Center for Hospice Care
choices to make the most of life

Board of Directors Meeting

501 Comfort Place, Conference Room A, Mishawaka
May 18, 2022
7:15 a.m.

BOARD BRIEFING BOOK

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CHAPTER ONE

AGENDA

Center for Hospice Care

BOARD OF DIRECTORS MEETING

501 Comfort Place, Conference Room A, Mishawaka

May 18, 2022
7:15 a.m.

A G E N D A

1. **Welcome –** Jennifer Ewing (2 Minutes)

2. **Consent Agenda** – Jennifer Ewing (10 minutes)
   A. Approval of February 16, 2022 Board Meeting Minutes *(action)*
   B. QI Committee Meeting Minutes 02/22/22 included in your packet *(information)* – Angie Fox, DON, is available for questions
   C. Revised Policies *(action)* – Angie Fox, DON, is available for questions
   D. Revised Human Resources Manual 2022-2024 – Karl Holderman, VP/CFO, is available for questions

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

4. **Finance Committee** *(action)* – Kurt Janowsky (11 minutes)
   A. 12/31/21 Audit
   B. April YTD 2022 Financial Statements

5. **Hospice Foundation Report** *(information)* – Mary Newbold (15 minutes)

6. **Board Education *(information)* – "Market Snapshot" – Craig Harrell, Director of Marketing and Access (15 Minutes)**

7. **Chair's Report** – Jennifer Ewing (2 minutes)

Next CHC Board Meeting August 17

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Center for Hospice Care
choices to make the most of life

CHAPTER TWO

CONSENT AGENDA

Center for Hospice Care
Board of Directors Meeting Minutes
February 16, 2022

Members Present:	Andy Murray, Brian Huber, Jeff Bernel, Jennifer Ewing, Kevin Murphy, Mark Wobbe, Mary Newbold, Roland Chamblee, Wendell Walsh
Absent:	Kurt Janowsky
CHC Staff:	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 11/17/21 meeting as presented. The motion was accepted unanimously.	M. Newbold motioned K. Murphy seconded
3. QI Committee	• The QI Committee met 11/16/21. In the 4th quarter 2021 everything is falling within normal ranges. In 2022, we are focusing on areas where we want to improve upon. One is on falls in the home. The majority of these the caregiver is with the patient, so we are doing a great deal of caregiver training. In 2022 we will continue to improve upon practices to prevent falls. • Therapy – We use contracted therapists for PT, OT, and Speech. If there is a fall, the therapist reviews it and brainstorms ideas on how to prevent them. When the nurse identifies a patient could benefit from having a therapist, Dr. Karissa Misner reviews it. We had nearly 20 falls in the 3rd and 4th quarters. The therapists focus more on teaching transfer techniques rather than strengthening exercises.	
4. Policies	• Home Health patient care policies were reviewed and updated. Most of the changes were related to the state survey. Biggest changes were in initial assessments and start of care. Medications – A patient could be on several medications, and we have to document the side effects of all of them, including over-the-counter medications. The policies help guide the nurses. There are several regulatory boards and organizations that we subscribe to such as NHPCO, IHPCO, and CAPC, and we get alerts of any changes in regulations. Policies are reviewed by an interdisciplinary team, then the administrative team, and then to the Board for final approval.	

Topic	Discussion	Action
	• A motion was made to accept the revised Home Health policies as presented. The motion was accepted unanimously.	W. Walsh motioned K. Murphy seconded
5. President's Report	• January ADC 280, February 1st 277, and Monday it was 291. We continue to have staffing issues. We want census to increase but we need the staff to care for them. A lot of hospices are turning patients away because they don't have the staff. We have not done that so far. Census at Raclin House has been choppy. It could be seven one day then one the next. Our staffing challenges are particularly for overnight and weekends. We are currently rotating Patient Care Coordinators and team leaders through there. Staff are also retiring or moving away to be closer to family. We have adjusted wages, but many of those who leave have reasons that have nothing to do with CHC or pay. • We are now CHAP accredited for Hospice and are now working towards CHAP Home Health accreditation. This should mean the IDH surveyors will no longer do our surveys. We had five different surveys in a four-month period just for home health. We have done the pre-survey items to get ready for CHAP. Once we tell them we are ready, they will be here within 45 days. We have to have a certain number of home health patients on census before they will come. We are waiting to be above that minimum before we tell them we are ready due to deaths and discharges to hospice. • As of the 01/27/22 CMS vaccine mandate deadline, 100% of our staff are either vaccinated or submitted an exemption. We didn't lose any staff specifically due to the vaccine mandate. We are in compliance 100% across the board. We have had a number of staff out with the so-called second round COVID. • Nursing home census is down nationally and locally is no different. This is normally about one-third of our census. One of the local nursing homes in Mishawaka is shutting down entirely and repurposing as an addiction recovery center. • 2021 and 2022 CHC goals are in the board packet. The Administration 2022 goals on page one is our strategic plan for the next three years. Mark M. had talked to Jen E. about not putting together another 30-to-40-page three-year strategic plan, in-part, because Mark M. will not be here in three years. Additionally, there is total uncertainty in the healthcare space at this time. • Center for Medical Services, LLC – We are getting our medical team of physicians and nurse practitioners credentialed with Medicare and Medicaid. An opportunity recently presented itself to us because Beacon is shutting down its outpatient palliative care clinic as of 02/25. We are in conversation with Dr. Amber Burger about transitioning	

Topic	Discussion	Action
	her patients to us. Dr. Karissa Misner is meeting with her this week and will insight on how she has run the palliative care clinic and help us to fine tune our clinic. Dr. Karissa is credentialed at Beacon and SJRMC and two of our NPs are credentialed at SJRMC. • Conflict of Interest Statement – Reminder to please sign the form. This is an annual IRS requirement for our 990 form and our auditors look for it. • The National Hospice Executive Roundtable (NHERT) met in person in January for the first time in two years. We talked about a Medicare Share Saving Program (MSSP) opportunity that possibly eight NHERT members will do. We decided it is nothing we are really interested in at this time. The cost of $60,000 would be divided by eight different programs. It is very complicated. • Hospice mergers and acquisitions – Last year was an all-time high for hospice programs. Mostly it is for-profits buying up hospices. What is new is not-for-profit hospices are now selling to for-profit chains. • We engaged Transcend Strategy Group to grow our census, improve lengths of stay, and recruit top talent. This is the same group that did our original rebranding in early 2008 and was very successful in growing our census. They will also look at creating an umbrella brand for our future. We do a lot of different things and have several 501c3's that are disconnected from the CHC brand. They helped Hospice of the Bluegrass in Lexington, KY do something like this, and they became Bluegrass Care Navigators. This would be done in 2023. • Census compared to state and national – It is a challenge across the country. It is better for hospices in certificate of need states like Florida and Kentucky where an agency would have to go to their state legislature to open a new hospice. We think the problem may have bottomed out. Our phone never stopped ringing. It is staffing and response times, and our relatively new MatrixCare EMR. Last year was our third biggest year financially when taking investments out. Are there opportunities with less well-run competitors to align or acquire some of their staff or clients? We are only looking at Hospice of the Calumet Area in Munster. Most of the hospices in Indiana are hospital owned. Only about five are independent free-standing, one of which is the one in Munster which has been in operation nearly as long as CHC. We do pursue staffing from competitors as aggressively as we can and have had some responses. There is such a limited pool of people right now, there really isn't a universe of people to even steal from.	

Topic	Discussion	Action
	• EMR issues – We work with MatrixCare and staff daily, and train staff how to use the tools we have. This will be a constant, ongoing challenge. Staff turnover and the ongoing need to train doesn't help matters. • Board Website – The new board website was not the solution we wanted, so the board packet had to be sent by encrypted email. We will have a solution in place for the May board meeting.	
6. Finance Committee	• The YTD 2021 financial statements were reviewed. We served 1,813 patients and budgeted for 2,115. ADC was 365. Operating revenue was $21.1MM, about $4.5MM under budget. Total revenue $26.1MM, total expenses $20.8MM, about $4.1MM less than budget. Most of this was due to the fact that staffing was down and lower patient care costs with a lower census. We had a YTD net gain of $5.3MM, and net without beneficial interest in Foundation of $1.1MM. This is about $12,000 more than we budgeted. All entities combined without investments, CHC and affiliates had a net gain of $2.3MM compared to $1.4MM in 2020 and $1.9MM in 2019. • Auditors will be here the week of 02/21. • We budgeted for some growth in 2022. Looking at the last three years, without investments 2021 was the best year we had. One factor we are dealing with is referrals from hospitals are typically shorter lengths of stay and faster turnaround. One thing we are concentrating on is getting patients further upstream. That would give us longer lengths of stay and less expenses. Staffing issues – We have been up front with referral sources about our turnaround time. Many are willing to wait. Some hospital discharge planners are under increasing pressure to get patients out. Referrals from families/self is higher which tends to be longer lengths of stay. Admissions is doing a good job converting referrals to admissions. The conversion rate was over 75% in 2020 and nearly 70% in 2021. This keeps us strong financially. Often family referrals may not be appropriate for hospice yet, but this gets them on our radar, and we follow up with them regularly to get them on service as soon as possible. Our competitors are struggling with same issues. We work at eliminating barriers to come into our program wherever we can. Board members can act as ambassadors for potential patients and employees. • A motion was made to accept the YTD 2021 Financial Statements as presented. The motion was accepted unanimously.	M. Wobbe motioned J. Bernel seconded

Topic	Discussion	Action
7. Hospice Foundation Update	• The Foundation operates under four pillars – fundraising, stewardship, education, collaboration. 2021 was our highest fundraising year in the history of the Foundation. A lot of that was because of the Milton Village initiative. We were on a fast track to raise money in a short period of time. To date we have raised $4.9MM towards our $6.1MM goal. There are still some prospects we want to talk with. Annual giving year over year is the things we can typically expect like the Annual Appeal, Friends of Hospice, etc. We had a dip in fundraising in 2020 because we didn't have the Helping Hands Dinner until 2021. Otherwise, the income would have been steady. We just came off a five-year campaign for the Mishawaka Campus. We raised $14MM of our $10MM goal. • New Plymouth office – We acquired the property in October and are in the planning phase with the architects and interior designer. The complex has six tenants. We anticipate completing this project by the end of the year. • 2022 Events Calendar. This will be updated throughout the year. We have a recommended honoree for the 2022 Helping Hands Award and will be discussing that at the Hospice Foundation Board meeting. We plan to hold a similar event for Elkhart in the fall tentatively at the Lerner. We see that as becoming another major fundraising event. • Center for Education & Advance Care Planning – Several things are happening, and we are working on various collaborations with health systems. We continue to do legislative outreach through the NHPCO MyHospice program. Elleah Tooker, our Community Education Coordinator, received a district award from NHPCO for her work as a MyHospice ambassador. Our community education panels are back on track. These seem to work better virtually, so we will continue to do them that way. We are working with the Hospice Foundation of America (HFA) to provide CE for staff and people in the community that need CE credits on hospice and palliative care. This has been very successful. The Notre Dame "Introduction to Hospice" class will be held in March over five Fridays. This time it will be in-person. These classes have been running for 10-11 years with the Ruth M. Hillebrand Center for Compassionate Care. It started as a half credit course and is now a 1.5 credit course taught by CHC staff. • Honoring Choices Indiana North Central – The next first-step facilitators training will be held in March. Over 100 people have been trained throughout Elkhart, St. Joseph,	

Topic	Discussion	Action
	and Marshall Counties. We are looking to move into LaPorte County as well. A lot is happening with advance care planning initiatives. • We continue to work with IUSB on a number of new initiatives. Cyndy Searfoss is teaching some of the sessions, as well as Dr. Matt Misner. We are also working with the MSN, BSN, and NP programs to bring those students over to intern or shadow staff. We hope this will help with recruitment as well. • PCAU – CHC has been partnered with PCAU since 2008. In 2009 we did a study of which districts had palliative care. At that time, it was in 34 districts and in 2019 it is in nearly all districts. Denis Kidde, our International Programming Representative, visited Uganda in December and January. This was the first visit in almost two years by a CHC/HF team member. We launched a new PCAU partnership website and also a Road to Hope website. Road to Hope has 53 students. Some have graduated from the program. We continue to work with providing scholarships for the Advanced Diploma in palliative care nursing (ADPCN) at Mulago School of Nursing. The mHealth mobile health project was cited by the World Health Organization in December as an important example on improving access to palliative care. We may be hosting PCAU's director, Mark Mwesiga, in October 2022. It has been four years since we hosted PCAU staff here. • GPIC – We currently have 37 partnerships. A couple of African partners visited the U.S. last year. We will be hosting a booth at the NHPCO LAC in March, an in-person GPIC advisory council meeting, and present the Global Partnership Award. Through GPIC, we have awarded 63 scholarships since 2011. We are working on a palliative care leadership project with Bluegrass Care Navigators to help develop the next generation of leaders.	
8. Board Education	• 2021 Year in Review. We served 1,813, which was down 13.63%. ADC was 365, which was down 15% from 2020. We hope telehealth will be made permanent for hospices by Congress. Our current average length of stay is 100. We continue to work with doctors to get patients in sooner. On average patients die within seven days of admission. • Andy M. commented in terms of the organization as a whole, every organization has been impacted by COVID. It is impressive to see the way the team has navigated those changes to requirements and changes outside of our control, and yet generate these results.	

Topic	Discussion	Action
9. Chairman's Report	• We have a policy on succession and selecting a new CEO. We should start thinking about Mark M. guiding us through the process. It is a very well-run organization. Thank you, Mark M., on behalf of the community and patients we serve.	
Adjournment	• The meeting adjourned at 8:35 a.m.	Next meeting 05/20

Prepared by Becky Kizer for approval by the Board of Directors on May 20, 2022.

Jennifer Ewing, Chair

Becky Kizer, Recording Secretary

Center for Hospice Care
QI Committee Meeting Minutes
February 22, 2022

Members Present:	Alice Wolff, Angie Fox, Chrissy Madlem, Craig Harrell, Deb Daus, Holly Farmer, Jennifer Ewing, Dr. Karissa Misner, Mark Murray, Tammy Huyvaert, Becky Kizer
Absent:	Carol Walker, Lance Mayberry

Topic	Discussion	Action
1. Call to Order	• The meeting was called to order at 8:00 a.m.	
2. Minutes	• A motion was made to accept the minutes of the 11/16/21 meeting. The motion was accepted unanimously.	D. Daus motioned A. Wolff seconded
3. Hospice Quality Monitoring	• We increased our quality monitoring from six areas to eight. • Support Services – The number of Service Intensity Add-On (SIA) hours has increased. We continue to work towards our goal of 100% of assessments being done within five days of admission. 4th quarter was 98.8% for chaplains and 98.6% for social workers. • Bereavement – We received the six-month Evaluation of Grief Support Services (EGSS) survey report for July-December 2021. We were below the national average in 13 areas. Received information about grief and loss CHC score 82% and national 89%. How to cope with grief and loss CHC 65% and national 56%. Reassurance that what you are going through is a common reaction to grief CHC 76% and national 89%. Towards the end of 2021 we modified the language in the survey letter, so we hope that will impact our scores. The EGSS is sent 13 months after the death. Our phone support score was 100% and national 59%. Holiday support program 100% and national 56%. Being sensitive to cultural and/or spiritual background CHC 82% and national 77%. We started coding the surveys so we could better track responses and follow up on any negative comments. The survey response rate January-June 2021 was 97 and July-December 2021 was 17. We send over a thousand surveys a year. We don't know why the response rate for the second half of the year was so low. • Triage Calls – Most calls are for med education/refills, change in condition/death, supplies, or wanting a call from the RN case manager. The volume of calls was down 7% in the 4th quarter. Starting in the 1st quarter 2022 we will show the raw numbers	

Topic	Discussion	Action
	instead of just percentages. Triage averages 1,000 to 2,000 calls a month. We try to identify the common reasons calls come in and provide extra education to patients/families and staff, especially on med refills. The biggest problem is ECFs needing med refills. With supplies, we can now order and have them dropped shipped directly to the patient's home. • Discharges Disposition – In 2021 we had 14.89% live discharges compared to NHPCO 17%. We had a lot of live discharges in the 3rd quarter, because we identified long-term patients that may be chronic and not terminal. Doctors did face to face visits and determined which ones were chronic and worked on a live discharge plan with them. Revocations were a little higher—7.28% compared to national 15.9% and state 6.5%. A lot of times a patient will go to the hospital before they call us. A QAPI is working on revocations. Transfers – 1.19% and NHPCO 2.20%. Moved out of service area 1.64% and NHPCO 1.60%. Moving out of our service area includes those that went to a facility where we do not have a contract. No longer terminal – 4.25%, national 13.4% and state 7.4%. Discharged for cause .075% and NHPCO 0.30%, mostly due to guns or drugs in the home. • Levels of Care Utilization – In the 4th quarter we had 1.47% GIP and national was 1.20%. We are getting ADRs on stays longer than five days. The doctors and NPs are monitoring those patients closely and when appropriate, change them to Routine level of care. Sometimes we have to delay Respite for a day or two. Social workers work with families on this. Continuous Care – We can only count this when it is at least eight hours. Even though it was 0%, we started Continuous Care on three or four patients, but never hit the eight-hour mark. We also have problems with getting transportation to get patients to the IPU because there is only one ambulance company available. So, we start Continuous Care in the home until the ambulance can arrive. • Falls – Patients are not using their DME. In the 4th quarter we 4.72 falls per 1,000 patient days and national was 3.43. Falls with injury 40% in 4th quarter and 35% in 3rd quarter. We have a QAPI looking at falls. The nurses are good at putting in new interventions when patients fall and educating them on using their DME. We also looking at patients that have multiple falls. • Hospice Item Set – We are close to the national average. Pain screening 92.83% compared to national 97.10%. We audited charts but could not find any patient not	

Topic	Discussion	Action
	screened for pain. We are working with IT on that. It may be something was not marked correctly in the EMR.	
4. Home Health Quality Reporting	• We are auditing Falls per 1,000 patient days, individualized care plans, and hospitalizations. Home Health is a small population of patients. There may be one to three falls per quarter. There was no increase in the number of pressure ulcers after a patient came on service. The UTI rate was down in the 4th quarter. Hospitalization rate was 16.67% compared to national rate of 15.4%. In the 4th quarter a patient went back to the hospital three times which will skew the data.	
5. QAPIs Home Health & Hospice	• In the 4th quarter we were looking at falls, individualized care plans, emergency visits and hospitalizations, and HCAHPS patient satisfaction surveys. These were rolled over to the 1st quarter 2022 because we were busy in 4th quarter 2021 with several IDH and CHAP surveys. • Falls – We identified that 62.3% of all incident reports were related to falls. We looked at research conducted to find preventive tools to use in the home and whether they were being used correctly. At this point, we are looking at developing our own tools. Each discipline will talk about fall prevention on their visits. Patients with advanced cancer are more prone to falls. Falls most often occur within the first five days after admission and one week prior to death. Patients 65 and older are also at risk for falls and injury. Maryjanet Swain created a checklist for falls and the QAPI is working on other tools. Fall risk information is brought to the IDT meetings. We are also looking at repeat falls. The PCC take a closer look at those patients. Once we get all the data and tools put together and track declines in falls, we could use that as a presentation an NHPCO conference. • Individualized care plans – Part of our survey plan of correction is that care plans need to be measurable and patient specific. We have done a lot of education with nurses. The PCCs are expected to review the care plans at every IDT and audit 100% of care plans until we reach a goal of 90% compliance. Once we achieve that goal, they will review 75% of charts. Right now, we are at 83%. This is both home health and hospice. • Emergency Visits and Hospitalizations – We are researching Triage notes to determine whether a visit is necessary. Triage is starting to put ERV at the beginning of their note, so we can pull a report. 15% of calls are related to Foley catheters. Another pattern is family dynamics – family afraid to give med and don't know what to do. Also, from the family's perspective we are not sending a nurse fast enough, so they	

Topic	Discussion	Action
	send the patient to the hospital. In January, 86 ERV were made within 24 hours of the last nurse visit. These include changes in condition and falls. We are looking at whether the case manager could have done more teaching or put interventions in place to decrease ERVs. • CAHPS surveys – We developed family survey where chaplain calls about ten days after admission and recert and ask if they are getting all the information they need. Chaplains let the case managers know if something need attention. There were 62 calls in the 4th quarter. 60 had no issues. 2 calls expressed dissatisfaction that they didn't get a return call when asked or as timely as they wanted. Staff have been asked to document all phone calls they make. 1st quarter 2021 CAHPS top box score 78.1%, 4th quarter 82.9%. • In the 2nd Quarter we will look at IPU GIP Documentation, HCAHPS Patient Satisfaction and bedside charting, Referral to Start of Care timeliness and documentation. We will monitor that we are meeting all COPs. Under home health, we have less than 48 hours to do a referral to admit. If there is a delay, we have to get another order. We also have to document the family was agreeable to the delay.	
6. Survey Update	• Within six months, we had IDH hospice and home health surveys as well as a CHAP Hospice Accreditation survey. CHAP said they could definitely see improvement since the IDH survey in our care plans. We continue to monitor care plans because staff is still struggling with making them individualized and writing measurable goals. Home Health – we got a conditional level deficiency for discharges. This has improved and the conditional level was lifted. IDH says we have to give a 15-day notice of discharge and CMS says two days. We are working on notifying families 15 days before discharge from home health and make sure the potential discharge status is documented in the chart. A Transfer Summary has to be sent to the facility. The PCCs and QA are also monitoring therapy notes for legibility and timeliness.	
Adjournment	• The meeting adjourned at 8:47 a.m.	Next meeting 05/24

PURPOSE: An ABN is issued when the provider has reason to believe Medicare will not pay for service prior to providing the items or services.

POLICY: The three situations that would require issuance of an ABN by a hospice are:

- Ineligibility because the beneficiary is not determined to be "terminally ill" as defined in 1879(g)(2) of the Act;
- Specific items or services that are billed separately from the hospice payment, such as physician services, are not reasonable and necessary as defined in either 1862(a)(1)(A) or 1862(a)(1)(C); or
- The level of hospice care is determined to be not reasonable or medically necessary as defined in 1862(a)(1)(A) or 1862(a)(1)(C), specifically for the management of the terminal illness and/or related conditions.

End of all Medicare covered hospice care
When it is determined that a beneficiary who has been receiving hospice care is no longer terminally ill and the patient is going to be discharged from hospice, the hospice may be required to issue the Notice of Medicare Noncoverage. If upon discharge the patient wants to continue receiving hospice care that will not be covered by Medicare, the hospice would issue an ABN to the beneficiary in order to transfer liability for the noncovered care to the beneficiary. If no further hospice services are provided after discharge, ABN issuance would not be required.

Hospice care delivered by non-hospice providers
It is the hospice's responsibility to issue an ABN when a beneficiary who has elected the hospice benefit chooses to receive inpatient hospice care in a hospital that is not under contract with the hospice. The hospice may delegate delivery of the ABN to the hospital in these cases.

When ABNs are not required for hospice services

- **Revocations** – Hospice beneficiaries or their representatives can revoke the hospice benefit. Revocations are not considered terminations under liability notice policy since the beneficiary is exercising his/her own freedom of choice. Therefore, no ABN is required.
- **Respite Care** beyond five consecutive days – Respite care is limited to five consecutive days under the Act. When respite care exceeds five consecutive days, an ABN is not required since additional days of respite care are not part of the hospice benefit. CMS encourages hospice providers to give the ABN as a voluntary notice to inform patients of financial liability when more than five days of respite care will be provided.

Signature:  President/CEO

- **Transfers** – Beneficiaries are allowed one transfer to another hospice during a benefit period. However, subsequent transfers within the same benefit period are not permitted. In either case, an ABN is not required.

- **Failure to Meet the Face to Face Requirement** – The ABN must not be issued when the face to face requirement for hospice recertification is not met within the required timeframe. Failure to meet the face to face requirement for recertification should not be misrepresented as a determination that the beneficiary is no longer terminally ill.

- **Room and Board Costs** for Nursing Facility Residents – Since room and board are not part of the hospice benefit, an ABN would not be required when the patient elects hospice and continues to pay out of pocket for long term care room and board.

~~An IDT meeting~~Discussion will be held to determine the reasons that Medicare may not cover the service with the~~. The~~ Medical Director/Hospice Physician ~~and Director of Nursing or designee must be present~~. Reasons for non-coverage will be discussed and a plan instituted for providing the patient with the notification.

Document the above in the patient's medical record.

(* Note: Expedited Determination Notice MUST be given, and ABN is also needed only when non-covered care continues after coverage ends.)

If the beneficiary refuses to sign the ABN, the Agency must write that the beneficiary refused to sign on the ABN itself, and provide a copy of the annotated ABN to the beneficiary.

Retention of the ABN

The Agency keeps the original version of the completed ABN, whether annotated or signed, in the beneficiary's record. The beneficiary receives a copy of the completed ABN.

REGULATION: 42 CFR Part 418.56 – Interdisciplinary Team (IDT) or Interdisciplinary Group (IDG), care planning, and coordination of services

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

POLICY: The Agency will have an Interdisciplinary Team (IDT) that includes at least the following persons:

- Doctor of Medicine or Osteopathy
- Registered Nurse
- Social Worker
- Chaplain

The IDT meets at least every 15 days and/or more frequently as needed.

Each member of the Interdisciplinary Team will be qualified to fulfill their individual position's job description and hospice licensure.

No member of the IDT shall be a family member, or related to a family member, of the patient.

Participation of team members will be reflected in documentation.

The Interdisciplinary Team will fulfill the following functions

- Establish the patient plan of care with the attending/primary physician and/or the Medical Director/Hospice Physician, prior to the provision of care, and review and update the plan of care at intervals specified in the plan.

- Provide or supervise care and services consistent with the established plan of care. Supervision of this care will be reflected in summaries of patient care conferences in which problems are reviewed by the Interdisciplinary Team and interventions are recommended.

- Report changes in condition/situation from the patient visit/contacts, and update the plan of care. At any time, an IDT member may initiate any form of communication or meeting to facilitate this exchange of information.

Signature: President/CEO

- Decide which services are considered reasonable and necessary for the palliation or management of the terminal illness and related conditions. The following questions may be asked to determine this:
  - What is the financial classification?
  - What is the patient's diagnosis?
  - What are the patient's options?
  - What are the expected outcomes for this particular patient?
  - To what extent is the proposed service life-limiting/prolonging?
  - Is there evidence that what is requested works and is used for that reason?
  - Is the patient able to make an informed consent?
  - Is this in the patient's plan of care? If not, should it be?
  - What symptoms are we palliating?
  - Are the symptoms related to the terminal illness?
  - What are the potential burdens?
  - What follow up is needed?

- Review patient's eligibility for his/her specific program every recertification period.

- IDTs are completed for:
  - Certification
  - Recertification
  - Plan of care initiation (after comprehensive assessment)
  - Changes to plan of care
  - Discharge alive for not meeting eligibility
  - ~~Transfers~~

- IDTs are not required for DME; only a physician's order.

- IDTs are required for:
  - Discharge for Cause
  - ~~Revocations~~

Center for Hospice Care

LEVELS OF CARE COMPLIANCE

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

PURPOSE: To ensure that all services provided to hospice patients are reasonable and necessary for the palliation or management of the terminal illness.

POLICY: Any patient admitted to the hospice program will meet the requirements of one of the different levels of care, and will have a clinical review as the patient's condition warrants, but no less frequently thane every 15 days.

1. All patients admitted to hospice care will have a pre-admission meeting done, followed by ~~an Interdisciplinary Team (IDT) meeting as deemed necessary,~~ discussion with hospice physician to determine eligibility and ~~to determine~~ the appropriate level of care to meet each patient's needs.

2. IDT meetings will be held as the patient's condition warrants, but no less frequently than every 15 days to review each patient's Plan of Care for the level, frequency, and duration of services in conjunction with a physician to determine whether the patient's medical condition justifies the level of services provided and billed.

Effective Date: 10/02	Revised Date: 03/2221	Board Approved: 05/19/21
Reviewed Date: 01/18		Signature Date: 05/19/21

Signature: President/CEO

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

PURPOSE: To ensure appropriate use of the Hospice Inpatient Level of Care (LOC).

POLICY: General Inpatient (GIP) is one of the three levels of care as designated by the Medicare/Medicaid regulations. It must meet the General Inpatient Hospice Medicare regulations. It must be provided by contracted facilities–participating hospitals, facilities, or by using our own Inpatient facility, Inpatient Unit. It is not intended to be a permanent solution to a negligent or absent caregiver.

Hospice is the manager of care and the Plan of Care must be followed, regardless of the location of where the care is provided.

Some examples of Hospice Inpatient LOC are, but are not limited to:

- Pain and symptom control
- Observation
- Stabilization treatment
- The patient's family is unwilling/unable to provide the needed care at home.

See Policy "Admission Criteria: Inpatient Unit" for additional information regarding other entry criteria.

- Documentation will reflect the reason they are in as an Inpatient~~, as well as the names of the disciplines involved in the IDT meeting~~. Specify the physician name who was involved in the ~~IDT in the documentation.~~determination of eligibility and level of care in the documentation.

- The reason for Inpatient LOC will be reflected at every shift in the documentation.

- Inpatient Unit should be used as the first choice for an Inpatient LOC.

- Currently, hospitals are the other location where we have contracts for Inpatient LOC.

Agency staff will be available to the inpatient facility 24/7.

Hospitalized patients being discharged to an ECF Medicare A skilled bed must be given education on the option to revoke in order for regular Medicare to cover their skilled ECF days. They should not be discharged.

Signature: President/CEO

Admitting a Patient in a General Inpatient Level of Care in an Acute Care Hospital that was not previously a CHC patient:

- Arrangements have been made with contracted area hospitals for patients to be admitted in a General Inpatient Level of Care who have not previously been our patient.
- All other policies and procedures are in effect relating to the assessment and admission criteria for these patients.
- CHC remains the case manager as this patient is our patient, only he/she is in another facility.
- Since CHC is the case manager, we will coordinate equipment and transportation needs as needed for transfer to Inpatient Unit.

REGULATION: 42 CFR 418.54 – Initial and Comprehensive Assessment of the Patient

PURPOSE: To give clear, concise guidelines for implementation and documentation of continuous care.

POLICY: Continuous care will be provided to hospice patients during periods of medical crisis, and only as necessary, if the patient and family goal is to maintain the patient in the home. Continuous Care is meant to be for a brief period of time, usually no more than one to two days. The need to change the patient's level of care from Continuous Care will be monitored daily by the ~~Interdisciplinary Team (IDT).~~Case Manager and hospice physician.

1. A registered nurse will assess the patient to determine whether he/she requires a level of care change to achieve palliative and/or management of acute symptoms in order to remain at home.

2. A hospice physician's order is obtained and documented in the medical record.

3. The registered nurse ~~confirms~~updates the team via communication app regarding the assessed need for a level of care change to Continuous Care ~~with the IDT,~~ ~~including~~. Verbal/telephone conversation will be conducted with the Patient Care Coordinator (PCC) or the Director of Nursing (DON), and the patient's attending/primary physician (if not a CHC medical staff) on the change in level of care.

4. The PCC, DON, or nursing leadership on call~~Assistant DON,~~ assigns available hospice RNs, LPNs, social work, chaplains, and hospice aides to respond to the Continuous Care needs of the patient. All care is delivered under the supervision of an RN. A minimum of 51% of the patient's care will be delivered by an RN/LPN.

5. Once the need for Continuous Care has ended. A physician order will be written for the change in level of care.

6. Computation of clinical care hours for billing purposes is based on the following statutory and regulatory requirements:
   (a) A minimum of 8 hours of care that is predominantly nursing, is provided during a 24-hour day that begins and ends at midnight;

Signature: President/CEO

(b) The care provided need not be continuous (for example, 4 hours may be provided in the morning and another 4 hours provided in the evening of the same day), as long as there is an aggregate need for 8 hours of care, and at least 51% of that care is provided by an RN/LPN;

(c) The computation of Continuous Care hours reflects the total number of direct care hours provided by nursing personnel and hospice aides;

(d) Continuous Care hours do not include time spent documenting care, making phone calls to the physician, supervision of aides, hours provided by social workers, volunteers, chaplains, or other disciplines. Only direct patient care provided by an RN, LPN, or hospice aide qualifies for Continuous Care computation of hours.

PURPOSE: To ensure continuity of care in all settings, to determine the appropriate location for patient care if the patient is Hospice Medicare or Hospice Medicaid Benefit, and to retain professional management responsibilities through the Interdisciplinary Team (IDT).

If the patient is being admitted under the Hospice diagnosis (not a 23-hour stay or being seen as an outpatient) and it is a Level of Care Change to Inpatient LOC, see Hospice Medicare or Hospice Medicaid Benefit Inpatient Level of Care policy.

Classifications: Hospice

Notify Patient Care Coordinator and appropriate ~~IDT~~ care team members of patient's hospital admission. Review patient's financial classification. ~~IDT should communicate prior to patient's admission to hospital.~~

Notify the Billing Department of patient's admission (both Agency and hospital). Document with whom he/she spoke, including date and time.

Hospice Medicare or Hospice Medicaid Benefit

The ~~IDT~~hospice physician will review the reason patient is going to the hospital and determine if it is related to the treatment of the symptoms of the terminal illness. The hospice physician~~IDT team~~ will determine whether it is part of the Hospice plan of care, and acknowledge the patient's and/or family's wish to revoke. See "Hospice Medicare or Hospice Medicaid Benefit Revocation" policy.

If hospice physician~~IDT~~ determines patient's hospitalization is related to the terminal illness and is included in the plan of care, see "Hospice Medicare or Hospice Medicaid Benefit Inpatient Level of Care" policy.

Hospitalized patients being discharged to an ECF Medicare A skilled bed must be given the option to revoke in order for regular Medicare to cover their skilled ECF days. They should not be discharged.

If hospice physician determines it is unrelated to the terminal diagnosis:

Notify Patient Care Coordinator and appropriate care~~IDT~~ team members of patient's hospital admission.

PURPOSE: To ensure appropriate discharge from Inpatient Unit (IPU).

The Hospice IDT will monitor the patient's care for discharge to the appropriate setting when:

- Specific symptoms are controlled and there is no further decline in condition
- Goals have been met
- Patient elects discharge
- ~~Patient expires~~
- Patient is no longer eligible for Hospice services by virtue of prognosis
- ~~Respite stay is completed~~

The social worker will initiate the discharge process with the patient/family in consultation with Inpatient Unit staff. .

~~The Hospice IDT will determine the appropriate discharge process.~~

POLICY: Staff validation will be provided by either a member of the same or higher job class on an annual basis.

These validations will include at a minimum:

- Medical Staff:
  - How to complete Certificate of Terminal Illness (MD/DO)
  - How to determine covered/noncovered service (MD/DO)
  - Level of Care Determination (ALL)
  - IPU Documentation (ALL)
  - Effective Care planning (ALL)
  - Discontinuation of Life Prolonging Procedures (Phy / Select NP)
  - De-Prescribing (ALL)
  - Infection Control (ALL)
  - Disaster Preparedness (ALL)
  - HIPAA & Patient Rights (ALL)
  - Abuse, Neglect & Elder Justice Act (ALL)

- Social Work
  - Infection Control
  - Disaster Preparedness
  - Effective Care planning
  - POST/Advance Directives
  - HIPAA & Patient Rights
  - Abuse, Neglect & Elder Justice Act

- Chaplains
  - Infection Control
  - Disaster Preparedness
  - Effective Care planning
  - HIPAA & Patient Rights
  - Abuse, Neglect & Elder Justice Act

- CNA's
  - Infection Control
  - Disaster Preparedness
  - 12 hours monthly in-services conducted by Clinical Educator or a PCC
  - Skills validation check list (onboarding and annually at evaluation)
  - Food Preparation (IPU)
  - Room cleaning (IPU)
  - HIPAA & Patient Rights
  - Abuse, Neglect & Elder Justice Act

- Nursing Staff
  - Infection Control
  - Disaster Preparedness
  - HIPAA & Patient Rights
  - Abuse, Neglect & Elder Justice Act
  - Annual skills validation will include but is not limited to:
    - CADD pumps
    - Subcutaneous infusions
    - Hypodermoclysis
    - Effective Care planning
    - Wounds
    - Transfusions (IPU)
    - Blood Glucose Monitoring (IPU)
    - Food preparation (IPU)
    - Room Cleaning (IPU)
  - Admission Representatives
    - Infection Control
    - Disaster Preparedness
    - HIPAA & Patient Rights
    - Abuse, Neglect & Elder Justice Act
    - Hospice Philosophy

PURPOSE: To establish a format writing and updating for all policies and formsy writing.

POLICY: All policies will contain the following:

A. Header

- Name of organization
- Title of policy
- Page number
- Section (tab, i.e., Patient Care Policies: General Information, Inpatient Unit, etc.)
- Category - Home Health vs. Hospice

B. Body

~~Purpose~~
~~Policy~~

1. No Roman numerals will be used. Policies and procedures should be written at 7th grade level.

2. **Purpose**
   Should contain no more than two sentences
   States the reasons this was written

3. **Policy**
   - The policy is the statement and answers the following:
   - Who, What, Why, When
   - Definitions can also be defined in this section.

C. Forms

1. All new policies/forms and updates to any policies/forms go to the Executive Office Manager for formatting.

2. All forms will have date/area/name of form in the footer.

3. Once complete, all forms go to the Director of Quality to obtain needed approvals.

4. The following sequence will be utilized in obtaining approval of all policies and forms ~~policy~~:
   - IDT Supervisory for recommendations (patient care related policies/forms)
   - All policies and Medicare/Medicaid forms need approval by the administrative team
   - Board of Directors (policies)
   - Present applicable policies/forms to staff at staff meeting or other educational methods.
   - Distribution in all policy manuals.

5. Depending on the content and urgency of the policy, the administrative team may approve the use of it being stamped "draft". It may be used until final Center for Hospice Care approval by the Board. Following final Board approval, it will be re-issued without the word "draft" on it.

6. Once a form has been approved, the Director of Quality or the Executive Office Manager will upload to Teams under the Forms folder.

7. Any attachments referencing forms or illustrations can be attached with title listed here. See Form A-10, A-11.

D. Footer

- Effective date
- Revised date
- Reviewed dates for past three years
- Signature of legal representative representing organization.
- Date of signature

Center for Hospice Care

INFECTION CONTROL – TB SCREENING OF STAFF AND VOLUNTEERS

Section: Patient Care Policies Category: Hospice

REGULATION: 42 CFR 418.60 – Infection control

PURPOSE: To screen healthcare workers that have the potential for direct patient contact for infection with the tuberculosis bacillus (mycobacterium tuberculosis) in accordance with OSHA Standard 29CFR 1910.1030, the CDC MMWR 2019, ~~Core Curriculum on Tuberculosis by the CDC,~~ state and federal regulations.

GENERAL INFORMATION

1. Annual TB screening~~testing~~ is mandatory for ALL employees that have the potential for direct patient contact. There will be no direct care until testing and/or evaluation is completed.

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

3. Any employee without a negative history for TB or a negative testing result in the 12 months must have a baseline two-step Mantoux method TST. If the individual has provided documentation of a negative Mantoux method TST or Quanti-FERON-TB assay anytime in the previous 12 months and those results were negative, they must receive a one-step TST.

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

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

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

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

Signature: President/CEO

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

9. Employees with an induration of 10mm or more (see #8) will be required to:
   - Review signs and symptoms of TB
   - Complete a TB Questionnaire
   - Receive a baseline chest x-ray
   - Be referred to their attending/primary physician for further examination and/or diagnostic tests, with chest x-ray results.
   - Be reported to the County Health Department within 24 hours
   - State law requires any new conversion or active disease to be reported to the Indiana Department of Health and the local health officer.
   - Refrain from working until declared free of infectious TB by their physician

10. In case of significant reaction (10mm or more), obtain a chest x-ray. This can be coordinated by the Clinical Staff Educator, Director of Nursing, or Human Resources. This x-ray will be obtained through our agency contracted Occupational Health agencies. If a reaction of greater than 10mm is read after 5:00 p.m. or on weekends, contact the nurse manager on call.

11. A significant positive reaction indicates only that the individual was exposed to TB. A chest x-ray is required as a baseline.

