Center for Hospice Care
choices to make the most of life

# Board of Directors Meeting

**501 Comfort Place, Conference Room A, Mishawaka**
**June 17, 2020**
**7:15 a.m.**

# BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

# CHAPTER ONE

# AGENDA

**BOARD OF DIRECTORS MEETING**
Administrative and Foundation Offices
501 Comfort Place, Room A, Mishawaka IN
June 17, 2020
7:15 a.m.

**A G E N D A**

1. **Welcome –** Mary Newbold (3 Minutes)

2. **Consent Agenda** – Mary Newbold (10 minutes)
   A. Approval of February 19, 2020 Board Meeting Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Sue Morgan available to answer questions.
   C. Human Resources Manual *(action)*
   D. QI Committee Meeting Minutes (February and May) *(information)*

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

4. **Finance Committee** *(action)* – Mark Wobbe (15 minutes)
   A. 2019 Audit
   B. Year to Date April 2020 Financial Statements

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

6. **Board Education** *(information)* **–** "CHC Market Trends with Increased Competition thru the Years" – Craig Harrell, Director of Marketing and Access (15 minutes)

7. **Chair's Report** – Mary Newbold (2 minutes)

Next meeting August 19, 2020

# # #

Center for Hospice Care
choices to make the most of life

# CHAPTER TWO

# CONSENT AGENDA

**Center for Hospice Care**
**Board of Directors Meeting Minutes**
**February 19, 2020**

| | |
|---|---|
| *Members Present:* | Amy Kuhar Mauro, Jennifer Ewing, Jennifer Houin, Jesse Hsieh, Mark Wobbe, Mary Newbold, Suzie Weirick, Tricia Luck, Wendell Walsh |
| *Absent:* | Andy Murray, Ann Firth, Kurt Janowsky, Roland Chamblee |
| *CHC Staff:* | Mark Murray, Craig Harrell, Dave Haley, Karl Holderman, Mike Wargo, Sue Morgan, Becky Kizer |

| Topic | Discussion | Action |
|---|---|---|
| **1. Call to Order** | • The meeting was called to order at 7:15 a.m. | |
| **2. Minutes** | • A motion was made to accept the minutes of the 11/20/19 meeting as presented. The motion was accepted unanimously. | T. Luck motioned<br>J. Ewing seconded |
| **3. Policies** | • AICDS: Articulation of Implanted Cardioverter/Defibrillators – revised. A motion was made to accept the revised policy as presented. The motion was accepted unanimously. | A. Mauro motioned<br>J. Houin seconded |
| **4. President's Report** | • Invitations were handed out at the meeting for the Circle of Caring reception in Florida, Helping Hands Award Dinner honoring Zoreen and Rafat Ansari, and a "Death by Chocolate" advance care planning event at Chicory Café Mishawaka.<br>• As of end of the year, Cerner will no longer support our electronic medical record, so we are in the process of auditioning replacements for our EMR.<br>• CMS and Palmetto audits are going on. Last summer there were two negative OIG reports regarding hospices. We received a request for records of 20 Routine Level of Care and 20 GIP patients from Palmetto. We have been paid for all except four that we are appealing. Then there are the regular ADR audits as well. A few weeks ago, we were selected for a major length of stay audit that many large hospices are going through, including NHERT members. They want all the records on ten patients admitted in 2017. Because this is a per diem program, that is 330 months of paperwork and 19,000 days of claims. We were able to get an extension to submit the data by 03/25. If we had to reimburse Palmetto, we could be at risk for $1.2M. People who have gone through this audit said the results are a 97-100% error rate. One good thing is no one has received a demand letter yet asking for money. Appeals cannot be done until the demand letter is received. We have signed an agreement with Meg Pekarske, | |

| Topic | Discussion | Action |
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| | 20-year veteran on hospice Medicare audits, and an attorney with Husch Blackwell who does nothing but help agencies with audits. We are uploading our records to her and they will send CD-ROM of organized pdf files to Noridian, the government contractor conducting this national audit. The auditors from Kruggel Lawton are here this week and will be talking to them about whether we should park a $1.2M reserve or a percentage of it in the future. This is not a Medicare sampling audit where they use extrapolation of a percentage of denied claims to a larger universe of claims. We have many appeals rights and can take it to an Administrative Law judge. If the appeals get to an administrative law judge, many times hospices and other Medicare providers win. This entire process could take five years. In November, the ALJ had a backlog of 440,000 claims being appealed. NHPCO is putting together a task force with Meg Pekarske and other well-known attorneys and hospice program compliance officers, and outcomes will go directly to CMS to say these audits are out of control. Edo Banach, Pres/CEO of NHPCO has asked Mark for CHC to participate in the task force.<br>• Census continues to do very well and continues in record territories. January ADC was 430, February 440, and YTD 434, which is already above the 2019 annual year to date ADC.<br>• The updated CHC website at cfhcare.org is now live. Now all of our various websites have the same look and color pallet.<br>• Raclin House – We feel we'll be in a position to receive the required state inspections the week of 03/09. Once we have those approvals, we will begin the process of admitting patients. However, we have no control over when the state can get here to perform the Life Safety Code inspection. The tentative plan is to keep patients at the South Bend IPU, so we won't have to move them and begin admitted new patients to Raclin House. The average length of stay in the IPU is five days. We may have to double staff for a few days. Other patients could be diverted to the Elkhart IPU until Raclin House is open. We had a lot of issues with contractors, because there are so many projects going on in the area, which pushes back everyone else. Project completions dates are late everywhere. | |
| **5. Finance Committee** | • The Finance Committee met 02/14 and reviewed the December 2019 YTD pre-audited financial statements. They also reviewed the 2018 audit of CHC's retirement plan. It is a defined contribution plan. There were a couple of minor deficiencies that were addressed. | |

| Topic | Discussion | Action |
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| | • In 2019 we served 2,071 patients, compared to 2,045 in 2018. We budgeted to serve 2,069. Total operating revenue YTD was $23M, MADS revenue $357,000, interest and other income $65,000, beneficial interest in affiliate $4.3M, total revenue $27.7M, total expenses $21.7M, net gain $6M, net without beneficial interest $1.7M. Compared to the annual budget, operating revenue was $665,000 over budget, and total expenses were $285,000 under budget.<br>• Receivables – We had concerns over past year or two, but we made significant progress over the past two to three months. Unbilled Receivables are down from $4M in July to $140,000 in December. That will affect the cash flow in January and February as those payments come in. Claims are submitted in 30-day increments. Dr. Gifford retired 12/31/19 and spent about six weeks doing nothing but certs, recerts, and physician narratives to get us caught up. We have processes in place to avoid returning to that backlog.<br>• A motion was made to except the December 2019 YTD pre-audited financial statements as presented. The motion was accepted unanimously. | S. Weirick motioned<br>J. Ewing seconded |
| **6. Hospice Foundation Update** | • Cornerstones for Living: The Crossroads Campaign officially ended 06/30/19. At that time, we still had several outstanding asks, which resulted in additional campaign-related donations flowing in by year-end. As a result, the campaign raised over $14M.<br>• Fundraising over the last ten years has been pretty steady as far as annual giving is concerned. The value of charity care from an annual giving point is still nowhere near the amount of charity care we provide. Areas of support in 2019 were 67.54% discounted patient care, 17.54% bereavement services, 8.44% unreimbursed patient care, and 6.48% community services.<br>• Education – Dr. Collin Bowman was the third Vera Z. Dwyer Fellow in Hospice and Palliative Medicine. We are finding that Fellows already have jobs lined up before they begin the Fellowship. The fourth Dwyer Fellow, who will begin the program in July, is a doctor from Goshen and we are talking to her about job opportunities.<br>• The Honoring Choices Indiana - North Central coordinator, Sr. Eileen Wrobleski, is retiring at the end of the month. We are in the process of searching for a replacement and have two candidates that will be meeting with the advisory board next week. We recently developed an “Are You Prepared” brochure in both English and Spanish and are working on translating our other materials into Spanish as well. | |

| Topic | Discussion | Action |
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| | • GPIC – The Road to Hope children's camp was held in January. 55 of the 57 Road to Hope children were able to attend. Volunteer Roberta Spencer was in Uganda to assist with the camp and other initiatives for a few weeks.<br>• Raclin House – We are hoping to have the required inspections completed the week of 03/09. We have been working with contractors the last several weeks to take care of last-minute details. Though behind-the-scenes construction was still in process, we decided to hold a ceremonial ribbon cutting and reception in November, before many of the donors went to Florida for the winter. We have also been giving tours to referral sources and other community groups.<br>• Residential House – In exchange for some land, we had made a commitment to the City of Mishawaka to build at least one home and sell it, which we have done. As a member of the Edgewater Neighborhood District, we hosted a meeting of the Mishawaka Historic Preservation Commission for all the neighbors here last week. The neighborhood association is working on obtaining designation as a historic district. Mayor Wood attended and said he credits CHC as being the driver behind all the developments around downtown Mishawaka.<br>• A list of upcoming events is in board packet. Staff from PCAU will be here 03/05 to 04/03. This is their sixth exchange visit to the U.S. Mark Mwesiga is the new country director of PCAU. Rose Kiwanuka retired but will continue to be involved in some way. Joyce Zalwango is the Capacity Building and Advocacy Officer. She was one of the students we sponsored in the Diploma in Clinical Palliative Care course at Hospice Africa Uganda. Okuyamba Fest will be held at The Brick on 04/02.<br>• We will be doing the Notre Dame "Introduction to Hospice and Palliative Care" course on four Friday afternoons: 03/20, 03/27, 04/03, and 04/17. The classes will all be taught by CHC staff.<br>• Milton Adult Day Services – We continue to work with the architects, REAL Services, and Alzheimer & Dementia Services on design ideas for "Caregiver Connections at Milton Village." We anticipate being able to preview some conceptual renderings at the May board meeting. The target date to open the facility is in summer 2021, which is when we need to be out of the existing building.<br>• The Helping Hands Award Dinner honoring Zoreen and Rafat Ansari is 05/06. Thank you to Jennifer Ewing for chairing the event. Dr. Rafat Ansari has been practicing in | |

| Topic | Discussion | Action |
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| | the community for 40 years, the same amount of time as CHC. We will be doing some tie-ins related to that. | |
| **7. Board Education** | • 2019 Year in Review – The number of patients served was up 1.3%. This is the sixth year in a row we cared for more than 2,000 patients in a calendar year. ADC was the highest it has ever been at 420, a 7% increase. Total referrals increased 1%. Palliative care admissions under our home health license increased 59%. The admission department is doing a much better job at having people start under palliative care prior to transitioning to hospice. The conversion increased to 71.86% from 71.79%. Industry standard says anything over 70% is very good. DBAs increased to 8% from 7.6%of all referrals. This has had no affect on market share. Mark M. will check with the NHERT members to see if there is an industry rate for DBAs. The rate varies so much. New York is the worst and Colorado is the highest. Patients refusing admission decreased from 4.05% to 3.08%. Hospital referrals increased to 46.5% of all referrals. They have the shortest lengths of stay. The ALOS for physician referrals increased from 77 to 88 days and the median from 26 to 37 days. Family/self conversion rate increased from 67.82% to 68.80%. Since 01/01/1980 we have served 39,078 patients, so the 40,000$^{th}$ patient may be admitted around June. 42% of the 39,078 were seen in the last eight years, and 25% in the last five years.<br>• We have 31 competitors in our service area. About 65% of all hospices nationally are for-profit. Here it is about 71% that claim to cover all or part of our service area. Elara Caring Network, formerly Great Lakes Hospice, is now the largest hospice in Indiana, because they have a single provider number for seven offices. Our largest competitors are Heart to Heart, Heartland, and Southern Care. We are addressing this with the local hospitals and emphasizing our quality of care. Our ECF census saw its highest increase in seven years. ECF patients (nursing homes, assisted living, and group homes) ADC increased from 128 to 142. Barb King, Professional Relations Liaison, is doing a great job focusing on ECFs and how we can work better together.<br>• Diagnosis – Cancer was 34.87%. Thirty years ago, nearly all patients were cancer. Cardiopulmonary, dementia, and COPD are over half, which is why we have our BreatheEazy, HeartWize, and Dementia Care programs. The ALOS and median stayed about the same. HMB LOS is still very good—about 83 days. The Hospice Per Diem days were up 5%. Original admissions were up 3.6%. The average admissions per day were 4.66 admissions. DBAs were 8% of total referrals. Where referrals are coming | |

| Topic | Discussion | Action |
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| | from really didn't change much from the previous year. The IPU census was up 1.6% and the occupancy rate was up a little. The GIP rate increased slightly. We are hitting Respite very hard and making sure families are aware of this benefit.<br>• Our Bereavement staff served 2,987 clients. 24% did not have prior CHC experience, 69% did, and 7% were families of DBA patients. They averaged 139 deaths per month. 64% of individual/family counseling sessions were with community clients, 35% with CHC clients, and 1% with DBA clients. We are meeting a great need in the community.<br>• Volunteers – We have hundreds of active volunteers in a wide variety of areas. Hospices are the only Medicare providers that have a volunteer requirement. We must record, put a dollar amount, and report the hours to Medicare annually. In 2019, volunteers worked 16,000 hours or the equivalent of 7.5 FTE employees, and drove 46,000 miles within nine counties. This was a saving to CHC of $418,000, an increase of 3% from 2018. Volunteer Recognition is on 04/21 at The Brick at 11:30 a.m. Invitations will be sent to board members.<br>• The Press Ganey survey includes two questions – Did you have a positive experience with CHC. 97% said yes. Would you recommend CHC to others? 97% said yes.<br>• We Honor Veterans – We achieved Level 5 recognition by the end of 2019. The focus is on quality care for veterans and their unique needs and educate staff on how to handle their needs in a proper way. We were the second agency in Indiana to achieve level five status, and at that time, only 12 hospices in the country had achieved that level. In addition, we are partners of the Vietnam War 50th Commemoration. Last year we did about 500 pinnings for veterans.<br>• In 2019 we hired 77 new employees and had 9 rehires. We added one new position – Community Relations and Engagement Liaison. At the end of the year we had 253 employees. | |
| **8. Chairman's Report** | • We are now posting the board packet on Tuesday instead of Thursday, so board members have more time to review it. If you have any questions after reading it, email them to Mary N. before Monday and she'll pass them on to Mark M. in case he needs to get gather additional information together.<br>• Reminder to sign the Conflict of Interest form and give it to Becky K. This is an annual IRS requirement. | |

| Topic | Discussion | Action |
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| **Adjournment** | • The meeting adjourned at 8:20 a.m. | Next meeting 05/20 |

Prepared by Becky Kizer for approval by the Board of Directors on May 20, 2020.

Jennifer Houin, Secretary

Becky Kizer, Recording Secretary

REGULATION: 42 CFR Part 418.52 – Patient's Rights

PURPOSE: To meet the needs of patients that are hearing impaired.

PROCEDURE: Community Services with All Deaf (CSAD) will provide qualified sign language interpreters on an as needed basis seven days a week, 24 hours a day.

Contact is (574) 314-5425 and after hours (574) 514-8431.

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| Effective Date: 04/20 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

Signature: President/CEO

PURPOSE: To reduce the risk of further spreading the COVID-19 virus in cases of a pandemic outbreak.

POLICY: Patients with the COVID-19 virus will be identified and actions will be taken to limit the further transmission, while adhering to local, state, and federal guidelines in cases of a pandemic.

DEFINITION: COVID-19: Strain or type of coronavirus that was first detected in Wuhan, China. It is linked to the same family of coronaviruses that causes MERS-CoV and SARS-CoV.

PROCEDURE:

1. Center for Hospice Care (CHC) will coordinate with the Indiana State Department of Health and local Heath departments in the event of a pandemic for reporting protocols, securing testing and medical supplies, including vaccine.

2. During a Pandemic "alert" period, CHC will assure adequate supplies and equipment so that cross contamination from patient to patient will not occur.

   A. CHC will ensure all staff have access to an appropriate amount of personal protective equipment for each patient seen on a daily basis.

   B. Supplies and personal protective equipment should include
      1) Surgical masks,
      2) N95 face mask/respirator
      3) Gloves,
      4) Goggles/face shield
      5) Disposable gowns,
      6) Antimicrobial Soaps
      7) 60-95% Alcohol based hand hygiene products
      8) Other disposables as indicated by ISDH or CDC

      **Note**: See Personal Protective Equipment Policy.

3. When making a home visit, staff will identify patients at risk for having COVID-19 infections before or immediately upon arrival to the home. Staff will ask the patient and family members/caregivers in the home the following questions prior to a visit or immediately upon arrival to the patient's home, before entrance into home:

A. Does the patient have signs or symptoms of a respiratory infection that is not related to their hospice diagnosis? Clinical criteria for identifying patients with COVID-19 include:
   1) Fever
   2) Cough
   3) Dyspnea
   4) Sore throat
   5) Other symptoms as recognized by the government on: https://www.cdc.gov/coronavirus/2019-ncov/about/symptoms.html

B. In the last fourteen 14 days, has the patient had contact with someone who or is being tested for COVID-19, or are ill with a respiratory illness?

C. Has the patient traveled internationally or out of town, especially to a U.S. pandemic hot spot within the last fourteen (14) days to countries with sustained community transmission? For updated information on affected countries visit: https://www.cdc.gov/coronavirus/2019-ncov/index.html

D. Does the patient reside in a community where community-based spread of COVID-19 is occurring?

4. Patients require emergency medical attention if the following occur:

   A. Difficulty breathing or shortness of breath.

   B. Persistent pain or pressure in the chest.

   C. New confusion or inability to arouse.

   D. Bluish lips or face.

   E. Other concerning signs and symptoms.

5. Management of patients who have symptoms indicating possible COVID-19 infection during a pandemic will be handled by:

   A. Following any local, state, or federal guidelines during the pandemic.

   B. Implement source control measures, (i.e., placing a facemask over the patient's nose and mouth)

   C. Inform your supervisor and other authorities as directed.

   D. Obtaining any clinical specimens as ordered, using proper bio-containment protocols

E. Educate patients and caregivers with suspected infection about isolating from others in household.

F. Instruct patient and families on hand hygiene (including the how to wash hands, use of hand sanitizer/soap and water, and avoid touching eyes, nose and mouth with unwashed hands), proper disposal of tissues, etc.

G. Instruct patient and caregivers on cleaning all "high-touch" surfaces everyday such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.

6. Staff should follow CHC standard precautions, including:

A. Hand hygiene: Wash hands before and after patient contact, after contact with any potentially infectious material, and before and after donning protective equipment, including gloves and masks. This applies to patients and caregivers as well.

B. Gloves: Wear gloves for any contact with potentially infectious material (e. g., secretions, tissues, dirty linens).

C. Gowns: Gowns should be worn with patient care activity when contact with body fluids is likely, including respiratory excretions.

D. Staff should follow droplet precautions for patients with suspected or confirmed COVID-19 for fourteen (14) days, or longer. Droplet precautions include:

1) All of the standard precautions, plus

2) Placing patient in separate room away from other residents or family members, if possible.

3) Instruct on using tissue when coughing or sneezing and to place used tissues immediately in plastic bag for disposal in regular trash.

4) Wear mask (preferably N95) prior to entering room.

5) Instruct patient to call ahead prior to visiting a health care facility.

6) Instruct patient to wear mask, if possible, when leaving the home for appointments and to limit visitors to home.

7) Instruct the patient on self-quarantine and self-isolation procedures.

7. Staff with signs and symptoms of a respiratory infection should not report to work.

8. If staff develop signs and symptoms of a respiratory infection while on-the-job that staff member should:

   A. Immediately notify their supervisor, stop work, put on a facemask, and self-isolate at home.

   B. Supervisors should notify the DON of information on individuals, equipment and locations the staff member came in contact with and assist in notifying state and local authorities as required.

REFERENCE: Protocol for Positive or Presumptively Positive COVID-19 Patients

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| Effective Date: 03/20 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

Signature:  President/CEO

PURPOSE: To meet CMS guidelines, during a pandemic, for documentation.

POLICY: When pandemic quarantine guidelines are authorized by state and/or federal government causing disruption in service to hospice patients, documentation of calls and attempts to see patients will be documented in the Electronic Medical Record

PROCEDURE:

1. A folder will be started in the AAA common drive for all notices regarding ECF's and information for staff regarding the pandemic.

2. When quarantine status is initiated, case managers (CM) will review all patients. CM will determine the following:
   - The minimum visits patients need to manage diseases and symptoms
     - All plan of cares will be updated to reflect new visit strings for nurse and CNA's
     - If there are wound care changes due to decreased visits, the wound care plan will be updated to include reason for decrease in wound care visits, i.e. COVID-19 Pandemic
   - Care calls will be made to patients when unable to visit due to quarantine.
   - Nurses will check to make sure patient has enough:
     - Medications
     - Supplies
     - Check for any symptoms or needs

3. Case managers will document in the EMR under Skilled Nurse Phone Call the following:
   - Declines for home visits
   - Declines from facilities to visit patient, including staff member name who declined visit to facility.
   - Care calls and conversation with patient/family/caregiver
   - Reinforcement to family or facility need to call for falls, condition changes, or actively dying patients.

4. Social Work will update:
   - Their visit strings to reflect decrease in visits
   - Plan of care to reflect change in visits
   - Document in EMR under Social Work Phone calls conversations with patient/caregiver when unable to visit patients

5. Chaplains will update:
   - Their visit strings to reflect decrease in visits
   - Plan of care to reflect change in visits

Signature: President/CEO

- Document in EMR under SCC Phone calls conversations with patient/caregiver when unable to visit patient

**ECF Visits During Pandemic**

Process for visits and documenting in ECFs during the pandemic response.
In order to comply with ISDH recommendations for limiting visits and time spent in ECFs during a pandemic, CHC staff will follow the process outlined below.

1. Interdisciplinary visits will be decreased as much as possible while still meeting the needs of the patient and comply with regulations.

2. Staff will not take the following items into the facility:
   - Personal bags or purses
   - Laptops
   - Printers
   - Scanners

3. Staff will follow the current CDC and ISDH guidelines for PPE.

4. Items that are needed for every visit and therefore taken into more than one facility will be disinfected after each visit.

5. Documentation for visits in the ECF will be completed at the staff member's home, printed, and then taken to the facility at the next visit.

6. CHC staff will explain this process to the facility staff and inform them to call CHC if documentation is needed sooner and it will be faxed.

7. If visits have been decreased to every 2 weeks a care call will be made at least once on the opposite week, more often if the patient condition is changing. See care call script for guidance.

8. Wound documentation for patients on every 2 week visits will be done at the regular visit and measurements will be requested from the facility staff during the care call for the opposite week.

**Care Call Scripting**

When calling patients and families in the home setting, use these guidelines:

1. Hello, I am _____ from Center for Hospice Care.

2. I am calling to see how you are all doing.
   - If the pandemic is COVID-19 related:
     (a) Does anyone in the home have a cough, fever, or shortness of breath not related to their hospice diagnosis?
     (b) Has anyone been in direct contact with someone known to have Coronavirus in the last 14 days?
     (c) If any yes to the questions, please notify your PCC as how to proceed.

3. Are there any medications that may run out in the next 2-3 days?

4. Are there any supplies that you are running low on?

5. Do you need any additional items (DME) in the home?

6. Do you have any questions regarding your or your loved one's plan of care?

7. How can I be of any assistance at this time?

PURPOSE: To reduce the risk of further spreading the COVID-19 virus in cases of a pandemic outbreak.

POLICY: Patients with the COVID-19 virus will be identified and actions will be taken to limit the further transmission, while adhering to local, state, and federal guidelines in cases of a pandemic.

The Medical Director, in conjunction with the nursing department, will determine whether to put a patient in quarantine and the following procedures in place.

PROCEDURE: If a patient or caregiver tests positive or is presumptively positive for COVID-19, the following protocol will be followed:

1. Each office will have a specified team of nurses that will care for these patients. Only these nurses will make visits. Each office will designate two nurses on days and one nurse on evenings and nights.
   - Phase 1 – Each office will assign any COVID-19 patients to the case manager in that particular territory. The case manager will then make that patient the last visit of the day.
   - Phase II (COVID surge) – All offices will collaborate to designate a total of four case managers, one evening shift nurse, one night shift nurse, and one weekend dayshift visit nurse to be part of the team. The team will be put into place when the organization as a whole reaches a previously agreed upon number of COVID-19 patients.
   - When the team is activated, the case managers will rotate a M, W, F and T, Th 8A-5P schedule. The Plymouth evening visit nurse will cover from 5P – 1A, and the Elkhart night visit nurse will cover from 1A – 9A. (On the case manager's off days, they will continue to manage their previous caseload.)
   - The weekend visit nurse will cover from 8A – 8P, and the remaining team members will rotate through an 8P-8A weekend rotation.

2. The Admission Department will designate an RN to assess and complete the admission assessment in conjunction with the COVID-19 Response Team.
   - The COVID Team will be in charge of new patient admissions. A representative from the admissions department will be in charge of training the team on the admission process. Additionally, the Admissions Coordinator will be available for any questions/support or will assign someone from the admissions department as a resource if he/she is not available.

3. All team members will attend an educational program for proper PPE.

4. As soon as a patient/caregiver is identified as being positive or presumptively positive, the nurse will notify the PCC and DON.
   (a) The DON will notify the Medical Director and COO.

5. Attempts will be made to manage the patient's needs by phone. If this fails, the nurse will make arrangements with the designated team for someone to see the patient.
   (a) Visits will be kept to the minimum needed to manage/care for the patient.

6. All Social Worker and Chaplain services will be conducted over the phone to minimize staff that enter the home.

7. When a visit is needed, the nurse will wear a surgical gown/full body suit, N95 mask, and gloves.

8. All procedures including baths will be performed by the nurse when he/she is doing the assessment to limit exposure.

9. If a patient is actively coughing, the nurse will give the patient a mask to wear during the visit.

10. The nurse will wait in another room if the patient is using a nebulizer treatment until the treatment is complete and the machine is off.

11. Procedure to following when donning PPE:
    (a) Clean hands by using ABHR (alcohol-based hand rub) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water and after touching or adjusting the respirator (if necessary, for comfort or to maintain fit).
    (b) Put on a respirator or facemask BEFORE entry into the home or patient room.
    (c) Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, perform hand hygiene as described above.
    (d) Use a pair of clean (non-sterile) gloves when donning a used preferably N95 respirator mask if available. Change gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.
    (e) Remove N95 after exiting the home and keep the N95 in a clean, breathable container such as a paper bag between uses.
    (f) Have a trash bag handy outside the home and place the gown and gloves in the trash bag. Tie securely and dispose of in trash receptacle.
    (g) Clean hands by using ABHR with 60-95% alcohol after removing all PPE.

12. Above procedure will continue until the patient is proven negative for COVID-19 or symptoms have abated and the CHC Medical Director determines quarantine can be lifted.

13. The visit will be considered one COVID visit for assessment and hygiene needs. An admission assessment is a 1.5 COVID visit.

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| Effective Date: 03/20 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

Center for Hospice Care

# INPATIENT UNIT COVID-19 VISITOR RESTRICTIONS DRAFT

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

PURPOSE: To ensure limited exposure from outside visitors into the Inpatient Unit (IPU) during the COVID-19 pandemic.

POLICY: The exposure from outside visitors during the COVID-19 pandemic will be limited through enforcing visitor restrictions.

