Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
May 19, 2021
7:15 a.m.

BOARD BRIEFING BOOK

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Center for Hospice Care
choices to make the most of life

CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING
Administrative and Foundation Offices
Via Zoom
The board meeting begins at 7:15 AM, but you may begin logging in anytime after 7 AM.

Zoom Link Below

https://cfhcare.zoom.us/j/98460979568?pwd=eXBnWVBJakhWdnd5TWFkR3h6QVVWUT09

Meeting ID: 984 6097 9568
Passcode: 326062

May 19, 2021
7:15 a.m.

A G E N D A

1. **Call Meeting to Order and Roll Call** – Jennifer Ewing (3 minutes)

2. **Consent Agenda** – Jennifer Ewing (12 minutes)
   A. Approval of February 17, 2021 Board Meeting Minutes *(action)*
   B. Patient Care Policies *(action)* – Included in your board packet. Lance Mayberry available to answer questions.
   C. QI Committee Minutes 02/23/21 *(information)*

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

4. **Finance Committee** *(action)* – Kurt Janowsky (20 minutes)
   A. 2020 Audit
   B. YTD April 2021 Financial Statements

5. **Hospice Foundation Update** *(information)* – Mary Newbold (20 minutes)

6. **Chair's Report** – Jennifer Ewing (4 minutes)

7. **Adjournment** – Jennifer Ewing *(action)* -- (1 minute)
   (Five-minute break until HF/GPIC board meetings. Becky Kizer notifies the staff of the Hospice Foundation / GPIC that the next board meeting will commence in five minutes via the same Zoom call.)

Next CHC Board meeting August 18, 2021

# # #

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 17, 2021

Members Present:	Andy Murray, Brian Huber, Jeffrey Bernel, Kevin Murphy, Kurt Janowsky, Mark Wobbe, Roland Chamblee, Wendell Walsh
Absent:	Jennifer Ewing, Mary Newbold
CHC Staff:	Angie Fox, Craig Harrell, Karl Holderman, Lance Mayberry, Mark Murray, Mike Wargo, Becky Kizer

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 7:15 a.m.	
2. Welcome	• Welcome to new Board members Jeff Bernel, Brian Huber, and Kevin Murphy.	
3. Election of Officer	• A motion was made to accept the nomination of Kurt Janowsky as Treasurer. The motion was accepted unanimously.	W. Walsh motioned R. Chamblee seconded
4. Minutes	• A motion was made to accept the minutes of the 11/18/20 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned K. Janowsky seconded
5. Policies	• A motion was made to accept the revised policies as presented. The motion was accepted unanimously.	W. Walsh motioned K. Janowsky seconded
6. President's Report	• January ADC was 396. The weekend after Thanksgiving we had 22 deaths. We normally see several deaths immediately after the holidays. The ADC in the IPUs has been choppy. We are still seeing some patients/families not wanting to go to a facility due to COVID and other issues. • We have started to begin the process for accreditation through Community Health Accreditation Program (CHAP). This is a goal in the current Strategic Plan. Initially CHAP will review our policies and then they will come to do a survey. Angie F. is updating our documents to make sure we are in compliance with CHAP standards. Another reason we are going to accreditation is that it will keep the Indiana Department of Health from doing surveys. Indiana is a deemed status state, so CHAP would be our survey agency and would follow up on any complaints and report the results to the state. The state then approves the reports. When Medicare Advantage	

Topic	Discussion	Action
	programs are allowed to add hospice as a benefit – it is currently carved out --they would likely only want to contract with hospices that have achieved accreditation. • We switched our media to recruitment for staffing. We have 22 open positions as of today. The advertisements have helped because we have received many more responses. We still have issues with CNAs simply not showing up for the interview and then not showing up on the first day of work. In response to these openings, HR and administrators are meeting every two weeks to discuss recruitment. We instituted a sign on bonus and a referral bonus for existing staff. The 22 openings are about double from a year ago. Every health care organization in the area is having these conversations. • We have another doctor on staff—Dr. Matt Misner. He is a pediatrician and will play an important role in advancing our pediatric palliative care program. We will be the only hospice in the area with a full-time pediatrician on staff. • One of our 2021 goal has already been met as we are now certified through the National Institute for Jewish Hospice (NIJH). Issues of inclusion, equality and diversity will possibly be a theme in the next Strategic Plan and this certification will go along with that. • CHPN (Certified Hospice and Palliative Nurse) – We offer an incentive to our nurses to pursue this certification by paying for the review course and test if they pass the exam. They are also given an annual stipend if they keep up the certification. We have 15 CHPN nurses, which is 10% of all the CHPN nurses in the state. This is another important differential for CHC. • The 2020 goal final report and the 2021 goals are in the board packet. The fact that we got as much done as we did last year in light of COVID was very good. • We held a blood drive on 02/09 for staff, family, and friends and 28 units of blood were donated. We had to add hours because more people wanted to donate that originally anticipated. It was an amazing event. • The NHERT met virtually in January. One interesting thing we talked about is how COVID may affect hospice census in the future through 2022. Some people who survived COVID have had very serious co-morbidities that may affect their heart and lungs in the future. The data is very preliminary and speculative. We will continue to talk about this and see where the data actually goes, but we may see these patients coming to hospice in late 2021 and be a pull-through to 2022.	

Topic	Discussion	Action
	• We held COVID Vaccine clinics for staff on 01/18 and 02/15 and added volunteers on 02/15. The third clinic will be 03/15. We are working with Walgreens on this and the vaccine is/was open to any staff member of CHC and our affiliates. • Board committees – We would love to have each board member serve on a committee. If interested, send Mark M. an email. The list of board committee opportunities is in the board packet. • Another goal for this year was to join NHPCO's Quality Connections. This program is heavy on staff and patient education as well as quality. NHPCO has been talking about doing this for 15 years. Within 24 hours of NHPCO saying you could sign up, we did. • Every year the Conflict of Interest form needs to be signed by each board member and this is an IRS requirement. Becky K. will mail that to you.	
7. Finance Committee	• Census – In 2019 we served 2,071 patients, budgeted in 2020 for 2,152, and actually served 2,099. ADC in 2019 was 420, budgeted in 2020 for 425, the breakeven is 398, and actual was 431. • Receivables continue to be in much better shape than a year ago. Other Liabilities – We are carrying money from the HHS Stimulus. In conjunction with conversations with Kruggel Lawton, we moved those dollars to the income statement. There is a line item of $1.4M, but we have plenty of expenses to back that up. We received $1.4M from HHS in April 2020 towards COVID related expenses. We engaged the Rybar Group to assist us in accounting for those funds. We are able to justify that number and beyond. We lost fundraising revenue—we didn't have the Helping Hands Award Dinner. IPU census has been down since 2019. Compared to 2019, the number of IPU patient days was down in 2020—a loss of $500,000. Staffing costs – Care staff were paid an incentive to see COVID positive patients. We could also include the cost of the administrative team meeting daily to develop COVID policies and procedures. Direct expenses – the cost of additional PPE and cleaning supplies. Our COVID expenses surpassed the HHS Stimulus grant. • YTD December 31, 2020 total operating revenue $24.2M—we budgeted for $24.5M. Total revenue was $28.8M. Total expenses $21.7M. Net gain $7M and net without beneficial interest in the Hospice Foundation was $4M. • Long length of stay audit – In January we received the initial results. There were $1.2M in claims audited and the CMS contracted vendor rejected $1.1M. We	

Topic	Discussion	Action
	engaged Meg Pekarski at Husch Blackwell to assist us in this audit. They do nothing but help hospice programs with audits such as this and make sure they are paid appropriately by Medicare. This audit covers 2017-2019 for ten patients and 300 claims. Everyone in NHERT is in the same audit. The audit is done by a Medicare contractor and they are saying there is an error rate of 94%. This may go on for a couple years because there are a lot of appeals, we can take it up to an Administrative Law Judge. In the last two weeks, Husch Blackwell has recovered $55M for their clients in this audit. We think our chances of winning an appeal are fairly good for most of these claims. We are waiting for the demand letter from Palmetto GBA, our Medicare Fiscal Intermediary, and when we receive it, we have 30 days to make the decision whether to allow Medicare to recoup the money now, or if we don't, we'll be on the hook to pay the $1.1M at 9-11% interest in the future. We will let Medicare take the money back now and repay us with interest which is about 3-4% on the denied claims we win. We are working with Kruggel Lawton as to how this will be reflected on our 2020 year-end financial statements. • The difference between budgeted expenses and actual expenses regarding personnel is $1.2M under budget in total wages. The first factor is we are conservative in the budget process, especially in wages. There were 22 open positions we didn't staff, so those expenses were lower. We also budgeted ten new positions in 2020 and filled none of those. • Office costs were $190,000 over budget and phone costs were $120,000 over budget. These are due to year-end accounting adjustments. At year-end we may not meet the capitalization threshold, so as a part of that process those costs will be expensed so December looks off compared to the rest of the year. The funding differences on group health plan was one of the large adjustments for the year. We are a partially self-funded health insurance plan. In 2019 we had a couple of large claims, so we funded at a larger level. In 2020 with people not seeing doctors and not having elective surgeries, this expense went down and was overfunded by $600,000, so there was an adjustment for that in December. • A motion was made to accept the YTD December 31, 2020 financial statements as presented. The motion was accepted unanimously.	M. Wobbe motioned K. Janowsky seconded

Topic	Discussion	Action
8. Hospice Foundation Update	• Fundraising activities include annual giving, endowments, planned giving activities, and fundraising with the MADS project. Our theme for the Annual Appeal was "Now more than ever." Through 01/31/21 this campaign has raised $107,487.56—the single largest in its history. The campaign started around Thanksgiving and continues through May. • Endowment – We have several established. One is the Linda Lloyd Mission Endowment for Camp Evergreen, which donated another $50,000 last month. The fund has about $300,000 and our goal is $400,000 which would throw off $20,000 a year to fund Camp Evergreen. • MADS – This is a project in conjunction with REAL Services and Alzheimer's & Dementia Services of Northern Indiana. We are working with about 20 donor prospects to raise funds. We submitted one ask for $1.5M to a foundation. We also have a number of individuals and families that we are having conversations with. The target date for completion and opening of the facility is November 2021. Consultants were brought in from the Netherlands who created a Dementia Village program there. We need to prepare for our role at how to deal with expected growth in the number of Dementia patients. • Cornerstone Society – This is our planned giving program. We received nearly $400,000 in estate gifts in 2020. We continue to receive inquiries from people in the community about including us in their estate giving. Usually, we find out about it after the fact. • Annual fundraising that we see year over year is trending up. In 2019 it totaled $1,237,000 and in 2020 it was $1,246,000. We had no event income in 2020. Since we were not engaged in activities, we could focus on stewardship and we are seeing more generosity as a result of going back to donors. We had a Capital Campaign for the Elkhart office in 2007-2009 and the Cornerstone for Living campaign 2014-2019. Our fundraising initiative for this year is for the new MADS facility. If you look at the total fundraising numbers, Karl H. numbers are different than what the Hospice Foundation reports because Karl's numbers book revenue with receivables that are payable in the future, and the Foundation is booking it at cash coming in. • We had a meeting last week with the chairs of the Helping Hands Award dinner and based on everything we are seeing we are looking at moving the event to 09/08 or 09/15 instead of May.	

Topic	Discussion	Action
9. Board Education	• 2020 Year in Review. COVID changed everything we had planned. Staff were not allowed to see patients in hospitals or nursing homes. Even today most of the 83 facilities where we have contracts with are only letting nurses in, and a few are allowing social workers and chaplains. Despite COVID and the myriad of issues, we never furloughed or laid off staff members and they all were paid. • 2020 was our 40th anniversary for caring for patients. We were incorporated in 1978 and saw our first patient in January 1980. In 2020 we served 2,099 patients, a 1.35% increase. Census plunged in March and April. We are still in the top 3% of hospice in the country. ADC was 431, up 3%. Total referrals were down 2.8%. The conversion rate of referral to admission was 75%, up from 72% in 2019. Anything above 70% is considered outstanding by industry standards. Responding to referrals is not the end of the story. It is convincing patients/families to elect hospice care. Our admission team is doing a very good job explaining our program and getting people in which may include palliative care under our home health license. Same/next day admissions were 53%, up from 47% in 2019. Deaths before admissions (DBAs) were about the same at 8%. Refusing admission increased to 4% from 3% in 2019. We think a lot of that had to do with COVID. Hospital referrals fell to 45% from 46% in 2019. The median length of stay for all hospice patients dropped to 13 days from 14 days in 2019. The average length of stay for all hospice patients increased to 85 days from 75 days in 2019. The percentage of self/family referral conversion rate increased to 75% from 69% in 2019. • Since we began seeing patients in January 1980, CHC has cared for over 41,000 patients. Nearly half of all the patients served have been served in just the last ten years alone, and 25% have been served in just the last five years alone. • We have 31 competitors in our service area. About 70% of all hospices nationally are for-profit and this is no different in our service area. • The average length of stay for hospice only patients was 85 days, the median was 13 days, and the most frequent length of stay continued to be two days. Hospice Medicare patient's average length of stay in 2020 was 90 days—the highest it has been in at least the last ten years. DBAs were 8% of total referrals, which was the same as 2019. Referrals were down 2.8%. 45% of referrals were from hospitals, 27% from patients/families, 17% from physicians, 7% from ECFs, and 3% from other sources. This is little changed from previous years.	

Topic	Discussion	Action
	• Bereavement served 3,055 clients, 33% of which were from the community with no prior hospice experience – the highest ever. Bereavement did see a lot of people that lost a loved one due to COVID. We provide bereavement services to anyone in the community at no charge. The Bereavement Department averaged 128 hospice deaths per month and had a total of nearly 4,700 individual and family counseling sessions. • Volunteers – We have hundreds of volunteers that participate in wide variety of services. Medicare requires volunteer participation in direct patient care and hospice programs. This requirement was lifted in early 2020 because of COVID, so the number of volunteer hours, mileage, and savings to CHC were down considerably. Volunteers worked 6,091 hours compared to 15,711 in 2019. They drove 14,281 miles compared to 46,281 in 2019. Savings to CHC were $171,521 compared to $418,498 in 2019. • There are two questions on the Press Ganey survey that we look at closely—did you have a positive experience with CHC—97% responded yes; would you recommend CHC to others—97% said yes. We have been at 97% on these two questions for many consecutive years.	
10. Chairman's Report	• Administrators then left the meeting. • Board Self-Evaluation 2020 results. The survey is done every other year. The number of surveys returned in December were down. We have five new board members and chairs of committees. A lot of changes are going on. One thing the Executive Committee has talked about is sharpening our strategic initiatives and reviewing future plans and strategies. • Renewal of CEO employment agreement – Jennifer E. and Mark W. met with Mark M. last week. According to policy, the executive committee has the responsibility to annually review with the CEO his performance and then every three years renew, or not, the contract. The annual review includes any feedback from non-executive committee board members. Board members are always encouraged to speak to a member of the executive committee when they have comments. As part of the review, the executive committee does an annual review of the Pres/CEO compensation. They are currently guided by a compensation study done two years ago where we contracted with two national consulting firms to perform the study. We are consistent in his salary and compensation package compared to other CEOs with similar responsibilities and organization size.	

Topic	Discussion	Action
	• A motion was made to approve the recommendation of the executive committee to renew the President/CEO employment agreement with Mark Murray. The motion was accepted unanimously.	M. Wobbe motioned J. Bernel seconded
Adjournment	• The meeting adjourned at 8:40 a.m.	Next meeting 05/19

Prepared by Becky Kizer for approval by the Board of Directors on May 19, 2021

Mark Wobbe, Vice Chair

Becky Kizer, Recording Secretary

Center for Hospice Care

INPATIENT UNIT PRIVATE PAY ROOM AND BOARD - DRAFT

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

PURPOSE: To establish a fee schedule when there is no third-party reimbursement (Medicare, Medicaid, and/or Private Insurance) when family is requesting IPU stay short-term outside a Respite or GIP stay or extending their stay after patient is no longer eligible for GIP or Respite.

PROCEDURE:

1. Patients who have had a GIP or Respite stay in the Inpatient Unit may have the opportunity to extend their stay based on IPU bed availability.

2. Families may also utilize routine private pay care at the IPU for short-term care outside a GIP or Respite stay based on IPU bed availability.

3. Circumstances for which a family may use private pay will be granted on a case-by-case basis by administration. Some examples are:
   - Extended vacation for caregivers
   - Patient waiting on ECF placement
   - Family needing extra time to prepare home or paid caregivers before patient arrives

4. Consult with the Billing Department on any ECF Medicaid patients before accepting.

5. Social Worker will educate the family that there must be a discharge date established before the patient arrives to the IPU.

6. Transportation will not be covered by CHC.

7. Patient's daily rate is set at $325 a day.
   - Sliding scale fee agreement is not applicable to private pay patients

8. Payment is due for five (5) days in advance of stay.
   - If the patient departs prior to the five days, the remaining balance will be refunded.
   - After the initial five day stay, subsequent stays in increments of five days payable in advance, based on availability.

9. Any questions or payment concerns can be directed to the Billing Department.

Effective Date: 05/21	Revised Date:	Board Approved:
Reviewed Date:		Signature Date:

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

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

1. The "Certification of Terminal Illness" form specifies that the patient's prognosis is for a life expectancy of six months or less if the terminal illness runs its normal course.
2. The certification of the patient's terminal illness is based on the physician's clinical judgment regarding the normal course of the patient's illness.
3. Clinical information ~~(which may be provided verbally)~~ and other documentation that supports the patient's medical prognosis and the physician's certification of terminal illness is included in the patient's medical record and documented as part of the hospice's eligibility assessment.
4. The RN may take a verbal certification at admission from the primary and Hospice physician. Quality assurance will send out the Certification of Terminal illness for signature after two days of admission.
5. The signed "Certification of Terminal Illness" form is available in the patient's medical record prior to submitting claims for payment.

PURPOSE: To ensure appropriate admission to hospice services.

SCOPE OF PRACTICE: Registered Nurse.

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

If completed before admission, review the ~~Pre-admission~~ consents to verify ~~completion~~.understanding and accuracy.

~~Complete LCD.~~ Review clinical data and IDT ~~at time of referral~~ from preadmission to verify that patient is appropriate for services.

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

Consents to be Signed at Admission

	Hospice Medicare	Hospice Medicaid	Hospice Commercial (includes VA)	Replacement Programs	Hospice Self-Pay
~~General~~ Admission Consent and Release of Information	X	X	X	X	X
Notice of Election of Hospice Benefit	X		X	X	X
Notice of Hospice Non-Covered Items, Services and Drugs	X	~~X~~	~~X~~	~~X~~	~~X~~
Medicaid Hospice Election		X		X	X
Commercial Insurance Verification			X	X	
Fee Assessment Worksheet			X	X	

Effective Date: 05/95 Revised Date: ~~07/20~~ 03/21 Board Approved: 08/19/20
Reviewed Date: 09/14 Signature Date: 08/19/20

Signature: President/CEO

PURPOSE: To ensure the availability of initial medications and treatments after the admission of a patient.

POLICY: Standing orders will be requested of the primary~~attending~~ physician upon admission of the patient onto CHC services.

1. Standing orders will be sent out at the time of admission to the primary~~attending~~ physician for his/her signature.