12. It takes 8-10 weeks after exposure to the TB bacillus for a positive reaction to show on the Mantoux TST.

13. Positive readings can be due to the individual who:
   - Has received a previous BCG vaccine
   - Has a positive cross reactivity to an atypical bacilli
   - Allergic reaction to TST solution
   - Has been exposed to TB

14. False negatives can be caused by:
   - Reaction to major surgery
   - Overwhelming disease
   - Nasal flu mist (wait six weeks after nasal flu to receive TST)

15. After an individual has received BCG vaccine, a Mantoux TST may read positive for the next 5-10 years and then it can convert back to negative.

TB EXPOSURE INCIDENT

If employee is exposed, TST will be given 10-12 weeks after exposure.

If TST is positive, it is presumed employee/volunteer was infected by exposure incident and will be referred to personal physician.

If positive for TB, an employee may return to work following initial treatment and three consecutive negative sputum.

TB test may only be given and read by staff that have completed the IDH-Basic Tuberculosis and TB skin testing.

ATTACHMENT See CDC TB Screening Recommendations 2019

REGULATION: 42 CFR 484.32 – Therapy services.

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

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

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

The plan of care will be obtained from the specific therapist and the Agency will show incorporation it into ours.

- The initial evaluation will be received by the therapist within 5 business days of initial evaluation.
- Therapy evaluation will be sent to the attending physician for signature within five days of receipt from contracted therapy agency.
- QA Department will obtain all orders for therapy once the evaluation is done.
- All follow up visit notes will be received at CHC ~~the day after the visit~~ by the Tuesday following the visit.
    - All therapy notes will be deemed legible before uploading to patient EMR.
- QA department will upload these reports to the patients EMR.

~~The therapist will be responsible for obtaining all orders and forwarding to QA to add to EMR.~~

Center for Hospice Care

MEDICATION REVIEW

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

REGULATION: 42 CFR 484.55(c) – Drug Regimen Review

POLICY: A Drug Regimen Review comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions. The following five areas must be included in the Drug Regimen Review:

- Potential adverse effects
- Drug reactions
- Ineffective drug therapy
- Side effects
- Significant drug interactions
- Duplicate drug therapy
- Non-compliance with drug therapy

Documentation stating that a drug regime review has been completed will be documented at a minimum of admission, recertification, and resumption of care. Documentation will be completed on:

- OASIS form under Medications ~~"Drug Regime Review"~~
- ~~60 day~~ Medication Profile review, or
- Individual documentation ~~that has occurred~~ during the skilled nursing visit when there have been changes, additions, or deletions to the profile.

Documentation will include a listing of the medications that the patient is taking. This shall include over-the-counter and herbal medications.

All potential adverse effects and/or reactions shall be reported to the physician. Severe or major interactions must be called to the physician. Non-severe or minor interactions can be faxed to the physician.

Medications shall be labeled with the patient's name and all applicable information according to regulations.

The physician will also be notified for any medication or dose adjustments needed, in addition to any duplication or non-compliance issues.

Effective Date: 08/04	Revised Date: 04/22~~03/17~~	Board Approved: 06/28/17
Reviewed Date: 11/21		Signature Date: 06/28/17

Signature: President/CEO

AND AFFILIATES

Human Resources Policies Manual
July 2022 – June 2024

OUR MISSION

To improve the quality of living

OUR VALUES

Compassion
Dignity
Innovation
Integrity
Quality
Service
Stewardship

OUR VISION

To be the premiere hospice and palliative care organization for all end-of-life issues.

TABLE OF CONTENTS

PURPOSE OF THE HUMAN RESOURCES POLICIES MANUAL

This Human Resources Policies Manual spells out the goals, standards, values, and benefits of Center for Hospice Care ("CHC"), the Foundation for Center for Hospice Care ("HF"), and Global Partners in Care ("GPIC") (together, HF and GPIC are "Affiliates" of CHC). Wherever CHC is mentioned in this manual it should be construed to additionally mean to include "CHC and its Affiliates." The standards of conduct govern all employees and are intended to help us all get along in a professional and productive atmosphere. At the same time, this manual serves only as a general guide to what we can reasonably expect from each other in the conduct of our business.

Neither this manual nor any of its provisions constitute an employment agreement or contract of any kind or a guarantee to continued employment. Employees may be terminated at will by CHC, with or without cause or prior notice, or they may resign at any time. Only the President/CEO has the authority to enter into any agreement for employment.

Please be aware of possible changes in procedure and policy as a result of our agency's growth and change. Updates in the Human Resources Policies Manual content, as well as procedural changes, will be disseminated through electronic and written communication; however, under certain circumstances, policies may change without prior notice.

Revised ~~08/21 Reviewed 05/20~~05/22

TERMINATION AND CHANGE OF STATUS

Employment with CHC is at will and is based on mutual consent. Therefore, either the employee or the employer may terminate the employment, at any time, for any reason~~, with or without cause notice~~. CHC does not tolerate discriminatory or other unlawful conduct, and all employment decisions will uphold this policy. The employer may terminate the employment with or without prior notice. Employees are required to provide written notice to their supervisor or designee of their resignation and to work their regularly scheduled hours during the following notice period:

Management & Salaried
(Supervisor, Coordinator or above) – 4 weeks
Non-Management and Hourly – 2 weeks

Benefit days are not included as part of the notice period and any unscheduled absence during that time will be unpaid time off. Employees who resign with less than required notice will forfeit any accrued vacation time and may be ineligible for rehire. Without divulging specific information, eligibility for rehire status will be acknowledged as part of the employment verification process.

Employees are encouraged to schedule an exit interview with the Director of Human Resources upon giving notice of resignation. All CHC property is to be returned to the supervisor or designee on the last day of employment.

Employees interested in changing their employment status to PRN must obtain approval from their supervisor and provide the same notice as a terminating employee.

Revised ~~03/22; Reviewed 05/20~~05/22

MEDICARE COMPLIANCE

The Board of Directors of Center for Hospice Care has adopted separate Medicare compliance plans for both hospice and home health in accordance with all applicable Medicare laws and regulations. It is the expectation that all employees will abide by that compliance plan. Failure to do so will result in ~~progressive~~ discipline ~~as defined in the Progressive Discipline policy~~, up to and including termination.

The Board of Directors has mandated the administration of CHC to ensure, to the best of its ability, full compliance with the rules and regulations for participation in Medicare and other federal and state health care programs. Intentional violators may be immediately terminated.

Revised 11/04, Reviewed ~~03/22~~05/22

STEPS TO FOLLOW WHEN GOVERNMENT AND STATE AGENCIES, MEDICARE/MEDICAID CONTRACTORS, AND OTHERS MAKE A REQUEST FOR INFORMATON

Telephone Requests

Any Staff who receives a Request for Information by telephone from any person who claims to represent a Government Agency, State Agency, Medicare / Medicaid Contractor (hereafter "Government Agency") should take the caller's full name and contact information, write it down and advise them that their call will be promptly returned. The caller's information should be delivered to the Compliance Officer promptly so that the Compliance Officer, or in the Compliance Officer's absence, such other person(s) designated below, can arrange for prompt follow up, as appropriate. No staff should schedule an appointment or otherwise furnish information to the caller without the Compliance Officer's prior express approval.

If the Compliance Officer is unavailable, present the information to the following staff in the following order of availability: VP/COO, VP/CFO, President/CEO or any other member of the Administrative Team (hereafter simply referred to as "Compliance Officer.")

In Person Requests

Any staff who receives a Request for Information from a person who physically presents in the office and claims to represent a Government Agency should take the person's full name and their business card (if available) and any written materials that they wish to present in support of their Request and ask the person to have a seat in the waiting room. Staff shall immediately contact the Compliance Officer. Staff shall deliver the person's information and any written materials to the Compliance Officer immediately (by email, scan, or FAX as necessary) so that the Compliance Officer can review same and meet with the person. NOTE: Any Request that appears to be a subpoena or search warrant requires the immediate attention not only of the Compliance Officer but also of designated legal counsel who will be contacted by the Compliance Officer. As before, no staff should furnish any information to the person without the Compliance Officer's prior express approval.

Out-Of-Office Requests

It is possible that staff may be approached by a person who claims to represent a Government Agency outside the business office after normal business hours, either at their home, shopping mall or other location within the community. Although staff are permitted to speak with the person, please note that they have the legal right to choose not to speak to the person at that time and to have their own attorney present before the interview is conducted at a later time. As before, any such Request should be reported to the Compliance Officer immediately so that the Compliance Officer can arrange for prompt follow up, as appropriate.

Compliance Officer Response to Requests

Upon receipt of any Request for Information, the Compliance Officer shall obtain additional information regarding the nature of the Request, as appropriate, and confer with the President/CEO or his/her designee, before disclosing any information in response to the Request. Because certain Requests may require immediate attention, as in the case of search warrants, grand jury subpoenas and other lawful processes, the Compliance Officer should contact designated legal counsel immediately.

Absolutely No Obstruction of Justice or Interference with Investigations

Center for Hospice Care has a firm policy against obstructing or interfering with any audit, investigation or enforcement action that may be the subject of a Request for Information. Therefore, no staff shall, under any circumstances:

- Destroy or alter any records, documents, emails, or other information in anticipation of a request for the document or record by a Government Agency;
- Lie or make false or misleading statements to any person who claims to represent a Government Agency; or,
- Attempt to persuade any other person to provide false or misleading information in response to a Request or to otherwise refuse to cooperate with an investigation conducted by a Government Agency.

2012; Reviewed ~~03/22~~05/22

SUBPOENAS

Any CHC employee that receives a subpoena on any subject involving CHC or a current or past CHC patient or family member, should immediately contact their supervisor and the Executive Office Manager, or in his/her absence the President/CEO. Do not communicate with any attorneys on the matter. A copy of the subpoena should be sent to the Executive Office Manager who will then contact the agency attorney for direction. The Executive Office Manager will keep the employee, their supervisor, and the President/CEO informed of the response from the agency attorney. A copy of the subpoena will be kept in the employee's personnel file.

Reviewed ~~03/22~~05/22

CODE OF CONDUCT

CHC and its employees are committed to consistently providing quality health care in accordance with practices,

which ensure that its patients and families receive services in strict adherence to regulations and guidelines set forth by the Office of Inspector General.

You may report suspicion of any unethical practices to any member of the Administrative Team, members of the Compliance Committee, or leave your concerns anonymously in the compliance box located in each office. The compliance box is not to be used for personal or human resource issues.

Revised 03/16, *Reviewed 03/22*

STANDARDS OF CONDUCT

Our compliance program provides guidance to all colleagues and assists us in carrying out our daily activities within appropriate ethical and legal standards. These obligations apply to our relationships with patients, physicians, third-party payers, contractors, vendors, consultants, and one another. The compliance program has been developed to ensure we meet our ethical standards and comply with applicable laws and regulations.

We have developed a set of policies and procedures to serve as guidance for those directly involved in a particular area. The policies in the compliance program are mandatory and must be followed.

The compliance committee must ensure their colleagues have sufficient information to comply with laws, regulations, and policies. The committee must help create an environment, which promotes the highest standards of compliance and ethics. Everyone must be encouraged to share concerns as they arise. We must never sacrifice compliant behavior in the pursuit of business objectives.

We treat all patients with respect and dignity and provide care that is necessary and appropriate. We make no distinction in care, referrals, or admissions based on ~~age~~race, ~~gender~~color, religion, sex, disability, ~~race, ethnicity, religion, or~~ sexual orientation, gender identity, U.S. military veteran status, age, national origin, citizenship status, or other class protected by law. Clinical care is based on identified ~~healthcare~~ health care needs, not on health care economics.

Each patient is provided with a written statement of the Patient Bill of Rights. This statement includes information that the patient is able to make decisions regarding medical care and conforms to all applicable state and federal laws.

Patients are informed of the right to make advance directives. Every effort will be made to honor advance directives.

Each patient and/or representative will be allowed to voice confidential concerns and receive an opportunity for resolution of complaints.

We collect information about the patient's medical condition, history, medication, family, and illness to provide quality care. We are committed to maintaining confidentiality. We do not release or discuss patient specific information unless it is necessary to serve the patient or as required by law.

Any business arrangement with a physician must be structured to ensure compliance with legal requirements.

We do not pay for referrals. We accept patient referrals and admissions based on the patient's clinical needs and our ability to provide the services. Violations of the policy may have consequences for the organization and individuals involved, including civil and criminal penalties, and possible exclusion from participation in federally

funded ~~healthcare~~ health care programs.

We do not accept payment for referrals we make. No employee or any other person acting on behalf of the organization is permitted to solicit or receive anything of value, directly or indirectly, in exchange for the referral of patients. When making patient referrals to another ~~healthcare~~ health care provider, we do not take into account the volume or value of the referrals that the provider has made (or may make) to us.

We take great care to assure all billings to government payers, commercial insurance payers, and patients are true and accurate and conform to all pertinent federal and state laws and regulations. We prohibit any employee from knowingly presenting or causing to be presented claims for payment or approval, which are false, fictitious, or fraudulent.

We operate oversight systems designed to verify claims are submitted only for services actually provided and services are billed as provided. As part of our documentation effort, we will maintain current and accurate medical records.

We are required to submit certain reports of our cost of operation. We comply with all applicable federal and state laws relating to all cost reports. These laws and regulations define what costs are allowable and outline the appropriate methodologies to claim reimbursement for the cost of service provided to program beneficiaries. Given the complexity, all issues related to the completion and settlement of cost reports must be communicated through the President/CEO and the Vice-President/CFO.

We will be forthright in dealing with any billing inquiries. Requests for information will be answered with complete, factual, and accurate information. We will cooperate with and be courteous to all inspectors and surveyors and provide them with the information to which they are entitled during a survey or inspection.

During a survey or inspection we will never conceal, destroy, or alter any documents; lie; or make misleading statements. There will not be any attempts to cause another colleague to fail to provide accurate information or obstruct, mislead, or delay the communication of information of records relating to a possible violation of law.

We will provide our employees with the information and education needed to comply fully with all applicable laws, regulations, and conditions of participation that are relevant to the job description.

Medical and business documents are retained in accordance with the law and our record retention policy. Medical and business documents include paper documents, computer based information, disk or tape, and any other medium that contains information. We will retain and destroy documents according to our policy.

To obtain guidance on a compliance or ethics issue, employees may choose from several options as outlined in the compliance policy, which is reviewed at the initial orientation. There will be no retribution~~-~~, retaliation, or adverse disciplinary action taken against individuals who report a violation in good faith. Any employee who deliberately makes a false accusation with the purpose of harming or retaliating against another employee will be subject to disciplinary action.

We are committed to investigating all reported concerns promptly and confidentially. The compliance committee will coordinate any findings from the investigation and will recommend corrective action or changes as appropriate. We expect all employees to cooperate with investigation efforts. When an internal investigation substantiates a reported violation, it is the policy to initiate corrective action.

All violators of the compliance plan will be subject to disciplinary action. The discipline utilized will depend on the nature, severity, and frequency of the violation and may result in any of the following disciplinary actions: oral warning, written warning, probation, termination, and restitution.

Revised ~~06/10; Reviewed 03/22~~05/22

RECRUITING AND NON-DISCRIMINATION

CHC is an equal opportunity employer and complies with the rules and regulations of all applicable state and federal laws.

Employment at Center for Hospice Care is made on a non-discriminatory basis and without regard to ~~age~~race, ~~gender~~color, religion, ~~race, ethnicity, national origin~~sex, disability, sexual orientation, gender identity, U.S. military veteran status, ~~or marital~~ age, national origin, citizenship status, or other class protected by law. All decisions with respect to employment are made to abide by equal employment opportunity principles.

The President/CEO has final determination on hiring and termination.

Anyone that believes they may have been discriminated against should report the suspected violation to the CHC President/CEO immediately.

Revised ~~06/10; Reviewed 03/22~~05/22

REASONABLE ACCOMMODATION

CHC complies with the requirements of the Americans with Disabilities Act ("ADA") and related state and federal laws. A disability under the ADA means a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. CHC will provide reasonable accommodation to an employee who is a qualified individual with a disability so the employee can perform the essential functions of their job, unless (a) the accommodation would pose a direct threat to the employee, patients, or others in the workplace; or (b) the accommodation would create an undue hardship for CHC. Contact Human Resources with questions or to make a request for accommodation.

Added 05/22

HARASSMENT

It is the policy of CHC that all employees have a right to work in an environment free of discrimination, which includes freedom from harassment~~—~~ - whether that harassment is based on ~~sex~~race, ~~age, race, ethnicity, national origin~~color, religion, sex, disability, sexual orientation, ~~marital~~ gender identity, U.S. military veteran status, ~~veteran~~ age, national origin, citizenship status, or membership in other protected groups. CHC prohibits harassment of its employees in any form~~—~~ - by supervisors, co-workers, volunteers, customers, or suppliers in the workplace or at any CHC related function. Such conduct may result in disciplinary action up to and including dismissal of an employee who harasses others. With respect to non-employees, offending customers and suppliers will be asked to leave and not to return.

Specifically, no supervisor shall threaten or insinuate either explicitly or implicitly that any employee's submission to or rejection of sexual advances will in any way influence any personnel decisions regarding that employee's employment, evaluation, wages, advancement, assigned duties, shifts, or any other condition of

employment or career development.

Other harassing conduct in the workplace, whether physical or verbal, committed by supervisors or others is also prohibited. This includes, but is not limited to: slurs, jokes or degrading comments concerning ~~sex~~race, ~~age, race, ethnicity, national origin~~color, religion, sex, disability, sexual orientation, ~~marital~~ U.S. military veteran status, ~~veteran~~ age, national origin, citizenship status, or membership in other protected groups; repeated sexual flirtation, advances, or propositions; continual or repeated abuse of a sexual nature; graphic verbal comments about an individual's body; and the display in the workplace of sexually suggestive objects or pictures. Employee behavior which creates a hostile environment for staff or volunteers will not be tolerated. This includes the distribution of hurtful and destructive gossip.

Employees who have complaints of harassment should report such conduct to their supervisor or Human Resources. Employees who observe harassment should also report such conduct to their supervisor or Human Resources. CHC will investigate the matter. Where investigations confirm the allegations, appropriate corrective action will be taken. All employees are expected to cooperate with the investigation. Failure to do so may lead to progressive discipline up to and including termination. Information provided by individual employees in the course of an investigation will be treated as confidential and only be provided to those who have a need for investigating the complaint. CHC prohibits unlawful retaliation made against any employee who brings forth a complaint of discrimination or who participates in any related investigation. CHC also prohibits deliberately making false and/or malicious allegations of discrimination, as well as deliberately providing false information during an investigation. Doing so could result in progressive discipline~~-~~, up to and including ~~discharge~~termination.

Any employee who believes he/she may be the victim of the above should report the facts immediately to his/her supervisor or the Director of Human Resources. All complaints will be investigated and appropriate corrective action will be taken against harassers. A record of all complaints, investigations, and actions taken will be maintained by the Director of Human Resources.

Revised ~~06/10; Reviewed 03/22~~05/22

REPORTING ILLEGAL ACTIVITIES
("Whistleblower" Policy)

Employees are encouraged to talk promptly to supervisors, managers, or other appropriate personnel about observed illegal activities, including violations of law, rules, or regulations, and otherwise when in doubt about the best course of action in a particular situation. The supervisor, manager, or other appropriate personnel to whom such matters are reported should not be involved in the observed illegal activities. Any supervisor or manager who receives a report of violation or potential violation must report it immediately to the President/CEO. It is the policy of the organization not to allow retaliation for reports of misconduct by others made in good faith by employees. Employees are expected to cooperate in internal investigations of misconduct. Any person involved in an investigation of possible misconduct in any capacity must not discuss or disclose any information to anyone outside of the investigation, unless required by law or when seeking his/her own legal advice.

Any use of these reporting procedures in bad faith or in a false or frivolous manner will be considered a serious violation of this organization's commitment to ethical behavior in the workplace and may be cause for disciplinary action. We must all work together to ensure prompt and consistent action against illegal activities; however, we cannot anticipate every situation that will arise. It is important that we have a way to approach a new question or problem. These are some steps to keep in mind:

- Make sure you have all the facts. In order to reach the right solutions, we must be as fully informed as possible.

- Ask yourself: What specifically am I being asked to do? Does it seem improper or illegal? This will enable you to focus on the specific question you are faced with, and any alternate options you may have. Use your judgment and common sense; if something seems improper or illegal, it probably is.

- Clarify your own responsibility and role. In most situations, there is shared responsibility. Are your colleagues informed? It may help to get others involved and discuss the problem. Mistakes and gaps in processes happen without any intent to violate laws, rules, or regulations. CHC welcomes opportunities to correct and improve.

- Discuss the problem with your supervisor. This is the basic, first-step guidance for all situations. In many cases, your supervisor will be more knowledgeable about the question, and will appreciate being brought into the decision-making process. Remember that it is your supervisor's responsibility to help solve problems.

- Seek help. In the rare case where it may not be appropriate to discuss an issue with your supervisor or where you do not feel comfortable approaching your supervisor with your question, discuss it with the Director of Human Resources, any member of the Administrative Team, or directly with the President/CEO.

- Your report of illegal activities may be made in confidence and without fear of retaliation. If your situation requires that your identity be kept secret, your anonymity will be protected. This organization does not permit retaliation against employees for good faith reports of illegal activities.

- Always ask first, act later: If you are unsure of what to do in any situation, always seek guidance before you act.

Effective 07/10; Reviewed ~~03/22~~05/22

DIVERSITY IN THE WORK PLACE

It is the policy of CHC to promote a safe and secure working environment, which encourages diversity.

For the purposes of this policy, "safe and secure" are defined as promoting a work place environment where employees feel they may, although they are not required to, acknowledge their ~~age~~race, color, ~~race~~religion, ~~ethnicity~~sex, ~~gender~~disability, sexual orientation, ~~marital and family~~ U.S. military veteran status, ~~religion~~age, national origin, ~~veteran status,~~ citizenship, or pregnancy~~, or disability~~ freely, and are respected without bias, hostility, or intimidation.

CHC is committed to diversity throughout the organization. CHC does not and will not tolerate discrimination against any person or group on the basis of age, color, race, ethnicity, gender, sexual orientation, ~~marital~~ citizenship status, religion, national origin, veteran status, or disability.

Revised ~~06/10' Reviewed 03/22~~05/22

BUILDING AND GROUNDS

BUILDING ACCESS

- Normal business hours are defined as 8:00 a.m. to 5:00 p.m. Monday through Friday exclusive of Holidays.

South Bend – unlocked 8:00 a.m. – 5 p.m.
Elkhart – unlocked 7:00 a.m. – 7:00 p.m.
Mishawaka – unlocked 7:30 a.m. – 5:00 p.m.
Plymouth – unlocked 8:00 a.m. – 5:00 p.m.
LaPorte – unlocked 8:00 a.m. – 5:00 p.m.

- Facility doors will be locked and the security alarm set, unless meetings or events are still in progress.
- Locked doors are not to be propped open.
- Access to other agency locations will be as designated by an Administrator.

USE OF CHC OWNED BUILDINGS BY OUTSIDE GROUPS AND ORGANIZATIONS

CHC does not seek outside organizations to use our facilities. CHC will occasionally grant permission to outside organizations to hold meetings or events at one of our owned facilities. Organizations requesting this approval must have a connection to CHC, which may include associations like a similar mission, a partnership with CHC in the community, a like-minded educational interest, or being a supporter of CHC/HF in some manner. CHC staff may request approval for use on behalf of outside organizations, and if approved, may be required to take on responsibility and accountability for the meeting and the facility use, including being personally present before, during and after the meeting/event.

All requests for use by outside groups and organizations require approval by a member of the CHC Administrative Team. It is the general intent that outside groups would only hold meetings or events during CHC's regular weekday business hours of 8 ~~AM~~ a.m. to 5 ~~PM~~p.m. Requests outside of these times are generally denied and require prior approval by the CHC President/CEO, and CHC staff must be present on a volunteer basis in numbers necessary to ensure the security of the CHC properties. CHC facilities are not available for rent or for use for personal functions and events by outside individuals or groups.

The CHC offices in Plymouth and La Porte are not owned by CHC and are not available for any meetings of any kind by any outside individuals or groups.

USE OF CHC OWNED FACILITIES FOR STAFF PERSONAL EVENTS

CHC will occasionally grant permission for staff to hold events for co-workers only such as baby showers, retirement parties, etc., at one of our facilities. All requests require approval by a member of the CHC Administrative Team. If approved, staff must be present on a volunteer basis and may be required to take on responsibility and accountability for the event and the facility use, including being personally present before, during and after the event, ~~clean~~ cleaning up, and ~~ensure~~ ensuring the security of the facility. It is the general intent that such events would only be held outside CHC's regular weekday business hours of 8 ~~AM~~ a.m. to 5 ~~PM~~p.m. No alcohol will be permitted at these events.

PARKING

- Staff parking is available for your private, licensed, passenger vehicle. Parking is not permitted for recreational vehicles, boats, trailers, etc.
- Parking in front of the entrance to the Inpatient Unit canopy is prohibited at all times.
- Overnight parking is prohibited without prior supervisory approval.
- The speed limit in the parking lots is 5 MPH. All posted traffic signs are to be obeyed.
- Any additional rules imposed by the landlords of rented facilities are also applicable.
- All staff must have their parking tags displayed in their vehicles when parking in the facility lots.

GENERAL EXTERIOR RULES

- Decorating of the exterior of the building and/or grounds is prohibited. No additional plants, bushes, or grasses are permitted.
- No animal habitats are permitted (e.g., bird houses/baths, squirrel twirlers, etc.). Please do not feed the ducks, squirrels, etc.
- When weather permits, staff is welcome to use the outdoor spaces in owned facilities. The deck will have hours posted when it is available to patients and families.
- Any additional rules imposed by the landlords of rented facilities are also applicable.

GENERAL INTERIOR RULES

- All applicable Fire and Life Safety codes will be adhered to.
- **Tacking, taping, gluing, or using a sticky material on surfaces that are painted/stained or covered with wall fabric, or publicly visible glass or windows, is not permitted.**

- Appropriateness of all personal decorations is subject to administrative approval.
- Thermostatic controls are not to be adjusted by staff. Requests for temperature adjustments should be made to the maintenance staff.
- The thermostatic controls in Inpatient Unit patient rooms may be adjusted by staff only at the request of patients and/or family members.
- Space heaters are not permitted.
- Lit candles are not permitted inside any CHC rented or owned facility at any time.
- Never touch a sprinkler head. Never adjust a smoke alarm. Never adjust a glass-break monitor. Report any concerns with the alarm systems to the maintenance staff.
- Non-administrative and non-maintenance staff are never permitted on the roofs.
- The bathrooms and all restrooms/shower facilities in the Inpatient Unit are for the exclusive use of Inpatient Unit patients, their families or caregivers.
- Any additional rules imposed by the landlords of rented facilities are also applicable.

SPIRITUAL REFLECTION ROOMS

- Do not rearrange the room or place anything in the fountain and deter visitors from doing so.
- Remove religious literature which may have been left behind by visitors.
- At the South Bend facility, operate the Shoji screen with great care, as it is a fragile, artistic window covering and not intended to be operated like tracked closet doors.

STAFF BREAK ROOMS

- The staff refrigerator and microwave are located in the staff break rooms. Be respectful of space in the refrigerator and limit what you bring in.

- The staff break rooms are intended for use by all employees. Please be sensitive to others by cleaning up after yourself, wiping up any spills and splatters on counters, sinks, floor, microwave, and refrigerator. Please avoid leaving food in the refrigerator for extended periods of time, as they will eventually generate bacteria and foul odors.
- Do not post items on the refrigerator or any other appliances. In Elkhart, use the tack board provided.
- In Elkhart, put your own dirty dishes in the dishwasher, not in the sink. If the dishwasher is full of clean dishes, please empty the dishwasher prior to placing dirty dishes inside.

LACTATION ROOMS

- CHC will provide reasonable break time for employees who are nursing their child up to one year old to express milk, in accordance with applicable law.
- At all CHC locations and upon request, CHC will make available a private location (other than a restroom) to express milk that is away from view and is free from intrusion by coworkers, patients, or others.
- Employees needing to request such break time and/or a lactation room should contact Human Resources for additional information.

INPATIENT UNITS

- Only those on staff or volunteers in the Inpatient Unit, those who are making specific scheduled visits with Inpatient Unit patients or those staff with specific business should be inside the Inpatient Unit.

INPATIENT UNIT KITCHEN

- The Inpatient Unit kitchen is intended for the storage and preparation of food for Inpatient Unit only.

INPATIENT UNIT FAMILY LOUNGE / KITCHEN

- The patient/family kitchen area located in the Inpatient Unit, which includes the microwave, refrigerator, and cupboards, are for the exclusive use of patient families and the staff of the Inpatient Unit on all shifts, with the knowledge that patient and family needs are met first.
- The ice machine in the Inpatient Unit is for the exclusive use of Inpatient Unit patients and should be operated by Inpatient Unit staff for patient needs only.

RESERVING CONFERENCE AND MEETING ROOMS

- The training and conference rooms may be scheduled using the employee website and should be reserved in advance whenever possible.

- The training and conference rooms may be used for impromptu meetings provided they have not already been reserved for use by another staff member.

- After you sign out a conference room and then discover you will not need it for a meeting, please release the reservation as soon as you know it~~'s~~ is not going to be used to allow others to use the space.

PERSONAL WORK AREAS

In keeping with the spirit of collaborative environments, strive to keep your work area open, clean, functional, and personalized:

- Work areas should be kept as absolutely neat as possible.
- Display of awards and personal photographs are acceptable, and encouraged, provided they are tastefully framed and coordinated to match your personal workspace.
- Only CHC provided artwork may be displayed on walls without prior approval.
- Personal heaters are not allowed.
- Post-its and other notes are not allowed to be posted on computers or monitors.
- The number of papers and folders on your work surface should be limited to those on which you are working at the time. Papers and files on which you are not presently working should be stored in your in-box, drawer, or filing cabinet.

- Desks should be cleared of papers and files and put away at the end of the business day.

Privacy Panels
- Nothing should extend above panel height.
- Items tacked to panels need to be limited to work related and only at "belt line" panel height (one panel above work surface) or on tack boards.

Overheads/File Cabinets
- Nothing is allowed on the fronts or tops of overheads.
- Keep overheads/file cabinets neatly arranged and closed at all times when not accessing.
- Binders and folders must be stored in overheads, upright on shelves, or in file cabinets. These should not extend above panel height.
- Intermediate and long-term storage should be in the storage areas (Elkhart – second floor; South Bend – records room).

Wire Management
- All wires on the floor need to be hidden from view.
- Computer wires need to be hidden from view where possible.

Floor
- Do not store boxes on the floor of your workstation. Dispose of empty boxes immediately.
- Place laptop bags, etc., in a drawer or in an inconspicuous area in your workstation.

MISCELLANEOUS

- Nothing should lean against the walls of the workstations or pedestals, etc.
- Only approved calendars are acceptable.

TRAINING AND CONFERENCE ROOMS

- Care should be taken for the protection of surfaces.
- Blinds should be reopened at the conclusion of meetings.
- The space should be cleaned after serving food and returned to original set up. Each person should dispose of his/her own trash when attending a meeting.
- Be sure to remove any extra handouts and other papers before you leave.
- Put away all equipment as soon as the meeting is over. Do not leave equipment sitting on the table.
- Return chairs to the correct position before leaving.
- All flip charts are to be stored in the proper place when the meeting is over.

COPY AND MAIL ROOM AREA

- These areas should be kept neat at all times. By the end of the day, all printing, faxes, and all mail should be picked up.
- Keep cabinet doors closed.
- No papers should be placed on top of the copier, fax, or workstation. These should remain in the printer/fax bin or distributed in the mailboxes or inbox.
- When sending a fax, wait for the confirmation that the fax has been successfully transmitted. This will take less time than finding out later that your fax did not go through. If it is not possible, then remember to collect your confirmation as quickly as possible.
- Do not place boxes next to the trash can in the copy area. Please dispose of any empty boxes in designated

areas.

COMMUNICATION

~~Obviously, we don't want to avoid communication, but a few simple considerations will really help out:~~ Please consider and implement the following recommendations to facilitate effective communication in the workplace:

Consider your neighbors

- Avoid interrupting someone who is using the telephone. Refrain from using sign language to attract the attention of someone who is on the phone. The more polite approach is to wait until the call is finished before approaching.
- A quick call to ask if "now might be an okay time to walk over to have a quick chat" is a great way to show consideration to others.
- Keep your phone ringer low, as well as your voice.
- When you're on the phone, remember to face into your work area so you are not projecting across the entire area.
- Avoid conversations in the aisles and main walkways near occupied workstations.
- Avoid the speakerphone unless in a private office or in a conference room. Use conference room for conference calls.

SECURITY

- The protection of the organization's assets and information is everyone's business. The last person to leave in the evening should turn off the lights and lock the door after setting the alarm and ensure that all other doors are also locked.
- It is a good practice to lock down your computer when you leave your area for any length of time—use a screensaver with password or a network logoff.
- Please do not leave your workstation unprotected with active logins to information systems.
- If you see someone you do not know walking through unaccompanied, say "hello" and ask if you can help him/her. We need to be gracious hosts to our guests and vigilant about recognizing people who have no official business here.
- By following a few simple guidelines, CHC will maintain the high standards it has set for its services and staff.

Revised ~~*03/22; Reviewed 05/20*~~*05/22*

EMPLOYEE FITNESS AREA (Mishawaka Campus)

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

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

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

- The Fitness Area is provided as an employee benefit~~,~~ to be used by the employee only~~, no~~. No other guests

are permitted. Its use is optional and, as such, employees will not be reimbursed time and mileage.

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

Bicycle Loan Program

- Bicycles are for the exclusive use of CHC employees only.

- When checking out a bike, the employees must complete the Activity Log located in the Bike Room, listing the bicycle's number, employee's name, date, and checkout time. Return the bicycle to the Bike Room and note the check in time on the Activity Log. Bicycles are not intended for immediate use and are not to be transported in a vehicle to be ridden in another location nor kept overnight. Report any damage to the Mishawaka Maintenance Technician immediately.

- Employees must wear a helmet at all times the bicycle is in motion, and use a lock to secure the bicycle if it will be parked during the time it is checked out. Always fill the bicycle's tires to 60 psi before leaving the Bike Room using the pump located just inside the door.

Revised 03/22; Reviewed 05/22

CLASSIFICATION OF EMPLOYEES

CHC makes no promises with regard to the number of hours available for work on any particular day, day of the week, week, month, or year. Employees are categorized as follows based on their regularly scheduled hours and/or their exempt or non-exempt status. CHC designates each employee as either exempt or non-exempt in compliance with applicable federal and state law. CHC will not take any deductions from employees' salaries except those allowed by applicable federal and state law.

EXEMPT EMPLOYEE / SALARIED

Exempt employees are executive, administrative and professional employees as defined under the Fair Labor Standards Act (FLSA). These employees are paid for the job they perform rather than the hours worked.

NON-EXEMPT EMPLOYEE / HOURLY

Non-Exempt employees, as defined under FLSA, are paid at an hourly rate and will receive overtime pay of time-and-a-half for all hours worked over 40 each week, unless state regulations dictate otherwise.

FULL-TIME EMPLOYEE

An employee who is regularly scheduled to work thirty ~~-~~ two (~~30~~32) hours or more per week. Group health insurance, long-term disability, and life insurance are available to employees who work "power weekends" or ~~a minimum of thirty~~ thirty-two (~~30~~32) hours or more per week.

PART-TIME EMPLOYEE

An employee who is regularly scheduled to work less than thirty ~~(30~~ two (32) hours per week.

POWER WEEKEND EMPLOYEE

Designated employees regularly scheduled to work twelve (12) hour shifts on two consecutive days.

PRN EMPLOYEE

Employees who work on an "as needed" basis. PRN employees do not have regularly scheduled hours (see PRN Employees).

Revised ~~03/22; Reviewed 05/20~~05/22

~~-~~ PRN EMPLOYEES

PRN employees are required to work a minimum of 48 hours every three months as long as hours are available and offered. Some departments may require participation in On Call and holiday rotation to maintain PRN status. Employees who have been offered and refuse to work the minimum number of hours may be terminated.

PRN employees who work a minimum of 250 hours annually may be eligible for a pay increase at the time of their annual review, unless they have reached the top of their salary range. Employees working less than this number of hours will be eligible for a pay increase only when applicable salary ranges are adjusted.

Revised 03/16; Reviewed ~~03/22~~05/22

JOB DESCRIPTION

CHC believes job descriptions are important tools for documenting the requirements of and skills needed to successfully perform on the job. Accordingly, reasonable efforts shall be undertaken to develop and maintain job descriptions for all job classifications in accordance with the following provisions:

1. Job descriptions shall be developed for new positions by the Director of Human Resources in collaboration with the supervisor and the Administrative Team member ultimately responsible for the position. Job descriptions for new positions must have the final approval of the President/CEO prior to initiating the recruiting process.

2. Following a material change in the essential functions of a current position and/or at the filling of a vacant position.

The Director of Human Resources shall be responsible for developing and maintaining operating standards that promote compliance with the terms of this policy.

Due to the nature of our work and the sheer number of activities performed, no CHC job description should be considered 100% finite and absolute.

Revised 03/16; Reviewed ~~03/22~~05/22

INITIAL PROBATIONARY PERIOD

The first 90 days of employment are considered an initial probationary period. During this time, the supervisor will review work performance assessing how well the employee is meeting performance expectations.

At the end of the initial probationary period, the supervisor will complete a performance evaluation either releasing the employee from probation or extending it to provide additional time for training and assessment. Successful completion of the probationary period does not guarantee continued employment with CHC or in any way change the at-will status of employment.

Revised 08/09; Reviewed ~~03/22~~05/22

PERFORMANCE REVIEW

Following the 90-day review, employees will receive an annual performance evaluation during the month of their anniversary hire date. Home health aide evaluations must be done between the first of the month and on or before the anniversary date of their original hire date.

Employees who change positions within the organization and now function under different job descriptions will be subject to a new initial probationary period. Annual reviews will still coincide with the original hire date.

Employees who work in more than one position will receive only one annual performance review. The supervisor for the position where the majority of hours were worked in the previous 12 months will be responsible for coordinating the review between the supervisors.

The review will be based on supervisor observation and interaction, documented feedback from other staff (if applicable), documented feedback from outside sources including, but not limited to, client satisfaction surveys (if applicable).

Revised 11/16; Reviewed 03/22

PERFORMANCE PAY INCREASE

All non-PRN employees may be eligible for a yearly performance-based pay increase effective the first pay period of the month following their anniversary month. The cumulative score received on the annual performance evaluation will determine the amount of the increase.

Should a non-PRN employee reach the top of his/her salary range due to employment longevity or continuous, outstanding performance evaluations, he/she will be eligible for a one-time performance award determined by the cumulative score received on the annual performance evaluation. Employees may be eligible for this award any year they are at the top of their salary range.

Revised 06/10; Reviewed 03/22

PERSONNEL FILE

A personnel file is maintained by CHC for each employee. Inform Human Resources in writing, of any changes in your name, address, home telephone number, or who to notify in case of emergency. Your personnel file contains, but is not limited to, the following information:

- Inservice Records (if applicable)
- Signed Job Description for each position worked
- Evaluations/Other performance documentation
- Application for Employment, Resume
- ~~Delete Reference checks~~
- Skills Checklist (if applicable)
- Completed Orientation Schedule
- Professional License/Certification/Diploma (if applicable)
- Federal and State Withholding forms
- Benefit Enrollment Forms (if applicable)
- Human Resources Policies Manual acknowledgment form
- Confidentiality Agreement
- Compliance/Code of Conduct Agreement
- Miscellaneous Correspondence, Workshop Attendance
- Motor Vehicle Report (if applicable)
- ~~Delete copy of Driver's License – I9 kept separated~~
- Proof of auto insurance coverage (if applicable)

While you are an active employee of CHC, your personnel file is open and available to you for inspection by appointment by contacting Human Resources.

All CHC personnel should direct incoming inquiries regarding credit reference or employment verification on

present or former employees to Human Resources.