PROCEDURE:

1. GIP, Routine, or Respite patients will be allowed two visitors per day.

2. Visitors must be screened daily before entrance to the IPU.
   - Any visitor that answers Yes to any of the COVID-19 screening questions will not be allowed to visit.
   - If the patient is actively dying and the visitor answers Yes to any of the COVID-19 screening questions, the visitor will not be able to visit.
   - Visiting hours for the IPU are 8 AM to 8 AM.
   - Only two visitors are to be named.

3. Visitors must remain in the patient's room with the exception of the bathroom.
   - In Elkhart, they can use the patient's bathroom if it is not being used by patients, since those bathrooms are private.
   - Visitors will be instructed to use the call light for questions rather than coming to the nursing station.

4. Palliative extubations and actively dying patients will be allowed a maximum of two immediate family visitors at a time in the patient's room. No rotation of visitors. Visitors must also follow #2 and #3 above.

5. Family areas, kitchens, showers, and the all-season room in Elkhart will be closed to visitors.
   - The door off of the sunroom in Elkhart will remain locked during these restrictions.

6. Changes in visitor restrictions will be handled on a case by case basis by the IPU Coordinator and the ADON/DON.

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| Effective Date: 04/20 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

PURPOSE: To ensure appropriate admission to hospice services.

PROCEDURE: Regardless of the referral source, the General Inpatient (GIP) level of care on new admissions to CHC in a contracted hospital setting will only take place if the patient cannot survive transport to one of the CHC inpatient units (IPU) as determined by CHC medical staff, and/or the patient is imminently dying.

Transport potential is entirely decided by CHC medical staff and not by the hospital staff or a hospitalist physician.

If the CHC medical staff determines a patient can be transported safely to a CHC IPU, and the patient and/or family refuses, the patient will not be admitted to a GIP level of care while in the hospital. The patient may be admitted later once discharged from the hospital at another location such as a CHC IPU, and Extended Care Facility (ECF), or home setting.

PURPOSE: To ensure effective communication and comfort in weaning patients from high flow oxygen in Inpatient Units (IPUs).

POLICY: Effective communication will be maintained between the Hospice Physician/Nurse Practitioner and patient/family regarding weaning of high flow oxygen. The Inpatient Unit RN will implement Hospice Physician/Nurse Practitioner orders and monitor patient tolerance.

PROCEDURE:

1. The Hospice Physician/Nurse Practitioner will contact family to confirm desire to wean high flow oxygen.

2. The Hospice Physician/Nurse Practitioner will write specific oxygen titration orders reflecting oxygen percentage amount and frequency of titration.

3. Inpatient Unit RN will wean oxygen as ordered while monitoring for respiratory distress or signs of discomfort as evidenced by any of the following:
   (a) Increased respiratory rate of greater than five breaths per minute from baseline.
   (b) Labored breathing.
   (c) Increased heart rate of greater than ten beats per minute from baseline vital signs.
   (d) Increased restlessness, agitation, confusion.
   (e) Cyanosis.
   (f) Diaphoresis.

4. Inpatient Unit RN will medicate the patient as ordered.

5. Inpatient Unit RN will discontinue titration process with any of the above noted symptoms and will notify the Hospice Physician/Nurse Practitioner for further orders.

Center for Hospice Care

# INPATIENT UNIT – MEDICATION ROOM DRAFT

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

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

PURPOSE: To establish procedure within the Inpatient Units (IPUs) where medications are secured in accordance with federal, state, and local laws.

POLICY: Medications shall be stored in a secure manner to protect public health and safety, and to promote patient care.

SCOPE OF PRACTICE: Registered Nurse (RN) and Licensed Practical Nurse (LPN).

PROCEDURE:

1. All medications will be secured in the medication room in the IPU.
   (a) Medication room will have either proximity card access or keypad access.
      - If keypad access, the access code will be changed twice yearly in April and November.
      - Code for keypad should never be communicated via email or written down anywhere in the IPU.
   (b) Medications will be stored in either locked cabinet, locked refrigerator, or Omnicell.
2. Keys to patient medication cabinet and refrigerated must remain on the RN/LPN at all times.
3. IPU RN/LPN must remain in the medication room when access is granted to any unauthorized personnel, i.e., housekeeping, maintenance.
4. Medication room door must remain closed at all times.
5. If the door does not secure or medication cabinet or refrigerator does not lock, the RN/LPN is to immediately notify:
   (a) PCC/Nurse Leadership on call
   (b) Maintenance
6. When unit is closed, they keys to the medication cabinet/refrigerator should be kept:
   (a) Esther House – Lock box in IPU PCC's office—call PCC/Maintenance for code.
   (b) Raclin House – Lock box in Volunteer closet—call PCC/Maintenance for code.
   (c) Codes for lockbox will be changed after each use.

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| Effective Date: 05/2020 | Revised Date: | Board Approved: |
| Reviewed Date: | | Signature Date: |

Signature: President/CEO

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

PURPOSE: To ensure the safe management of all medications and biologicals related to the care of the hospice patient residing in the Inpatient Unit (IPU).

POLICY: This policy sets forth the procedures relating to automated medication dispensing systems (AMDS)-Omnicell

PROCEDURE:

1. Per applicable law CHC may use the Omnicell to access:
   - Emergency Medications
   - First does, medically necessary medications and interim orders
   - Routine medications

2. Medications removed from the Omnicell must have a corresponding physician/prescriber order.

3. The Omnicell must be placed in a secure area of the facility and assure any monitoring devices such as cameras. are in working order, if applicable:
   - Omnicell should be locked at all times when not in use
   - Per state law the Omnicell should be located in an area behind locked doors
   - Temperature should be monitored daily by maintenance and maintained at 59-77 degrees Fahrenheit for medications
   - The temperature of the room should never exceed 95 degrees Fahrenheit

4. The IPU will e-fax census and payer status changes to Omnicare related to patient admissions and discharges.

5. IPU staff should notify Omnicare of all discontinued orders as soon as received to assure dispensing accuracy.

6. IPU coordinators will determine the content of the Omnicell in conjunction with Omnicare, CHC Medical Director, and in accordance with applicable law.
   - Changes to the content of the Omnicell should be approved by pharmacy and CHC medical director or designee. IPU nurses shall notify PCC, ADON, and DON of all changes
   - Controlled substances may be contained in the Omnicell and must be secured in a separately locked cabinet within the Omnicell, per applicable law.

7. CHC will ensure that only licensed nurses who have the approval of the DON and who have received appropriate training will have access to medications in the Omnicell.
   - Secure user names and passwords should be maintained by the DON or Omnicare per state regulation
   - Keys to manually unlock the Omnicell will be under the control of the DON and Omnicare
   - When an IPU nurse is no longer employed by CHC, the user's name and password should be deleted from the system

8. CHC will document IPU staff training on the use of the Omnicell including:
   - Content
   - Security and access
   - Accessing medications
   - Replacement of medications, including controlled substances
   - Wasted dose disposal or return to Omnicell
   - Emergency plan for outages
   - Patient confidentiality

9. When the Omnicell is used to provide routine medications, the Omnicell shall be subject to all of the following requirements:
   - A pharmacist shall review and approve all orders prior to a medication being removed from the Omnicell for administration
   - The pharmacist shall review the prescriber's order and the patients' profile for potential contraindications and adverse medication reactions
   - After the pharmacist reviews the prescribers order, access by authorized, IPU nurses shall be limited to medications ordered by the prescriber and reviewed by the pharmacist and that are specific to the patient

10. Upon receipt of a new medication order IPU nurses should check for allergies and check with the pharmacy if they are unfamiliar with the medication ordered
    - IPU nurses should obtain the number of doses necessary to cover the period of time from administration of the first dose until the pharmacy has processed the medication order and makes it available in the system for dispensing.
    - Controlled substances must be authorized by the pharmacist before removal

11. IPU nurses may return medications removed from the Omnicell if permitted by and in accordance with applicable law.
    - A witness should observe the return of a controlled substance
    - IPU nurses shall destroy any medications that cannot be returned to the Omnicell in accordance with CHC policy

12. Medications are restocked on an agreed upon date and time, based on inventory utilization

13. Upon delivery of the refill medications, Pharmacy staff shall:
    - Place each medication into the proper compartment of the Omnicell as soon as possible to assure availability of doses
    - Assure removal and replacement of controlled substance canisters is witnessed by an IPU nurses. The name of the pharmacy staff member and IPU nurse will be documented with signature, date, and time or restocking. The quantity is recorded in the IPU's inventory.

14. The Omnicell shall be routinely inspected by Omnicare
    - When a pharmacy representative services the Omnicell for inventory count, maintenance, or other reason they shall be accompanied by an IPU nurses.

15. In the event of a system malfunction or failure, IPU nurse should:
    - Notify their PCC/nurse leadership on call
    - Contact pharmacy

16. In the event of a power outage, not addressed by the generator power, IPU nurse should:
    - Notify their PCC/nurse leadership on call
    - Notify maintenance
    - Contact pharmacy

17. In the even of a power outage, IPU nurse may access the Omnicell manually until power is restored. Staff should manually document any removals or returns during the power failure, noting the following information:
    - Medication name
    - Patient name
    - Date and time removed
    - Quantity removed
    - Nurses name
    - Waste

18. Any medication errors caused by a malfunction of the Omnicell will be immediately reported to the PCC and pharmacy to investigate and resolve.

PURPOSE: To assure continuity of care in all settings, to determine the appropriate location for patient care, and to retain professional management responsibilities through the care team.

PROCEDURE: When a patient is ~~or plans on being~~ admitted, ~~to the hospital,~~ the following questions must be asked:

- Financial class~~What is the financial classification?~~
- ~~What is the patient's diagnosis?~~
- Type of admission (inpatient or 23-hour observation)
- Why did the patient ~~What is the reason for~~ want~~ing~~ to go to the hospital? What symptoms were reported?
- ~~What are the patient's options?~~
- What is~~are~~ the expected outcome~~s~~?
- Was our Agency notified prior to the hospitalization?
- ~~Is this in their plan of care?~~
- ~~What symptoms are we palliating?~~
- ~~Are their symptoms related to the symptoms of their life limiting disease?~~
- ~~Has the care team met to review these questions?~~
- ~~Did the patient/family notify us in advance of the patient going or wanting to go to the hospital?~~
- ~~Is the patient being seen as an outpatient, being admitted, or staying for a 23-hour stay?~~

These questions will assist the Interdisciplinary Team (IDT)~~care team~~ in appropriate decision making on whether to include the hospitalization in the patient's plan of care.

**~~Classifications: Home Health~~ ~~(Home Health Medicare [HHM], Medicaid, Private Insurance, Self-Pay)~~**

**Actions by the Case Manager once questions reviewed:**

- Notify the attending physician, Patient Care Coordinator, and ~~appropriate care~~pertinent team members of patient's hospitalization~~ admission. Review patient's financial classification to confirm financial responsibilities~~.
- After notification, write an order in the care plan to place services on hold. ~~contacting the physician, write an order to place Agency services on hold w while in acute care facility.~~
- Send~~Distribute~~ Secure Messag~~ing~~ to "Changes," "Billing," and specific care team to notify ~~staff~~ of patient's admission and location.

Signature: President/CEO

- Add hospitalization to the "Inpatient Stays" tab~~Document in the computer under patient notes patient's hospitalization~~.
- Medicare and Medicaid ONLY – C~~C~~omplete the transfer~~an~~ OASIS ~~Transfer to Inpatient Facility if the patient is home health Medicare (HHM) or Medicaid~~.
- Daily hospital phone contact to be made and documented to obtain updates and pending discharge date.~~Periodic contact will be made to obtain condition updates and pending discharge date. Contact the billing office at the hospital to ensure that the bill is sent to the proper insurance company. Document who he/she spoke with, including date and time~~.
- ~~Complete a Resumption of Care OASIS if patient returns home and is HHM or Medicaid.~~
- Contact the hospital's billing office the day after the admission to ensure the bill is sent to the proper insurance company. Document name, date, and time. ~~Write an order to "resume services under current plan of care with the following changes" then list them.~~

**After patient's discharge and return to Home Health services:**

- Medicare and Medicaid ONLY – Complete Resumption of Care OASIS within 48 hours of hospital discharge.
- Call attending physician to receive an order, then update the care plan to "Resume services and review changes to plan of care." Discontinue order in care plan for services on hold.
- Send secure message to "~Changes," "~Billing," and specific are team to notify of patient's discharge and location.

Please Note: If a patient is in the hospital under 23-hour observation or was treated in the emergency room and released, an OASIS does not apply. OASIS is only for patient payor source of Medicare or Medicaid. Private insurance or self-pay do not need an OASIS completion.

# SUPERVISION OF SATELLITE OFFICES



REGULATION: 42 CFR 418.100(f) – Organization and administration of services

POLICY: Within its Center for Medicare and Medicaid Services (CMS) and state approved service area, the corporation may operate one or more satellite offices or hospice inpatient units (IPUs). These offices are referred to as additional sites. All satellite offices and IPUs are under the direction and supervision of the approved site of operation by the ISDH.

Members of the Administrative Team supervise general operations at all satellite offices and IPUs. Direct supervision of various satellite office and IPU staff is accomplished via telephone, email, and in-person visitations and regularly scheduled management meetings.

The site of operations will be responsible for the following:

- All policies and procedures.
- Supervisory control
- Complete authority over satellite office(s) and IPU personnel issues, including recruitment, hiring, orientation, and termination.
- Clinical services, policies, and procedures are no different at the satellite offices and IPUs.
- Quality improvement at the satellite offices and IPUs.

Effective Date: 06/01 Revised Date: 03/2005/16 Board Approved: 10/19/16
Reviewed Date: 07/19 Signature Date: 10/19/16

Signature: President/CEO

REGULATION: 42 CFR 418.54 – Initial and Comprehensive Assessment of the Patient
42 CFR 418.110 – Hospices that provide inpatient care directly

PURPOSE: To provide a standard of care for all patients being admitted to Inpatient Unit (IPU).

POLICY: Patients requiring General Inpatient (GIP) level of care, Respite, or Routine care in the inpatient unit setting will be identified through the interdisciplinary process.

EQUIPMENT: DME required for symptom management or safety of the patient will be ordered from Alick's Home Medical by the IPU Nurse, and will need to be delivered to IPU prior to patient transportation.

PROCEDURE: The nurse who assesses the patient for IPU will complete the TB and Communicable Disease screen before transfer to IPU.

**NEW ADMIT TO INPATIENT UNIT**

1. Admissions Department will request a physician's order from the hospital if one has not already been written to admit the patient to IPU. If the physician's order for hospice services is more than seven days old, the physician must be contacted and a new order obtained. The order is to include, "Admit to Inpatient Level of Care at Inpatient Unit."

2. All medications will be ordered by a physician or nurse practitioner in accordance with the patient's plan of care.

3. An interdisciplinary team (IDT) meeting must take place prior to IPU admission. The IDT will be facilitated and documented by the Admission Department. Documentation will include full names of staff participating and must include a physician, admission nurse/representative, IPU nurse, and a social worker. If a nurse practitioner is scheduled to make rounds on the day the admission is taking place, then the nurse practitioner should be included in the IDT. The chaplain may need to be included per team discretion.

4. The following information needs to be included in the IDT discussion:
   (a) Code Status
   (b) IDT discussion to include, but is not limited to:
   - Most recent vital signs if pertinent to eligibility
   - Mental Status
   - Pain
   - Respiratory – if pertinent to eligibility
   - Cardiovascular – if pertinent to eligibility

- Gastrointestinal – if pertinent to eligibility
- Genitourinary – if pertinent to eligibility
- Musculoskeletal – if pertinent to eligibility
- Skin – if pertinent to eligibility

(c) Infusion/Access Sites – Femoral, Jugular, and PICC lines will need to be discontinued/removed at the hospital prior to transportation to IPU, unless the IDT deems necessary. Patients may be admitted to IPU with peripheral sites. Upon arrival, the IPU nurse will determine patency to use or discontinue.

(d) Special consideration such as isolation precautions, safety concerns, or infestations – If a patient has been treated for C-Diff and continues to have loose stools, the patient will be placed in isolation upon admission. If the patient has finished treatment and has formed stool for 24 hours, isolation is no longer required.

(e) Social status to include POA, health care representative, family, as well as anticipated discharge plan/goal.

(f) Hospital contact person and phone number.

5. The Admission Nurse/Representative will:
   - Obtain signatures on consents prior to transportation of the patient to IPU.
   - Consents will be either handed to the IPU staff or uploaded to the patient's Outlook folder.
   - The Admission Nurse will complete the TB and Communicable Disease screen. If the PA is done by an Admission Representative, either the Admission Coordinator or an admission nurse will complete the TB and Communicable Disease Screen.
   - The admission nurse will complete and lock the LCD and attach it to the Pre-admission contact in Cerner.
   - The admission nurse or Admission Coordinator will complete the Certificate of Terminal Illness (COTI).

**ECF TRANSFER TO INPATIENT UNIT**

1. CHC will coordinate with an ECF DON/Executive Director~~designee~~ the transfer of one of the ECF Hospice patients to the Inpatient Unit for an Inpatient Level of Care change.

2. CHC social worker will notify the facility social worker of when the transfer will occur and arrange transportation to the IPU after discussion with the IPU nurse.

3. The case manager/visit nurse notifies the facility nursing staff when the transfer will occur, initiates the completion of the ~~appropriate~~ TB and Communicable Disease Screen ~~protocol~~ before arrival, and obtains a copy of facility MAR (medication administration record).

**CURRENT PATIENT TRANSFER TO INPATIENT UNIT**

1. Follow the Inpatient Unit Direct Transfer Flow Sheet.

**ARRIVAL AT INPATIENT UNIT**

1. After the pre-admission has been completed and the IDT determines the level of care appropriate for IPU admission, the IDT will review the patient's needs and begin to develop a plan of care. Once the IDT agrees to transfer the patient to IPU, the IPU Nurse will do the following:
   a) Obtain and review the patient's chart.
   b) Facilitate DME delivery to IPU.
   c) Call the hospital RN caring for the patient to obtain report.
   d) Phone the Medical Director/Hospice Physician or Nurse Practitioner to obtain orders for IPU.
   e) Fax new medication orders to IPU contracted pharmacy and request medication releases from the Emergency Drug Kit (EDK).
   f) After the DME and medication releases have been received, the IPU Nurse will call the hospital/facility contact person to have them set up transportation.
   g) Complete the new patient checklist, which includes steps for admitting patients in Cerner.

2. After receiving the patient into the assigned IPU room:
   a) Perform a complete assessment.
   b) Complete a Fall Risk Assessment.
   c) Complete a Braden Scale Assessment.
   d) Review IPU services, environment, guest guidelines, and nutritional information sheet with the patient and family.
   e) Continue to document status of patient, assessment, and treatment at minimum during each shift.
   f) Discharge planning from IPU will begin upon admission to IPU by social work.
   g) Support Services staff will continue to follow the patient while in IPU, unless otherwise designated.

3. A secure message will be sent for transfers from home/ECF to Inpatient Unit.
   a) Billing
   b) Care Team
   c) QA Changes

Center for Hospice Care

# INPATIENT UNIT – AIDE RESPONSIBILITIES

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

REGULATION: 42 CFR 418.76 – Hospice aide and homemaker services

PURPOSE: To describe the areas of responsibility of the Hospice Aide/CNA (Aide).

POLICY: Works within the scope of practice as defined by the Inpatient Unit Aide Job Description.

Supervised by the Inpatient Unit Coordinator and Assistant Director of Nursing.

PROCEDURE:

1. Obtains assignments from and reports to the Inpatient Unit Staff RN.
2. When reporting for duty, the Aide will receive current patient information through rounding report with the ~~via report process from~~ previous shift.
3. The Aide documents each shift on the HHA Visit Note~~Hospice Aide/CNA Flow Sheet form~~ for each patient.
4. The Hospice Aide/CNA Care Plan is made out by the Staff RN. The Aide will update the Staff RN on any changes to the patient. ~~The Aide completes charting on each shift and makes comments at the bottom of the form when necessary.~~
5. The Aide documentation is reviewed by the Staff RN at the end of each shift ~~and locked~~ to verify that the care was performed.
6. The Staff RN will update each Hospice Aide/CNA Care Plan as needed, including isolation process guidelines and special instructions.

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| Effective Date: 11/96 | Revised Date: 04/20~~02/18~~ | Board Approved: 05/16/18 |
| Reviewed Date: 07/19 | | Signature Date: 05/16/18 |

Signature: President/CEO

# INPATIENT UNIT – COMBATIVE PATIENT



PURPOSE: Provide the best care for combative patients in Inpatient Unit.

POLICY: To provide instructions for staff to ensure safety of patients, staff and visitors.

PROCEDURE:

1. Alert other staff members.
2. Close doors of other patient rooms.
3. Quickly determine a possible cause for aggression.
4. Remove the cause if able to be determined and redirect patient.
5. Call family if not present to come help calm the patient.
~~4.~~6. Work with the family of the patient for best outcome.
~~5.~~7. Medicate with PRN medications for agitation/pain if appropriate.
~~6.~~8. If in public area, ask visitors to return to rooms that they are visiting.
~~7.~~9. Notify the Medical Director/Hospice Physician and obtain further orders.
~~8. Notify on call nurse to come in if needed.~~
~~9. Work with family of patient for best outcome.~~
10. Notify Patient Care Coordinator/Nursing Leadership on call.
~~10.~~11. Notify social worker on call.
~~11. Notify Nursing Leadership on call.~~
12. If all of the above have been tried or if in immediate danger to staff and others, call 911.
13. Care plan should outline any special precautions.
~~13.~~14. If 911 is called or the patient comes in physical contact with any person aggressively, complete an Incident Report.

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| Effective Date: 06/16 | Revised Date: 02/2002/18 | Board Approved: 05/16/18 |
| Reviewed Date: 07/19 | | Signature Date: 05/16/18 |

Signature: President/CEO

Center for Hospice Care

# INPATIENT UNIT – COMMUNICABLE DISEASE ASSESSMENT



REGULATION: 42 CFR 418.60 – Infection control
42 CFR 418.110(i) – Hospices that provide inpatient care directly

PURPOSE: To help ensure that patients admitted into Inpatient Unit are free of communicable diseases.

POLICY: Center for Hospice Care observes the rules and guidelines outlined by the Indiana State Department of Health publication 410 IAC 1-2.3, effective 10/11/00, Communicable Disease Morbidity and Laboratory Reporting.

PROCEDURES: A TB and/or communicable disease screen will be done prior to entry into Inpatient Unit, and any uncertain results are referred to the Hospice Physician for further guidance.

The following process will be used to assess for potentially communicable diseases (including active TB):

1. New Admission from the Hospital for All Levels of Care
   If the patient is coming from the hospital, a nurse will complete the TB and Communicable Disease Screening Tool, and review results with the IDT prior to admission.
   - If there is no evidence of communicable disease (including active TB), the patient may come to Inpatient Unit.
   - If there is uncertainty, consult the Medical Director/Hospice Physician.
   - A patient cannot be admitted to Inpatient Unit until it is confirmed that he/she is free of communicable disease.

2. Admission from the Home for GIP Level of Care
   If the patient is coming from home to GIP Level of Care, a nurse will complete the TB and Communicable Disease Screening Tool, and review results with the IDT prior to admission.
   - If there is no evidence of communicable disease (including active TB), the patient may come to Inpatient Unit.
   - If there is uncertainty, consult the Medical Director/Hospice Physician.
   - A patient cannot be admitted to Inpatient Unit until it is confirmed that he/she is free of communicable disease.

Signature:  President/CEO

3. Admission from the Home for Respite Level of Care
   If the patient is coming from home to Respite Level of Care, a nurse will complete the TB and Communicable Disease Screening Tool. ~~In addition, a Mantoux TB test will be placed and read prior to the patient's respite stay. These review results with the IDT prior to admission.~~
   - If there is no evidence of communicable disease (including active TB), the patient may come to Inpatient Unit.
   - If there is uncertainty, consult the Medical Director/Hospice Physician.
   - A patient cannot be admitted to Inpatient Unit until it is confirmed that he/she is free of communicable disease.

If during the communicable disease screening process a patient is found to have the potential for a communicable disease (including active TB), the Hospice Physician and the patient's Attending Physician (if any) will be contacted for further medical evaluation. There will be no admission to Inpatient Unit until the patient is determined to be non-communicable.

Center for Hospice Care

# INPATIENT UNIT – DEATH DURING TRANSPORTATION TO INPATIENT UNIT



PURPOSE: To provide guidelines for patients that die during transportation to Inpatient Unit (IPU).

POLICY: Death before admission to IPU will be handled in a positive, supportive manner.

PROCEDURE:

1. If ambulance calls that patient died in transport, have the ambulance continue to bring the patient to the IPU.
2. Have the body taken to the room by the paramedics.
3. Identify immediate family needs and contact a chaplain or social worker.
4. Obtain report from the paramedics of time of death and circumstance.
5. Prepare the body for funeral home pick up.
6. Call the funeral home of family's choice.
7. The CHC Medical Director/Hospice Physician or attending physician may sign the death certificate if needed.
8. Do not admit the patient to CHC.
9. Add Memo to the referral patient chart with times and facts.
10. Make sure the caregiver/POA contact information is in Cerner.
11. Send secure message/email to admissions, social work, and bereavement.
12. Notify the on call nursing leadership of the event.
13. ~~12.~~ Notify the hospital of the patient's death prior to arrival.
14. ~~13.~~ If there will be involvement with the Indiana Donor Network (IDN) or Indiana University Anatomical Education Program (IU), notify the social worker for assistance.
15. ~~14.~~ CHC would not be responsible for transporting the body to any facility (IDN or IU will arrange transport if needed).
16. ~~15.~~ Send email to the Admissions department and they will complete the DBA and discharge in Cerner.

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| Effective Date: 06/16<br>Reviewed Date: | Revised Date:04/20 ~~07/19~~ | Board Approved: 11/20/19<br>Signature Date: 11/20/19 |

Signature: President/CEO

REFERENCE: Indiana's Health Care Consent Act (Indiana Code 16-36-1-1, et seq.)
Indiana's Living Will Statute (Indiana Code 16-36-4-1, et seq.)
Indiana's Power of Attorney Statute (Indiana Code 30-5-1-1, et seq.)
In the Matter of Sue Ann Lawrence, 579 N.E.2d 32 (Ind. 1991)
Brenda Spar v. Jin S. Cha, M.D., 881 N.E.2d 70 (Ind. App. 2008)

PURPOSE: To define the circumstances under which life prolonging procedures will be discontinued, and the process to follow when supporting the patient and family through the resulting dying process.

POLICY: Center for Hospice Care (CHC) affirms every patient's right to self-determination through his/her informed consent to health care, including care, treatment, services, or procedures to maintain, diagnose, or treat an individual's physical or mental conditions. This right to consent to a course of treatment includes the right to refuse a course of treatment, including the discontinuation of life prolonging procedures. Care planning includes the patient or his/her health care representative, the patient's attending physician, and the CHC Interdisciplinary Team (IDT).

REQUIRE-MENTS

1. All efforts to palliate the patient's pain and suffering shall be taken, and shall be thoroughly documented in the patient's record.

2. Before discontinuing life prolonging procedures, the following conditions must be met:
   (i) The patient must be diagnosed with a terminal illness, the patient must be in a futile care circumstance defined, for purposes of this policy, as a situation where, based on the patient's diagnosis and prognosis, the continuation of life prolonging procedures is not beneficial, or is excessively burdensome as determined by the patient or the patient's health care representative, after consultation with the patient's attending physician and other relevant health care givers, or the patient must be in a persistent vegetative condition.

