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CERTIFICATE OF NEED APPLICATION
HOSPICE AGENCY

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

Signature and Title of Responsible Officer:

DocuSigned by:
Russell Hilliard
97DFC127E73B4CF...

Date:
1/24/2023

Dr. Russell Hilliard, PhD, LCSW, LCAT, MT-BC, CHRC, CHC
Senior Vice President, Market Expansion Initiatives

Email Address:
RussellHilliard@AccentCare.com

Telephone Number:
(954) 952-6194

Legal Name of Applicant:
Seasons Hospice & Palliative Care
of Pierce County Washington, LLC

Project Type:
[X] New Agency
[ ] Expansion of Existing Agency
[ ] Other

Address of Applicant:
AccentCare, Inc.
17855 Dallas Parkway, Suite 200
Dallas, TX 75287-6857

Project Location:
Pierce County, Washington

Estimated Capital Expenditure:
$106,700

Project Summary:

The applicant proposes to establish a Medicare and Medicaid-Certified Hospice Agency to serve residents of Pierce County who select and qualify for palliative, end of life care. In addition to providing the federally mandated services of routine home care, general inpatient care, respite care and continuous care, a variety of services and options include, but are not limited to bereavement, pastoral care, music therapy, nursing services, social work services, home aide assistance all available 24 hours a day, seven days a week, including admission assessments. A staffed call center connects each patient and family with the clinical care team for real time response around the clock.

Submitted to:

Department of Health
Certificate of Need Program
111 Israel Road SE
January 31, 2023

FILING FEE

AccentCare

Vendor ID	Vendor Check Name	Payment Number	Check Date	Check Number
[redacted]	WASHINGTON DEPARTMENT OF HEALTH	[redacted]	01/23/2023	[redacted]

Voucher Number	Invoice Number	Invoice Date	Description	Outstanding Amt	Net Paid Amt	Net Check Amt
[redacted]		01/18/2023	PIERCE COUNTY WA CERT OF NEE	$21,968.00	$21,968.00	$21,968.00

TOTALS:	$21,968.00	$21,968.00	$21,968.00

DOCUMENT IS PRINTED ON CHEMICALLY REACTIVE PAPER - THE BACK OF THIS DOCUMENT INCLUDES A TAMPER EVIDENT CHEMICAL WASH WARNING BOX

accentCare.
Reimagining Care, Together.

[redacted]

JPMorgan Chase

[redacted]

[redacted]

DATE	AMOUNT
Jan 23, 2023	$21,968.00

Twenty One Thousand Nine Hundred Sixty Eight Dollars and 00 Cents

PAY TO THE ORDER OF:
WASHINGTON DEPARTMENT OF HEALTH
P O BOX 47852
CERTIFICATE OF NEED PROGRAM
OLYMPIA, WA 98504 7852

THE FRONT OF THIS DOCUMENT INCLUDES A VOID PANTOGRAPH

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TABLE OF CONTENTS

I. APPLICANT DESCRIPTION

1. ***Provide the legal name(s) and address(es) of the applicant(s).***
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-3106-010(6).

The legal name of the Applicant is **Seasons Hospice & Palliative Care of Pierce County Washington, LLC.** Throughout the application, reference to the "*Hospice*", the" Applicant" or "*Seasons Pierce County*" refers to Seasons Hospice & Palliative Care of Pierce County Washington, LLC.

2. ***Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).***

The Applicant, Seasons Hospice & Palliative Care of Pierce County Washington, LLC, is a for-profit, limited liability company, created on December 28, 2020. A copy of the Certificate of Formation and application for the Certificate of Registration with the State of Washington appear in **Exhibit 1**. The Unified Business Identifier (UBI) is 604-700-776.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is the Applicant and intended licensee of the proposed hospice program. This entity is 100% wholly owned by **AccentCare, Inc.** On December 22, 2020, AccentCare, Inc. merged with Seasons Hospice & Palliative Care, combining a national leader of post-acute health care with a national network of community-based hospice providers. AccentCare, Inc. owns and operates a number of healthcare providers throughout the country. An organizational chart showing the business structure of Seasons Hospice & Palliative Care of Pierce County Washington, LLC is included herewith in response to Question 5. Information on the healthcare entities which fall under the AccentCare, Inc. umbrella, including the 31 currently operating Seasons Hospice & Palliative Care providers, is provided in response to Question 6. The broader organization increases access and expands the continuum of post-acute, home-based care. Additional information about the company can be found at www.accentcare.com.

Seasons Pierce County will enter into a management services agreement with AccentCare, Inc. to provide back-office functions to support billing and reimbursement, payroll and human resource functions, information technology services, and other general administrative services. AccentCare, Inc. provides such administrative services to over 40 hospice programs across the country. A copy of the "Services Agreement" is attached as **Exhibit 2** but does not include any professional medical or hospice services. The Services Agreement includes, but is not limited to, billing, payroll, records management, information technology resources, Human Resources, marketing, compliance, and legal services.

All of the AccentCare hospice programs benefit from the back-office support. Each AccentCare Hospice & Palliative Care hospice program is its own operating entity that is legally and operationally separate and distinct from the others. Each hospice program has its own license in the state in which it operates and its own administrator. Each hospice is responsible for its own management, and no actions of one hospice program affect any other hospice program. Each agency is operationally independent.

The Applicant's objective is to develop and operate a hospice program under the federal and state statutes, continuing through to licensure. No change occurs either pre or post-licensure in the Applicant or the controlling entity for the hospice program.

3. ***Provide the name, title, address, telephone number, and email address of the contact person for this application.***

   Dr. Russell Hilliard, PhD, LCSW, LCAT, MT-BC, CHRC, CHC
   Senior Vice President, Market Expansion Initiatives
   AccentCare
   6400 Shafer Court, Suite 700
   Rosemont, Illinois 60018
   (954) 952-6194
   RussellHilliard@AccentCare.com

4. ***Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).***

   Tracy Merritt
   Health Care Planning & Development Director
   MSL Girvin Group, LLC
   307 W. Park Avenue, Suite 211
   Tallahassee, FL 32301
   (850) 681-8705, Ext. 5509
   tmerritt@MSLCPA.com

5. ***Provide an organizational chart that clearly identifies the business structure of the applicant(s).***

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is 100% directly owned by AccentCare, Inc. AccentCare, Inc. owns and operates a number of healthcare providers throughout the country. An organizational chart showing the business structure of Seasons Hospice & Palliative Care of Pierce County Washington, LLC appears in the following figure:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
Organizational Chart

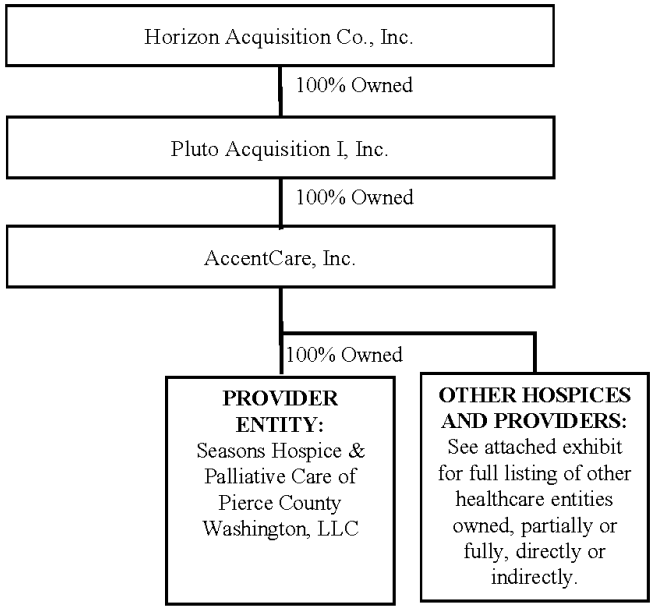


Figure 1. The organizational chart for Seasons Hospice & Palliative Care of Pierce County Washington, LLC ownership rests 100% with AccentCare, Inc.

6. ***Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:***

   - ***Facility and Agency Name(s)***
   - ***Facility and Agency Location(s)***
   - ***Facility and Agency License Number(s)***
   - ***Facility and Agency CMS Certification Number(s)***
   - ***Facility and Agency Accreditation Status***
   - ***If acquired in the last three full calendar years, list the corresponding month and year the sale became final***
   - ***Type of facility or agency (home health, hospice, other)***

Seasons Hospice & Palliative Care of Pierce County Washington, LLC, the Applicant, is a developmental stage company with no operations at this time. The Applicant seeks a Certificate of Need (CN) for a hospice program that will result in licensure as a hospice agency for operations to begin. The Applicant is wholly owned by AccentCare, Inc. AccentCare, Inc. owns over 180 post-acute care facilities with 260 locations in 31 states, including home healthcare agencies, hospice agencies, personal care services and private duty nursing, all of which are listed in **Exhibit 3.** This exhibit also includes the ***AccentCare By the Numbers*** brochures that highlight the locations, volume and partnerships throughout the U.S. Within the state of Washington, AccentCare has one personal care services agency and is in the process of licensing a new hospice agency in King County authorized by Certificate of Need #1916.

It should be noted that Seasons Hospice & Palliative Care of Pierce County Washington, LLC received CN #1947 on September 30, 2022 to establish a hospice in Pierce County. However, the state's decision to approve the CN remains under appeal. Therefore, this application is filed under the assumption that should litigation result in revocation of CN #1947, Seasons Hospice & Palliative Care of Pierce County Washington, LLC could still prevail with a CN during the current cycle for which additional need was published on October 14, 2022.

II. PROJECT DESCRIPTION

1. ***Provide the name and address of the existing agency, if applicable.***

This criterion is not applicable. The Applicant does not own, operate or manage and existing hospice agency.

2. ***If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.***

This criterion is not applicable. The Applicant does not own, operate or manage and existing hospice agency.

3. ***Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.***

The address of the proposed office for the hospice is as follows:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
4301 South Pine Street
Tacoma, Washington 98409

A copy of the lease is attached as **Exhibit 4.** The lease is between 3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as Landlord and Seasons Hospice & Palliative Care of Pierce County, LLC as Tenant. The lease includes three amendments, extending the term through December 31, 2029. In addition to the lease, a letter from the landlord agrees to assignment of the lease to the Applicant, Seasons Hospice & Palliative Care of Pierce County Washington, LLC.

Enrolled patients receive hospice services in their own homes. Therefore, the location of the business office is the repository for medical records, staff training and staff conferences for the purpose of care team meetings. All care staff are dispatched generally from their homes to provide in-home care to patients.

4. ***Provide a detailed description of the proposed project.***

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is applying for a certificate of need (CN) to establish a Medicare and Medicaid certified hospice agency to serve residents of Pierce County, Washington. Hospice services include nursing care, pastoral care, medical social work, respite services, home care, as well as 24-hour continuous care in the home at critical periods and bereavement services for the family. Seasons Pierce

County proposes an integrated service delivery system that includes the capability to provide palliative care as well as end of life care. The target population resides in Pierce County.

Honoring Life -Offering Hope

Recognize that individuals and families are the true experts in their own care

Support our staff so they can put our patients and families first

Find creative solutions which add quality to life

Strive for excellence beyond accepted standards

Increase the community's awareness of hospice as part of the continuum of care

Seasons Pierce County staff provide the federally mandated core services of routine home care, respite care, inpatient, and continuous care in conjunction with volunteers. All volunteers receive training in AccentCare standards of patient care to provide them with expertise to become a member of a hospice care team. Seasons Pierce County adopts the values of care, compassion and service, reflected in the Mission and Vision statements that appear in the box to the right. With these mandates, Seasons Pierce County becomes the ***"can do"*** hospice.

The hospice staff retain responsibility and accountability for the care of patients in the program. The interdisciplinary group (IDG) collaborates with each other in real-time through the electronic medical record (EMR) so that each team member is aware of the patient's status and needs at all times. The team, along with the patient and family, develop the individualized plan of care. The assessment process identifies in detail the patient's condition at enrollment and over time that includes all the services required. Each plan is individualized and uniquely suited for the patient's requirements and is evaluated regularly and adjusted as needed. The ***Circle of Care*** describes the team approach to service delivery that places the patient at its center.

Hospice Patient. Each patient has a different story, and the priority is to care for them every step of the way during their end of life journey. Patients live in private residences, nursing homes, assisted living facilities, and other locations.

Family & Friends. Families and friends are an important part of the patient's journey. Social workers and chaplains

provide assistance and guidance as desired. They answer questions and help with processing grief and bereavement. A library is available with resources for all ages.

Medical Director. The hospice Medical Director determines and certifies when a patient is eligible for hospice care. They lead the care team in developing each patient's individualized plan of care and advise on updating it as needed during the end-of-life journey. AccentCare keeps any attending physicians (usually a primary care physician or a physician at the patient's nursing facility) informed of care and prognosis as it changes over time. The hospice team physician can co-certify hospice eligibility if a patient does not have an attending physician. The team physician assesses needs and determines the best management for symptoms and pain, including medication prescription.

Attending Physician. The patients' attending physician assists with determining and certifying when a patient is eligible for hospice care. AccentCare keeps any attending physicians (usually a primary care physician or a physician at the patient's nursing facility) informed of care and prognosis as it changes over time. The hospice team physician can co-certify hospice eligibility if a patient does not have an attending physician.

Hospice Care Consultant. When someone has received a hospice diagnosis and has questions about how to enroll in hospice, the hospice care consultant (HCC) is there to assist. They educate on how hospice can be beneficial to patients and their families, as well as what types of support AccentCare can provide. They answer questions about care and services, meeting face-to-face, over the phone, or can drop off, mail, or email more information about services.

Registered Hospice Nurse. The nurses are experienced in providing pain relief and symptom management and communicate regularly with the patient's physician to update them on the status and the effectiveness of the plan of care so that any changes necessary can be made as the illness progresses. They also assist in monitoring medications and making sure all medical supplies and equipment are ordered. Our nurses work to anticipate needs and educate patients and families to help them understand the progression of illness and hospice plan of care.

Hospice Aide. Our hospice aides provide direct personal care designed to increase comfort and assist with needed activities of daily living. Aides assist with activities such as bathing, hair care, shaving, skin care, catheter care, and linen changes. They help with dressing and other personal care a family or personal caregiver may need. Hospice aides report back on patient status to the nurse and the rest of the IDG. A patient's hospice aide will likely be the same each visit.

Social Worker. Facing a serious illness can be a time of stress, confusion, and strong emotions. Social workers help patients and families navigate challenges that arise as a disease progresses. They provide direct therapeutic counseling and bereavement support and connect patients and families with appropriate community agencies within the local community. They collaborate with the hospice team to ensure patients and families are comfortable and have their needs met. Social workers are also integral to the Leaving a Legacy program, which focuses on helping patients find tangible ways to share their history with their family.

Music Therapist. During private sessions with patients and their families, music therapists practice music-as-medicine. The application of music therapy for hospice patients is a clinical discipline. Board-certified music therapists perform favorites songs or hymns for their hospice patients and familiar genres to ease pain, bring comfort and create connections. They use music to calm a racing heart or steady respiration rates. Music therapists also work with patients and families to create legacies of songs and voice recordings that memorialize a patient's life. Music therapists are also integral to the Leaving a Legacy program, which focuses on helping patients find tangible ways to share their history with their family. A music therapist holds at least a bachelor's degree, plus an additional certification from the Certification Board for Music Therapists. Many AccentCare music therapists have advanced or graduate degrees.

Chaplain. AccentCare chaplains honor all faiths and religious traditions. Chaplains are fully prepared to provide patients and families with spiritual support that speaks to their faith journey or beliefs and will honor individuals according to their faith tradition or wishes. Spiritual care can be provided to all who ask, including patients, families, partners, or friends. Chaplains provide support, companionship, and can lead in prayer and spiritual readings. They also provide bereavement services and help with conversations about grief and loss.

Volunteers. After completing a selection and training process, volunteers work alongside professional staff to support patients and families. They provide comfort, non-medical care and compassion to our patients and their families. They perform tasks such as visiting or calling patients and families, having conversations, reading aloud, or listening to music together. They help at inpatient centers as vigil volunteers or serve on the pet therapy team. Direct care volunteers are required to take background checks and participate in initial hospice volunteer training and basic orientation.

Call Center. Seasons Pierce County has the advantage of full integration with the AccentCare Call Center. The call center, staffed 24 hours a day, seven days a week with nurses and other professionals, integrates care team members and patients by accessing the patient's medical record. The success of the call center relies upon a fully integrated medical record and the ability of employees to link up with their communication devices. Care teams in the field use software that allows access to the medical record and resources in real time.

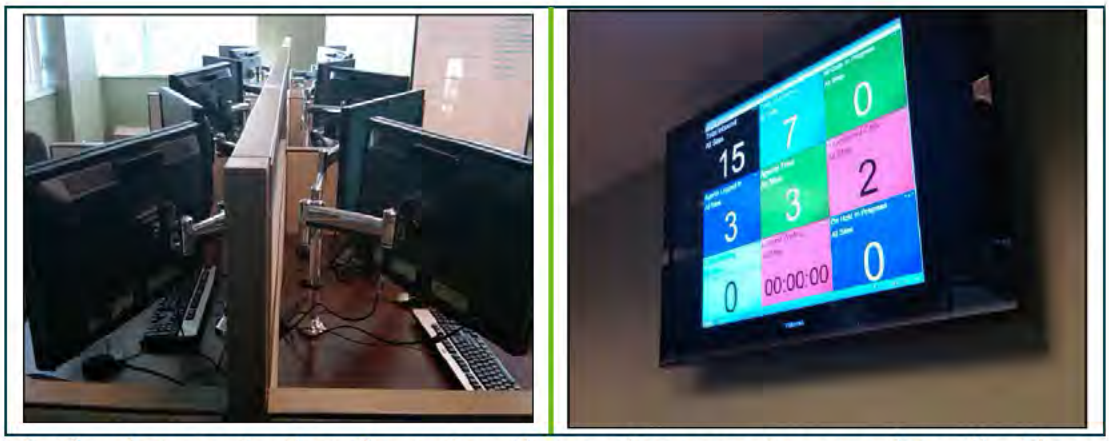


Figure 2. The photographs show the stations that employees use to respond to calls. The monitor displays which of the stations are engaged and the response type in which the employee is engaged.

The photographs above showcase the call center. Call center staff receive special training and must be proficient in both call operations and the electronic medical record. The monitor shows each staff member's level of call traffic and response types in progress. The monitor, visible to all in the center, ensures the highest level of cooperation, communication, and support. AccentCare staff are multilingual and represent the communities AccentCare serves. If staff who speak the patient's language are unavailable, Language Line services are used to translate, although AccentCare's priority is to use its own multilingual staff.

Core Services. The core services are those mandated by federal regulations and include Routine Care, Respite Care, Inpatient Care, and Continuous Care. The provision of care involves employees trained in disciplines to provide services and volunteers on the care team that includes the hospice physician, chaplain, nurses, social workers and counselors. Music therapists also are active team members.

The objectives of the core services are these as they appear below.

- Complete symptom management, including control of pain.
- Emotional and spiritual support for the individual and loved ones.
- General inpatient care when extensive medical intervention is necessary.
- Physician-directed medications, medical equipment and therapy services.
- Schedule routine home care including nursing visits and 24-hour on-call service.
- Offer palliative care from employees as well as trained volunteers.
- Coordinate with primary care physicians and the hospice medical director care that addresses the patients' conditions.

Routine Care. **Care in the patient's home is the goal of the hospice program and routine home care forms the bulk of the patient's palliative services. The abundance of services and programs provide the terminally ill with options for a range of services specified in each individual's plan of care. They form the basis of care in the patient's home.**

Hospice aide and homemaker services provide the patient with assistance to accomplish personal care and home care needs. The hospice aide meets the training, attitude, and skill requirements specified in Sec. 484.36, Chapter IV, Title 42, Code of Federal Regulations.

Respite Care. **Respite care relieves the family members or other persons caring for the individual, and may be provided only on an occasional basis, for no longer than five days at a time. The facility providing respite care agrees to provide 24-hour nursing services that meet all patients' nursing needs and are furnished under each patient's plan of care. Each patient receives all nursing services as prescribed and is kept comfortable, clean, groomed, and protected from accident, injury, and infection.**

General Inpatient Care. **Seasons Pierce County assures the provision of an inpatient level of care through a contract with a nursing home and evidences enrollment as a provider of Medicare or Medicaid services. This allows pain control and symptom management for the hospice patient.**

Seasons Pierce County proposes to seek contracts with one or more skilled nursing facilities (SNF) for the provision of general inpatient care prior to receiving its license. A sample SNF contract for inpatient care is provided in **Exhibit 6**. The care team communicates with the patient and his or her representative of the availability of short-term inpatient care for pain control, symptom management, and respite purposes and the names of the facilities with which the hospice has a contract agreement. Seasons Pierce County retains the responsibility for ensuring that the training of personnel who will be providing the patient's care in the inpatient facility has been provided and that a description of the training and the names of those giving the training are documented.

Seasons Pierce County retains responsibility for the care of the patient. In addition, Seasons Pierce County respects the patient's right to refuse to talk to persons not associated with its organization or not directly involved in the patient's care, e.g. visitors, vendors, accreditation surveyors, or representatives of community organizations.

In addition, the inpatient provider's policies conform to those of the hospice and must agree to abide by the patient care protocols established by the hospice for its patients. The inpatient provider agrees to notify Seasons Pierce County of any change in the patient's

condition, orders, and other treatments. Elements of the contract require the following spatial necessities:

1. Physical space for private patient and family visitors (patients may receive visitors at any time, including young children);
2. Accommodations for family members to remain with the patient throughout the night;
3. Accommodations for personal items;
4. Accommodations for food preparation by the patient/family;
5. Accommodations for family privacy after a patient's death; and
6. That is homelike in design and function.

Responsibility for the general inpatient care requires that the hospice patient's inpatient clinical record include all inpatient services furnished and events regarding care that occurred at the facility and that a copy of the inpatient medical record and discharge are available to Seasons Pierce County. This allows the care team to resume services in the home.

Continuous Care. Seasons Pierce County assures the provision of continuous care for patients in their homes in periods of crisis. These crises result from acute medical symptoms requiring active involvement from professionals and intensive services to achieve palliation. At least 8 hours of care in a 24-hour period constitute continuous care with services of a registered or practical nurse. Homemaker or home health aide services may be furnished to supplement the care. The provision of continuous care generally is less than 0.3% of total hospice days. Staff provide this core service.

Integrated with the core services, Seasons Pierce County commits to the following as part of its hospice and palliative care services:

- Become a partner in care by working with a patient's primary care physician and the staff of the assisted living or nursing home in which the patient resides. This partnership requires that the hospice provide support to the staff through education and accountability, clearly stated expectations, and defined services.
- Offer the platinum certified program Services and Advocacy for Gay Elders (SAGE).
- Offer We Honor Veterans a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs (VA). The program contains five progressive levels to train staff and volunteers on veteran-centric care, and provides outreach and educational materials. From veterans enrolled in the hospice, AccentCare honors his or her service with a recognition pinning ceremony with accompaniment of music therapists singing the hymn from his or her service branch.

- Develop services to reach all persons through the Inclusion Initiative. This initiative recognizes diversity in the general population and develops volunteer councils that act as key informants for particular subpopulations. These include, racial, ethnic, and cultural segments who provide the hospice with understanding that result in improvements to outreach, to innovate or to alter services that increases the acceptance of hospice care.
- Enhance the workforce through diversity to improve access.

Seasons Pierce County commits to serving patients and families from diverse backgrounds. The Cultural Inclusion Council (CIC) was founded out of a desire to honor and respect the diverse communities that AccentCare serves, and to address the disparities in access to hospice and palliative care. The purpose is to consider the cultural values of all AccentCare's patients, families, and staff, provide care that respects what is most important to each individual, improve the community understanding of hospice and palliative care, and educate staff to ensure that all needs are being met. The CIC's goals reinforce AccentCare's priority of equitable care so all patients, no matter their race, gender, ethnicity, religion, sexual orientation, language, gender identity, or class, die comfortably, with dignity. The CIC acts as a resource to help Seasons Pierce County support the needs of a diverse patient population so that both patients and colleagues experience inclusion, sensitivity, feel honored and respected.

Religious affiliation affects how hospice care appeals to a person. The subject of death made manifest by illness and decline either for oneself or family member raises a host of feelings and emotions, many of which may involve fear of the unknown, aversion to pain, and helplessness. Therefore, understanding and sensitivity at the interpersonal level create a bridge to access care. Seasons Pierce County provides spiritual support and services to a range of religious groups outside of Christian faiths.

5. ***Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.***

Seasons Pierce County will serve all residents of Pierce County, regardless of location within the county. The proposed agency will establish its office proximate to the most populous areas of Pierce County to ensure availability and accessibility to the entire geography of the county. Enrolled patients receive hospice services in their own homes. However, when necessary, a patient may require inpatient respite or general inpatient services, which are temporary and typically less than one week, at a facility under contract. Therefore, the location of the business office is the repository for medical records, staff training and staff conferences for the purpose of care team meetings. All care staff are dispatched generally from their homes to provide in-home care to patients. All staff use computer technology to communicate with the office as well as each other, and the call center.

To demonstrate accessibility, the figure that follows shows the location of the home office on a map with 30 minute and 45-minute drive time contours around it. The contours establish the feasibility of staff being able to access the home office for meetings, in-service training, care team conferences and medical records. The location allows an access point to the majority of the population, as indicated in the map. Specifically, the map shows the projected 2027 population by Zip Code. The 30-minute drive-time contour captures 87.3% of the total population in Pierce County, while the 45-minute drive-time contour captures 95.3%, documenting accessibility of the proposed program. This map utilizes data from the Claritas 2022-2027 population estimates, which can be found in **Exhibit 7**.

2027 Population by Zip Code

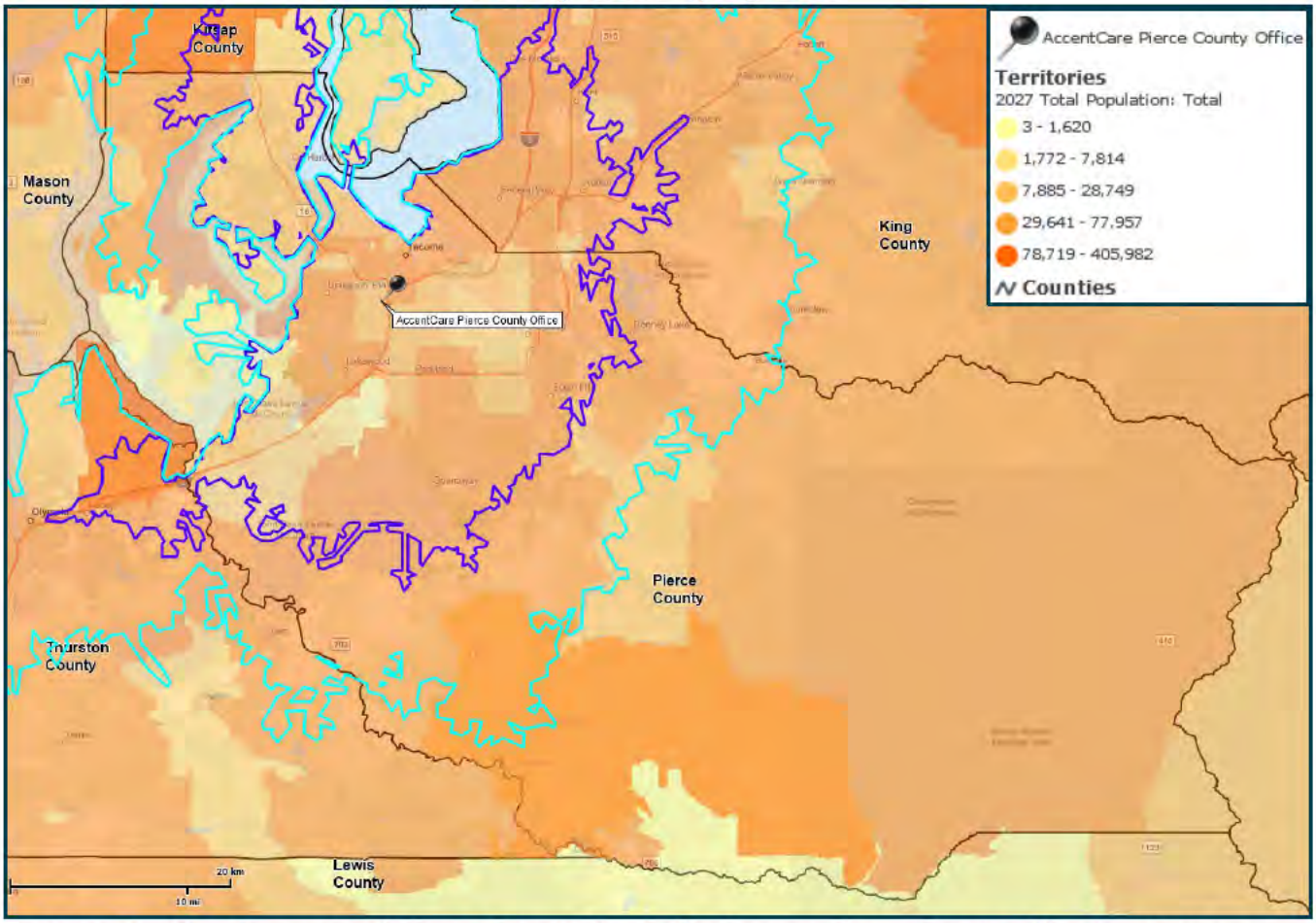


Figure 3. The above map of Pierce County shows the Seasons Pierce County office location as a black pin at 4301 South Pine Street, Tacoma, WA 98409. The dark blue line shows a 30-minute drive time from the office, and a light blue line shows a 45 minute drive time contour. The contours show accessibility and availability of the location for employees most of whom are expected to reside in Pierce County. The projected 2027 total population is shown by Zip Code.

6. ***With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:***

The project establishes a new hospice agency for Pierce County. Therefore, approximately 9-12 months are needed to prepare for licensure and certification, including furnishing and equipping office space, hiring executive and nursing staff, conducting training, and hold mock surveys prior to licensing and certification surveys. The table below shows the estimated timeline for project implementation.

Event	Anticipated Month/Year
CN Approval	September 2023
Design Complete (if applicable)	N/A
Construction Commenced (if applicable)	N/A
Construction Completed (if applicable)	N/A
Agency Prepared for Survey	May 2024
Agency Providing Medicare and Medicaid hospice services in the proposed county.	July 2024

7. ***Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.***

- [X] Skilled Nursing
- [X] Home Health Aide
- [X] Physical Therapy
- [X] Occupational Therapy
- [X] Speech Therapy
- [X] Respiratory Therapy
- [X] Medical Social Services
- [X] Palliative Care
- [X] Other: See below.
- [X] Durable Medical Equipment
- [X] IV Services
- [X] Nutritional Counseling
- [X] Bereavement Counseling
- [X] Symptom and Pain Management
- [X] Pharmacy Services
- [X] Respite Care
- [X] Spiritual Counseling

Seasons Pierce County proposes to bring an array of programs to all patients served by its hospice in Pierce County. In addition to those checked above, these include the following:

Cardiac Care and AICD Deactivation Program. The program uses hospice physicians and cardiac trained hospice nurses to provide the latest heart failure guideline-based therapies, along with education to provide support for patients and families in their home environment. AccentCare utilizes software that integrates the electronic medical records with the call center. Seasons Pierce County will offer its AICD Deactivation as part of its Cardiac Care Program in Pierce County. Automatic implantable cardioverter-

defibrillators (AICDs) are similar to pacemakers but are used on patients with a higher risk for sudden cardiac arrest.[1]

The following goals define the program's operations.

1. Deliver The American College of Cardiology Foundation/American Heart Association **(ACCF/AHA)** guideline-based care to the Class IV Stage D heart failure (HF) patients
2. Provide symptom relief with HF guideline medications, including IV inotropes and IV diuretics
3. Provide emergency support and management tools to prevent calls to 911
4. Provide hospice care while maintaining support for the IVAD and heart transplant patient
5. Improve quality of life for HF patients and families by implementing strategies to recognize, report and treat symptoms

The clinical care for Class IV Stage D patients with end-stage heart failure include the following services:

- Guideline medication management and titration as appropriate
- IV/PO diuretic therapy management
- ICD LVAD deactivation compatible with patient expectations of care
- IV inotropic therapy
- Emergency management protocol
- Oxygen for comfort and symptom management
- Cardiac Comfort Kit, including IV Furosemide
- Regular communication with referring or attending physician

Patients eligible for the Cardiac Care Program meet the following requirements:

- Have Class IV Stage D HF with significant symptoms despite treatment with HF guideline medications
- Have been admitted to the hospital for HF decompensation >3 times in last six months
- Are not candidates for high-risk revascularization, LVAD, transplant or have inoperable aortic stenosis
- Are end-stage LVAD or heart transplant
- Are unable to tolerate indicated guideline medications

[1] www.wjmc.org/our-services/heart-vascular-care/pacemaker-and-defibrillator-implantation/

Compassionate Ventilator Removals and Education. When the decision is made to allow a natural death for the patient, it can cause distress and suffering for the family when mechanical life support such as ventilators are removed. Most patients would prefer for their death to occur in a familiar setting outside of the hospital, but it is estimated that 20% of deaths occur in the Intensive Care Unit.[2] AccentCare's goal is to maintain the respect and comfort of patients and their family members during the end-of-life process in non-ICU settings. The AccentCare care team makes a special effort to perform ventilator withdrawal (extubation) while honoring the wishes of patients and their loved ones, and to ensure that death comes with dignity.

AccentCare provides compassionate ventilator removal for patients who have mechanical-assisted breathing, either through a tracheotomy or intubation.[3] AccentCare has developed a protocol that allows hospice staff to remove mechanical ventilation in a manner that shows respect for the patient and also provides a more peaceful environment for families and loved ones. The process includes a high degree of teamwork and communication by caregivers, including physicians, to ensure that the patient remains comfortable and gets the support they deserve. Through this program, AccentCare staff can schedule the process for a time when a patient can be surrounded by loved ones. AccentCare has a Licensed Music Therapist at the patient's bedside (whether in an inpatient unit or at home) to play their favorite music before, during and after removal. This music improves the patient's experience and also shields loved ones from mechanical noises associated with machines. AccentCare also has a chaplain who will be present, according to patient and family wishes. Seasons Pierce County will offer this service through these protocols.

Seasons Pierce County will offer an annual continuing education event to area hospitals on the hospice approach to compassionate ventilator weaning for the first three years of operations. This educational event will be offered free of charge, and will inform hospital physicians, nurses and administrators about how hospice providers can offer vent weaning for eligible end of life patients, rather than having the hospital perform the extubation before discharging to hospice care.

Cultural Inclusion Council. Seasons Pierce County commits to serving patients and families from diverse backgrounds. The Cultural Inclusion Council (CIC) was founded out of a desire to honor and respect the diverse communities that AccentCare serves, and to address the disparities in access to hospice and palliative care. The purpose is to consider the cultural values of all AccentCare's patients, families, and staff, provide care that respects what is most important to each individual, improve the community understanding of hospice and palliative care, and educate staff to ensure that all needs are being met. The CIC's goals reinforce Seasons' priority of equitable care so all patients, no matter their race, gender, ethnicity, religion, sexual orientation, language, gender identity, or class, die comfortably,

[2] "Compassionate Extubation in a Non-Intensive Care Unit Setting." Abstract published at Hospital Medicine 2015, March 29-April 1, National Harbor, MD Abstract 61 Journal of Hospital Medicine, Volume 10, Suppl 2. https://shmabstracts.org/abstract/compassionate-extubation-in-a-non-intensive-care-unit-setting/

[3] Seasons has found this to be a very successful program in many of its hospice service areas, including Miami-Dade and Monroe counties.

with dignity. The CIC acts as a resource to help Seasons Pierce County support the needs of a diverse patient population so that both patients and colleagues experience inclusion, sensitivity, feel honored and respected.

Designated Caregiver Program. Hospice services rely upon designated caregivers within the home. AccentCare expects some patients will not have a designated person who can function as their primary caregiver; thus, hospice appropriately arranges to meet their physical needs. The hospice team leader identifies and directs safe and effective provision of hospice care when the terminally ill patient requires assistance with self-care and skilled services. Care is provided in a location of the patient's choice.

The process for determining a patient's need for a designated caregiver follows these steps. A social worker first completes a patient and family assessment, which may find that the patient does not have caregiver to assist with in-home care but can care for themselves initially. The assessment also estimates how long the patient can be independent, and when to reassess. If the patient cannot meet their own needs for self-care and symptom management, the assessment will identify "lack of primary caregiver" as a problem. This designation will lead to these events:

- The plan and frequency for reassessment of the patient's need for care assistance.
- A Social Worker assessment of the patient's ability and desire to pay independently for hired care givers.
- A discussion of anticipated care needs with the patient and collaboration on a plan to meet those future needs.

As the disease progresses and the patient's functional capacity declines, the care team will consider these options, in collaboration with the patient and family:

- Availability of friends, neighbors, and community members as a potential future support network. The hospice team will provide support, management, teaching, oversight, and emergency intervention to this network if one is identified.
- Use of Seasons Pierce County's Caregiver Relief Program to provide custodial care.
- Use of Seasons' Compassionate Companions Program to increase volunteer visits.
- Use of medical alert devices and services,4 paid for by the Seasons Hospice Foundation for those who qualify
- Placement in a group home, public housing, or shelter.
- Placement in a skilled facility.
- Continuous care if arranged caregiver support cannot manage pain and symptoms and the patient desires to remain at home.
- Placement in a general inpatient bed when pain and symptoms are unmanageable at home.

[4] Medical alert services provide devices to a person that can request an emergency contact be notified at the push of a button. Some of these services also alert caregivers and medical staff to a suspected fall.

The patient makes the final decision on which option to pursue.

Death with Dignity – Physician Aid in Dying. Seasons Pierce County implements Washington's Death with Dignity Act, working with patients, their families, and caregivers, to honor the patient's wishes. With affiliates in the states of Oregon, California, Colorado and New Jersey that enact similar provisions, a terminally ill patient can obtain legally accelerated physician assistance in dying.

As indicated in **policy C 2.2**, found in **Exhibit 8**, AccentCare team members discuss the provisions of the Death with Dignity Act and provide information about the Compassion and Choices Advocacy Group. With the patient's primary care physician, support exists for the patient and his or her family at the end of life, fulfilling the patient's last instructions. This support also includes staff present at bedside when the patient self-administers aid-in-dying medication. Through this policy Seasons Pierce County supports residents above and beyond other hospice programs that may not allow their physician to prescribe or for their staff to be at the bedside during ingestion. Additional information about how AccentCare supports the state's Death with Dignity Act appears in **Exhibit 8**.

Jewish Hospice Services. AccentCare understands there are many levels of religious observance. This service honors the cultural values of Jewish patients and their family members. Each member of the care team receives training and education about the full spectrum of Judaism, including its practices, laws, traditions and values. The care team is committed to working collaboratively to provide end-of-life care that respects Jewish values and religious practices, including the family's Rabbi in the decision-making processes. Chaplain Rabbis are available to serve as a member of the care team. Support and assistance is provided with funeral planning, working with a variety of funeral homes and Chevra Kadisha when requested. In addition, the hospice offers bereavement services to help family members cope with the loss of their loved one.

Holocaust Survivor Care. Holocaust survivors and their loved ones have unique spiritual, cultural and psychosocial needs. AccentCare clinicians and care teams are educated and sensitive to survivor traumas that may resurface during the end-of-life transition. AccentCare caregivers also recognize the unique bonds between the generations in many Holocaust families.

Kangaroo Kids Pediatric Hospice & Palliative Care. When a pediatric patient requires palliative as well as end of life care, Seasons Pierce County reviews the care team staff and assembles a designated pediatric care team. The pediatric care team provides direct care to the pediatric patient, teaches the parents how to provide care at home, the regimen of care, and schedule for medicines and other services. The Pediatric team focuses upon support to the larger system, including specialized, developmentally appropriate support to siblings, grandparents, and the community at large (especially when the pediatric patient is school-aged). The Pediatric team advocates for the pediatric child's voice and

wishes to be heard. Pediatric care volunteers schedule time in the home to interact with the child, parents and caregivers to assure palliative care at end of life.

Leaving a Legacy. This program assists patients in creating memories and tangible recordings, art works, journals, scrapbooks, memory bears, fingerprint necklaces, and other mementos for the family to assist with coping during bereavement. AccentCare helps each patient identify their life's purpose and meaning through these innovative legacy projects. Capturing a story told in the patient's voice is a powerful connection for the family after the patient's death. It is common to record patients reminiscing or singing with the music therapist to provide a legacy for the family. Families often report this lasting connection is one of the most important aspects of hospice care for them.

Music Therapy. The American Music Therapy Association defines music therapy as "*an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages.*" Music consoles and comforts persons even when unconscious or nonverbal. The Seasons' video, ***Mr. Gregg – the Life of the Party***, shows how music improves lives. To view, type https://vimeo.com/240891008 into the web-browser.

AccentCare employs board-certified music therapists (MT-BC). AccentCare is the largest employer of MT-BCs nationally. For patients who simply need entertaining beyond the therapeutic interventions of the MT-BC), AccentCare offers a ***Music Companion***.

Techniques used include these:

- Guided imagery
- Singing/instrumental work
- Lyric analysis/discussion
- Song writing
- Music relaxation
- Recording personal tape
- Drum work
- Breath work
- Making music choices and listening
- Rhythmic movement
- Dancing

Goals in the plan of care reflect each person's directions, and most have music as a service. Some of the goals include those listed below.

- Reminiscence—focus on assets and positive experiences
- Identify and express emotions
- Life review with assessment of actions
- Increased socialization
- Establish trust relationship/rapport
- Maintain/ improve physical comfort
- Permit discussion around dying/ death issues
- Explore religious tradition /musical associations
- Reality orientation/thought organization
- Assessment of physical/mental capabilities
- Support independent thinking/ decision making
- Develop effective coping skills

- Improve self-esteem
- Gain insight into problems/ situations
- Mood management
- Medium for closure
- Provide distraction during difficult situations/procedures
- Muscle relaxation
- Regain sense of control
- Guided imagery

Namaste Care. This dementia care program, designed by internationally recognized dementia expert, Joyce Simard, and the author of the text **Namaste Care,** uses multi-modal interventions to find human connectedness, decrease dementia-related symptoms, and enhance quality of life. AccentCare is the only national hospice approved to implement Namaste Care and all staff are oriented by Joyce Simard through virtual and e-learning modules.

Namaste Care reflects a highly specialized program for use with people in the advanced stages of dementia and other neurological illness. It focuses on person-centered approaches to improve quality of life through meaningful sensory activities, stimulation, relaxation, offer comfort, and serenity.

The following program description provides the detail about the Namaste Care and its effectiveness in providing a "loving touch" at end-of-life progresses. Care team staff receive training for this enhanced program.

As a specific service, when required, Namaste Care appears in the care plan. All members of the hospice interdisciplinary staff and volunteers participate. Certified nurses' aides provide bathing, dressing, grooming, and hydration as meaningful activities rather than tasks. Other disciplines and volunteers provide gentle hand massages, spiritual reading, music, and reminiscences. Each session targets the preservation of the person's dignity.

Criteria used for program assignment:

- 6 months or less prognosis
- Stage 7 (Functional Assessment Staging (FAST) scale)
    - Unable to ambulate
    - Cannot dress or bathe without assistance
    - Urinary or fecal incontinence
    - No meaningful communication, speaks fewer than six words

Criteria used for dementia:

- 6 months or less prognosis
- Within the past 12 months, the patient had at least one of the following conditions:
    - Aspiration pneumonia
    - Upper urinary infection
    - Septicemia (microbes in blood)
    - Multiple State 4 of 5 decubitus ulcers
    - Fevers that recur after antibiotic therapy
    - Inability to maintain sufficient fluid and caloric intake, with 10% weight loss during the previous six months

Benefits:

- Person-centered care employing meaningful activities to individualized care based on the Lifestyle Assessment
- Uses sensory stimulation and that helps soothe and evoke feelings of comfort
- Creates a clam, relaxing environment for the provision of care
- Teaches loved ones ways to interact with the person with advanced dementia
- Adds a layer of professional caregivers to the existing team

Outcomes:

- Enhances the quality of life for people with advanced dementia
- Diminishes feelings of stress and anxiety
- Eases suffering
- Supports family by providing coping skills
- Promotes feelings of personal meaningfulness

No One Dies Alone. AccentCare recognizes the moment of death is profound for patients and their families. The goal is to ensure all patients and their families have the support of Seasons throughout life's final transition, to prevent unwanted hospitalizations, and to honor patients' wishes of dying at home (or within their established long-term care setting.) AccentCare educates its staff and volunteers to identify when patients are approaching the final weeks of their lives. At this point, staff and volunteers offer additional support and if the patient/family accept it, continuous care or volunteer vigils are provided. If the patient is not appropriate for continuous care, AccentCare will offer its Volunteer Vigil program which uses specially trained volunteers to stay at the patient's home. If volunteers are not available, Seasons Pierce County staff will hold vigil to ensure no patient dies alone against their wishes.

Open Access. This program allows eligible patients currently receiving medical treatments and/or experiencing intense psychosocial challenges access to hospice services earlier. The Open Access program also opens the door for some patients who would otherwise not receive hospice care by providing services many other hospices will not consider, such as ventilators for home use, radiation therapy, and chemotherapy. Seasons Pierce County will offer its Open Access program in Pierce County so patients and families are able to access hospice and advanced care planning earlier.

The patient with complications or with multiple system involvement besides the terminal diagnosis may need additional medical interventions such as those listed below.

- ✓ IV antibiotics
- ✓ TPN
- ✓ IV Hydration
- ✓ Cardiac drips
- ✓ Chest tubes
- ✓ Tube feedings
- ✓ Hemo/peritoneal dialysis for co-occurring diagnosis
- ✓ Palliative radiation
- ✓ Oral chemotherapy
- ✓ Biological response modifiers (such as Procrit, Neupogen, Epogen)

- ✓ Patients needing additional time to complete the discharge planning from the acute care setting
- ✓ Patients who must finish a course of treatment

Patients with complex psychosocial needs who have:

- ✓ Not yet made long term care plans
- ✓ Not engaged in thorough acute care discharge planning
- ✓ Been unable to arrange safe, appropriate caregiving in home setting
- ✓ Not yet applied for Medicaid or have other financial needs

The benefits of this program are those listed below.

- ✓ Increases the time for patients and families to engage in advance care planning and process issues related to the advanced illness while utilizing hospice care services
- ✓ Allows patients to receive hospice care services earlier and provides them with more assistance and in care planning
- ✓ Begins hospice services while the patients are transitioning from curative care to palliative care
- ✓ Supports collaborative effort between the hospice team and the hospital or other discharge planning team during difficult communications with patients and their families
- ✓ Helps patients and families understand when care is futile and allows them to request discontinuation of measures on their own schedule
- ✓ Demonstrates significant length of stay reduction in the acute care setting
- ✓ Incorporates the referring physician's recommendations into coordinated plan of care with the patient and family

Palliative Care Program. This program provides clinical symptom management for people living with an advanced illness and emotional support for their families and caregivers. This program treats all age groups, with a focus on the alleviation of symptoms to provide comfort care as well as meeting the emotional and spiritual needs of patients and families.

The program is different from hospice—

- Intervenes earlier in the disease process than hospice
- Does not require a six-month prognosis
- Can be utilized with traditional curative care
- Can be accessed while the patient is undergoing rehabilitation at a skilled nursing facility
- Provides physician and nurse practitioner consultations whereas hospice includes an array of services such as 14-hour support from the interdisciplinary Hospice Care Team, as well as durable equipment.

This program is available to persons who are in hospitals, at home, in assisted living facilities, in long-term care facilities, oncology clinics, and outpatient offices.

