439	429	425	428	424	432

PATIENTS IN FACILITIES

Of the 599 patients served in January 2020, 171 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in January 2020 was 142 compared to 129 in January 2019.

FINANCES

Karl Holderman, CFO, reports the year-to-date December DRAFT 2019 Financials will be posted to the Board website on Friday morning, February 14th following Finance Committee approval. For informational purposes, we are pleased to present the unapproved November 2019 year-end financials on the next page. As always, we will only be covering the year-end 2019 Financials at this February meeting. January – April 2020 financials along with the 2019 audited financial statements will be presented at the May 2020 CHC board meeting.

On 11/30/19, at the HF, intermediate investments totaled $4,788,197. Long term investments totaled $21,849,506. The combined total assets of all organizations, including GPIC, on September 30, 2019 totaled $66,823,744, an increase of $13,159,391 or an increase of 25%, from November 2019. Year-to-date investments as of 11/30/19 showed a gain of $3,602,273.

From a year-to-date budget standpoint at 11/30/19, CHC alone was over budget on operating revenue by $646,893, over budget on total revenue by $3,143,242, and under budget on operating expenses by $1,089,344.

Year to Date November 2019 Financials

November 2019 Year to Date Summary	**Center for Hospice Care**	**Hospice Foundation**	**GPIC**	**Combined**
CHC Operating Income	21,097,463			**21,097,463**
MADS Revenue	331,848			**331,848**
Development Income		2,205,071		**2,205,071**
Partnership Grants			464,414	**464,414**
Investment Income (Net)		3,602,273		**3,602,273**
Interest & Other	27,735	60,298	34,525	**122,558**
Beneficial Interest in Affiliate	3,125,009	(4,526)		
Total Revenue	**24,582,055**	**5,863,116**	**498,940**	**27,823,628**
Total Expenses	**19,069,922**	**2,738,107**	**503,466**	**22,311,495**
Net Gain	**5,512,133**	**3,125,009**	**(4,526)**	**5,512,133**
Net w/o Beneficial Interest	*2,387,124*	*3,129,535*		
Net w/o Investments				***1,909,860***

CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

With the retirement of Gregory Gifford, MD, JD, on December 31, 2019, Karissa Misner, D.O., M.P.T., who joined our medical staff on August 19, 2019 has been appointed to the position of Medical Director. Dr. Misner is Board Certified in Rehabilitative Medicine and is Board Eligible in Hospice and Palliative Medicine. Before Dr. Gifford retired, he devoted himself full-time to completing hospice Medicare certifications and recertifications. Unbilled receivables in July of 2019 were $4.3 million. As of December 31, unbilled receivables were down to about $140,000.

We currently have an opening for two full-time physicians to assist with the growth in the level of patients we are experiencing. Dr. Misner and Dave will be attending the annual meeting of the American Association of Hospice and Palliative Medicine from April 18 to 21. The purpose will be to recruit another physician and to introduce Dr. Misner to Molly Feely, MD, the Hospice and Palliative Medicine Fellowship Program Director at the Mayo Clinic.

Amanda Schmidt, MD, a Family Practice physician in Goshen, Indiana will be visiting our Mishawaka campus on February 13. She will be attending the Indiana University School of Medicine Hospice and Palliative Medicine Fellowship Program in Indianapolis beginning in July 2020. She will be named the new Vera Z. Dwyer Fellow in Hospice and Palliative Medicine for 2020-2021.

John Mulder, MD, FAAHPM, HMDC, the Hospice and Palliative Medicine Fellowship Program Director at Holland Home Hospice in Grand Rapids, Michigan, will be visiting our campus on February 17. We will be discussing a possible affiliation between our organizations for the training of Hospice and Palliative Medicine Fellows.

For the four-year period from 2016 to 2019 we had 1,228 patients in our HeartWize program for congestive heart failure. 99% of these patients did not go to an Emergency Room. 98% were not admitted to a hospital. For the same time period we had 964 patients in our BreatheEazy program for chronic obstructive pulmonary disease. 99% did not go to an Emergency Room. 97% were not admitted to a hospital. These high numbers speak to our ability to keep patients out of the hospital through the high-quality patient care we provide.

There were 1,495 total deaths in 2019. This averages out to 4.1 deaths every day or one death every six hours on average. There were also three patient suicides during 2019. Our annual Bereavement Services held on November 24 had 508 attendees. They were held at the Kroc Center in South Bend, Trinity Church on Jackson in Elkhart, and at Christos in Plymouth.

There were 132 total Hospital referred deaths before admission (DBAs) in 2019 resulting from 1,088 total Hospital referrals. This resulted in 1 out of every eight Hospital referrals being a DBA. This amounts to 13%' which is 1 every 2.8 days. The highest months were February, December, and March (47%). The most frequent day of the week for a DBA was Friday (21%).

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 were presented: "How to Develop an ELNEC (End of Life Nursing Consortium) Program for your Clinical Staff" and "QAPI Success—End Stage Cardiopulmonary Program." The evaluations from the programs were all rated at a good to excellent level.

The following Education Programs were held since our last board meeting:

- Annual Nursing Skills Competency Fair: which included skill sets related to Infusions, Wounds, Pacemakers and TB certification for all nurses. The program is required on an annual basis and there was 100% attendance.
- Cardiac and Pulmonary Boot Camp: which is an eight-hour program for all nurses to review the Breatheazy and Heartwize Programs.
- Activity Levels for Patients during an Emergency: this was an independent learning packet to review levels of care required for patients in their home during an emergency or disaster.

- Education Corner: A newsletter is published weekly for all nursing personnel with current updates related to clinical care of the patient and their families.

- Certification in Hospice and Palliative Nursing (CHPN): During this quarter three RN's and one CNA received their Certification in Hospice and Palliative Nursing. This is an examination which confirms their knowledge base to care for terminally ill patients. Presently there are 12 RN's certified and 3 CNA's. In March 2020, 7 RN's are scheduled to take the exam for certification. This certificate is awarded by the Advanced Expert Care by the Hospice & Palliative Nurses Credentialing Center.

On January 23, The Indiana State Department of Health completed our Retail Food Establishment Inspection at the South Bend Inpatient Unit. There were no deficiencies or non-compliance noted in this unannounced survey. CHC is in full compliance.

The Raclin House inpatient unit is currently in the process of organizing supplies and the medication room. Education and competencies related to the building, new hospital beds, emergency preparedness, and safety is occurring for all staff in preparation of the Raclin House opening to care for patients.

Since June of 2019 we have been collaborating with McKesson, our contracted company for our medical supplies. We have coordinated with McKesson to standardize and decrease our inventory. Since the implementation of reviewing the inventory and usage levels we have had a significant decrease from 400 items to 250 items. Comparing the 3rd Quarter to the 4th quarter we have a spending variance decrease of -26%. During 2020 we will develop a formulary and electronic scanners for ordering to further decrease the inventory and cost.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

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

Year to Date Total Revenue (Cumulative)

	2016	2017	2018	2019
January	65,460.71	46,552.99	37,015.96	62,707.48
February	101,643.17	199,939.17	93,912.90	113,771.80
March	178,212.01	282,326.61	220,485.17	369,862.26
April	341,637.10	431,871.55	310,093.61	565,568.94
May	579,888.08	574,854.27	505,075.65	663,483.70
June	710,175.32	1,066,118.11	633,102.69	850,496.19
July	1,072,579.84	1,277,609.56	767,397.15	918,451.53
August	1,205,050.76	1,346,219.26	868,232.25	1,018,532.22
September	1,297.009.78	1,466,460.27	994,301.35	1,122,498.94
October	1,421,110.26	1,593,668.39	1,074,820.86	1,778,379.29
November	1,494,702.09	2,443,869.12	1,173,928.93	1,841,457.95
December	2,018,630.54	2,730,551.86	1,635,368.33	2,946,889.74

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	57,214.65
December	161,519.80	138,328.11	286,687.74	191,211.72	225,547.36
Total	**1,257,310.96**	**1,064,532.86**	**1,319,883.75**	**1,134,560.06**	**1,236,924.15**

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. Since our last report, the addition of campaign gifts solicited prior to 6/30/19 and received since that date resulted in a new campaign total of $14,080,165.

Planned Giving

Estate gifts since the last report totaled $3,000. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients.

Annual Giving

Response to our 2019 annual appeal mailing, sent out in late November 2019 continues to be positive with gifts totaling $87,309.68 through 12/31/19.

Special Events & Projects

We welcomed Dr. Collin Bowman as the most recent Vera Z. Dwyer Fellow in Hospice and Palliative Medicine at a reception on November 21 in Raclin-Carmichael Hall at the IU School of Medicine-South Bend.

CHC benefitted from the Mishawaka Police Department's first No Shave November fundraiser. Sixty-four Mishawaka police officers, the Veterans Affairs Police Department and private donations resulted in a donation of $3,062 to CHC. Representatives of the police department visited CHC on December 4 to make a check presentation.

A dedication ceremony, open houses and tours of the Ernestine M. Raclin House began in November. The facility was dedicated at an event that took place on November 19, 2019. Ernie Raclin attended, toured the facility and shared some comments at the event. We estimate that more than 150 people attended and toured the Raclin House dedication. Two subsequent open houses took place on December 10 and 17. We partnered with the South Bend Regional Chamber of Commerce to host the December 10 event, which was open to the general public. On December 17, the Raclin House was open to all staff members and volunteers from all CHC offices to tour.

We were fortunate to benefit from two holiday related fundraisers in December. The first Claus and Cookies event took place on December 21 at Pella Windows and Doors Pella Experience Center located at Indian Ridge Plaza in Mishawaka. Those participating in the event had an opportunity to decorate cookies and visit with Santa. While there was no charge, donations to CHC were accepted. Wellfield Botanic Gardens selected CHC/HF to decorate a giving tree to be displayed as part of its annual Winter Wonderland Holiday Lights Giving Tree project. The bereavement staff decorated a Camp Evergreen themed tree. As a participant in the project, we received both a percentage of the online ticket sales and a percentage of the sale of the tickets sold at the gate on December 27, the night that our tree was featured.

Palliative Care Association of Uganda (PCAU)

We will host our partners from PCAU between March 15th – April 4th, 2020. This will be PCAU's sixth exchange visit to the US. Mark Mwesiga, the new PCAU Country Director, and Joyce Zalwango, the Capacity Building and Advocacy Officer, are scheduled to make the visit. This will be Mark's third time to visit but his first as PCAU's Country Director. Joyce will be traveling to the US for the first time. She is one of the many nurses CHC/HF sponsored through the Diploma in Clinical Palliative Care course. The exchange visit provides a platform for CHC/HF and PCAU staff to meet in person to deepen relationships, gain first-hand experience to better understand each other's work, and share knowledge and ideas to enhance access of hospice and palliative care. We are planning several meetings and events to engage our staff and community partners such as Notre Dame, IUSB and others. Mark will also travel to the NHPCO Leadership and Advocacy Conference with CHC/HF staff. In addition, this year's edition of Okuyamba Fest will be held on April 2nd at The Brick.

Roberta Spencer, our long-time CHC/HF volunteer, was in Uganda from Jan 17th - Feb 7th. As with previous visits, she supported the Road to Hope (RTH) program and participated in the annual RTH Camp and Empowerment Retreat. Her blog can be found on our website at https://foundationforhospice.org/uganda-trips/

The RTH Camp and Empowerment Retreat was held on Jan 23rd – 25th; 55 of the 57 children on the program attended. The goal of this retreat is to help the children feel loved, valued as individuals, and empower them to the best of their abilities – and in making good choices, especially with making friends. According to Roberta's reports, the children are doing well and have grown emotionally and physically since the last camp. They are appreciative of their sponsors and realize that the education they receive is thanks to their sponsors. The children began the first trimester of the year on Feb 3rd. We are continuing to work on our overall fundraising strategy. Some sponsors have increased their giving since we shared the new sponsorship costs, but we still have gaps to fill.

Kat Kostolansky, a junior at the University of Notre Dame who spent a successful summer working with PCAU supporting the Road to Hope program, will continue her internship in the office for the spring semester. She will work with us on an evaluation of the RTH program. Ainur Kagarmanova, a Master of Science in Global Health student from the University of Notre Dame, is working with the mHealth project. She will be in Uganda during May and June.

Regarding the Advanced Diploma in Palliative Care Nursing (ADCPCN), the continuing students will be resuming their semester on 20th January 2020. The new students will be interviewed in March, then start the program in July 2020. Coordination with the hospital directors and district health officers is ongoing to ensure effective recruitment of the students.

Health System/Education Collaborations

During December, the Center for Education & Advance Care Planning (CEACP) hosted "Cupcakes to Die for" on our Mishawaka Campus. This event showcased the educational opportunities offered through CEACP to area organizations. Through the event we connected with Grand Emerald. We will be collaborating with them in 2020 on a webinar series that offers CEs for their home health administrative employees. The collaboration will be built on the same model as the Saint Joseph Health System (SJHS) webinar series. One of the many benefits of working with SJHS is that it has increased awareness of end-of-life issues to a variety of disciplines as well as giving CHC/HF another touchpoint there. We are scheduling the 2020 series now.

Legislator Education

As the MyHospice Ambassador for the state of Indiana, Elleah Tooker took on "social media day" at the beginning of November. Elleah and I partnered with Dr. Lyle Fettig, Director of the Hospice and Palliative Medicine fellowship program at the IU School of Medicine to send a letter to Senator

Mike Braun requesting his support for the Palliative Care and Hospice Education and Training Act (PCHETA). This bill is supported by NHPCO and garnered bipartisan support in the House where it passed. Elleah is also working with the offices of senators Mike Braun and Todd Young to arrange visits to our Mishawaka Campus. Senator Braun's staffers have pushed to have him visit in 2020. In her role as a MyHospice Ambassador, Elleah will continue to work with our senators and representatives to ensure that bills benefiting the hospice community are supported in the House and Senate.

Community Education

We are partnering with Chicory Café (Mishawaka) to bring "Death by Chocolate" to downtown Mishawaka. This Mardi Gras-themed event will focus on normalizing conversations about end-of-life care by providing a welcoming atmosphere with food and educational games. The event is scheduled for 5:30 pm on February 25th – watch your email for an invite with RSVP.

Advance Directives Education

Part of our work with Honoring Choices Indiana – North Central 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.

Professional Education Collaborations

We held our first education webinar with Advocacy Links in January. Advocacy Links provides services for individuals with intellectual and developmental disabilities. The company provides training webinars quarterly and worked with the Center for Education & Advance Care Planning to develop educational offerings for their employees. The first was "Hospice 101"; in October we will provide another webinar on supported choices and end-of-life arrangements.

Ernestine M. Raclin House

Construction is complete at our new 12-bed inpatient facility, the Ernestine M. Raclin House. Staff orientations took place in January. We are presently working on completing behind-the-scenes IT and AV infrastructure items as well as furnishing and open punch list items. Once all those items are completed, we will schedule the required inspections with the ISDH and open immediately thereafter.

Residential Housing

The Cedar Street home was sold at a purchase price of $384,900. The new neighbors have moved in. They also purchased the second lot, there will be no second residential property, and this project is completed.

Roseland Remodel

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 Village and the Caregiver Connection at Milton

Village, and the offices for the Institute for Advance Memory Care operated by Alzheimer's and Dementia Services of Northern Indiana.

Maintenance Building

Plans are underway for construction of the new maintenance building which will be located on our land located at the corner of the Pine Street and Comfort Place. Construction will begin this spring.

GLOBAL PARTNERS IN CARE

General Updates

We were awarded a $10,000 grant from the Ronald W. Naito MD Foundation in Portland, OR to support our Partnership Program. They actually contacted us to apply. We are working closely with Chris Taelman to make further advances in this area and GPIC is now included as an area of focus for the larger HF fundraising strategy which is being guided by an outside consultant. The HF is planning to add a grant writer to staff this year, which will benefit GPIC as well. In 2019, we established two new partnerships and had two additional potential partnerships that we are hopeful will launch in the coming months. St. Luke's Hospital (Malawi) visited Hospice of Northwest Ohio (Toledo) and HNO and St. Luke's staff visited GPIC Feb 5-7, spending the 6th with us at the Mishawaka Campus. All visitors stayed at our guest house.

GPIC activities for 2020 continue to center around three goals: 1.) Research and Education, 2.) Effectively communicate GPIC branding and raise profile of GPIC internationally, and 3.) Establish financial and operational sustainability for GPIC. We currently have 37 partnerships.

We continue to remain engaged in several research collaborations with various university and organizational partners, all of whom are very supportive of our role as a collaborator on these projects. They include: Understanding the Challenges of the Ageing Population in Ghana with the University of Alberta, College of Saint Benedict and St. John's University in Minnesota, and the African Palliative Care Association (APCA); and Telehospice in Tanzania with the University of Kansas Medical Center (KUMC), University of Notre Dame (UND) and Evangelical Lutheran Church in Tanzania;

GPIC will be attending the NHPCO Leadership and Advocacy Conference, Washington, DC in late March. We will have a team attending this conference representing both CHC and GPIC. GPIC will hold a meeting of our Advisory Council and a GPIC luncheon to gather our partners and give our Global Partnership Award. As we did in 2018 GPIC will be present at the International Congress on Palliative Care, Montreal, CA to raise GPIC's profile among potential partners. This was a good meeting place for some partner organizations. We have submitted an abstract for a partnership workshop and are considering attending in 2020. GPIC staff person Lacey Ahern and Sheba Nyakaisiki (from Uganda Martyrs University) will likely be attending the Consortium of Universities for Global Health Conference, Washington, DC. CHC/HF and the University of Notre Dame have worked with Sheba on the mHealth project with PCAU. She will also visit SB/Mishawaka in April and be hosted by the University of Notre Dame along with CHC/HF.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for November & December 2019 – January 2020

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities in order to build relationships and generate referrals. In November 2019 through January 2020 our four Professional Relations Liaisons completed 1,492 visits to current and potential referral sources within our service area. They accomplished 419, 479, and 594 visits in November thru January respectively.

Peter Ashley, Community Relations and Engagement Liaison, left CHC in December to take a VP of Marketing position at Hanover College. We're proud to announce that Sarah Youngs has accepted and begun working in her new role. Previously, Sarah worked in the Admissions Department for six years, in part as Admissions Coordinator, where she gained extensive knowledge and experience of educating the public regarding our mission, values and services. She will oversee non-medical referral sources such as veteran groups, community organizations, faith communities and chambers of commerce. Sarah also comes to Center for Hospice Care's Marketing Department with 10+ years marketing and operations experience where she previously operated and/or marketed a start-up home health agency 2007-2011, adult day care 2017-2019 and assisted living 2019. While at each company, Sarah was instrumental in their growth by increasing referrals, community outreach and awareness as well as overall success of the companies. We're extremely excited that Sarah has returned to CHC.

Access

We also were able to maintain a conversion rate of over 70% with the final statistic being 71.86%. That includes considering that we had an increase in "deaths before admission" (DBA) of 8.03% of all referrals which was an increase over the previous year of 5.1%.

In 2019 the average daily census (ADC) in hospice increased while home health increased 57.84% for an overall increase of 6.81%. Part of our Marketing focus has been in long-term care which led to an increase in the number of our patients in facilities (Extended Care Facilities, Assisted Living Facilities and Group Homes) of over 11.51% compared with the same time last year. Our same or next day referral to admit was 51.55% in 2019, with no significant statistical change over 2018.