2. Standing orders are NOT valid until they are signed, dated, and returned by the primary~~attending~~ physician/nurse practitioner (NP). Verbal orders will not be allowed for standing orders.

3. Once the signed standing orders have been returned, if there are exclusions, additions, or changes, documentation will be made in the EMR regarding the exclusion, addition, or changes.

4. If the ~~attending~~ primary physician is unavailable, the Medical Director/Hospice Physician/NP ~~will~~ may ~~write orders~~ initiate standing orders.

5. Standing orders are never to be placed in the long-term care (LTC) facility charts.

6. Standing orders are **NOT** to be used on the pediatric patient or on any patient weighing less than 95 pounds.

Center for Hospice Care

DO NOT RESUSCITATE ORDER

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

PURPOSE: To facilitate Do Not Resuscitate (DNR) decisions for the patient.

1. At admission ~~if applicable~~, the ~~RN~~admission staff will initiate conversation with the patient, their designated health care representative, or significant family members regarding ~~current~~ DNR status.

2. If the patient already has an Indiana POST form ~~DNR~~, photograph a copy for the EMR.

3. If the patient or health care representative is unable or unwilling to make DNR decisions at this time, the admitting RN will make a referral to the appropriate social worker for follow up.

4. The social worker will continue to explore the patient's DNR status and keep the Interdisciplinary Team (IDT) advised.

5. Complete and obtain signature on the Indiana POST form if the patient, their designated health care representative, or significant family members wish to sign.

6. Using the iPad, photograph a copy of the signed Indiana POST form and upload to clinical documents.

7. The patient/primary caregiver must be educated to keep the yellow copy, in the handbook, available in the event should it be needed.

8. QA will send the Indiana POST form to the primary physician for signature.

Effective Date: 02/94	Revised Date: 01/21~~04/18~~	Board Approved: 05/16/18
Reviewed Date: 07/19		Signature Date: 05/16/18

Signature: President/CEO

MEDICAID HOSPICE PLAN OF CARE FOR CURATIVE CARE PATIENTS 20 YEARS AND YOUNGER

REGULATION: Affordable Care Act 2302 – Concurrent Care for Children

PURPOSE: The Medicaid Hospice Plan of Care for Curative Care form (State Form 54896) is to be submitted to CHC and include information related to curative care services.

POLICY: The Plan of Care (POC) for each provider will allow CHC to work collaboratively to plan hours or visits of care to meet the patient's needs.

Prior Authorization

- The Prior Authorization (PA) process remains unchanged.

Admission

- A blank POC will be sent to each agency involved in the care with a request to complete and return to CHC within five calendar days.
- A completed Medicaid Hospice Plan of Care for Curative Care Patients 20 Years and Younger (MHCP) form, including the POC with proper signatures. Billing must submit within five calendar days

Billing

- The Billing Department is responsible for submitting the MHCP to Indiana Health Coverage Programs (IHCP) in ten days.
- At each recert period Billing will submit the POC for all providers to IHCP.

Effective Date: 01/17	Revised Date: 03/21	Board Approved: 02/15/17
Reviewed Date: 07/19		Signature Date: 02/15/17

Signature:  President/CEO

PURPOSE: To maintain current competency and clinical skills by utilizing a reference which is a reputable resource for nursing procedures.

POLICY: When there is no current written procedure to follow, the nurse will utilize all avenues of expertise including but not limited to:

- Clinical Educator
- Other RN's with clinical experience in the procedure
- Perry & Potter

CHC patient care services will follow nursing procedures by utilizing the resource "Clinical Nursing Skills and Techniques" by Perry & Potter.

A copy of ~~the book~~ Perry & Potter is available at all CHC offices.

Effective Date: 06/16	Revised Date: 03/21	Board Approved: 10/19/16
Reviewed Date: 07/19		Signature Date: 10/19/16

Signature: President/CEO

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

PURPOSE: To provide for the services of a licensed pharmacist.

POLICY: The services of a licensed pharmacist will be available 24 hours a day, 7 days a week through CHC contracted pharmacy or Pharmacy Benefit Manager.
A licensed pharmacist will:

- dispense all prescription drugs prescribed by the primary ~~attending~~ physician
- ensure that medications conform with the physician's orders and that the order is current and that the drug and dosage are current
- be available for consultation

Effective Date: 02/94 Revised Date: ~~08/09~~ 03/21 Board Approved: 08/19/09
Reviewed Date: 07/19 Signature Date: 08/19/09

Signature: President/CEO

REGULATION: 42 CFR 418.74 – Physical therapy, occupational therapy, speech-language pathology, and dietary counseling

PURPOSE: To ensure that necessary therapies for patients care are available to patients.

POLICY: The Agency will make available physical therapy, occupational therapy, and speech language pathology services in a manner consistent with accepted standards of practice. Contracted agencies will be used.

Services will be provided according to the plan of care by appropriately trained and supervised personnel.

All therapy education, consultation, and/or services will be incorporated into the patient's plan of care.

Effective Date: 02/94	Revised Date: ~~11/01~~ 03/21	Board Approved: 12/04/01
Reviewed Date: 07/19		Signature Date: 12/04/01

Signature: President/CEO

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

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

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

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

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

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

5. The interventions offered ~~all~~ hospice bereaved based on assessed level of risk are:
   - **Low Risk**
     - Call/contact by at least one patient care staff.
     - Condolence Card sent within two weeks after the death including an insert with signatures from patient care staff.
     - General letter from Bereavement Department including magnet with office phone numbers and booklet of available services sent around two weeks after the death.
     - One to two phone call attempts by bereavement counselor within a month after the death starting around three weeks after the death.
     - If bereaved is not reached by phone, counselor will send letter offering condolences, mentioning the attempts to reach by phone, mentioning available services, mentioning mailing program inviting them to call and cancel if they do not want mailings.
     - When reached by phone, updated assessment of bereavement risk and need will be attempted and offer will be made to explain services.
     - Mailing Program will be sent unless bereaved declines.

Center for Hospice Care

BEREAVEMENT – ONLINE/ DISTANCE COUNSELING

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

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

PURPOSE: To ensure that online/distance counseling services are available to bereaved clients when appropriate.

POLICY: Online/distance counseling services are made available to bereaved clients when they are unable to come to the office and a bereavement counselor is unable to travel to their location. CHC IT approved technology will be utilized.

1. ~~Completing~~Individual, family, and group clients and/or parent/guardian will complete an online/distance counseling consent form ~~will be required~~.

2. In case of online technology failure, the off-site client will be called once so the session can continue over the phone.

3. When g~~G~~roup counseling is meeting in person and there are clients attending virtually:
   - Clients will complete a consent form allowing technology to be utilized for a client that is off site due to inability to attend the group session. If all group members do not complete a consent form, the off-site group member will not be included in the session. For minor clients (younger than 18 years of age), parent/ guardian consent will be obtained.
   - For group counseling and the privacy of the on-site group members, the off-site counseling client is to be in a private room during the session. If a private room is not available, the off-site counseling client will agree to wear ear buds/headphones.
   - Video for group counseling clients will be of off-site client only. Video for off-site client will be of group facilitator only.
   - In case of online technology failure, the off-site client will be called once so the session can continue with a conference call. If off-site client is not reached, the group will continue as usual.

Effective Date: 05/16	Revised Date: 01/21	Board Approved: 10/19/16
Reviewed Date: 07/19		Signature Date: 10/19/16

Signature: President/CEO

Center for Hospice Care

PATIENT SATISFACTION SURVEYS

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

REGULATION: 42 CFR 418.58 – Quality assessment and performance improvement

PURPOSE: To provide a mechanism for monitoring the quality of patient/family care and total agency functioning.

POLICY: The monitoring of the quality care includes:

- Problem identification, assessment, correction, monitoring, and documentation.
- Use of critiques by patients' families regarding services.
- Evidence of policy implementation and monitoring of staff performance.
- Recommendations to the Administrative personnel and the Board of Directors for improving patient care.
- Implementation of recommendations resulting from evaluations and studies.

~~PROCEDURE~~:

One Month Survey

- The CAHPS (Consumer Assessment of Healthcare Providers Survey) surveys are processed by our contracted agency Press Ganey. Survey are mailed to the family/primary caregiver identified in MatrixCare on or near the one month anniversary of the patient's death.
- Results are compiled and reviewed quarterly.
- Surveys containing service delivery issues will be referred to the Consumer Concerns Committee.

One Year Bereavement Survey

- Surveys are mailed to the designated bereaved receiving the mailing program~~family/primary caregiver~~ around~~on or near~~ the 13-month anniversary of the patient's death. A self-addressed stamped envelope is included with the survey.
- Results are compiled and reviewed twice a year~~quarterly~~.
- Returned surveys will be routed to appropriate staff for review.
- Surveys containing service delivery issues will be referred to the appropriate Coordinator or Director.

Effective Date: 02/94	Revised Date: 01/21~~07/19~~	Board Approved: 11/20/19
Reviewed Date: 09/14		Signature Date: 11/20/19

Signature:  President/CEO

REGULATION: 42 CFR 418.106(a) – Managing Drugs and Biologicals

PURPOSE: The hospice must ensure that the interdisciplinary team confers with individuals with education and training in drug management to ensure that drugs and biologicals meet each patient's individual needs.

Initial Medication Review and Profiling

1. At the initial nursing visit the Admission Nurse will review all current medications and biologics the patient is taking.

2. The Admission Nurse will review this list for accuracy, repeated therapies, and any other relevant considerations related to medication therapy meeting the patient's individualized needs.

3. This review will include all prescription and over-the-counter medications, dose, frequency, and route of administration.

4. All medications will be reviewed at time of admission with the physician to reconcile, update, or remove medications. Medication coverage will be reviewed with the physician.
   (a) Any non-covered items will require a "Notice of Non-Covered Items, Services, and Drugs" form. Education on the non-covered medications will be reviewed and a copy will be provided to the patient or caregiver after signature obtained.

5. All current and valid medications will then be profiled into the patient's electronic medical record (EMR) for electronic interfacing with our pharmacy management agency.

Ongoing Medication Review and Profiling

1. Medications and biologics can be reviewed and updated by hospice physicians and nurse practitioners at the time of admission, interdisciplinary team (IDT) every 14 days, Inpatient Unit initial IDT, and other times as needed.

2. During these reviews the hospice physician or nurse practitioner will review for: (1) relatedness to the terminal prognosis; (2) efficacy of the medication regimen; (3) duplicate therapy and any other relative considerations related to medications meeting the patient's individualized needs.

Signature: President/CEO

3. Case Managers and visit nurses can review medications ordered and profiled in the EMR with patients or family members at any of the following times: (1) Care Plan review and updating; (2) during comprehensive assessments; (3) prior to recertification of hospice services.
   (a) Any non-covered items will require a "Notice of Non-Covered Items, Services, and Drugs" form. Education on the non-covered medications will be reviewed and a copy will be provided to the patient or caregiver after signature obtained.

4. During medication profile reviews completed by nurses, they will be reviewing efficacy, appropriateness, relatedness to terminal illness, and any side effects of medication therapy and any other relative considerations related to medications meeting the patient's individualized needs.

5. The medication profile review will be documented in the EMR and updates are to be made in the medication profile for electronic interfacing with our pharmacy management agency.

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

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

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

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

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

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

10. Medical records are retained and protected for ten (10) years from the last date of service.

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

12. In the event paper documentation is completed due to EMR failure, all paper documents will be scanned into the EMR once EMR is working again.

13. If the record is not on site in the records room, it will be stored at Integra Certified Document Destruction, 2300 Johnson Street, Elkhart, Indiana. The Executive Office Manager will maintain an inventory of records stored off site and the date when the records can be destroyed. The date and list of the records destroyed will be maintained permanently by the Executive Office Manager.

Center for Hospice Care

AICDs: ARTICULATION OF IMPLANTED CARDIOVERTER/DEFIBRILLATORS

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

PURPOSE: The articulation of:

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

POLICY:

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

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

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

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

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

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

Effective Date: 09/06	Revised Date: ~~11/19~~ 3/21	Board Approved: 02/19/20
Reviewed Date: 07/19		Signature Date: 02/19/20

Signature: President/CEO

Center for Hospice Care

EMERGENCY DETENTION PROTOCOL

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

PURPOSE: To establish an emergency detention protocol for persons who are determined dangerous to self and/or others.

POLICY: A social worker (for patients and family members) or bereavement counselor (for bereaved clients) will assess the situation. Social Work assessments will~~,~~ include~~ing~~ a face-to-face interview with the patient. An RN may also assess the situation for a patient/family member if a social worker ~~or bereavement counselor~~ is unavailable. The assessment will be based upon:

1. Lethality of threat to self and others. If danger is imminent, call the police (911). For patient care, d~~D~~o not attempt to confront the patient alone. For bereaved clients, complete the suicide risk assessment and if client is determined to be in imminent danger of harming self and no other caregivers are available to transport the client, call the police (911). -At this time, the police officer may initiate a 24-hour Immediate Detention and transport the patient to the appropriate mental health inpatient facility. The attending police officer will obtain an ambulance should the situation warrant medical intervention. Should the police determine that the patient or significant other is not a danger to self or others, and the social worker, bereavement counselor, or RN disagrees, follow the steps outlined for 72-hour Emergency Detention.

2. Description of behavior through first hand observations and the Diagnostic and Statistical Manual (DSM)-IV criterion and language, i.e., labile mood, disorientation to time and place, etc.

Once factual information is collected, for patient care, consult with the ~~Social Work Coordinator or~~ Director of Support Services and Medical Director/Hospice Physician. For bereaved clients, staff the situation with the Director of Bereavement Services, Resource Bereavement Counselor, or Director of Support Services. In the event that the supervisor is not available, contact another administrator to apprise them of the situation. The social worker, bereavement counselor, or RN will act on his/her professional opinion and apprise supervisor should the situation be too emergent to first contact an administrator and/or the Medical Director/Hospice Physician.

The following steps apply should the decision be made to pursue a 72-hour Emergency Detention:

1. Obtain form "Application for Emergency Detention" and locate family physician and/or Medical Director/Hospice Physician.

2. Contact the local mental health facility for the appropriate county to determine if the person meets admission criteria and ensure the facility's ability to accept the patient.

Signature:  President/CEO

Center for Hospice Care

ECF: SKILLED NURSING FACILTY PLAN OF CARE COORDINATION

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

REGULATION: 42 CFR 418.112 – Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

PURPOSE: To facilitate the coordination of the plan of care between Agency and the Skilled Nursing Facility (SNF) facility.

POLICY: The Agency interdisciplinary staff and the SNF interdisciplinary staff will meet to facilitate the coordination of the plan of care for the Agency patient residing in the LTC facility.

1. On admission, the nurse will initiate the plan of care, leaving a ~~written~~ printed copy in the facility chart ~~and starting the plan of care in the computer.~~

2. The first visit for the case manager will be two-fold: one to assess the patient, and second to coordinate the plan of care with the facility staff

3. The coordinated plan of care will be reviewed at each visit and any changes in the plan of care will be communicated to the SNF staff when they occur and documented in both charts.

4. Upon receiving notice of a conference time, the team member will notify other team members ~~in writing~~ via email.

5. The Agency team will attend the care conference and document their attendance.

Effective Date: 01/02	Revised Date: ~~05/16~~ 3/21	Board Approved: 10/19/16
Reviewed Date: 07/19		Signature Date: 10/19/16

Signature: President/CEO

ECF: TRANSFER OF ECF HOSPICE PATIENT TO INPATIENT UNIT

REGULATION: 42 CFR 418.112 – Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.

PURPOSE: To facilitate entry of patients into Inpatient Unit (IPU) from an Extended Care Facility (ECF).

POLICY: Hospice will coordinate with an ECF the ~~discharge~~ transfer of one of the ECF Hospice patients to Inpatient Unit for an Inpatient Level of Care change.

Follow the policy "Entry to Inpatient Unit of a Current Hospice Patient," and when appropriate, "Entries for Patients from Field Offices," plus the following:

1. The social worker will notify the facility social worker of when the transfer will occur and arrange transportation to Inpatient Unit.

2. The nurse notifies the facility nursing staff when the transfer will occur, initiates the completion of the appropriate TB protocol before arrival, and obtains a copy of facility MAR (medication administration record).

3. If the patient does not bring the ECF medications, the Inpatient Unit nurse will call the medications in to contracted pharmacy and a local pharmacy at the time of transfer. The prescriptions are given to the family to give to the pharmacy when picking up the medication.

4. Nursing leadership should be notified at the time of identifying a patient transfer to the IPU, and the case manager shall also notify the administrator, DON, and Social Services at the ECF.

Effective Date: 02/04 Revised Date: ~~07/19~~ 3/21 Board Approved: 11/20/19
Reviewed Date: 09/14 Signature Date: 11/20/19

Signature: President/CEO

SUBCUTANEOUS ADMINISTRATION OF MEDICATIONS

PURPOSE: To provide for the administration of medication via the subcutaneous tissue.

POLICY: Subcutaneous access will be utilized to administer medication via intermittent or continuous small volume into the subcutaneous tissue where medication is absorbed through both adipose and connective tissue.

Subcutaneous access will be utilized when patient does not have an existing VAD or IV line and other routes of medication are not an option

Subcutaneous medications require a physician/NP order

In the home setting education, utilizing teach back method, will be provided for caregivers when intermittent medication is needed.

- When possible medication will be drawn up by the nurse, labeled, and left for the caregiver
- Patients must have a site for each subcutaneous medication needed
- Caregivers will be instructed to call triage with any problems or site comes out

For continuous small volume infusion see CADD pump policy

- Education will be provided to caregivers on caring for subcutaneous site
- Caregivers will be instructed to call triage with any problems or site comes out

Nurse evaluation of sites will happen at every visit and documented in the EMR.

Effective Date: 06/04 Revised Date: ~~05/16~~ 3/21 Board Approved: 10/19/16
Reviewed Date: 07/19 Signature Date: 10/19/16

Signature: President/CEO

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

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

Registered nurse will verify orders for initiating CADD pump in the medication profile before connecting the CADD pump to the patient.

CADD pump settings must be visually verified by a second nurse/pharmacist when initiating pump, changing dosages, or changing cartridges.

PCC/Nurse leadership on call must be promptly notified when ever there is a deviation from policy or nurse notes discrepancy in programming

Any mechanical problem with pump will be reported to Infusion Company.

Effective Date: 06/16	Revised Date: ~~08/20~~ 3/21	Board Approved: 11/18/20
Reviewed Date:		Signature Date: 11/18/20

Signature: President/CEO

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

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

SCOPE OF PRACTICE: Registered Nurse

POLICY: The Agency will provide blood product transfusions to patients 18 years or older for the management of symptoms associated with anemia

IDT will determine if a blood transfusion is within the hospice plan of care.

Obtain physicians order for blood transfusion

These transfusions can occur in the patient's home or in the ~~patient's preferred~~ Inpatient Unit.

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

PURPOSE: To have available refrigerated medications needed for patient use in an emergency.

When there is an emergency need for a medicine that the patient does not presently have, the RN/LPN will do the following:

1. Contracted pharmacy provider shall provide an emergency drug kit (EDK) containing medications determined by the Medical Director/Hospice Physician.

2. A new EDK is replaced when the current one has been opened, except on weekends.
   - RN/LPN may keep unopened EDK.
   - Pharmacy will send extra controlled substance EDK at the following times:
     - Long weekend involving a holiday on Monday or Friday.
     - Potential for inclement weather that could prevent deliveries.