Seasons Pierce County will offer community-based palliative care through a team of physicians, nurse practitioners, and social workers. Partnering with physicians in the community to identify patients needing pre-hospice palliative care services provides pathways to address unmet hospice need in Pierce County.

- **Cardiac Care Pathway** – Is designed to help patients with cardiac disease access hospice in a timely manner, preventing unnecessary hospitalizations and honoring patients' wishes to be at home. High-tech interventions such as cardiac drips and IVs are supported by and paid for by the hospice program.
- **Pulmonary Care Pathway** – Partners with area pulmonologists to help identify patients in the disease process who are eligible for hospice care. These patients are closely monitored to prevent respiratory distress by specially-trained staff and volunteers, and pharmacological and non-pharmacological interventions will maximize such prevention.
- **Stroke/CVA Pathway** – Partners with physicians and long-term care facilities to help identify patients at risk of stroke or who have suffered a stroke and who are eligible for hospice care.

Patient & Family Resources Hub. Seasons Pierce County commits to supporting the greater community to understand hospice and palliative care, and gain access to resources and tools to help them navigate their hospice journey. Whether the community is interested in learning more about what to expect as they or a loved one nears end of life, understanding bereavement resources, learning how to interpret symptoms, or simply looking to know more about what AccentCare provides, this hub of videos and articles are designed to help and inform. This online resource includes a 24-hour number where the community can speak directly to a team member for additional support.

In summary, the services available from Seasons Pierce County rely upon a well-trained and dedicated workforce. To that effect, the result creates value to the community through job creation and continues with the engagement with professionals as well as individuals. Thus, the workforce includes the many volunteers who provide direct or indirect services that enhance patient care and supportive services.

Pharmacy Consultation. Consultation regarding prescriptions is an important service that is available 24 hours a day, seven days a week for all nurses and physicians to assist in pharmacologic consultation. The provision of drugs, particularly for pain management and palliative care, forms a central service for Seasons Pierce County. AccentCare employes full-time pharmacists (PharmD) and consults with nationally recognized Dr. Lynn McPherson to ensure that no patient experiences untreated symptoms at the end of life. Dr. McPherson provides quarterly education through PharmSmarts, a newsletter read by all AccentCare physicans and nurses to ensure education of cutting edge interventions for pain and symptom management. A sample newsletter/blog appears in **Exhibit 5**. The list below provides a glimpse of the topics.

Volume 11, Number 12: Please Help! The Itching Won't Go Away! Causes and Management of Pruritus
Volume 11, Number 11: Choosing Wisely! Ten Things Providers and Patients Should Question – Society for Post-Acute and Long-Term Care medicine
Volume 11, Number 10: Medication Interactions! Why Can't We All Just Get Along?
Volume 11, Number 9: Difficult to Control Pain: And What a PAIN It Is!
Volume 11, Number 8: Choosing Wisely from the American Geriatrics Society: Ten Things Clinicians and Patients Should Question
Volume 11, Number 7: Opioid Conversion MISCalculations: Achieving Pain Relief Quickly AND Safely!
Volume 11, Number 6: Medication Administration by Enteral Feeding Tube
Volume 11, Number 5: What's the Skinny on Transdermal Fentanyl?
Volume 11, Number 4: Speed Dating with a Hospice Pharmacist!

Virtual Reality. For appropriate[5] patients who elect to participate, an AccentCare RN and Patient Experience team member will remain with the patient throughout participation in VR and for discussion afterwards. They will complete a Support Needs Approach for Patients (SNAP) assessment prior to and post implementation to ensure the experience has the desired effects.

Virtual Reality (VR) is "an artificial environment which is experienced through sensory stimuli, such as sights and sounds, provided by a computer and in which one's actions partially determine what happens in the environment."[6] During VR, users become fully immersed in the virtual environment via a head mounted display, complete with stereo visual image and motion trackers which adjust the visual image according to their movement. In hospice and palliative care, VR can be used to show patients a relaxing virtual environment of their choosing (such as a beach or a forest), or allow them to explore a country they have never visited. VR can also provide users with the experience of walking along a nature trail or visiting a location where they have fond memories.

An article in the Journal of Palliative Medicine found that VR "has found use in a variety of clinical settings including pain management, physical medicine and rehabilitation, psychiatry and neurology." The authors conducted a pilot study of VR for residents of an inpatient hospice and found that "participants found the VR experience to be both enjoyable and useful."[7] A 2019 study of terminal cancer patients using VR to travel to a memorable place or old home found patients reported improvement in pain, shortness of breath, depression, anxiety and well-being after their VR session.[8]

[5] VR participation is not recommended for individuals who are susceptible to seizures, nausea, have a pacemaker, psychiatric diagnosis, or history of significant PTSD, trauma, or anxiety.
[6] Merriam-Webster Dictionary. Available at: https://www.merriam-webster.com/dictionary/virtual%20reality
[7] Johnson, Tracy et al. Virtual Reality Use for Symptom Management in Palliative Care: A Pilot Study to Assess User Perceptions. *Journal of Palliative Medicine* Vol. 23, No. 9.
[8] Niki, Kazuyuki et al. A Novel Palliative Care Approach Using Virtual Reality for Improving Various Symptoms of Terminal Cancer Patients: A Preliminary Prospective, Multicenter Study. *Journal of Palliative Medicine* Vol. 22, No. 6. Available at: https://www.liebertpub.com/doi/pdfplus/10.1089/jpm.2018.0527

In addition to alleviating symptoms, VR can assist in the granting of wishes to patients on hospice who have limited functional ability by allowing them to feel as if they have traveled back to a memorable location or one they have always wanted to visit.

We Honor Veterans. Seasons Pierce County commits to serving veterans of the armed forces, as all AccentCare hospice programs participate in the *We Honor Veterans* a program of the **National Hospice and Palliative Care Organization (NHPCO)** in collaboration with the Department of Veterans Affairs (VA). The program contains five progressive levels to train staff and volunteers on veteran-centric care, and provides outreach and educational materials.

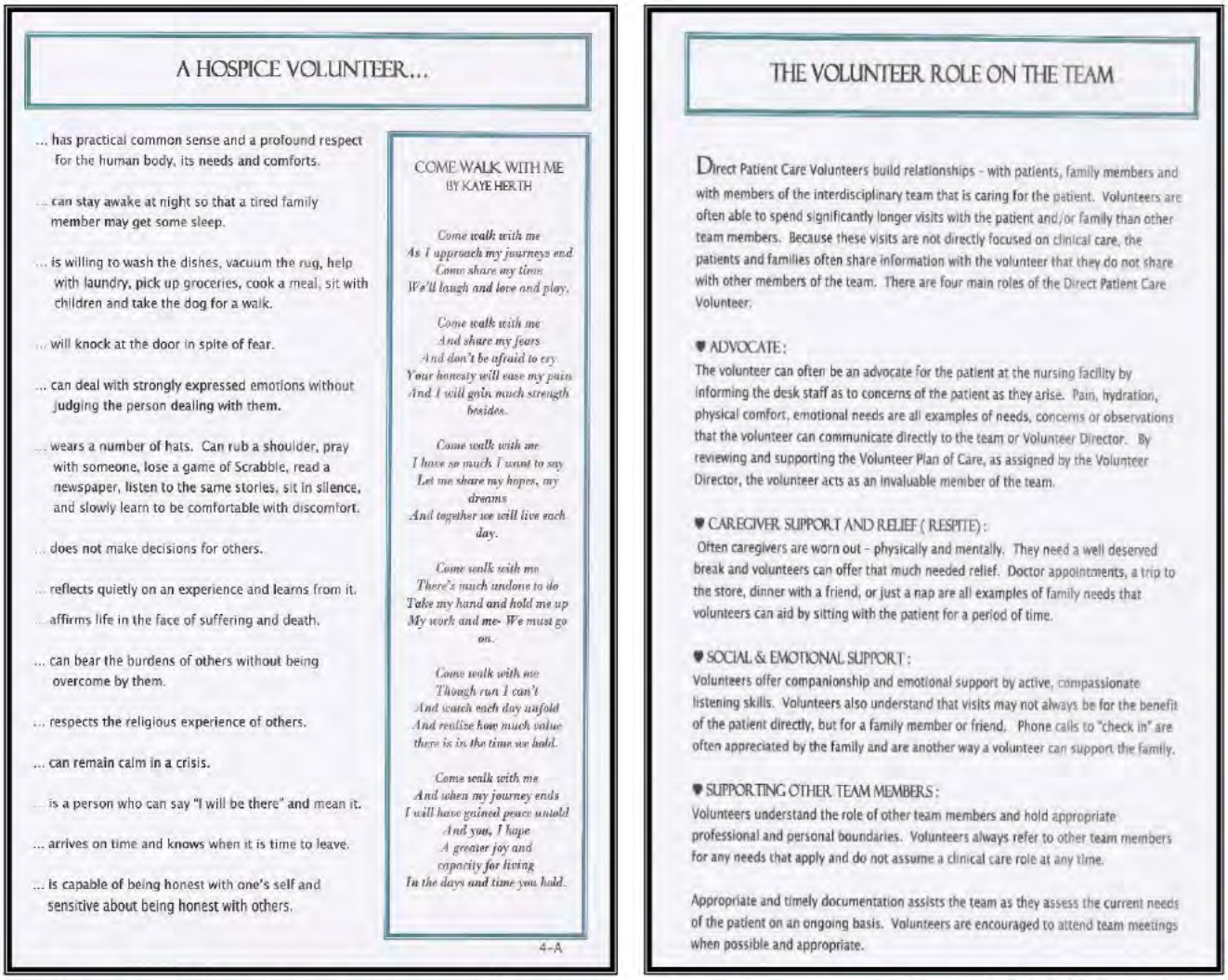
To honor the veterans, a pinning ceremony occurs, that includes invited veterans to participate in acknowledging the honoree. One or more music therapists sing a hymn from the veteran's branch of military service. The photograph below shows a pinning ceremony.

Figure 4. In the photograph to the left, the honoree is Donald Reese, a World War II Veteran. He was awarded two bronze battle stars, a World War II Victory Ribbon, and two Presidential Unit Citations upon his return from Army service that included the years 1945 to 1947 in the famous Battle of the Bulge. Seasons pinning ceremony honors veterans in a special way.

❖ Services Provided by Volunteers

Federal participation standards require a hospice to provide volunteers in administrative or direct patient care for five percent or more of the total patient care hours of all paid hospice employees. AccentCare meets this requirement in all its operational hospices. The Applicant will recruit and train volunteers to join the care teams as active participants. The Applicant will give each volunteer the knowledge, skills and tools to meet or exceed standards for patient care and management.

Volunteers provide important services essential to effective hospice care for patients and their families. All volunteers receive comprehensive training and education to prepare them to engage with patients and their families and become active members of the care team. Highly regarded within the hospice, volunteers play an active, ongoing role in the delivery of services to patients. An excerpt from the training manual for volunteers is below. This excerpt shows the contribution volunteers make and highlights the roles and importance of volunteers to the hospice team.



A HOSPICE VOLUNTEER...

... has practical common sense and a profound respect for the human body, its needs and comforts.

... can stay awake at night so that a tired family member may get some sleep.

... is willing to wash the dishes, vacuum the rug, help with laundry, pick up groceries, cook a meal, sit with children and take the dog for a walk.

... will knock at the door in spite of fear.

... can deal with strongly expressed emotions without judging the person dealing with them.

... wears a number of hats. Can rub a shoulder, pray with someone, lose a game of Scrabble, read a newspaper, listen to the same stories, sit in silence, and slowly learn to be comfortable with discomfort.

... does not make decisions for others.

... reflects quietly on an experience and learns from it.

... affirms life in the face of suffering and death.

... can bear the burdens of others without being overcome by them.

... respects the religious experience of others.

... can remain calm in a crisis.

... is a person who can say "I will be there" and mean it.

... arrives on time and knows when it is time to leave.

... is capable of being honest with one's self and sensitive about being honest with others.

COME WALK WITH ME
BY KAYE HERTH

Come walk with me
As I approach my journeys end
Come share my time
We'll laugh and love and play.

Come walk with me
And share my fears
And don't be afraid to cry
Your honesty will ease my pain
And I will gain much strength
besides.

Come walk with me
I have so much I want to say
Let me share my hopes, my
dreams
And together we will live each
day.

Come walk with me
There's much undone to do
Take my hand and hold me up
My work and me- We must go
on.

Come walk with me
Though run I can't
And watch each day unfold
And realize how much value
there is in the time we hold.

Come walk with me
And when my journey ends
I will have gained peace untold
And you, I hope
A greater joy and
capacity for living
In the days and time you hold.

4-A

THE VOLUNTEER ROLE ON THE TEAM

Direct Patient Care Volunteers build relationships - with patients, family members and with members of the interdisciplinary team that is caring for the patient. Volunteers are often able to spend significantly longer visits with the patient and/or family than other team members. Because these visits are not directly focused on clinical care, the patients and families often share information with the volunteer that they do not share with other members of the team. There are four main roles of the Direct Patient Care Volunteer:

♥ ADVOCATE:
The volunteer can often be an advocate for the patient at the nursing facility by informing the desk staff as to concerns of the patient as they arise. Pain, hydration, physical comfort, emotional needs are all examples of needs, concerns or observations that the volunteer can communicate directly to the team or Volunteer Director. By reviewing and supporting the Volunteer Plan of Care, as assigned by the Volunteer Director, the volunteer acts as an invaluable member of the team.

♥ CAREGIVER SUPPORT AND RELIEF (RESPITE):
Often caregivers are worn out - physically and mentally. They need a well deserved break and volunteers can offer that much needed relief. Doctor appointments, a trip to the store, dinner with a friend, or just a nap are all examples of family needs that volunteers can aid by sitting with the patient for a period of time.

♥ SOCIAL & EMOTIONAL SUPPORT:
Volunteers offer companionship and emotional support by active, compassionate listening skills. Volunteers also understand that visits may not always be for the benefit of the patient directly, but for a family member or friend. Phone calls to "check in" are often appreciated by the family and are another way a volunteer can support the family.

♥ SUPPORTING OTHER TEAM MEMBERS:
Volunteers understand the role of other team members and hold appropriate professional and personal boundaries. Volunteers always refer to other team members for any needs that apply and do not assume a clinical care role at any time.

Appropriate and timely documentation assists the team as they assess the current needs of the patient on an ongoing basis. Volunteers are encouraged to attend team meetings when possible and appropriate.

Figure 5. The excerpt expresses the contribution volunteers make and highlights the volunteer's roles and the importance to the hospice team

Seasons Pierce County administrative staff will recruit, train, and supervise volunteers to accomplish these goals:

- Provide appropriate orientation and on-going training that is consistent with acceptable standards of hospice practice; successful completion of training and orientation will be documented;
- Use volunteers in administrative or direct patient care roles;
- Keep the volunteer informed of a patient's condition and treatment to the extent necessary to carry out his/her function;
- Document active and ongoing efforts to recruit and retain volunteers;
- Maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5% of the total patient care hours of all paid hospice;

- Document the cost savings achieved through the use of volunteers, including these facts and statistics:

  - ✓ The positions filled by volunteers;
  - ✓ The work time spent by volunteers; and
  - ✓ The dollar costs if paid employees filled those positions.

- The expanded care and services achieved through volunteers, including the type of services and the time worked.

Direct Patient Care Volunteer. This type of volunteer is an integral member of the Hospice Interdisciplinary team, providing comfort, support, and/or practical assistance to hospice patients and their family members. Direct Patient Care Volunteers include: Adult Patient Care, Pediatric Care and Vigil Patient Care, and Bereavement Care in all settings including homes, nursing facilities, and Hospice House inpatient facilities. They must:

- Have the qualifications and skills to provide the prescribed services. Any volunteer functioning in a professional capacity shall meet the standards of the appropriate profession;
- Know the patient's condition and treatment as indicated on the written plan of care;
- Provide services in accordance with the written plan of care which may include, but is not limited to providing support and companionship to the patient and family, caregiver relief, running errands, light chores, visiting, and bereavement services; and,
- Document their care on the appropriate form.

Direct patient care volunteers complete 16 hours of training on the following topics.

- ✓ Active Listening and Reminiscing
- ✓ Self-Care and Setting Boundaries
- ✓ Family Dynamics
- ✓ Understanding Diseases
- ✓ Pain Management
- ✓ Approach Death
- ✓ Personal Death Awareness
- ✓ Spirituality & Culture
- ✓ Grief & Bereavement
- ✓ Personal Safety
- ✓ Emergency Preparedness
- ✓ Documentation
- ✓ Volunteer Policies
- ✓ Volunteer Resources
- ✓ Volunteer Vigil Program

The training gives the direct patient care volunteer competency in the following areas of support:

- ✓ Emotional support
- ✓ Social interaction
- ✓ Supportive listening
- ✓ Spiritual support
- ✓ Companionship
- ✓ Respite and/or Practical Support

Bereavement Program. These services cover a variety of spiritual, emotional, religious, and interpersonal interactions to ease grief, share empathy, and assist the bereaved with coping skills. Bereavement services extend for at least 13 months and are offered upon a loved one's passing. Cessation occurs when the family withdraws from needing further services. Clergy, volunteers, and staff with training and experience in providing counseling and comfort provide bereavement services. Bereavement counseling is offered in person and virtually for individuals, families, and in group support meetings. AccentCare facilitates annual memorial services, grief education series, routine mailings with psychoeducation information about grief and loss, and provides bereavement volunteers. See **Exhibit 9** for an example of bereavement materials distributed.

Seasons Pierce County also has **Camp Kangaroo,** a camp for children to assist them in their grief and help them cope with the death of those close to them. As needed, Seasons Pierce County also has access to other programs through Seasons Hospice & Palliative Care that allow children to engage in healing ways that provide comfort to them.

Other bereavement programs offer options to those who recently experienced a death of a friend, spouse, or other family member, such as the ***Friendly Visitor Bereavement Program*** for low risk bereaved clients who are coping well with the loss but who are lonely and socially withdrawn or isolated.

Spiritual Presence. Direct patient care volunteers serve patients who need someone to simply be spiritually or religiously present beyond the spiritual counseling services of the hospice chaplain. An important component in the volunteer manual teaches recognition that intensions can for some produce anxiety and unintentional negative reactions. The training encapsulates the motto, **GIVE THE GIFT OF PRESENCE.** Aspects of the program include the following components.

- A true companion
- Are ready to concentrate
- Offer receptive silence
- Listen with no agenda
- Ask "cup-emptying" questions; that is, ask about the wisdom learned from this experience with death and dying—ask about the other persons discernment in this event of life
- Ask "virtue-reflection" questions; that is, ask questions that integrate thinking and feeling that provoke how the individual will become aware of and find the inner strength to solve the situation within
- Give acknowledgement of each person's attempt at discernment and resolve

Volunteers receive training in nondenominational content, guided by the experience of Reverend Ms. Linda Siddall, Chaplain of Mission Hospice and Home Care. One woman in hospice with her son, who was dying of terminal brain cancer, expressed what many dying persons and family members want. When asked what she most needed, she responded she wanted people who *"would just come and sit, let me talk if I needed to, or cry. Sometimes they*

would play a game with Jason, and they brought food." The Direct Patient Care program grew from this fundamental need where volunteers can make a difference. Highly trained volunteers direct the Volunteer Vigil Program.

Volunteer Vigil Program. Vigil Volunteers are direct patient care volunteers who complete the core volunteer requirements, six months of active patient care, and sign a participation request. Vigil volunteers must regularly be available to serve within their geographic service area for shifts of two or more hours. Volunteers provide schedules to inform the hospice when they can serve. Once enrolled, the volunteer receives a Self-Study Module. Volunteers must pass the Competency Test and complete the Availability Grid before serving as a Vigil Volunteer.

Circle of Care Volunteers. This program provides volunteers who call home care patients weekly to check in with them to ensure they have all of their needs met and assess patients who need additional hospice team members' visits beyond what was originally assessed.

Loyal Friends Pet Team. The Volunteer Coordinator oversees the pet therapy program. Often, patients and their families request this service, with the animals showing they are true professionals. Scheduled pet visits by therapy dogs and handlers are part of the plan of care. Volunteers with certified pet therapy animals provide comfort, enrichment and palliation from interaction with pets. Animals provide distraction, unconditional acceptance, and companionship, especially when a quiet atmosphere is needed for the patient. When live animals are contraindicated or not available, AccentCare will use PARO, the robotic therapeutic seal. Research with PARO and the elderly found patients who interacted with PARO required fewer medications for anxiety and reported a higher quality of life. The video link provides a short explanation:
https://www.youtube.com/watch?v=PAJ2GxzaJtQ **.**

Indirect Patient Care Volunteer. This volunteer is an integral member of the hospice team, providing administrative assistance or special projects that enhance the work of the in-house staff and supports patients, families, and the efforts of the teams in the field. Indirect Care Volunteers include Office Volunteers and Special Project Volunteers. Important activities include examples of the following tasks.

- ✓ Assistance with mailings—answering phones—filing
- ✓ Putting together Sign-Up, Nursing Assessment, or Marketing packets
- ✓ Computer input searches
- ✓ Copying and shredding documents
- ✓ Assisting in tasks identified by individual needs of staff members

For those volunteers on special projects, the volunteers use their skills to make a difference in the lives of patients and families and staff, such as sewing blankets, creating

databases, painting walls or making signs. Special project volunteers successfully complete the interview process and basic orientation program that includes but is not limited to the following components.

- ✓ Assuring the confidentiality of patients and their medical records and family matters
- ✓ The history of hospice and the specific hospice in which they volunteer
- ✓ Role of the Volunteer with instruction for specific tasks as applicable to projects including equipment operation
- ✓ Infection Control, HIPPA requirements, and Safety regulations

❖ Services Provided by Contracted Professionals

AccentCare employees deliver most hospice services assisted by volunteers. Most of the contracted services are therapy services: physical, respiratory, speech, massage, art and occupational therapy. Other contracted services are acupuncture and other palliative care services. Seasons Pierce County also contracts for a medical director and physician services. The executed Medical Director Agreement and sample Physician Independent Contractor Agreement are provided in **Exhibit 19**.

The hospice is professionally, financially, and administratively responsible for contracted services. Seasons Pierce County will have legally binding written agreements which will include.

- Identification and availability of the services to be provided;
- Required documentation of the services provided;
- Orientation to hospice care for employees of contracting agencies
- A stipulation that services may be provided only with the authorization of the hospice under the physicians' orders and as directed by the hospice plan of care;
- How the contracted services are coordinated, supervised, and evaluated by the hospice;
- Delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, the interdisciplinary team meetings, the interdisciplinary plan of care, and the on-going provision of palliative and supportive care;
- The qualifications of the personnel providing the services include verification of licensure, certification, or registration when applicable;
- The financial arrangements and charges, including donated services;
- The duration of the contract;
- The party responsible for implementing each provision of the contract and,
- The signature (and date) of the Executive Director or designee and the duly authorized official of the agency providing the contractual services.

These provisions also apply:

- Employees of an agency providing a contractual service shall not seek or accept reimbursement besides that due the agency from AccentCare.
- Sharing fees between a referring agency or an individual and the hospice is prohibited.
- Seasons Pierce County will not charge fees for services normally provided directly by the hospice care team but currently being provided by contractual services.
- Seasons Pierce County will review and/or revise all contracts annually and will evaluate the contracted care, treatment, and services to determine whether they are being provided according to the contract and the level of safety and quality that AccentCare expects.

Services provided by consultation, contractual arrangements, or other agreements will meet Joint Commission or CHAP standards.

8. ***If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).***

This criterion is not applicable. The Applicant does not propose to expand an existing hospice agency.

9. ***If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.***

This criterion is not applicable. The Applicant does not propose to expand an existing hospice agency.

10. ***Provide a general description of the types of patients to be served by the agency at project completion (e.g. age range, diagnoses, special populations, etc.)***

Seasons Pierce County will serve patients of all ages and diagnoses that qualify for hospice. Seasons Pierce County strives to identify sectors of the population with the greatest needs or those with apparent access issues or that choose hospice less frequently that other demographics. In this way Seasons Pierce County fills gaps in service to increase hospice utilization overall throughout the planning area with minimal impact on existing providers and health systems. By establishing relationships with providers and community organizations, underserved groups are educated about the benefits of hospice care and access barriers are broken down.

The target population to be served are those persons who have one year or less to live as determined by a physician. **All ages will be served, including pediatrics.** The **World Health Organization** (**WHO**) compiles lists of age-adjusted death rates for the conditions with the highest rates. For the United States, WHO uses the information from the **Centers for Disease**

Control and Prevention (CDC). The leading causes of death for Pierce County and their corresponding rates appear in the table below. Of the top 15 causes of death, the table excludes Accidents, Suicide, Influenza/Pneumonia, and homicide, as they are not appropriate for hospice care. The detailed information from WHO appears in **Exhibit 10**. The exhibit also includes additional supporting information on national death rates, HIV/AIDS, and Parkinson's disease. Cancer diagnoses reflect the majority of patients enrolled in hospice and is the second leading cause of death behind heart disease in Pierce County and the U.S., with cancer ranking first in the State.

Table 1
Centers for Disease Control and Prevention: Age-Adjusted Death Rates for Selected Causes
Pierce County, Washington, and the United States, 2020

Cause of Death	Pierce County	Washington	United States
Heart Disease	185.37	134.57	168.19
Cancer	178.08	138.74	144.13
Stroke	50.02	34.74	38.84
Lung Disease	48.41	29.6	36.41
Alzheimer's Disease	40.73	42.92	32.45
COVID-19	31.7	36.67	84.96
Diabetes	25.52	22.67	24.81
Liver Disease	10.95	14.18	13.26
Parkinson's Disease	8.22	9.5	9.87
Hypertension/Renal	8.26	9.52	10.08
Blood Poisoning	7.74	6.96	9.73
Nephritis/Kidney	6.47	4.41	12.71

https://www.worldlifeexpectancy.com

As the information in the table above shows for Pierce County, the age adjusted death rate for the top four causes of death are markedly higher than for the state or the nation. The leading cause of death, heart disease, occurs at a rate of 185.37 per 100,000 persons, compared to Washington State at 134.57 per 100,000 and the nation at 168.19 per 100,000. Likewise, cancer, the second leading cause of death for Pierce County, occurs at a rate of 178.08 per 100,000, but represents 138.74 per 100,000 persons for Washington. Stroke and lung disease, the third and fourth ranked causes of death, respectively, show similar disparity in occurrence for Pierce County when compared to Washington and the nation. The death rates shown above inform the types of patients that Seasons Pierce County can expect to enroll in hospice care. Thus, Seasons Pierce County's Open Access, Cardiac Care, Music Therapy, and Namaste Care programs provide the hospice team members the capability to address the specific needs of persons at end of life in Pierce County.

The advances in medical treatment for persons with HIV/AIDS extends their lives, with the rate of death for that group lower than in the past. Consulting the Department of Health's **HIV/AIDS Epidemiology Report 2022**, the rate of new HIV diagnoses in the state of Washington per 100,000 has dropped over the past few years, from 5.4 per 100,000 in 2014 to 5.3 per 100,000 in 2021. However, with 59 new HIV cases reported in Pierce County in 2021, the county ranks second in the state behind King County for having the most cases. The county's rate per 100,000 is 6.6, above the state average at 5.3. The report for 2022 shows that Pierce County had a prevalence of 1,633 cases of HIV in 2021, representing 11% of the state's 14,517 cases. Persons living with HIV/AIDS represent all races and ethnicities, but rates are higher for the Black population and Foreign-born citizens, and minorities are less likely to be engaged in care. Furthermore, while 69% have initial linkage to HIV care in Pierce County, 20% (12 persons in 2021) are diagnosed late in the progression of the disease. These numbers demonstrate an increase from reported values from 2020. Pierce County's rate of new HIV cases was 5.7 per 100,000 and 51 new HIV cases were counted in 2020. A copies of the referenced HIV/AIDS Reports can be found in **Exhibit 11** at the end of this application.

Seasons Pierce County has a variety of programs and services and training necessary to deliver care to a wide range of patients with competence and sensitivity.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC commits to the following under-served populations described below in detail.

- **The Homeless**
- **Minority populations, including Asian Americans, Black Americans, Latinxs, and the LGBT community**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Residents with Alzheimer's Disease**
- **Persons Requesting Medical-Aid-In-Dying under the Death with Dignity Act**

❖ Commitment to Serving the Homeless

Homeless do not have access to healthcare "on the street" and have shorter life spans than the general population due to environmental exposure. Many are known to suffer from mental illness and addiction, further shortening life span. For every age group, homeless persons are three times more likely to die than the general population.

> *Research has shown that individuals experiencing homelessness have greater morbidity and mortality rates than the general population and experience more co-morbidities than their housed counterparts. When compared to non-homeless populations, individuals experiencing homelessness face a multitude of*

complex health and social issues that are often integrated with past, present, and daily trauma that impact these individuals' prioritization and decision-making efforts.[9]

The insert (right) from the National Health Care for the Homeless Council, indicates that the average age of death of homeless persons is about 50 years, but the risk of death on the streets is only moderately affected by substance abuse or mental illness. **Physical health conditions similar to those of the general population, such as heart problems or cancer, are more likely to lead to an early death. The homeless are also more likely to die of HIV.**

According to the January 2022 Washington State Point-in-Time (PIT) Count of Persons Experiencing Homelessness, 25,452 are homeless, of which 1,851 or 7.3% are in Pierce County. In fact, Pierce County has the second largest number of homeless persons in the state. The trend data of PIT counts appears below. Although Pierce County experienced a total increase in homelessness of 17% over the 5-year period, compared to the state at 14%, homelessness in Pierce County jumped by 84% between 2021 and 2022. This may be due to a lack of reporting the homeless population due to COVID-19 populations, however, research on the pandemic predicts unemployment and homelessness will increase. Research articles on homelessness are found in **Exhibit 12**.

Homeless Persons' Memorial Day, 2006

The Hard, Cold Facts About the Deaths of Homeless People

Information from the National Health Care for the Homeless Council

Homelessness dramatically elevates one's risk of illness, injury and death.

For every age group, homeless persons are three times more likely to die than the general population. Middle-aged homeless men and young homeless women are at particularly increased risk.[1]

The average age of death of homeless persons is about 50 years, the age at which Americans commonly died in 1900.[2] Today, non-homeless Americans can expect to live to age 78.[3]

Homeless people suffer the same illnesses experienced by people with homes, but at rates three to six times higher.[4] This includes potentially lethal communicable diseases such as HIV/AIDS, tuberculosis and influenza, as well as cancer, heart disease, diabetes and hypertension.

Homeless persons die from illnesses that can be treated or prevented. Crowded, poorly-ventilated living conditions, found in many shelters, promote the spread of communicable diseases. Research shows that risk of death on the streets is only moderately affected by substance abuse or mental illness, which must also be understood as health problems. *Physical* health conditions such as heart problems or cancer are more likely to lead to an early death for homeless persons. The difficulty getting rest, maintaining medications, eating well, staying clean and staying warm prolong and exacerbate illnesses, sometimes to the point where they are life threatening.

[1] O'Connell, Jim, MD. *Premature Mortality in Homeless Populations: A Review of the Literature* Nashville: National Health Care for the Homeless Council, December 2005. p.13. http://www.nhchc.org/PrematureMortalityFinal.pdf
[2] O'Connell, p. 13.
[3] National Center for Health Statistics, at http://www.cdc.gov/nchs/fastats/lifexpec.htm
[4] Wright JD. "Poor People, Poor Health: The health status of the homeless." In Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 15–31.

[9] *Suicide and Homelessness, Data Trends in Suicide and Mental Health Among Homeless Populations*, National Health Care for the Homeless Council Fact Sheet, May 2018

Table 2
Point in Time Counts, 5-Year Trend, Pierce County and Washington State

	2018	2019	2020	2021	2022
Pierce County Total Homeless	1,628	1,486	1,897	1,005	1,851
Pierce County Population	872,220	888,300	920,393	928,200	937,400
Pierce Homeless per 100,000	187	167	206	108	197
Washington State Total Homeless	22,304	21,621	22,923	11,521	25,452
Washington State Population	7,427,570	7,546,410	7,706,310	7,766,975	7,864,400
Washington Homeless per 100,000	300	287	297	148	324

Source: www.commerce.wa.gov/serving-communities/homelessness/annual-point-time-count/
Population estimates are from OFM April 1, 2022 estimates of Cities, Towns and Counties
(See **Exhibit 12** for PIT Count data.)

Of the total 1,851 homeless in Pierce County, 1,184 or 64% are sheltered, 420 or 23% are chronically homeless (continuously homeless for a year of more), and 161 or 9% are veterans. The large number of homeless individuals represents a vulnerable population in need of health services, including end of life care, and the number is rising.

With the second largest number of homeless persons in the state, Pierce County needs assistance in caring for those without shelter. If approved, Seasons Pierce County commits funding to help identify terminally ill homeless persons and assure that they have appropriate shelter and hospice care. Through the Seasons Foundation, contributions of over $4.5 million annually in charity care, touch lives by realizing hopes and dreams of individuals on hospice care.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC will donate funds each year, beginning with $12,500 the first year of operation, to Seasons Hospice Foundation restricted to Pierce County programs that directly serve homeless persons. Seasons Pierce County increases funding for the homeless to $25,000 in year two and $50,000 in year three. Seasons Hospice Foundation honors Seasons' ***No One Dies Alone*** policy and provides funds for housing the homeless in Pierce County, including those suffering from a terminal illness.

❖ Commitment to Serving Minority Populations

To promote diversity with its *Inclusion Initiative*, Seasons Hospice & Palliative Care of Pierce County Washington, LLC commits creating a seven member diversity council (Refer to Exhibit 13). The composition of the council includes a Black board member, a Latinx board member, an Asian American board member, and an advocate from the LGBT community, with the remaining three members selected by the initial four members.

As an advisory body, the diversity council provides Seasons Pierce County with guidance as to best ways to engage with minorities, the information and referral materials to provide, and key-informant information regarding introducing hospice and providing hospice services.

With respect to the LGBT (Lesbian, Gay, Bisexual and Transgender) community, all Seasons hospice programs seek platinum level of distinction in serving LGBT seniors, with **SAGE *Care certification***. SAGE, Services and Advocacy for GLBT Seniors, a national organization, credentials agencies that train staff to be culturally competent in the care of LGBT seniors.

This minority group often receives negative reactions and offensive interactions from members of the public as well as providers of services. Such offenses result in some members of the LGBT community foregoing hospice services based on applied stigmas. As Seasons Pierce County acts on the mandate, **No *one dies alone***, the result assures access and availability of hospice care to LGBT community's members. **Seasons Pierce County intends to apply for SAGE Care certification to further expand the numbers of Seasons hospices having that certification.**

As shown in the table below, the total population of Pierce County grows at an annual rate of 1.21%, adding 57,588 persons over the next five years. The white race represents 69.23% of the population with 644,335 persons, with the proportion of whites decreasing to 67.12% of the total population by 2027. In contrast, the minority populations have higher compound annual growth rates and proportionately increase by 2027. Hispanics reflect the largest single minority group, with 113,805 persons representing 12.23% of the population, followed by African Americans with 70,730 (7.6% of total), and Asians with 65,901 (7.08% of total). All minority groups with the exception of Native Indian/Alaskans are expected to increase by at least 2% per year over the next five years, resulting in total five-year growth rates exceeding 17% for Hispanics, nearly 11% for African Americans, 13% for Asians, and 17% Hawaiian/Pacific Islanders. Persons identifying with more than one race account for over 76,000 persons and will increase by 2.66% per year. The table that follows shows the composition of the county.

Table 3
Racial and Ethnic Composition of Pierce Residents for Years 2022 and 2027

Race Category	Total 2022 Population	Percent	Total 2027 Population	Percent	Compound Annual Growth Rate	Increase
White	644,335	69.23%	663,314	67.12%	0.58%	18,979
Black/African	70,730	7.60%	78,510	7.94%	2.11%	7,780
Asian	65,901	7.08%	74,634	7.55%	2.52%	8,733
Hawaiian/Pacific	16,419	1.76%	19,254	1.95%	3.24%	2,835
Indian/Alaskan	13,453	1.45%	14,611	1.48%	1.67%	1,158
Other Races	42,931	4.61%	50,247	5.08%	3.20%	7,316
Two or more Races	76,946	8.27%	87,733	8.88%	2.66%	10,787
Total	**930,715**	**100.00%**	**988,303**	**100.00%**	**1.21%**	**57,588**
Ethnic Category						
Hispanic	113,805	12.23%	133,744	13.53%	3.28%	19,939

Data provided by Claritas, LLC , (https://www.claritas.com/) **Pop-Facts Demographics Select**, DATA-DEMO-PFSE-ZIP, DATA-DEMO-PFSE-CTY, and DATA-DEMO-PFSE providing, age cohorts, race and ethnic categories by county and Zip Code for Washington for available projection period 2022 to 2027. (See **Exhibit 14**)

Seasons Palliative Care of China was formed in 2018 to expand end of life care in Mainland China. With Chinese teams and expertise in Seasons' US-based programs, leveraging palliative care to China was a natural progression in the extension of these much-needed services. This is the only Western Hospice operating in Mainland China, with a 20-bed inpatient center in Shanghai.

Several U.S. based AccentCare/Seasons hospice programs located on the west coast, including operations in Oregon and seven locations in California, also serve large Asian American populations. Because ***Seasons is an industry leader in serving Asian American populations***, they are well positioned to meet the needs of the Asian and Pacific American community residing in Pierce County.

In addition to the Cultural Advisory Board, AccentCare is also prepared to ensure interpreters or bilingual staff are available to serve those with limited English. The facility will also work with the Aging and Long-Term Support Administration, Tribal Affairs Division, to engage the American Indian populations within Pierce County.

❖ Commitment to Serving Children

Table 4, below, shows that over 16% of pediatric deaths in Washington State in 2018 occur in Pierce County, up from 14% in 2015, the baseline for which cause of death is known. By excluding sudden and external causes of death, an "expected" death rate is calculated for 2015, representing 22.1% of deaths for children from birth to age 19 for the state. This rate is applied

to the 2018 deaths, resulting in an estimate of 29 pediatric deaths in Pierce County that may benefit from hospice and palliative care.

Table 4
Child Deaths and Estimate of Expected Deaths, 2015 Baseline and 2018

	2015 Deaths by Age					
2015 Baseline	**<1**	**1-4**	**5-14**	**15-19**	**Total**	
Pierce Deaths	62	5	18	29	114	
WA Deaths	431	79	107	194	811	
	Selected Washington Deaths by Cause and Age					
Cause of Death*	**<1**	**1-4**	**5-14**	**15-19**	**Total**	
Malignant Neoplasms (C00-C97)	0	14	21	13	48	
Congenital Anomalies (Q00-Q99)	109	4	5	0	118	
Cerebrovascular Diseases (I60-I69)	0	2	0	0	2	
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	0	0	5	6	11	
WA Expected Deaths	**109**	**20**	**31**	**19**	**179**	**22.1%**

2018 Deaths by Age and Expected Child Deaths

	0-1	**1-4**	**5-9**	**10-14**	**15-17**	**18-19**	**Total**	***Estimated Expected Deaths***
Pierce Deaths	73	14	8	10	12	15	**132**	**29**
WA Deaths	401	63	45	64	102	130	**805**	**178**

*Excludes assault, Sudden Infant Death Syndrome, Short Gestation & Low Birth Weight, Maternal Complications, intentional self-harm, unintentional injury & other causes.
Source: https://www.doh.wa.gov/DataandStatisticalReports/HealthStatistics/Death/DeathTablesbyTopic, Mortality Table A9, Age Group by County of Residents, 2015; Mortality Table C3, Leading Causes by Age Group and Sex for Residents, 2015; (See **Exhibit 10** for Mortality Tables.) 2019 Deaths come from https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/MortalityDashboards/AllDeathsDashboard

While the number of deaths is relatively small, the impact on a family having a terminally ill child is significant, and Seasons Pierce County's pediatric program, ***Kangaroo Kids Pediatric Hospice & Palliative Care,*** offers a choice to residents over existing hospice providers.

The Kangaroo Kids Program, described previously, provides palliative and end of life care to terminally ill children. The pediatric care team provides direct care to the pediatric patient, teaches the parents how to provide care at home, the regimen of care, and schedule for medicines and other services.

Seasons Pierce County, through Seasons Hospice & Palliative Care, can call upon the ***Make a Wish Foundation*** and other dream-granting agencies as necessary to provide end of life care to children in cooperation with the parents and extended family. This program coordinates support to parents while providing compassionate care for the terminally ill children. In

addition, the Seasons Hospice Foundation fulfills wishes as well as emergent needs for pediatrics in the Kangaroo Kids program. Care for the surviving children (such as siblings) continues through bereavement with developmentally appropriate grief support and children's bereavement camps through ***Camp Kangaroo.***

❖ Commitment to Serving the Elderly in Nursing Homes and Assisted Living Facilities

Seasons Pierce County reaches persons in nursing homes and assisted living facilities. Hospice services for persons in long-term care settings provides personalized care that augments the care that facility staff provide. AccentCare's national hospice experience reflects efforts to engage terminally ill elders with results based upon the approach of becoming a partner in care with the staff in long term care settings.

Table 5
National Seasons Admissions by Location

Location	2021 Admissions	Percent
ALF	2,820	7.9%
Home	16,515	46.5%
Hospital	6,590	18.6%
Inpt. Hospice Facility	4,632	13.0%
SNF	4,149	11.7%
Other	802	2.3%
Total	**35,508**	**100.0%**

Source: AccentCare Hospice Enterprise data, site of service at admission for 2021.

Looking at the most recent available twelve months (January 2021 to December 2021) in **Table 5**, overall experience of all AccentCare hospice programs indicate approximately 7.9% of admissions arise from persons whose home is an assisted living facility and another 11.7% arise from persons in a nursing home. Overall, 19.6% of total admissions are elders in supportive long term care residences.

The enrollment of elders in nursing homes and assisted living facilities requires the employees possess the skills to augment the facilities' staff with that of the hospice care team, and together, enhance rather than duplicate services at end of life. Seasons Pierce County's **Partners in Care** program (discussed previously) makes available education and training for the personnel within the facilities. The purpose sets expectations, assigns responsibility and accountability, provides active liaison with the hospice care team, and establishes respect of the facilities' caregivers. Both the facility staff and that of the care team adopt the same care plan and goals for the resident, and the care team relies upon the facility staff to advise, confirm, acknowledge, and share information about the resident and his or her family's wishes.

Therefore, continuity of care exists, improving quality of care for residents, and increasing future hospice referrals from long term care provider.

❖ Commitment to Serving Residents with Alzheimer's Disease and Dementia

Related to the ability to reach persons in nursing and assisted living facilities is to address Alzheimer's disease and the progression of it to provide responsive and compassionate care at end of life. Alzheimer's disease ranks among the top 5 causes of death, and is higher for Pierce County, with an age adjusted death rate of 40.73 per 100,000 persons, than the national average of 32.45 deaths per 100,000 persons.[10]

Seasons Pierce County's commitment to the subgroup of persons with Alzheimer's disease is supported by the Namaste Care program (described in detail previously with all programs). Developed by internationally recognized dementia expert Joyce Simard, MSW, the program is specifically designed for persons with the advanced stages of dementia and other neurological illness. With approval of Seasons Pierce County, access improves for residents with Alzheimer's disease and dementia.

As a hospice provider, Seasons Pierce County expects to serve all persons with a medically determined terminal diagnosis of one year or less to live.[11] Outreach efforts to religious groups, community organizations, and the medical community forms a community network, connecting terminally ill area residents to the hospice benefit.

Recall that in the foregoing narrative description, the Applicant made commitments for the homeless, minority populations that include African-Americans, Hispanics, Asians, and LGBT persons, persons residing in nursing homes and assisted living facilities, those with Alzheimer's disease, and children. Persons in these groups are expected to experience the same age-adjusted death rates per 100,000 persons in Pierce County appearing in **Table 1**, Page 36, above. Therefore, the following forecast incorporates all potential residents in these groups.

Further information regarding patient admissions, average daily census and average length of stay appears in the upcoming section within the financial requirements

11. *Provide a copy of the letter of intent that was already submitted according to* WAC 246-310-080 *and* WAC 246-310-290(3).

A copy of the letter of intent is included in **Exhibit 15**.

[10] Data come from https://www.worldlifeexpectancy.com, from the World Health Organization and reflects reported deaths by state and county as reported to the Centers for Disease Control and Prevention. Reproduction of the rates by county in the state of Washington appear within this document as **Exhibit 10**.

[11] Medicare requires six months or less to live for hospice eligibility. Private insurance may allow one year or less to live to be eligible for hospice coverage.

12. ***Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.***

Seasons Hospice & Palliative Care of Pierce County Washington, LLC intends to enroll as a provider in both Titles XVIII and XIX of the Social Security Act to attain Medicare and Medicaid certification.

III. CERTIFICATE OF NEED REVIEW CRITERIA

A. Need (WAC 246-310-210)

1. ***For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.***

This criterion is not applicable. The Applicant does not own, operate or manage and existing hospice agency.

2. ***Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.***

The forecast below for Pierce County is consistent with most recent need methodology produced by the Department of Health. The Financial forecast uses Seasons Hospice & Palliative Care of Oregon as a proxy, having similar programs and services as the proposed project, and a location with multiple hospice providers and similar population size and demographics as Pierce County. Demographic data comparing Pierce County with Multnomah County, Oregon and the Oregon Service Area is provided in **Exhibit 16.**

Table 6
Seasons Pierce County Forecast, First Three Years

Pierce County	Partial Year 7/24-12/24	Year 1 CY 2025	Year 2 CY 2026	Year 3 CY 2027
Total number of admissions	57	157	207	258
Patient Days	2,236	8,344	12,791	15,938
Average Length of Stay	39.00	53.00	61.89	61.89
Average Daily Census	6	23	35	44

A step by step methodology of the utilization projections is provided below.

Step 1: Calculate Statewide Hospice Use Rates

In accordance with WAC 246-310-290(8)(a) and consistent with the October 14, 2022 published need methodology, statewide hospice use rates for patients age 0-64 and for age 65 and over are calculated by dividing the most recent three year average number of unduplicated hospice admissions by the three year average number of deaths. The data and resulting use rates are shown below.

Table 7
Washington Hospice Admissions and Deaths
Calculation of 3-Year Average and Resulting Hospice Use Rates by Age Cohort

WA Hospice Admissions	2019	2020	2021	Average	WA Use Rates
0-64	3,712	3,680	3,893	3,762	23.16%
65+	26,175	27,957	27,884	27,339	58.07%
Total	29,887	31,637	31,777	31,100	49.11%
WA Deaths	**2019**	**2020**	**2021**	**Average**	
0-64	14,047	16,663	18,015	16,242	
65+	44,159	46,367	50,717	47,081	
Total	58,206	63,030	68,732	63,323	

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022.

Step 2: Calculate the 3-Year Average Deaths for Pierce County

In accordance with WAC 246-310-290(8)(b) and consistent with the October 14, 2022 published need methodology, the 3-year average number of deaths for Pierce County is computed for residents age 0-64 and those age 65 and over. The most recent three years' deaths and resulting averages by age cohort are shown below.

Table 8
Pierce County 3-Year Average Deaths by Age Cohort

Pierce Deaths	2019	2020	2021	Average
0-64	1,911	2,364	2,574	2,283
65+	5,002	5,608	6,264	5,625
Total	6,913	7,972	8,838	7,908

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022.

Step 3: Calculate Projected Hospice Patients for Pierce County by Age Cohort

In accordance with WAC 246-310-290(8)(e) and consistent with the October 14, 2022 published need methodology, the 3-year average number of deaths for Pierce County is multiplied by the statewide hospice use rate for residents age 0-64 and those age 65 and over to project the number of expected hospice patients. The data is shown below.

Table 9
Pierce County 3-Year Average Deaths and Projected Hospice Patients by Age Cohort

Age	Average Deaths	WA Use Rate	Projected Patients
0-64	2,283	23.16%	529
65+	5,625	58.07%	3,266
Total	7,908	49.11%	3,795

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022.