Website

Our new website launched in January and is designed to allow caregivers and those facing life-limiting illnesses to easily find information about hospice, and specifically, information about Center for Hospice Care that would encourage them to contact us for help. The homepage has three tabs entitled, "I am a caregiver.", "I have a life-limiting illness." and "I am grieving the loss of a loved one." Also listed are testimonial quotes, links to patient stories as well as upcoming events and links to further information about our organization. It is branded with the consistency of the other CHC websites including the Hospice Foundation, Center for Education for Advance Care Planning, Global Partners in Care and soon to be Milton Adult Day Care. Although the bulk of the changes are complete, the website will be an ongoing project. One of the new features will be 360-degree photos of specific locations (patient rooms, common areas, etc.) of the new Ernestine M. Raclin House that will allow a realistic view of the facility with plans to also include Esther's House soon. The new site is also responsive and is easily viewed on mobile devices without losing quality of content.

Social Media

Facebook (Center4Hospice)

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. CHC reached 135,992 people for the period of November 2019 – January 2020, and had 17,259 reactions, comments and shares. Our leading post was on January 7th: Our People are Everything. It highlighted our incredible team of passionate and professional staff along with how honored we are to be with patients and families at this special time in their life. It reached 4,315 people and generated 529 reactions, comments and shares. The second most viewed posting was on January 25th and explained that CHC, for over 40 years, has lived up to its promise that anyone eligible for hospice services will not be turned away. It reached 3,815 people and generated 413 reactions, comments and shares, as well as 203 post clicks. We currently have over 4,300 Facebook followers.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of November – January it generated 153 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 10.36%.

CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There is only one clinical policy on the agenda, and it represents some simple cleanup of an existing policy "Articulation of Implanted Cardioverter/Defibrillators."

NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MET IN JANUARY

The National Hospice Executive Roundtable met January 5-6 in Miami, FL, home of our consultant, Peter Benjamin of the Huntington Consulting Group. We meet each year the week after New Year's because hotel rates are low and because Peter lives there and the group incurs no travel expenses for him. Topics included program updates, positioning for the potential Medicare Hospice Managed Care carve out, ongoing contractor audits of hospice programs, CMS changes and strategies to deal with them, ransomware attacks, EEOC complaints, FLSA complaints, and Senior Team Composition/"Business Development" role/functions. We also had a guest speaker, Bob Tavares, Chief Strategy Officer, at Cyft. in Boston, MA who presented on using Artificial Intelligence to accurately predict life expectancy. Cyft. helps leading healthcare organizations turn their raw data into improved clinical and operational outcomes, including Harvard Medical School, Brigham and Women's Hospital, the Department of Defense, the National Cancer Institute, over

200 Department of Veterans Affairs Hospitals, Johns Hopkins, University of Utah, over 60 community hospitals, Ariadne Labs, Optum, Senior Whole Health, Beacon Health Options, Neighborhood Health Plan, and more. A recent NHPCO webinar indicated that A.I. can predict life expectancy in three-month windows (0-3, 3-6, 6-9) with 90% accuracy today. Referral sources overestimate life expectancy by a factor of five, and hospice medical directors get the three-month window accurate at a rate of just 12%.

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

Care Synergy (The Denver Hospice, Halcyon Hospice, Pikes Peak Hospice and Palliative Care, Colorado Visiting Nurse Association, and Pathways), Denver, CO.
Empath Health (Suncoast Hospice, et. al), Clearwater, FL
Ohio's Hospice (Ohio's Hospice of Dayton, Ohio's Hospice at United Church Homes, Ohio's Hospice of Miami County, Ohio's Community Mercy Hospice, Ohio's Hospice of Butler and Warren Counties, Hospice of Central Ohio, Ohio's Hospice of Fayette County, Ohio's Hospice LifeCare, Ohio's Hospice Loving Care, and Community Care Hospice), Dayton, OH.
Bluegrass Care 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
Catholic Hospice, Miami Lakes/Fort Lauderdale, FL
Center for Hospice Care, Mishawaka, IN

2019 ANNUAL GOALS FINAL RESULTS

Included in your packet is a copy of the final status for the 91 individual goals for 2019. Final status is broken down into four categories: "Met" means that the goal was achieved; "In Process" means the goal was started, but not yet completed during calendar year 2019 and likely carried over to 2020; "Not Doing" means after evaluating the goal we decided that for whatever reason we were not going to do the project; and "Not Met" means that we simply didn't get to that goal at all or external factors made the goal unrealistic during the calendar year. Results for 2019 are as follows:

Total Number of Published Goals = 91

Met = 65 (71%)
In Process = 19 (21%)
Not Met = 5 (5%)
Not Doing = 2 (2%)

For 2019, 92% of the 91 individual goals were either completed or were in the process of being completed at the end of the year. We are delighted to answer specific questions on any of the goals and their status at the end of the year.

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

2020 GOALS

Included in your packet are the 2020 Goals for Center for Hospice Care, Hospice Foundation, and Global Partners in Care. Like we have done every year for the past 20 years, we have placed individual goals under the traditional headings which match the four overarching goals of the Strategic Plan. The four overarching goals are: Enhance Patient Care; Position for Future Growth; Maintain Economic Strength; and Continue Building Brand Identification. Annual Goal development begins at the Coordinator level of management and they work their way up through Directors and eventually to the Administrative Team for final approval. We always commence with ideas and concepts from what line staff and middle management staff believes we should accomplish as a leading hospice organization which allows us to improve and enhance our agency and the care we deliver. For 2020, we have 76 individual goals.

2019 BEREAVEMENT STATISTICS

Of the total bereaved clients served (2,987) in 2019, 24% were from community with no connection to CHC. 69% were hospice family survivors and 7% were DBA (Died Before Admission)/Other (bereaved of patients who discharged alive and then died). Last year, the Bereavement Department was averaging 139 deaths per month (including DBA/Other deaths). Of the total individual/family counseling sessions (4,582) 1% were sessions with DBA/Other clients, 35% were with hospice clients and 64% were sessions with community clients.

2019 VOLUNTEER STATISTICS

CHC has several hundred volunteers in a wide variety of service. Medicare requires that volunteers who are participating in direct patient care and hospice programming have their time and mileage be recorded, a dollar amount applied, and these amounts are reported to Medicare as a savings to the hospice on an annual basis. Medicare Hospice is the only provider in the Medicare system required to have a volunteer component under federal statute. During 2019, CHC hospice program volunteers worked 15,711 hours. This is equivalent to 7.5 FTEs who never call in sick or take vacations. These volunteers drove 46,281 miles. This is like driving around the world nearly two times. Volunteers in this capacity provided dollar savings to CHC during 2019 totaling $418,498, up 3% from 2018.

CHC IN CMS CPI LONG LENGTH OF STAY AUDIT

Like many hospice programs across the country, including those members of the National Hospice Executive Roundtable, CHC received notification in a letter dated 1/17/2020 that we are now part of a long length of stay audit. The CMS contracted vendor is requesting everything (thousands of pages) on ten patients who were all admitted or on census in 2017. These account for 330 months of claims and a claim is generated daily as Medicare Hospice is a per diem program. The total dollar amount of these claims total around $1.2MM. From what I hear, no provider who is going through this audit – which began over a year ago -- has received any demand letters so far. Toledo went through this back in June of last year and there has been no recoupment of funds or any attempt. This is a very large national audit of individual programs. I contacted Meg Pekarske, Hospice Law Attorney at Husch Blackwell, LLP, to represent us in this matter and we have engaged her and her team. She is a nationally recognized hospice attorney who has been doing this for 20 years. She is one of the best and most respected in the nation on situations such as these and is being used by numerous Roundtable clients as well as many other large and leading hospice organizations. https://www.huschblackwell.com/professionals/meg-pekarske The Administrative Team had a one-hour phone call with her on 1/29/2020 and are on our way in putting together the requested material. We were successful in being granted an extension by the government contractor conducting this audit, Noridian, and now have until 3/25/2020 to get the materials to them which, because of the sheer volume of records requested, will be sent via CD-ROM. Meg also indicated that this contractor is generating reports for individual programs after examining the materials that all have a 97% to 100% error rate. Some are being told everything they sent is wrong. This is not an audit where sampling methodology is used and then extrapolated into a larger take back by applying the error rate to a universe of claims. There are numerous appeals processes and an eventual appeal before an Administrative Law Judge where hospices frequently win if they can get that far. Getting that far could take as long as five years. Several years ago, you may remember that we were in a Medicaid hospice audit on 12 patients with much shorter lengths of stay. After about five years we were eventually paid for all but two of the patients and our Chief Medical Officer did eventually speak to an ALJ.

Most hospice CEOs in my sphere believe this is the new normal for hospice programs in the United States.

2019 - 2021 STRATEGIC PLAN UPDATE

Included in the February 2019 board packet was the 2016 – 2018 Strategic Plan final status report and the new 2019 – 2021 Strategic Plan, "Preparing for Things to Come." The current strategic plan contains items for the Hospice Foundation and Global Partners in Care. Because those boards are also on the CHC Board, it seemed more expeditious and manageable to present one plan for all three entities than three separate plans. Items in development from the plan during calendar year 2019 included: *Develop a marketing plan for private pay room and board for CHC's inpatients units* (this is currently in development); *fully integrate palliative care into CHC programming and provide resources, innovations, education, and communication on palliative care to the community* (this continues to be in development and palliative care patients were up 59% in 2019 compared to 2018. We are continuing to monitor on a bill currently in the Indiana State Legislature to allow hospice programs to care for non-hospice eligible patients under "palliative care." This is something I've personally been working on as a member of the state funded Indiana Palliative Care and Quality of Life Advisory Council (2016-2019). The Council's funding was sunset last year. *Redomesticate Global Partners in Care from the State of New York to Indiana* (our Indianapolis-based non-profit specialty attorney is working on this now. Due to the peculiarities of New York State, we will have to create a new Indiana corporation first and then transfer GPIC here); *Consider developing a new position tentatively titled "Director of Strategic Initiatives"* (I have personally approached three individuals regarding this position with no luck. I am now planning on paring down the draft job description); and *Continue expanding CHC/HF's role to be perceived as the* *principle resource, leader and voice of hospice and palliative care by being the convener to engage key community stakeholders in the design of what end-of-life care looks like in our community* (Honoring Choices Indiana – North Central, now a d/b/a of Hospice Foundation, continues to grow programming and hired a part-time staff person (who recently announced her retirement) and potential new, additional committee members were interviewed two weeks ago. Again, this is a brief update of what we were working on during 2019 to advance the plan.

The issue the bill currently in the State Legislature referenced above is attempting to resolve:
1. The gap in care between curative care and hospice care.
2. Indiana hospice license does not provide for community based palliative care services.
3. Palliative care is not time limited and curative treatment can continue
4. Palliative care is no longer defined in state statute.

With the perceived solution that would:
1. Define palliative care and community based palliative care
2. Allow licensed hospice providers the opportunity to provide community based palliative care to non-hospice eligible patients
3. Per ISDH, require approved palliative care certifications in addition to hospice license to provide care in home settings.

The IHPCO Board of Directors met on February 6 and my impression is that all of us had serious reservations. Comments like "cart before the horse" and "not ready for primetime" were common.

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.

CONFLICT OF INTEREST POLICY STATEMENT

You will be asked to sign a conflict of interest policy statement for 2020. This is the same statement used in previous years. It is signed each year by every member of the board of directors to meet the requirements of our annual audit and answer specific questions on the IRS Form 990, the nonprofit "tax" return. The document is included as an attachment to this report for you to review prior to Wednesday's meeting. We will have hard copies available for you to sign at the board meeting.

BOARD EDUCATION SECTION

The board education section will be "2019: The Year in Review" presented by your humble narrator.

OUT AND ABOUT

Several staff and board members attended the welcome reception for Dr, Colin Bowman, the latest Vera Z. Dwyer Fellow in Hospice and Palliative Medicine at the Indiana University School of Medicine at the University of Notre Dame on November 21.

All CHC/HF/GPIC and Milton Adult Day Services employees and their children/grandchildren were invited to our annual "Donuts with Santa" on Saturday, December 7 from 9-11 AM at the Mishawaka Campus. 95 people attended compared to 72 in 2018.

The Vivium Hoewey group from the Netherlands spent nearly three days with us to discuss programming for Milton Village. They are international leaders in programming for dementia patients and well respected around the world.

I attended the National Hospice Executive Roundtable meeting in Miami, FL January 5 – 7.

The Administrative Team participated in New Board Member Orientation on January 28 from 7:30 - 9:30 AM.

Saint Joseph Regional Medical Center leadership along with some Trinity staff from Livonia, MI, held several meetings at the Ernestine M. Raclin House on January 29 and 30. A reception was held in their honor the afternoon/evening of 1/30 in the family room which they generously underwrote.

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 Newsletters for December 2019, January 2020, February 2020

Board Committee Opportunity Sheet

Conflict of Interest Policy

Copy of final status report for the 2019 Goals

Copy of the 2020 Goals

NHPCO Statement on House Program Integrity Legislation

Press Release on 73-year-old man bicycling from Florida to California in memory of his daughter to raise funds for CHC.

NPR Morning Edition article, "Patients Want to Die at Home, But Home Hospice Care Can Be Tough on Families"

Front page South Bend Tribune article from 1/5/2020 on "Making Dementia Care More Inclusive" regarding our plans on repurposing the South Bend property for expansion of Milton Adult Day Services

Thank you letter for care received locally from Malvern, PA.

Front page South Bend Tribune article, from 11/22/19 regarding "Hospice Inpatient Site to Open Soon"

South Bend Tribune article from 12/15/2019 regarding the Mishawaka Police Department raising money for CHC for No Shave November.

Article from Science News "Planning for Future care May be Linked to Longer Survival in Terminally Ill Patients"

CNN Wire Story "More People in the US are Dying at Home than at the Hospital"

STAT article, "More Americans are Dying at Home. Is that a Good Thing?"

HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING

January 2020 CHC Financials.

2020 HF Events Schedule that all Board Members are Invited to Attend

Conflict of Interest Policy Statement for the required signatures

Common Abbreviations (always handed out at board meetings)

NEXT REGULAR BOARD MEETING

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

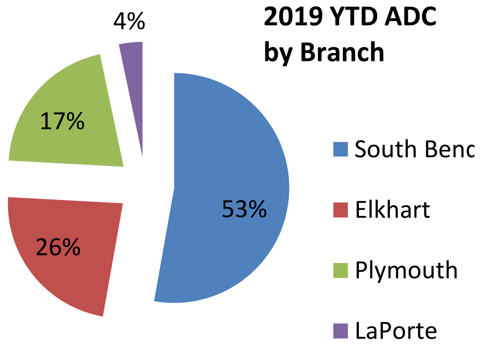
# # #

Center for Hospice Care

2019 YTD Average Daily Census (ADC)

(includes Hospice House and Home Health)

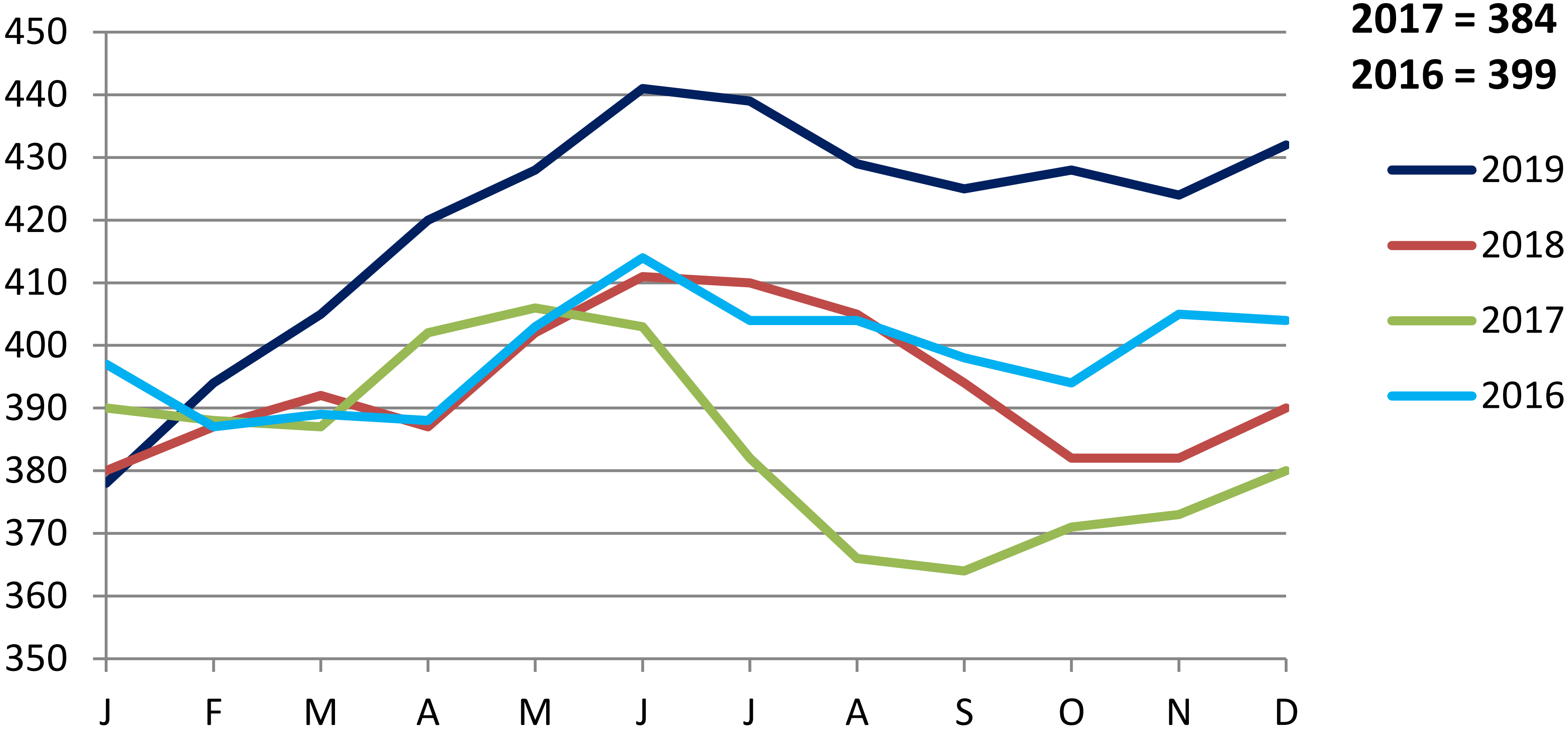
	All	South Bend	Elkhart	Plymouth	LaPorte
J	378	195	95	74	14
F	394	202	98	77	18
M	405	209	99	79	18
A	420	222	101	77	20
M	428	225	105	74	24
J	441	233	109	76	23
J	439	240	111	67	21
A	429	237	111	66	15
S	425	229	114	69	13
O	428	234	114	68	12
N	424	236	110	65	13
D	432	231	119	71	12
2019 YTD Totals	5043	2693	1286	863	203
2019 YTD ADC	**420**	**224**	**107**	**72**	**17**
2018 YTD ADC	394	208	91	82	13
YTD Change 2018 to 2019	26	16	16	-10	NA
YTD % Change 2018 to 2019	**6.7%**	**7.9%**	**17.8%**	**-12.3%**	**NA**



Center for Hospice Care
Total Average Daily Census (ADC)