3. The RN/LPN and pharmacy representative count and record the drugs in the opened EDK. The following are returned to the pharmacy with the opened kit:
   (a) EDK count sheet, which has been co-signed
   (b) Used medication charge slips

4. When ~~necessary~~ it is a non-covered medication, a local provider will be used to obtain a supply of medication. A family member ~~or volunteer~~, if available, will be asked to pick up the medication as needed. A courier may be used when family is not available to pick up the medication.

5. Upon delivery, inspect the package for tampering. If doubt, count the pills. Obtain a receipt of delivery and place in the Inpatient Unit Coordinator's mailbox.

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).

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 by the IPU Manager.
      - Code for keypad should never be communicated via email or written down anywhere in the IPU.
      - Only RN/LPNs may have access with their proximity card to the Medication Room.

   (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, pharmacy personnel.

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) IPU Clinical Leader/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 Manager's office—call the IPU Manager/IPU Clinical Leader for code.
   (b) Raclin House – Lock box in Volunteer closet—call the IPU Manager/IPU Clinical Leader for code.

Signature: President/CEO

Center for Hospice Care

INPATIENT UNIT – CONTROLLED MEDICATIONS RECONCILIATION

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

REGULATION: 42 CFR 418.54 - Initial and comprehensive assessment of the patient
42 CFR 418.106 – Drugs and biologicals, medical supplies, and durable medical equipment

PURPOSE: To verify and maintain an accurate count of controlled medications in the Agency's in-patient units.

POLICY: All controlled medications (Level 2, 3, 4) will be counted by two persons upon receipt of the medication and at the change of each shift. The count will be entered in the Medication Count book. All controlled medications will be kept in a locked box or cabinet. The key to the locked box/cabinet will be kept on the person of the RN/LPN responsible for medications on each shift when not in use.

1. When a new controlled medication is received for a patient in Inpatient Unit, two RNs or RN/LPN will verify the number/amount of medication being received. If there is not a second RN available in Inpatient Unit, the RN on duty will count the medication with the person presenting the medication. If no family member presents with the patient's medications, the controlled medication count will be witnessed by the Inpatient Unit Aide, who will sign verifying the original count. The number/amount of the medication will be entered in the appropriate place in the Medication Count book located in the medication room.

2. At change of shift, the RN/LPN ending the shift and the RN/LPN beginning the new shift will count each controlled medication and sign by the number entered in the Medication Count book. If the total does not equal the beginning shift count, minus the number given, a supervisor/manager will be notified and an incident report will be completed.

3. When a controlled medication is discontinued, the medication will be counted by two RNs or RN/LPN at the change of each shift. The medication sheet will be marked as DISCONTINUED. Any discrepancy in the count will be reported to a supervisor/manager, and an incident report will be completed.

4. Final disposal of medications in Inpatient Unit will be in accordance with the Agency's Medication Disposal policy.

5. If the unit is closing and there is only one nurse available, see agency's medication disposal policy

ATTACHMENT: Medication Deposition Record

Effective Date: 04/11	Revised Date: ~~07/19~~ 3/21	Board Approved: 11/20/19
Reviewed Date: 09/14		Signature Date: 11/20/19

Signature: President/CEO

Center for Hospice Care

INPATIENT UNIT – PATIENT ROOM CLEANING

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

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

PURPOSE: To establish guidelines for the terminal cleaning of patient rooms upon discharge of patients from Center for Hospice Care (CHC) MishawakaSouth Bend and Elkhart inpatient units.

POLICY: CHC ensures that patient rooms provide a clean, home-like atmosphere free of the transmission of air and blood borne pathogens.

CHC personnel will have training upon hire into the IPU on how to appropriately clean and sanitize a room

CHC personnel will show yearly competency on appropriately cleaning and sanitizing patient room

When outside cleaning agencies are used they will provide to the maintenance coordinator proof of training and competency in appropriate cleaning and sanitizing of patient rooms

Effective Date: 12/09	Revised Date: 3/21	Board Approved: 12/16/09
Reviewed Date: 07/19		Signature Date: 12/16/09

Signature: President/CEO

INPATIENT UNIT – KITCHEN USAGE

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

PURPOSE: To establish kitchen use guidelines.

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

Snacks or meals may be warmed in the microwave by staff or volunteers.

The prep kitchen will be used only by staff for patient-only food.

Patient kitchen will be inspected monthly by contracted Registered Dietitian and any deficiencies noted will be brought to the attention of the IPU Manager

Effective Date: 08/96 Revised Date: ~~07/19~~ 3/21 Board Approved: 11/20/19
Reviewed Date: 09/14 Signature Date: 11/20/19

Signature: President/CEO

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

PURPOSE: To ensure safe food handling and preparation.

POLICY: Any staff member or volunteer who prepares any food provided by Hospice, such as any food items ordered from a local restaurant or that was previously purchased by Hospice (soup, milk, juice, frozen meals or sandwiches) is described as a food handler and will follow the state guidelines.

1. Thoroughly wash hands according to policy.
2. Apply hairnet or head cover upon entering the kitchen for any reason (see Hair Restraints policy).
3. Prior to the beginning of food preparation, close doors to the kitchen. Do not allow entrance into the food preparation by other individuals~~,~~ that have not followed these guidelines~~,~~ until the food preparation is complete.
4. Apply disposable gloves.

Center for Hospice Care

INPATIENT UNIT – HAIR RESTRAINTS

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

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

PURPOSE: To ensure food safety.

POLICY:

1. Hair restraints shall be worn by all employees and volunteers while preparing food for a patient, regardless of the source of the food. Employees and volunteers in the same room where food is being prepared will also wear hair restraints. Once food is prepared and covered for delivery to a patient's room, the hair restraint may be removed.

~~2.~~ Kitchen doors will be closed while preparing food.

1. All hair, including bangs, shall be completely restrained in hairnet, white cap, or other cap while preparing food for a patient. Long hair must be pulled back and secured.

3. Hairnets or caps are not to be shared with anyone else. If used by the same person, they do not have to be discarded after each use.

3. Men with full beards must wear hair protection over beard or refrain from preparing or serving food.

Effective Date: 06/00 Revised Date: ~~05/16~~ 3/21 Board Approved: 10/19/16
Reviewed Date: 07/19 Signature Date: 10/19/16

Signature: President/CEO

Center for Hospice Care

INPATIENT UNIT – PET VISITATION

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

REGULATION: 42 CFR 418.110 – Hospices that provide inpatient care directly will provide homelike environment.

PURPOSE: To ensure safe pet visitation.

1. Pets owned by patients will be allowed to visit them for brief periods of time at the discretion of the Inpatient Unit ~~Coordinator~~ Manager or in her absence, nurse leadership.
   - Pets may not be left in care of the patient
   - IPU staff will not be responsible to feed, water, or otherwise care for patient pets

2. Pets must be kept on a leash or in the patient's room at all times. Pets that are disruptive or not on a leash will need to be removed from the inpatient unit (IPU).

3. Pets must be current in vaccinations with documentation on file in the patient's chart before pet visitation.

4. Consideration will be given to patients, visitors, and staff who have allergies to any pets. The Inpatient Unit ~~Coordinator~~ Manager will evaluate and advise accordingly.

5. Therapy pets must be registered as a therapy pet and must have that paperwork, as well as vaccination paperwork, on file with administration before visiting any area of the agency.
   - Therapy pets must be approved by the administrative team.

Effective Date: 08/96	Revised Date: ~~08/19~~ 3/21	Board Approved: 11/20/19
Reviewed Date: 09/14		Signature Date: 11/20/19

Signature:  President/CEO

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

PURPOSE: To provide for standardized linen handling and to dispose of contaminated linen.

~~PROCEDURE~~ All linen used by patients will be laundered by a licensed, contracted vendor. No patient linen may be laundered at the IPU.

Clean Linen:

1. Clean linen will be stored in a closed cabinet to protect it against airborne contamination.
2. Staff will take only the linens for that particular patient into a patient's room.
3. Any linen taken into a patient's room is considered dirty linen and must be used for that patient or be removed from the room as soiled linen.
4. It is permissible to store unused linen in the bedside cabinet if kept to a minimum. These linens will be removed upon discharge of the patient.
4. Linen will be changed to provide a clean, comfortable environment for the patient a minimum of two times a week and PRN for patient cleanliness and comfort.

Soiled Linen:

1. Standard precautions are used with linen handling.
2. Hampers will be utilized in patient room/bathroom and lined with a plastic bag. When hamper plastic bag is full, it is tied and transferred to soiled utility room.
3. Linen dropped on the floor will be considered dirty and not used for the patient.
4. Soiled linen will not be thrown on the floor.
5. Soiled linen from a patient in isolation will be placed in a double plastic bag to provide identification for the laundry vendor.

Effective Date: 08/96	Revised Date: ~~06/16~~ 3/21	Board Approved: 10/19/16
Reviewed Date: 07/19		Signature Date: 10/19/16

Signature: President/CEO

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

PURPOSE: To prevent air contamination and spreading of germs by proper disposal of waste material.

1. Waste receptacles will be lined with plastic bags. The trash filled bag will be tied and removed from the receptacle.

2. Waste receptacles located in the dining room, kitchen and soiled utility room will be lined with heavy plastic to prevent leakage. The receptacles will be covered.

3. Waste receptacles will be emptied daily and as needed.

4. Housekeeping will clean any waste receptacles visually soiled.

5. Gloves will be worn to pick up trash found on the floor in accordance with Universal Precaution Guidelines.

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

PURPOSE: To provide a safe environment consistent with CDC and OSHA guidelines. Contact Precautions are designed to interrupt the mode of transmission of infections that are spread by direct or indirect contact with the patient or the patient's environment.

POLICY: This policy and ~~Procedure~~ is in conjunction with other pertinent infection control policies to help prevent the spread of infections.

Definitions:

- Nosocomial Infection – An infection acquired during hospitalization.
- Communicable Diseases – Infectious diseases that result from transmission of an infectious microorganism or its products to a susceptible human host either directly or indirectly.
- Contagious Disease – Communicable diseases transmitted by direct contact.

Inpatient Unit

1. Prior to entry into Inpatient Unit, patients will be screened for a communicable disease (including active TB). See ~~Communicable Disease~~ TB screening tool.

2. Upon entry to Inpatient Unit, identified patients at risk will be provided a safe environment by:
   - Posting signage at the door that will inform staff, visitors and volunteers of all guidelines prior to room entry.
   - Maintaining contact precaution supplies outside the patient's room in a manner that provides appropriate access to PPE prior to entry into the patient's room.
   - Following policy titled "Linen."

3. Educating visitors and volunteers of the importance of following recommended guidelines with all being educated on proper hand hygiene and use of appropriate PPE.

4. Communicable or infectious diseases will receive the least restrictive precautions necessary to prevent the spread of the organism, while maintaining the integrity of the process, dignity of the patient, and preventing discrimination. See Guide to Implementing Standard vs. Contact Precautions.

6. ~~Patient will have a private bathroom.~~ Patients who are admitted with Clostridium Difficile that had formed stools for 24 hours may have isolation discontinued.

Signature: President/CEO

- This qualitative fit testing will be repeated as needed and repeated immediately when the wearer has a:
  - Weight change of 20 pounds or more
  - Significant facial scarring in the area of the face piece seal
  - Significant dental changes (i.e., multiple extractions without prosthesis or
  - acquiring dentures)
  - Reconstructive or cosmetic surgery
  - Any other condition that may interfere with face piece sealing

- Summary of all fit testing log shall be maintained. Summary log shall include:
  - Name of test subject
  - Date of testing
  - Name of test conductor
  - Respirator selected (manufacturer, model, size, and approval number)

Fit testing may be temporarily suspended during an endemic when approved by the CDC/OSHA.

REGULATION: 42 CFR 418.60 – Infection control

PURPOSE: To screen healthcare workers and volunteers that have the potential for direct patient contact for infection with the tuberculosis bacillus (mycobacterium tuberculosis) in accordance with OSHA Standard 29CFR 1910.1030, the Core Curriculum on Tuberculosis by the CDC, state and federal regulations.

GENERAL INFORMATION

1. Upon hire, each employee or volunteer who will have direct patient contact may provide proof of a negative two-step TB test result anytime within the previous 12 months. This negative result can be determined from the following testing methods: Mantoux method TST (tuberculin skin test) or a quantiferon-TB assay ' for those who do not have a history of positive results with these testing methods.

2. If new hire has not had a negative two-step TB test in the previous 12 months must have a baseline two step Mantoux completed before patient contact.

3. The two-step method of Mantoux TST is administer the first TST and repeat the TST one to three weeks following the first test.

4. Any person with a documented history of tuberculosis or a previously positive test result for TB, or has completed treatment for TB, or has a newly positive to the Mantoux method TST must have a documented chest x-ray to exclude a diagnosis of TB. These chest x-ray results are to serve as their baseline and to show medical evaluation for active disease was conducted.

5. Pregnancy will not exclude someone from receiving Mantoux method TST unless they have a physician's note to that effect. If a physician states someone cannot receive the required TB testing (skin test or chest x-ray), they will not be allowed to work until testing can be performed.

6. Reaction following administration of the Mantoux TST is identified as a hard induration at the injection site, transverse diameter measured with an mm ruler. Redness or erythema is not measured.

7. Record results in mm of induration on the Agency TB record:
   - Area of induration 0-4mm/negative, **no action needed**
   - Area of induration 5-9mm/possible significant, **retest in one week**
   - Area of induration 10mm and more/significant reaction, **obtain a chest x-ray**—see #9 and #10.

Signature: President/CEO

REGULATION: 42 CFR 418.114 – Personnel qualifications

PURPOSE: To provide a system in which all new employees are oriented in the philosophy of the agency, personnel policy manual, benefits, patient care policies, quality assurance programs, and general core information.

POLICY: All new employees will be oriented on all applicable subjects listed on the employee orientation checklist.

The employee signature represents that they have received and understand the information.

Each department will be responsible for generating an employee department specific orientation.

- Nursing department will generate their job specific orientation in conjunction with the Clinical Educator

Effective Date: 03/99	Revised Date: ~~10/05~~ 3/21	Board Approved: 10/18/05
Reviewed Date: 07/19		Signature Date: 10/18/05

Signature: President/CEO

REGULATION: 42 CFR 418.114 – Personnel qualifications

PURPOSE: To certify and verify that Agency staff are licensed in accordance with federal, state and local laws and regulations.

POLICY: Agency staff providing patient care must be licensed or certified in accordance with applicable laws or regulations for their individual discipline upon employment.

Employees are responsible for maintaining current licensure or certification as required for their position.

Employees with expired licenses will not be allowed to work until renewal occurs and is verified.

Verification of professional licensures and certifications will be completed and maintained by the Human Resources department.

All professional licenses will be verified with the Health Professions Bureau in Indianapolis to verify a current license and one in good standing prior to offering employment. Proof of this verification will be maintained by the Human Resources Manager.

Human Resources electronically verifies licensure. The employee is responsible for maintaining current Indiana licensure.

Center for Hospice Care
QI Committee Meeting Minutes
February 23, 2021

Members Present:	Alice Wolff, Amber Doland, Carol Walker, Carolyn Burke, Craig Harrell, Holly Farmer, Dr. Karissa Misner, Lance Mayberry, Larry Rice, Mark Murray, Natalie Barnes, Tammy Huyvaert, Becky Kizer
Absent:	Angie Fox, Deb Daus, Jennifer Ewing

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 11/17/20 meeting. The motion was approved unanimously.	T. Huyvaert motioned C. Harrell seconded
3. Medical Staff Update	• We have been tracking medical staff IPU visits since the first quarter of 2020. There 465 IPU patients in 2020 and of those, 348 received a visit from medical staff. Of the 117 not visited – 14 died on a weekend stay, 100 died within one day, and 3 were unknown—we have since collected that information. We are looking at the 100 that died within one day. That number was down compared to 2019. • QA is tracking signed consents for palliative extubations. We started two forms—one is for palliative extubation and the other is for the medications used to sedate the patient in order to do the extubation. We will be tracking this in 2021.	
4. Support Services Update	• Chaplains – 91% of patients admitted in 2020 chose chaplain support, which is down from 94% in 2019. COVID may have had something to do with that, but we are still well above the national average which is in the 70's. We are also tracking compliance regarding spiritual assessments being done in the first five days of admission—we had 99% compliance and our goal is 100%. Chaplains are looking at increasing spiritual care provided to Enhanced Services patients and doing daily contact with them. • Social Work – Compliance regarding psychosocial assessments being done in the first five days of admission was 95%, which is down from 99% in 2019. We had some staffing issues in 2020. We will continue to monitor this to improve that percentage. 109 Respites were scheduled in 2020 with and we had 100% compliance in Respite documentation. Social workers continue to speak about the availability of Respite to patients and families. One of our 2021 goals is to increase	

Topic	Discussion	Action
	Enhanced Services hours and offer to call daily if the family agrees. We have started training to incorporate social workers into our specialty programs including palliative care education. • Bereavement – EGSS survey report for January-June 2020, CHC was above the national average in 10 areas and below in 22. For July-December 2020, CHC was above the national average in 26 areas and below in 6. Julie Fairchild enters the EGSS data into a spreadsheet so can see monitor for trends as they happen. Holly F. continues to meet with NHERT bereavement members. They talked about the EGSS survey. Not everyone uses it. We also created our own survey for individuals and families which includes a lot of community clients. The initial review shows 99% would recommend our bereavement services and 96% were satisfied with the bereavement services they received. We will continue to bring additional data from these surveys to the committee.	
5. Quality Monitoring – Triage Calls	• The top three reasons for calls to triage were: (1) medications/symptom management, (2) change in condition/death, (3) falls/needing lift help. In 2021 we are focusing on improving customer service with patients on the phone and meeting all their needs. We are also looking at improving internal and external phone problems we have had. We are now monitoring all calls at an individual level, not just the volume of calls, to see whether something could have done before the call came in.	
6. Discharges	• Reviewed NHPCO's 2018 numbers compared to CHC in 2019 and 2020. Revocations – CHC was 5.4% in 2020 compared to 6.6% nationally in 2018. In 2019 we identified we were a little above the national average, so we began to focus on that and had successful results. Our score was down 1.4% from 2019. We worked with hospitals to help educate patients/families. We also communicated with patients/families on any anticipatory procedures and incorporate that into the plan of care as related to the terminal diagnosis. • Transfers were down from 1.3% in 2019 to 1.1% in 2020, which is still below the national average of 2.2%. • Moved out of area – These are patients that moved out of our service area or went to a non-contracted facility. 2019 was 2.2% and 2020 was 1.9% compared to the national average of 1.6%. These discharged are initiated by the patient and not as monitored as things that CHC initiated.	