Step 4: Calculate Pierce County Use Rate by Age Cohort and Projected Hospice Volume Through 2027

In accordance with WAC 246-310-290(8)(d) and consistent with the October 14, 2022 published need methodology, the 3-year average number of deaths for Pierce County is multiplied by the statewide hospice use rate for residents age 0-64 and those age 65 and over to project the number of expected hospice patients. The use rate is then applied to future population estimates to estimate hospice volume (admissions). Since 2026 and 2027 population projections by age group were not included as part of the Hospice Numerical Need Methodology publication, these values were calculated using the most recent available, 2017 GMA Projections – Medium Series from the Washington State Office of Financial Management (OFM), which is provided in **Exhibit 16**. The data is shown below.

Table 10
Calculation of Pierce County Use Rate (Hospice Patients to 3-Year Average Population) by Age Cohort and Resulting Hospice Volume for Projected years 2022 through 2027

		EXISTING POPULATION				
Resident/ Patient Age	**Projected Patients**	**2019**	**2020**	**2021**	**3-Year Ave.**	**Pierce Use Rate**
0-64	529	756,339	765,139	769,918	763,799	**0.00069**
65+	3,266	130,688	136,114	142,422	136,408	**0.02394**
Total	3,795	887,027	901,253	912,340	900,207	**0.00422**
Resident/	**PROJECTED POPULATION, PIERCE COUNTY**					
Patient Age	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**
0-64	774,696	779,475	784,253	789,032	792,630	796,677
65+	148,729	155,037	161,344	167,652	172,821	178,150
Total	923,425	934,512	945,597	956,684	965,451	974,827
Resident/	**PROJECTED HOSPICE VOLUME**					
Patient Age	**2022**	**2023**	**2024**	**2025**	**2026**	**2027**
0-64	536	540	543	546	549	552
65+	3,561	3,712	3,863	4,014	4,138	4,266
Total	4,097	4,252	4,406	4,560	4,687	4,817

Sources: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022; 2026 and 2027 Population Estimates by age group calculated using Office of Financial Management (OFM) Projections, provided in **Exhibit 16**.

Step 5: Calculate the 3-Year Average Hospice Capacity for Pierce County, Then Subtract the Current Capacity From the Total Projected Volume in Step 4 to Determine Need Through 2027.

In accordance with WAC 246-310-290(8)(e), the current supply is calculated as the 3-year average hospice admissions for Pierce County. That number is then subtracted from the projected volume in Step 4, above, to determine the unmet need for hospice admissions. However, to demonstrate sufficient need for a new hospice program in an area where a new hospice agency was recently approved or licensed, adjustments are made to ensure not only a sufficient need, but that existing providers are not adversely impacted by an additional hospice agency. Therefore, the published Need Methodology adjusts the total annual admissions for hospice programs that fall short of that number or have not yet began operations, by substituting "default admissions."

To determine "Default Admissions", assume an Average Daily Census (ADC) of 35 and multiply by 365 days to determine 12,775 default patient days. These days are then divided by the statewide Average Length of Stay (ALOS) as

determined by CMS (61.89) to arrive at 206.4 default admissions for the current period.[12]

In the October 14, 2022 published need methodology, the state adjusts, or substitutes the default admissions for total admissions in 2019-2021 for the following five agencies approved to serve Pierce County as proxy years:

- Providence Health & Services
- Envision Hospice
- Continuum Care of Snohomish
- Puget Sound Hospice
- Seasons Pierce County

As stately previously, this CN application is submitted under the assumption of the remote possibility that CN #1947 may be revoked, depending on the outcome of pending litigation. Several of the above hospices were recently approved and the Certificates of Need remain under appeal, including CN #1947 for Seasons Hospice & Palliative Care of Pierce County Washington. However, this application assumes that the number of new and approved hospices will remain the same. This application also assumes one additional hospice is warranted per the state's published Need Methodology.

[12] The source document for Washington's ALOS, MDCR HOSPICE 3, Medicare Hospices: Utilization and Program Payments for Medicare Beneficiaries, by Area of Residence, Calendar Year 2020, CMS, appears in **Exhibit 16.**

Hospice admissions by provider are shown in the following table. With the adjustment for the five recent approvals, the 3-year average total hospice admissions for Pierce County is 4,157 as published.

	2019	2020	2021	**3-Year Ave.**
Current Volume	4,758	4,171	3,541	**4,156.74**

Table 11
Pierce County Hospice Admissions by Agency, Most Recent Three Years

	2019 Admissions			**2020 Admissions**			**2021 Admissions**		
Hospice Agency	**0-64**	**65+**	**Total**	**0-64**	**65+**	**Total**	**0-64**	**65+**	**Total**
Franciscan Hospice	364	2,236	2,600	232	1,630	1,862	141	1,081	1,222
Kaiser Permanente HH & Hospice (Group Hlth)	25	176	201	30	181	211	21	156	177
MultiCare Home Health, Hospice & Palliative Care	167	758	925	161	866	1,027	145	914	1,059
Envision Hospice of Washington LLC				1	20	21	8	113	121
Northwest Healthcare Alliance, Inc. dba Assured Home				0	1	1	0	1	1
Wesley Homes Hospice, LLC				1	16	17	6	44	50
Providence Hospice of Seattle							1	1	2
Puget Sound Hospice							0	0	0
Total	**556**	**3,170**	**3,726**	**425**	**2,714**	**3,139**	**322**	**2,310**	**2,632**
Adjustments for New Hospices			1,032.1			1,032.1			1,032.1
Adjusted Total			**4,758**			**4,171**			**3,541**

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted October 14, 2022.

The 3-year average of 4,156.74 is then subtracted from the total projected hospice volume for Pierce in **Step 4 (Table 10)** to project unmet need (admissions). The forecast is expanded beyond the published 2024 need to 2027, the projected third full calendar year of the project.

Table 12
Pierce County Projected Unmet Need Admissions, Years 2022 Through 2027

	2022	2023	2024	2025	2026	2027
Projected Hospice Volume	4,097	4,252	4,406	4,560	4,687	4,817
Current Volume	4,157	4,157	4,157	4,157	4,157	4,157
Unmet Need Admissions	-59	95	249	404	530	660

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022; 2026 and 2027 estimates are calculated using Office of Financial Management (OFM) Population Projections by Age Group, provided in **Exhibit 16.**

Step 6: Multiply the Unmet Need in Step 5 by the Statewide ALOS to Determine Unmet Need Patient Days Through 2027.

In accordance with WAC 246-310-290(8)(f), the unmet need admissions in Step 5 is multiplied by the statewide ALOS as determined by CMS to calculate the unmet need patient days for Pierce County through year 2027, the projected third calendar year of the project.

Table 13
Pierce County Projected Unmet Need Patient Days, Years 2022 Through 2027

	2022	2023	2024	2025	2026	2027	**ALOS**
Unmet Patient Days	-3,672	5,880	15,431	24,983	32,797	40,867	**61.89**

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022; 2026 and 2027 estimates are calculated using Office of Financial Management (OFM) Population Projections by Age Group, provided in **Exhibit 16.**

Step 7: Divide the unmet patient days from Step 6 by 365 to Determine Unmet Need ADC Through 2026.

In accordance with WAC 246-310-290(8)(g), the unmet patient days in Step 6 are divided by 365 to determine the unmet ADC. Projections are carried through to 2027, the projected third calendar year of the project.

Table 14
Pierce County Projected Unmet Need of Average Daily Census, Years 2022 Through 2027

	2022	2023	2024	2025	2026	2027
Unmet Need ADC	-10	16	42	68	90	112

Source: Washington Department of Health 2022-2023 Hospice Numerical Need Methodology, posted October 14, 2022; 2026 and 2027 estimates are calculated using Office of Financial Management (OFM) Population Projections by Age Group, provided in **Exhibit 16.**

Step 8: Determine the number of agencies needed by 2024 with an ADC of 35.

In accordance with WAC 246-310-290(8)(h), the 2023 census of 111 from Step 7 is divided by an ADC of 35 which results in need for one (1) new hospice agency for Pierce County.

Step 9: Assume a Market Share Based on Past Experience.

Although Seasons Pierce County is a new entity without experience, it looks to other AccentCare Hospice programs and their start-up experience nationwide, including the Oregon agency, to gauge service levels and estimate a market share. (See **Exhibit 16** for the start-up utilization of new hospice programs over the past 10 years which have Administrative Services Agreements with AccentCare, Inc.) That, and the default calculations for Washington Hospice Agencies, are taken into consideration. Implementation date is July 1, 2024.

Table 15
Seasons Pierce County Projected Patients and Share of Unmet Admissions, 2024 – 2027

	2024	2025	2026	2027
Pierce Unmet Admissions	249	404	530	660
Seasons' Share of Unmet Patients	23.0%	39.0%	39.0%	39.0%
Seasons' Hospice Patients	**57**	**157**	**207**	**258**

The data above shows Seasons Pierce County's share of unmet patients increasing from 23% in 2024 to 39% in 2027. Market shares are estimated based on historical patient volumes of other AccentCare start-ups in recent years. Therefore, the Seasons Pierce County forecast is reasonable and achievable based on start-up experience and is within the calculated unmet need so as not to adversely impact existing providers. Furthermore, the market share of unmet projected admissions never exceeds one third of total unmet admissions, recognizing that the state has published need for 3 new hospice agencies. The resulting market share for Seasons Pierce County by its third full year of operations in 2027 is 5.3% of the total volume for the county.

Step 10: Assume an ALOS Reflective of a New Agency for Washington State

Again, Seasons Pierce County looks to the start-up experience of other AccentCare Hospice programs nationwide to determine a length of stay that increases during its first 6 months while becoming established in the Medicare and Medicaid programs and its first calendar year. The program is assumed to reach the Washington statewide ALOS of 61.89 days by its second calendar year, 2026. Implementation date is July 1, 2024. This conservative approach yields the following patient days and census for the forecast period. Seasons Pierce County proxy data is provided in **Exhibit 16.**

Table 16
Seasons Pierce County Projected Patients and Share of Unmet Admissions, 2024 – 2027

	2024	2025	2026	2027
ALOS	**39**	**53**	**61.89**	**61.89**
Seasons' Patient Days	**2,236**	**8,344**	**12,791**	**15,938**
Seasons' Share of Unmet Days	14.5%	33.4%	39.0%	39.0%
Seasons' ADC	**6**	**23**	**35**	**44**
Seasons' Share of Unmet Census	14.5%	33.4%	39.0%	39.0%

3. ***Identify any factors in the planning area that could restrict patient access to hospice services.***

Pierce County has a large, diverse population. Reaching residents across the area and from all walks of life takes innovation and diligence, in addition to increased resources in the form of additional hospice agencies. Under-service to specific patient populations demonstrate access issues that can be addressed through the introduction of a new hospice agency such as Seasons Pierce County that has an array of innovative programs and services to identify and serve those in need. Access barriers range from a lack of information about hospice and what it is, to financial barriers or isolation from society.

Across the nation, Seasons Hospice affiliates admitting Covid positive patients, helping hospitals by admitting them at home with hospice, avoiding the isolation from family that results from hospitalization. Daily monitoring of staff health, education about proper use of personal protection equipment (PPE), and securing adequate supplies of PPE to keep staff safe ensures staff are cared for, alongside the patients they serve.

Seasons Pierce County breaks barriers by developing targeted programs to expand access and offer additional services where they are most needed by complementing, rather than competing with existing service providers. Specifically, access issues exist for the following groups.

- **The Homeless**
- **Minority populations, including Asians Americans, Black Americans, Latinxs, and the LGBT community.**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Persons Requesting Medical-Aid-In-Dying under the Death with Dignity Act**

❖ The Homeless

Information presented previously addressed the large and persistent homeless population of Pierce County. Pierce County has the third largest number of homeless persons of all counties in the state, representing a subpopulation with barriers to necessities including health care. Furthermore, the pandemic and rising unemployment put many more residents at risk of homelessness.

The Homeless do not have access to healthcare "on the street" and have shorter life spans than the general population due to environmental exposure. As stated in the article, ***The Hard, Cold Facts About the Deaths of Homeless People,*** Homeless persons die of the same causes as the general population, but at a younger age. Many are known to suffer from mental illness and addiction, further shortening life span. For every age group, homeless persons are three times more likely to die than the general population.

"*Research has shown that individuals experiencing homelessness have greater morbidity and mortality rates than the general population and experience more co-morbidities than their housed counterparts. When compared to non-homeless populations, individuals experiencing homelessness face a multitude of complex health and social issues that are often integrated with past, present, and daily trauma that impact these individuals' prioritization and decision-making efforts.*"[13]

Seasons Pierce County commits to serving the homeless population, providing assistance with housing and hospice care for the terminally ill. Ongoing training and partnerships with community based organizations within the service area help identify, educate and serve those in need.

❖ Minority Populations

Racial and ethnic minorities have long been identified as experiencing health care disparity in terms of access and quality of life. Research studies reveal the most prevalent causes are lack of trust of the health care community, cultural differences, and lack of knowledge or understanding about what hospice is. One article, *Racial Disparities in*

[13] *Suicide and Homelessness, Data Trends in Suicide and Mental Health Among Homeless Populations*, National Health Care for the Homeless Council Fact Sheet, May 2018

Hospice: Moving From Analysis to Intervention, suggests that diversity among hospice staff influences diversity among hospice patients.[14] Seasons Hospice affiliates have experienced this. By developing a diverse staff, hospice admissions among minorities increase within the community. Other examples of disparity are found in two articles by JoAnn Mar, *Racial Disparities in End-of-Life Care – How Mistrust Keeps Many African Americans Away from Hospice*, and *Challenges and Cultural Barriers Faced by Asians and Latinos at the end of Life.*[15] In addition to lack of trust and language barriers, many Latino and Asian cultures do not discuss death openly. Other reasons for disparity include failure to plan, poverty and tendency to delay treatment, and threat of deportation. Yet these populations can be educated through outreach efforts within their communities. Copies of the above referenced articles are found in **Exhibit 13**.

Evidence of racial and ethnic disparities in hospice care in Pierce County is shown in the data below. Recall from Table 3 the Pierce County population by race and ethnicity. The numbers are significant, warranting attention and outreach efforts to assure equality in access. With Hispanics representing 12% of the population, African Americans representing 7.5% of the population, and Asians representing 7.1%, the expectation is for hospice admissions to reflect a similar proportion of service. However, that is not the case in Pierce County. The majority of hospice patients are covered by Medicare. Therefore, looking at hospice admissions for the Medicare population provides a benchmark of service. The table below shows the most recent (2021) admissions data from the Centers for Medicare and Medicaid Services (CMS). Rather than showing a 12% representation of Hispanics, 7.5% representation of Blacks/African Americans and 7.1% representation of Asians, approximately 82% of all hospice admissions are whites, with 5% Black, 3.5% Asian and 0.5% Hispanic. The Native Indian/Alaskan population and other unidentified minorities also show disparity in hospice use.

A use rate is calculated based on population estimates to gauge service levels. The number of admissions per 100,000 for each race yields divergent results, with whites admitted to hospice more than twice as often as other races. Assuming all races have equal access, applying the use rate of the white population to other races provides an estimate of expected hospice admissions. The difference, shown in the table below represents the unmet need.

[14] *Virtual Mentor*, September 2006, Vol. 8, American Medical Association Journal of Ethics
[15] University of Southern California, Annenberg Center for Health Journalism's 2018 California Fellowship, JoAnn Mar.

Table 17
2020 Medicare Hospice Admissions by Race and Ethnicity and Expected Admissions
Pierce County Recipients

Race/ Ethnicity	Admissions	Percent	2022 Population	Admits per 100,000	Expected Admissions	Difference
White	2,629	81.65%	596,094	441	2,629	0
Hispanic	16	0.50%	113,805	14	502	-486
Black	159	4.94%	66,728	238	294	-135
Asian	111	3.45%	64,368	172	284	-173
North Amer. Native	26	0.81%	10,741	242	47	-21
Other	73	2.27%	78,979	285	348	-275
Unknown	23	0.71%	-	-	-	-
Total	**3,220**	**100.00%**	**930,715**	**350**	**4,010**	**-818**

Source: CMS Hospice Standard Analytic File, 2020; Claritas Population Estimates by County, Race & Ethnicity, 2021.

The above data confirms that minorities, including Hispanics, the Black population, and Asians are not being served in numbers proportionate to their Caucasian counterparts. For instance, if Hispanic residents in Pierce County were enrolling in hospice in proportionate numbers, an additional 486 admissions would result. Furthermore, the large number of North American Natives are not represented above. Other & unknown hospice admissions each represent 2 percent or less of the total.

To initiate outreach efforts, identify unmet communities, and develop cultural competencies specific to the service area, Season Pierce County will establish a **Minority Advisory Board.** Board members, representing Asian Americans, Latinxs, Black Americans, and Native Americans will be instrumental in identifying specific needs and targeted programs to address them, forging alliances within their communities to educate residents and providers, promoting hospice care and its benefits. Community leaders ensure cultural competence and evaluate the delivery of hospice care. Hospice leaders provide education and resources to help minority leaders increase public awareness and improve access to hospice and palliative care. The Board will meet at least twice per year to strengthen minority relationships, facilitate diversity training, and promote minority enrollment.

Similar outreach efforts of other AccentCare Hospice Agencies around the country toward minorities, such as the Asian American community in Southern California or the Latinx community in Miami-Dade Florida, document proven capability in developing hospice programs to reach underserved populations, filling gaps in service overlooked by other hospice programs. One way to ensure minorities have access to service is to hire minorities.

For instance, Seasons Hospice & Palliative Care of Southern Florida is successful in part due to having a staff reflective of the population it serves. In this case, approximately half identify as Latinx. Furthermore, Seasons Pierce County, as with all other Seasons Hospice Agencies, will become Services and Advocacy for Gay Elders (SAGE) Platinum Certified, showing a level of commitment and accountability to serve all those in need with dignity and sensitivity. Essentially, Seasons Pierce County provides the level of innovation and commitment necessary to bring hospice care to the next level in Pierce County.

Seasons Pierce County assures availability to people from all walks of life, regardless of race, religion, marital status, color, creed, gender, sexual orientation, pregnancy, childbirth, age, disability, national origin, or status with regard to public assistance. With diversity training, employees and volunteers approach all persons and referral sources as friends being introduced to hospice and its benefits. Seasons Pierce County's staff will reflect the population it serves, providing access to the diverse population.

❖ Children

Over a quarter of a million children under the age of 18 are expected to reside in Pierce County by 2027, representing 23% of the total population. Yet there are no hospice agencies with a dedicated pediatric program, which limits access to hospice and palliative care for terminally ill children. Although MultiCare Home Health, Hospice & Palliative Care has an affiliate that provides pediatric palliative care (Mary Bridge Children's Health Center's COMPASS program: Communication, Palliative and Support Service), it is not a program of the hospice.

The current (2022) and five-year projected 2027 pediatric population by age cohort appears in **Table 18** (below) for Pierce County and the state. The data shows that Pierce County's population below the age of 18 is expected to increase by 11,305 or 5.2%, compared to 4.2% for the state, over the next five years.

Table 18 2022 and 2027 Pediatric Population Estimates Pierce County and Washington				
	Pierce County Population Estimates			Children Percent
	Age 0-17	Age 18+	Total	of Total
2022 Population	216,124	714,591	930,715	23.22%
2027 Population	227,429	760,874	988,303	23.01%
5-Year Pop. Increase	11,305	46,283	57,588	
5-Year Growth Rate	5.23%	6.48%	6.19%	
	Washington Population Estimates			Children Percent
	Age 0-17	Age 18+	Total	of Total
2022 Population	1,705,079	6,153,322	7,858,401	21.95%
2027 Population	1,776,699	6,560,899	8,337,598	21.65%
5-Year Pop. Increase	71,620	407,577	479,197	
5-Year Growth Rate	4.20%	6.62%	6.10%	
Source: Claritas Population Estimates, 2022-2027				

Seasons Pierce County's pediatric program, ***Kangaroo Kids Pediatric Hospice & Palliative Care,*** offers a choice to residents over existing hospice providers. The Kangaroo Kids Program, described previously, provides palliative and end of life care to terminally ill children. The pediatric care team provides direct care to the pediatric patient, teaches the parents how to provide care at home, the regimen of care, and schedule for medicines and other services. In addition, the Seasons Hospice Foundation fulfills wishes as well as emergent needs for pediatrics in the Kangaroo Kids program. Care for the surviving children (such as siblings) continues through bereavement with developmentally appropriate grief support and children's bereavement camps through ***Camp Kangaroo.*** The table below shows the volume of patients under the age of 18 that were served by AccentCare programs in 2022.

Table 19 Pediatric (Ages 17 and under) Patients Served by AccentCare by State in 2022	
AccentCare Location	**Patients**
Wisconsin	17
Minnesota	11
Indiana	10
Other (includes FL, NJ, MD, TX)	8
Total	**46**

❖ The Elderly

One of the most vulnerable populations and the one most likely to need hospice care, the elderly are often isolated, whether due to living conditions, location, or lack of nearby family or support. This impedes access to timely, appropriate health care, including hospice care.

Seasons Pierce County has the ability to reach these individuals through a strong outreach campaign geared toward faith-based and community-based organizations, as well as retirement communities and skilled nursing facilities willing to contract for inpatient beds, and physicians who will refer patients. Programs such as *Namaste Care dementia program* and services provided under *Open Access* benefit the elderly and improve access. Seasons Pierce County will work closely with facilities and physicians to ensure they understand the benefits of hospice care so residents and patients can be referred timely and benefit.

❖ Death with Dignity

The Washington State Department of Health 2020 Death with Dignity Act Report states that in the year 2020, 333 total individuals participated in the Act. Of the total, 270 were age 65 or older. After taking the medication, 252 died, of which 90% were enrolled in hospice care. The 2021 Death with Dignity Act Report states for 2021, 387 total individuals elected to participate in the Washington Death with Dignity Act. Of those, 312 were age 65 and older. There were 291 that died after taking the medication, of which 91% were enrolled in hospice care. Copies of the referenced reports are found in **Exhibit 29**.

AccentCare recognizes that those wishing to use medical aid-in-dying (MAID) services are underserved group in Pierce County and the State of Washington due to the prevalence of the existing faith-based hospice providers that do not provide MAID services. Therefore, **AccentCare supports a patient's election of medical aid-in-dying (MAID) consistent with Washington Death with Dignity Act. AccentCare ensures patients electing medical aid-in-dying have access to hospice care.**

The table below demonstrates that AccentCare has a history of supporting patients that wish to use MAID services.

Table 20 Summary of AccentCare Patients that have used MAID services in participating states	
2020-2022	**Patients**
California	135
Other (includes CO, NJ, OR)	9
Confirmed Completed	56
Initiated MAID	88
Total	**144**

Note: "Confirmed Completed" indicates that AccentCare staff were present during ingestion of aid-in-dying drug. "Initiated MAID" indicates that AccentCare staff were not present at ingestion and thus it cannot be confirmed whether or not ingestion of the drug occurred.

AccentCare policy C 2.2. includes a summary of Washington's Death with Dignity Act, it also:

- Confirms hospice staff will continue to provide the full suite of hospice care, regardless of a patient's election. This ensures patients are not denied hospice services if they elect medical aid-in-dying.
- Requires hospice staff to review a patient's desire for the election to ensure any contributing factors are addressed in the care plan. If, for example, a patient wants to move forward with a medical aid-in-dying election due to pain, the hospice team will make sure pain is being addressed as part of the plan of care while the patient's election and process moves forward.
- Confirms the hospice physician may serve as the physician participant in the patient's election. Hospice physicians are not prohibited from serving in this capacity.
- Confirms hospice staff may be present during a patient's administration. Staff are not prohibited from attending.

❖ Use of Telemedicine

The Electronic Medical Record is a technology that provides the avenues for feedback to referral sources, provides physicians with status reports, allows the hospice to track performance, benchmark outcomes, and respond to patients and their families. It also helps maintain safety, performance, an environment of care, and accountability throughout the delivery of care. These functions tie contractors, employees, and volunteers together in real time for each patient, allowing faster and accurate responses. As an industry leader, AccentCare hospice affiliate programs have been doing this for more than 15 years. In 2020

AccentCare programs across the country engaged in approximately 70,000 virtual visits. From Chaplain calls to Music Therapy, Volunteer Bereavement calls, Physician Virtual Communication, and other patient management services, Seasons Pierce County has the resources to stay connected with patients, families, and providers.

The staff's ability to access the medical record electronically and the ability to ask questions of each other via remote, wireless devices and get answers to those questions means that the patient and his or her family remain the focus and center of care. By removing impediments to communication and information, staff can focus on caring for patients. Reducing the numbers of barriers or problems that employees must deal with increases efficiency of staff and increases their satisfaction, leading to high employee and volunteer retention rates.

Improving communication also requires repeated educational efforts targeted at local gatekeepers, and includes personal contact with religious organizations, public services, and schools, to name a few. Knowing the community results in targeting the development of materials, promotions and outreach efforts that address residents within the various communities. Enlisting input from locals and following through generates identity, familiarity, and understanding. The results establish hospice as an important part of every community's service.

One important effort appearing within this proposal involves employing telecommunication, often referred to as "telemedicine," to reach all persons throughout the service area. This effort adopts cell phone technology or use by notebook or laptop applications available to the public. The result allows linkage to hospice patients who reside in areas where a hospice volunteer or team member may undergo longer drive times.

As explained previously, AccentCare operates its own nurse-employees staffed call center. The center links in real time patients with team members, and allows hospice team members, including physicians, pharmacist, nurses, social workers and others to be notified of and respond to patient or family needs. Plans of care and medical records appear, along with any patient issues, as well as the status in the course of palliative care.

To augment the call center in Pierce County, AccentCare employs existing technology to allow a patient or family at bedside to call the team leader and engage by face to face interaction. If the patient's call requires the dispatch of a team member or volunteer to the patient's home, the telecommunication link allows the team member to explain, face to face, who will come and the approximate time. While engaged, the link allows the team member to ask questions, give instructions, ask about vital signs, and other information that will help the patient and family member handle the issues. Most importantly, the team member provides assurance, information, and support. Should a team member be on his or her way, the link allows assurance and feedback to the patient and family of the help, and the continued contact to explain, soothe, and manage stress or address the patient's concerns.

The **AccentCare Call Center** is staffed with nurses licensed in every state AccentCare' Hospice agencies serve using the latest technology and integrated with the EMR. Call center staff can access certain information and can verify, inquire, respond to patients and other clinical and nonclinical staff. Call center staff can route and arrange for patient assessment 24 hours a day, 7 days a week.

Seasons Pierce County would fill a range of needs, fulfilling numerical need, service and quality gaps, and attracting and educating health care professionals. The proposed Advisory Board will change community misconceptions about hospice care, bridging the gaps by engaging the community and its residents. Additional barriers brought about by the COVID-19 pandemic are addressed through education and safety measures as well as telemedicine.

4. ***Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.***

The result of the publication of need for an additional hospice agency signifies opportunity to enhance and augment service to Pierce County where the established hospice provider base falls short of meeting demand. New hospice agencies such as Pierce County will bring fresh ideas and programs, creating diversity among providers for greater outreach capabilities.

The programs and services highlighted in this application demonstrate a breadth and depth unsurpassed by others. Each hospice offers services that, while similar in some respects, may differ in others. Diversity of programs and services creates greater opportunities for residents to find a good match for their needs and enroll in hospice.

Impact on the existing programs appears in the chart and tables that follow. For gauging impact, the admissions during the baseline (based on the average admissions from 2019-2021) for the existing hospice programs remain unchanged, with the forecasted caseload increasing from a baseline of 3,541 in 2021 to 4,817 in 2027 (year 3 of the project). As demonstrated, the impact of introducing Seasons Pierce County produces no negative consequences because the availability of additional hospice admissions appears.

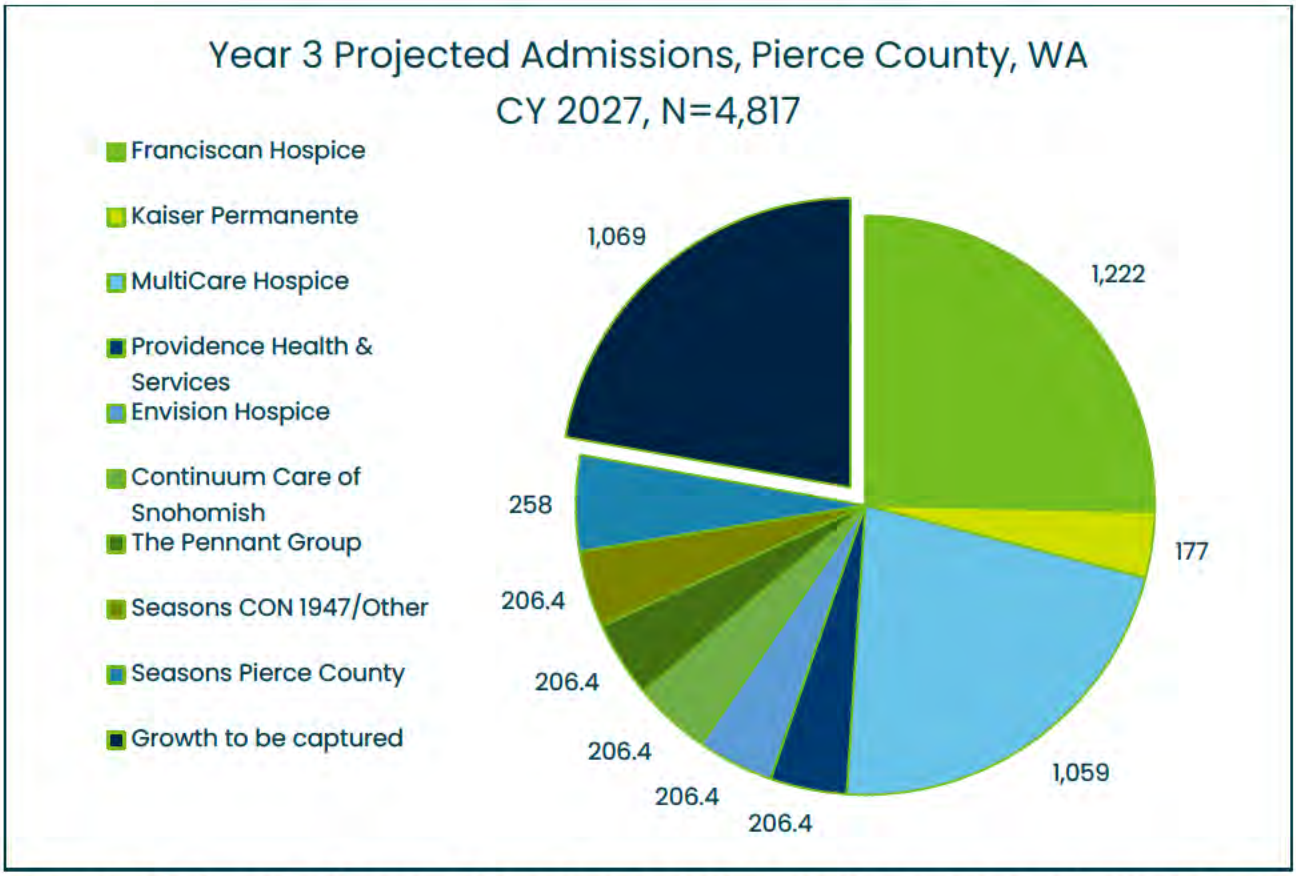


Figure 6. The impact of Seasons Pierce County attaining its forecast does not cause existing hospices to fall below the caseloads in the baseline year. Hence, no adverse impact results.

The table below shows the projected hospice admissions and growth over the baseline, given the addition of Seasons Pierce County through the third full year of operations, 2027.

Table 21
Pierce Projected Growth in Hospice Admissions, CY 2024 – CY 2027

Year	Pierce Admissions	Seasons Admissions	Remaining Cases for Others	Growth from Baseline
Baseline Cases, 2021	3,541			
CY 2024	4,406	57	4,349	808
CY 2025	4,560	157	4,403	862
CY 2026	4,687	207	4,480	939
CY 2027	4,817	258	4,560	1,018

The calculation above, showing the increase in admissions over the baseline period after entry of Seasons Pierce County yields an increase of 808 to 1,018 admissions over the

period. Taking this one step further, the existing hospice agencies' market shares is applied to the increase to demonstrate the potential for all programs to grow. Therefore, no duplication occurs.

Table 22
Projected Growth in Hospice Admissions by Provider, CY 2024 – CY 2027

	Baseline, CY 2021		Increase from Baseline (Admissions)			
Hospice Name	**Admissions**	**Market Shares**	**Year 2024**	**Year 1 2025**	**Year 2 2026**	**Year 3 2027**
Franciscan Hospice	1,222	34.51%	279	297	324	351
Kaiser Permanente HH & Hospice (Group Hlth)	177	5.00%	40	43	47	51
MultiCare Home Health, Hospice & Palliative Care	1,059	29.91%	242	258	281	305
5 New/Approved Hospices @ 206.4	1,032	29.14%	235	251	274	297
Others not licensed in Pierce	51	1.44%	12	12	14	15
TOTAL	**3,541**	**98.6%**	**808**	**862**	**939**	**1,019**

It is noted that Wesley Homes served patients during the Emergency expansion provisions which has now expired. Yet, need persists.

The Governor of the State of Washington issued Proclamation 20-36 in the early days of the COVID-19 pandemic to allow health care facilities to meet demands for COVID surge capacity. This proclamation temporarily waived Certificate of Need (CN) requirements for various healthcare facilities, including hospices. Wesley Homes Hospice, which is licensed to serve King County, has also been serving residents in Pierce County since 2020 due to this proclamation. On October 27, 2022, Proclamation 20-36 was formally rescinded. Therefore, Wesley Homes Hospice requires a Certificate of Need in the future to serve Pierce County residents. Copies of the pertinent proclamations issued by the State of Washington and the PowerPoint discussing COVID-19 Offboarding procedures is included in **Exhibit 28** *at the end of this application.*

Normally, new providers spur competition, with existing providers rising to the occasion by increasing admissions and improving quality to capture additional market share. As the saying goes, "a rising tide lifts all boats." Pierce County is no exception, as growth is expected to continue, increasing need for hospice services in future years.

Furthermore, as a for-profit company, Seasons Pierce County does not actively compete with the non-profit providers competing for fundraising dollars. Seasons Pierce

County will establish balance and offer an alternative approach to service with a different model of care, filling gaps in service, rather than competing for like patients.

Hospice admissions in Pierce County have failed to keep up with demand, resulting in need for an additional hospice agency to serve residents of Pierce County. As a new market entrant, Seasons Pierce County will focus outreach efforts on educating institutional providers, the medical community, community and faith-based organizations, and the general public on hospice care – what it is, where care is provided, and when to call for enrollment. Through educational seminars, partnerships, and outreach efforts, Seasons Pierce County improves awareness, resulting in higher admission rates and patients enrolling earlier in their disease progression. Earlier enrollments improve patient and family satisfaction, ensuring a more peaceful and fulfilling experience at end of life. The community becomes more engaged, leading to earlier enrollments as well as a higher number of enrollments.

Education goes beyond seminars and web-based information. AccentCare has established protocols and materials used to train physicians and nursing staff on how to identify potential hospice patients and to ensure understanding of the benefits of hospice and palliative care, providing continuity of care where currently a disjointed system prevails. The end result is increased access and availability to hospice care.

5. ***Confirm the proposed agency will be available and accessible to the entire planning area.***

As stated in **Section II. *Project Description*, Item 5,** the proposed Seasons Pierce County Agency will be available and accessible to the entire planning area of Pierce County, with sufficient staff and resources allocated for project success.

6. ***Identify how this project will be available and accessible to under-served groups.***

Seasons Pierce County's programs increase enrollments by creating a diversity council or councils whose member volunteers come from minority groups, an example of which appears in **Exhibit 13**. These councils act as key informants that identify impediments that may exist that limit hospice enrollment. The councils also participate with Seasons Pierce County employees to develop solutions to remove barriers to hospice care.

For example, recruiting employees that are members of minority groups brings insight into how to approach members in each minority group. Bilingual staffs open many doors sharing cultures and languages. Other options include making promotional materials available in other languages that invites requests for more information.

Including in the promotional materials information about accepting all persons with a terminal illness without regard to ability to pay sends an invitation to low-income persons to openly ask for information, freeing them from concerns regarding money. Seasons Pierce County's commitment to all persons regardless of race, ethnicity, income, religion, gender, or physical or mental disability establishes an "open roadway" into care.

Recognizing the need for additional outreach to the disadvantaged and vulnerable population, those typically categorized as under-served, Seasons Pierce County commits to serving the following under-served populations, as described previously.

- **The Homeless**
- **Minority populations, including Asian Americans, Black Americans, Latinxs, and the LGBT community**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Residents with Alzheimer's Disease**
- **Persons Requesting Medical-Aid-In-Dying under the Death with Dignity Act**

Of utmost importance in maintaining the pathway into care is the call center. With 24 hour, seven days a week capability to meet the patient and his or her family for an assessment, the patient understands that he or she matters, that his or her concern is important, and that Seasons Pierce County exists to address all needs as a partner in care. Referral patterns will be established with providers in the health care delivery system, as well as with community-based organizations that help identify those in need.

7. ***Provide a copy of the following policies:***

- ***Admissions policy***
- ***Charity care or financial assistance policy***
- ***Patient Rights and Responsibilities policy***
- ***Non-discrimination policy***

Suggested additional policies include any others believed to be directly related to patient access (death with dignity, end of life, advanced care planning)

Exhibit 17 contains the policies identified below.

- Admission Criteria (HOS 2-024)
- Admission Process (HOS 2-024), including referrals
- Charity care policy and the Application for Financial Assistance (C 3.3.4 & C 3.3.4.1)
- Patient Rights and Responsibilities (HOS 1-013)
- Notice of Privacy Practices (H-010)

- Non-Discrimination & Grievance Procedure (C 2.4.1)
- Availability of Services (HOS 2-001)
- Standards of Practice (C 1.4)
- Informed Consent (HOS 1-007)
- Patient Discharge (HOS 2-082)
- Communication with Sensory Impaired or Limited English Proficient Persons (C 1.6.1)
- Hospice Care to Residents in a Facility (HOS 2-042)
- Emergency Management Program (C 2.11.A)

8. ***If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:***

    - ***All applicable review criteria and standards with the exception of numeric need have been met;***
    - ***The applicant commits to serving Medicare and Medicaid patients; and***
    - ***A specific population is underserved; or***
    - ***The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.***

The above criterion is not applicable to this project which is submitted in response to the Department of Health's Need Methodology published October, 2022, identifying need for an additional hospice agency in Pierce County.

B. Financial Feasibility (WAC 246-310-220)

The information that follows in this section of the application addresses all the schedules and tables as defined in this section of the application. ***The supporting worksheets appear in*** **Exhibit 18.**

1. ***Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:***

   - ***Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.***
   - ***Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.***
   - ***Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.***
   - ***For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.***

A complete methodology and assumptions for utilization projections was provided previously in response to the Certificate of Need Review Criteria (WAC 246-310-210). The forecast is repeated below for consistency.

Table 23
Utilization Projections, Seasons Pierce County, First Three Years

Pierce County	Partial Year 7/24-12/24	Year 1 CY 2025	Year 2 CY 2026	Year 3 CY 2027
Total number of admissions	57	157	207	258
Patient Days	2,236	8,344	12,791	15,938
Average Length of Stay	39.00	53.00	61.89	61.89
Average Daily Census	6	23	35	44

Seasons Pierce County admissions and patient days are similar to other AccentCare Hospice programs and their start-up experience nationwide. (See **Exhibit 16** for the start-up utilization of new hospice programs over the past 10 years which have Management Services Agreements with AccentCare, Inc.) The Financial forecast and visit estimates use Seasons Hospice & Palliative Care of Oregon as a proxy, having similar programs and services as the proposed project and a location with similar population size and demographics as Pierce County. Demographic data comparing Pierce County with Multnomah County and the Oregon Service Area is provided in **Exhibit 16.**

The pro forma revenue and expense projections for the partial first year and three full calendar years of operation appear below.

Table 24
Revenue and Expenses for Seasons Pierce County
Initial Partial Year and First Three Calendar Years

REVENUES	7/1/24-12/31/24	CY 2025	CY 2026	CY 2027
Patient Service Charges				
Medicare & Medicare Managed Care	$510,370	$1,904,114	$2,918,943	$3,637,198
Medicaid & Medicaid Managed Care	$5,609	$20,924	$32,076	$39,970
Health Options (BHP)	$11,217	$41,848	$64,152	$79,938
Charity Care	$5,608	$20,924	$32,076	$39,969
Private Pay	$8,413	$31,386	$48,114	$59,954
Third Party Insurance	$16,825	$62,773	$96,229	$119,908
Other (Champus, VA)	$2,804	$10,463	$16,039	$19,984
Total Patient Service Charges	**$560,846**	**$2,092,433**	**$3,207,629**	**$3,996,920**
Revenue Deductions				
Medicare & Medicare Managed Care	$62,863	$234,532	$359,530	$447,999
Medicaid & Medicaid Managed Care	$1,022	$3,813	$5,845	$7,284
Health Options (BHP)	$2,243	$8,370	$12,830	$15,988
Charity Care	$5,608	$20,924	$32,076	$39,969
Private Pay	$6,730	$25,109	$38,492	$47,963
Third Party Insurance	$841	$3,139	$4,811	$5,995
Other (Champus, VA)	$701	$2,616	$4,010	$4,996
Total Revenue Deductions	**$80,009**	**$298,503**	**$457,595**	**$570,194**
Net Patient Service Revenues				
Medicare & Medicare Managed Care	$447,507	$1,669,582	$2,559,412	$3,189,199
Medicaid & Medicaid Managed Care	$4,587	$17,111	$26,231	$32,686
Health Options (BHP)	$8,973	$33,479	$51,322	$63,950
Charity Care	$0	$0	$0	$0
Private Pay	$1,683	$6,277	$9,623	$11,991
Third Party Insurance	$15,984	$59,635	$91,418	$113,912
Other (Champus, VA)	$2,103	$7,847	$12,029	$14,988
Total Net Patient Service Revenues	**$480,837**	**$1,793,930**	**$2,750,034**	**$3,426,726**
Non-Operating Revenues	$11,010	$41,160	$63,062	$78,557
TOTAL REVENUES	**$491,847**	**$1,835,090**	**$2,813,097**	**$3,505,283**

Table Continued on next page.

Table 24
Revenue and Expenses for Seasons Pierce County
Initial Partial Year and First Three Calendar Years, *continued*:

EXPENSES	7/1/24-12/31/24	CY 2025	CY 2026	CY 2027
Advertising	$7,500	$15,000	$15,000	$15,000
Allocated Costs	$0	$0	$0	$0
Depreciation and Amortization	$6,085	$12,071	$12,071	$12,071
Dues and Subscriptions	$2,500	$5,000	$5,000	$5,000
Education and Training	$779	$2,907	$4,457	$5,553
Employee Benefits	$70,429	$176,759	$194,384	$219,284
Equipment Rental	$0	$0	$0	$0
Information Technology/Computers	$33,110	$19,580	$19,580	$19,580
Insurance	$1,302	$4,859	$7,449	$9,282
Interest	$0	$0	$0	$0
Legal and Professional	$801	$2,988	$4,581	$5,708
Licenses and Fees	$19,476	$20,444	$23,194	$25,944
Medical Supplies	$31,303	$116,793	$179,038	$223,092
Payroll Taxes	$30,519	$76,595	$84,233	$95,023
Postage	$100	$374	$574	$715
Purchased Services (Utilities, other)	$34,678	$129,378	$198,332	$247,135
Rental/Lease	$20,844	$42,729	$44,011	$45,331
Repairs and Maintenance	$230	$858	$1,316	$1,639
Salaries and Wages (DNS, RN, OT, clerical, etc.)	$469,523	$1,178,392	$1,295,892	$1,461,892
Supplies	$778	$2,903	$4,450	$5,545
Telephone/Pagers	$4,889	$18,243	$27,965	$34,846
Service Fees	$60,000	$60,000	$60,000	$60,000
Washington State B & O Taxes	$7,378	$27,526	$42,196	$52,579
Travel (patient care, other)	$5,063	$18,890	$28,958	$36,083
TOTAL EXPENSES	**$807,288**	**$1,932,291**	**$2,252,680**	**$2,581,303**
Contributions to Seasons Hospice Foundation		12,500	25,000	50,000
NET INCOME	**($315,441)**	**($109,701)**	**$535,417**	**$873,980**

The required worksheets and assumptions for the revenues and expenses appear in Exhibit 16.

The pro forma balance sheet for the partial first year and three full calendar years of operation appears below.

Table 25
Seasons Pierce County Balance Sheet and Statement of Cash Flows

BALANCE SHEET

Current Assets	31-Dec-22	1/01/24-6/30/24	7/01/24-12/31/24	CY 2025	CY 2026	CY 2027
Cash	$2,000,000	$1,609,457	$1,262,730	$1,036,007	$1,445,033	$2,241,499
Accounts Receivable	$0	$0	$80,079	$298,775	$458,007	$570,704
Total Current Assets	**$2,000,000**	**$1,609,457**	**$1,342,810**	**$1,334,782**	**$1,903,040**	**$2,812,203**
Long Term Assets						
Land						
Buildings						
Equipment		$106,700	$106,700	$106,700	$106,700	$106,700
Security Deposit		$3,000	$3,000	$3,000	$3,000	$3,000
Total Long-Term Assets		**$109,700**	**$109,700**	**$109,700**	**$109,700**	**$109,700**
Less Accumulated Depreciation			$6,085	$18,157	$30,228	$42,299
Net Long Term Assets		**$109,700**	**$103,615**	**$91,543**	**$79,472**	**$67,401**
Total Assets	**$2,000,000**	**$1,719,157**	**$1,446,424**	**$1,426,326**	**$1,982,512**	**$2,879,604**
Liabilities and Equity						
Current Liabilities						
Accounts Payable	$0	$172	$10,803	$29,743	$39,727	$47,140
Salaries Payable	$0	$14,902	$47,539	$119,312	$131,209	$148,017
Current Portion of Long-Term Debt	$0	$0	$0	$0	$0	$0
Debt	$0	$0	$0	$0	$0	$0
Total Current Liabilities	**$0**	**$15,074**	**$58,342**	**$149,055**	**$170,936**	**$195,157**
Long Term Debt	$0	$0	$0	$0	$0	$0
Total Liabilities	**$0**	**$15,074**	**$58,342**	**$149,055**	**$170,936**	**$195,157**
Equity	**$2,000,000**	**$1,704,084**	**$1,388,082**	**$1,277,270**	**$1,811,577**	**$2,684,446**
Liabilities Plus Equity	**$2,000,000**	**$1,719,157**	**$1,446,424**	**$1,426,326**	**$1,982,512**	**$2,879,604**

STATEMENT OF CASH FLOWS

	31-Dec-22	1/01/24-6/30/24	7/01/24-12/31/24	CY 2025	CY 2026	CY 2027
Net Income	$0	($295,916)	($315,441)	($109,701)	$535,417	$873,980
Less Depreciation	$0	$0	$5,525	$10,961	$10,961	$10,961
Decrease (Increase) in Accounts Receivable	$0	$0	($80,079)	($218,696)	($159,232)	($112,697)
Increase (Decrease) in Accounts Payable	$0	$15,074	$43,269	$90,713	$21,881	$24,221
Net Cash Flow from Operations	**$0**	**($280,843)**	**($346,727)**	**($226,724)**	**$409,026**	**$796,466**
Purchase of Property, Plant, and Equipment	$0	($106,700)	$0	$0	$0	$0
Security Deposit	$0	($3,000)	$0	$0	$0	$0
Payment of Long-term Debt	$0	$0	$0	$0	$0	$0
Net Cash Flow from Investing	**$0**	**($109,700)**	**$0**	**$0**	**$0**	**$0**
Contribution of Capital	$2,000,000	$0	$0	$0	$0	$0
Beginning Cash	$0	$2,000,000	$1,609,457	$1,262,730	$1,036,007	$1,445,033
Ending Cash	**$2,000,000**	**$1,609,457**	**$1,262,730**	**$1,036,007**	**$1,445,033**	**$2,241,499**

Assumptions appear in the work papers in Exhibit 18.