ADC

YTD 2019 = 420
2018 = 394
2017 = 384
2016 = 399



South Bend
Average Daily Census

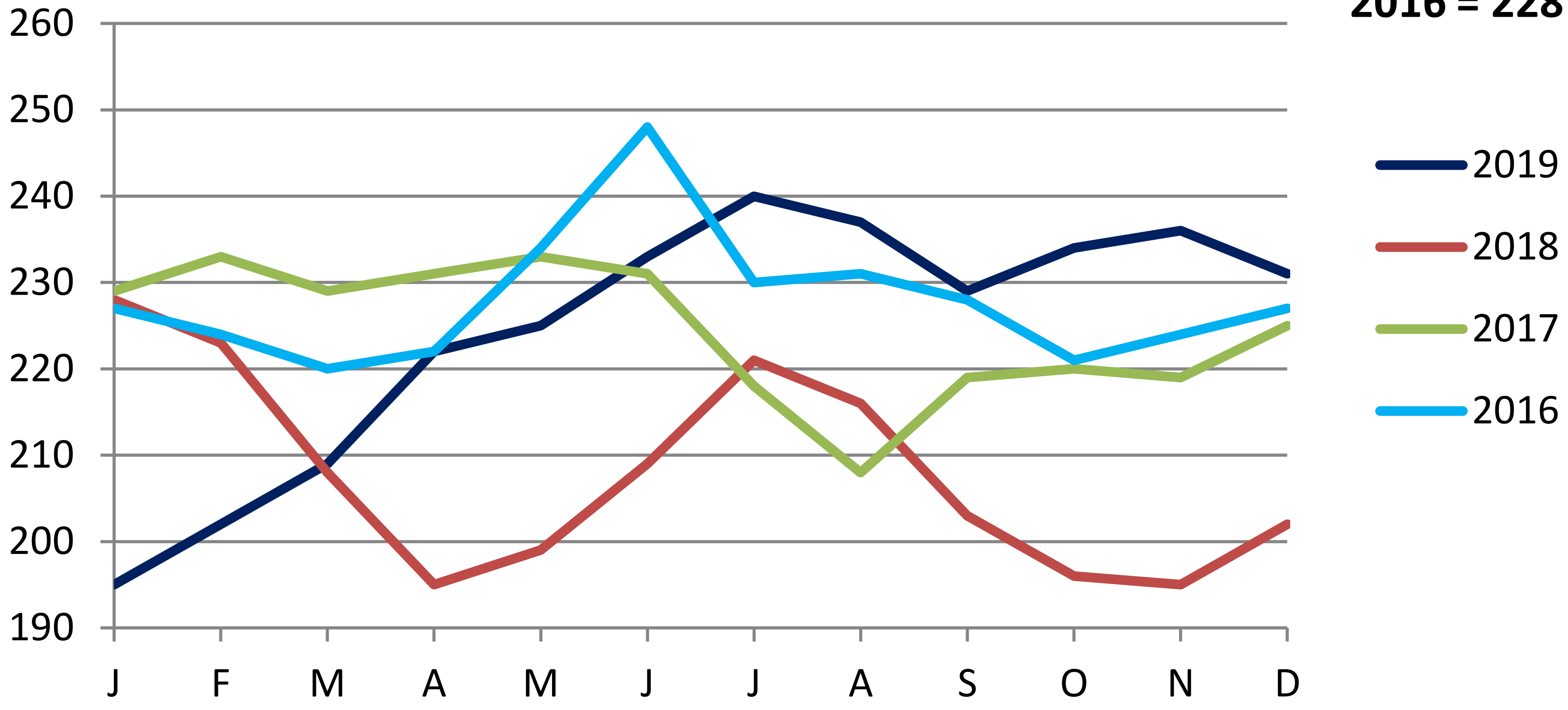
ADC

YTD 2019 = 224

2018 = 208

2017 = 225

2016 = 228



Elkhart
Average Daily Census

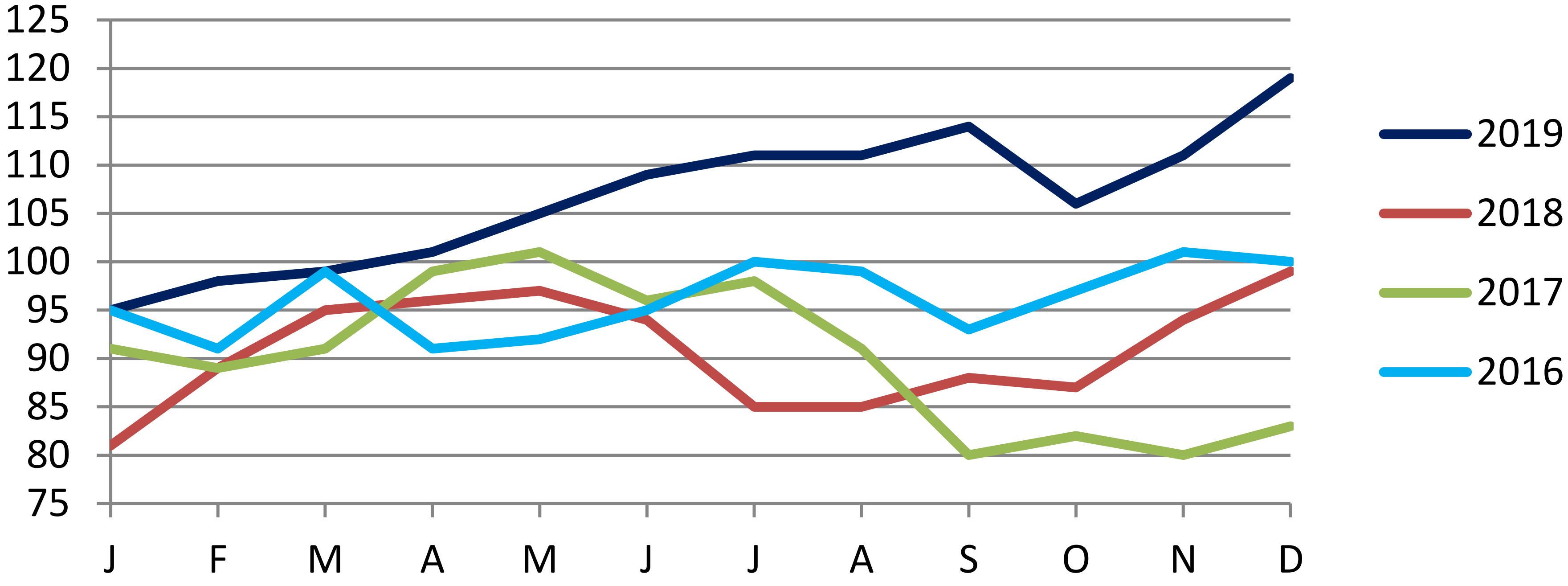
ADC

YTD 2019 =107

2018 = 91

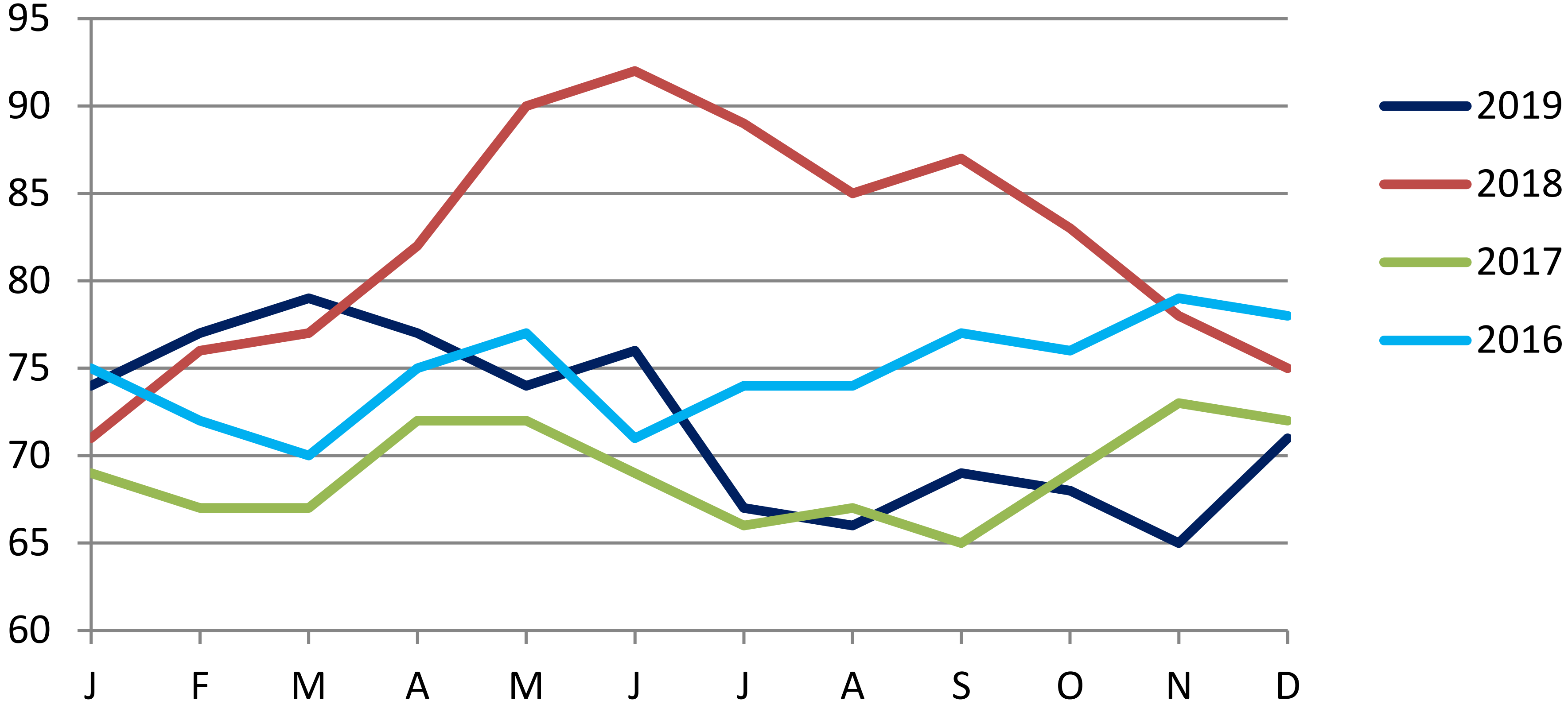
2017 = 90

2016 = 96



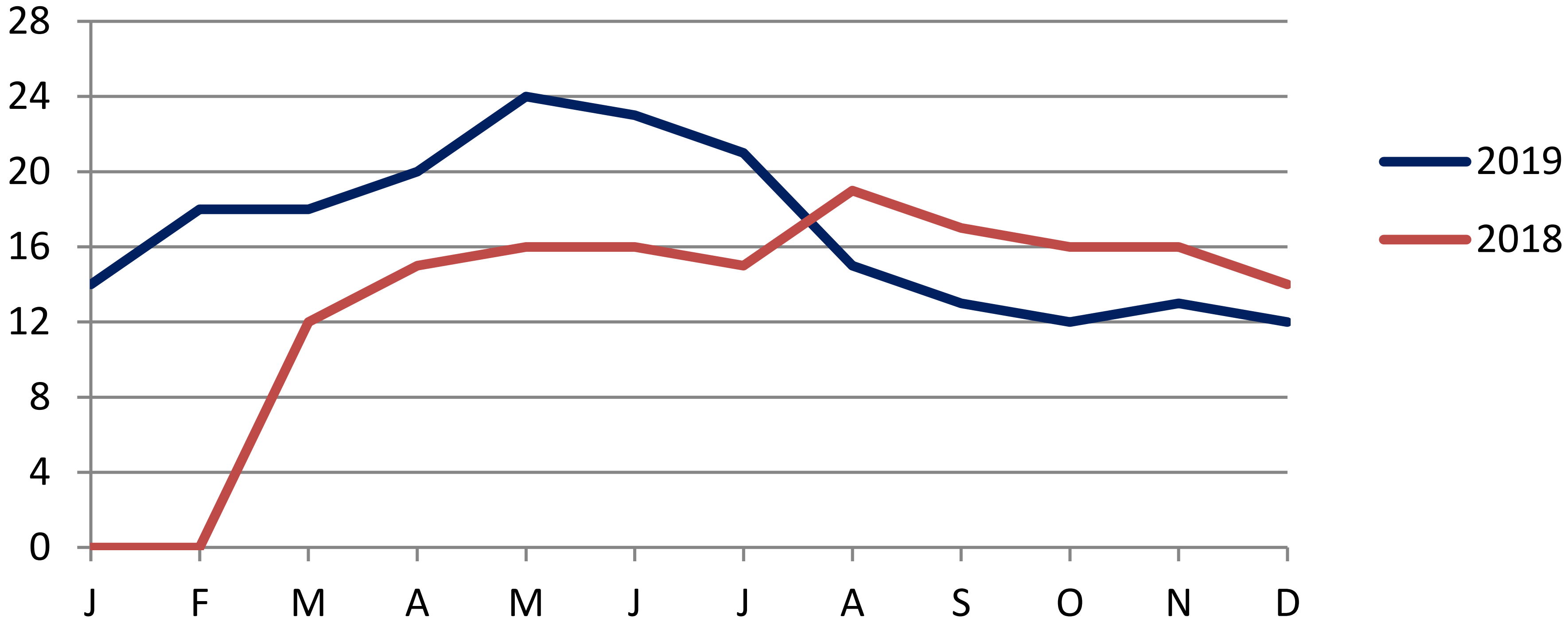
Plymouth
Average Daily Census

ADC
YTD 2019 = 72
2018 = 82
2017 = 69
2016 = 75



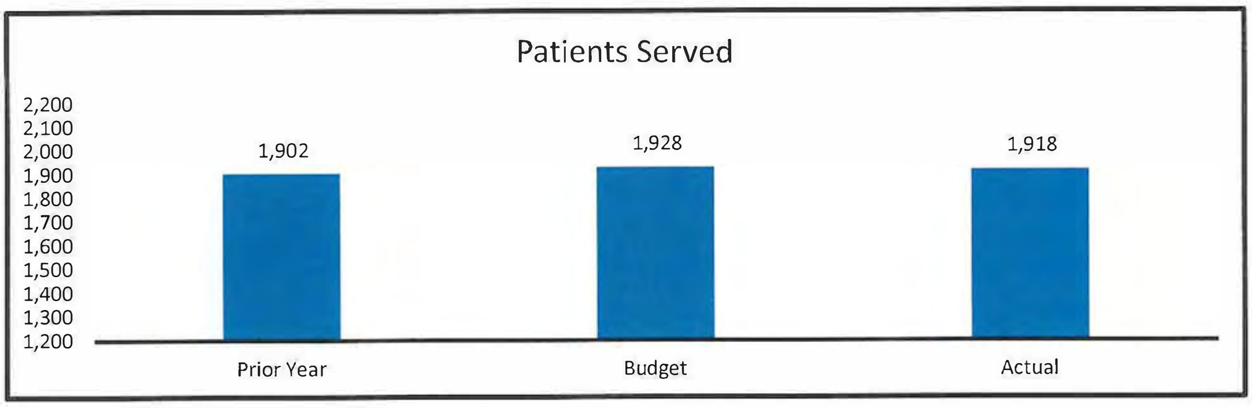
LaPorte
Average Daily Census

ADC
YTD 2019 = 17
2018 = 13

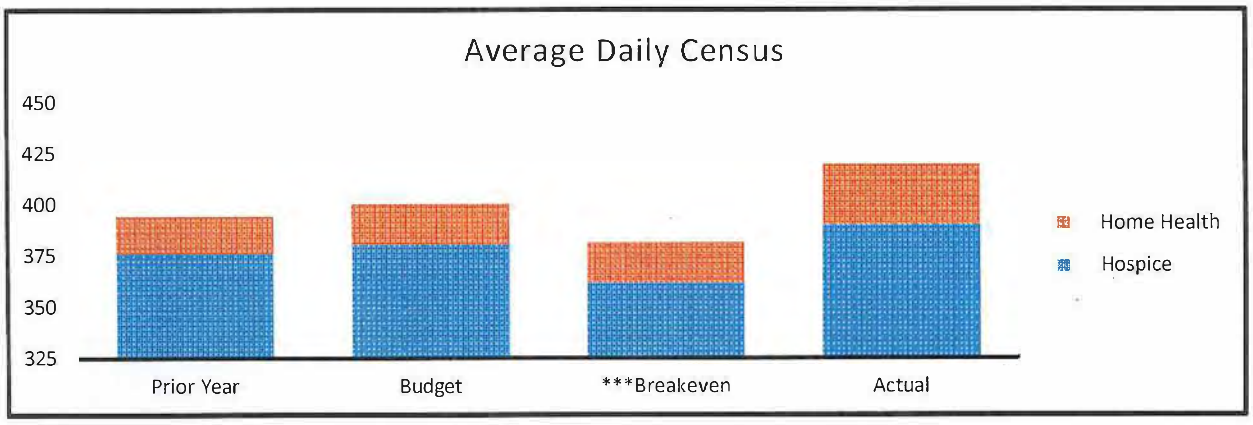


Center for Hospice Care
November 30, 2019

	Prior Year	Budget	Actual
Patients Served	1,902	1,928	1,918

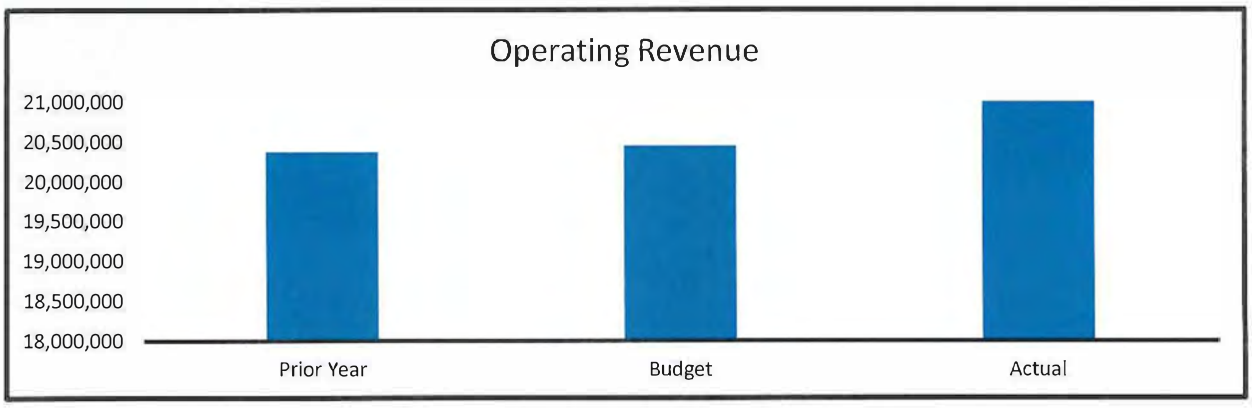


Average Daily Census	Prior Year	Budget	***Breakeven	Actual
Hospice	375.80	380.00	361.93	389.80
Home Health	18.16	20.00	19.05	29.52
Total Average Daily Census	**393.96**	**400.00**	**380.98**	**419.32**

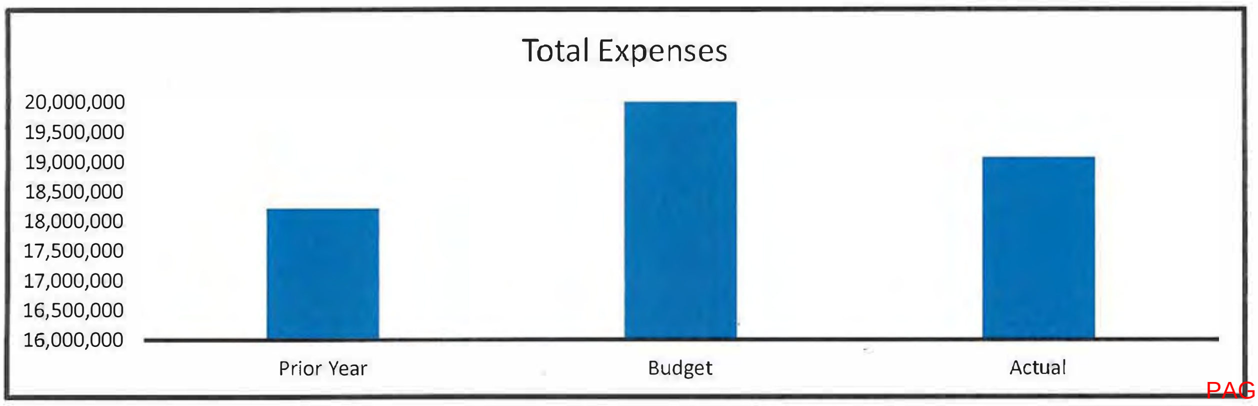


**** Budgeted Breakeven*

	Prior Year	Budget	Actual
Operating Revenue	20,369,503	20,450,570	21,097,463



	Prior Year	Budget	Actual
Total Expenses	18,208,223	20,159,266	19,069,922



December 2019
Volunteer Newsletter

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

How to Deal with Grief During the Holidays

By: Amy Morin

The swell of grief around the holidays is a common reason clients enter my therapy office this time of year. People often seek help for the immense sorrow that starts surfacing right around Thanksgiving.

