Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
November 17, 2021
7:15 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

BOARD OF DIRECTORS MEETING

November 17, 2021
7:15 a.m.

A G E N D A

1. **Welcome –** Jennifer Ewing (3 Minutes)

2. **Consent Agenda** – Jennifer Ewing (5 minutes)
   A. Approval of August 18, 2021 Board Meeting Minutes *(action)*
   B. QI Committee Meeting Minutes 08/24/21 included in your packet *(information)* – Jennifer Ewing is available for questions

3. **President's Report** *(information)* - Mark Murray (20 minutes)

4. **Finance Committee** *(action)* – Kurt Janowsky (15 minutes)
   A. 2022 Flex Spending Account Limit
   B. 2020 403B Retirement Plan Audit
   C. Year to Date October 2021 Financial Statements
   D. 2022 CHC Budget

5. **Hospice Foundation Report** *(information)* – Mary Newbold (12 minutes)

6. **Board Education, "Challenges with Referrals and Census" –** Craig Harrell, CHC Director of Marketing and Access (10 Minutes)

7. **Chair's Report** – Jennifer Ewing (5 minutes)
   A. Re-election of Mark Wobbe and Andy Murray to a second three-year term on the CHC Board of Directors

Next meeting February 16, 2022

# # #

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501 Comfort Place	112 S. Center St., Ste C	22579 Old US 20 East	309 W Johnson Rd, Ste A
Mishawaka, IN 46545	Plymouth, IN 46563	Elkhart, IN 46516	La Porte, IN 46350
(574) 243-3100	(574) 935-4511	(574) 264-3321	(219) 575-7930
Fax: (574) 243-3134	Fax: (574) 935-4589	Fax: (574) 264-5892	Fax (219) 476-3965

CHAPTER TWO

CONSENT AGENDA

DRAFT

Center for Hospice Care
Board of Directors Meeting Minutes
August 18, 2021

Members Present:	Brian Huber, Jeffrey Bernel, Jennifer Ewing, Kevin Murphy, Kurt Janowsky, Mark Wobbe, Mary Newbold, Wendell Walsh
Absent:	Andy Murray, Roland Chamblee
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. Minutes	• A motion was made to accept the minutes of the 05/19/21 meeting as presented. The motion was accepted unanimously.	W. Walsh motioned J. Bernel seconded
3. Policies	• Revised policies were in the Board packet. Some of the revisions were related to COVID that we expanded to include any pandemic. A motion was made to accept the policies as presented. The motion was accepted unanimously.	K. Janowsky motioned B. Huber seconded
4. QI Committee Minutes	• The Quality Improvement Committee minutes from 05/25/21 were included in the board packet. Per regulations, the governing body must be involved in quality programs so every time the QI Committee meets, we include those minutes in the board packet, so the board is aware of what we are doing. The committee meets quarterly. Jennifer Ewing, Chair of the CHC Board, is also on the QI Committee. Mark M. answers any questions the Board may have so we can show a surveyor how the governing body is included in our quality plan.	
5. President's Report	• Throughout the year, census has been trending down. There are several reasons for this. If our census was over 400, would we have the staff to care for them. We have 20 staff openings. YTD census is down 10% from 2020 at 389 with breakeven budget of 414. We are not spending expenses we expected because we don't have the census to justify doing that. Part of the problem is nursing homes and assisted livings don't have the residents they had before COVID. Normally they have a turnover of about 30% of their residents a year. During the pandemic, people were afraid to go to a facility. Long term care industry experts say facilities may not recover until the end of 2022. With the	

Topic	Discussion	Action
	pandemic, other preliminary studies say there may be a rush of patients at the end of 2022 that were COVID survivors and have co-morbidities. We have had some competitors refer patients to us because they didn't have the staff. So far, we have not had to turn anyone away. Referrals are down 3% from 2020 and new admissions are down 14%. Our conversion rate is 68% compared to 76% last year which was the highest in our history. In the industry, anything over 70% is considered very good. • Palliative care/home health ADC YTD through July is up 39% from last year, and 2020 was up 37% from 2019—a 76% increase in just 2.5 years. Palliative care is under our home health license. We are working on getting patients further upstream with an eventual trajectory for hospice care. Patients in facilities were 95 in July compared to 136 in July 2020. June ADC of patients in nursing homes and assisted livings was 119 in May (29% of ADC), 119 in June (28% of ADC), and 95 in July (25% of ADC), compared to 136 patients in July 2020. We have lost 24 patients a day in those facilities. • IPU days in 2019 were 1,639, 2020 was 1,383, and 2021 is 1,468. Esther's House has been closed since 07/04 for refurbishing. We don't have the clinical staff to run Esther's House 24/7, so those employees have been moved to Raclin House where we have seen a great deal of patients. We had 12 patients on one day in July. We hope to have Esther's House open soon. Patients can also be seen at Elkhart General Hospital under our GIP contract. • Staffing issues continue. We have offered sign on bonuses for nurses and aides, and referral bonuses to staff who refer someone that is hired. We held a networking event and over 40 people attended that have never been here before. Since the May board meeting, we have hired 28 new clinical staff and a full-time recruiter. We are having recruitment success everywhere but Elkhart. • We had an Indiana Department of Health (IDH)/CMS survey at the end of June/first of July. The surveyors visited every office. We don't have the official results yet. We don't anticipate we will have any serious problems. It should be things we can easily and quickly fix. The surveyor referenced how our employees were so engaged. • Our annual volunteer recognition event was held in-person on 07/20 at The Amory. About 160 people attended. Volunteers were recognized for 5+ years of service including one person for 25 years of service. Along with this year's Krueger Award recipient, last year's recipient was recognized as well because the event was held	

Topic	Discussion	Action
	virtually last year. Thank you to Kurt Janowsky for donating the space, tables, etc., at The Armory for the event. • We have submitted our documents to our attorney for the $1.2MM long length of stay audit. • On 07/28 we held our first in-person staff meeting since 2020. The other offices participate via webcast so we can see each office. Usually new staff is introduced at the staff meetings; however, we've hired 92 people since the last in-person meeting, so we will restart that at the September staff meeting. New hires are also listed in the weekly announcements as well as staff anniversaries. We provide a retention bonus that increases the longer a person is an employee. • GPIC is now an actual not-for-profit corporation in Indiana. We have the official letter from the IRS, so we can do fundraising. We will shut down the New York corporation and bring everything back to Indiana. It is a very long process. • The 2020 Year in Review has a new layout. Cyndy Searfoss helps edit and Jim Wiskotoni does the layout in-house. • The reporting capabilities of the new EMR system, MatrixCare, are subpar. They said an admission would be fast and easy and cut processes in half, but it has increased it from three hours to four. It has about 10% of the reporting capability compared to Cerner. Extracting data is very labor intensive and if we do get reports, we don't know if they are correct. We are setting up a meeting with our IT Department to put pressure on MatrixCare. MatrixCare is new to hospice organizations. We asked for a new sales demo to see where we are on those items. They are blocking access to our data cube, which we have a right to access. If they continue to block it, we will file a complaint with CMS. If we have access to our raw data, then we would be able to get the reports and information we need. A lot of the reports in Cerner were custom built. From a cash flow perspective, MatrixCare's billing and claims submission is much better than Cerner. When we switched to Cerner it took three months before we could submit claims, and with MatrixCare it took about two weeks. Our goal is to solidify our partnership with MatrixCare and help them get a better product out there. Kevin M. said our greatest leverage is partnerships with other hospices. We should express our disappointment and desire to help them. • COVID Vaccinations – The CHC Adminisrative Team is meeting next Tuesday to discuss what direction we are going in relation to mandating staff receive the vaccine.	

Topic	Discussion	Action
	We told staff at the July staff meeting that we will be mandating the vaccine once the Emergency Use Authorization (EUA) is lifted. We need to look at the potential for loss of staff and how we will respond and take care of patients. We only know the staff that participated in the three vaccine clinics we held in our building. Some got it at other venues. Ohio Hospice tried offering a $5,000 prize drawing if staff to get the vaccine, but no one responded. 27% of their nurses are vaccinated. They will mandate it for staff in October. Per HIPAA, we cannot ask staff if they are vaccinated. There are conflicting regulations. In nursing homes, we have to prove our staff tested negative or were vaccinated. Employers want to do the right thing but also need employees.	
6. Finance Committee	• The Finance Committee met last week and approved the YTD July 2021 financial statements. Through July, total operating revenue was $13MM, which was $2MM under budget. Other income was $2.6MM which was $1.8MM over budget. Total revenue was $16MM, which was $98,128 under budget. Total expenses were $12MM which was $2.4MM under budget. One of the benefits of a lower census is direct patient care costs are not being utilized. Also driving budget numbers is the lower group health insurance expenses are down significantly because hospitals are only doing emergency-type care. We budgeted for people getting the treatments they didn't do last year, but they have not done them this year either. Overall net gain was $3.5MM, and net without beneficial interest in Foundation was $1MM. • The Finance Committee also talked about the audit we received in May for 2020. That was in draft format. We received HHS Stimulus funds which triggered a single audit of the receipt and use of those funds. That was going to be incorporated into the 2020 audit; however, the portal to submit our report didn't open until July 2021. The Rybar Group is waiting for further guidance before submitting it, because HHS has changed the rules multiple times. So, the single audit will not be included in the 2020 audit and will be deferred to the 2021 audit process. The audit the Board saw in May will become the final audit report. We don't anticipate changes to it. Most of the work has already been done by Kruggel Lawton and our consultants. We had about $300,000 more in expenses than the amount we received, so we expect to keep what we received. • The Finance Committee also talked about the 2022 reimbursement rates that were released. The Government's fiscal year starts October 1st. Our overall new reimbursement rates went up on average about 2%. On an annual revenue basis, based on the current case mix and census levels, equals about $475,000 in additional revenue	

Topic	Discussion	Action
	in 2022. There are different rates for Routine level of care. We get reimbursed a higher rate the first 60 days and then a lower rate 60+ days. Rates are based on the CBSA (Core-Based Statistical Areas). The Sequestration 2% rate cut may go back in effect after January 1st. It has been on hold during the pandemic. • Milton Adult Day Care – Construction for the new facility continues on pace. The building on Colfax Avenue was in a bad state of repairs. Based on that, we negotiated to leave the building in late June and identified temporary space on Grape Road where Active Day Adult Day Care was located. IDH had already approved that space as an adult day care center. We moved over the July 4th weekend and opened on 07/06. Staff like it and the clients like the windows and watching the traffic. Their census hit a high at 18, which we have not seen since before the pandemic. This is also an opportunity to get rid of things we don't need, and we will do that again when we move to the new building in Roseland. • A motion was made to accept the YTD July 2021 financial statements as presented. The motion was accepted unanimously.	M. Newbold motioned M. Wobbe seconded
7. Hospice Foundation Update	• Since the inception of the Hospice Foundation's fundraising through annual giving, campaigns and bequests, we show an anomaly in 2021 in the $2MM we have received through July in campaigns and bequests, most of which is due to fundraising for the Milton project. Total assets for the Hospice Foundation are up $6.6MM from a year ago. The investment portfolio has also done extremely well. The Annual Appeal raised $120,000—the most ever in its history. • The Center for Education and Advance Care Planning is working with health systems and family residency programs for physician and Fellowship rotations. We are offering IU Talk through the IU School of Medicine. We continue to collaborate with Hospice Foundation of America (HFA) for continuing education opportunities. We participated in the Hospice Action Network (HAN) "Hill Day" recently and were able to meet with Indiana legislative offices. We are hosting a series of virtual panel discussions to introduce and expand end-of-life conversations. • Honoring Choices Indiana North Central did several recent presentations to various organizations through last month. We have 83 trained facilitators. Palmer Funeral Homes in conjunction with Honoring Choices will be sponsoring television spots promoting advance care planning. We applied for a grant along with other Honoring Choices partners to the Robert Wood Johnson Foundation, and we received a $5,000	

Topic	Discussion	Action
	grant from the Community Foundation of Elkhart County to promote advance care planning in Elkhart County. We are also working on opportunities in LaPorte County. Thank you, Jeff Bernel, for his assistance in this area. We are working collaboratively with all health systems in the area. • GPIC – There has been an increase in COVID with various partners in Sub-Saharan Africa. We continue to work with them and their U.S. partners to provide resources. Funding continues to come through to assist those partners. We currently have 37 partnerships. We are working on scholarship fundraising for nurses and social workers to receive additional training. A number of research projects are continuing, as well as internships—most of it virtually. We continue to work on a palliative care leadership project with PCAU and Bluegrass Care Navigators to deliver leadership training to various leaders within palliative care programs in various countries. We are seeing a lot of people that started hospice and palliative care programs starting to retire and they didn't do a good job of training a successor. • PCAU continues to provide COVID support and funding for resources to work from home. We continue to work with Mark Mwesiga, the PCAU director, on leadership development, mentoring, board investment, getting people onboard to lead the organization, staff development, etc. The PCAU International Biennial Conference will entirely virtual this year. CHC employees selected to be presenters or participants are Cyndy Searfoss, Dr. Matt Misner, Annette Deguch, and Lacey Ahern. We received an anonymous donation of $17,500 to support Road to Hope children while they are at home. • Milton Village – We continue to make good progress on the new location. The Institute for Excellence in Memory Care and Alzheimer's & Dementia Services of Northern Indiana will be housed there as well. Our goal to be in place by the end of the year. • Helping Hands Award dinner honoring Drs. Zoreen and Rafat Ansari is still scheduled to be held 09/08 at the Hilton Garden Inn. Jennifer Ewing and Tom Housand are the co-chairs. We are expecting about 300-350 people. At this time, we will delay making any decision regarding mask protocols. We will decide about a week in advance based on recommendations from the St. Joseph County Health Department. We should also consider the possibility of a negative response from the public of a health care organization holding a large event.	

Topic	Discussion	Action
8. Board Education	• Lance Mayberry, Vice-President/COO, gave an update on CHC's Community Based Palliative Care program. We are doing palliative care through our home health program and our Center for Palliative Care clinic. We have not seen the volume in use of the clinic that we would like to see. We have met with our NPs and area hospitals to look at what they need and have added other things to our program. If we don't reorganize how we do palliative care, we could miss out on some reimbursement from CMS. Initially there were about 15-17 various payers and now there are over 40 that offer some type of reimbursement for palliative care. Enrollment in Medicare Advantage programs has increased over the years. 50% of them only contract with a certain number of hospice programs, so we could have less access to 50% of patients. We have very limited exposure to our current insurance programs and by expanding our palliative care program, we will have relationship with those insurance programs. • Currently, no one in our area is providing community-based palliative care in the home. We have been meeting as a team to look at care models and working with our Center for Education and Advance Care Planning as a resource. We have four NPs on staff that will help in developing this program. When someone makes a referral for palliative care, it is to our medical team of doctors, NPs, and social workers that review it. An LCSW will act as navigator, and we can bill for the social worker's initial conversation with the patient. About 40% of these patients will go to hospice care. Everything will be reviewed by the medical team before the social worker goes out. Jen E. said a clinical person should be the one having the conversation with the patient about their goals of care. That should be clear when we explain our palliative care program to clinicians. • We have established the "Center for Medical Services LLC" for our medical team. We will transition our current home health/palliative care patients to be seen by an NP. We have also created an outpatient clinic at Milton Village. A medical team member could go there once a week and see Milton clients for consults. We will do education outreach to the community, so they know what we are offering. Over the next 12-24 months we plan to do controlled growth by working with oncology, cardiac, pulmonary, and outpatient clinics. There are different reimbursement models we can bill for that we would have access to under this model. Some regulations are out there trying to expand access to palliative care programs (Senate Bills 2565 and 2566, and telehealth waivers from CMS).	

Topic	Discussion	Action
	• We received a $500,000 matching grant from the Vera Z. Dwyer Trust for palliative care programs. It is a restricted gift for those purposes. We also have money restricted for palliative care program to seed these programs. We meet with Chuck Nelson who oversees the Dwyer Trust about once a year to talk about what we are doing in that realm and what we have been doing with those funds. Telehealth will be under palliative care. We are getting more referrals from Riley and could bring pediatrics under palliative care. Our clinic will give us more exposure. We bought the building when we did because it was available knowing not much would happen there until our program is up and running. Memorial is talking about putting a palliative care office on their campus. We will have those conversations with them about utilizing us. • Brian H. commented that palliative care is the most misunderstood thing. Recruiting patients from hospitals should not be our goal. The PCPs have people that would fit this model. Those in hospitals are generally ready for hospice. We should focus on PCPs who are managing those patients not sick enough for hospice or hospitalization but will be in five years. That is the population that would benefit from palliative care. The South Bend Clinic has 48% of the PCPs. Focus education with PCPs on how their patient is appropriate and how to get them over to CHC. These patients should not have to be managed on a daily basis. We should be checking in once a month. These patients could be on this program for 3-5 years.	
Adjournment	• The meeting adjourned at 9:10 a.m.	Next meeting 11/17

Prepared by Becky Kizer for approval by the Board of Directors on November 17, 2021.