2. ***Provide the following agreements/contracts:***
   - ***Management agreement***
   - ***Operating agreement***
   - ***Medical Director agreement***
   - ***Joint Venture agreement***

The following agreements and contracts are all valid through at least the first three full years following completion or have a clause with automatic renewals.

- ***Management Services Agreement***

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is a single purpose entity, created to open and operate a hospice program in Pierce County, Washington. It will not have an operating agreement or joint venture agreement. However, Seasons Pierce County shares a common mission, vision and values with the other AccentCare hospice programs and their founders, and will have an Management Services Agreement with its parent entity, AccentCare, Inc.

Through the Services Agreement, Seasons Pierce County start-up and ongoing operations can take advantage of existing back-office operational knowledge and mechanisms that do not need to then be duplicated at the program level. While AccentCare, Inc. does provide certain back-office support services to individual hospice programs, AccentCare, Inc. does not direct or exercise operational control. Seasons Pierce County itself directs, operates, and manages its program, controls hiring and firing of all personnel, and retains authority for the directions and control of assets. This is demonstrated in the Services Agreement, which provides, among other things:

- The parties acknowledge and agree that AccentCare, Inc. as the parent shall have no responsibility for medical judgments and such medical judgments shall remain the responsibility of [Seasons Pierce County's] medical staff (Section 1.2(b)).
- [Seasons Pierce County] shall retain authority and shall exercise control over the business, policies, operation, and assets (Section 1.2(a)).

A copy of the Management Services Agreement appears in **Exhibit 2.**

- ***Medical Director***

Seasons Pierce County will contract with Balakrishnan Natarajan, M.D. to serve as Medical Director for the proposed hospice. Dr. Natarajan is a graduate of Northwestern University Medical School and has been the Chief Medical Officer of Accent Care, formerly Seasons Hospice, since 2005. Board-certified in internal medicine, hospice and palliative care, and sports medicine, Dr. Natarajan has authored book chapters and articles in peer-reviewed journals. He has also lectured across the United States and around the world,

including at the Annual Meeting of the American College of Physicians. Dr. Natarajan currently serves on the board of directors for the National Hospice & Palliative Care Organization.

The Medical Director becomes a contractor of Seasons Pierce County. The terms and conditions for the Medical Director appear in the contract in **Exhibit 19**. Prior to licensure, Dr. Natarajan provides consultation to the planned hospice. This position serves an administrative rule requiring approximately 1 hour of service per week, consistent with the experience of other AccentCare hospice agencies in operation and meets the conditions of participation for Medicare and Medicaid services.

The proposed Medical Director serves a medical administrative role as specified in Exhibit A of the Medical Director Agreement (found in **Exhibit 19** of the application.) Responsibilities include participating in monthly leadership and quality meetings, providing quality oversight and medical expertise, supervising team physicians, establishing relations with the medical community, assist in developing education and research programs, and performing other administrative duties as necessary. Although the proposed Medical Director resides in Illinois, he is licensed in the State of Washington and will direct the program by providing in person site visits and interacting remotely in between site visits.

In addition to the Medical Director Agreement, a sample Physician Independent Contractor Agreement is also provided in **Exhibit 19.** The Medical Director position assumes administration duties, while the Physician Support Team refers to the individual physicians who lead hospice teams in providing direct patient care, e.g., making visits to patients. A Medical Director may also become a Physician Independent Contractor. Please refer to the Medical Director Agreement and sample Physician Independent Contractor Agreement for additional detail. The independent physician contractors who will provide patient care services for Seasons Pierce County have not been identified at this point. Furthermore, **Exhibit 19** includes Dr. Balakrishnan Natarajan's credential verification (MD61027396) for the State of Washington confirming eligibility for these roles.

3. ***Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.***

   If this is an <u>existing</u> hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the projection year. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

If this is a new hospice agency at a new site, documentation of site control includes one of the following:

a. An executed purchase agreement or deed for the site.

b. A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

c. An executed lease agreement for at least three years with options to renew for not less than a total of two years.

d. A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, and includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

The project establishes a new hospice program for Pierce County and therefore does not have a current location. The proposed office site for Seasons Pierce County is identified as follows:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
4301 South Pine Street
Tacoma, Washington 98409

Additional detail about the proposed location appears in the lease provided in **Exhibit 4**. The lease agreement provides an initial location from which to establish the proposed hospice program in the event a Certificate of Need is issued.

4. *Complete the table on the following page with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed in the table, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.*

In the table below only capitalized cost are included, those that furnish and equip the proposed office space. Any sales tax applicable to the equipment is included in that line item. Expenses, such as legal and consulting fees, are not included.

Table 26
Summary of Capital Costs for AccentCare Pierce

Item	Cost
a. Land Purchase	
b. Utilities to Lot Line	
c. Land Improvements	
d. Building Purchase	
e. Residual Value of Replaced Facility	
f. Building Construction	
g. Fixed Equipment (not already included in the construction contract)	
h. Movable Equipment*	$ 106,700
i. Architect and Engineering Fees	
j. Consulting Fees	
k. Site Preparation	
l. Supervision and Inspection of Site	
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	
2. Building	
3. Equipment	
4. Other	
n. Washington Sales Tax	
Total Estimated Capital Expenditure	**$ 106,700**

Includes sales tax

Office furniture, electronics and telecommunication devices comprise capital cost for the project along with the cost of low voltage wiring of the office to support telecommunications. However, telecommunication devices, computers, cell phones, licenses, internet charges are expenses and appear as such in the operating statements. (Detail appears in **Exhibit 18**.)

Unlike a patient treatment facility, Seasons Pierce County's primary location is an office for staff and patient records. Over 98% of the hospice care occurs in the patient's home, including a nursing home or an assisted living facility. The remaining two percent or less may occur in inpatient respite or general inpatient facilities with whom Seasons Pierce County would have contracts and not operate or own directly.

Consumable items, such as office supplies and personal care, such as adult diapers, bandages, gauze, tape, and paper cups fall into the category of expenses. As such, the costs

are written off in the year in which the costs were incurred. Most often, the patient and his or her family provide the disposable supplies.

Medical equipment, such as a hospital bed, also is expensed as the devices are rented for a short period of time when needed, and then returned to the DME provider. For the majority of patients who are elderly and whose care is reimbursed under the Medicare Program, some home care supporting equipment, such as walkers and portable toilets, may already be among the patients' possessions.

Given the home-based nature of hospice care, the majority of costs lie in the category of expenses, incurred in the year in which they are incurred, and therefore, under **Generally Accepted Accounting Principles** are not capital costs.

Seasons Pierce County requires no special or technical equipment unique to the provision of care. Each nurse receives a care kit, which includes but is not limited to a stethoscope, disposable syringes, glucose meter, blood pressure cuff, disposable thermometers, urine sample collection supplies, blood draw supplies, and other supplies. For the project forecast period, a total of $5,340 is allocated for care kits.

5. ***Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide a breakdown of percentages and amounts for each.***

The Applicant has $2 million in assets provided by the owners of Seasons Hospice & Palliative Care of Pierce County Washington, LLC. A letter from the Chief Financial Officer for AccentCare, Inc. (the parent organization of Seasons Hospice & Palliative Care of Pierce County Washington, LLC) and Horizon Acquisition Co., Inc. (found in **Exhibit 20**) commits to available funding for the hospice's capital costs, pre-opening expenses, and operating deficits in the initial year of operation. Included as an exhibit in this application are the audited financial statements for Horizon Acquisition Co., Inc. The hospice has the option of using AccentCare, Inc., for purchasing equipment and furnishing the office in Pierce County. The items above reflect the types of expenditures made in connection with start-up hospice programs. The item costs reflect corporate pricing agreements with the AccentCare, Inc.'s vendors and are inclusive of applicable state and local sales taxes.

6. ***Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.***

Start-up costs and assumptions are detailed in the financial schedules included in **Exhibit 18**. Capital expenditures include furnishing and equipping office space. Pre-opening

expenses include office rent, salaries for staff and their orientation and training, and advertising are identified, and reflect pre-opening expenses of similar projects. Specifically, operations for Seasons Hospice & Palliative Care of Oregon, are used as a proxy. The cash assets allow the Applicant to cover pre-opening costs, costs incurred prior to obtaining Medicare certification, and the projected losses for the initial partial year (July 1, 2024 – December 31, 2024) and first full year of operation (CY 2025). The hospice breaks even in calendar year 2026, showing a profit of $535,417.

7. ***Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide a breakdown of percentages and amounts for each.***

A letter from the Chief Financial Officer for AccentCare, Inc. on behalf of Seasons Hospice & Palliative Care of Pierce County Washington, LLC demonstrates the Applicant entity has $2 million dollars available to fund the hospice's non-capital expenditures prior to opening and initiating service. The CFO's letter is found in **Exhibit 20**.

8. ***Explain how the project would or would not impact costs and charges for healthcare services in the planning area.***

Several studies have demonstrated cost efficiencies and improved quality of life with increased hospice use. One such study, ***Cost Savings Associated with Expanded Hospice Use in Medicare,*** estimates an annual cost savings nationally ranged from $316 million to $2.43 billion, depending upon an increase in hospice duration of either 4 weeks or 24 weeks.[16]

Dr. Ziad Obermyer, an emergency medicine physician and researcher at Brigham & Women's Hospice, sampled 18,000 patients with poor-prognosis cancers enrolled in hospice care before death, and matched them with an equal number of patients who died without hospice care. The average cost of care for patients in the non-hospice group was $71,517, compared to $62,819 for those enrolled in hospice. The median hospice stay was 11 days. Furthermore, 74% of patients in the non-hospice group died in a hospital or nursing home, compared to only 14% of hospice patients. Surveys indicate most American wish to die at home, rather in a healthcare setting. Hospice allows them to do that, thereby improving quality of life in their final days, surrounded by family in a comfortable setting.[17]

The third annual report evaluating the Medicare Care Choices Model indicates that "MCCM led to a 25 percent decrease in total Medicare expenditures, which generated $21.5 million in net savings between January 1, 2016 and September 30, 2019, largely by reducing

[16] Cost Savings Associated with Expanded Hospice Use in Medicare, Brian W. Powers, AB, Maggie Makar, BS, Sachin H. Jain, MD, MBA, David M. Cutler, PhD, and Ziad Obermeyer, MD, MPhil; Journal of Palliative Medicine, Vol. 18, No. 5, 2015.
[17] Hospice Leads to Better Care, Lower Costs at End of Life: JAMA, December 7, 2014, Hospice and Palliative Care, Politics and Law, www.lifemattersmedia.org

inpatient care through increased use of [Medicare Hospice Benefit] by the 3,603 Medicare beneficiaries who enrolled in the model and died during this period."[18]

With approval of Seasons Pierce County, a new service provider is added, increasing the number and diversity of hospice agencies offering different types of services and programs. With greater numbers of hospice agencies and offerings, terminally ill residents are more likely to find a hospice that meets their specific needs and preferences. Physicians and others in the healthcare delivery system are also more likely to refer a patient to hospice when there are a greater number of hospice agencies to educate the medical community and work with them to increase enrollment. Therefore, with increases in hospice enrollment, overall costs for care are lowered in the planning area.

Copies of the above referenced articles are included in **Exhibit 21** in the Appendix.

9. ***Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.***

The project is not expected to impact costs and charges for healthcare services in the planning area. The majority of hospice care is reimbursed by Medicare and Medicaid. Hospice reimbursement and charges are on the basis of patient day and core services. The hospice must meet all the service needs of each patient, and funds received from the per diem rate are used to cover the cost of care, including any contracted services. Therefore, the hospice is responsible for fiduciary activities.

Two caps exist on the hospice program. One cost cap is based on the number of enrolled Medicare beneficiaries. That amount is the absolute dollar limit per Medicare beneficiary that a hospice can receive. The cap works like this: if the hospice's total payments exceed the total payments received calculated as the total number of Medicare patients multiplied by the cost cap, the hospice must repay the difference. **CMS sets the cost cap for the Fiscal Year 2023 at $32,486.92 per beneficiary**.

Under the per beneficiary cap, the hospice receives a per diem rate whether or not the beneficiary receives care so long as the beneficiary remains enrolled. Thus, the daily rate, set for each core service, covers the care the beneficiary receives. The per diem rate must cover all the services specified in the plan of care the hospice provides to each beneficiary. Thus, the hospice is at financial risk should care exceed the per diem rate, furnishing all necessary services.

[18] Evaluation of the Medicare Care Choices Model, Annual Report 3, Contract #HHSM-500-2014-000261/T0005, October 2020, Abt Associates in partnership with Brown University, General Dynamics Information Technology, L&M Policy Research, Oregon Health & Science University, RAND Corporation.

A second cost cap applies to the hospices that limits the use of inpatient care, the costliest core service, to not more than 20% of total annual patient days. Rates to hospices under this cap receive both wage and geographical rate adjustments. Refund for overpayment should the 20% limit be exceeded occurs. ***(Information about cost caps appears in Exhibit 22.)***

For Seasons Pierce County, **Exhibit 18, work papers #2 through #6** provide the relevant information respectively, **patient days by setting and payor, patient charges by service and payor, and net revenues by payor and setting**.

10. ***Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If "other" is a category, define what is included in "other."***

Table 27 below presents the revenues by payer. The information below shows the percentage of gross revenues as well as the percentage of patient days by payor that is consistent throughout the forecast period. This is based on the past experience of similar hospice agencies. Additional detail and assumptions are provided in **Exhibit 18.**

Table 27
Seasons Pierce County's Percentage of Gross Revenue and Patient Days by Payor

Payor	Percent of Gross Revenue	Percent of Patient Days
Medicare & Medicare Managed Care	91.0%	91.0%
Medicaid & Medicaid Managed Care	1.0%	1.0%
Health Options (BHP)	2.0%	2.0%
Charity Care	1.0%	1.0%
Private Pay	1.5%	1.5%
Third Party Insurance	3.0%	3.0%
Other (Champus, VA)	0.5%	0.5%
Total Gross Patient Service Revenues	**100.0%**	**100.0%**

11. ***If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.***

The criterion is not applicable. The project establishes a new hospice agency to serve Pierce County.

12. ***Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.***

The table below provides a detailed list of capital expenditures for the initial office location to start the hospice agency.

Table 28
Detail of Capital Expenditures for Seasons Pierce County

Item	Item Cost	Qty	Total
Conference Table	$4,660	1	$4,660
Conference Chairs	$470	12	$5,640
Employee Desk	$1,600	9	$14,400
Employee Desk Chair	$530	9	$4,770
Guest Chair	$400	9	$3,600
Filing Cabinet	$1,200	5	$6,000
Reception Area Guest Chair	$870	6	$5,220
Reception Area End Table	$270	3	$810
Reception Area Coffee Table	$530	1	$530
Kitchen Table	$670	2	$1,340
Kitchen Chairs	$270	8	$2,160
Patient Care Kit	$890	6	$5,340
Employee Workstations	$890	9	$8,010
Subtotal Furnishings			**$62,480**
Electronics and Telecom			
Server, HPE ProLiant ML 150, G9	$9,900	1	$9,900
Firewall, Fortinet Fort iGate 100D	$3,300	1	$3,300
Network Switch 2xAdtran Netvana 1638p	$3,520	1	$3,520
One-time Low Voltage Wiring Installation	$16,500	1	$16,500
Xerox Work Center	$11,000	1	$11,000
Subtotal Electronics and Telecom			**$44,220**
TOTAL			**$106,700**

The estimates in the table above reflect modest costs for equipping a business office in the Renton area of Pierce County. The annual depreciation expense of $12,071 accounts for $4,877 for furnishings, with items depreciated over a 15-year period, and the care kits' depreciated over a five year period. Depreciation for the electronics and telecommunications equipment cover a five-year period with the low voltage wiring

depreciated on a 10-year basis, for a total of $7,194. The initial investment in office furnishings, electronics, and telecommunication devices in the first year are expected to serve throughout the first three full years, with no additional items required during the forecast period.

The pro forma analysis and utilization forecast establish that these costs do not have a material impact on either the capital or operating costs and charges of the proposed hospice program.

13. ***Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.***

A letter from the Chief Financial Officer for AccentCare, Inc. commits $2 million for Seasons Hospice & Palliative Care of Pierce County Washington, LLC. The CFO's letter found in **Exhibit 20** further provides the 2020 and 2021 audited financial statements for Horizon Acquisitions Co., Inc., and Subsidiaries, which demonstrates that sufficient reserves are available to fund the proposed project.

14. ***If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.***

This criterion is not applicable. The project will not be debt financed.

15. ***Provide the most recent audited financial states for:***
    - ***The applicant, and***
    - ***Any parent entity responsible for financing the project.***

Exhibit 20 contains a letter from the Chief Financial Officer for AccentCare, Inc. (the parent organization of Seasons Hospice & Palliative Care of Pierce County Washington, LLC) and Horizon Acquisition Co., Inc. explaining that Seasons Hospice & Palliative Care of Pierce County Washington, LLC is a new entity without operations or audited financial statements. As such, audited financial statements for Horizon Acquisition Co., Inc. and Subsidiaries for the years ending on December 31, 2021 and 2020 are provided within **Exhibit 20** of this application.

C. Structure and Process (Quality) of Care (WAC 246-310-230)

1. Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.

Seasons Pierce County initiates the hospice program with a core staffing that grows over time as the admissions increase. The proposed hospice staffing will meet or exceed all licensure, Medicare, Medicaid, and accreditation standards. Staffing increases appear in the table below, consistent with the growth in average daily census. Full-Time Equivalents (FTE's) are employees, while contracted positions are shown to demonstrate the level of service provided based on census.

Table 29
FTEs for Seasons Pierce County by Program Year

Department	FTEs First 6 Months	FTEs Year 1	FTEs Year 2	FTEs Year 3
Average Daily Census=	6	18	30	43
Admissions Department	0.0	0.0	0.0	1.0
Business Development-Department	2.0	3.0	3.0	3.0
Business Operations-Leadership	1.0	1.0	1.0	1.0
Chaplain	1.0	1.0	1.0	1.0
Executive Director	1.0	1.0	1.0	1.0
Hospice Aide	1.0	2.0	3.0	4.0
Music Therapy	1.0	1.0	1.0	1.0
Nursing	2.0	3.0	4.0	5.0
Social Work	1.0	1.0	1.0	1.0
Clinical Nutritionist	0.1	0.1	0.1	0.1
Team Assistant	1.0	1.0	1.0	1.0
Team Director	1.0	1.0	1.0	1.0
Volunteer-Department	0.0	1.0	1.0	1.0
Subtotal Employees	12.1	16.1	18.1	21.1
Physician-Leadership (Medical Director)*	0.030	0.030	0.030	0.030
Physician-Team Support*	0.200	0.200	0.200	0.200
Physical Therapy*	0.015	0.015	0.015	0.015
Occupational Therapy*	0.011	0.011	0.011	0.011
Speech Therapist*	0.025	0.025	0.025	0.025
Subtotal Contractors	0.281	0.281	0.281	0.281
Total All Positions	12.4	16.4	18.4	21.4

*Contracted position

Where an FTE is not noted in year 1, other staff assume those responsibilities until census growth occurs to justify an FTE. The Medical Director position assumes

administration duties, while the Physician Support Team refers to the individual physicians who lead hospice teams in providing direct patient care, e.g., making visits to patients. These services are separate and distinct from the medical administrative duties/services provided by the Medical Director. Physicians who provide direct patient care services will contract with Seasons Pierce County pursuant to a Physician Independent Contractor Agreement, a sample of which is found in **Exhibit 19.** The individual physician contracted as the Medical Director could also choose to provide patient care services and if so, he or she would enter into a Physician Independent Contract Agreement and be paid for these services over and above the Medical Director fee. Please refer to the Medical Director Agreement and sample Physician Independent Contractor Agreement in **Exhibit 19** for additional detail.

2. If this application proposes the expansion of an existing agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.

This criterion is not applicable. The application proposes establishment of a new hospice agency, rather than an expansion of an existing agency.

3. Provide the assumptions used to project the number and types of FTEs identified for this project.

Assumptions are provided in Exhibit 18, work papers # 9 and #10.

4. Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projects.

Seasons Pierce County uses a staffing model based on census to ensure coverage of support and care functions at appropriate levels for program needs. A copy of the staffing ratios is provided in Exhibit 18. Seasons Pierce County's staffing ratios reflect similar ratios found among other hospices across the county, including other AccentCare Hospice programs and are consistent with the NHPCO *Staffing Guidelines for Hospice Home Care Teams.*[19] That document also acknowledges the following:

> No one "best standard" in the literature regarding hospice staffing caseloads currently exists. Around the nation, hospices have evolved in various directions, creating diverse models of care to serve hospice patients and families. The Staffing Guidelines for Hospice Home Care Teams is based on the recognition of the current diverse nature of hospice care and allows for individualization of staffing caseloads according to the organizational and environmental characteristics specific to each hospice, in much the same way hospices individualize patient care.

[19] Staffing Guidelines for Hospice Home Care Teams, www.nhpco.org

AccentCare adds staff as admissions increase, as shown in Table 29 above, which lists the type of number and category of staff for the first 3 full years of operation. Ratios vary based upon the numbers of patients in the program, the diseases represented, length of stay, and patients' needs. The ratios above compare favorably with an overall ratio in the third year of operations of 0.42 staff to each patient. In addition, volunteers who provide augmented services increase the patient and hospice interactions and add to the actual FTE spent with patients. The training program for volunteers assures that they are active members of the care team and render services that patients experience at the end of life is compassionate and caring with support for the family.

5. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

Seasons Pierce County will contract with Balakrishnan Natarajan, M.D., a physician board certified in internal medicine, hospice and palliative care, and sports medicine. Dr. Natarajan is a licensed physician and surgeon in several states, including Washington (License #MD61027396). His credential verification from the Washington Department of Health displaying his license number is provided in Exhibit 19 behind the Medical Director Contract.

6. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

The Medical Director has a contract agreement, as shown in Exhibit 19.

7. Identify key staff by name and professional license number, if known. (nurse manager, clinical director, etc.)

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is a developmental stage entity, with no employees and no operations at this time. The Applicant seeks a certificate of need for a hospice program that will result in licensure as a hospice agency for operations to begin.

The officers identified below bring national hospice knowledge and experience to Pierce County. New employees provide knowledge of area needs and insight locally, while management personnel can support, enhance, and equip them for success.

Stephan S. Rogers, Chief Executive Officer

Stephan Rodgers is the Chief Executive Officer of AccentCare®, Inc. He has over 25 years of healthcare experience including home care, insurance, consulting, and employee benefits. Prior to joining AccentCare, Mr. Rodgers was CEO of OptumHealth Collaborative Care, a division of UnitedHealth Group, which owns, manages, and provides administrative and technology services to healthcare delivery systems. Earlier in his career he was a healthcare executive at General Electric Company, responsible for purchasing healthcare benefits. Mr. Rodgers holds a Bachelor of Arts in biochemistry from the University of California, Berkeley.

Ryan Solomon, Chief Financial Officer

Ryan Solomon is Chief Financial Officer of AccentCare®, Inc. He has over 15 years of finance experience. Prior to joining AccentCare, Mr. Solomon was CFO for Apple Leisure Group, a multi-billion-dollar company in the travel industry, after holding several previous finance positions at the company. Previously, he held several senior positions at American Airlines. Mr. Solomon has a Master of Business Administration for Finance from Texas Christian University and a bachelor's degree in economics from Texas A&M University.

Katy Black, Chief of Staff

Katy Black is Chief of Staff for AccentCare®, Inc. She has over 15 years of healthcare experience. Prior to joining AccentCare, Ms. Black was Vice President and Chief of Staff for Tenet Healthcare. Previously, she held senior positions at Concentra, Spectrum Health, and Deloitte Consulting. Ms. Black has a Master of Business Administration from University of Chicago and a Bachelor of Business Administration from the University of Wisconsin-Madison.

Todd Stern, BBA, MBA, CHA, Executive Vice Chairman & CEO of Hospice

Mr. Stern joined Seasons Hospice & Palliative Care in 2001 as the organization's Chief Financial Officer and Managing Principal, and was appointed the Chief Executive Officer in 2005, in 2020 Seasons merged with AccentCare to become one of the nation's largest post-acute providers, and serves as the Executive Vice Chairman and CEO of Hospice. Mr. Stern holds a BBA and MBA from Loyola University Chicago and is a Certified Hospice Administrator. He began his career in healthcare working for medical supply and long-term care companies.

Mr. Stern, a former member of both the National Hospice and Palliative Care Organizations (NHPCO) Public Policy Committee and the Hospice Action Network (HAN) Board, is highly supportive and active within hospice advocacy. With Mr. Stern's support, AccentCare's leaders represent and serve on nearly every NHPCO and HAN committee and both respective boards of directors. Under Mr. Stern's leadership, Seasons Hospice & Palliative Care grew to become one of the leading hospice and end of life care providers in the nation and is now leading one of the largest hospice organizations within AccentCare.

Balu Natarajan, M.D., Chief Medical Officer

Dr. Natarajan is a graduate of Northwestern University Medical School and has been the Chief Medical Officer of Accent Care, formerly Seasons Hospice, since 2005. He served in various capacities for Seasons from 2000 until 2005, including holding the position of Medical Director of the Illinois program.

Board-certified in internal medicine, hospice and palliative care, and sports medicine, Dr. Natarajan has authored book chapters and articles in peer-reviewed journals. He has also lectured across the United States and around the world, including at the Annual Meeting of the American College of Physicians, AAHPM Annual Meeting, and NHPCO MLC, LAC and Clinical Conferences. He won the Scripps Howard National Spelling Bee in 1985.

Dr. Natarajan is certified by The American Board of Internal Medicine in Hospice and Palliative Medicine and also by the

Hospice Medical Director Certification Board HMDCB. He is a NHPCO Board Member, former Member and Vice Chair of Public Policy Committee, and Chair of Palliative Care Council. Dr. Natarajan is a Faculty member for the Online Master of Science and Graduate Certificate in Palliative Care at the University of Maryland and Mentor for the Women in Leadership Program at George Washington University since October 2021. He holds medical credentials in most states in which AccentCare operates, including Florida (License #ME111782).

Russell Hilliard, PhD, LCSW, LCAT, MT-BC, CHRC, CHC

Russell Hilliard is the Senior Vice President of Key Initiatives at AccentCare and the Founder of the Centers for Music Therapy in End of Life Care. In his 25-year hospice career, he has created innovative end of life care programs, devised robust documentation procedures, and assured processes support the highest quality patient and family care. He is a social worker and music therapist and is certified in Healthcare and Healthcare Research Compliance. His scholarly research has been published in a variety of peer-reviewed journals, and he is a sought-after speaker internationally. He is the author of the text, *Hospice and Palliative Care Music Therapy: A Guide to Program Development and Clinical Care*, and has contributed to chapters in several books regarding end of life and bereavement care. At AccentCare, Dr. Hilliard has shaped supportive care programs, created the national ethics committee, led quality and education departments, served as the operations lead for programs in multiple states, and he leads the organization's operational strategies for expansion and development nationally and internationally. As a native Floridian, Dr. Hilliard's passion is promoting hospice care in his home state where he proudly resides.

Chris Dimos, Chief Operating Officer

Chris has over 30 years of healthcare experience, including community pharmacy, non-foods merchandising, and global pharmaceutical supply chain. Before joining AccentCare, he was the President of Retail Solutions at McKesson Corporation, a global healthcare company. Earlier in his career, he was the President of Pharmacy and Non-Foods Merchandising for SUPERVALU Inc., a national food and drug retailer, and was responsible for community pharmacy operations and category management strategies

and execution. Chris holds a Bachelor of Science in Pharmacy and Pharmaceutical Sciences from Purdue University.

Rafael A. Fantauzzi – Chief of Diversity, Equity, and Inclusion

Rafael joined AccentCare in 2021. He develops the infrastructure for culture and inclusion under the Employee Experience function and enhances the Health Equity and Access vision for the company. Rafael is a certified Corporate Citizenship Executive from the Boston College Carroll School of Management and a certified Executive on Corporate Governance by the Harvard Business School and has an executive master's in leadership from the McDonough School of Business at Georgetown University. Rafael was born and raised in Puerto Rico and lives in Pennsylvania with his wife and two daughters. Before joining AccentCare, Rafael was IKEA North America's first Country Equality, Diversity, and Inclusion Officer. He also worked as the President and Chief Executive Officer of the National Puerto Rican Coalition, a national Hispanic nonpartisan, nonprofit civil rights organization.

As an overview of the key positions involved in hospice care, the policy on the interdisciplinary group, policy number HOS 2-003, appears in Exhibit 17. In addition to the patient and family, the interdisciplinary group will consist of individuals who are qualified and competent to practice in the following professional roles (a team member may serve more than one role on the team):

- A doctor of medicine or osteopathy;
- A registered nurse;
- A social worker;
- Music therapist;
- Nutritionist; and,
- A pastoral or other counselor.
- Other healthcare practitioners providing services such as physical therapy, occupational therapy, speech therapy, dietary counseling, hospice aide services or other services may be included in the team when appropriate.

Some hospices consider music therapy and dieticians as ancillary services, but AccentCare identifies them as core team members; they are included in the interdisciplinary group.

Clinical Supervision Plan, **Exhibit 17**, further explains how important it is for the patient's attending physician to participate or his or her nurse practitioner, to assure coordination for care.

Plan of Care, policy HOS 2-030, Exhibit 17, also provides additional information as to how the interdisciplinary team functions to address the patient's needs and scope of care.

8. For existing agencies, provide names and professional license numbers for current credentialed staff.

This criterion is not application. The project establishes a new hospice program rather than an expansion of an existing agency.

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

Pierce County was designated as a Medically Underserved Area for Primary Care in 1982 and again updated in 1994 with a Medical Underservice Index Score of 61.2, just below the threshold of 62.0. It has three designated geographic Health Professional Shortage Areas (HPSAs), including Buckley, Eatonville/Roy, and Longbranch. Two primary care community health clinics with multiple locations, and two Indian Health Service/Tribal Health/Urban Indian Health Organizations also qualify as HPSA. The three geographic HPSA's 2021 population of 43,582 account for less than 5% of the county's 920,730 total population. (Reports generated from the Health Resources & Services Administration at www.data.hrsa.gov documenting the Pierce County MUA and HPSA are provided in Exhibit 23.) Seasons Pierce County will provide outreach and education to the community-based organizations throughout the entire county, including inner city communities that have limited access to healthcare.

A 2017 report from the Health Resources and Services Administration, Supply and Demand Projections of the Nursing Workforce: 2014-2030 indicates that while Washington has an adequate supply of Registered Nurses, Licensed Practical Nurses have a deficit of 27.3% of those needed by 2030. A copy of that report is included in Exhibit 23. Further evidence on the need for finding appropriate clinical placements for nursing students is addressed in a news article published by the South Sound Business, *The Nurse-Case Scenario.* (See the excerpt below and the full article in Exhibit 23.)

"Finding clinical placements is extremely difficult," said Babbo at Olympic College.

According to Giglio, MultiCare can host only roughly 500 aspiring registered nurses in clinical settings annually, and has to turn applicants away. MultiCare would take on more students, but the company needs to balance the training of students, the training of newly hired nursing school graduates, and the workloads of experienced nurses who already are caring for patients.

"I know that our neighbors (CHI Franciscan Health) down the street do their part, as well," said Giglio. "We are part of a consortium of schools and other healthcare employers who work together to share the load in providing quality clinical experiences for the students. We train hundreds of nursing students, and still there's an unmet demand."

An article taken from the National Center for Biotechnology Information (NCBI) Bookshelf discussing the nursing shortage cites the aging population, an aging work force, and nurse burnout as some of the major issues concerning the future of the nursing profession (Exhibit 23). Another barrier is the impact of the COVID-19 pandemic on the workforce. Frontline workers are not only exposed to greater mortality and morbidity from the threat of this infectious disease, they are experiencing both physical and mental fatigue. The Fall 2021 issue of *The Washington Nurse Magazine* – the official publication of the Washington State Nurses Association – published an article discussing burnout associated with the pandemic as well as post-traumatic stress disorder contributing to the "exodus" of nurses. In the wake of the COVID-19 pandemic, health care providers need to be responsive to the changing needs, advisories, and requirements moving forward. The article from *The Washington Nurse* further places emphasis on investing in nursing education as a solution to shortage (the full article can be found in Exhibit 24).

Seasons Pierce County has the resources to meet these challenging times. Empowering staff with training, equipment, and having open channels of communication with management, ensures they have the resources needed to focus on their job without fear.

Continuing education includes recent courses on topics relevant to dealing with COVID-19. Exhibit 25 includes a list of current educational offerings, including, but not limited to the following topics identified below, plus a sampling of course descriptions, to document available training resources, not only to Seasons Pierce County staff, but others in the healthcare industry.

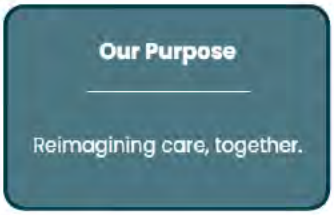
- Strategies to Feel Empowered Amidst Moral Distress
- The Clinical Path of COVID-19
- Advanced Directives & Cultural Consideration

- How Healthcare Workers Can Still Create Connections in Time of Social Distancing
- This is Hard! My Facility is in Lockdown and I'm Struggling
- COVID-19 & PTSD: Preserving Self-Care While Managing Symptoms of PTSD During Patient Care

As testament to the model of care for delivering quality hospice services in the current environment, AccentCare was able to start a new hospice agency during the COVID-19 pandemic in 2020 – in Pasco County, Florida. The hospice census by month is provided in the graph below demonstrating the ability to meet or exceed projections.

Figure 7: AccentCare of Pasco County Growth in Hospice Census April 2020 through December 2022

❖ Recruitment and Retention Practices



There are many techniques for recruiting employees. Success in recruitment results from position descriptions that specify the experience, education, and training each job requires. The internet creates new avenues for recruiting employees and showcasing the facility through information, photographs, and videos. The internet enables quick review of position descriptions, vacancy posts, and frequently asked questions (FAQs), and allows for submitting and receiving online employment applications. Other avenues of recruitment include:

- AccentCare website, www.accentcare.com select "Find a Job" from the main page
- National job search sites (Indeed.com, Monster.com, etc.)
- Professional publications that maintain lists of job-seekers or that allow recruiting advertisements
- Vocational, professional technical school resource offices
- Job fairs
- Social media postings
- Arrangements with local colleges and universities that serve as a training site

Seasons Pierce County recognizes the national nursing shortage and will take proactive steps to ensure there are well-qualified nurses in its program. Word of mouth from the existing workforce reaps benefits. Internal recruiting opens avenues with the local population, and vacancies may be filled more quickly when employees encourage friends or acquaintances to apply for open jobs. An employee referral campaign will leverage the networks of existing AccentCare and Seasons employees nationwide and offer sign-on bonus to employees who refer a successful new hire to Seasons Pierce County.

Seasons Pierce County will also utilize O'Grady Payton International and MedProInternational to recruit foreign-trained, high quality workforce members. These well-established organizations facilitate a mutually beneficial relationship between foreign-educated healthcare professionals and healthcare organizations recruiting additional staff. Recruiting through these organizations also allows Seasons Pierce County to establish a team of professionals who reflect the increasingly diverse population in Washington.

Existing AccentCare hospice programs share vacancy announcements, allowing employees to consider advancement or a relocation. Keeping employees within the larger family retains the workforce and accommodates changes when a relocation may be necessary. Likewise, sharing information among offices allows for movement within to meet career goals or promotions.

Professional websites and periodicals that provide job postings attract professionals. Within the communities, the office reaches out to colleges, universities, and other social and health care providers through networking. Oftentimes, collaborative efforts to recruit qualified personnel occur together, particularly when part-time workers respond to job-postings. Hiring part-time qualified persons opens the door to full-time.

Aware of the skill levels and talents prospective employees offer, human resource personnel conduct interviews that provide the opportunity to learn what a prospective employee seeks in a working environment, and what their goals and advancement objectives, and work ethic are. By understanding what employees look for in an employer, AccentCare can develop workplaces that support the employees and give them reasons to stay with the company.

Seasons Pierce County follows an inclusive employment policy. That policy assures equal employment opportunities to all people without regard to race, religion, marital status, color, creed, gender, sexual orientation, pregnancy, childbirth, age, disability, or national origin, or status. Seasons Pierce County policy on Equal Opportunity Employment, policy HR-4, appears in Exhibit 17.

Once a person is hired, AccentCare focuses on employee retention. Retaining a trained workforce is a top priority since costs of replacing and training employees in the long-term care setting are high. Turnover disrupts caregiving and increases anxiety among residents and their families. AccentCare's education programs and shared objectives create a culture of care and compassion. Employees strive for excellence that exceeds standards of care.

Each program's executive director determines how to grant leave on holidays and how to cover patient care assuring sufficient staff. One option staggers the paid holiday

time for employees over the same pay period. Typical holidays that require staffing include those in the list below.

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving Day
- Christmas Day
- Floating Holiday

AccentCare offers a competitive benefits program reflecting commitment to employees. Benefits include these items:

- Medical & Dental Plan
- Vision Care Plan
- Dependent Care
- Medical Flexible Spending Accounts
- Life Insurance
- Disability Benefits
- Retirement Savings Program
- Paid Time Off and Holidays

Additional benefits include those listed below.

- Eligible employees to accrue paid time off during the employment year in a Paid Time Off (PTO) bank.
- A bonus Mental Health Day each quarter to eligible employees based on their attendance during the previous quarter.
- Full-time regular employees are eligible to receive differential pay if they are required to participate in active military duty for training.
- AccentCare Hospice employees are encouraged to fulfill their civic responsibilities and duties, such as voting or jury duty and are compensated for their time in these activities.

❖ Training and Education

Seasons Pierce County provides in-service training and staff development programs for employees that are appropriate to their responsibilities and to the maintenance of skills necessary to care for patients and families. All newly hired employees undergo an orientation period for the first 90 days of employment. Orientation includes a review of policies, procedures, philosophy, objectives, goals, job orientation emphasizing allowable duties of the new employee, safety and appropriate interactions with patients and families. A focus on company culture is emphasized with the mission and vision and values (see below) driving end of life experiences for each patient and family.

Exhibit 17 includes policies that explain the content of the orientation period (policy HR-11), training/in-service education, (policy HOS 3-012), and privacy and security training (policy C 4.3). In addition to these policies, additional ones show the extent of training available to employees. The tuition assistance (policy HR-46) shows how employees' skill sets advance.

With Washington State's Death with Dignity Act, Seasons Pierce County will also provide in-service training on the responsibilities of hospice workers under the law and per AccentCare policy pertaining to hospice aide plan of care (policy HOS 2-005) and physician aid in dying (policy C 2.2), as shown in Exhibit 7. The policy outlines the roles and responsibilities of hospice staff when a patient requests aid in dying. Exhibit 17 also includes sample materials on Patient & Family Education that explain the importance of educating the patient and family about his or her condition, as well as the program of care available and the assistance the hospice provides.

The hospice employs an e-learning approach with different modules for employees' general orientation along with the orientation required for hospice aides, nurses and supportive care providers. A comprehensive training program is provided for volunteers, using e-learning modules, virtual classrooms, bedside experiences, office orientation, and reading materials.

The education program ensures on-going quality of care and employee engagement. As part of that process, professional videos in e-learning modules show actual patient care to teach new staff their roles in creating perfect end of life experiences. Additionally, a series of virtual classrooms led by national experts including board-certified palliative care physicians, teach disease-specific end of life care.

Below are a few examples of the interactive, searchable, and hyperlinked training resources available to field staff.

- RN Case Manager Training Manual: https://issuu.com/seasons-hospice/docs/rncm_v2
- Supportive Care Training Manual for Social Workers, Music Therapists, and Chaplains: https://issuu.com/seasons-hospice/docs/sc-manual
- IPC RN Training Manual: https://issuu.com/seasons-hospice/docs/ipc_rn

The links below are examples of weekly "Risky Business" short burst learning segments that are targeted by job title.

- Patient's Rights: https://vimeo.com/368110584/f507ff8832
- GIP: https://vimeo.com/328285208/c0c86c4c3a
- Copy & Paste: https://vimeo.com/329673476/4ef1f5cbd1
- Documentation of Eligibility: https://vimeo.com/347929460/88ba8413bb

Policies supporting training and education are provided in Exhibit 17.

Seasons Pierce County supports development of new talent, actively engaging the education community, providing internship opportunities and training initiatives. Continuing educational opportunities are available to both employees and the medical

community. Through these initiatives, Seasons Pierce County is able to build a strong workforce.

Seasons Pierce County will work with area colleges and universities to establish internship opportunities. Following are activities that the hospice will utilize to engage the educational and medical communities.

- Internship programs support the next generation of hospice workers. Through internship experiences, many students go on to careers in hospice, increasing the size of the available workforce.

- Continuing Education Units (CEU) offerings improve staff confidence and performance. AccentCare also plans to offer CEU credits to local nurses and social workers not affiliated with the hospice so they may benefit from the programs.

- Compassionate Allies Program offers nursing and pre-medical students experience in working with terminally ill patients. This allows them to gain insight in the benefits of palliative care so that once in medical practice, appropriate referrals will be made to hospice at the right time to maximize comfort and care for the terminally ill patient.

Policies supporting training and education are provided in Exhibit 17. A sample Continuing Education Announcement is provided in Exhibit 25.

❖ Research and Advancements in Hospice Care

Seasons Pierce County supports a variety of research efforts in end-of-life care by partnering with local and state colleges and universities to support masters' theses, doctoral dissertations, and faculty-led research initiatives through a National Research Committee available through AccentCare, Inc. Through these efforts, advancements in care can be examined and then implemented for continuous quality improvement. The list below is a sample of research projects from 2016 to 2018, along with the affiliated research organization, for which an AccentCare hospice program has served as a participant.

- Dr. Lynn McPherson at the University of Maryland:
  1. An evaluation of nonprescription medications used in a hospice population
  2. The use of antiplatelets and anticoagulants in a hospice population
  3. The use of medications by pediatric hospice patients
  4. The use of medications by ALS patients in hospice
  5. The use of drugs by Parkinson's patients in hospice
  6. Characterization of diabetes medications in hospice care
  7. Knowledge, Skill, and Attitudes Regarding the Use of Medical Cannabis in the Hospice Population: An Educational Intervention
- Aykiya McQueen, University of Miami:

Music Therapy with Immigrants from Spanish Speaking Countries: A Survey of Families' Perspectives and Experiences of Music Therapy for their Loved Ones Receiving Hospice Care

- Jennifer J. Borgwardt, MT-BC; Temple University:
  Accompanying the dying: A phenomenological investigation of the music therapy process during compassionate vent weaning
- Mary Kraft, Indiana University:
  Enhancing Family Communication with Children Utilizing Legacy Art and Discussion When a Loved One is Near the End of life: Survey of Parental Satisfaction Responses to Interventions

Familiarity exists with the region with the affiliate Seasons Hospice & Palliative Care of Oregon, LLC having a program as well as an inpatient contract at the Oregon Health and Science University Hospital. Seasons Pierce County intends to interact with and develop local agreements with area universities and schools and leverage existing national contracts to provide internships in Pierce County as a condition of the CN.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

Seasons Pierce County's hours of operation are 24 hours a day, seven days a week. The administrative office will be open Monday-Friday 8:30-5:00 p.m. with the clinical team working and available 24 hours a day, seven days a week. A call center and clinical team respond to patient/family and referral source needs 24 hours a day, seven days a week, year-round, even during times of administrative office closings due to inclement weather or emergencies.

Exhibit 17 includes policy number HOS 2-024, Admission Process, of which the purpose is *to establish standards and a process by which a patient can be evaluated and accepted for admission within 24 hours of the inquiry unless the patient, family, referral source or physician/provider requests a later date.*

11. For existing agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the hospice agency.

Although this criterion is not applicable, as the Applicant is not an existing agency, the proposed Seasons Pierce County agency will have a method for assessing customer satisfaction and quality improvement.

The Centers for Medicare and Medicaid Services (CMS) mandates that all hospices measure quality through the use of the Hospice Item Set (HIS) quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, with both methods linked to specific National Quality Forum endorsed measures of quality. Both

components of the Hospice Quality Reporting Program allow individual hospices to compare their results to the national benchmark for the measure. Seasons Pierce County also plans to use the CHECKSTER Pulse survey for employee satisfaction. A copy of the CHECKSTER survey appears in Exhibit 26. Exhibit 17 contains applicable policies that Seasons Pierce County will implement to assure quality assessment and program improvement:

- Quality Assessment & Performance Improvement, policy HOS 4-004
- Sentinel Events, policy C 2.7.9
- Performance Improvement Program and Annual Agency Evaluation, policy C 4.2

Seasons Pierce County will review all policies on an annual basis and conforms the policies to location-specific requirements.

In addition to the local sites performing their own Performance Improvement Projects, AccentCare, Inc. provides a National Workgroup of quality experts to help the organization find root causes to problems impacting quality, find creative solutions, and make changes nationally that directly improve the quality of care for patients and families. By performing National Performance Improvement Projects, the sites are able to double their quality focus - one at the local level and the other at the national level impacting the local program. This attention to quality led by quality experts has resulted in reducing survey deficiencies, improved quality outcomes, and greater patient and staff satisfaction.

12. For existing agencies, provide a listing of ancillary and support service vendors already in place.

This criterion is not applicable, as the Applicant is not an existing agency.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

This criterion is not applicable, as the Applicant is not an existing agency and has no existing ancillary or support agreements.

14. For new agencies, provide a listing of ancillary and support services that will be established.

Exhibit 17 includes three policies that describe how ancillary and support services function with the care team.

- Standards of Practice, policy C 1.4
- Contracted Services, policy C 3.2
- Financial Management, policy C 3.3.5

Seasons Pierce County uses employees to deliver services, and contract personnel to supplement the skills that may not be routinely available among the employees when the plan of care requires such services. Most often, these contract services include physical, respiratory, speech, and occupational therapists. A patient may also require acupuncture, massage, or other palliative treatments for which a licensed professional is required.

Because ancillary personnel serve under contracts, they augment the plan of care by adding some additional services specified in the plan of care. At all times, AccentCare employees are in control of the delivery of care, and retain control, thus assuring that the contracted personnel can meet the service demand. Contract employees are also discussed in previously mentioned policies, appearing in Exhibit 17.

Some hospices consider music therapy and dieticians as ancillary services, but AccentCare identifies them as core team members; they are included in the interdisciplinary group.

15. For existing agencies, provide a listing of healthcare facilities with which the hospice agency has working relationships.

This criterion is not applicable, as the Applicant is not an existing agency.

16. Clarify whether any of the existing working relationships would change as a result of this project.

This criterion is not applicable, as the Applicant is not an existing agency and therefore has no existing working relationships with healthcare facilities in Pierce County.

17. For a new agency, provide a listing of healthcare facilities with which the hospice agency would establish working relationships.

Active in the community, Seasons Pierce County's educational, promotional, and outreach efforts intersect with facilities, advocacy groups, religious institutions, service providers, physicians, social workers, funeral directors, and insurers (including HMOs). Working relationships often occur from the following groups:

- Nursing homes
- Hospitals
- Assisted Living Facilities
- Health Maintenance Organizations
- Physicians
- Dialysis Centers
- Social Workers
- Home Health Organizations
- Churches
- Funeral Directors
- Social Services Organizations
- Families
- Individuals

In order to assure access and availability of general inpatient care close to the patients' homes, AccentCare proposes contractual agreements with nursing homes and hospitals throughout Pierce County. Lists of facilities that AccentCare will reach out to for establishing contracts are included in Exhibit 30. As a new hospice, Seasons Pierce County will work toward establishing relationships with these and other health care facilities and practitioners throughout the service area. Letters of support will be provided during the public comment period identifying individuals and facilities with which the Applicant will establish working relationships.