Revised 03/22; Reviewed ~~05/20~~05/22

PRE-EMPLOYMENT DRUG SCREEN

As part of the pre-employment process, all prospective employees must complete a urine drug screen. Eligibility for hire is dependent upon having a confirmed negative screening for illegal drugs. The definition of an illegal drug for the purpose of this policy includes:

- use of substance that is not legally obtainable
- use of a prescribed drug for purposes other than that prescribed or in amounts exceeding that prescribed
- use of someone else's prescribed medication.

Substances tested in the drug screening process include amphetamines, cocaine, THC, opiates, and PCP. Drug screening specimens will be collected in accordance with the National Institute of Drug Abuse (NIDA) by an agency authorized testing facility. Physicians from these facilities are qualified to act as Medical Review Officers (MROs) and will be responsible for follow-up with prospective employees who have had "laboratory positive" drug screen results.

All drug screen test results will be held in confidence and will ~~not be released to anyone other than the Director of Human Resources and the President/CEO~~only be disclosed as authorized by applicable law.

For Home Health Aides Only:

On an annual basis, CHC will ~~randomly test~~ conduct random drug screening of at least fifty percent (50%) of the Home Health Aides who meet both of the following: (a) ~~Provides~~ provides direct patient care or has direct contact with a patient; AND (b) ~~Is~~ is NOT licensed by a board or commission under Indiana Code 25 (Indiana Code 16-27-2.5-2(b)).

If the employee's test result is positive and the employee does not have a valid prescription for the substance for which the employee tested positive on the test, a confirmation test is required at the employee's expense. If a confirmation test verifies a positive result, the agency shall: (a) ~~Discharge~~ terminate the employee~~, or,~~ ; or (b) ~~Suspend~~ suspend the employee from direct patient care for at least six (6) months (Indiana Code 16-27-2.5-3)).

Upon notification from Human Resources, you will have 24-hours to complete your ~~Random Drug Test~~ random drug test at Anytime Labs. Failure to complete your test in the required timeframe will be considered refusal of test. Refusal of test will be grounds for progressive discipline up to immediate termination.

Revised ~~01/22~~05/22

EMPLOYEE SCREENING PROCEDURES

Motor Vehicle Check - Verifies validity of driver's license and driving record of individual for last seven years~~.~~ (~~If~~ if applicable).

Professional License Verification - All professional licenses, i.e., nursing, social work, counseling, are verified through the Indiana State Department of Health.

~~**Education Verification** – Delete~~

Nurse Aide Registry - The Indiana Nurse Aide Registry is checked prior to employment of any home health aide. The registry provides verification of certification and that the home health aide is "in good standing."

IRCA Verification (I-9 form) - New employees are required to provide proof of their identity and work authorization.

~~**Previous Employment** - Delete~~

Social Security Number Verification - This is done indirectly by using the social security number to perform the driver's license and professional license search.

Medicare Sanction Check - Verifying employee has not been sanctioned by the federal Medicare program~~.~~ (if applicable)~~.~~

Criminal History Check – A State and/or National Criminal History Check will be done within three days of initial employment on all employees.

CHC/HF/CADS prohibits the hiring (or contracting with) a person convicted of crimes including, but not limited to, a sex crime (IC 35-42-4); exploitation of an endangered adult (IC 35-46-1-12); abuse or neglect of a child (IC 35-42-2-1); failure to report battery, neglect, or exploitation of an endangered adult or dependent (IC 35-46-1-13); theft (IC 35-43-4 ~~(~~(except as provided in IC 16-27-2-5(a)(5)~~)~~)); murder (IC 35-42-1-1); voluntary manslaughter (IC 35-42-1-3); involuntary manslaughter (IC 35-42-1-4); battery (IC 35-42-2).

Pre-Home Placement Physical – According to Indiana State Department of Health guidelines, prior to beginning work with CHC/HF/CADS, all direct patient care employees must submit documentation showing their status regarding infectious and communicable disease.

Revised 03/22; Reviewed ~~05/20~~05/22

COMPLIANCE WITH CMS MANDATORY COVID-19 VACCINE

On November 5, 2021, the Centers for Medicare and Medicaid Services (CMS) published an interim final rule, "The Omnibus COVID-19 Health Care Staff Vaccination Rule" in the Federal Register (the "Vaccination Rule"). The Vaccination Rule revised the Medicare Conditions of Participation for Home Health Agencies/Hospice Providers to require all Staff to be ~~fully vaccinated~~ Fully Vaccinated (as defined below) against COVID-19 by February 26, 2022, unless exempted under other federal laws such as the Americans with Disabilities Act ~~of~~ ("ADA") or Title VII of the Civil Rights Act. As a Medicare Certified Provider, Center for Hospice Care (the "Agency") is required to comply with all of the Medicare Conditions of Participation. Employees are required to comply with CHC's Mandatory Vaccination Policy, which is available for review on CHC's intranet. The Mandatory Vaccination Policy may be updated from time to time. Employees should contact the Director of Human Resources with questions regarding the Mandatory Vaccination Policy.

Revised 05/22

~~This policy sets forth the Agency's procedures regarding ensuring all Covered Staff Members are Fully Vaccinated as required by the Vaccination Rule, 42 C.F.R. 484.60(d)(2)/418 C.F.R 418.70(d)(2), on or before February 26, 2022.~~

1. **DEFINITIONS**

1.1 Fully Vaccinated. For purposes of this policy and procedure, an individual is considered to be Fully Vaccinated if it has been two (2) weeks or more since the individual completed a primary vaccination series for COVID-19.

1.2 Completed Primary Vaccination Series. An individual is considered to have completed a Primary Vaccination Series when they have received a dose of a single dose COVID-19 Vaccine or all required doses of a multi-dose vaccine. If permitted or recommended by CDC, an individual can complete a Primary Vaccination Series for COVID-19 by combining vaccine doses from different manufacturers.

1.3 Covered Staff Members

1.3.1 The following Agency Staff, who provide any care, treatment or other services for the Agency and/or its patients are required to comply with this policy and referred to as Covered Staff Members throughout this policy. It does not matter whether the individual has clinical responsibility or patient contact, this applies to any staff in the following categories:

1.3.1.1 All employees working at any CHC owned or rented office;

1.3.1.2 Students, trainees, and volunteers; and

1.3.1.3 Individuals who provide care, treatment, or other services for the hospice and/or its patients, under contract or by other arrangements.

1.3.2 The following Agency Staff are not considered Covered Staff Members and are not required to comply with this policy, if they do not have any direct contact with Agency patients, patient's families and caregivers, and other staff specified in section 1.3.1 of this policy:

1.3.2.1 Staff who exclusively provide telehealth or telemedicine services outside of the settings where hospice services are provided to patients; and,

1.3.2.2 Staff who provide support services for the hospice that are performed exclusively outside of any CHC office and outside of the settings where hospice services are provided to patients.

1.3.2.3 CHC currently has no position available or options for any that are exclusively remote and offers telework and CHC has no plans to create them at this time.

1.4 Exempt Staff Members. As used in this policy, Exempt Staff means staff who are exempted from the requirements of this policy due to a medical contraindication, sincerely held religious belief, or those staff for whom vaccination must temporarily be delayed due to clinical consideration (see Section 3). Completion of CHC exemption form required.

1.5 Sincerely Held Religious Belief or Practice. For purposes of this policy and procedure, sincerely held Religious Belief or Practice includes all aspects of religious observance and practice, as well as belief, this "includes moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views. This is the standard that the EEOC has consistently applied in its decision. It does not impact the assessment of the Covered Staff Member's request for an accommodation that no religious group espouses such beliefs or the fact that the religious group to which the individual professes to belong may not accept such belief. Completion of CHC exemption form required.

2. COVID-19 VACCINATION REQUIREMENT

2.1. On or before January 27, 2022, all Covered Staff Members must either (i) provide proof of having received a single dose COVID-19 Vaccine or the first dose of the Primary Vaccination Series for a multi-dose COVID-19 vaccine; (ii) provide proof of a need for a temporary delay due to clinical precautions and considerations as recommended by the CDC; (iii) have a pending request for an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice, or (iv) have been granted an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice. Covered Staff Members who are not in compliance with this section by January 27, 2022, may not provide any care, treatment, or other services for the Agency and/or its patients; and will be subject to CHC progressive discipline up to and including termination. Employees not working due to noncompliance must use available benefit time to become compliant.

2.2. On or before February 26, 2022, all Covered Staff Members must either (i) provide proof that they are Fully Vaccinated; (ii) provide proof of a need for a temporary delay due to clinical precautions and considerations as recommended by the CDC; (iii) have a pending request for an exemption due to a Medical Contraindication or a Sincerely Held Religious Belief or Religious Practice, or (iv) have been granted an exemption due to a Medical Contraindication or a Sincerely Held Religious Belief or Religious Practice. Covered Staff Members who are not in compliance with this section by February 26, 2022, may not provide any care, treatment, or other services for the facility and/or its patients. Completion of CHC exemption form required. Employees not working due to noncompliance must use available benefit time to become compliant.

2.3. While undergoing and upon completion of the Primary Vaccine Series, a Covered Staff Member will be considered Fully Vaccinated and able to continue working but will be required to take the same precautions as unvaccinated staff members until 14 days after they have completed the Primary Vaccine Series.

3. REQUEST TO DELAY COMPLIANCE DUE TO CLINICAL PRECAUTIONS AND CONSIDERATIONS.

3.1. A Covered Staff Member may seek an extension of the deadlines in Section 2 of this Policy when clinical precautions and considerations, as recommended by the CDC, prevent the Covered Staff Member from becoming Fully Vaccinated. A Covered Staff Member seeking a delay due to clinical precautions and considerations as outlined in the CDC Interim Considerations for Use of COVID-19 Vaccine must submit their request in writing and provide documentation supporting the requested extension. Completion of CHC exemption form required.

3.2 Documentation Supporting Requested Extension. The documentation supporting the request to delay compliance must be signed and dated by a licensed practitioner, who is not the individual requesting the extension, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws. The documentation must include:

3.2.1 All information specifying the clinical precautions and considerations that prevent the Covered Staff Member from becoming fully vaccinated;

3.2.2 A statement by the authenticating practitioner recommending that the staff member be allowed a delay in complying with the Agency's COVID-19 vaccination requirements for staff based on the recognized CDC clinical precautions and considerations; and,

3.2.3 When the clinical precautions and considerations will no longer prevent the Covered Staff Member from becoming Fully Vaccinated.

Completion of CHC exemption form required. The Documentation Supporting the Requested Extension shall be maintained with the other medical information in the Covered Staff Member's personnel file. This documentation shall be kept secure and confidential.

3.3 A Covered Staff Member who must delay becoming fully vaccinated due to clinical precautions and considerations will be allowed to continue providing care, treatment, or other services for the facility and/or its patients during the period vaccination must be delayed. The Covered Staff Member will be required to follow all precautions that Exempt Staff Members are required to follow until fourteen (14) days after the Covered Staff Member has completed a Primary Vaccine Series.

4. DOCUMENTING VACCINATION STATUS OF COVERED STAFF

4.1. Covered Staff Members, who either (i) do not have a pending request for an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice, or (ii) have not been granted an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice, must document their Vaccination Status by submitting proof of vaccination to the Human Resources Manager prior to January 27, 2022 for the single dose or first of a two-shot series, and by February 26, 2022 for the second of a two-shot series.

4.2. Proof of Vaccination. The following documents will be accepted as proof that a Covered Staff Member is Fully Vaccinated.

4.2.1. The Covered Staff Member's CDC COVID-19 vaccination record card (or a legible photo of the card),

4.2.2. Documentation of vaccination from a health care provider or electronic health record, or

4.2.3. State immunization information system record.

4.2.4. If the Covered Staff Member was vaccinated outside of the U.S., a reasonable equivalent of any of the previous examples will suffice.

4.3 Agency will make a copy of the Covered Staff Member's Proof of Vaccination. The document will be placed in the medical section of the Covered Staff Member's personnel file. As with other medical information in personnel files, the Agency shall keep vaccination status information secure and confidential.

4.4 Agency shall maintain a list of Covered Staff Members Vaccination Status. This list shall include all Covered Staff Members and will document:

4.4.1 Date of first vaccine dose

4.4.2 Date of second vaccine dose (if Covered Staff Member received a multi-dose vaccine)

4.4.3 Date of Booster dose(s) (if and when recommended by the CDC)

4.4.4 Need for Delay

4.5 Date of Exemption Request (if one was submitted) and status of request. This list shall be stored securely and maintained confidentially.

5. STAFF EXEMPTIONS DUE TO MEDICAL CONTRAINDICATIONS/DISABILITIES

5.1. Covered Staff Members who are unable to become Fully Vaccinated due to Medical Contraindications to the COVID-19 vaccines or other Disabilities that prevent them from becoming Fully Vaccinated are entitled to seek reasonable accommodation for their inability to be vaccinated as outlined in the Americans with Disabilities Act. Completion of CHC exemption form required to be submitted to the Human Resources Manager.

5.2. Documentation.

5.2.1. Covered Staff Members seeking an Exemption from this Policy due to a Medical Contraindication or other Disability must provide documentation supporting the Exemption. Completion of CHC exemption form required. This documentation must be signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws. The documentation must include:

5.2.1.1. All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and

5.2.1.2 A statement by the authenticating practitioner recommending that the staff member be exempted from the Agency's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

5.3. Information provided to the Agency regarding the Covered Staff Member's Medical Condition/Disability will be placed in the medical information section of the Covered Staff Member's personnel file. It will be maintained in a secure and confidential fashion, as required by the ADA.

5.4. Assessing Covered Staff Member's Request.

5.4.1. When a Covered Staff Member requests to be exempted from the COVID-19 Vaccination requirement due to a Medical Contraindication or Disability, the request must be granted, unless: (i) the Covered Staff Member poses a significant risk of substantial harm to the health or safety of the Covered Staff Member, Agency Patients, or others in the workplace **and** (ii) that risk cannot be eliminated or reduced by reasonable accommodation (see Section 7).

6. STAFF EXEMPTIONS DUE TO SINCERELY HELD RELIGIOUS BELIEFS OR RELIGIOUS PRACTICE

6.1. Agency staff who have a sincerely held religious belief or religious practice that prevents them from becoming Fully Vaccinated have a right under the First Amendment to the U.S. Constitution and Title VII of the Civil Rights Act of 1967 to receive a reasonable accommodation to allow them to maintain their Sincerely Held Religious Belief or Religious Practice.

6.2 Covered Staff members who seek an exemption for this policy due to their Sincerely Held Religious Belief or Religious Practice must submit a request for a religious accommodation,

also known as a reasonable accommodation, in writing to the Human Resources Manager. Completion of CHC exemption form required.

6.3 Reviewing Request. When a request for a religious accommodation is received, it shall be reviewed by the Administrative Team. Completion of CHC exemption form required.

7. REASONABLE ACCOMMODATIONS FOR EXEMPT STAFF

7.1. Covered Staff Members who are granted exemptions under Sections 4 or 5 of this policy will be required to take the following steps as a reasonable accommodation in place of becoming Fully Vaccinated

7.1.1. Agency will reduce the risk of COVID-19. This will include staff monitoring themselves for symptoms, use of masks and other PPE, quarantining when exposed, etc., and signing a self-screening log prior to commencing any day of work at CHC and its affiliates via a mechanism to be determined.

7.1.1.1 Face coverings are required in all CHC offices when physical distancing of six feet or more cannot be maintained. This includes walking through the facility and accessing common areas (kitchens, break rooms, restrooms, waiting areas, outdoor areas, etc.).

7.1.1.2 All staff that have access to direct patient care may be subject to on-going testing.

7.1.1.3 Individual supervisors will be responsible for monitoring compliance of exempted staff

7.1.1.4 Failure to comply will result in termination.

7.1.1.5 Additional requirements as needed or mandated by CMS.

8. FUTURE CHANGES AND UPDATES

8.1. This policy and procedure may be changed and updated at any time as needed, including when CMS compliance regulations change. Staff will be notified via email of future changes and their effective dates.

Revised 01/04/22

ATTENDANCE

Regular attendance and punctuality are considered an essential part of an employee's work responsibility, as well as a factor in determining overall job performance. Employees who cannot report for work as scheduled must notify their supervisor/designee as far in advance of their start time as possible. Inpatient Unit employees must notify the nurse on duty at least two hours prior to their scheduled start time. Individual supervisors may designate the manner in which notification is provided. Employees must provide a doctor's note indicating their ability to return to work if absent due to illness/injury for three (3) or more consecutive work days.
An absence is classified as one of the following:

- **Scheduled absence** - approved employee time off which is scheduled in advance to allow for appropriate staffing coverage.
- **Unscheduled absence** - unapproved, unscheduled employee time off (applicable to any shift an employee has been scheduled to work), i.e., employee or dependent illness, car problems, etc.

An excessive number of unscheduled absences by an employee can create problems in the workplace impacting co-workers and interfering with the efficiency of operations. To minimize this negative impact and to ensure all

employees are dealt with fairly and consistently, the following guidelines will be used in determining how many unscheduled absences are considered excessive absenteeism.
Note: Each unscheduled absence is defined as one or more consecutively scheduled work days. Exceptions to this would include bereavement days, jury duty, and emergency ~~LOAs~~leaves of absence.
Scheduled Days Per Week

- Five days – more than five unscheduled absences in a rolling 12-month period.
- Four days – more than four unscheduled absences in a rolling 12-month period.
- Three days – more than three unscheduled absences in a rolling 12-month period.
- Two days – more than two unscheduled absences in a rolling 12-month period.

Based on these criteria, employees who have excessive absenteeism will be subject to progressive disciplinary action.

One extra ~~Personal Day~~personal day, in addition to those they are already eligible for, will be awarded to those full-time employees who have had zero unscheduled absences in the one preceding consecutive calendar year. The added ~~Personal Day~~ personal day is subject to the *Personal Days policy.* ~~–~~

An extra one-half ~~Personal Day~~personal day, in addition to those they are already eligible for, will be awarded to those half-time employees who have had zero unscheduled absences in the one preceding consecutive calendar year. The added ~~Personal Day~~ personal day is subject to the *Personal Days policy*.

Revised 03/22; Reviewed ~~05/20~~05/22

ATTENDANCE AT WORK RELATED ACTIVITIES

Only CHC staff should attend department, staff, or other work related meetings or activities. Bringing non-CHC staff will not be permitted, unless they are relevant to the meeting or activity. Staff may receive non-work related outside visitors; however, such visits should be infrequent, short in duration, and not disruptive to fellow CHC staff.

Reviewed ~~03/22~~05/22

OVERTIME, WORK SCHEDULES

CHC provides services 24 hours per day, 7 days per week, 365 days per year. All work schedules are established by the supervisor and may be changed at the discretion of management to meet workload demands.

Non-exempt (hourly) employees that work more than 40 hours per week (Sunday through Saturday) will receive overtime compensation at a rate that is time and a half their average hourly rate.

CHC does not offer compensatory time off.

Revised 03/22; Reviewed ~~05/20~~05/22

TIMESHEETS

Clinical non-management staff and all non-exempt employees are required to submit timesheets each week showing actual hours worked and any benefit days used. Time sheets must be approved by the supervisor and forwarded to Human Resources by ~~10:30am each Monday. Timesheets that are submitted late by the employee (after 10:30 am) Monday of a payroll processing week) will not be paid until the following pay date.~~10:30 a.m. each Monday. Failure to do so may result in a delay in payroll processing. Repeated violations of this policy may result in disciplinary action, up to and including termination.

Revised 05/22
~~*Revised 03/22; Reviewed 05/20*~~

PAY DAYS

Employees are paid every other Friday, 26 times per calendar year. Direct deposit is available to all staff, but not mandatory~~ Delete~~ . Pay advances on earned or unearned wages is not an option. Issues with pay checks should be directed to Human Resources.

Revised 03/22; Reviewed ~~05/20~~05/22

DRESS CODE

Our organization's image is reflected by our employees. We ask that all employees take pride in their professional appearance, and that everyone is clean, well groomed, and appropriately dressed for their position.

Employees who come in contact with patients and families should be aware as professionals that attention to details in appearance will help instill confidence in patients and families. Projecting a professional appearance projects professional care.

CHC has established the following guidelines, which include, but are not limited to:

1. Agency photo identification must be worn at all times by patient care staff.

2. Fingernails should be clean, well-trimmed, and not interfere with duties. Based on CDC and OSHA guidelines to reduce the risk of ~~healthcare~~ health care acquired infection, artificial nails (including acrylics, gels, wraps, overlays, etc.) are not to be worn by anyone with patient contact or patient food preparation. Nail polish may be worn on natural nails by patient care staff, but it should not be chipped.

3. Perfume/cologne should not be worn by patient care staff.

4. Hair should be clean and neatly fashioned. Patient care staff must keep long hair tied back when performing patient care. Inpatient Unit staff must do so at all times.

5. Jewelry can be worn sparingly, for example, rings, watches, short necklaces, and small earrings. Jewelry may not be worn on visible pierced body parts (excluding ears).

6. Clothing should not be form fitting (leggings, spandex, Lycra) or reveal lines/color of undergarments.

7. Clothing cannot display questionable graphics or any wording. This includes, but is not limited to, alcohol or tobacco logos.

8. Non-canvas athletic shoes may be worn by direct patient care staff, if they are appropriate to dress. They must also be solid in color. Nurses and Aides providing patient care must wear closed toe shoes.

9. Bib overalls, sweat pants, shorts, and denim pants are not permitted.

10. Business Capri pants must be of a length to cover the calf portion of the leg. Individual supervisors will be responsible for ensuring that staff who wear Capri pants meet agency expectations for professional appearance.

11. Skirts or dresses should not be more than two inches above the knee.

12. Patient care staff is required to wear Agency issued career wear when making patient visits. All Nurses and Aides are required to wear Agency issued scrubs when providing patient care. Additional Agency issued career wear and scrubs will be available for purchases on the CHC website.

Individual supervisors are responsible for ensuring that the appearance of their employee is appropriate, and may, at his/her discretion, in consultation with the Director of Human Resources, implement and define appearance standards which are more restrictive than those listed above, but never less restrictive. Employees who appear for work inappropriately dressed may be sent home and directed to return to work in proper attire. Under such circumstances, non-exempt employees will not be compensated for the time away from work. Dress Code policy violations will be handled in accordance with the Progressive Discipline policy.

Revised 05/20; Reviewed ~~03/22~~05/22

PROGRESSIVE DISCIPLINE

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

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

- Violation of HIPAA ~~Policies~~ policies

Specific penalties in each case may depend upon the seriousness of the rule or policy violated, the frequency of the rule or policy violated, and the employee's overall record. Employees who are under a progressive disciplinary action may not be eligible for internal transfer depending upon the ~~recentcy~~ recency and nature of the performance issue, or have received a less than satisfactory rating on their most recent performance review. CHC's decision to use progressive discipline when appropriate does not alter the nature of the employment-at-will relationship.

Revised 05/20; Reviewed ~~03/22~~ 05/22

SOLICITATION FOR NON-CHC FUNDRAISING ACTIVITIES

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

10/18; Reviewed ~~03/22~~05/22

PROBLEM SOLVING PROCESS

Employees must follow the chain of command starting with their supervisor when dealing with disagreements or problems in the work place. Employees are not required to directly confront anyone who is the source of their problem.

CHC recognizes that there may be situations that require a more formal process in achieving problem resolution. An employee can request a grievance reporting form from the Director of Human Resources~~, however, this must be done within five (5) business days of the occurrence of the problem. The~~ . Upon an employee's submission of a completed grievance reporting form, the Director of Human Resources will conduct an investigation in conjunction with the President/CEO or other leadership, as appropriate. ~~The~~ Once the investigation is concluded, the employee will then be ~~provided a final decision in writing within five (5) business days.~~notified of the outcome of the grievance. Employees should submit a grievance reporting form promptly when a grievance arises.

CHC prohibits unlawful retaliation made against any employee who makes a good faith complaint of wrongdoing or utilizes the problem-solving process or who participates in any related investigation.

Revised 08/09; Reviewed ~~03/22~~05/22

SUBSTANCE ABUSE

CHC defines substance abuse as consumption of drugs or alcohol leading to impairment of an employee's job performance or participation in any agency-related activity. CHC reserves the right to test employees for substance abuse via a drug screening if cause exists to indicate that their health or ability to perform work might be impaired. Factors that could establish cause include, but are not limited to:

- Appearance of impairment
- Sudden changes in work performance
- Repeated failure to follow instructions or operating procedures

- Violation of company safety policies
- Involvement in a work-related accident in which the employee seeks medical treatment through workers compensation
- Discovery or presence of illegal or suspicious substances or materials in an employee's possession or near the employee's workplace

Employees that choose not to consent to appropriate testing when requested by management or who are tested and have a positive result for substance abuse, will be subject to disciplinary action up to and including termination of employment.

CHC prohibits and does not tolerate being under the influence of illegal drugs, or the possession or use of illegal drugs~~-~~, while working or participating in any Agency-related activity.

Revised ~~08/09; Reviewed 03/22~~05/22

ON CALL

The On Call policy is subject to change in order to accommodate patient care 24 hours per day, 7 days per week. The On Call schedule is given to participating staff. Once the schedule is posted, it becomes the employee's responsibility to find a replacement if necessary – subject to supervisory approval.

Home Care nurses in the Call rotation are required to provide coverage outside their regular Call schedule for the unscheduled absence or position vacancy of a triage, emergency visit, or On Call nurse.

Employees

Compensation for non-exempt staff:

- **On Call –** employees will receive $2.00/hour Regular On Call pay and will be paid their base rate for actual hours worked or the overtime rate when applicable.
- **Emergency On Call -** employees will receive $5.00/hour Regular On Call pay and will be paid their base rate for actual hours worked or the overtime rate when applicable.

Compensation for exempt Clinical staff:

On Call – employees will receive $2.00/hour Regular On Call pay and will be paid $90.00 per billable visit.

Emergency On Call - employees will receive $5.00/hour Emergency On Call pay and will be paid $90.00 per billable visit.

Compensation for exempt Admissions staff:

On Call – employees will receive $2.00/hour Regular On Call pay and will be paid $55.00 for a PA visit and an Admission Visit will be paid $140.00/per visit.

Compensation for Medical Social Services:

On Call - employees will receive $2.00/hour Regular On Call pay and will be paid $55.00 per billable visit.

PAY DIFFERENTIALS:

Shift Differential:

Non-exempt employees who work evening ~~7pm 7am~~ 7 p.m.-7 a.m. shift will be paid a shift differential of $3.00/hour, in addition to their regular hourly rate.

Other non-exempt employees, whose regular work hours fall outside of ~~8am-5pm~~8 a.m.-5 p.m. will be paid shift differential as follows:

- Shift differential will be paid for all hours worked when more than 50% of the hours are after 5:00 p.m.
- Shift differential will be paid for hours worked after 5:00 p.m. when 50% or less of the hours are after 5:00 p.m.

  Shift differential for Inpatient Unit ("IPU-") and Home Health Aides for ~~7pm-7am~~ 7 p.m.-7 a.m. shift will be paid at $3.00/hour on top of their regular rate.

Power Weekend Differential
Non-exempt employees who regularly work a "power weekend" schedule, defined as working 12-hour shifts **every** Saturday and Sunday, will be paid for the following differential in addition to their regular hourly rate:

- RN / LPN - $6.00/hour
- CNA - $4.00/hour
- Social Work - $6.00/hour
- Chaplain - $6.00/hour

Hours worked by "power weekend" employees outside of their normal weekend schedule will be paid at their regular hourly rate and will include shift differential if applicable.

Weekend Shift Differential:
Any non-exempt employee who works or picks up a shift on a Saturday or Sunday will receive Weekend Differential at $1.00/hour, in addition to their regular hourly rate.

Double Time Pay:
IPU Double Time Guidelines:

Double time is only offered to CNAs working vacant CNA positions and RN's working vacant RN positions. Call Offs within the scheduled work week will forfeit double time pay. All double time shifts must be approved by the ~~DON~~Director of Nursing.

INPATIENT UNIT:
On ~~call~~ Call is rotated by nursing staff, and is available 24 hours a day, 7 days a week.

The ~~on call~~ On Call nurse will be responsible for coming in to cover any hours that may be vacant during his/her call time. Call offs are to be phoned in to the nurse staffing the Inpatient Unit. The nurse staffing the Inpatient Unit shall make every attempt to contact and obtain staffing. If unsuccessful, the ~~on call~~ On Call nurse is to be notified. He/she is then responsible for staffing those uncovered hours. Situations involving security concerns, clinical issues, staff/patient/family issues, and questions regarding patient admissions may also need to be addressed by the ~~on call~~ On Call nurse.

Revised ~~03/22~~05/22

USE OF BENEFIT DAYS

Employees are required to use existing benefit days when requesting scheduled time off. If benefit days have been exhausted or have not yet been earned due to length of employment, scheduled time off will not be approved. Employees must request and receive approval from their supervisor prior to taking scheduled time off.

For the purpose of this policy, a day is defined as follows:

Exempt – Any business day (or any portion thereof) the CHC administrative offices are open. Generally this is Monday through Friday, with the exception of Holidays. Exempt employees must use benefit days in whole day increments.

Non-Exempt – ~~A day~~ For non-exempt employees, a day is a workday. A workday reflects the number of hours an employee is regularly scheduled to work on a particular day. For example, if an employee is regularly scheduled to work 12 hours, then their ~~day~~ workday is 12 hours. If they are regularly scheduled to work 4 hours, then their ~~day~~ workday is 4 hours. Non-exempt employees must use benefit days in ~~half day~~ half-workday or whole ~~day~~ workday increments.

Revised ~~03/16; Reviewed 03/22~~05/22

EMPLOYEE BENEFITS

Contact Human Resources for specific eligibility, enrollment~~-~~, and coverage details regarding the benefits listed below. Open enrollment is held December 1st through December 15th each year. Elections made at that time are effective January 1st of the next calendar year. Deductions for benefits are taken for 24 pay periods. This is the only time that changes can be made to benefits outside of a COBRA qualifying event as defined by the summary plan description.

Life Insurance – Effective the first day of employment, CHC automatically provides life insurance equal to ~~1x~~ one times the employee's annual salary or a minimum of $20,000 for power weekend employees and all staff with weekly scheduled hours of 32 or more.

Accidental Death and Dismemberment Insurance – CHC provides ~~1x~~ one times the annual earnings in AD&D insurance for staff with weekly scheduled hours of 32 or more as well as power weekend employees. This is also effective the first day of employment.

Long Term Disability Insurance – CHC provides a long term disability insurance benefit equivalent to 60% of the employee's base salary at time of disability and begins 90 days following the date of disability. It will continue until the employee reaches the age of 65 or is no longer disabled. Power weekend employees and staff with scheduled hours of 32 or more receive this benefit automatically upon hire.

Group Health Insurance and Health Savings Account – Group health insurance is available to staff with weekly scheduled hours of 32 or more as well as power weekend employees. Coverage is effective the first day of the month following employment or January 1st if elected during CHC's open enrollment period. CHC will establish a Health Savings Account (HSA) and provide an annual contribution for all employees that elect its group health insurance. New employees will receive a pro-rated contribution following completion of their 90~~-~~ day probationary period.

Dental Insurance – Dental insurance is available the first day of the month following employment to staff with weekly scheduled hours of 32 or more as well as power weekend employees.

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

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

403B/Roth 403B – Non-PRN employees regularly scheduled to work 20 hours or more per week are eligible to participate in CHC's retirement plan following completion of their 90 day probationary period. Vesting is 100% upon enrollment. CHC will match at 25% the first $16,000 of the employee's contribution.

AFLAC – Short-term disability insurance, supplemental life insurance, personal recovery insurance and cancer insurance are available through AFLAC to non-PRN employees upon completion of their 90 day probationary period.

Employee Assistance Program (EAP) – CHC provides an Employee Assistance Program to help ~~non-prn~~ non-PRN employees, their spouses and eligible children in coping with personal problems and stress. CHC will pay the cost of four counseling sessions per employee and eligible family members each calendar year. This is effective immediately upon employment. Employees may contact the EAP provider directly to schedule confidential appointments. The number of employees participating is the only information shared with CHC.

Continuing Education – ~~Non-prn~~ Non-PRN employees are eligible to attend seminars/conferences on job-related topics with the approval of their supervisor. Employees interested in obtaining a job-related certification, may be eligible for some financial assistance as part of their continuing education.

Professional Membership Dues – CHC will pay for/reimburse staff for some professional memberships/dues with prior Administrator approval. The expense must be relevant to the employee's position and should provide benefit to both CHC and the employee.

Retention Bonus - On the pay date of the first full pay period in the month following an employee's hiring anniversary, each employee will receive a separate payroll check for $100 for each year of service at CHC up to a maximum of $1,000. This check will only have applicable federal, state, and local taxes withheld. The amount received will be determined by your status on your anniversary date. To be eligible for this anniversary payment you must be an employee in good standing on your anniversary date (not on probation); if you are a rehire the calculation will be based on your most recent rehire date. PRN staff will receive $250 per year after three years of service.

Healthy Lifestyle Benefit – Employees who participate in CHC's medical insurance are eligible for reimbursement of 50% of the cost up to $250.00 per calendar year for participating in the following:

Gym Membership (single membership rates)
Weight loss counseling or education
Organized exercise programs such as Zumba, Yoga or Pilates

Invoices can be turned in during the month of December through January 15th each year.

HPCC Certification – Employees who have completed their CHPN, ACHPN, and or HPNA certification are eligible for reimbursement. The following will be paid biweekly:

CHPN - $38.46
ACHPN - $48.07
CHPNA - $28.84

FUNERAL LEAVE

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

- 5 day/week – 3 Bereavement Days
- 4 day/week – 3 Bereavement Days
- 3 day/week – 2 Bereavement Day
- 2 day/week – 1 Bereavement Day

Non-Immediate Family Member - Employees may take up to one day off with pay to attend the funeral of a close friend or non-immediate family member. This time off will be considered by the employee's supervisor on a case-by-case basis. CHC may require verification of the need for the leave time.

Additional Time Off - CHC recognizes the impact that death can have on an individual or a family. Employees may request to use their accrued vacation or personal days to extend their funeral leave time. This is subject to supervisory approval.

HOLIDAYS

CHC recognizes the following as paid holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. ~~DELETE~~ Substitutes for these days can be arranged by contacting Human Resources. ~~DELETE~~ Full-time employees are paid eight hours for each holiday. Half-time and power weekend employees are paid four hours and part-time employees are paid for two hours. When the holiday falls on a regularly scheduled day of work for an employee, he/she will be compensated for the number of hours normally worked. When a holiday falls on a Saturday, the observed holiday will be Friday and when it falls on Sunday, the observed holiday will be Monday. For Inpatient Unit staff only, the holiday will be considered the actual calendar date beginning at 7:00 a.m. and ending at 7:00 a.m.

VACATION

Accrued Vacation Time – Vacation time is accrued each pay period and can be used by staff after completion of six months of employment and with approval from their supervisor. Caps are established limiting the number of days that can be accrued. The cap is equivalent to twice the number of vacation days an employee would accrue based on the table below. When employees hit their cap, they will stop accruing vacation days until they once again fall below it. Accrual rates and cap numbers will be adjusted due to a status change or an increase in vacation time based on years of service.

Employees who have completed six months of service will be paid for any accrued vacation time upon termination of their employment as long as appropriate notice is given.

Hourly employees can request vacation time in half or whole day increments. Exempt employees can take only whole days.

Employees who have changed employment status may not qualify immediately for the increased accrual associated with specific years of service. A certain number of years of consecutive service at a particular status level may be necessary first. This will be reviewed on a case-by-case basis.

Employees will accrue vacation days based on their years of service and the number of days they are regularly scheduled to work each week.

To find your accrual rate, please use the "Accumulation Each Pay Period" numbers for the scheduled days you work a week and multiply that by the number of hours you work in a week. Vacation days will be accumulated according to the following table:

Scheduled Days Per Week	Accumulation Each Pay Period	Yrs 1-2	Accumulation Each Pay Period	Yrs 3-6	Accumulation Each Pay Period	Yrs 7-9	Accumulation Each Pay Period	Yrs 10+
5	0.3846	10	0.5769	15	0.7692	20	0.9615	25
4	0.3076	8	0.4615	12	0.6153	16	0.7692	20
3	0.2307	6	0.3461	9	0.4615	12	0.4615	12
2	0.1538	4	0.2307	6	0.3076	8	0.3076	8
Power Weekend	0.1923	5	0.2884	7.5	0.3846	10	0.3846	10

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

PERSONAL DAYS

Employees receive the following paid personal days each January 1st to be used during that specific calendar year-, and such personal days will not be paid out if not used by the end of that year. Compensation is based on the number of hours staff is regularly scheduled to work. Only non-exempt employees have the option of requesting personal days in half or whole day increments. Personal days are not considered an earned benefit and as such, employees will not be paid for any unused personal days upon termination of employment.

Scheduled Days Per Week	Yearly Personal Days
5	4
4	3
3	2
2	1
Power Weekend	2

New Employees hired between the following dates will receive the designated number of personal days to be used during their first calendar year of employment and **after completion of their 90 day probationary period**:

Scheduled Days Per Week	**01/01 – 02/28**	**03/01 – 04/30**	**05/01 – 07/31**	**08/01 – 08/31**	**09/01 – 12/31**
5	4	3	2	1	0
4	3	3	2	1	0
3	2	2	1	1	0
2	1	1	1	0	0
Power Weekend	2	2	1	0	0

SICK DAYS

Upon completion of their 90 day probationary period, new employees hired between the following dates will receive the designated number of sick days to use for their **own personal injury/illness/procedure.**

Scheduled Days Per Week	**01/01 – 04/30**	**05/01 – 08/31**	**09/01 – 12/31**
5	5	3	0
4	4	2	0
3	3	2	0
2	2	1	0
Power Weekend	2	1	0

Each January 1st, additional sick days will be added to the number remaining from the previous year. Only non-exempt employees can use sick time in either half or whole day increments. Since sick days are not considered an earned benefit, employees will not be paid for any unused sick time upon termination of employment.

A change in employment status from half-time to full-time will not affect the number of sick days available to an employee during the calendar year, unless the employee has worked full-time for six consecutive months. Employees who change from half-time to full-time status after June 30th will not receive any additional sick days until the next calendar year. Employees changing from full-time to half-time status will retain any unused sick days still remaining.

Employees must provide a doctor's note indicating their ability to return to work if absent due to illness/injury for three (3) or more consecutive work days. ~~Bolded letters~~

Employees will receive the following designated sick days each January 1st based on their regularly scheduled days each week. The maximum number of days which can be accrued is also listed.

Scheduled Days Per Week	**Sick Days**	**Maximum Day Accrual**
5	5	90
4	4	60

3	3	30
2	2	30
Power Weekend	2	30

Revised ~~03/22, Reviewed 05/20~~05/22

COMPENSATION FOR WORKED HOLIDAYS

CHC recognizes the following as paid holidays: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day and Christmas Day. The following guidelines will be used to determine compensation for employees scheduled to work or who provide "~~on call~~On Call" coverage for the actual holiday or CHC observed holiday. Differentials **will not** be included in holiday compensation. When the holiday falls on a regularly scheduled day of work for an employee, he/she will be compensated for the number of hours normally worked. When a holiday falls on a Saturday, the observed holiday will be Friday and when it falls on Sunday, the observed holiday will be Monday. For Inpatient Unit staff only, the holiday will be considered the actual calendar date beginning at 7:00 a.m. and ending at 7:00 a.m.

Exempt and Non-Exempt Home Care Staff:

- Nurses **scheduled to work** for specific periods of time will be paid a holiday premium based on the number of hours scheduled.

- Nurses providing On Call coverage will receive holiday On Call pay for the designated visit rate of $90.00 for each visit made.

- Home Health Aides and Triage staff scheduled to work the holiday will be paid one and one half times their hourly rate.

Exempt Chaplains and Social Worker Staff:

- Staff providing On Call coverage will receive holiday On Call for hours covered plus the designated visit rate of $82.50 for each visit made.

Admissions RN Staff:

Nurses providing On Call coverage will receive holiday On Call pay for the designated PA Visit at $82.50 per visit and an Admission Visit is paid at $210.00 for each visit made

Staff compensation for holidays:

- **On Call Nurse** – will be paid $5.00/ hour On Call pay plus ~~time-and-~~one and one-half times their base rate for actual hours worked on the holiday.