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Jennifer Ewing, Chair

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Becky Kizer, Recording Secretary

Center for Hospice Care
QI Committee Meeting Minutes
August 24, 2021

Members Present:	Angie Fox, Carol Walker, Craig Harrell, Deb Daus, Holly Farmer, Dr. Karissa Misner, Lance Mayberry, Larry Rice, Mark Murray, Tammy Huyvaert
Absent:	Alice Wolff, 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 05/25/21 meeting. The motion was accepted unanimously.	T. Huyvaert motioned D. Daus seconded
3. Committee Updates	• We are taking a different look at the material and whether it is the data we should be reporting to this committee. We are always working on continuous improvement. QAPI and QA/QI monitoring is an important part of CHC. Natalie Barnes, QA/Medical Records Coordinator, is changing to PRN. As she transitions, she will be with us this week to help with some reports. Tammy H. will be taking over as Director of QA as of 09/12. • We had our Indiana Department of Health hospice recertification and emergency preparedness surveys, and we passed the emergency preparedness survey 100%. We had no condition level deficiencies. There are ten areas we are addressing. Staff did a good job during the survey.	
4. Hospice Quality Monitoring	• Support Services – For a couple of years we have been monitoring those assessments are done by the chaplain and social worker within five days after admission. This year we were at 99% or above. We monitor the Service Intensity Add On (SIA) hours when a patient is declining. The goal is chaplains will do a daily contact. The social worker goal is to increase SIA hours by 20% over 2020 or 326 hours and they are already at 200 hours. Bereavement survey – NHPCO had some errors in their system so the report for January-June 2021 has not been released. We can submit data to NHPCO until 08/20. SIA hours have an internal signal that a patient is on "enhanced services." We had about twice as many patients in the first quarter, so that signal went out less often in the second quarter, but we are still above 2020 numbers. Support services staff should be talking to the case	

Topic	Discussion	Action
	manager when they notice the patient is declining. We will look at who is placed on enhanced services and who is not. • Triage Calls – The QAPI is focusing on the top three reasons for calls and explore why the person is calling in and break out those numbers. As of 08/01 we started a retroactive study. We will back out calls for med refills, supplies, nurse and medical staff call ins, changes in condition, and deaths. We look at the volume of calls and the reasons. The volume of calls in the first quarter were down 4.3% from the fourth quarter 2020 and calls in the second quarter were up 7.2% from the first quarter. We educate families to call anytime so they feel confident in making that call. We can get better insight as to why they are calling and whether it is an emergency, or they just want to talk to someone. • Discharge Disposition – 85% of discharges in the second quarter were deaths, which is in line with the national rate (83%). Live discharges in second quarter were 14.99% compared to national rate 17%. Revocations – In second quarter 7.49% compared to national rate 6.60%. Transfers – We are making sure we look at why they are transferring to another hospice. No longer terminally ill – 3.46% in second quarter which was well below the national and state averages. We may be too rigorous in our admission process. Dr. Karissa M. looks at long lengths of stay reports weekly and sends someone from the medical team to do a face-to-face visit to make sure the patient is still eligible. • Levels of Care Utilization – Continuous Care. Last Friday we started Continuous Care at 6 AM for a patient and around 4 PM the patient transferred to the IPU. Some other cases would have been Continuous Care, but they were less than 8 hours in a 24-hour period. • Respite has doubled. The majority of hospices' respite patients go to a skilled nursing facility following their respite stay. We are seeing a lot of patients going from Respite to GIP while they are in the IPU. They probably could have come to the IPU a few weeks prior. Only one in five hospices have their own inpatient unit. Our utilization should be higher. We are looking at that. • Patient Falls – We looked at the data and saw an error had been made in that some home health and hospice rates were combined. This report shows just hospice data. Historically we see an increase in falls in the summer. The national number of patient falls per 1,000 patient days was 3.40. In the first quarter we had 3.13 and	

Topic	Discussion	Action
	second quarter 5.10. Eight out of ten falls the patient was not using their DME. Tammy H. reviews triage calls and a lot of the falls occur when staff is not there. Triage notifies the case manager, and we make sure that education is done and documented. Sometimes when the nurse goes out the family will say the patient fell five days ago, but they never notified us. • Hospice Item Set – We are auditing Admissions and QA to make sure we reach our goal of 100%. Admission is doing a good job increasing those numbers. CMS will do a 4% sequestration if a hospice is not reporting results above 90%. We are well above that.	
5. Palliative Home Health Program	• We are looking at adverse events, hospitalizations, and QAPIs. We saw an uptick in the number of patients assigned to a case manager, so we are looking at how to divide caseloads. We have been talking with MatrixCare on fixing some of the data. At the Board meeting last week, we discussed how hard it is to extract this data and the data analytics we don't have access to. • Hospitalizations – Home Health patients can go back any time. Typically, we see a higher national rate even though our goal is to keep the patient out of the hospital. The majority came from certain zip codes and different income levels versus other zip codes. We will be looking at what we can do to improve this. We will also look at the diagnoses. These are procedure based, not symptom related: catheter placements, pleurix drains, and g-tube came out. We will track if they were hospitalized or were just in the ER. We are also tracking if they were in the HeartWize or BreatheEazy programs.	
6. Quality Overview	• Quality improvement program – The QA scorecard was launched in December 2020 to look at 18 documentation areas we are monitoring in relation to compliance. 3,480 documentation areas were audited in the first quarter. • The HIM (health information management) Committee is working on streamlining our education resources into one location for clinical staff, and Tammy H. is working on having one area for standard operating procedures. • Education – Talent LMS was launched. We are in the process of developing a robust resource library. We are also taking 15-20 minutes at each IDT to review a compliance issue or concern and driving those things home.	

Topic	Discussion	Action
	• QA Scorecard – Our goal is 100% compliance. There is an opportunity to do education and follow through on these elements. The PCCs get a report several times a week. We have problems with MatrixCare that we are addressing. Natalie B. and Lance M. are going through QA reports. We are trying to make it easier for nurses to see their patients. • QAPI – In the second quarter we focused on consumer and caregiver surveys. The chaplains are calling families seven days after the admission and to ask some questions. Our goal is to improve our Press Ganey CAHPS scores. One question on the caregiver survey is did the family feel prepared for pain and symptom management and it was 100%. Family Handbook – we ask if they know where it is and what information is in there. The case manager puts an action plan in place based on the answers from the caregiver survey. • Service Essentials – This was launched 07/01/21. The leadership team will help develop service essentials education. The first and last 72 hours are the most important time to make a good impression with families. We are looking at what the patient/family should expect from admission to bereavement. We will be rolling this education out in the third and fourth quarters. • Yearly QAPI plan – In the second quarter we focused on CAHPS scores. In the third and fourth quarters we will focus education on decreasing hospitalizations, adverse events, and triage calls. Therapists will be invited to participate in a QAPI program.	
7. NHPCO Quality Connections	• There are roughly 122 data points geared around education elements. The QA team is working on various elements of it. One element is pulling information out of MatrixCare, doing that education, applying it to our services and creating innovative models. We continue working with MatrixCare on this and make sure we have a plan in place to finish the education and get the applications in place.	
8. Other Business	• Let us know if there are any elements we should add to the QI Committee report, more or less information on specific areas, etc. Carol W. said drilling down and looking at broader topics is wise. When we see outliers, what are our action steps on that? When we see scores of 100% for two quarters, can that area be retired? Goals need to be measurable. After an area is retired, we should monitor it at least monthly to make sure we are still doing it. Larry R. will continue his practice of monitoring. If by day five the social worker or chaplain has not done their five-day	

Topic	Discussion	Action
	assessment, he tells them they need to get out today. About 10% of staff has to be reminded, so Larry R. will continue to monitor this and report on it at these meetings. • CMS mentioned recently they are changing the hospice quality reporting program to be claims-based measures. These will be reporting and benchmarks against other hospices.	
Adjournment	• The meeting adjourned at 9:00 a.m.	Next meeting 11/16

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
November 17, 2021
(Report posted to Secure Board Website on November 11, 2021)

This meeting takes place in-person in Conference Room A at the Mishawaka Campus. The HF and GPIC Board meetings will follow in the same rooms after a very short break.

CENSUS

Census continues to be a challenge. Referrals Year-to-Date (YTD) Oct. are down 5% from YTD October 2020. Please see the attached article on the "Shifting Hospice Referral Mix" since the pandemic began. New original admissions are down 15% from same time last year. The conversion rate (turning a referral into an admission) is down to 67% YTD from 74% in 2020. From October 1 – 26, we had 95 unique admissions and 130 deaths and discharges. With the staffing challenges we have been fortunate not to have to turn referrals away (See attached New York Times article, "Short on Staff, Some Hospices Ask New Patients to Wait.") From August 1 to October 31, we had 23 new hires and 31 terminations, including six people who were hired and terminated during that same period. I will talk more about staffing at the meeting. Esther's House in Elkhart remains closed due to staffing. We thought we were close to reopening, but an RN who was in orientation for a position there walked off the job in the middle of a shift at Raclin with no notice. We have attempted to utilize staffing agencies with reopening Esther's House. But even if we paid their extraordinarily high rates, they don't have anybody to send us anyway. Census challenges is the topic of the education section at this board meeting.

October 2021 Overall	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	424	1,602	1,839	-12.89%
Original Admissions	117	1,205	1,416	-14.90%
ADC Hospice	306.42	327.92	391.89	-16.32%
ADC Home Health	20.94	47.68	40.04	19.08%
ADC CHC Total	327.38	375.60	431.93	-13.04%

October 2021 Inpatient Units	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Raclin House Pts Served	46	295	284	3.87%
RH House ALOS	3.76	5.21	4.39	18.68%
RH House Occupancy ***	46.51	42.31%	54.41%	-22.24%
Esther's House Pts Served	0	96	231	-58.44%
EH House ALOS	0.00	6.23	5.85	6.50%
EH House Occupancy	0.00%	28.10%	63.33%	-55.63%

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	**2021** Sept	**2021** Oct	**2021** Nov	***2020*** Dec
Mish:	214	215	208	205	210	209	197	187	188	182		214
Ply:	80	81	79	75	67	63	62	56	52	50		76
Elk:	85	85	84	84	83	85	94	100	90	76		90
Lap:	9	12	14	18	18	16	18	15	12	14		12
RH:	5	4	5	6	5	5	6	5	5	6		5
EH:	3	2	4	5	3	2	0	0	0	0		2
Total:	396	399	394	392	386	379	377	361	347	327		399

PATIENTS IN FACILITIES

In October 2021, the average daily census of patients in independent living, assisted living facilities, long term care facilities, and other facilities was 89. Year-to-date through October 2021 the ADC of patients in facilities was 92. For comparison purposes, YTD October of 2019 it was 136. Due to COVID, facilities are struggling and not seeing beds filling or the usual attrition of patients being replaced since last year and some experts in the field say they won't recover until the end of 2022. They are also having staffing issues like everybody else. Assisted living facilities and nursing homes are experiencing a worse labor crisis than any other healthcare sector, according to a report from the American Health Care Association / National Center for Assisted Living. Assisted living communities have seen industry employment levels drop by 38,000 jobs (an 8.2% loss) since the beginning of the pandemic, while nursing homes experienced a loss of 220,000 jobs (14%), according to October employment data from the Bureau of Labor Statistics.

FINANCES

Karl Holderman, CFO, reports the year-to-date October 2021 financials will be presented and voted on at the Finance Committee meeting on Friday, November 12, 2021, and then posted to the secure board website later that morning. For informational purposes, the un-approved September 2021 YTD Financials are presented below.

On 9/30/21, at the HF, intermediate investments totaled $5,038,483. Long term investments totaled $29,226524. The combined total assets of all organizations (CHC/HF/GPIC), on September 30, 2021 totaled $76,118,515 an increase of $3,551,450 from September 2020. Year-to-date investments as of 9/30/21 showed a gain of $1,998,869.

From a year-to-date budget standpoint at 9/30/21, CHC alone was under budget on operating revenue by $3,108,037, and under budget on operating expenses by $2,964,964.

Year to Date September 2021 Unapproved Financials

September 2021 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	16,214,335			16,214,335
MADS Revenue	155,245			155,245
Development Income		1,919,842		1,919,842
Partnership Grants			350,824	350,824
Investment Income (Net)		1,998,869		1,998,869
Interest & Other	146,085	133,535	40,988	320,608
Beneficial Interest in Affiliate	1,673,753	(4,775)		
Total Revenue	**18,189,418**	**4,047,471**	**391,811**	**20,959,722**
Total Expenses	**15,722,921**	**2,373,718**	**396,586**	**18,493,225**
Net Gain	**2,466,497**	**1,673,753**	**(4,775)**	**2,466,497**
Net w/o Beneficial Interest	*792,744*	*1,678,528*		
Net w/o Investments				*467,628*

2022 CHC BUDGET ON THE AGENDA FOR NOVEMBER MEETING

The Finance Committee was expected to review and approve the 2022 CHC Budget at their meeting on November 12th. The approved budget will be posted to the secure board website following approval by the Finance Committee at its meeting on 11/12/2021. CHC's budget alone is over $25 million dollars for next year. This was a difficult budget to predict, and we always begin with an average daily census and go from there. Plenty of questions remain regarding what will actually happen in 2022. A looming unknown is that if the census begins to recover, we will have the staff to care for the patients. To continue business into the new year, it is very important that we have a quorum at our next board meeting. Please plan to attend the board meeting in-person on Wednesday, November 17th.

CHC VP/COO UPDATE

Lance Mayberry, MBA, CHC VP/COO reports…

The third quarter was a busy time here at Center for Hospice Care, from visitors from the state, unprecedented clinical recruiting tactics in the industry, and continuous improvement projects.

CHC facilitated a meeting with 29 National Hospice Palliative Care Organization Members who operate hospice inpatient units across the United States. The hospice inpatient units ranged in size from 5 to 20+ beds. The meeting concentrated on two focus areas: staffing and bed management. The group shared various tactics for bed management and ideas on staffing models and how to adjust for the fluctuation of patients.

After multiple CHC focus groups and surveys, we transitioned our hospice inpatient unit (IPU) staffing model to all hospice IPU team members working 12-hour shifts. This model was widely appreciated and accepted by the CHC team members. The implementation has allowed us to retain team members who were looking for greater flexibility in their schedules and improved the coordination of care between shifts.

We had two critical promotions over the third quarter. Tammy Huyvaert, Assistant Director of Nursing, was promoted to Director of Quality Assurance. Neil Davis, Chaplain, was promoted to Inpatient Unit Manager.

The clinical team has been collaborating with the marketing and access team to streamline the admissions process. We still have more work in this area, but we successfully launched a direct pilot admission process to our IPU from key Palliative Physicians at Memorial hospital. The process has become permanent, and the goal is to continue to streamline the process to allow greater access to CHC care by reducing the number of steps in the admissions process.

On September 18th, our Bereavement Department hosted their annual Camp Evergreen Family Workshop. The workshop had 35 participants throughout the one-day event. We received several positive comments, and the children seemed to enjoy the various activities and sessions. The outdoor yoga was a great icebreaker to the day-long event.

We have held several meetings with our electronic medical record vendor, MatrixCare, to develop a partnership to overcome the obstacles we are experiencing as an organization. MatrixCare has fixed many issues on their Skilled Nursing product line and has a 12–18-month timeline to enhance the hospice product line. We continue to have scheduled monthly meetings to strengthen capabilities and know-how to work with MatrixCare to improve on the functionality of the product.

Our Palliative Care Program continues to develop to the next level as we have ascertained our Indiana Business License from the state of Indiana under the name of Center for Medical Services, LLC. Our next step in the process is to obtain our National Provider Identification number.

CHC DIRECTOR OF NURSING UPDATE

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

The CHC clinical team has been working diligently on the Plan of Correction items from the Indiana Department of Health (IDH) State and Federal Medicare Recertification, state licensure, and Emergency Preparedness Survey for our hospice agency from July. Our Plan of Correction was

accepted on the first submission and surveyors from IDH are not expected back for any hospice surveys. Improvement are being seen in all areas identified.

While working on the previously mentioned hospice Plan of Correction the IDH surveyor entered on a physical environment complaint survey on 10/14/2021 for the Raclin House IPU. In a matter of hours this complaint was determined to be unsubstantiated, and no deficiencies were found.

IDH returned on 10/20/2021 to conduct the Federal Medicare Recertification, state licensure, and Emergency preparedness survey for our home health agency. One surveyor was here to complete that survey and exited on 10/27/21. To date there is no final report for that survey.

We continued to work on site visit readiness for CHAP accreditation. The Community Health Accreditation Partner (CHAP) is a national, independent, U.S. not-for-profit accrediting body for community-based health care organizations. CHAP is the oldest national, community-based accrediting body with more than 9,000 agencies currently accredited nationwide. Indiana is a "deemed status" state and through CHAP accreditation there will be no future visits from the IDH surveyors. At this time CHC is focusing on CHAP accreditation for hospice and once the IDH survey results are provided we will schedule for CHAP site visit for home health. We anticipate the arrival of CHAP for hospice any day now.

All CHC nurses completed the annual skills validation the month of November 2021. Influenza vaccinations were provided on-site for CHC employees. We are awaiting information from Walgreen's on scheduling a vaccination clinic for COVID booster shots for CHC employees.

Staff is very active in QAPI and Quarter 4 is on reducing falls and hospitalizations. We now have our own CHC PRN physical therapist on the QAPI team for falls. Our new PT will also perform PT assessments when needed.

On October 20,2021 CHC hosted a family panel luncheon. The group consisted of seven family members that recently lost a loved one, and the following CHC Team Members Nichole Summe, RN Case Manager, Dr. Karissa Misner, Chief Medical Officer, Angie Fox, Director of Nursing, and Lance Mayberry, Chief Operating Officer. The goal for this panel was to learn from the families what went well in their hospice journey, and under the framework of continuous improvement what areas could we improve upon. CHC team members will be meeting to review the outcome of the luncheon and determine if there are any items needed implemented to improve patient/family satisfaction.