18. Identify whether any facility or practitioner associated with the application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    (a) A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or
    (b) A revocation of a license to operate a healthcare facility; or
    (c) A revocation of a license to practice a health profession; or
    (d) Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC has no history. The entity is a newly created limited liability company formed for the purpose of obtaining a certificate of need for a hospice entity that will operate in the state, serving residents of Pierce County. No healthcare agency nor any principle or officer affiliated with the Applicant have had any denials or revocations of licenses nor criminal convictions.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

The application requires a certificate of need in order to implement a hospice program. Persons who receive a physician-determined terminal prognosis may qualify for hospice for end of life care. Some individuals also may elect home health agency care.

Under the hospice benefit and program of care, the hospice's interdisciplinary team coordinates a range of palliative care and provides patient and family support for end of life care. The patient's attending physician participates with the hospice medical director and the interdisciplinary team, of which the patient and family belong, to identify the services that will maintain comfort for the patient based on his or her terminal diagnosis.

Seasons Pierce County's plan for general inpatient care requires contracts with nursing homes to serve as the short-term placement of the patient to stabilize the patient and control symptoms, including medicinal management, so that the patient attains a level of comfort and returns home. Nursing homes also provide the family with respite care, caring for the patient for a brief stay, so that the family caregiver has a break from daily care of the patient. A sample copy of a nursing facility services agreement is found as Exhibit 6.

Seasons Pierce County intends to work with nursing homes and assisted living facilities that are residences of patients enrolled in the hospice program. These facility residences also have staff that provide services to those who reside within them. Seasons Pierce County's training program for nursing home and assisted living facilities' employees explains the roles and responsibilities, the accountability for care, and defines the roles of the facility staff and that of the hospice staff. The result in cooperation and avoidance of duplication while ensuring care for the hospice patients.

In the proposal, another specialty population subgroup is the homeless. Seasons Pierce County's commitment to this group requires cooperation and coordination with agencies and advocates that serve the homeless, as well as hospitals and emergency departments that also may encounter the homeless. Promotional materials and direct outreach to hospitals, fire departments, police departments and advocacy groups about the program acts as a coordination hub for assuring that homeless persons do not die alone. The homeless program provides housing vouchers and other means to provide a qualifying home with caregiver so that hospice services can be provided to them.

Seasons Pierce County's Inclusive Initiative develops diversity councils to identify impediments for those groups to hospice services, and to create pathways to remove them. Volunteers with hospice employees staffing the councils work cooperatively within and across the broader communities within the county to provide appropriate and sensitive materials that address those identified factors that can be overcome. Ways of outreach, such as community meetings, church visits, special programs, revised or newly developed educational materials, expand how minority groups can reach out to hospice. One important lesson learned from other states is to diversify the workforce so that the workforce's diversity reflects the broader community's makeup.

Hospitals are often the place where case identification occurs for end-of-life prognosis. The hospice social workers share information with hospital discharge planners and patient advocates about the program and services and explain that Seasons Pierce County's staff will make assessment visits 24 hours a day, seven days a week. The ability to interact with the patient and family and provide assessments with care and compassion relieves the hospital of longer stays.

Seasons Pierce County targets community physicians to provide CEUs and other information about hospice, informing them of the benefits the hospice provides and the services. Information regarding how to open communication about palliative care and end of life care equips the community physicians with the material to engage in productive communication with the patient and family. Seasons Pierce County's assessment team or other personnel offer the community physicians to pursue palliative care discussions and planning for end-of-life care.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

AccentCare, Inc. personnel assist in implementation of all new hospice programs. Experience within different states and with the federal program requirements provide the Applicant with the ability to implement the project as scheduled. Most hospice patients are elderly, and while many die from cancer, heart disease, and stroke—the nation's top three causes of death, others are elderly and have reached the end of life.

Many frail, elderly of advanced age are entering end stages of life. This fact is often overlooked, and leads many to assume that hospice care is not appropriate. However, upon careful inspection of medical records, many persons of advanced age and frailty are in fact, terminal, with respiratory and cardiac conditions for which no more curative options are available. The education of physicians and outreach efforts to facilities establish working relationships that produce appropriate referrals to hospice.

Oftentimes, hospice is called in as an "intervention". The looming death of a person becomes an event that was somehow not foreseen. Seasons Pierce County will offer more outreach and education, more hope for well-directed care, within the service area, to timely hospice care.

Seasons Pierce County engages the health care system by becoming a partner in care, working with a patient's primary care physician and the staff of the assisted living or nursing home in which the patient resides. This partnership requires that the hospice provide support to the staff through education and accountability, clearly stated expectations, and defined services. Specifically, the enrollment of elders in nursing homes and assisted living facilities requires the employees possess the skills to augment the facilities' staff with that of the hospice care team, and together, enhance rather than duplicate services at end of life.

Seasons Pierce County's Partners in Care program (discussed previously) makes available education and training for the personnel within the facilities. The purpose sets expectations, assigns responsibility and accountability, provides active liaison with the

hospice care team, and establishes respect of the facilities' caregivers. Both the facility staff and that of the care team adopt the same care plan and goals for the resident, and the care team relies upon the facility staff to advise, confirm, acknowledge and share information about the resident and his or her family's wishes. Therefore, continuity of care exists, improving quality of care for residents, and increasing future hospice referrals from long term care provider.

21. The department will complete a quality-of-care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.

The CMS Hospice Quality Reporting Program Hospice Item Set (HIS) quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for hospice programs allow individual hospices to compare their results to the national benchmark for the measure. Although the Applicant entity, Seasons Hospice & Palliative Care of Pierce County Washington, LLC is a new legal entity that will hold its own license and operate independently from other healthcare agencies of the owner entity, a quality review of all AccentCare, Inc. healthcare agencies for 2019-2021 did not disclose any patterns of conditional-level findings. As noted previously, a list of all facilities affiliated with AccentCare, Inc. is provided in Exhibit 3. Agencies that were acquired by AccentCare, Inc. during this timeframe are also identified by date in Exhibit 3.

Licensing and accreditation surveys for 2020-2022 reveal adherence to quality standards and timely implementation of corrective action plans followed by satisfactory compliance survey when necessary. One AccentCare hospice agency received condition-level citations in 2020, followed by three agencies receiving condition-level findings in 2021 and in 2022. Although the results do not rise to the level of a pattern of condition-level findings, for transparency, copies of the surveys are provided in Exhibit 27.

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.

The quality review noted in response to Question 21, above, did not disclose any pattern of conditional-level findings that would jeopardize the delivery of safe and adequate care. In 2021, AccentCare invested in changing the electronic medical record (EMR) platform to a new system to prevent documentation inconsistencies and better reflect the high-quality care clinicians routinely provide.

D. Cost Containment (WAC 246-310-240)

1. ***Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.***

Seasons Pierce County is responding to the Department of Health's October 2022 methodology documenting a need for an additional hospice agency to serve residents of Pierce County. Any alternative that does not include adding a program in Pierce County does not address the unmet need identified by the Department of Health.

Regardless of need, the only alternative in a state that requires CN is to acquire an existing hospice agency or enter a joint venture with one. However, no opportunities to purchase, or joint venture with, an existing agency have been identified.

The alternatives rejected by Seasons Pierce County include:

- **Maintain the status quo and do nothing.** This fails to address the hospice needs within Pierce County and does nothing to contain health care costs.
- **Purchase an existing hospice agency.** This alternative is unavailable. Seasons Pierce County has not been able to identify any Pierce County Hospice Agencies for sale.
- **Joint Venture with an existing health care provider.** This alternative is unavailable. Seasons Pierce County has not been able to identify any Pierce County Hospice Agencies willing to enter a Joint Venture to expand hospice care.

Establishing new hospice agencies in areas where they are needed most, such as Pierce County, Washington, the principals of AccentCare Hospice & Palliative Care are able to continue the mission of honoring life and offering hope to the terminally ill and their families. As business opportunities increase, so do the benefits the companies offer to the communities they serve. The alternative of not pursuing this project results in lack of choice in hospice providers and diminished access to hospice care within Pierce County.

2. ***Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.***

As stated above, no viable alternatives exist for establishing a new hospice program within Pierce County, given the announcement of need. There is no hospice currently serving Pierce County that is available for purchase or to enter a joint venture with, and not

applying for a CN to establish a new hospice limits patient access to hospice in an area with documented need.

Patient Access. As the methodology in use by the Department of Health demonstrates, the current capacity of hospices serving the market is 4,156, lower than the forecast of 4,406 by CY 2024. The import of the methodology shows that without program expansion, existing providers' program growth lags the future forecast, limiting patient access. Approval of a new hospice program spurs market growth through innovations and new services, thereby improving access and quality of care. **Maintaining the status quo does nothing to improve access. Likewise, expansion of hospice service either through acquisition of an existing hospice or through a joint venture is unavailable.**

As discussed previously, racial, and ethnic disparities in accessing hospice care are seen in Pierce County. Seasons Pierce County believes it can overcome many of the cultural barriers through its proposed outreach efforts, diversity in staffing, and programs developed to overcome such racial and ethnic barriers. This is based on the experience of AccentCare Hospice affiliates throughout a diverse range of communities across the nation. Furthermore, a recent article, *Closing the Gap in Hospice Utilization for the Minority Medicare Population*, concludes that "*the prevalence of for-profit hospices was associated with significantly increased hospice utilization among racial/ethnic minorities.*"[20] The article provides evidence that while racial and ethnic disparities in hospice care exist, for-profit hospices enroll more minorities, which in turn leads to increased access and overall lower healthcare costs. A copy of this article is found in **Exhibit 13**. **Therefore, with establishment of a new hospice under Seasons Pierce County, access to hospice care improves.**

Capital Cost. Capital costs are minimal to establish a new hospice agency. Since care is provided at the patient's location - in the home, assisted living facility, nursing home, or hospital, the only capital costs are to furnish and equip a base office for employees. Therefore, capital costs have little impact on the project. Capital costs are addressed in **Section III.B., *Financial Feasibility*,** and in the Pro Forma provided in **Exhibit 18**.

Capital cost outlays are small relative to establishment of a new healthcare facility, as the service for hospice care is delivered in home. Seasons Pierce County's hospice agency is funded with $2 million in cash to furnish and equip office space and fund initial operating deficits during the start-up period. The program reaches a breakeven point during the second full year of operations, CY 2026. Moreover, as indicated in the above referenced article, increasing access to minorities, an under-served population, lowers Medicare costs, with an average savings of approximately $2,105 per Medicare hospice enrollee. **Overall, this leads to improved access and quality of life while producing a cost savings. Maintaining the status quo limits access to hospice and does nothing to lower healthcare costs.**

[20] Closing the Gap in Hospice Utilization for the Minority Medicare Population, M. Courtney Hughes, PhD, MS and Erin Vernon, PhD, MA; Gerontology & Geriatric Medicine, Vol. 5: 1-8, 2019

Staffing. The Applicant is able to staff the project with minimal impact to the service area as discussed in ***Section C, Structure and Process (Quality) of Care, Question #9***. The parent corporation's vast experience in operating hospice agencies, including starting new facilities, demonstrates its ability to operate quality, efficient programs in a variety of markets.

Furthermore, Seasons Pierce County addresses staffing issues in ***Section C, Structure and Process (Quality) of Care, Question #9,*** and is not repeated here. Recruitment and retention efforts, along with education and outreach efforts ensure a strong workforce result with establishment of Seasons Pierce County. This improves operating efficiencies throughout the healthcare system. **Therefore, the impact on staffing is positive as development opportunities increase for the healthcare workforce. Without the project, staffing issues continue.**

Quality Improvement. Hospice care reflects a highly personalized and specialty managed regimen of services. End of life care requires personal interactions among medical and nursing professionals, the patient, the family, significant others, and volunteers aligned to meet the last wishes of the patient for a painless experience during the process of dying. Sensitivity, compassion, attention to detail, managing emotions and reactions, and producing comfort form a hallmark of hospice care. Adherence to state licensing regulations, maintaining accreditation, and participation in the Medicare and Medicaid programs ensure quality. **Through choice of a wide variety of hospice programs with various services and offerings, many tailored to the needs of the community, quality improves for the population served.**

Overall, Seasons Pierce County's proposed hospice program is consistent with the Department's need methodology, assures residents of Pierce County with ongoing access to quality hospice services, and improves job opportunities for nursing and social services. The hospice promotes cost containment within the healthcare delivery system for Pierce County. The opportunity to expand hospice service through acquisition or joint venture is unavailable, and maintaining the status quo limits availability, access and does not contain health care costs.

3. ***If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):***
   - ***The costs, scope, and methods of construction and energy conservation are reasonable; and***
   - ***The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.***

This criterion is not applicable. The proposal does not involve construction of a health care facility.

4. ***Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.***

Increasing availability and access to hospice care through the introduction of a new hospice agency or agencies within the planning area has a positive effect on cost containment. As the majority of hospice care is reimbursed by Medicare and Medicaid, charges are limited by the reimbursement rates and program limits. As discussed previously in response to **Section B, *Financial Feasibility*, Question #8**, cost efficiencies and improved quality of life are demonstrated with increased hospice use. The cited articles documenting cost containment and quality assurance appear in **Exhibit 21** in the Appendix.

The numerous programs and services of Seasons Pierce County described in detail in ***Section II, Project Description,*** and in response to ***Question #7,*** demonstrate the innovative ways in the delivery of hospice service. The Applicant's commitment to seeking CHAP or Joint Commission accreditation and adherence to conditions of participation in the Medicare and Medicaid programs demonstrate the program's ability to deliver quality care. Therefore, quality, choice, and cost-effective care results with approval of Seasons Pierce County. The new hospice agency will increase the number of hospice enrollments and provide a diverse array of services to improve quality of life for terminally ill residents of Pierce County.

IV. HOSPICE AGENCY SUPERIORITY

Superiority Criteria WAC 246-310-290(11)

(11) To conduct the superiority evaluation to determine which competing applications to approve, the department will use only the criteria and measures in this section to compare two or more applications to each other.

(a) The following measures must be used when comparing two or more applications to each other:

(i) Improved service to the planning area;

Service improvement can be measured on a qualitative basis, such as improving customer service or quality, or quantitative basis, such as increasing the number served, length of service, or types of service. While publicly available quality data, such as the national quality measures that utilize the Hospice Item Set (HIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey are addressed in subsection (v) below, quantitative service improvements, or ways to increase hospice service and utilization, are explored here.

As a national leader in post-acute care, AccentCare has the resources to expand hospice service in Pierce County. Having the ability to bring key personnel together to open the program ensures success. Management's experience with hospice implementation covers multiple states, some of which have differing requirements. As mentioned previously, AccentCare Hospice affiliates were able to start new hospice agencies during the COVID-19 pandemic, with the Pasco County, Florida agency exceeding its first year projections despite limitations.

As a new provider in Pierce County, AccentCare's representatives visit the county for the purpose of meeting people, understanding the county and its operations, reviewing health care providers, and talking with both citizens and professionals. Information gleaned from the assessment provides the basis for tailoring hospice services for each community, avoiding a "one size fits all" approach to community care. AccentCare's visits to Pierce County results in understanding preferences and needs as expressed by residents and professionals within the county so that the hospice can fill gaps in service. For instance, AccentCare recognizes the difficulty residents face when exploring the state's Death with Dignity laws and can improve access and service to this patient population drawing from experience of affiliates in other states having similar laws.

Employees understand that patients lie within the center from which they direct choices in their care. Likewise, management and administration place employees at the center of care delivery system vesting in them the trust to meet each person's needs. Recruitment and retention play important roles in what becomes the force behind each service a patient receives.

The application showcases the following components that will improve service to Pierce County.

- **Expertise in successful opening and operating hospice across the nation with strong financial backing.**

- **Expertise in implementing innovative programs (such as Namaste Care, Cardiac Care Program, Kangaroo Kids, and Camp Kangaroo) and meeting patients' specific requests, such as placing a ventilator to allow patient to die at home, or supporting patients that wish to utilize the state's Death with Dignity provisions.**

- **Expertise in employing technologies that enhance patient care and delivery of services, including identifying hospice eligible patients sooner in the disease trajectory, which can increase hospice enrollment, length of stay, and quality of life.**

- **Expertise that reaches into communities to diversify the workforce and in so doing, reach under-served persons through strong Diversity, Equity, and Inclusion (DEI) initiatives.**

- **Expertise in analyzing unmet need within communities and tailoring hospice services to reach and meet such need, such as making hospice service more available to the indigent population through a Homeless Program, establishing a Pediatric Hospice and Palliative Care Program, and providing hospice services under the state's Death with Dignity laws.**

- **Expertise in empowering the workforce through comprehensive training and education through Continuing Education Courses available to all health professionals.**

- **Expertise in networking and creating linkages to schools and universities for internships and other experiences to encourage hospice care as a career choice, thereby increasing the number of hospice professionals.**

(ii) Specific populations including, but not limited to, pediatrics;

Seasons Pierce County's commitment to serving the disadvantaged and vulnerable populations such as the homeless, minorities, the elderly, and children, will bring hospice care to traditionally underserved groups. Seasons Pierce County also commits to serving individuals exploring use of the Death with Dignity Act, another under-served population due to the prevalence of faith based hospice programs that do not participate in medical aid-in-dying (MAID) services. Outreach to homeless shelters, community health centers, and other community and social service organizations will increase awareness and enrollment in hospice care.

As discussed previously in ***Section II, Project Description, Question 10,*** Seasons Pierce County's diversity programs and dedication to under-served populations like the homeless; minorities; persons seeking medical aid-in-dying services; pediatric population; elderly, particularly those in assisted living and nursing homes; as well as those with Alzheimer's disease and other dementias, open doorways to greater cooperation among other social and advocacy organizations. Choice among providers allows residents to find a "hospice home" in which their needs find compatibility. Seasons Pierce County offers hospice services tailored to these and other populations (e.g., veterans), ensuring the end of life needs of multiple populations are met, filling gaps in service.

(iii) Minimum impact on existing programs;

The AccentCare hospice programs across the nation reflect strength and experience that brings a new market entrant to Pierce County with resources for education and case-finding. Additional marketing efforts and outreach benefit all hospices because greater knowledge occurs among residents. The increase in promotion brings attention to hospice, and through the new entrant's efforts, increases awareness. Seasons Pierce County will work closely with facilities and physicians to ensure they understand the benefits of hospice care so residents and patients can be referred timely and benefit.

What Seasons Pierce County offers residents is greater differentiation among services that validates the hospice end of life experience. Though a competitor in one sense, hospices with common missions create synergy as well as opportunities to reach farther into subpopulation groups. Seasons Pierce County's initial area analysis identifies unmet needs so that service complements that of other programs, filling the gaps in delivery of hospice care to area residents.

Seasons Pierce County's diversity programs and dedication to under-served populations like the homeless and those seeking choice in Death with Dignity options open doorways to greater cooperation among other social and advocacy organizations. Choice among providers allows residents to find a "hospice home" in which their needs find

compatibility. By seeking out the under-served, Seasons Pierce County fills the gaps in service with minimal impact to existing providers.

Seasons Pierce County's ability to attract and recruit staff from across the United States and abroad, in addition to supporting local colleges and universities with internship placements and building the next generation of nurses, help to minimize impact of staffing a new program.

(iv) Greatest breadth and depth of hospice services; and

As discussed in ***Section II, Project Description,*** and in response to ***Question #7,*** Seasons Pierce County offers a breadth and depth of services and programs equal to or superior to others across the industry. A review of the section on programs showcases the advantages that Seasons Pierce County brings to residents. Notably, Seasons Pierce County is able to provide services under Washington State's Death with Dignity laws, having similar services in place in other states, such as California, Oregon, Colorado, and New Jersey. Seasons Pierce County leverages the experience and expertise from the entire network of AccentCare Hospice Programs, raising the bar for hospice care in Pierce County. Seasons Pierce County's program offerings, particularly the electronic medical record and 24-hour, seven days a week call center, make accessible and available services that distinguish the programs.

Within the organization, although each program operates independently, all share a common vision and service to their communities. Within the network of providers, innovation is encouraged, often with new programs stemming from specific needs identified locally. For instance, a recently licensed hospice program in Pasco County Florida, Seasons Hospice & Palliative Care of Pasco County, LLC, discovered a large homeless population during its initial needs assessment during the CN process and developed a Homeless Program. That program is now being adopted by other Seasons and AccentCare Hospice programs, including Seasons Pierce County, to ensure that the homeless and disadvantaged residents get appropriate end of life care.

Seasons Hospice & Palliative Care developed through a desire to care for families whose needs were not being met by other hospice programs. Similarly, patient care programs shared throughout the network of providers evolve through finding solutions to specific needs. For example, a patient on ventilator support wished to die at home. No hospices in the Chicago area would provide in-home mechanical ventilation. Seasons Hospice leadership said a way would be found, and did so, developing the in-home mechanical ventilation program now available at all Seasons and AccentCare Hospices. AccentCare's Open Access program and others allow residents to receive palliative care and hospice care at the right time, and in the right setting. Other programs, such as Namaste Care, develop to improve quality of care. In this case, Alzheimer's' patients needed

specialized care to improve the way in which care is delivered, recognizing specific needs of dementia patients. The program's success, adopted across all AccentCare Hospice Programs, is now taught to all care staff and volunteers to improve quality for all patients. **Seasons Pierce County's focus on resident-centered care allows patients' needs to drive programs and services.**

(v) Published and publicly available quality data.

As noted previously, each AccentCare Hospice & Palliative Care hospice program operating nationally is its own operating entity that is legally, operationally, and financially separate and distinct from the others. Each hospice program has its own license in the state in which it operates and its own administrator. Each hospice is responsible for its own management, and no actions or financial conditions of one hospice program affect any other hospice program. The most recent Hospice Item Set (HIS) quality measures and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results for all of AccentCare, Inc.'s healthcare agencies across the country show that all operate quality programs. Both components of the Hospice Quality Reporting Program allow individual hospices to compare their results to the national benchmark for the measure.

V. MULTIPLE APPLICATIONS IN ONE YEAR

Multiple Applications in One Year WAC 246-310-220

1. ***Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.***

   If the answer to this question is no, there is no need to complete further questions under this section.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC is the Applicant and intended licensee of the proposed hospice program. This entity is wholly owned by **AccentCare, Inc.** AccentCare, Inc. did not submit any other hospice applications under either of this year's concurrent review cycles.

2. ***If the answer to the previous question is yes, clarify:***
   - ***Are these applications being submitted under separate companies owned by the same applicant(s); or***
   - ***Are these applications being submitted under a single company/applicant?***
   - ***Will they be operated under some other structure? Describe in detail.***

This question is not applicable since neither Seasons Hospice & Palliative Care of Pierce County Washington, LLC nor AccentCare, Inc. have submitted any other hospice applications for this concurrent review cycle.

3. ***Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the applicant, assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the applicant assuming approval of all proposed projects in this year's review cycles showing the first three full calendar years of operation.***

This question is not applicable since AccentCare, Inc. has not submitted any other hospice applications for this concurrent review cycle.

4. ***In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements <u>may</u> be required.***
    - ***If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.***
    - ***If your applications proposed operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.***

This question is not applicable since AccentCare, Inc. has not submitted any other hospice applications for this concurrent review cycle and AccentCare, Inc. and its affiliates do not propose operating multiple counties under the same license.

APPENDIX

EXHIBIT 1

Applicant Entity Certificate of Formation and Washington Application of Foreign Registration

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC", FILED IN THIS OFFICE ON THE TWENTY-EIGHTH DAY OF DECEMBER, A.D. 2020, AT 5:33 O`CLOCK P.M.

Jeffrey W. Bullock, Secretary of State

4560540 8100
SR# 20208770731

Authentication: 204432994
Date: 12-29-20

You may verify this certificate online at corp.delaware.gov/authver.shtml

State of Delaware
Secretary of State
Division of Corporations
Delivered 05:33 PM 12/28/2020
FILED 05:33 PM 12/28/2020
SR 20208770731 - File Number 4560540

CERTIFICATE OF FORMATION

OF

SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC

This Certificate of Seasons Hospice & Palliative Care of Pierce County Washington, LLC (the "Company"), dated as of 28th day of December, 2020, is being duly executed and filed by the undersigned, as an authorized person, to form a limited liability company and in accordance with the Delaware Limited Liability Company Act (6 Del. C. § 18 101, et seq.). The undersigned hereby certifies as follows:

FIRST. The name of the limited liability company formed hereby is Seasons Hospice & Palliative Care of Pierce County Washington, LLC.

SECOND. The address of the registered office of the Company in the State of Delaware is c/o The Corporation Trust Company, 1209 Orange Street, Wilmington, Delaware 19801.

THIRD. The name and address of the registered agent of the Company for service of process in the State of Delaware is The Corporation Trust Company, 1209 Orange Street, Wilmington, Delaware 19801.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation as of the date first above written.

By: /s/ Imole Ogowewo
Name: Imole Ogowewo
Title: Authorized Person

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, KIM WYMAN, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF REGISTRATION

to

SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC

A/AN **DELAWARE LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 01/29/2021
UBI Number: 604 700 776

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman, Secretary of State

Date Issued: 01/29/2021

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 01/29/2021
Effective Date: 01/29/2021
UBI #: 604 700 776

FOREIGN REGISTRATION STATEMENT

UBI NUMBER

UBI Number:
604 700 776

BUSINESS NAME

Business Name
SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC

DOING BUSINESS AS (DBA) NAME RCW 23.95.525

DBA Name:

JURISDICTION

Country:
UNITED STATES

State:
DELAWARE

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501, UNITED STATES

REGISTERED AGENT CONSENT

Customer provided Registered Agent consent? - **Yes**

PRINCIPAL OFFICE

Phone:

Email:
HSISCEL@SEASONS.ORG

Street Address:
6400 SHAFER CT STE 700, ROSEMONT, IL, 60018-4989, UNITED STATES

Mailing Address:
6400 SHAFER CT STE 700, ROSEMONT, IL, 60018-4989, UNITED STATES

GOVERNORS

Title	Governor Type	Entity Name	First Name	Last Name
GOVERNOR	INDIVIDUAL		TODD	STERN

DATE OF FORMATION IN HOME JURISDICTION

Date of formation in its Home Jurisdiction:
12/28/2020

PERIOD OF DURATION IN HOME JURISDICTION

Duration:
PERPETUAL

NATURE OF BUSINESS

Nature of Business:
HOSPICE AND PALLIATIVE CARE

DATE BEGAN DOING BUSINESS IN WASHINGTON

Date Began doing Business in WA:
01/29/2021

EFFECTIVE DATE

Effective Date:
01/29/2021

TRANSFER OF REGISTRATION

For Transfer of Registration refer RCW 23.95.545

STAFF CONSOLE - CERTIFICATE OF EXISTENCE IS INCLUDED

Certificate of Existence is included? - **Yes**

RETURN ADDRESS FOR THIS FILING

Attention:

Email:

Address:

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date

EMAIL OPT-IN

☐ I hereby opt into receiving all notifications from the Secretary of State for this entity via email only. I acknowledge that I will no longer receive paper notifications.

AUTHORIZED PERSON - STAFF CONSOLE

☑ Document is signed.

Person Type:
ENTITY

First Name:
JEFF

Last Name:
MINER

Entity Name:
C T CORPORATION SYSTEM

Title:
REP

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE TWENTY-SIXTH DAY OF JANUARY, A.D. 2021.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN ASSESSED TO DATE.

4560540 8300

Authentication: 202368713

SR# 20210223861

Date: 01-26-21

You may verify this certificate online at corp.delaware.gov/authver.shtml

Work Order #: 2021012600056888 - 2
Received Date: 01/26/2021
Amount Received: $400.00

Office of the Secretary of State
Corporations & Charities Division

James M. Dolliver Building
801 Capitol Way South • PO Box 40234
Olympia, WA 98504-0234
Tel: 360.725.0377
www.sos.wa.gov/corps

Congratulations:

You have completed the initial filing to create a new business entity. **The next step in opening your new business is to complete a Business License Application.** You may have completed this step already. The Business License Application can be completed online or downloaded at: http://www.bls.dor.wa.gov/

If you have any questions about the Business License Application, or would like a Business License Application package mailed to you, please call Business License Services at 1-800-451-7985.

C T CORPORATION SYSTEM
711 CAPITOL WAY S STE 204
OLYMPIA WA 98501

IMPORTANT

You have completed the initial filing to create a new entity. To keep your filing status active and avoid administrative dissolution, you must:

1. **File an Annual Report** and pay the annual license fee each year before the anniversary of the filing date for the entity. A notice to file your annual report will be sent to your registered agent. It is the corporation or LLC's responsibility to file the report even if no notice is received.

2. **Maintain a Registered Agent** and registered office in this state. You must notify the Corporations Division if there are any changes in your registered agent, agent's address, or registered office address. Failure to notify the Corporations Division of changes will result in misrouted mail, and possibly administrative dissolution.

If you have questions about report and registered agent requirements, please contact the Corporations Division at 360-725-0377 or visit our website at: www.sos.wa.gov/corps

LIMITED LIABILITY COMPANY AGREEMENT

OF

SEASONS HOSPICE & PALLIATIVE CARE OF PIERCE COUNTY WASHINGTON, LLC

This Limited Liability Company Agreement (this "Agreement") of Seasons Hospice & Palliative Care of Pierce County Washington, LLC (the "Company") is entered into by AccentCare, Inc., as the sole member (the "Member") as of the 28th day of December, 2020.

The Member, by execution of this Agreement hereby forms a limited liability company pursuant to and in accordance with the Delaware Limited Liability Company Act (6 Del. C. § 18-101, *et seq.*), as amended from time to time (the "Act"), and hereby agrees as follows:

1. Name. The name of the limited liability company formed hereby is Seasons Hospice & Palliative Care of Pierce County Washington, LLC.

2. Filing of Certificates. Imole Ogowewo, as an authorized person within the meaning of the Act, shall execute, deliver and file all certificates (and any amendments and/or restatements thereof) required or permitted to be filed with the Secretary of State of the State of Delaware. The Member is authorized to execute, deliver and file any other certificates, notices or documents (and any amendments and/or restatements thereof) necessary or desirable for the Company to qualify to do business in any jurisdiction in which the Company may wish to conduct business.

3. Purposes. The Company is formed for the object and purpose of, and the nature of the business to be conducted and promoted by the Company is, engaging in any lawful act or activity for which limited liability companies may be formed under the Act.

4. Powers. In furtherance of its purposes, but subject to all of the provisions of this Agreement, the Company shall have and may exercise all the powers now or hereafter conferred by Delaware law on limited liability companies formed under the Act and all powers necessary, convenient or incidental to accomplish its purposes as set forth in Section 3.

5. Principal Business Office. The principal business office of the Company shall be located at such other location as may hereafter be determined by the Member.

6. Registered Office. The address of the registered office of the Company in the State of Delaware is c/o The Corporation Trust Company, 1209 Orange Street, Wilmington, Delaware 19801.

7. Registered Agent. The name and address of the registered agent of the Company for service of process on the Company in the State of Delaware is The Corporation Trust Company, 1209 Orange Street, Wilmington, DE 19801.

8. Member. The name and the mailing address of the Member is as follows:

Name	Address
AccentCare, Inc.	17855 North Dallas Parkway, Suite 200 Dallas, TX 75287

9. Appointment of Officers. The Member may, from time to time as it deems advisable, appoint officers of the Company (the "Officers") and assign in writing titles (including, without limitation, President, Vice President, Secretary, and Treasurer) to any such person. The Officers appointed by the Member as of the date hereof are set forth on Exhibit A. Unless the Member decides otherwise, if the title is one commonly used for officers of a business corporation organized under the Act, the assignment of such title constitutes the delegation to such person of the authorities and duties that are normally associated with that office, including, without limitation, the execution of documents, instruments and agreements in the name of and on behalf of the Company. Any delegation pursuant to this Section may be revoked at any time by the Member in writing. Any officer may be removed at any time with or without cause by the Member. The Member by written instrument signed by the Member may, in the sole discretion of the Member, ratify any act previously taken by an officer acting on behalf of the Company. Except as provided in this Section, the Member shall be the sole person with the power to bind the Company.

10. Limited Liability. Except as otherwise provided by the Act, the debts, obligations and liabilities of the Company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the Company, and the Member shall not be obligated personally for any such debt, obligation or liability of the Company solely by reason of being a member of the Company.

11. Capital Contributions. The Member shall execute and deliver a counterpart of this Agreement and is deemed admitted as a member of the Company on the effective date of this Agreement.

12. Additional Contributions. The Member is not required to make any additional capital contribution to the Company. However, the Member may voluntarily make additional capital contributions to the Company at any time.

13. Capital Accounts. The Company shall maintain for the Member a separate account (a "Capital Account") in accordance with the rules of Section 704 of the Internal Revenue Code of 1986, as amended and Treasury Regulation Section 1.704-1(b)(2)(iv).

14. Maintenance of Separate Existence. The Company shall do all things necessary to maintain its limited liability company existence separate and apart from the Member and any affiliate of the Member, including holding regular meetings of the Member and maintaining its books and records on a current basis separate from that of any affiliate of the Company or any other person or entity, and shall not commingle the Company's assets with those of any affiliate of the Company or any other person or entity. In furtherance, and not in limitation, of the foregoing, the Company shall not:

(a) fail to (i) maintain or cause to be maintained by an agent under the Company's control physical possession of the records required to be kept under the Act, (ii) account for and manage all of its liabilities separately from those of any other person or entity, including payment by it of administrative expenses and taxes, other than income taxes, from its own assets or (iii) identify or cause to be identified separately all of its assets from those of any other person or entity;

(b) commingle, or permit the commingling of, its funds with the funds of any Member or any affiliate of any Member or use its funds for uses other than the Company's uses; or

(c) maintain, or permit the maintenance of, joint bank accounts or other depository accounts to which any Member would have independent access.

15. Allocation of Profits and Losses. For so long as the Member is the sole member of the Company, the Company's profits and losses shall be allocated solely to the Member.

16. Distributions. Distributions shall be made to the Member at the times and in the aggregate amounts determined by the Member. Notwithstanding any provision to the contrary contained in this Agreement, the Company shall not make a distribution to the Member on account of its interest in the Company if such distribution would violate the Act or other applicable law.

17. Management.

(a) The Member shall have the power to do any and all acts necessary, convenient or incidental to or for the furtherance of the purposes of the Company described herein, including all powers, statutory or otherwise, possessed by members of a limited liability company under the laws of the State of Delaware. Notwithstanding any other provision of this Agreement, (i) the Member is authorized to execute and deliver any document on behalf of the Company without any vote or consent of any other person and (ii) the Member has the authority to bind the Company.

(b) Waiver of Fiduciary Duties. This Agreement is not intended to, and does not, create or impose any implied duty (including, without limitation, any fiduciary duty and, for purposes of clarity, any prohibition on usurping opportunities of the Company) otherwise existing at law or in equity on the Member, any Officer, or any affiliate, officer, director, employee or agent of any of the foregoing (each of the foregoing, a "Responsible Party"). To the fullest extent permitted by applicable law, and notwithstanding any duty otherwise existing at law or in equity, each of the Company, the Member, and any other person or entity that is a party to or is otherwise bound by this Agreement (including, without limitation, (a) the Company in its capacity as a debtor or debtor in possession in a bankruptcy case commenced under 11 U.S.C. (a "Bankruptcy Case"), (b) any successor to the Company in a Bankruptcy Case or otherwise, including, without limitation, a trustee, a litigation trust or estate representative, including, without limitation, a representative under 11 U.S.C. section 1123(b), and (c) any creditor or committee of creditors or equity holders seeking or obtaining standing to assert claims of the estate in a Bankruptcy Case, each of the foregoing, a "Bound Party") hereby expressly waives all

duties (including, without limitation, any fiduciary duty) and, for purposes of clarity, any prohibition on usurping opportunities of the Company, that absent such waiver, may be implied at law or in equity or otherwise owed to a Bound Party, and in doing so, recognizes, acknowledges and agrees that the duties and obligations of the Responsible Parties are only as expressly set forth in this Agreement; provided that a Responsible Party shall act in good faith and in a manner that it subjectively believes is in or not opposed to the best interests of the Company.

(c) Other Business Opportunities. Any Responsible Party may engage in or possess an interest in other business opportunities or ventures (unconnected with the Company) of every kind and description, independently or with others, including, without limitation, businesses that may compete with the Company and/or any Bound Party. No Responsible Party shall be required to present any such business opportunity or venture to any Bound Party, even if the opportunity is of the character that, if presented to any of such persons or entities, could be taken by them. No Bound Party shall have any rights in or to such business opportunities or ventures or the income or profits derived therefrom by virtue of this Agreement, notwithstanding any duty otherwise existing at law or in equity. The provisions of this Section 18 shall apply to the Responsible Parties solely in their capacities as the Member or an Officer of the Company or affiliate, officer, director, employee or agent of the Member or an Officer and shall not be deemed to modify any contract or arrangement, including, without limitation, any noncompete provisions, otherwise agreed to by the Company and such Responsible Party.

(d) Exculpation and Indemnification.

(e) No current or former Member, Officer, employee or agent of the Company and no affiliate, stockholder, equityholder, officer, director, employee or agent of any Member (including the executors, heirs, assigns, successors or other legal representatives of any such persons) (collectively, the "Covered Persons") shall be liable to the Company, any Member, or any other person or entity who is a party to or is otherwise bound by this Agreement for any loss, damage or claim incurred by reason of any act or omission performed or omitted by such Covered Person in good faith on behalf of the Company and in a manner reasonably believed to be within the scope of the authority conferred on such Covered Person by this Agreement, unless there has been a final and non-appealable judgment entered by a court of competent jurisdiction determining that, in respect of the matter in question, the Covered Person engaged in fraud or intentional malfeasance.

(f) To the fullest extent permitted by applicable law, a Covered Person shall be entitled to indemnification from the Company for any loss, damage or claim incurred by such Covered Person by reason of any act or omission performed or omitted by such Covered Person in good faith on behalf of the Company and in a manner reasonably believed to be within the scope of the authority conferred on such Covered Person by this Agreement, unless there has been a final and non-appealable judgment entered by a court of competent jurisdiction determining that, in respect of the matter in question, the Covered Person engaged in fraud or intentional malfeasance; provided, however, that any indemnity under this Section shall be provided out of and to the extent of Company assets only, and no Member shall have any personal liability on account thereof.

(g) To the fullest extent permitted by applicable law, expenses (including reasonable legal fees) incurred by a Covered Person in defending any claim, demand, action, suit or proceeding shall, from time to time, be advanced by the Company prior to the final disposition of such claim, demand, action, suit or proceeding upon receipt by the Company of an undertaking by or on behalf of the Covered Person to repay such amount if it shall be determined that the Covered Person is not entitled to be indemnified as authorized in this Section.

(h) A Covered Person shall be fully protected in relying in good faith upon the records of the Company and upon such information, opinions, reports or statements presented to the Company by the person or entity as to matters the Covered Person reasonably believes are within such other person or entity's professional or expert competence and who has been selected with reasonable care by or on behalf of the Company, including information, opinions, reports or statements as to the value and amount of the assets, liabilities, or any other facts pertinent to the existence and amount of assets from which distributions to the Member might properly be paid.

(i) The provisions of this Agreement, to the extent that they restrict or eliminate the duties and liabilities of a Covered Person otherwise existing at law or in equity, are agreed by the Member to replace and eliminate, as applicable, such other duties and liabilities of such Covered Person.

(j) Notwithstanding the foregoing provisions of this Section, the Company shall indemnify a Covered Person in connection with a proceeding (or part thereof) initiated by such Covered Person only if such proceeding (or part thereof) was authorized by the Member; provided, however, that a Covered Person shall be entitled to reimbursement of his or her reasonable counsel fees with respect to a proceeding (or part thereof) initiated by such Covered Person to enforce his or her right to indemnity or advancement of expenses under the provisions of this Section to the extent the Covered Person is successful on the merits in such proceeding (or part thereof).

(k) The foregoing provisions of this Section shall survive any termination of this Agreement.

(l) No amendment, modification or repeal of this Section shall have the effect of limiting or denying any rights under this Section with respect to actions taken or omitted to be taken or proceedings arising prior to any amendment, modification or repeal.

18. Transfers; Assignments A Member may transfer or assign in whole or in part its limited liability company interest in the Company. If a Member transfers or assigns any of its interest in the Company pursuant to this Section, the transferee or assignee shall be admitted to the Company, subject to Section 21 upon its execution of an instrument signifying its agreement to be bound by the terms and conditions of this Agreement, which instrument may be a counterpart signature page to this Agreement. If a Member transfers or assigns all of its interest in the Company pursuant to this Section, such admission shall be deemed effective immediately prior to the transfer or assignment, and, immediately following such admission, the transferor or assignor Member shall cease to be a member of the Company. Any transfer or assignment or

purported transfer or assignment of an interest in the Company not made in accordance with this Section shall be null and void ab initio.

19. Resignation. The Member may at any time resign from the Company. If a Member resigns pursuant to this Section, an additional member shall be admitted to the Company, subject to Section 21, upon its execution of an instrument signifying its agreement to be bound by the terms and conditions of this Agreement. Such admission shall be deemed effective immediately prior to the resignation, and, immediately following such admission, the resigning Member shall cease to be a member of the Company.

20. Admission of Additional Members. One or more additional members of the Company may be admitted to the Company with the written consent of the Member.

21. Dissolution.

(a) The Company shall dissolve and its affairs shall be wound up upon the first to occur of: (i) the written consent of the Member, (ii) any time there are no members of the Company, unless the Company is continued in accordance with the Act, (iii) the entry of a decree of judicial dissolution of the Company under Section 18-802 of the Act.

(b) In the event of dissolution, the Company shall conduct only such activities as are necessary or advisable to wind up its affairs (including the sale of the assets of the Company in an orderly manner), and the assets or proceeds from the sale of the assets of the Company shall be applied in the manner, and in the order of priority, set forth in Section 18-804 of the Act.

22. Benefits of Agreement; No Third-Party Rights. The provisions of this Agreement are intended solely to benefit the Member and the Responsible Parties and Covered Persons and, to the fullest extent permitted by applicable law, shall not be construed as conferring any benefit upon any creditor (other than Covered Persons) of the Company (and no such creditor shall be a third-party beneficiary of this Agreement), and the Member; each Responsible Party shall have no duty or obligation to any creditor of the Company to make any contributions or payments to the Company.

23. Severability of Provisions. Each provision of this Agreement shall be considered severable and if for any reason any provision or provisions herein are determined to be invalid, unenforceable or illegal under any existing or future law, such invalidity, unenforceability or illegality shall not impair the operation of or affect those portions of this Agreement which are valid, enforceable and legal.

24. Entire Agreement. This Agreement constitutes the entire agreement of the parties with respect to the subject matter hereof.

25. Governing Law. This Agreement shall be governed by, and construed under, the laws of the State of Delaware (without regard to conflict of laws principles), all rights and remedies being governed by said laws.

26. Amendments. This Agreement may not be amended, modified or supplemented in any manner, whether by course of conduct or otherwise, except by an instrument in writing specifically designated as an amendment hereto, executed and delivered by all of the Member.

27. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original of this Agreement, and all of which together shall constitute one and the same instrument.

[The remainder of this page is intentionally left blank.]

IN WITNESS WHEREOF, the undersigned, intending to be legally bound hereby, have duly executed this Agreement.

AccentCare, Inc.

Name: TIMOTHY RYAN
Title: SECRETARY

Exhibit A

Company Officers

Chief Executive Officer and President: Todd Stern

Treasurer: Ryan Solomon

Assistant Treasurer: Dave Donenberg

Secretary: Kate Proctor

Assistant Secretary: Charles Pierce

EXHIBIT 2

Services Agreement

MANAGEMENT SERVICES AGREEMENT

THIS MANAGEMENT SERVICES AGREEMENT is effective as of the 20th day of October, 2022 (the "Effective Date"), by and among AccentCare, Inc., a Delaware corporation having its principal place of business at 17855 North Dallas Parkway, Suite 200, Dallas, Texas 75287 ("Parent"), on the one hand, and its subsidiaries and joint ventures signatories hereto (each, a "Subsidiary" or "Joint Venture" and collectively, the "Subsidiaries and Joint Ventures"), on the other hand.

RECITALS

WHEREAS, each Subsidiary is a direct or indirect wholly owned subsidiary of Parent;

[redacted]

WHEREAS, the Subsidiaries and Joint Ventures require various administrative and management services as more fully described in ARTICLE II hereof (the "Management Services");

WHEREAS, Parent has in place the necessary personnel and capabilities to meet the Subsidiaries' and Joint Ventures' administrative and management needs; and

WHEREAS, the parties desire to enter into an agreement whereby Parent will furnish the personnel and capabilities to carry out and perform each Subsidiary's and Joint Venture's support, administrative and management services requirements in exchange for the payment by each Subsidiary or Joint Venture of a management fee to Parent.

AGREEMENT

NOW, THEREFORE, incorporating the foregoing recitals and in consideration thereof and of the mutual agreements, provisions, and covenants contained herein, and for other good and valuable consideration, the receipt and legal sufficiency whereof are hereby acknowledged, the parties hereto agree as follows:

ARTICLE I
RETENTION OF PARENT

Section 1.1 Performance of Services.

(a) Each Subsidiary and Joint Venture hereby engages and retains Parent on an exclusive basis to perform the Management Services, and Parent hereby accepts and agrees to provide such Management Services to each Subsidiary or Joint Venture upon the terms and conditions set forth herein.

(b) Parent shall determine the corporate facilities to be used in rendering the Management Services and the individuals who will render such Management Services.

(c) Nothing herein shall be deemed to restrict Parent or its directors, officers or employees from engaging in any business, or from contracting with other parties, including, without limitation, other related parties of Parent, for similar or different services.

Section 1.2 Retention of Authority by Subsidiaries and Joint Ventures.

(a) Notwithstanding anything contained anywhere to the contrary, throughout the Term, each Subsidiary or Joint Venture, through its respective Board of Directors in the case of Subsidiaries or Members in the case of Joint Ventures (or any similar governing body) (each referred to herein as a "Board"), shall retain all authority and shall exercise control over the business, policies, operation, and assets of such Subsidiary or Joint Venture, in accordance such Subsidiary's or Joint Venture's respective governance documents (each, "Governing Documents") and all relevant laws, ordinances, rules and regulations of state, local, or federal governments applicable to the operations of such Subsidiaries or Joint Venture and with Board policy. Parent shall, as each Subsidiary's and Joint Venture's exclusive outside manager, perform the Management Services described in this Agreement in accordance with each Subsidiary's or Joint Venture's respective Governing Documents and policies and directives and any future policies of such Subsidiaries and Joint Ventures as may be from time to time approved in writing by the Boards (collectively, "Board Policies"). By entering into this Agreement, no Subsidiary or Joint Venture delegates to Parent any of the powers, duties, and responsibilities vested in their respected Board by law or by their respective Governing Documents.

(b) Each Board shall communicate all Board Policies to Parent, and Parent shall be entitled to rely on and assume the validity of communications from, and shall report to, the Boards, the Chairman of any Board, or any written designee of any Board. All matters requiring professional medical judgment shall remain the responsibility of the Subsidiaries' or Joint Ventures' medical staffs. Parent shall have no responsibility whatsoever for such judgments.

Section 1.3 Disclaimer, Limited Liability.

(a) Parent makes no express or implied representations, warranties or guarantees relating to the Management Services or the quality or results of Management Services to be performed under this Agreement.

(b) Parent will use reasonable efforts to make the Management Services available to each Subsidiary and Joint Venture with substantially the same degree of care as it employs in

making the same Management Services available for its own operations; provided, however, that Parent shall not be liable to any Subsidiary, Joint Venture or any other person for any loss, damage or expense which may result therefrom or from any change in the manner in which Parent renders the Management Services, so long as Parent deems such change necessary or desirable in the conduct of its own operations.