I experienced that wave of grief in my own life when my husband passed away. Christmas music, holiday parties, and festive decorations that were meant to bring joy, served as painful reminders of my loss. Like most people experiencing loss, the holiday season was the most painful time of all.

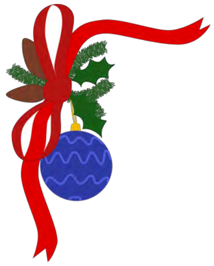
If you're wondering how to get through the holidays this year without your loved one, these strategies can help:

1. Trust that Grief is Part of Healing

Time doesn't heal the pain associated with a loss, it's what you do with that time that matters. Grief is the process by which you heal. Experiencing the pain rather than constantly trying to escape it can actually help you feel better in the long term.

So while it may be tempting to pretend the holidays don't exist, or to numb the pain with alcohol, temporarily avoiding the pain, only prolongs the anguish. Eventually, the holidays will get easier, but only if you allow yourself to

Continued on page 6



Inside this issue:

Welcome to the Team

Christy Campbell
Elkhart IPU Coordinator

Courtney Dye
South Bend IPU RN

Maranda Houser
Resource Social Worker

Sari Moore
Commercial Billing Representative

Agnes Ndisya
Mishawaka Social Worker

John Piper
IT Service Desk Technician

Stacy Stephens
Home Health Billing Representative

Gayle Waldenmaier
Nurse Practitioner

Birthdays

12/1	Barbara Zimlich
12/1	Tim Lankford
12/2	Sarah Nerenberg
12/2	Richard Schweizer
12/3	Kate Siupinski
12/5	Leslie Eid
12/6	Al Levy
12/7	Pamela Garrett
12/9	Ruth Ann Gardner
12/9	Blanche Sailor
12/11	Mary Kay Ferry
12/14	Norah Ray
12/15	Michael Seraphin
12/16	Norma Diedrich
12/18	Amy Deel
12/20	Marjorie Fink
12/24	Richard Keen
12/25	Carolyn Bennett
12/25	Catherine Bly
12/25	Kathleen Matuszak
12/28	Shelley Rivard
12/30	Carole Moats
12/31	Carol Briggs

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 Break from 1:00-1:30pm

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

donahuek@cfhcare.org

Or (574) 286-1198

Who should attend?

All Level 3 trained CHC volunteers. Those who have completed training to help patients with personal care.

How often do we need to be validated?

Once a year. In 2020, we are offering a skills validation day in January and one in the summer. Level 3 volunteers must attend one of these.

Volunteer Spotlight

Ingrid Hirte, South Bend

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

I volunteer for CHC as an ECF companion and visit my assigned hospice patient weekly. I have been with CHC for just over 1 year now.

Why do you volunteer with CHC?

Last fall at Notre Dame, I took a course on hospice and palliative care and CHC came in to talk more about what their services involve. At the end of the presentation, they discussed volunteer opportunities that were available, and at that time, I was volunteering in the ER at a local hospital cleaning rooms and wanted to have more patient interaction. I reached out and signed up to volunteer with hospice. The reason I chose hospice volunteer work is because I am a very outgoing individual who loves spending time with others and getting to know them better. I wanted to take time out of my schedule to give back and be present for my patient.

What is your favorite quote?

“I always get to where I’m going by walking away from where I’ve been” – Pooh

What do you like to do in your spare time?

In my free time I really enjoy catching up on sleep because sleep is essential for college! I love cooking and baking, working out, tutoring student-athletes in organic chemistry and cell biology, golfing, hunting and spending time with my friends and boyfriend. When I can go home from school, I really enjoy walking my Siberian Husky, Yukon, and spending time with my parents.

Where are you from originally?

I’m from Green Bay, WI and I’m a big Packers fan! I am a Senior at the University of Notre Dame currently and am majoring in Science Pre-Professional studies with a minor in Compassionate Care in Medicine. After I graduate, I will be attending medical school, but I’m still in the interviewing process and have not yet determined where I will go.

What talents/hobbies do you enjoy?

I really enjoy figure skating, ice hockey, volleyball, running, water skiing, wake boarding and wake surfing. I like reading books and watching cooking shows when I have some free time.

“Ingrid is a young lady with a big heart for hospice work! Her compassion bridges any age gap and improves the quality of life for every patient she serves at CHC.”

Debra Mayfield,
Mishawaka 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

Decreased Appetite

One of the most misunderstood and difficult things for families to deal with is a patient's lack of appetite or in many cases, no appetite. We've chosen to address this change at length, because it is so stressful for families.

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

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

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

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

- Less fluid in the throat and lungs to reduce coughing and congestion
- Decreased stomach fluids that may reduce episodes of vomiting
- Less need for urination
- Swelling may decrease, lessening feelings of pressure and tightness

A patient's comfort and dignity will always be our priority. We will consult and work with the physician and family to meet the patient's needs. Staff is always available to talk with the family about their feelings, especially regarding difficult issues.

Welcome New Volunteers

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

Richard Pipher
Elkhart

Stacy Pynaert
Mishawaka

Donna Jewell
Plymouth

Kay Kizer
Plymouth

Heidi Payton
Mishawaka

Comments from Our Families

- Even though she was in your care only a short time, we appreciate all the kindness that was shown to her and the family. Everyone we came in contact with was awesome. Thank you for making us all as comfortable as possible during mom's illness. I'm sure if mom was here she would agree the quality of care you provide is the best. Thanks again.
- CHC was very helpful. The staff and volunteers were great. When I would call and ask for help or anything, they were right here. I could not ask for anything that I didn't receive. Thank you for everything.
- Our hospice rep arranged for my dad to have a military pinning ceremony with a veteran Marine and was given a medal and plaque for his service. This was very special for our family, as my dad was cremated and wanted no funeral, so a military funeral was not possible. Much appreciated by all of our family members.

Continued from page 1

experience the grief of going through them without your loved one.

2. Set Healthy Boundaries

You certainly don't have to force yourself to face every holiday event or celebratory tradition, however. If attending a tree lighting ceremony or participating in the office gift swap is likely to bring about too many painful memories this year, be willing to say no. Other people may try to convince you to participate, but you certainly don't have to try and please everyone.

3. Focus on What You Can Control

There are a lot of things you can't control about the holidays. You may be subjected to Christmas music in the waiting room of your doctor's office or you may overhear your co-workers constantly talking about their holiday plans. While you can't prevent those things from happening, there are some things you can control.

Think about what you can do to lessen the heartache when you can. It's OK to limit your decorations or shop for presents online only. Pick a few things you can do to assert some control over the holiday cheer and keep in mind, that life goes on for other people and it's OK that they're happy to celebrate this year.

4. Plan Ahead

Often, the anticipation over how hard something is going to be is worse than the actual event. So while Thanksgiving dinner may only last two hours, you could easily spend three weeks dreading it. Create a simple plan for how you'll get through the holidays to avoid extending your anguish.

About the Author: **Amy Morin** is a licensed clinical social worker, psychotherapist, college psychology instructor and internationally recognized expert on mental strength.

https://www.psychologytoday.com/us/experts/amy-morin

8 TIPS TO SUPPORT A GRIEVING FRIEND THIS HOLIDAY

Knowing how to support a friend who is grieving is never easy. Though one size doesn't fit all, here are a few tips to get you started.

brought to you by WhatsYourGrief.com

1 SUPPORT THEIR HOLIDAY CHOICES

You may not love their decision to skip certain holiday events, drop or change traditions, fly to Bali, or whatever else they have decided to do to cope. Keep in mind the holidays are incredibly difficult in grief, so respect and support their coping choices.

2 INVITE THEM TO HOLIDAY EVENTS, BUT DON'T PUSH

Extend holiday invitations, but make it clear that you absolutely understand if they aren't up for it. Even if they have said no the last few years, still extend invitations while making clear you won't be offended if they don't make it.

3 BE PREPARED THAT PLANS MIGHT CHANGE

Whether it is a last minute bail on a holiday party, or a last minute decision to accept the holiday dinner invitation you extended that they initially declined, try to be flexible and understanding.

4 SEND A THOUGHTFUL HOLIDAY CARD

It can sometimes be hard to see all the smiling, happy families without feeling a tinge of pain about their now incomplete family. Instead of the standard photo-card, send a thoughtful handwritten note acknowledging how tough the holidays must be and sharing a memory.

5 CONSIDER A MEMORIAL GIFT OR DONATION

If you exchange gifts with your friend, there are many beautiful memorial gifts out there that may be a good option. You can also acknowledge their grief this holiday by making a donation in their loved one's name/memory to a charity that is important to them or that was important to their loved one.

6 OFFER PRACTICAL HELP AND SUPPORT

Try to offer something specific rather than offering a vague. Some things that might be helpful are offering to help them with decorating (if they plan to decorate), help with holiday shopping, gift wrapping, watching their kids so they can go shopping, offer to take their kids to holiday events they might not be up for, cleaning, prepping for a holiday meal, etc.

7 LISTEN WITHOUT MINIMIZING, JUDGING, OR GIVING ADVICE

If your friend just needs to vent, complain, and emote about their misery trying making it through the holidays, just listen and support them. Don't try to find a silver lining, don't tell them they should be over it, don't telll them what they 'should' or 'shouldn't' do. Just be there!

8 REMEMBER, GRIEF DOESN'T ONLY IMPACT THE FIRST HOLIDAY SEASON!!

After the death of a loved one, grief just kind of becomes a part of a person's holiday season. Many people will probably make your friend feel like they should be "over it" by the second or third holiday season. Make sure you provide them with the same kindness, support, and consideration that you did in the first year.

check out the full article and tons of other grief support articles at
www.whatsyourgrief.com

January 2020
Volunteer Newsletter

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

Finishing Well:
Glimpses of Stan Miller's Diary

By: Kristiana Donahue

Stan Miller lives on a gorgeous piece of property dotted with beautiful barns, a farmhouse and even a curious cat. I came to talk to Stan about his life. A polite teenager greeted me with a smile and welcomed me inside. Stan was already talking with his nurse, Jessica. The house was warm and cozy, full of family photos and farmhouse charm. Yet the warmest feeling came when Stan opened up in a vulnerable and sincere way. With genuine transparency, Stan's words challenge us to open up ourselves and allow our common humanity to bind us together.

Stan began journaling soon after his diagnosis with ALS, commonly referred to as Lou Gehrig's disease. Per Wikipedia, "ALS is characterized by stiff muscles, muscle twitching, and gradually worsening weakness due to muscles decreasing in size. Most eventually lose the ability to walk, use their hands, speak, swallow, and breathe." September 9, 2015 was the day he was diagnosed with ALS. Two weeks after diagnosis, Stan wrote this entry:

I was peaceful with receiving the diagnosis. I felt an urgency to move into action, to do the things that were most important. To do important things, not urgent things. Spend time with family. Write a testimony for God. Finish the barn.

Spending Time with Family

On the ride home after receiving the diagnosis, Stan and his wife, Elvera, began planning a trip out west. Years ago, they took a road trip to California during which the older children raved about the Redwoods. Now, with younger children added to the family, they wanted to take the trip again. It wasn't the most convenient time to do it - with crops ready to harvest - but crops were urgent, this was important. Stan noted in his journal:

I am shocked at how fast my condition is moving. My muscles are shrinking fast. An electrical sensation has covered my entire body, making sleep difficult. Fatigue is keeping me from functioning. I was looking forward to this western trip, figuring if we did it right away, I would really enjoy it. I really have to push myself. I can't keep up with my family. They have been so understanding. I have loved being with them. Trying to help the children process what is happening. They're all very angry at God. They have had so much loss.

Continued on page 5

Inside this issue:

Welcome to the Team

Jenifer Bain
Coding & Verification Billing Representative

Ida Holloway-Jordan
Mishawaka Housekeeper

Regina Linn
Elkhart IPU RN

Quiona Phillips
Elkhart IPU CNA

Tracy Plummer
Mishawaka RN

Diane Revard
Elkhart IPU PRN RN

Heather Schnick
LaPorte Patient Care Coordinator

Birthdays

1/3	Jennifer Stanley
1/5	Lisa Melin
1/5	Norm Woolet
1/6	Doug Jaques
1/7	Lynn Blessing
1/7	Lindsey Mortensen
1/8	Kathy Walsh
1/11	Darlene Nolen
1/15	Thomas Wruble
1/17	Pam Weinland
1/20	Linda Strain
1/21	David Ricchiute
1/22	Linda McFarland
1/23	Jonathan Couri
1/24	Frieda Cultice
1/27	Chrystal Snow-Schmatz
1/28	Steven Listenberger
1/29	Sharon Jennings
1/29	Barbara Reasor
1/31	Bill Blum

Skills Validation Day

Tuesday, January 14, 2020

Location: Mishawaka Campus

Time Slots: 30 minute time slots

Morning time slots are all booked.

Afternoon time slots are still available.

Lunch Break from 1:00-1:30pm

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

donahuek@cfhcare.org

Or (574) 286-1198

Who should attend?

All Level 3 trained CHC volunteers. Those who have completed training to help patients with personal care.

How often do we need to be validated?

Once a year. In 2020, we are offering a skills validation day in January and one in the summer. Level 3 volunteers must attend one of these.

Volunteer Spotlight

Casey Kasper, Elkhart

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

I volunteer in the Elkhart inpatient unit every other Friday night and started volunteering in the spring of 2018.

Why do you volunteer with CHC?

First and foremost, I'm a social worker and felt this would be a great way to continue helping people outside my work week, while doing work that was different enough from the work I do. Plus, philosophically, people in general are far too squeamish about death and dying, even though it's one of life's guarantees. Just as I would want people to have good lives, I also think we need to talk about what makes for a good death. I want to make sure individuals are able to receive proper end of life care, as well as do what I can to help their families and friends through the grieving process. And just because it's natural does not mean that it is easy for the individual or their support systems.

What is your favorite food and why?

Any and all Middle Eastern food. I lived in the Ann Arbor/Detroit area for about ten years and had regular access to some of the best Middle Eastern food I've ever had. Sadly nothing around here quite compares, so I make a point to stop by my favorite restaurants anytime I'm in that area.

Favorite movie and why?

About Time, a Richard Curtis film from 2013 about a man who learns he has the ability to time travel on his 21st birthday and how he can use those abilities to make the most out of the time he has. My best friend and I went to go see it on a whim, thinking it was going to be a silly romantic comedy. As it turns out it remains one of the best movies either of us have ever seen.

Tell us a bit about your family.

I just married my significant other of five years, Todd, on November 9th. We live in Elkhart. He has 13 and 15 year old daughters who are absolutely delightful and split their time between us and their mom and stepdad. We also have a two year old Scottish Terrier named Rupert and a 14 year old grumpy old tomcat named Dartanian. I'm incredibly close to my family. They are some of the best and most important people in my life. My parents and maternal aunts and uncles live in Dowagiac, MI. I also have a brother who recently relocated to Boston, and a sister, who is getting her PhD in Linguistics at the University of Chicago.

"Casey is a busy mom and career person who takes time out of her Friday evening every other week to assist at our inpatient unit in Elkhart. Staff there tell me she is a task master and she gets the job done! She is also very compassionate and has a way about her that eases patients. We are so fortunate to have Casey on our team!"

Marlane Huber,

Elkhart 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

- Hairdressers
- Barbers
- Pet Visitors

Elkhart

- Hairdressers
- Barbers

Plymouth

- Need volunteers to help cover the Walkerton, North Liberty and Culver areas!
- Office Volunteers
- Veteran Volunteers

LaPorte

- Any opportunity, but especially hospitality

Training Tips & Reminders

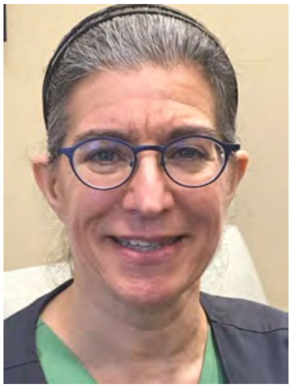
Speech, Vision and Hearing

As a patient makes efforts to communicate, caregivers may experience a sense of frustration as their **speech** may become difficult to understand. The lack of understanding may make them feel as though they are not "pleasing" the patient. Refrain from asking unnecessary questions of the patient if verbal communication is difficult or impossible. If the caregiver has difficulty understanding a patient's speech, they need to let the patient know they are having difficulty and it is due to their weakness. They may want to have a list of basic needs that the patient can respond to with "yes" or "no."

Vision can also fail and patient's eyes may become dry, sunken or glazed over in an apparent stare. If it is apparent that vision is failing, keep the patient well-informed as to who is present, and of the day and time. A warm damp cloth can be used to remove any eye secretions, and eye drops may be given if necessary. Keep the room lighting as the patient wishes

The last sense to be lost is **hearing,** and it may remain acute up until the time of death. Avoid saying anything in the patient's presence that would make him or her feel uncomfortable or uneasy. Reassure the patient that someone will always be around to provide their care. Soothing music may be enjoyed, as well as conversation from family and friends. This is an excellent time to express love and caring. Touch is also a good way to be with a patient by giving a gentle massage or simply holding the patient's hand.

Welcome New Volunteers



Help us welcome this new volunteer who finished her training in December. Please introduce yourself to her as she begins her service with CHC.

Loukia Verhage
Mishawaka/LaPorte

Continued from page 1

Stan and his wife are no strangers to loss themselves. They built their beautiful family with the bittersweet pieces of love and heartbreak. They had three biological children; all of them with significant medical needs. Two passed away, and Stephanie, lives with them still, needing daily care and support. They've adopted six other children, including several older ones who had moved around quite a bit. It is quite evident that Stan wants to pour himself into the lives of his children – and realizing his "plans" were cut short was tough.

I had this great idea about writing letters to all the children for the important events in their lives that I would not be around for. You cannot take a child further than they are emotionally and mentally ready for. There is so much I would love to guide and teach and pass on, but they are not ready for much of this. So I need to move it to a few things that they can remember.

Confronting Death and Prioritizing Life

Stan's initial prognosis was dire, being told he had only a few months to live. Soon after diagnosis, Stan began noticing his physical decline. He was put on oxygen almost immediately and this affected his perception of his days. He quickly had to confront the imminent possibility of death, and help those he loved do the same.

Tonight, I am struggling to figure out how to respond to death. When I think of all of the important things that should be done, I realize I can never make that happen. Once you're sick with a disease, it is not the time to do extra things. God, I need the wisdom to decide what things to let go of and which things will make the biggest difference. Death is like life. You need to do your best and trust God for the rest.