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

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

	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	963,783.86
June	1,066,118.11	633,102.69	850,496.19	608,907.96	1,226,150.74
July	1,277,609.56	767,397.15	918,451.53	676,956.69	1,965,823.42
August	1,346,219.26	868,232.25	1,018,532.22	818,805.78	2,087,178.64
September	1,466,460.27	994,301.35	1,122,498.94	901,877.85	2,162,148.78
October	1,593,668.39	1,074,820.86	1,778,379.29	984,590.41	2,239,987.25
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	54,437.96
June	146,200.17	46,947.92	69,026.39	42,369.40	115,237.02
July	61,505.45	64,243.53	67,591.20	42,034.72	83,873.96
August	63,593.03	61,803.98	54,739.37	40,023.54	120,659.30
September	120,261.01	117,984.73	68,812.68	71,574.73	74,539.46
October	127,208.12	79,852.69	50,019.27	68,718.24	77,305.23
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**	**708,968.44**

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) -- Prospective donor tours of the facility during construction continue to be the most effective way to procure large gifts. Major gift donor prospects continue to be identified, cultivated, and solicited. Recent meetings with existing and prospective major gift donors resulted in new verbal pledges and a payment of $250,000 totaling an additional $1,500,000 dedicated to the initiative. Our goal is $6.16 million and to date we have commitments totaling $4,362,500.

Annual Appeal – "Now More Than Ever" -- Response to our 2020 Annual Appeal, "Now More Than Ever" through 10/31/21 totals $120,998.61. This appeal focused on our need for support as CHC cares for all patients seeking hospice care regardless of their ability to pay.

2021 Friends of Hospice Appeal -- Our 2021 Friends of Hospice Appeal, "Serving Veterans as They Have Served Us" has resulted in gifts totaling $33,682 as of 10/31/21.

Planned Giving

Estate gifts from January through October 2021 totaled $99,048.32. 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 took place at the Hilton Garden Inn on September 8, 2021. Despite challenges related to a late summer increase in local COVID-19 cases, the event was well attended. Revenue generated from the event was less than recent pre-pandemic dinners, but it was greater than we anticipated.

"Creating is Healing: Paintings and Drawings of Grieving" took place at the South Bend Museum of Art's (SBMA) Jerome J. Crowley Community Gallery from July 31 to September 26. The exhibit featured 24 pieces of artwork created by 24 participants of CHC's After Images Art Counseling Program. A reception, open to the public and attended by many of the artists having artwork on display, took place on September 3. This was an awareness event intended to cultivate more knowledge of the After Images program rather than a fundraiser. We expect it to help us cultivate additional support for the After Images endowment fund. SBMA contributed to the program in appreciation for the opportunity to host the exhibit.

HF's annual Veterans Memorial Tribute featuring the dedication of memorial plaques and bricks resumed being an in-person event at CHC's Mishawaka Campus on October 19, 2021. Brad Ulick, Sergeant United State Marines, retired, was our featured speaker. He shared his experience as a survivor of the 1983 bombing of the U.S. Embassy in Beirut. The event was well attended and included an opportunity for Vietnam veterans to receive special 50-year commemorative pins.

Education and Collaborative Partnerships

In addition to the nine 2021-2022 family medicine residents from Saint Joseph Hospital who began their rotations with CHC we have also hosted a health services management fellow from Memorial Hospital. The first of three IU School of Medicine students rotated through two weeks of their hospice and palliative care rotations, and we have two other collaborations with the IU School of Medicine in the works. We anticipate offering IU Talk to both local family medicine residency programs, either virtually or in person, during the spring. These rotations and workshops continue to be an opportunity to recruit fellows for the Vera Z. Dwyer Fellowship in Hospice and Palliative Medicine. We are scheduling a meeting with the IU School of Medicine – South Bend to develop a summer internship project for the summer of 2022. We are pleased to announce our 2021-2022 Vera Z. Dwyer Fellow, Dr. Lindsay Schroeder. Dr. Schroeder is a graduate of the Indiana University School of Medicine. She completed a residency in emergency medicine at the University of Texas Southwestern in June 2017 and practiced emergency medicine in the Dallas-Fort Worth area before beginning our fellowship in July of 2021. We will hold a reception in her honor in the spring.

Outreach to Legislators

NHPCO's grassroots campaign, MyHospice, continues to be part of our community outreach/advocacy. Elleah Tooker, Community Education Coordinator, has prioritized email outreach this quarter to continue developing relationships with our legislators. COVID-19 and hospice priorities have been the focus and our priority is to ensure that Indiana's congressional delegation are aware of those issues as they meet to discuss current bills. Telehealth-related bills have been emailed to representatives and one of Representative Jackie Walorski's staffers, Griffin Nate, will be touring the Mishawaka Campus in December. The visit will highlight Center for Hospice Care's mission and new buildings along with revisiting priorities from NHPCO.

Community Education

The Center for Education & Advance Care Planning (CEACP) will offer in-person and virtual events in 2022 with COVID-19 safety protocols in place as may be required. The virtual panel discussions are being rebranded as spotlight videos with trusted advisors invited to discuss end-of-life topics in 30-minute video segments. The Panel Discussions will return in-person with trusted advisors discussing end-of-life issues related to their respective fields. The goal for 2022 is to expand our in-person panel discussions into LaPorte County and maintain a presence in Elkhart, South Bend, and Mishawaka. Engagement on CEACP's Facebook page has become more important as we grow our viewer base. The panel discussion series has engaged community members in views, likes, shares, and comments. The first panel discussion with Joel Dendiu, attorney at law has 545 views, the second with Wendell Walsh reaching 396 views, and the third with Ashlie Collier reaching 371 views. Mark Sandock and Steve Chupp's video has reached 75 views while the spotlight with Steve Chupp has reached 293. Holly Farmer, director of bereavement services, joined a discussion on bereavement and has reached 362 views and our video with Goshen-based funeral director and past CHC board member, Tim Yoder, has reached 414. Our follow-up discussion with Steve Chupp and Mark Sandock has reached 356 views and our two shorter videos in line with Honoring Choices have both received 135 and 47 views respectively. Our three most recent panels have reached 353, 112, and 241 views respectively. Elleah is arranging our final 2021 Facebook live presentations in November and possibly December. She is also setting up the trusted advisors to be scheduled in 2022. We have found that bringing trusted advisors into the Facebook Live sessions allows us to expand our reach by having them share the clips with their own audiences. We have also expanded posting and created interactive posts tailored for comments.

Our Hospice Foundation of America membership was renewed for the rest of 2021 and all of 2022. Webinar packages being compiled to provide educational opportunities for professional organizations such as hospitals and extended care facilities. These will begin in 2022 with in-person webinar viewing with COVID-19 protocols in place as required. Social Media has become a larger topic of discussion and development as COVID-19 has driven much our communication online. We continue to expand our online presence to drive likes and interactions on the page. Social media offers us the ability to check in with community members through questions and true or false statements that encourage participation. National days, along with book recommendations, have been posted to encourage participation on the page as well. Links to our updated website have also been posted. The website has been revised to include podcasts, books, social media links and movies to engage community members at all ages in the conversations surrounding end-of-life. CEACP posts each weekday and boosts the page to gain more likes and

expand our audience outreach. Outreach to universities and colleges continues as we gear up to enter the classroom both virtually and in-person. Prezi presentations, along with short videos/documentaries to spark discussion around end-of-life, are available for a variety of majors/areas of study. Our next Introduction to Hospice and Palliative Care course at the University of Notre Dame is scheduled to begin in March 2022. It has been expanded from a one credit hour course to 1.5 credits. Much of the additional content will be focused on personal applications rather than strictly professional preparation. This content will include advance care planning, conversations about end-of-life care with family members and caring for a loved one with a life-limiting condition. We encourage you to visit our CEACP resource page at:
https://educate4endoflife.org/resources/
If you're on Facebook, be sure to visit – and like – our page:
https://www.facebook.com/CenterForEducationAndAdvanceCarePlanning

<u>Honoring Choices Indiana® – North Central (HCIN-NC)</u>

This quarter we have held two First Steps® trainings. The latest, in October, was attended by 11 people from a variety of organizations including Palmer Funeral Home, Beacon Health System, Saint Joseph Regional Medical Center and Goshen Hospital. Two CHC staff members were also certified. We now have more than 100 certified First Steps trainers. In addition to providing certifications, we continue to provide a quarterly refresher call with facilitators. With a solid base in place, we plan to hold our first Advance Steps® training (which provides training on POST forms) in 1st quarter 2022. Steve and board volunteers have delivered a number of community presentations to various organizations, including The SAGE Group, Trinity Lutheran Church, and extended care facilities in St. Joseph and Elkhart Counties. We continue to look for opportunities to present to faith-based organizations, community groups, medical providers, and others. As noted in last quarter's report, we have a partnership with Palmer Funeral Homes to promote advance care planning and our services. These :30 spots are scheduled to run for six months. We launched our inaugural HCIN-NC e-newsletter in October. We had an outstanding open rate of 60%, with 40 recipients clicking through to the Honoring Choices or Hospice Foundation websites. As we move into 2022, we plan to update the website with a series of guest blogs that provide personal stories about the importance of advance care planning. Finally, funding and sustainability of the program continue to be a focus. We recently learned that Honoring Choices Minnesota, the convener of the U.S. Honoring Choices programs, will cease to exist at end of year due to financial struggles. This also impacts the state helpline grant they were spearheading. While this won't impact the branding of the Honoring Choices program nationwide it points to the need for a sustainable funding stream for our work.

<u>Palliative Care Association of Uganda (PCAU)</u>

Uganda is gradually easing lockdown measures and some sectors of the economy have returned to business. Schools are still closed, however. Pandemic numbers are small compared to the U.S. but comparing the two countries may be misleading. As of Nov. 1, there were a total of 126,321 confirmed cases and 3,279 registered COVID-19 deaths. Roughly 2% of Ugandans have received at least one dose of the COVID-19 vaccine, which has been the case for months. On Sept 20th, the U.S. government donated 1,674,270 doses of Pfizer vaccine, an addition to the earlier donated 647,080 Moderna doses. Uganda purchased 9 million Johnson and Johnson vaccine doses, to be delivered in a phased manner, with the first batch of 196,800 received on October 7, 2021. Uganda hopes to have 12 million people vaccinated by the end of 2021. With a little less than 30% of the

population fully vaccinated, Uganda expects reopening the economy – including schools – in January 2022.

On September 23rd and 24th PCAU and Uganda Cancer Institute (UCI) held a very successful conference, PCAU's first virtual conference. Uganda Broadcasting Corporation (UBC) partnered with them to televise the conference throughout Uganda (and beyond), it was a great opportunity to extend information about cancer and palliative care across the country. The TV audience cannot be counted, but there were over 350 participants online and 14 satellite facilities broadcasting the conference to their staff. Eight CHC/HF staff attended the virtual conference, with three making formal presentations: Cyndy Searfoss, Lacey Ahern and Annette Deguch.

Looking at the Road to Hope (RTH) program, tertiary institutions – including universities and vocational schools – reopened on November 1st and seven RTH students have returned to in-person classroom learning. The remaining 47 children are continuing with homeschooling through 2021. PCAU continues to provide food relief, home schooling, psychosocial support, and health care for both the children and their families courtesy of a $17,500 grant from an anonymous. donor. Anita Balikobaku started in August as the new RTH programs manager. In this position, she will also oversee and be actively involved in the RTH program. In the last quarter of this year, PCAU is holding regional retreats with all RTH children with two primary goals: 1) introducing Anita to the children and 2) determining how children are doing and how PCAU can best support them. Some of the children have been struggling with psychosocial and emotional issues during the lockdown. One of the children has been diagnosed with nasopharyngeal carcinoma. PCAU has been actively involved in his care and treatment over the past several months. Unfortunately, the cancer has spread, and he is now receiving palliative care.

Students resumed their in-person learning in September and are currently on-site placement for clinical experience at the national referral hospital and PCAU member organization, Kawempe Home Care. The program planned an intake of new students in July/August, but with schools closed, this did not happen this year. Uganda's Nursing and Midwifery Training Institution, Mulago School of Nursing and Midwifery (MSNM), is looking forward to admitting a new class and they are already reviewing applications. Graduation of the first cohort of students (2019) at MSNM will continue to be delayed due to lockdown measures. Discussions are underway as to whether they will be held virtually.

Toward the goal of introducing the new palliative care health management information system (HMIS) data collection tools in each region, PCAU continues dissemination and training of these data collection tools in collaboration with the Ministry of Health. We held a workshop on national data collection at the recent conference. This brought together mHealth participants, biostatisticians, palliative care providers and Ministry of Health Officials to discuss the future of palliative care data collection, including the implementation of the District Health Information Software 2 (DHIS2), the importance of training and capacity building in data collection and monitoring and evaluation.

In September, we held the first meeting of the PCAU Intern Alumni Network of past interns. Since the launch of CHC/HF and PCAU partnership in 2008, more than 30 university students have interned with PCAU. The goal of this network is to provide a platform for past interns, CHC/HF and PCAU to engage, network and maintain relationships and to keep them updated on PCAU's work and generate support and awareness of our mutual work.

In an effort to expand their fundraising income and diversify funding streams, PCAU applied to become an official partner on the online Global Giving platform. To successfully join the platform, PCAU needed to raise at least $5,000 from a minimum of 40 donors in one month. We helped PCAU spread the word and they successfully reached this goal. They now have a permanent position on this giving platform and can continue to receive donations, launch new campaigns, and hopefully grow their global donor base.

Facilities

At our Roseland property, remodeling is nearing completion on the Care Connections Center at Milton Village project. 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. A punch list walk-thru is scheduled for November 18th and we expect to be open for business there in December.

We closed on the acquisition of the former PNC Bank location and strip mall as a new home for the Plymouth Office on October 21. Cressy Commercial Real Estate has been retained as our property manager. In this capacity they will be responsible for collecting rent from tenants, paying bills associated with maintaining the property and performing any necessary maintenance at the complex. We are beginning to work with Helman Sechrist Architecture and Office Interiors on plans to remodel the space we will occupy.

GLOBAL PARTNERS IN CARE UPDATE

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

The COVID-19 pandemic continues to affect our work and decisions, particularly as our partner countries struggle with the pandemic and access to vaccines. We will continue to navigate these challenges as we do both strategic and operational planning. Building on our strategic planning discussions over the past four months, GPIC staff met for an internal assessment brainstorming session on October 20th. Going into the assessment, we recognized that: 2022 will mark five years of GPIC being an affiliate of CHC/HF, which lends itself to an assessment; there are continuing uncertainties of the global pandemic, especially given the different, and in some cases, worsening conditions in many of our partner countries; and the global palliative care landscape is being impacted by lack of finances and sustainability. The ensuing discussion was wide-reaching and invigorating for the team. Our next step is to pose some of the same discussion questions to our advisory council and board. We will send this out via an anonymous, online survey to gather reflections on the last five years and vision for GPIC in the coming years.

Partnerships

We continue to focus on supporting our current partnerships and have seen some significant re-engagement between several partners. This is very encouraging to see that our focused time and support to consult with each partnership does yield positive results. The partnerships with whom we have spent significant time with (and in person) are doing quite well. This has reinforced the idea that we ought to focus on in-person engagement and support where possible. While not a focus right now, we continue to pursue opportunities to recruit US partners for the several

international partner applicants we have. We continue to send Focus on Compassion to past partners who have remained on our subscription list. They also receive our annual reports. We are exploring the possibility of reengaging them in a partnership or a Champion Program. We have been in conversation about a potential partnership with Hospice of Michigan since early this year. We are now in the final stages of partnering them – hopefully with the Palliative Care Association of Malawi. This will be only the second current partnership with a national association. We are setting up a Zoom call to introduce the two organizations. Hospice of Michigan is a past partner (2007 – South Africa) – they are now part of a merged organization, NorthStar Care Community, which also includes former partner Arbor Hospice (2013 – Malawi). This could be a model for engaging past partners in our work again. We continue to develop the revised Champion Program to engage US organizations in less intensive, one-time opportunities. We currently have two defined projects from prospective international partners and will seek the engagement of a US organization who might fundraise and support the project. We will act as facilitators for the engagement and hope it might catalyze deeper interest on the part of the US partner.

#GlobalPallCareHero Campaign

We wrapped up this campaign on World Hospice and Palliative Care Day, October 9th. We still have some postings coming in and we will continue share and archive them. We produced a final video on the campaign which can be viewed on our website: https://globalpartnersincare.org/pc-heroes/.

COMMUNICATIONS, MARKETING, AND ACCESS

Craig Harrell, Director of Marketing and Access, reports on marketing and access activities for July - October 2021…

Referral, Professional, & Community Outreach

Our Professional Liaisons continue to contact doctor's offices, clinics, hospitals, group homes and extended care facilities to build relationships and generate referrals. Professional referral sources have continued to become more accessible as time progresses, however staffing is an issue industry wide and often times our contacts are unavailable. The amount of turnover lately at referral sources continues to be extremely challenging. Due to the high turnover rates of employees at many of the facilities where we have contracts, relationships are starting back at square one.

Our Professional Liaisons are continuing to gather Facility Protocols to better ensure quality customer service in our extended care facilities. This information includes key contacts, communication preferences and requirements, medications, DME & supplies, along with Best Practices. These protocols, which will be tailored to the unique needs and requests of each facility, will be accessed by our care team prior to entering a facility to ensure the best customer service possible.