(c) Officers and employees of Parent who provide Management Services to the Subsidiaries or Joint Ventures shall not be liable to any Subsidiary, Joint Venture or to any third party, including any governmental agency, for any claims, damages or expenses relating to the Management Services provided pursuant to this Agreement, and each Subsidiary or Joint Venture shall have the ultimate responsibility for all Management Services provided herein.

(d) Parent shall not be liable to any Subsidiary or Joint Venture for the consequences of any failure or delay in performing any of Parent's obligations under this Agreement, other than for damages arising from Parent's gross negligence or willful or reckless misconduct.

(e) Each Subsidiary or Joint Venture shall indemnify and hold harmless any employee of Parent who performs Management Services for such Subsidiary or Joint Venture pursuant to this Agreement to the same extent that Parent would indemnify such employee if the employee were to perform such services for Parent.

ARTICLE II
MANAGEMENT SERVICES

Section 2.1 **Provision of Management Services**. Parent shall, at the request of any Subsidiary or Joint Venture, provide such Management Services as Parent determines to be reasonably required by such Subsidiary or Joint Venture. Management Services, for these purposes, shall include, without limitation, the following:

(a) corporate accounting functions;

(b) corporate financing arrangements;

(c) corporate development programs;

(d) oversight of facilities development;

(e) oversight of facility operations;

(f) certain risk management functions;

(g) financial and budget analysis, and corporate consolidations;

(h) financial audits and external financial reporting;

(i) all tax matters, including without limitation, the preparation of all federal and state income tax filings including quarterly estimated tax payments and extension requests;

(j) training for accounting, financial, information systems, patient accounting, human resources and compliance;

(k) investor relations services;

(l) certain clinical functions;

(m) oversight and management of information systems;

(n) preparation of certain facility cost reports;

(o) legal services, including corporate legal compliance;

(p) cash management services;

(q) human resources services including oversight of benefits and related support services;

(r) corporate governance matters;

(s) insurance and related support services;

(t) all billing, coding, and collection services;

(u) all accounts payable functions;

(v) all purchasing functions;

(w) support for all marketing initiatives;

(x) such other Management Services as the Subsidiary or Joint Venture requests and the Parent agrees to provide.

Section 2.2 **Employee Services**. All services relating to the provision of (a) such employees and services as are necessary for the Subsidiaries and Joint Ventures to provide services to customers in accordance with applicable law, and (b) services incidental to the provision of such employees, including, without limitation, employee payroll, benefits, supervision and management, shall be provided by Parent, pursuant to an Employment Services Agreement (the "Employment Services Agreement"), among Parent, Joint Ventures and the Subsidiaries, and shall not be deemed Management Services hereunder or considered in the calculation of the management fee hereunder.

Section 2.3 **Confidentiality**.

(a) Parent recognizes and acknowledges that, by virtue of entering into this Agreement, Parent may have access to certain information of customers of the Subsidiaries and Joint Ventures that are confidential. Parent shall not use or disclose any protected health information and individually identifiable health information, as defined in 45 CFR Part 164 and any medical information as defined in the civil codes or other relevant laws of the state in which each Subsidiary or Joint Venture operates (collectively, the "Protected Health Information"), concerning any customers of the Subsidiaries and Joint Ventures other than as permitted by this

Agreement or provisions of the federal privacy regulations (the "Federal Privacy Regulations") and the federal security standards (the "Federal Security Regulations") as contained in 45 CFR Part 164 and civil codes or other relevant laws of the state in which each Subsidiary or Joint Venture operates. Parent will implement appropriate safeguards to prevent the use or disclosure of a customer's Protected Health Information, in addition to those provided for by this Agreement. Parent will promptly report to a Subsidiary or Joint Venture any use or disclosure of its customer's Protected Health Information not provided for by this Agreement of which Parent becomes aware. Parent will make its internal practices, books, and records relating to the use and disclosure of a customer's Protected Health Information available to the Secretary of Health and Human Services to the extent required for determining compliance with the Federal Privacy Regulations and the Federal Security Regulations. Notwithstanding the foregoing, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by any Subsidiary, Joint Venture or Parent by virtue of this Section 2.3(a).

(b) Upon the written request of the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives, Parent and any of its affiliates providing services with a value or cost of $10,000.00 or more over a twelve-month period shall make available to the Secretary the contract, books, documents, and records that are necessary to verify the nature and extent of the cost of providing such services. Such inspection shall be available up to seven (7) years after the rendering of such services. The parties hereto agree that any applicable attorney-client, accountant-client, or other legal privilege shall not be deemed waived by virtue of this Agreement.

ARTICLE III
COMPENSATION

Section 3.1 Compensation for Management Services. In consideration of the Management Services performed on the Subsidiaries' and Joint Ventures' behalf by Parent, during the initial Term and during each extension thereof, each Subsidiary or Joint Venture shall pay to Parent a management fee calculated and payable in accordance with Exhibit 1 attached hereto and incorporated herein by this reference.

ARTICLE IV
TERM AND TERMINATION

Section 4.1 Term. This Agreement shall be effective for an initial term of three (3) years from and after the date hereof (the "Term"). At the end of this initial Term, this Agreement shall automatically renew without notice for additional successive one (1) year terms on each anniversary of the date hereof unless earlier terminated in accordance with the terms hereof. Any renewal period of this Agreement shall be considered an extension of the original Term.

Section 4.2 Termination. Notwithstanding Section 4.1, this Agreement may be terminated with respect to any or all Subsidiaries or Joint Ventures as follows:

(a) by any party hereto (but only with respect to such individual party's rights and obligations hereunder) if such party provides the other parties with written notice terminating the Agreement with respect to such party at least thirty (30) days prior to the end of the Term or any extension thereof;

(b) by any Subsidiary or Joint Venture on the one hand or Parent on the other hand (but only with respect to such individual party's rights and obligations hereunder) upon written notice to the other parties in the event that at any time during the Term or any extension thereof, any Subsidiary or Joint Venture in the case of Parent or Parent in the case of any Subsidiary or Joint Venture (i) ceases to conduct its business, or (ii) breaches any provision of this Agreement and such breach, if curable, is not cured by the breaching party within thirty (30) days of the breaching party's receipt of notice thereof from the non-breaching party; or

(c) by any Subsidiary or Joint Venture on the one hand or Parent on the other hand (but only with respect to such individual party's rights and obligations hereunder) without notice in the event any Subsidiary or Joint Venture in the case of Parent or Parent in the case of any Subsidiary or Joint Venture becomes insolvent or makes a general assignment for the benefit of creditors or if a petition of bankruptcy is filed by such other party or by any third party against such other party, or if such other party is adjudicated bankrupt, or if a receiver or other custodian, either permanent or temporary, is appointed by any court with respect to the assets or business of such party, or if a proceeding for the relief of creditors under any foreign, state or federal law is instituted by or against such party.

For the avoidance of doubt, Parent may terminate this Agreement with respect to one or more Subsidiaries or Joint Ventures in accordance with the terms hereof and this Agreement shall continue without interruption among Parent and the remaining Subsidiaries and Joint Ventures. In the event any Subsidiary or Joint Venture terminates this Agreement in accordance with its terms, the Agreement shall terminate only with respect to such Subsidiary or Joint Venture and shall continue without interruption among Parent and the remaining Subsidiaries and Joint Ventures.

Section 4.3 **Changes in Law**. Notwithstanding any other provision of this Agreement, provided that this Agreement is not terminated by Parent or any Subsidiary or Joint Venture pursuant to any other provision of this Agreement, if the governmental agencies that administer the Medicare, Medicaid, or other federally funded programs (or their representatives or agents), or any other federal, state or local governmental or non-governmental agency, or any court or administrative tribunal pass, issue or promulgate any law, rule, regulation, standard, interpretation, order, decision or judgment, including but not limited to those relating to any regulations pursuant to state or federal anti-kickback or physician self-referral statutes (collectively or individually "Legal Event"), which, in the written opinion of counsel for any party hereto (the "Noticing Party"), materially and adversely affects such party's licensure, accreditation, certification, or ability to refer, to accept any referral, to bill, to claim, to present a bill or claim, or to receive payment or reimbursement from any federal, state or local governmental or non-governmental payor, or which subjects the Noticing Party to a risk of prosecution or civil monetary penalty, or if in the good faith opinion of counsel to such party any term or provision of this Agreement could trigger a Legal Event, then the Noticing Party may give the other party or parties notice of desire to amend this Agreement. In the event of such notice, the Noticing Party and the other affected party or parties shall have thirty (30) days from the giving of such notice (the "Renegotiation Period") within which to attempt to amend this Agreement. For the avoidance of doubt, in any notice or negotiation under this Section 4.3, any affected Subsidiaries or Joint Ventures shall be represented by one representative who shall be given authority to act on behalf of all affected Subsidiaries or Joint Ventures. If this Agreement is not so amended within the Renegotiation Period for any reason whatsoever, Parent may unilaterally amend this Agreement to the extent Parent deems reasonably necessary to avoid the

consequences of such Legal Event, including, if such amendment is impossible, the termination of this Agreement.

ARTICLE V
INSURANCE

Section 5.1 Required Insurance Policies. Each Subsidiary, Joint Venture, and Parent shall have in effect and maintain throughout the Term and any extension thereof, the following minimum insurance coverages, unless a particular requirement is waived by Parent and an individual Subsidiary or Joint Venture:

(a) Each Subsidiary or Joint Venture shall have in effect and maintain throughout the Term and any extension thereof, at such Subsidiary's or Joint Venture's cost, commercially customary insurance coverage for comprehensive healthcare professional liability, general liability, and bodily injury and property damage liability, including without limitation, property damage or casualty insurance covering damage to the buildings, furnishings, fixtures and equipment of such Subsidiary or Joint Venture covering the full replacement value of such items, with the attributes reasonably acceptable to Parent.

(b) Each Subsidiary or Joint Venture shall have in effect and maintain throughout the Term and any extension thereof, at such Subsidiary's or Joint Venture's cost, comprehensive, bodily injury and property damage automobile liability insurance underwritten by an insurance company authorized to transact such insurance business in the state in which such Subsidiary or Joint Venture operates in amounts customary and ordinary for companies such as such Subsidiary or Joint Venture operating in such state.

(c) Parent shall have in effect and maintain throughout the Term and any extension thereof, at Parent's cost, commercially customary insurance coverage for workers' compensation, general liability, and bodily injury and property damage liability, including without limitation, property damage or casualty insurance, relating to Parent's duties or responsibilities under this Agreement.

(d) Parent shall be named as an additional insured under each insurance policy of the Subsidiaries and Joint Ventures, with respect to this Agreement. The policies required hereunder shall not be terminated or not-renewed except upon thirty (30) days' prior written notice to the other parties. No later than thirty (30) days following the execution of this Agreement, and thirty (30) days following the end of each policy year, each Subsidiary or Joint Venture shall give to Parent a copy of the endorsements naming Parent as an additional insured.

ARTICLE VI
MISCELLANEOUS

Section 6.1 Inspection of Records. Parent shall maintain such books, accounts and records of its operations as may be reasonably necessary for purposes of this Agreement or as required by applicable law in the jurisdiction in which each Subsidiary or Joint Venture is located. Each Subsidiary or Joint Venture shall have the right to examine such books, accounts and records at any reasonable time or times for the purpose of verifying the payments required to be made by it hereunder at such Subsidiary's or Joint Venture's sole cost and expense. Although all operating procedures, protocols, information systems, operating data, computer databases, reports and other non-public proprietary business systems

or information shall be owned by Parent and shall remain the exclusive property of the Parent, upon termination or expiration of this Management Services Agreement, all data will be made available immediately and for a period of not less than seven (7) years following the termination or expiration.

Section 6.2 Indemnity.

(a) Each Subsidiary or Joint Venture assumes all liability for and agrees to defend, indemnify and hold Parent, its employees, officers, directors, shareholders, agents and affiliates (other than such Subsidiary or Joint Venture) (collectively, the "Parent Indemnified Parties"), harmless from and against all demands, liability, damages, costs and expenses, including attorneys' and expert witness fees (each, a "Loss"), incurred by Parent arising from or in connection with (a) alleged or actual failure by such Subsidiary or Joint Venture to perform any of its duties hereunder; (b) any pending or threatened claims asserted against Parent based on actions or omissions by any Subsidiary or Joint Venture during the Term, to the extent such claims have not been caused in whole or in part by the gross negligence or willful or reckless misconduct of any Parent Indemnified Party; (c) any action against Parent brought by any of such Subsidiary's or Joint Venture's employees or former employees related to claims of employment by such Subsidiary or Joint Venture or related rights or benefits; (d) any act or omission by any employee or agent of such Subsidiary; (e) any violation of any requirement applicable to such Subsidiary or Joint Venture under any federal, state, or local environmental, hazardous waste or similar law or regulation, to the extent such claims have not been caused in whole or in part by the gross negligence or willful or reckless misconduct of any Parent Indemnified Party; and (f) any action by Parent properly undertaken in accordance with a written directive by the Board of such Subsidiary or Joint Venture, in each case whether as a result of direct claims or third party claims that the Parent Indemnified Parties or any of them may suffer or incur.

(b) Parent assumes all liability for and agrees to defend, indemnify and hold each Subsidiary or Joint Venture, its employees, officers, directors, shareholders, agents and affiliates (other than Parent) (collectively, the "Subsidiary/JV Indemnified Parties"), harmless from and against all Losses incurred by such Subsidiary or Joint Venture arising from or in connection with (a) alleged or actual failure by Parent to perform any of its duties hereunder; (b) any pending or threatened claims asserted against such Subsidiary or Joint Venture based on actions or omissions by Parent during the Term, to the extent such claims have not been caused in whole or in part by the gross negligence or willful or reckless misconduct of any Subsidiary/JV Indemnified Party; (c) any action against such Subsidiary or Joint Venture brought by any of Parent's employees or former employees related to claims of employment by Parent or related rights or benefits; (d) any act or omission by any employee or agent of Parent; (e) any violation of any requirement applicable to Parent under any federal, state, or local environmental, hazardous waste or similar law or regulation, to the extent such claims have not been caused in whole or in part by the gross negligence or willful or reckless misconduct of any Subsidiary/JV Indemnified Party; and (f) any action by such Subsidiary or Joint Venture properly undertaken in accordance with a written directive by the Board of Parent, in each case whether as a result of direct claims or third party claims that the Subsidiary/JV Indemnified Parties or any of them may suffer or incur.

Section 6.3 Notices. All notices and other communications hereunder shall be in writing and shall be delivered by hand or mailed by registered or certified mail (return receipt requested) or transmitted

by facsimile to the parties at the address of such parties on file with one another (or at such other addresses for a party as shall be specified by like notice) and shall be deemed given on the date on which such notice is received.

Section 6.4 Independent Contractor. Parent shall be an independent contractor and not an employee of, or partner with, any Subsidiary or Joint Venture solely by virtue of this Agreement.

Section 6.5 Compliance with Laws. Parent and the Subsidiaries and Joint Ventures desire that this Agreement and the obligations performed hereunder be in full compliance with (a) the terms and conditions of all licenses, permits and authorizations issued to a Subsidiary or Joint Venture by any governmental entity in connection with the conduct of the Subsidiary's or Joint Venture's business; (b) all applicable healthcare laws and policies, including the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, 45 C.F.R. Parts 160 and 164; and (c) any other applicable law. If any governmental entity determines that any provision of this Agreement violates any applicable law, the Subsidiaries, Joint Ventures, and Parent shall use their best efforts to immediately bring this Agreement into compliance, consistent with the terms and spirit of this Agreement.

Section 6.6 Events Beyond Control of Parties. No party hereto shall be responsible for any failure to comply with the terms of this Agreement where such failure is due to *force majeure*, which shall include, without limitation, fire, flood, explosion, strike, labor disputes, labor shortages, picketing, lockout, transportation embargo or failures or delays in transportation, strikes or labor disputes affecting supplies, or acts of God, civil riot, acts of terrorism, war or insurrection, acts of the federal government or any agency thereof, or judicial action. Specifically excluded from this definition are those acts of the federal government or any agency thereof or judicial action which could have been avoided by compliance with such laws or regulations as are publicly available and reasonably expected to be known by a party. Upon the cessation of any cause operating to excuse performance of any party under this Section 6.6, this Agreement shall continue in full force and effect unless or until otherwise terminated pursuant to this Agreement.

Section 6.7 Entire Agreement. This Agreement constitutes the entire understanding among the parties hereto with respect to the subject matter hereof and all prior agreements or understandings shall be deemed superseded hereby. No representations, warranties and certifications, express or implied, shall exist as among the parties except as stated herein.

Section 6.8 Amendments. Except as set forth in Section 4.3 above, no amendments, waivers or modifications hereof shall be made or deemed to have been made unless in writing executed by the party to be bound thereby.

Section 6.9 Arbitration of Disputes and Claims.

(a) Any dispute between or among the parties hereto regarding alleged non-compliance with this Agreement shall be submitted to a joint ad hoc dispute resolution committee made up of one representative for the affected Subsidiaries or Joint Ventures and one representative of Parent (the "Dispute Resolution Committee"). The Dispute Resolution Committee shall meet for the purpose of negotiating a mutually satisfactory resolution of the then outstanding dispute between or among the parties. All resolutions reached by the Dispute Resolution Committee shall be final and binding. If the Dispute Resolution Committee is unable to reach a resolution within fifteen (15) days of being appointed by the parties (or such other time period as mutually agreed to in writing by the parties), the dispute at issue shall be submitted to

a mediator selected by the Dispute Resolution Committee. If the mediator is unable to assist the parties in reaching a resolution within thirty (30) days of being appointed (or such other time period as mutually agreed to in writing by the parties), the dispute at issue shall be submitted to arbitration in accordance with Section 6.9(b) of this Agreement.

(b) Any unresolved dispute under Section 6.9(a) that is not resolved by the Dispute Resolution Committee may be submitted by a party to binding arbitration for resolution. Such arbitration shall be final and binding. The arbitrator shall be mutually selected by Parent and one representative of the affected Subsidiaries or Joint Venture. The arbitrator shall be a nationally recognized health care consultant with a business and financial background who works predominantly in the healthcare field, and who is familiar with the business and financial aspects of home healthcare. The arbitrator shall be instructed to make decisions in accordance with the principles, goals, and intentions of the parties, as set forth in this Agreement. All arbitration shall be conducted in Dallas, Texas. The costs of the arbitration and the fees of the arbitrator shall be paid by the non-prevailing party(ies), as determined by the arbitrator.

Section 6.10 Binding Agreement; Severability. This Agreement shall be binding upon and inure to the benefit of each party hereto and their respective permitted successors and assigns. If any provision of this Agreement is determined to be invalid or unenforceable in whole or in part, the remaining provisions shall be enforceable to the greatest extent possible.

Section 6.11 Time of Essence. Time is of the essence in the performance of all matters under this Agreement.

Section 6.12 Counterparts. This Agreement may be executed in any number of counterparts (including via email with scan attachment or facsimile), each of which when so executed shall be deemed to be an original and all of which when taken together shall constitute this Agreement.

Section 6.13 Successors and Assigns. This Agreement shall not be assignable, in whole or in part, directly or indirectly, by any party hereto without the prior written consent of the other party hereto, and any attempt to assign any rights or obligations arising under this Agreement without such consent shall be void; *provided, however*, that Parent may assign this Agreement or delegate some or all of Parent's obligations hereunder to one or more affiliates or subsidiaries of Parent, provided that Parent shall remain liable and responsible to the Subsidiaries and Joint Ventures for the performance of any such assignee(s). This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

Section 6.14 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Texas and of the United States.

Section 6.15 No Third-Party Beneficiaries. This Agreement is solely for the benefit of the parties hereto and should not be deemed to confer upon third parties any remedy, claim, liability, reimbursement, claim of action or other right in excess of those existing without reference to this Agreement.

Section 6.16 Waiver. The failure of any of the parties hereto to enforce any provision of this Agreement cannot be construed to be a waiver of such provision or of the right thereafter to enforce the same, and no waiver of any breach shall be construed as an agreement to waive any subsequent breach of the same or any other provision.

Section 6.17 **Headings**. The section and paragraph headings used in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

[Remainder of Page Intentionally Blank, Signatures on Following Pages]

IN WITNESS WHEREOF, the undersigned have caused this Agreement to be duly executed and operable as of date first written above.

AccentCare, Inc. ("Parent")

By: _____

Name: Ryan Solomon

Title: Chief Financial Officer, Executive Vice President, and Treasurer

[redacted]

[redacted]

Seasons Hospice & Palliative Care of Pierce County Washington, LLC;

[redacted]

By: _____
Name: Dena L. Schwartz-Doty
Title: Vice President

EXHIBIT I

COMPENSATION

In consideration for the Management Services provided hereunder, the Subsidiaries and Joint Ventures (other than any excluded subsidiaries or joint ventures ("Excluded Subsidiaries and Joint Ventures") listed and detailed in Exhibit II attached hereto) shall pay to Parent a quarterly management fee equal to the Aggregate Management Fee (less any Pro Rata Portion of the Aggregate Management Fee attributed to Excluded Subsidiaries and Joint Ventures). Each such Subsidiary or Joint Venture shall be responsible for its Pro-Rata Portion of the Aggregate Management Fee. Except with respect to Excluded Subsidiaries and Joint Ventures, the Aggregate Management Fee and each Subsidiary's or Joint Venture's Pro Rata Portion, thereof, shall be computed quarterly, with charges for and payments of each Subsidiary's or Joint Venture's Pro Rata Portion accounted for in the inter-company accounts established between Parent and each Subsidiary or Joint Venture.

This Agreement recognizes that other management agreements between the Parent and the Subsidiaries or Joint Ventures may have already been in effect and if any other management agreement fees were charged under any other management agreement during the Term, full credit will be afforded in the computation of that particular Subsidiary's or Joint Venture's Pro Rata Portion. This shall not include the Employment Services Agreement as detailed in Section 2.2 of the Agreement which shall not be deemed to be a management agreement and shall not be considered in the calculation of the Aggregate Management Fee.

Excluded Subsidiaries and Joint Ventures shall not be charged their respective Pro Rata Portion of the Aggregate Management Fee.

Notwithstanding anything contained herein to the contrary, the Aggregate Management Fee shall not exceed twelve percent (12%) of the aggregate revenues of the Subsidiaries and Joint Ventures other than Excluded Subsidiaries and Joint Ventures.

Definitions. As used in this Agreement, the following capitalized terms shall have the following meanings:

(a) "Aggregate Management Fee" means, for any calendar quarter, an amount equal to all costs and expenses incurred and/or accrued by Parent during such calendar quarter in providing the Management Services hereunder, including without limitation, salaries and other employee expenses related to Parent's employees reported or reportable on Form W-2, costs of employee benefit plans, general office and administrative expenses, costs of insurance and risk management, leasehold and equipment rental expenses, depreciation expense, professional fees and related expenses, certain taxes and business fees excluding taxes on income, advertising expense, recruiting expense, and expenses of independent contractors. For the initial Term, a five percent (5%) mark-up will be applied to the Aggregate Management Fee. For any successive one-year extensions of the Term, the same five percent (5%) mark-up will be applied. In no event shall the Aggregate Management Fee exceed fair market value, and if a payment hereunder would exceed fair market value, then instead only fair market value amounts shall be paid.

(b) "Excluded Subsidiary or Joint Venture" means a Subsidiary or Joint Venture listed on Exhibit II.

(c) "Pro Rata Portion" for any Subsidiary or Joint Venture means an amount equal to (i) such Subsidiary's or Joint Venture's Net Sales for the applicable quarterly period of the Term, divided by (ii) the aggregate Net Sales of all Subsidiaries and Joint Ventures (including Excluded Subsidiaries and Joint Ventures) for such applicable quarterly period of the Term.

(d) "Net Sales" means gross operating revenue less contractual adjustments and allowances.

EXHIBIT 3

AccentCare, Inc. Brochures
AccentCare, Inc. Facility List

accentCare.™

By the Numbers

AccentCare® is a nationwide leader in post-acute health care, with innovative partnerships and care models covering the full continuum from personal, non-medical care to care management, skilled nursing, rehabilitation, and hospice care.

210,000+ PATIENTS/CLIENTS ANNUALLY

- **130,000** HOME HEALTH
- **40,000** PERSONAL CARE SERVICES
- **40,000** HOSPICE
- **400** MEDICAL HOME CARE

29,000+ EMPLOYEES

- **3,700** NURSES
- **1,200** THERAPISTS
- **22,900** OTHER CAREGIVERS
- **2,200** ADMINISTRATORS

WE WORK WITH **25,000+** PHYSICIANS/PHYSICIANS GROUPS

WE CARE FOR PATIENTS/CLIENTS IN **10,000+** FACILITIES (HOSPITALS, SNFS, REHABS)

Joint Ventures

Asante® • Baylor Scott & White Health • ChristianaCare® • Fairview® Health Services • Memorial Regional Hospital South • Miami Jewish Health • UCLA Health • UC San Diego Health at Home

[1]Locations counted include all offices that deliver patient care, products, and services.

Professional Development • Standards of Excellence • Service to Our Communities

TRAINING, DEVELOPMENT, AND RECOGNITION

AccentCare Education
Over 2,000 online courses, books, and videos
Clinical Ladder Advancement Program
Awards and Recognition
AccentCare Culture Awards
Annual clinical and sales awards

DISTINCTIONS

HomeCare Elite designations
Joint Commission recognition
CHAP accreditations
4.6 overall CMS quality star rating[2]
We Honor Veterans partnership

[2]OASS-based measures: 07/01/2020-06/30/2021; Claims based measures: 01/01/2019-12/31/2019. CMS April 2022 report.

PHILANTHROPY

Employee Assistance Fund
Financial resources for employees, by employees
Hospice Foundations
Nonprofit organizations providing financial aid to hospice patients and families with needs unmet by traditional funding sources

accentCare.

Home Health

By the Numbers

AccentCare® is a nationwide leader in post-acute healthcare, with innovative partnerships and care models covering the full continuum from personal, non-medical care to care management, skilled nursing, rehabilitation, and hospice care.

130,000+
PATIENTS ANNUALLY

7,800+
FACILITIES (HOSPITALS, SNFS, REHABS)

110+
LOCATIONS[1]

SERVICE AREA
CA, CO, FL, GA, IL, IN, MA, MI, MN, MS, NE, NH, NM, OH, OK, OR, PA, TN, TX, VA

4,600+
EMPLOYEES

- 2,100 NURSES
- 1,200 THERAPISTS
- 200 AIDES
- 1,100 ADMINISTRATORS

WE WORK WITH
22,500+
PHYSICIANS/ PHYSICIANS GROUPS

[1]Locations counted include all offices that deliver patient care.

What Sets Us Apart

TRAINING, DEVELOPMENT, AND RECOGNITION

AccentCare Education
Over 2,000 online courses, books, and videos
Clinical Ladder Advancement Program
Awards and Recognition
AccentCare Culture Awards
Annual clinical and sales awards

DISTINCTIONS

HomeCare Elite designations
CHAP accreditations
4.6 overall CMS quality star rating[2]

HomeCare Elite® AGENCY 2019

CHAP

CMS RATING

[2]OASIS-based measures: 07/01/2020-06/30/2021; Claims-based measures: 01/01/2019-12/31/2019. CMS April 2022 report.

PHILANTHROPY

Employee Assistance Fund
Financial resources for employees, by employees
Hospice Foundations
Nonprofit organizations providing financial aid to hospice patients and families with needs unmet by traditional funding sources

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Hospice

By the Numbers

AccentCare® is a nationwide leader in post-acute health care, with innovative partnerships and care models covering the full continuum from personal, non-medical care to care management, skilled nursing, rehabilitation, and hospice care.

40,000+
PATIENTS/CLIENTS ANNUALLY

2,100+
FACILITIES

SERVICE AREA
CA, CO, CT, DC, DE, FL, GA, IN, MA, MD, MI, MN, MO, MS, NJ, OR, PA, TN, TX, WI

60+
LOCATIONS[1]

1,500 NURSES
600 SUPPORT CAREGIVERS
600 AIDES
500 ADMINISTRATORS

3,200+
EMPLOYEES

WE WORK WITH
1,800+
PHYSICIANS/ PHYSICIANS GROUPS

[1]Locations counted include all offices that deliver patient care.

What Sets Us Apart

TRAINING, DEVELOPMENT, AND RECOGNITION

AccentCare Education
Over 2,000 online courses, books, and videos
Clinical Ladder Advancement Program
Specialty Programs
Largest employer of Board Certified Music Therapists in US
Namaste Care for dementia
US based call center for 24/7 nationwide patient care

DISTINCTIONS

Accreditations
We Honor Veterans partnership

PHILANTHROPY

Employee Assistance Fund
Financial resources for employees, by employees
Hospice Foundations
Nonprofit organizations providing financial aid to hospice patients and families with needs unmet by traditional funding sources

accentCare.

Personal Care Services

By the Numbers

AccentCare® is a nationwide leader in post-acute healthcare, with innovative partnerships and care models covering the full continuum from personal, non-medical care to care management, skilled nursing, rehabilitation, and hospice care.

40,000+
CLIENTS ANNUALLY

SERVICE AREAS
AZ, CA, IL, MA, NY, OH, PA, TN, TX, WA

21,300
NURSES

21,900+
EMPLOYEES

600
ADMINISTRATORS

[1]Locations counted include all offices that deliver patient care.

What Sets Us Apart

TRAINING, DEVELOPMENT, AND RECOGNITION

AccentCare Education
Over 2,000 online courses, books, and videos
Clinical Ladder Advancement Program
Awards and Recognition
AccentCare Culture Awards
Annual clinical and sales awards

KEY FEATURES

- Personalized private duty care, sensitive to patient and family needs
- Clients include children and young adults, as well as seniors
- Payment options may include: private insurance, private pay, workers' compensation, school districts, federal payors, long-term care polices, trust funds, Medo-Cal/Medicaid

PHILANTHROPY

Employee Assistance Fund
Financial resources for employees, by employees
Hospice Foundations
Nonprofit organizations providing financial aid to hospice patients and families with needs unmet by traditional funding sources

Caring For Veterans With Posttraumatic Stress Disorder at the End of Life

TIPS FOR RECOGNIZING TRAUMA-RELATED SYMPTOMS

PTSD Symptoms at the end of life may be challenging to recognize

Symptoms may present as:

SIMILAR	SPECIFIC	INTERNAL
to common end of life symptoms like agitation or sleep disturbance	to PTSD like intrusive memories of a traumatic event	such as thoughts and feelings and be hard to know unless one asks

Key Facts about PTSD in late life

1	7%	33%
Most older adults have at least **1 traumatic event** in their lifetimes.	**Among older adults, 7%** experience PTSD during their lifetimes.	**Among Vietnam Veterans, 1/3** experience PTSD in their lifetimes.

How PTSD may look at the end of life

Symptom	Example
Intrusive memories, nightmares, flashbacks	Distressing thoughts or dreams of trauma
Avoiding reminders of traumatic events	Missing appointments around Veterans Day or Memorial Day
Expressing feelings of guilt	Saying things like "I shouldn't have made it"
Irritability and anger	Anger when healthcare workers come to the home
Agitation and increased restlessness	Terminal restlessness that seems minimally responsive to medications
Resistance to care	Refusing medical care
Sleep impairment	Unable to fall or stay asleep
Fractured family relationships	Close family minimally involved or absent

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Rural Health

Caring For Veterans With Posttraumatic Stress Disorder at the End of Life

TIPS FOR RECOGNIZING TRAUMA-RELATED SYMPTOMS

Conversation Starters for Clinicians

As some people navigate serious illness they experience memories of previous frightening or shocking events. Is this something that you experience?

Some veterans think more about military service later in life. Is this true for you?

Primary Care PTSD Screen for Clinicians 5 questions screen for PTSD

https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

Sample – In the past month have you...
Had nightmares about the event(s) or thought about the event(s) when you did not want to? (yes/no)

Sample – In the past month have you...
Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the events may have caused? (yes/no)

PTSD Checklist 20 self-report questions for PTSD

https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Sample - How much are you bothered by:
Being "superalert" or watchful or on guard? (rate 0-4)

Sample - How much are you bothered by:
Feeling distant or cut off from other people? (rate 0-4)

LOSS Scale 11 or 44 self-report questions about re-engaging military memories in late life

https://www.ptsd.va.gov/professional/assessment/adult-sr/loss_scale.asp

Sample –
My family and friends tell me that I have recently been speaking more emotionally about the war. (rate 0-4)

Sample –
Lately, I think more about friends I lost during the war. (rate 0-4)

For more help contact the VA PTSD Consultation Program at 866-948-7880 or PTSDconsult@va.gov

P0355

ANCC
AMERICAN NURSES CREDENTIALING CENTER
ACCREDITATION

8515 Georgia Ave., Suite 400
Silver Spring, MD 20910

January 27, 2020

Jennifer Nycz MSN, RN, CHPN
Seasons Hospice and Palliative Care – P0355
6400 Shafer Ct
Rosemont, IL 60018
jnycz@seasons.org

COMMISSION ON ACCREDITATION ACTION

The American Nurses Credentialing Center's Commission on Accreditation reviewed your application for accreditation as a provider of nursing continuing professional development on **January 27, 2020.** The Commission is pleased to inform you that accreditation has been granted for **four** years, from **January 27, 2020 - July 31, 2024.**

Please note: Your accreditation expires **July 31, 2024,** which means your re-accreditation cycle is scheduled for **November 2023.**

Organizations accredited as providers use the appropriate ANCC Commission on Accreditation terminology related to accreditation status in all communications. The appropriate terminology is:

> Seasons Hospice and Palliative Care is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

Note to applicant:

- Please remember to identify the names, credentials and role of all persons in a position to control content.
- Provide evidence of method for calculating contact hours and number of contact hours being awarded.

It is the responsibility of the accredited organization to be aware of changes to the accreditation criteria or process. Any changes will be posted on the accreditation website, https://www.nursingworld.org/organizational-programs/accreditation/primary-accreditation/.

P0355

Marketing materials to convey accreditation status are available on the web site at: https://www.nursingworld.org/organizational-programs/accreditation/primary-accreditation/. The login is:

Username: [redacted]
Password is: [redacted]
The Commission acknowledges your commitment to life long learning and commends you in achieving accreditation.

Amy Bernard

Amy Bernard, MS, BSN, RN-BC, CHCP
Chairperson, Commission on Accreditation

From: Veronica Martin
To: Tracy Merritt; Russell Hilliard
Cc: Darcy DeLoach
Subject: FW: ASWB Approval of name change
Date: Monday, October 17, 2022 4:13:29 PM
Attachments: ANCC Approval Letter 2022.pdf

Good Afternoon!
Below is the confirmation letter for ASWB. I'm attaching the ANCC letter. Have a great day!
Roni

From: Karen Crowe <kcrowe@aswb.org>
Sent: Thursday, December 30, 2021 6:58 AM
To: Ryana Goldberger <RGoldberger@Seasons.org>
Subject: Re: Question on how to handle brand change

Ryana,

Yes- the name change is approved.

Thanks,
Karen Crowe

> On Dec 29, 2021, at 12:05 PM, Ryana Goldberger <RGoldberger@seasons.org> wrote:
>
> Hello! Did you receive the form I sent a couple of weeks ago? We are in the process of getting ready to advertise a CE event in February so I'd like to ensure we can use the new name. Thank you and Happy New Year!
>
> **From:** Ryana Goldberger
> **Sent:** Tuesday, December 14, 2021 9:52 AM
> **To:** Karen Crowe <kcrowe@aswb.org>; Darin Szilagyi <darinszilagyi@accentcare.com>
> **Subject:** RE: Question on how to handle brand change
>
> We are on top of it from multiple angles! I confirmed the effective date last night so I will email the form shortly to ace@aswb.org. Thank you, Karen!

Ryana Goldberger, MSW, LCSW, ACHP-SW
Director-Supportive Care Instruction
Seasons Hospice & Palliative Care
6400 Shafer Court, Suite 700
Rosemont, IL 60018
Cell: 858-260-4081
rgoldberger@seasons.org
www.seasons.org | www.seasonsfoundation.org
Follow us on Facebook | Twitter | YouTube
Honoring Life~Offering Hope
<image001.jpg>

From: Karen Crowe <kcrowe@aswb.org>
Sent: Tuesday, December 14, 2021 7:20 AM
To: Darin Szilagyi <darinszilagyi@accentcare.com>
Cc: Ryana Goldberger <RGoldberger@Seasons.org>
Subject: RE: Question on how to handle brand change

Darin,

Ryana reached out to ACE regarding the name/branding change. Attached is my email response to her.

Thanks,

Karen S. Crowe
Continuing Competence Project Coordinator
17126 Mountain Run Vista Ct., Culpeper VA 22701
800.225.6880, ext. 3051
aswb.org

<image003.jpg>

From: Darin Szilagyi <DarinSzilagyi@AccentCare.com>
Sent: Monday, December 13, 2021 3:32 PM
To: ace <ace@aswb.org>
Subject: Question on how to handle brand change

Hi

My name is Darin Szilagyi, and I will be managing the Seasons Hospice/AccentCare ACE program communication going forward

May I ask a question? So that we are compliant on our future ACE offering and collateral, is there any filings that you will require as we rebrand our organization from Seasons Hospice to AccentCare? As you might know, Seasons and AccentCare merged in 2020, and we are just now starting to rebrand everything under one name

I really appreciate any help you can provide.
DS

Darin Szilagyi, FACHE | Vice President, Marketing & Communications
17855 North Dallas Parkway, Suite 200
Dallas, TX 75287
Office: 972.366.2169
Cell: 281.536.5725
Fax: 972.267.1116
Email: DarinSzilagyi@accentcare.com

<image004.png>
<image005.png>

accentCare™

Reimagining care, together.

Certificate Of Need
Talent Acquisition

TALENT ATTRACTION STRATEGY

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Talent Acquisition – 90-day Launch Plan

Strategic Recruiting Plan

- Market Announcement – Partner with Marketing Team to implement market announcement
- Social Media launch
  - ❑ LinkedIn
  - ❑ Facebook
- Digital Marketing Email Campaign
- Text Recruit Campaign
- Direct Mail Cards
- Market Open House
  - ❑ Invite Community Association
- Circa/DEI Community Programs Connections
  - ❑ LGBTQ Commission/Pride Foundation
  - ❑ National Asian Pacific Center on Aging
  - ❑ National Hispanic Nurses Association
- O'Grady Peyton International Nurses
  - ❑ Hired – 30 RN's – Will be assigned to Branches throughout Enterprise
  - ❑ 8 RN's currently on assignment
- University/Trade School Partnerships
  - ❑ Chamberlain University – New Grad RN opportunities/Offer Clinical Rotations
  - ❑ Aguilas International Technical School – Florida Certified Nursing Aide Certification Program – 2 hires per graduating class

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What Sets Us Apart!

Circa / DEI Partnership

*LGBTQ Commission/Pride Foundation

*National Asian Pacific Center on Aging

*National Hispanic Nurses Association

*Black Nurses Associations

Clinical Hiring Manager Model

CHM's were previous Leaders in AC Branches. They interview LVN, RN, HHA, and Therapy roles. The Clinical Hiring Manager Model **goal** is to provide enhanced, scalable professional talent services & support to clinical leaders to help them ***select***, ***develop***, ***retain*** and ***engage*** the clinical talent they need to deliver exceptional patient quality care & outcomes.

Home Health/Hospice Aides

*Partnership with Aguilas International Technical School in Tampa, Florida Certified Nursing Aide Certification Program – Will hire 2 new grads per graduating class

*HHA School partnerships developing across the enterprise for feeder programs in hard to fill markets

Chamberlain University and AccentCare are building on strong foundation of collaboration based on:

- Aligned **missions** and a commitment to **innovation** to address the current **nursing crisis**
- Chamberlain the **largest school of nursing** in the United States, with more than 35,000 students and over 100,000 alumni
- Significant **geographic overlap** for pre-licensure BSN programs
- Position to have RN clinical rotations at select Accent Care locations
- Chamberlain will find nursing candidates for Accent Care for "hard to fill" locations
- Expected **194,000 RN openings** every year through **2030** as nurses retire and patient demand increase. Current average age of RN is **52 years**

Dedicated Recruitment Team

Dedicated Recruitment Team for each market that focuses on market analytics, recruitment strategy and community partnerships

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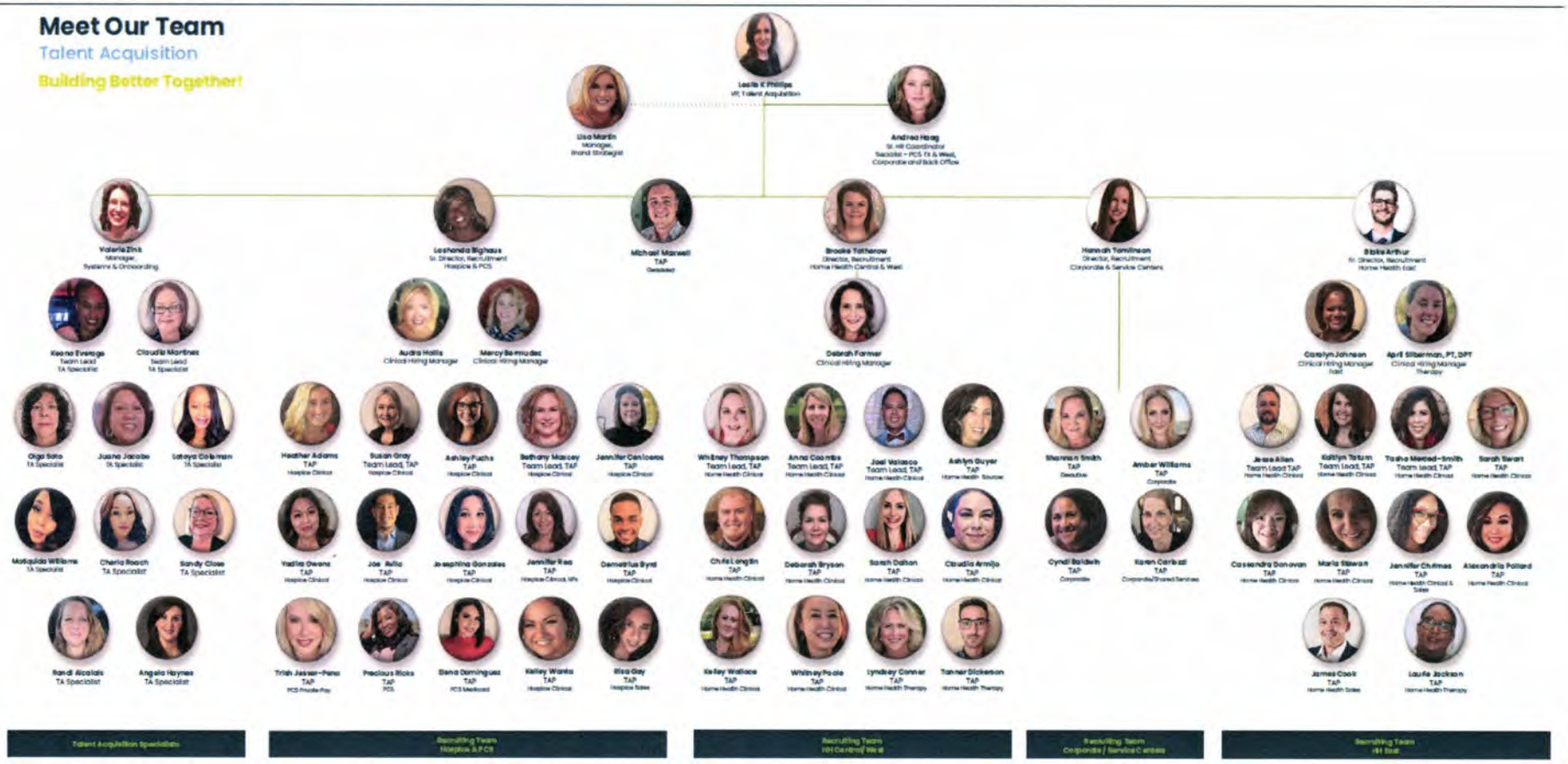
Talent Acquisition Team



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International Nursing

Hires 30

8 RN's on assignment

Last Name	First Name	Location	Accent Care Referral	Est. Start Date	Country of Origin
Martial- Leopoldie	Gilee	HH-Houston	OGP	3/28/2022-Started	St. Lucia
Gariba	Mohammed	HOS – ATL IPU	OGP	4/18/2022-Started	Ghana
Chinyemba	Winnett	HOS-Broward IPU	OGP	4/25/2022-Started	Zimbabwe
Walker	Nichole	HOS-Broward IPU	OGP	5/2/2022-Started	Jamaica
Chishom	Radeesha	HOS – Broward IPU	OGP	5/30/2022 – Started	Jamaica
Williams	Delecia	HOS-Hillsborough IPU	OGP	5/16/2022- Started	Jamaica
Ekwunife	Chidinma	HOS – Broward IPU	OGP	5/16/2022- Started	Nigeria
Jarencio	Joster	HOS-DFW IPU	OGP	7/11/2022-Started	Philippines
Soriano	Katrin Anne	HH-Mckinney	OGP	6/30/2022 – Started	Philippines
Munodzana	Chido	HH – S. Austin	OGP	6/30/2022 – Started	Ireland
Amaechi	Christiana	HOS-Chicago IPU	OGP	10/1/2022 – Started	Nigeria
Siringin	Jamaica	HOS-MD IPU	OGP	12/20/22	Philippines
Amakye-Ansah	Deborah	HOS-DFW IPU	OGP	9/30/2022	
Macatangau	Eleanor O.	HOS-Broward IPU	Dr. Cadenas	12/30/2022	Philippines
Cometa	Mary Abelyn	HOS-Tampa	Dr. Cadenas	12/30/2022	Philippines
Calo-Oy	Cherry Ann	HOS – ATL IPU	Dr. Cadenas	12/30/2022	Philippines
Parnes	Rosabel	HOS-Broward IPU	Dr. Cadenas	12/30/2022	Philippines
Zabala	Ronel Ryan	HOS-Broward IPU	Dr. Cadenas	12/30/2022	Philippines
Corpus	April Carmelite	HOS-DFW IPU	Dr. Cadenas	12/30/2022	Philippines
Gonzales	Estelara Kristine	HOS-Broward IPU	Dr. Cadenas	12/31/2022	Philippines
Parducho	Sylvette	HOS-DFW IPU	Dr. Cadenas	12/31/2022	Saudi Arabia
Santos	Susan	HOS-Chicago IPU	Dr. Cadenas	12/31/2022	Philippines
Cunanan	Noel	HOS-DFW IPU	Dr. Cadenas	12/31/2022	Phillipines
Ramos	Herold	HOS-Broward IPU	Dr. Cadenas	12/31/2022	Philippines
Ramos	Jinnalyn	HOS-Broward IPU	Dr. Cadenas	12/31/2022	Philippines
Ledesma	Lovely	HOS-DFW IPU	Dr. Cadenas	12/31/2022	Philippines
Marcelo	Eymards Nicolas	HOS-MD IPU	Dr. Cadenas	12/31/2022	Philippines
Ballestros	Kristine	HOS-Broward IPU	Dr. Cadenas	12/31/2022	
Lall	Padminie	HOS-MD IPU	OGP	12/31/2022	UK/Guyuna

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Hospice: Current Academic Affiliations

Approximately **150** Academic Affiliations

- Northwest
  - Willamette University
  - University of the Pacific
  - UCSF
- Southwest
  - UCSD
  - California State University Northridge
- Southeast
  - University of Miami
  - West Coast University
  - Regis University
  - University of Phoenix
  - Aguilas International Technical School

- South
  - Sam Houston University
  - Southern Methodist University
- Northeast
  - Berklee College
  - Lesley University
  - NYU
  - Montclair State University
- Central
  - University of Michigan
  - Northwestern University
  - Loyola University Chicago
  - Perdue University

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dei

diversity. equity. inclusion.