- **Power Weekend staff that work on a holiday that falls on Saturday or Sunday** will be paid at ~~time-and-one-half~~ one and one-half times their base rate for actual hours worked. Additionally, they will receive 12 hours of holiday pay at their base rate.

- **Power Weekend staff that work** a holiday that does not fall on Saturday or Sunday will be paid at ~~time-and-one-half~~ one and one-half times their base rate for actual hours worked. Additionally, they will receive four hours of holiday pay at their base rate.

- **Full-time staff that works on a holiday that falls on Saturday or Sunday** will be paid at ~~time and one-half~~ one and one-half times their base rate for actual hours worked, plus 12 hours of holiday pay at their base rate.

Revised ~~03/22~~05/22

LOCAL STAFF TRAVEL / MILEAGE

All staff must exercise personal responsibility by determining and traveling the shortest reimbursable mileage distances between destinations. All mileage and travel time reimbursement is subject to approval by each staff person's supervisor. Staff mileage is reimbursed at a rate established by CHC in accordance with applicable law. Policies regarding education and longer distance travel reimbursement may be found under "Education and Long Distance Travel and Reimbursement."

Care Related:
In all cases, commuting mileage (for example) from employee residence to office or office to employee residence cannot be reimbursed.

CHC will reimburse all care staff for travel time and mileage between the CHC office and the patient's home, and, between patient homes. For the first and/or the last visit of the day, CHC will reimburse the time and lesser of the mileage between the patient's home and CHC office, or patient's home and employee's residence.

Staffs who are required to make a visit(s) while ~~on call~~ On Call will be reimbursed travel mileage from their home to the patients' home (round trip) and between patients' homes if more than one visit is made while away from their personal residence and covering ~~on call~~On Call.

All requests for mileage reimbursement must take place within 45 days of incurring the expense ~~or the requests will not be processed~~.

Non-Care Related:
In all cases, commuting mileage (for example) from employee residence to office or office to employee residence cannot be reimbursed.

CHC will reimburse non-care staff for travel time and mileage between the CHC office and the business destination, and between business destinations. For the first and/or last business destination of the day, CHC will reimburse the time and lesser of the mileage between the business destination and the CHC office, or business destination and employee's residence.

All requests for mileage reimbursement must take place within 45 days of incurring the expense or the requests will not be processed.

CHC MILEAGE STANDARDS
Mishawaka to Elkhart = 19 miles one way
Mishawaka to Plymouth = 30 miles one way
Mishawaka to South Bend = 8 miles one way
Mishawaka to La Porte = 38 miles one way
Elkhart to Plymouth = 44 miles one way
Elkhart to South Bend = 28 miles one way

Elkhart to La Porte = 51 miles one way
Plymouth to La Porte = 38 miles
Plymouth to South Bend = 29 miles

Revised 09/11; Reviewed ~~03/22~~05/22

EDUCATION TRAVEL PROCEDURE AND GENERAL EXPENSE REIMBURSEMENT

This policy is intended to ensure that employee education travel is consistent with the objectives of CHC. It also defines procedures for authorized business travel and guidelines for general expense reimbursement.

CHC encourages employees to continue their education and advance their skills by attaining certain certifications, attending conferences, seminars, and workshops outside of ~~the inservices~~ in-services and training sessions provided in-house. Registration fees for education and other events, and the employee travel expenses associated with it, will be authorized only in circumstances which are clearly consistent with the mission of CHC.

Supervisor and Director Responsibilities:

1. Supervisors and Directors must know CHC's current travel policy and inform their departmental staff of company policy and procedures when questions arise.

2. Determine if registration and travel is actually necessary to achieve a particular goal.

3. Approve expenses in accordance with this policy.

CHC will pay or reimburse certain charges related to registration and round-trip travel. Prior approval must be obtained from your supervisor. Education travel must also be approved in advance of attending. Budget considerations, staffing requirements, appropriateness of the educational experience, and other factors will be taken into consideration before approval is granted. CHC strongly encourages using any available "early bird" discounts for registration. Requests for registration after discount deadlines have passed may influence the approval.

For travel by personal car, employees will be reimbursed for mileage at a rate established by CHC. Tolls and parking at the site will be reimbursed. Reimbursable mileage is always based on miles to and from the CHC office. The exception to this is when you must leave or return from your home and your residence is closer to your destination than the CHC office. Always use the lesser amount for calculating mileage. Mileage claimed must be substantiated using *MapQuest* (or similar program) showing starting point, ending point, and calculated mileage; a printout must be attached to the prescribed expense report form. CHC never reimburses commuting mileage or miles not actually traveled.

For travel that requires air transportation, CHC will pay round-trip airfare for the lowest published Third Class or Coach rate as researched by the designated CHC internal travel planner. The designated travel planner may not choose a more expensive flight on an alternate airline to gain personal super-saver miles or any other airline/credit card perks. Employees may retain all benefits from frequent flyer club memberships. All dues for such clubs must be paid by the employee. All air travel arrangements must be made with prior approval of your supervisor and by the designated CHC internal travel planner. The CHC designated travel planner will attempt to ensure whenever possible that no more than six company employees, four Coordinators or Directors, and three Administrators are booked on the same flight.

Employees choosing to use alternate modes of travel between cities serviced by regularly scheduled airlines must

request the travel planner to research the cost of the lowest flight at the time of travel approval. CHC will only reimburse the lesser of the previously researched airfare costs or the actual expenses of the alternate mode of travel. Documentation of this research must be submitted with the prescribed expense report form.

CHC will pay for charges for overnight accommodations related to a room on-site at a conference. When on-site accommodations are sold out, CHC may pay for a close by hotel facility or major chain, as available.

CHC will reimburse an employee for reasonable charges for meals while attending an educational experience, with the approval of your supervisor. Meals eligible for reimbursement on days of travel are as follows:

Day of Departure:

- Before 6:30 a.m. – all meals eligible for reimbursement
- After 6:30 a.m. – before 11:00 a.m. – lunch and dinner eligible for reimbursement
- After 11:00 a.m. – before 5:30 p.m. – dinner eligible for reimbursement

Day of Return:

- After 6:30 a.m. – before 1:30 p.m.– breakfast eligible for reimbursement
- After 1:30 p.m. – before 7:30 p.m. – breakfast and lunch eligible for reimbursement
- After 7:30 p.m. – all meals eligible for reimbursement

For conferences or educational meetings in other cities where air travel is required, CHC will pay for ground transportation to and from the airport of destination and the conference site. CHC will reimburse employees for the lesser of ground transportation to and from the airport of origination, or the cost of long term parking at the airport of origination. CHC will pay for the use of a rental car when necessary and with prior approval. Automobiles should be rented only when the cost advantages are clearly justified (i.e., the cost of the rental car would be less than using taxis, etc.) and prior approval is required. Employees can request either compact or intermediate size cars. Rentals for other types of cars are not permitted except with manager approval for large groups of employees traveling to the same destination. Luxury, premium, and specialty car rentals will be reimbursed only at the intermediate car rate. Whenever possible, employees must refill gasoline prior to returning the rental car for drop off. Gas charges at the rental location average 50% more than independent filling stations.

~~If less than full-time employees voluntarily attend an education experience on a day they are not normally scheduled to work, they will not be paid wages. If the supervisor has determined their attendance necessary on a day the employee does not normally work, they will receive their normal hourly wage up to their normal working hours. Full-time employees are not paid wages for attending an educational experience outside of their normal working hours.~~

A non-exempt employee's voluntary attendance at an educational experience may or may not be compensable, in accordance with applicable law. If the educational experience occurs outside of the employee's work hours, is truly voluntary, is not directly related to the employee's job, and does not require or involve any productive work by the employee during attendance, the employee will not be paid for their participation.

When day of departure travel takes place in the last half of a regular workday, CHC staff is expected to work some portion of the travel day. For example, CHC would not expect a staff person to not report at all on a regular business day when their departure time can be estimated during the afternoon.

With advance notice of at least three weeks, cash advances for travel expenses may be available on an as needed basis prior to departure. Contact your supervisor for further information. Receipts are still required upon return and any unused funds, or incurred expenses without proof of receipt, must be returned to CHC.

In the event of an accident while traveling, you must notify Human Resources immediately.

The following are not reimbursed as business expenses by CHC:

- Commuting mileage costs to and from the airport of origination, unless the airport is located outside the CHC service area, and the cost is more economical to drive than other available transportation.
- Any and all incidental charges.
- While on overnight travel, incidental charges beyond the cost of the hotel room and applicable taxes.
- Personal long distance telephone calls and hotel telephone surcharges. Personal use and/or mileage of rental cars or personal cars, shuttles, taxis, and all ground transportation, unless included in the registration fee for the conference.
- Personal entertainment or recreational expenses and expenses for “optional" special events that may be offered to conference attendees for an additional fee.
- Unapproved conference or seminar educational purchases.
- Any portion of any expenses that are a direct result of any person traveling or attending a meeting or event with you.
- Childcare expenses for a traveling employee.
- Substitute food expenses for meals that are already covered within a registration fee paid for by CHC.
- First class travel, and upgrades to air travel, car rentals, or hotel rooms.
- Purchase of clothing, luggage, toiletries, and other miscellaneous personal items.
- Supplemental travel or car rental insurance.
- Fines, penalties, or legal fees.

While CHC will not reimburse you for the expenses listed above, you may qualify for a tax deduction on some of the expenses listed. Please consult a professional tax preparer for more information. In unusual circumstances and in its sole discretion, CHC may make a case-by-case determination regarding reimbursement of non-reimbursable expenses.

In all cases, for all expense reimbursement to be considered, employees must provide bona fide receipts, attached to the prescribed expenses report form, to their supervisor for approval of payment by CHC. Employees will not be reimbursed for expenses without proof of receipt. In order for reimbursement to take place, all receipts and requests for reimbursement, including mileage reimbursement, must ~~take place~~ be submitted within 45 days of incurring the expense.

CHC generally does not reimburse dues unless there are subscriptions or other educational materials and/or educational benefits (for example, reduced fees [not to exceed the cost of the dues] for conference attendance) that accompany dues structure, with supervisor approval. This occurs on a case-by-case basis.

CHC generally does not reimburse individual ~~CME or~~ continuing medical education (CME) or continuing education unit (CEU~~-~~) expenses which are required to maintain certification or licensures.

Revised ~~*05/18; Reviewed 03/22*~~*05/22*

FAMILY AND MEDICAL LEAVE

All CHC employees who have been employed for at least 12 months and worked at least 1,250 hours in the previous 12 months are eligible to take up to 12 weeks of Family and Medical Leave of Absence (hereafter referred to as FMLA) in a rolling 12 month period due to their own serious health issue, to care for an immediate family member ~~as~~ (defined by federal law as including a spouse, son, daughter, or parent) with a serious health condition, or for the birth or adoption of a child ~~(defined as spouse, parents, and children under the age of 18)~~.

The following conditions apply:

- ~~Any~~ All FMLA leave will be counted against the employee's annual ~~Family and Medical Leave~~ FMLA entitlement.

- In all cases involving illness or medical necessity of the employee or qualifying family member, it is required of the employee to furnish to CHC prior to the FMLA leave, a medical certification signed by a physician detailing the serious health condition which would qualify for ~~an~~ FMLA leave. Failure by the employee to provide said medical certification shall cause denial of the FMLA leave. CHC reserves the right to request periodic medical certifications signed by a physician on a reasonable basis during the course of the FMLA leave. For CHC employees, a personal serious illness or serious health condition is defined as one: (a) requiring inpatient care; (b) that creates an absence of greater than three days for treatment or recovery; (c) that includes absences for treatment of the condition which if left untreated **would likely** result in an absence of greater than three days; or, (d) that requires continued treatment from a health care provider amounting to two or more visits or treatments or one visit which leads to a regimen of continuing treatment.

- Employees must use all applicable accrued benefit days during their FMLA. If sufficient benefit days are not available to cover the duration of the FMLA leave, the remaining time off will be unpaid. CHC observed holidays which may fall during an employee's FMLA leave, will not be paid out. Employees may use earned benefit days in lieu of taking the ~~day~~ holiday without pay. Vacation accrual will be suspended while employees are on a FMLA, and reinstated upon their return.

- It is the employee's financial responsibility to continue payments for participation in payroll deduction for insurance and the Medical/Dependent Savings Plan if applicable. Failure to do so could result in the immediate cancellation of these benefits.

  In the event that the employee fails to return to work from ~~the~~ FMLA leave, CHC will collect all health insurance premiums from the employee that were paid by CHC on his/her behalf during ~~the~~ FMLA leave and do so to the fullest extent allowed by law. However, if a "serious health condition" or "other circumstances beyond the control of the employee" prevents the employee from returning to work, CHC will take no recourse to collect insurance premiums that were paid on the employee's behalf during the FMLA leave.

- Employees who have taken an FMLA leave for a personal serious illness are required to present a fitness-for-duty medical certificate signed by a physician upon returning from their FMLA leave.

- Upon returning from an FMLA leave within the maximum 12-week period, CHC will restore the employee to the same or equivalent job, wage or salary in all cases with the exception of the potential consequences for "key employees." Generally, "key employees" are the Administrative Team positions at CHC, but federal law will determine specifically who is a "key employee" based upon CHC's salary structure at any given time.

- If an FMLA leave is foreseeable based on an expected birth or adoption placement, or planned medical treatment, the employee must provide no less than 30-day notice before the date the FMLA leave is to begin or as much notice as is practical.

- **FMLA** leave for the birth or placement of a child **cannot** be taken intermittently or on a reduced work schedule basis. **However,** if the FMLA leave is for the employee's own illness or for the care of an ill spouse, child, or parent, it may be taken intermittently or on a reduced work day or work week scheduled if it is medically necessary to do so.

- In the event that a qualifying husband and wife are both employed by CHC, they are entitled to 12 workweeks of FMLA leave between them in the aggregate if the FMLA leave is for the birth or placement of a child, or to care for a sick parent. If ~~the week the~~ FMLA leave is for their own illness or to care for an ill child or spouse,

each of them is entitled to 12 workweeks.

- Employees who are considered "key employees" as defined by federal law, may be granted FMLA leave, but may be denied restoration of position and salary guarantees under the following circumstances:
  - If it is necessary to prevent substantial and grievous economic injury to the operation of CHC,
  - CHC notifies the individual of its intent to deny return on such basis, and
  - If the FMLA leave has commenced and the employee elects not to return to employment after receiving the notice.

Military Family Leave - An eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member.

Revised 03/14; Reviewed ~~03/22~~05/22

MEDICAL LEAVE OF ABSENCE

Any available benefits under the Family and Medical Leave Act must be exhausted first, prior to invoking the Medical Leave of Absence.

Employees requiring time off in excess of three working days for their own non-work related illness or injury are required to apply for a Medical Leave of Absence (MLA). A physician's statement is required initially to support the request for leave. A statement from the physician is also required upon the employee's return verifying the return to work date and the employee's ability to fully perform the essential functions of the job.

When an approved MLA is not expected to exceed six weeks, every effort will be made to keep the employee's position open. In the case of a MLA that is longer than six weeks, efforts will be made to place the employee in the same job classification upon his/her return; however, there is no guarantee unless required by applicable law.

Employees must use all of their available benefit days during the leave period. When benefit days are exhausted, the remainder of the MLA will be unpaid time off. Vacation accrual will be suspended during the LOA and reinstated upon the employee's return. CHC observed holidays are not paid out if they occur during the leave period.
Employees are encouraged to provide as much notice as possible when requesting a MLA.

Revised 11/06; Reviewed ~~03/22~~05/22

PERSONAL LEAVE OF ABSENCE

Employees may request time off work for personal reasons by applying for a Personal Leave of Absence (PLA). Approval of a PLA is at the discretion of the employee's administrator, with approval by the President/CEO. Consideration will be given to the effect the employee's absence will have on the workload of others in the department. Personal leave must be taken in a single block of time and cannot total more than 8 weeks of leave time in a calendar year. CHC is not obligated to grant any request for personal leave.

Employees requesting a PLA will not be guaranteed that their position will be available upon their return.

Employees must use all of their applicable benefit days during the leave period. When benefit days are exhausted, the remainder of the PLA will be unpaid time off. Vacation accrual will be suspended during the PLA and reinstated upon the employee's return. CHC observed holidays are not paid out if they occur during the leave period.

Revised 03/22; Reviewed ~~05/120~~05/22

MILITARY LEAVE

An employee who shall have entered or been called into active military duty with the Armed Forces of the United States or their state of residence shall be placed on military leave without pay.

CHC abides by the Uniformed Services Employment and Re-employment Rights Act (USERRA) of 1994, which prohibits discrimination against any employee or prospective employee with regard to hiring, retention, promotion, or benefits of employment due to past, present, or future application for, or membership in, a uniformed service.

Revised 10/01; Reviewed ~~03/22~~05/22

SMOKING

All CHC facilities and grounds are considered smoke-free environments. Smoking, including the use of e-cigarettes, is strictly prohibited on any of its properties. Failure to adhere to this policy will result in progressive disciplinary action.

Revised 03/16; Reviewed ~~03/22~~05/22

WORKERS COMPENSATION

CHC employees are covered by Workers Compensation Insurance in accordance with the statutes of the State of Indiana.

Injuries incurred by employees while performing job duties must be reported to their supervisor immediately. An Incident Report form needs to be completed by the employee or the supervisor if the employee is unable to do so, and submitted to Human Resources within 24 hours of the injury.

During normal business hours, Human Resources should be contacted immediately if medical treatment is necessary or if the injury affects the employee's ability to continue performing his/her duties. In the case of an extreme emergency, employees should go to the closest hospital emergency department.

If a work related injury requiring immediate treatment occurs outside of normal business hours, employees should go to the closest hospital emergency department or urgent care center.

Revised 11/06; Reviewed 03/22

JURY DUTY

Employees called for jury duty or subpoenaed as a witness must notify their supervisor immediately to ensure appropriate staffing is maintained. A copy of the jury summons or subpoena should be forwarded to Human Resources along with a statement from the court clerk indicating days served.

Employees called for jury duty or subpoenaed as a witness will continue to receive their regular wages minus their jury duty compensation.

Revised 05/08; Reviewed 03/22

CONFIDENTIAL INFORMATION

Contact between the patient and CHC is a highly privileged, confidential relationship. Information about patients or observations made about them by employees on or off duty must not be discussed outside the CHC Team. Employees are ethically and legally obligated to maintain the confidentiality of patients/ families. Patient information will not be released without prior patient/ caregiver consent or in accordance with applicable law. In all cases, requests for information regarding deceased patients, past or present employees, must be directed to the President/CEO or designee.

Professional boundaries must be observed by staff at all times. Personal problems or concerns, information or opinions about the CHC workplace and/or staff members are **not** to be shared or discussed with patients/ caregivers and/or volunteers through any manner of communication including social media (i.e., Facebook, Twitter, etc.). A professional relationship with those served and with our volunteers must be maintained at all times.

All of CHC's trade secrets, confidential and proprietary information and all other information and data that is not generally known to third persons, including, but not limited to, client lists, client requirements and needs, client medical records or reports, proprietary financial information, internal financial documents, budgets, forecasts, business methods and processes, marketing data, pricing data, strategic business plans, and information about prospective clients or prospective products and services, is considered confidential information. Any breach of confidential information may lead to disciplinary action up to and including termination of employment.

All employees, volunteers, students, and agency contracted employees are required to sign a Confidentiality Agreement upon hire and annually thereafter as evidence of CHC's communication of its confidentiality policy.

Nothing in this manual should be construed as limiting, nor is intended to limit or be interpreted as limiting, precluding, or dissuading an employee's engagement in protected, concerted activity protected by state or federal law, including pursuant to Section 7 of the National Labor Relations Act.

Revised ~~09/14; Reviewed 03/22~~05/22

ELECTRONIC MEDICAL INFORMATION: CONFIDENTIALITY

In light of the broad access to patient information possible with electronic medical record keeping, the Agency takes specific steps to guard patient information from unauthorized viewing, as well as from dissemination. Employees of the Agency will acquire medical information from electronic sources only as necessary for the evaluation of eligibility for services or for the provision of care through this agency.

Any other use of electronic medical information systems is a violation of that patient's privacy as guaranteed

under HIPAA and may be grounds for immediate termination of employment.

Examples of specifically forbidden use of electronic medical information systems includes, but are not limited to:

- Looking up medical information on celebrities who may be hospitalized in local hospitals.
- Looking up medical information on immediate family, relatives, yourself, etc.
- Looking up medical information on neighbors, friends, fellow parishioners, etc.
- Looking up medical information on co-workers.

Previously stated protections regarding the release of patient information apply equally to information obtained from electronic medical information sources.

The Agency will include instructions regarding this area of confidentiality as part of its annual confidentiality training.

Where possible, the Agency will obtain and review reports of staff member access to electronic patient information to verify necessity for each record accessed.

Staff members who use electronic medical information systems for unauthorized purposes will be subject to disciplinary action up to and including termination of employment.

Reviewed ~~03/22~~05/22

CONDUCT IN PATIENT'S HOME

While in any patient's home, CHC employees are required to refrain from smoking. Employees are also to refrain from using the patient's phone unless it is absolutely necessary for official CHC business. Solicitation for any fund raising, gifts, gratuities and/or tips from patients or their families is absolutely prohibited. Staff is prohibited from accepting gifts. Cash gifts, gift cards, or gifts of any kind are prohibited under all circumstances.

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

Revised 05/20; Reviewed ~~03/22~~ 05/22

FRATERNIZATION

The socialization of care providers with CHC patients and their family members is a natural and healthy part of a good clinical environment, so long as those relationships are tempered with good business sense. Due to the nature of the relationship, care providers should interact on only the most professional level with CHC patients and the members of patients' families. Any personal fraternization between care providers and patients, or between care providers and patient family members, that involves any other behavior that is not on a professional work level is strictly prohibited. Violators of this policy are subject to potential disciplinary action up to, and including, the termination of employment

Effective 10/01; Reviewed ~~03/22~~05/22

WITNESSING OF DOCUMENTS

Employees are forbidden to witness any legal document such as, but not limited to, wills, living wills, or advance directives. This policy is for the sake of the patient and/or family members. This is important in order to avoid any possibility of conflict of interest or "undue influence" allegations that may arise when the will is probated or when directives are being implemented. Failure to abide by this policy may result in disciplinary action. This policy also extends to any volunteers affiliated with CHC or any of its affiliates. This policy also includes witnessing of any documents for the general public. Additionally, any available notary public services provided by CHC are exclusively intended for internal business purposes of CHC and its affiliates only, and the notaries providing such services are forbidden to witness any legal documents for patients and patient families. Notaries are not available at most CHC offices, nor will they be available at all times when requested.

Revised 11/00; Reviewed ~~03/22~~05/22

CARE OF RELATIVES

Staff is prohibited from functioning in their CHC employment role for any family member that becomes a patient of this ~~agency~~Agency.

Effective 06/10; Reviewed ~~03/22~~05/22

CARE OF STAFF AND VOLUNTEERS

Clinical staff is prohibited from providing clinical care, counseling, or presenting clinical opinions or advisement to fellow staff and volunteers, unless they are or have been an admitted patient or primary caregiver, or specifically and formally sought out CHC bereavement services.

Revised 06/14; Reviewed ~~03/22~~05/22

WORKPLACE VIOLENCE

CHC is committed to working with its employees to maintain a work environment free from violence. Violence may be described as verbal or physical threats, intimidation, and/or aggressive physical contact. Prohibited contact includes, but is not limited to, the following:

- Intimidation, harassment, assault, battery, stalking, or conduct that causes a person to believe that he or she is under a threat of death or bodily injury.
- Inflicting or threatening injury or damage to another person's life, health, well-being, family or property.
- Possessing a firearm, explosive, hazardous devices or substances, or other dangerous weapon, or using an object as a weapon on Agency property or during any Agency-related activity.
- Abusing or damaging employee property.
- Using obscene or abusive language or gestures in a threatening manner.
- Raising voices in a threatening manner.

All reports of incidents of this nature, including oral or written statements, gestures or expressions that communicate a direct or indirect threat of physical harm, will be investigated and dealt with appropriately.

Employees who observe or experience such behavior by anyone on CHC premises or while performing CHC business, should immediately report it to their supervisor or the Director of Human Resources.

Employees found to have committed such acts will be subject to disciplinary action up to and including termination.

Revised 08/09; Reviewed ~~03/22~~05/22

WEATHER DAY

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

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

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

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

Revised 05/20; Reviewed ~~03/22~~05/22

LOW CENSUS DAY

In the event that patient census temporarily decreases to the point that we have excessive staffing, the supervisor may require staff to take time off. The option will be given to staff on a volunteer basis, and then followed by a rotating basis, at the discretion of the supervisor. On these days, PRN staff will not be utilized. An ongoing list of staff rotation will be kept by your immediate supervisor.

Non-Exempt staff may choose to take unused Vacation or Personal Days to facilitate getting a paid Low Census Day. Exempt staff is required to use applicable benefit days.

Revised 03/16; Reviewed ~~03/22~~05/22

EMPLOYMENT OF RELATIVES

No employee may supervise or be supervised by a relative.

For purposes of this policy, "relative" includes: spouse, sibling, parent, grandparents, children, grandchildren, niece, nephew, aunt, uncle, in-laws, or persons living in the same household substantially comparable to any of the above.

An employee may seek special permission for waiver of this policy by submitting a request in writing to the President/CEO.

Revised 08/09; Reviewed ~~03/22~~05/22

TELEPHONE USAGE

Occasional personal phone calls are acceptable. However, supervisors have the discretion to limit their employees' personal phone calls if they are interfering with job performance, deemed excessive, or cause disruption in the department.

CHC land line phones are intended for the transaction of CHC business. Personal long distance phone calls and/or faxes are not permitted.
CHC cell phones are to be used solely for CHC business. Personal use of these phones is prohibited. Company and personal cell phones should be set on silent mode or turned off during all CHC meetings.

Revised 05/08; Reviewed ~~03/22~~05/22

WIRELESS PHONE USE

Employees whose job responsibilities include regular or occasional driving are expected to refrain from using a cell phone or other wireless devices while driving.

If acceptance or placement of a call is unavoidable, employees should pull off to the side of the road and safely stop the vehicle before using the phone.

Employees who are charged with traffic violations or accidents resulting from the use of any cell phone or other wireless communication devices while driving for CHC business, will be solely responsible for all liabilities that result from their actions. Violators of this policy will be subject to disciplinary action in accordance with company policy.

Revised 11/06; Reviewed ~~03/22~~05/22

PERSONAL BELONGINGS

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

Revised 10/18, Reviewed ~~03/22~~05/22

LOSS, DAMAGE AND DESTRUCTION OF PROPERTY

All CHC employees have the responsibility for insuring the safekeeping of CHC property while on or away from the office premises.

A CHC employee may be charged~~-~~, in accordance with applicable law, for repair or replacement of lost, damaged or destroyed CHC property resulting from careless, negligent or unintended use by said employee.

A CHC employee may be charged for replacement costs of property that is lost or damaged during a period of time when said employee is responsible for its safekeeping (examples could include, but are not limited to: beepers, cellular phones, computers and their accessories, etc.). When the appropriate authorities are notified of theft within 24 hours, CHC employees will not be responsible for replacing CHC property that has been stolen.

When lost, damaged or destroyed property is covered under an insurance policy purchased by CHC, the employee responsible for the careless and/or negligent loss, damage or destruction of insured CHC property will be charged the insurance deductible amount necessary for CHC to obtain repair(s) or replacement(s).
This policy shall also be construed to include loss, damage and destruction resulting from careless, negligent, or unintended use of property belonging to patients/families by CHC employees while performing duties as a representative of CHC.

Revised ~~11/00; Reviewed 03/22~~05/22

CONSULTATIONS / PRESENTATIONS TO OUTSIDE ORGANIZATIONS

CHC staff is often asked to make presentations by organizations. The Director of Marketing and Access or designee must be notified of all requests and a presentation form should be completed.

Presentations

CHC will not charge for such presentations, nor is staff to be compensated by the sponsoring organization. If the sponsoring organization desires to compensate, CHC is to be the recipient of such funds.

Consultations

Hourly rates may be charged for staff consultations. This may include travel, lodging and food reimbursement. CHC is the recipient of these funds. All qualifying staff expenses for travel, lodging and food will be directly reimbursed by CHC.

Under no circumstances shall any employee of CHC share, release, mail, or answer questions verbally or in writing regarding the policies, procedures, or protocols of CHC to another organization without the prior permission of a member of the administrative team.

When in doubt concerning whether to involve yourself or CHC in such projects, consult your administrator. Any contact regarding information made by any organization outside of CHC should be reported to the President/CEO or designee.

Revised 03/16; Reviewed ~~03/22~~05/22

COMPUTER

Our proprietary software contains extensive patient information and must be treated with the same degree of respect and confidentiality as any other patient information, and other agency related confidential information, i.e., finances, fundraising, etc. The users need to be aware of the following and agree to confidentiality requirements of CHC.

1. Only the authorized users are expected to enter or view information on any patient. All CHC confidential data will reside only on CHC owned computers. This includes all information.

2. No individual other than the authorized users shall have knowledge of access and passwords to the CHC computer systems.

3. The authorized users will not allow the equipment provided by CHC to be used for any other purpose than CHC authorized software applications.

4. No applications other than those authorized by CHC shall be loaded onto the equipment. This includes, but is not limited to, accessing bulletin boards, Internet services, games, etc. If such use of CHC computers is discovered by CHC, it may result in immediate dismissal of the employee.

5. No individual, other than the President/CEO, Vice-President/CFO, or Information Technology personnel will be allowed to disassemble or modify the setups of the equipment.

6. Violation of any of the above may lead to immediate termination of employment. CHC may seek further legal assistance and may pursue other legal options against the parties involved.

7. Use of computer equipment, software, and Internet access are intended for the purpose of conducting CHC business. Use of the Internet and email will be monitored by CHC.

Upon termination of service with CHC, employees may not retain any computer related programs, files, or materials for personal possession. All computer-related materials are the property of CHC.

All software, and all copyright, patent and trade secrets and other intellectual ~~proprietary~~ property rights are the valuable property of their individual owners. The trade secret information used to develop these products, and future products, are not generally known to the public or available elsewhere in the same or similar form. This includes the software design, functionality, screen layouts, reports, etc. CHC agrees to hold this information of the software confidential and requires its employees to act in accordance to the following guidelines:

1. Licensed Software products will be used only by CHC employees.

2. All employees and subcontractors of CHC agree to the terms of conditions of the appropriate vendor license agreement.

3. In the event any information is shared with someone other than an agent of CHC, CHC will contact the appropriate vendor and disclose the potential risk of exposure.

4. If any other individuals or entities desire to view or use the software product, you shall provide the name/organization to the Director of Finance, who will contact the appropriate vendor.

Care of Physical Equipment

The equipment purchased by CHC is expensive to purchase and maintain. An appropriate care and maintenance schedule is required to maximize the longevity of our investment.

1. The equipment will be fully inventoried and product numbers registered by the IT Director.

2. All equipment files will note the individual and checkout date of each item.

3. The equipment files will have a listing of software authorized for use on each computer.

4. A maintenance routine will be established on each item.

5. Individuals will be instructed on the care and safety of all equipment. The following rules apply to all CHC employees who use the computer software and hardware:
   - Always keep equipment out of the hot sun.
   - Allow equipment to reach normal temperature before using.
   - Always lock equipment up when left unattended.
   - Do not place the equipment near sinks, bathtubs, toilets, etc.
   - Clean and dry hands before touching the keyboard.
   - Do not eat or drink over the equipment.
   - Never set the laptop computer on an uneven surface (i.e., your car); use the shoulder strap at all times when transporting the laptop; place the laptop on the floor of your car when driving, not on the seat; place the laptop in the trunk when leaving it unattended in your car; do not leave laptop in your car overnight or for extended periods of time. Do not expose to temperature extremes.
   - Report all software/hardware problems to the applicable member of the computer committee the next business day if problems occur outside of business hours.

The Loss/Theft/Damage to Property policy should be periodically reviewed by all staff.

E-Mail

E-mail transmissions are considered CHC property, therefore, employees should have no expectation of privacy. CHC reserves the right to monitor all e-mail messages, and may override any individual password(s) in order to ensure compliance with CHC policies. CHC e-mail is intended for the transaction of CHC business. Soliciting or advertising matters unrelated to CHC business (including, but not limited to personal business ventures, social gatherings, political, religious, or charitable causes) is prohibited without the expressed permission of an administrator.
Misuse of e-mail can result in disciplinary action, up to and including termination. Examples of misuse include, but are not limited to:
- Transmission of profane, obscene, or offensive material

- Sending messages, jokes, etc., that violate CHC's harassment policies or otherwise create a hostile work environment
- Forwarding of confidential information to unauthorized parties
- Non-secured PHI.
- Expressing of political and/or other personal views in CHC's name

The sending or receiving of proprietary information, trade secrets, or any other confidential information via e-mail (or any other means) is prohibited.

E-mails should be treated as formal documents. E-mails should be written with the awareness that they are a permanent record. "Deleted" messages may still exist electronically; therefore, all e-mails must be treated as if they could be read in the future by a third party.

HIPAA Security

Individuals will be instructed on the HIPAA Electronic Security Rule regarding Electronic Protected Health Information (ephi). Failure to comply with the HIPAA policies may result in the application of the progressive discipline policy.

If a HIPAA security violation is suspected, the Information Systems Coordinator and the applicable Administrator will conduct an investigation to determine the nature and severity of the violation.

The applicable Administrator will initiate the progressive disciplinary process (if applicable) based upon the type and severity of the violation.

Revised 05/18; Reviewed ~~03/22~~05/22

SOCIAL MEDIA

The purpose of this policy is to define appropriate usage of online social networking tools for Center for Hospice employees authorized to post on behalf of CHC.

CHC employees who use online social networking tools (e.g., Facebook, Twitter, LinkedIn, blogs, podcasts) personally or professionally must not share confidential information on social networking websites and must comply with all CHC privacy policies.

CHC will use social media as a means to communicate relevant information to the public and will have authorized personnel managing CHC's social media accounts. The Marketing and Access Department will notify personnel who are authorized to update CHC social media accounts. A file of authorized personnel will be maintained in Human Resources.

Nothing in this manual should be construed as limiting, nor is intended to limit or be interpreted as limiting, precluding, or dissuading an employee's engagement in protected, concerted activity protected by state or federal law, including Section 7 of the National Labor Relations Act.

PROCEDURE FOR EMPLOYEES:

1. Employees' Internet postings should not disclose any information that is confidential or proprietary such as financial information, volume information such as the daily census, etc.

2. Employees must maintain patient privacy on social networking websites and adhere to all CHC HIPAA policies.

3. Employees are not permitted to use online social networking websites on work time unless they are authorized personnel.

4. Employees should write in first person and make it clear that they are speaking for themselves and not on behalf of CHC.

5. When employees comment on anything related to CHC, they should clearly identify themselves and their roles.

6. Employees with a blog should include a disclaimer stating that the views are their own and not those of CHC. Employees may use this example: The views expressed on this [blog; website] are my own and do not reflect the views of my employer.

7. When employees find a comment they make on a social networking website pertaining to CHC to be incorrect, they should acknowledge and correct it in a timely fashion.

8. Employees are advised to use common sense (e.g., be respectful, use appropriate language, etc.) with online social networking. Employees should be aware that the public can view their social networking websites and it is important to adhere to all of CHC privacy policies when posting on these websites.

9. Any violators of this policy will be subject to disciplinary action according to CHC policy.

PROCEDURE FOR AUTHORIZED PERSONNEL:

1. Only authorized personnel may post on behalf of CHC.

2. Internet postings by authorized personnel should not disclose any information that is confidential or proprietary, such as financial information, volume information such as the daily census, etc.

3. Authorized personnel must maintain patient privacy on social networking sites and adhere to all CHC HIPAA policies.

4. Authorized personnel may use online social networking websites on work time as along as it pertains to CHC.

5. Authorized personnel should not post personal information on any of CHC's social networking websites.

6. When authorized personnel find a comment they make on any of CHC's social networking websites to be incorrect, they should acknowledge and correct it in a timely fashion.

7. Any violations of this policy will be subject to disciplinary action according to CHC policy.

Social media are Internet based tools used for sharing and discussing information.

Online social networking is the act of using Internet based tools to share and discuss information.

Common social media websites:
- Blogs

- Facebook
- LinkedIn
- Twitter
- YouTube

Social Media Questions and Answers

Q: How do I protect my privacy on Social Media?

A: Most social networking websites offer a variety of privacy settings so you can control who sees the information on your account. You can personalize your settings by going to the setting control on your social networking website and adjusting your settings to your personal comfort level.

Q: How do I determine how to set my privacy settings?

A: Some people may be comfortable having all of their information available for the entire online world to see, while others may only be comfortable sharing information with close family and friends.
It is up to you to decide how private you would like to be when using these websites. Please make sure to check your privacy settings on your social networking websites to make sure they are set in a manner in which you feel is appropriate for your personal level of comfort.
Please note: No matter how you set your privacy settings, it is always inappropriate to share confidential or proprietary information on social networking websites and you must always abide by Center for Hospice Care Social Media Engagement Policy.

Q: What do I do if a patient or patient's family member contacts me on Facebook?

A: You should redirect anyone that contacts you through a social networking site regarding professional issues to Center for Hospice Care.

Q: Is it okay to share an important lesson that I learned from a patient on my blog?

A: You may share lessons you have learned on your blog as long as they do not violate HIPAA. You should never mention a patient by name, share detailed information about a case, or share pictures or videos of patients.

Q: Is it possible for others to break into my social media accounts? Am I at risk?

A: Yes, *phishing* is when someone posing as a trustworthy source steals sensitive information such as user names, passwords, and credit card information. Anyone who has a social networking website it at risk of being phished. To avoid getting phished you should not reply to e-mails requesting personal or financial information, be cautious when clicking on links or downloading files from e-mails, and use anti-virus software.

Q: Who do I contact if I have questions about social media?

A: Although many social media websites are for personal use, the information on them can often overlap into your professional life. Contact the Director of Marketing and Access if you find yourself in an uncomfortable situation related to your job on a social networking website.

Additional Resources:
www.facebook.com/safety

~~http://www.myspace.com/index.cfm?fuseaction=cms.viewpage&placement=safety_pagehome~~
~~http://help.twitter.com/forums/26257/entries~~
~~www.youtube.com/t/community_guidelines~~
~~www.onguardonline.gov~~
~~http://www.ftc.gov/bcp/edu/pubs/consumer/alerts/alt127.shtm~~

~~*Revised 03/16; Reviewed 03/22*~~

MEDIA

Refer all media inquiries to the Director of Marketing and Access or in his/her absence, the President/CEO.

Under no circumstances are employees of CHC and its affiliates permitted to ~~represent themselves as employees~~ communicate on behalf of CHC or represent the operations of CHC or any of its affiliates by talking, discussing, writing to, granting interviews with, requesting publicity, or online publishing related to CHC or any of its affiliates, or in any way communicating with reporters or staff members of newspapers, magazines, radio and television stations, websites, social media, and any other media outlets without prior approval of the President/CEO of CHC.

There are no exceptions to this policy.

Employees of CHC who do not abide by this policy may face immediate termination.

Revised ~~08/21; Reviewed 05/20~~05/22

PRIVACY

Employees of CHC should not have ~~any~~ an expectation of privacy ~~when it comes to~~ within the workplace~~. This includes~~ generally, including, but ~~is~~ not limited to, the employee's use of computers, Internet, e-mail, voice mail, telephones, workspace, and the employee's personal property brought into the workplace or onto company grounds.

Effective 10/01; Reviewed ~~03/22~~05/22

PRIVATE EMPLOYMENT OF CHC STAFF

All staff employed directly by CHC providing services on behalf of CHC for any active patient on agency census at any time, may not be employed privately by those patients or their families/caregivers, or by third-party or other business entities providing the same or similar private pay services.

This policy remains in effect for as long as the staff is considered an employee with CHC, or within thirty (30) days following the death/discharge of the patient from the active census of CHC.