Access

Our Admission Department is beginning to shorten the response times from referral to admission now that some new nurses have begun to complete orientation and as they become more familiar

with the process. Recently we met with various referral resources to discuss their concerns and issues. As much as we would like to think that quality of patient care is most important when referring, they've stated that response times were their number one concern when choosing a hospice agency. They're under tremendous pressures to discharge patients and the fastest there is being used. However, we've seen that as those agencies that were at one time more responsive begin to have response issues due to staffing, our referrals are increasing. Ironically, many agencies are losing nurses to the hospitals who are paying premium wages. This in turn affects their ability to respond to hospitals who need to discharge patients. We've also had a large number of discharges over the past months. From July – October we had 405 deaths. In addition to the deaths, we had an additional 147 discharges that range anywhere from 'no skilled need', 'no longer meets hospice criteria', 'revoked hospice benefit', etc.

Website

Our website has seen a significant increase in traffic between July & October compared to the same time the previous year. We've seen a 36.19% increase in all users as well as a 38.8% increase in new users. Not only have we seen an increase in traffic, but our visitors are also viewing more pages while there. Beginning in December we diverted a major portion of our digital campaign to staff recruitment which remained throughout this period. While the most viewed page was Services, the second most viewed has been Careers.

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 May - June, we focused on National Nurses Week (May), Memorial Day, Alzheimer's, and Brain Awareness Month (June), Men's Heart Health Month (June), as well as staff recruitment. CHC reached 81,341 people for the period of July - October and had 9,339 reactions, comments, and shares. Our leading post was on Sunday, October 3rd, "Breast cancer is the second leading cause of cancer deaths in women", which encouraged screening for early detection. It reached 3,948 people and generated 134 reactions, comments, and shares. The second most viewed posting was on August 2nd: "August is National Wellness Month". It reached 3,471 people and generated 410 reactions, comments, and shares. CHC currently have 4,955 Facebook followers.

CHC continues to have social media presence on Twitter (710 followers), Instagram (904 followers), YouTube (45 followers), and LinkedIn (371 followers) as well.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the above months it generated 95 telephone calls. As competition for digital visibility increases, the cost per click also increases, while at the same time, impression share has been reduced by 51.67% (2020 = 51.62%, 2021 = 24.95%). 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 7.63%.

CMS COVID-19 MANDATE

On November 5, 2021, the Federal Register published the Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule with comment [CMS-3415-IFC], with an effective date of November 5, 2021. This interim final rule by the Centers for Medicare and Medicaid Services (CMS) requires most Medicare- and Medicaid-certified providers and suppliers, including hospices and home health agencies, to implement mandatory COVID-19 vaccinations for all eligible staff. This is different than the Dept. of Labor's via OSHA mandate for employers with more than 100 employees and which is currently blocked by a federal appeals court. This mandate is stricter and covers over 10 million people and applies to around 76,000 healthcare providers including hospitals, nursing homes, hospice, and home health agencies, and nearly any provider that accepts Medicare. Somehow, physicians' offices were not included. The interim final rule is effective immediately without the standard comment period that follows publication. However, there is a 60-day comment period following its publication. Providers that fail to comply with the mandate will eventually lose access to Medicare and Medicaid funds.

The basic requirements include:

1. Have a process or plan for vaccinating all eligible staff.
2. Have a process or plan for providing exemptions and accommodations for those who are exempt.
3. Have a process or plan for tracking and documenting staff vaccinations. The regulation also requires that processes meet the following deadlines: 1st Dose or One-Dose Vaccine by December 5, 2021 and received all shots for full vaccination by January 4, 2022.

This rule takes priority above other federal vaccination requirements and any state rules in effect now or in the future under the federal Supremacy Clause within Article VI of the U.S. Constitution which dictates that federal law is the "supreme law of the land." CMS's oversight and enforcement will exclusively monitor and address compliance for the provisions outlined in the CMS Omnibus Staff Vaccination Rule, while also continuing to monitor for proper infection control procedures as established under previous regulations. Surveyors will check for compliance. If non-compliance is found, a warning will be given and an opportunity to come into compliance. If non-compliance continues civil money penalties and fines will be given. If non-compliance continues, the program will be excluded from the Medicare and Medicaid program.

This rule effects every CHC employee at every CHC office regardless of their position or whether they have patient contact or not. It also includes volunteers, board members, interns, students, vendors -- practically everybody coming into the building. If they are not vaccinated, we will go back to masks, screenings, and other mitigation practices from previous times. Staff who have COVID-19 antibodies are not exempt from CMS requirements.

Administration has been reviewing materials from four different law firms, participated in a 10,000 person Zoom call with CMS, reviewed policy templates from various sources including the general counsel for the Indiana Association for Hospice and Home Care, as well as exemption templates for both medical and religious exemptions. For medical exemptions, we must ensure documentation is signed and dated by a licensed practitioner. For religious exemptions, facilities must ensure the exemption requests are documented and evaluated based on applicable federal law. Unlike the OSHA mandate, the CMS mandate does not offer turning down the vaccine in exchange for weekly

testing. It does offer the two exemptions and if a medical or religious exemption is granted, those staff will be required to, at the very least, mitigate exposures to all others with appropriate PPE and screenings. At the All Staff meeting on November 9th, staff was alerted that this was coming and strongly encouraged to get vaccinated prior to December 5th. The first shot of a two-shot regime or the one-dose shot, must be done by 12/6/21 and the second shot by 1/4/2022.

Ten Republican state attorneys general sued on Wednesday, November 10, to stop the Biden administration's vaccine mandate for U.S. health workers saying it would worsen staff shortages. The attorneys general of Missouri, Nebraska, Arkansas, Kansas, Iowa, Wyoming, Alaska, South Dakota, North Dakota, and New Hampshire jointly filed a lawsuit in the U.S. District Court for the Eastern District of Missouri in St. Louis. The lawsuit said the CMS rule was heavy handed and did not take local factors and conditions into account. CMS has said there have not been widespread resignations within healthcare providers that have already mandated vaccines, including 41% of U.S. hospitals, and that applying the mandate to all healthcare settings ensures staff cannot quit one setting to seek jobs in another. (They can go to physicians' offices and independent living facilities.) With many employers already mandating vaccination, and with nearly all local (and distant) healthcare employers requiring vaccination under this rule, we expect that such effects will be minimized," CMS said in introducing the rule.

NOW GENERAL INPATIENT LEVEL OF CARE STAYS ARE BEING AUDITED

As if we don't have enough audits, including ones that took back $1.2MM for CHC due to alleged "long lengths of stay" from years ago, hospices are now being audited on general inpatient (GIP) level of care days. Apparently, the magic number is seven. Any GIP stay over seven days is suspect. There is nothing in the Medicare regulations that limits GIP stays to any certain number of days as long as the documentation supports that level of care each day. Please see attached article from Hospice News, "Hospices Feel Strain of GIP Audits as Inpatient Care Days Dwindle" for complete details. We are frequently not being paid for GIP days over seven days long until we prove that those days were appropriate for that level of care. Nationwide, nearly one-third of all GIP days occur in a dedicated hospice inpatient unit like Raclin and Esther's House. GIP days represent only 1% of all days billed in the Medicare Hospice Benefit. The trend in the use of this level of care has been dropping for several years due to CMS changing the interpretations of what is appropriate and making it more difficult to prove eligibility. GIP represented 1.7% of patient care days in 2014 and then incrementally dropped to 1.2% by 2018. Simply actively dying does not qualify for GIP. There must be symptoms to manage that cannot be controlled in any other setting.

BOARD SECOND TERM RELECTIONS

We have no new board members starting terms in 2022. We have no board members going off the board according to the rules of the Bylaws. We do have two board members who are completing their first three-year term and need to be elected to a second three-year term. They are Mark Wobbe and Andy Murray. Both have agreed to a second three-year term. The officers and Executive Committee will remain the same in 2022.

NEW SECURE BOARD WEBSITE COMING FOR FEBRUARY 2022 MEETING

We will be updating our secure board website in early 2022 and moving to the Microsoft Teams platforms. All existing documents will be migrated to the new site. Content will remain the same and materials will be posted as usual prior to the meeting scheduled for 2/16/22. Login instructions will be emailed to all board members well before the February meeting.

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.

BOARD EDUCATION SECTION

The topic of the board meeting education section will be census and staffing challenges we have been experiencing. Craig has a presentation on referrals and admissions and Lance, Angie, and I will briefly describe our staffing challenges.

OUT AND ABOUT

A reception was held at the South Bend Museum of Art for the CHC exhibit "Creating is Healing: Paintings and Drawings of Grieving by the Participants of AfterImages Bereavement Art Counseling Program" on September 3rd.

The Helping Hands Dinner was held at the Hilton Garden Inn to honor Rafat and Zoreen Ansari on September 8th.

I attended the Hospice Action Network Board of Directors meeting and the NHPCO Combined Boards Issues Session via Zoom on September 23rd.

Several of us attended a well-publicized and attended Open House for our La Porte office on September 30th.

After booking flights and hotels, the majority of the National Hospice Executive Roundtable voted, nearly at the last minute, to not meet in-person due to COVID fears of flying (perhaps the safest place one can be) and instead met via Zoom over two days on October 4th and 5th. We are currently scheduled to meet in-person January 9 – 11, 2022.

Our annual Veteran's Tribune Ceremony and Dedication of donated items on the south lawn of the Mishawaka Campus was well attended. The special guest speaker was Brad Ulick, Sergeant United States Marines, Ret., who discussed his experience as one of the 81 peacekeepers who survived the 1983 suicide terrorist attack on the Marine Corp barracks in Beirut. Another 241 service members were killed in the attack.

I attended the Indiana Hospice and Palliative Care Organization Board of Directors Meeting via Zoom on October 28th.

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

Karl Holderman's monthly dashboard summaries.

Volunteer Newsletters for September to November 2021

Board Committee Opportunity Sheet.

Hospice News article, "Time Technology of the Essence in Shifting Hospice Referral Mix"

New York Times article that mentions CHC, "Short on Staff, Some Hospices Ask New Patients to Wait"

Hospice News article, "Hospices Feel Strain of GIP Audits as Inpatient Care Days Dwindle"

Northwest Times article, "Center for Hospice Care Moves into New location"

Hospice News article, "Hospices Compete for Staff in Job Seekers' Market"

LaPorte County Life article, "Center for Hospice Care Announces Staff Certification as End-of-Life Dementia Care Professionals

LaPorte County Life article, "Center for Hospice Care Announces Success of Specialty Programs for Chronic Health Conditions"

McKnight's Long Term Care News article, "SNF Staffing Shortages May Get Much Worse"

2022 Board Meeting Dates

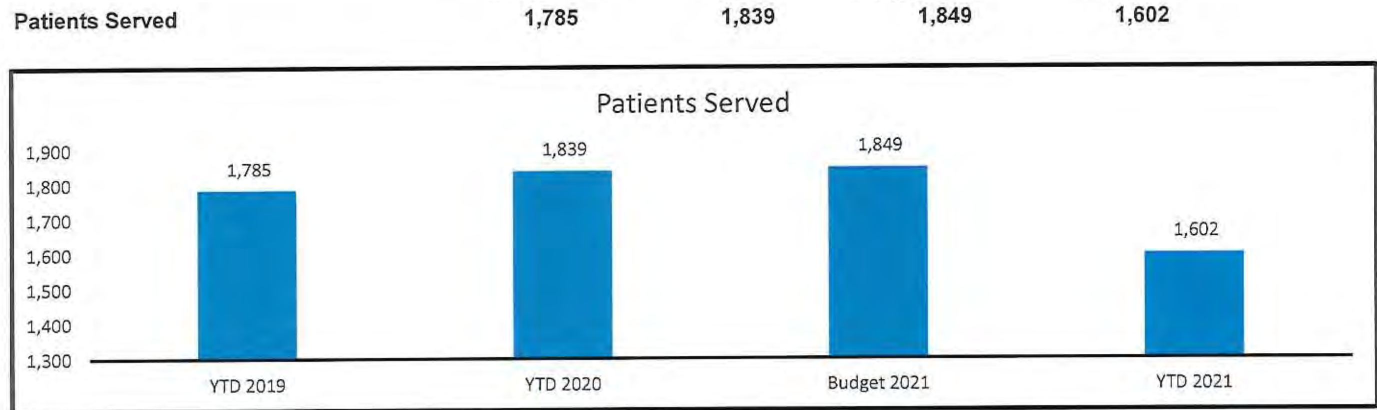
NEXT REGULAR BOARD MEETING

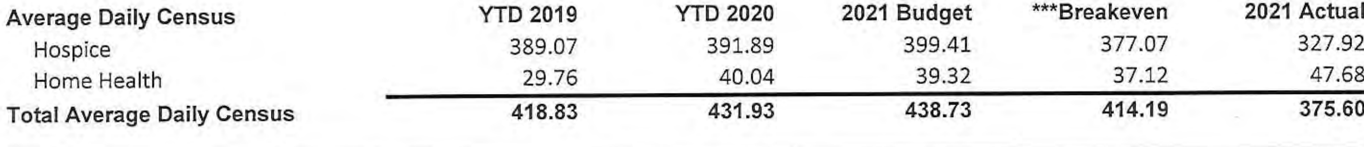
Our next regular Board Meeting will be **Wednesday, February 16, 2022 at 7:15 AM**. In the meantime, if you have any questions, concerns, suggestions, or comments, please contact me directly at 574-243-3117 or email mmurray@cfhcare.org .

# # #

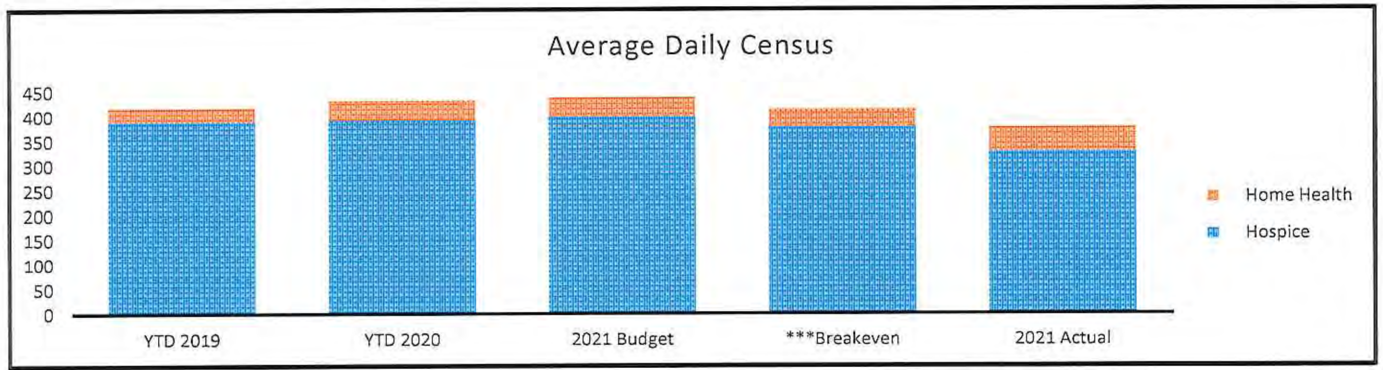
Center for Hospice Care
October 31, 2021

Patients Served	YTD 2019	YTD 2020	Budget 2021	YTD 2021
	1,785	1,839	1,849	1,602



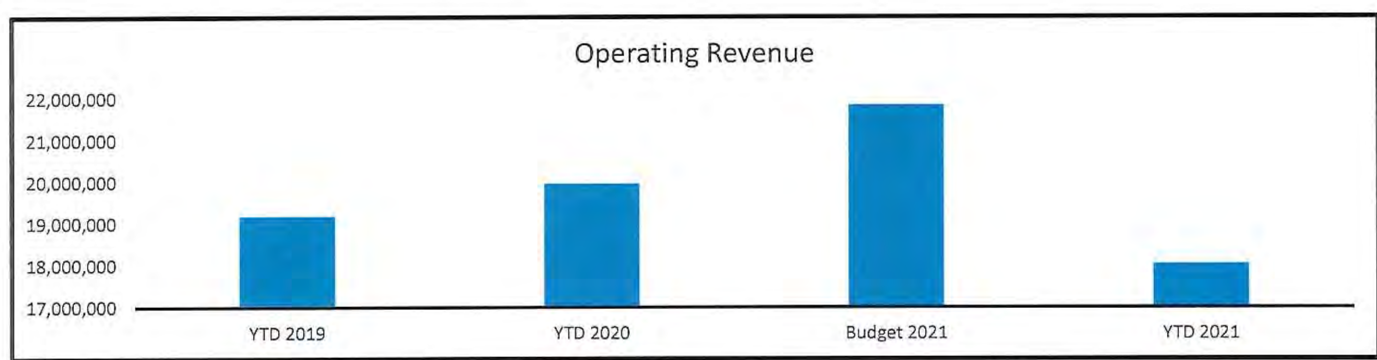


Average Daily Census	YTD 2019	YTD 2020	2021 Budget	***Breakeven	2021 Actual
Hospice	389.07	391.89	399.41	377.07	327.92
Home Health	29.76	40.04	39.32	37.12	47.68
Total Average Daily Census	**418.83**	**431.93**	**438.73**	**414.19**	**375.60**