   (ii) **If the patient is terminally ill and competent**, the patient must execute a Living Will Declaration, which complies with the requirements of the Indiana Living Will Statute, Ind. Code 16-36-4-1, et seq., and the attending physician of the patient must make the following written certifications in the patient's record: (1) the patient has an incurable injury, disease or illness; (2) the patient's death will occur within a short time; and (3) the use of life prolonging procedures would serve only to prolong artificially the patient's dying process. Additionally, the patient must execute CHC's Consent to Discontinuation of Life Prolonging Procedures. (Both the Living Will and the

Consent to Discontinuation of Life Prolonging Procedures must be signed by the patient or by another person in the patient's presence and at the patient's express direction if the physical limitation of the patient makes signature of the patient not possible or too burdensome.)

(iv) **If the patient is terminally ill and incapacitated**, verify whether the patient executed a Living Will which complies with Indiana's Living Will Statute, Ind. Code 16-36-4-1, et seq., and whether the patient's attending physician has made the required written certifications in the patient's record pursuant to the Living Will Statute (see 2.b. above). If the patient executed a Living Will and physician written certification exists, discontinuation of life prolonging procedures may occur if the requirements found in 3 and 4 below, and the Procedures of this policy are followed. If the patient did not previously execute a Living Will in this circumstance, discontinuation of life prolonging procedures may not occur absent authorization by the patient's health care representative or guardian as provided in paragraph 2.d., e., or f. below.

(v) **If the patient is terminally ill or in a futile care circumstance (as defined in paragraph 2.a. above), and the patient is incapacitated and the patient executed a Health Care Representative Appointment or Power of Attorney for Health Care, which complies with the requirements of Ind. Code 30-5-1-1, et. seq. (regarding Powers of Attorney) or Ind. Code 16-36-1-1, et seq. (regarding Health Care Representative Appointments),** then discontinuation of life prolonging procedures may occur upon direction by the patient's duly authorized attorney-in-fact for health care purposes, or health care representative, if the written appointment includes language which is substantially in the same form as the following statutory language:

> I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.
>
> My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or

physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available (Ind, Code 30-5-5-17).

Before discontinuing life prolonging procedures for a patient pursuant to direction from the patient's health care representative or attorney-in-fact for health care purposes under this paragraph, the patient's health care representative or attorney-in-fact also must first execute CHC's Consent to Discontinuation of Life Prolonging Procedures, and the patient's attending physician must certify in writing that the patient is terminally ill or in a futile care circumstance (as defined in paragraph 2.a. above). Written appointment of the Health Care Representative or Attorney-in-Fact for health care purposes, the executed Consent to Discontinuation of Life Prolonging Procedures and the attending physician's written certification all must be placed in the patient's chart.

(vi) **If the patient is terminally ill or in a futile care circumstance (as defined in paragraph 2.a. above), and the patient is incapacitated and the patient did not execute a Health Care Representative Appointment or Power of Attorney for Health Care containing the statutory language, as provided in paragraph 2.d. above,** then determine if a guardian for the person of the patient has been appointed to make health care decisions for the patient. If such guardian has been appointed, then the guardian may authorize discontinuance of life prolonging procedures for the patient if the guardian provides certified Letters of Appointment as Guardian, a copy of which must be placed in the patient's chart. The Guardian also must execute CHC's Consent to Discontinuation of Life Prolonging Procedures and the patient's attending physician must certify in writing that the patient is terminally ill or in a futile care circumstance (as defined in paragraph 2.a. above). The attending physician should also certify in writing in this circumstance that he or she is unaware of any contradictory direction from the patient regarding termination of life prolonging procedures.

(vii) **If the patient is terminally ill or in a futile care circumstance (as defined in paragraph 2.a. above) and the patient is incapacitated, and the patient has not appointed a Health Care Representative or Attorney-in-Fact for health care purposes pursuant to a written authorization, and a Guardian has not been appointed** for the patient, then the following steps must be taken:

(a) Determine who among a spouse, a parent, an adult child, or an adult sibling, or a religious superior, if the individual is a member of a

religious order, wishes to serve as the patient's health care representative. (The proposed representative also must not have been disqualified by the patient previously in writing.) (If no disagreement amongst these potential surrogate decision makers exists, then document in the patient's chart the identity of the patient's health care representative and their relationship to the patient.) (If disagreement exists, then attempt to facilitate agreement among these potential surrogates. If agreement cannot be reached, consult with legal counsel about the possible need to obtain an Order from the Court appointing the surrogate decision maker.)

(b) Upon determination of the identity of the patient's health care representative as provided in paragraph 2.f.(1) above, the health care representative must execute CHC's Consent to Discontinuance of Life Prolonging Procedures before the support may be discontinued.

(c) The patient's attending physician must certify in writing that the patient is terminally ill or in a futile care circumstance as defined in paragraph 2.a. above. The attending physician should also certify in the patient's chart that he or she is unaware of any contrary instruction from the patient regarding termination of life prolonging procedures.

(vii) **If the patient is in a persistent vegetative state, though not terminally ill,** discontinuance of life prolonging procedures may occur, if the attending physician is unaware of a contrary instruction from the patient, and CHC's Consent to Discontinuation of Life Prolonging Procedures is executed by any of the following surrogate health care decision makers on behalf of the patient, in the following priority:

(a) A Health Care Representative or Attorney-in-Fact for health care pursuant to written Health Care Representative Appointment or Health Care Power of Attorney executed by the patient while having capacity, and which contains the authorizing language found in paragraph 2.d. above;

(b) A Guardian of the patient having health care decision making power for the patient;

(c) Any of the following family members of the patient, if no disagreement between these family members exist: a spouse, a parent, an adult child, or an adult sibling, or a religious superior, if the individual is a member

of a religious order (and unless previously disqualified by the patient in writing);

(d) If disagreement among family members exist, then by a health care representative appointed by Court Order;

(e) If discontinuance of life prolonging procedures for a patient in a persistent vegetative state occurs, pursuant to this provision, then the patient's attending physician must also certify in writing that the patient is in a persistent vegetative state, that recovery is not expected, and that the physician concurs with the patient's surrogate decision maker that termination of the life prolonging procedures is in the patient's best interests and not contrary to any previously expressed wish of the patient.

3. Psychological and spiritual assessments may assist health providers in assisting patients or their health care representatives in making these decisions, but are not required.

4. Discontinuance of life prolonging procedures may only be performed under the direction of~~with~~ the patient's attending physician or Medical Director/Hospice Physician present and by the attending physician pursuant to ~~that physician's~~ the signed Order Discontinuing Life Prolonging Procedures, which shall be placed in the patient's chart. The attending physician must be an MD or DO of CHC.

5. An employed Nurse Practitioner with CHC may discontinue life prolonging procedures under the direction of the Medical Director/Hospice Physician. This includes the signed order and being written by the Medical Director/Hospice Physician.

~~4.~~ 6. The Nurse Practitioner as an employee of CHC is deemed competent in the discontinuation of life prolonging procedures after the completion of three P~~p~~procedures under the proctoring of the Medical Director/Hospice Physician with direct observation and completion of a competency established by the Medical Staff. The proctoring and competency will be maintained in the Nurse Practitioner's employee file.

PROCEDURE:

1. Ensure that all appropriate measures have been taken to palliate the patient.

2. Contact the Medical Director/Hospice Physician who will then confer with the patient's attending physician.

Signature: President/CEO

3. Assemble the IDT to ensure that the above policy requirements have been met and that appropriate psychological and spiritual supports are offered.

4. Obtain:
   (a) The patient's executed Living Will and CHC's Consent to Discontinuation of Life Prolonging Procedures executed by the patient; or

   (b) A Consent to Discontinuation of Life Prolonging Procedures executed by the patient's representative (whether Health Care Representative, Attorney-in-Fact for Health Care, or Guardian); and

   ~~(b)~~(c) A copy of the Health Care Representative's written appointment or Attorney-in-Fact's written appointment or Guardian's Letters of Guardianship, or Health Care Representative's Court Order of Appointment (if applicable). N.B. If the Health Care Representative is selected from eligible persons pursuant to Indiana's Health Care Consent Act as provided in paragraph 2(vi)(a) above, and not by written appointment, simply document the identity of the representative and his or her relationship to the patient in the patient's chart; and

   ~~(c)~~(d) Health Care Representative is selected from eligible persons pursuant to Indiana's Health Care Consent Act as provided in paragraph 2.f.(1) above, and not by written appointment, simply document the identity of the representative and his or her relationship to the patient in the patient's chart; and

   ~~(d)~~(e) The attending physician's Written Order to Discontinue Life Prolonging Procedures; and

   ~~(e)~~(f) The attending physician's written certification that the patient is terminally ill, in a futile care circumstance or in a persistent vegetative state as provided in paragraphs 2.a., b., or 2.g(5) above; and
      i. Educate the patient, Health Care Representative or Attorney-in-Fact, and family members on the imminence of death once life prolonging procedures have been stopped, and that measures will be taken to relieve the patient's symptoms; and

      ii. Assemble necessary equipment and medications to palliate the patient; and

      iii. Have the patient's attending physician or Medical Director/Hospice Physician present who will personally discontinue the life prolonging procedures; and

iv. Follow all other applicable CHC procedures for necessary documentation.

PROTOCOLS:

Admission Coordinator/Scheduler

1. After gathering all information from referral source, send email with *Potential Extubation at IPU* in the subject line. Who, where, and when is the PA is in the body of the email.

2. Email should go to:
   - Medical Staff
   - Both IPUs
   - Social Workers
   - Chaplains
   - ADON and DON

3. PA should be scheduled as early as possible.

Admission Nurse:

1. Discuss with patient, family, and/or caregivers the following:
   - Hospice philosophy and usual hospice discussion
   - What their expectations for removal of life prolonging equipment is
   - Discussion on time frames:
     - Patient transfer is generally in the morning/early afternoon
     - Patient cannot go overnight in the IPU with a vent
     - Potential for patient to linger after removal
   - Funeral Plans

2. Obtain usual hospice admission consents including DNR.

3. Include the following people in the IDT:
   - CHC Physician
   - CHC Nurse Practitioner
   - IPU Nurse
   - IPU Coordinator
   - Social Worker
   - Chaplain

IPU Before Arrival of Patient:

1. IPU Coordinator will schedule second nurse for patient.

2. After IDT:
   - Call for DME and find out time of delivery
   - Assign room closest to one of the waiting rooms, if possible
   - Obtain orders from Hospice medical staff
   - Check EDK to assure adequate medications
   - Obtain releasees from Omnicare
   - Communicate with hospital to determine transfer time
   - Notify social worker and chaplain of arrival time and/or date

IPU Arrival of Patient:

1. IPU staff to admit patient.

2. Notify social worker and chaplain that patient has arrived. Social worker and chaplain should be on the unit through extubation.

3. Physician, social worker, and nurse to meet with family in private for physician to discuss plan of care and extubation.
   - POA will sign the Consent to Discontinuation of Life Prolonging Procedures

4. Nurse will remain at bedside, with the computer on wheels, during entire preparation.

5. All CHC employees are to wear PPE during the procedure.

6. When family is ready, the physician/nurse practitioner will begin medication regime to prepare patient for extubation.

7. Physician/nurse practitioner will extubate patient when he/she deems patient is sufficiently sedated.

8. Social worker and chaplain will remain onsite to assist with family during the process.

9. Patient will remain 1:1 nursing care until at least one hour after extubation or death, whichever comes first.

# INPATIENT UNIT – DISHWASHER



REGULATION: 42 CFR 418.110 – Hospices that provide inpatient care directly

PURPOSE: To ensure food safety.

PROCEDURE: All dishes must be washed in the dishwasher, **not** in the sink.

Wash dishes in dishwasher according to dishwasher instructions, which are posted. Detergent used is per manufacturer guidelines.

The dishwasher temperature will be taken weekly. The temperature will be read off of the ~~holding~~ thermometer that is at the bottom~~inside~~ of the dishwasher. The temperature must read at least 160 degrees Fahrenheit. The temperature is to be recorded on the Dishwasher Temperature form (see attached).

When the dishwasher is out of order:

- All dishes and utensils that require washing **cannot be used**
- All food preparation for patients will employ disposable dishes, cups, utensils, etc.
- Disposable items will be stored in a box labeled "FOR INPATIENT UNIT USE ONLY".
- A sign will be posted notifying all staff that disposables are to be used.

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

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

PROCEDURE: Patients will go to the Inpatient Unit (IPU) of their choice. If the IPU cannot accommodate them, they will be given the option of going to the other IPU or if they choose not to go to the other IPU, they may be given the choice of delaying respite stay. Medicare contracted facility may only be used if both IPUs are full.

**Before a patient is scheduled for Respite stay:**

- Case Manager/Visit nurse will complete the Communicable Disease form before transfer.
  - Emergency respites are defined as:
    - Caregiver illness/injury and cannot physically care for patient
    - Loss of utilities or sudden unsafe home condition
    - Other as determined by administration
- As soon as the family has made the request for respite, the Social Worker will enter all respites on the public calendar labeled IPU Respite Reservations.
- On the date the patient/caregiver is requesting to start respite, the social worker will add the following:
  - Under Subject:
    - Patient name
    - Date entered into calendar
    - Length of stay
  - Under Location:
    - Preferred location
  - Under the body:
    - ~~If TB test done~~
    - Diagnosis
    - Anything that would be pertinent to the stay
- IPU staff member will complete the CHC Respite Stay Questionnaire profile before arrival to the IPU.
  - If family is requesting same day respite and there is no time for IPU staff to complete the questionnaire, Social Work will complete it with the family.
- An IDT will be scheduled within 24 hours of start of Respite by the Social Worker.
  - Respites that will begin on Sunday or Monday may be IDT'd on Friday in order to include the patient care team.

Signature: President/CEO

## FITNESS AREA (Mishawaka Campus)

- The Fitness Area at the Mishawaka Campus is comprised of the fitness room, bicycle room, locker rooms and showers. The Fitness Area is for the exclusive use of CHC employees only.

- The Fitness Area and Bike Room are available daily from 6:00 a.m. – 10:00 p.m.

- Before use, staff must sign the **Fitness Area Usage Agreement** Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement. Once completed, it should be forwarded to the IT Director. The IT Director will then issue the employee a proximity key card, which will enable the staff member to gain access to the Fitness Area. The IT Director will then forward the Agreement to the Maintenance Technician at the Mishawaka Campus to keep on file.

- The Fitness Area is provided as an employee benefit. Its use is optional and, as such, employees will not be reimbursed time and mileage.

- Do not wear non-athletic shoes in the fitness area. All shoes must be clean and dry. Snow, rain, dirt, or salt can damage the fitness room floor.

*Revised 05/18*

## PROGRESSIVE DISCIPLINE

CHC uses a system of progressive discipline when dealing with behavior that is not in conformity with CHC policies. This includes a first written warning, second written warning, probation, and discharge. However, some behavior is so serious it may warrant immediate termination of employment. Such behavior includes, but is not limited to, the following:

- Insubordination
- Falsification of any CHC records, documentation, reports, time sheets, or employment application
- Theft, destruction or misuse of property belonging to CHC, patients or employees
- Substance abuse on the job
- Provoking or engaging in violence of any type
- Carrying a dangerous weapon on CHC premises or in the patient's home
- Soliciting gratuities or gifts from patients or their caregivers
- Accepting cash gifts, gift cards, or gifts of any kind (except as allowed by the Consultation/Presentation to Outside Organizations policy)
- Divulging confidential information
- Removing original CHC records from the premises
- Acting in a dishonest or deceitful manner
- Commission of a crime
- Committing fraud or abuse activities related to the federal Medicare, state, or other health care programs
- Behavior listed as prohibitive in this manual
- Sexual harassment
- Gross neglect of duties and/or gross misconduct
- Two consecutive work days of no show, no call
- Violation of smoking policy
- Violation of HIPAA Policies

Specific penalties in each case may depend upon the seriousness of the rule or policy violated, the frequency of the rule or policy violated, and the employee's overall record. Employees who are under a progressive disciplinary action may not be eligible for internal transfer depending upon the recentcy and nature of the performance issue, or have received a less than satisfactory rating on their most recent performance review.

*Revised 05/20 ~~03/14; Reviewed 05/18~~*

## SOLICITATION FOR NON-CHC FUNDRAISING ACTIVITIES

Solicitation for any non-CHC, HF, GPIC, or Milton ADS fundraising related activities such as, but not limited to, schools, churches, or sports fundraisers is prohibited. Staff may not sell or attempt to sell anything to patients, caregivers, employees, or volunteers. Failure to abide by this policy may result in progressive discipline up to and including termination.

*10/18*

## EMPLOYEE BENEFITS

**Flex Spending** – Following completion of the 90-day probationary period non-prn staff are eligible to deduct up to $2,000 of their salary each calendar year for reimbursement of IRS allowable non-insured medical, dental or vision expenses or substantiated childcare costs.~~In accordance with government regulations, any withholdings not claimed for reimbursement by the CHC specified date will be forfeited.~~ Employees are eligible to receive the maximum amount of reimbursement (the amount elected for contribution for the year) at any time during the calendar year regardless of the amount contributed to date. The maximum amount eligible for reimbursement is the total amount elected for contribution to the Flex Spending plan for the year. Any withholdings not claimed for reimbursement within one month of the calendar year end will be forfeited.

Terminated employees are eligible to receive the maximum amount of reimbursement (the amount elected for contribution for the year). The maximum amount eligible for reimbursement is the total amount elected for contribution to the Flex Spending plan for the year. Only IRS allowable expenses incurred on or before an employee's termination date are eligible for reimbursement. Expenses incurred after an employee's termination date are not eligible for reimbursement. Any withholdings not claimed for reimbursement within one month of an employee's termination date will be forfeited.

*Revised 05/20*

### FUNERAL LEAVE

**Immediate Family Member** - When a death occurs in an employee's immediate family, full-time employees may take up to three days off with pay to attend the funeral or make funeral arrangements. Time off is pro-rated for part-time employees. Immediate family member is defined as an employee's spouse or domestic partner, children, stepchildren, parent/stepparent, brother/stepbrother, sister/stepsister, mother-~~-~~in-law or father-in-law~~s~~, grandparent, or grandchild.

**Vacation Exchange** – Employees have the option of receiving the cash value for a portion of this benefit instead of taking paid time off. To be eligible, an employee must have a minimum of six days (or the hourly equivalent) of available vacation time and the buyout cannot drop an employee below three days (or the hourly equivalent) of available vacation time. The buyout of vacation time will be paid at 90% of the employee's regular rate of pay at the time of the buyout. Employees electing to use this option must submit an email request to Human Resources. The request will be processed as part of the normal payroll cycle ~~and the employee will receive the cash equivalent of the vacation hours on their paycheck~~. Any unused vacation paid out at termination of employment will be paid at 100%.

*Revised 05/20*

## CONDUCT IN PATIENT'S HOME

While in any patient's home, CHC employees are required to refrain from smoking. Employees are also to refrain from using the patient's phone unless it is absolutely necessary for official CHC business. Solicitation for any fund raising, gifts, gratuities and/or tips from patients or their families is absolutely prohibited. Staff is prohibited from accepting gifts ~~without prior approval of their supervisor~~. Cash gifts, gift cards, or gifts of any kind are prohibited under all circumstances.

Staff may not sell or attempt to sell anything to patients, families, or caregivers. Failure to abide by this policy may result in progressive discipline up to and including termination.

*Revised 05/20*

## WEATHER DAY

CHC intends to remain operational during snowstorms or emergencies of any nature. A Weather Day is a highly unusual event. As a professional healthcare provider routinely dealing with emergency matters of life and death, employees should assume the agency is remaining operational during snowstorms or other natural events, unless they are otherwise notified.

The President/CEO or designee will make the final decision as to whether the office will observe a Weather Day. He/she will notify the Administrative Team, who will in turn notify all employees. The President/CEO or designee shall inform all local radio and television stations. On designated Weather Days, non-care staff will not report.

Because of the nature of care, the type of care, and the type of patient and family we serve, the nursing staff on duty on a Weather Day will have to decide in conjunction with the nursing management whether attempts must or need to be made to visit a particular patient. If conditions during major snowfall or emergencies of any nature warrant, your supervisor may direct you to contact ~~Civil Defense~~Emergency Management Agency to enable emergency care of our patients. ~~Civil Defense~~Emergency Management Agency may also be contacted to transport CHC employees to the Inpatient Unit. Telephone contacts should be attempted to patients scheduled to be seen.

If it is impossible for you to report to work on any day due to a declared weather emergency or other disaster when CHC is open, your absence will be charged to any personal or vacation day allowance; however, this will not be counted as an unscheduled absence. If, however, you are notified that CHC is closed, you will receive regular pay for time off if you are scheduled to work on those days.

*Revised 05/20*

## PERSONAL BELONGINGS

CHC assumes no responsibility for the loss, ~~or~~ theft, or damage of any type of personal property, regardless of its location. This includes the pickup or delivery of personal packages to a CHC office. Personal belongings should always be kept in an inconspicuous place as a precautionary measure. Employees should take it upon themselves to see that all offices are locked and secured during office hours. Employees must submit an employee incident report if a theft occurs.

*Revised 10/18*

**Center for Hospice Care**
**QI Committee Meeting Minutes**
**February 25, 2020**

| | |
|---|---|
| *Members Present:* | Craig Harrell, Dave Haley, Deb Daus, Heather Schnick, Holly Farmer, Karissa Misner, Kim Geese, Larry Rice, Natalie Barnes, Sue Morgan, Tammy Huyvaert, Becky Kizer |
| *Absent:* | Carol Walker, Jennifer Ewing, Mark Murray |

| Topic | Discussion | Action |
|---|---|---|
| **1. Call to Order** | • The meeting was called to order at 8:00 a.m. | |
| **2. Minutes** | • A motion was made to accept the minutes of the 11/19/19 meeting. The motion was accepted unanimously. | T. Huyvaert motioned<br>D. Daus seconded |
| **3. HQRP** | • Hospice Quality Reporting – CoPs 418.58 addresses developing and maintaining an effective, ongoing QAPI program. The program covers 14 areas. We are currently working on nine of them and will address the remaining six in the future. Our scores for rating of hospice and willing to recommend exceeded the national average for periods from April 2016 to December 2018. We were below the national average for help for pain and symptoms. At the March nurses meeting we will be reviewing the Press Ganey questions, and in April we will educate the nurses on pain and symptom management. We will include the social workers and chaplains in the March meeting, and we will ask CHPN nurses to do presentations on the areas we need focus more on at future nurses' meetings. | |
| **4. Hospice QAPI Programs** | • We presently have four QAPIs – pediatrics, live discharges, dementia, and enhanced care visits in the last 72 hours of life.<br>• Pediatrics – The aim of the QAPI is to create a protocol from referral through bereavement for pediatric patients (birth to age 21), and to provide quality end of life care through standardized interdisciplinary communication, documentation and processes. This came about because we recently admitted a pediatric patient and it did not go as smoothly as we would have liked. We did a debriefing to look at what we could do better in the future. We decided to go to age 21 because of Concurrent Care and some patients are developmentally challenged between ages 18-21. Pediatric patients are very high risk, low volume. Today we have four patients on census. We identified the need to have a coordinator from referral to bereavement, | |

| Topic | Discussion | Action |
|---|---|---|
| | so Tammy H. or an IPU Coordinator will be that person, or the PCC for home care patients, and they will oversee the patient on a daily basis. We also have a perinatal committee, and eventually this QAPI will roll into that committee. We have a designated interdisciplinary pediatric team with identified staff from each office. We will update the referral source on a regular basis. We will use Raclin House for patients that need the IPU, because a couple of the rooms are larger and could comfortably accommodate a crib. More resources are also available in Mishawaka, including the guest house. We will market our program to Riley and Memorial and other referral sources. All nurses are ELNEC trained, but not all of them are clinically sound to care for pediatrics as case manager. Everyone in admissions is trained on what questions to ask. We have special pediatric supplies in stock, including a variety of formula and diapers. QA will make sure we have all documentation in place daily.<br>• A motion was made to accept the Pediatric QAPI proposal as presented. The motion was accepted unanimously.<br>• HeartWize – We had 104 patients in December. 1 patient revoked in November to check the pacemaker battery, and one patient revoked in December to seek a Medicare A bed after a fall. About 75% of eligible patients were enrolled in HeartWize. We have worked with admissions on presenting our specialty programs to families so there is not a gap in getting them enrolled in these programs.<br>• BreatheEazy – We had 72 patients in October and 65 in November and December. Two patients revoked in October due to dyspnea, and one revoked for no longer wanting treatment. There was one revocation in both November and December to seek treatment for dyspnea.<br>• We made some internal changes in Admissions and QA to make sure everything is in place for these programs. QA checks the ICD10 codes to identify these patients and make sure the paperwork is there. We are monitoring the reason for the ER visit by symptom, if the box was checked to indicate it was related to the hospice diagnosis, and if the free text box includes additional information. Once we get the email from triage that a patient went to the ER, there is a designated person in QA tracking that information. | C. Harrell motioned<br>T. Huyvaert seconded |
| **5. Hospice Quality Indicators** | • Documentation – In January we started updating IPU documentation for the doctors and NPs., including a creating a step by step reference guide for documentation. | |

| Topic | Discussion | Action |
|---|---|---|
| | • Volunteers Hours – Per CoPs 418.78(e), volunteers must provide services in an amount that at a minimum equals 5% of total patient care hours of all paid hospice employees and contract staff. In 2019 volunteers met 7.5%.<br>• Live Discharges – In 2019, 11.6% of our discharges were live, compared to 17.1% nationally in 2017. Revocations 6.8%, national 6.5%. Transfers 1.3%, national 2.1%. Moved out of service area 2.2%, national 1.4%. No longer terminal 1.1%, national 6.7%. Discharged for cause 0.1%, national 0.3%. We started a Live Discharge QAPI and created revocation cue cards for nurses to aid them in their documentation. In 2019 we had 115 revocations. Of those, 63 went to acute care, 57 revoked in the acute setting for symptoms, 10 had more than one revocation totaling 27 revocations. 51 patients in non-acute settings sought curative treatment, 8 revoked for drain placements, 3 sought IV antibiotics, and 16 changed to a Med A bed. 51% of patients returned within 72 hours. We are looking at what are costs to send patients out for drains and the cost benefit of paying for the procedure instead of the patient revoking and then be readmitted a few days later. QA review revocation documentation daily.<br>• Support Services – Initial assessments by the social workers and chaplains occurring within five days of admission – 100% compliance. Documentation on the availability of an IPU bed for a Respite stay – 100% compliance. Bereavement is looking at low rated areas such as emotional support immediately following the death and how we can improve those scores. We are also reviewing bereavement policies to make sure they reflect current practices. Social work is responsible for grief issues before the death. Bereavement assessments being created on time and updating the care plan – 100% compliance. Our scores for the NHPCO EGSS grief survey for July-December 2019 were at or above the national average. Holly F. also created a survey that was sent to community bereaved clients.<br>• Dementia QAPI – We are working with the Institute for Excellence in Memory Care on dementia certification for CHC staff. We will hold a five-hour class in May primarily for CNAs, and another class in the fall for other staff. This will also be a great marketing tool for us.<br>• Patient Safety – There were 746 falls and 123 non-Falls (med errors, adverse events) in 2019. In July, four patients had repeated falls for a total of ten, and in September, three patients had repeated falls for a total of 12. We try everything we can to | |

| Topic | Discussion | Action |
|---|---|---|
| | prevent home falls. We are monitoring where the falls occur (acute care, facilities, IPU, home). We get to a facility after a fall as soon as we can, and offer to come to the home for families. The top reasons for falls in 2019 were weakness, cognition, and Dementia. We'll start breaking out IPU falls. We always see falls increase in the summer.<br>• Emergency Preparedness – We have three levels of patient acuity to determine which patients need assistance first in a natural disaster or man-made emergency. Level one is the patient cannot leave house and may not have an eligible caregiver. Level two has a caregiver but needs assistance in leaving home in any way. Level three patients are in an ECF or can leave home safely by themselves. This starts at admission and the case manager updates the acuity level as the patient's condition changes.<br>• Education – Topics reviewed in fourth quarter 2019 included orientation to the new Mishawaka clinical staff building, nursing skills validation, cardiopulmonary boot camp, death procedures, and wound care.<br>• ISDH follow up – Social work and chaplain assessments within five days – 100% compliance. IDT for home health is now separate from hospice – 100% compliance. Medication reconciliation in the IPU – 100% compliance in October and November, and 80% compliance in December. Individual staff re-education was done on the importance of doing med reconciliation. Respite documentation – 100% compliance. Wounds – May 68% compliance and December 99%. We submitted a proposal to NHPCO to do a presentation on our wound monitoring program at the clinical conference in October. | |
| **6. Home Health QAPI Programs** | • Quality Updates and Monitoring – CoPs 484.65. Some QAPI activities in 2019 included OASIS and Home Health CoPs update training, policy review when a home health patient is admitted to the hospital, and nurse education on the home health program.<br>• Home Health Compare – The Home Health website is now live. We need a certain percentage of active home health patients in order to participate, but we do not have enough patients. We are monitoring entry criteria, the plan of care is updated, and medical supervision by the attending physician.<br>• Patient Safety – There were no adverse events in 2019. August had a total of eight falls, five of which were from two patients. Falls always spike in the summer. | |

| Topic | Discussion | Action |
|---|---|---|
| | • Hospitalizations – We are monitoring palliative care hospitalizations, the reason for the hospitalization, if it is related to the primary diagnosis, and if the hospitalization is agency covered. | |
| **7. Other Business** | • We have a quality reporting calendar that shows what we are monitoring each quarter.<br>• DME – We meet regularly with Nafe Alick to discuss any concerns. We've had some issues lately with the timeliness of deliveries.<br>• If a patient dies in transit, we should contact the DON at the hospital or facility in writing. We will make sure that is in the policy. | |
| **Adjournment** | • The meeting adjourned at 9:00 a.m. | Next meeting 05/19 |