Failure to comply with this policy may cause the immediate termination of the employee. The application of this policy shall not adversely alter the level of care of any CHC patient.

Revised 02/14; Reviewed ~~03/22~~05/22

REDUCTION IN FORCE

Economic or business circumstances may dictate a permanent reduction in the size of our workforce. When an actual termination of employment is necessary, a reduction-in-force may be implemented. Under these circumstances, there is no opportunity for recall. There are no promises of advance notice with regard to a reduction-in-force, although CHC will comply with all applicable laws with respect to a reduction-in-force.

The President/CEO shall decide when a reduction-in-force is necessary. They shall also determine and identify those offices, departments, teams, and/or job classifications where workload will not support current staff and the number of employees who will be affected. The following procedures apply:

1. Part-time employees will be considered for reduction first, regardless of years of service. Factors in determining which part- time employees are affected will include ability and skills and the adequacy of individual performance records.

2. Half-time employees will be considered for reduction next, regardless of years of service. Factors in determining which half- time employees are affected will include ability and skills and the adequacy of individual performance records.

3. Full-time employees will be considered for reduction next, with length of continuous service as a full-time employee an important factor in determining which employees will be affected. Of equal importance in making this determination will be the ability and skills of the employees affected, as well as the adequacy of their performance record.

4. Management and supervisory position employees will be considered next and these reductions shall be heavily influenced by the number of reductions within a given manager or supervisor's office, department, team, and/or job classification. A determination will be made regarding whether the manager or supervisory position within the company is still relevant. Which managers and supervisors are included in a reduction shall be determined both to an equal extent by factors of ability and skills, along with the adequacy of the performance record.

When economic or business conditions change sufficiently to allow the company to hire additional staff, no promises are made or inferred within this policy to indicate that employees previously affected by a reduction-in-force will receive preferential treatment.

Unemployment compensation information will be provided to a requesting employee through the assistance of the Indiana Department of Employment and Training Services and Health Plan Benefits, where applicable, and will be available in accordance with the law.

If an employee affected by a Reduction-In-Force is recalled for the same position within one year, all benefits and/or benefit days available to that employee at the time of their termination will again be made available; with the exception of paid Vacation Days. Vacation will begin accruing (at previous level) from date of recall.

If an employee affected by a Reduction-In-Force is later rehired for a position other than the one they held prior to the Reduction-In-Force, or a year or more following a Reduction-In-Force, they will begin as a new employee in every respect and policy.

~~*Revised 11/00; Reviewed 03/22*~~

~~SAFETY~~

~~PROCEDURES~~

WORKPLACE EMERGENCY PROCEDURES

Immediate Emergency Situation

Call 911 and report as many details as possible to the emergency operator.

If the situation allows, stay on the phone and take direction from the emergency operator.

If personal safety is at risk, leave the area notifying as many others as possible. If leaving is not a possibility, hide and protect yourself.

Do not try to negotiate with an assailant armed with a weapon. Follow instructions given by the perpetrator.

Non-emergency Situation

Separate the people involved in the potentially violent situation by verbal interaction or command – **DO NOT** engage them physically.

Notify an administrator about the situation immediately.

If the people involved do not separate and the situation escalates, call 911 and follow the steps previously described as immediate emergency situation.

Complete an *Incident Report* form within 24 hours.

Reviewed 03/22

PERSONAL SAFETY GUIDELINES FOR HOME CARE STAFF

Cars

- Lock your car doors at all times. Keep valuables out of sight.
- Keep car in good working order. Have enough gas to carry you through the day. Carry emergency supplies in your trunk.
- When walking to your car, carry keys between knuckles (to use as a weapon, if necessary). Have the door key ready so you can enter your car quickly.
- Before entering your car, check the back seat. When approaching your car, be sure to look under and around the car.
- Park as close to your destination as possible. Park in such a way that you can easily pull out after the visit and in the direction you will be traveling. Park in an area visible to others, in a well-lighted location, away from trees and shrubs.
- When stopping for traffic lights, allow sufficient room to quickly maneuver your car away, if necessary.
- If you suspect you are being followed while driving, drive to the nearest police, fire, or gas station.

Walking

- Always be alert and aware.
- Avoid walking down alleys or taking short cuts across deserted lots or private property.
- Walk in the center of the sidewalk, away from buildings. Observe windows and doorways for loiterers.
- Never walk through a crowd. If a group of people is blocking the sidewalk, walk around them or cross the street.
- If a car is following you while you are walking, turn and walk in the opposite direction.

Making the Home Visit

- Note presence of any safety precautions in the clinical record before visiting the patient.
- If in doubt about your safety at all, call the family prior to visiting and ask them to meet and escort you. The police may also be contacted to escort you.
- Leave the patient's home if you feel unsafe (i.e., heated family argument in process). Inform the patient of return visit plans. Discuss your safety expectations before a return visit is made. Report the situation to your supervisor.
- Do not attempt to break up a domestic argument.
- If pets are in the home and are a nuisance, politely, but firmly, ask the family to put them in another room for all visits.
- If firearms are present and apparent in the home, ask the family to put them in another room for all visits.

Revised ~~*03/16; Reviewed 03/22*~~*05/22*

END OF MANUAL

~~DOG BITE PREVENTION~~

Why Might a Dog Bite?

- **Stress/Anxiety:** A dog can bite in any stressful situation…
  - **Fear:** People, places, objects and situations all can elicit a fear response. Anxiety in a human also can provoke fear in a dog.
  - **Protection:** Often, dogs are trying to protect something/someone when they bite. Dogs can be very protective of their home and family.
  - **Resource Guarding:** Highly valued personal items, such as food, bones and toys often are worth fighting for.
  - **Illness/injury:** Pain and discomfort can make dogs more irritable. Petting them in the wrong spot can elicit a reaction to pain.
  - **Restraint/Confinement:** Dogs in crates or on leashes often are more stressed, and therefore more prone to bite.
  - **Accidentally:** During play, excitement or interaction with another dog.

Signs That a Dog May Bite - A dog may exhibit one or more of the following:

- Barking
- Lip curling
- Growling
- Rigid posture
- Staring
- Hair raised
- Ears flattened
- Dominance
- Not listening to owner
- Acts sick or injured
- Yawning
- Tail wagging (yes, in some cases)

What to Do

- **Assume that the dog is stressed**
- **Assess the situation**
  - Look for the warning signs
  - Check out the dog's environment
- **Always ask permission**
  - Offer the back of your hand and allow the dog to approach you
- **Take a deep breath, remain calm and carry mints in your pocket**
  - Popping an altoid or other such mint in your mouth will help to camouflage the scent of fear/anxiety

How to Avoid Being Bitten

- Never approach a strange dog, particularly one who meets the aforementioned criteria.
- Always assume that you are being perceived as a threat.
  - Do not make an overt motion toward the dog's owner/human with the dog nearby.
- Never assume that a dog won't bite.
- Avoid rapid movement and loud noises.
  - Stand still and speak softly
  - Do not smile

- Do not challenge a dog, or appear weak or subservient
  - Avoid direct eye contact
  - Do not reach over the dog's head
  - Do not stoop down to a dog's level
- Let sleeping dogs lie
  - Do not surprise a dog from behind or when eating or sleeping.
- Do not turn your back on a dog and walk or run away
- Shield yourself
  - Place a blanket, pillow, purse, briefcase, clipboard, jacket, etc., between you and the dog
- If you fall or are knocked down, curl into a ball with your face to the ground and hands over your ears to protect your head and neck. STAY STILL and call for help.

Effective 05/12; Reviewed 03/22

SEVERE WEATHER EVENTS

Severe weather events include any warnings, such as tornado, thunderstorm, or snow.

Weather alert monitors are located at the nurse's station in the Inpatient Unit. The monitors are left on at all times and will emit a warning tone followed by a National Weather Bureau announcement.

When a Tornado Warning is issued during regular business hours (8:00 a.m. 5:00 p.m., Monday through Friday), the receptionist will announce, "tornado warning" over the intercom system. After hours, Inpatient Unit staff will notify anyone left in the building.

Staff and visitors will take cover in designated interior spaces until "all clear" has been announced.

When the Tornado Warning expires, "all clear" will be announced.

Patients, visitors, and staff will be assessed for injuries and first aid will be initiated. If needed, emergency transportation will be arranged for area hospitals.

Structural damage will be assessed for safe occupancy. If needed, the Evacuation Procedure will be initiated. If no structural damage or injuries occurred, normal activities will be resumed.

INPATIENT UNIT

If time permits, unplug beds and move all non-ambulatory patients in beds against an interior wall and protect them with blankets and pillows. Ambulatory patients and visitors should be directed to take cover in the designated interior spaces. After giving instructions and initiating movement of patients and visitors, Inpatient Unit staff will take cover in designated interior spaces.

OTHER AGENCY LOCATIONS

When a Tornado Warning goes into effect, staff should seek cover in the designated safe area for their location.

FIELD STAFF

If you are in a **patient's residence** and a tornado threatens, go to the lowest level possible – preferably a basement. Once on the lowest level, go to the middle of the room away from windows, into a bathroom or hallway or closet if possible. The safest place to be in is a basement. If this is not an option, seek shelter in an interior room on the lowest level. Putting as many walls as you can between you and the outside will provide additional protection. If possible, get under something sturdy to provide protection against falling objects. Protect your head and neck from falling or flying objects, since these areas are more easily injured than other parts of the body.

If you are **in a car or in a mobile home**, seek shelter in a nearby sturdy building. If this is not possible, lie flat in a low-lying area where wind and debris will blow above you.

TORNADO DRILLS

The above plan will be reviewed periodically and rehearsed with staff on each shift, with special emphasis placed on carrying out the procedures necessary to protect patients and others. Documentation will be kept in the maintenance department.

Tornado Danger Signs

- **Dark, often greenish sky.** Sometimes one or more clouds turns greenish (a phenomenon caused by hail) indicating a tornado may develop.
- **Wall Cloud**. This is an isolated lowering of the base of a thunderstorm. The wall cloud is particularly suspect if it is rotating.
- **Large Hail.** Tornadoes are spawned from powerful thunderstorms and the most powerful thunderstorms produce large hail. Tornadoes frequently emerge from near the hail-producing portion of the storm.
- **Cloud of Debris**. An approaching cloud of debris can mark the location of a tornado even if a funnel is not visible.
- **Funnel Cloud**. A visible rotating extension of the cloud base is a sign that a tornado may develop.
- **Roaring Noise**. The high winds of a tornado can cause a roar that is often compared with the sound of a freight train.
- **Tornadoes may occur near the trailing edge of a thunderstorm and be quite visible**. It is not uncommon

to see clear, sunlit skies behind a tornado. They may also be embedded in rain and not visible at all.

Revised 05/18; Reviewed 03/22

SEVERE WEATHER STAFFING PROCEDURE

1. The scheduled incoming employee is responsible for notifying the Inpatient Unit staff currently on duty of anticipated safe arrival time.

2. The Inpatient Unit staff currently on duty will proceed in providing staffing for patient care until scheduled staff or other relief staff arrives.

3. The St. Joseph County Emergency Management (235-9234) and Elkhart County Emergency Management (535-6590) will place the Inpatient Unit on a list for staff pick-up and take-home only if there is a severe blizzard or declared disaster. The response will depend on placement on the assistance list and available 4x4 vehicles. Marshall County – contact the city or county police department.

Revised 05/18; Reviewed 03/22

FIRE PLAN PROCEDURE

IN CASE OF FIRE:

Rescue - any client or person in immediate danger.
Alarm - page location of fire and pull nearest alarm.
Confine - the spread of smoke and fire.
Extinguish - the fire if possible.

FIRE EXTINGUISHERS

Fire extinguishers are located throughout the buildings that are owned and/or leased by CHC. The locations of the devices can vary depending on the building and its usage. It is important for staff be aware of the device locations for the buildings where they frequent. Locations include but are not limited to: hallways, patient rooms, kitchens, and maintenance areas.

To Operate Extinguishers

Pull the pin
Aim hose at base of flame
Squeeze the trigger
Sweep from side to side

DISCOVERY OF FIRE IN THE INPATIENT UNIT

- Sound alert verbally to other staff, "Fire"
- Remove patients/visitors from IMMEDIATE danger. DO NOT move bed into the corridor.
- Pull fire alarm or instruct other staff member to do so
- Confine fire and smoke by closing doors and windows
- Attempt to extinguish fire. Stand in the doorway of the room where fire is located. Discharge extinguisher. Close the door to the room and set the extinguisher in front of the room door.
- Report to nurse's station.

- Non-Inpatient Unit staff should report to the designated area outside of the building (South Bend – west area of parking lot. Elkhart – staff parking lot.)

DISCOVERY OF FIRE IN CHC OFFICE AREA

- Pull fire alarm
- Assist anyone injured to a safe area
- Close all doors and windows
- Attempt to extinguish fire
- Exit the building and report to the designated area

DISCOVERY OF FIRE IN CHC SATELLITE OFFICE

- Verbally alert anyone in the office of fire and location
- Call 911 and provide necessary information
- Assist anyone injured to a safe area
- Close all doors and windows
- Attempt to extinguish the fire
- All personnel will exit the building by the closest safe exit door and go to the designated safe area to await instructions

NOTE: "All Clear" will be announced when conditions are safe or fire drill is concluded. Quarterly fire drills will be conducted on different shifts in the Inpatient Unit with documentation maintained by the Maintenance Coordinator.

Revised 05/18; Reviewed 03/22

SPRINKLER AND FIRE ALARM FAILURES

Appropriate agencies and persons will be notified when either the sprinkler or fire alarm systems become non-operational for a period of more than four consecutive hours. Also, a Fire Watch shall be implemented in the Inpatient Unit.
Maintenance, or whomever does the notifications, shall document the time, date, and name of persons they notified.

For the duration of time beyond four consecutive hours that either the sprinkler or fire alarm systems are non-operational, Inpatient Unit staff shall conduct a walkthrough of all areas in the Inpatient Unit **every 15 minutes** to observe for smoke or fire. Each time rounds are made, the time, date, and signature of the person performing the rounds shall be recorded on the Fire Watch log sheet.

Revised 05/18; Reviewed 03/22

CARBON MONOXIDE DETECTOR

Maintenance personnel will perform a semi-annual inspection of the carbon monoxide detector.

1. Remove detector from electrical socket.

2. Replace battery in the back of the detector.

3. Depress the test button on the front of the detector for proper function.

4. Reinstall the unit in the wall socket and depress the test button again to test for proper function.

Reviewed 03/22

INPATIENT UNIT EVACUATION PROCEDURE

When fire, smoke or an internal or external disaster requires facility evacuation, implement the following:

1. The evacuation will be accomplished according to the specific instructions issued by Fire Department personnel or designated staff member. During 8:00 a.m. 5:00 p.m., Monday-Friday, the designated staff member will be an Administrator or designee. After 5:00 p.m. and on weekends, it will be the Inpatient Unit R.N. until the arrival of the Fire Department or Administrator.

2. All available staff will help evacuate bed bound patients in accordance with transfer techniques learned during orientation and annual in-servicing. Evacuation of patients, staff, and families will be: South Bend – west parking lot area; Elkhart – staff parking lot. A head count of Inpatient Unit patients, families, and staff and will be done by the Inpatient Unit R.N. All other staff will be counted by an Administrator or designee.

3. Patient records will be removed next if safe conditions permit.

4. If needed, area ECF's will be notified for possible admissions. Appropriate transportation will be arranged. Patients will be reassured and kept comfortable during the evacuation process.

5. Physicians and primary caregivers will be notified of patient transfer.

6. Refer to the emergency evacuation exit floor plans posted throughout the building.

Revised 05/18; Reviewed 03/22

AUTOMOBILE SAFETY

All Indiana traffic laws are to be obeyed and you are asked to utilize defensive driving tactics at all times. Failure to do so may be cause for immediate termination.

In case of an accident arising out of and in the scope of their employment with CHC, employees shall contact the police, make a police report, obtain necessary car insurance information from those involved, and provide that information to CHC. If injury prevents this at the scene, file an accident report with the police and provide CHC with a copy. This is for information we will have to provide for the CHC liability policy and for Worker's Compensation.
CHC employees are required to have a valid driver's license, and proof of automobile insurance equal to or greater than what is mandated by the state of Indiana, if using an automobile while transacting CHC business.

Failure to comply with these safety policies can result in disciplinary action/dismissal of an employee.
CHC is not responsible for acts of vandalism or theft.

AUTO SAFETY TIPS

Following are suggestions from the Department of Transportation on how to handle emergency driving situations:

What to do if your brakes fail

- Work your vehicle into the right lane and then toward the shoulder or, if possible, toward an exit.
- When you reach the right lane, turn on your emergency hazard lights.
- Let the car slow down gradually by taking your foot off the gas pedal. Just steer as your vehicle slows and shift the car into a lower gear to let the engine help slow the car.
- Once off the traveled roadway, shift into neutral and gradually apply the hand brake until the vehicle stops. If that brake also fails, direct the car onto a soft shoulder or rub the wheel against a curb to slow the car down.
- When the car is stopped, leave the emergency flashers going and seek assistance. Do not be tempted to drive the vehicle, no matter how slowly, without brakes. Have the vehicle towed.

What to do if you have a blowout on a high-speed highway

- Do not slam on the brakes – let the car slow down gradually by taking your foot off the gas pedal.
- Work your vehicle toward the shoulder or if possible, toward an exit.
- Steer as your vehicle slows down. It is better to roll the car off the roadway (when you have slowed to 30 miles per hour) and into a safe place than it is to stop in traffic and risk a collision. Put your emergency hazard lights on.
- It is important to have the car well off the pavement and away from traffic before stopping, even if proceeding to a place of safety means rolling along slowly with the bad tire flapping. You can drive on a flat if you take it easy and avoid sudden moves. Don't worry about damaging the tire. It is probably ruined anyway.
- If you are not able to change the tire yourself, raise your hood and tie something to the antenna, if possible, so police officers will know you need help.

Winter Driving Tips

Following is a suggested list of items to keep in your car during winter driving:

- Flashlights with extra batteries
- First aid kit with pocket knife, scissors
- Necessary medications
- Several blankets or a sleeping bag
- Plastic bags (for sanitation)
- Matches in waterproof container
- Extra set of mittens, socks, cap
- Sack of sand for generating traction under wheels
- Shovel, small tools, booster cables, windshield scraper
- Flares or reflective triangle
- Dried fruit, nuts, high-energy bars, hard candy, bottled water

If trapped in a car during a blizzard:

Stay in the car. Do not leave the car to search for assistance unless help is visible within 100 yards. You may become disoriented and lost in blowing and drifting snow.

Display a trouble sign. Hang a brightly colored cloth on the radio antenna and raise the hood.

Occasionally run engine to keep warm. Turn on the car's engine for about 10 minutes each hour. Run the heater when the car is running. Also, turn on the car's dome light when the car is running.

Beware of carbon monoxide poisoning. Keep the exhaust pipe clear of snow, and open a downwind window slightly for ventilation.

Watch for signs of frostbite and hypothermia. Do minor exercises to keep up circulation. Clap hands and move arms and legs occasionally. Try not to stay in one position for too long. If more than one person is in the car,

take turns sleeping. For warmth, huddle together. Use newspapers, maps, and even the removable car mats for added insulation.

Avoid overexertion. Cold weather puts an added strain on the heart. Unaccustomed exercise such as shoveling snow or pushing a car can bring on a heart attack or make other medical conditions worse. Be aware of symptoms of dehydration.

Frostbite and Hypothermia: Frostbite is a severe reaction to cold exposure that can permanently damage its victims. A loss of feeling and a white or pale appearance in fingers, toes, or nose and ear lobes are symptoms of frostbite. Hypothermia is a condition brought on when the body temperature drops to less than 90 degrees Fahrenheit. Symptoms of hypothermia include uncontrollable shivering, slow speech, memory lapses, frequent stumbling, drowsiness, and exhaustion.

If frostbite or hypothermia is suspected, begin warming the person slowly and seek immediate medical assistance. Warm the person's trunk first. Use your own body heat to help. Arms and legs should be warmed last because stimulation of the limbs can drive blood toward the heart and lead to heart failure. Put person in dry clothing and wrap their entire body in a blanket.

Never give a frostbite or hypothermia victim something with caffeine in it (like coffee or tea) or alcohol. Caffeine, a stimulant, can cause the heart to beat faster and hasten the effects the cold has on the body. Alcohol, a depressant, can slow the heart and also hasten the ill effects of cold body temperatures.

Reviewed 03/22

Summary Report	
Title	**compareDocs Comparison Results**
Date & Time	5/11/2022 5:29:08 PM
Comparison Time	3.32 seconds
compareDocs version	v5.0.200.14

Sources	
Original Document	[#13885089] [v1] HR Policies Manual 2022-2024 DRAFT.docx
Modified Document	[#13885094] [v4] HR Policies Manual 2022-2024 (Final for Client Review).docx

Comparison Statistics	
Insertions	158
Deletions	100
Changes	120
Moves	2
Font Changes	0
Paragraph Style Changes	0
Character Style Changes	0
TOTAL CHANGES	380

Word Rendering Set Markup Options	
Name	Standard
Insertions	
~~Deletions~~	
Moves / ~~Moves~~	
Font Changes	
Paragraph Style Changes	
Character Style Changes	
Inserted cells	
Deleted cells	
Merged cells	
Changed lines	Mark left border.

compareDocs Settings Used	Category	Option Selected
Open Comparison Report after saving	General	Always
Report Type	Word	Redline
Character Level	Word	False
Include Comments	Word	False
Include Field Codes	Word	True
Flatten Field Codes	Word	False
Include Footnotes / Endnotes	Word	True
Include Headers / Footers	Word	True
Image compare mode	Word	Insert/Delete
Include List Numbers	Word	True
Include Quotation Marks	Word	False
Show Moves	Word	True
Include Tables	Word	True
Include Text Boxes	Word	True
Show Reviewing Pane	Word	True
Summary Report	Word	End
Detail Report	Word	Separate (View Only)
Document View	Word	Print

Center for Hospice Care
choices to make the most of life

CHAPTER THREE

PRESIDENT'S REPORT

Center for Hospice Care
President / CEO Report
May 18, 2022
(Report posted to Secure Board Website on May 12, 2022)

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

CENSUS

Referrals Year-to-Date (YTD) April 2022 was up 0.02% from YTD April 2021. As a percentage, referrals from facilities were down to 5.79% of all referrals compared to 6.43% a year ago. Facilities are not recovering census and having staffing issues like everybody else. At least one local nursing home has completely gone out of business. YTD April new original admissions were down 12.62% from 2021. The conversion rate (turning a referral into an admission) YTD April was at 57%, down from 69% in 2021. This is an where we have engaged Transcend Strategy Group for assistance. We are continuing to experience staffing challenges, especially for overnight shifts and on weekends. At a meeting of the National Hospice Executive Roundtable the first week of May, all members' censuses are down as well across the board. All are experiencing staffing issues. Some reported having a negative budget passed by their boards and the potential need to use reserves to fund operations. Hospice census is down generally across the U.S. primarily due to the decrease in census in facilities. Esther's House in Elkhart remains closed due to staffing and we're barely hanging on with staffing at Raclin.

April 2022 Overall	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Patients Served	375	734	912	-19.52%
Original Admissions	107	450	515	-12.62%
ADC Hospice	269.70	274.05	341.13	-19.66%
ADC Home Health	14.90	12.40	53.94	-77.01%
ADC CHC Total	284.60	286.45	395.07	-27.49%
ADC Outpatient Palliative	46.70	32.84		
Grand Total Patients	331.30	319.29		

January 2022 Inpt. Units	**Current Month**	**Year to Date**	**Prior Year to Date**	**Percent Change**
Raclin House Pts Served	37	144	108	33.33%
RH House ALOS	4.11	4.06	5.45	-25.50%
RH House Occupancy	42.22%	40.56%	49.00%	-17.22%
Esther's House Pts Served	0	0	72	-100%
EH House ALOS	0.00	0.00	5.79	-100%
EH House Occupancy	0.00%	0.00%	49.64%	-100%

MONTHLY AVERAGE DAILY CENSUS BY OFFICE AND INPATIENT UNITS

	2022 Jan	**2022** Feb	**2022** Mar	**2022** Apr	**2021** May	**2021** June	**2021** July	**2021** Aug	**2021** Sept	**2021** Oct	**2021** Nov	**2021** Dec
Mish:	158	160	162	154				187	188	182	183	171
Ply:	51	54	56	54				56	52	50	49	50
Elk:	57	55	52	51				100	90	76	69	64
Lap:	14	15	17	20				15	12	14	15	13
RH:	4	4	6	5				5	5	6	5	5
EH:	0	0	0	0				0	0	0	0	0
Total:	284	288	293	285				361	347	327	323	303

PATIENTS IN FACILITIES

In April 2022, the average daily census of patients in independent living, assisted living facilities, long term care facilities, and other facilities was 84. Year-to-date through April 2021 the ADC of patients in facilities was 83 compared to 142 for year-end, pre-pandemic 2019 – a 42% drop. Due to COVID, facilities are struggling and not seeing beds filling and the usual attrition of patients being replaced since last year is not taking place. Some experts in the field are now questioning whether this sector will ever recover to pre-pandemic levels. They continue to have serious staffing issues like everybody else. One local nursing home has shut down, and I'm sure you've heard about Miller's Merry Manor and the potential layoff of 700 people.

FINANCES

Karl Holderman, CFO, reports the year-to-date April 2022 financials will be presented and voted on at the Finance Committee meeting on Friday, May 13, 2022 and then distributed to the board later that morning. For informational purposes, the un-approved March 2022 YTD Financials are presented below.

On 03/31/22, at the HF, intermediate investments totaled $4,806,907 – a decrease of $193,813 from same time a year ago. Long term investments totaled $27,502,969 – an increase of $468,140. The combined total assets of all organizations (CHC/HF/GPIC), on March 30, 2022, totaled $76,918,463, a decrease of $283,546 from March 31, 2020. Year-to-date investments as of 03/31/21 showed a loss of -$2,059112.

From a year-to-date budget standpoint at 03/31/22, CHC alone was under budget on operating revenue by $1,091,771 and under budget on operating expenses by $846,374.

Year to Date March 2022 Unapproved Financials

March 2022 Year to Date Summary	Center for Hospice Care	Hospice Foundation	GPIC	Combined
CHC Operating Income	4,567,158			**4,567,158**
MADS Revenue	52,765			**52,765**
Development Income		1,319,757		**1,319,757**
Partnership Grants			152,362	**152,362**
Investment Income (Net)		(2,059,112)		**(2,059,112)**
Interest & Other	40,050	27,153	6,520	**73,723**
Beneficial Interest in Affiliate	(1,554,900)	5,859		
Total Revenue	**3,105,073**	**(706,343)**	**158,882**	**4,106,653**
Total Expenses	**4,856,944**	**848,557**	**153,023**	**5,858,524**
Net Gain	**(1,751,871)**	**(1,554,900)**	**5,859**	**(1,751,871)**
Net w/o Beneficial Interest	*(196,971)*	*(1,560,759)*		
Net w/o Investments				***307,241***

2021 DRAFT CONSOLIDATED FINANCIAL AUDIT AND STATEMENTS

The DRAFT 2021 audited financial statements are on the Board Agenda. They were reviewed by the Finance Committee on Friday May 13th at an extended Finance Committee meeting with the auditors from Kruggel Lawton CPA. Following Finance Committee approval, the DRAFT audited financial statements will be posted to the board website on 5/13/22. Hard copies of the 2021 audited financial statements by Kruggel Lawton CPAs will be distributed to all board members at the board meeting.

CHC VP/COO UPDATE

Lance Mayberry, MBA, CHC VP/COO reports…

The First Quarter of 2022 was an arduous and exciting quarter for the Center for Hospice Care, from the ongoing pandemic staffing challenges and surveys to exciting news in achieving our 2nd CHAP accreditation and our enhancement of our Palliative Care Clinic.

We enhanced our Palliative Care Clinic from being open by appointment only to performing 146 in-person patient encounters between March 1st and May 5th. Three key components were instrumental in allowing us to enhance our Palliative Care Clinic during the First Quarter were: planning, timing, and teamwork.

1. Planning
    1. In 2021, we decided to re-engineer the medical rounding model in the hospice houses. The model modification has resulted in greater flexibility of the staff allowing them to gain time back in their busy schedule and allowed us to streamline our communications protocols for admissions nurses and case managers.
    2. In the summer of 2021, we started formalizing the Palliative Care Clinic as a Part-B outpatient provider.
2. Timing
    a. Our Marketing and Intake department became aware that Beacon outpatient Palliative Care Clinic was shutting down in three weeks. Dr. Misner made the initial contact with the clinic, and within three weeks we had new expanded hours.
3. Teamwork
    a. It was an all-hands-on-deck to ensure patients received the care they needed and deserved, from intake, scheduling, medication management, and clinical collaboration. We have learned a great deal in the few short months and will continue to enhance our program over the years.

Center for Hospice Care Bereavement Department served 938 individuals in the 1st Quarter. Our Bereavement Department continues to provide an instrumental amount of support to our community, especially those who did not have an opportunity to experience the care of our hospice team. The number of requests has been growing over the years, and the request at times outnumbers the team's availability. This year, we have launched routine strategic meetings for the bereavement department to ensure the continuous enhancement and evolvement of our program.

	Total	Hospice	Community
Counseling Sessions	1187	22%	78%
Youth	118	8%	92%
Group Contacts	648	18%	22%
Art Counseling Sessions	133	18%	82%
Community Presentations	14		

In January, NHPCO announced Center for Hospice Care achieved level 3 in their new Quality Connections Program. Only 27 hospices in the United States achieved a level 3 or 4 status in the inauguration year of the program. Quality Connections participants are required to achieve milestones within defined timeframes by participating in education and competence, application of education, performance measurement, and innovation that promotes high quality care delivery, that leads to service excellence. As an organization, we will continue to strive for the highest level 4 achievement, but our success will be contingent on our ability to ascertain data from MatrixCare our Electronic Health Record.

Our team has been very busy this quarter in the support of our education outreach programs. The below programs would not be successful without the willingness of the staff, and the coordination

and leadership of Cyndy Searfoss, Director of Education & Collaborative Partnerships, at Hospice Foundation.

St Mary's Winter session 2022

1. Jan – April 26
2. 400 hours with case managers and IPU nurses

IUSB Winter session 2022

1. Jan - April 26
2. 360 hours with case managers and IPU nurses

Noter Dame Spring Palliative Class

1. Five team members from the clinical and support staff taught one or more classes
2. Dr. Matt Misner hosted 3 pre-med students from the class in our Raclin inpatient unit for a day

IUSB Palliative Program

1. Dr. Karissa Misner and Dr. Matt Misner continue to work collaboratively developing curriculum with Dr. Bunmi Okanlami, Bicentennial Chair of Palliative Care, IUSB
2. Larry Rice, Director of Support Service, and various team members of the clinical and support staff were guest lecturer at the undergraduate classes at IUSB this spring.
3. We hosted a mock Interdisciplinary meeting compromising of several CHC team members
4. Lance Mayberry, VP/COO, is developing curriculum, and will be a guest lecturer at the nurse practitioner graduate program.

Kathy Eash, NP, who had been with CHC for six years relocated to Kentucky to be with her grandchildren. This is the second NP who has moved out of the area in the past nine months. We were able to quickly source a new team member through our employee referral program, and I'm happy to announce Alyssa Yoder, NP, from Goshen Oncology will be joining us this month.

We received our 2019-2021 PEPPER Report, (Programs for Evaluating Payment Patterns) this quarter, and CHC continues to achieve exceptional results. The PEPPER provides provider-specific Medicare data statistics for discharges/services vulnerable to improper payments. PEPPER can support a hospital or facility's compliance efforts by identifying where it is an outlier for these risk areas. This data can help identify both potential overpayments as well as potential underpayments. Only one of the 12 measurements was outside of 80th percentile benchmark: Medicare Part D Claims in the last three days of life in Skilled Nursing Facility (SNF). This is a new measure and the first time it's been used. We are currently working with our local SNFs for accurate medication billing. Logistically, ensuring which medications are covered by hospice and which aren't and achieving accurate party billing in a SNF is not an easy assignment. Medicare believes there is "leakage" and there is. We will do what we can to correct it.

CHC DIRECTOR OF NURSING UPDATE

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

Community Health Accreditation Program, Inc., (CHAP) announced on 4/27/2022 that Center for Hospice Care has been awarded CHAP accreditation under the CHAP Home Health Service for which accreditation received Standards of Excellence. We are very pleased that in less than one year we have been able to achieve not only one accreditation but two accreditations that meets the industry's highest nationally recognized standards. We had previously received CHAP accreditation for hospice a few months ago. Rigorous evaluation by CHAP focuses on structure and function, quality of services and products, human and financial resources, and long-term viability. CHAP arrived on 4/5/2022 for home health site visit and exited on 4/7/2022. Survey results were received on 4/13/2022. CHC received no conditional level tags and five G tag deficiencies were cited. Plan of Correction was submitted to CHAP on 4/21/2022, and final approval on 4/27/2022. During the exit conference the surveyor commented multiple times on the level of professionalism and competency she observed on in-person patient visits. The surveyor completed three joint visits to patient's homes during the survey.

Director of Quality, Tammy Huyvaert will be attending the Indiana Association of Home and Hospice Care annual conference on May 10-11, 2022. She will be actively participating in key program sessions such as: Building a Successful QAPI program and Change the Culture of Care: Strategies to Recruit, Engage & Retain Today's Frontline Workforce, and several other key items impacting the hospice industry.

Raclin House continues to serve the community, and we are staffed strong on our days shift, and we are actively recruiting for the overnight shift since January after the previous team members in those roles moved out of state and took roles at the local hospitals. We continue to actively recruit for Esther's house, and we will need to add five night nurses between Esther's and Raclin House. During the quarter our IPU Manager, resigned his role to take a leadership pastoral position in the community, and we are actively recruiting for that position. Recruitment and retention remain a focus for CHC. CHC's new internal recruiter Robin Allen has been sourcing candidates and setting up interviews. Total no show interviews continue to be a trend here at CHC and in the industry.

STAFFING UPDATE

From 1/1/22 to 4/10/22, we have hired 24 new employees. From 1/1/22 to 4/10 we have had 35 terminations. Terminations have been for a wide variety of reasons when it comes to self-terminations. Even with being short staffed, and the current recruitment issues, to continue our patient care quality and reputation, we have continued to terminate the bad actors even though it increases the staffing scarcity. In the clinical area, we continue to be challenged to find weekends and overnights. We endure substantial no shows at scheduled interviews. Recently, we had 18 interviews scheduled for a maintenance tech position and just one showed up. This week in our latest class of six new orientees/onboarding group beginning on Monday, one emailed on Monday morning that she didn't think "hospice was a good fit for me" and she quit. Quitting without showing up on her first day. This was following the expense of sourcing, interviewing, national background check, and drug testing. We had a weekend overnight RN at Raclin House from a staffing agency call off at nearly the last minute because an agency in Ft. Wayne was offering a

little bit more. On a bright note, our new recruiter is doing an excellent job and putting in place significantly improved communications and messaging as part of retention efforts while concentrating on recruitment. She has visited all CHC offices to meet with the staff. Each Friday she sends an email to staff to let them know how many people invited to apply from Indeed, how many interviews were scheduled, how many actually showed up, how many offers were made, and how many new hires took place that week and in which department. This has been met very positively by staff and the transparency is wonderful as staff now know as much as I know every Friday. We also had a prize drawing for a $50 gas card for anybody that reviewed us on Indeed. Multiple positive comments were posted about working at CHC on Indeed. We did not request positive comments, just reviews. Robin Allen, Recruiter, has been sending very positive messaging and I believe it's making a difference. In light of what's happening locally, we are also going to be promoting the stability of CHC and the fact that in more than 40 years CHC has never had a RIF or layoff. We are actively working to connect with the 700 potential layoffs at Miller Merry Manor (MMM), including people we know who left here to go there because they lived closer, etc., and all of liaisons and staff who see patients there are taking their referral cards. We have contacts with every MMM in our nine-county service area and have had for 20+ years. Working at CHC is not a temporary job at an inflated rate for a short period of time. It's a stable career for the long term. On a somewhat different note, the Indiana Hospice and Palliative Care Organization's (IHPCO) Executive Director reported at the last IHPCO board meeting on 4/28 – while looking for potential new member contacts – that of the 95 hospice programs in Indiana, 12% had a CEO turnover in just a seven-week period during Q1 2022. Also note attached article, "Hospital CEO departures are on the rise."

HOSPICE FOUNDATION VP / COO UPDATE

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

Fund Raising Comparative Summary

	2018	2019	2020	2021	2022
January	37,015.96	62,707.48	79,642.06	44,297.77	706,739.60
February	93,912.90	113,771.80	222,116.20	92,053.38	744,945.66
March	220,485.17	369,862.26	295,882.74	302,752.14	831,998.95
April	310,093.61	565,568.94	414,128.88	894,989.96	
May	505,075.65	663,483.70	565,824.55	963,783.86	
June	633,102.69	850,496.19	608,907.96	1,226,150.74	
July	767,397.15	918,451.53	676,956.69	1,965,823.42	
August	868,232.25	1,018,532.22	818,805.78	2,087,178.64	
September	994,301.35	1,122,498.94	901,877.85	2,162,148.78	
October	1,074,820.86	1,778,379.29	984,590.41	2,239,987.25	
November	1,173,928.93	1,841,457.95	1,036,179.10	2,754,268.82	
December	1,635,368.33	2,946,889.74	1,719,702.83	3,443,708.15	

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

	2018	2019	2020	2021	2022
January	37,015.96	51,082.36	52,550.56	43,733.76	37,419.52
February	56,896.94	45,621.02	140,985.12	44,539.12	37,775.38
March	113,969.42	254,547.16	70,044.19	50,251.42	68,836.18
April	87,978.18	194,857.93	118,092.10	44,391.21	
May	182,601.92	97,864.76	149,945.67	54,437.96	
June	46,947.92	69,026.39	42,369.40	115,237.02	
July	64,243.53	67,591.20	42,034.72	83,873.96	
August	61,803.98	54,739.37	40,023.54	120,659.30	
September	117,984.73	68,812.68	71,574.73	74,539.46	
October	79,852.69	50,019.27	68,718.24	77,305.23	
November	94,053.07	57,214.65	51,099.68	51,389.39	
December	191,211.72	225,547.36	398,935.27	271,633.01	
Total	**1,134,560.06**	**1,236,924.15**	**1,246,373.20**	**1,031,990.84**	**144,031.08**

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) – Our focus remains on the final $1.2 million needed to meet our $6.1million goal. To date we have payments and totaling $4,835,000. New development staff members at REAL Services are being brought up to speed and engaged in this fundraising initiative.

- Plymouth/Marshall County Initiative – We are expecting an initial gift from Plymouth FOP Lodge 195. Initial contact with former board members and community leaders is taking place as we organize the fundraising initiative focused on supporting the establishment of Center for Hospice Care's new home in Marshall County.

Annual Appeal – "I Give Because"

Response to our recent Annual Appeal, "I Give Because" through 4/30/22 totals $95,588.86. This appeal focused on utilizing testimonials from our supporters to share how annual giving benefits Center for Hospice Care.

Planned Giving

Estate gifts from January 1, 2022, through April 30, 2022, totaled $5,100. These gifts in some instances require that we respond to inquiries from those managing the distribution of an estate, which is a process that spans many months or up to a year.

2022 Events

Gardens of Remembrance and Renewal Dedication will take place on Tuesday, June 7th. We will dedicate memorial items at our Elkhart Campus. This is an outdoor event in our Gardens of Remembrance and Renewal.

Veterans Tribute Ceremony is scheduled to take place on the afternoon of Tuesday, October 11 at the Captain Robert J. Hiler Jr. Veterans Memorial.

Okuyamba Fest will take place on Thursday, October 27. More information is forthcoming.

Education & Collaborative Partnerships

We will have ten Saint Joseph Hospital family medicine resident rotate at CHC for the 2022-2023 year. We are also working with the Memorial Hospital residency program to expand the amount of time and exposure that residents studying in the practice management/public health rotation (PMPH) have during their time at CHC. We have created a brief survey for residents to take in advance so we can create a customized schedule that matches their areas of interest.