Topic	Discussion	Action
	• No longer terminally ill was 1.5% in 2020 which is well below the national average of 6.3%. We can contribute this to the fact that our doctors are very involved in the admission process. QA is also monitoring recert documentation to see how the patient is doing and whether processes are in place for communication if the patient is borderline and we want to review something for a longer length of stay. We have had excellent outcomes with that communication. • Discharged for cause is rare. A lot of it is related to drug diversion or dangerous behavior. We are on par with the national averages. As a team, we review patient care so we can try to meet patients where they are.	
7. Specialty Programs	• HeartWize and BreatheEazy – Hospitalizations remain very low, which confirms these programs work. The next steps are to incorporate these programs into palliative care. We are working towards Dementia education for staff and once that is completed, we will report how we are doing and what those measurements look like.	
8. Adverse Events	• We continue to use the hospital standard of falls per 1,000 patient days. The national average is 3-5 and we are within those numbers. Falls decreased significantly in 2020. We will be able to pull reports in MatrixCare from patient visits, so we will be able to identify more falls and events especially if they were the result of medication reaction or suspicion of abuse/neglect.	
9. Hospice CAHPS	• We used Carol W.'s suggestion to collaborate with Press Ganey as consultants on strategies. They provided the top key driver focus areas for the data from July-December 2020: train to safely move, emotional support received, really cared about patient, and, kept informed about care. If we can hit those top box scores for three of those key drivers, there is a 96% likelihood we would be scored 9 or 10 in all other areas. We did education during last summer on various areas as identified from our scores. We will use the tools Press Ganey built and get these processes ingrained in our culture.	
10. Administrative Services	• We have been able to review all the CoPs for program data except administrative services. One area we looked at is having a copy of the CPR certificates of nurses in their HR files and we had 100% compliance. A new regulation states our Aides also need to be CPR certified, so we will be working on that in 2021.	

Topic	Discussion	Action
11. HIS	• Per CMS we are assessing the common areas at the time of admission where patients are in need, discussing treatment preferences, and providing education on our services. Historically we have been above 90%. We focused on the fourth quarter 2020 because that was when we converted to a new EMR. As of January 2021, we are back above 90% in all areas.	
12. Hospice QAPI Programs	• The areas we focused on were CAHPS scores, care planning, infection monitoring, decrease the number of emergency nursing visits, and decrease number of calls to triage. One resource that has been helpful is NHPCO's Quality Connections. This is a new program to help build and keep focus on QAPIs. We will also be utilizing Press Ganey as a resource. This is a good measure of anticipatory skills to decrease the number of calls to triage and emergency nurse visits. Care plans are an exceptional tool for communication between clinicians. Infection control – We review to make sure we are monitoring and using MatrixCare as a tool to meet these standards.	
13. Palliative Home Health Program	• Adverse Events per 1,000 patient days – With MatrixCare, we are to get a direct report from the documentation. Other areas we are monitoring are decline in more than 3 ADLs, and UTI rates. We can also identify is pressure ulcers, oral meds, abuse, etc., so we can show how to document effectively in MatrixCare to make sure these areas are met.	
14. Home Health QAPI	• We are monitoring hospitalizations, falls and adverse events, CAHPS scores, and documentation and incorporating preventative measures.	
15. Quality Improvement Report	• In conjunction with MatrixCare we have created QA monitoring tools. This is similar in structure to the wound monitoring tool in which we can review data in relation to what the topic is, who is in compliance, and whether that area was met. We can do that at the individual level, which will allow us to identify individual needs for education. • HIM Committee – The committee is working on updating the files and tools on the staff website to insure it is organized and help staff have easy access to the information. • Education on CoPs – We do education regarding home health and how it is different from hospice. We are focusing on that doing that at meetings.	

Topic	Discussion	Action
	• We are doing weekly MatrixCare education. Natalie B. is working with Amber D. on having structured education to ensure each clinician is getting the same education at the same time. We do a staff survey on which areas they would like to review. • Accreditation and survey readiness – We are working on policies and preparation for becoming accredited. • Root cause analysis – We are working on having the ability to collaborate on education so we can provide robust reviews as a team. In January we were compliant in 75.5% of 18 various areas we are monitoring regarding all documentation. We discuss the foundational points of documentation for hospice and home health. We are making sure clinicians have that flow of documentation from Cerner and understand it is in MatrixCare and can find it to make sure those areas are still being documented. Our goal is to be in compliance 95% or greater. We were able to reach that goal with full monitoring.	
Adjournment	• The meeting adjourned at 8:35 a.m.	Next meeting 05/25

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report

May 19, 2021

(Report posted to Secure Board Website on May 13, 2021)

This meeting takes place exclusively on Zoom with no in-person option on Wednesday, May 13, 2021. **Zoom connection information will be sent in a separate email.** The HF and GPIC Board meetings will follow with the same Zoom connection after a very short break. We hope to be back to an in-person meeting with no Zoom option in August. CHC bylaws require in-person attendance for board meeting participants. This directive has been disregarded during the pandemic.

CENSUS

Year-to-date through April 2021, referrals are down 2.6% from same time last year. YTD the percentage of referred patients dying before they could be admitted is at 7.87%, up from 6.64% in 2020. The YTD average daily census is down 8% from last year. The inpatient units did not start out the year strong but have slowly picked up. The bright spot is the average length of stay (ALOS) in both units has increased from same time last years. Raclin's ALOS is currently at 5.45 days compared to 3.93 days in 2020 and Esther's House is at 5.79 days compared to 4.40 days last year. Much of the decrease in referrals and average daily census is due to nursing facilities and assisted living facilities and their low census related to COVID-19. I cover this in detail in a section later in this report. They simply don't have the numbers of patients currently to send to hospice.

April 2020 Overall	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	482	912	1,008	-9.52%
Original Admissions	124	515	589	-12.56%
ADC Hospice	333.87	341.13	393.98	-13.41%
ADC Home Health	58.00	53.94	37.02	45.71%
ADC CHC Total	391.97	395.07	431.00	18.34%

April 2020 Inpatient Units	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Raclin House Pts Served	34	108	120	-10.00%
RH House ALOS	5.35	5.45	3.93	38.68%
RH House Occupancy ***	50.56%	40.90%	55.73%	-26.61%
Esther's House Pts Served	30	72	112	-35.71%
EH House ALOS	4.50	5.79	4.40	31.59%
EH House Occupancy	64.29%	49.64%	58.21%	-14.72%

NOTE on Year over Year Comparisons: SB IPU 1/1/20-9/14/20 = 7 beds; Raclin House 9/15 – 10/31 = 12 beds

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2021 Jan	**2021** Feb	**2021** Mar	**2021** Apr	**2021** May	**2021** June	**2021** July	**2021** Aug	**2020** Sept	**2020** Oct	**2020** Nov	**2020** Dec
Mish:	214	215	208	205					224	219	232	214
Ply:	80	81	79	75					82	77	77	76
Elk:	85	85	84	84					104	103	101	90
Lap:	9	12	14	18					20	18	16	12
RH:	5	4	5	6					4	6	5	5
EH:	3	2	4	5					3	4	4	2
Total:	396	399	394	392					437	423	435	399

PATIENTS IN FACILITIES

In April 2021, the average daily census of patients in nursing homes, assisted living facilities, and group homes was 90. Year-to-date through April 2021 the ADC of patients in facilities was 92.

2020 DRAFT CONSOLIDATED FINANCIAL AUDIT AND STATEMENTS

The DRAFT 2020 audited financial statements are on the Board Agenda. They were reviewed by the Finance Committee on Friday May 14th at an extended Finance Committee meeting with the auditors from Kruggel Lawton CPAs via Zoom. Following Finance Committee approval, the DRAFT audited financial statements will be posted to the board website on 5/14/21. Hard copies of the 2020 audited financial statements by Kruggel Lawton CPAs will be distributed to all board members at the August in-person board meeting. Due to the HHS surprise and not requested stimulus funding that CHC (and most all Medicare providers) received in April 2020, a second single audit was additionally required. That single audit will be included in the overall audit. Because HHS still has no mechanism to submit the required expense report (which they still haven't published instructions or what they are looking for yet either) and because the required single audit is related to our regular audit where the HHS funding is mentioned, you will be asked to approve the DRAFT audit at this time. The 2020 audit will remain in DRAFT form until the federal government gets around to figuring out what they want to do regarding the billions of dollars they handed out over a year ago. K&L will be putting together a cover letter explaining the reason for the DRAFT status to inform any third parties -- like grant makers, community foundations, etc. – who request a copy of the 2020 CHC and affiliates audited financial statements.

FINANCES

Karl Holderman, CFO, reports the year-to-date April 2021 financials will be presented and voted on at the Finance Committee meeting to be held via Zoom on Friday, May 14, 2021 and then posted to the secure board website later that morning. For informational purposes, the un-approved March 2021 YTD Financials are presented below.

On 3/31/21, at the HF, intermediate investments totaled $5,000,467. Long term investments totaled $27,034,829. The combined total assets of all organizations (CHC/HF/GPIC), on March 31, 2021 totaled $77,202,009 an increase of $11,691,796 from March 2020. Year-to-date investments as of 3/31/21 showed a gain of $717,977.

From a year-to-date budget standpoint at 3/31/21, CHC alone was under budget on operating revenue by $459,979, and under budget on operating expenses by $1,265,876.

Year to Date March 2021 Unapproved Financials

March 2021 Year to Date Summary	**Center for Hospice Care**	**Hospice Foundation**	**GPIC**	**Combined**
CHC Operating Income	5,792,638			**5,792,638**
MADS Revenue	42,915			**42,915**
Development Income		170,289		**170,289**
Partnership Grants			170,050	**170,050**
Investment Income (Net)		717,977		**717,977**
Interest & Other	39,962	29,384	2,806	**72,152**
Beneficial Interest in Affiliate	172,815	3,931		
Total Revenue	**6,048,330**	**921,581**	**172,855**	**6,966,020**
Total Expenses	**4,903,728**	**748,766**	**168,924**	**5,821,418**
Net Gain	**1,144,602**	**172,815**	**3,931**	**1,144,602**
Net w/o Beneficial Interest	*971,787*	*168,884*		
Net w/o Investments				***426,625***

CHC VP/COO UPDATE

Lance Mayberry, MBA, CHC VP/COO reports…

Several new initiatives focused on continuous improvements in patient satisfaction, quality assurance, and employee appreciation have been instituted since our last board meeting.

Our triage department, staffed by Registered Nurses 24 hours, 7 days a week, has launched a robust answering system with RingCentral. The implementation of the new system has led to positive results in the following key areas: Reduced hold times; Stability of our call system; quality assurance monitoring; and flexibility in staff scheduling.

We made a capital investment in seven new Hill-Rom beds for Esther's House, retiring the original beds placed into service in 2010. The life expectancy of a hospital bed is ten years. The new beds are identical to the beds installed in Raclin House in 2021. The Hill-Rom beds provide several safety and comfort features for patients and employees, from pressure-reducing mattresses to body assistive positioning.

Natalie Barnes, RN, Quality Assurance/ Medical Records Coordinator, has joined the NHPCO Quality Connections to ensure the Center for Hospice Care QAPI program is at the forefront of ensuring quality care. The new program is designed to enhance our team members' knowledge base, skills, and competency. Quality Connections is structured around four fundamental pillars: Education; Application; Measurement; and Innovation. Quality Connection membership provides education, tools, resources, and opportunities for engagement and interaction with other hospice providers, which will position CHC to achieve and sustain continuous quality improvement to be the premiere hospice and palliative care organization for all end-of-life issues in the communities we serve.

Angie Fox, RN, DON, facilitated multiple employee engagement sessions with various clinical team members focusing on developing a foundation of employee engagement and retention tools. There was positive feedback from the meetings, and the clinical leadership is integrating the feedback into quarter-over-quarter employee engagement plans.

Amber Doland, RN, Clinical Staff Educator, and steering committee successfully launched the CHC Learning Management System (LMS). The LMS will give team members greater flexibility in completing their annual education through our Intranet / Staff website in addition to: ensure consistency in content delivery; streamline orientation information for new hires, create a foundation to simplify our process to create curriculum, automate the tracking of attendance/ compliance.

We are proud to announce we are off to a great start in achieving our 2021 goal of increasing utilization of our Enhanced Services. Our 2021 goal is to achieve a 20% increase over 2020 as measured by Service Intensity Add On (SIA) based on available hours. During our first quarter as an entire program, we are well above the 20% goal, and look forward to quarter over quarter growth of our Enhanced Services offering. The SIA is an additional Medicare hospice payment for RN and social work visits made during the seven last days of life. The payment is made in fifteen-minute increments and the national rate is about $60 an hour. Medicare views these visits as important and in the process of publicly adding each hospice's performance as a quality measure.

With the addition of Dr. Matt Misner, Pediatrician, we have evolved our Pediatric Protocols over the last quarter. In such a short time, Riley Hospital in Indianapolis has noticed Dr. Matt Misner's passion for quality care and thoroughness which has resulted in increased referrals to our program. Dr. Matt Misner continues to further his relationships to create awareness of our Pediatric program with pediatric palliative care teams at St. Vincent's in Indianapolis and locally at Memorial Hospital.

We continue to strengthen our relationship with the local education systems. We have launched a nursing student survey to capture the students' experiences with our CHC preceptor nurses. The survey was designed around the following pillars: celebrate strengths of preceptorship, identify areas for leadership growth, encourage the understanding and interest in Hospice Care, spark interest for a nursing career with CHC. We recently received a very nice letter from our partners at Indiana University South Bend, Rebecca Zellers DNP, MSN - Nurse Educator, RN, Clinical Assistant Professor, Vera Z. Dwyer College of Health Sciences and it is attached to this report.

Dr. Karissa Misner, MD, CMO has been working with Dr. Bumni Oklanlami in the curriculum development for a palliative care minor at Indiana University South Bend. Dr. Misner is in ongoing discussions with Dr. Okanlami in assisting in the facilitation of various areas of the curriculum. We have also been in the process of forming an Oncologic Palliative Committee to oversee the development of a palliative oncology specialty program. Initial meetings have been held with Oncology Physicians, and nurse educators from the local health systems.

CHC DIRECTOR OF NURSING UPDATE

Angie Fox, CHPN BSN RN. CHC DON, reports…

Angie is on a personal leave of absence and will return on June 1.

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 2021, the Development Department recorded the following calendar year cash gifts as compared with the same period during the previous four years:

Year to Date Total Revenue (Cumulative)

	2017	2018	2019	2020	2021
January	46,552.99	37,015.96	62,707.48	79,642.06	44,297.77
February	199,939.17	93,912.90	113,771.80	222,116.20	92,053.38
March	282,326.61	220,485.17	369,862.26	295,882.74	302,752.14
April	431,871.55	310,093.61	565,568.94	414,128.88	894,989.96
May	574,854.27	505,075.65	663,483.70	565,824.55	
June	1,066,118.11	633,102.69	850,496.19	608,907.96	
July	1,277,609.56	767,397.15	918,451.53	676,956.69	
August	1,346,219.26	868,232.25	1,018,532.22	818,805.78	
September	1,466,460.27	994,301.35	1,122,498.94	901,877.85	
October	1,593,668.39	1,074,820.86	1,778,379.29	984,590.41	
November	2,443,869.12	1,173,928.93	1,841,457.95	1,036,179.10	
December	2,730,551.86	1,635,368.33	2,946,889.74	1,719,702.83	

Year-to-Date Monthly Revenue
(less major campaigns, bequests, and significant one-time major gifts)

	2017	2018	2019	2020	2021
January	31,552.99	37,015.96	51,082.36	52,550.56	43,733.76
February	35,125.58	56,896.94	45,621.02	140,985.12	44,539.12
March	79,387.44	113,969.42	254,547.16	70,044.19	50,251.42
April	149,569.94	87,978.18	194,857.93	118,092.10	44,391.21
May	142,982.72	182,601.92	97,864.76	149,945.67	
June	146,200.17	46,947.92	69,026.39	42,369.40	
July	61,505.45	64,243.53	67,591.20	42,034.72	
August	63,593.03	61,803.98	54,739.37	40,023.54	
September	120,261.01	117,984.73	68,812.68	71,574.73	
October	127,208.12	79,852.69	50,019.27	68,718.24	
November	75,809.56	94,053.07	57,214.65	51,099.68	
December	286,687.74	191,211.72	225,547.36	398,935.27	
Total	**1,319,883.75**	**1,134,560.06**	**1,236,924.15**	**1,246,373.20**	**182,915.51**

Fund Raising Initiatives

Based upon previously reported strategic planning sessions, action plans are underway with regard to HF's Tier 1 fundraising priorities:

- Care Connections Center at Milton Village (Milton Adult Day Services/Roseland facility Rehab) – We hosted our first hard hat tour of the facility in April as we continue donor outreach through Zoom calls with current donors and cultivation calls with prospective major gift donors. Top tier donor prospects continue to be identified, cultivated, and solicited.
- Annual Giving – Please review "Annual Appeal" update that follows.
- Sister Carmel Helping Hands Fund (charity care) – We were encouraged by Sister Carmel to apply for additional funding from the Sisters of the Holy Cross (CSC). We continue to build this fund with support from the Sisters along with funds from Annual Appeal donors who directed their donations to the Sister Carmel Helping Hands Fund.

- GPIC/International – Our work with a grant writer on a contractual basis is resulting in grant applications for funding from various corporate, public, and private foundations.
- Honoring Choices Indiana – North Central – The same grant writer tasked with GPIC is dedicating time to identifying and applying for funding from various sources.

Annual Appeal – "Now More Than Ever"

Response to our 2020 Annual Appeal, "Now More Than Ever" through 4/30/21 totals $119,229.45. This appeal focused on our need for support as CHC cares for all patients seeking hospice care regardless of their ability to pay. Our messaging to donors involved sharing our need for support at all levels of giving during a time when all of HF's fundraising events were cancelled in 2020 due to the COVID-19 pandemic.

Planned Giving

Estate gifts from January through April 2021 totaled $50,151.75. Some of these gifts were in process for many months. We continue to field requests from financial advisors and attorneys about planned giving options and bequests from their clients.

2021 Events

Our 36th Helping Hands Award Dinner honoring Drs. Zoreen and Rafat Ansari is taking place on September 8, 2021. This will be the first time that we have a two-year Helping Hands Award recipient due to the pandemic which resulted in rescheduling our May 2020 event to September 8. To RSVP, sponsor or learn more, please visit: FoundationforHospice.org/HHAD2021.

Due to the ongoing COVID-19 gathering restrictions, we plan to conduct this year's Elkhart Campus Gardens of Remembrance and Renewal Memorial Dedication Ceremony virtually on June 22, 2021.

Health System/Professional Education Collaborations

The 2020-2021 family medicine residents from Saint Joseph Hospital are completing their time with CHC as they do their four-week geriatric rotations. We hosted two IU School of Medicine students here in February and March, each for two weeks of their hospice and palliative care rotations. Planning is beginning for the 2021-2022 residency programming which will begin in July.

Another IU School of Medicine collaboration included facilitating a virtual version of IU Talk for the Saint Joseph Health System residency program on February 10. Eighteen residents attended the afternoon-long session. We anticipate offering this on a yearly basis to the family medicine residency programs at both Saint Joseph and Beacon Health Systems, either virtually or in person, as we come out of the COVID-19 pandemic. These rotations and workshops continue to be an opportunity to recruit fellows for the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine.

We have renewed our Hospice Foundation of America membership and CE accreditations for the upcoming year. Our Center for Education and Advance Care Planning (CEACP) is working with various CHC departments to determine which webinars are needed. COVID-19 safety measures are in place to allow employees to watch these in person for CE credits.

Outreach to Legislators

NHPCO's grassroots campaign, MyHospice has continued to grow with our community education coordinator and NHPCO ambassador Elleah Tooker, HF Community Education Coordinator, prioritizing email outreach during this time to continue to develop relationships with our legislators. COVID-19 and hospice priorities have been discussed in detail during this time and our priority is to ensure that Indiana's Senators and House members are aware of those issues as they meet to discuss current bills. Through these efforts the Rural Access to Hospice Act was passed. The group continues to advocate for other hospice-related bills to our representatives. The program has grown to include new states and representatives which have allowed Elleah to engage with multiple hospice communities across the country.