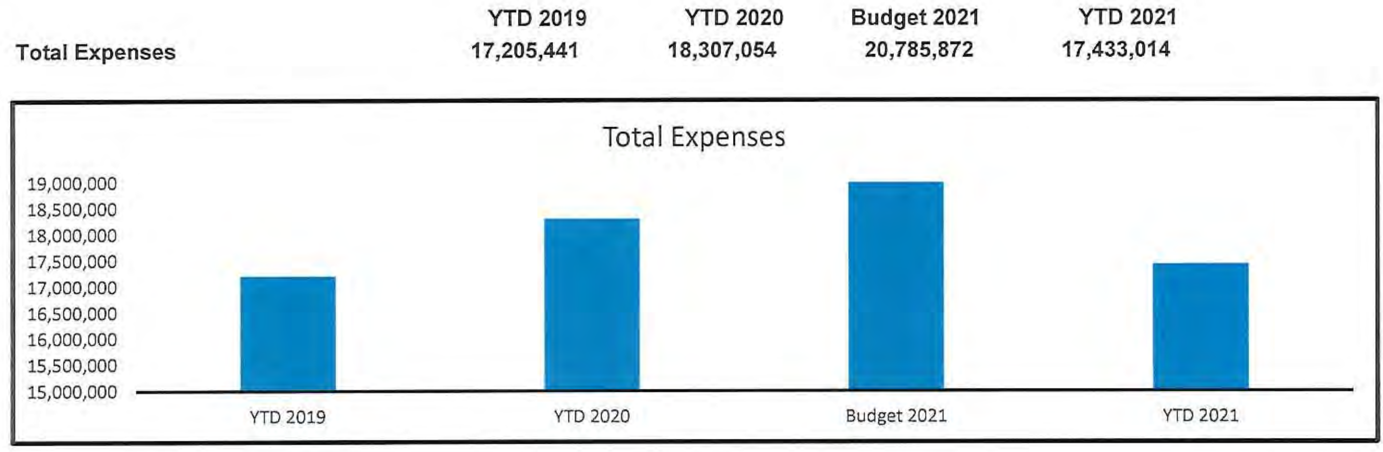


*** *Budgeted Breakeven*

Operating Revenue	YTD 2019	YTD 2020	Budget 2021	YTD 2021
	19,188,147	19,971,891	21,842,198	18,047,755



Total Expenses	YTD 2019	YTD 2020	Budget 2021	YTD 2021
	17,205,441	18,307,054	20,785,872	17,433,014



September 2021

Volunteer Newsletter

A Hand Crafted Musical Legacy

By: Kristiana Donahue

In Memory—Timothy Lorenc 1/12/1949-8/4/2021

Sears made Silvertone guitars, and for $11.00 Tim Lorenc was able to purchase one at Jack's Jewelers Pawn Shop. This began his lifelong love of music and stringed instruments. These were parlor guitars, and were popular in an era where neighbors and families would get together and make their own music. When he was 17, he had a South Bend paper route. He would collect money on Friday nights and when he entered the Hungarian neighborhoods of the city, he was introduced to some of the best musicians. He followed their tunes to the south side of town, where he would spend his time soaking up their sad, dramatic music. "There were some Hungarian bars on the south side of town," Tim reminisced. "I'd go there after I graduated from high school, and I'd go there and listen to these guys on a Friday night. The music was the culture. I'd just sit there and listen."

Friends would gather and have hootenannies, a time to sing and play popular folk songs. Tim even shared one of the songbooks that they would use. From gospel, soul, folk and Americana, the book was full of popular songs that would entertain the youth for hours on end. That time would be cut short when he was drafted for military service during the Vietnam War. He spent four years in the service, his last year in Thailand. He found a rather intriguing treasure far from home at this military base. "I was going through the library one day," he explained. "And they had a book called *Classical Guitar Construction* by Irving Sloane." This book piqued his interest and in 1973 he "cooked" his first guitar on his mother's stove.

"You have to cook the guitar," Tim continued. "The resin softens as you heat it. As you're boiling this wood you can put it into a form and slowly you can start to change the shape." The basic parts of the guitar are the top, the two sides, the back and the neck. It is quite tricky to make sure everything is glued together and doesn't spring back on you. "There is a lot of tension… stress that is going on," Tim said. "This is called resonance." Over the years, Tim has taken this guitar apart and put it back together. It even sat in parts for eight years. Today it is a beautiful instrument, with artistic inlays and rich wooden hues.

He joined a folk band and while he played music, he also continued to make other instruments. He has made a heart-shaped guitar, a banjo and a banjolele (a cross

Continued on Page 2

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Welcome to the Team	3
Mark Your Calendars	3
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FAQ for New Hospice Volunteers	4
FAQ for New Hospice Volunteers	5

Birthdays

9/7
Mary Perron

9/8
Mary Adams

9/8
Barbara Adcock

9/11
Kathleen Hojnacki

9/12
Becky Donahue

9/12
Nancy Whipple

9/14
Cheryl Barker

9/16
Sharon Leamon

9/16
Max Rarick

9/17
Matthew Huyvaert

9/20
Robert Tyler

9/21
Judith Adkinson

9/22
Jim Rahilly

9/23
Lino Rodriguez

9/24
Jane Sharp

Continued from Page 1

between a banjo and a ukulele). All of them are rich and beautiful and perfectly unique. One of them has inlays of shells that they had gathered on a trip to Mexico. "The way to make something sound different is to sand it," he explained. "To start taking layers off. That's the way to fine tune it."

The band gave Tim much more than enjoyment and something to do on weekends and evenings; it also brought him and his wife, Pat, together. Tim had to go to a band member's home to bring money they collected for that evening. "It was winter, so he came to the door and I opened it," Pat shared. "He just stood there, and I said, 'Shut the door, it's cold.' Then he came in."

They married on July 7, 1978 and have celebrated 43 years together. Pat is also a musician.

Music continued to be a part of their lives, though sometimes it had to take a place on the side of other important life events. Tim taught school for Niles Community Schools and then worked in housing rehab for a time as well. He also worked for Oaklawn, a provider of mental health and addiction services . He was able to integrate his love of music with his work at times. He worked at Portage Manor and would organize Christmas caroling concerts and fun music activities for the residents there. He'd continue to play a gig here and there during these busy days. In more recent days, Tim has been involved with The California Street String Band and Music Village. These have been wonderful avenues for his talent.

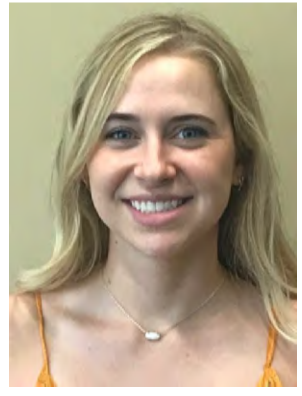
Tim wishes his fingers moved as expertly as they used to. Even so, he was able to pluck out some pretty impressive tunes. However, cancer and the resulting treatments have really made it difficult for him to play. Chemo has made him so fatigued that he doesn't have the stamina to play. But he has a physical therapist, and the wonderful thing is that his therapist is also a guitar player. "He was so weak from the pneumonia he couldn't use his fingers," Pat said. "The therapist got him using his fingers and then getting back and playing the instruments more."

Hospice is about continuing to live the life we want to live, as long as we can make it possible. We may have to make some changes; however, what is important to someone should still be a priority at any stage of life. When he became a Center for Hospice Care patient, we wanted to celebrate and recognize his gifts and talents, because even if his body may make it more difficult, he is still wonderfully and beautifully gifted. He can still share his passions with the world. Pat has appreciated Arlin, their chaplain and the support. "If you have a question or run into an issue," she said. "You just pick up the phone and call somebody." We are driven to celebrate and support him and his family. Tim stays connected with his Music Village group. He may not go in person, but on Tuesdays, sometimes they Zoom. He'll practice a song and if he feels up to it, he'll play and sometimes he won't.

That $11.00 at the pawn shop when Tim was only 11 years old was a very wise investment. It provided him a lifetime of music, beautiful handmade instruments, the introduction to his wonderful wife and many memories.

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.



Lauren Aucoin
Mishawaka

Carol Kuhns
Elkhart

be.
here.
now.

Welcome to the Team

Cindy Barnett
IPU RN

Mary Brubaker
IPU RN

Christina Eshelman
Admission RN

Debbra Fisher
IPU Housekeeper

Ann Leed
Plymouth RN

Satia Lloyd
ECF RN

Lori Lutin
Mishawaka Case Manager

Kiara Moore
Recruiter

Michele Nestico
IPU RN

Kathy Wolff
Mishawaka LPN

Mark Your Calendar

Mishawaka Annual Skills Validation Day
Wednesday, September 22, 2021
Appointments made between 9:00am-2:00pm
Slots are filling up.
Mishawaka Campus
501 Comfort Place

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

Comments from our Families

- All hospice staff were very kind and helpful. The chaplain helped conduct my mother's funeral and cemetery burial. Hospice is the best!
- I can never put words on paper for the comfort I felt when my husband was in hospice. The nurses and the way they cared for him. He was so happy to see his nurse each week. What a wonderful caring person. God bless your organization.
- It was exceptional. My husband had a high quality of care during his passing. We could not have done it without the support we received.
- Dad's aide was amazing. She worked well with him and he felt comfortable with her assistance. Dad's nurse was great. She explained and listened to both dad and me. CHC did a military honor ceremony for dad. He was a World War II Navy vet.

FAQ for New Hospice Volunteers:

15 Simple Questions You're Afraid to Ask

The following information comes from an article - "15 Simple Questions You're afraid to Ask" - written for *PAL-LIMED,* a hospice and palliative medicine blog. The author is Lizzy Miles who started her career in hospice as a volunteer and went on to become a hospice social worker.

Before I was a hospice social worker, I was a volunteer. I was so nervous to visit my first patient. Over time, I became more comfortable. Through the course of switching careers from volunteer to social worker, I attended volunteer training at several organizations. There is a lot of really good information provided, but sometimes hospice staff forget what it's like to be NEW. These are the questions I had when I first started. Once I gained experience, and went to school for further training, I decided it might be helpful to write out the answers for others who are just embarking on their hospice journey. It is rewarding.

Q: How do I start the conversation?

If you are meeting a patient for the first time it may be helpful to speak with the volunteer coordinator to get some helpful information about the patient. Introduce yourself and explain who you are and why you are there. If this is not possible, then it may be helpful to start by checking in with the patient, "How are you feeling?" Ask them about their comfort level and possibly "Do you have any pain?" Ask them about their family, interests, and if they would like to share anything. A good conversation starter and question is "tell me about.... cars, when you were young, a time when you were happy?

Other tips:

- Talk about weather, news, or something that is going on currently. It's probably best to stay away from politics, but if patient wants to talk about it, you can listen.
- Silence is okay, give them time to think. Avoid rapid fire questions as they will confuse and be hard to understand.
- Look around the room for cues of things to talk about: pictures, decorations, religious artifacts, figurines.
- You can comment on people in pictures, but keep in mind, if patient has dementia, they may be distressed by not being able to identify who it is. So you can remark on their expression. "She looks happy!"
- Make this time about them. Redirect back to them if they ask you too many questions about yourself.
- Be patient. It takes time to build a relationship.
- Listen and observe their body language.

Q: Why do I need to ask permission?

Hospice philosophy emphasizes patient-centered care. Hospice patients and families can feel like they have no control over the situation they are in. By asking permission before you sit or start a visit, you are giving them a sense of control. As a volunteer you want to show respect for patients and make them as comfortable as possible. When you ask permission, they know they have the option to say NO, or refuse your visit. In addition, being courteous and respectful helps to open up the conversation and ensure the patient is willing to meet today.

Q: What do I do if they are sleeping?

If a patient is sleeping you can wake them if you are only there to see this patient and do not want to waste a visit. They can always send you away if they do not want to visit. You will learn by their reaction the first time you try to wake them whether it is a good idea.

Sometimes all you have to do is sit down next to the patient and they hear you and wake up on their own.

The best way to wake a patient is to call their name at a slightly raised voice. If this does not work, then proceed to touch their forearm or hand just above the wrist, and call their name again. If after several attempts to wake the patient they do not wake, whether you stay in the room or leave will depend on the plan of care you've been given and the purpose of your visit. Your volunteer coordinator may be able to offer suggestions regarding the best time of day to visit.

Other tips:
Facility patients: If you have other patients in the facility, then go and see them first and then return to this patient.
Home patients: The caregiver can give you guidance as to whether to wake the patient.

Q: What do I say when they ask me about myself?

If you feel comfortable answering the question and sharing about yourself then that is okay. Be aware that some information should not be shared and the visit is for the patient. The patient has enough to worry about with their own life without worrying about us, so we should keep our sharing on a positive note. One should share information if it will help to strengthen the relationship and build rapport with the patient. If you do not feel comfortable with a question simply tell them so. Sometimes patients will ask your opinion on things. You can redirect back to them by saying, "I'm not sure. What do you think?"

Q: What do I say if the patient asks me, "Why am I still here?"

It is not uncommon for patients at the end of life to have existential questions. They do not really expect you to have an answer to this. A simple way to respond to these type of questions would be to provide a reflective statement. "You're wondering why you're still here."

Q: What do I do if family is there? (Facility)

Introduce yourself as a hospice volunteer. Ask if the family member(s) would like you to join them with visiting the patient or if they want time alone. Their visit takes priority, so never let them feel they need to leave so you can visit. However, sometimes family members will use the arrival of a volunteer to allow themselves to leave. You will have to read the situation.

Q: What do I do if they ask me to leave?

Say "Thank you for your time" and leave. It is important to remember that this is their home whether in the community or in a facility. As a volunteer we should respect their wishes and their desire for privacy. If the situation

allows, ask if you can return some other time to visit with them.

Q: What if I have to leave and they won't stop talking?
The best way to handle a talkative patient is to start "leave-taking" behavior before you actually need to leave. Leave-taking behavior is the non-verbal actions that someone does when they are about to leave a room. If you do them slowly, the patient will understand your visit time is coming to an end. Behaviors can include putting on a coat, gathering your things or shifting forward in your chair. When you have the opportunity to say something, you can tell the patient "I have to leave in 5 mins." Another way of saying this is "I'm sorry, I have to get going and I had a wonderful time with you today. I hope we can continue our conversation next time we visit."

As you get to know the patient, you will learn how much time in advance that you need to start the leave-taking. If you are scheduled as a regular volunteer with the patient, you can tell them that you will continue the conversation the next time and that you look forward to hearing more about xyz. If they ask when your next visit will be, you may tell them an answer if you know (i.e. next week, in a few days).

Q: What does it mean to "be present"?
When we are with a hospice patient or family member, we want to be completely there, both physically and mentally. Turn off your cell phone and put it away. Disregard what has happened on your way to see the patient and do not think about what is happening after the patient. Give 100% to the patient and what their needs are at this moment.

Q: What do I do if they want to give me something?
Hospice patients and families are considered to be "vulnerable populations." It is not uncommon that they may feel indebted for the time that you are spending with them. Gracefully decline all gifts, as it is hospice policy. Assure them that knowing them is a gift in itself. If they want to do "something" you can tell them to write a thank you letter to the hospice, or tell their friends and family about their positive hospice experience.

Q: What if I want to give the patient or family something?

Remember, that for most patients, they are learning to "let go" of the material world. Patients at the end of life have a greater appreciation for the intangible gifts such as your time and presence. Do not underestimate the value of what you do.

Ask the volunteer coordinator if you have something in mind that you want to give the patient. It may be acceptable to give a small item such as a flower, but beware of the power of reciprocity. By giving gifts you could create a greater feeling of imbalance. Food items can be tricky for multiple reasons. Family members may have a different idea of what the patient should be eating, or the patient could have a medical condition that affects their swallowing or digestive capabilities.

Q: What do I do or say if the patient or family member starts crying?
Allow the tears to flow. Don't be uncomfortable with the tears and do not rush to offer a tissue unless they appear to be looking for one. (Try to read their body language.) You don't have to say anything, but if they seem like they want to talk about it, you can say something like, "It seems like I may have said something that has stirred up some emotions. Would you like to talk about whatever is going on?"

Q: What do I do if they say they are in pain?
Hospice nurses are specialists in pain control and so this is not likely to be a frequent occurrence, but it could happen. If the patient is in a facility, you can press the call button or ask the patient if they want you to find a nurse. Sometimes a patient may describe pain but then tell you they do not want you to call a nurse. If a patient is at home, notify the patient's caregiver of their pain report. In the meantime, you can ask if there is anything you can do to make them more comfortable (i.e. adjust their pillow or blankets, hold their hand).

Q: What to do if they fall?
Do not move them!! Ask if they are okay. If in a facility go and get a nurse or notify a staff member that the patient needs assistance. If at a home notify a family member and call the hospice nurse or volunteer coordinator. As a volunteer we are not trained to assess a fallen patient or assist in transferring them safely so it is best to leave it to those who are familiar with the process.

Q: What to do if they complain about a facility?
There are some things about our lives that we can change and some things we cannot. Sometimes patients just need to vent. It's important to remember that we cannot necessarily "fix" every situation. Your primary role is to let the patient feel they are being heard. You may also ask them if they have raised their concerns with the facility. If they haven't, then encourage them to share their concern with the appropriate department.

Some questions or complaints are resolvable "I don't know when dinner is."

Do not get involved in trying to resolve an issue, unless it is an immediate need that you can support by finding someone, "I pressed the call button 20 minutes ago and they still haven't come." You may be able to walk to the nurse's station and relay the patient's need. Talk with your volunteer coordinator if you have questions or concerns related to information the patient tells you.

Depending on the nature of the complaint, you may also be able to *reframe* or *redirect*.

When you *reframe*, you are helping the patient look at the situation in a new light. For example, if they are talking about the food being bad then say something like "you were telling me the other day how much you loved the tapioca pudding."

To *redirect* a patient, you might say something like, "it's not the same as home-cooked meals. What were some of your favorite foods to make?"

Always remember you are not in this alone. The volunteer coordinator is just a phone call away for any questions or concerns that you have.