IU Talk will be offered in-person on June 8th at IU South Bend's Elkhart Campus to 18 Master of Science in Nursing Family Nurse Practitioner (MSN/FNP) students. The half-day workshop will focus on building communication skills to effectively discuss life-limiting/chronic conditions.

Legislative Outreach

NHPCO's grassroots campaign, MyHospice, continues to be part of our community outreach/advocacy. COVID-19 and hospice priorities have been discussed in detail and the group's priority is to ensure that Indiana's federal legislators are aware of those issues as they meet to discuss current bills. Elleah Tooker, CHC/HF's MyHospice Ambassador, has been working successfully with legislators and staff to prioritize hospice and palliative care-related bills. A Hill Day fly-in is slated for June 13-14. We plan to have Elleah attend, visit the offices of our Senators and Representatives, and share materials/statistics that highlight the benefit of the hospice and palliative care CHC provides to the communities we serve.

Community Education

We renewed our Hospice Foundation of America membership for 2022 and have compiled webinar packages to send out to area professional organizations such as hospitals and extended care facilities for their staff to earn CE credits. Our Center for Education & Advance Care Planning (CEACP) will host a three-part series beginning in mid-June, on our Mishawaka Campus, offering three webinars with CE credits for professionals within our community.

We have a new end-of-life awareness building event slated for the summer of 2022. "Death on Tap," scheduled for Thursday, June 23rd on our Mishawaka Campus, will feature local breweries and our end-of-life information/education offerings through CHC, CEACP and Honoring Choices Indiana – North Central (HCI-NC). On April 16, we conducted informational sessions at Lippert Components in advance of National Healthcare Decisions Day.

For five consecutive Fridays in March and April, CHC staff lead the "Introduction to Hospice and Palliative Care" course at the University of Notre Dame. It is now a 1.5 credit course. The course was offered through the Ruth M. Hillebrand Center for Compassionate Care in Medicine/Jordan College of Science for the seventh time. Beginning this year, it will be offered every spring rather than every third semester. This expanded format includes some additional modules including "Why Hospice at the End of Life?" "Our Younger Patients," and "Hospice and Palliative Care Models."

We continue to collaborate with IU South Bend to provide guidance on course content and guest lecturers for the 100-level Introduction to Palliative Care course taught by Dr. Bunmi Okanlami. We are now assisting with the development of a 300-level course as well. In addition to the IU Talk workshop, we are developing a plan to offer experiential learning opportunities for MSN/NP students. We are also exploring opportunities to collaborate on learning experiences for BSN students (BSN) at Milton Adult Day Services as well as recruitment of their graduates. Other programs at the Vera Z. Dwyer College of Health Sciences have expressed an interest in collaborating at MADS as well.

Honoring Choices Indiana® – North Central

Honoring Choices Indiana – North Central (HCI-NC) continues to focus on three primary activities to accomplish its mission to proactively engage the people of our community in conversations with loved ones and medical caregivers about their goals for quality of life and advance care planning.

These are:
1. Provide educational Advance Care Planning (ACP) presentations to organizations, faith groups, and healthcare systems.
2. Train and certifying facilitators to host ACP conversations with individuals.
3. Engage individuals in ACP conversations to identify and record their values and wishes.

Through the end of April, HCI-NC staff and volunteers have made ten presentations to 142 individuals and have an additional ten presentations scheduled. In addition, we now have 122 certified facilitators, having trained an additional 12 facilitators at our First Steps® training on March 15 and 16. Since the beginning of 2022 we engaged 232 individuals in ACP conversations resulting in 82 completed documents. More documents were likely completed after the conversations. HCI-NC has undertaken a host of other activities to promote ACP and increase organizational sustainability, including:

- Partnering with area organizations and corporations to promote ACP. This includes Goodwill in Elkhart County; a collaboration being funded by a $5,000 grant from the Community Foundation of Elkhart County.
- Targeting underserved populations by connecting with their trusted advisors.
- Connecting and resourcing our current facilitators through quarterly "refreshers."
- Expanding services such as Advanced Steps facilitator training with emphasis on POST forms (Physician Order for Scope of Treatment).
- Collaborating with the other Honoring Choices programs in the US to develop resources and innovative programming.

- Participating in the Indiana Patient Preferences Coalition to help draft state ACP statutes and develop new forms.
- Raising additional funds in order to expand services.

Palliative Care Association of Uganda (PCAU)

In April the Ministry of Health (MoH) reported the country has sustained low transmission of COVID-19 with a positivity rate of less than 2% since February 2022. They have attributed the success to the early decisive and sustained measures put in place to curb the spread of COVID-19 and the cooperation of all Ugandans to adhere to these measures, including getting the COVID-19 vaccination. Although progress has been made in vaccinating the population, only 48 percent of the targeted population, aged 18 years and above, are fully vaccinated. Since Uganda's median age is just 16, this figure represents just 22% of the entire population. Uganda's vaccination campaign focused on targeting healthcare workers, teachers, and the elderly – and they have been successful in vaccinating over 80% of these three populations. Face masks continue to be required for crowded indoor spaces.

PCAU is facing several funding gaps in their 2022 budget. This is a result of a confluence of several factors, the two greatest being steep cost increases across the country for various goods and services, including fuel and Internet service; and loss of funding from the American Cancer Society (ACS) which has been one of their key donors for many years. ACS cut their funding to PCAU by 50% due to their own funding challenges with the COVID-19 pandemic. ACS funding supports activities related to the morphine supply chain and the Pain Free Hospital Initiative. They have also provided core funding for staff salaries and operations. They remain supportive of PCAU and are currently working with the team to help identify solutions for this $18,000 funding gap.

The other priority need is a new PCAU vehicle. Their current Land Cruiser, which was donated by the United States Agency for International Development (USAID) in 2010, needs to be replaced. It has been invaluable in facilitating PCAU's work across the country, but they now have frequent mechanical breakdowns and high maintenance costs. This is limiting PCAU's movements and activities across the country. The approximate cost of a new vehicle is $80,000 and we are in discussions to see how we may be able to assist in their fundraising efforts. PCAU has also appealed to the Office of the President and the Ministry of Health, as well as other development partners, to help with funding for this critical component that enables them to perform their mission.

We are planning to host PCAU for an exchange visit in October/November 2022. Their last visit was in 2018. They were last scheduled to be with us in March 2020, but the trip was canceled due to the pandemic. Mark Mwesiga and Joyce Zalwango will be visiting for approximately two weeks. We are tentatively planning to host Okuyamba Fest on Thursday, October 27th.

Road to Hope (RTH)

PCAU has continued to do an extraordinary job supporting children on the RTH program. The children have completed the first school term of the year and had their school break in early May. PCAU hosted the annual children's camp during this holiday, and we expect to hear an update on this soon. The children and PCAU staff were excited to gather again as a group.

A few Road to Hope children decided to pursue vocational education to focus on a trade of their interest. This allows them to be done with school in less time so they can become employed or start businesses sooner. We suspect that the difficulties they encountered during the extended lockdowns, and increased financial hardship, have influenced this decision for some students. During the pandemic, nine children have switched to vocational studies from primary or secondary school. The new enrollees in vocational studies have elected to pursue courses in construction, fashion and design, hairdressing, and motor-vehicle mechanics. PCAU reports that all the children on the program are happy and settling in well in their respective schools.

Although the Advanced Diploma in Palliative Care Nursing (ADPCN) program had significant challenges due to the pandemic, it is already making a difference to scale up human resources for palliative care in Uganda. In January, 21 students graduated, and an additional seven students are awaiting results to graduate. PCAU continues to provide mentorship and support supervision with graduates once they are back in their health facilities implementing palliative care activities. Out of 44 applications for the 2022 cohort, 13 scholarships were awarded to qualified candidates. These students are from 11 districts with limited or no palliative care services. They presented recommendation letters from their current employers, and after completing the one-year course, will return to their home districts to establish palliative care units in their respective health facilities. In addition to training more palliative care nurses, PCAU continues to work with relevant government entities such as the Commissioner of Clinical Services, Commissioner of Nursing and Midwifery and the Nurses and Midwifery Council to ensure there is infrastructure to support trained palliative care nurses. We understand that they are in process of officially adding palliative care nursing as a recognized, registered position. This will help with funding to support this specialized position and allow health facilities to hire specifically for those positions.

mHealth Project/Palliative Care Data

Throughout the first quarter of this year, PCAU and the Ministry of Health (MOH) have been assessing and revising the data collection tools in an effort to optimize them. Necessary changes were made based on feedback from facilities already collecting palliative care data and with input from the Clinical Services Department and a senior biostatistician at the MOH. The updated books have already been printed and PCAU continues with the dissemination and training of the palliative care data collection tools in collaboration with the MOH. Now that pandemic restrictions are fully lifted, PCAU will be able to move ahead with other project goals: supporting the strengthening of national palliative care data and information system, redefining PCAU mHealth data collection, and establishing and implementing an automated monitoring and evaluation system.

GLOBAL PARTNERS IN CARE UPDATE

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

We are now celebrating five years of GPIC being part of the Hospice Foundation. As we continue to face uncertainties due to the global pandemic, and as we consider that the global palliative care landscape is being impacted by lack of finances and sustainability, we are reflecting on our work and future direction for GPIC. As previously reported, we have gathered input from the board and other stakeholders, including the Advisory Council, as we develop a collective vision for the next 3-5 years. We also held a lengthy discussion about these areas at our last Advisory Council meeting

and will incorporate them into a strategic plan. From the feedback we have gathered thus far, there are a few key areas and messages that stood out, which are categorized and described below:

Partnership Program Growth

- Despite the recognized challenges of recruiting US organizations for partnership, we need to grow this program. This includes growing the number of partnerships, but also growing the financial participation and partnership engagement of existing partners.
- We need a clear and manageable growth strategy, especially given limits to our staff capacity and the changing face of the hospice industry (e.g., mergers, increasing number of for-profit agencies, etc.).
- Continue engagement with associations and larger organizations, which should help support partnerships and open doors for new, creative approaches to growing partnerships. This could include state associations and NHPCO.
- Education
- Growing educational support for our partners is important to the accessibility of palliative care, and the provision of connections and resources, has been perceived as a positive. As organizational capacity expands, we can grow this area even more.
- Research is part of education, and we should continue to pursue strategic research engagement with established partners such as African Palliative Care Association.
- Visibility and Impact of GPIC
- Building a larger presence and visibility for GPIC will be very important in expanding our base of support.
- We need to find ways to connect to more people who share our mission, perhaps directly targeting physicians and organizations
- We need to better define and collect data on the impact of our work. This includes impact on the ground (e.g., financial, patients served, etc.) as well as the impact of the partnership on the US organization (e.g., motivation, recruitment, etc.). Once we better measure and share this information, we will see our impact and visibility grow.

During the upcoming months, we will be working on a strategic planning document that will be coordinated with the broader strategic planning activities of CHC and HF. We welcome individual board member input and encourage you to share your ideas.

Current Partnerships

As we continue to focus support on our current partnerships, we are considering how to maximize our time and effort to support them. Cyndy and Lacey have been holding calls with all US partner working in a particular country (e.g., all US organizations who have partners in Tanzania). These have been very successful, and the US organizations appreciate networking and sharing. We will continue holding these two to four times per year, as requested by the group. We would also like to start holding African partner calls as well.

COMMUNICATIONS, MARKETING, AND ACCESS

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

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. Changes in the COVID status has once again begun to open opportunities to both professional contact as well as public presentations and events.

Community Liaison, Sarah Youngs, recently completed a very successful presentation series at the St. Joseph Public Library as well as participated in the first Muffet McGraw Women Build for Habitat for Humanity, St. Joe. After Sarah's meeting with Joe Hart, President of the South Bend Cubs, Center for Hospice Care will be participating in events the weekend leading up to Memorial Day. As a Level 5 We Honor Veterans Partner, we will be presenting pins to veterans in attendance both Saturday and Sunday. We will be recruiting our Vet-to-Vet volunteers to assist, especially focusing on Vietnam War Veterans with their unique pin. These "Welcome Home" pins are part of our 50th Anniversary Vietnam War Commemorative Partnership with the Department of Defense to acknowledge all conflict veterans prior to 2025. CHC has also submitted the renewal of our Level 5 activities. Sarah works on building relationships with some of the area's largest employers, such as Lippert Components. She recently met with their Director of Wellness and will begin presenting to three of their plants beginning in June on CHC services.

Our Professional Liaisons have been focusing on client relationship building and customer service. Most of these referral sources are at their breaking points, so we're making our case to allow us to help while creating value and reducing their costs.

Access

Our Liaisons and our Referral Specialist (i.e., Customer Service Representatives) will be undergoing training from Transcend Strategy Group (TSG) in June. TSG has developed techniques to address the challenges that are facing healthcare mentioned above. The Liaisons will be trained in those techniques that will continue to highlight real differences between CHC and our 33 area competitors.

We continue to struggle with response times due to decreasing Admissions staff. We've experienced turnover concerning our Referral Specialists and Nurses, and although we have new staff beginning within the next month, they will go through orientation and training. Our Admission Nurse Team Leader is returning to her previous Admission Nurse position. We currently have openings for two weekday admission nurses and a weekend Power Admission Nurse. In the meantime, we continue to triage patients that may be home with little or no support as opposed to someone who may be in a hospital setting and is being well cared for.

Website

Our website continues to see increases when compared to the previous year. We've seen a 38.93% increase in all users as well as a 41.02% increase in new users. The majority of our visitors are females aged 45-54, with females 35-44 being a close second. That is exactly our target demographic.

Milton Adult Day Services

Craig's department is also responsible for the Milton Adult Day Services (MADS) marketing. Beginning early this year, we began developing a strategy for publicizing our new location along with its services. We will be expanding a digital campaign once we're able to take advantage of as much free publicity as possible due to the excitement of the opening by news media outlets. Once that subsides, we will be focusing on a 20-mile radius from our Roseland location. This will be new to us in the fact that CHC has never marketed to Michigan residents due to licensing restrictions. With MADS, we will be able to extend our marketing into Niles, Buchanan, and Edwardsburg.

Social Media

Facebook (Center4Hospice)

Center for Hospice Care's social media presence is increasing steadily. We continue to use Facebook to communicate information and events. During the months of February-April, we focused on World Kindness Day and Caregivers Day. CHC reached 60,678 people for the period of February-April and had 6,312 reactions, comments, and shares. Our leading post was on Tuesday, March 22nd, which was photos of CHC's pinning ceremony of Jim Dewitt, CHC patient and Pearl Harbor survivor and which reached 3,284 people and generated 164 reactions, comments, and shares. The second most viewed post was the quote "What if today, we were just grateful for everything – Charlie Brown" along with the text, "We are grateful for the community we have the privilege to serve. What are you grateful for?" That post reached 3,173 people and generated 643 engagements. Women consists of 85.6% of our Facebook followers (54% are aged 55+) and 79.1% of our Instagram followers (50.2% are aged 35-54). That matches perfectly to our target demographic.

Our Instagram account reached 5,981 and had 129 profile visits.

CHC continues to have social media presence on Facebook (5,085 followers), Twitter (726 followers), Instagram (960 followers), YouTube (50 followers), and LinkedIn (443 followers) as well. Our Instagram account has increased in followers 103.2% over last year.

Digital Overview

The digital campaign focuses on delivering our ad to the proper audience at the proper time. For the above months it generated 50 telephone calls. As competition for digital visibility increases, the cost per click also increases. In the period between February-April, we were able to increase our impression share to 36.34%. Our Top Impression Rate increased for the same period to 84.89%, which means, every time somebody does a search for keywords such as hospice or palliative care, Center for Hospice Care is the listed at the top. In 2022 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 3.21 % and we continue to be high at 8.51%

MILTON ADULT DAY SERVICES OPENS AT NEW ROSELAND LOCATION

Milton Adult Day Services (MADS) was closed 4/28-4/29 at the Grape Road location while we prepared to move to the Milton Village in Roseland. That weekend would give a cushion in case something went awry. Nothing did. Monday morning, May 2nd we welcomed MADS clients to the new location and from what I'm told it all went very well and they were thrilled. There are some photos on our Facebook page. We will have an after-hours donor event in June and we're working on a specific marketing plan for this spectacular location. More to come.

GOOD NEWS WITH THE CMS LONG LENGTH OF STAY AUDIT

As you may remember, like many hospice programs across the country, including those members of the National Hospice Executive Roundtable, CHC received notification in a letter dated 1/17/2020 that we were part of a long length of stay Medicare hospice audit. The CMS contracted vendor, Noridian, requested thousands of pages of documentation on ten patients who were all admitted or on census in 2017. These account for 303 months of patient claims. A claim is generated monthly reflecting the patients per diem charges for that month. The total dollar amount of these claims for CHC totaled over $1.2MM. This is a very large national audit of individual hospice programs. Upon being notified that we would be part of this review, we contacted Meg Pekarski, Hospice Law Attorney at Husch Blackwell, LLP, to represent us in this matter and we have engaged her and her team. She is a nationally recognized hospice attorney who has been doing this for 20 years. She is one of the best and most respected in the nation on situations such as these and is being used by numerous NHERT members in this same audit and on other matters. Meg indicated over two years ago that this contractor is generating reports for individual programs after examining the materials that all have a 97% to 100% "error rate." There are numerous appeals processes and an eventual appeal before an Administrative Law Judge where hospices frequently win if they can get that far. We understood going in this was a multi-year adventure. We completed our part and sent literally thousands of pages of documentation and support materials to Husch Blackwell, LLP to send to the contractor. Nearly immediately, we received $89,000 back in reversed claims. On May 9th, 2022, we were notified that our reconsideration requests were granted / overturned on nearly 150 claims, reducing the alleged overpayment by $544,540.91, which the cut the error rate in half. Our next step was a call with Husch Blackwell on 5/12 to further discuss the results and talk about next steps, which includes submitting a request for an administrative law judge ("ALJ") hearing for the remaining denied claims. That request is due June 14, 2022.

NHERT MEETS MAY 1 - 3

The National Hospice Executive Roundtable (NHERT) CEOs from 13 of arguably the largest. oldest, and most respected non-profit hospice organization in the U.S. met the first week of May beginning Sunday at Tidewell Hospice in Sarasota, FL, who, now having merged with Empath Health in Clearwater, FL care for about 4,000 patients a day along with home health, palliative care, PACE, and everything else one could think of. All NHERT programs are non-profit, all have at

least one inpatient unit, and all have a charitable foundation. We begin meeting beginning Sunday night, then all day Monday thru dinner Monday night, and the same on Tuesday. Wednesday is a travel day. Besides program updates, we had guest speakers from Empath including Cecille Riggs, PT, MBA, who presented on "Home Care Overview and Trends," and Rhonda Sanders-Allamon, Empath Chief Mission Access Officer who spoke on "Improving Patient Access to Care." We also traveled and toured the Lakewood Ranch Hospice House, and, the Blue Butterfly Grief Center, which is a bereavement center exclusively for children funded 100% by donations. Conversations were wide-ranging and included:

-- Virtual Hospice admissions, telehealth, "RealTime Care"
-- Creating your own internal staffing agency
-- Population Health
-- The need for standardization
-- Being on the wrong side of the S curve
-- Cutting Costs
-- Goals alignment among various departments
-- The fact that excess deaths in 2020 and 2021 from COVID, overdoses, suicides and others will demographically reduce by up to 20% the available pool of potential hospice patients over the next decade. In 2019, before the pandemic, the CDC recorded 2.8 million deaths. But in 2020 and 2021, as the virus spread through the population, the country recorded roughly a half-million deaths each year in excess of the norm.
-- Having the difficult conversations with boards. Several programs had boards that approved a negative budget for 2022. Talking to boards about using reserves to temporarily fund operations, tumbling census, closing inpatient units, and more depressing news of the future.
-- If your market has a death service ratio (Hospice deaths) / (Resident Deaths) of 48% - 50% or higher you have no growth opportunities. For example, for 2021 St. Joseph County was 51% with multiple competitors. Nationally, about 48% of Medicare beneficiaries expired on hospice in 2021. It's still believed about half of all deaths in the U.S. are on hospice in a normal year. If you're in a county over 50%, and have competitors, what do you do to grow? The only mechanism for growth is share shift (meaning, steal market share).
-- None of the NEHRT member Foundations have anything invested in private equity due to how it might look to donors along with other reasons. Some even have within their investment policies that private equity funds are strictly forbidden.
-- Two members are retiring after very long hospice CEO careers. Neither of their organizations did searches. One due to a massive merger and the other moved the CMO up to the position. Some were uncomfortable with this, some thought it was OK. We also talked about
\ the Deborah Norville syndrome of who from the outside would want to follow a nationally well-known CEO who has been around as long as most of us, what would that mean for them, and why would they want to do that in this very small space of hospice?

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

- Care Synergy (The Denver Hospice, Pikes Peak Hospice and Palliative Care, Colorado Visiting Nurse Association, and Pathways), Denver, CO.
- Empath Health (Suncoast Hospice, et. al), Clearwater, FL
- Ohio's Hospice (Ohio's Hospice of Dayton, Ohio's Hospice at United Church Homes, Ohio's Hospice of Miami County, Ohio's Community Mercy Hospice, Ohio's Hospice of

Butler and Warren Counties, Hospice of Central Ohio, Ohio's Hospice of Fayette County, Ohio's Hospice LifeCare, Ohio's Hospice Loving Care, and Community Care Hospice), Dayton, OH.

- Bluegrass Care Navigators, Lexington, KY
- Arkansas Hospice, North Little Rock, AR
- Delaware Hospice, Wilmington, DE
- Transitions LifeCare, Raleigh, NC
- Catholic Hospice, Miami Lakes/Fort Lauderdale, FL
- Tidewell Hospice, Sarasota, FL
- Hospice of Washington County, Hagerstown, MD
- Hospice of East Texas, Tyler, TX
- Community Healthcare of Texas, Fort Worth, TX
- Center for Hospice Care, Mishawaka, IN

POLICIES ON THE AGENDA FOR APPROVAL

There are several revised clinical policies that reflect standard practices, regulatory changes, and clean-up language. Angie Fox, DON, will be available to answer questions. Interestingly, we now have a policy on writing policies.

2022- 2024 HR POLICY MANUAL ON THE AGENDA FOR APPROVAL

The next HR Policy Manual for the next two years is on the agenda. The Executive Committee (E.C.) acting as the Personnel Committee has approved this manual and recommends board approval. This comes after a request from the E.C. to have the policies reviewed by outside counsel. This was a very good idea and the E.C.'s approval comes after that legal review. Redlined changes and additions to the HR policy manual are included in this board packet. The review was completed by Shelley Jackson, one of our attorneys at Kreig Devault who has helped us over the last two years with COVID personnel policies and other issues. Shelley concentrates her practice in the areas of health law, employment law, professional license defense, and data privacy and security. She brings a diverse set of professional experiences to her work, including time spent both in a law firm setting and in-house as an assistant general counsel and chief privacy officer for a multi-national corporation. She routinely advises and represents clients in compliance and enforcement matters before administrative agencies, such as the Indiana Professional Licensing Agency, U.S. Equal Employment Opportunity Commission, U.S. Department of Labor, and U.S. Drug Enforcement Administration. She is also a seasoned litigator with more than a decade of complex litigation experience. She frequently writes and speaks on a number of health care and employment law topics. She, along with our E.C., have given this manual a seal of approval.

MOU SIGNED FOR NEVADA CARE CONNECT REACH ACO

I have signed a non-binding MOU with Nevada Care Connect a "High Needs" REACH ACO, a Medicare demonstration project through their Center for Medicare & Medicaid Innovation (CMMI). This demo was previously called Direct Contracted Entity (DCE). Basically, the REACH ACO can acquire all Medicare beneficiary data, run algorithms to identify high need patients that should be

monitored in an attempt to meet their needs and keep them out of the ER/hospital. Since hospice excels greatly at keeping patients out of the hospital and ER, we would be paid to monitor these patients and do just that. This is a very complicated program, I don't totally understand it, and as we continue to learn more, nothing formal will be decided until perhaps September. This could be an additional new revenue stream for us doing what we do normally each day. Nevada Care Connect is owned by Infinity Hospice in Las Vegas, Reno, Pahrump, NV and Phoenix, AZ. It's a family run business and the CEO and President are brothers Brian and Darren Bertram. I've known both of the brothers for at least a decade and have served on the NHPCO board with Darren and currently serve on the Hospice Action Network (HAN) board and HAN Executive Committee with Brian. More to come.

NOTRE DAME MBA STUDENTS STRATEGIC PLAN IS ATTACHED TO THIS REPORT

In very late February, three Mendoza College of Business MBA students from the University of Notre Dame spent four days with us on a class project. We assigned them to strategic planning. They took their 2022 spring interterm project as "CHC/HF Strategic Plan" with the purpose of evaluating the current goals for calendar year 2022, the next strategic plan, key obstacles for the organization, and opportunities for growth. We alerted them to the page one 2022 goals at the top as our current strategic plan. Their report is an attachment to this President's Report. They did a remarkable job of paying attention and really only met with staff for two of the four days. One of them was actually working fulltime and in and out. Hope you enjoy.

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.

TRANSCEND STRATEGY GROUP ENGAGMENT HAS BEGUN

The engagement with Transcend Strategy Group (TSG) in Toledo, OH began a few months ago with every other week Zoom meetings and now moving to weekly Zoom calls. TSG was formerly known as Transcend Hospice Marketing and CHC has had a long relationship with them going back about 14 years. The reconfirmed top priorities of their work on our behalf for this project is: 1.) growing hospice census, 2.) improving hospice length of stay, and 3.) recruiting top talent. We are currently in a research phase. They will also be doing training of our liaisons, admission reps, and call center staff the week of June 13th on messaging and dealing with barriers.

BOARD EDUCATION SECTION

The topic of the board meeting education section will be presented by Craig Harrell, Director of Marketing and Access. He will be presenting an abridged version of the Market Snapshot shared with us by Transcend Strategy Group (TSG) yesterday, 5/11. TSG is on a six-month engagement

with us, and we simply would like to take ten minutes to update you on where we are, what we're learning, and how what the research has shown will eventually lead to the refresh of our messaging.

OUT AND ABOUT

I attended the NHPCO Leadership and Advocacy Conference and HAN/NHPCO combined issues sessions in National Harbor, MD March 5-8.

Several staff attended the above meeting March 7-9. While not attending the conference, GPIC was on-hand as an exhibitor and several new potential partners were identified.

I participated along with several staff in the 1.5 credit hour "Hospice 101" classes at the University of Notre Dame over the course of five Friday afternoons.

I attended most of the events, along with Mike Wargo and Chris Taelman for Hospice Foundation donor meetings and events in Largo, St. Petersburg, and Sarasota, FL the week of May 28th.

Many staff attended the Annual Volunteer Recognition and Annual report held at The Amory Event Center on April 12th. The event was attended by 130 people. Thanks once again this year to CHC Board Member Kurt Janowsky for his generosity with this great event at The Amory Event Center.

I was a guest speaker and taught an MBA class for the "Transformations in Healthcare Innovations" course at the Mendoza College of Business at the University of Notre Dame.

Several of us attended the annual "Age of Excellence Awards" sponsored by REAL Services on April 19th. CHC/HF was a sponsor.

Several staff attended the annual "Salute to Business Luncheon" presented by the South Bend Regional Chamber of Commerce. CHC/HF was a sponsor on April 26th.

I attended the Board of Directors meeting for the Indiana Hospice and Palliative Care organization on April 28th via Zoom.

I attended the National Hospice Executive Roundtable meetings at member program Tidewell Hospice in Sarasota, FL, May 1-3.

Many staff attended the 37th Helping Hands Award Dinner at the Hilton Garden Inn on May 6th.

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

Karl Holderman's monthly dashboard summaries.

Board Committee Opportunity Sheet

Volunteer Newsletters for March, April, and May 2022

NPR transcript of "The pandemic pummeled long-term care – it may not recover quickly, experts warn"

Health Exec article, "Hospital CEO departures are on the rise"

Hospice News article, "Hospices See New Opportunities in Adult Day Market"

Hospice News article, "Hospices Hail CMS Pay Bump, Worry About Rising Costs"

Hospice News article, "Hospices Expand Inpatient Care, But Tread Carefully"

Hospice News article, "Lack of Payment, Training Curtail Pediatric Palliative Care"

McKnight's Long-Term Care News article, "MA enrollees with dementia report poor quality care: study"

JAMA Research Letter on "Excess Deaths From COVID-19 and Other Causes in the US, March 1, 2020, to January 2, 2021"

Notre Dame MBA Team Report

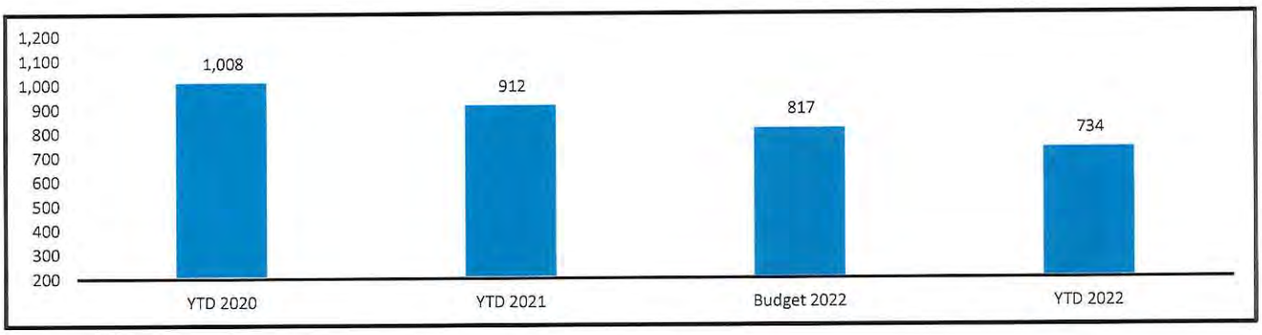
NEXT REGULAR BOARD MEETING

Our next regular Board Meeting will be **Wednesday, August 17, 2022, at 7:15 AM at the Mishawaka Campus in Conference Room A**. 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 .

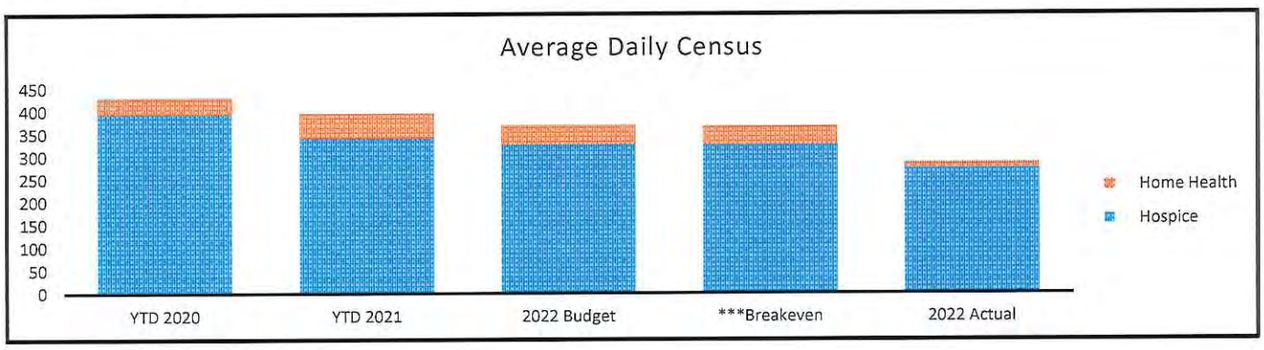
# # #

Center for Hospice Care
April 30, 2022

	YTD 2020	YTD 2021	Budget 2022	YTD 2022
Patients Served	**1,008**	**912**	**817**	**734**

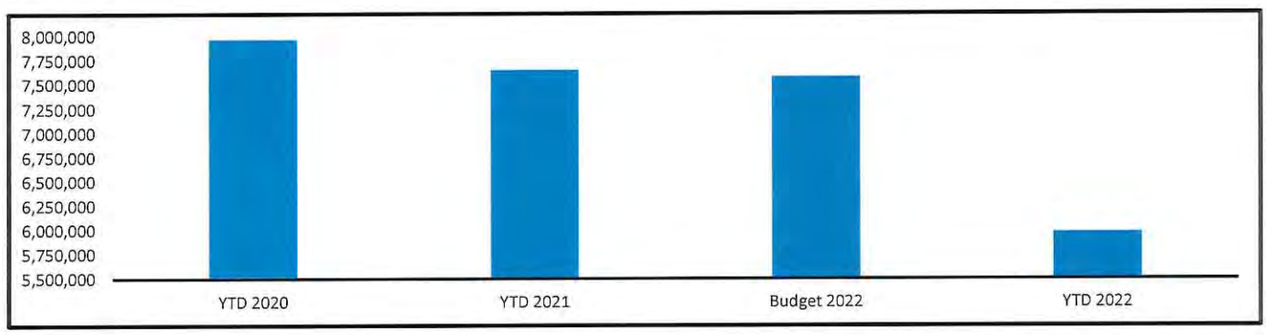


Average Daily Census	YTD 2020	YTD 2021	2022 Budget	***Breakeven	2022 Actual
Hospice	393.98	341.13	327.40	325.32	274.05
Home Health	37.02	53.94	42.03	41.75	12.40
Total Average Daily Census	**431.00**	**395.07**	**369.43**	**367.07**	**286.45**

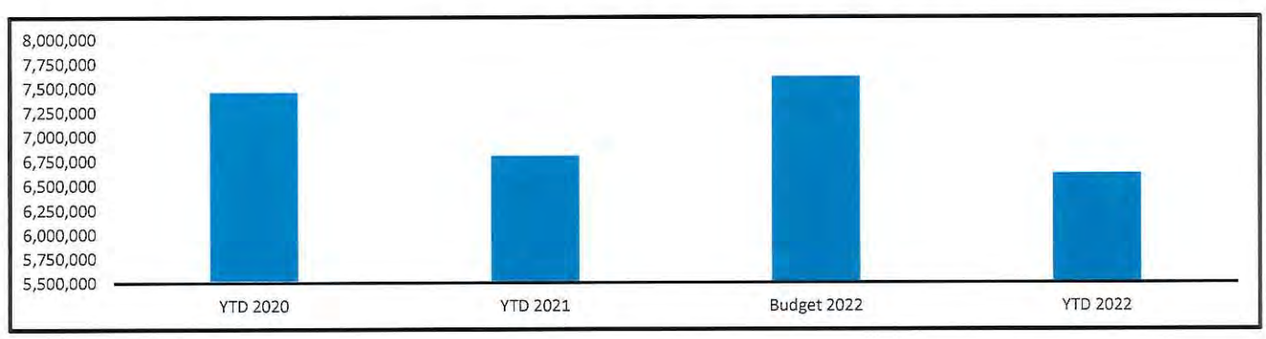


*** *Budgeted Breakeven*

	YTD 2020	YTD 2021	Budget 2022	YTD 2022
Operating Revenue	**7,964,888**	**7,650,593**	**7,576,553**	**5,982,900**



	YTD 2020	YTD 2021	Budget 2022	YTD 2022
Total Expenses	**7,455,488**	**6,797,136**	**7,613,210**	**6,618,440**



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.

March 2022
Volunteer Newsletter

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

Coming Full Circle Through Coffee

In Memory, Louis Myers 7/21/1935-12/31/2021

By Kristiana Donahue

It's quite rare to see stories come full circle, but when it happens it often makes us stop and think. Good deeds happen every day; probably most of them unseen by others. Louis Myers' good deed went exactly as he had planned—and that's a marvelous thing.

Linda Bradshaw is a Center for Hospice Care CNA. When she came into work at the Raclin House one day, she was completely floored. She saw Louis in one of the rooms and she cried when she saw him. "Staff were looking at me," Linda said. "You all just don't know! This is Louis." And she shared her story.

A few years back, Linda had been a long-time employee at Burger King. Louis Myers was a regular customer, coming in almost daily. Linda would give him a free senior coffee, which he much appreciated. Throughout the years a friendship developed—one that involved a free coffee, smiles and care. He knew providing for children is difficult for many parents and he helped Linda purchase winter coats for her kids one year. He loved coming to Burger King – as he is very social. Linda appreciated his kindness. When his wife passed away, Linda noticed how distraught he was and she gave him a hug. "After that," Linda shared, "he came in every single day I was there."

One day, Linda came back to work after a day off. "My manager said someone left a check for $1,000 and said that he wanted me to take care of him when he got old," Linda reminisced. Linda immediately refused the generous gift. The check was made out to the business that conducted CNA training. Linda had never considered becoming a CNA and never discussed this with Louis. According to Louis' daughters Lois and Suzie, this is common for their father. "He's an unusual guy," Suzie said. "Always has been." Whatever caused him to act on this idea ended up changing the course of Linda's life forever. "It was something I wasn't expecting to do," she said. "I had the time off and he wouldn't take the money back, so I just did it. I'm happy he did it."

She worked another year at Burger King, not truly trusting this new course in her life. However, she eventually went to St. Paul's. She had lost contact with Louis because she left Burger King and she had never seen him outside of work. One day, at St. Paul's she noticed Louis eating lunch in the dining room. His brother was a resident there and Louis came to visit him

Continued on Page 2

Inside this issue:

How does my friend become a CHC volunteer?

Do you have a friend or family member who is interested in becoming a CHC volunteer? Do you know someone who would be good as a CHC volunteer? Send them my way!

Do I need to have an application on hand if someone is interested?

No! If someone is interested in volunteering with CHC, simply direct them to our website, www.cfhcare.org. We have a volunteer page on our website with lots of information as well as an online application that takes just minutes to complete. If your friend or family member doesn't have a computer, you can have them call Kristiana Donahue at 574-286-1198 and she will take it from there.

What volunteer opportunities are needed at this time?

- Patient Home Visitors
- Raclin House Volunteers
- Hair Cut Volunteers

It's best to send them to Kristiana Donahue, who discusses our needs and their volunteer aspirations to make sure it's a good fit.

Continued from Page 1

for lunch on occasion. "Then I started having lunch with him and his brother," Linda shared.

Linda eventually moved from St. Paul's to Center for Hospice Care. Again, Linda assumed she wouldn't see Louis again. Until, after four years, Linda came to work one morning at the Raclin House and Louis Myers was there. She was overcome with the beauty of that moment. In 2010, he had told her that he wanted her to take care of him, and in 2021 she fulfilled that promise. "When I come in the morning and do my rounds," Linda said, "I take him his morning coffee."

This is exactly what he has done over the course of his life, according to his family. Lois and Suzie shared his quirky characteristics, but one endearing trait was his generous heart. "If he thought he could help someone, he would," Lois said. And that random act of kindness was not lost on Linda. "If it wasn't for him," she said. "Who knows where I would be or what I would be doing?... I wouldn't be here."

Some Changes Coming Your Way...

There are a few changes within the volunteer department that you will see this year. At this time we just want to give you a "heads up" regarding these changes so that you will keep your eyes peeling for news in the upcoming newsletters where we will share more information.

Life Story Volunteer Opportunity

For many years Center for Hospice Care has had a Life Story volunteer opportunity. Trained volunteers visit patients in their home to interview them about their lives. They then transcribe that patient's story into a program. Pictures may be added and when it is completed CHC prints and binds these stories to provide to the patient's family as a legacy.

In the past, CHC has utilized a web-based program from an outside provider. This year we are putting the final touches on an in-house Life Story

template. This will be more user-friendly than the previous program we used.

If you were a Life Story volunteer in the past or if you are interested in this opportunity, even if you have never done it before, watch for an upcoming training session where we will teach you how to use the new program. Volunteers who are interested in this opportunity should like to write and interview people. Feel free to let Kristiana Donahue and your volunteer coordinator know if you are interested in attending the training, once it has been scheduled.

Annual Skills Validation

Center for Hospice Care has a new Clinical Staff Educator, Ashley Hums, who will be conducting skills validations this year. For volunteers who do home visits or work in our inpatient care facilities (Esther House, Raclin House) your patient care skills must be validated once a year.

There are some changes to our skills validation this year—new volunteers have been receiving the new skills validation starting in January of this year. Volunteers who do any hands on care will need to complete skills validation; however, they are able to be validated only on the skills that they are able and willing to complete. We understand some volunteers aren't able to complete some skills due to health issues. This new format will provide a way for our volunteers to get the needed training annually on the skills that they are able to complete. When Kristiana Donahue contacts you to schedule your annual skills validation, feel free to ask more questions. She will be making contacts soon for those volunteers who need to complete the required annual skills validation.