**Center for Hospice Care**
**QI Committee Meeting Minutes**
**May 19, 2020**

| | |
|---|---|
| *Members Present:* | Carol Walker, Carolyn Burke, Craig Harrell, Dave Haley, Deb Daus, Holly Farmer, Jennifer Ewing, Dr. Karissa Misner, Kim Geese, Larry Rice, Mark Murray, Natalie Barnes, Sue Morgan, Tammy Huyvaert, Becky Kizer |
| *Guests:* | Christy Campbell, Heather Schnick, Kim Snyder |

| Topic | Discussion | Action |
|---|---|---|
| **1. Call to Order** | • The meeting was called to order at 8:00 a.m. | |
| **2. Minutes** | • A motion was made to accept the minutes of the 02/25/20 meeting. The motion was accepted unanimously. | T. Huyvaert motioned<br>N. Barnes seconded |
| **3. HQRP Reporting** | • This most recent Hospice Compare Website data is from October 2016 to March 2019. We are focusing on eight areas from the CAHPS survey. We exceeded the national scores for emotional/spiritual support, rating of hospice, and willing to recommend. We have done targeted education with staff on the areas of improvement, especially help for pain and symptoms. Nurses will be educated on the CAHPS survey questions in June and how to incorporate those questions into our care, so families feel confident in the care they are providing in the home when staff is not present.<br>• Reviewed the Hospice Item Set (HIS) data for April 2018 to March 2019. The HIS is completed at the time of admission and discharge. Our scores during this period were above the national average in all areas. | |
| **4. QAPI Projects** | • Working on enhancement of services and on the pediatric admission process. Goal is to have these done by the middle of July. | |
| **5. Infection Control – COVID-19** | • We have been updating our policies and procedures in relation to COVID-19. We put an Alert in Cerner for any patients that have tested positive. IPU staff have been educated on visiting hours for families. We are now required to report any COVID-19 deaths directly to the state instead of to the local health department. We have created a COVID-19 Response Team of CHC nurses from each office. They will be the only ones taking care of any COVID-19 patients in the home. Staff have been | |

| Topic | Discussion | Action |
|---|---|---|
| | educated on COVID-19 screening questions and the proper use of PPE. We have had two patients die from COVID-19. For the period of March-May 2020, we have had five patients test positive. Eight employees were exposed to COVID-19 and none had symptoms. They self-quarantined for 14 days. 12 employees felt they had symptoms, but all tested negative. Their exposures didn't occur at work. Three were non-clinical employees, and one of them was tested twice. Two employees tested negative with exposure on the job that had symptoms, but both tested negative and quarantined 14 days. One patient refused getting tested.<br>• We made some changes with daily practices, including the use of telehealth and virtual visits. We are using telehealth for patients in facilities that won't allow us in. Someone in the ECF needs to assist us on their end for virtual visits. The medical staff are utilizing face time and Zoom for face-to-face visits. For the period of April 16-May 8, medical staff completed 59 virtual visits. Our IT staff has done a phenomenal job helping us with this. A new care plan was added for patients whose facilities allowed only virtual visits.<br>• Care plans have been updated to identify the acuity level for all patients, so in any emergency situation we know which patients need priority. | |
| **6. HeartWize & BreatheEazy** | • In March, one HeartWize patient was hospitalized with CHF and one BreatheEazy patient was hospitalized with pneumonia. | |
| **7. Non-Hospitalizations** | • We continue to monitor non-hospital admits where patients went to the ER but were not admitted. We track this daily. In the first quarter 2020 there were 16 non-hospitalizations, six of which were related to falls. | |
| **8. Documentation Updates** | • Education was done at the January medical staff meeting on documentation in the medical record, so we have consistency. A reference guide was developed, along with a history and physical and progress notes. Since 01/24/20, we have had 123 IPU patients. Out of those, 84 patients were visited and there were 183 medical entries. Of those not documented, four had weekend stays, and medical staff doesn't make rounds on weekends, 32 died within 24 hours, and 3 were unknown. | |
| **9. Extubations** | • This is a low frequency/high risk procedure. In the first quarter 2020, we had six extubations and we usually have three or four a year. Our extubation policies and procedures were updated. We added that nurse practitioners will be able to do extubations after being proctored by the medical staff. | |

| Topic | Discussion | Action |
|---|---|---|
| **10. Support Services Update** | • We continue to monitor all new admissions to make sure the chaplains and social workers are doing their assessments within five days of admission. In the first quarter, compliance was 99-100%. The chaplains are doing peer reviews of charts. Social workers are verifying that all respite stay documentation is complete—100% compliance.<br>• Chaplains, social workers, and bereavement are looking at the transition of emotional support from the time the patient is on census until after death. The social workers and bereavement are looking at the bereavement policies to make sure they reflect current practices for providing bereavement support and the expectations are clear on the role for each discipline before and after the death.<br>• Natalie B. helped create some bereavement monitoring tools. Each month Holly F. monitors 30% of each counselor's assessments. The first quarter 2020 had 100% compliance. The bereavement staff participated in education on distance counseling/telehealth, providing support and pandemic modifications for care, and, facilitating grief support groups over Zoom. A few years ago, we created a policy for remove bereavement work, so we already had that in place. Education has continued into the second quarter with free webinars from HFA, the TAPS Institute, and the National Alliance for Grieving Children. | |
| **11. Patient Safety** | • In the first quarter 2020 we had 122 falls and 59 non-falls. We are using the Acute hospital setting of 3-5 falls per 1,000 patient days as a guide, because there is no current standard or comparison for hospice or home health. The 2019 Hospice falls per 1,000 patient days mean was 5 in 2019 and 3.4 in the first quarter 2020. Most of the falls occurred in the home or ECF. The top reasons for falls were advanced disease, cognition, and non-compliance. There were no significant non-falls adverse events.<br>• Wounds – We record any patients coming to us with a pressure ulcer from a hospital or ECF, and likewise if they leave us and go to a hospital or facility with a wound. We know we cannot heal pressure ulcers at the end of life. Other non-fall events that occurred in the first quarter 2020 included one DME malfunction, one documentation error meds, three medication not in the home, and two drug diversions. We look at these on an individual basis to see what is happening in the home. Sometimes we have patient sign an agreement with regards to drug diversion | |

| Topic | Discussion | Action |
|---|---|---|
| | or discharge them for cause. If the caregiver of an ECF patient has concerns, we are completing an incident report. | |
| **12. Education Update** | • Education topics first quarter – With the aides we reviewed care of Dementia patients at end of life, infection control, and patient rights and cultural differences. With nurses we reviewed CHC's Emergency Preparedness Plan, acuity levels, live discharges, and self-care. | |
| **13. Raclin House** | • Raclin House – We are in the process of working on our plan of correction for the Life Safety Code inspection done on 04/29/20. The report is due to ISDH by 05/29. These are easy fixes. | |
| **14. Home Health QAPI Programs** | • Home Health Compare website – We will review these at the next meeting. There are some quality areas we can review.<br>• Patient Safety – We are reviewing non-hospitalizations. There were four patients in the first quarter 2020. There were no adverse events in the first quarter. There were 0.3 falls in the first quarter per 1,000 patient days. | |
| **15. ISDH 2019 Survey Monitoring** | • We continue to monitor areas of noncompliance from the 2019 survey. Social work and chaplains are doing assessment within five days of admission—99% compliance in the first quarter. Home Health IDT is separated out from hospice—100% compliance. We are only required to do IDTs every 60 days, but we continue to do it every 14 days. Medication reconciliation in IPUs at time of admission of respite patients 100% compliance. Respite stay documentation – 86% compliance in January, 100% compliance February and March. We educate the staff person that was not compliant in January.<br>• Wound monitoring was 68% compliance in May 2019 and 99% compliance in March 2020. Compliance has been above 98% since November. Kathy K. and Chrissy M. submitted a proposal to do presentation at the NHPCO clinical conference on our wound monitoring program, but they were not chosen at this time. We will continue to monitor these areas. | |
| **Adjournment** | • The meeting adjourned at 8:50 a.m. | Next meeting 08/25 |

Center for Hospice Care
choices to make the most of life

# CHAPTER THREE

# PRESIDENT'S REPORT

**Center for Hospice Care**
**President / CEO Report**
**May 20, 2020**
***(Report posted to Secure Board Website on June 9, 2020 due to meeting postponement)***

This meeting takes place in-person in Conference Room A and B for physical distancing purposes at the Mishawaka Campus at 7:15 AM on **Wednesday, June 17, 2020**. **We are encouraging in-person attendance, but for this one meeting only, we are providing the option to attend via Zoom. Zoom call-in and/or computer connect information will be sent in a separate email.** The Hospice Foundation and GPIC Board meetings follow immediately in Conference Room C.

## CENSUS

Despite COVID-19 (an entire section on this topic is presented later in his report), our census has remained steady, unlike many of my colleagues across the country who have seen decreased average daily census (ADC) and a dramatic drop in referrals and admissions our ADC is running 8% above same time last year. In March we saw a slight uptick in patients as hospitals were discharging and making way for a surge of COVID-19 patients that never really materialized. Referrals from physician offices dropped off dramatically when they were closed. Nursing home referrals have seen declines and we have not been allowed inside most of them for months and telehealth is the norm. April YTD referrals were down 14.3% from last year, but the conversion rate stood at a record high at 75.35%, an increase of 9.27%, meaning we are converting our referrals into admissions with remarkable frequency and efficiency. The biggest downside we have seen is loss of revenue for our inpatient units. For example, comparing the South Bend IPU from YTD April 2019 to YTD April 2020, GIP days are down 114 days. All the other 11 NHERT CEOs are also reporting a significant decrease in IPU days since the beginning of the pandemic likely due to fear of facilities and the decrease in available patients upstream at the hospitals.

| **April 2020** | **Current Month** | **Year to Date** | **Prior Year to Date** | **Percent Change** |
|---|---|---|---|---|
| Patients Served | 526 | 1,008 | 974 | 3.49% |
| Original Admissions | 121 | 589 | 605 | -2.64% |
| ADC Hospice | 394.30 | 393.98 | 367.88 | 7.09% |
| ADC Home Health | 36.70 | 37.02 | 31.20 | 18.65% |
| ADC CHC Total | 431.00 | 431.00 | 399.08 | 8.00% |

## CHC HOSPICE INPATIENT UNITS

| **April 2020** | **Current Month** | **Year to Date** | **Prior Year to Date** | **Percent Change** |
|---|---|---|---|---|
| SB House Pts Served | 19 | 120 | 129 | -6.98% |
| SB House ALOS | 3.58 | 3.93 | 4.68 | -16.03% |
| SB House Occupancy | 32.38% | 555.7% | 71.90% | -22.49% |
| | | | | |
| Elk House Pts Served | 27 | 112 | 101 | 10.89% |
| Elk House ALOS | 4.37 | 4.40 | 4.85 | -9.28% |
| Elk House Occupancy | 56.19% | 58.21% | 58.33% | -0.21% |

**MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS**

| | **2020** Jan | **2020** Feb | **2020** Mar | **2020** Apr | **2020** May | **2020** June | **2020** July | **2020** Aug | **2019** Sept | **2019** Oct | **2019** Nov | **2019** Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| S.B.: | 220 | 226 | 217 | 221 | | | | | 224 | 230 | 230 | 225 |
| Ply: | 70 | 70 | 70 | 73 | | | | | 69 | 68 | 65 | 71 |
| Elk: | 120 | 113 | 115 | 114 | | | | | 111 | 111 | 107 | 114 |
| Lap: | 14 | 17 | 15 | 16 | | | | | 13 | 12 | 13 | 12 |
| SBH: | 4 | 5 | 5 | 2 | | | | | 5 | 4 | 6 | 5 |
| EKH: | 4 | 5 | 4 | 4 | | | | | 3 | 3 | 4 | 4 |
| Total: | 431 | 436 | 426 | 431 | | | | | 425 | 428 | 424 | 432 |

**PATIENTS IN FACILITIES**

Of the 526 patients served in April 2020, 153 resided in facilities. The average daily census of patients served in nursing homes, assisted living facilities and group homes in April 2020 was 131 and YTD thru April it was 139. To illustrate the decline since the pandemic, the ADC in January 2020 for facilities was 142. Based upon what I am hearing from other CEOs, I am honestly surprised it has not slipped more.

**FINANCES**

Karl Holderman, CFO, reports the year-to-date April 2020 financials along with the 2019 audited financial statements will be presented and voted on at the May 2020 CHC board meeting. An extended Finance Committee meeting was held via Zoom on May 15th with representatives of Kruggle & Lawton CPA (also on Zoom) who covered the 2019 financial audit in detail. There was an opportunity for the Finance Committee to question K&L without management present on the virtual call as well as the reverse. K&L, in my opinion, is very thorough, extraordinarily well informed of the latest IRS expectations and regulations, and helpful in their approach. Nothing is overlooked, presenting Karl and I an opportunity to learn. We received an unqualified opinion, the highest we can receive, and no audit problems were reported by either the auditors or management. The 2019 audited financial statements will be posted to the board website on June 9th along with this report. Each board member will also receive a hard copy of K&L's audit at the board meeting.

On 4/30/20, at the HF, intermediate investments totaled $4,887,285. Long term investments totaled $20,554688. The combined total assets of all organizations, including GPIC, on April 30, 2020 totaled $67,903,512, an increase of $8,441,923 from April 2019. Year-to-date investments as of 4/30/20 showed a loss of -$1,692,765.

From a year-to-date budget standpoint at 4/30/20, CHC alone was over budget on operating revenue by $87,235, and under budget on operating expenses by $396,451.

Year to Date April 2020 Financials

| **April 2020 Year to Date Summary** | **Center for Hospice Care** | **Hospice Foundation** | **GPIC** | **Combined** |
|---|---|---|---|---|
| CHC Operating Income | 7,964,888 | | | **7,964,888** |
| MADS Revenue | 68,975 | | | **68,975** |
| Development Income | | 422,762 | | **422,762** |
| Partnership Grants | | | 137,325 | **137,325** |
| Investment Income (Net) | | (1,692,765) | | **(1,692,765)** |
| Interest & Other | 11,041 | 23,937 | 9,542 | **44,520** |
| Beneficial Interest in Affiliate | (2,319,944) | (20,891) | | |
| **Total Revenue** | **5,724,960** | **(1,266,957)** | **146,867** | **6,945,705** |
| **Total Expenses** | **7,455,488** | **1,052,987** | **167,759** | **8,676,234** |
| **Net Gain** | **(1,730,528)** | **(2,319,944)** | **(20,891)** | **(1,730,528)** |
| *Net w/o Beneficial Interest* | *589,416* | *(2,299,053)* | | |
| *Net w/o Investments* | | | | ***(37,763)*** |

## 2019 CONSOLIDATED FINANCIAL AUDIT AND STATEMENTS

The 2019 audited financial statements are on the Board Agenda. Again, they were reviewed by the Finance Committee on Friday May 15th at an extended Finance Committee meeting with the auditors from Kruggle Lawton CPAs via Zoom. The 2019 Finance Committee approved audited financial statements are now posted to the board website as of 6/9/20. Hard copies of the 2019 audited financial statements by Kruggle Lawton CPAs will be distributed to all board members at the board meeting.

## CHC VP/COO UPDATE

Dave Haley, CHC VP/COO, reports…

Mr. Haley did not respond to any of my requests for updates for this report. His last day was June 2, 2020. He retired after 14 years at CHC and is making his home in Parkland, FL to be closer to his children and his grandchildren all of which now live in Florida. His position has been advertised nationally for several weeks now and resumes have been coming in steadily. We have received several applications from California, one from Texas, two PhD's and, as expected, an interesting assortment of completely unqualified candidates. There have been local applications as well. I am not in a total panic-rush to fill this position, and frankly at this moment, there are other competing priorities that are more important. My intention, as always, is to do what is best for CHC. I am personally taking up some of his functions and as of 6/3 now have two additional temporary direct reports. After seven years as VP/COO I became Pres/CEO and waited nine years until filling the VP/COO position. Haley's departure has given me an opportunity to closely review the position and I've updated the job description for the first time in many years, deleting some items that are no longer relevant, and adding some items from the DRAFT job description for the potential new position of Director of Strategic Initiatives described in the current Strategic Plan.

**DIRECTOR OF NURSING UPDATE**

Sue Morgan, DON, reports…

The following Education Programs were held from February through April.

Nurses:
- 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.
- Review of Wound Care Basics
- Education in the Care of a Patient with Terminal Restlessness
- Preceptor Class

Certified Nursing Assistant (CNA):
- Dementia Care and Communication
- Infection Control
- Hospice 101
- Cultural Awareness.

Currently, we have 14 RN's with their certification in hospice and palliative nursing, CHPN, and four CNA's with their CHPNA. This is an examination which confirms their knowledge base to care for terminally ill patients. This certificate is awarded by the Advanced Expert Care by the Hospice & Palliative Nurses Credentialing Center. A requirement for nurses to maintain their certification is to develop and give a presentation/lecture. During 2020 at the Nurses' Meetings a RN with her/his certification will be asked to develop objectives, content, and the presentation.

A program for Certification of Dementia Care will be offered in October and November for the CNA's. This is a five-hour class which will be held on site by the Alzheimer's and Dementia Services of Northern Indiana.

The Raclin House (eventually) and Esther's House will be utilizing an Omnicell for automated dispensing of medications. The machines have been installed and they will improve our controls over medication dispensing and give us significantly increased opportunity for documentation and verification of dispensed medication as well as act as another barrier to avoid potential medication diversion. The Indiana State Board of Pharmacy completed their inspection on March 14. Approval has been given for the use of the machines.

We have continued our collaboration with McKesson, our contracted vendor for primarily one-time use medical supplies. We have coordinated with McKesson to standardize and decrease our inventory and have a much better grasp on par levels and only purchasing what we need and have limited the staff who may replenish supplies. During the COVID 19 pandemic they have worked closely with us to procure additional needed supplies.

## 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 April 2020, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous four years:

| | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| January | 65,460.71 | 46,552.99 | 37,015.96 | 62,707.48 | 79,642.06 |
| February | 101,643.17 | 199,939.17 | 93,912.90 | 113,771.80 | 222,116.20 |
| March | 178,212.01 | 282,326.61 | 220,485.17 | 369,862.26 | 295,882.74 |
| April | 341,637.10 | 431,871.55 | 310,093.61 | 565,568.94 | 414,128.88 |
| 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)

| | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| January | 52,156.98 | 31,552.99 | 37,015.96 | 51,082.36 | 52,550.56 |
| February | 36,182.46 | 35,125.58 | 56,896.94 | 45,621.02 | 140,985.12 |
| March | 73,667.84 | 79,387.44 | 113,969.42 | 254,547.16 | 70,044.19 |
| April | 163,425.09 | 149,569.94 | 87,978.18 | 194,857.93 | 118,092.10 |
| May | 93,318.98 | 142,982.72 | 182,601.92 | 97,864.76 | |
| June | 127,315.24 | 146,200.17 | 46,947.92 | 69,026.39 | |
| July | 52,394.52 | 61,505.45 | 64,243.53 | 67,591.20 | |
| August | 97,470.92 | 63,593.03 | 61,803.98 | 54,739.37 | |
| September | 92,459.02 | 120,261.01 | 117,984.73 | 68,812.68 | |
| October | 71,323.54 | 127,208.12 | 79,852.69 | 50,019.27 | |
| November | 66,490.16 | 75,809.56 | 94,053.07 | 57,214.65 | |
| December | 138,328.11 | 286,687.74 | 191,211.72 | 225,547.36 | |
| **Total** | **1,064,532.86** | **1,319,883.75** | **1,134,560.06** | **1,236,924.15** | **381,671.97** |

Strategic Planning/Fund Raising Initiatives Beyond the Crossroads Campaign

Hospice Foundation is transitioning from its focus on the Crossroads Campaign to other funding priorities and has begun the process with strategic planning meetings. These sessions coordinated by our fundraising consultant, Dan Reagan, have enabled us to identify strategies and tactics to build upon the momentum of the campaign. Following multiple meetings and individual interviews with the HF CEO, Karl Holderman, Mike Wargo, Chris Taelman and Cyndy Searfoss, Dan recently generated a planning report that provides us with a logical and effective approach to CHC/HF fundraising during the next three years and beyond.

The planning process generated six core areas of focus:

1) Annual Giving: Expand unrestricted giving through existing annual giving programs while identifying and evaluating new programs to bolster this area.
2) Endowment: Endow key mission support programs (e.g. Camp Evergreen, After Images, We Honor Veterans, etc.)
3) Annual Planning: Establish a process to establish annual fundraising priorities.
4) GPIC: Determine, and then pursue, a realistic base of support for GPIC.
5) Planned Giving: Establish, announce, and immediately begin to promote a planned giving society – name to be determined.
6) New Donor Acquisition: Work towards the identification, education, cultivation and eventual solicitation of the next generation of hospice donors.

Though COVID-19 related restrictions have required us to shift or adjust our focus on the core goal implementation outlined above, we are now in the early stages of implementing specific recommendations associated with these core goals. As the pandemic required us to work remotely, we have been focusing on staying in touch with donors by using technology like Zoom calls and email newsletters, or when appropriate, making telephone calls and sending letters and handwritten notes.

Our outreach during the pandemic includes donor messaging that is informative and positive while demonstrating that CHC/HF requires charitable support to be effective. This donor communication effort during the pandemic remains relatively frequent as our intent is to help keep CHC/HF "top of mind" with donors and prospects.

As we monitored opportunities to apply for financial support related to the COVID-19 pandemic, we determined that our immediate needs did not warrant applying for special pandemic-related emergency funding, at least for the time being. In our communication with community foundations and other sources of this emergency funding, we've explained our understanding that many other local non-profit organizations and healthcare provider partners are facing more immediate and critical assistance in covering COVID-19 related costs than CHC – for now. Furthermore, we've communicated with local foundations that we want to support these partners in every way possible which includes opting out of applying for emergency funding in an effort to open up additional emergency dollars for organizations demonstrating the greatest need.

Annual Giving

Response to our 2019 annual appeal mailing, sent out in late November 2019 continues to be positive despite fewer donations in recent weeks. The appeal generated $100,655.11 through 4/30/20.

Friends of Hospice Campaign

To begin making progress toward our goal of new donor acquisition, we are exploring alternative communication strategies. For example, as we plan for our upcoming Friends of Hospice campaign, we have engaged Federated Digital Solutions (FDS) to assist us in developing a digital marketing campaign using social media and geofencing strategies to supplement a scaled back direct mail solicitation.

Special Events

We hosted our Florida donor event on Tuesday, February 25, at Naples Kensington Golf and Country Club. Our hosts this year were Susan and Jim Wagner and Francie and Dennis Beville. This event along with individual donor meetings that took place in Naples and Tampa/St. Pete generated donations totaling approximately $125,000.

Dale Coddington, a 73-year-old cycling enthusiast, recently finished his ride from the East Coast to the West Coast in memory of his daughter, Tania Coddington Deren. Tania's daughter Abby selected Center for Hospice Care's Life Transition Center as the benefactor of funds generated by Dale's cross-country journey after she participated in CHC's bereavement programs following her mother's death. The ride began on the morning of February 8 with the wheels of Dale's bike touching the Atlantic Ocean at Crescent Beach in St. Augustine, Fla. Dale faced many challenges on his ride, the greatest being the COVID-19 pandemic. Thanks to the nature of Dale's riding route, coupled with the fact that he and his wife were able to social distance in their RV, Dale was able to finish his ride on April 20 as his wheels splashed into the Pacific Ocean at Coronado Beach near San Diego. Every dollar donated to Center for Hospice Care because of Dale's coast-to-coast ride is being directed to support our grief counseling programs that serve participants at no charge. To date, Dale has raised just over $21,000 of his $25,000 goal.

Based on guidance from the CDC and Indiana State Department of Health regarding mass gatherings, we made the decision in mid-March to postpone this year's Helping Hands Award Dinner from May 6 to September 30. As soon as it became apparent that our May date was not feasible, we worked diligently with our awardees (Drs. Zoreen and Rafat Ansari), dinner chairs (Jen Ewing and Tom Housand) and our vendors to secure the new date and look forward to seeing you at the 36th Annual Helping Hands Award Dinner at the Hilton Garden Inn on September 30th! As previously reported, we have made the decision to cancel both Bike Michiana for Hospice and Walk for Hospice. We announced the cancellation of these events in conjunction with the announcement of the postponement of the Helping Hands Award Dinner as well as this year's Elkhart Campus Gardens of Remembrance and Renewal Memorial Dedication, originally scheduled for June 2, 2020. We will announce the new date as soon as we are able to select it.

Health System/Professional Education Collaborations

As part of our professional education outreach, the Center for Education & Advance Care Planning hosted a Hospice Foundation of America (HFA) webinar at Saint Joseph Hospital on February 11th. Additional webinars were scheduled for March, April, May, and June but have been postponed due to COVID-19. HFA has provided one virtual webinar with CE credits which was also made available to staff at Saint Joseph Hospital; more are slated throughout the year as we transition from a world of in-person learning to virtual education. In addition, HFA webinars continue to be available to CHC staff. Continuing education credits are available to employees through HFA.