> The way you approach death will be how you lived your life.

Life often becomes an endless to-do list that can overwhelm even the most disciplined person. Coming to the end of life can exacerbate the anxiety created by the list, but it also has a keen way of filtering out the unimportant things, leaving time for the most important.

Acknowledging the "Elephant in the Room"

Throughout life we strive to talk about the important things with our loved ones. From faith to relationships to problems in our society - finding a kindred spirit to discuss our ideas truly helps us feel ready for, confident in and content in our decisions. It's no different with acceptance of death and dying. Yet finding people to talk to can be challenging.

"I need to talk about death and dying. You find that death and dying are pretty taboo subjects," Stan wrote.

As ALS ravaged his body, his mind was continuing to process the all changes happening in his life. Questions about the future swirled in his head.

How and when will my body change? How quickly will this affect my independence? How will this affect my relationships? How does one finish well? Knowing that I'm dying makes me feel isolated.

Stan would be the first to express that he's had a wonderful support network of family and friends. He's felt truly loved and cared for, which has helped him tremendously. Yet, even with a wonderful support network and people willing to listen, feelings of isolation are often part of this final journey. Stan shared the often confusing balance of encouraging his family to continue with life as "normal," while daily recognizing the reality of his disease. Even when he has had people that would listen to his inner thoughts, he held

Continued on page 6

Comments from Our Families

- Some of the nurses went the extra mile to make sure it was a memorable experience.
- This is the third parent we've used hospice for. They've always provided the utmost care. We felt so loved and confident in the care.
- The nurses, bath aides, volunteers were outstanding in their care, attention and love for my husband. We always looked forward to their outstanding service to us. Thanks and love to all.
- The two nurses were excellent when offering care to my husband. They were generous in their support of me. The chaplain was a big support spiritually. As a retired minister, I was very impressed with the care we received.

Continued from page 5

back some of his deepest. This illness was his to face, and he didn't want to burden everyone around him with his "elephant."

When I did talk about it, I did not go into it as deeply as my heart would have liked. I didn't want to overwhelm the people I was talking to.

Living with a terminal illness can be hard for everyone. Denial is a very effective coping skill. But, using it indiscriminately isn't healthy. At some point in this life and death play, the primary actors need to admit that everything isn't OK. I get that. But it doesn't mean I understand it.

Many people are uncomfortable to talk about death and dying. Even the person that is dying finds it difficult to talk about. Maybe it's because these are subjects we have never heard discussed.

Stan has thought a lot about this "elephant." He's forced to think about it. But in reality, it's a topic all of us will face at some point. Ignoring it doesn't make it go away. In fact, engaging in healthy conversations about death and dying with those we trust may do everyone good. Stan mentioned that at times he thought there was an "elephant" in the room, when in fact, it was just his perception. We may be surprised that some people may be more open than we realize. Stan has thought about how to address the difficult topics people don't really want to talk about, and came up with his own formula.

Verify that the elephant is real. Acknowledge its presence. Consider timing. Make a plan. Have a direct, honest, detailed conversation.

Gradual Detachment

ALS is a journey of detachment. From what I could once do, along with anticipation and preparation for what I will not be able to do in the near future.

Stan's progression with ALS took an immediate toll, but was also unusual. Soon after his diagnosis he noticed a decline. His voice became so soft it was difficult to understand him. He couldn't roll over in bed anymore and was only able to swallow soft foods. Macaroni became a staple diet. Due to the rapid progression, and his doctor's prognosis that he wouldn't make it to February 2016, Stan had to hastily prepare his heart and mind.

Then in January 2016, all those abilities came back to him. He started to roll over in bed, he could communicate clearly and eat anything he wanted. It's been like a miracle. However, though Stan doesn't know the timeline, he knows the probability that those losses will return are somewhere on the horizon.

I recognize the fact that I have not even really started my journey with ALS yet. Everything can be taken away from me. But one thing, the last of human credence, to choose one's attitude in any given set of circumstances. I was determined not to let ALS touch my soul or spirit.

While Stan realizes that ALS will take things away from him, it has also given him something else. He has gained some new friends on this journey. The staff from Center for Hospice Care, especially his nurse Jessica, who has been with him since he started care, have been some of those new friends.

I would have to say my life has been rich and full and rewarding these last several years. I have probably had more, really deep, meaningful conversations in the last several years than I have had for a lot of years. I find that my diagnosis brings people to me that want to talk about deeper things. And it gives me a great opportunity to get to learn their heart and to share my heart.

Finishing Well

Jessica and Stan have been talking about what it means to finish well.

What does it look like to finish well? Jessica helped me with that a lot. I realized that what I really wanted to do is live well. Because if you live well, you finish well. It needs to be a changing target. As I have lost ability, living well is fleshed out in a different way.

Stan continues to encourage all of us to live well all along the way. Why put off the good things that we could do today? Why wait for retirement to take that dream trip? Prioritize the "important" things, not the "urgent" things.

The way you approach death will be how you lived your life.

February 2020

Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

New inpatient center for hospice patients to open soon in Mishawaka

By Greg Swiercz South Bend Tribune

Published November 22, 2019

MISHAWAKA — A new 12-bed inpatient center is expected to open early next year at the Center for Hospice Care's Mishawaka campus.

The 17,000-square-foot facility, called the Ernestine M. Raclin House, is built on Comfort Drive just east of the organization's current buildings along the St. Joseph River east of Central Park.

The facility should begin accepting hospice patients early in 2020, according to Mike Wargo, vice president and chief operating officer for the Hospice Foundation.

While construction crews put finishing touches on what officials describe as a "classic contemporary Craftsman-style" facility, Wargo said the center is the culmination of a five-year fundraising campaign.

Donors, staff and agency officials dedicated the new center earlier this week.

The 12-bed facility will replace the current seven-bed Hospice House inpatient center the agency has operated for the past 23 years in Roseland.

Wargo said once the new center opens, Roseland patients and staff will be transferred to Mishawaka.

The Roseland Hospice House will be converted into the new home of the center's Milton Adult Day Services, serving people with dementia.

The center also runs a similar seven-bed Hospice House at the eastern end of Elkhart County that

Continued on page 6

Inside this issue:

In Loving Memory

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

Bill Blum, Mishawaka
Sister in Law, Mary Blum
Saturday, December 21, 2019

Connie Nyerges, Mishawaka
Son, Randy Bazyk
Wednesday, January 8, 2020

Welcome to the Team

Julianne Havens
Mishawaka RN

Jackie Hostetler
Elkhart RN

Birthdays

2/6	Pat Langfeldt
2/10	Earl Metzler
2/11	Tammy Jacobi
2/13	Janet Gruwell
2/13	Carl Mayfield
2/13	Joyce Metzler-Smith
2/15	Marlane Huber
2/15	Ann Hughes
2/19	Donna Jewell
2/20	Bob Evans
2/20	Anila Mondabaugh
2/21	Kathy Bowlby
2/21	Mary Jane Lawson
2/21	Fred Longenecker
2/23	Larry Brucker
2/23	Martha Lewallen
2/24	Elizabeth Kreskai

9 Tips for Visiting Someone in Hospice

By Jennifer Modlinger

No matter your feelings about extravagant weddings and the British royal family, I think we can all agree that they did a beautiful mitzvah by turning the flowers from Prince Harry and Meghan Markle's wedding into bouquets for hospice patients.

And whether or not you are of royal blood, visiting a loved one who has entered hospice care can be a nerve-wracking experience. But it doesn't have to be.

There are things you can do to bring comfort and joy to a person in hospice. We pulled together the following tips from the hospice nurses, social workers, and clergy at MJHS Health System.

1. Timing is Everything.

Plan the time of your visit carefully. Find out when your friend or relative is feeling most energetic: morning, midday, or night? When do medications need to be taken? Speak with the patient, family caregiver, hospice staff, or close friend to determine the best time of day to visit. And make sure to double check that it is still a good day and time to visit before heading over.

2. Comfort Food — Or Not

Don't just show up with your specialty brisket or noodle kugel without checking in first. Find out if there are any dietary restrictions, or if the patient is craving something. If he or she is on a liquid diet, you could bring a smoothie or milkshake. If martinis were a favorite but alcohol is no longer an option, make a toast over water in martini glasses. Sometimes smelling a favorite food can be a comfort, even if it can no longer be eaten — the aroma of a freshly baked challah or a fragrant pot of chicken soup can bring back beautiful memories even if they can't be tasted. But again, ask first.

3. Technology Can be a Powerful Tool

Even if the patient can no longer travel, he or she can still be part of a family simcha. Facetime, Skype, and live streaming are all ways to help someone be a virtual guest at a Bat Mitzvah, a bris

Continued on page 6

Volunteer Spotlight

John Harringer, Camp Evergreen

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

I have been a camp buddy for Camp Evergreen for 16 years. I also volunteer for the Camp Workshop. This will be the second year in September.

Why do you volunteer with CHC?

It makes me feel good doing things for others. I get to see the difference in the kids' lives that go through camp. I have received cards from some of the kids that I was a buddy for and they have told me how I made a difference in their lives.

What is your favorite food?

1st is blueberry pie, 2nd banana cream pie. I like the taste of both. I like the fact that blueberry pie has antioxidants in the blueberries.

What is your favorite movie?

I like science fiction movies. Whatever scares me to death. Anything with martian invaders. I also like John Wayne westerns.

Favorite music?

I like any kind of music that makes sense. I like big band music because it is soothing. I like rock and roll, especially Elvis Presley. I like country music. It's just good music. I like John Denver and Johnny Cash in that order.

What do you do in your spare time?

I'm retired now so I don't have a clock. I do whatever I want to do. If I see something that sounds interesting I'll just pack a bag and go.

Where are you originally from?

Louisville, KY. My family moved to South Bend when I was 3-4 years old. I attended Central High in South Bend. I joined the Marine Corp when I was in high school. Paris, South Carolina is where I went to boot camp. I finished high school after boot camp. After my military service I came back to South Bend and worked at Bendix.

Where in the world would you like to go?

The good ole' USA is good enough for me. I did some traveling while in the Marine Corp. I did a tour of duty in Japan in 1964 and was able to see the 1964 Olympics there. I did a tour in Vietnam in 1966.

Hobbies?

I enjoy photography. I like to take photos of historical places and also scenery.

> "John does a great job capturing meaningful moments on film as a camp photographer volunteer. His talent as a photographer provides campers and volunteers with special keepsakes of their Camp Evergreen experience."
>
> *Kim Mathews,*
>
> *Camp Evergreen Director*

Mark Your Calendars

Volunteer Recognition Luncheon

Tuesday, April 21, 2020

11:30am-1:00pm

The Brick

1145 Northside Blvd.

South Bend, IN

Mandatory Annual In-service

Tuesday, June 9, 2020

More details to follow.

Training Tips & Reminders

Level 3 Training Now Available Online

We are pleased to announce that we now have all of our volunteer training available online—all three levels. Level 3 still has a face-to-face and hands on teaching and validation component.

Some current volunteers had mentioned a desire to do Level 3 once it was available online. If you would like to move forward with your training and increase your level to a Level 3, please contact Kristiana Donahue and she can inform you of what steps need to be taken.

donahuek@cfhcare.org or 574-286-1198.

Volunteer Needs

We are always looking for **Home Visit Volunteers** across the area. If you are willing to be a Home Visit Volunteer and need to complete Level 3 training, keep in mind that we can increase your training at any time.

Please take a look at the needs the VCs have shared. If you are willing to take any of these opportunities, let your VC know. If you know anyone who would like to become a volunteer, let Kristiana Donahue know. We have a need for the following:

South Bend

- **Hairdresser, Barbers, Pet Visitors**

Elkhart

- **Reception Volunteer, Tuck-In Volunteer, Hairdressers, Barbers**
- Volunteers willing to help with household chores (cleaning, laundry, dishes, vacuuming, etc.).
- Volunteers willing to travel to Nappanee, Middlebury, Goshen, Wakarusa, Shipshewana and Warsaw

Plymouth

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

LaPorte

- Any opportunity is needed in LaPorte
- **Hospitality Volunteers** who are willing to travel throughout the county

Training Tips & Reminders

South Bend/Mishawaka Volunteers

Reminder! Any Mishawaka/South Bend volunteer that sends in patient time sheets, please remember to throw away any return envelopes that have a South Bend PO Box address on them. Do not use them anymore.

If you need new envelopes, please contact Debra Mayfield and she will send some to you. The new envelopes have a Kalamzoo, MI PO Box on them. Please check your supply.

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.

Theresa Gross
LaPorte

Andrea DeSonia
Elkhart

Brendan Fitzpatrick
Mishawaka

Left to Right

Angela Lewellen
Plymouth

Cara Lewellen
Plymouth

Comments from Our Families

- I am a physician and consider the Hospice Care exceptional. All of our meds were tended to in a kind and efficient manner.
- Our experience was as perfect as we could have hoped for. They walked us through each and every point of my father's care. We couldn't have done it without everyone! Thank you.
- The nurse was an angel to me. There was perfect communication. We worked well together. Mom was well taken care of and looked forward to her coming.
- I am so thankful for your support services. The death we experienced was expected and I was prepared for it. I believe many families are "saved" by your support and services. Keep up the great work!

Continued from page 1

will remain open.

Hospice care involves medical care, pain management, and emotional and spiritual support for patients and their families when a patient faces a terminal illness.

All 12 rooms at the new Hospice House face the St. Joseph River. Wargo said patios and common areas were designed to allow patients and family members to take in the river setting.

Patients who will make use of the center fall into several categories. Wargo said people discharged from hospitals can be admitted if the patient's condition prevents them from going home.

Others admitted to the center can be people who are having acute medical issues. Wargo said often these inpatients may be stabilized over the course of a several-day stay.

The center also offers primary caregivers of hospice patients respite. Patients can be admitted if caregivers are going out of town or need a break.

Wargo said the average stay for admitted patients to the inpatient center is 5 1/2 days, and all will have the full array of hospice services offered there.

National statistics provided by the National Hospice and Palliative Care Organization for 2018 show that while 80% of Medicare hospice patients die at home (48.2%) or in a nursing facility (31.8%), only 11.2% die in inpatient hospice facilities.

About 86% of annual revenue from the nonprofit Center for Hospice Care comes from Medicare through the hospice benefit, with 1% from Medicaid. Private insurance accounts for 6%, while fundraising fills in the remaining 6%, Wargo said.

Features in the new center are designed to accommodate the patients and families. A large common area houses a large kitchen with two refrigerators and two large living spaces that can handle multiple families of patients.

A four-season room on the west side of the building will have furnishings that resemble a patio and the view will offer people a vista of the park and river.

Rooms for teens, for children and even for a future therapy dog are planned.

"The setting here is so unique," Wargo said. "We have large living spaces. This (facility) provides spaces for all to feel comfortable."

Continued from page 2

or a wedding.

4. Think Twice About Bringing Decorations

Fragrant flowers are beautiful but can be majorly problematic for someone with respiratory issues; a giant bunch of balloons might crowd a small room. Find out if there is something particularly meaningful — and not too large — that you can bring. Homemade cards and drawings, as well as family photos, are always a good choice.

5. Don't Bring an Entourage

If you planned to come alone, don't decide on a plus-one — or two! — at the last minute. Additional guests can be overwhelming and can make a room feel crowded.

6. Children are a Blessing — Usually

Kids can bring lots of energy and joy into the room — but only if that energy and joy will not overwhelm the patient. Exuberant hugs and kisses may be welcomed, or they can exacerbate existing pain. Let the patient be your guide.

7. Keep an Eye on the Clock

Don't overstay your welcome — patients often tire easily. You may be having a lovely visit and dreading what could be a final farewell, but be mindful of any cues you may be getting from the patient or family members.

8. No Surprises

This isn't the time to try and mend fences or settle a long-standing family feud unless specifically requested by the patient. He or she may have already made her peace with whatever quarrel or drama happened in the past, and resurfacing matters may do more harm than good.

9. Don't Take It Personally

Don't take offense if a patient doesn't express delight over a thoughtful gift or painstakingly crafted card or drawing. He or she may be too tired to be effusive about the gift. The same goes for not talking during the visit, ending the visit suddenly, or seeming apathetic about a holiday or celebration.

The bottom line when visiting someone in hospice is to let the patient be your guide, to be present and in the moment, and remember that it isn't about you. Visiting a loved one who is in hospice care for a life-limiting condition is going to bring up all sorts of emotions, and it may be hard to squish those emotions down — particularly if you aren't having the kind of visit you envisioned. In the end, remember that you are doing a huge mitzvah — even if you aren't bringing a leftover bouquet from the royal wedding. Like so many things in life, it's about showing up and showing you care.

https://www.kveller.com/9-tips-for-visiting-someone-in-hospice/

Center for Hospice Care
Committees of the Board of Directors

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

Bylaws Committee

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

Milton Adult Day Services Advisory Committee

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

Nominating Committee

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

Personnel Committee

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

Special Committees

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

Center for Hospice Care
Conflict of Interest Policy

Article 1

Purpose

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

Article II

Definitions

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

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

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

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

Article III

Procedures

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

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

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

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

Article IV
Records of Proceedings

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

Article V
Compensation

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

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

Article VI

Annual Statements

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

Article VII

Periodic Reviews

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

Article VIII

Use of Outside Experts

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

____________________________________ __________________

Signature **Date**

____

Print Name

2010

Center for Hospice Care

Goals for Calendar Year 2019

Updated 01/14/2020

Goal A: Enhance Patient Care

Category	Status	Goal
Administration	Not Met	1. Review all commercial insurance plans for current rates, assignability, and discounts.
	Not Met	2. Review all job descriptions to insure they are accurate for current practices, particularly as the organization has grown and added new entities with overlapping staff.
	Met	3. Begin the process of redomesticating GPIC from New York to Indiana.
	Met	4. Begin the repurpose of 111 Sunnybrook for Milton Adult Day Services.
Admissions	Met	1. Increase same day referral/admissions to 55%.
	Met	2. Increase admission RN PA to Admission conversion rate to 72%.
	In Process	3. Ensure 100% of admission nurses complete Pediatric ELNEC.
	In Process	4. Have 75% of Admission RNs complete or are working to complete CHPN.
	Met	5. Maintain admission medication charting compliance 97% or greater.
	Met	6. Continue tracking PA to Admission time, as well as continue to track referral to PA time tracking.
	Met	7. Continue tracking live discharges, reasons for discharge, and readmission rate.
	Met	8. Implement training sessions quarterly to educate Admission Representatives and RNs to overcome barriers to admissions.
	Met	9. Update intake form to improve triage at referral level.
Volunteers	Met	1. Pursue new volunteer opportunities – Pet Peace of Mind.
	Met	2. Expand volunteer services provided to veteran patients and families – Level 5 Partners Activities.
	Met	3. Recruitment, training, and placement of LaPorte area volunteers.
	Met	4. Create targeted orientation classes for online module: veterans, hair dressers, pet visitor, etc.
	Met	5. Develop a minimum of one training option for current volunteers for online module.
	Met	6. Continue to evaluate and refine the annual skills validation process for Level 3 volunteers.
Nursing	Met	1. Establish Nurse Preceptor Program.
	Met	2. Identify strategies to promote improved wound assessments and documentation.