We do have dates for our annual skills validation clinics scheduled.

1st Annual Skills Validation Clinic

Mishawaka Campus
May 17, 2022
1.5 hour slots
8:30am, 10:00am, 12:00pm, 1:30pm

2nd Annual Skills Validation Clinic

Elkhart Campus
June 7, 2022
1.5 hour slots
9:00am, 10:30am, 1:00pm

3rd Annual Skills Validation Clinic

Mishawaka Campus
September 6, 2022
1.5 hour slots
8:30am, 10:00am, 12:00pm, 1:30pm

Important Reminders

Missed Visits

When there is any change in a visit schedule—whether that is a cancelled visit or a change of date, the volunteer coordinators need to know this as soon as possible. Volunteer coordinators need to document these within a short time frame. Please make sure you contact your volunteer coordinator as soon as you know of a change in schedule.

Patient Information Dissemination

Our volunteer team wants to remind all volunteers that we are unable to freely disseminate information about patients on our care, even if these are individuals volunteers know personally. Volunteers do receive personal health information, but only for patients whom that volunteer is providing service for. Remember that HIPAA states that giving out information is on a need to know basis. If a volunteer isn't caring for a patient, then we can't share information about them.

Comments from our Families

- This Hospice care included a global pandemic which grades above and beyond. Words alone cannot describe what employees and volunteers of CHC were subjected to. I will always grade their service as excellent. Above and beyond their call to their duties.
- The best! Compassionate care at its best. They made a difficult situation tolerable and helped me when I needed it most!
- Thank you for helping me be able to keep my husband of 61 years at home so he could die with his loving family with him.
- My hospice experience was excellent. I can't say enough about how caring and personal each person from Hospice was while with both my husband and myself. They are the best. Thank you, Hospice!

Welcome to the Team

Raushell Gingerich

Elkhart RN

In Loving Memory

Our condolences and heart-felt sympathies go out to these volunteers who have lost loved ones recently.

Sylvia Ford, Mishawaka

Richard Marshall, Brother

Thursday, February 17, 2022

Lana Zeltwanger, Mishawaka

Richard Kendall, Father

Tuesday, February 22, 2022

Birthdays

3/2
Marne Austin

3/4
Richard Pipher

3/8
Lindsay Estrada

3/9
Benjamin Bower

3/15
Joan Fitt

3/15
Julie Shamo

3/16
Ann Bowers

3/18
Brandy Carich

3/19
Lauren Anastas

3/22
Alison Westerink

3/23
Anna Riblet

3/24
Richard Puterbaugh

3/25
Sandra Witkowski

3/26
Linda Burrell

3/28
Ilene Crutchfield

3/31
Margaret Schroder

Welcome New Volunteers

Debra Hembrecht
Mishawaka

Barbara Scully
Mishawaka

Joy Smith
Plymouth

Welcome Denise Benedict

Our volunteer department is pleased to introduce you to our new volunteer coordinator in the Elkhart office, Denise Benedict. Please join us in welcoming her to our volunteer team!

Tell us a bit about your family.

My significant other, James and I are empty nesters. We have six kids between the two of us, and three grandbabies.

Where are you from? How long have you been in the area?

I was born and raised in Hastings, Michigan. Moved to this area in the early 80's. We currently reside in Goshen. It's just far enough out that it feels like the country, but truly only a few minutes from everything.

What are some of your hobbies? What do you like to do for fun?

We love camping, RVing, festivals, and second hand treasure hunting. I am a mixed media artist, I sell hand painted greeting cards at arts and craft shows. I also bake. I love to make those really pretty intricate design sugar cookies. Great stress reliever!

What does hospice mean to you?

Hospice came into my mother's home and helped us keep her comfortable in the last two months of her life. They were a Godsend. My stepdad spent his last three days of life at Esther House. It was traumatic to see him so agitated. The nurses and social worker were amazing with explaining what to expect, and how we could stay involved. I love Center for Hospice Care's values: compassion, dignity, innovation, integrity, quality and stewardship.

What are you most looking forward to in being Elkhart's new volunteer coordinator?

I am really excited to meet all the volunteers, and spend a little time getting to know each other. Feel free to stop in, and introduce yourselves!

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

Elkhart
Volunteer Coordinator
Denise Benedict
benedictd@cfhcare.org
(574) 322-9814

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

April 2022
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Ethics in Hospice Care

Four cornerstone concepts frame the foundation of the hospice philosophy of care: (1) dying as an experience pregnant with meaning; (2) family-centered care; (3) the nature and relief of suffering; and (4) the integrity of persons as a condition of creating and experiencing meaning in life and exercising moral agency (Kirk, 2014).

Dying as an Experience

Hospice care is focused on the experience of dying. There are several important nuances surrounding the way in which the "experience of dying" is conceptualized. The first is that dying is a process, not an event. That is, dying is not something that occurs at the moment one satisfies the clinical criteria for cardiopulmonary or brain death. Rather, dying is the process one goes through in the months and weeks preceding that moment.

Second, dying is not simply a biological event experienced by physiological organisms. Rather, a primary implication of dying as an "experience" is that it is experienced by persons, and the process involves all of the different elements of their personhood—their emotional lives, their spiritual lives, their relational lives, their professional lives, and many others—and not just their bodies. So, while the death of the body occasions the end of these different pieces of personhood in their current forms (they are, after all, embodied), to consider death as merely a biological process fails to capture the full meaning of the process for all involved.

Third, the experience of dying can be meaningful—both for the one dying and for that person's loved ones. The focus in hospice care on dying in one's home—rather than the hospital, for example—is rooted in this commitment to the experience of dying as a valuable one: being surrounded by the conditions in which one has built and discovered meaning throughout life is thought to maximally enable persons to create and find meaning in the last weeks to months of life as well.

Family-Centered Care

Hospice care incorporates relationships with loved ones in the care of dying persons precisely because relationships constitute some of the very structures through which persons find and create meaning across the lifespan. Indeed, rather than disrupt the relational structures through which we have given and received care across our lives—a disruption that the founders of hospice thought was a significant drawback of hospital-based care—hospice

Continued on Page 2

Inside this issue:

2022 Volunteer Recognition and Annual Report Luncheon

Tuesday, April 12, 2022
11:30am-1:00pm

The Armory
727 South Eddy Street
South Bend, IN

Please join us as we express appreciation to you and honor the recipient of the 2022 John E. Krueger, MD Hospice Caring Award

Please RSVP by Monday, April 4, 2022. Call Kathy Kirsits at (574) 277-4100 or email KirsitsK@cfhcare.org

Continued from Page 1

seeks to support patients through those very structures.

The impact of intimate relationships is often reciprocal; that is, just as the experiences of dying persons can be significantly impacted by the involvement of their family members as caregivers, so, too, the dying of persons can significantly impact the lives of those who love them. Therefore, caring for the family is not disconnected from caring for the patient; it is part of the same process.

The Nature and Relief of Suffering

Saunders developed this idea in her concept of "total pain." For Saunders, total pain was not simply a bodily phenomenon. Rather, it had the potential to insinuate itself into multiple aspects of personhood, becoming a noxious inhibitor of one's ability to engage the world in many ways—emotionally, spiritually, psychologically, relationally, and intellectually as well as physically. In short, it could arise from—or find its way into—the totality of one's existence (Clark, 2000). To treat such pain in a biomedical model would require identifying and eliminating its cause. Given that this is often not possible in patients with advanced disease (especially the cancer patients whom Saunders had in mind for hospice), the goal shifted from treating disease to addressing symptoms.

Restoring and Supporting Moral Agency

The fourth cornerstone concept of the hospice philosophy of care is delivering care that maximally supports patients such that they can continue to live with the integrity and sense of self required to find and create meaning until the moment of death. This constitutes a robust commitment to moral agency: supporting the patient such that she can explore and express who she is, continuing to live in a manner that honors what she finds most valuable and meaningful in life up until the moment of her death.

Consistent with the hospice concepts of suffering, family-centered care, and dying as a meaningful experience, a core component of the hospice philosophy is to provide care in a way such that support of the patient and family empowers the patient to recover/rebuild/maintain the wholeness and integrity of self through which to find and create meaning across the entire dying experience. Indeed, for Saunders, death was the final act in the life of a person, and the experience of dying is the final opportunity for that person to create and discover meaning. "At no time," wrote Saunders, "in the total care of a cancer patient is the awareness of him as a person of greater importance" (Saunders, 1979, p. 636).

Taken from National Hospice and Palliative Care Organization's (NHPCO) *Guide to Organizational Ethics in Hospice Care*, which is a resource to hospice programs and professionals.

Some Changes Coming Your Way...

There are a few changes within the volunteer department that you will see this year. At this time we just want to give you a "heads up" regarding these changes.

Life Story Volunteer Opportunity

For many years Center for Hospice Care has had a Life Story volunteer opportunity. Trained volunteers visit patients in their home to interview them about their lives. They then transcribe that patient's story into a program. Pictures may be added and when it is completed CHC prints and binds these stories to provide to the patient's family as a legacy.

In the past, CHC has utilized a web-based program from an outside provider. This year we are putting the final touches on an in-house Life Story template. This will be more user-friendly than the previous program we used.

If you were a Life Story volunteer in the past or if you are interested in this opportunity, even if you have never done it before, watch for an upcoming training session where we will teach you how to use the new program. Volunteers who are interested in this opportunity should like to write and interview people. Feel free to let Kristiana Donahue and your volunteer coordinator know if you are interested in attending the training, once it has been scheduled.

Annual Skills Validation

Center for Hospice Care has a new Clinical Staff Educator, Ashley Hums, who will be conducting skills validations this year. For volunteers who do home visits or work in our inpatient care facilities (Esther House, Raclin House) your patient care skills must be validated once a year.

There are some changes to our skills validation this year—new volunteers have been receiving the new skills validation starting in January of this year. Volunteers who do any hands on care will need to complete skills validation; however, they are able to be validated only on the skills that they are able and willing to complete. We understand some volunteers aren't able to complete some skills due to health issues. This new format will provide a way for our volunteers to get the needed training annually on the skills that they are able to complete. If you have not yet scheduled your annual skills validation, please do so. Kristiana made contact with volunteers who need to complete skills validation, please reach out to her if you have any questions.

1st Annual Skills Validation Clinic

Mishawaka Campus
May 17, 2022
1.5 hour slots
8:30am, 12:00pm, 1:30pm

2nd Annual Skills Validation Clinic

Elkhart Campus
June 7, 2022
1.5 hour slots
9:00am, 10:30am, 1:00pm

3rd Annual Skills Validation Clinic

Mishawaka Campus
September 6, 2022
1.5 hour slots
8:30am, 10:00am, 12:00pm, 1:30pm

Comments from our Families

- It was comforting to have an inclusive team of caring people. The team members all deserve to be paid well! Glad to see CHC is an equal opportunity employer. God bless!
- I and my family were very satisfied with our experience with CHC and have recommended them to friends.
- As an MD, the care was truly exceptional.
- Very positive experience all around. This probably saved my mental health. All personnel were positive, helpful, and caring. A+++!
- I don't usually fill out surveys. I had to complete this one. Hospice helped my family and I so much during the last months of a difficult journey with my dad. Thank you hospice team for all that you do. We so appreciate our hospice nurse—she rocked!
- I have nothing but amazing things to say about your Hospice staff and grief support. You are all such loving, caring, wonderful people!

Welcome to the Team

Robin Allen
Recruiter

Denise Benedict
Elkhart Volunteer Coordinator

Lori Bontrager
PRN IPU RN

Margaret Gillis Stough
Mishawaka Case Manager RN

Rod Holmes
Mishawaka Chaplain

Laura King
Mishawaka RN

Kristin Kydd
Mishawaka LPN

Billie Northrop
IPU CNA

Michelle Rawson
IPU CNA

Birthdays

4/4	4/12	4/23
Carmen Sheets	Beth Davis	Peg Stutzman
4/7	4/13	4/24
Debra Krebs	Linda Williams	Julie Schlundt
4/7	4/15	4/25
Patrick Kuzan	Ed Craft	Jan Atwood
4/8	4/15	4/25
Michael Finn	Linda Wruble	Marlene Taylor
4/10	4/16	4/26
Stephen Dinehart	Sherry Sigsbee	Jeanette McKew
4/10	4/20	4/29
David Foster	Paul Go	Amanda Parkinson
4/10	4/22	4/30
Susan Fron	Terry Trimmer	Nicholas Greely

Welcome New Volunteers

Nicholas Greely
Mishawaka

Heather Pepper
Mishawaka

Plymouth Happenings

Our Plymouth team has been busy! Kim Morrison, volunteer coordinator in Plymouth, and Ramona Lichtenberger, Plymouth bereavement counselor, both led an event called "The Soup Fix." While attendees enjoyed delicious food, Ramona and Kim shared about Center for Hospice Care's volunteer and bereavement services. Some current volunteers were in attendance to encourage and recruit new people for our volunteer program. That event alone resulted in four applications by the end of that night! Marvelous recruitment!

Kim Morrison along with volunteers Sandra Houghton and Ed Craft were also featured on a local radio program to encourage others to join our volunteer team.

We appreciate your efforts to recruit new volunteers!

Volunteer Recruitment & Training Coordinator

Kristiana Donahue

donahuek@cfhcare.org

(574) 286-1198

Elkhart

Volunteer Coordinator

Denise Benedict

benedictd@cfhcare.org

(574) 322-9814

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

May 2022
Volunteer Newsletter

Center for Hospice Care

choices to make the most of life™

Volunteer Recognition Luncheon 2022

On April 12, 2022 a roomful of CHC volunteers joined staff, board members and the volunteer team to recognize the wonderful work our volunteers provide to our families, patients and the community each year.

CHC President and CEO, Mark Murray, shared an annual report. He said that our volunteers give thousands of hours annually equating to about 8 full time employees who never get sick or take a day off! We are very fortunate that even through the many months of COVID, our volunteer force has remained faithful and committed to their service. We are grateful! Mike Wargo shared an annual report from the Hospice Foundation, including pictures of the new Milton Adult Day Service building.

We were so happy that The Armory was able to host our event again, including a buffet of delicious food and desserts. Our volunteer team was able to give a small gift as a token of our appreciation. If you were unable to attend, please reach out to your volunteer coordinator to coordinate a time to pick up your gift.

Thank you all for coming!

Inside this issue:

Birthdays

5/1
Ilene New
5/12
Bill Probst
5/12
Nicole Youngs
5/17
Janet Van De Veire
5/22
Carol Kuhns
5/22
Joy Smith
5/23
Pat Goeller
5/23
Cindy Kilgore
5/24
Betty Kay Eley
5/25
Jack Benchick
5/25
Loretta Blowers
5/25
Connie Roberts
5/30
John Kile

2022 John E. Krueger, MD Hospice Caring Award Winner: Kathleen Hojnacki

We are pleased to announce and celebrate our 2022 John E. Krueger, MD Hospice Caring Award winner—Kathleen Hojnacki!

The John E. Krueger, MD Hospice Caring Award was initiated in 1994 and awarded to the man whose name it bears for his years of devoted volunteer service. This award is given annually to a volunteer who exemplifies his commitment.

Kathleen began volunteering for CHC in 2006 after retiring from a 40 year nursing career in the South Bend medical community. Her compassion and skills blend together to make her an ideal volunteer. She has served in almost every volunteer capacity available in the last 16 years. She's logged nearly 2,000 hours and has served countless patients and families.

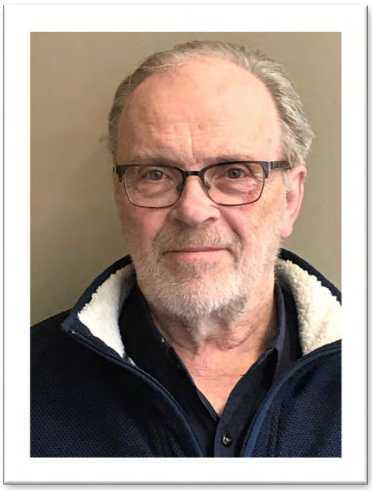
She's the kind of volunteer who is not afraid to brainstorm with a patient's care team, assist a family in finding community services and forces others to think outside the box when it comes to patient's care and needs.

We are most grateful for Kathleen's service to Center for Hospice Care and for pouring into the lives of our patients, their families as well as our staff. We appreciate you and are pleased to recognize you as this year's John E. Krueger, MD Hospice Caring Award winner!

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.

Philip Bender
Elkhart



Gerard Welling
Mishawaka

Welcome to the Team

Esther Adu
PRN Visit Nurse

Barbara Brockhoff
Referral Specialist

Russell Muhammad
Maintenance Technician

Maureen Rasmussen
Palliative Care Social Worker

Elias Rice
Customer Service Representative

In Case of Fire

Rescue - any client or person in immediate danger.
Alarm - page location of fire and pull nearest alarm.
Confine - the spread of smoke and fire.
Extinguish - the fire if possible.

To Operate Fire Extinguishers

Pull the pin
Aim hose at base of flame
Squeeze the trigger
Sweep from side to side

Skills Validation

Annual Skills Validation

For volunteers who do home visits or work in our inpatient care facilities (Esther House, Raclin House) your patient care skills must be validated once a year.

If you have not yet scheduled your annual skills validation, please do so. Kristiana made contact with volunteers who need to complete skills validation, please reach out to her if you have any questions.

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FULL—No slots left

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thank you!

2022 Service Awards

5 Years

(Left to right): Linda Williams, Linda Burrell, Norman Woolet, Carolyn Peterson, Janet Van de Veire

10 Years

(Left to right): Kathy Schlegelmilch, Ann Bowers

15 Years

(Left to right): Denise Conery, Kathleen Hojnacki, Anna Riblet

25 Years

Marlene Taylor

20 Years

(Left to right): Nancy Whipple, Dan Schuppert, Vera Tiani, Joan Fitt

2022 Service Awards

5 Years

Linda Benwell
Lynn Blessing
Bill Blum
Linda Burrell
Beth Davis
Bria Floyd-CE
Cindy Kilgore
Sharon Marshall
Linda Meeks
Carolyn Peterson
Doris Shea
David Simons
Janet Van de Veire
Cynthia Ward
Linda Williams
Norman Woolet

10 Years

Ann Bowers
John Guyse
Kathy Schlegelmilch

15 Years

John Bickel-CE
Denis Conery
Kathleen Hojnacki
Sandra Maichen
Jim Rahilly
Anna Riblet

20 Years

Joan Fitt
Dan Schuppert
Vera Tiani
Nancy Whipple

25 Years

Becky Donahue
Marlene Taylor

CE—denotes Camp Evergreen Volunteers

Comments from our Families

- Hospice is a blessing when grief and depression play with your mind.
- I was pleasantly surprised at the care and kindness and the complete courtesy from each and everyone. Thank you. I cannot imagine getting through this with any and everything we needed. Thank you. May God bless you all.
- The nurse was so kind and compassionate. At first I thought I'd prefer going back to the nursing home. Boy, was I wrong and blessed! The Raclin House was amazing! I felt like my mom had been accepted to a top-notch college. It was our perfect last "vacation" together. Just she and I. Not having my only sibling care enough to come (but he expected me to do lots of Facetime) was hard, but your team was my family. Thank you.

The pandemic pummeled long-term care – it may not recover quickly, experts warn

Rhitu Chatterjee 4-Minute Listen

Nurse's aide Patricia Johnson has worked for the Ambassador Nursing and Rehabilitation Center on the north side of Chicago for nearly 24 years. The pandemic has been grueling on her and her colleagues. "The hardest part is watching people die alone without their families," says Johnson, who now sometimes works double shifts due to staff shortages.

Jennifer Swanson/NPR

Nursing homes and other long term care facilities have lost a record number of residents and staff to COVID-19 – representing about a quarter of all COVID deaths in this country.

Now, the industry is suffering through a historic staffing shortage, further exacerbated by omicron. Workers have quit in record numbers since the pandemic started. And during the worst of omicron many frontline staff had to stay home because of breakthrough infections.

"Quite frankly, it's been pretty brutal here," says Nathan Schema, president and CEO of the Good Samaritan Society, a large non-profit provider of long-term care in the country, with facilities in 23 states. From Washington to Florida and from Maine to California, facilities and staff are struggling.

Of Good Samaritan's 15,000 staff, several hundred tested positive for COVID-19 during the worst part of the surge, Schema says, putting them into contingency staffing across the organization. "In some of our more rural communities, it doesn't take, but, one or two nurses to be out with COVID to really create a tough situation."

"You can see it in people's eyes – the tiredness, the exhaustion," says Jenna Szymanski, a nurse at the Good Samaritan Society's Luther Manor in Sioux Falls, South Dakota. "All the staff, I think, are pretty burnt out right now."

Researchers are concerned the situation could have a lasting impact on an industry which has struggled with a high rate of turnover and staffing shortages for a long time.

"At some point, you know, the system is going to fracture because people need care," says Tricia Neuman, a senior vice president with the Kaiser Family Foundation. "And you can't get by without someone there to provide basic daily needs."

Frontline workers face exhaustion

Around the country, the entire industry is feeling the strain, with managers having to fill in for other staff who are out sick, Schema says. He's had to limit admissions and close a few facilities in two states.

So has Tabitha, a non-profit senior care provider in Nebraska, which had to close two short-term and one long-term care unit because of staff shortages, says Christie Hinrichs, CEO of Tabitha.

That, in turn, is causing backups in hospitals, she says, as they are unable to discharge patients who need long term care. "But we don't have the staff to care for them," she says.

But the pressures of the situation can often be worst for the low-paid staff

that make up the backbone of daily care in the industry: nursing aides.

"The stress is unbearable," says Patricia Johnson, a nurse aide at Ambassador Nursing and Rehabilitation Center in Chicago.

Johnson's daily duties include everything from regularly checking in on residents, to feeding them, documenting their food and water intake, and helping them go outside for fresh air or a smoke.

The pandemic had already made her and her colleagues work much harder.

"You've got to basically keep yourself safe, keep the residents safe, and then you've got to make sure that you do everything that you're supposed to do," says Johnson, who has lost residents, colleagues and cousins to COVID-19.

The recent staff outages linked to omicron only made things worse. She's had to put in extra hours, do double shifts, and she hasn't taken a vacation since the start of the pandemic.

She hesitates about taking time off because it will only add to her colleagues' workload. "We're just trying to work and keep everything together, basically," says Johnson.

At the western edge of the country, in a long-term care facility in Bellingham, Wash., there have been times in recent weeks when nurse's aide Sherylon Hughes was the only frontline staffer who showed up to work when two or three were needed.

"There would be a lot of scrambling to try and get somebody to stay from the previous shifts to get someone else to come in," says Hughes. "I got to work with a lot of my managers that weren't expecting to work and stay up all night, but that's what we had to do."

She'd never seen her facility hire so many temporary workers.

"It's definitely like a last resort for a facility that is desperate," she says. "By the time they figure out how we do things and they get comfortable and get to know our residents, the contract is over and they leave. So it's sort of a continuous influx of people who are just learning the ropes."

Sherylon Hughes is a nurse's aide at a long-term care facility in Bellingham, Wash. She's worked at the facility for over a decade and says that the recent staffing shortage is the worst she's ever seen.

Chona Kasinger for NPR

Lowered standards and moral distress

Hughes says there have been times when she's had to care for as many as 25 residents — it's affecting the level of care she can give.

"If there was a fall or something else bad happening, say there is a confused resident having a hard time that really needs one-on-one attention, and you're not able to give it to them to get them to calm down so that they can rest, that is frustrating. It's sad, and it makes you want to not go back to work," says Hughes, who has worked at the facility for more than a decade.

This is a common theme among frontline workers across the country.

In South Dakota before the pandemic, Szymanski says she could visit with each of her residents, "spend more time focusing on making sure they're OK, mind, body and soul."

These days, she's hardly able to have that kind of one-on-one time. And she's concerned she's missing the little things that can go a long way towards improving her residents' well-being, like washing or curling

someone's hair.

"I feel I am not able to provide the care that I would like to provide," says Szymanski.

Frontline workers in long term-care are feeling they are letting their patients down, says Susan Reinhard, executive director of AARP's Public Policy Institute.

"If you have too many people to care for, you're going to feel moral distress like, 'I'm not doing my best. I can't do the best job I've been trained to do,'" says Reinhard. "That is really devastating personally, just day after day."

"That leads to more collapse, that leads to more people choosing not to work anymore," says Hughes.

A chronic problem exacerbated by the pandemic

A recent industry report estimated that nursing homes and assisted living facilities together have lost more than 250,000 jobs since the start of the pandemic. And an analysis by the Kaiser Family Foundation suggests the industry has continued to have problems employing people while other health service industries have recovered in the past year or so.

However, the industry's staffing issues didn't start with COVID.

"We know that even before the pandemic, two years ago, there were already staff shortages," says the AARP's Reinhard. "It's a perennial problem."

It's a hard job, with low pay, especially for those providing direct care, like nursing aides.

And it's physically and emotionally demanding, adds Hughes.

"You're lifting and pushing and pulling [people]," she says. "You have to have a strong stomach. We're dealing with people's bodily functions. You have to be able to stand that."

It can be sad to watch residents with dementia and other degenerative disorders decline over time. "That can be distressing," she says.

The work becomes even more demanding when there are fewer people doing it, says Laurie Brewer, the long-term care ombudsman for New Jersey. Many facilities, especially for-profit ones, have not been meeting minimum staffing requirements, she says.

"Sometimes money is not the problem," says Brewer. "It's working conditions that are the problem."

The pandemic only exacerbated all these issues, by making the work even harder, and bringing more personal risk to long-term care workers, says Neuman. They have put their own lives and those of their loved ones at risk. They have watched their colleagues and residents die of COVID-19 in record numbers.

"So it's just been a lot tougher now," she adds.

Hughes says there was a "significant mass exodus of nurses, nurse's aides, office workers, nurses" at her facility.

But COVID has inspired some improvements in many facilities, including pay raises

"For our certified nursing aides, we made about a 15% increase last fall," says Tabitha CEO Hinrichs. And she's planning another 5.5-6% raise for all

nursing staff soon.

In Bellingham, Hughes' employer has given staff hazard pay, and last year, she and her fellow union members negotiated raises. She and her colleagues are lobbying for more state funding for the industry and to make sure the money goes directly to frontline staff.

"There just isn't any other way to fix this problem. We have to be able to offer a better living wage to people that are going to be coming in and doing one of the most important jobs in health care," she says.

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HealthExec
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Hospital CEO departures are on the rise

Amy Baxter

Healthcare CEOs are participating in The Great Resignation, leaving their roles every quarter at a rising pace.

In fact, the number of CEOs who left their positions nearly doubled in the first quarter of 2022 compared to the same three-month period in 2021, according to a report from Challenger, Gray & Christmas, an outplacement & career transitioning firm. Twenty-nine hospital CEOs have departed from their roles year-to-date in 2022, compared to 15 over the same time period in 2021.

"A high rate of Americans are quitting their jobs each month, and CEOs are no exception," Andrew Challenger, senior vice president of Challenger, Gray & Christmas, said in a statement. "Meanwhile, inflation concerns may have some boards looking to new leadership to weather the coming storm."

The trend is similar among pharmaceutical CEOs—nine have left their positions year-to-date, compared to 3 year-to-date in 2021.

Across all industries, 395 CEOs have left their posts, up 29% from the 307 who changed positions in the first quarter of 2021, the report revealed. When CEOs leave their roles, some are taking other positions or taking on other roles within their organization. Of the 92 CEOs who have retired so far this year across industries, 28 stepped into other high-level roles within the company, such as chair or advisor, while 8 left for new opportunities.

Amid the c-suite shuffling, there is one bright spot—more women are stepping into leadership positions. The rate of women taking over the incoming CEO role ticked up to

26% so far in 2022, up from 25% in the first quarter of 2021. However, 21% of the 395 CEOs who left their posts in the first quarter of 2022 were women, up from 16.3% of the 307 who left their posts in the first quarter of 2021.

Among the healthcare/products sector, the number of CEOs who left their roles actually declined in 2022 compared to last year—34 left their posts in the first three months of 2022, down 17% from the 41 exits in the first quarter of 2021.

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UnitedHealthcare names new CEO

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OPERATIONS

Hospices See New Opportunities in Adult Day Market

By Holly Vossel | April 5, 2022

MarandaP

Share

More hospice providers are diversifying their business lines to include adult day services. Some hospices see these programs as an extension of their mission to support aging and chronically ill patients and their caregivers.

Adult day service centers are designed to care for individuals who require assistance during the day in the absence of caregivers or family members. Specific services vary, but these centers typically allow access to community-based social, health and specialized care services that include recreational and therapeutic activities, meals, and medical services. They also provide assistance with activities of daily living such as eating, bathing, dressing and walking.

It "makes total sense" for hospice providers to get into the space of adult day programming, according to YoloCares CEO Craig Dresang.

Related Stories

DATA

Hospices Must Invest in Staff, Expand Referral Sources to Meet Rising Demand

April 5, 2022

"The idea of hospice and palliative care organizations now offering adult day support seems like a natural and beautiful evolution and extension of our care," Dresang told Hospice News. "The more we can support seniors as they age, the better chance they have of living better. This is really bigger than hospice. It's about aligning a person's goals of care, their values and their interests with the kind of care and support they receive."

Adult day is a rapidly growing industry. Centers have become more prevalent in recent years. Currently, more than 7,500 adult day service centers provide care across the United States, according to National Adult Day Services Association (NADSA) research.

This is up from 2018's estimated total of 4,200 centers which provided care to roughly 251,000 patients nationwide, the U.S. Centers for Disease Control and Prevention (CDC) reported.

Davis, Calif.-based YoloCares, formerly Yolo Hospice, recently completed a rebranding to reflect its growing scope of services while also launching a new adult day program. The program is housed in a new adult day center, Galileo Place, following a $1.6 million renovation on Yolo's existing campus.

The company last year affiliated with the California Hospice Network, a collaborative of nonprofit hospices seeking to leverage their collective scale and resources in value-based payment programs and expand access to care.

REGULATION

Hospices Hail CMS Pay Bump, Worry About Rising Costs

April 4, 2022

according to Dresang.

The pandemic slowed the center's opening. The need to socially distance was among the challenges faced, as was the industry-wide staff shortage.

While the clinical disciplines represented at adult day centers can vary among organizations, An estimated 80% of adult day centers have nurses on staff. Nearly half have at least one social worker and roughly 60% offer case management services, according to another NADSA report.

Adult day centers also provide family members with reprieve from caring for loved ones. YoloCares will offer a caregiver lab through its adult day center. The lab will feature regular classes for community members to learn caregiving skills such as feeding and wound care best practices, along with self-care.

YoloCares is not alone among hospices integrating adult day services.

Wisconsin-based Agrace last summer also opened a new adult day center. The community-based hospice and palliative care provider serves a total 11,000 square miles of smaller communities, mid-sized towns and the City of Madison.

As with Galileo Place, the pandemic delayed the center's opening. Encouraging clients to remain masked was among the "biggest challenges" faced during the center's initial eight months since opening, Agrace CEO Lynne Sexten told Hospice News.

Mask mandates within the provider's community service region were in place through March of this year. The community-based hospice and palliative care provider serves a total 11,000 square miles of smaller communities, mid-sized towns and the City of Madison. As COVID-19 cases declined in the area, Agrace ultimately saw the benefits of opening the facility outweigh the risks to the community.

Providers launching these programs must "do their homework" to understand the full scope of community needs, along with regulatory and licensing requirements within their state, according to Sexten.

Part of that homework requires providers to forge ties with other community organizations that work or communicate with seniors, according to the NADSA research.

"During this process, we have been in close communication with other adult day programs in our area in northern California, probably half a dozen of them," said Dresang. "We've heard their stories about how their businesses were impacted [by COVID], and it's been pretty brutal for them. We have some things built in that help us weather those storms with less sweat over our brow, but not everybody is able to benefit from that. The need is much bigger than the capacity available in our communities."

Developing community ties has allowed for advisory group members to be "ambassadors" for the program. Their advocacy helped build the participant waiting list that Dresang said he anticipates for Galileo Place.

When hospices launch business lines like these, those services do not operate in a vacuum. Programs such as adult day can complement other services that a hospice offers, Dresang told Hospice News.

"All these programs complement one another," Dresang said. "Humans don't live in compartments, so our care shouldn't be presented to the public as being compartmentalized either. The values and needs of people are diverse, and oftentimes connected to other parts of their human existence."

Coordination of these services may also have other, potentially unexpected benefits.

For example, an adult day program may bring opportunities for hospices to reach patients sooner in their illness trajectories as well as engage with underserved patient populations.

Adult day participants in 2018 were younger and more racially and ethnically diverse, according to the CDC. Nearly 40% were younger than 65, while roughly 55% were Hispanic, African American or other people of color.

African Americans, Asians and Hispanics face disparities in access to hospice care. In 2018 those communities combined represented less than 20% of Medicare hospice patients, the National Hospice and Palliative Care Organization reported. The remaining 80% identified as Caucasian.

Adult day support can also ease family caregiver burden and reduce burn out.

"For patients experiencing cognitive decline, the caregiving burden placed on family members is significant," Sexten told Hospice News in an email. "Too often, families hope to get some relief by enrolling their loved ones in hospice, only to be told the patient is not yet eligible. It is part of our mission to provide relief for those caregivers, while at the same time offering an array of rich daily activities for those with cognitive decline who may someday need our hospice services."

Companies featured in this article:

Agrace, California Hospice Network, National Adult Day Services Association, National Hospice and Palliative Care Organization, Yolo Hospice, YoloCares

Holly Vossel

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REGULATION

Hospices Hail CMS Pay Bump, Worry About Rising Costs

By Jim Parker | April 4, 2022

rhysadams

The U.S. Centers for Medicare & Medicaid Services (CMS) recently proposed a 2.7% pay increase for hospice care for Fiscal Year 2023. While reimbursement increases are always welcome to providers, some stakeholders question whether this will be enough to fend off continuing COVID-19 headwinds and skyrocketing inflation.

Also on providers' minds is the phased-in return of sequestration that began on April 1 – a 1% withholding that will rise to the standard 2% as of June 30, representing a headwind that some hospices consider "devastating." CMS had temporarily suspended sequestration during the pandemic.

If finalized as written, the rule would also raise the aggregate payment cap to $32,142, up a corresponding 2.7% from $31,297.61 in 2022.

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With these factors in play, some stakeholders fear that the ' ncrease may be inadequate relative to rising costs.

"In reading CMS's proposed rule for FY23 Hospice Payment Rates, what we see is partial recognition of the value of hospice care. A 2.7% increase is clearly an improvement from FY22 rates, but not enough to keep pace with the rising costs of doing business in today's economy," Edo Banach, president and CEO of the National Hospice and Palliative Organization, told Hospice News in an email. "How can hospices compete for talent when their reimbursement grows slower than inflation?"

Many health care providers are beginning to see a light at the end of the tunnel when it comes to the pandemic. Even if that perception is correct, the economic symptoms of COVID will not disappear overnight.

Hospices continue to face surging costs for personal protective equipment (PPE) and COVID-19 testing kits, paid leave for staff and investments in telehealth. They have also seen declines in institutional referrals and hospice length of stay, further eroding their margins.

Providers are also contending with rising wages in an intensely competitive labor market, as well as the price inflation affecting the nation at large.

As of January, the consumer price index was up 7.9% from a year earlier, according to the U.S Department of Labor, reaching a 40-year high.

REGULATION
Hospices Hail CMS Pay Bump, Worry About Rising Costs
April 4, 2022

News. "Certainly, as drug prices go up, they do have an impact, but I think definitely it's labor costs by far that have folks are most concerned."

Also worrisome is the price of gasoline, which surged upwards following the Russian invasion of Ukraine. Retail gas prices rose 19.3. allon as of March, the American Automobile Association reported.

These increases pose difficulty for hospices considering th st clinical staff routinely drive to conduct patient visits.

These are matters that hospice organizations will bear in mind as they prepare their comments on the proposed rule. The comment period expires on May 31.

"As NHPCO prepares to formally respond to the proposed rule, we're asking a lot of questions about the assumptions baked into the rule, and the impact it will have: Why are the calculations based on cost reports from 2019 – before the pandemic or the inflationary spike?" Banach said.

However, providers may feel relieved that the proposed rule does not contain substantial regulatory changes. CMS provided updates on ongoing projects, such as phased-in changes to the agency's methods for applying the wage index to payment rates.

CMS is changing the data sources it uses to adjust hospice payment amounts to account for differences in wage rates among markets. The implementation strategy is designed to minimize disruption as well as the monetary impact on providers.

The proposal also includes an update on the agency's testing of the Hospice Outcomes & Patient Evaluation (HOPE) tool, which will replace the Hospice Item Set (HIS) quality reporting system when completed.

"[The proposed rule] is pretty straightforward in terms of the issues that it deals with. CMS has decided not to pursue a great number of new policy initiatives, and the ones that they have put forward are ones that we think are very, very good policy," Forster said. "That would include the proposal to limit the losses based on the wage index value changes."

Hospices should take note that the agency is moving forward on a development of a Technical Expert Panel (TEP) that will design a new Special Focus Program (SFP) for regulatory enforcement. The SFP will have the power to impose enforcement remedies against hospices with a track record of poor performance on regulatory or accreditation surveys.

reimbursement, appoint temporary management to bring the hospice into compliance, or revoke a provider's Medicare certification.

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Congress directed CMS to establish the SFP through the Consolidated Appropriations Act of 2021. Legislators included the SFP la ge in response to July 2019 reports on hospice quality from the O of the Inspector General (OIG) at the Department of Health and Hu n Services (HHS).

"When they do come up with a plan for how that SFP will l at will be subject to public rulemaking," Forster said. "That would be for the Fiscal Year 2024 payment year, so we'll have an opportunity to take a look at what they've come up with and provide additional input."

Companies featured in this article:

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

Jim Parker

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OPERATIONS

Hospices Expand Inpatient Care, But Tread Carefully

By Holly Vossel | April 15, 2022

Hospice inpatient centers have proliferated since the U.S. Centers for Medicare & Medicaid Services (CMS) rebased payment rates in 2020. While reimbursement increases can foster growth, a convergence of factors complicate providers' ability to balance a healthy margin with the expanded access to care.

The 2020 rebasing instituted a 2.7% payment increase in payments for three levels of care: general inpatient care, inpatient respite care and continuous home care. This came with a 2.7% cut to routine home care to maintain budget neutrality.

The reimbursement adjustment has allowed hospices to expand their inpatient care programs, according to Todd Stern, executive vice chair of AccentCare.

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change of reimbursement was fair and thoughtful in allowing us to do that."

AccentCare last year built a new facility in Phoenix. At the time, the facility operated under the auspices of Seasons Hospice & Palliative Care, but the company later unified all of its brands under the AccentCare name.

Like AccentCare, a growing contingent of hospice providers have prioritized greater access to inpatient care.

Among these is VITAS Healthcare, a subsidiary of Chemed Corp. (NYSE: CHEM), which earlier this year opened two inpatient centers in Florida. The company anticipates care for upwards of 900 patients annually. This follows an additional inpatient unit that VITAS opened in the same state the prior year.

Also in 2021, ProCare Hospice of Nevada and CareOusel Pediatrics opened a new unit in its home state's southern region.

Other 2021 openings included an Ohio's Hospice of Miami County facility in the city of Troy on the campus of Upper Valley Medical Center.

While 2.7% sounds like a small number, prior to the rebasing, the cost of providing those three levels of care exceeded the amounts hospices were paid.

But the additional dollars did not guarantee smooth sailing. Providers still contend with regulatory and labor pressures, rising costs and the pandemic's toll on facility-based services.

On the regulatory front, CMS and its Medicare Administrative Contractors have prioritized audits for general inpatient care (GIP) stays

EARNINGS

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April 14, 2022

hospices provide in the home. In addition to across-the-board expenses like wages and salaries, medications and supplies, hospices that operate freestanding facilities must pay to maintain them. To open a facility, construction costs also come into play.

Meanwhile, hospices are seeing higher price tags for building supplies as inflation balloons, while the workforce shortage pushes up wages, according to Stern.