Community Education

The Center for Education & Advance Care Planning (CEACP) offers a variety of events to organizations in our community to introduce – and expand – end-of-life conversations. As we continue our transition to a virtual platform due to COVID-19, virtual panel discussions are being presented via Facebook Live. This series has engaged community members in views, likes, shares and comments. For example, the funeral planning Facebook Live event held on January 28th reached 285 people, with seven responding to the event. In addition, we had 11 likes/hearts along with 19 comments and 404 views. The video reached Goshen, South Bend, Mishawaka, Elkhart, and Granger viewers ranging in ages from 18 to 65+. The bereavement Facebook Live held on February 4th reached 206 people ranging in ages from 25 to 65+ with 10 responses to the event. The video reached South Bend, Mishawaka, Goshen, Granger and Knox viewers with 15 comments and 349 views as well as nine reactions to the video. On March 11th CEACP held a deep dive panel discussion into Advance Care Directives (ACDs) which reached 165 people with three responses. Viewership reached Goshen, South Bend, Alexandria Virginia, Mishawaka, and Middlebury. Viewers ranged in ages from 18 to 65+. There were reactions along with 15 comments and 342 views on the video.

Outreach to universities and colleges is underway as CEACP gears up to enter the classroom once again. CEACP has been compiling a listing of related class topics as well as professor emails to reach out to and offer educational pieces. Prezi presentations along with short videos and documentaries to spark discussion around end-of-life topics have been created aimed at students in a variety of educational fields.

Our next "Introduction to Hospice and Palliative Care" course at the University of Notre Dame is scheduled for the spring semester of 2022. We are anticipating that this will be a hybrid offering (part online/part in person) and that it will become a 1.5 credit hour course rather than a one-credit course. This is primarily directed to undergraduates pursuing the healthcare field.

Honoring Choices Indiana® – North Central

As we begin to move out of the COVID-19 pandemic, we are seeing an uptick in requests for presentations and facilitator training. We anticipate these will ultimately lead to more advance care planning conversations. Steve Chupp, the HCI-NC coordinator, became a certified First Steps instructor in March. Michael White, a former advisory council member and retired palliative care nurse, has become an Advance Steps® instructor as well. Presentations continue to be the primary

way we are educating the community of the need for advance directives. Steve Chupp and Dr. Mark Sandock, who chairs our HCIN-NC advisory board, continue to make presentations to community organizations as well as extended care facilities and healthcare organizations. Steve and Michael are leading two First Steps® facilitator training workshops to certify Beacon Health associates. Twenty-five people have been registered for these workshops. In addition, we are working with the South Bend Clinic to develop an ongoing program to train staff members as facilitators. They can then assist patients with developing or updating their advance directives. An on-going focus of HCIN-NC continues to be sustainability. The group recently received $10,000 from Trinity Health (St. Joseph) and has been notified that we will receive $5,000 from the Community Foundation of Elkhart County. Steve is continuing to collaborate with Honoring Choices-MN (HCMN)to establish several state-wide advance care planning hotlines, including one for Indiana. HCMN is in the process of applying for major funding ($100,000 per state per year for two years) from the Robert Woods Johnson Foundation.

Palliative Care Association of Uganda (PCAU)

While COVID-19 is still an issue, the number of cases in the country are not high currently. As of May 1, there were a total of 41,973 confirmed cases and 342 registered COVID-19 deaths. On March 5th, Uganda received its first COVID-19 vaccine doses (AstraZeneca), and vaccinations began with healthcare workers, teachers, and those in high-risk groups (including the elderly). As of May 1, 339,607 people had been vaccinated, which translates into just 0.8% of Uganda's population. Availability and vaccination hesitancy are both factors contributing to the low numbers. The government of Uganda recently changed its entry requirements, and the US is currently in Category 2 which encourages travelers to postpone any non-essential travel. With the spike in COVID-19 cases in India, travelers from this country have been placed in Category 1; Uganda has suspended all passengers/flights originating from India until further notice. All travelers are subject to testing and quarantine requirements.

Since Uganda's national election on Jan 14th there have been many internal dissenting voices, and the US recently announced visa restrictions on those believed to be responsible or complicit in undermining the democratic processes. The presidential swearing-in and inauguration ceremony will take place on May 12; some protests or violence are expected in the weeks around this date. PCAU is planning to hold their annual general meeting (AGM) on May 28 but are keeping an eye on the political tensions in hopes that their meeting and other ongoing project activities will not be disturbed.

Lydia Nakawuki, the Road to Hope program officer, left PCAU in March to pursue a new career. PCAU received more than 200 applications for the opening and is working with an HR agency to identify finalists for PCAU to interview. They hope to fill the position by the end of May. In the meantime, Stephen Kasula, RTH graduate, medical school student and PCAU volunteer, has stepped up to help with the RTH program. Also, in March, PCAU hired Lisa Christine Irumba into the newly created position of research and advocacy officer. This position is key for their strategic plan. Christine was previously with Hospice Africa Uganda (HAU), so she was able to hit the ground running. The Ministry of Health (MoH) recently announced a new directive that all public hospitals must allocate space/room for a palliative care unit in their hospitals. This a significant development for palliative care, and a very important advancement for PCAU's vision – palliative care for all in need in Uganda. Over a number of years PCAU has laid the groundwork for this goal and now will be instrumental in helping all public hospitals meet this directive. It will be a big task.

The mHealth project and ADPCN program – both heavily supported by CHC/HF – will be crucial in realizing this implementation.

PCAU and Uganda Cancer Institute will jointly hold the Uganda Conference on Cancer and Palliative Care on September 23 – 24, 2021. CHC/HF will be a cosponsor of the conference again this year. The conference will be conducted in a hybrid format (part in-person and part virtual). This year's theme is "Cancer and Palliative Care in COVID-19 and Other Challenging Situations." Due to recommended travel restrictions, CHC/HF staff will not travel to Uganda this year but will participate virtually. We are thinking creatively about how we can engage our staff in a virtual Uganda experience to supplement the conference.

Schools in Uganda reopened on March 1 in accordance with the COVID-19 protocols that minimize classroom crowding and meet other safety measures intended to mitigate the spread of COVID-19. The majority of the RTH children are now back to school and happy to be learning in the classroom. Children in primary three and senior two are still receiving home schooling support from PCAU and will resume classes in late May and early June. The 13 children in candidate classes (senior four and primary seven) who reported back to school in October 2020 completed their national exams and are now on school holiday while awaiting the government to announce the results (hopefully in June). Each child's performance will determine whether they can advance to the next level. As they wait, these children are back home with families, helping around the house and with farming since it is the rainy season. PCAU is in frequent communication with the children and will make plans with each for their next steps as soon as the exams results are released. With a no-cost extension granted through May, PCAU has been able to extend the $25,000 grant we received for their benefit to continue providing food relief, home schooling support, psychosocial support, and health care for both the children and their families.

The Mulago School of Nursing and Midwifery, which runs the ADPCN program, will have two intakes in 2021, one in March and the other in July/Aug. The March intake included just six students because the time between schools reopening and the intake interviews was very short. More are expected in the July/August cohort. The first ADPCN graduation is being planned for October 2021. This will include the 10 inaugural students, whose graduation was delayed last year, and the 15 students who completed their exams in December 2020.

This project continues to demonstrate a great collaboration between PCAU and the Ministry of Health (MOH), which has begun to take more ownership over palliative care data collection in the country. This has always been the long-term vision of the project. The palliative care Health Management Information System (HMIS), managed by MOH, has so far been distributed in two regions (northern and eastern) at a total of 33 health facilities. It should be implemented throughout the country before the end of this year. As the MOH picks up on the routine data collection in the country, the mHealth infrastructure will shift toward a research platform for palliative care. We will continue to work closely with PCAU, Uganda Martyrs University and University of Notre Dame on this important initiative.

ND graduate and former intern, Ainur Kagarmanova, continues to work with Lacey and PCAU to bring her analysis of the mHealth project to publication. Notre Dame junior Kat Kostolansky is still engaged with us on a project basis, mostly focused on the RTH program. She is helping with the PCAU partnership and RTH website. We are just beginning to work with another Notre Dame

student, Mariah Horvath, on establishing a research project related to the mental health and wellbeing of healthcare workers during the COVID-19 pandemic.

Facilities

Mike continues to work closely with Helman Sechrist Architecture, Jones Petrie Rafiniski, DJ Construction, Office Interiors and VISTA AV Integration on the remodeling project of our Roseland building. Once completed, the facility will house CHC's Milton Village Adult Day Center as well as Alzheimer's & Dementia Services of Northern Indiana's Caregiver Resource Center and Institute for Excellence in Memory Care. Interior demolition is complete, and framing is in process. With construction continuing to be on schedule, we anticipate being able to begin the move into the new facility before year end.

GLOBAL PARTNERS IN CARE UPDATE

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

Redomestication of GPIC from New York to Indiana

Due to the peculiarities of the Office of the Attorney General in New York State which doesn't allow for transfers of non-profit entities out of New York, we had to file for a new 501(c)3 status with the IRS for the Indiana version of GPIC. Due to COVID-19, the IRS basically did nothing with any applications for many months. The latest update on the status of the tax-exemption application of the new Indiana Global Partners in Care is that there is no update. We filed on December 3, 2020. The IRS is now processing applications filed on November 13, 2020, so we expect we will hear something in the next month. They've been moving through the backlog much faster since they are now 100% online applications.

COVID-19 Pandemic Response and Partnerships

Many of our partners continue to share that they are purchasing PPE and related items and basic needs for their patients with the funds they receive through GPIC and their US partners. These needs are unlikely to lessen anytime soon. While the COVID-19 situation looks very different in our partner countries, the worsening economic situation is everywhere. The severity of the situation in India is concerning for countries in Africa as well. We also continue to network with partners to understand the situations locally and to provide resources and information on COVID-19 to both African and US partners. The membership to AAHPM offers another source of COVID-19 resources for some of our partners. Nearly half of our international partners redirected donations from their US partner to COVID-19 needs and several partners noted multiple disruptions to their partnerships including: canceled exchange visits, communication difficulties, canceled fundraising events, too much workload or pressing issues which took their attention away from the partnership.

Current Partnerships

There is no change in our current partnership numbers since the last report in February. We have 37 partnerships. We are still uncertain of the continued engagement Hospice of Siouxland (Iowa), but we are in touch with their longtime partner, Howick Hospice Association. Much of our

partnership focus is on supporting our existing partners, though we are beginning to intentionally carve out more time for partnership recruitment. Among US partners, 47% saw a decrease in fundraising for their international partner, 24% saw an increase, and 29% reported no change. All of those who saw a decrease attributed it to pandemic-related difficulties in fundraising.

Partnership Recruitment

We are still cultivating two potential partners: Cornerstone Hospice and Comfort Homesake. Former GPIC partner, Hospice of Michigan, visited our Mishawaka campus during the last week of April. We had the opportunity to talk with them about their past partnership and they are interested in re-engaging. Over the past three years we tried numerous times to connect via email and phone with no success. In-person connection remains an important way to recruit. We may need to begin some on-the-road recruiting. We exhibited at the virtual NHPCO Leadership and Advocacy Conference (LAC) at the end of March. Booth traffic and engagement was not significant, but our participation did open deeper conversations with NHPCO about opportunities to collaborate. NHPCO CEO Edo Banach mentioned GPIC in his opening remarks of the conference and in a daily conference email. They will publish a story on GPIC in their quarterly NewsLine magazine, and NHPCO oversees the US eHospice publication and welcomed us to submit content.

Palliative Care Hero recognition campaign launch and activities

We officially launched this campaign at the virtual NHPCO Leadership and Advocacy Conference on March 24th. We also had a lot of activity on social media on April 7th, World Health Day. We have reached out to many collaborators and our partners with invitations to participate and we already have a number of them actively participating in social media. Because we received few applications this year for the Global Partnership Award (GPA), and in discussion with the GPA Task Force, we decided to not award the GPA to a single partnership this year. Instead, we focused our efforts on the PC Hero campaign to acknowledge all palliative care workers. This year only, the campaign will take the place of the GPA. In 2021 (awarded in 2022), we will revert to our normal process of acknowledging an outstanding partnership.

Education Scholarship Fund for Nurses and Social Workers

This remains a key area of GPIC programming and collaboration with African Palliative Care Association (APCA). We received more than 30 applications for nurses and only a few applications from social workers and will need to develop a new strategy for next year to ensure we are reaching qualified social worker applicants for these scholarships. We are just wrapping up review of applications for the 2021 cycle and we expect to award up to eight scholarships this year.

Leadership Project with Bluegrass Care Navigators (BCN)

We continue to meet monthly and have recently engaged BCN's philanthropy team. Our monthly meetings are currently focusing on fundraising and sustainability, with the scholarships and palliative care training as a focal point. This will help toward our goal of growing the scholarship funds. We are also still engaging in strategic discussions aimed at helping with APCA organizational sustainability.

Communications Webinar Series

The series is targeted at building the communications capacity of palliative care organizations, with a focus on online engagement. In December 2020, we hosted a beginners' webinar for strengthening an organization's online presence, and in February 2021, we focused on how national associations can help their members improve their online presence and in May we expanded on the topic of having an impactful online presence and is open to any palliative care organization. These have been well attended and feedback is positive. We are also offering one on one consultations with any organization joining a webinar to give them specific ideas and support for their communications.

Interns and Research Projects

APCA, the University of Leeds, and the University of Notre Dame are collaborating to advance a project to map palliative care research that has been done across the continent into a usable online tool and central repository for easy access. We have just agreed on an internship with a master's in public policy student from Oxford, Khalid Saleem. He will work virtually with APCA and GPIC beginning next month. John Couri, a student at the University of Notre Dame, continues to work with us as an office intern (virtually for the most part) but is also developing a research project around pediatric palliative care for his senior honors thesis. We are working in partnership on this with Palliative Care Support Trust in Malawi.

American Academy of Hospice and Palliative Medicine

Feedback collected from those to whom we gave a one-year membership to AAHPM showed that most participants valued the membership. The feedback was overwhelmingly positive – they especially appreciated access to resources and publications. AAHPM also has an online chat/blog where members can share and crowdsource ideas from their colleagues, which several found valuable. Almost all noted that they used COVID-19 resources. Several participants shared some AAHPM learning materials with others in their organization. Many noted that they have not taken full advantage of the membership given how busy and difficult the past year has been because of the pandemic. We extended the membership for another year (through March 2022) and added a few more key partners – there are now 35 memberships under our umbrella. We have outlined an engagement plan with AAHPM for the next year with quarterly goals to help our members maximize this opportunity. We held a call earlier this month that included AAHPM board president, Nathan Goldstein, and the leadership of their Global Special Interest Group (SIG). GPUC Advisory Council member, Jim Cleary, MD also joined this call. The Global SIG may be the likely first line of engagement for many of our partner members. Currently, we are orienting our partners to the mentorship and planning for a joint webinar to for our members to take place in June.

GPIC Advisory Council Memberships

Two new members joined in January of 2021: Andre Wagner, Chair of APCA Board of Directors (will serve as APCA's representative on the council); and Edo Banach, President/CEO of NHPCO. With a desire to deepen our engagement in Nepal, we are reaching out to Dr. Bishnu Paudel, President of the Nepalese Association of Palliative Care, to ask him to join the Advisory Council.

We will have two additional members ending terms in December 2021 and hope to continue to grow our representation of international representation on the council.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for January – April 2021…

Referral, Professional, & Community Outreach

Our Professional Community Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. In the past couple of months, all professional referral sources have become more accessible with some more than others and many COVID visitation restrictions have been lifted.

We have completed our implementation of our new Customer Relations Management (CRM) software and have trained all current users. The software Referral Connect, is a product of MatrixCare and integrates with the new MatrixCare EMR we began using on the clinical side in October. It's able to provide real-time data to our Liaisons allowing them to be able to easily track a patient from the time of referral through the admissions process. We've just begun to tap into the potential of the product, which I'm sure will become more apparent as we become more familiar with it.

During the course of the pandemic, many healthcare professionals have changed employers or left the workforce completely. As a result, our first focus is to update our contacts and database, as well as reaffirm their preferred choice of communication. We're also in the process of working with Hospice Foundation to contribute to a shared database which will include relationships with donors who also may be referral sources.

Access

Even with refocusing of our advertising dollars having been switched from patient/family outreach to staff recruitment, Facilities, Family/Self, and Physicians have all increased over 2020. The exception is hospitals, where we've seen a 38% decrease in referrals compared to this time last year. Last year during the pandemic, we experienced a surge of discharges during these same months with the anticipation of beds being needed for COVID-19 patients. The percentage of non-admits due to "Death Before Admission" (DBA) has increased over 15% compared to the same time last year.

Website

We continue to fine-tune our new website focusing on what makes Center for Hospice Care different than other agencies. We're in the process of adding all our collateral print material/brochures online for easy access and education. When the Board of Directors begins to meet in-person, we will have portraits taken of each member to add to our website.

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. During the months of February – April, we focused on National Volunteers Month (April), National Doctors Day, National Healthcare Decisions Day (4/16), National Social Worker's Month (March), and National Caregiver's Day (2/19) as well as staff recruitment. CHC reached 63,287 people for the period of February - April and had 4,399 reactions, comments, and shares. Our leading post was on April 7th, "Keep going. Tomorrow will be a better day." It reached 2,200 people and generated 363 reactions, comments, and shares. The second most viewed posting was on April 20th: "As each day passes by, we become stronger versions of ourselves." It reached 1,900 people and generated 207 reactions, comments, and shares. CHC currently have 4,927 Facebook followers. CHC continues to have social media presence on Twitter, Instagram, YouTube, and LinkedIn as well.

Digital Overview

Beginning in December we diverted a majority portion of our digital campaign to staff recruitment which remained throughout this period. The Internet-based digital campaign focuses on delivering our ad to the proper audience at the proper time. For the above months it generated 40 telephone calls from potential patients or their family members. As competition for digital visibility increases, the cost per click also increases. In 2021 we've allocated additional funds to offset this factor and continue our high online visibility. Google industry benchmarks show an average click-through rate in the Health & Medical field of 3.27 % and we continue to be high at 9.07%.

POLICIES ON THE AGENDA FOR APPROVAL

Every year we review and update our patient care policies for either our home health license or our hospice license and the respective Medicare certifications. This is the year for our hospice patient care policies. We have included a red-lined version of all changes, and all new policies are completely red. Changes and additions have been made due to clarifications, to reflect current practice, and due to regulatory necessity. Lance Mayberry, VP/COO will be available to answer any questions.