Federal / State Lawmaker Education

NHPCO's grassroots campaign, MyHospice, has continued to grow despite the COVID-19 pandemic. One of the tasks Elleah Tooker, our community education coordinator, has taken on in her role as ambassador is continuing to maintain contact with legislators electronically to continue nurturing those relationships. The COVID-19 crisis and its impact on the provision of hospice services has been communicated in detail. MyHospice's objective is to ensure that Indiana's legislators are aware of those issues as they review current bills.

Community Education

One of our on-going community education collaborations is with Forever Learning. The spring edition of Issues in Aging moved to a Zoom delivery rather than in person. We had 14 attendees for the "Hospice 101" session and many questions after the presentation.

Using social media to communicate with a wider audience has become a focus during the COVID-19 pandemic. With the assistance of Hannah Nichols and Jim Wiskotoni, we launched a Center for Education & Advance Care Planning (CEACP) Facebook page (please visit and "like" us if you have not already). To engage visitors and encourage participation, we have been posting questions and true or false statements on the page.

We have launched new initiative to create a community Google map of organizations, trusted advisors, and colleges/universities with whom we have collaborated on education initiatives. We will soon be extending this to extended care facilities as well. These resources are mapped into a page containing details about the partner (e.g. primary contact, URL, the type of collaboration, etc.). Our intent is to develop a visual representation of our existing connections within the community.

This will allow us to plan an effective, sustainable outreach program, help coordinate connections made by CEACP/CHC/Honoring Choices, as well as develop priorities for future efforts.

The sixth iteration of the "Intro to Hospice and Palliative Care" course, that we teach in conjunction with the Ruth M. Hillebrand Center for Compassionate Care in Medicine at the University of Notre Dame, was moved to a virtual platform during the COVID-19 pandemic. To accommodate the tight production schedule for online delivery, the course was offered through a combination of video from past courses, recorded Zoom sessions and live in a virtual classroom setting via Zoom. HF/CHC staff serving as faculty for the class included: the CHC CEO, Mike Wargo, Cyndy Searfoss, Elleah Tooker, Sue Morgan, Kristiana Donahue, Kim Mathews, Lacey Ahern. Larry Rice and Holly Farmer. One addition to this year's offering was a session on advance directives. After Dr. Mark Sandock presented about Honoring Choices Indiana – North Central and advance directives, Cyndy and Elleah walked students through completion of Indiana's advance directives and provided tools and resources so they could begin having conversations with loved ones at home. A total of 61 students were enrolled in this semester's course offering.

Honoring Choices Indiana – North Central

Sr. Eileen Wrobleski, Honoring Choices coordinator, left the organization at the end of February. A new coordinator, Steve Chupp, was hired in March and has been working with the HCI-NC steering committee and board of directors to address the organization's sustainability and how facilitated conversations can be offered to those wanting to complete their advance directives during the COVID-19 pandemic. Twenty advisory board members participated in a half-day retreat on Saturday, May 10, 2020. The focus of the retreat was to agree upon the volunteer portion of the organization's structure and to identify alternatives sources of funding. The entire meeting was conducted via Zoom and was facilitated by local not-for-profit consultant, John Pinter.

COVID-19 Impact on our partnership with PCAU

The COVID-19 pandemic continues to impact the Palliative Care Association of Uganda (PCAU) and its work in Uganda as well as our partnership activities. The Ugandan government has been very proactive in implementing preventive measures to deter the spread of COVID-19 in the country. On March 18th, the president mandated a countrywide lockdown that has been extended until May 19 (at this point). The government has a comprehensive website on the COVID-19 Situation in Uganda. PCAU has had to scale down many activities but they have taken a significant leadership role in ensuring those in need still receive palliative care during the lockdown. CHC/HF stepped in immediately to support PCAU through these unprecedented times. Upon learning of the impending country lockdown, we granted $500 (from funding earmarked for the mHealth program) to be used immediately for staff to purchase Internet and cell phone communication bundles so they could stay connected while working from home. Each PCAU staff member is already equipped with a retired CHC laptop computer. Additionally, CHC/HF sent PCAU a $10,000 grant to support their COVID-19 emergency response efforts. As a national association, our colleagues at PCAU are working hard to ensure their member hospice and palliative care organizations across the country is preparing for and supported during this pandemic. They have directed these funds toward: public health messaging, securing PPE for hospice and palliative care providers, supporting our Road to Hope children while schools are closed, and so much more.

Global Partners in Care provided PCAU with a Zoom license to further enable communication among PCAU staff and members during the lockdown. With this license, PCAU is also hosting a weekly online discussion with palliative care stakeholders in Uganda to share updates, best practices and hold collective discussions during this pandemic. The leadership and coordination from PCAU have been impressive and appreciated by their colleagues.

PCAU continues their important advocacy work, and on April 6, 2020 sent a statement to the Prime Minister of Uganda and Coronavirus National Taskforce) on COVID-19 Response and Palliative Care Work in Uganda. PCAU is part of the national COVID-19 Case Management Committee which is planning for the potential surge in cases, and they are helping train ICU nurses in basic palliative care to help them manage and support COVID-19 patients and their families. The country has only 55 ICU beds for more than 40 million people.

Exchange Visit

Following the outbreak of the COVID-19, this activity was postponed to a date yet-to-be-determined (but we do not expect it to happen in 2020). The initial plans were to host this activity from March 15th – April 4th, 2020. As a result, we also made the decision to postpone Okuyamba Fest until PCAU can visit in the future.

Road to Hope (RTH)

The closure of all schools was included in the lockdown announced on March 18 and children in schools were to return to their families and communities within two days. PCAU mobilized quickly, contacting all schools the Road to Hope children attend, the children's families and guardians, and the regional palliative care nurses who support the children to help in coordinating their safe return home. By Friday, March 20, all 56 RTH children had been safely returned to their families and guardians in the various regions of Uganda.

According to the RTH Program Officer, Lydia Nakawuki, at PCAU, "We are glad to report that all children both in day and boarding schools were able to go back home safely. In the different discussions with the guardians, we managed to talk to them about coronavirus and also share the safety measures that have been put out by the World Health Organization and the Ministry of Health so that they keep the children safe during this period."

The government (Ministry of Education and Sports – the National Curriculum Development Center) published home schooling packages for each class level, but distribution of these to each child has been problematic. The newspaper printed some content as inserts in the daily papers and PCAU is ensuring each child at least gets these. PCAU is regularly checking in with the children; we do not yet know what the rest of the school year will hold for the children.

PCAU Interns

Ainur Kagarmanova, a Master of Science in Global Health student from the University of Notre Dame, will no longer travel to Uganda to work on the mHealth project during May and June. She will, however, still complete her capstone project on assessing the status of palliative care in Uganda by analyzing data from the mHealth project along with some other literature analysis and GIS mapping of services.

Advanced Diploma in Palliative Care Nursing (ADPCN)

Interviews for the next cohort of ADPCN students that was scheduled for March 2020 is on hold. PCAU, Ministry of Health (MOH) and Mulago School of Nursing and Midwifery (MSNM) continue to meet via Zoom to hold planning meetings for the program.

mHealth Project

PCAU is in touch with MOH and the new palliative care point person (Dr. Lilian Ajambo) to keep advancing the integration of data collection into the national data collection (District Health Information System 2) and the approval and launch of the palliative care register. The conversations are ongoing, but the actual implementation will likely be delayed due to the pandemic.

Facilities

While construction has been complete for some time on the Ernestine M. Raclin House, we are awaiting final approval from the Indiana State Department of Health (ISDH) to begin admitting patients there. An ISDH inspector performed a site visit and Life Safety Code survey on April 29th. Though we are still awaiting his official report, all the needed modifications identified during his visit, and discussed during the exit interview, have either already been completed or will be completed during the upcoming week.

Residential Housing

As previously reported, the Cedar Street home was sold at a purchase price of $384,900. We are currently working closely with the new owners to coordinate the landscape design between our adjacent properties.

Roseland Remodel for MADS

We are currently working with Jeff Helman and Brad Sechrist on plans to remodel and transform the Roseland facility into the new home for Milton Adult Day Services.

Maintenance Building

Construction of the new maintenance building located on our land located at the corner of Pine Street and Comfort Place is underway. We anticipate taking possession of the new building and getting it fully operational in June.

Elkhart Campus

We recently expanded and upgraded our parking lot lighting.

**GLOBAL PARTNERS IN CARE UPDATE**

For informational purposes for the CHC board, GPIC presents this update…

Operational Impact of COVID-19 Pandemic

The COVID-19 pandemic has affected nearly all aspects of our work. We have shifted many of our activities to help support our partners during the pandemic, some events have already been canceled, and we are rethinking other activities we have planned for the year. At the start of the year, we noted three important areas of focus:

- Fundraising: Focus and planning has been redirected because of the pandemic. Our immediate focus is raising money for the disaster fund to direct toward COVID-19 response efforts of our partners. It is crucial that we continue to look for general and operational support for GPIC and we will continue to do so, though we expect it will need to be wrapped into pandemic response efforts to be successful.

- Recruiting US partners: We started 2020 with this as a high priority. We began planning our strategy (e.g. NHPCO conferences, reaching out to individual programs, etc.) but were quickly diverted with the pandemic. None of our planned messaging and approach is appropriate right now, nor do we think it will be soon. We believe it may be possible that through our focus on COVID-19 support, the opportunity to attract new partners may arise, so we are rethinking this entire effort.

- Nepal: Deepening our engagement in Nepal is a crucial next step in expanding beyond Sub-Saharan Africa. While a physical trip or engagement at a conference is no longer possible this year, we will still take what steps we can to advance our relationships and possible engagement there. We are in touch with NAPCare and have provided them a Zoom license and membership to AAHPM (read more about this project below).

2020 Goals

Our key goals for 2020 remain the same and all modified activities thus far are still helping us achieve these goals:

- Develop our programs in a collaborative way that enhances access to palliative care worldwide,
- Effectively communicate GPIC branding and raise profile of GPIC internationally,
- Establish financial and operational sustainability for GPIC.

Over the next several weeks, we will be thinking through what activities have changed for 2020 and how to best carry out these goals in a modified way. Additionally, we may need to consider new areas of focus.

Disaster Response Fund (DRF)

In March, we made the decision to temporarily redirect these funds to COVID-19 response for our partners. We set up structures and streamlined procedures to send money quickly and to engage our US partners in donating as well. Immediate needs from partners all relate to their ability to continue providing necessary services to their patients. They are using the funds to purchase PPE, extended supplies of medicines and nutritional support (to help their patients through countrywide

lockdowns) and some operational support as many of our partners lost huge percentages of their income during the lockdowns.

African Palliative Care Association (APCA) and National Association Support

Given our commitment to collaborate with national and regional associations, we responded to a request from APCA to help them produce resources for their members. GPIC awarded them a $4,000 grant to build COVID-19 public health communication tools that can be adapted by palliative care leaders in African countries. Our two national association partners in Kenya and Uganda received direct support as well. This funding came from the RW Naito Foundation grant we received late last year. We received permission from them to redirect these funds. PCAU received $10,000 support from their US partner, Center for Hospice Care and KEHPCA received a $2,000 grant from GPIC to acquire PPE and additional morphine stock for their members. KEHPCA's partnership with the Missouri Hospice and Palliative Care Association had just launched before this pandemic hit, so they have not yet begun to engage in partnership activities.

Partner Support

Cyndy Searfoss, Director of Education and Collaborative Partnerships for HF, and Lacey Ahern, Program Director for GPIC, are in regular communication with our partners. Many have expressed their gratitude for our solidarity during this difficult time and they are sharing stories and challenges along with good wishes for our well-being in the US. We are beginning to plan for the development of additional partner resources to offer partners, including alternatives strategies to fundraising events and initiates that have been canceled.

Communications

Following some best practices on connecting with our constituents during the pandemic, we decided it was important to be in frequent communication with our US partners and other donors. We are keeping constituents updated on partner COVID-19 response by sharing stories, challenges, and donation options. We are doing this through a weekly e-newsletter and more frequent social media postings on Facebook, Twitter, and Instagram. Through this, we are establishing frameworks and processes that will be helpful in developing an overall communication plan for GPIC.

Fundraising

We began researching potential grants for COVID-19 response funding (for partners and for GPIC). There is a great deal of news on COVID-19 funding from foundations, corporations, governments, etc. but much of it is being directed to existing partners and is not available for unsolicited proposals. We will need to focus more within the coming weeks and months as we think about not only funding our disaster response but GPIC's longer term sustainability as well.

Educational Projects

Collaboration with the American Academy of Hospice and Palliative Medicine (AAHPM)
We have provided a one-year membership to AAHPM to selected GPIC members and collaborators. GPIC will act as a central umbrella organization for these 31 memberships and is

working with the AAHPM membership director to help maximize the benefit to our members. Our expectation is that the person selected to receive this membership, within each partner organization, will utilize the connections and resources from AAHPM to enhance palliative care knowledge and efforts for both themselves and their organization. We believe many of the resources AAHPM offers will help our partners and they may also form new collaborations or networks that will enhance their work. We will be asking for feedback and monitoring use over the course of the year to assess the value of the membership to our partners. Our cost is less than $30 per member and we anticipate a good return on investment. About half of the participants are representatives of national associations or governments that APCA is working closely with to develop palliative care in their respective countries. The other half are our level IV (very active) GPIC partners.

African Palliative Care Education Scholarship Fund for Nurses and Social Workers

Awarding of these scholarships has been delayed as many of the educational programs in Africa have delayed admissions processes during country lockdowns. Along with APCA, we are waiting to see what the next steps are for palliative care educational programs before awarding scholarships this year.

Conferences

It is not yet clear if the conferences we have considered attending in the fall will take place (i.e. International Congress on Palliative Care in Montreal, NHPCO Interdisciplinary Conference in Arkansas). We will continue to monitor the situation knowing the possibility that they may be canceled.

Research Projects

Understanding the Challenges of the Ageing Population in Ghana - University of Alberta, College of Saint Benedict and St. John's University in Minnesota, and APCA. This project did not receive the research grant we had applied for, but the team is committed to continuing collaborative work and identifying other funding as we also monitor how the pandemic will affect research project activities.

Telehospice in Tanzania - University of Kansas Medical Center (KUMC), University of Notre Dame (UND) and ELCT (and maybe University of Maine Medical Center). The pandemic has also delayed advancement in this project, though we are still in conversation with partners on advancing this work – and possibly evolving the project as telehospice becomes more important during this pandemic. Lead researchers from KUMC and University of Maine Medical Center will have a call this month.

Regarding the Palliative Care Leadership Project with Bluegrass Care Navigators and APCA, after several discussions, partners have agreed to move forward with a concrete one-year engagement that will focus on supporting APCA's new strategic plan. This will involve structured coaching and support from Bluegrass to help APCA stay on track with their strategic goals, identify challenges and strategies to address them, and help the organization establish itself as a center of palliative care leadership. The expectation is this initial project between the organizations will build a better foundation of partnership and collaboration that will help support the development of a larger leadership project.

Intern Research

We are moving forward with two GPIC internships for the summer. Initially, the students were supposed to be based in Uganda with APCA and in Malawi with Palliative Care Support Trust. Working with the partners, we have determined that both will be remote internships.

- Dr. Onyekachukwu Erobu (Onyeka), APCA: Onyeka is a medical doctor currently in the Master of Public Policy program at Oxford. She is from Nigeria and, in addition to working as a doctor, she has worked with NGOs (including Save the Children International) in Nigeria. Onyeka will be working on best practices for national palliative care policy development. It will also now include review of whether national palliative care policies include the role of palliative care during fatal viral infections/epidemics.

- Jonathan C. Couri, Palliative Care Support Trust: John is a sophomore at the University of Notre Dame working towards a BS in biological sciences and is in the Glynn Family Honors Program. He interned at St. Jude Children's Hospital and is a Center for Hospice Care volunteer. John will research the importance of nutritional support in palliative care programs. We also plan to hire John as a general GPIC support intern for the summer once our current intern, Jacob Fry, graduates. Exact dates are TBD. As a side note, Jonathan is a varsity cheerleader for Notre Dame.

**COMMUNICATIONS, MARKETING, AND ACCESS**

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for February – April, 2020…

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. Although the COVID-19 pandemic limited the ability of the liaisons entering many facilities, they continued to reach out via phone and email. In March through April of 2020 our four Professional Relations Liaisons completed 1,348 contacts to current and potential referral sources within our service area. They accomplished 480, 490, and 378 visits in February through April, respectively. The biggest drop was in the Extended Care Facilities (ECFs) where the availability of staff was extremely limited.

Once the outbreak occurred, professional contacts immediately limited our access to patients, families, and staff. Our Liaisons had to become very creative in their outreach to referral sources. Our communication was consistent in letting them know we are open as normal and available to help in any need they may have. Emails, phone calls, notes of encouragement, and even parades at ECFs were the alternative of face-to-face visits.

Access

Obviously, the impact of the pandemic has had a tremendous effect on our referrals and admissions. During the period of February – April of 2020, the hospital referrals decreased by 16.5% compared

to the same period in 2019. In April alone, when the pandemic peaked, our hospital referrals decreased by over 33% compared to the previous year. However, we were able to increase our conversion rate to 74.85% with an admission rate of 67.2% within 24 hours of the call which helped to maintain our monthly average daily census (ADC) of 436, 431 and 431 February – April respectively. Part of this was due to our focus on streamlining the admissions process. It was already on our agenda for this year, but the lack of access to patients was an opportunity to put these theoretical procedures into practice. Like when we assess a patient coming from outside our service area, we do our assessment via phone and by speaking to the professional referral source. We began doing the same for the convenience of local hospitals. Even though it is not as optimum as actually meeting with the patient and family, our long-term relations appreciated the expediency of the process.

The number of "Died Before Admission" (DBA) dropped in total due to the lower number of referrals. The percentage of non-admits due to DBA remained the same as last year.

Website

We continue to fine-tune our new website that was recently launched. Its simplification has helped the visitors find the resources they need to decide to contact us for assistance. Like every aspect of our organization, the usage and visits were down considerably for the period of February – April. However, we have seen a slight increase in new users in comparison to the same time last year. We recently completed new portraits for CHC Administration Team, Coordinator positions and above as well as Certified Hospice and Palliative Care Nurses and Aides. Those photos will be added as we continue to build out the site.

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 122,378 people for the period of February – April and had 13,512 reactions, comments, and shares. Our leading post was on May 8th, The Rain Never Lasts Forever / After the storm comes the rainbow. It reached 8,595 people and generated 1,700 reactions, comments, and shares. The second most viewed posting was on April 10th: Busy Hands of Michiana. It recognized our community support, specifically Director Chris Deitchley and their donation of masks to help keep our staff safe. It reached 7,377 people and generated 920 reactions, comments, and shares. CHC currently have over 4,500 Facebook followers.

CHC continues to have social media presence on Twitter, Instagram, YouTube, and LinkedIn as well.

Digital Overview

The digital report activity from February – April 2020 continues to be strong. The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the months of February - April it generated 157 telephone calls. Google industry benchmarks show an average click-through rate in the Health & Medical field of 3.79 % and we continue to be high at 8.58%.

## CLINICAL POLICIES ON THE AGENDA FOR APPROVAL

There are nine new and ten revised clinical policies on the agenda for board approval at the next meeting. They are included in this Board Briefing Book as attachments. Sue Morgan, DON, will be present at the in-person board meeting to answer any questions.

Policies for Board Meeting – 9 New Policies

1. Sign Language Interpreting – new
2. COVID-19 Pandemic Infectious Disease – new
3. COVID-19 Pandemic Response – Documentation – new
4. COVID-19 Protocol for Positive or Presumptively Positive Patients – new
5. Inpatient Unit – COVID-19 Visitor Restrictions – new
6. Inpatient Unit – GIP in Hospital – new
7. Inpatient Unit – High Flow Oxygen Titration – new
8. Inpatient Unit – Medication Room – new
9. Inpatient Unit – Omnicell - new

Policies for Board Meeting – 10 Revised Policies

1. Hospitalizations (home health) – revised
2. Supervision of Satellite Offices – revised
3. Inpatient Unit – Admission – revised
4. Inpatient Unit – Aide Responsibilities – revised
5. Inpatient Unit – Combative Patient – revised
6. Inpatient Unit – Communicable Disease Assessment – revised
7. Inpatient Unit – Death During Transportation to Inpatient Unit – revised
8. Inpatient Unit – Discontinuation of Life Prolonging Procedures – revised
9. Inpatient Unit – Dishwasher – revised
10. Inpatient Unit – Respite Patient Care – revised

## CHC RESPONDS TO COVID-19

I could easily type more than 30+ pages, single spaced, about CHC's response to COVID-19. For me personally, and for several other Administrators, the virus, and the response to it has taken up at least 80% of my time since our last board meeting in February. Between the Governor's Executive Orders, telecommuting by some staff, and other challenges, there has been little strategic activity that has been getting done and/or annual goals being met. Our priorities changed forcefully nearly overnight and with little warning. Today, as I type this, this now seems like a manifestation of unexpected events from a very, very long time ago. **I cannot begin to express my sincere appreciation and gratitude for the diligent efforts of our Administrative Team and our entire staff (not just clinical, but across the board -- back office, billing, IT, finance, HR, etc.) regarding their dedication and flexibility during this crisis and their ongoing, totally astonishing and superior attempts to keep each other and all of our patients and families safe. I believe our COVID-19 data – and the lack of it -- proves this outstanding response by the entire CHC family and all its affiliates.** While I understand we have "new traditions" (rather than a "new normal") that will never entirely go back to the way it was, we do look forward to a sense of

normalcy by 7/4/2020. I am also hopeful that some of the many concessions CMS has made due to COVID-19 (regulatory, allowing hospice telehealth, etc.) will become standard processes in the way hospices perform their daily activities. I remain hopeful that good things can emerge from the bad. Please see attached article, "Rapid Changes to Health System Spurred by COVID May Be Here to Stay" from Kaiser Health News on 6/8/20.

Here are some of the highlights of CHC and COVID-19. My thanks to Sue Morgan, DON, who put together a PowerPoint outlining our various responses and that content is below as the bulleted items.

The Administrative Team responded to the many issues related to COVID-19 and implemented the Emergency Management Plan approximately March 18. This included a daily meeting to review, patient staffing, employee safety, supplies, environmental factors, telehealth, admission information, communication, and updates from our contact sources. The following were initiated based on resources available:

- Communication via e-mails and letters to families, patient's, extended care facilities, employees, and board members.
- Tracking and trending exposures related to COVID-19 for employees and patients.
- Daily reminders related to COVID-19 on our employee Intranet web site.
- Patient Concerns: A dedicated COVID-19 Response Team of nurses that volunteered to specifically care for patients with COVID-19.
- Education of personal protective equipment (PPE) was reviewed with all direct patient care providers.
- Nursing visits were limited to homes and ECF's based on patient family need, and the plan of care.
- Social Work and Chaplain visits were completed through telephone calls.
- Social distancing was accomplished within the in-person Interdisciplinary Team by limiting attendance.
- CHC implemented telehealth via Zoom, Facetime, and Skype for patients in extended care facilities and assisted living facilities.
- Triage screened all patients prior to a nurse completing an emergency or death visit.
- A CHC Medical Director reviewed all admissions for any potential COVID-19 patients prior to them being admitted.
- A daily stock inventory was completed regarding availability of needed supplies, including PPE.

- So far, we have had four patients test positive for COVID-19, two in the CHC IPU, one in a residential home setting, and one at an extended care facility.

- We developed numerous new patient care policies specific to COVID-19 on a very fast turnaround.

- Employee Concerns: Employees were encouraged to work from home, communication of signs and symptoms related to COVIS-19 were communicated to all employees, CDC signage was posted at all offices related to hand washing and masks, hand sanitizer and disinfecting wipes and products are readily available at all offices, a specific "CHC Back on Track Plan" was communicated to all employees inclusive from May 15th through July 4th and beyond.

So far, out of 248 staff, no CHC/HF/GPIC/MADS employees have tested positive for COVID-19.

I am proud to say there have been no staff layoffs or furloughs at any time throughout the pandemic. Hourly staff with reduced hours that could be attributed to COVID-19 were made "whole" through May 23rd. We continue to monitor how the HHS Stimulus funding might help with some other issues, and we did use the Family First Coronavirus Response Act with our payroll vendor and some staff, depending upon individual circumstances, were able to take advantage of this. We did not apply for any federal Payroll Protection Program grants and we are glad we made that decision early-on based upon the information on hand at the time. Several of my friends in the National Hospice Executive Roundtable did and now wonder what they are going to do and how they are going to spend the funding.

**MILTON ADULT DAY SERVICES UPDATE**

The Indiana Division of Aging closed all adult day services business in the state on April 2nd. They announced they would not pay for any Medicaid Wavier clients and encouraged adult day providers to go into "home care" to provide services. An impossible suggestion. MADS was closed on 4/2. Governor Holcomb's "Back on Track Indiana: Stage 2 May 4th – 21st indicated that all adult day services would be closed at least until May 31st.

**CHC RECEIVES $1.4 MILLION IN HHS STIMULUS FUNDING**

When it was announced by CMS Administrator, Seema Verma, during a Friday, April 10th White House press conference re: the HHS Medicare Stimulus Funding saying, "There are no strings attached, so the health care providers that are receiving these dollars can essentially spend that in any way that they see fit," my professional colleagues and hospices CEOs around the country were ecstatic about this news and funding just showed up in our program's checking accounts without even asking. The funding was intended to help with unplanned COVID-19 expenses and the amounts received by each Medicare provider was calculated within an arcane formula based upon 2018 Medicare net patient revenue. The next week we learned of a ten-page, single-spaced Terms and Conditions of keeping the funds published by HHS. The later clarification from HHS showed more strings than the entire Montovani recorded musical library added together. Listed limitations included that we could not use the funds on such things as abortions, pornography, illegal drugs,

and human trafficking, just to name a few. We were given 30 days to decide to accept the Terms and Conditions via a web portal that did not initially exist or give back the funds via a mechanism that did not exist either. This was been like a reverse grant. You receive the funds first without asking, then you are told what you must do to keep them. A backwards application process. The funds are currently sitting in our interest-bearing overnight sweep account earning a little something. We eventually agreed to the CMS Terms and Conditions regarding the funding prior to the deadline. After a very good conference call Karl and I had on Wednesday morning April 29 with The Rybar Group (https://therybargroup.com/), we engaged this firm to assist us with the necessary documentation to be able to keep the funds as they are related to COVID-19 expenses. Rybar is an accounting firm in Michigan that was recommended to us by Kruggle & Lawton through their common alliance with BDO. Their practice is making sure Medicare providers get paid appropriately and stay out of trouble with the False Claims Act, Medicare audit prevention, etc. This HHS Stimulus funding will be a Medicare contractor auditor's dream come true for many years to come. Rybar will help us with documentation of COVID-19 related expenses, filing the quarterly forms to HHS, be available for Q&A, and more. Additionally, they will be available in the future for four years if HHS, CMS, or somebody else comes back and claims we did not use the funds for what we said we did. During our call we discovered there were some items that neither Karl nor I thought about that could be used for this funding reimbursement. There seemed to be more of a "there" there than we initially understood. However, we do not believe it will be close to $1.4MM. The fees to The Rybar Group would also qualify under the stimulus $$$ because we would have never engaged them had it not been for COVID-19.