Demographics

2022 Q3 V 1.0

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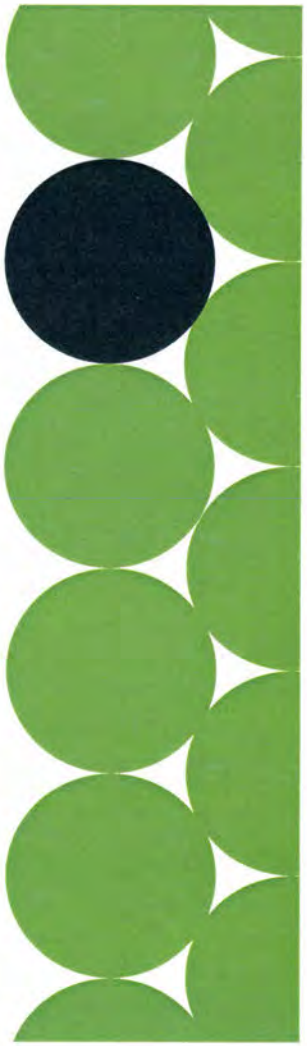
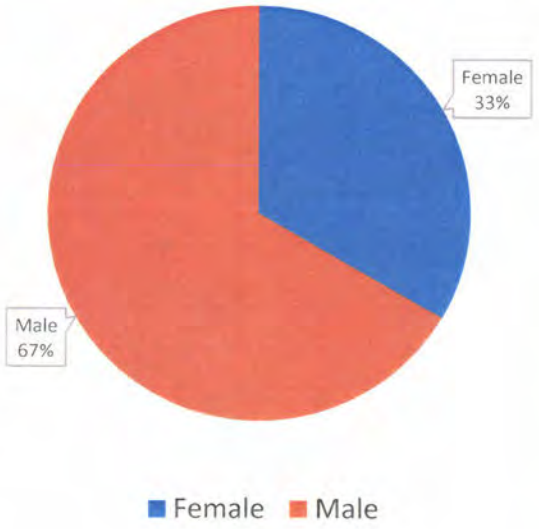
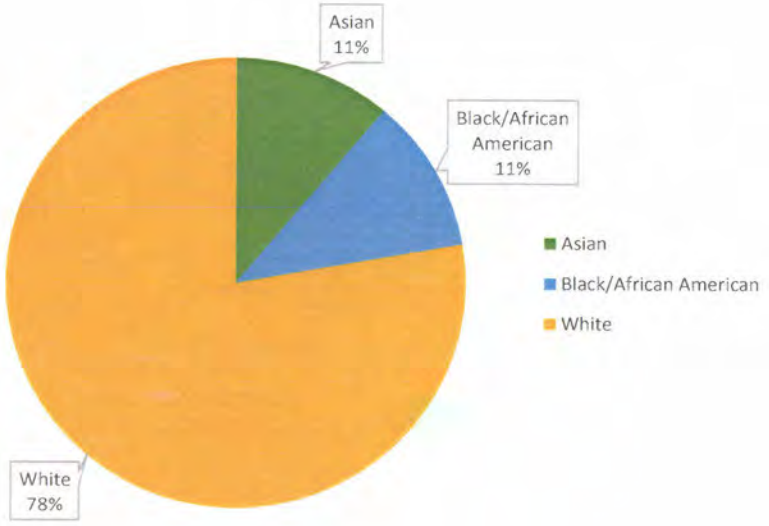


AccentCare Board (Gender/Ethnicity)

Census: 9 as of 09/01/22





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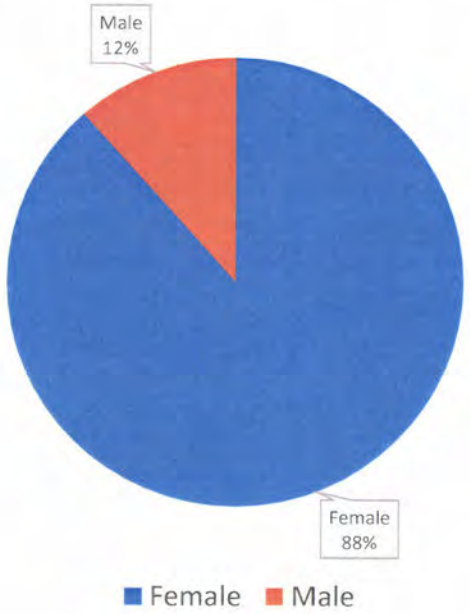
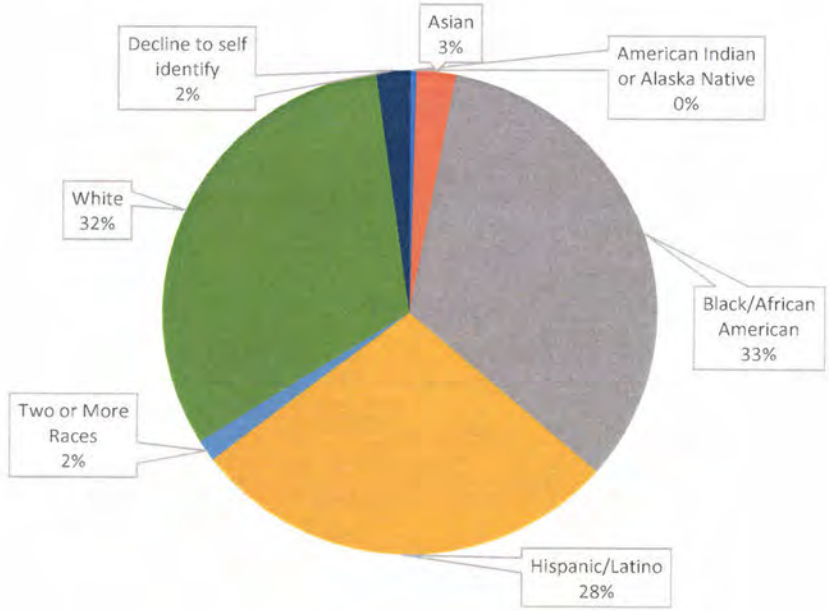
Total Workforce (Gender/Ethnicity)

Census: 29,517 as of 09/01/22





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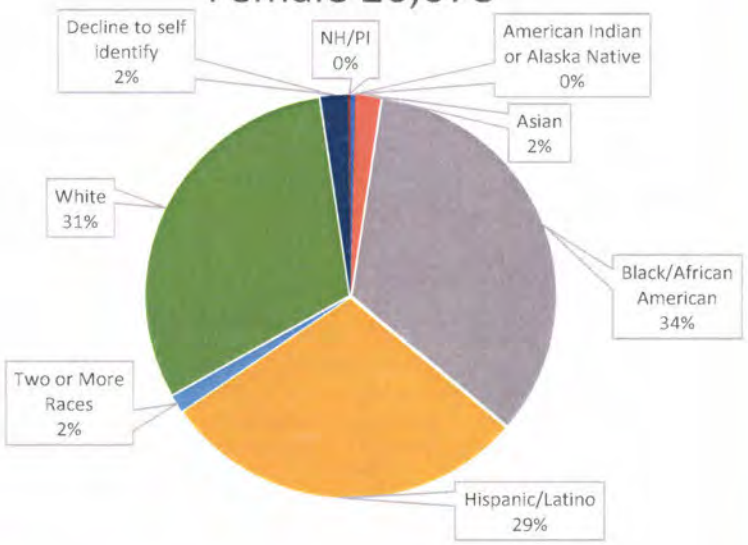
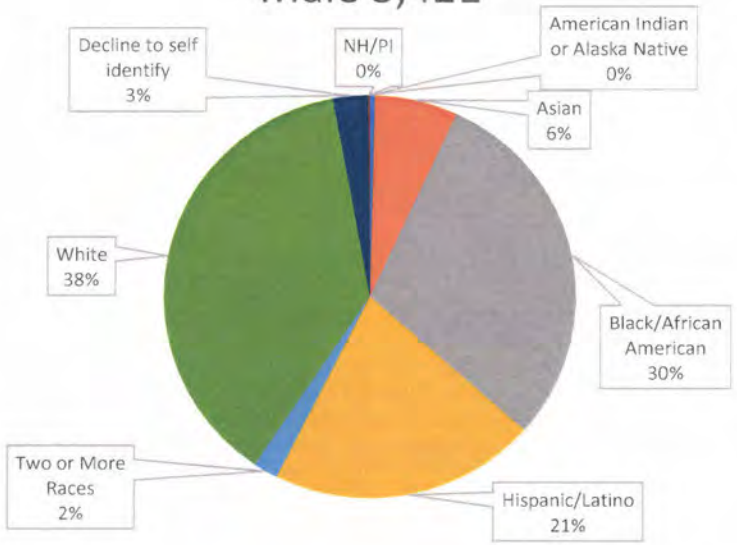
Gender & Ethnicity (INTERSECTIONALITY)

Census: 29,517 as of 09/01/22

Female 26,078



Male 3,421



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SEASONS HOSPICE & PALLIATIVE CARE®

an AccentCare® Company

Seasons is a national hospice and palliative care provider.
We are available 24 hours a day,
7 days a week, every day of the year.

If you have questions or need help understanding
how to use this guide you can talk to our supportive staff at
855-812-1136.

To learn more about how hospice can help patients
and families facing the end of life,
visit us at www.seasons.org

Honoring Life ~ Offering Hope

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SEASONS HOSPICE & PALLIATIVE CARE®

an AccentCare® Company

**Even if you become to sick to talk,
you can still let your doctors,
family and friends know
what your care choices are.**

This is a guide to help you understand your choices and make sure your doctor and your loved ones understand what you want. It is important that you know that this is not a legal form. If you need help with this, you can call 855-812-1136

What you should understand about comfort care, also called hospice care.

People who are very sick, often choose hospice comfort care.

- Hospice comfort care makes you feel more comfortable and feel better.
- Hospice comfort care eases your pain.
- Hospice comfort care will not cure your illness.
- Hospice comfort care comes to you, where ever you live. You do not need to go to a doctor's office or a hospital to get hospice comfort care.
- Hospice comfort care is paid for by Medicare and Medicaid.

What happens if you choose hospice comfort care?

There is a hospice comfort care team to help care for you and your family:

- A nurse comes to visit you to keep you pain free.
- A hospice aide comes to visit you to help with baths and other personal care.
- Other hospice workers come to help you and your family. The things you need to feel comfortable are delivered to you. For example: medicine, a wheelchair, a special bed, or oxygen to help you breath.

If you or someone you know who is very sick, hospice comfort care can help.

SEASONS HOSPICE & PALLIATIVE CARE®
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How do I make sure my wishes and choices about my care are followed if I can't talk?

There are two ways to make sure your choices are followed:

1. **You can pick a person you trust to talk for you.**
   This person must be 18 years old or older and know you well. You are choosing this person to make healthcare choices for you if you are too sick to talk. You write this person's name on a form that says this person is your Healthcare Decision-Maker. The form may call this person a "surrogate."
2. **You can make healthcare decisions now while you are still able to talk.**
   You write them on a form that says these are my Healthcare Choices. This form is also called a Living Will. If you get too sick to talk, the form tells the doctor what you want.

Even if you are not sick, it is important to take the time now and write down what you want.

There are two forms on the next pages to help you do that. They are easy to fill out. You can fill out one or both, it is your choice.

It is very important that you sign your name at the bottom of each form. It is also important that you ask other people to sign it too.

Make copies of this booklet to give to your family, your doctors, and whoever cares for you.

If you change your mind, you can write down new choices, but it is important to remember to sign the new forms, get others to sign the new form and make new copies to give to whoever cares for you.

Form 1

The Person Who is My Healthcare Decision-Maker (also called a Surrogate)

Today's Date: My Name:

If I am sick and can't talk to my doctors, this is the person I choose to make my healthcare decisions.

Name:

Street Address:

State:

Phone Number:

If the first person cannot do the job, then I want this person to make my healthcare decisions if I am sick and can't talk to my doctors.

Name:

Street Address:

State:

Phone Number:

I want my healthcare decision-maker to do this:

(Put an X next to only one choice)

- ☐ Make all healthcare decisions based on what I write in My Healthcare Choices (also called a Living Will)
- ☐ Make all healthcare decisions based on guessing what I would say if I could talk.
- ☐ Make sure everything is done to help keep me stay alive as long as possible.

I also want my healthcare decision-maker to do these things:

(Put an X next to the one sentence you agree with.)

- ☐ Ask the doctors to give me hospice comfort care.
- ☐ Stop any treatments, including a feeding tube.
- ☐ Apply for public benefits to pay for my healthcare.

My healthcare Decision-maker should also know this:

(Using another piece of paper, write down anything else you want to tell your healthcare decision -maker)

You must sign your name on the line below while two other people watch you. These two people are witnesses to the healthcare choices you are making.

Your signature:

Today's date:

Witnesses #1 signature:

Today's date:

Witnesses #2 signature:

Today's date:

Make copies of this filled out booklet to give to your family, doctors and whoever cares for you.

Form 2
My Healthcare Choices (also called a Living Will)

Today's Date: My Name:

If I am too sick to tell you what I want and my doctor says I might die soon, this is what I want:

(Put an X next to one choice.)

- ☐ I want to be at home with the people I love.
- ☐ I want to be in a hospital or nursing home.
- ☐ I don't know what I want.

If I am too sick to tell you what I want and my doctor says I might die soon, this is something else I want:

(Put an X next to one choice.)

- ☐ I want to have everything done to help me stay alive as long as possible.
- ☐ I want hospice comfort care. That means stop everything that could extend my life, including a feeding tube.
- ☐ I want my doctors to try treatments to help me get better. If the treatments don't work, stop doing them.

My doctor should also know:

(Using another piece of paper, write down anything else you want to tell your doctor.)

You must sign your name on the line below while two other people watch you. These two people are witnesses to the healthcare choices you are making.

Your signature:

Today's date:

Witnesses #1 signature:

Today's date:

Witnesses #2 signature:

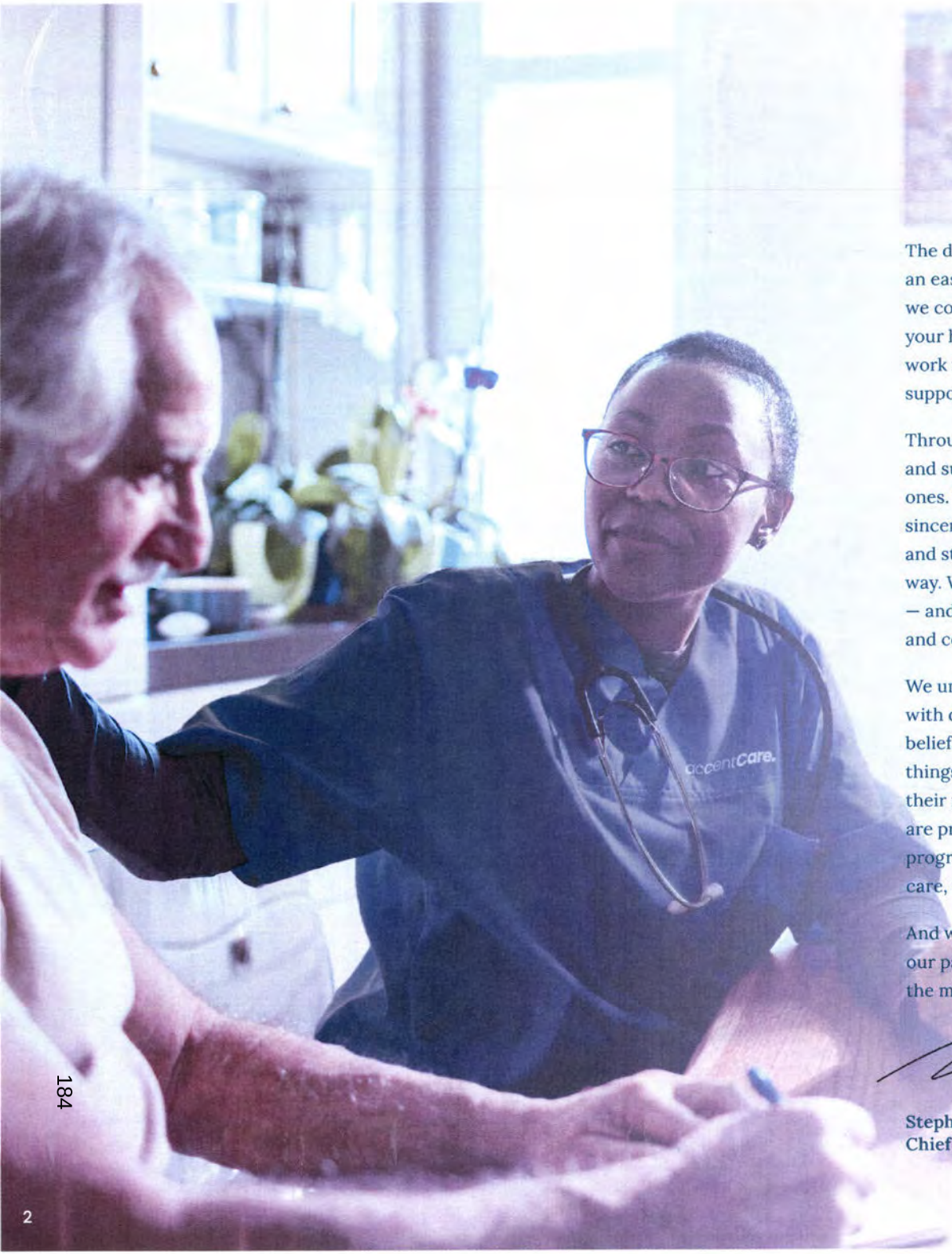
Today's date:

Make copies of this filled out booklet to give to your family, doctors and whoever cares for you.

A HOSPICE GUIDE

for Patients, Families, and Friends

accentCare.



The decision to enter hospice may not be an easy one to make. Here at AccentCare®, we commit to being a trusted guide through your hospice journey. Our care teams will work to provide comfort, counseling, and support for those needing hospice care.

Throughout our history, we've guided families and supported end-of-life care for their loved ones. We've approached each individual with sincerity, cared for patients with tenderness, and stood beside families every step of the way. We've shared life's most difficult moments — and helped patients and families find peace and comfort when it is needed most.

We understand that our patients come to us with different backgrounds, cultures, values, and beliefs — and we are committed to honoring the things that make them unique while fulfilling their individual health needs. To achieve this, we are proud to offer community-leading specialty programs such as music therapy, Namaste care, and Veterans' programs, among others.

And we commit to providing all of this where our patients tell us they want to receive care the most: the place they consider home.

Stephan Rodgers
Chief Executive Officer

Every AccentCare location is certified by Medicare to provide the full hospice benefit. However, not all specialty services are available at all locations. Please talk with your local team to understand which programs are offered in your area.

Questions you may have

What is hospice care?

Hospice is a specific type of care that focuses on pain and symptom management instead of curing an illness. We also provide emotional and spiritual support to our patients and their families.

Hospice care is provided wherever you or your loved one call home. That might be in your own residence, or at a skilled nursing or assisted living facility. Hospice care supplements the care that you are already receiving from your family or from the facility in which you live.

Our patients can expect routine visits from members of your hospice interdisciplinary team, including:

- Nurses
- Social Workers
- Chaplains
- Hospice Aides
- Music Therapists
- Volunteers

You'll also be assigned a hospice physician from our team, who may make periodic visits to check-in on you as needed.

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Does hospice mean we are giving up?
Hospice is not giving up. Hospice changes the focus of care from fighting a disease to living life with as much quality and comfort as possible.

Who is eligible for hospice care?

You are eligible for hospice care under Medicare guidelines if two physicians agree that you have a life expectancy of six months or less, and you are no longer seeking a cure to your illness.

Admission to our program is made upon the recommendation of your doctor, which is then reviewed and confirmed by one of our hospice physicians. One of our Hospice Care Consultants (HCC) may visit with you to discuss our hospice care services and answer any questions you may have. When you choose to use AccentCare, our HCC or another member of our team will help you fill out all required paperwork. An admissions nurse will also visit with you at the start of your care to assess your immediate needs and develop an individualized care plan for you and your family.

Who pays for hospice care?

For those with Medicare, the Medicare Hospice Benefit covers your time on hospice with no co-pays or fees. The benefit covers medical services related to the terminal prognosis from our doctors and nurses, medical supplies and appliances, medications for symptom management and pain relief, short-term stays in our inpatient centers and access to programs like music therapy, as well as other physical and occupational therapies as needed.

We also work with many private insurance companies as well as Medicaid to cover the cost of hospice care. If you have no insurance, we offer a sliding payment scale, as well as charity care for those that qualify. Your AccentCare team will work with you to arrange billing with the appropriate party.

What are the different levels of care?

AccentCare offers several levels of care for the different stages of your hospice journey. Eligibility for each level of care is decided based on your clinical status. Your hospice interdisciplinary team will help determine which level of care you may qualify for.

Routine Home Care: Provided by hospice team members who visit you in your home.

Continuous Care: Through extended visits, nurses and certified nursing assistants provide care in your home or facility to help manage and palliate out-of-control symptoms.

General Inpatient Care: Provided at one of our inpatient centers, in a hospital, or skilled nursing facility for patients who have pain or symptoms that cannot be managed in another setting.

Inpatient Respite Care: Up to 5 days of care at our inpatient center or a contracted facility to give the family/caregiver a rest.

The people who provide care

The Interdisciplinary Group and the Circle of Care

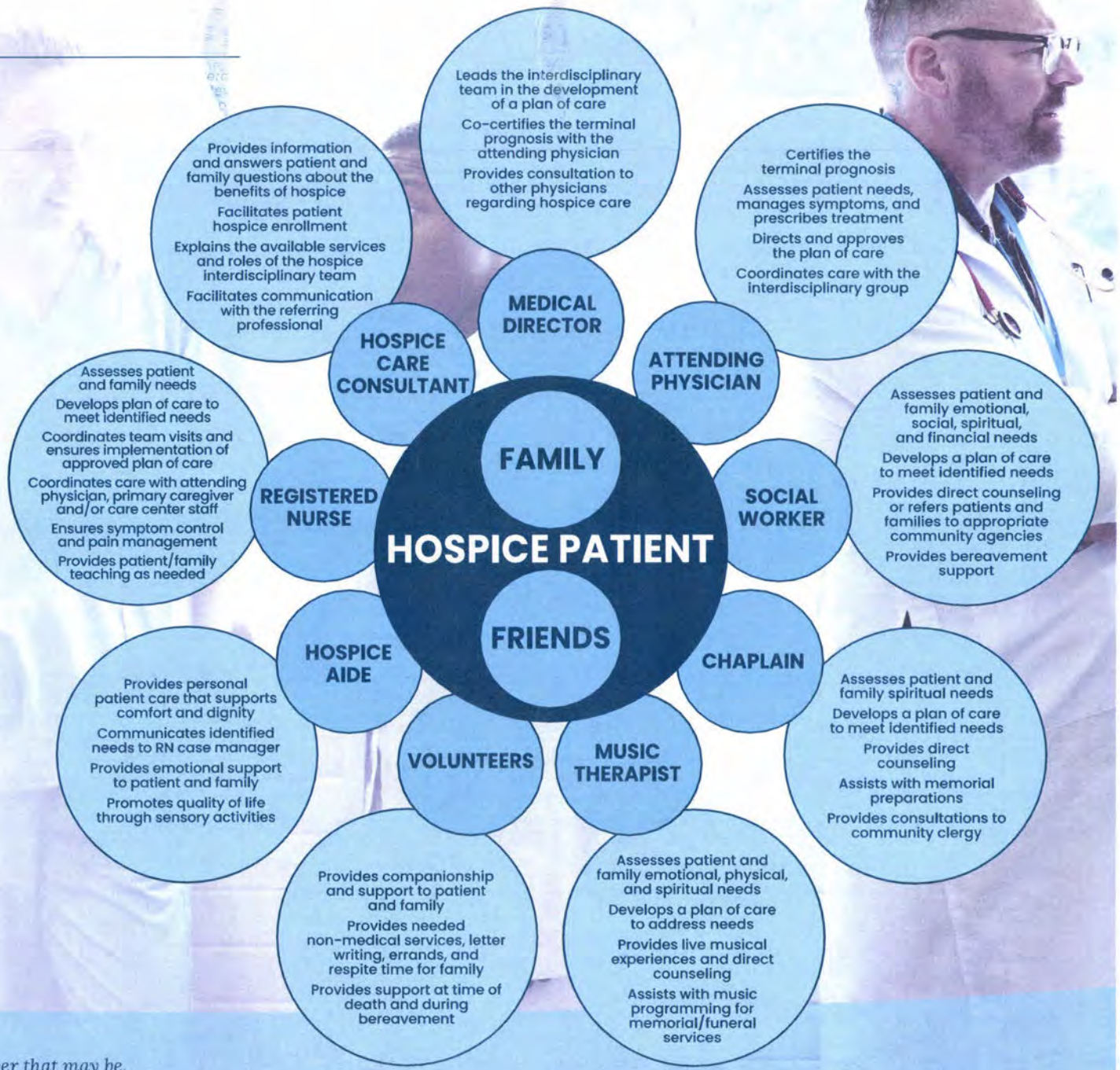
We understand that hospice and palliative care may be unfamiliar to you and your family. Too often, end-of-life care can be a complex and intimidating process. With AccentCare, you aren't alone. We'll work to earn your trust and educate you about the care hospice provides and how it can help during difficult moments.

Our care starts by working to understand your specific care needs and desires. Hospice care is as unique as the person receiving it. The care we provide is custom tailored to what matters most to you. At the heart of this philosophy is a holistic support system we call the "Circle of Care." Our approach relies on the Interdisciplinary Group (IDG), a team of specialists who support you and your loved one with deep experience. This diverse team works to lift the weight off your shoulders by developing a care plan that ensures your individual needs are met.

Our specialists collaborate with your physician and share regular updates with them about your clinical status. Care plans are regularly reviewed to address any changing needs. Simply put, you can have peace of mind that we are working to provide you with comfort and support, each step of the way.

AccentCare Specialty Programs

- AccentCare Open Access
- Music Therapy
- Namaste Care
- 24/7 Call Center staffed with registered hospice nurses, and after-hours support as needed
- Camp Kangaroo grief support programs for kids
- Hospice Foundation Wish Fulfillment
- Please ask your hospice team which specialty programs are available in your area



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Where Is Hospice Care Provided?
Hospice care is given in the patient's home, wherever that may be.

Is Hospice Expensive?
Medicare, Medicaid and many commercial insurance providers cover most, if not all costs of hospice care.

Your AccentCare Team

Hospice Care Consultant

If you've just received a hospice diagnosis and are wondering what this means, your hospice care consultant (HCC) is the perfect person to go to with questions. They can talk you through how hospice care will be beneficial to you and your family, along with what type of support AccentCare can provide for you. Whether you have questions about how often you'll be visited by a team member, or what to expect as your hospice journey begins, our HCCs are here to support you. They're happy to meet with you face-to-face or talk over the phone. They can drop off, mail, or email you more information about the services we offer. If you decide that hospice care through AccentCare is the right choice for you and your family, your HCC will facilitate the sign-on process to ensure that you can begin benefiting from the services AccentCare provides as soon as possible.

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"Each level of your staff treated him with the utmost care, always maintaining his level of dignity."

The Interdisciplinary Group — IDG

Medical Director
Co-certifies a patient's hospice admission and works with the IDG to develop and implement a personalized plan of care.

Attending Physician
Co-certifies the patient's hospice admission. This may be the primary care physician for the patient before they entered hospice, or a physician at a nursing facility where the patient resides.

Registered Hospice Nurse
Assesses the patient and family, coordinates team visits and ensures implementation of the plan of care. Also ensures symptom control and pain management and provides education to the patient and their family as needed.

Hospice Aide
Provides personal care and comfort measures to the patient and family.

Social Worker
Identifies the patient and family's emotional, social, spiritual and financial needs. Provides direct counseling or refers families to appropriate community agencies and provides bereavement support. May help with funeral planning.

Music Therapist
Assesses the patient and family's emotional, physical, and spiritual needs and provides live, one-on-one clinically therapeutic musical experiences that can calm a patient and ease pain.

Chaplain
Assesses the spiritual needs of the patient upon request and meets with them as needed and desired. We respect the religious choices of our patients and their families, and we never impose specific spiritual beliefs or traditions on any patient or their family.

Volunteers
Provide companionship and support to the patient and family, as well as non-medical needs like errand running or respite time for caregivers.

- IDG coordinates care through the Electronic Medical Record (EMR)
- The IDG communicates and collaborates regularly with a patient's attending physician
- Each plan of care is regularly reviewed and revised to address a patient's changing needs

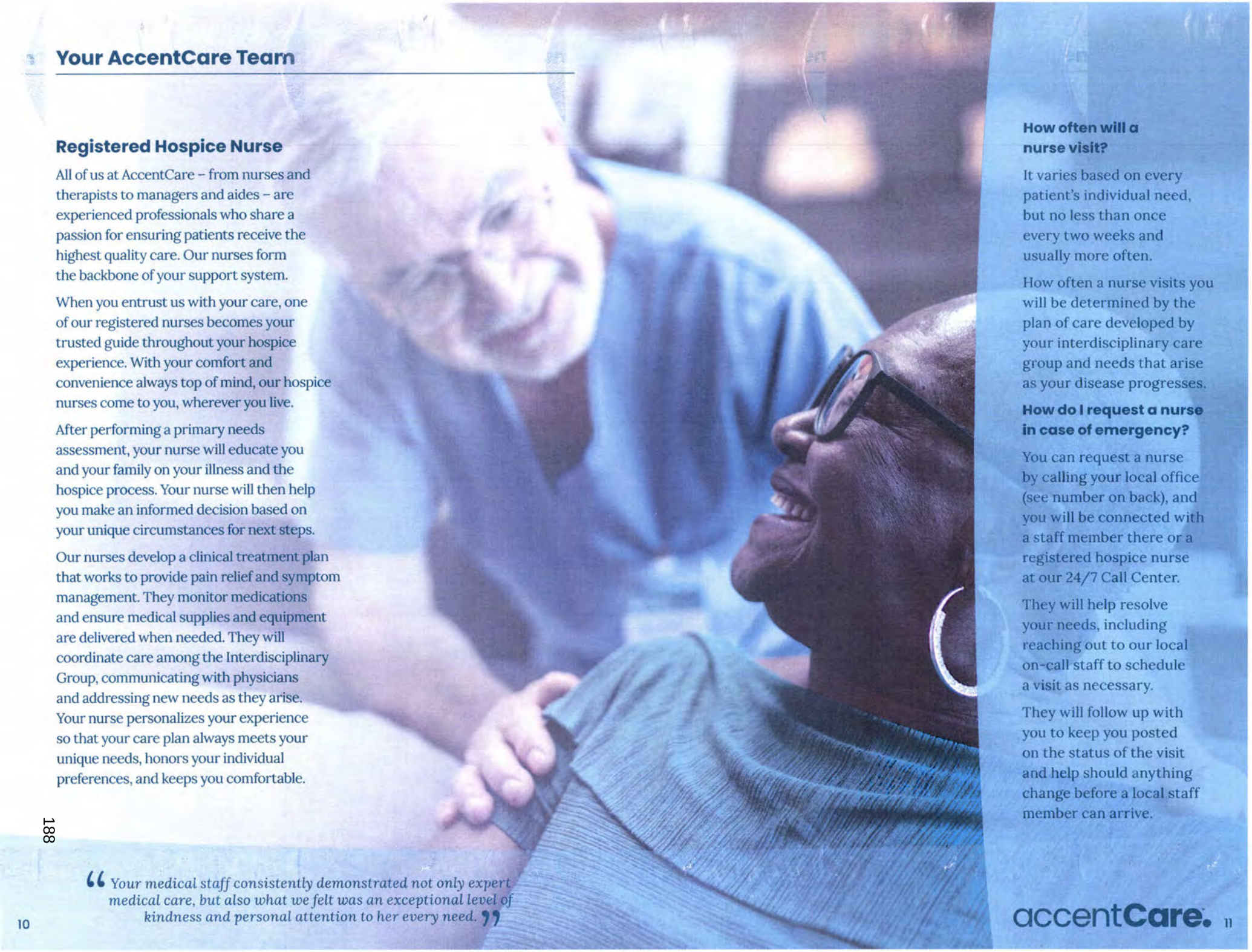
Registered Hospice Nurse

All of us at AccentCare – from nurses and therapists to managers and aides – are experienced professionals who share a passion for ensuring patients receive the highest quality care. Our nurses form the backbone of your support system.

When you entrust us with your care, one of our registered nurses becomes your trusted guide throughout your hospice experience. With your comfort and convenience always top of mind, our hospice nurses come to you, wherever you live.

After performing a primary needs assessment, your nurse will educate you and your family on your illness and the hospice process. Your nurse will then help you make an informed decision based on your unique circumstances for next steps.

Our nurses develop a clinical treatment plan that works to provide pain relief and symptom management. They monitor medications and ensure medical supplies and equipment are delivered when needed. They will coordinate care among the Interdisciplinary Group, communicating with physicians and addressing new needs as they arise. Your nurse personalizes your experience so that your care plan always meets your unique needs, honors your individual preferences, and keeps you comfortable.



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"Your medical staff consistently demonstrated not only expert medical care, but also what we felt was an exceptional level of kindness and personal attention to her every need."

How often will a nurse visit?

It varies based on every patient's individual need, but no less than once every two weeks and usually more often.

How often a nurse visits you will be determined by the plan of care developed by your interdisciplinary care group and needs that arise as your disease progresses.

How do I request a nurse in case of emergency?

You can request a nurse by calling your local office (see number on back), and you will be connected with a staff member there or a registered hospice nurse at our 24/7 Call Center.

They will help resolve your needs, including reaching out to our local on-call staff to schedule a visit as necessary.

They will follow up with you to keep you posted on the status of the visit and help should anything change before a local staff member can arrive.

Your AccentCare Team

Hospice Aide

Our hospice aides spend the most time with our patients, providing direct personal care. These aides have been carefully chosen to work for AccentCare because of their compassion and experience in caring for others.

Aides assist with activities such as bathing, hair care, shaving, skin care, catheter care, and linen changes. They will help you change your clothing and with any other personal care your family or personal caregiver may need assistance providing. Hospice aides do not dispense medication, but they do report back on your status to the nurse and the rest of the IDG. Your aide will likely be the same each visit, but your AccentCare team will give you notice if a different aide may be coming for a visit.

Hospice aides are experts in administering Namaste Care to our patients. Namaste Care is a highly specialized program for all AccentCare patients. It uses person-centered approaches to improve quality of life through sensory activities that stimulate the senses and promote relaxation. This includes activities like hand massages, spiritual reading, music, and reminiscence.

How often will an aide visit?

You will receive visits from an aide at least once but up to multiple times a week, as laid out in your plan of care.

What care does a hospice aide provide?

Personal care that supports patient dignity, like bathing, hair care, shaving, skin care, catheter care, and linen changes.

What care does a hospice aide not provide?

Hospice aides do not administer medications, provide housekeeping, or cook. Aides supplement the care that a caregiver, such as a family member or facility staff, is already providing.

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"It gave us peace of mind knowing that we could count on you all."

Medical Director and Physician

Our hospice medical director, along with your attending physician, will certify your eligibility for hospice. They may consult with your other physicians such as oncologists or cardiologists regarding your hospice care. They also lead your interdisciplinary care group in developing your individualized plan of care and advise on updating it as needed during your hospice journey. AccentCare will keep your attending physician (usually your primary care physician or a physician at your nursing facility) informed of your care and prognosis as it changes over time.

The hospice team physician can co-certify your hospice eligibility if you do not have an attending physician. Our team physician will assess your needs and determine the best management for your symptoms and pain. They will prescribe medications as needed and will direct and approve the plan of care and coordinate the care.

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"Many thanks to you and your team for helping us through this journey and helping to keep mom comfortable in her own home."

Social Worker

Facing a serious illness can be a time of sadness, stress and confusion for you and your family. Your social worker will help you navigate the emotions and challenges that you face as your disease progresses. They can connect you with supportive services both within AccentCare and in your community. They will collaborate with the IDG team to ensure you and your family members are comfortable, and that your needs are being met. They offer counseling and grief support.

Social workers are also integral to our Leaving a Legacy program, which focuses on helping you find tangible ways to share your history with your family. Legacy projects can take a variety of forms at AccentCare, from simple but moving photographs of you and your family holding hands, to comprehensive family histories and life reviews. These projects allow you to leave your family with precious memories and facilitate healthy bereavement and processing of feelings that can arise at the end-of-life.

What can a social worker help me with? Some of the services provided by our social worker include:

- Providing emotional support, counseling and guidance to you and your family as you cope with potential stress related to your illness
- Offering information about advance directives
- Identifying appropriate and helpful community resources available to both you and your family
- Identifying the need for respite services and support for an overwhelmed caregiver
- Providing conflict resolution and counseling amongst your support system
- Assisting your family with anticipatory grief and bereavement services for your family and loved ones
- Connecting you to funeral and estate planning services
- Leaving a Legacy project and life review

Music Therapist

Music has the ability to positively impact our physical and emotional well-being. It affects bodily functions that we think are beyond our control, including heart rate, blood pressure and release of the body's natural painkilling chemicals.

During private sessions with patients and their families, our music therapists perform old favorites and familiar genres to bring comfort and create connections. They use music to calm a racing heart or steady respiration rates. Music therapists also work with patients and families to create legacies of songs and voice recordings that memorialize a patient's life.

Music therapists are also integral to our Leaving a Legacy program, which focuses on helping you find tangible ways to share your history with your family.

In the 1950s, the National Association of Music Therapy was established, defining music therapy as "the application of music to aid in the treatment of an illness."

Since then, the introduction of music in a variety of rehabilitation and palliative care settings has steadily increased.

Today, AccentCare is one of the few hospices to have a comprehensive Music Therapy Department, employing the largest number of full-time, board-certified music therapists in the country.

A music therapist holds at least a bachelor's degree, plus an additional certification from the Certification Board for Music Therapists. Many AccentCare music therapists have graduate or other advanced degrees.

Music therapists can help with your physical symptoms (in partnership with medication and other support), as well as psychosocial concerns like fear, anger, isolation, rejection, and distress.

If you are interested in receiving music therapy, you can call your local office or speak with one of our other interdisciplinary group team members.

> *"Music... can name the unnameable and communicate the unknowable."*
> — Leonard Bernstein

Please ask your hospice team which specialty programs are available in your area.

"When she came with the guitar he was so excited ... it made me feel good that he felt good. It was amazing how my husband reacted to the music."

Your AccentCare Team

Chaplain

AccentCare chaplains honor all faiths and religious traditions. We are fully prepared to provide you and your loved ones with spiritual support that speaks to your individual faith journey, however you define it. Our chaplains will honor you according to your faith tradition and beliefs or support your search for spirituality. We offer spiritual care to all who ask, including patients, families, partners, and friends.

What is Spiritual Care?

At AccentCare, we understand spiritual life as each person's unique experience of a power beyond her or himself, a sense of order in the universe, of purpose in living and of connection. Spirituality can also be an organizing set of beliefs, values, hopes, and yearnings by which each person makes sense of their life.

At AccentCare, we do not believe that spirituality is only for those who are members of various religions. We believe that all people can be spiritual, regardless of religious affiliation or devotion. Spiritual dimensions of a patient's life can provide them with profound awe, wonder, joy, fulfillment, and unity. Spirituality may also be expressed in some of the most difficult moments of fear, terror, guilt, and brokenness. All of these experiences are important and valid, and they shape life in many ways.

What is a chaplain?

A chaplain is a specially trained professional who is endorsed by a faith community. The chaplain provides spiritual and emotional support to all people, regardless of religious background or spiritual beliefs.

A hospice chaplain provides:

- A safe place for listening with compassionate acceptance
- Companionship
- Support for upcoming decisions and crisis support
- Prayer and sacred readings, as well as contact with the faith community
- Sacramental care
- Memorial observances
- Bereavement support

How do I reach a hospice chaplain?

You can reach your AccentCare chaplain by letting your AccentCare registered nurse know you're interested in a visit.

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"We know we made the right decision choosing AccentCare. The kindness and support of your staff made us feel we were not alone in this difficult time."

Volunteers — compassion in action

The hospice movement in the United States began as an all-volunteer movement. A vital part of the hospice philosophy of care is our carefully selected and well-trained volunteers who work alongside our professional staff to support our patients and families. Hospice is the only Medicare benefit that mandates volunteers be a part of the interdisciplinary care group.

These special volunteers help not only our staff but also our patients in a variety of ways.

Our volunteers help by providing comfort, support, non-medical care and compassion to our patients and their families. They do things like visiting or calling our patients and families, having conversations or reading aloud or listening to music together. They sit with our patients, so caregivers can have essential free time, help patients write or record messages for their families, and also help with bereavement. They help at our inpatient centers, as vigil volunteers, or on our pet therapy team.

Direct care volunteers are required to take background checks and participate in initial hospice volunteer training and orientation.

Will I be visited by a volunteer?

Ask a member of your care team if you would like to learn about how a volunteer can assist you.

Supportive Care Services

Legacy Projects

Our staff members are happy to help create a legacy project for each of our patients.

Legacy projects are clinical therapeutic projects designed to help patients' feelings of loss that end-of-life can raise, as well as create tangible memories for the family and friends of the patient. Legacies are created through collaboration with the patient and family.

We capture life stories, lessons, memories, and traditions, in the form of recorded interviews and videos, personalized cards written for loved ones' milestone events like birthdays and anniversaries, and so much more. These legacies provide comfort to loved ones and are a lasting tribute to the lives of our patients.

More examples of legacy projects:

- Thumb print necklaces
- Holding hand plaster molds
- Songs or poetry set to custom music by your AccentCare music therapist
- Family history booklets
- Heartbeat recordings
- Memory bears
- Milestone notes
- Personal stories

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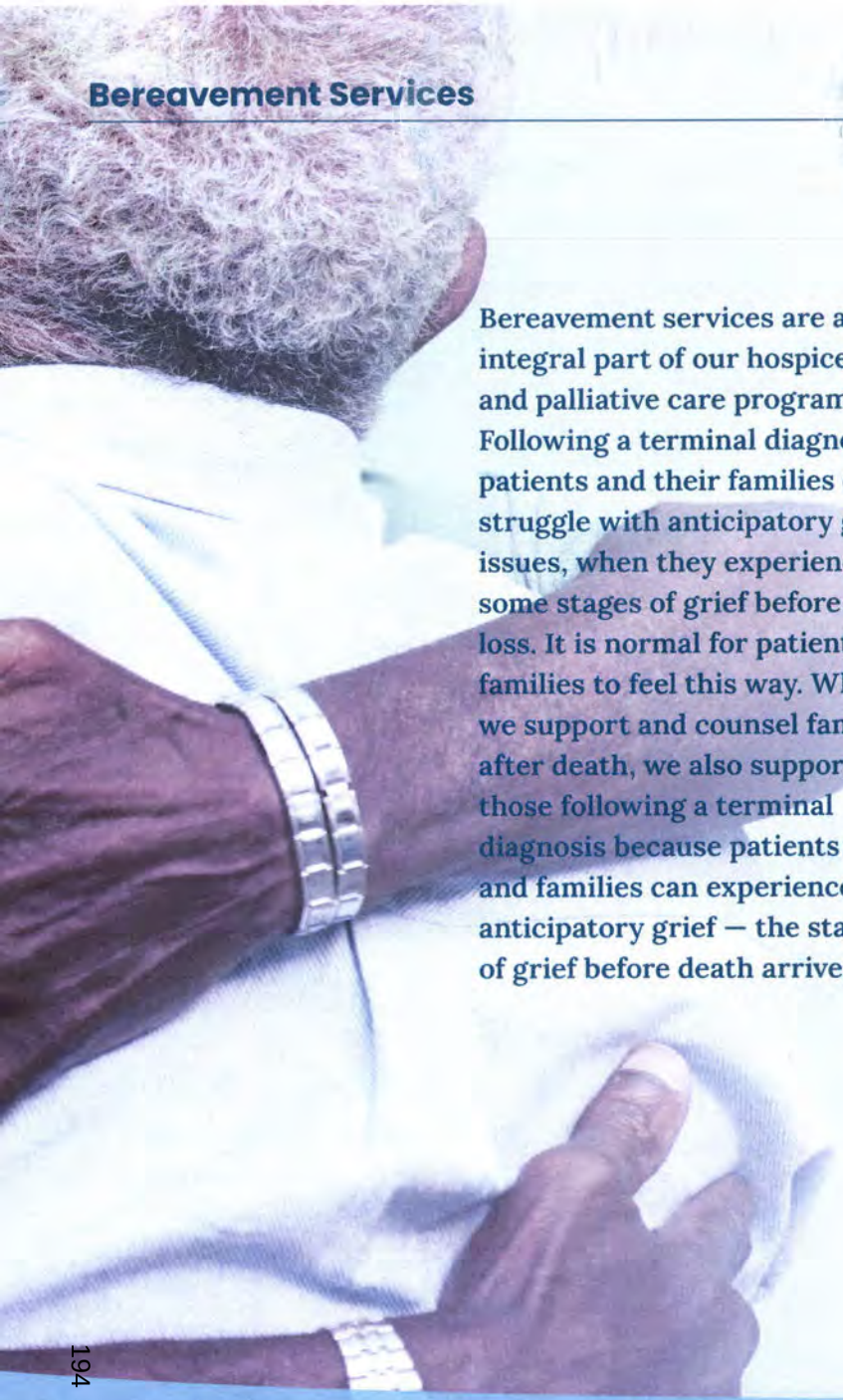
"My mom was such a loving presence and an integral part of our everyday lives that it is difficult to comprehend that she will be with us only in spirit, but the many wonderful memories we have will be with us forever."

Bereavement Services



Bereavement services are an integral part of our hospice and palliative care program. Following a terminal diagnosis, patients and their families can struggle with anticipatory grief issues, when they experience some stages of grief before a loss. It is normal for patients and families to feel this way. While we support and counsel families after death, we also support those following a terminal diagnosis because patients and families can experience anticipatory grief — the stages of grief before death arrives.

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"I am grateful for the support they provided, not just for him, but for the whole family."

Though there are many kinds of sadness, there is a peculiar kind of grief that only comes from the loss of a loved one. If someone you love dies in hospice, you may feel anxious, angry, confused, scared, or sorrowful — or all of these emotions at once. These emotions are natural and common — you're not alone in your feelings. At AccentCare, we recognize that your healing journey may be different than that of another family member, or it may be more difficult than you expected. We are here to help you process your loss. While no one can prepare you for these moments, we will walk beside you through the journey that is grief. We will work to build an environment of trust, where we can help guide you and your family towards healing.

For decades, we have come alongside families and helped them heal. All members of a family, including chosen family and friends may receive bereavement services from AccentCare. Following death, our dedicated team continues to provide bereavement support to the loved ones of a patient for thirteen months or more, as needed.

Bereavement services include:

Person to Person Support: Our team is available for counseling, companionship or conversation, whether in person, by phone or email, from the time of death to thirteen months after a loved one's death. A personal visit request begins with just a phone call.

Memorial Services: We offer annual Celebrations of Remembrance that are ecumenical and interfaith. We focus on remembering the meaning, purpose and impact of a loved one's life, regardless of religious affiliation.

Support Groups: Facilitated by our psychosocial staff, we provide a safe and supportive place for bereaved people to share experiences of loss, to learn ways to cope from each other, and to heal and form friendships.

Written Resources: We have a library of materials available that can help you understand and follow your journey through grief and bereavement. We also send a quarterly bereavement newsletter for a year following the death of a loved one.

Camp Kangaroo: We work with our hospice foundation to offer a free bereavement camp for children at various locations across the country. You can find out more by asking your local bereavement team.

To request bereavement services, talk to your social worker or call your local office.