CHC CLINICAL STAFFING UPDATE

The healthcare industry lost approximately 4,100 jobs in April alone according to new data released May 7th from the Bureau of Labor Statistics (BLS). The nursing home sector lost about 19,500 jobs last month, compared with 3,200 jobs lost the month prior. BLS reports healthcare employment still is down by about 542,000 since February 2020. McKinsey & Company researchers surveyed 400 nurses across different settings in February and found a 60% increase in the number planning to leave compared with their 2020 report. More than half said they would leave for a role not involved in direct patient care or simply retire. Baptist Health System in San Antonio announced this week that it is offering ICU nurses, as well as patient care and lab associates, up to $20,000 sign-on bonus. Like all healthcare providers, CHC is struggling in clinical

staffing. A very frustrating area is with hospice aides/CNAs. Many respond to our recruiting efforts, make an appointment, and then never show up for the interview. Or, they accept the position and are a no show/no call on their first scheduled day. We have also had our share of retirements lately, changes of career, and self-terminations for a variety of reasons and many of which were welcomed. Because of this, we have recently redoubled our efforts on recruitment and have seen some successes. Recently we raised the staff referral bonus for nurses through the end of July and have continued our sign-on bonus offers. We have two staff members who had referrals for hire dates this month who will receive the new higher referral bonus rate. We have also reengineered salaried RN pay which will begin in a few weeks. It's a simplification of our current system and most RNs should realize an overall increase and all of them should become more aware of how much they actually make. We have eliminated many of the extras and add-ons to the base salary and wrapped those into the base while maintaining most productivity expectations. Very recent successes in clinical hiring the last few weeks include: a documentation RN started 5/10, a Mishawaka Visit RN, started 5/24, three very much needed Plymouth Case Manager RNs start 5/24, a Mishawaka Case Manager RN, will start on 6/7/21, and a PRN Triage Visit Nurse will start 6/21. We have added Zip Recruiter to our recruitment portfolio of Indeed, social media, radio/TV recruiting spots as well as our own websites. For both Zip and Indeed we now have the option of viewing applications when someone new posts their resume online and we can now then send them an immediate email message response. We interviewed an LPN for Raclin on 5/10, have interviews with a potential RN and CNA/aide later this week, more calls lined up this week, and we could have more face-to-face interviews yet this week and/or early next week. During the time of this writing, there are about 20 clinical positions posted on the "Careers" section of the CHC website in various capacities. We are also currently advertising for a fulltime recruiter as an addition to our HR department.

CHC IN CMS CPI LONG LENGTH OF STAY AUDIT

We did receive a demand letter from our fiscal intermediary Palmetto, GBA explaining their plans to recoup the funds. We did allow them to do that which allowed us to get several months to prepare for the appeals processes. We are currently sending our attorney, Meg Pekarske, at Husch Blackwell and her team thousands of pages of documentation to begin our appeals process. As you remember, by allowing them to recoup now, we don't pay interest, get more time, and for anything we win Medicare will pay us interest on what they took. By last February, Meg and her firm had recovered $55MM for her clients in this particular audit. She also has a client who had a $44MM recoupment that was now down to just $40,000 following appeals. We will continue to keep you posted on this.

$1.4 MILLION HHS STIMULUS FUNDING UPDATE

We have engaged The Rybar Group to assist us with the necessary documentation to be able to keep the HHS Stimulus funds of nearly $1.4MM received without asking on April 10, 2020 related to COVID-19 expenses. Rybar is an accounting firm in Michigan that was recommended to us by Kruggel & Lawton through their common alliance with BDO. Their practice is ensuring Medicare providers are paid appropriately and stay out of trouble with the False Claims Act, Medicare audit

prevention, etc. The HHS portal where we are to transmit our expenses has been delayed and is still only open for Medicare providers to register. We have. We have continued to track COVID-19 expenses and our total expense dollar amount exceeds the $1.4 million we received.

NHERT MEETS VIRTUALLY MAY 3 AND 4

Rather than meeting at a member's program as we usually do the first week of May, the National Hospice Executive Roundtable (NHERT) met via Zoom on May 3rd and 4th. In addition to getting to know our four new members, discussing program updates, attempting to create or join a Medicare Shared Savings Program, reporting on census declines due to long term care facilities, we also had a guest speaker, Brooke Bumpers, JD, from Hogan Lovells who provided an update on the Washington, DC scene since the election. Brooke works closely with the Hospice Action Network on advocacy and NHPCO. She has spent her entire legal career working with health care and life sciences organizations, helping them understand federal and state regulatory and legislative issues to resolve their problems. She has comprehensive knowledge of the regulation of clinical laboratories and medical device companies, including Clinical Laboratory Improvement Amendments (CLIA) and state regulation, as well as in the areas of hospice and palliative care and end-of-life issues. Her father, Dale Bumpers, was Governor of Arkansas and Brooke grew up in the Governor's Mansion. Her father was also the lead counsel for President Bill Clinton during his impeachment.

The NHERT now is comprised of the CEOs from the following 13 programs:

Care Synergy (The Denver 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
Arkansas Hospice, North Little Rock, AR
Delaware Hospice, Wilmington, DE
Transitions LifeCare, Raleigh, NC
Catholic Hospice, Miami Lakes/Fort Lauderdale, FL
Tidewell Hospice, Sarasota, FL
Hospice of Washington County, Hagerstown, MD
Hospice of East Texas, Tyler, TX
Community Healthcare of Texas, Ft. Worth, TX
Center for Hospice Care, Mishawaka, IN

The NHERT plans on meeting in-person in October.

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 are open to all board members.

In is in our Bylaws that we review our Bylaws every three years. The Bylaws for both CHC and HF need to be reviewed in 2021 (GPIC was reviewed in 2020). We have openings for the Bylaws Committee and if any board member would like to be on that committee, please let me or Becky Kizer know. We will meet prior to the end of the year and there is no specific date set at this time.

BOARD EDUCATION SECTION

Due to the agenda and the logistics of Zoom and timing, the Board Education section will be postponed to August.

OUT AND ABOUT

I was interviewed for the Edo Banach, President of NHPCO, podcast *Leading Person-Centered Care, Conversations with Edo Banach* on March 4th.

Several staff participated in the annual Salute to Business presented by the South Bend Regional Chamber of Commerce on March 16th.

I attended the virtual Hospice Action Network Board of Directors meeting and the NHPCO Board Issues Session on March 23 and 24th

Several of us participated in the GPIC Advisory Council international Zoom call on April 29.

I attended the IHPCO Board of Directors meeting via Zoom on May 6th.

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

Karl Holderman's monthly dashboard summaries.

Volunteer Newsletter for March, April, and May 2021

Board Committee Opportunity Sheet.

Hospice News article, "Hospices Fight Rising Turnover During Pandemic" from 4/9/20

Thank you letter from the IUSB School of Nursing

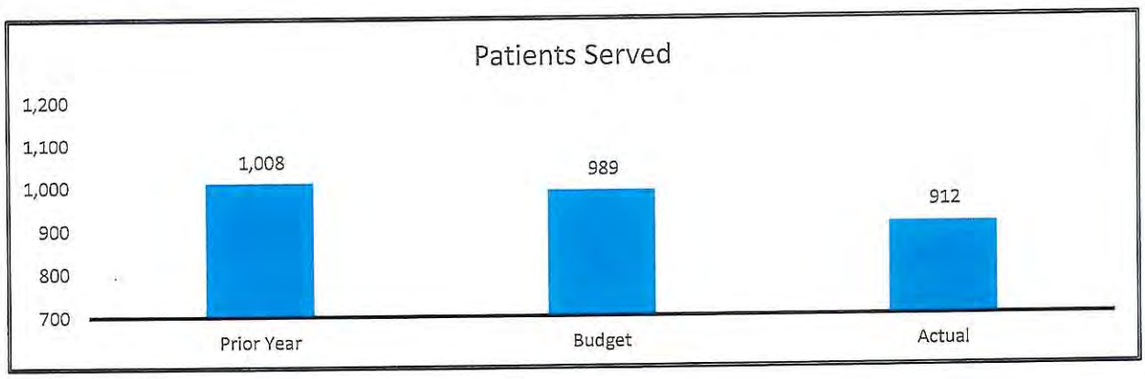
NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, August 18, 2021 at 7:15 AM**. We are planning on an in-person meeting with no Zoom option. In the meantime, if you have any questions, concerns, suggestions, or comments, please contact me on my direct line at 574-243-3117 or email mmurray@cfhcare.org .

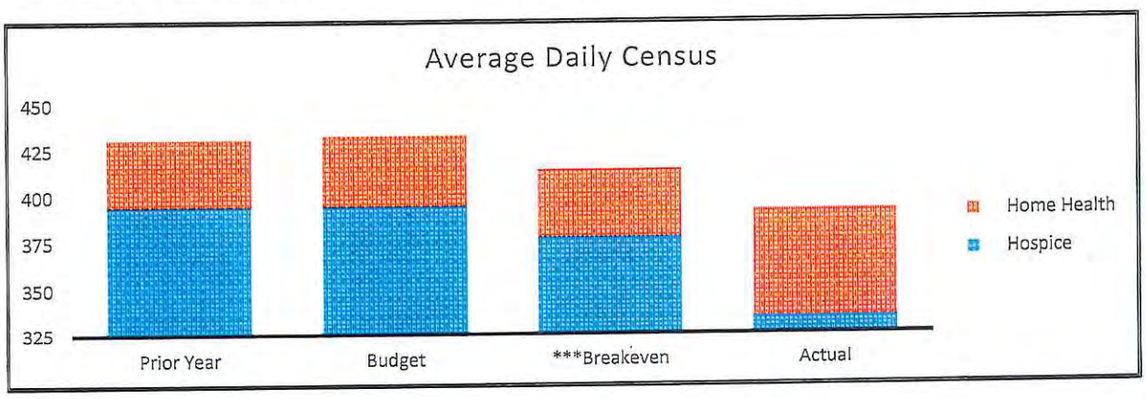
# # #

Center for Hospice Care
April 30, 2021

	Prior Year	Budget	Actual
Patients Served	1,008	989	912

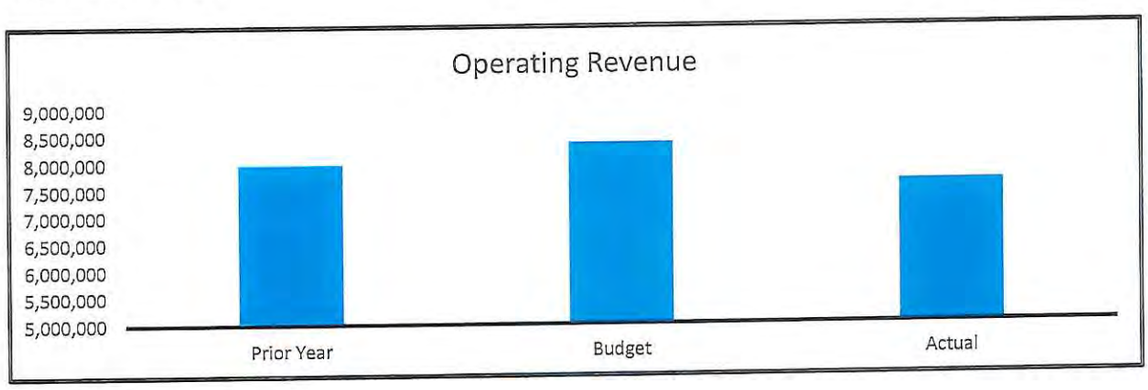


Average Daily Census	Prior Year	Budget	***Breakeven	Actual
Hospice	393.98	394.14	377.07	333.87
Home Health	37.02	38.80	37.12	58.00
Total Average Daily Census	**431.00**	**432.94**	**414.19**	**391.87**

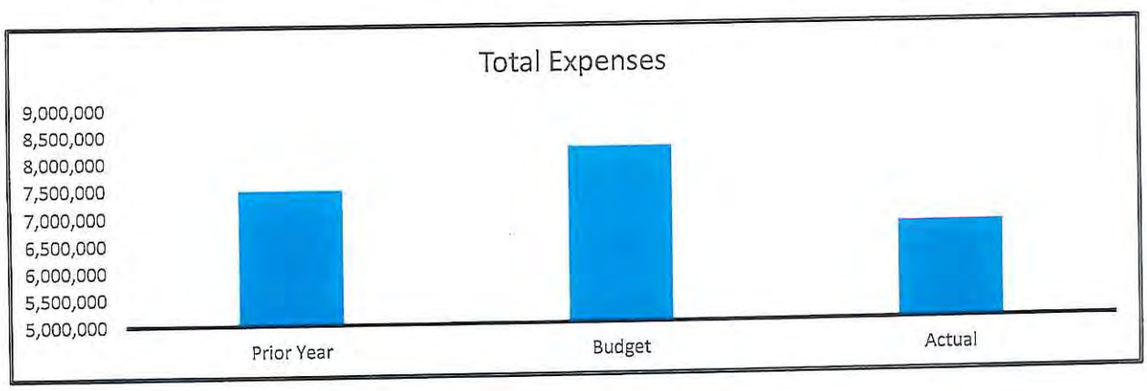


*** Budgeted Breakeven

	Prior Year	Budget	Actual
Operating Revenue	7,964,888	8,367,898	7,650,593



	Prior Year	Budget	Actual
Total Expenses	7,455,488	8,245,786	6,797,136



March 2021
Volunteer Newsletter

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

Coffee & Conversation

Richard and Janet Van De Veire, his CHC volunteer.

By: Kristiana Donahue

It's just a small, unassuming little building. The Boss' Place offers breakfast staples such as biscuits and gravy to daily specials of a chicken salad croissant sandwich or blue gill dinner, all for a very affordable price. For Richard Zawacki, a Center for Hospice Care (CHC) patient, this little restaurant has been part of his weekly routine for over thirteen years.

Richard is very social. If you spend more than ten minutes with him, he'll already be cracking jokes. He was a truck driver; he drove an oil truck and a coal truck. He was also a manager for Wagner Fuel.

"That's my back up," Richard said, pointing to his daughter, Sue Kline. "She knows more about me than I know." He laughed. She offered details throughout the conversation, and it was evident that her support extended to many areas of his life.

Sue realized how important trips to The Boss' Place were for him, and when the heart doctor told him he could no longer drive, it was disheartening. Richard signed up for care through CHC and Sue decided to ask if there might be some assistance driving him to his favorite spot.

Janet Van De Veire has been a CHC volunteer since 2016. "I like to socialize," she said. "And you can tell he's very social." Kim Morrison, Plymouth volunteer coordinator, paired Richard and Janet together, especially to allow him some time at his restaurant. He was pretty mobile and able to get into and out of the vehicle, which allowed for this very special volunteer mission.

Richard usually gets eggs and bacon, or whatever seems delicious on the menu that day. He made Janet get the gigantic pancake. The two of them got along really well. He also had other friends that he'd talk with, all thanks to The Boss' Place. "I met a lot of people there," Richard said. "There were two of them that would sit at a table. Never talked. One day, I asked one of the guys a question. And since then, he hasn't

Continued on page 6

Inside this issue:

In Memory

Melia Sue Byrer, 33, of Bremen, left to become one of God's angels on Feb. 15. Melia was born on Aug. 14, 1987, the daughter of Luke and Edith (Anderson) Workman.

On July 25, 2009 in Bourbon Bible Church, she married Matthew Byrer.

She leaves behind a loving husband, Matt Byrer and their sons, David (age 7) and Theodore (age 2); parents, Luke and Edith Workman; twin sister, Stefany (Dustin) Yoder and sister, Elizabeth (Danny) Thomas; and a second family of in-laws, Jim and Karen Byrer, Wendy (Brad) Douglass and Lisa (Shaun) Sauer. She has an abundance of nieces and nephews that she loved as her own, Aaron, Jacob, Sydney, Madison, Savannah, Makaya, Oaklin and Jonathon.

Melia had a passion for people and chose a career as a Hospice Social Worker. She often talked about her co-workers and patients that touched her life. When Melia wasn't investing in family and people, she could be found enjoying things such as camping, hiking, crafting, cooking and baking. She also enjoyed reading, singing, drawing and painting.

Birthdays

3/2
Marne Austin

3/4
Richard Pipher

3/8
Lindsay Estrada

3/15
Joan Fitt

3/15
Julie Shamo

3/16
Ann Bowers

3/23
Anna Riblet

3/24
Richard Puterbaugh

3/25
Sandra Witkowski

3/26
Linda Burrell

3/26
Flora Lee Stone

3/28
Ilene Crutchfield

Welcome New Volunteers

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

Sophia Baker
Mishawaka

Emily Patterson
Mishawaka

Belinda Rogers
Elkhart

"NEVER DOUBT THAT A SMALL GROUP OF THOUGHTFUL, COMMITTED CITIZENS CAN CHANGE THE WORLD; INDEED, IT'S THE ONLY THING THAT EVER HAS."
-MARGARET MEAD

Volunteer Spotlight

Sarah Nerenberg, Mishawaka

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

I have been a volunteer for almost four years. I started at the inpatient care unit for a few months but have been doing home visits since then. I have been lucky to get to know some amazing caregivers and, with each new assignment, to learn something new about myself and to appreciate people's life journeys.

Why did you decide to volunteer with CHC?

Ever since I was little I have been drawn towards working with seniors and have spent a lot of time in the role of a companion. Volunteering at CHC has added another dimension to that role including providing support for caregivers, which has been very rewarding.

What is your favorite food and why?

I love to cook - especially different types of ethnic foods. With the pandemic and with a lot of time at home (and a captive audience with my college-age kids stuck at home), I have lately been experimenting with cooking Ethiopian and Indian dishes including all of the accompanying types of breads.

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

My greatest joy is walking the streets and having a coffee in a new city. My husband is a professor and we have taken advantage of many sabbatical and summer abroad teaching programs including in Santiago (Chile), London, Alcoy (Spain) and, hopefully, this summer in Berlin. I also enjoy sitting on benches to people watch and imagining the life stories of the people walking by.

Where are you from originally?

I grew up mostly in upstate New York but ended up working in Chicago after grad school where I met my husband. He got a position at Notre Dame 17 years ago and we have been here since then. Having not grown up locally, I love learning about the area from the families that I visit through hospice.

What do you like to do in your spare time?

I have a proposal development consulting (grant writing) business and have three kids, a dog, a cat and four chickens so that keeps me pretty busy. I do a lot of volunteer work at their schools and through my faith community including with the Michiana Jewish Historical Society. Finally, I am part of a Masters rowing team (8 people in a boat) that rows out of the South Bend boathouse and hope that we can get back on the river this summer!

"Sarah is smart, kind and hard working. She is a great companion and respite volunteer who searches out ways to meet patients at their individual need. Sarah is a joy to have on the team!"

Debra Mayfield, Mishawaka Volunteer Coordinator

Mark Your Calendar

Mishawaka Annual Skills Validation Day

Tuesday, March 23, 2021

No more March slots—March 23, 2021 is completely booked.

Mishawaka Annual Skills Validation Day

Wednesday, September 22, 2021

Appointments made between 9:00am-3:00pm

Slots are filling up.

Mishawaka Campus

501 Comfort Place

Elkhart Annual Skills Validation Day

Wednesday, June 30, 2021

Appointments made between 9:00am-3:00pm

Elkhart Office

22579 Old US 20E

Plymouth Annual Skills Validation Day

Wednesday, December 15, 2021

Appointments 9:00am & 10:00am

Location TBD

To schedule your appointment, contact Kristiana Donahue at donahuek@cfhcare.org or call at 574-286-1198.

Volunteer Updates

Annual Skills Validation 2021

For volunteers who have trained to do hands on care (Level III), annual skills validation is required. 2020 didn't allow us to finish skills validation for many/most of our volunteers.

As the validation dates approach, Kristiana will be emailing all volunteers who need the skills validation. However, if you want to schedule your validation now, feel free to reach out to Kristiana anytime.