**CHC CHOOSES NEW ELECTRONIC MEDICAL RECORD SOFTWARE**

As you may remember, we were informed by Cerner in October 2019 that they would be abandoning their HomeWorks/RoadNotes product on 12/31/20 and no longer providing support. Cerner has been our EMR since November 2010. We began seeking a new EMR vendor and started scheduling demos last November. We looked at four major vendors and each demo lasted about five to six hours, starting with in-person demos until the pandemic caused them to move to virtual. We followed up with each of them and called back one vendor for another look and decided. We have chosen MatixCare/Brightree as our new EMR vendor. This was also the company that Cerner recommended last year although that did not have any real weight on our determination. Earlier this year, MatrixCare/Brightree's Home Health and Hospice EMR solution earned Best in KLAS honors, receiving a top-ranked score of 87.1 in this year's "Best in KLAS: Software & Services" report. The software offering surpassed the average for home health and hospice EMR vendors by more than 6 points. Best in KLAS winners are determined annually through extensive surveys and interviews with healthcare providers on the efficiency and quality of health IT products. KLAS research methodology rates and ranks vendors according to their ability to meet certain current and future expectations. Vendors are evaluated on six key categories: culture, operations, product, relationship, value, and loyalty. MatrixCare/Brightree's Home Health & Hospice EMR solution saw a 12-point improvement over the last two years. This is a cloud-based system and the device for our clinical staff in the field will be iPads. I do not believe anybody will miss lugging the laptops around. While switching to a new EMR is daunting and frustrating adventure, I believe once we are up and running the new interfaces, increased efficiencies, and streamlined reporting opportunities it will all be well worth it. We have a "Go LIVE" date of October 1 and we will be very busy on this project over the next few months.

**RACLIN HOUSE UPDATE**

Raclin House is still not open. We waited quite a while for our Life Safety Code Survey from the Indiana State Department of Health (IDSH). When that inspector arrived on April 29th, he had been on lock down at home for the prior three weeks. We received our report and there were some corrections that needed to be made, most of them very easy. We submitted our Plan of Correction within the time frame required and still awaiting to see whether that has been accepted. While we have been told, this is all we needed to do, the ISDH is now saying we need to have a "health facilities" survey to see if we meet the regulations at 42 CFR 484.110- Hospices that Provide Inpatient Care Directly. This is completely new to us. We did not have such a survey when we opened South Bend in 1996 and no such survey has ever been performed at the Elkhart IPU since it opened eleven years ago. Further, ISDH is now saying they cannot do such a survey because CMS has a ban on such surveys due to COVID-19 and no such surveys will be permitted until CMS lifts the ban. Part of this is probably due to CMS demanding that all states survey all nursing homes in the state for infection control issues due to COVID-19 by 7/31/20 or risk losing their HHS Stimulus funding. Presumably, all surveyors have been assigned to this nursing home project to keep their funding. From what I read; Indiana is not the only state way behind in these nursing home surveys. For hospice and home health, according to the ISDH website, the hospice and home health surveyors now only total just four Public Health Nurse Surveyors as of 1/07/20. I have heard through my contacts in Indy, that the ISDH is very understaffed and having a difficult time. I have contacted authorities there to inquire about this "health facilities" survey and whether we had to have patients on hand for the survey to be performed. During such a survey, they are supposed to be checking IPU plans of care, staffing, etc. and if there are no patients, this obviously cannot be inspected. I have received no return emails on my questions at the time of this writing.

**2020 – 2022 HR POLICY MANUAL**

The Executive Committee, acting as the Personnel Committee, has reviewed and unanimously approved changes to the 2020- 2022 HR Policy Manual. This takes place every two years and this time around there were few changes. The changes are listed as an attachment to this report. The entire DRAFT 54-page manual for the next two years is posted to the board website. Regarding changes of note, we have updated the Flex Spending policy and lifted IRS language directly, published the end date for receipt reimbursement, and clarified how this affects terminated employees regarding their flex accounts. This is reflected under Employee Benefits. During our recent financial audit, Kruggle & Lawton indicated a potential problem with our Vacation Exchange policy that has been in effect for the last 12 years. According to K&L, if staff cash in vacation days without taking some kind of "haircut" the IRS will view this as taxable income. To avoid this, the IRS will let it go if there is at least a 10% haircut for cashing in the days. Over the years this has been an important benefit for some staff, particularly those who have used it for assisting with college tuition payments. K&L says these changes will now bring us into line with what the IRS is looking for. This is also reflected under Employee Benefits.

**NATIONAL HOSPICE EXECUTIVE ROUNDTABLE MET VIA ZOOM IN MAY**

The National Hospice Executive Roundtable (NHERT) was scheduled to meet in-person at member program Delaware Hospice in Wilmington, DE on May 3 – 5. This did not happen, but we did meet

virtually via MS Teams for over four hours on 5/4 and 5/5. Discussion items included: "Mini Program Updates" focused on sharing near term learnings about the COVID 19 situation; initial reflections about the future vis a vis our "customers": do things go back to normal/defined as before COVID 19, what is likely to change short term/medium term, what might we be needing to start acting upon in terms of our "relationships" and how we do business with hospitals, LTC, ALF, physicians and payors; might the carve-in be particularly "opportunistic" if the alternative is restricted access with referral sources?; what are possible big picture opportunities for us, which might include not just "using telehealth" but the bigger idea of "might we want/see secular change in terms of paying for outcomes and not interventions and as a result, needing to know more about each?; is this the moment where it is actually "OK" to talk about less "local jobs" because having local IT vs. the cloud puts you at risk as an organization, because trying to have all infrastructure to support your organization locally puts you at risk; and is this the moment, not just because of/in response to COVID 19, that we "reset" our overall cultures in terms of the roles/responsibilities of all staff in "promoting" our organization, helping us grow? Should marketing be in everybody's job description?

Additionally, the NHERT has been having virtual calls via MS Teams every Thursday afternoon for two hours specifically on COVID-19 matters. We are sharing experiences, solutions, best practices, unexpected problems, and real horror shows. I have found these calls to be very beneficial. We are clearly in better shape than most other member programs. One member has an inpatient unit that takes up an entire floor of a hospital. The two floors above them were the COVID-19 floors. Three staff tested positive and the local county health department described it as an "outbreak", and it got into the local media. Another member has 25 staff test positive, two were hospitalized and were on the hospice program's partially self-insured group health insurance plan and both hit the stop gap in less than 72 hours. One member in California reports a native American reservation near their office has 300+ positive people. Another reported their HHS Stimulus funding was $1.9MM more than what they should have received, and they are not sure how to return it. All NHERT members are reporting a decrease in their IPU census. One reported new admissions were down 25% while another reported their average monthly admissions were running 220 a month and May had dropped to 119.

The NHERT now is comprised of the CEOs form 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

## BOARD COMMITTEE SERVICE OPPORTUNITIES

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

## BOARD EDUCATION SECTION

The board education section will be "CHC Market Trends with Increased Competition thru the Year." This was a board member requested topic earlier this year. Craig Harrell will present based upon the only data we have available which is Medicare Hospice Fee for Service.

## OUT AND ABOUT

Since the last board meeting, Mike Wargo, Chris Taelman, and Crossroads Campaign chair, Catherine Hiler, went to Tampa and Naples, FL for events and meetings with donors February 25-28.

Many of us presented the one-credit course "Introduction to Hospice and Palliative Care" over several afternoons in mid-March at the University of Notre Dame. Presentations were either recorded ahead of time or presented over Zoom. Multiple staff were involved in these presentations which were well received. This undergraduate class is presented every third semester in collaboration with the Ruth M. Hillebrand Center for Compassionate Care in Medicine at Notre Dame.

I was a guest lecturer in Jesse Hsieh, MD's University of Notre Dame MBA class, Transformations in Healthcare Innovations, speaking on the topic of "End of Life Care in America" via Zoom on April 21st. This took place at Jesse's office and went very well.

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

Dave Haley's Census Charts.

Karl Holderman's Monthly dashboard summaries.

CHC Volunteer Newsletters for March, April, and May.

Board Committee Opportunity Sheet

**HARD COPY BOARD ITEMS TO BE DISTRIBUTED AT THE MEETING**

Year-to-date April 2020 CHC Financials.

Hard copy of the 2019 financial audit by Kruggel Lawton, CPA.

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

Common Abbreviations (always handed out at board meetings)

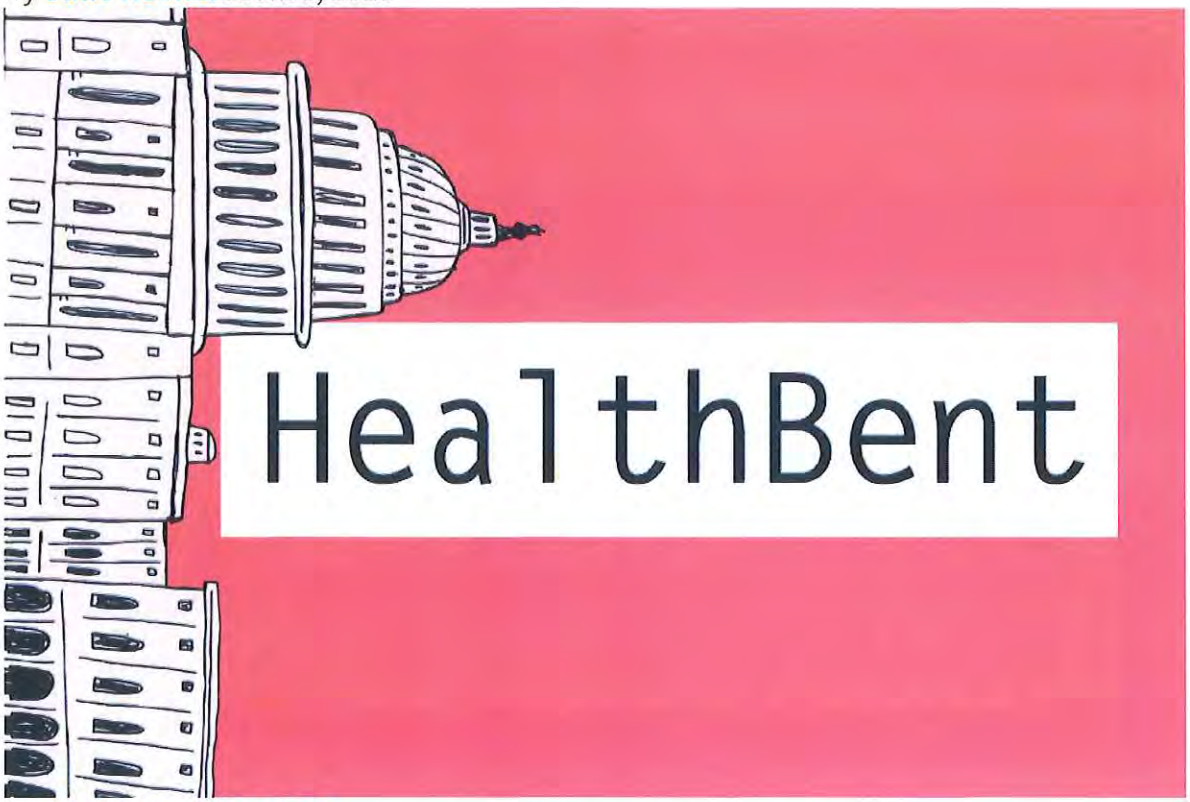
**NEXT REGULAR BOARD MEETING**

Our next regular Board Meeting will be **Wednesday, August 19, 2020 at 7:15 AM** in Conference Room A, first floor at the Mishawaka Campus, 501 Comfort Place, Mishawaka, IN 46545. In the meantime, if you have any questions, concerns, suggestions or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org .

# # #

# Rapid Changes To Health System Spurred By COVID Might Be Here To Stay

By **Julie Rovner** JUNE 8, 2020




**ABOUT HEALTHBENT**

KHN's chief Washington correspondent, Julie Rovner, who has covered health care for more than 30 years, offers insight and analysis of policies and politics in her regular HealthBent columns.

The U.S. health care system is famously resistant to government-imposed change. It took decades to create Medicare and Medicaid, mostly due to opposition from the medical-industrial complex. Then it was nearly another half-century before the passage of the Affordable Care Act.

But the COVID-19 pandemic has done what no president or social movement or venture capitalist could have dreamed of: It forced sudden major changes to the nation's health care system that are unlikely to be reversed.

"Health care is never going back to the way it was before," said Gail Wilensky, a health economist who ran the Medicare and Medicaid programs for President George H.W. Bush in the early 1990s.

Wilensky is far from the only longtime observer of the American health care system to marvel at the speed of some long-sought changes. But experts warn that the breakthroughs may not all make the health system work better, or make it less expensive.

That said, here are three trends that seem likely to continue.

**Telehealth For All**

Telehealth is not new; medical professionals have used it to reach patients in rural or remote settings since the late 1980s.

But even while technology has made video visits easier, it has failed to reach critical mass, largely because of political fights. Licensing has been one main obstacle – determining how a doctor in one state can legally treat a patient in a state where the doctor is not licensed.

The other obstacle, not surprisingly, is payment. Should a video visit be reimbursed at the same rate as an in-person visit? Will making it easier for doctors and other medical professionals to use telehealth encourage unnecessary care, thus driving up the nation's $3.6 trillion health tab even more? Or could it replace care once provided free by phone?

Still, the pandemic has pushed aside those sticking points. Almost overnight, by necessity, every health care provider who can is delivering telemedicine. A new survey from Gallup found the number of patients reporting "virtual" medical visits more than doubled, from 12% to 27%, from late March to mid-May. That is due, at least in part, to Medicare having made it easier for doctors to bill for virtual visits.

It's easy to see why many patients like video visits – there's no parking to find and pay for, and it takes far less time out of a workday than going to an office.

Doctors and other practitioners seem more ambivalent. On one hand, it can be harder to examine a patient over video and some services just can't be done via a digital connection. On the other hand, they can see more patients in the same amount of time

and may need less support staff and possibly smaller offices if more visits are conducted virtually.

Of course, telemedicine doesn't work for everyone. Many areas and patients don't have reliable or robust broadband connections that make video visits work. And some patients, particularly the oldest seniors, lack the technological skills needed to connect.

**Primary Care Doctors In Peril**

Another trend that has suddenly accelerated is worry over the nation's dwindling supply of primary care doctors. The exodus of practitioners performing primary care has been a concern over the past several years, as baby boomer doctors retire and others have grown weary of more and more bureaucracy from government and private payers. Having faced a difficult financial crisis during the pandemic, more family physicians may move into retirement or seek other professional options.

At the same time, fewer current medical students are choosing specialties in primary care.

"I've been trying to raise the alarm about the kind of perilous future of primary care," said Farzad Mostashari, a top Health and Human Services Department official in the Obama administration. Mostashari runs Aledade, a company that helps primary care doctors make the transition from fee-for-service medicine to new payment models.

The American Academy of Family Physicians reports that 70% of primary care physicians are reporting declines in patient volume of 50% or more since March, and 40% have laid off or furloughed staff. The AAFP has joined other primary care and insurance groups in asking HHS for an infusion of cash.

"This is absolutely essential to effectively treat patients today and to maintain their ongoing operations until we overcome this public health emergency," the groups wrote.

One easy way to help keep primary care doctors afloat would be to pay them not according to what they do, but in a lump sum to keep patients healthy. This move from fee-for-service to what's known as capitation or value-based care has unfolded gradually and was championed in the Affordable Care Act.

But some experts argue it needs to happen more quickly and they predict that the coronavirus pandemic could finally mark the beginning of the end for doctors who still charge for each service individually. Mostashari, who spends his time helping doctors make the transition, said in times like these, it would make more sense for primary care doctors to have "a steady monthly revenue stream, and [the doctor] can decide the best way to deliver that care. Unlimited texts, phone calls, video calls. The goal is to give you satisfactory outcomes and a great patient experience."

Still, many physicians, particularly those in solo or small practices, worry about the potential financial risk – particularly the possibility of getting paid less if they don't meet certain benchmarks that the doctors may not be able to directly control.

But with many practices now ground to a halt, or just starting to reopen, those physicians who get paid per patient rather than per service are in a much better position to stay afloat. That model may be gain traction as doctors ponder the next pandemic, or the next wave of this one.

**Hospitals On The Decline?**

The pandemic also might lead to less emphasis on hospital-based care. While hospitals in many parts of the country have obviously been full of very sick COVID patients, they have closed down other nonemergency services to preserve supplies and resources to fight the pandemic. People with other ailments have stayed away in droves even when services were available, for fear of catching something worse than what they already have.

Many experts predict that care won't just snap back when the current emergency wanes. Dr. Mark Smith, former president of the California Health Care Foundation, said among consumers, a switch has been flipped. "Overnight it seems we've gone from high-touch to no-touch."

Which is not great for hospitals that have spent millions trying to attract patients to their labor-and-delivery units, orthopedic centers and other parts of the facility that once generated lots of income.

Even more concerning is that hospitals' ability to weather the current financial shock varies widely. Those most in danger of closing are in rural and underserved areas, where patients could wind up with even less access to care that is scarce already.

All of which underscores the point that not all these changes will necessarily be good for the health system or society. Financial pressures could end up driving more consolidation, which could push up prices as large groups of hospitals and doctors gain more bargaining clout.

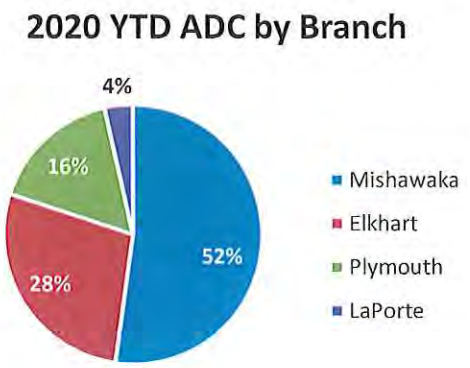
But the changes are definitely happening at a pace few have ever seen. Said Wilensky, "When you're forced to find different ways of doing things and you find out they are easier and more efficient, it's going to be hard to go back to the old way."

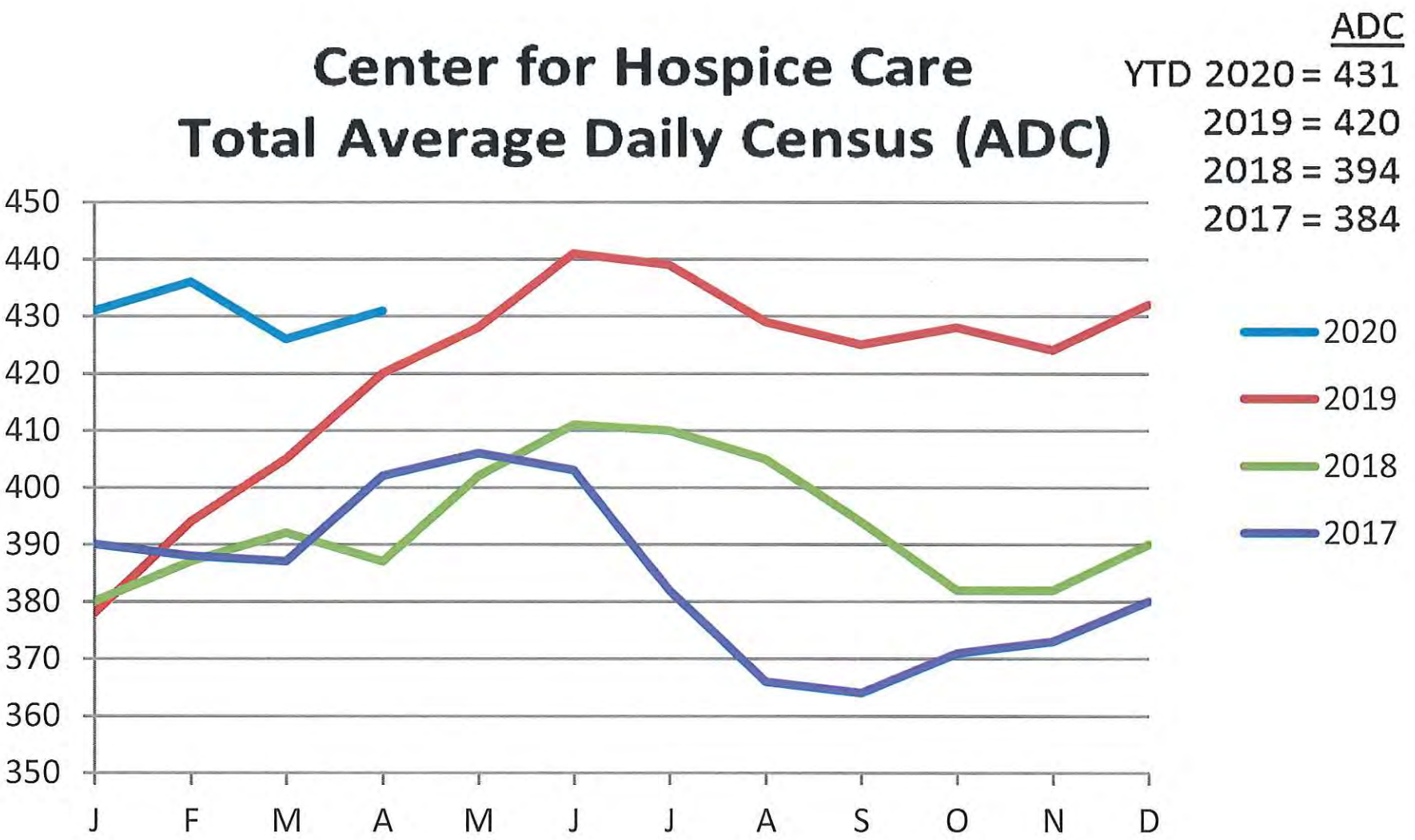
Julie Rovner: jrovner@kff.org, @jrovner

## 2020 YTD Average Daily Census (ADC)

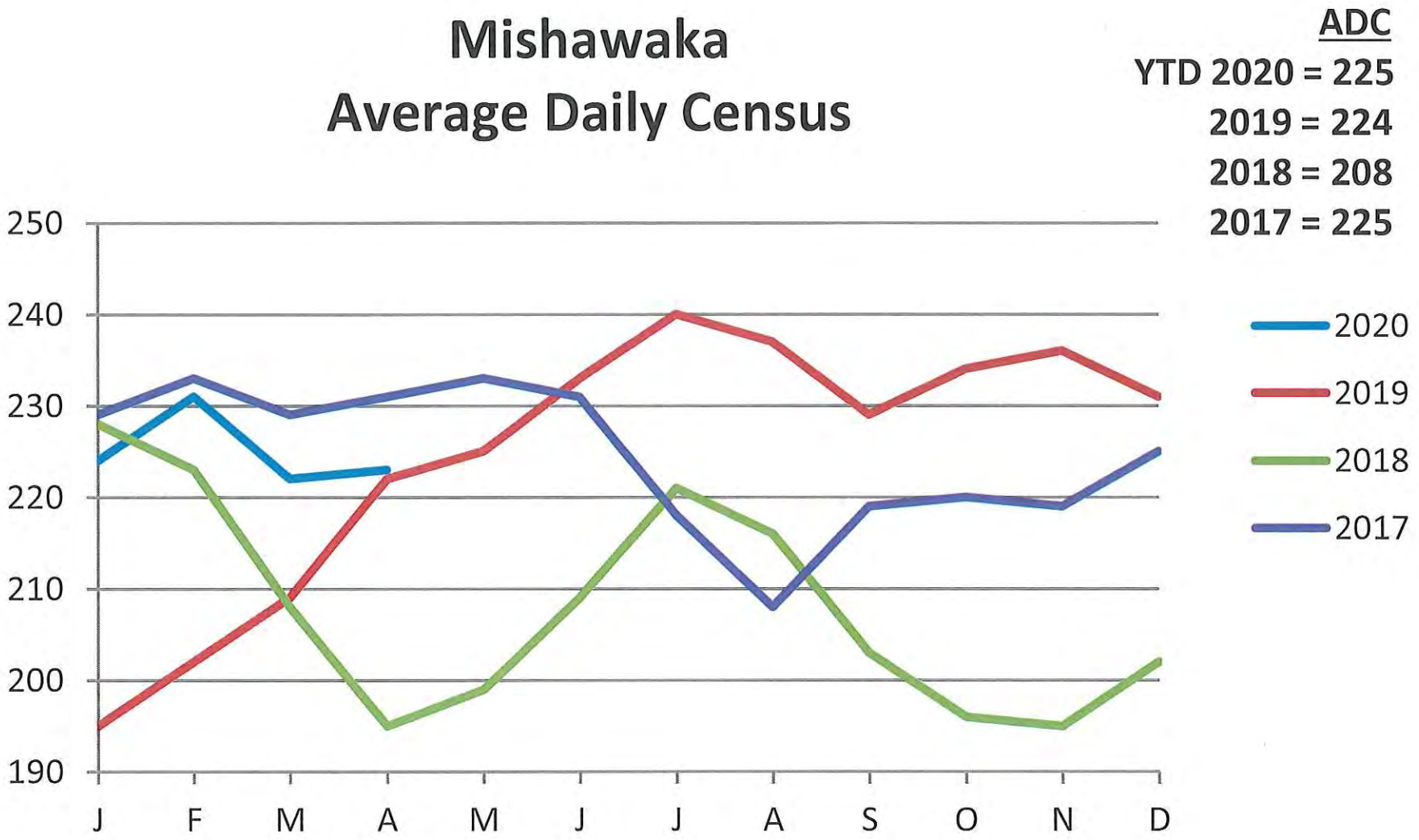
(includes Hospice House and Home Health)

| | All | Mishawaka | Elkhart | Plymouth | LaPorte |
|---|---|---|---|---|---|
| J | 431 | 224 | 124 | 70 | 14 |
| F | 436 | 231 | 118 | 70 | 17 |
| M | 426 | 222 | 119 | 70 | 15 |
| A | 431 | 225 | 120 | 71 | 16 |
| M | | | | | |
| J | | | | | |
| J | | | | | |
| A | | | | | |
| S | | | | | |
| O | | | | | |
| N | | | | | |
| D | | | | | |
| 2020 YTD Totals | 1724 | 902 | 481 | 281 | 62 |
| **2020 YTD ADC** | **431** | **225** | **120** | **71** | **15** |
| 2019 YTD ADC | 399 | 207 | 98 | 77 | 18 |
| YTD Change 2019 to 2020 | 32 | 18 | 22 | -6 | NA |
| **YTD % Change 2019 to 2020** | **8.0%** | **8.7%** | **22.7%** | **-7.8%** | **NA** |