Lizzy Miles, MA, MSW, LSW is a hospice social worker in Columbus, Ohio and author of a book of happy hospice stories: Somewhere In Between: The Hokey Pokey, Chocolate Cake and the Shared Death Experience. Lizzy is best known for bringing the Death Cafe concept to the United States. You can find her on Twitter @LizzyMiles_MSW

October 2021

Volunteer Newsletter

Healthy Boundaries

Boundaries provide healthy rules of interaction to define the limits of a relationship. They protect you, hospice patients and families.

Definition of Boundaries

- Boundaries provide healthy rules of interaction to define the limits of a relationship.
- A boundary is the personal space located within an arm length perimeter. It is also the personal/ emotional space designated by morals, values and experience. Cultural differences also may change boundaries.
- The limits that protect the space between the volunteer's power and the patient/caregiver vulnerability. Maintaining appropriate boundaries controls the difference in power and allows for a safe connection between the parties based on the patient/ caregiver needs.

Issues that can affect boundary comfort

- Gender (both the patient and volunteer) Men generally are more likely to touch others than to be touched. Women are more likely to disclose personal information.
- Age of both parties
- Cultural norms
- History of sexual abuse

Preparation/Practice

- Have clear self boundaries, know yourself and your comfort level
- Be aware of your role – you are not a friend, family member or medical person. You are a trained volunteer who reaches out to individuals in a supportive and caring way.
- Set boundaries such as time, purpose, etc., prior to or at the beginning of the visit.
- Always be respectful. Don't seem too familiar with telling emotional stories and jokes.
- Limit involvement of personal feelings and emotions.
- Realize that sometimes

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Hot Chocolate Recipe

Kristiana Donahue, our Volunteer Recruitment and Training Coordinator loves this hot chocolate recipe. It is VERY rich and not for the faint of heart, but if you like rich indulgent hot chocolate, try it out!

Ingredients

- 6 cups whole milk
- 14 ounces sweetened condensed milk
- 2 cups heavy whipping cream
- 2 cups semi-sweet chocolate chips
- 1/4 cup unsweetened cocoa powder
- 2 teaspoons vanilla

1. Add all ingredients into a 6 quart or larger slow cooker and stir to combine.
2. Cover and cook on LOW for 2 hours, whisking every now and then to combine the melted chocolate chips with the milk. (I have tended to need more than 2 hours).
3. Ladle hot chocolate into mugs and serve with marshmallows or whipped cream if desired.

Continued from Page 1

a volunteer assignment may end for other reasons besides death (i.e. patient decline, family request, ECF staff request, CHC staff request, patient discharge, etc.) Know that this happens on occasion and may have nothing to do with anything the volunteer has done.

Good questions to ask ourselves:

- Why am I here?
- Whose needs are being met?
- Is this part of the care plan?

Types of Relationships

A hospice volunteer relationship

- Focuses on the needs of clients
- Has an agreed upon purpose
- Involves a specific time frame
- Relies on specialized knowledge of the volunteer
- Has an unequal balance of power

A social relationship:

- Usually meets needs of both parties
- Often has no time frame
- Ideally involves an equal balance of power
- Promotes two-way sharing of knowledge/skills

Hospice patients/ families are particularly vulnerable because:

- They are often needy
- They are often grateful for hospice help
- They are often facing the most difficult time of their lives
- They are inviting us into the intimacy of their home
- There is an expectation of trust

I may be exceeding my boundaries when:

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

Remember:

- You do not have to do things you are not comfortable doing.
- You do not give patients/families your phone number. The Volunteer Coordinator will assist you.
- You can always consult with the Volunteer Coordinator and social worker with concerns or questions.

Everyone crosses boundaries occasionally.

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.

Lauren Anastas
Mishawaka

Amir Khouzam
Mishawaka

Nadim Khouzam
Mishawaka

Quincy Strefling
Mishawaka

Elkhart Ice Cream Social

Elkhart Volunteer Ice Cream Social

We will be holding off on this year's Elkhart volunteer ice cream social. Marlane will announce the date of the 2022 ice cream social in the upcoming months.

Welcome to the Team

Jessalyn Field
Triage RN

Elizabeth Heighes
Referral Specialist

David Macri
PRN Social Worker

Alice Moore
Referral Specialist

Colinda Purkett
IPU RN

Stephanie Walsh
PRN Physical Therapist

William Ward
Maintenance Coordinator

Comments from our Families

- Everyone was wonderful. They were reassuring, they completely focused on my mother and did everything they could to be supportive of my entire family. Very grateful for everyone.
- We had COVID in the house. We are thankful for the prayer prayed on the phone when he died. Due to COVID, the social worker could not come, but all the staff that did come were very supportive. Most of our interactions with Hospice were wonderful. All of them are greatly appreciated. COVID made our situation more complex. We are eternally grateful for absolutely everything everyone did.
- All of you at CHC, especially at Esther's House, do a wonderful job. I've learned a lot about grief and it's not an easy thing to talk about and seek help as you always think it will get easier. Thank you for all your hard work.

Ways to Celebrate Autumn

- Take a fall foliage drive
- Get lost in a corn maze
- Make some hot chocolate (try the recipe in this newsletter)
- Visit an orchard
- Pick your pumpkin décor by visiting a pumpkin patch
- Curl up with a blanket and book on a crispy, gray autumn day
- Step on crunchy leaves
- SOUP! Make buckets of delicious soups and enjoy leftovers on days you don't want to cook
- Roast marshmallows on a campfire
- Rent a cabin and enjoy some time in nature
- Spend a day baking and then deliver your baked goods to your friends and family
- Enjoy college football. Tailgate. Eat good food!
- Roast pumpkin seeds
- Make a list of things you are thankful for
- Tell ghost stories
- Enjoy an evening walk under the stars
- Jump in a pile of leaves

Birthdays

10/1
Ann Baucus

10/2
Noreen Buczek

10/2
Sue Ermeti

10/3
Lisa Schaeffer

10/5
Jaclyn Levendusky

10/6
Martha Skrzeszewski

10/11
Donald Zimlich

10/13
Joan Hunt

10/14
Steven Madar

10/15
Catherine Schiff

10/15
Carolyn Tihen

10/18
Hugh O'Donnell

10/21
Margaret Cunningham

10/21
Theodore Stanley

10/24
Janice Berger

10/26
Heidi Payton

10/27
Cynthia Ward

10/28
Juanita Downing

10/29
Marie Varner

10/30
Sharon Marshall

10/30
Kay Swett

10/31
John Bolstetter

10/31
Robert Putnam

Infection Control

Hand washing

To be effective, hand washing must include the following components:

- Completely wet hands and wrists under warm running water, keeping fingertips down.
- Use non-abrasive soap - liquid granules or foam - for routine hand washing. Detergents are also acceptable. Both suspend soil and microorganisms which allows them to be easily rinsed off.
- Apply soap, spreading it over entire hands, wrists, between fingers, under nails and two inches above wrists.
- Vigorously rub together all surfaces of lathered hands for 20 seconds to one full minute.
- Friction helps remove dirt and microorganisms. Wash around and under rings, under fingernails, and include wrists.
- Keep splashes to a minimum and try not to touch the sink itself.
- Rinse hands thoroughly under warm running water, fingers pointing down.
- Running water rinses away dirt and debris.
- Point fingers down so water and contaminants don't drip toward elbows.
- Dry hands and wrists completely with a clean, dry paper towel.
- Turn off faucet with a

paper towel between the faucet and your hand and immediately discard the towel.

Use of Hand Sanitizer

- Use when soap and water are not available and when there is no visible soil.
- Apply the manufacturer's recommended amount of the hand sanitizer in the palm of one hand.
- Rub hands together so the hand sanitizer covers all surfaces of the hands and fingers.
- Continue to rub until hands are dry

- Have an evening campfire on the beach with friends
- Set up a picnic at a park
- Host a murder mystery dinner party
- Attend or host a Friendsgiving
- Throw a themed costume party for Halloween
- Try everything pumpkin, salted caramel or apple flavored
- Take a stroll through the farmers market
- Go antiquing
- Try a recipe from another country
- On rainy, cold days, spend the day on the couch under blankets having a movie marathon
- Plant bulbs in your garden for next spring
- Make s'mores
- Watch geese fly south for the winter
- Make a pinecone bird feeder
- Attend fall festivals
- Take a bike ride
- Carve pumpkins
- Make a big batch of chili
- Learn to knit
- Cozy up in your favorite fall sweaters
- Make apple or pumpkin pie

November 2021

Volunteer Newsletter

Dr. Matt's Trip to Peru

What a great experience this was for me and my 9 year old daughter Violet. While Violet went to a Spanish speaking school during the day hours, I worked in both the hospital and in the clinical settings. We spent most of our time located at this site, but we were able to visit more remote villages further along the Napo River. When we weren't with the patients, we were playing soccer and interacting with the wild animals that were reared as pets in the community: macaws, monkeys, tapirs, sloths, etc.

I was able to assess the need for hospice and palliative care services in the region. The patients mainly received Tylenol and NSAID medications for pain and suffering and narcotics were not available and benzodiazepines were rarely used. I spoke with Sr. Yanabel who is both a nun in the Catholic Church, as well as the head charge nurse, and discovered that narcotics are accessible but rarely

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Mark Your Calendars

Center for Hospice Care's Time of Remembrance Memorial Service will be held on **Sunday, November 21, 2021.**

It is wonderful and beneficial for our CHC families to be able to talk with the volunteers and staff that supported them through their loved one's dying experience.

We always need volunteer helpers to assist before and after the service with set-up, parking, registration, serving refreshments and clean-up.

If you're interested in helping on 11/21/21 for this wonderful event, contact your volunteer coordinator.

We will be following mask and social distancing guidelines of the individual locations. Information on guidelines will be available at cfhcare.org/bereavement on November 19.

Kroc Center
2:00pm
900 W. Western Avenue
South Bend, Indiana 46601

Omega Event Center
2:00pm
2130 Middlebury Street
Elkhart, Indiana 46516

Christos Banquet Center
4:00pm
830 Lincolnway E.
Plymouth, Indiana 46563

Continued from Page 1

used. I would like to eventually implement a program at this site like the one established in Uganda, although probably on a smaller scale.

Lastly, I look forward to the opportunity to build further relationships with the wonderful people of Santo Clotilde. There are visiting medical and nursing staff from Spain that provide care at this site and I hope that our organization might be able to provide some assistance as well in the future. Opportunities to share provide opportunities for growth.

Matthew R Misner, D.O., M.A.P.S.

Welcome to the Team

Elijah Breden
Mishawaka Social Worker

Zayna Grant
IPU RN

Victoria Phillips
IPU CNA

Carly Rohrer
IPU CNA

Patricia Rummel
Mishawaka Social Worker

Arlena Williams
IPU CNA

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.

Brandy Carich

Elkhart

Morgan Carich

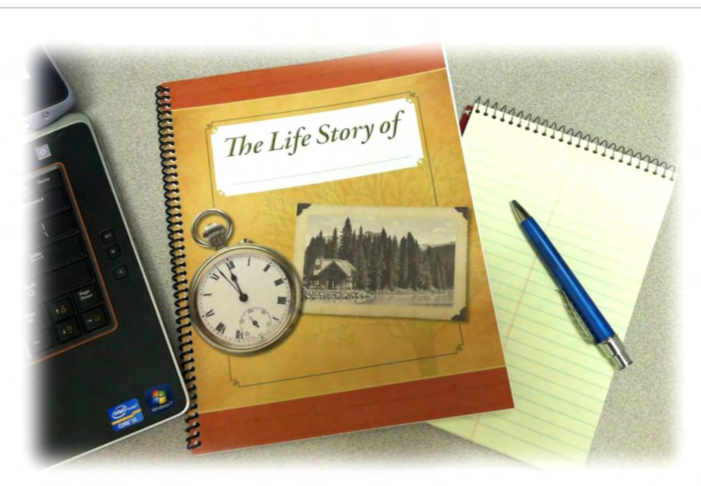
Elkhart

Martha Elliott

Elkhart

Did You Know?

Did you know that Center for Hospice Care has a volunteer opportunity called Life Story Volunteer? Trained volunteers are able to meet with patients and their families to interview them about their life—asking questions about memories, significant moments and other important topics. We can gather pictures that the family provides and then compile them in a Life Story. We print and bind them and offer copies to the family as a wonderful legacy for generations.



This opportunity is a wonderful way to honor our patients. If you are interested in this volunteer opportunity, let your volunteer coordinator know. Some additional training would be needed.

Our volunteer team needs to know of any patient interested in having their Life Story written so we are able to pair them up with one of our trained volunteers.

Comments from our Families

- Our experience with hospice was nothing short of amazing. They were by our side the whole way and we couldn't have done it without them. Their concern, compassion, and faith were there consistently, which allowed us to keep my father home until he passed.
- Our nurse had a wonderful personality and was a teacher when she needed to be, a friend when you needed to talk, a woman of faith when you were asking questions with no answers, and a mind reader telling us what was next before we could ask. She will always hold a special place in our hearts.
- Our social worker made this difficult time a little easier with her kind words and her veteran's ceremony. It had us all in tears, but my dad was able to hear the music and be celebrated before he passed on. It was priceless. You should all be extremely proud of the organization you have put together that does such needed work. We truly feel blessed to have had you with us through such a difficult time.

Elkhart Campus

Our Esther House, at the Elkhart Campus, is undergoing some minor repairs and refreshing. We will keep you posted on when they are complete and staff and patients will return to Esther House.

While the Esther House may be getting some improvements, business in Elkhart is going on as usual. Patients all over the Elkhart and surrounding areas are still being seen by staff and volunteers.

Volunteers in this area who have any questions about their assignments should direct those to Marlane Huber, Elkhart volunteer coordinator.

Birthdays

11/1
Nancy DeMaegd

11/7
Martha Jones

11/8
Susan Danielson

11/8
Karen Goodnough

11/10
Ruth Anne Gray

11/10
Kathleen Griffin

11/17
Jenny Cowsert

11/18
Nancy Jackson

11/18
Nancy Noecker

11/20
Karen McCormick

11/22
Bill Singler

11/23
Katherine Fuchs

11/23
Belinda Rogers

11/23
Marceille Wanke

11/24
Jennifer Lutz

11/25
Nellie Vels

11/29
Phyllis Hong

Grief During the Holidays

Holidays, anniversaries, birthdays, and other special occasions are usually times for family gatherings and celebrations. A loved one will be missing this year. Grieving people often tell us that parties and presents all seem meaningless, even painful at times. In fact, you may find yourself feeling angry or resentful as you observe others involved in their usual traditions.

You may be asking yourself, "How will I make it through this most difficult time of year?" We feel that no matter what your beliefs or traditions may be, we can offer some suggestions you might find helpful.

Start your planning by setting realistic expectations for yourself. Recognize that as a recently bereaved person, you probably will not be able to function at your usual level. Consider which activities are truly meaningful and enjoyable for you. You may reduce stress by eliminating or reassigning some of these activities to others. The predictability of traditions may offer a comforting structure to your holiday routine, or you may want to start new traditions. Above all, remember that your situation is unique. What works for someone else may not feel right for you, just as your ideas for coping may not appeal to someone else. Trust yourself. If it makes holidays and the special days more bearable for you, then do it your way.

Thanksgiving

- Ask family/friends to share why they are thankful your loved one was in their lives.
- Choose to eat at a

restaurant for dinner.

- Ask someone else to do the dinner this year and visit them.
- If you choose to cook, make it simple and have guests bring a dish.
- Keep the clean up easy and ask for assistance, use plastic plates, have others clean up for you.
- Light a candle in memory of your loved one. Place it on the table during the meal.
- Write your loved one a note.
- Attend worship services.

"What we have once enjoyed and deeply loved we can never lose, for all that we love deeply becomes a part of us." Helen Keller

10 Ways to Survive the Holidays

1. Remember the anticipation of the holiday without your loved one is usually more difficult than the actual holiday.
2. Acknowledge that, as you grieve, you are not functioning at full capacity.
3. Realize that you define your expectations and determine what is most meaningful and what you are comfortable with.
4. It is alright to keep your holidays the same as in the past or give yourself permission to change them based on your needs.
5. Make your needs known to family members. You may need to say it more than once to be heard.
6. Plan ahead for family gatherings; if possible schedule a family meeting to discuss personal choices that will help everyone.
7. Remember that each family member is struggling with their own grief.
8. Avoid over indulgence in alcohol, drugs, caffeine or sugar. Get adequate rest and exercise.
9. Talk about your feelings with supportive comforting people. Remember, tears are healing.
10. Don't be afraid to enjoy the good things in life.

Volunteer Recruitment & Training Coordinator
Kristiana Donahue
donahuek@cfhcare.org
(574) 286-1198

Elkhart
Volunteer Coordinator
Marlane Huber
huberm@cfhcare.org
(574) 970-0401

Mishawaka
Volunteer Coordinator
Debra Mayfield
mayfieldm@cfhcare.org
(574) 243-3127

LaPorte & Plymouth
Volunteer Coordinator
Kim Morrison
morrisonk@cfhcare.org
(574) 243-2411

Elkhart, Fulton, Kosciusko, LaGrange, LaPorte, Marshall, Porter, St. Joseph, Starke

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.

Embrace interoperability with a solution-driven EHR
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OPERATIONS

Time, Technology of the Essence in Shifting Hospice Referral Mix

By Holly Vossel | November 1, 2021

Share

Hospices have seen a shift in their referral mix in the last year and half during the pandemic, with patient streams moving away from institutions and towards physician offices. Adapting to the ways they market, educating and coordinating care with referring partners, as well as building and growing these relationships, has hospices honing focus on time and technology management.