Goals for Calendar Year 2019

Updated 01/14/2020

Category	Status	Goal
	In Process	3. Identify strategies and tools to improve and streamline the IDT process through all branches.
	Not Doing	4. Design and implement a "Hospice Language" to ensure all staff are presenting, responding, and training families and caregivers in a similar fashion.
	Met	5. Establish a CHC new orientation program, including all departments.
	Met	6. Review and update policies and procedures for Hospice and Home Health.
	Met	7. Increase CHPN certification by five registered nurses.
	Met	8. Review and implement an Action Plan to address the 2018 Employee Satisfaction Survey related to nursing strengths and weaknesses.
Bereavement	Met	1. Create an admission packet tailored to the type of death/who died for new bereaved counseling clients, including general grief information, grief services booklet, online resources, booklists, etc.
	Met	2. Continue to improve bereavement counseling support for Veterans by having current bereavement counselors complete Tier Two and Tier Three Star Behavioral Health Providers Training, and have any newly hired bereavement counselors complete Tier One as trainings are available.
	Met	3. Explore providing group bereavement services to young adults, 18 to 24 years old.
Social Work	Met	1. Create and implement an educational training plan to increase awareness of cultural competencies.
	Met	2. Create and implement a training plan for social workers and RNs to increase awareness of abuse and neglect.
	Met	3. Identify strategies for ongoing assessment for anticipatory grief with patients and families.
	Met	4. Identify and implement an assessment tool for anxiety and stress for patients and families.
Chaplains	Met	1. Update the Chaplain Care plan template in Cerner.
	Met	2. Look into the possibility of hosting local ministerial association meetings at the Mishawaka Campus and Elkhart office.
	Met	3. Provide education to nursing, including IPU staff, social work, and bereavement departments via team meetings regarding the chaplain's scope of practice.
	Met	4. Host a Trauma Informed Care Seminar with Chaplain Gregg Fry from Oaklawn Psychiatric Center for patient care staff.
Medical Directors	Met	1. Assist in recruitment of one more HPM physician.
	Met	2. Assist in recruitment of additional MD/DO/NPs to offload face-to-face visits.
	In Process	3. Complete original COTIs within 19 days on average.

Category	Status	Goal
	Met	4. Fully implement the relationship with the Elkhart Clinic.
	In Process	5. Increase Palliative Care program at the Center for Palliative Care clinic.
	Not Met	6. Establish professional relationship with Dr. John Mulder's Grand Rapids Hospice and Palliative Medicine Fellowship program with opportunity for Fellow rotations at CHC.

Goal B: Position for Future Growth

Category	Status	Goal
Administration	Met	1. Perform cost-benefit analysis to determine best options for Mishawaka Campus security and implement.
	Met	2. Revise Mishawaka Campus policies and procedures manual.
	Met	3. HF staff cross-functional training and organizational development program.
Mishawaka Campus & Regional Expansion	Met	1. Construct first Cedar Street home to be sold (two-story).
	Met	2. Design Mishawka Campus landscaping master plan.
	Met	3. Complete construction on Clinical Staff Building.
	In Process	4. Design and begin construction on new Milton facility.
	In Process	5. Complete construction on Ernestine M. Raclin House.
	Met	6. Successfully transition Roseland staff and operations to Mishawaka Campus.
	Met	7. Campaign Celebration/Ribbon-Cutting.
Global Partners in Care	Not Doing	1. Release five-year Strategic Plan.
	Met	2. Identify external sources of funding.
PCAU	Met	1. Review and revise Road to Hope sponsorship guidelines.
	Met	2. Publish 10-year PCAU report.
	In Process	3. Devise a strategy for Road to Hope Fund's long-term sustainability.
	In Process	4. Revise Road to Hope Fund website.
	Met	5. Work with PCAU to finalize establishment of a DCPC program at Mulago School of Nursing and Midwifery.

Goals for Calendar Year 2019

Updated 01/14/2020

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

Goal C: Maintain Economic Strength

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

Goals for Calendar Year 2019

Updated 01/14/2020

Goal D: Continue Building Brand Identification

Category	Status	Goal
HF Marketing	In Process In Process In Process	1. Complete Hospice Foundation branding documents. 2. Develop revised social media strategy. 3. Develop a comprehensive PR and communications plan for HF.
CHC Marketing	Met	1. Attain Level 5 of the We Honor Veterans program: (a) Recruit Community Partners (b) Incorporate Vietnam War Commemoration into WHV events.
	Met	2. Focus on ERs as hospice referral sources.
	Not Doing	3. Create materials that focus on Home Health in SNFs.
	Not Met	4. Increase referrals by 5% (2,460).
	Met	5. Convert CHC and MADS websites to WordPress with branding like FoundationForHospice.org: (a) Focus on current most visited pages. (b) Make user friendly.
	Met	6. Increase ECF admissions by 5%.
	In Process	7. Help establish and promote Pet Peace of Mind.
	In Process	8. Create virtual tours of Esther's House and Raclin House.

Center for Hospice Care

Goals for Calendar Year 2020

Updated 02/06/20

Goal A: Enhance Patient Care

Category	Status	Goal
Administration		1. Review all commercial insurance plans for current rates, assignability, and discounts. 2. Review all job descriptions to insure they are accurate for current practices, particularly as the organization has grown and added new entities with overlapping staff. 3. Branding and marketing home health as Palliative Care. 4. 24/7 QA monitoring and correction of errors. 5. Successful move from South Bend IPU and opening of Raclin House. 6. Significantly more frequent PR on everything we do. 7. Begin the expansion of Milton Adult Day Services at the Sunnybrook property.
Admissions		1. Ensure 100% of admission nurses complete Pediatric ELNEC. 2. Have 75% of Admission RNs complete or are working to complete CHPN. 3. Create and implement an expedited process for admitting GIP patients from hospitals to our Inpatient Units. 4. Increase conversion rate to 72%. 5. Increase census in long-term care facilities by 8%.
Volunteers		1. Launch Pet Peace of Mind. 2. Recruitment, training, and placement of La Porte area volunteers. 3. Create targeted orientation classes for online module: veterans, hairdressers, pet visitor, etc. 4. Develop a minimum of one training option for current volunteers for online module. 5. Recruitment of volunteers in rural areas. 6. Explore group project ideas for outside volunteers.
Nursing		1. Maintain or increase all CAHPS scores to 90% or above. 2. Collaborate with the Alzheimer’s Association to offer a Dementia certification program to the RNs, LPNs, and CNAs. 3. Establish criteria for staff to attend educational programs through criteria-based selection process in addition to NHPCO webinars.

Category	Status	Goal
		4. Develop an ongoing program for the IPU to maintain current competencies and skill sets. 5. Identify strategies and tools to improve and streamline the IDT process throughout the agency.
Bereavement		1. Investigate ways to improve emotional support after death for primary caregivers and collaborate with social work and chaplaincy to address CAHPS survey results in that area. 2. Review bereavement patient care policies to confirm, and update where appropriate, that the policies reflect the current procedures for addressing bereavement needs while the patient is alive and post death. 3. Continue to improve bereavement counseling support for Veterans by having current bereavement counselors complete Tier Three Star Behavioral Health Providers Training and have any newly hired bereavement counselors complete Tier One and Tier Two as trainings are available.
Social Work		1. Investigate ways to improve emotional support after death for primary caregivers and collaborate with bereavement and chaplaincy to address CAHPS survey results in that area. 2. Work with bereavement on the review of bereavement patient care policies to confirm, and update where appropriate, that the policies reflect the current procedures for addressing bereavement needs while the patient is alive. 3. Review current social work care plans in Cerner and update where appropriate. 4. Have social workers attend the first level of Star Behavioral Training in relationship to working with veterans and mental health as trainings are available.
Chaplains		1. Investigate ways to improve emotional support after death for primary caregivers and collaborate with social work and bereavement to address CAHPS survey results in that area. 2. Explore ways to increase local faith communities' awareness and utilization of CHC resources. 3. Review, update, and educate on the spiritual screening section of the CHC Hospice Admission Outline and CHC Comprehensive Admission Outline. 4. Use Spiritual Care Week (last full week in October 2020) as a time to educate staff on spirituality and spiritual care in fun, interactive, and thought-provoking ways.
Medical Staff		1. Establish a professional relationship with Dr. John Mulder's Hospice and Palliative Care Fellowship Program in Grand Rapids, Michigan to begin Fellow training rotation at CHC. 2. Facilitate relationships with local hospital physicians and inpatient care teams to increase referrals to our IPUs. 3. Restructure face-to-face visits to improve physician productivity. 4. Assist in recruitment of an H&PM physician to be responsible for developing the Center for Palliative Care.

Category	Status	Goal
		5. Minimize the backlog of COTIs. 6. Work with the IU Palliative Care Chair, Dr. Olubumni Okanlami, to improve regional Palliative Care. 7. Enhance documentation on IPU patients to comply with Medicare regulations for justification of IPU stays and for billing purposes. 8. NPs and physicians to begin billing for IPU Evaluation and Management of patient care.

Goal B: Position for Future Growth

Category	Status	Goal
Facilities		1. Design and begin construction on new Milton facility. 2. Design and build new maintenance building. 3. Complete Ernestine M. Raclin House and successfully relocate Roseland staff. 4. Complete Mishawaka Campus landscaping and grounds projects.
Global Partners in Care		1. Launch PCL training with APCA and Bluegrass Care Navigators. 2. Establish a program to support existing unpartnered national associations in Sub-Saharan Africa. 3. Complete process of re-domesticating GPIC from New York to Indiana.
PCAU		1. Host biennial exchange visit. 2. Devise a strategy for Road to Hope Fund's long-term sustainability. 3. Revise Road to Hope Fund website. 4. Help equip new PCAU leader with capacity building and sustainability resources in three areas: leadership training and support; fundraising and sustainability training/consultation; and, research development.
Education		1. Develop branded recruiting materials to market the Vera Z. Dwyer Fellowship to area physicians. 2. Develop a medical student internship program with IUSM-SB. 3. Leverage the Leighton Foundation challenge grant for palliative care to support CHC's palliative care priorities. 4. Develop a marketing and community engagement plan to promote our professional and community education programs.

Category	Status	Goal
		5. Create a focused marketing program to more effectively promote IU Talk to area residency programs. 6. Design and launch Honoring Choices Indiana – North Central website.

Goal C: Maintain Economic Strength

Category	Status	Goal
Fund Raising and Stewardship		1. Kamm Society Rollout. 2. Complete development and begin implementation of a post-campaign fundraising plan. 3. Pursue HC Foundation of LaPorte County opportunities. 4. Complete Milton Adult Day Care fundraising initiative. 5. Hire Annual Giving Coordinator. 6. Hire Grant Writer. 7. Establish a CHC/HF online store with items available for pickup at Mishawaka Campus Main Building.

Goal D: Continue Building Brand Identification

Category	Status	Goal
HF Communications		1. Complete Hospice Foundation branding documents. 2. Develop revised social media strategy. 3. Develop a comprehensive PR and communications plan for HF. 4. Streamline mailing list management processes and clearly define roles and responsibilities.
CHC Marketing		1. Create collateral material for the Pediatric Palliative Care program. 2. Create new commercials for broadcast, digital, and radio. 3. Update Milton Adult Day Services website with branding of other CHC websites. 4. Create virtual tours of Esther's House and Raclin House. 5. Create promotional and marketing materials for Private Pay Room and Board in the IPUs. 6. Explore ways to promote our Center for Palliative Care.

Mark Murray

From: NHPCO <info@nhpco.org>
Sent: Monday, February 10, 2020 5:13 PM
To: Mark Murray
Subject: NHPCO Statement on House Program Integrity Bill

[EXTERNAL]

House of Representatives HOSPICE Act

NHPCO
Leading Person-Centered Care

NHPCO Releases Statement on House Program Integrity Legislation

February 10, 2020

(Alexandria, VA) – Today the House of Representatives introduced the *"Helping Our Senior Population in Comfort Environments" Act* or the *"HOSPICE" Act (H.R. 5821)* sponsored by Representatives Jimmy Panetta (D-CA-20) and Tom Reed (R-NY-23). This legislation follows OIG reports released in July 2019 that outlined deficiencies with CMS monitoring of hospice and examples of poor care.

National Hospice and Palliative Care Organization thanks Representatives Panetta and Reed and the committee for their leadership and commitment to improving hospice care provided to beneficiaries at the end of life.

NHPCO has strongly stated that the survey process is flawed and needs to be overhauled. The HOSPICE Act incorporates NHPCO recommendations for improving the survey process by including increased surveyor training and competency. Proper training will not only benefit the surveyors in their work but has the potential for improving the survey process. NHPCO does not support increasing survey frequency to every two years for all hospice providers across the board.

"NHPCO supports smart oversight when it does not hinder access to high-quality care for patients and their families," said NHPCO President and CEO Edo Banach. "Hospice providers that are following the rules should not be subjected to excessive administrative burden and forced to needlessly divert resources from patient care."

"Most hospices are compassionate caregivers who are deeply concerned for their patients and families. But, there are some that can neglect and even abuse patients. This bipartisan legislation will hold those bad actors accountable, enhance the integrity of the entire hospice program, and improve the quality of care for patients in the last stages of life," said **Congressman Panetta**.

"When my mother became sick, there was nothing I wouldn't have done to cure her, but she taught me that what truly mattered to her was comfort and time spent with her family. Surrounded by a wonderful team of hospice care providers, we watched as her wishes were met. However, we must hold bad actors in the caregiver community accountable, and I am proud to co-lead this legislation to demand additional oversight and transparency of Medicare hospice providers," said **Congressman Reed**.

NHPCO will continue to work with lawmakers to improve quality and access to hospice care especially for beneficiaries in rural and underserved populations. To that end, NHPCO encourages Congress to pass the *Rural Access to Hospice Act of 2019 (H.R. 2594/S.1190)*, bipartisan legislation introduced by Representatives Ron Kind (D-WI-3) and Jackie Walorski (R-IN-2) and Senators Shelly Moore Capitol (R-WV) and Jeanne Shaheen(D-NH) that will allow hospice beneficiaries to be served by their Rural Health Clinic or Federally Qualified Health Center.

NHPCO looks forward to continued work with the Committee to help further their understanding of the intersection of high-quality hospice care and program integrity. Further refinement of the proposals is needed, including the removal and replacement of civil monetary penalties.

"It has been NHPCO's long standing position that if a hospice does not provide high-quality care, they should find another line of work," said Banach.

To stay up-to-date with the latest in hospice and palliative care legislative news, visit the Hospice Action Network's Legislative Action Center.

-###-

Media Contact:
Jon Radulovic
Vice President, Communications
Ph: 703-837-3139

About NHPCO

As the leading organization representing integrated, person-centered healthcare, NHPCO gives ongoing inspiration, practical guidance, and legislative representation to hospice and palliative care providers so they can enrich experiences for patients and ease caregiving responsibilities and emotional stress for families.

MEDIA ALERT

73-year-old man to bicycle from Florida coast to California coast in memory of daughter
Proceeds of fundraiser to go to Center for Hospice Care in Mishawaka, Indiana

MISHAWAKA, IN – Dale Coddington will begin his *Coast to Coast for Hospice* ride – a fundraising, cross-country bicycle trek on his 73rd birthday, Saturday, February 8th at 9:30 a.m. He will depart from 5473 4th Street, St. Augustine Florida on a ride that has been his dream for several years to honor the memory of his late daughter, Tania Coddington Deren.

To see him off, a group of friends, family, and supporters will be there when he departs – media and supporters are welcome to attend. His trip will take an estimated three months to complete and will end in San Diego, California. Coddington hopes to raise $125,000 in support for Center for Hospice Care, located in Mishawaka, Indiana. So far, even before departing, he has raised almost $7,000.

Coddington chose Center for Hospice Care to receive the funds because his granddaughter, Abby, utilized their bereavement services in their Life Transition Center after her mother's unexpected death in February of 2014.

"Abby wanted the funds to go to their bereavement program because of the help they gave her. Center for Hospice Care not only helps those in the last days of their lives, they help those left behind to grieve. I want to thank Center for Hospice Care for the part their counseling services played in helping Abby through a very difficult time in her life," Coddington said.

He will ride his bicycle from coast to coast while his wife, Carole drives their family RV to the rest stops each night. Coddington is covering all of the costs of the ride so that every dollar donated will go directly to benefit Center for Hospice Care's Life Transition Center to fund bereavement services.

To learn more and donate: https://secure.qgiv.com/event/account/878995/
Follow Dale's ride on Facebook: https://www.facebook.com/CoasttoCoastHospice/

About Center for Hospice Care:
Center for Hospice Care is a community-based, non-profit organization that works to improve the quality of living through hospice, home health, grief counseling and community education. Since 1980, Center for Hospice Care has kept its promise that no one eligible for hospice services in their nine-county service area will be turned away due to their inability to pay. The Hospice Foundation supports CHC's mission by advancing projects, raising funds and creating educational programming that improve the quality of living in the communities we serve.

Contact Information:
Hannah Nichols
Communications & Events Coordinator
Hospice Foundation
Email: NicholsH@FoundationForHospice.org
Direct Line: 574.243.3119

Health Inc.

Patients Want To Die At Home, But Home Hospice Care Can Be Tough On Families

January 21, 20205:06 AM ET

Heard on Morning Edition

Blake Farmer

From NASHVILLE PUBLIC RADIO wpln news & 91classical

Patients Want To Die At Home, But Home Hospice Care Can Be Tough On Families

- Transcript

Enlarge this image
Maria Fabrizio for WPLN

Maria Fabrizio for WPLN

"I'm not anti-hospice at at all," says Joy Johnston, a writer from Atlanta. "But I think people aren't prepared for all the effort that it takes to give someone a good death at home."

Even though surveys show it's what most Americans say they want, dying at home is "not all it's cracked up to be," says Johnston, who relocated to New Mexico at age 40 to care for her dying mother some years ago. She ended up writing an essay about her frustrations with the way hospice care often works in the U.S.

Johnston, like many family caregivers, was surprised that her mother's hospice provider left most of the physical work to her. She says that during the final weeks of her mother's life, she felt more like a tired nurse than a devoted daughter.

According to a recent Kaiser Family Foundation poll, seven in 10 Americans say they would prefer to die at home. And that's the direction the health care system is moving, too, hoping to avoid unnecessary and expensive treatment at the end of life.

The home hospice movement has been great for patients, says Vanderbilt palliative care physician Parul Goyal, and many patients are thrilled with the care they get.

"I do think that when they are at home, they are in a peaceful environment," Goyal says. "It is comfortable for them. But," she notes, "it may not be comfortable for family members watching them taking their last breath."

Still, when it comes to where we die, the U.S. has reached a tipping point. Home is now the most common place of death, according to new research, and a majority of Medicare patients are turning to hospice services to help make that possible. Fewer Americans these days are dying in a hospital under the close supervision of doctors and nurses.

Hospice allows a patient deemed to have fewer than six months to live to change the focus of their medical care — from the goal of curing disease to a new goal of using treatments and medicines to maintain comfort and quality of life. It is a form of palliative care, which also focuses on pain management, but can be provided while a patient continues to seek a cure or receive treatments to prolong life.

Usually, hospice care is offered in the home, or sometimes in a nursing home.

Since the mid-1990s, Medicare has allowed the hospice benefit to cover more types of diagnoses, and therefore more people. As acceptance grows among physicians and patients, the numbers continue to balloon — from 1.27 million patients in 2012 to 1.49 million in 2017.

According to the National Hospice and Palliative Care Association, hospice is now a $19 billion industry, almost entirely funded by taxpayers. But as the business has grown, so has the burden on families, who are often the ones providing most of the care.

For example, one intimate task in particular changed Joy Johnston's view of what hospice really means — trying to get her mom's bowels moving. Constipation plagues many dying patients.

"It's ironically called the 'comfort care kit' that you get with home hospice. They include suppositories, and so I had to do that," she says. "That was the lowest point. And I'm sure it was the lowest point for my mother as well. And it didn't work."