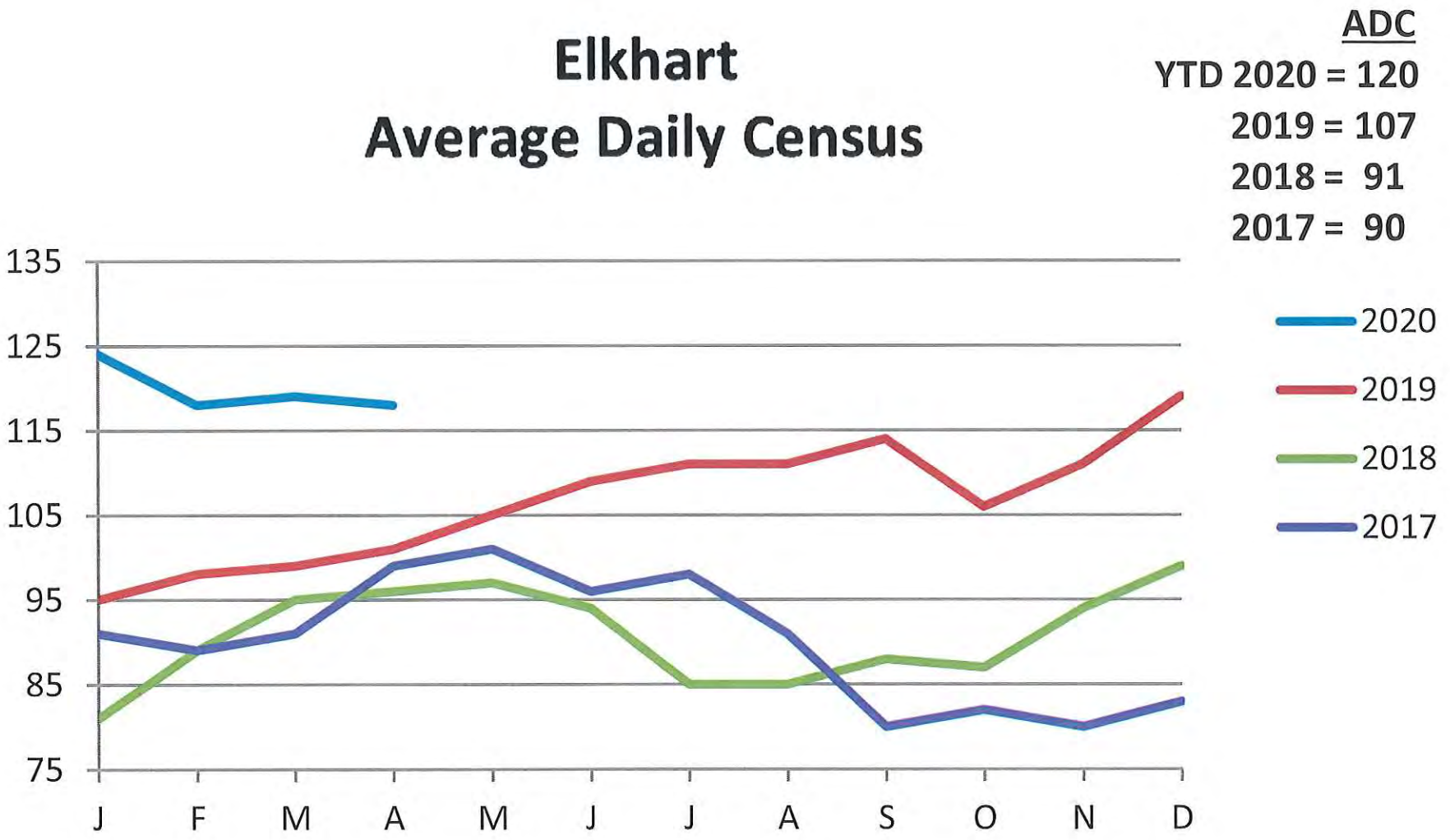


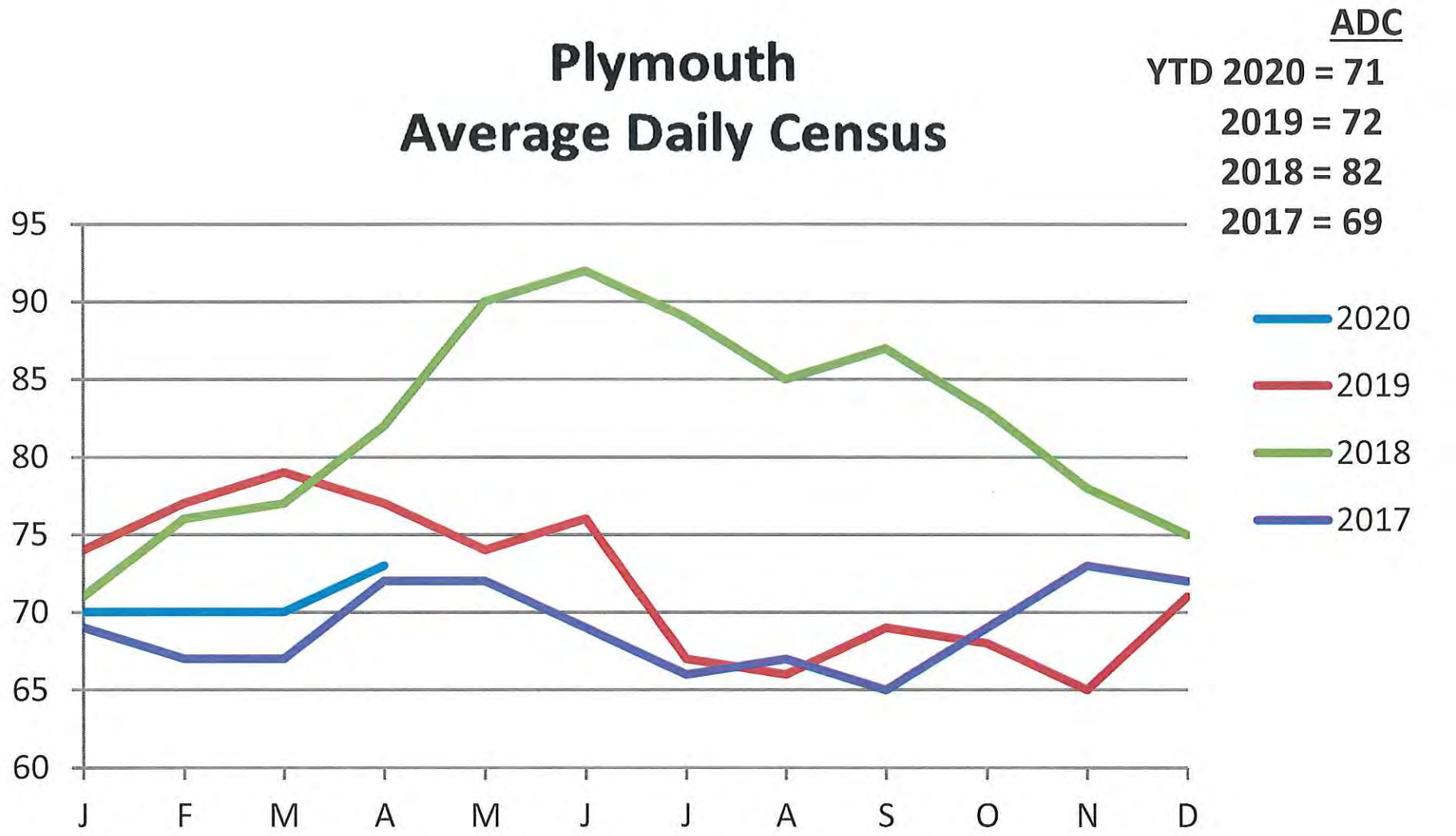

Center for Hospice Care
Total Average Daily Census (ADC)
ADC
YTD 2020 = 431
2019 = 420
2018 = 394
2017 = 384
450
440
430
420
410
400
390
380
370
360
350
J
F
M
A
M
J
J
A
S
O
N
D
2020
2019
2018
2017

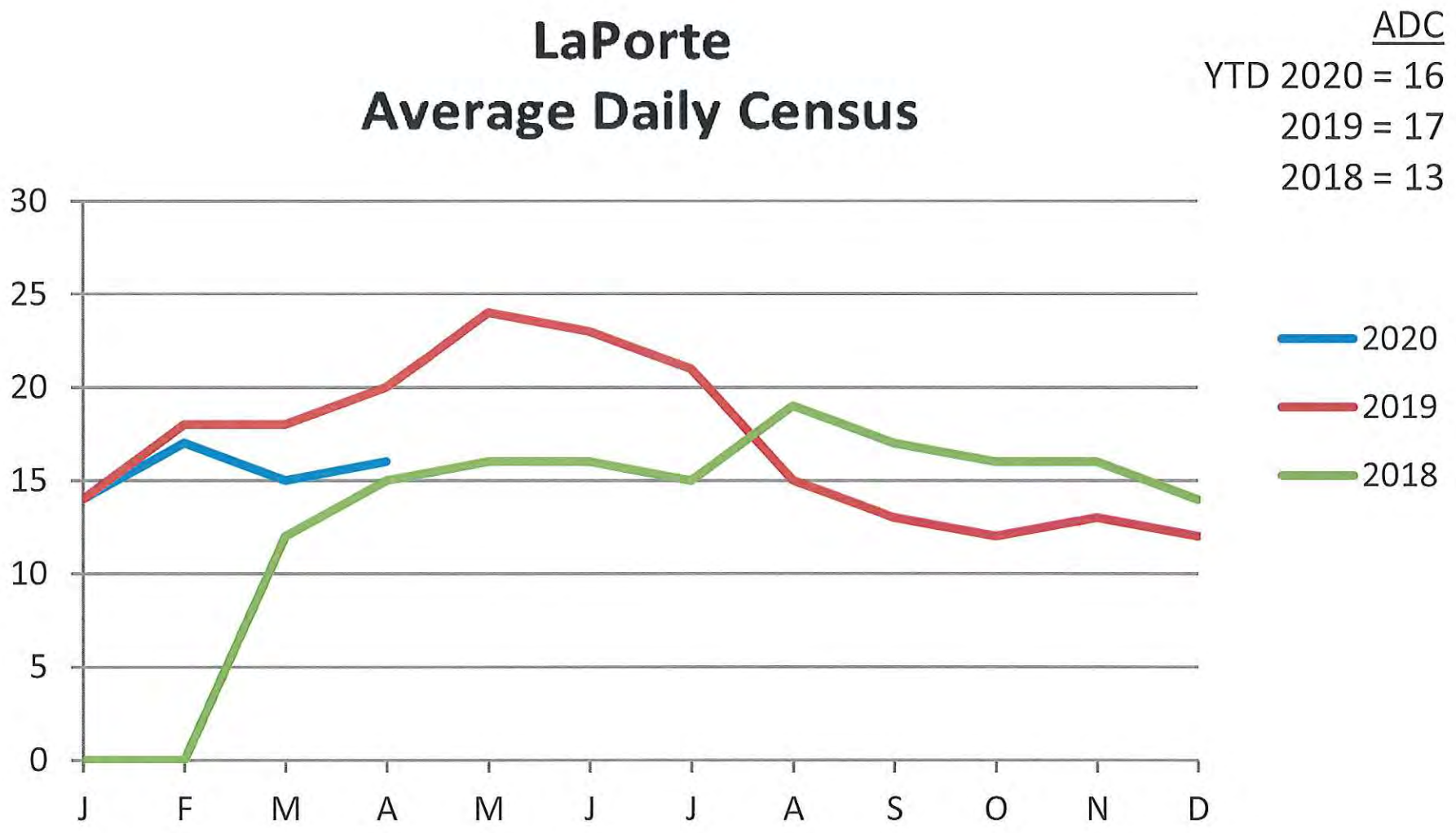
# Mishawaka
# Average Daily Census



# Elkhart
# Average Daily Census

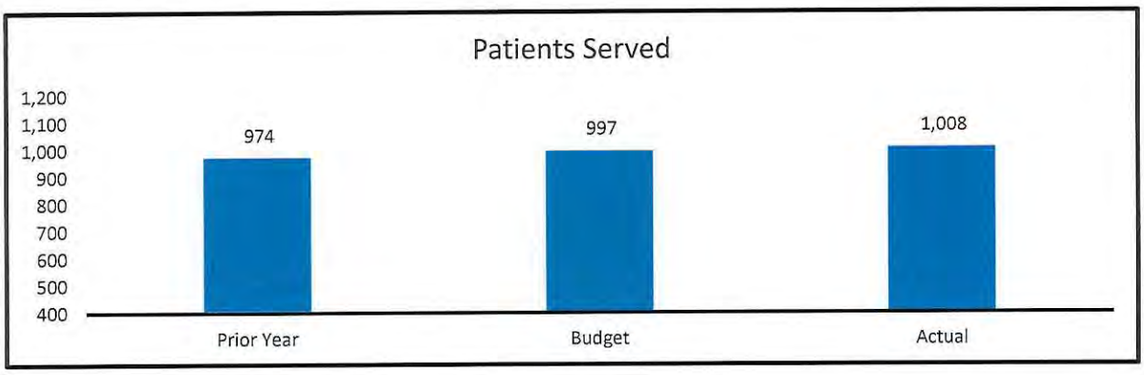



Plymouth
Average Daily Census
ADC
YTD 2020 = 71
2019 = 72
2018 = 82
2017 = 69
95
90
85
80
75
70
65
60
J
F
M
A
M
J
J
A
S
O
N
D
2020
2019
2018
2017

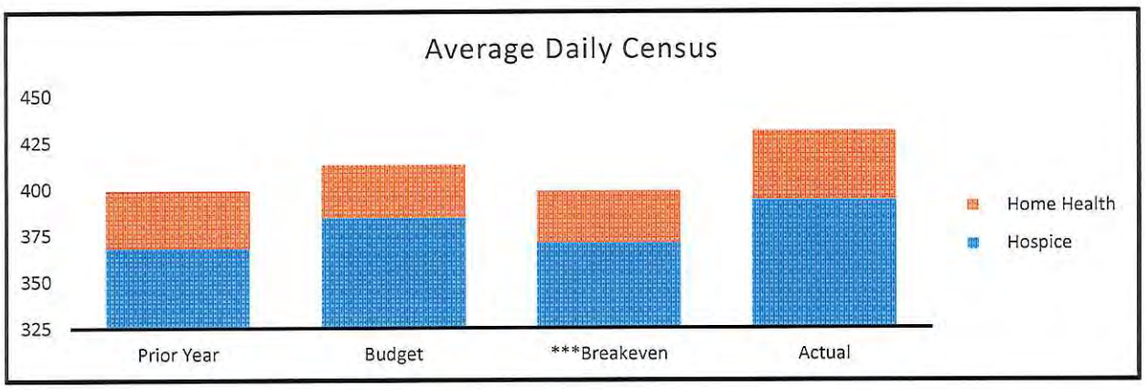

LaPorte
Average Daily Census
ADC
YTD 2020 = 16
2019 = 17
2018 = 13
30
25
20
15
10
5
0
J
F
M
A
M
J
J
A
S
O
N
D
2020
2019
2018

# Center for Hospice Care
## April 30, 2020

| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Patients Served** | **974** | **997** | **1,008** |

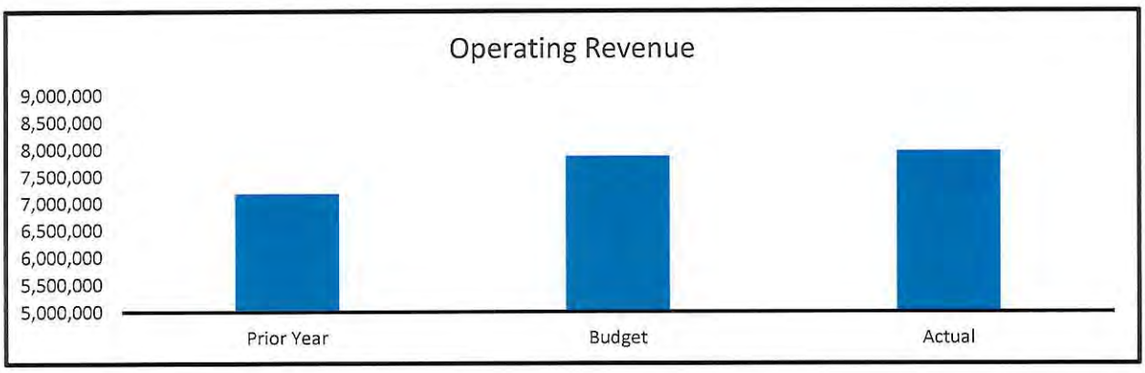



| **Average Daily Census** | **Prior Year** | **Budget** | *****Breakeven** | **Actual** |
|---|---|---|---|---|
| Hospice | 367.88 | 384.42 | 370.80 | 393.98 |
| Home Health | 31.20 | 28.67 | 27.66 | 37.02 |
| **Total Average Daily Census** | **399.08** | **413.09** | **398.46** | **431.00** |

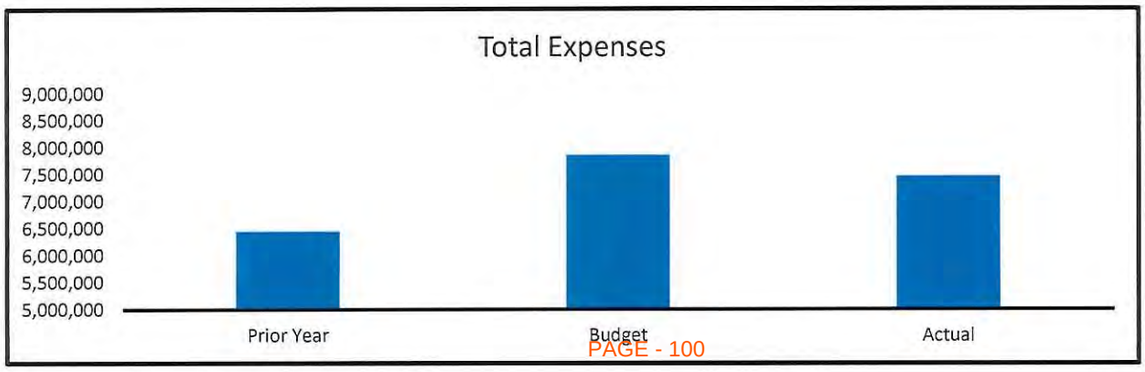



**** Budgeted Breakeven*

| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Operating Revenue** | **7,178,776** | **7,877,653** | **7,964,888** |




| | Prior Year | Budget | Actual |
|---|---|---|---|
| **Total Expenses** | **6,443,654** | **7,851,939** | **7,455,488** |



March 2020
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

# Q&A with CHC's new Medical Director: *Dr. Karissa Misner*

### Tell us a bit about your family and where you're from.

I grew up in Northern VA but both of my parents are originally from Indiana. My Dad grew up in Bremen and his brothers and sisters still live in this area. My husband, Matt, is a Pediatrician and works for Maple City Health Care Center in Goshen, IN. We have 3 children- Tyrian (age 2), Violet (age 8) and Lydia (age 10). Lydia and Violet attend Mishawaka Catholic School.

### Do you have any interesting hobbies or talents?

With 3 young active children,I don't have a whole lot of time for my own personal interests. When I do have free time, however, I enjoy reading motivational /faith based books. I find solace in attending mass. I like to cook with my daughters and create menus during the holidays and on special occasions with them. I can read old cookbooks for hours at a time.

### Why did you decide to go into the medical field?

I decided to go back to medical school after obtaining a Masters degree in physical therapy and working as a Physical Therapist for 5 years. I worked primarily in nursing homes and enjoyed taking care of the elderly population. I developed a strong interest in helping the elderly not only regain their strength and independence, but also found myself wanting to help take care of their medical issues.

### What is your background in medicine?

After medical school I did a 4 year residency at The Johns Hopkins Hospital in Baltimore, MD. I specialized in Physical Medicine and Rehabilitation since it aligned well with my experience as a physical therapist.

*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.

Nellie Vels, Mishawaka

Brother, Vance Swope

Tuesday, January 28, 2020

## Welcome to the Team

**Catherine Anderson**
Mishawaka CNA

**Libbie Bishop**
Triage RN

**Anita Youts**
Mishawaka RN

## Birthdays

3/1
Cindy Proffitt

3/2
Marne Austin

3/4
Richard Pipher

3/8
Lindsay Estrada

3/8
Harold Yoder

3/11
Penelope Hug

3/15
Joan Fitt

3/15
Julie Shamo

3/16
Ann Bowers

3/19
Erin Ryal

3/19
Fran Schuster

3/23
Anna Riblet

3/25
Sandra Witkowski

3/26
Linda Burrell

3/26
Flora Lee Stone

## Isolation

Excerpt taken from the book *Unscripted: Experiences of a Hospice Volunteer, the Joy in the Journey, and Thoughts on End of Life Care* by Lesley Andrus.

My patient had gone through a difficult time period in her life, experiencing extreme depression and attempting suicide. She had survived, moved to this small mountain town and started a new life. Now, however, with Parkinson's consuming her body, she was again having moments of depression.

"How do you deal with this sadness?" I ask.

"I try to live one moment at a time," she explains. "I get up in the morning and ask myself, "Do I shower this morning, or is it my day to swim? I go through my closet and pick out something colorful, something I haven't worn in a while to make me feel different from yesterday. I may remember something I heard on the news last night and decide to write my congressman, though I do need help for that as I can't see well and sometimes my shaky hand makes writing a little too difficult and impossible to read."

"Do you know why you feel sad?" I ask.

"Because I am alone. I am not really connected any more. I don't go out to the symphony, to the theatre, to dinner," her voice echoing in loss. She is tethered to an oxygen machine and while her caregiver does have a portable tank, it is an effort and now just used for those necessities, like doctor's appointments and therapy, or a few little personal things to make her feel better, like a haircut or manicure. There is so much less of a connection to the outside world.

"Also, everything I was is now gone," she explains. "Everything that defined me, or that I allowed myself to be defined by—I was a dancer, a mother, a producer, an assistant to an oceanographer, a wife, a lover. I am no longer these things. I am peripheral."

But it is not only the loss

*Continued on page 5*

# Volunteer Spotlight

## Dave Ricchiute, Mishawaka

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

A volunteer since 2016, I work as an extended care-facility companion—although, in each of the last three years, I've volunteered also at the one-day *Camp Evergreen Family Workshop*.

### Why do you volunteer with CHC?

CHC is the book-end opposite of my beginning-of-life volunteering at the Beacon Children's Hospital *Ronald McDonald House*. There's a common, and I think remarkable, resilience among CHC patients at the end of life and RMH parents navigating care in a young child's early life.

### What is a favorite quote?

Here's one among the many quotes I wish that I'd said first: "The best way to keep children at home is to make the home atmosphere pleasant and to let the air out of the tires." Dorothy Parker

### What is your favorite movie and why?

For the sheer number of quips that survive—some that ring with telling truth (e.g., "Forgive, forget. Life is full of misfortune.")—it's tough to beat *The Godfather* movies, made over 40 years ago.

### A bit about your family?

My wife, Jean, and I have two married children: Marc (Michaela), father of twins in Denver, and Kristin (Chad), mother of four near Cincinnati. How did I get along before them, the treasure that each one is to me now?

### Where are you from originally?

I was born and raised in Rhode Island—near the ocean, but not near enough—and have lived in the South Bend area since 1977.

"Dave's compassion and commitment are unwavering in his quest to serve others. He is an awesome volunteer who embraces the CHC mission to improve the quality of living for our patients."

*Debra Mayfield,*

*Mishawaka Volunteer Coordinator*

## Mark Your Calendars

NEW Volunteer Orientation

April 20, 23, 27, 2020

9:00am-12:00pm

April 29, 2020

9:00am-3:00pm

Mishawaka Campus

501 Comfort Place

Mishawaka, IN

Anyone interested must apply first.

Contact Kristiana Donahue at donahuek@cfhcare.org or 574-286-1198 with any questions.

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

### Time Sheet Procedures

- Make sure to use black ink
- Enter date of service—the date the visit was made
- Enter the patient's name—print and do not use nicknames
- Enter the length of time—this should include the visit time and the round trip travel time
- Enter the mileage to and from the patient's location
- Print your name
- Check the correct division
- Check the correct Patient Care Time Code for your visit
- Check all conditions of the patient that applied during your visit
- Complete Reporting Documentation section

  Be clear and concise, state facts only.

  Document only what you see and do—**Not what you think or believe**

  **Avoid** the following:

  Providing any judgments, thoughts, assessments or feelings.

  Using "White Out" or scratching out words.

  Making comparisons about the patient.

  For example: *The patient slept more today than last week.*
- Avoid the following words in documentation:

  Appeared

  Seemed

  Looks or Looked

  Think or Thought

  Feel or Felt
- Sign your name and date form
- Turn in the time sheet **directly following each patient visit.**

State regulations require time sheets be placed in patients' charts within seven days of a volunteer visit. This allows staff time to process the time sheet information

# Isolation

*Continued from page 2*

of identity that she feels now. In her mind there is something worse—"I have nothing to offer," she says. "I am just here, waiting for people to come to me, for something to happen to me."

How do I tell her how untrue is her last statement? How can I even describe what she has given to me? Two days a week for over two years she has shared her life, her hopes, her dreams, her regrets. We have lively debates about the state of the world, religion, prejudice, technology, the environment, immigration, health, children, friends. She has stimulated my brain, made me think, and now she is my editor, helping me share all these stories.

She still has her interest in the world, her imagination and her sense of humor. It is hard to focus on these things when her physical life, like her vision, continues to dim, and daily she becomes less connected to everything around her. How can we give our patients a sense of purpose in light of these physical failings?

Then I realized that

- By listening to the stories of her life, I am validating her existence
- By bringing in articles to discuss and debate, I am acknowledging the importance of her opinion
- By writing about her thoughts and feelings, I am allowing her to leave written evidence of her life
- By soliciting her opinion and editorial comments on my stories, I am giving her an opportunity to contribute
- By simply listening I am telling her how important she is to me, how much needed.

All of these activities give her a purpose, something to look forward to, a validation of her worth, her being, her life. I tell her.

# 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.

Tonya Emmerke
Mishawaka

Lindsay Estrada
Elkhart

Marin Gorman
Mishawaka

# Comments from Our Families

- Since my experience with hospice, I have told many other people about the excellent experience I had with hospice members from nurses, doctors, aides, and chaplains. My wife received better care from CHC than she did from the hospital.
- CHC was a tremendous support and comfort for my dad and my family in his last days. The nurse was compassionate, kind and loving. They continue to care for my mom and give her all she needs.
- A special thank you to the bath person who did an outstanding job way beyond making him comfortable and soothed.
- Wonderful experience. The help and concern for our needs the day of the death was superb. Amazing kindness and caring.

*Continued from page 1*

I practiced for 10 years in this specialty, working as Medical Director of several inpatient rehabilitation units.

### When were you introduced to hospice care?

I have known about hospice care for quite some time now, as I spent 5 years working in nursing homes prior to going to medical school. I was always interested in end of life care and tried to refer my patients sooner rather than later to hospice if they qualified. My grandmother lived in our home under hospice care while I was in residency training.

### Why do you want to work in hospice care?

My husband and I served as medical missionaries in Arequipa, Peru for 2 years. Our children came with us. I cared for a number of dying/critically ill patients there with very little resources. I had always been interested in hospice care, but my experiences in Peru solidified my passion for caring for people at the end of life.

### What are you most looking forward to as Medical Director at CHC?

We have a very diverse medical staff, each with different personalities and gifts. I am looking forward to developing our medical staff so that they can each utilize and grow their own special talents. I am also hoping to develop strong, cohesive relationships between the medical staff and all of the other disciplines.

### What visions/dreams do you have for the work we do?

We all have a very important role to play in the last chapter of our patients' lives. We, as clinical staff members, witness death and dying on a daily basis . We cannot forget, however, that for each of our patients, it is their only death. Each patient is an individual with their own wishes about how their end of life should look and we need to help them write their last chapter the way they envision it.

### Any other words?

Center for Hospice Care is a large hospice-the largest not for profit hospice in the state of Indiana. Being that big is a blessing, but we need to remember that the quality of the care we give to our patients is more important than the numbers. Each person at the Center for Hospice Care has an important role to play for the people that choose to have their care under us-from the janitor to the billing office. In order for us to do an awesome job at caring for our patients, we all need to work together.