Nearly 70% (68.32%) of hospice, home health and palliative care providers recently surveyed by Hospice News and Axxess reported that they lost relationships

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for hospice referrals as more patients balk at facility-based care out of fear of contracting COVID-19, or being unable to see family and friends due to safety restrictions.

Hospices are navigating through new barriers to traditional hospice referral sources, rethinking their outreach tactics and relationship management methods. Reaching patients further upstream in their illnesses meant honing focus on making timely connections to patients and other providers across the continuum, according to Erika Gaudio, senior vice president of sales at VITAS Healthcare, a subsidiary of Chemed Corp. (NYSE: CHEM).

"We had to get smarter about the way that we're staffing to provide care and how we're leveraging telehealth on the sales front," Gaudio said during the Hospice News Elevate conference. "What we've all learned during the pandemic is the word 'time.' How do we target the right audiences to give patients more time to access care? It means going further upstream and not spending all of our time in the hospital, but also not neglecting the

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REGULATION

CMS Delays Hospice Special Focus Program, Approves Survey Redesign

November 2, 2021

growth opportunity for referral partnerships in 2020 and 2021, according to the Hospice News 2021 Hospice Industry Outlook Report. A little more than 40% of hospice leaders identified physician practices as their greatest opportunity, up from 27% in 2019. For 2020, this outranked other referring settings such as hospital systems and assisted living facilities at 24% and 15%, respectively.

The complexity of referral management represents a significant hurdle. Hospices are walking tightropes to balance existing partnerships while establishing new relationships to make up volume. To achieve this providers are leveraging technology, including electronic health record (EHR) interoperability. This can help facilitate a timely response to referral sources, which is a top priority for physician offices.

However for many, their interoperability capabilities are not yet where they need to be to achieve the best results.

management for Forcura. "You don't need another challenge, and you don't need more disruption in order to connect those systems. Interoperability really is an issue. It's going to take a lot of effort and a lot of collaboration to get everyone moving in a connected fashion in hospice."

Data is also an important element in supporting hospice growth, according to Gaudio. Hospices can leverage evidence-based information to demonstrate their effectiveness and quality of care, said Gaudio, particularly when it comes to patient outcomes and reductions of hospital admissions or emergency department visits.

"Having the data of the individual providers enables you to show them the areas of opportunity in which they can refer earlier [to hospice], whether it's through your own claims data, perhaps patients that they have referred," Gaudio said. "It's being able to tell the story through a patient that they're familiar with and being able to show that provider with metrics, with facts and with data what that means and how it could help their practice. This is huge for practices, facilities, and hospitals as well."

Companies featured in this article:

Axxess, Chemed Corp., Forcura, VITAS Healthcare

Holly Vossel

interests include book reading, hiking, roller skating, camping and creative writing.

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Mark Murray

Subject: FW: New York Times article on hospice challenges

https://www.nytimes.com/2021/10/16/health/coronavirus-hospice-staff.html

Short on Staff, Some Hospices Ask New Patients To Wait; The New Old Age

By Paula Span, October 16, 2021

Anne Cotton had enjoyed her years at an assisted living facility in Corvallis, Ore. But at 89, her health problems began to mount: heart failure, weakness from post-polio syndrome, a 30-pound weight loss in a year.

"I'm in a wheelchair," she said. "I'm getting weaker. I'm having trouble breathing." On Sept. 30, Dr. Helen Kao, her palliative care doctor and a medical director at Lumina Hospice & Palliative Care, determined that she qualified for hospice services — in which a team of nurses, aides, social workers, a doctor and a chaplain help patients through their final weeks and months, usually at home.

Ms. Cotton, a retired accountant and real estate broker, embraced the idea. "I've lived a very full life," she said. "I'm hoping I'm near the end. I need the help hospice gives." Her sister died in Lumina's care; she wants the same support. For older patients, Medicare pays the cost.

But Lumina and other hospices that serve Benton County, Ore., are grappling with pandemic-fueled staff shortages, which have forced them at times to turn away new patients or delay their enrollment — as it did with Ms. Cotton. "It's devastating," Dr. Kao said.

Another of her palliative care patients, Ruth Ann McCracken, 91, has declined physically and cognitively since suffering two strokes last year. Last month, her family made an appointment for hospice enrollment.

The day before the appointment, Dr. Kao made a difficult call to Ms. McCracken's daughter, explaining that Lumina had lost several nurses and could not safely admit new patients, perhaps for several weeks.

Distressed and fearful of delay, the family followed her advice and made an appointment for enrollment with another local hospice, Samaritan Evergreen — only to have that meeting postponed, too, because of a nursing shortage.

Hospice staff shortages have developed across the country, and while closing to new patients is not a common response, "it's getting worse," said Edo Banach, the president and chief executive of the National Hospice and Palliative Care Organization. "If this goes on much longer, it's going to happen more."

In a stressed health care system, some routine procedures or elective surgeries can be deferred without much harm. But more than half of the 2.3 million Medicare beneficiaries who die annually rely on hospice care, Medicare reported. To qualify for hospice, patients are deemed to be within six months of death, which cannot be postponed.

Because many put off enrolling — American patients spend only a median of 18 days in hospice — even short waits can mean the loss of valuable care, from pain relief to help with household tasks.

"It causes huge distress to tell a family, 'We can't serve you,'" said Barbara Hansen, who directs Oregon's and Washington's state hospice and palliative care organizations.

The Center for Hospice Care in northern Indiana, which serves about 2,000 patients annually, has not had to turn away patients. But the smaller of its two inpatient units, a seven-bed hospice in Elkhart, has remained closed since July because of inadequate staff. The Center had planned to reopen it on Oct. 1, but a newly hired nurse left, so the unit remains unavailable. "I keep thinking it's going to get better," said Mark Murray, the Center's president and chief executive.

In New York State, "it's a day-to-day jigsaw puzzle that puts a strain on the organization," said Jeanne Chirico, the president and chief executive of the state's Hospice and Palliative Care Association. Some hospices, which often pride themselves on enrolling new patients within a day, may take an additional day or two, since admissions are a labor-intensive process. They may send home aides for fewer hours.

Many hospices are trying to recruit staff with signing bonuses; on the high end, EvergreenHealth Hospice Care in Seattle is offering $15,000 for registered nurses and $5,000 for licensed practical nurses. It has not lost much staff, said Brent Korte, the agency's chief home care officer, "but we may go from our average care load of 12 patients per nurse to 15, temporarily."

The shortage, hospice administrators say, stems partly from an exhausted staff who visited patients' homes through the worst of the pandemic, wearing full protective gear (once they could acquire it).

Now Willamette Valley Hospice and Palliative Care, which also serves Corvallis, has lost 25 percent of its registered nurses since the pandemic began and has closed to new patients several times. "The fatigue, the disappointment is hitting us," said Iria Nishimura, its executive director.

Staff shortages also reflect economic pressures. Hospice nurses typically earn less than those employed by hospitals or traveling nurse agencies, which have raised their wages and bonuses as they also face a pandemic-related lack of nurses.

In Oregon and Washington, for instance, a registered nurse working for a hospice might make $40 to $60 an hour, Ms. Hansen said. Agencies in those states are advertising up to $130 an hour for traveling nurses, she said, and one in Seattle is said to be dangling $275. "No hospice can match that," she said.

At Lumina, where staff turnover has run 80 percent higher than usual, "we've had job postings for months without any applicants at all," Dr. Kao said. It has begun offering $2,000 bonuses for registered nurses.

Hospice aides, who are usually certified nursing assistants, are being lured away, too, sometimes leaving health care entirely. "When they're getting paid in the low double digits and Amazon pays twice that, it's hard to compete," Mr. Banach said.

Vaccination resistance is also shrinking hospice staffs in states — roughly 20, according to Leading Age, which represents nonprofit senior care providers — that mandate shots for health care workers.

Hospice organizations have supported such mandates, and report that most workers have complied. But losing even a few resistant hospice staff — perhaps five percent in New York State so far, Ms. Chirico estimated — could bring temporary closures, wait lists or higher caseloads for the remaining staff. (Rules for the Biden administration's federal mandate, governing all health care providers that receive Medicare and Medicaid funding, including hospices, are expected soon.)

Hospice organizations received aid through several rounds of federal pandemic relief, but they need more to rebuild their staffs, Mr. Banach said. They could also benefit from changes in immigration law to help bolster the work force.

Those kinds of changes take time, however. Hospice workers require specialized training. Even if scrambling hospices could hire nurses tomorrow, it would take several months for most to be fully ready to work with dying patients.

"It's going to be a tough six months," Ms. Hansen predicted; other administrators interviewed found her statement optimistic.

In Oregon, Samaritan Evergreen Hospice began receiving overflows from other local hospices and, for two weeks in September, was forced to practice triage. "We were taking the most ill, actively dying patients first," said Karen Daley, the hospice director. Those who weren't struggling with symptoms and had good support at home waited for several days.

Evergreen's staff has stabilized for now, and triage is no longer necessary, although it could resume at any time. Ms. McCracken, to her family's relief, was enrolled on Oct. 8.

Ms. Cotton prefers to use Lumina, so she is still waiting. "I don't know how many people are ahead of me," she said. "Basically, I have to wait for people to die, and that's not a pleasant thought."

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REGULATION

Hospices Feel Strain of GIP Audits as Inpatient Care Days Dwindle

By Jim Parker | August 13, 2021

pixabay

Hospice providers nationwide are reporting an increase in Medicare Administrative Contractor (MAC) audits pertaining to claims for general inpatient care (GIP) stays that are longer than seven days. These audits can be expensive and time consuming processes for hospices; some of whom say they fear that this practice will inhibit patient access to that level of care.

The U.S. Centers for Medicare & Medicaid Services (CMS) requires hospice providers to offer all four levels

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"General inpatient care is allowed when the patient's medical condition warrants a short-term inpatient stay for pain control or acute or chronic symptom management that cannot feasibly be provided in other settings," CMS indicated in the email. "For a hospice to provide and bill for the general inpatient level of care, the patient must require an intensity of care directed towards pain control and symptom management that cannot be managed in any other setting."

Hospice utilization among Medicare decedents rose to exceed 50% for the first time during 2018, according to CMS. As utilization climbs, so does the amount of dollars CMS spends on hospice care, spurring the agency and other regulators to step up enforcement in an effort to control costs. Medicare hospice expenditures rise by about $1 billion annually.

Documentation errors and omissions, live discharges and lengths of stay beyond six months are frequent red flags that could cause regulators to come knocking at a hospice's door.

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medical review audits related to a limited number of topics. These topics include "review of inpatient claims for inpatient hospice care (GIP) greater than or equal to 7 days for revenue code 656 and for place of service codes Q5004 – Q5009," according to Judi Lund Person, vice president for regulatory and compliance for the National Hospice and Palliative Care Organization (NHPCO).

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Lund Person indicated that scrutiny of GIP utilization has been ongoing for a number of years, dating back to 2013 reports from the U.S. Department of Health & Human Services Office of the Inspector General.

"I would not expect that scrutiny of long stay GIP claims will subside," Lund Person said. "A hospice must be vigilant with documentation and continuing assessment of whether the patient continues to meet GIP eligibility criteria."

Complete and accurate documentation is critical to avoiding or navigating these audits. Hospices need to consistently monitor the patient's condition and

CMS told Hospice News that while each MAC will periodically adjust the volume of medical reviews for GIP or other Medicare services based on data analysis and workload, the agency does not believe the number of claims reviewed has increased significantly. Two of the largest MACs, CGS and Palmetto GBA – both subsidiaries of the Celerian Group – did not respond to inquiries from Hospice News.

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Nevertheless, providers have said otherwise in discussions with Hospice News and have reported increased GIP audits in communication with national industry associations.

"It's sad to me, because I feel like we have a great hospice program that's really vulnerable because of this activity," said Christy Whitney, CEO of Colorado-based hospice provider HopeWest. "We are losing money hand over fist, partly because we have all this administrative overhead. It's become almost like a no-win situation to running your hospice program."

Whitney told Hospice News that the prevalence of these audits are creating a chilling effect for providers. She said that a contingent of hospices have stopped sending patients to inpatient care, often leading to increased revocations of the benefit and higher hospitalizations and readmissions.

The health care data analytics firm HealthPivots recently analyzed claims data from 4,750 separate provider numbers for Medicare-certified hospices for calendar year 2020. Their analysis found that 2,283 of those provider numbers reported no general inpatient

Nearly two-thirds of GIP occurs in a dedicated hospice facility, compared to 31% provided in hospitals and 2% in skilled nursing facilities, according to HealthPivots. Hospices that do not operate their own facilities can contract with hospitals or skilled nursing operators to offer GIP in their buildings.

HealthPivots also found that while between 15% and 20% of hospice patients spend some time in GIP, that level of care represents only about 1% of hospice care days. This indicates that while a substantial number of patients receive GIP, length of stay is often very short, according to HealthPivots President Jay Cushman.

"The provision of GIP is driven largely by whether or not programs can organize their own hospice facilities, which are costly, or have contracts with other providers, like hospitals or skilled nursing facilities," Cushman said. "It's harder to organize those programs than routine home care."

Data from NHPCO show that 2020 was not an outlier year due to the pandemic. GIP represented 1.7% of patient care days in 2014 and incrementally dropped to 1.2% by 2018.

In addition the the MACs, Supplemental Medical Review Contractors such as Noridian Healthcare Solutions, conducted post-payment reviews of GIP claims for calendar year 2017, finding that the most common reason for denial was that documentation did not sufficiently support the medical necessity of that that level of care, according to Lund Person.

Documentation is the critical piece when it comes to these audits, but other considerations do at times muddy the waters. This includes the inherent complexity and unpredictability of a patient's illness trajectory, most particularly with non-cancer diagnoses.

Determining a six-month terminal prognosis and selecting an appropriate level of care is often a judgement call rather than an exact science, as is the case in some instances for the auditors evaluating those claims. Some stakeholders have argued that claims denials indicate a difference of opinion between the health care provider and the payor or regulatory body, rather an evidence of malfeasance.

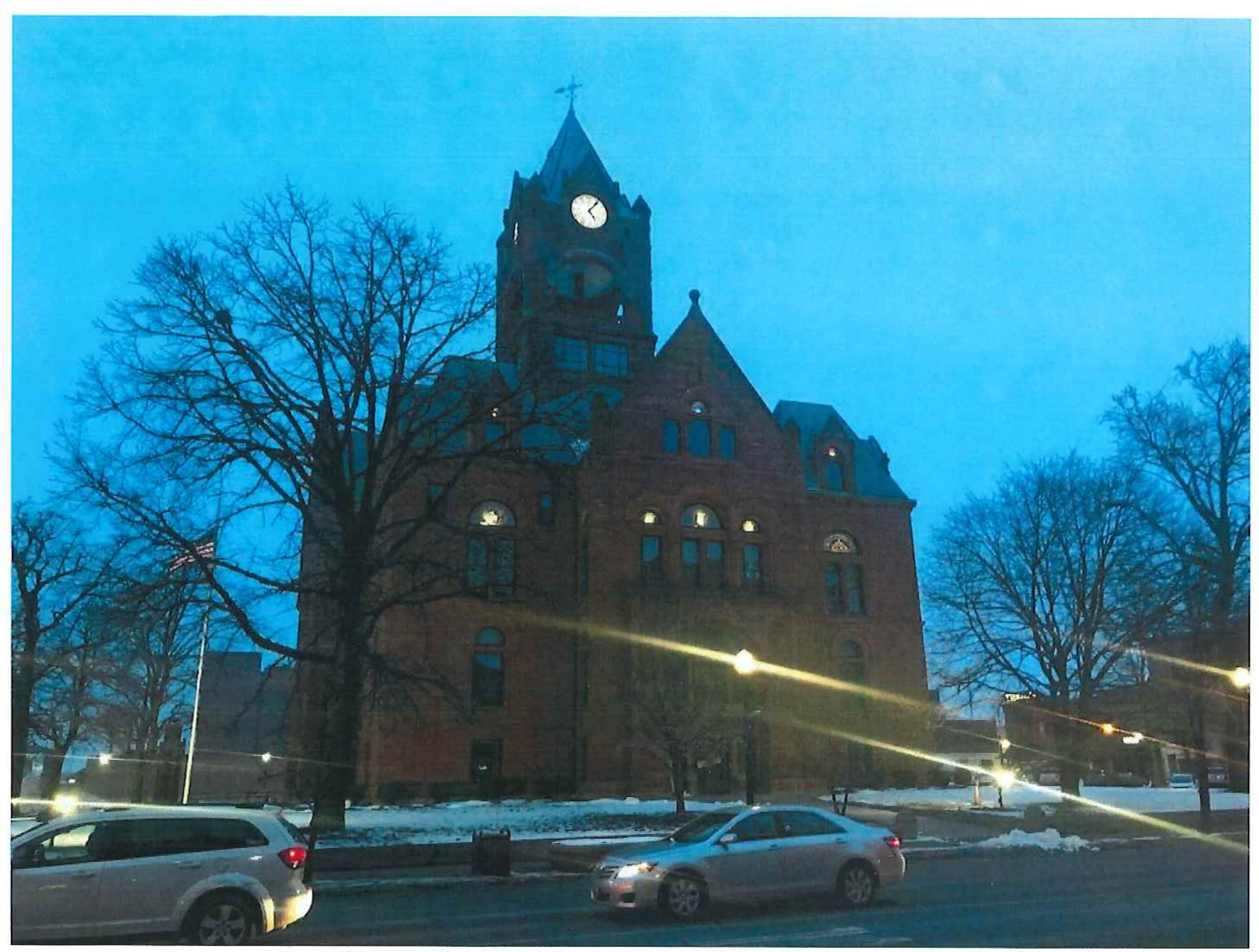
Whitney recounted a HopeWest patient with a broken pelvis who transitioned to general inpatient care after suffering a heart attack. Following the cardiac event, her pain had worsened; she became bedridden and was virtually comatose for about 10 days prior to death. The MAC pulled the patient's chart for an audit and denied the claim for a billing period that included only the patient's final day of life. The patient was Whitney's own mother.