Hospice agencies primarily serve in an advisory role and from a distance, even in the final, intense days when family caregivers, or home nurses they've hired, must continually adjust morphine doses or deal with typical end-of-life symptoms, such as bleeding or breathing trouble. Those decisive moments can be scary for the family, says Dr. Joan Teno, a physician and leading hospice researcher at Oregon Health and Science University.

"Imagine if you're the caregiver, and that you're in the house," Teno says. "It's in the middle of the night, 2 o'clock in the morning, and all of a sudden, your family member has a grand mal seizure."

That's exactly what happened with Teno's mother.

"While it was difficult for me to witness, I knew what to do," she says.

In contrast, Teno says, in her father's final hours, he was admitted to a hospice residence. Such residences often resemble a nursing home, with private rooms where family and friends can come and go and with round-the-clock medical attention just down the hall.

Teno called the residence experience of hospice a "godsend." But an inpatient facility is rarely an option, she says. Patients have to be in bad shape for Medicare to pay the higher inpatient rate that hospice residences charge. And by the time such patients reach their final days, it's often too much trouble for them and the family to move.

Hospice care is a lucrative business. It is now the most profitable type of health care service that Medicare pays for. According to Medicare data, for-profit hospice agencies now outnumber the nonprofits that pioneered the service in the 1970s. But agencies that need to generate profits for investors aren't building dedicated hospice units or residences, in general, mostly because such facilities aren't profitable enough.

Joe Shega, chief medical officer at for-profit Vitas, the largest hospice company in the U.S., insists it's the patients' wishes, not a corporate desire to make more money, that drives his firm's business model. "Our focus is on what patients want, and 85 to 90 percent want to be at home," Shega says. "So, our focus is building programs that help them be there."

For many families, making hospice work at home means hiring extra help.

'I guess I've just accepted what's available'

At the kitchen table of her home outside Nashville, hospice patient Jean McCasland is refusing, on the day I visit, to eat a spoonful of peach yogurt. Each morning, nurse's aide Karrie Velez pulverizes McCasland's medications in a pill crusher and mixes them into her breakfast yogurt.

"If you don't, she will just spit them out," Velez says.

Like a growing share of hospice patients, McCasland has dementia. She needs a service that hospice rarely provides — a one-on-one health attendant for several hours, so the regular family caregiver can get some kind of break each day.

John McCasland (right) of Goodlettsville, Tenn., hired a private caregiver to help with his wife, Jean (left), who suffered from dementia for eight years. Even when hospice took over, he still found he needed the extra help from Karrie Velez (center). Jean died in October after 13 months on home hospice. **Blake Farmer/WPLN hide caption**

John McCasland (right) of Goodlettsville, Tenn., hired a private caregiver to help with his wife, Jean (left), who suffered from dementia for eight years. Even when hospice took over, he still found he needed the extra help from Karrie Velez (center). Jean died in October after 13 months on home hospice.

When Velez is not around, John McCasland — Jean's husband of nearly 50 years — is the person in charge at home.

"I have said from the beginning that was my intention, that she would be at home through the duration, as long as I was able," John says.

But what hospice provided wasn't enough help. So he has had to drain their retirement accounts to hire Velez, a private caregiver, out-of-pocket.

Hospice agencies usually bring in a hospital bed, an oxygen machine or a wheelchair — whatever equipment is needed. Prescriptions show up at the house for pain and anxiety. But hands-on help is scarce.

Medicare says hospice benefits can include home health aides and homemaker services. But in practice, that in-person help is often limited to a couple of baths a week. Medicare data reveals that, on average, a nurse or aide is only in the patient's home 30 minutes, or so, per day.

Jean McCasland's husband hasn't complained. "I guess I've just accepted what's available and not really thought beyond what could be," John says. "Because this is what they say they do."

Families rarely consider whether they're getting their money's worth because they're not paying for hospice services directly: Medicare gets the bills. John keeps his monthly statements from Medicare organized in a three-ring binder, but he had never noticed that his agency charges nearly $200 a day, whether there is a health provider in the home on that day or not.

That daily reimbursement also covers equipment rentals and a 24-hour hotline that lets patients or family members consult a nurse as needed; John says it gives him peace of mind that help is a phone call away. "There's a sense of comfort in knowing that they are keeping an eye on her," he says.

The rate that hospice charges Medicare drops a bit after the patient's first two months on the benefit. After reviewing his paperwork, John realizes Medicare paid the hospice agency $60,000 in the first 12 months Jean was on hospice. Was the care his wife got worth that?

"When you consider the amount of money that's involved, perhaps they would provide somebody around the clock," he says.

Sue Riggle is the administrator for the McCaslands' hospice agency and says she understands how much help patients with dementia need.

"I think everybody wishes we could provide the sitter-service part of it," says Riggle. "But it's not something that is covered by hospices."

Her company is a small for-profit business called Adoration; she says the agency can't provide more services than the Medicare benefit pays for.

I checked in again with John and Velez (Jean's long-time private caregiver) this winter. The two were by Jean's side — and had been there for several days straight — when she died in October. The hospice nurse showed up only afterward, to officially document the death.

This experience of family caregivers is typical, but often unexpected.

'It's a burden I lovingly did'

"It does take a toll" on families, says Katherine Ornstein, an associate professor of geriatrics and palliative medicine at Mount Sinai Hospital in New York, who studies what typically happens in the last years of patients' lives. The increasing burden on loved ones — especially spouses — is reaching a breaking point for many people, her research shows. This particular type of stress has even been given a name: caregiver syndrome.

"Our long-term-care system in this country is really using families — unpaid family members," she says. "That's our situation."

A few high-profile advocates have even started questioning whether hospice is right for everybody. For some who have gone through home hospice with a loved one, the difficult experience has led them to choose otherwise for themselves.

Social worker Coneigh Sea has a portrait of her husband that sits in the entryway of her home in

Murfreesboro, Tenn. He died of prostate cancer in their bedroom in 1993

Coneigh Sea is a social worker from Murfreesboro, Tenn., who cared for her husband as he died on home hospice. Now, she wants to make sure her children don't do the same for her.

Enough time has passed since then that the mental fog she experienced while managing his medication and bodily fluids — mostly by herself — has cleared, she says. But it was a burden.

"For me to say that — there's that guilt," she says, then adds, "but I know better. It was a burden that I lovingly did."

She doesn't regret the experience but says it is not one she wishes for her own grown children. She recently sat them down, she says, to make sure they handle her death differently.

"I told my family, if there is such a thing, I will come back and I will haunt you," she says with a laugh. "Don't you do that."

Sea's family may have limited options. Sidestepping home hospice typically means paying for a pricey nursing home or passing away with the cost and potential chaos of a hospital — which is precisely what hospice care was set up to avoid.

As researchers in the field look to the future, they are calling for more palliative care, not less — even as they also advocate for more support of the spouses, family members and friends who are tasked with caring for the patient.

"We really have to expand — in general — our approach to supporting caregivers," Ornstein says, noting that some countries outside the U.S. pay for a wider range and longer duration of home health services.

"I think what we really need to do is be broadening the support that individuals and families can have as they're caring for individuals throughout the course of serious illness," Ornstein says. "And I think that probably speaks to the expansion of palliative care in general."

# # #

Tribune Photo/SANTIAGO FLORES

Clients make cards at Milton Adult Day Services in South Bend.

Making dementia care more inclusive

Dutch-inspired center reaches for community

By Joseph Dits
South Bend Tribune

SOUTH BEND — The idea, announced this summer, seemed a bold turn for the nonprofit Milton Adult Day Services — to move and totally remake its day center for people with dementia and other impairments to feel more like a home and village where they can shop, have a bite, get their hair done or laze by a creek.

It still aims to "decrease the negative stigma of a dementia diagnosis," said Angel Baginske, director of Alzheimer's and Dementia Services of Northern Indiana.

But organizers are now tweaking their redesign after seeing that it falls short in one area: It wouldn't be socially inclusive enough. Clients would be too segregated from caregivers and the public.

Milton Adult Day Services

Milton Adult Day Services at 922 E. Colfax Ave., South Bend, is open from 7:30 a.m. to 5 p.m. Mondays through Fridays. Cost is $60 for five hours of care and $99 for eight hours; it can be covered by Medicaid, Medicaid waiver, CHOICE or veterans benefits. Shower, shaving and meals are available, along with an on-site nurse. (574-232-2666; www.MiltonADS.org)

See DEMENTIA, A9

FROM PAGE A1

Dementia

That came to light in November as local organizers met with consultants from the Netherlands who'd inspired this makeover, who'd pioneered a residential village that has gained attention around the world.

"We are working on the emancipation of people with dementia, because they are human beings," Eloy van Hal, senior adviser and a founder of The Hogeweyk, told the group gathered in Mishawaka at the Center for Hospice Care, which runs the Milton center.

The Hogeweyk, in a small town near Amsterdam, cares for 169 people with advanced dementia who each live in homes of five to seven residents that all face into an expansive, outdoor courtyard where they can spend the day by a fountain or garden, watch films in a theater or shop in actual stores. Even with 40% in wheelchairs, van Hal said they can take part in 30 different activities, including some, like swimming, where they go into town. They can dine at a restaurant that's open to the public.

The Dutch village — which is a licensed nursing home, though completely reimagined — has inspired about 50 initiatives around the world, van Hal said. Some use a few of The Hogeweyk's concepts, and a few use all of them.

Tribune Photos/SANTIAGO FLORES

Director Nancy DeMaegd passes out supplies as clients make holiday cards at Milton Adult Day Services in South Bend.

But more than 20 years after first experimenting with the idea, he said, if Hogeweyk's founders were to build a new village, they'd make it more open to the community — so that residents and the public interact more — while weighing questions about residents' wandering and safety.

On a typical day in South Bend, about 25 people come to the Milton center, now at 922 E. Colfax Ave., to do arts, crafts, singing and socializing in two large activity rooms and a wood shop. Unlike Hogeweyk, it isn't residential. Clients come for mental stimulation and to give their caregivers a break, then return to their own homes.

The newly renamed Care Connections Center at Milton Village would move to a new site. It's expected to open late in 2020 after renovations finish in the former Hospice House on Indiana 933 just south of the Indiana Toll Road. The possibly $3.2 million project, financed by private grants, would create a living room and kitchenette but also a space that mimics an old-time South Bend downtown. There would be a beauty salon, chapel, pub, library, theater, storefronts and ice cream shop, plus a gardened outdoor space by Juday Creek.

Caregivers, who are often family members, would also find rooms for quiet, exercise, counseling, classes and meetings, but these would be separate — and that's where van Hal had an issue.

Local organizers are now tweaking their designs so that caregivers and clients use more shared spaces, not separated, though van Hal acknowledged that there are moments when both of them need privacy.

Adults at Milton Adult Day Services in South Bend make holiday cards.

Baginske said local officials are still finalizing the changes.

Among the suggestions, van Hal said, was creating a sort of Alzheimer's cafe or letting other groups use spaces in the center, like schools.

More welcome

If community is important, it begs a personal question: How do you keep friends engaged in the person's life?

"Someone with dementia, who has forgotten who you are, still knows the sound of your voice and the touch of your hand," said Paula Abraham, a Milton board member whose mother died in 2016 after living with Alzheimer's disease. "You don't have to be afraid of them."

People often ask her: What do I say? What do I do? She advises: Hold the person's hand, read a book, go for a walk or watch a show with the person.

She is among four people trained to give presentations in a newly formed chapter of Dementia Friends Indiana, a group that educates the public so people with dementia will be accepted and understood in the community.

The group plans to start with local fire departments but hopes to reach out to banks, grocery stores and churches.

The fire departments in Carmel and Noblesville, both in central Indiana, became the first in the state to require Dementia Friends training for emergency responders, helping them to identify someone who may have dementia. They're learning how body language, eye contact and tone of voice can help to calm and communicate with someone with dementia, who can become agitated or combative in crisis, according to Dementia Friends Indiana.

Abraham recalls a visit to a hospital with her late mother when the emergency room staff wouldn't let Abraham follow her mom and help to communicate. Abraham, too, was diagnosed with early onset Alzheimer's but later stopped her memory lapses after a change in an unrelated medication. Drugs and nutrient imbalances can mimic the symptoms of dementia.

More normal life

The Milton village would be the first non-residential "day center" that's officially modeled after Hogeweyk. Van Hal said Hogeweyk's main concept isn't about the bricks and mortar but has a lot to do with supporting a person's own preferences.

"You make your own decisions," he said. "Choice is very important."

That can be a challenge since people with dementia often have a hard time knowing or deciding what they want to do. Van Hal said staff try to "motivate or stimulate" residents to participate but not to "take over" for them. But he said it's first critical for Hogeweyk to understand each person's lifestyle and preferences — so residents continue to do things they're used to doing. Having a more "normal environment," he said, makes that easier.

"We must figure out what that person really wants or not wants to do," he said.

Some people want to spend part of the day alone. Small activities can be important, he said, like having residents help to set the table or do the dishes. They often fix their own sandwiches.

Homes are themed according to residents' tastes. Traditional homes have plastic tablecloths. Formal homes have linen cloth. The menu in each house also caters to the residents, be it more traditional cuisine or modern.

Van Hal notes that the village isn't a cure. Residents still deal with the anxieties that come with dementia, though the use of medications for it is much less.

Showing a photo of a resident peeling potatoes for a meal, he said, "By doing this very Dutch thing, peeling potatoes, they feel alive."

jdits@sbtinfo.com
574-235-6158

December 20, 2019

Mark Murray
President & CEO
Center for Hospice Care
501 Comfort Place
Mishawaka, IN 46545

Dear Mark:

My Mother Vicki Bennett passed on December 9, 20019 peacefully at home. My family and I were aided by your team and I just wanted to say thank you.

While she was only a member for a few days, I had the opportunity to meet a few of your staff. They included:

- Tina Zimmerman who was Mom's caseworker
- Jim Peinkofer who was the visiting social worker
- "Cat" an RN who visited the night of her passing to help me determine whether to change her
- An aide named Michelle I believe who helped me give her a sponge bath, and
- A beautiful young RN whose name I cannot recall who "pronounced her" late in the evening and helped me prepare Mom for the Funeral Home whose name I regrettably cannot recall. It ws a nit of a blur, but her name may have been Elizabeth…

Each were compassionate and helpful and I could not be more grateful for the assistance they provided.

Please be sure to thank them all for the services they rendered and if appropriate circulate this letter.

Thank you for the work you and your team do!

Sincerely,

R. Scott Bennett
Bennett2x4@gmail.com
610.574.9663

or Drewrys plans

an. 1,
molition

ctions, arguing
rious states of dis-
iolated state and
e building laws,
d asked admin-
hearing officer
Heppenheimer
n the orders.
t the end of the
, Heppenheimer,
Bend attorney, ef-
brokered a deal
n the city and
-based owner

ee DREWRYS, A3

Tribune Photo/ROBERT FRANKLIN

Demolition debris at the former Drewrys brewery site as seen on Sept. 26. On Thursday the city agreed to give the site's owner, Phoenix-based Steve Durkee, until the end of next year to repair four sections of building to avoid a demolition order.

Tribune Photo/MICHAEL CATERINA

nbrella Thursday, Nov. 21, 2019 on Michigan Street in downtown South

DBYE RAIN,

Tribune Photo/GREG SWIERCZ

The Center for Hospice Care in Mishawaka dedicated the Ernestine M. Raclin House, a 12-bed inpatient center situated on the bank of the St. Joseph River to provide care for hospice patients and families in a homelike setting.

Hospice inpatient site to open

By Greg Swiercz
South Bend Tribune

MISHAWAKA — A new 12-bed inpatient center is expected to open early next year at the Center for Hospice Care's Mishawaka campus.

The 17,000-square-foot facility, called the Ernestine M. Raclin House, is built on Comfort Drive just east of the organization's current buildings along the St. Joseph River east of Central Park. The facility should begin accepting hospice patients early in 2020, according to Mike Wargo, vice president and chief operating officer for the Hospice Foundation.

While construction crews put finishing touches on what officials describe as a "classic contemporary Craftsman-style" facility, Wargo said the center is the culmination of a five-year fundraising campaign.

Donors, staff and agency officials dedicated the new center earlier this week.

The 12-bed facility will replace the current seven-bed Hospice House inpatient center the agency has operated for the past 23 years in Roseland. Wargo said once the

See HOSPICE, A4

OneRepublic

he Netflix drama "13 Reasons Why," and 'Connection," which was part of Fiat Chrysler's Summer of Jeep campaign.

American Authors is a rock band known for its breakthrough "Best Day of My Life," which earned a triple-platinum certification and has received numerous film, television, video game and sports syncs, according to information on the Idea Week website.

Indie-rock duo The Bergamot, which includes wife-and-husband team Jillian Speece and Nathaniel Hoff, formed in South Bend but is now based in New York. This fall, they released their latest album, "Mayflies."

The couple met while teenagers at Marian High School, and they're proud of their roots, which is why they come back home often.

The Bergamot said in a news release they were "excited" to open for OneRepublic and American Authors in their "first-ever arena show."

The goal of Idea Week, hosted by Notre Dame as well as other organizations at various locations, is to highlight entrepreneurial efforts in the region.

Idea Week is also slated to feature an e-sports tournament with tens of thousands of dollars in prize money; speakers; a comedian; various other musical performances; meet-ups; workshops; and more.

More than 21,000 people attended part of Idea Week last year, and about 18,000 attended in its inaugural year in 2018.

Tribune Photos/GREG SWIERC

The Center for Hospice Care in Mishawaka dedicated the Ernestine M. Raclin House, a 12 bed inpatient center situated on the bank of the St. Joseph River to provide care for hospic patients and families in a home-like setting. The large family living space has room for mul tiple families and a full kitchen.

FROM PAGE A1

Hospice

new center opens, Roseland patients and staff will be transferred to Mishawaka.

The Roseland Hospice House will be converted into the new home of the center's Milton Adult Day Services, serving people with dementia.

The center also runs a similar seven-bed Hospice House at the eastern end of Elkhart County that will remain open.

Hospice care involves medical care, pain management, and emotional and spiritual support for patients and their families when a patient faces a terminal illness.

All 12 rooms at the new Hospice House face the St. Joseph River. Wargo said patios and common areas were designed to allow patients and family members to take in the river setting.

Patients who will make use of the center fall into several categories. Wargo said people discharged from hospi-

Each room for patients in the Center for Hospice Care Mishawaka has a patio and a view of the river.

Many seating areas in the Center for Hospice Care are situ
ed near the main nurse's desk inside the center's main

medical care, pain management, and emotional and spiritual support for patients and their families when a patient faces a terminal illness.

All 12 rooms at the new Hospice House face the St. Joseph River. Wargo said patios and common areas were designed to allow patients and family members to take in the river setting.

Patients who will make use of the center fall into several categories. Wargo said people discharged from hospitals can be admitted if the patient's condition prevents them from going home.

Others admitted to the center can be people who are having acute medical issues. Wargo said often these inpatients may be stabilized over the course of a several-day stay.

The center also offers primary caregivers of hospice patients respite. Patients can be admitted if caregivers are going out of town or need a break.

Wargo said the average stay for admitted patients to the inpatient center is 5 1/2 days, and all will have the full array of hospice services offered there.


Many seating areas in the Center for Hospice Care are situated near the main nurse's desk inside the center's main hall.

National statistics provided by the National Hospice and Palliative Care Organization for 2018 show that while 80% of Medicare hospice patients die at home (48.2%) or in a nursing facility (31.8%), only 11.2% die in inpatient hospice facilities.