*Each patient is an individual with their own wishes about how their end of life should look and we need to help them write their last chapter the way they envision it.*

April 2020
Volunteer Newsletter

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

# Appreciating What You Do


The volunteer department is usually gearing up for our annual volunteer appreciation luncheon in April. With the spread of COVID-19 amongst not only our nation but our world, the appreciation luncheon is unfortunately postponed. Our department loves this time of recognition where we can gather together and celebrate the work you all do daily. Whether you provide respite in patient homes, to tuck-in calls, to haircuts, veteran pinnings and office support, our agency is so grateful for the support given to us.

Our volunteers are as diverse as our patients and the gifts and talents you bring are immeasurable. If we quantify the value of volunteers to CHC, volunteers provided over 15,000 hours in 2019, equating to 7.5 full time employees who never got sick or took vacations. Our volunteers saved CHC over $418,000 in expenses. This is indeed something to be proud of. However, I want to add that the value of volunteers to individual patients and families goes even deeper. To be the compassionate community for those we care for is something that has lasting benefits.

Many of you may be able to relate to the following story. This is an excerpt from the book *Unscripted: Experiences of a Hospice Volunteer, the Joy in the Journey, and Thoughts on End of Life Care* by Lesley Andrus. No price tag can be placed on this snapshot of what many of you do every single day.

## Chapter Title: Touch

*I must have been destined to be the one there at the end. It was my very first assignment as a hospice volunteer. It was to be a very simple assignment—just sit with this woman who was not conscious while her husband took the dog for a walk and bought groceries. I did have to change a bandage, but otherwise that first afternoon was uneventful, except for the touch.*

*They had been married for a long time. Their 60th anniversary had likely long passed. He was a gentle, very quiet man. He walked slowly. She was bathed and dressed and made comfortable in a hospital bed which took up all the space in their small apartment living room. When he returned from his walk, he came straight to her. He touched her face. "Would you like some water?" he*

*Continued on page 6*

**Inside this issue:**

## Welcome to the Team

**Tierra Easton**
Clinical Documentation Specialist

**Clarissa Gentry**
Plymouth CNA

**Alex Holloway**
Plymouth RN

**Eva Justice**
Elkhart CNA

**Julie Kawalski**
Accounting Manager

**Aubrey Minies**
Bereavement Assistant

**Michelle Newer**
Triage RN

**Chrystal Pletcher**
Elkhart Receptionist

**Jonah Wilder**
South Bend IPU RN

**Erika Woods**
Referral Specialist

## Birthdays

4/2
Patricia Lawton
4/4
Carmen Sheets
4/7
Patrick Kuzan
4/9
Steve Bussman
4/10
Stephen Dinehart
4/10
Susan Fron
4/12
Beth Davis
4/13
Linda Williams
4/15
Linda Wruble
4/17
Kathryn Brown
4/20
Paul Go
4/22
Terry Trimmer
4/23
Margaret Stutzman
4/24
Julie Schlundt
4/25
Jan Atwood
4/25
Marlene Taylor
4/26
Jeanette McKew
4/29
Jean Lucas
4/29
Dennis Thornton

## COVID-19 Q&A

### Are all volunteer services shut down at this time?

At this time, per our President/CEO Mark Murray, there will be no volunteer activities (home visits, facility visits, IPU visits / staffing, tuck-in calls, administrative activities at CHC facilities, etc.) until further notice. We appreciate all that you do and hope that we are able to get back to normal soon, but until then, we ask that you all do your best to remain safe and healthy.

### Is wearing rubber gloves while out in public effective in preventing the new coronavirus infection?

No. Regularly washing your bare hands offers more protection against catching COVID-19 than wearing rubber gloves. You can still pick up COVID-19 contamination on rubber gloves. If you then touch your face, the contamination goes from your glove to your face and can infect you.

(from WHO)

### Who is at risk of developing severe illness?

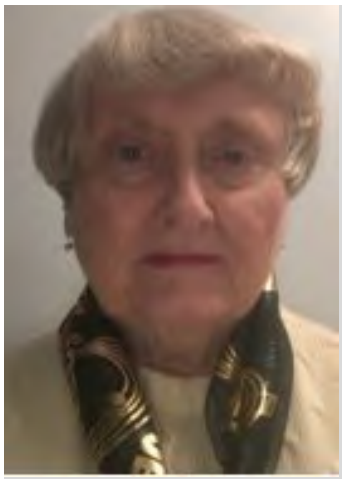
While we are still learning about how COVID-2019 affects people, older persons and persons with pre-existing medical conditions (such as high blood pressure, heart disease, lung disease, cancer or diabetes) appear to develop serious illness more often than others.

(from WHO)

*Continued on page 5*

# Volunteer Spotlight

## Sharon Marshall, Mishawaka



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

I am an Assistant Grief Facilitator. I started out doing clerical work in the office in Roseland around 2007. Then I took training to visit patients. I did that until September 2011. My husband died in 2012, and I joined several grief groups. When I graduated from the groups, I started facilitating in grief groups. I am still doing that.

**Why do you volunteer with CHC?**

I like to give back for the help I received. My mother and husband were both in Hospice care when they died.

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

Holland, because my grandparents immigrated from there. I was able to go to Ireland and meet family of my fraternal grandfather, and I'd love to do the same with my maternal grandparent's family in Holland

**What is your favorite quote?**

Philippians 4:4 "Rejoice in the Lord always, again I will say rejoice."

**What do you like to do in your spare time?**

I really enjoy the fact that I can do so much with it. I volunteer in the gift shop at St. Joe Hospital and I am secretary on our HOA Board. I visit two women who are shut-ins, one at Creekside Village and another at home.

**Tell us a bit about your family.**

My husband is deceased. I have a son who lives in Mishawaka, and a daughter who lives in Madison, WI. I have five grandchildren, and two step grandchildren.

**Where are you from originally?**

I grew up in Hammond, IN, lived for a number of years in the Chesterton, Michigan City area and moved to Kentucky for ten years before moving here.

**What hobbies/talents do you enjoy?**

I spend a lot of time on my computer. I sew some, do puzzles, and like to read. I spend a good deal of time every day studying my Bible.

"As a volunteer, Sharon is dedicated to her role as a group co-facilitator. She brings her experience with grief to the group in a way that inspires group members and gives them hope that they too will survive their grief journey."

*Michele Guldberg,*

*Bereavement Counselor*

## Mark Your Calendars

### NEW Volunteer Orientation

April Volunteer Orientation has been postponed for a to be determined future date.

### Volunteer Recognition Luncheon

The Volunteer Recognition Luncheon originally scheduled for April 21, 2020 has been postponed for a to be determined future date.

### Mandatory Annual In-service

Tuesday, June 9, 2020

At this time, this event is still on the calendar; however, please stay tuned for more details regarding this event.

## Online Connecting

### Online Training Refresher Courses Available

While we have found ourselves with countless hours at home right now, some of us may have found it difficult to watch one more TV show or even do another home project. It is also hard to feel connected to the volunteer work we have come to love so much. While our volunteer service may need to take a break for now, we thought this might be a great time to refresh skills and re-learn the content that some of us may have learned years ago in volunteer orientation.

We have created some online refresher training courses that you can do from the comfort of your own home—your recliner, bed or kitchen table! While these aren't required trainings, we hope that it may simply enrich your skill set and keep you connected to your hospice volunteering. At this time, the following topics are ready for you:

- Changes at the End of Life
- Grief
- Hand Washing and PPE
- Empathy
- Dementia

If interested, please contact Kristiana Donahue at donahuek@cfhcare.org or (574) 286-1198.

### Level 2 Plus Annual Validation

I will be emailing Level 2 Plus volunteers who still have to complete their annual validations this year. All of this work can be done through online training. For those of you who don't have access to a computer or internet, don't worry, we will make sure that you have a means to complete it before the end of the year. This is a great time to complete your Level 2 Plus annual validation. If you have any questions, just contact me, Kristiana Donahue at donahuek@cfhcare.org or (574) 286-1198.

## Camp Evergreen Volunteers Needed!

We are in need of volunteers for the Camp Evergreen Weekend held June 5th – 7th for youth and teens ages 10 – 17 (18 if they're a senior in high school).

Please email evergreen@cfhcare.org for more information.

# COVID-19 Q&A

*Continued from page 2*

### What can I do to protect myself and prevent the spread of the disease?

Stay aware of the latest information on the COVID-19 outbreak, available on the WHO website and through your national and local public health authority. Many countries around the world have seen cases of COVID-19 and several have seen outbreaks. Authorities in China and some other countries have succeeded in slowing or stopping their outbreaks. However, the situation is unpredictable so check regularly for the latest news.
You can reduce your chances of being infected or spreading COVID-19 by taking some simple precautions:

- Regularly and thoroughly clean your hands with an alcohol-based hand rub or wash them with soap and water. Why? Washing your hands with soap and water or using alcohol-based hand rub kills viruses that may be on your hands.
- Maintain at least 1 metre (3 feet) distance between yourself and anyone who is coughing or sneezing. Why? When someone coughs or sneezes they spray small liquid droplets from their nose or mouth which may contain virus. If you are too close, you can breathe in the droplets, including the COVID-19 virus if the person coughing has the disease.
- Avoid touching eyes, nose and mouth. Why? Hands touch many surfaces and can pick up viruses. Once contaminated, hands can transfer the virus to your eyes, nose or mouth. From there, the virus can enter your body and can make you sick.
- Make sure you, and the people around you, follow good respiratory hygiene. This means covering your mouth and nose with your bent elbow or tissue when you cough or sneeze. Then dispose of the used tissue immediately. Why? Droplets spread virus. By following good respiratory hygiene you protect the people around you from viruses such as cold, flu and COVID-19.
- Stay home if you feel unwell. If you have a fever, cough and difficulty breathing, seek medical attention and call in advance. Follow the directions of your local health authority. Why? National and local authorities will have the most up to date information on the situation in your area. Calling in advance will allow your health care provider to quickly direct you to the right health facility. This will also protect you and help prevent spread of viruses and other infections.
- Keep up to date on the latest COVID-19 hotspots (cities or local areas where COVID-19 is spreading widely). If possible, avoid traveling to places – especially if you are an older person or have diabetes, heart or lung disease. Why? You have a higher chance of catching COVID-19 in one of these areas.

(from WHO)

# Comments from Our Families

- I did want to mention how helpful and considerate the hospice nurses were to my brother and I. When I asked questions about what was happening to him, they didn't belittle me or make me feel like I was a bother. They treated my brother and I with respect and it was very much appreciated.

- The nurse assigned gave her exceptional care and helped direct others to make sure she was comfortable. She spent time checking on the family each time. Two volunteers sat with her so the family could attend a wedding. Thank you for all the extra care and attention during a difficult time.

- Everyone was so nice and great, and to help me out with my mom. They were better than the doctor. I have no complaints, even the lady on the phone was so nice to help me out, and the nurse that helped me out the day my mom had died. You have a very good number of people that work at hospice.

Continued from page 1

*asked simply. There was no response, no indication that she even heard the soft, caring voice. He rubbed her arm so gently. He looked into her eyes though they were as opaque as clouded glass. He touched her face again and gently rubbed her head.*

*I felt honored to be in the presence of such love.*

*Though I was not scheduled to return the next day, I had time and offered to come. "How about 9:00?" I suggested. "No, I need to get her bathed and dressed first," he responded. "I can help you," I offered. "No, I want to do it. 10:00 will be fine."*

*The next morning the dog came to the door to greet me. I walked into the living room. He was sitting next to her. When he heard me, he stood only partially turning toward me, his eyes floating in tears. "She died 10 minutes ago," he whispered. I put my arms around him. Tears came to my eyes too. We sat next to each other and next to her, wet tissues filling our hands. We talked a little. I asked him to tell me about her. He got up and shuffled to the refrigerator where he took down a picture, handing it to me. A woman was riding a bike on the beach, a balloon trailing behind her. "We used to ride bikes and we camped. She loved flowers and balloons." He told me more about her. The quiet was warm and comfortable and so peaceful. I felt privileged once more, being in that room filled with gentle love and a lifetime of unspoken memories. Mostly I remember his touch.*

## thank you!

- *Your dedication is second to none and we are indeed blessed to have such wonderful persons working beside us helping to meet and exceed our services to the patients/ families we serve.*
  Caron Gleva, Development Clerk

- *Our volunteers give selflessly of their free time. Some work a full time job but still manage to find time to volunteer. They have true servants' hearts and it shows in everything that they do for Center for Hospice Care.*
  Chrystal Pletcher, Receptionist

- *I've gotten wonderful comments from my patients who have had the pleasure of volunteers coming on a regular basis. Many of them become like friends that the patients look forward to seeing each week, and the families appreciate having a moment of time to themselves. Our volunteers are such huge blessings to our patients & families.*
  Shanda Stevens, RN Hospice Case Manager

- *I so appreciate all of our volunteers and all of the varied support provided to our bereaved, our hospice families, our patients and staff. We could not do all that we do without your dedication and generosity with your time. Thank you!*
  Holly Farmer, Bereavement Coordinator

- *There is a tremendous strength that is growing in the world through sharing together, praying together, suffering together, and working together. ~Mother Teresa I have seen each and every volunteer living this out with our patients and families! They are the best!*
  Neil Davis, Chaplain

- *I appreciate the positive attitude and joy our volunteers bring. When I interact with them in homes, facilities, or at the office they are always so kind. The families feel this too and are so thankful for the veteran pinnings and respite care we are able to offer.*
  Leah Miller, MSW, LSW, Social Worker

- *We are so grateful to our event volunteers. Their enthusiasm for our mission and our work is contagious. They're there before the sun comes up to make sure everything is ready for our participants. They solve problems and help the staff keep things running smoothly. We can't thank them enough!*
  Cyndy Searfoss, Director of Education and Collaborative Partnerships

May 2020
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

# Adapting

## Staying Engaged When Life Changes

By: Kristiana Donahue

"Every Amish quilt has a defect in it somewhere, because only God is perfect" Esther shared. "My husband's great grandmother was Mennonite. I learned that through his family. I have an Amish quilt his grandmother had made. They dared me to find the defect. It's really small."

It may be hard to find Esther Miller inside her home at Southfield Village, as she is a very active lady. In the morning, she may be working on a puzzle, while in the afternoon she may be sewing blankets or dresses for children overseas. Esther finds that staying busy with meaningful activities is what makes her life significant, even with newfound limitations.

Esther is originally from Colorado Springs. She grew up learning about Native American lore. She would search for arrowheads at her aunt and uncle's cattle ranch, 50 miles from Colorado Springs. Born into a family of educators, Esther's grandparents taught in a one room schoolhouse. She fondly remembers McGuffey readers being present in that schoolhouse and she grew up read-

*Continued on page 6*

**Inside this issue:**

## Welcome to the Team

**Carolyn Burke**
Social Work Coordinator

**Steve Chupp**
Honoring Choices Coordinator

**Nicole Leiter**
Resource Social Worker

**Amanda McKinney**
Manager of HR & Volunteer Services

**Carrie Robinson**
South Bend IPU RN

**Denise Robles**
Plymouth LPN

## In Loving Memory

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

Cindy Proffitt, Mishawaka
Mother, Linda Sue (Butts) Croy
Tuesday, March 31, 2020

## Birthdays

5/1
Ilene New

5/4
John Huber

5/5
Lisa Svelmoe

5/10
Kathleen Gaspar

5/11
Allen Falls

5/12
Bill Probst

5/17
Janet Van De Veire

5/18
Connie Fisher

5/23
Pat Goeller

5/23
Cindy Kilgore

5/24
Betty Kay Eley

5/25
Loretta Blowers

5/25
Lynn Ward

5/29
Sarah Wargo

## What is Honoring Choices?

Honoring Choices®
INDIANA – NORTH CENTRAL

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

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

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

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

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

# Volunteer Spotlight

## Mary Jane Lawson, Mishawaka

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

I am currently a Volunteer Patient Home Visitor. I have been a volunteer with CHC since March 2016.

### Why do you volunteer with CHC?

I became a volunteer with CHC because my mother was diagnosed with chronic lymphocytic leukemia when I was a senior in high school. She died 13 years later when she was 62. I was only 31 years old and at the time of her death. I promised her as soon as I was no longer working I would volunteer for hospice. I kept that promise. I retired from a job I had held for 46 years on February 1, 2016. That month I signed up for volunteer training and have been a patient home visitor ever since.

### What is your favorite quote?

My favorite quote is from the book of Matthew 7:25-34. "*Therefore do not worry about tomorrow for tomorrow will worry about itself. Each day has enough trouble of its own.*"

### What is your favorite book?

My favorite book is *Gone with the Wind*. I first read it when I was 13 and my grandparents took me to see the movie shortly after. I love to read and am in a monthly book club. As a rule I tend to read historical fiction. I'm fortunate that I have a room with a rocking chair which is a perfect place to read in.

### What do you like to do in your spare time?

In my spare time, my husband and I take our rescue dog, Gus, on walks around the neighborhood or to nearby parks.

I am passionate about flower gardening both inside and out. My husband built me a fenced area for perennials with pathways to make it easier to weed. I always go to Varner's around Mother's Day and pick out flats of annuals to plant and make hanging baskets and large pots with all kinds of flowers.

My daughter-in-law is a manager of a large book store and provides me with all types of books to read. I turn to reading as my go-to stress reliever.

### Tell us a bit about your family.

I am originally from South Bend, IN. I met my husband, Greg of 46 years at Hillsdale College on a blind date. My husband and I have two married children. Our son Jonathan and his wife live here in town. Our daughter Jennifer and her husband have lived in Paris, France for over 3 years. She is a kindergarten teacher in a bilingual school. We have the good fortune of visiting her when we can. We add a different country each time we go to see her. Our other favorite place we visit is northern Michigan. We have a family cottage 32 nautical miles off the coast located on Beaver Island. I have been going there every year since I was 3 years old. My parents are both deceased and my family share the cottage with my two brothers and their families. It is a wonderful community and offers all sorts of opportunities for enjoying the beauty of nature.

"It's been said that volunteers are love in motion. That's a perfect way to describe Mary Jane! She enjoys meeting new patients and excels at connecting with them at their point of need. A visit from Mary Jane brightens everyone's day."

*Debra Mayfield, Mishawaka Volunteer Coordinator*

## Online Courses

We have online courses that current volunteers can take advantage of at anytime. These are meant to refresh skills and enrich your volunteer experience.

At this time, the following topics are ready for you:

- Changes at the End of Life
- Grief
- Hand Washing and PPE
- Empathy
- Dementia

If interested, please contact Kristiana Donahue at donahuek@cfhcare.org or (574) 286-1198.

### Level 2 Plus Annual Validation

This is a great time to complete your Level 2 Plus annual validation as it is available online. It is easy to complete and takes less than an hour. Many of you have completed it already; however, if you still need to do so, please contact Kristiana Donahue.

## June In-Service

Due to COVID-19, this year's June In-Service will not be held in person. We continue to exercise caution and care to keep everyone safe.
We will be offering two options to complete your mandatory annual in-service:

### 1. Mailed Packet

We will compile all the training information into a packet. Volunteers must read the material and complete and return the enclosed quizzes.

### 2. Online Training

Some volunteers have already utilized our online training. We will be offering the in-service material in the online training format. Online training allows users to view videos and take quizzes all on the computer or desired device.

### Contact your volunteer coordinator

Every volunteer needs to contact their volunteer coordinator to inform them of their preferred method of training. If you want to train using the online training, instructions will be emailed to you.

### Annual TB Testing

Volunteers who normally do annual TB tests will still need to complete their annual TB testing. We are working with our nursing department to devise a way to meet this requirement this year. We will update you with more information when we know more.

## Camp Evergreen Update!

In the face of the uncertainties presented by the coronavirus outbreak and a commitment to support the safety of our community, we have rescheduled the Camp Evergreen Weekend to

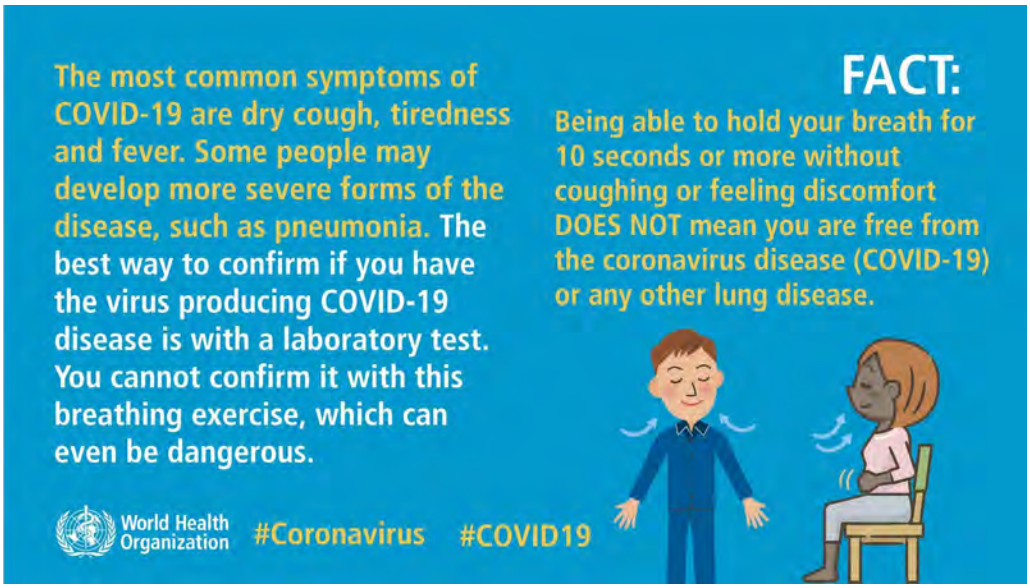
**Friday, August 21st – Sunday, August 23rd.**

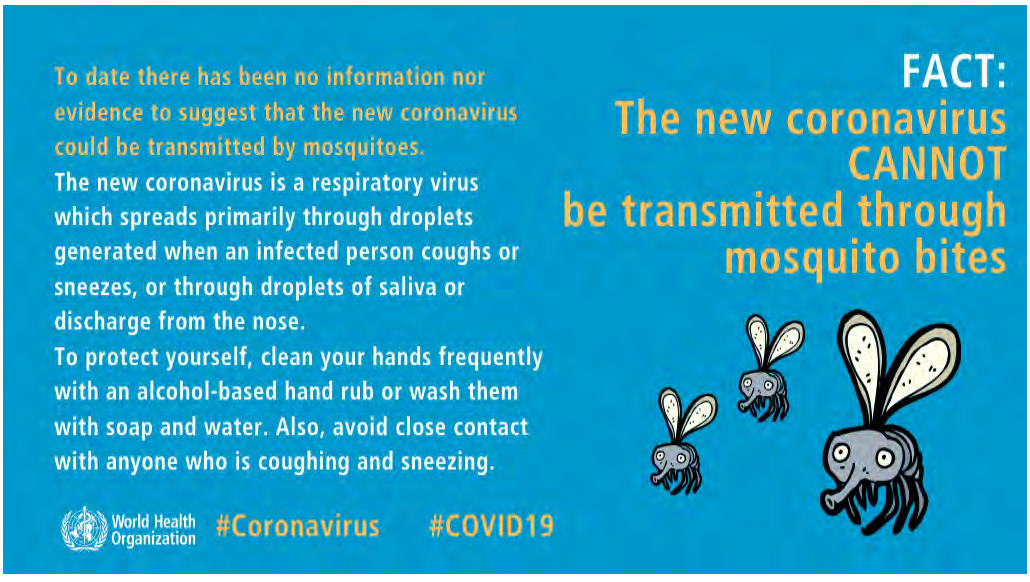
Email evergreen@cfhcare.org for more information about being a camp volunteer.

# COVID-19 Myth Busters

There is a lot of information out there about COVID-19. Not all of it is true or accurate. While we are still learning about this virus and don't know everything, be sure to get your information from reliable sources.

Here are some Myth Busters found on www.who.int, the World Health Organization's website. Make sure to fact check what you hear and follow good hygiene practices. This is a great time to continue to practice your proper handwashing procedures and universal precautions that were taught to you as CHC volunteers. Stay safe and stay connected!




# Comments from Our Families

- I am so thankful to CHC and especially our nurse who cared for my mom and our entire family with compassion, as well as excellent medical treatment. I could not have honored my mom's wish to die at home without them! Thank you.

- I can't say enough good things about the care, support and reliability of everyone we dealt with in every aspect of the Hospice team. In what was the hardest time of my life, Hospice was a Godsend. I will be forever grateful. Thank you.

- CHC was such a blessing to my mom and all of us her children who were caring for her. We thank God for this organization and its staff and volunteers. CHC helped mom and us get through her disease and last days on earth with a better understanding of how the body prepares to leave this earth and go to her/his eternal home. Thank you for helping people at such a tough time. God bless you all.

*Continued from page 1*

ing them. Later in life, while tutoring students at Ancilla College, she was asked where she had learned to read. She explained that she had learned from those McGuffey readers that were in her aunt and uncle's schoolhouse and she read through all of them. The professor couldn't believe it. "She told me that if I went through that series, I would have more than a college degree nowadays! They were hard, very challenging!" Esther remembered.

Esther met her husband while living in Colorado. He had been all over the world. and he had just arrived home in Fort Carson, Colorado from touring Korea, when they had met. Her husband was a combat engineer in the Army. He was originally from Indiana, so when he left the military, they returned to the Midwest together. Esther started out her career by teaching History and English. She recalls that learning has always been a part of her life, and it still is today.

Figuring out how to stay active when life changes around you is something that requires determination. Esther moved to Southfield Village after her husband died 5 years ago. Sadly, her son died two months before her husband. Understandably, the transition was laced with so much grief that she didn't enjoy it at the beginning. "At first I didn't enjoy it here," she said "because it was different. I didn't know anyone here. You had to get acquainted and involved in things." This was also coupled with the start of her care with Center for Hospice Care. Fortunately, she had some experience with hospice because of her husband, but it was still hard to come to terms with it.

You have to engage yourself and become involved in things. You may have to switch sometimes what you'd like to do, but you find something else to replace it.

"You think, oh boy, I'm going to die" she shared. "That's the first thing you think of. Well, that's not necessarily true. My staff from CHC told me that they wanted me to live what life I have left to the fullest."

Try to find Esther today and you may have to search awhile for her. She spends time visiting with her volunteer, Greta, who is a Notre Dame student. "We do things sometimes, sometimes we just sit and talk" she said. Esther works on puzzles. She explained that there is a sort of "unspoken rule" that everyone must contribute a few pieces to one of the many puzzles in progress around Southfield Village. Esther sews. There is a sewing circle that meets weekly and they work on projects for Feed the Hungry. They have crocheted hats for newborns, sewn dresses for girls and have made quilts. Esther loves to knit. She also reads voraciously. "For one thing," she explained, "it keeps my mind working. You have to engage yourself and become involved in things. You may have to switch sometimes what you'd like to do, but you find something else to replace it." Esther exudes positivity. Even when she realizes she has had enough with one activity, she can always find something else to do.

Esther is not only active, but she seeks out others to bring cheer and chase loneliness. "There was a lady here who wouldn't talk with anyone or become involved in anything." Esther explained. "When I saw her at first, I just kept telling her 'hello.' That's all I'd ever say, 'hello!' Finally she got to where she does talk to me and we've got her out now doing a little bit. I've made her smile, which she never did before." Making another human smile must be one of the most productive ways to spend a day.

Like an Amish quilt, our lives aren't perfect. They have their flaws. However, when looking at our lives, what we've learned, how we can contribute to the world around us, even at the end of life when our bodies can't do what they used to—our lives are beautiful works of art—and it can be hard to spot the defect. We want Esther to continue to live life fully—as she has been.

**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.