- You will schedule a time slot by contacting Kristiana Donahue.
- Kristiana will send an email with links to videos that will help refresh you on the skills that you will be validated on.
- Show up to skills validation at your scheduled time and complete skills validation with Amber Doland.

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

Hands On Care Reinstated

We are very pleased to announce that we have been given the "green light" to go back to utilizing our volunteers for hands on care. During COVID-19 we had to scale back our volunteer roles to keep our entire CHC community safe (staff, families, patients and volunteers). Our commitment to continue safe practices (i.e. utilizing standard precautions, wearing masks, etc.) doesn't change; however, for volunteers who want to return to roles that may include hands on care (i.e. inpatient care unit and home visits) may do so as of April 1, 2021.

Please be in communication with your volunteer coordinator. We need to identify which volunteers want to return to this role.

Level III Training

We will be resuming Level III training (volunteer training on personal care skills) for new volunteers. There are some volunteers who may have completed training in 2020 and weren't offered Level III due to our pause in providing hands on care. If you are a volunteer who wants to complete Level III training and have never done so, please contact Kristiana Donahue, Volunteer Recruitment and Training Coordinator.

Plymouth Volunteer Orientation

We have scheduled a Plymouth Volunteer Orientation for March 15, 16 and 17 from Noon to 3:00pm. This training already has a few people signed up for it, but we can add more.

If you know of anyone in the Plymouth-area that would like to volunteer with CHC, please have them go onto our website at www.cfhcare.org to fill out a volunteer application, or contact Kristiana Donahue at donahuek@cfhcare.org or 574-286-1198.

Anyone interested in attending the training must apply, interview and complete other processes ahead of time; therefore, anyone interested needs to apply ASAP.

HIPAA Reminders

What is PHI?

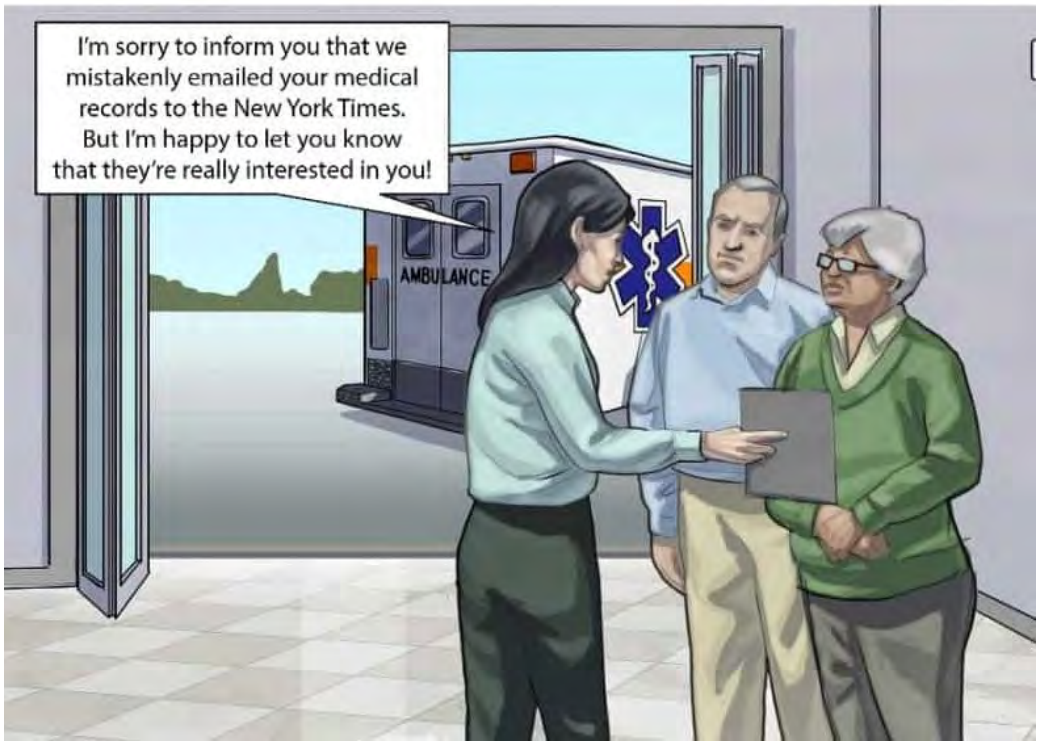
Any information—oral, written on paper or sent electronically about a person's

- Physical health
- Mental health
- Services they are receiving
- Payment for services they are receiving

EXAMPLES

Names, Addresses, Social Security or other identification numbers

- Make sure you don't put any paperwork that contains PHI in plain sight (i.e. the seat of your car, on the kitchen counter, etc.)
- Also know that **no details** of a patient can be discussed even **AFTER** the person has passed away. Their information is still covered under HIPAA after their passing.
- Reminder—As a volunteer you are a trusted member of CHC, do not discuss patient information with your family or others.
- Secure ALL non electronic records at all times—Office, Car, Patient Home, Your Home



Comments from our Families

- We were very pleased with our hospice and would highly recommend them. The on call chaplain that came the night daddy died was very good. Our hospice volunteer went above and beyond. Excellent.
- My dad had a very happy death experience and hospice in our home was an important part of that.
- My personal experience was extremely good. My social worker was very pleasant and kind while helping me walk through the final days. Thanks!
- Received the best care above and beyond. Thank all of hospice for everything. God bless all of you.

Continued from page 1

"I met a lot of people there," Richard said of The Boss' Place, his favorite restaurant.

been able to shut up." Janet recognized that Richard had many friends there. "When we'd go there with him," she shared. "Everyone would say hi and it was good to see him."

This is quality of life. This is part of the support that Center for Hospice Care provides. Richard really gets along with his aide, Yolanda. "She's just as ornery as he is," Sue said, knowing that the match has made all the difference in his care. Stacy, his nurse, also is able to dish the jokes back at him. "They're perfect for him," Sue continued. While we take care of his physical needs, we also know that feeding his social need is part of the emotional care we provide. There are so many life changes for those dealing with health issues. It is often the simple things of life: the daily routines and the little habits that can foster our best life. So even though it may be a cup of coffee and a quick conversation, these are the moments to look forward to.

Next Training dates are:

Monday, March 15, 2021 12:00-3:00 pm

Tuesday, March 16, 2021 12:00-3:00 pm

Wednesday, March 17, 2021 12:00-3:00 pm

Location: Plymouth Public Library, Room Laramore A

Registration required. Application and interview required before registration, so inquire in advance to ensure place in training.

Please contact:

Kristiana Donahue,
Volunteer Recruitment & Training Coordinator

donahuek@cfhcare.org • 574.286.1198

April 2021
Volunteer Newsletter

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

Keeping Pets & People Together

What is Pet Peace of Mind?

This important program benefits our patients – and our community – in a number of ways. It helps our patients enjoy a higher quality of living by helping them keep their pets at home. It gives our volunteer program a new dimension and it reduces the number of pets entering shelters in our community. Pet Peace of Mind® is a non-profit organization that provides hospices, home health care and palliative care providers with training and tools so they can provide care for the pets of hospice patients. The hospice organization provides specially trained volunteers to assist with daily care like feeding, exercising the pet and pet sitting. They may also arrange trips to the veterinarian, groomer or boarding facility. Another aspect of the program is developing an adoption/foster care plan for pets who need to be placed after the patient dies.

Helping Care for Our Patients' Fur-ever Friends

Pets seem to instinctively grasp Center for Hospice Care's mission "to improve the quality of living." Whether it's a wagging tail, a gentle purr or the comfort of a warm, furry body resting nearby, their love and comfort is an important part of our patients' lives. That's why we have become a Pet Peace of Mind® partner. "Keeping their pet near them is important to our patients, but they worry about their care. They may no longer be able to clean the litterbox, take the dog for a walk or go to the store to get food. They may not have family members who can help with these tasks," said Craig Harrell, Center for Hospice Care's Director of Marketing and Access. "We find that we also have patients who worry what will happen to their pet after they die. Pet Peace of Mind® addresses all of these concerns."

Improving the Quality of Living for Patients and Pets

Pet Peace of Mind® helps Center for Hospice Care patients keep their beloved pets at home, improving the quality of living for people and pets. While some patients have a network of family and friends who can help with pet care duties, others aren't so lucky. And sometimes, the pet is overlooked during the patient's illness or after the patient dies by loved ones who don't understand the bond between the patient and their pet.

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Patrick Kuzan
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Michael Finn
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Steve Bussmann
4/10
Stephen Dinehart
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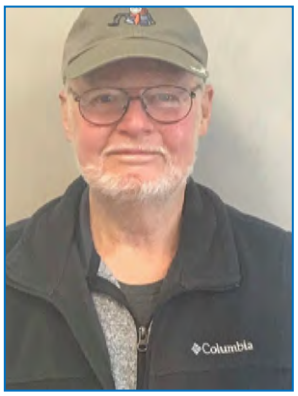
David Foster
4/10
Susan Fron
4/12
Beth Davis
4/13
Linda Williams
4/15
Ed Craft
4/15
Linda Wruble
4/20
Paul Go
4/22
Terry Trimmer
4/23
Peggy Stutzman
4/24
Julie Schlundt
4/25
Jan Atwood
4/25
Marlene Taylor
4/26
Jeanette McKew
4/29
Jean Lucas
4/29
Amanda Parkinson

Welcome New Volunteers

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

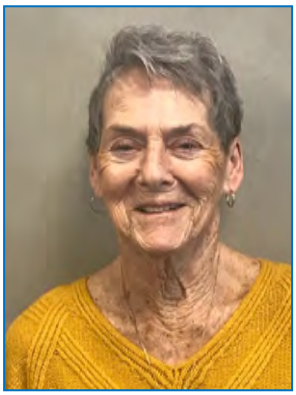


Ed Craft, Plymouth

Danile Martens, Mishawaka

Marissa Million, Mishawaka

Christi Risk, Mishawaka



Eileen Schroder, Plymouth

Jane Sharp, Plymouth

Patti Siroky, Plymouth

Marie Varner, Mishawaka

Alison Westerink, Mishawaka

Volunteer Spotlight
Julie Schlundt, Mishawaka

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

My name is Julie Schlundt. I am a volunteer for CHC and provide respite care by going into the homes. I have been with CHC for over one year now.

Why did you decide to volunteer with CHC?

I love volunteering as I love people. I love being a source of light and encouragement to both the patient and their family. Sometimes all it takes is to be positive and be kind and be present to offer this encouragement to others.

Tell us a little bit about yourself.

I am also a Registered Nurse since 1981 and graduated from Memorial Hospital School of Nursing in South Bend. I grew up in Mishawaka graduating from Mishawaka High School. I married my high school sweetheart Randy Schlundt and we have 3 grown children and 5 granddaughters.

What do you do in your spare time?

In my spare time, I work as a nurse at Saint Mary's Sisters of Holy Cross. I have also been a Sale's Director with Mary Kay since 1996. I love spending time outdoors especially hiking and riding my bicycle. I enjoy traveling and prefer warmth and sunshine. We lived 6 years in South Carolina for my husband's job and I absolutely loved having palm trees in our neighborhood

Other thoughts?

We returned home to be closer to my aging parents who live very near to us currently. My dad has dementia and we just lost my mother in law which has been difficult. I feel more equipped and prepared in dealing with the cycle of life and death because of my volunteering at Center of Hospice Care. I am very grateful that my close friend, a former volunteer at CHC suggested I take on this role when I moved back from South Carolina.

I feel that God has brought me to this opportunity to not only minister to others but to minister and bless me. I have nothing but great things to say about this wonderful place, staff and resource. So pleased and honored to be a part of this beautiful center!

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"Julie is a gem!" Her compassion and bedside manner are her strong suits. Families count themselves lucky to get Julie as their respite volunteer.

Debra Mayfield, Mishawaka Volunteer Coordinator

Mark Your Calendar

Mishawaka Annual Skills Validation Day

Wednesday, September 22, 2021

Appointments made between 9:00am-3:00pm

Slots are filling up.

Mishawaka Campus

501 Comfort Place

Elkhart Annual Skills Validation Day

Wednesday, June 30, 2021

Appointments made between 9:00am-3:00pm

Elkhart Office

22579 Old US 20E

Plymouth Annual Skills Validation Day

Wednesday, December 15, 2021

Appointments 9:00am & 10:00am

Location TBD

To schedule your appointment, contact Kristiana Donahue at donahuek@cfhcare.org or call at 574-286-1198.

Volunteer Updates

Annual Skills Validation 2021

Our first Annual Skills Validation Day was held on March 23, 2021. **We had 100% attendance!** Thank you to all who attended and it was a wonderful start to our validation process for this year.

For the upcoming skills validation days, Kristiana will be emailing all volunteers who need to complete it.

- You will schedule a time slot by contacting Kristiana Donahue. First come, first served.
- A short refresher course is available to view in an online training module. Kristiana will send information on how to access that.

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

Hands On Care Reinstated

We are very pleased to announce that we have been given the "green light" to go back to utilizing our volunteers for hands on care. During COVID-19 we had to scale back our volunteer roles to keep our entire CHC community safe (staff, families, patients and volunteers). Our commitment to continue safe practices (i.e. utilizing standard precautions, wearing masks, etc.) doesn't change; however, for volunteers who want to return to roles that may include hands on care (i.e. inpatient care unit and home visits) may do so as of April 1, 2021.

Please be in communication with your volunteer coordinator. We need to identify which volunteers want to return to this role.

Milton Adult Day Services Volunteers

Milton Adult Day Services, a service of Center for Hospice Care, provides a structured setting to adults who need health, social, and support services during the day. This community-based service is designed to meet the individual needs of functionally impaired adults who require supervision during the day. Milton Adult Day Services promises to be respectful, offer opportunities for an enhanced quality of life, and assures participants' safety.

Milton Adult Day Services utilizes volunteers to help participants with a variety of activities daily. From gardening, to music programs to cooking classes, Milton engages the senses to engage the participants and provide meaningful daily interaction.

Milton Adult Day Services is located in South Bend at 922 E. Colfax Avenue. Renovations are currently underway at our Roseland building, where Milton will be relocated after completion.

We are looking for some volunteers interested in volunteering at Milton Adult Day Services to interact with and assist the participants. We also are looking for many entertainment volunteers! We are looking for musicians or other entertainers. If you are interested in volunteering at Milton Adult Day Services, contact Debra Mayfield at mayfieldd@cfhcare.org

Jewish Holidays Information

We are presenting the traditional observances to give you the most information, which then needs to be tailored to each individual family's Jewish lifestyle.

Passover-Pesach 2021

The holiday of Passover is this year from March 28, 2021, through April 4, 2021. The two Seder nights are Saturday night March 27, and Sunday night March 28, 2021. Please note that all Jewish holidays, including the Sabbath, start at sundown the night before and continue until full darkness on the last day.

Historical Background

Pesach, in English "Passover" or Festival of Freedom, commemorates the Exodus of the Jews from the slavery of ancient Egypt. Its celebration includes a festive meal, called the Seder, on the first two nights of the eight-day holiday.

Usually, the entire extended family and invited guests celebrate the Seder together. It is common to have two, three or four generations join in the Seder. Many synagogues have communal Seder. The Seder is one of the highlights of the year, with each family having their own traditions. It is a fun and exciting event, with lots of singing and everyone, especially the children, participate. The word "Seder" actually means "order," pertaining to the fifteen steps of the Seder. The "Haggadah" is read, which tells the entire story of how Moses, chosen by God, led the Jews out of slavery in Egypt; from the bitter enslavement, to the Ten Plagues, to the splitting of the Red Sea and to the Exodus and Freedom.

Although Passover is one of the most important Jewish holidays, only the first two days and the last two days have Major status. The intermediate days, the days in between, have Minor status.

On the Major holidays, more traditional Jews will refrain from business, and the use of most electric items. They will not turn lights on or off, and will not answer the phone. On Minor holidays, the day is a regular day with the addition of the holiday observances, business

Continued on page 6

Comments from our Families

- The facility and the hospice staff and volunteers made this experience as comforting as possible for my mother and her family. We were so relieved that she was able to spend her final days there.

- Thank you CHC. This was a new experience for us. Your kindness and gentle teaching will never be forgotten.

- Myself and my siblings were quite impressed with all the services we received during our mother's last days. The nurses were kind and compassionate, as were the people representing Hospice. I would definitely tell anyone who is looking for help in regard to the last days of life to contact Hospice. It is a wonderful organization and I'm glad we were able to utilize it.

Continued from page 5

can take place and electricity is used.

Observances

Food: On all eight days of Passover, all grain products (from wheat, barley, oats, spelt and rye), including all bread, pasta, cereals and non-Passover cakes, are called "Chametz" and should not be eaten, nor owned. Therefore, bread is replaced by Matzah. Matzah is a thin cracker type of bread of only flour and water, made without any leavening agents, baked specially for Passover. All processed foods need to be Kosher for Passover. Kosher for Passover indicates that not only is it kosher, but that is has no grain ingredients, was processed in a plant that used no grain ingredients and is therefore kosher for Passover use. (Even Coke makes a special run of Kosher for Passover with special yellow caps!) All raw foods, such as fruits and vegetables may be eaten.

In line with the Kosher for Passover laws, many will use special pots and pans, dishes and silverware that are used exclusively for Passover.

The hospice worker should be instructed to not bring any food into the patients' home, for example, even their own coffee and Danish, as it could cause serious problems for the homeowner.

The Seder: There are more rituals associated with the Passover Seder than with any other ritual meal in Judaism.

The "Haggadah" is read. The youngest child traditionally sings the "Mah Nistana," the Four Questions, which begins, "Why is this night different from all other nights?"

At the beginning of the Seder, three pieces of Matzah are placed under a special cover. Later, the middle Matzah is broken into two pieces and one piece, called the "afikoman," is hidden. The children at the Seder search for the afikoman and barter it with the adults for a special gift. The afikoman, which means "dessert," is eaten at conclusion of the Seder.

Other customary foods at the Seder include "maror," the bitter herbs, usually ground horseradish or romain lettuce—a reminder of the bitterness of servitude; "charoset," a mixture of fruit, wine, nuts, and spices, which symbolizes the mortar used by the Jewish slaves in building the pyramids of Egypt; and hard-boiled eggs in salt water. Four cups of wine are served to each guest during the course of the Seder. A fifth cup of wine, designated as the Cup of Elijah, is placed on the table and the door is opened to symbolically welcome the prophet Elijah, harbinger of the Messiah, who is said to visit every Seder table.

Hospice Concerns & Issues

A physician should be consulted as to whether Matzah and wine, and the other ritual foods, are medically permitted for the hospice patient. The Matzah can be soaked in water to soften it. Diluted grape juice, or even tea, can be substituted for wine, if need be.

Prescribed drugs should be taken, of course, but should be kept separate from Passover food. Anything containing "Chametz" (produced from grains) should not be used, unless specifically required for medicinal purposes.

If in a hospice unit, the patient's family may need special accommodations for observing the many specific food practices unique to Passover.

May 2021
Volunteer Newsletter

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

Closely United

By Kristiana Donahue

"They were meant to be together," Juergen said of his parents, who died only 25 days apart this past holiday season. Erika, who had Alzheimer's, spent the days following her husband Walter's death searching the house for him. Unable to express her grief with words, all she could do was pace her home day after day looking for her beloved Walter. While her family was surprised at her quick decline, it was understandable. She simply wanted to be by his side, and it broke her heart when he wasn't there.