"I think CMS needs to be directed to clarify the criteria for general inpatient care by the Congress, because they have not been willing to do it themselves," Whitney told Hospice News. "We use the [Medicare Hospice Benefit] as it was designed and, constantly, we have care denied that was provided in good faith and according to all the rules. I think that the auditors are making everything black and white."

URGENT

Center for Hospice Care moves to new location

Joseph S. Pete
Sep 23, 2021



Downtown LaPorte is shown.

Joseph S. Pete

Joseph S. Pete

Center for Hospice Care has moved to a new location in LaPorte to be more easily accessible to the public.

The community-based not-for-profit moved its office to 309 W. Johnson Road. A public ribbon-cutting ceremony hosted by the LaPorte Economic Advancement Partnership will take place between 4 and 6 p.m. Sept. 30.

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WATCH NOW: Riding Shotgun with NWI Cops — Patrolling Low...

Go on patrol with Aaron Crawford, a Cpl. with the Lowell Police Department, as he speaks about joining the force, DUI enforcement grants, and police Jiu-jitsu training.

"By locating strategically on Johnson Road, not only is our staff able to reach all parts of LaPorte and Porter counties with ease, but we can also now provide easy access to individuals needing bereavement care," President and CEO Mark Murray. "Center for Hospice Care is unique in that we offer grief support to all residents, regardless of whether or not their family used our hospice services."

The community-based nonprofit offers hospice, home health, grief counseling and community education services across northern Indiana. It has cared for more than 42,000 patients and their families in its nine-country service since 1980.

WATCH NOW: Riding Shotgun with NWI Cops: Justin Dyer preview

Coming Sunday, ride along with Specialist Dyer as he patrols LaPorte.

The Center for Hospice Care does not charge for its grief support program and does not turn anyone away for grief or hospice care. Last year, the nonprofit with a stated mission of "improving the quality of living in the community" provided $2.3 million in unreimbursed medical care.

As a hospice, it provides end-of-life care to patients, giving them palliative care to ensure the best possible quality of life so they can appreciate their remaining time with their loved ones. The Center for Hospice Care also provides bereavement services to the community.

The ribbon-cutting event is open to the public and will feature hors d'oeuvres catered by Portofino Grill. Anyone interested in attending can RSVP at **www.laportepartnership.com**.

For more information, visit **www.cfhcare.org** or call 219-360-0931.

NWI Business Ins and Outs: Olive Garden coming to Highland, LongHorn Steakhouse under construction in Schererville, new dunes gift shop open; Sears closes last Illinois location

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OPERATIONS

Hospices Compete for Staff in Job Seekers' Market

By Holly Vossel | August 30, 2021

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Hospice providers are competing more intensely to fill their ranks from a smaller pool of prospective employees. Hospices will need to offer flexible schedules, mental health support and a diverse and inclusive culture to attract and retain staff in what has become a job seekers' market.

Workforce shortages have long predated the coronavirus pandemic, but COVID-19 has exacerbated the issues as hospice providers ramp up recruitment and retention efforts. The outbreak has taken a tremendous toll on the nation's health care workforce. Stress brought on by the pandemic has led a little more

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"It's hard to take on patients when we don't have enough nurses to take care of them. There's just not enough of them out there," said Shelley Henry, founder and president of The Amity Group, a Louisiana-based hospice staffing agency. "One thing that has to be done is that patients can't be accepted if you don't have the nurses to take care of them. Maybe you take fewer patients right now, but you're going to keep your staff happier and you can grow stronger over time. Hospices that stick to their staffing ratios have a very stable staff."

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The nation's health care workforce has been reduced by 502,000 people since February 2020, according to a report from the Bureau of Labor Statistics. Likewise, upwards of 35% of hospice leaders surveyed by Hospice News earlier this year cited staffing shortages as a top concern for their organizations, along with regaining access to patients in facility-based settings.

Hospice providers of all stripes are seeking best practices that can help them recruit and keep employees. Developing an organizational culture in

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REGULATION

Hospice Community Responds to Proposed Survey Reforms in CMS Home Health Rule

August 31, 2021

Kristen Yntema, president and CEO of North Carolina-based AuthoraCare Collective. Encourages providers to survey staff regularly to discover their unique needs that "fill their cups."

"Self care is essential for the serious and taxing work that hospice care entails. Administrators need to review staff surveys and collaboratively create the supportive environment desired," said Yntema. "It is an employee and team-centered approach to discovering and implementing benefits that are meaningful. Robust programming and strong benefits that promote and support self care will set the hospice apart from competing employers."

Staff burnout has been putting pressure on the hospice community. About 62% of hospice clinicians have experienced burnout at some point in their careers, according to a 2019 study. Scheduling flexibility and employee programs that help support both physical and mental health can be important benefits, according to Jake Massacci, vice president of human resources for Jet Health.

Colorado and Idaho.

Hospices have been reevaluating their staffing policies, including applying increased paid time off and holidays, with many restructuring and adapting telecommuting policies during the pandemic as more employees began working from home.

Allowing for more flexible schedules will go a long way towards recruitment and retention, according to Massacci.

"Aside from price points, people are really looking beyond that and saying, flexible schedules really do make a difference for me and my family," Massacci told Hospice News. "Flexibility is probably the biggest thing that really sticks out to me that makes an organization more attractive. Unfortunately, offering that staff flexibility is getting more and more difficult when you look at where the market is with a shortage of employees out there who are willing and able to come to work every day."

The ability to strike a healthy balance between workload and personal life has become increasingly challenging for hospice providers, given the rising demand and the dwindling workforce. Seniors 65 and older will number 1 billion or roughly 12% of the global population by 2030, the U.S. Census Bureau projected in 2018. This represents a yawning gap for hospices to fill.

The shortage is impacting a range of disciplines, including physicians. The United States has 13.35 hospice and palliative care specialists for every 100,000

While offering higher wages, competitive pay and attractive benefits packages can go a long way to staff recruitment, an employer's working environment and overall culture go farther when it comes to retention, according to Yntema. Featuring employee engagement activities and offering job-sharing opportunities as career path explorations can help hospices to keep staff interested and engaged in growing with their organization.

Hospices are also casting a wider net as they seek a more diverse and inclusive workforce, according to Yntema.

"Employers need to work to create an inclusive workplace and also support their staff as they navigate home-based care amid a diverse patient population. Staff need to feel supported and that their differences are recognized, celebrated, and leveraged as a collective strength," Yntema told Hospice News. "Creating belonging — both for employees and patients — requires a robust and authentic commitment to diversity, equity and inclusion work."

Hospices nationwide have made diversity initiatives a rising priority. Many hospices that are trying to address racial and ethnic health care disparities among their patient populations are also working to establish a more diverse workforce, according to a 2020 study published in the BMJ Supportive & Palliative Care Journal. More than 70% of organizations surveyed in an Axxess report of home-based and hospice providers

differentiator when it comes to having a strong and inclusive culture, according to Henry. Gauging their reputation against competing hospices will be essential to knowing where an organization measures up in a crowded employee market..

"A lot of agencies may have a reputation that they don't even know about, or one that's not deserved," said Henry. "It's really important that each agency truly takes measures to find out what is being said about them in the community, because maybe it's something that's not even true and they need to be able to counter that or if it is something that's accurate, they need to ask how they can fix it. It's really important that the company is known for standing behind their nurses and supporting their nurses – even above sciences and even about profit."

Though competition for staffing resources is fierce, hospices may see some improvement in coming years. Employment in health care occupations is anticipated to outpace other sectors with the addition of roughly 2.4 million jobs, a growth by 15% from 2019 to 2029, according to projections the Bureau made this May. The Bureau indicated the jump was largely attributed to an anticipated rising demand for health care fueled by demographic tailwinds of an aging population.

Companies featured in this article:

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Center for Hospice Care Announces Staff Certification as End-of-Life Dementia Care Professionals

By: Center for Hospice Care Last Updated: September 1, 2021

Center for Hospice Care (CHC) – a not-for-profit, community-based organization is pleased to announce the certification of 51 employees who have completed specialized training to advance their knowledge of end-of-life dementia care. The goal is to have 75 staff members trained by the end of the year. These staff members are now certified as End-of-Life Dementia Care Professionals (EDCP). This training seminar was provided to Center for Hospice Care by the Institute for Excellence in Memory Care and their parent company, REAL Services and is approved by the Indiana State Board of Health Facility Administrators.

By completing this curriculum and earning this certification, Center for Hospice Care staff can offer superior memory care to their patients. For instance, non-verbal indicators of pain require special training to recognize and interpret. CHC staff can better comprehend and verbalize the unique needs for those living with Alzheimer's and other Dementia diseases as well as identify dangers and areas of risk for caregivers.

Center for Hospice Care also owns Milton Adult Day Services which is temporarily located at 3607 Grape Road in Mishawaka. As part of their commitment to serve current and future area residents struggling with all neurological issues including Alzheimer's and Dementia, they are repurposing their previous Roseland facility into Care Connections Center at Milton Village later this year. Unique in concept and design, the facility incorporates input from world-renowned dementia care experts and will be able to care for up to 60 clients daily. The completely remodeled facility will also be the new home for Alzheimer's & Dementia Services of Northern Indiana, The Institute for Excellence in Memory Care as well as numerous resources for caregivers. More information, including daily rates and payment options, can be found at MiltonADS.org.

LAPORTECOUNTY.LIFE™

Center for Hospice Care Announces Success of Specialty Programs for Chronic Health Conditions

By: Center for Hospice Care Last Updated: October 19, 2021

Center for Hospice Care (CHC) – a not-for-profit, community-based organization is pleased to announce the success of their independently created specialty programs, 'HeartWize' and 'BreatheEazy.'

In 2016, Center for Hospice Care developed and implemented these innovative programs to help meet the needs of their patients. HeartWize for individuals living with advanced heart disease and BreatheEazy for individuals living with COPD and other lung diseases. Each program addresses the unique needs of patients affected by these diseases, such as, optimal nutrition while living with certain diseases, disease education for everyone that is customized, symptom management and medication management. End stage heart disease and lung disease have comprised almost half of the diagnoses of all CHC patients. Both programs include the use of emotional, spiritual, and complementary approaches to care, as appropriate.

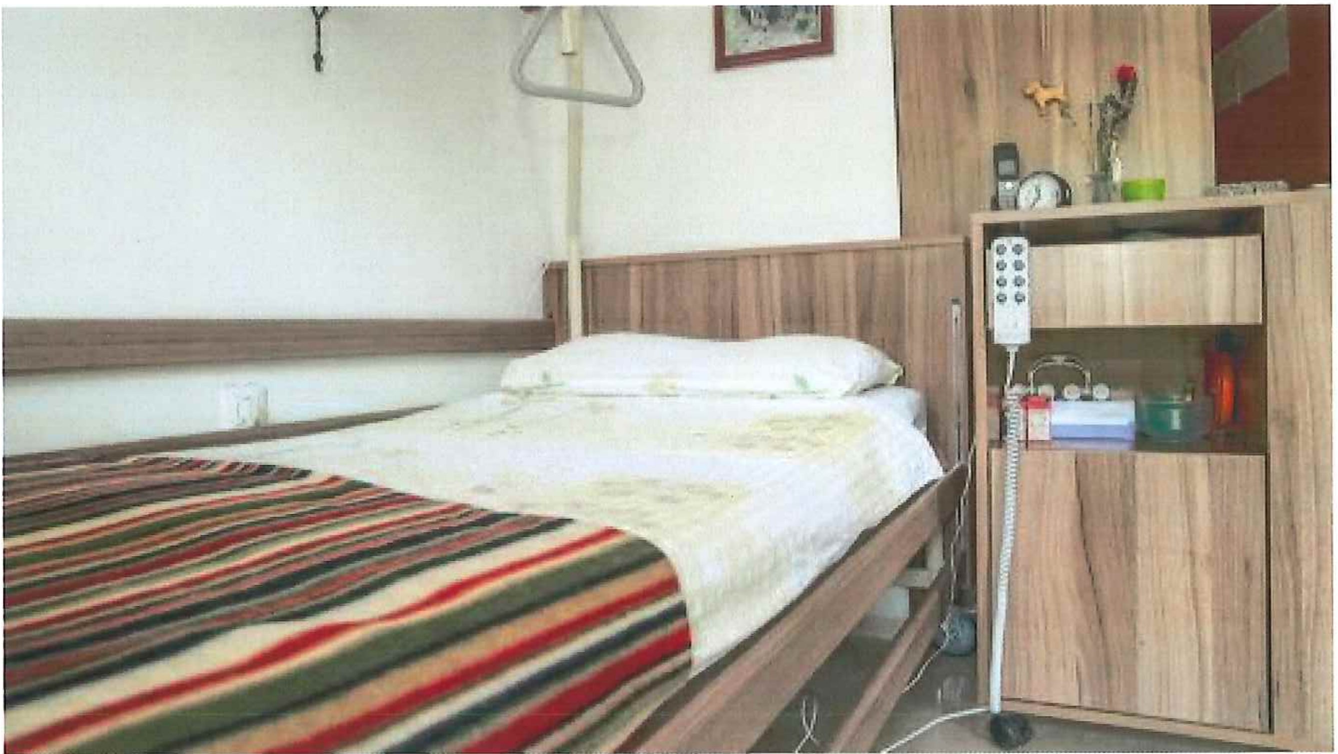
Center for Hospice Care's HeartWize program for patients with advanced heart disease has shown tremendous results in reducing both emergency room visits and hospital readmissions. This specialty program takes an interdisciplinary approach and includes the use of emotional and spiritual support for both patient and family. Specialized protocols and treatment pathways are designed for each patient. Over the past four years, CHC cared for 3,281 patients who also participated in the HeartWize program, which is an option for optimal care management. In 2016-2020, the program had a 99.6% effective rate of keeping patients from visiting the emergency room and a 99.2% rate of reducing hospitalization readmission.

Center for Hospice Care's BreatheEazy program for patients with chronic obstructive pulmonary disease (COPD) has shown tremendous results in reducing both emergency room visits and hospital readmissions. Over the past four years, CHC cared for 2,461 patients who also participated in the BreatheEazy program. In 2016-2020, the program had a 99.5% effective rate of keeping patients from visiting the emergency room and 97.7% rate of reducing hospitalization readmission.

Center for Hospice Care is a community based, not-for-profit organization, improving the quality of living through hospice, home health, grief counseling, and community education. Put simply, our mission is "to improve the quality of living" for those in our community through our support of Center for Hospice Care, an organization that helps patients and their loved ones experience the best possible quality of living even as they face end of life.

SNF staffing shortages may get 'much worse'

Danielle Brown



Source: CasarsaGuru/Getty Images Plus

Nursing homes and other residential care facilities have already lost about 380,000 workers since the start of the COVID-19 pandemic in February 2020, and the shortages are expected to get even worse, according to the National Investment Center for Seniors Housing & Care.

A new NIC analysis on the labor crisis and the ripple effect it has created on skilled nursing operations predicts that staffing shortages likely haven't hit their peak and, in fact, may get "much worse," based on recent data, wrote authors Omar Zahraoui and Bill Kauffman.

The biggest shortages of staff reported by SNFs have been among aides and nursing staff, which also represent the largest share of all SNF workers. Facilities experiencing shortages of both groups have also reported higher per-resident rates of new COVID-19 infections and lower occupancy rates compared to SNFs reporting no shortages of nursing staff and aides.

NIC found that in December 2020, infection rates peaked at 4.76% on a four-week moving average for SNFs reporting shortages of hands-on essential workers, while SNFs that had no shortages reported an infection rate peak of 2.54%.

"This suggests that shortages of staff translate into lower staff-to-resident ratios and consequently increase 'one-to-many' interactions between available staff and residents," wrote Zahraoui and Kauffman, a NIC data analyst and senior principal, respectively. "These 'one-to-many' interactions could lead to higher virus transmission among residents."

There's also a high turnover rate among aides and nursing staff, the analysis said. Federal data shows a lower labor force participation rate in general in the US economy, and that's affecting this, according to NIC's Chief Economist Beth Mace, who also worked on the analysis.

"So, the labor shortage is here, is going to be here for the foreseeable future," she told *McKnight's* on Friday. .

"For our industry in particular, it's challenging since a lot of our workers are intimately involved with people," she added. "It's a human industry, person helping person. You can't really substitute that with a machine. You can't substitute that [a machine] with having human care."

She suggested that industry stakeholders collectively help determine and figure out ways to bring staff back in a way that's appealing to workers. For

example, convincing them with benefits like flexible hours, bonuses and higher wages.

"There's a lot of attention being given to that, so this isn't anything new. What this blog shows is that we have room to go," Mace said. "There are still shortages that are being cited and there are shortages that are bleeding over to the ability to do business and to expand business."

2022 BOARD OF DIRECTORS MEETINGS

Administrative and Foundation offices
501 Comfort Place, Mishawaka IN 46545
Conference Room A
Wednesdays at 7:15 a.m.

Date	Topic of Focus
February 16	2021 Year in Review First meeting for new Board members
May 18	Review of 2021 Audit
August 17	Quality Assurance Performance Improvement updates
November 16	2023 Budget Election of new members and officers

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