About 86% of annual revenue from the nonprofit Center for Hospice Care comes from Medicare through the hospice benefit, with 1% from Medicaid. Private insurance accounts for 6%, while fundraising fills in the remaining 6%, Wargo said.

Features in the new center are designed to accommodate the patients and families. A large common area houses a large kitchen with two refrigerators and two large living spaces that can handle multiple families of patients.

A four-season room on the west side of the building will have furnishings that resemble a patio and the view will offer people a vista of the park and river.

Rooms for teens, for children and even for a future therapy dog are planned.

"The setting here is so unique," Wargo said. "We have large living spaces. This (facility) provides spaces for all to feel comfortable."

The Center for Hospice Care has scheduled a public open house at the Ernestine M. Raclin House from 4-6 p.m. Dec. 3.

FROM PAGE E1

Borlik

At Penn, **James McPhee** was her physics teacher for two years and he convinced her to look at engineering. "I was always interested in science. I was thinking about becoming a doctor." Mr. McPhee said "engineering would be a good first step. Once at Purdue, it all fell into place. "It has had an incredible impact on me. All you need is a good teacher."

She added that the ability to communicate ideas is very important. That was a bit of a shoutout to English majors.

Sadie said it is very exciting at NASA right now with the new programs. How about becoming an astronaut? "I would love it, but the odds aren't great." There are more than 18,000 applicants.

Eventually she would like to get her master's from Purdue's online program. Then, eventually teach in high school. And she could be that one good teacher who molds thinkers, makes someone look at the stars a little differently and dream big.

Contact Kathy at kfborlik@yahoo.com.

BENEFITING OTHERS

American Technology Components, Inc., held its second annual food drive within the company. In one week, the Elkhart company collected cash donations and almost 400 pounds of nonperishable food to support both the community and employee. Natalie Martin, one of the organizers of the event, said, "we know everyone needs help at some point in their lives."

• • •

More than $3,000 was raised by the **Mishawaka Police Department** during its No Shave November fundraiser. A check for $3,062 was presented to Center for Hospice Care in Mishawaka this month.

VOLUNTEERS

REAL Services is looking for Meals on Wheels volunteers. Free lunch and a small gas stipend included. Call 574-284-7138 or email volunteer@realservices.org for details.

CLUBS

BUCHANAN — The **Papasan-Mamasan Korean Veteran Association** holds its Christmas party today at American Legion Post 51, 403 E. Front St. Social hour is at noon, dinner follows at 1 p.m. Those attending are asked to bring a dish to pass. Meat, refreshments and table service will be provided. For more information, contact Don Holmes at 260-695-1133.

• • •

SOUTH BEND — **South Bend Green Drinks** meets Tuesday from 5:30 to 7 p.m. at The Lauber, 504 E. LaSalle Ave. The group

Planning for future care may be linked to longer survival in terminally ill patients

10-Dec-2019

Effects strongest among those with diseases other than cancer, exploratory findings show

BMJ

Sharing preferences for end of life care, known as advance care planning, may be linked to longer survival in terminally ill patients, suggests the first study of its kind, published online in the journal *BMJ Supportive & Palliative Care.*

Advance care planning enables adults to discuss wishes and priorities for their care, including stopping treatment to prolong life, when they are no longer able to do so.

But it's not known what impact this might have on survival in patients who are terminally ill.

The researchers used data from a previously published randomised controlled trial, which aimed to find out if advance care planning had any impact on meeting terminally ill patients' preferences for place of death.

This involved tracking the date of death for 205 terminally ill patients, 102 of whom had had a conversation about their preferences for end of life care with a doctor, and 103 of whom hadn't.

Around half the patients in each of the groups had advanced cancer, and half had been terminally ill with heart and lung conditions.

Additional analysis of these data showed that there was a difference in survival after a year of monitoring between those who had had this type of conversation and those who hadn't.

Nearly three out of four of those (73%) of those who had done so were alive after a year compared with over half (57%) of those who hadn't.

While there was no significant difference in survival between terminally ill cancer patients who had and hadn't had an advance care planning conversation, there was between those with other types of terminal illness, the analysis showed.

Among this group, nine out of 10 (90%) of those who had done so were alive after a year, compared with two thirds (67%) of those who hadn't.

By way of a possible explanation for this finding, the researchers suggest that this type of conversation helps these patients better understand the life-limiting nature of their illness.

This may change their views about having treatment that prolongs life, such as steroids, which, paradoxically, have been associated with a heightened risk of death and other illness - at least among those with serious lung disease, say the researchers.

The researchers didn't set out to look at the potential impact of advance care planning on survival, and this finding was a by-product of their research in a relatively small number of people, so requires further study, they say.

"[Advance care planning] was associated with a significantly improved survival among terminally ill patients, primarily [those] with non-cancer diseases. However, the analysis was explorative, and the association must be investigated further before drawing any firm conclusion," they conclude.

###

Peer reviewed? Yes
Evidence type: Further analysis of randomised controlled trial data
Subjects: People

More people in the US are dying at home than at the hospital

POSTED 5:41 PM, DECEMBER 11, 2019, BY CNN WIRE

For the first time since the early 20th century, more people in United States are dying at home than at the hospital, according to a report published in the New England Journal of Medicine on Wednesday.

The researchers looked at the number of natural deaths in the United States based on data collected by the US Centers for Disease Control and Prevention and the National Center for Health Statistics. They define natural deaths as when a medical condition leads directly to death, meaning people died from heart problems or cancer, among other diseases, rather than dying in a car accident, for example. The authors looked at data from 2003 to 2017.

They found that hospital deaths are still common, but that number is declining. There were 905,874 hospital deaths in 2003 — 39.7% of deaths — and by 2017 there were 764,424 hospital deaths, 29.8% of deaths.

The number of deaths at home, though, increased from 543,874 (23.8%) in 2003 to 788,757 (30.7%) in 2017.

There was also an increase in the number of people dying in hospice facilities. In hospice, an interdisciplinary team of professionals that specialize in end-of life-care address the whole person. They work to help manage pain and the person's physical needs, as well as their mental and spiritual distress. Hospice also helps the family and coordinates care.

In 2003, 5,395 (.2%) died in hospice, in 2017, the number rose to 212,652 (8.3%).

The number of deaths at nursing homes also declined. In 2003, there were 538,817 (23.6%) deaths. In 2017, there were 534,714 (20.8%).

Patients with cancer had the greatest odds of dying at home or in hospice, the report said. People with dementia died more often at a nursing home, and stroke patients had the lowest odds of dying at home.

While an increasing number of people use hospice, other studies have shown that kind of care is underutilized. Medicare covers up to six months of hospice care, yet, most people only turn to hospice days, instead of months, before death, earlier studies found.

Deciding where to die

Previous studies have shown that the majority of people would prefer to die at home and feel more at peace with the experience.

"I cannot emphasize enough the point of having these conversations, not just what kind of care you want in later stages of an illness, but also what the person's thoughts are about where they want to be," said Deborah Waldrop, a professor of social work at the University at Buffalo School of Social Work who studies end-of-life decision-making. Waldrop did not work on the new study.

She said this report is important because people often wait too long to have these conversations.

"Honestly, some of my worst moments in practice is when someone tells me 'I don't know what she wants, we never talked about it,'" Waldrop said.

If someone wants to die at home, it's important that a caregiver feels the same way. Caring for the dying, even with hospice help, is physically and mentally difficult and not "all deaths are pretty," Waldrop added.

"In this country, we have romanticized the notion of death at home. That is not to say it can't be wonderful for the family and for the person they are caring for, but we often think about this as a loving time where people are singing and holding hands and praying, when in reality it is a very hard job," Waldrop said.

She advises talking with a provider about what comes next. Knowing what will happen can help someone think through if they are able to provide that kind of care.

It's also important to be mindful of little things, she said, like deciding where in the home someone will die. If you clear out the dining room table for the hospital bed, for example, what happens next Thanksgiving?

"People can work through it, but that memory doesn't go away," Waldrop said.

Support for caregivers

The report's authors argue that the country needs to develop more policies and offer more services to ensure high-quality care for people who die at home.

Some states provide financial help for friends or family who care for someone who is dying, Waldrop said. Studies have shown that many people have to leave a job or retire early to provide this support, and that's not financially feasible for many families.

A 2016 AARP study showed that family caregivers provide 37 billion hours of care worth an estimated $470 billion to their parents, spouses, partners and other adult loved ones.

"It is important to keep a promise to our loved one and if dying at home is what they want, we need to make sure they have the support that is needed," Waldrop said. "Caregiving is a 24/7 job, and even with hospice, they cannot be there 24/7.

"It is important to decide what a person can realistically offer and to make sure there is no mismatch in what someone wants and what someone can provide."

STAT

More Americans are dying at home. Is that a good thing?

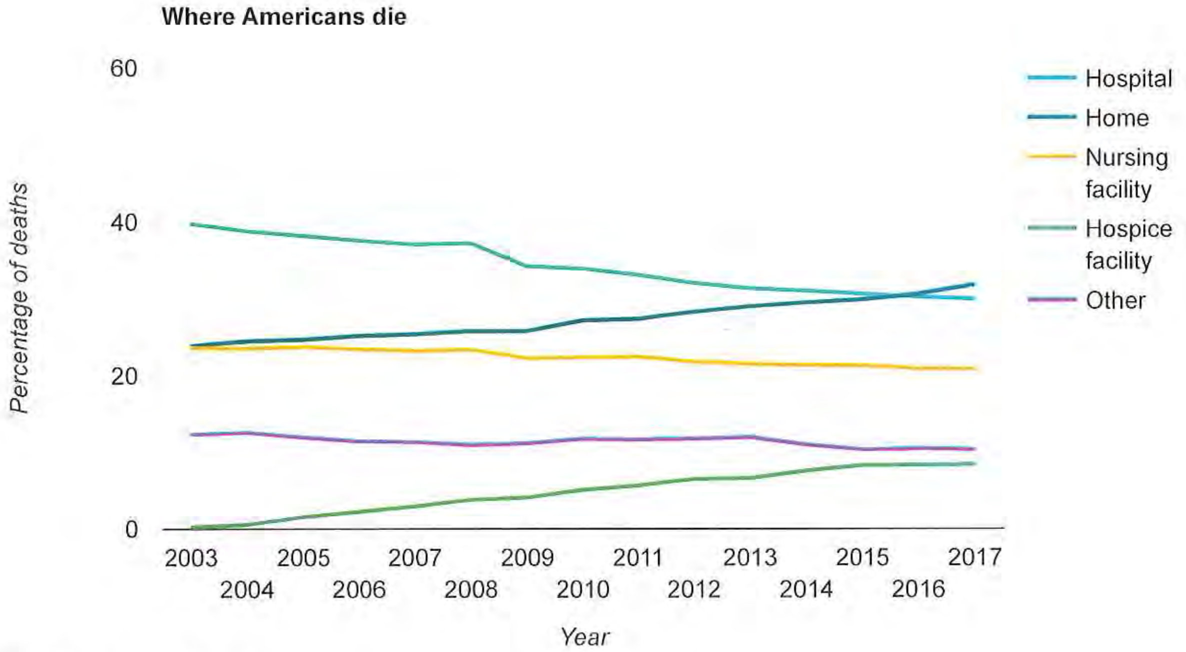
By Sarah H. Cross *and* Haider J. Warraich

December 11, 2019

Adobe

How Americans die has fundamentally changed[2] with advances in medical technology and the ways diseases are treated. For centuries, death commonly occurred in one's home with care provided by relatives and community members. Yet since the 1960s, the hospital and intensive care unit have become places of passage as people approach the end.

In this week's New England Journal of Medicine, we report[3] that home has become the most common place of death among Americans dying of natural causes for the first time since the early 20th century[4], while deaths in hospitals and nursing facilities have declined. Our analysis of data from the Centers for Disease Control and Prevention and the National Center for Health Statistics also showed striking differences in place of death according to who you are and what you die of: individuals who are nonwhite or those dying from diseases other than cancer are less likely to die at home than those who are white or those who die from cancer.



STAT *Patrick Skerrett / STAT*Adapted from The New England Journal of Medicine 2019; 381:2369-2370

These findings are encouraging. But they can also have a dark side, illustrated by Margaret Peterson, who helped her husband, Dwight, die at home in Illinois. "My experience was positive in the sense that my husband succeeded in dying in his own damn bed, in his own damn house," she wrote in response to a query that one of us (H.J.W.) posted on a Facebook group for caregivers. "It was negative in the sense that the medical management we needed, such as subcutaneous or intravenous morphine, was not available. It was terrible."

The emergence of hospice

Concerned by the inadequacy of care provided to the dying, Cicely Saunders[5] founded the modern hospice movement in England in 1967. The growth of hospice in the United States[6] was likewise fueled by growing disillusionment with the aggressive treatment that cancer patients received even when death was approaching.

Hospice is specialized interdisciplinary care for those with limited life expectancies. It focuses on managing symptoms and maintaining quality of life. It differs from palliative care, which may be administered at any stage of serious illness and in conjunction with conventional treatment.

In the United Kingdom and Europe, hospice is predominately an inpatient service; in the United States, home care is prioritized. End-of-life care in the U.S. was revolutionized by the Medicare hospice benefit[7], which became permanent in 1986.

Related: [8]

Hopewell House hospice has closed. You should care about that [8]

Hospice has since been transformed from a social movement into an essential component of the health care system. The rise in home deaths documented in our study is likely a result of greater use of hospice along with broader efforts to de-medicalize and improve end-of life care.

Hospice in the U.S. is a uniquely American creation: an insurance benefit intended to make hospice a cost-neutral service. It was designed based on the needs of people with cancer, a disease that progresses differently from other common causes of death such as heart failure or dementia. It was also created with the expectation that family members would provide the majority of hands-on care.

Hospice does not provide 24-hour care in the home except in short crisis situations. Symptom flare-ups, like a spike in pain or difficulty breathing, may be challenging to manage at home and the day-to-day burdens on caregivers are often significant.

Inpatient hospice facilities, which are able to provide intensive symptom management, are at increased risk of closure[8] due to insufficient funding and strict Medicare regulations.

Improving the system

We are advocates for hospice and are encouraged by the expansion and uptake of this service. But many individuals need the kind of care that the current hospice model cannot provide. Given the rising number of people dying at home, ensuring the availability of services to support them and their caregivers is a matter of urgency.

Only about half of Americans die while receiving hospice services, and home-based non-hospice palliative care is still in its infancy. We need a new movement, one that embraces the best of what hospice pioneers envisioned but that also adapts to the reality of modern health care and society.

Upgrade hospice. By agreeing to cease potentially "curative" care, patients who choose hospice are expected to have reduced expenditures from expensive treatments and hospitalizations. This model of care was unfair from the start, but it is now terribly outdated[9] as the line between "curative" and symptom-easing treatments has become increasingly blurred with the development of new medical technologies. Hospice should be redesigned with quality of care as its priority, not the cost of care. Eligibility criteria for hospice should be based on a patient's needs, not inaccurate estimations of prognosis or the treatments she or he is willing to forgo.

Change the one-sized fits all approach. Current policies present barriers to wider hospice use for people with non-malignant condition[10], who may benefit from disease-directed therapies late in their disease course and whose prognosis is less predictable. Racial minorities[11] have lower rates of hospice use, likely due to greater mistrust of the health care system, cultural beliefs and preferences, and greater desire for life-sustaining care regardless of prognosis. The ability to receive disease-directed treatment should be incorporated into new models of hospice care and the viability of disease-specific hospice benefits should be explored.

As our population becomes increasingly diverse, the need for care that incorporates varying cultural backgrounds and preferences[12] will also grow. Geographic disparities and workforce shortages have fueled innovative telehealth hospice programs[13]. We will need other inspired programs to extend high-quality person-centered care to all.

Pay attention to social determinants of health. People with fewer socioeconomic resources are less likely to die at home[16] — presumably because they lack the ability to afford and access services that make dying at home feasible. Paying for private caregivers is beyond the ability of most Americans and the current hospice benefit provides coverage only for limited social services. Many hospices, however, report using internal funds to assist patients with non-reimbursable needs[17] such as food, shelter, and utilities. We must think outside the box and develop programs that meet social needs at the end of life and consider incorporating additional social supports into new care models.

Make quality end-of-life care available in all settings. When asked, most people say they would prefer to die at home, and hospice use increases the likelihood of this occurring. Yet a home death is neither preferable nor possible for everyone. It is good when preferences can be honored and people are able die in the place of their choosing. Yet the reality of serious illness and the capability for caregiving are complicated. Every individual is different, as are their needs and preferences. Indeed, both may change over time. Everyone, regardless of the setting in which they receive end-of-life care, should have access to high-quality symptom management and psychosocial support at the end of life.

Hospice allows many people to experience what some refer to as a "good death" in their homes. The goal of our health system should be to ensure that all Americans have the ability to choose such an opportunity.

One such person was Mary who, in her late 90s, realized she was dying. Her daughter-in-law Nancy described her final moments. "She died on April 24, peacefully and painlessly, about an hour after her hospice aide, Marie, had given her a loving bed bath and shampoo, changed her sheets, and massaged her feet and hands with oil," Mary wrote to us in an email.

"Mary held out her hand to Marie and said 'Thank you,' snuggled down into her bed, and about an hour later was gone."

Sarah H. Cross, M.P.H., is a doctoral candidate in the Sanford School of Public Policy at Duke University in Durham, N.C., and a former hospice and palliative care social worker. Haider J. Warraich, M.D., is the associate director of the heart failure program at the VA Boston Healthcare System, a cardiologist at Brigham and Women's Hospital, and an instructor in cardiology at Harvard Medical School.

About the Authors

Sarah H. Cross

sarah.h.cross@duke.edu[18]
@Sarah_H_Cross[19]

Haider J. Warraich

hwarraich@partners.org[20]
@haiderwarraich[21]

Tags

Links

1. https://www.statnews.com/category/first-opinion/
2. https://www.sciencedirect.com/science/article/pii/S0735109717388769?via%3Dihub
3. http://www.nejm.org/doi/full/10.1056/NEJMc1911892
4. https://us.macmillan.com/books/9781250104588
5. https://global.oup.com/academic/product/cicely-saunders-9780190637934?cc=us&lang=en&
6. https://read.dukeupress.edu/jhppl/article-abstract/41/4/697/13856/Regulating-and-Paying-for-Hospice-and-Palliative
7. https://www.medicare.gov/Pubs/pdf/02154-Medicare-Hospice-Benefits.PDF
8. https://www.statnews.com/2019/11/19/hopewell-house-hospice-closed/
9. https://www.statnews.com/2016/10/26/hospice-care-patients/
10. https://www.cfrjournal.com/articles/hospice-use-among-patients-heart-failure
11. https://www.nytimes.com/2015/08/25/health/a-racial-gap-in-attitudes-toward-hospice-care.html

12. https://www.postandcourier.com/health/beaufort-study-helps-doctors-approach-patients-with-cultural-understanding-at/article_e3a3a60c-c81c-11e9-a0a9-4716df8c47b6.html
13. https://www.resolutioncare.com/
14. https://www.statnews.com/signup/
15. https://www.statnews.com/privacy/
16. https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1653994
17. https://www.liebertpub.com/doi/abs/10.1089/jpm.2016.0459
18. https://www.statnews.com/2019/12/11/more-americans-die-at-home/mailto:sarah.h.cross@duke.edu
19. https://twitter.com/Sarah_H_Cross
20. https://www.statnews.com/2019/12/11/more-americans-die-at-home/mailto:hwarraich@partners.org
21. https://twitter.com/haiderwarraich
22. https://www.statnews.com/tag/end-of-life/