Erika and Walter Siebert met in Germany. At 17, Walter was wounded on the Russian front as he served in the German military. It wasn't much of an option for him; serving as a soldier was expected. He and Erika met after the war. Germany was torn apart after WWII and times were incredibly difficult. They married in 1947 and started their family in 1948 with their first-born son, Werner. Juergen was born in August 1951, then at the end of 1955, their family got on a boat and headed for America.

New Years Day 1956 was spent on a boat in the midst of the Atlantic, and then a few days later, January 10, 1956, they arrived in New York City. They had to go through the proper processing procedures at Ellis Island. The FBI did a thorough investigation and Walter was able to get his green card quickly. They moved to St. Joseph, Michigan, where their American sponsors lived. They helped to get Walter a job at Whirlpool, while Erika stayed home and took care of the children. It wasn't easy. They had left Germany with $10 in their pocket and an unknown future. While the strong German community in St. Joseph helped, becoming fluent in English, establishing a new life and creating new friendships was a daunting task. Together, they started to build a new life here, eventually adding to their family their youngest child, Walter.

The 1970's ushered in leisure suits, bellbottoms as well as a new chapter for the Sieberts. Walter joined his family in starting a sheet metal shop in Mishawaka, River Valley Sheet Metal. Commuting back and forth from Michigan took its toll on them, so Walter began building the family home on a beautiful piece of land off Dragoon Trail. They moved into a partially finished home during the fall of 1974. They cooked using a Coleman stove and suffered through some inconveniences, but eventually the family home took shape and provided a place where Erika and Walter took sanctuary.

Over the years, they put their stamp on the property. Planting trees densely in the acreage behind their home has today become a wonderfully lush forest. Walter had an artistic eye and dabbled in stained glass once he retired from the sheet metal company. Erika was also a creative soul. She loved flowers and gardening and made delicious German treats. "They enjoyed being here in their house," Juergen said. "They had a garden. He built the barn. He kept putting little additions on here and there…he liked to stay busy and do things."

While their home provided their peace and tranquility, they also enjoyed traveling. Walter ended up working for their youngest son, who had a neon sign business. "Mom and dad would jump

Continued on page 6

Inside this issue:

Birthdays

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Julie Driggers
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Janet Van De Veire
5/23
Patricia Goeller
5/23
Cindy Kilgore
5/24
Betty Kay Eley
5/25
Loretta Blowers
5/29
Sarah Wargo

Time to Volunteer Again?

It's been a long year! If we all were told in 2019 that our world would drastically change in just a few short months due to a global pandemic...most of us would have laughed. But over a year later, masks have become such a part of our daily attire, shaking hands is a thing of the past and interactions with people are still not where they used to be.

Volunteering at Center for Hospice Care took a big "pause" last year. As of April 2021, we have fully opened up our volunteer opportunities again. We are continuing to practice exceptional standard precautions, including the use of masks during all interactions.

Understandably, the global pandemic affected the ability of some of our volunteers to continue in their service. Some have had to step away from volunteering. We completely understand this. However, many other volunteers have resumed their service. CHC understands that each volunteer needs to make the best decision for themselves and their families. This does mean that we are looking for a few good volunteers!

Recruiting needs for CHC:

- Outlying Counties: Elkhart, LaGrange, Kosciusko, Marshall, Starke, Porter, Fulton and LaPorte
- Always looking for volunteers willing to do Level 3 training—allowing them to help patients with some personal care tasks
- Volunteers willing to travel
- Musicians or Entertainers
- Other opportunities such as hair cutters, massage therapists, Pet Peace of Mind and 11th Hour

How can you help?

- Share CHC posts on your social media
- Share with your friends and family the impact CHC volunteering has had for you
- Contact Kristiana Donahue or your volunteer coordinator if you'd be willing to post information in places you frequent (church, gym, coffee shops, clubs, libraries, etc.)

What if someone is interested?

- Our website www.cfhcare.org has a volunteer page with information and an online application
- Have them contact Kristiana Donahue, Volunteer Recruitment and Training Coordinator at donahuek@cfhcare.org or (574) 286-1198.

Volunteer Spotlight

Sarah Klinedinst, Mishawaka

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

I have been a volunteer with CHC for a year and a half. This coming March will be two years. Prior to the pandemic I did visits at a long term care facility and delivered hospitality bags. Thankfully during the pandemic I've still been able to deliver the hospitality bags with the awesome blankets folks have made.

Why did you decide to volunteer with CHC?

I volunteer with CHC because it's a small way I can be involved in my community and honor the people who are a part of it. Being able to offer someone a small bit of comfort with a cozy blanket or being able to sit with someone who might otherwise be a bit lonely are good things to do. Spending time with someone who shares their stories and life with you, even if you are mostly a stranger, is special. In some respects it turns into a selfish endeavor because I always felt better after visiting with someone or delivering a care bag.

What is your favorite food and why?

It's tough to pick just one favorite food! I think my favorite meal is breakfast and I could eat it three times a day. So maybe my favorite food is eggs and potatoes. You can eat eggs and potatoes a million different ways. I also have a sweet tooth so desserts are always tough to pass up.

Favorite book and why.

My favorite book is *The Giver* by Lois Lowry. I think I read it for the first time in 4th grade and have loved it ever since. When I graduated from Saint Mary's the author, Lois Lowry, was on campus and now I have a signed copy of the book. I think I like it so much because each time I read it, it still resonates with me and emphasizes how important our memories and shared experiences are to life.

What do you like to do in your spare time?

In my spare time I love to bake and be outside, especially in the summer. I try to go on a walk everyday. Last Christmas I baked croissants for the first time and they were a success! My husband doesn't eat sweets often so I like to share with our neighbors.

"As a hospitality volunteer Sarah brings a smile to the door each time she delivers a hand made blanket to a new CHC family."

Debra Mayfield, Mishawaka Volunteer Coordinator

Mark Your Calendar

Mishawaka Annual Skills Validation Day

Wednesday, September 22, 2021

Appointments made between 9:00am-3:00pm

Slots are filling up.

Mishawaka Campus

501 Comfort Place

Elkhart Annual Skills Validation Day

Wednesday, June 30, 2021

Appointments made between 9:00am-3:00pm

Elkhart Office

22579 Old US 20E

Plymouth Annual Skills Validation Day

Wednesday, December 15, 2021

Appointments 9:00am & 10:00am

Location TBD

To schedule your appointment, contact Kristiana Donahue at donahuek@cfhcare.org or call at 574-286-1198.

Volunteer Updates

Volunteer Recognition 2021

We are very pleased to announce that our annual Volunteer Recognition Luncheon will be in person this year! We are so excited that this will be possible, as we truly enjoy seeing your faces and offering a nice event to celebrate your accomplishments. This event will take place later this year and we will provide you with details as soon as we confirm them.

Milton Adult Day Services Volunteers

Milton Adult Day Services, a service of Center for Hospice Care, provides a structured setting to adults who need health, social, and support services during the day. This community-based service is designed to meet the individual needs of functionally impaired adults who require supervision during the day. Milton Adult Day Services promises to be respectful, offer opportunities for an enhanced quality of life, and assures participants' safety.

Milton Adult Day Services utilizes volunteers to help participants with a variety of activities daily. From gardening, to music programs to cooking classes, Milton engages the senses to engage the participants and provide meaningful daily interaction.

Milton Adult Day Services is located in South Bend at 922 E. Colfax Avenue. Renovations are currently underway at our Roseland building, where Milton will be relocated after completion.

We are looking for some volunteers interested in volunteering at Milton Adult Day Services to interact with and assist the participants. We also are looking for many entertainment volunteers! We are looking for musicians or other entertainers. If you are interested in volunteering at Milton Adult Day Services, contact Debra Mayfield at mayfieldd@cfhcare.org

Spring Throw Back Picture

To celebrate the colors of spring and our wonderful volunteers, enjoy this throwback picture of Kathy Fuchs (left) and Edie Schott (right) caring for our potted plants at our Roseland location a few years back. This will soon be the new home of Milton Adult Day Services.

Pediatric Services

Pediatric Palliative Care

Palliative care is available for a child 20 years old or younger with a serious illness requiring skilled nursing care.

Skilled nursing care in the home includes:

- Management of symptoms
- Drains or feeding tubes
- Lab draws if needed
- Management of port or PICC lines
- Trach care
- Education Medication management

Pediatric Hospice Care

To qualify for pediatric hospice care, a patient must have an expected life span of six months or less. The goal of hospice care is to improve the quality of the child's life. Studies have shown that having hospice care prolongs life expectancy as symptoms are better managed. CHC is one of the only hospices in Northwest Indiana that accepts pediatric patients. Management of care will be provided by hospice while actively coordinating a plan with the child's care providers. Skilled nursing is available under hospice care. Depending on the health care plan, a child may be eligible for concurrent care, which allows a child 20 years of age or younger to have hospice and curative treatment.

Where is care provided?

- Homes
- Hospitals
- Extended care facilities
- Our inpatient units

Perinatal Palliative Care

What is it?

Perinatal palliative care is compassionate support for parents and families who find out during pregnancy that their baby has a potentially life-limiting condition. Care focuses around the needs of the family in a holistic nature. This support is provided from the time of diagnosis throughout the baby's life. Perinatal palliative care helps parents embrace whatever time they have with their child and make it meaningful, memorable and family-focused.

During Pregnancy

Our team consists of the family, a nurse and a counselor.

- Our team will listen and learn what is important to the family
- Answer questions
- Advocate
- Support
- Explore ways to express love and care to the baby
- Design a birth plan and share with the health care provider

After the baby's birth

Our perinatal support team provides the best care for newborns that have a potentially life-limiting condition. A nurse will meet with the family at the hospital and together will identify their goals and wishes for them and the baby.

Comments from our Families

- A big thank you to the three ladies who stayed with us while we watched mom take her last breaths. Just having them there to ask questions and support us was wonderfully comforting. Thank you.
- My dad was at Raclin House. The room was very nice looking out of the window seeing the water. Dad likes the water.
- I am so thankful that everyone was so helpful with everything we needed and I did not feel like I was all alone taking care of my husband. Thank you so much.
- The professional staff at hospice made the sadness of my mother's final journey a positive experience. The care and concern of each person I dealt with was very evident. Thank you!

Continued from page 1

into a truck with neon signs," Juergen shared. "They'd head up to California, Arizona, Washington or out to the East Coast. They just went all over the place." It seemed as if the two of them truly did life together, side by side, sincere life companions.

In 2000, the family had to call Center for Hospice Care (CHC) for the first time. Walter and Erika's youngest son utilized our support for the last six months of his life. He died at the age of 42. Though it ached to say goodbye to him at such a young age, they appreciated the support that Center for Hospice Care gave during that time. Like so many of our past patient families, it was that understanding of what we do and how we help that made it an easy decision to call us for Walter and Erika.

Erika was aware of her cognitive decline at the beginning of her Alzheimer's journey. "It was difficult for them both," their daughter-in-law, Carolyn said. The early days were so hard because she was aware that something was wrong and understood that it would most likely get worse. In the later stages, the awareness of her cognitive impairment wasn't present. Her Alzheimer's journey was around 10 years long. Walter remained lucid until just the last few days of his life.

Walter started care with CHC late spring. Erika started care mid-summer. "People usually think hospice and think they're about to die," Juergen explained. "But hospice is about getting them there…in the best possible, most comfortable way. It's for the family, surrounding the person and for the person themselves." Nichole was the Siebert's nurse. She would come in regularly to check in on them and guide the whole family on what to expect. She let them know when it was time to consider a hospital bed. When they felt lost, Nichole would point them in the right direction. Michelle was the Aide that would patiently guide Erika through her baths. Bathing people with Alzheimer's can be difficult. Erika was quite pleasant and wasn't difficult to deal with, until bath time. Michelle would truly take the efforts needed to get her bathed despite the resistance. Carolyn provided a lot of care to Erika and Walter. They would always look forward to her coming to see them. Juergen and Carolyn truly wanted to help them stay in their home, if possible. As Carolyn provided so much of the support to her in-laws, the additional help was appreciated. "It would have been horrible to go through this without Center for Hospice Care," Carolyn shared. "It felt like we really had people that cared."

Even through the end of their lives, the Sieberts shared everything and were right next to each other throughout it all. When Alzheimer's would crowd out the quality of their days, the family would bring them together with pictures and memorabilia. "That would take them off into their world again," Juergen said. "Just enjoying each other's company and talking. Even in the end, mom and dad had that connection. They always shared their food and their water. And when dad was bedbound, mom would be there, standing right next to him."

When Walter died, Erika was fairly healthy, physically speaking. That's why the quick decline was such a shock to the family. "It was like she jumped off a cliff," he said. "She walked back and forth in their house. She put miles on, just looking for dad." Twenty-five days after Walter died, Erika joined him once again. "Everything, right from the beginning to the end with hospice," Carolyn said. "Was just perfect, as far as I'm concerned. It couldn't have gone any better."

What is the family left with after the significant loss of two most connected people? Family. Every two years, Erika and Walter would return to Germany to connect with their family. They invested in their sons and their family here as well. "Family was an important thing to them," Juergen said. He said that this continues to this day with his relationship with his brother.

It was the sincere privilege of Center for Hospice Care and staff to come along beside the Siebert family. CHC focuses on what's important to each patient and family, which is usually to remain in their home while they finish their journey. What a pleasure to allow them to be near each other and care for each other for each remaining moment. "They were meant to be together, you know," their son said. "Forever and ever."

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.

OPERATIONS

Hospices Fight Rising Turnover During Pandemic

By Holly Vossel | April 9, 2021

Staff turnover and burnout have been higher since the coronavirus pandemic first hit the nation. Hospices are adopting strategies to stem the tide, with providers increasingly working to build career paths for nurses and other hospice staff.

The coronavirus pandemic has taken a heavy toll on hospice staff since its onset. Slightly more than 20% of health care workers have considered leaving the field due to stress brought on by the pandemic, and 30% have considered reducing their hours, according to a recent study publishing in JAMA Network Open today.

The weight of COVID-19 has led to overwhelmed and understaffed clinical teams and back-office operations. Fostering staff resilience has been a top priority among the health care system at large, with hospice leaders learning valuable lessons from the past year's challenges.

"Staff retention is one of the most important quality measures and has a huge impact on the bottom line," said Dianne Hansen, CEO of Partners In Home Care, Inc. "Our agency saw a much higher number of nurses and hospice aides leaving the workforce or moving out of the area, primarily related to family needs. Labor pools are extremely tight in many areas of the country."

Hospices have struggled to fill their ranks long before COVID-19. More than 35% of hospice leaders surveyed by Hospice News and Homecare Homebase earlier this year cited staffing shortages as a top concern for their organizations, along with regaining access to patients in facilities.

The United States has 13.35 hospice and palliative care specialists for every 100,000 adults 65 and older, according to an April 2018 study. The research estimated that by 2040 the patient population will need

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10,640 to 24,000 specialists; supply is expected to range between 8,100 and 19,000.

Hospices have increasingly sought ways to boost staffing recruitment and retention. Hospice and home health provider Amedisys (NASDAQ: AMED) is embracing data analytics to reduce staff turnover amid staffing shortages exacerbated by the pandemic. The company's system predicts with 80% accuracy whether an employee may be leaving their positions, allowing opportunities for intervention.

LHC Group (NASDAQ: LHCG) is stepping up efforts to recruit clinical staff to match the home health and hospice provider's rate of expansion, foreseeing rising demand of clinicians amid an 8% growth in same-store hospice admissions during 2021.

Compounding the problem, nursing and medical schools may not have enough open slots in their programs to meet the growing demand.

"Even for the residents who are interested in health care careers, and specifically nursing careers, we don't have enough nursing faculty," said Johanna Beliveau, president and CEO of Visiting Nurse and Hospice for Vermont and New Hampshire (VNH). "We saw the

potential of bringing new graduate nurses directly from their undergraduate education programs and into the practice of home-based care, which has not historically been the pathway."

While hospices contend with rising turnover, they are also seeking solutions for educational barriers to building the hospice workforce. LHC Group recently invested $20 million in the University of Louisiana at Lafayette College of Nursing and Allied Health Professions to help grow interest in hospice employment and help their own staff advance their careers.

VNH partnered with the VNA Health System of Northern New England to offer registered nurse graduates a one-year nurse residency program as a way to address the ongoing home health care nursing shortage. The residency is intended to promote the development of competency and role transition from student to professional nurse, supporting the resident professionally, emotionally and socially during the first year of clinical practice.

"Together we recognized the increasing demand for nursing within our region, the increasing competition for recruitment of experienced nurses in our environments," Beliveau told Hospice News. "This is an early novel approach. We will be piloting expanding the home health model to really learn from it and understand how to do this successfully, and then adapt it for our hospice team."

With the aging population growing, hospice and palliative care providers will need to increasingly invest in a shrinking workforce to sustain rising demand for end-of-life and serious illness care. According to a 2018 U.S. Census Bureau report, more

than 617 million people were 65 and older in 2015, representing about 9% of the world's overall population, with projections that this aging population will grow to about 1.6 billion, or 17%, by 2050.

Providers face unique challenges when it comes to recruiting medical, social work and nursing students, largely due to limited exposure to hospice and palliative care during training. Most students in clinical disciplines do not feel prepared to provide end-of-life care, according to a 2018 study.

One goal is to adapt the nursing residency program for hospice in the near future, according to Beliveau.

"It's a great example of the culture in our organizations and what we're striving to achieve, which is really continual learning and development through various stages of people's careers," said Beliveau. "From a retention perspective, our hope is that clinicians see programs that we are beginning to develop and see that we are also working on a career ladder or career progression model where someone can come into our organization who is less developed than the residency program. These are the things that we are exploring, because we have to invest in the workforce."

Companies featured in this article:

Amedisys, Homecare Homebase, LHC Group, Partners In Home Care, Visiting Nurse and Hospice for Vermont and New Hampshire

Holly Vossel

Holly Vossel is a word nerd and a hunter of facts with reporting roots sprouting in 2006. She is passionate about writing with an impactful purpose, and

developed an interest in health care coverage in 2015. A layered onion of multifaceted traits, her personal interests include book reading, hiking, roller skating, camping and creative writing.

Mark Murray

Subject: FW: Thank you from IUSB School of Nursing

From: Zellers, Rebecca S [mailto:rszeller@iu.edu]
Sent: Monday, May 10, 2021 10:31 AM
To: Tammy Huyvaert
Subject: Thank you from IUSB School of Nursing

[EXTERNAL]

Tami,

Thank you for allowing the IUSB senior nursing students to complete community clinical with you. The students unanimously stated their experience was not what they expected hospice to be (it was soooo much better than their preconceived notions going into it) and hospice provides a holistic way of providing nursing care to patients. The students had wonderful things to say about every hospice nurse that preceptored them.

We went into the semester knowing it was going to be taxing and an endurance run - but, we made it and I could not have done so without your help. Thank you so much! Next fall, community health clinicals will be on Tuesdays and Wednesdays. I hope that I can continue to place nursing students at The Center for Hospice. When possible, I continue to place students that live in the Plymouth, Elkhart or Mishawaka areas at the closest hospice to their home thus allowing the students to save gas money but to also know that their local hospice is a future place for employment!!

Thank you,
Becky

Rebecca Zellers DNP, MSN - Nurse Educator, RN
Clinical Assistant Professor
Vera Z. Dwyer College of Health Sciences
Indiana University South Bend