"The cost to develop inpatient facility structures has risen, as well as wage inflation. These are universal challenges that affect the development of these types of facilities," said Stearn. "There's no question that it's a complex and expensive level of care to provide, but the reimbursement adjustment offsets the costs and makes it more accessible to ensure that we can deliver inpatient care to those who need it."

Some fear that these concerns create a chilling effect that deter hospices from offering robust inpatient services.

Data from the analytics firm HealthPivots show that among 4,750 separate providers for Medicare-certified hospices in calendar year 2020, about 48% reported no general inpatient care stays that year.

The firm also found that while between 15% and 20% of hospice patients spend some time in a hospice inpatient center, that level of care represents only roughly 1% of care days.

One might assume that this was a result of pandemic-related disruption, but data from the National Hospice and Palliative Organization show that 2020 was not an outlier year. Inpatient stays represented 1.7% of patient care days in 2014 and incrementally dropped to 1.2% by 2018.

Nevertheless, COVID-19 did cause widespread disruption..

The accelerated workforce shortages caused North Carolina-based hospice provider Amorem to temporarily close two of its inpatient care units, consolidating those operations into a single facility.

The outbreak likewise forced HMC Hospice of Medina County to shut down a facility in 2020, though it was able to reopen early this year. The Ohio-based hospice provider is an affiliate of Hospice of the Western Reserve.

But inpatient growth did not stop altogether.

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Texas-based Abundant Hospice opened a general inpatient in San Antonio last year. Rising need stemming from the pandemic led the hospice to open the facility "sooner rather than later," CEO co-founder Denise Jawarski told Hospice News, though COVID cause some complications.

"So many people were separated from their families because of the pandemic and their loved ones were dying alone," Jawarski "We opened Abundant Hospice Home in 2021 and are providing a service to patients and their families so they're able to have a better end-of-life experience. Looking back at the launch, we faced some delays with the government and state agencies [such as] getting licensed with Medicaid for example, due to the pandemic and related shut-downs."

Companies featured in this article:

Abundant Hospice, AccentCare, Alivia Care, Amorem, CareOusel Pediatrics, Chemed Corp., Community Hospice & Palliative Care, HealthPivots, HMC Hospice of Medina County, Hospice of the Western Reserve, National Hospice and Palliative Care Organization, Ohio's Hospice of Miami County, ProCare Hospice Nevada, Upper Valley Medical Center, VITAS Healthcare

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PEDIATRIC CARE

Lack of Payment, Training Curtail Pediatric Palliative Care

By Jim Parker | May 6, 2022

Robotoaster

Children who have life-limiting illnesses need palliative care as much as adults, but a slough of obstacles often prevents them from getting it. Many of the barriers that palliative care providers encounter — fears, misconceptions, limited reimbursement, lack of specialized clinical training — become even more complex when it comes to pediatrics.

The bulk of the care these children receive comes from primary care or subspecialty providers, and many experience frequent hospitalizations, according to research by the American Academy of Pediatrics (AAP). Few seriously ill pediatric patients have access to home- and community-based services, and even fewer receive them in a timely manner, AAP found.

Seriously ill children deserve the chance to optimize their quality of life, according to Kristen James, executive director of the Greater Illinois Pediatric Palliative Care Coalition (GIPPCC),

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"Unfortunately, the number of children with complex and ' niting illnesses is only going to grow," James said at the Hospice News Palliative Care Conference in Chicago. "Kids are left in the hospital, w onger hospitalizations, more emergency room visits, and die suffering. We have the option to do it better. We often say you can't change the prognosis, but you can change the way you care for children."

Effecting such change is a difficult proposition.

Palliative care programs are difficult to sustain across the board, largely due to the lack of a robust reimbursement model. While value-based care models have provided some in-roads, to date these have been oriented almost exclusively around the needs of seniors.

OPERATIONS

Transitions Care Leverages Tech, New Care Models to Improve Patient Outcomes

May 5, 2022

The Affordable Care Act requires states to offer Medicaid coverage for concurrent hospice and curative care for pediatric patients, but those services still require a six-month terminal prognosis for eligibility.

Determining a six-month prognosis is challenging even for adult patients, particularly for those who have conditions with relatively unpredictable trajectories, like dementia.

These determinations are even more complicated when it comes to children. Health care providers and families often find it understandably difficult to acknowledge a child's impending death, but the complexities don't end there.

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Even if the medical field were able to easily settle the six-month prognosis question, this excludes pediatric patients who are not expe .o die within that time frame.

Though symmetries exist, palliative care and concurrent h ce care are not the same thing.

Some states such as California, Illinois and some others have aken steps to make pediatric palliative care more available, but these ams are limited to the confines of those states. Each of these states also takes its own approach, so payment and care models are often inconsistent across geographic regions.

Beyond payment and policy, caring for children requires a degree of specialization that many community-based hospice and palliative care providers do not have.

The needs and conditions of pediatric patients differ from adults in terms of diagnoses, illness trajectories, medication dosing and equipment, as well as family dynamics and support. Clinical training for providing hospice and palliative care is scarce across the board, but even more so when it comes to the specific needs of children.

"Adult hospice and palliative and our pediatric program are completely different approaches. It's completely different staff, and it's different training," Sara Dado, senior director of clinical programs, for Lightways Hospice and Serious Illness Care."The worst mistake I think a hospice can make is to tell their adult team that they are now going to take care of kids. That's a recipe for disaster."

Despite these challenges, more community-based hospice and palliative care providers are making the necessary investments to build pediatric palliative programs, according to Dado.

But without sufficient reimbursement and expanded access to training and human resources, even best-intended and well-designed programs are difficult to scale.

To further change, providers can advocate for greater support for pediatric palliative care, including educating clinicians in other settings, as well as engaging with the public and with policymakers.

understanding of what community-based care looks like. Palliative care was a foreign term in the the health care industry 15 years ago, and now it's much more recognized."

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Companies featured in this article:

Greater Illinois Pediatric Palliative Care Coalition, Lightwa ospice and Serious Illness Care

Jim Parker

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Medicare policy changes tied to drop in hospice use for dementia

Recent changes in Medicare policies are associated with reductions in the share of patients with an Alzheimer disease and related dementias (ADRD) code receiving hospice care, according to a study published online May 6 in *JAMA Health Forum*.

Kan Z. Gianattasio, M.P.P., from the George Washington University Milken Institute School of Public Health in Washington, D.C., and colleagues examined whether hospice use among patients with ADRD changed in

association with recent policies aimed at reducing hospice misuse and long hospice stays in an observational cross-sectional study. Data were included for 11,124,992 unique hospice episodes between 2008 and 2019 among Medicare hospice beneficiaries aged 65 years or older at the time of enrollment.

The researchers found that during the months of the 2014 Improving Medicare Post-Acute Care Transformation (IMPACT) Act passage and implementation, the percentage of new enrollees with an ADRD code decreased significantly (−1.42 and −1.98 percentage points, respectively) but increased again during the following months. At the time of implementation of the 2016 two-tier payment system, no significant changes were observed (0.15 percentage point), but the average rate of increase was slower during the subsequent period than in earlier periods (0.01 versus 0.05 percentage points per month).

"We found evidence to suggest that recent Medicare policy changes targeting patients with long stays in hospice care were associated with lasting reductions in the share of patients receiving hospice care admitted with an ADRD code compared with expectations based on preimplementation trends," the authors write.

One author disclosed financial ties to Biogen.

CLINICAL DAILY NEWS

MA enrollees with dementia report poor quality of care: study

ALICIA LASEK

MAY 9, 2022

SHARE

Medicare Advantage plan beneficiaries with dementia report worse care experiences than enrollees with other chronic conditions, a new study finds. These patients are due more attention and support as the MA population continues to grow, the researchers say.

Investigators examined MA consumer service assessment surveys. Study participants had Alzheimer's disease or related dementias (ADRD) and had used nursing home, home health or inpatient services within the last three years. When analyzed, the data showed that dementia patients were more likely to report lower scores for needed care and customer services when compared with MA recipients without ADRD.

Left out

Notably, beneficiaries with dementia were also twice as likely to be excluded from the performance measures surveys, either because they weren't eligible or didn't respond. This undercounting may result in MA plans not being held accountable for their outcomes, the researchers wrote.

Among other standout findings, respondents who did not use proxies to complete their assessment forms reported worse outcomes than those whose proxies filled out the forms. However, non-proxy respondents with ADRD rated their MA plans more highly overall than their peers without dementia.

The investigators also looked at whether people with dementia who enrolled in MA special needs plans (SNPs) experienced improvements in care. SNPs are designed for patients with complex care needs, such as dementia. Despite rapid SNP enrollment growth, they found no significant care improvements for these enrollees.

Closing care gaps

There are a number of possible reasons for these care discrepancies, the researchers proposed. Based on prior research, MA beneficiaries tend to be admitted to lower-quality care settings than those in traditional Medicare, for example. Barriers to care such as prior authorizations and narrow networks may also contribute to additional burdens on these patients when compared to healthier enrollees. Finally, there is evidence that these enrollees face challenges in selecting the right plan, potentially leading to lower-rated care experiences, the researchers wrote.

Going forward, policy makers must design performance measures that more equitably include beneficiaries who have serious health conditions and functional and cognitive decline, and who require proxies to report on their care experiences, they added.

"Otherwise, plans may not be properly incentivized to address these care experience gaps," they concluded.

Full findings were published in the *Journal of the American Geriatrics Society*.

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Author Affiliations: Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, Maryland (Boyarsky, Massie, Segev, Garonzik-Wang); Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland (Werbel, Avery); Department of Pathology, Johns Hopkins School of Medicine, Baltimore, Maryland (Tobian).

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Corresponding Author: Dorry L. Segev, MD, PhD, Department of Surgery, Johns Hopkins University Medical Institutions, 2000 E Monument St, Baltimore, MD 21205 (dorry@jhmi.edu).

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Excess Deaths From COVID-19 and Other Causes in the US, March 1, 2020, to January 2, 2021

A study analyzing US mortality in March-July 2020 reported a 20% increase in excess deaths, only partly explained by COVID-19. Surges in excess deaths varied in timing and duration across states and were accompanied by increased mortality from non-COVID-19 causes.[1] This study updates the analysis for the remainder of 2020.

Methods | The Supplement details the methods. A Poisson regression model used mortality data from 2014-2019 to predict US expected deaths in 2020. Observed deaths in weeks ending March 1, 2020, through January 2, 2021, were taken from provisional, unweighted death counts for the District of Columbia and 49 states, excluding North Carolina for insufficient data. Data sources included the National Center for Health Statistics[2-4] and US Census Bureau.[5] Data for 8 geographic regions were grouped into distinctive surge patterns. COVID-19 deaths included all deaths for which COVID-19 was cited as an underlying or contributing cause.

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Supplemental content

Temporal changes in mortality rates from non-COVID-19 causes (eg, Alzheimer disease/dementia, heart disease, diabetes, and 9 other grouped causes; see Supplement) were examined. Data included all deaths in which non-COVID-19 conditions were listed as the underlying cause of death (potentially including deaths for which COVID-19 was a contributing cause). The Joinpoint regression program version 4.8.0.1 (Statistical Research and Applications Branch, National Cancer Institute) was used to specify the weeks (joinpoints) when slopes changed (measured by the annual percentage change [APC]) and their statistical significance (2-sided test, $\alpha = .05$ threshold).

Results | Between March 1, 2020, and January 2, 2021, the US experienced 2 801 439 deaths, 22.9% more than expected, representing 522 368 excess deaths (**Table**). The excess death rate was higher among non-Hispanic Black (208.4 deaths per 100 000) than non-Hispanic White or Hispanic populations (157.0 and 139.8 deaths per 100 000, respectively); these groups accounted for 16.9%, 61.1%, and 16.7% of excess deaths, respectively. The US experienced 4 surge patterns: in New England and the Northeast, excess deaths surged in the spring; in the Southeast and Southwest, in the summer and early winter; in the Plains, Rocky Mountains, and far West,

Table. Excess Deaths, March 1, 2020, to January 2, 2021, US and Selected States and Regions

Jurisdiction	Expected deaths (95% CI)[a]	Observed deaths (ratio of observed to expected)	Excess deaths, No. (95% CI)	Excess deaths/ 100 000[b]	COVID-19 deaths[c]	Excess deaths attributed to COVID-19, %[c]
US[d]	2 279 071 (2 278 117 to 2 280 026)	2 801 439 (1.23)	522 368 (521 413 to 523 322)	164.4	378 039	72.4
Alabama	43 621 (43 495 to 43 747)	54 361 (1.25)	10 740 (10 614 to 10 866)	219.0	6767	63.0
Alaska	3740 (3719 to 3761)	4205 (1.12)	465 (444 to 486)	63.6	167	35.9
Arizona	50 305 (50 166 to 50 443)	66 378 (1.32)	16 073 (15 935 to 16 212)	220.8	9523	59.2
Arkansas	26 652 (26 561 to 26 742)	32 300 (1.21)	5648 (5558 to 5739)	187.2	4077	72.2
California	223 220 (222 892 to 223 548)	273 584 (1.23)	50 364 (50 036 to 50 692)	127.5	34 350	68.2
Colorado	33 680 (33 573 to 33 787)	40 636 (1.21)	6956 (6849 to 7063)	120.8	5123	73.6
Connecticut	25 837 (25 749 to 25 925)	32 379 (1.25)	6542 (6454 to 6630)	183.5	6222	95.1
Delaware	7618 (7582 to 7654)	9278 (1.22)	1660 (1624 to 1696)	170.5	914	55.0
District of Columbia	5104 (5078 to 5130)	6370 (1.25)	1266 (1240 to 1292)	179.4	927	73.2
Florida	175 117 (174 826 to 175 409)	206 940 (1.18)	31 823 (31 531 to 32 114)	148.2	22 013	69.2
Georgia	71 514 (71 341 to 71 687)	88 079 (1.23)	16 565 (16 392 to 16 738)	156.0	10 449	63.1
Hawaii	9735 (9692 to 9778)	10 012 (1.03)	277 (234 to 320)	19.6	281	101.4
Idaho	11 721 (11 671 to 11 771)	14 117 (1.20)	2396 (2346 to 2446)	134.1	1506	62.9
Illinois	88 632 (88 436 to 88 829)	110 524 (1.25)	21 892 (21 695 to 22 088)	172.8	16 843	76.9
Indiana	55 892 (55 743 to 56 040)	66 603 (1.19)	10 711 (10 563 to 10 860)	159.1	9602	89.6
Iowa	25 336 (25 249 to 25 424)	30 368 (1.20)	5032 (4944 to 5119)	159.5	4814	95.7
Kansas	22 059 (21 980 to 22 138)	26 506 (1.20)	4447 (4368 to 4526)	152.6	3527	79.3
Kentucky	40 166 (40 046 to 40 286)	47 241 (1.18)	7075 (6955 to 7195)	158.4	4651	65.7
Louisiana	38 475 (38 358 to 38 591)	48 468 (1.26)	9993 (9877 to 10 110)	215.0	7068	70.7
Maine	12 415 (12 363 to 12 468)	13 086 (1.05)	671 (618 to 723)	49.9	356	53.1
Maryland	41 068 (40 947 to 41 190)	51 296 (1.25)	10 228 (10 106 to 10 349)	169.2	6805	66.5
Massachusetts	48 764 (48 630 to 48 899)	58 723 (1.20)	9959 (9824 to 10 093)	144.5	10 237	102.8
Michigan	81 079 (80 892 to 81 265)	98 891 (1.22)	17 812 (17 626 to 17 999)	178.4	12 372	69.5
Minnesota	38 264 (38 147 to 38 381)	44 383 (1.16)	6119 (6002 to 6236)	108.5	5897	96.4
Mississippi	26 185 (26 096 to 26 275)	33 919 (1.30)	7734 (7644 to 7823)	259.9	5142	66.5
Missouri	53 505 (53 361 to 53 649)	64 960 (1.21)	11 455 (11 311 to 11 599)	186.6	8052	70.3
Montana	8642 (8602 to 8681)	10 254 (1.19)	1612 (1573 to 1652)	150.9	1231	76.3
Nebraska	14 075 (14 018 to 14 132)	16 867 (1.20)	2792 (2735 to 2849)	144.3	2258	80.9
Nevada	21 547 (21 469 to 21 626)	26 780 (1.24)	5233 (5154 to 5311)	169.9	3576	68.3
New Hampshire	10 212 (10 167 to 10 257)	11 491 (1.13)	1279 (1234 to 1324)	94.0	768	60.1
New Jersey	60 594 (60 440 to 60 749)	82 871 (1.37)	22 277 (22 122 to 22 431)	250.8	18 180	81.6
New Mexico	15 294 (15 233 to 15 354)	19 466 (1.27)	4172 (4112 to 4233)	199.0	2792	66.9
New York	126 811 (126 571 to 127 050)	175 160 (1.38)	48 349 (48 110 to 48 589)	248.5	38 596	79.8
North Dakota	6079 (6049 to 6109)	7590 (1.25)	1511 (1481 to 1541)	198.3	1428	94.5
Ohio	100 843 (100 632 to 101 054)	123 114 (1.22)	22 271 (22 060 to 22 482)	190.5	15 178	68.2
Oklahoma	32 559 (32 455 to 32 662)	39 410 (1.21)	6851 (6748 to 6955)	173.1	5254	76.7
Oregon	30 551 (30 451 to 30 650)	34 063 (1.11)	3512 (3413 to 3612)	83.3	1558	44.4
Pennsylvania	109 953 (109 732 to 110 173)	133 247 (1.21)	23 294 (23 074 to 23 515)	182.0	18 690	80.2
Rhode Island	8719 (8679 to 8759)	10 408 (1.19)	1689 (1649 to 1729)	159.4	1873	110.9
South Carolina	41 606 (41 483 to 41 729)	50 518 (1.21)	8912 (8789 to 9035)	173.1	5545	62.2
South Dakota	6882 (6849 to 6915)	8766 (1.27)	1884 (1851 to 1917)	213.0	1666	88.4
Tennessee	62 606 (62 446 to 62 765)	75 504 (1.21)	12 898 (12 739 to 13 058)	188.9	8027	62.2
Texas	168 716 (168 432 to 168 999)	218 242 (1.29)	49 526 (49 243 to 49 810)	170.8	33 828	68.3
Utah	15 985 (15 922 to 16 048)	18 905 (1.18)	2920 (2857 to 2983)	91.1	1618	55.4
Vermont	4837 (4812 to 4862)	5217 (1.08)	380 (355 to 405)	60.9	106	27.9
Virginia	57 788 (57 637 to 57 940)	67 478 (1.17)	9690 (9538 to 9841)	113.5	6244	64.4

(continued)

Table. Excess Deaths, March 1, 2020, to January 2, 2021, US and Selected States and Regions (continued)

Jurisdiction	Expected deaths (95% CI)[a]	Observed deaths (ratio of observed to expected)	Excess deaths, No. (95% CI)	Excess deaths/ 100 000[b]	COVID-19 deaths[c]	Excess deaths attributed to COVID-19, %[c]
Washington	47 196 (47 063 to 47 328)	53 159 (1.13)	5963 (5831 to 6096)	78.3	3662	61.4
West Virginia	18 970 (18 899 to 19 041)	21 332 (1.12)	2362 (2291 to 2433)	131.8	1535	65.0
Wisconsin	45 013 (44 884 to 45 143)	53 256 (1.18)	8243 (8113 to 8372)	141.6	6325	76.7
Wyoming	3890 (3869 to 3912)	4734 (1.22)	844 (822 to 865)	145.8	416	49.3

[a] Seasonally adjusted death counts predicted by regression model (see Methods).

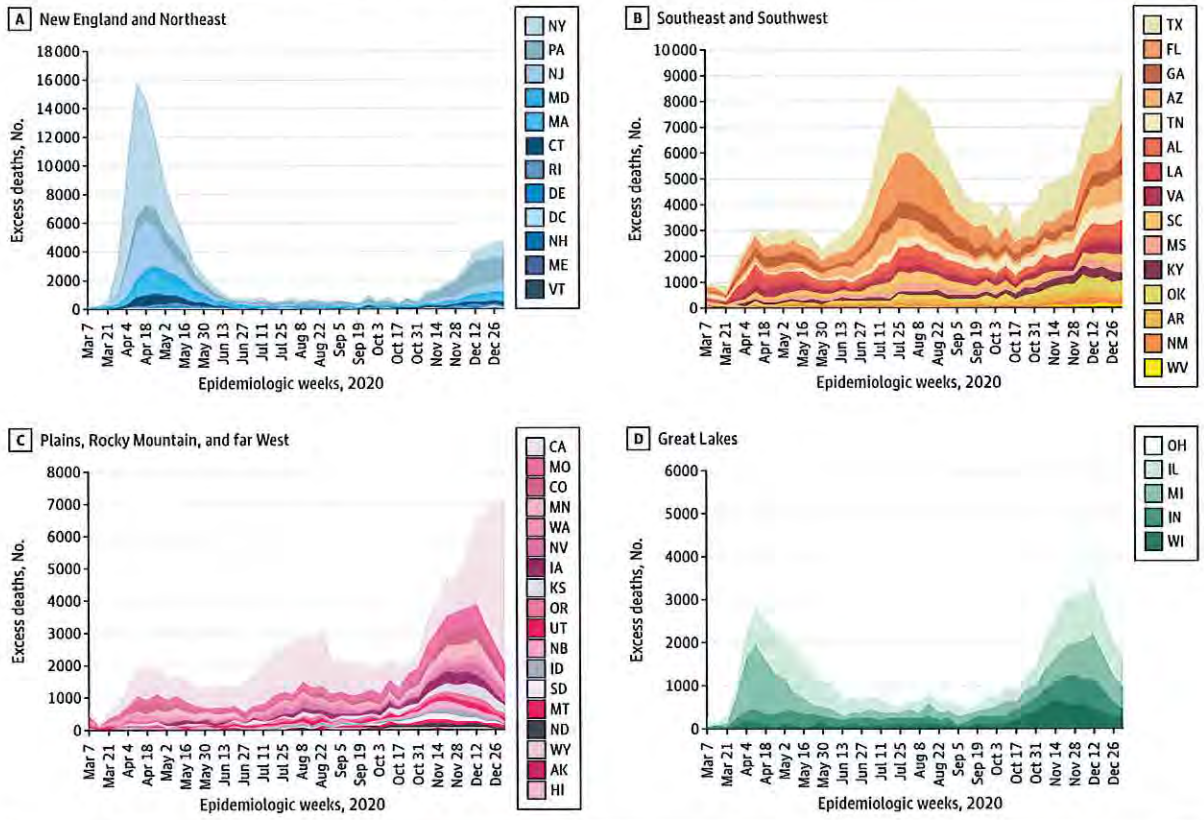
[b] Values shown are not annual mortality rates. The numerator counts only excess deaths that occurred between March 1, 2020, and January 2, 2021.

[c] COVID-19 deaths include deaths in which COVID-19 was identified as the underlying or a contributing cause of death (among multiple causes of death).

COVID-19 deaths in Hawaii, Massachusetts, and Rhode Island exceeded the estimate for excess deaths, in part because observed deaths from other causes were lower than would be predicted according to historic norms.

[d] The US total was calculated as the sum of results for 49 states and the District of Columbia. North Carolina was omitted because of delays in reporting.

Figure. Excess Deaths by Regions, March 1, 2020, to January 2, 2021



State data plotted from 8 regions, as defined by the US Bureau of Economic Analysis. Surge patterns were independently examined for each of the 8 regions (Supplement); epidemic patterns were similar and could be merged as shown, except a bimodal pattern in the Great Lakes region was distinctive and plotted separately. Negative excess deaths were plotted as zero. State-level data are available on request.

primarily in early winter; and in the Great Lakes, bimodally, in the spring and early winter (**Figure**). Excess deaths were increasing in all regions at the end of 2020. The 10 states with the highest per capita rate of excess deaths were Mississippi, New Jersey, New York, Arizona, Alabama, Louisiana, South Dakota, New Mexico, North Dakota, and Ohio. New York experienced the largest relative increase in all-cause mortality (38.1%). Deaths attributed to COVID-19 accounted for 72.4% of US excess deaths.

Joinpoint analyses revealed an increase in weekly mortality from non-COVID-19 causes, including heart disease from March 15 to April 11, 2020 (APC, 4.9 [95% CI, 0.7-9.3]), and from October 11, 2020, to January 2, 2021 (APC, 1.1 [95% CI, 0.8-1.4]); Alzheimer disease/dementia from March 15 to April 11, 2020 (APC, 7.1 [95% CI, 2.4-12.0]), from May 31 to August 15, 2020 (APC, 1.2 [95% CI, 0.7-1.6]), and from September 6, 2020, to January 2, 2021 (APC, 1.3 [95% CI, 1.1-1.5]); and diabetes from March 8 to April 11, 2020 (APC, 6.5

[95% CI, 2.8-10.3]), from May 31 to July 11, 2020 (APC, 2.6 [95% CI, 0.2-5.0]), and from October 18, 2020, to January 2, 2021 (APC, 2.2 [95% CI, 1.6-2.8]).

Discussion | The 22.9% increase in all-cause mortality reported here far exceeds annual increases observed in recent years (≤2.5%). The percentage of excess deaths among non-Hispanic Black individuals (16.9%) exceeded their share of the US population (12.5%),[5] reflecting racial disparities in COVID-19 mortality. Excess deaths surged in the east in April, followed by extended summer and early winter surges concentrated in southern and western states, respectively. Many of these states weakly embraced, or discouraged, pandemic control measures and lifted restrictions earlier than other states.[1,6]

Excess deaths not attributed to COVID-19 could reflect either immediate or delayed mortality from undocumented COVID-19 infection, or non–COVID-19 deaths secondary to the pandemic, such as from delayed care or behavioral health crises. Death rates from several non–COVID-19 diseases (eg, heart disease, Alzheimer disease) increased during surges. The model does not adjust directly for population aging, which could contribute to an overestimate of excess deaths. Other study limitations include reliance on provisional data, inaccurate death certificates, and modeling assumptions.

Steven H. Woolf, MD, MPH
Derek A. Chapman, PhD
Roy T. Sabo, PhD
Emily B. Zimmerman, PhD, MS, MPH

Author Affiliations: Center on Society and Health, Virginia Commonwealth University School of Medicine, Richmond (Woolf, Chapman, Zimmerman); Department of Biostatistics, Virginia Commonwealth University School of Medicine, Richmond (Sabo).

Corresponding Author: Steven H. Woolf, MD, MPH, Center on Society and Health, Virginia Commonwealth University School of Medicine, 830 E Main St, Ste 5035, Richmond, VA 23298-0212 (steven.woolf@vcuhealth.org).

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Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Woolf, Chapman, Sabo.
Critical revision of the manuscript for important intellectual content: All authors.
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Trends in the Prevalence of Concussion Reported by US Adolescents, 2016-2020

In 2016, 19.5% of US adolescents reported at least 1 concussion during their lifetime.[1,2] While knowledge about concussion and management of these injuries within the adolescent population have increased over the past decade,[3] to our knowledge, no national study has tracked whether rates of concussion have declined or increased. This study estimated trends in the lifetime prevalence of self-reported concussion among a national sample of adolescents between 2016 and 2020.

Methods | This study uses national cross-sectional data from the 2016-2020 Monitoring the Future (MTF) initiative.[4] The MTF initiative is an annual school-based survey of 8th-, 10th-, and 12th-graders conducted between February and June each school year; surveys are administered in classrooms and completed during normal class periods. The MTF stopped data collection for the 2020 survey early on March 14, 2020, due to COVID-19 (a representative sample was still maintained). The student response rates between 2016 and 2020 ranged from 79% to 90%. The University of Michigan institutional review board approved this study. A waiver of informed consent was sent to parents providing them a means to decline their child's participation.

A measure to assess concussion was added to the MTF in 2016, asking respondents the following: "Have you ever had a head injury that was diagnosed as a concussion?" Response options included "no," "yes, once," and "yes, more than once." The measure did not change across the 5 years.

Binary regression models (using Mplus 8.1) estimated linear trends for self-reported concussion; adjusted models controlled for sex, race/ethnicity, grade level, parental education, and participation in sports. Analyses report the unadjusted prevalence ratios, adjusted prevalence ratios, and 95% CIs. Statistical significance was set at $\alpha \leq .05$ for a 2-tailed test when assessing linear trends. Full information maximum likelihood estimation was used to account for item missingness for each of the binary regression models. All analyses take into account the complex multistage sampling design, including clustering of respondents in primary sampling units[4]; weights were incorporated to provide nationally representative estimates

MEMORANDUM

TO:	SENIOR MANAGEMENT OF CHC, HF, AND GPIC
FROM:	NOTRE DAME MBA TEAM: VINCE RAVOTTO; COLIN KIBBE; JOSH JOLLY
SUBJECT:	CHC, HF, AND GPIC STRATEGIC PLANNING ANALYSIS AND RECOMMENDATIONS
DATE:	MARCH 3, 2022

Purpose:

The Notre Dame MBA team (hereafter "we" or "our") approached the 2022 spring interterm project *CHC/HF Strategic Plan* with the purpose of evaluating the current goals for calendar year 2022, the next strategic plan, key obstacles for the organization, and opportunities for growth. This "strategic audit" was developed following conversations with the leadership teams from Center for Hospice Care ("CHC)", Hospice Foundation ("HF"), and Global Partners in Care ("GPIC"), collectively the ("Organization"). The intention of this document is to highlight areas of importance for the next strategic plan beginning in calendar year 2022.

Discussion:

Conversations with Organization leadership included discussions with Mark Murray (President/CEO CHC, HF, GPIC); Karl Holderman (Vice President/CFO CHC, HF, GPIC); Lance Mayberry (Vice President/COO CHC); Angie Fox (Director of Nursing, CHC); Dr. Karissa Misner (Chief Medical Officer, CHC); Mike Wargo (Vice President/COO HF, GPIC); Cyndy Searfoss (Director of Education & Collaborative Partnerships HF, GPIC); Chris Taelman (Chief Development Officer HF, GPIC); Lacey Ahern (Program Director GPIC); Craig Harrell (Director of Marketing & Access CHC); and Josh Gregory (Chief Information Officer CHC). Throughout these conversations, five broad topics emerged as consistent themes—the impact of staffing, emerging technology-driven paradigm shifts, the expansion of palliative care services, preparation for industry-wide policy changes, and the importance of integrated but strategically distinct organizations.

On February 28th, we met with all aforementioned members of management from the Organization to develop an understanding of the respective functions, responsibilities, priorities, and obstacles of each team member's role. On March 1st, we toured the Organization's Mishawaka campus with Mike Wargo and later met with Craig Harrell to further discuss issues and opportunities specific to CHC. On March 2nd, we met with Lacey Ahern, Lance Mayberry, and Mark Murray to discuss additional issues and opportunities facing the Organization. Through this process, we were able to form a detailed picture of the strategic priorities that exist at various levels throughout the Organization.

Strategic Recommendations:

Following conversations with Organization leadership and subsequent strategic analysis, we prepared the following recommendations for management's consideration:

The Impact of Staffing

Nurses

Staffing issues and concerns was one of the common themes present in our interviews with the Organization's management team. A national working shortage is underway, partially due to the current economic nature brought upon by COVID-19. Since the start of the pandemic, staffing for the elderly care industry is down 15%. Organization leadership previously identified this issue back in 2019 and subsequently increased wages of nurses to be more competitive in the market. While increasing wages resulted in early successes, the Organization's shortage of staff still plays a significant role in operations. We recommend the following considerations to help combat the current and potential future staffing crisis which impacts the entire healthcare industry:

1) Consider reviewing the nursing compensation and benefit package quarterly to ensure that staff is well cared for and motivated—bolstering recruitment and retention. One additional way to increase retention is to add tuition reimbursement as a way of further incentivizing career development of all employees.
2) Consider modifying the current recruiting and retention goals in the Center for Hospice Care Goals for Calendar Year 2022 to be specific, measurable, and time-bound goals. This could look like:
    a. Recruiting – hire XX number of nurses directly from school each year for the next XX years.
    b. Retention – retain XX% of nurses year over year for the next XX years.
3) Consider conducting exit interviews or surveys with nurses who leave CHC to determine the reason(s) why they left. This process could enable the Organization to identify and combat underlying staffing issues amongst current employees more clearly.
4) Consider hiring part-time nurses for specific needs, such as job sharing or hiring for 2nd and 3rd shifts on flexible schedules.
5) Consider reviewing the work from home policy for nurses in light of the operational efficiencies gained by telehealth. Changing the current policy to allow for remote access could increase the retention of nurses, enhance quality of care for patients, and increase the frequency of visits.

In the coming years, recruiting should be viewed through the lens of increased competition, with the mind set of "how can we improve our recruiting tactics and employee benefits to obtain the highest quality employees and gain an edge over our competition".

Management and Board Members

Diversity, Equity, and Inclusion (DEI) is an important topic in our country today, and countless prominent organizations have taken appropriate steps to include underrepresented populations in organizational management and boards. We noticed that there are two DEI goals currently listed

in the Center for Hospice Care Goals for Calendar Year 2022; however, we challenge management and the board members to construct goals for DEI that are specific, measurable, and time-bound, such as:

1) Management – At least XX% of management in the next XX years to consist of under-represented members.
2) Board Members – At least XX% of board members in the XX years to consist of under-represented members.

Recruiting with diversity in mind is an effective way of broadening the thinking of all members of management. Recruiting with respect to DEI will help to secure future grants, but more importantly will ensure that diverse voices are not lost in management conversations. Leading research suggests that gender-diverse companies are 21% more likely to outperform competition, ethnically diverse companies are 33% more likely to outperform competition, and in contrast, non-diverse companies are 29% more likely to *underperform* against competition.

Emerging Technology-Driven Paradigm Shifts

Telehealth

In our conversations with the leadership team regarding the evolution and future of palliative care, telehealth was one of the most frequently discussed topics. While the Center for Hospice Care Goals for Calendar Year 2022 already includes a line item for telehealth ("increase telehealth visits by 10% over 2022"), the Organization's next strategic plan should further emphasize the need to prepare for telehealth's growing presence in healthcare. In 2022, roughly 74% of patients in the U.S. said they would use telehealth services. Additionally, 74% of patients indicated that they are comfortable communicating with their doctor using technology instead of seeing them in person. Furthermore, 67% of patients indicated that telehealth somewhat or significantly increases their satisfaction with medical care.

While there are legitimate concerns to telehealth—including the sustainability of a telehealth business model, compliance issues, and barriers to effectively connecting with patients—the potential future benefits outweigh the current risks. Physicians in palliative care could double the number of patients they see, nurses could enhance their frequency of visits without cutting into the frequency of in-person visits, patients can enjoy the consistency of familiar faces, and telehealth can drive a culture towards increased personal care to patients. As wearable devices, the internet of medical things (IoMT), and remote patient monitoring continue to push what is possible in telehealth, CHC should strategically prepare for the inevitable presence of telehealth, such as:

1) Create a specific, measurable, and time-bound implementation goal for increasing the number of telehealth visits to patients.
2) Proactively prepare for future changes in the industry by developing partnerships with medical device remote monitoring companies.

AI-Powered Analytics and Big Data

In addition to wearables, IoMT, and remote monitoring, artificial intelligence (AI) and big data have been at the forefront of enabling advancements in the healthcare industry. The implementation of AI in healthcare big data could accurately identify referrals at the appropriate time, leading to faster quality hospice care for patients that need it most, a longer average length of stay for hospital referrals, and lower readmittance rates for hospitals.

AI-powered analytics could also enable the Organization to establish and maintain preferential partnerships with local hospital systems. AI-powered analytics will enable healthcare facilities to process big data in real-time, leading to better healthcare-related decisions and productivity of care delivery. With more insight into when referrals could be expected, same or next day referral to admissions could increase dramatically. As such, we recommend the following:

1) Consider implementing AI-powered analytics into the admissions process to improve same or next day referral to admissions.
2) Explore AI-powered partnerships with local hospitals on the basis of significant mutual benefit.

The Expansion of Palliative Care Services

After gaining further insights into the operations of CHC throughout the interview process, we identified a potential gap in coverage for patients who are admitted into the Milton Adult Day Services and end-of-life hospice care. While Milton Adult Day Services enables CHC to connect with patients further upstream, this gap in services provides the potential for strategic opportunities, such as:

1) Consider marketing CHC's growing community-based palliative care to patients who are currently or were previously in the Milton Adult Day Services.
    a. The goal is to maximize the revenue capabilities in patient's years while providing increased quality care for chronic and long-term issues in advance of eventual end-of-life hospice care.
2) Develop a conversion rate metric to analyze the outcomes of patients admitted to Milton Adult Day Services that eventually are eligible for hospice services.
    a. We understand that the sample size may be small, but consistently analyzing this metric could identify opportunities for future acquisitions or joint ventures as the Organization continues to expand services and into different counties in Indiana.

Preparation for Industry-Wide Policy Changes

In 2021, four U.S. senators introduced bipartisan legislation that would direct the Center for Medicare & Medicaid Innovation to develop a community-based palliative care payment and delivery model. While CMS began allowing Medicare Advantage plans to cover palliative care as a supplemental benefit in 2020, CMS has yet to create a dedicated benefit. Additionally, CMS is testing the inclusion of hospice in Medicare Advantage through its value-based insurance design model demonstration—enabling many hospice providers to diversify their services upstream.

As other bipartisan bills relevant to CHC get pushed forward—like the Improving Access to Transfusion Care for Hospice Patients Act—it is important for CHC to consider how best to prepare for any future changes in policy. In today's political climate, any policy change that would directly impact CHC still remains a distance away. We recommend the following:

1) Prepare for potential changes to CMS protocols to ensure that the Organization is ready for when change eventually comes.
2) Begin a thoughtful process of preparation to position CHC to have meaningful discussions with local representatives on how an eventual policy change could positively impact the Organization and the community.

Importance of Integrated but Strategically Distinct Organizations

One of the key goals for the Organization in calendar year 2022 is to "begin discussions on the creating of an umbrella brand to identify all programming—CHC, HF, GPIC, MADS, CFEACP, HCINC, CMS—as belonging to one organization". Undoubtedly, creating a recognizable and well marketed umbrella brand for the Organization has clear strategic value. An umbrella brand can help establish trust and credibility for CHC, HF, GPIC, and others; and there is no shortage of case studies where similar tactics proved to be extremely beneficial to organizations that employed them. However, the Organization is fairly unique in the sense that while there is subject matter overlap between CHC, HF, and GPIC the day-to-day operations for each entity are distinct and require different forms of attention, resources, expertise, and support.

There is undoubtedly strategic overlap between CHC, HF, and GPIC. However, strategy through the lens of hospice and palliative care in Northern Indiana is very different than strategy through the lens of development, outreach, and education and both are especially different than strategy through the lens of establishing and maintaining international partnerships to support the global need for palliative care. Renowned strategy researcher Michael Porter believes that good strategy needs to be focused and limiting. As such, we recommend that planning, developing, and executing the next three-year strategic plan should involve disseminating responsibility to key stakeholders in each individual organization. Apart from distributing the heavy lifting, there is a business case for evolving the current strategic planning process—more buy in on execution and more effective strategy to promote continued excellence and growth.

1) The strategic planning for CHC, HF, and GPIC should consider producing four distinct strategic planning documents:
    a. Organization (umbrella brand) Strategic Plan 2022 – 2024
    b. CHC Strategic Plan 2022 – 2024
    c. HF Strategic Plan 2022 – 2024
    d. GPIC Strategic Plan 2022 -2024

Conclusion:

As the Organization prepares for continued excellence over the next three years, we recommend an increased focus on five strategic areas: staffing, technology, expansion of palliative care, potential policy changes, and integrated but strategically distinct organizations. Through our analysis, we recommend that the next strategic plan, Strategic Plan 2022 – 2024, emphasize

staffing concerns, measurable DEI goals for leadership, preparation for telehealth and AI-powered partnerships, expansion of upstream palliative care offerings, preparation for potential changes to healthcare policy, integration towards a singular umbrella brand for the Organization, and distinct strategic planning processes for CHC, HF, and GPIC. These recommendations are intended to enhance the Organization's existing trajectory towards success—both as a community leader and as a quality care provider for patients and families.