Hospice Foundation

Healthcare is the most visible aspect of end-of-life care, but it isn't the only important component. Sometimes a patient's needs and wishes fall outside the limits of what Medicare, Medicaid and private insurance cover. Examples may include assistance with burial costs, the cost of utility bills for a family with a terminally ill child, or a chance to celebrate a couple's last anniversary together. Needs big or small — these are things that our hospice foundation can help with and that take on enormous significance in a person's last days.

Our foundation adds days to your life and life to your days, by providing:

Life Essentials
Whether a patient needs an air conditioner to rest comfortably at home or help paying rent or groceries, the Foundation can assist.

Life Enrichment
A gift basket with a patient's favorite foods. Audio books or new glasses for a visually impaired patient. A touch-screen tablet to read books with enlarged type. These are just a few examples of life enriching extras we have provided.

Wish Fulfillment
From holding a wedding ceremony, attending a family reunion out of state or seeing a final game played by their favorite sports team, the dedicated staff at AccentCare works with the foundation to carry out these wishes, creating lasting memories for patients and their loved ones.

Extended Supportive Care
The foundation also offers supportive healthcare services outside traditional hospice medicine, including reflexology, aromatherapy, massage, music, and even pet therapy.

The foundation also funds Camp Kangaroo, a bereavement camp for children staffed by our AccentCare team members and trained volunteers. Camps are held throughout the year in multiple locations across the country. This free camp provides a healing and supportive atmosphere for children ages 5-18 who've experienced a recent loss of a loved one.

To make a donation to support the work of the foundation, please reach out to your interdisciplinary care team.

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"I had the privilege of watching resilience, love and strength fostered all weekend. This is a special experience. Thank you for not only making it possible, but making it cozy and lovely and warm."

Camp Kangaroo
Seasons Hospice Foundation

The foundation also funds Camp Kangaroo, a bereavement camp for children staffed by our AccentCare team members and trained volunteers. Camps are held throughout the year in multiple locations across the country. This free camp provides a healing and supportive atmosphere for children ages 5-18 who've experienced a recent loss of a loved one.

To make a donation to support the work of the foundation, please reach out to your interdisciplinary care team.

Seasons Hospice Foundation was founded by Seasons Hospice & Palliative Care in 2011. On January 1, 2022 Seasons Hospice & Palliative Care became AccentCare. Seasons Hospice Foundation continues to offer hope and support to the AccentCare hospice patients and their families we are so privileged to serve. We strive to treat the whole person and their loved ones in ways that touch the human spirit — adding days to life and life to days.

Our programs are made possible by your generosity.

www.SeasonsFoundation.org

Other Special Supportive Services

At AccentCare, we strive to always put patients first. Each patient we serve has their own background, story and experience. We don't give you one-size-fits-all care, because your circumstances are unique. We strive to understand you as an individual, and we are committed to honoring your values, needs, and preferences. As a result, your plan of care will be tailor-made to fit the things that are important to you. When we create your customized care plan, you will find that it celebrates the unique individual that you are and supports your personal journey.

Some of these programs include:

AccentCare Call Center

The AccentCare Call Center takes calls from patients and families who may require information or assistance. Our hospice nurses and customer service representatives are available to help 24 hours a day, 7 days a week, on holidays and weekends, every day of the year. The customer service representatives can help with non-clinical questions such as "Is my nurse visiting today?" Nurses can provide clinical advice on managing symptoms such as pain or shortness of breath.

The Call Center staff have access to our computerized medical record (EMR). This allows them to look at the medication list and last visit notes while on the phone with you and provide immediate help. If you or your family needs additional in-person support visit, the AccentCare Call staff contacts the local "on-call" team to arrange a visit as soon as possible.

Palliative Care

Our Palliative Care program provides clinical symptom management for people living with an advanced illness and emotional support for their families and caregivers. Palliative care is comprehensive care for patients of all ages, including children, who are living with chronic conditions. Palliative care can be provided alongside curative treatments or therapies. The focus of care is the alleviation of symptoms and care coordination to provide comfort care as well as meeting the emotional and spiritual needs of patients and families. Palliative care can also encompass discussions about future care wishes and desires, including discussing advance directives.

Palliative care consultations are provided by physicians and nurse practitioners who are specialists in pain and symptom management. Visits are sometimes also provided by social workers or other disciplines. These highly skilled specialists work closely with the patient's care team to offer consultations and provide options that enhance quality of life. If you are interested in more information about palliative care, please ask your hospice care consultant.

Namaste Care

Namaste Care uses person-centered approaches to improve quality of life through activities that stimulate the senses, promote relaxation and offer comfort and serenity to those who may have anxiety or agitation. This care also provides moments of peace and tranquility to family caregivers.

Namaste care is provided by all members of the interdisciplinary care group. Bathing, dressing and grooming are presented as meaningful activities rather than just tasks to complete. Gentle hand massages, spiritual reading, music and reminiscing are also often included in this type of care. With Namaste Care, each person's individuality is respected and all care is offered with a loving touch.

We Honor Veterans

For any of our patients who served in the military, we offer a special service focused on respectful inquiry, compassionate listening and grateful acknowledgment. We often honor our veteran patients via pinning ceremonies and celebrations to honor their service. These ceremonies are individualized to our patients' wants and needs, but typically involve a song and written tribute specific to that patient's type of service.

With Medicare-certified hospice and palliative care offerings, our experienced staff will support you and your family through the uncertainty and pain of terminal illness and loss. And we know that with expert, compassionate support, hospice can be a most precious time of love and connection for families — a passage we honor with all our skills and hearts.

Thank you for welcoming AccentCare into your home, and for entrusting us with providing your care.

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Every AccentCare location is certified by Medicare to provide the full hospice benefit. However, not all specialty services are available at all locations. Please talk with your local team to understand which programs are offered in your area.

accentCare.

SEASONS HOSPICE FOUNDATION

camp Kangaroo

Seasons Hospice Foundation

Seasons Hospice Foundation
Camp Experience

Where Children Find Comfort, Camaraderie and Hope After Loss

CAMP KANGAROO is a free camp experience providing a supportive and therapeutic environment for children who have experienced the death of someone close to them.

LED BY DEDICATED PROFESSIONALS and trained volunteers from AccentCare Hospice, formerly Seasons Hospice & Palliative Care, Camp Kangaroo provides a unique opportunity for campers to build relationships with one another helping them to feel less alone in their loss. Participants will receive grief education and emotional support combined with fun camp activities.

WHO SHOULD ATTEND: Children 5-18 who have experienced the loss of a loved one in the last two years. Since children experience grief in their own unique way, our campers may be at different places of the bereavement process. Upon completion of the Inquiry Form below, one of our staff will contact you to complete an interview that will help our team to meet each individual camper's needs.

COVID RESPONSE: 2022 Camp Kangaroo will be virtual.Camp will include individual support, virtual, age grouped sessions, guardian support meetings as well as a custom kit with supplies and instructions. Camp will be held on November 5, 2022. Please reserve the entire day.

CAMP KANGAROO *fast facts...*

DATE:
November 5, 2022

Times will be announced, please reserve the day

LOCATION:
Online

DEADLINE FOR REGISTRATION:
October 15, 2022

CONTACT:
Sabrina Curtis
AccentCare Hospice (formerly Seasons Hospice & Palliative Care)
2644 Cypress Ridge Blvd.
Ste 104
Wesley Chapel, FL 33544
SabrinaCurtis@AccentCare.comc
813-364-0311

www.seasonsfoundation.org

Please complete this Inquiry Form and return to:
Sabrina Curtis, 2644 Cypress Ridge Blvd. Ste 104, Wesley Chapel, FL 33544, 813-364-0311

Name(s) of Camper(s): Age(s):

Name of parent or guardian:

Address: City: State: Zip Code:

Phone (Cell) Phone (Other): Email:

Camper's special person who died:

Relationship to Camper:

CK_MASTER_2019

Our Vision

We envision a future where more people will celebrate life and honor its end through the guidance of hospice.

SEASONS HOSPICE FOUNDATION

accentCare.

www.seasonsfoundation.org

847-692-1000

Camp Kangaroo is funded by the Seasons Hospice Foundation, a 501 (c) 3 non – profit organization, through the generous support of individuals, corporations and foundation donors. If you would like to make a donation to Seasons Hospice Foundation to support future programs like bereavement camps or just support the foundation's mission, visit www.seasonsfoundation.org.

Legal Entity	Service	Office Address	License #	Medicare #	Accreditation	Date Acquired by AccentCare, if Within Past 3 Years
AccentCare Fairview Home Health-East, LLC	Home Health	3507 Highpoint Drive North S140 Oakdale, MN 55128	405171	24-7166	N/A	Nov-20
AccentCare Fairview Home Health-West, LLC	Home Health	767 Eustis St, #150, Saint Paul, MN 55114-0018	405172	24-7078	N/A	Nov-20
AccentCare Home Health at UCSD Health, LLC	Home Health	5060 Shoreham Place, STE 220 San Diego, CA 92122-5977	550004034	05-3172	CHAP	
AccentCare Home Health of California, Inc.	Home Health	3170 Crow Canyon Place, STE 270 San Ramon, CA 94583-1160	020000285	05-7517	CHAP	
AccentCare Home Health of California, Inc.	Home Health	5050 Murphy Canyon Rd, STE 200 San Diego, CA 92123-4441	080000226	05-7564	CHAP	
AccentCare Home Health of California, Inc.	Home Health	2590 Goodwater Ave., STE 100 Redding, CA 96002-1550	230000205	55-7273	CHAP	
AccentCare Home Health of California, Inc.	Home Health	2295 Gateway Oaks, STE 125 Sacramento , CA 95833-4259	100000471	55-7253	CHAP	
AccentCare Home Health of California, Inc.	Home Health	1455 S Auto Center Drive, STE 150 Ontario. CA 91761-2239	240000267	05-7678	CHAP	
AccentCare Home Health of California, Inc.	Home Health	3636 Birch Street, STE 195 Newport Beach, CA 92660-2644	060000027	05-7573	CHAP	
AccentCare Home Health of California, Inc.	Home Health	2344 S 2nd, Suite A El Centro, CA 92243-5606	080000479	55-7425	CHAP	
AccentCare Home Health of California, Inc.	Home Health	119 S Court St, STE A Circleville, OH 43113	N/A	36-7270	CHAP	
AccentCare Home Health of Mountain Valley, LLC	Home Health	455 Sherman Street, STE 465 Denver, CO 80203-4402	04K558	06-7445	CHAP	
AccentCare Home Health of Rogue Valley, LLC	Home Health	691 Murphy Road, STE 236 Medford, OR 97504	13-505	38-7098	CHAP	
AccentCare Home Health of West Tennessee, LLC	Home Health	855 Ridge Lake Blvd Ste 604, Memphis TN 38120	CON 2203-016A	Pending	Pending	
AccentCare of Massachusetts, Inc. dba AccentCare Home Health of Massachusetts	Home Health	30 Perwal Street, Westwood, MA 02090	04307	22-7203	CHAP	
AccentCare of Massachusetts, Inc. dba AccentCare Home Health of Massachusetts	Home Health	30 Perwal Street, Westwood, MA 02090	N/A	22-7203	CHAP	
AccentCare UCLA Health, LLC	Home Health	9221 Corbin Ave, STE160 Northridge, CA 91324-1659	980000746	05-7761	CHAP	
Aloha Home Care LLC dba-AccentCare Home Health of Port Saint Lucie	Home Health	548 NW University Blvd Suite 101, Port St Lucie, FL 34986	299992038 File # 19964672	10-8134	CHAP	
Doctors Choice Jacksonville LLC dba AccentCare Home Health of Jacksonville	Home Health	1542 Kingsley Ave. Ste 131/132 Orange Park, FL 32073	299991611 File # 19964108	10-7725	CHAP	
Guardian Home Care of Central Georgia, LLC dba AccentCare Home Health of Central Georgia	Home Health	1551 Jennings Mill Road, Bulding 2500A Watkinsville, GA 30677-7274	029-279-H	11-7145	CHAP	
Guardian Home Care of Nashville, LLC dba AccentCare Home Health of Nashville	Home Health	741 Cool Springs Blvd., Suite 110 Franklin, TN 37067-2697	0000000607	44-7566	CHAP	
Guardian Home Care of Northeast Georgia, LLC dba AccentCare Home Health of Northeast Georgia	Home Health	5089 Bristol Industrial Way, Suite B Buford, GA 30518-1780	069-274-H	11-7139	CHAP	
Guardian Home Care, LLC dba AccentCare Home Health of Georgia	Home Health	11660 Alphareta Hwy, Suite 440 Roswell, GA 30076-3880	060-264	11-7131	CHAP	
Guardian Home Care, LLC dba AccentCare Home Health of Tennessee	Home Health	6116 Shallowford Road, Suite 114 Chattanooga, TN 37421-7202	0000000115	44-7559	CHAP	

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Halifax Health Services, LLC dba Accentcare Home Health of Daytona, eff 8/31/19	Home Health	1200 West Granada Blvd, Ste 4 Ormond Beach, FL 32174	299992196	10-8284	CHAP	
Health Resource Solutions, Inc. dba AccentCare Home Health of Illinois	Home Health	1806 S. Highland Avenue, Suite 225 Lombard, IL 60148-3948	1010385	14-7811	CHAP	Dec-20
HRS Home Health of Indiana, LLC dba AccentCare Home Health of Indiana	Home Health	11037 Broadway, Suite C Crown Point, IN 46307	IN008882	15-7436	CHAP	Dec-20
HRS Home Health of Michigan, LLC dba AccentCare Home Health of Michigan	Home Health	515 E. 11 Mile Rd, Madison Heights, MI 48071	N/A	23-9334	CHAP	Dec-20
HRS of Nebraska, Inc. d/b/a AccentCare Home Health of Nebraska	Home Health	900 S 74th Plaza, STE 111 Omaha, NE 68114	HHA201607	28-7151	CHAP	Dec-20
KindStar, Inc. dba AccentCare Health	Home Health	2728 Williams Ave. Bld K101 #U/V (GUY) Woodward, OK 73801 (12/1/19)	007836	37-7711	CHAP	
KindStar, Inc. dba AccentCare Health	Home Health	1111 N. Interstate 35, #204, Round Rock, TX 78664	009343	45-7821	CHAP	
KindStar, Inc. dba AccentCare Health	Home Health	eff 2/8/19 3800 E. 42nd ST. #203 (PMB), Odessa, TX 79762 1410 Rankin Hwy, Midland, TX 79701	012084	45-9246	N/A	
KindStar, Inc. dba AccentCare Health	Home Health	2950 50th (HH), Lubbock, TX 79413 eff 7/1/21	009402	67-9485	CHAP	
KindStar, Inc. dba AccentCare Health	Home Health	1801 W. 21st St, Clovis, NM 88101	003331	32-7210	PENDING	
KindStar, Inc. dba AccentCare Health	Home Health	1934 Medi Park Dr., Amarillo, TX 79106	008662	45-7754	CHAP	
Nurses Unlimited, Inc. dba AccentCare Home Health and Personal Care Services of Texas	Home Health	3800 E. 42nd, Suite 203 Odessa, TX 79762	001383	45-7528	CHAP	
Oahu Home Care LLC dba AccentCare Home Health of Melbourne	Home Health	2401 W. Eau Gallie Blvd #6, Melbourne, FL 32935 (12/15/19)	299991835	10-8218	CHAP	
SE Health Care at Home LLC dba AccentCare Home Health of Southeastern Pennsylvania	Home Health	4641 POTTSVILLE PIKE, STE 106 READING, PA 19605-9707	03800501	398114	Joint Commission	Jun-21
SOUTHEASTERN HEALTH SERVICES OFPENNSYLVANIA, LLC DBA: AccentCare Health of Pennsylvania	Home Health	1501 GRUNDY LN, STE 100 BRISTOL, PA 19007-1506	747205	397472 HIT 1K9912, 1K9935, 1K9937, 1K9942, 1K9945, 1K9950, 1K9953	Joint Commission	Jun-21
Southeastern Home Health Care, LLC DBA: AccentCare Home Health of Virginia	Home Health	7502 Lee Davis Road Mechanicsville, VA 23111	N/A	49-7508A HIT Q707230001 HIT Q707240001	Joint Commission	Jun-21
Southeastern Home Health Services of PA, LLC DBA: AccentCare Home Health of Central Pennsylvania	Home Health	278 MAYTOWN RD, STE 400 ELIZABETHTOWN, PA 17022	02960501	398062 HIT 1O1718	Joint Commission	Jun-21
Sta-Home Health Agency of Carthage, Inc. dba AccentCare Home Health of Carthage	Home Health	616 Hwy 35 S Carthage, MS 39051-5802	10985	25-7129	CHAP	
Sta-Home Health Agency of Greenwood, Inc. dba AccentCare Home Health of Greenwood	Home Health	205 Walthall St. Greenwood, MS 38930	11095	25-7131	CHAP	

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Sta-Home Health Agency of Jackson, Inc. dba AccentCare Home Health of Jackson	Home Health	130 Fairmont St., STE A Clinton, MS 39056-4714	11195	25-7102	CHAP	
Texas Home Health Group of College Station, LLC DBA: AccentCare Home Health of College Station	Home Health	1605 Rock Prairie Road, Suite 206 College Station, TX 77845-8358	018330	67-9189	CHAP	
Texas Home Health Group of Denton, LLC DBA: AccentCare Home Health of Denton	Home Health	225 W. Mulberry #101, Denton, TX 76201	19300	67-9325	CHAP	
Texas Home Health Group of DeSoto, LLC DBA: AccentCare Home Health of DeSoto	Home Health	911 York Dr. #203 DeSoto, TX 75115-2064	019958	67-9103	CHAP	
Texas Home Health Group of Fort Worth, LLC DBA: AccentCare Home Health of Fort Worth	Home Health	3880 Hulen Street, Suite 200A Fort Worth, TX 76107	018324	74-7526	CHAP	
Texas Home Health Group of Marble Falls, LLC DBA: AccentCare Home Health of Marble Falls	Home Health	1100 Mission Hills Drive, Suite 100 Marble Falls, TX 78654	018353	67-9520	CHAP	
Texas Home Health Group of McKinney, LLC DBA: AccentCare Home Health of McKinney	Home Health	6800 Weiskopf Ave., Suite 110 McKinney, TX 75070-5241	018485	67-9236	CHAP	
Texas Home Health Group of Taylor, LLC DBA: AccentCare Home Health of Taylor	Home Health	567 Chris Kelley Blvd. Suite 201 Hutto, TX 78634-2086	018337	67-7035	CHAP	
Texas Home Health Group of Temple, LLC DBA: AccentCare Home Health of Temple	Home Health	3809 South General Bruce Drive, Suite 105B Temple, TX 76502	018252	45-7443	CHAP	
Texas Home Health Group of Waco, LLC DBA: AccentCare Home Health of Waco	Home Health	8300 Central Park Dr. Suite A Waco, TX 76712-6667	018352	67-9200	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	400 Belcher, Suite 6 Cleveland, TX 77327-3654	008904	67-3151	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	5687 Eastex Freeway Beaumont, TX 77706-6923	008922	67-3115	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	101 W. Goodwin Ave, Suite 370 Victoria, TX 77901-6502	008990	67-3133	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	512 Santa Fe Drive, Suite 512 Weatherford, TX 76086	018168	45-7173	N/A	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	1809 Judson Road Longview, TX 75605-4710	007741	67-9090	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	12808 W. Airport Blvd. Suite 350 Sugar Land, TX 77478-6187	007751	67-9102	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	4619 North Street Nacogdoches, TX 75965-1816	007744	67-9108	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	2512 S. IH-35, Suite 320 Austin, TX 78704-5758	018406	74-7786	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	4801 NW Loop 410, Suite 115 San Antonio, TX 78229-5342	007949	67-9174	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	3520 Executive Center Drive, Suite G100 Austin, TX 78731-1625	007742	67-9120	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	10358 US 59 Hwy, Suite B Wharton, TX 77488-0709	008158	67-9233	CHAP	
Texas Home Health Skilled Services, LP DBA: AccentCare Home Health of Texas	Home Health	4920-F Seawall Blvd. Galveston, TX 77551-6011	007750	67-9104	CHAP	
AccentCare Fairview Hospice-West, LLC	Hospice	767 Eustis St, #150, Saint Paul, MN 55114-0018	405392	24-1514	N/A	Nov-20
AccentCare Home Health of California, Inc.	Hospice	2344 S 2nd, Suite B El Centro, CA 92243-5606	550003173	92-1522	CHAP	

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AccentCare Home Health of Mountain Valley, LLC	Hospice	4065 St. Cloud, STE 200 Loveland, CO 80538	17B924	06-1560	CHAP	
AccentCare Hospice & Palliative Care of Tennessee, LLC	Hospice	855 Ridge Lake Blvd Ste 604, Memphis TN 38120	623	Pending	Pending	Oct-22
AccentCare of Massachusetts, Inc. dba AccentCare Hospice of Massachusetts	Hospice	21 Father DeValles Blvd. Suite 105 Fall River, MA 02723	7218	22-1518	CHAP	
AccentCare of Massachusetts, Inc. dba AccentCare Hospice of Massachusetts	Hospice	275 Martine Street, Suite 109 Fall River, MA 02723	04306	22-7203	CHAP	
Guardian Hospice of Nashville, LLC dba AccentCare Hospice & Palliative Care of Nashville	Hospice	741 Cool Springs Blvd., Suite 102 Franklin, TN 37067-2697	0000000603	44-1591	CHAP	
KindStar, Inc. dba AccentCare Health	Hospice	101 W. Goodwin Ace #925, Victoria, TX 77901	009272	45-1779	CHAP	
KindStar, Inc. dba AccentCare Health	Hospice	2950 50th (HOS), Lubbock, TX 79413 eff 7/1/21	012120	45-1774	CHAP	
KindStar, Inc. dba AccentCare Health	Hospice	225 W. Mulberry #102 Rm HOS, Denton, TX 76201	011196	67-1528	CHAP	
Seasons Hospice & Palliative Care of Washington DC, LLC AccentCare Hospice & Palliative Care of Washington, DC	Hospice	601 50th Street NE, First Floor Washington, D.C. 20019	Pending	Pending	PENDING	Dec-20
Seasons Hospice & Palliative Care of Broward Florida, LLC dba AccentCare Hospice & Palliative Care of Broward County	Hospice	1200 S Pine Island Rd Ste 350 Plantation, FL 33324-4409	50370977	10-1555	N/A	Dec-20
Seasons Hospice & Palliative Care of California -Oakland, LLC d/b/a AccentCare Hospice & Palliative Care of California - Oakland	Hospice	7677 Oakport Street, Suite 500, Oakland, CA 94621-1931	550004462	A0-1539	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of California -Orange, LLC	Hospice	750 The City Dr South, Ste 120 Orange, CA 92868	080000773	05-1603	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of California -Sacramento, LLC	Hospice	2295 Gateway Oaks Dr, Ste 165 Sacramento, CA 95833	550003943	92-1743	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of California -San Bernardino LLC	Hospice	3110 E Guasti Rd, STE 315, Ontario, CA 91761	550001512	55-1621	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of California -San Diego, LLC	Hospice	16745 West Bernardo Dr, Ste 240 San Diego, CA 92127	550000796	55-1550	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of California, LLC d/b/a AccentCare Hospice & Palliative Care of California	Hospice	320 W Arden Ave, Ste 100 Glendale, CA 91203	980001546	05-1790	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Colorado, LLC d/b/a AccentCare Hospice & Palliative Care of Colorado	Hospice	9191 Sheridan Blvd, Ste 103 Westminster, CO 80031	17R289	06-1593	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Connecticut, LLC DBA: AccentCare Hospice & Palliative Care of Connecticut	Hospice	1579 Straits Turnpike, Ste 1E Middlebury, CT 06762	9915725	07-1539	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Delaware, LLC DBA: ChristianaCare-AccentCare Hospice & Palliative Care of Delaware	Hospice	220 Continental Dr, Ste 407 Newark, DE 19713	HSPC-010C	08-1508	Joint Commission	Dec-20

Legal Entity	Service	Office Address	License #	Medicare #	Accreditation	Date Acquired by AccentCare, if Within Past 3 Years
Seasons Hospice & Palliative Care of Georgia, LLC dba AccentCare Hospice & Palliative Care of Georgia	Hospice	11675 Great Oaks Way Ste 310 Alpharetta GA 30022	060-0244-H	11-1640	N/A	Dec-20
Seasons Hospice & Palliative Care of Indiana, LLC dba AccentCare Hospice & Palliative Care of Indiana	Hospice	2629 Waterfront Pkwy East Dr, Ste 375 Indianapolis, IN 46214	20-011779-1	15-1603	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Maryland, LLC DBA: AccentCare Hospice & Palliative Care of Maryland	Hospice	5457 Twin Knolls Rd, Ste 100 Columbia, MD 21045	H1507	21-1507A	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Massachusetts, LLC DBA: AccentCare Hospice & Palliative Care of Massachusetts	Hospice	1 Edgewater Dr., Suite 103 Norwood, MA 02062	7T5G	22-1578	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Michigan LLC dba AccentCare Hospice & Palliative Care of Michigan	Hospice	27355 John R Rd, Suite 100 Madison Heights, MI 48071	1041000088	23-1601	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Missouri, LLC dba AccentCare Hospice & Palliative Care of Missouri	Hospice	3660 South Geyer Rd, Ste 120 St. Louis, MO 63127	200-8HO	26-1641	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of New Jersey, LLC DBA: AccentCare Hospice & Palliative Care of New Jersey	Hospice	2147 Rt 27 South, Ste 101 Edison, NJ 08817	24819	31-1577	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Northern California, LLC	Hospice	400 Race St, Ste 101, San Jose, CA 95126	550002261	55-1750	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Oregon, LLC	Hospice	6500 S Macadam Ave, STE 160 Portland OR 97239	16-1063	38-1561	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Pasco County, LLC dba AccentCare Hospcie & Palliative Care of Pasco County	Hospice	2644 Cypress Ridge Blvd., Suite 104, Wesley Chapel, FL 33544	50370984 Cert 1621	10-1561	N/A	Dec-20
Seasons Hospice & Palliative Care of Pennsylvania, LLC DBA: AccentCare Hospice & Palliative Care of Pennsylvania	Hospice	2200 Renaissance Blvd, Ste 110 King of Prussia, PA 19406	17091601	39-1709	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Pinellas County, LLC dba AccentCare Hospice & Palliative Care of Pinellas County	Hospice	17757 US HWY 19 North, Ste 175 Clearwater, FL 33764	50370982 Cert 1619	10-1559	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Southern Florida, LLC dba AccentCare Hospice & Palliative Care of Southern Florida	Hospice	5200 Northeast Second Ave, 3rd Flr Stein Bldg Miami, FL 33137	50370965	10-1543	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Tampa, LLC dba AccentCare Hospice & Palliative Care of Hillsborough County	Hospice	1408 N Westshore Blvd, Ste 260 Tampa, FL 33607	50370980	10-1557	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Texas -Houston, LLC dba AccentCare Hospice & Palliative Care of Texas -Houston	Hospice	10318 Lake Rd, Bldg C Ste 102 Houston, TX 77070	14939	67-1741	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Texas -San Antonio, LLC dba AccentCare Hospice & Palliative Care of Texas -San Antonio	Hospice	300 E Sonterra Blvd, Bldg 1 Ste 1260 San Antonio, TX 78258	14478	67-1721	Joint Commission	Dec-20
Seasons Hospice & Palliative Care of Texas, LLC dba AccentCare Hospice & Palliative Care of Texas -Dallas	Hospice	6341 Campus Circle Dr E, Ste 150 Irving TX 75063	11037	67-1578	Joint Commission	Dec-20

Legal Entity	Service	Office Address	License #	Medicare #	Accreditation	Date Acquired by AccentCare, if Within Past 3 Years
Seasons Hospice & Palliative Care of Wisconsin, LLC dba AccentCare Hospice & Palliative Care of Wisconsin	Hospice	6737 W Washington St, Ste 2150 West Allis, WI 53214	2008	52-1571	Joint Commission	Dec-20
Seasons Hospice, LLC dba AccentCare Hospice & Palliative Care of Illinois	Hospice	606 Potter Road, 6th Floor Des Plaines, IL 60016	2003206	14-1582	Joint Commission	Dec-20
SOUTHEASTERN HOSPICE SERVICES, LLC DBA: AccentCare Hospice & Palliative Care of Southeastern Pennsylvania	Hospice	1501 GRUNDY LN, STE 100 BRISTOL, PA 19007-1506	17851601	391785	Joint Commission	Jun-21
Sta-Home Hospice of Mississippi, Inc. dba AccentCare Hospice & Palliative Care of Mississippi	Hospice	3500 Lakeland Dr, STE 515 Flowood, MS 39232-3017	023	25-1511	CHAP	
Texas Home Health Hospice - Austin, LLC dba AccentCare Hospice & Palliative Care-Austin	Hospice	3520 Executive Center Drive, Suite 320 Austin, TX 78731-1625	017838	67-1554	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	8300 Central Park Dr. Suite D Waco, TX 76712-6667	010507	67-1552	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	6800 Weiskopf Ave, Suite 105 McKinney, TX 75070-1639	018363	74-1652	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	2904 N. Fourth Street, Suite 102 Longview, TX 75605-5124	010521	67-1545	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	8876 Gulf Freeway, Suite 350 Houston, TX 77017-6513	010899	67-1559	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	1605 Rock Prairie Road, Suite 206 College Station TX 77845	016579	74-1588	CHAP	
Texas Home Health Hospice, L.P. dba-AccentCare Hospice & Palliative Care of Texas	Hospice	5685 Eastex Freeway Beaumont, TX 77706-6923	010904	67-1560	CHAP	
AccentCare Home Health of California, Inc.	Medical Home Care	2934 E Garvey Ave S, STE 210 West Covina, CA 91791-2190	980000845	55-9018	CHAP	
AccentCare Home Health of California, Inc.	Medical Home Care	5050 Murphy Canyon Rd, STE 201 San Diego, CA 92123-4441	080000433	57-7761	CHAP	
AccentCare Home Health of California, Inc.	Medical Home Care	2300 Contra Costa Blvd, STE 240 Pleasant Hill, CA 94523-3918	020000637	N/A	N/A	
AccentCare Home Health of California, Inc.	Medical Home Care	15455 San Fernando Mission Blvd., STE C400 Mission Hills CA 91345-1300	980001314	Pending	N/A	
AccentCare Home Health of California, Inc.	Medical Home Care	119 S Court St, STE A Circleville, OH 43113	N/A	36-7270	N/A	
AccentCare at Home of Michigan dba AccentCare Personal Care Services of Michigan	Personal Care Services	27335 John R Rd, Madison Heights, MI 48071	Pending	N/A	N/A	
AccentCare at Home of Minnesota, LLC dba AccentCare Personal Care Services of Minnesota	Personal Care Services	767 Eustis St, #150, Saint Paul, MN 55114-0018	Pending	N/A	N/A	
AccentCare at Home of Pennsylvania, LLC DBA: AccentCare Personal Care Services of Pennsylvania	Personal Care Services	1501 GRUNDY LN, STE 100 BRISTOL, PA 19007-1506	66533601	N/A	N/A	
AccentCare at Home of Pennsylvania, LLC DBA: AccentCare Personal Care Services of Pennsylvania	Personal Care Services	4641 Pottsville Pkiw, Suite 106 Reading, PA 19605	Pending	N/A	N/A	
AccentCare at Home of Pennsylvania, LLC DBA: AccentCare Personal Care Services of Pennsylvania	Personal Care Services	101 Valley St Marysville, PA 17053-1425	Pending	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	2340 W 24th St., STE B Yuma, AZ 85367	N/A	N/A	N/A	

Legal Entity	Service	Office Address	License #	Medicare #	Accreditation	Date Acquired by AccentCare, if Within Past 3 Years
AccentCare at Home, Inc.	Personal Care Services	5151 E Broadway Blvd, STE 1510 Tuscon, AZ 85711	N/A	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	500 E Fry Blvd, STE L-7 Sierra Vista, AZ 85635	N/A	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	60 S White Mountain, STE B Show Low, AZ 85901	N/A	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	3050 Navajo Dr, STE 110 Prescott Valley, AZ 86314	N/A	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	4001 N 3rd St, STE 410 Phoenix, AZ 85012	N/A	N/A	N/A	
AccentCare at Home, Inc.	Personal Care Services	1308 N Stockton Hill Rd, STE C Kingman, AZ 86401	N/A	N/A	N/A	
AccentCare Home Health of California, Inc.	Personal Care Services	119 S Court St, STE A Circleville, OH 43113	N/A	N/A	N/A	
AccentCare Home Health of Mountain Valley, LLC	Personal Care Services	455 Sherman Street, STE 465 Denver, CO 80203-4402	Pending	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	21515 Hawthorne Blvd., STE 200 Torrance, CA 90503	Pending	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	1910 Olympic Blvd., STE 235, Walnut Creek, CA 94956	074700019	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	411 Camino Del Rio S, STE 302 San Diego, CA 92108-3530	347400038	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	1451 River Park Drive, STE 150 Sacramento, CA 95815-4507	344700015	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	6840 Indiana Ave, STE 100 Riverside, CA 92506-4298	334700013	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	1301 Redwood Way, STE 240 Petaluma, CA 94954-1107	494700005	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	23725 Birtcher Dr, STE 150 Lake Forest, CA 92630	304700040	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	5855 Green Valley Circle, STE 310 Culver City, CA 90230	194700054	N/A	N/A	
AccentCare of Massachusetts, Inc. dba AccentCare Personal Care Services of Massachusetts	Personal Care Services	30 Perwal Street, Westwood, MA 02090	N/A	N/A	N/A	
AccentCare of Massachusetts, Inc. dba AccentCare Personal Care Services of Massachusetts	Personal Care Services	21 Father DeValles Blvd. Suite 103 Fall River, MA 02723	N/A	N/A	N/A	
AccentCare of New York, Inc.	Personal Care Services	27 Main Street Yonkers, NY 10701	1084L001; 1084L002	N/A	N/A	
AccentCare of Washington, Inc.	Personal Care Services	15 S Grady Way, STE 433 Renton, WA 98057-3219	000111	N/A	N/A	
Alliance for Health, Inc. DBA: AccentCare Personal Care Services of New York	Personal Care Services	105 Court Street, 2nd Floor Brooklyn, NY 11201	1170L001	N/A	N/A	
Gareda, LLC dba AccentCare Personal Care Services of Illinois	Personal Care Services	1431 Huntington Dr., Calumet City, IL 60409	3002048	N/A	N/A	Dec-20

EXHIBIT 4

Lease Documents

TACOMA MALL OFFICE BUILDING LEASE

This Lease, made and entered into at **4301 South Pine Street, Tacoma, Washington**, this **28th** day of **February 2020** by and between LANDLORD: **3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common** and TENANT: **Seasons Hospice & Palliative Care of Pierce County, LLC.**

Landlord hereby Leases to Tenant the following:

Suite 85, which includes the combination of Suites 55, 57, 81 and 85 (the Premises)

in **the Tacoma Mall Office Building** (the Building)

at **4301 South Pine Street, Tacoma, Washington** containing approximately **2,183** rentable square feet as shown on the attached floor plan. Tenant's proportionate share for purposes of Section 19 shall be 1.89**%**. This Lease is for a term commencing **March 1, 2020** and continuing **through February 28, 2021** at a Monthly Base Rental as follows:

Year	Base Monthly Rent
1	**$3,274.50**

Rent is payable in advance on the **1st** day of each month commencing **March 1, 2020**. If Tenant is not in default beyond any applicable cure period and Tenant has not assigned the Lease or subleased the Premises, at Tenant's option, and upon at least 60 days' written notice to Landlord prior to the end of the initial term, the term will be extended for an additional thirty-four (34) months commencing March 1, 2021 and continuing through December 31, 2024, with the Base Rent at the then Fair Market Rate, with 3% annual increases through the extended term.

Landlord and Tenant covenant and agree as follows:

1.1 Delivery of Possession. Should Landlord be unable to deliver possession of the Premises on the date fixed for the commencement of the term, commencement will be deferred, and Tenant shall owe no rent until notice from Landlord tendering possession to Tenant. If possession is not so tendered within 90 days following commencement of the term, then Tenant may elect to cancel this Lease by notice to Landlord within 10 days following expiration of the 90-day period. Landlord shall have no liability to Tenant for delay in delivering possession. In the event that the delivery of Possession is delayed, the parties agree to sign a commencement agreement memorializing the commencement and termination of the lease.

2.1 Rent Payment. Tenant shall pay the Base Rent for the Premises and any additional rent provided herein without deduction or offset. Rent for any partial month during the Lease term shall be prorated to reflect the number of days during the month that Tenant occupies the Premises. Additional rent means amounts determined under Section 19 of this Lease and any other sums payable by Tenant to Landlord under this Lease. Rent not paid when due shall bear interest at the rate of one-and-one-half percent per month until paid. Landlord may at its option impose a late charge of

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$.05 for each $1 of rent for rent payments made more than 10 days late in lieu of interest for the first month of delinquency, without waiving any other remedies available for default. Failure to impose a late charge shall not be a waiver of Landlord's rights hereunder.

3.1 Security Deposit. Upon execution of the Lease Tenant has paid the Base Rent for the first full and last full months of the Lease term for which rent is payable and in addition has paid the sum equal to the first month of rent as a Security Deposit. Landlord may apply the Security Deposit to pay the cost of performing any obligation which Tenant fails to perform within the time required by this Lease, but such application by Landlord shall not be the exclusive remedy for Tenant's default. If the Security Deposit is applied by Landlord, Tenant shall on demand pay the sum necessary to replenish the Security Deposit to its original amount. To the extent not applied by Landlord to cure defaults by Tenant, the Security Deposit shall be applied against the rent payable for the last month of the term.

4.1 Use. Tenant shall use the Premises as business for **general office** and for no other purpose without Landlord's written consent. In connection with its use, Tenant shall at its expense promptly comply and cause the Premises to comply with all applicable laws, ordinances, rules and regulations of any public authority and shall not annoy, obstruct, or interfere with the rights of other tenants of the Building. Tenant shall create no nuisance nor allow any objectionable fumes, noise, or vibrations to be emitted from the Premises. Tenant shall not conduct any activities that will increase Landlord's insurance rates for any portion of the Building or that will in any manner degrade or damage the reputation of the Building.

4.2 Equipment. Tenant shall install in the Premises only such office equipment as is customary for general office use and shall not overload the floors or electrical circuits of the Premises or Building or alter the plumbing or wiring of the Premises or Building. Landlord must approve in advance the location of and manner of installing any wiring or electrical, heat generating or communication equipment or exceptionally heavy articles. All telecommunications equipment, conduit, cables and wiring, additional dedicated circuits and any additional air conditioning required because of heat generating equipment or special lighting installed by Tenant shall be installed and operated at Tenant's expense. Landlord shall have no obligation to permit the installation of equipment by any telecommunications provider whose equipment is not then servicing the Building.

4.3 Signs. No signs, awnings, antennas, or other apparatus shall be painted on or attached to the Building or anything placed on any glass or woodwork of the Premises or positioned so as to be visible from outside the Premises without Landlord's written approval as to design, size, location, and color. All signs installed by Tenant shall comply with Landlord's standards for signs and all applicable codes and all signs and sign hardware shall be removed upon termination of this Lease with the sign location restored to its former state unless Landlord elects to retain all or any portion thereof.

5.1 Utilities and Services. Landlord will furnish water and electricity to the Building at all times and will furnish heat and air conditioning (if the Building is air-conditioned) during the normal Building hours as established by Landlord. Janitorial service will be

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provided in accordance with the regular schedule of the Building, which schedule and service may change from time to time. Tenant shall comply with all government laws or regulations regarding the use or reduction of use of utilities on the Premises. Interruption of services or utilities shall not be deemed an eviction or disturbance of Tenant's use and possession of the Premises, render Landlord liable to Tenant for damages, or relieve Tenant from performance of Tenant's obligations under this Lease. Landlord shall take all reasonable steps to correct any interruptions in service. Electrical service furnished will be 110 volts unless different service already exists in the Premises. Tenant shall provide its own surge protection for power furnished to the Premises.

5.2 Extra Usage. If Tenant uses excessive amounts of utilities or services of any kind because of operation outside of normal Building hours, high demands from office machinery and equipment, nonstandard lighting, or any other cause, Landlord may impose a reasonable charge for supplying such extra utilities or services, which charge shall by payable monthly by Tenant in conjunction with rent payments. In case of dispute over any extra charge under this paragraph, Landlord shall designate a qualified independent engineer whose decision shall be conclusive on both parties. Landlord and Tenant shall each pay one-half of the cost of such determination.

5.3 Security. Landlord may but shall have no obligation to provide security service or to adopt security measures regarding the Premises, and Tenant shall cooperate with all reasonable security measures adopted by Landlord. Tenant may install a security system within the leased Premises with Landlord's written consent, which will not be unreasonably withheld. Landlord will be provided with an access code to any security system and shall not have any liability for accidentally setting off Tenant's security system. Landlord may modify the type or amount of security measures or services provided to the Building or the Premises at any time.

6.1 Maintenance and Repair. Landlord shall have no liability for failure to perform required maintenance and repair unless written notice of such maintenance or repair is given by Tenant and Landlord fails to commence efforts to remedy the problem in a reasonable time and manner. Landlord shall have the right to erect scaffolding and other apparatus necessary for the purpose of making repairs, and Landlord shall have no liability for interference with Tenant's use because of repairs and installations. Tenant shall have no claim against Landlord for any interruption or reduction of services or interference with Tenant's occupancy, and no such interruption or reduction shall be construed as a constructive or other eviction of Tenant. Repair of damage caused by negligent or intentional acts or breach of this Lease by Tenant, its employees or invitees shall be at Tenant's expense.

6.2 Alterations. Tenant shall not make any alterations, additions, or improvements to the Premises, change the color of the interior, or install any wall or floor covering without Landlord's prior written consent, which may be withheld in Landlord's sole discretion. Any such improvements, alterations, wiring, cables or conduit installed by Tenant shall at once become part of the Premises and belong to Landlord except for removable machinery and unattached movable trade fixtures. Landlord may at its option require that Tenant remove any improvements, alterations, wiring, cables or conduit installed by or for Tenant and restore the Premises to the original condition upon termination of this Lease. Landlord and tenant both will have the

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right to approve the contractor used by the tenant for any work in the premises, and to post a notice of responsibility in connection with work being performed by tenant in the premises. Work by tenant will comply with all the laws then applicable to the premises.

7.1 Indemnity. Tenant shall not allow any liens to attach to the Building or Tenant's interest in the Premises as a result of its activities. Tenant shall indemnify and defend Landlord and its managing agents from any claim, liability, damage, or loss occurring on the Premises, arising out of any activity by Tenant, its agents, or invitees or resulting from Tenant's failure to comply with any term of this Lease. Neither Landlord nor its managing agent shall have any liability to Tenant because of loss or damage to Tenant's property or for death or bodily injury caused by the acts or omissions of other Tenants of the Building, or by third parties (including criminal acts). The foregoing indemnity shall only apply to the extent of the negligence or willing full misconduct of the content that occurs while on premises owned or controlled by landlord. In no event shall tenant's obligations hereunder be limited to the extent of any insurance available to or provided by landlord or any subcontractor thereof.

7.2 Insurance. Tenant shall carry liability insurance with limits of not less than **Two** Million Dollars (**$2,000,000.00**) combined single limit bodily injury and property damage which insurance shall have an endorsement naming Landlord and Landlord's managing agent, if any, as an additional insured, cover the liability insured under paragraph 7.1 of this Lease and be in form and with companies reasonably acceptable to Landlord. Prior to occupancy, Tenant shall furnish a certificate evidencing such insurance, which shall state that the coverage shall not be cancelled or materially changed without 10 days advance notice to Landlord and Landlord's managing agent, if any. A renewal certificate shall be furnished at least 10 days prior to expiration of any policy.

8.1 Fire or Casualty. "Major Damage" means damage by fire or other casualty to the Building or the Premises which causes the Premises or any substantial portion of the Building to be unusable, or which will cost more than 25 percent of the pre-damage value of the Building to repair, or which is not covered by insurance. In case of Major Damage, Landlord may elect to terminate this Lease by notice in writing to the Tenant within 30 days after such date. If this Lease is not terminated following Major Damage, or if damage occurs which is not Major Damage, Landlord shall promptly restore the Premises to the condition existing just prior to the damage. Tenant shall promptly restore all damage to tenant improvements or alterations installed by Tenant or pay the cost of such restoration to Landlord if Landlord elects to do the restoration of such improvements. Rent shall be reduced from the date of damage until the date restoration work being performed by Landlord is substantially complete, with the reduction to be in proportion to the area of the Premises not usable by Tenant.

8.2 Waiver of Subrogation. Tenant shall be responsible for insuring its personal property and trade fixtures located on the Premises and any alterations or tenant improvements it has made to the Premises. Neither Landlord, its managing agent nor Tenant shall be liable to

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the other for any loss or damage caused by water damage, sprinkler leakage, or any of the risks that are or could be covered by a special all risk property insurance policy, or for any business interruption, and there shall be no subrogated claim by one party's insurance carrier against the other party arising out of any such loss. This waiver is binding only if it does not invalidate the insurance coverage of either party hereto.

9.1 Eminent Domain. If a condemning authority takes title by eminent domain or by agreement in lieu thereof to the entire Building or a portion sufficient to render the Premises unsuitable for Tenant's use, then either party may elect to terminate this Lease effective on the date that possession is taken by the condemning authority. Rent shall be reduced for the remainder of the term in an amount proportionate to the reduction in area of the Premises caused by the taking. All condemnation proceeds shall belong to Landlord, and Tenant shall have no claim against Landlord or the condemnation award because of the taking.

10.1 Assignment and Subletting. This Lease shall bind and inure to the benefit of the parties, their respective heirs, successors, and assigns provided that Tenant shall not assign its interest under this Lease or sublet all or any portion of the Premises without first obtaining Landlord's consent in writing, which shall not be unreasonably withheld. This provision shall apply to all transfers by operation of law including but not limited to mergers and changes in control of Tenant. No assignment shall relieve Tenant of its obligation to pay rent or perform other obligations required by this Lease and no consent to one assignment or subletting shall be consent to any further assignment or subletting. Landlord shall not unreasonably withhold its consent to any assignment or subletting provided the effective rental paid by the subtenant or assignee is not less than the current scheduled rental rate of the Building for comparable space and the proposed Tenant is compatible with Landlord's normal standards for the Building. If Tenant proposes a subletting or assignment to which Landlord is required to consent under this paragraph, Landlord shall have the option of terminating this Lease and dealing directly with the proposed subtenant or assignee, or any third party. If an assignment or subletting is permitted, any cash profit, or the net value of any other consideration received by Tenant as a result of such transaction shall be paid to Landlord promptly following its receipt by Tenant. Tenant shall pay any costs incurred by Landlord in connection with a request for assignment or subletting, including reasonable attorneys' fees, up to $1,000.00.

11.1 Default. Any of the following shall constitute a default by Tenant under this Lease:

(a) Tenant's failure to pay rent or any other charge under this Lease within 10 days after it is due, or failure to comply with any other term or condition within 20 days following written notice from Landlord specifying the noncompliance. If such noncompliance cannot be cured within the 20-day period, this provision shall be satisfied if Tenant commences correction within such period and thereafter proceeds in good faith and with reasonable diligence to effect compliance as soon as possible. Time is of the essence of this Lease.

(b) Tenant's insolvency, business failure or assignment for the benefit of its creditors. Tenant's commencement of proceedings under any provision of any bankruptcy or insolvency law or failure to obtain dismissal of any petition filed

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against it under such laws within the time required to answer; or the appointment of a receiver for all or any portion of Tenant's properties or financial records.

(c) Assignment or subletting by Tenant in violation of paragraph 10.1.

(d) Vacation or abandonment of the Premises without the written consent of Landlord or failure to occupy the Premises within 20 days after notice from Landlord tendering possession.

11.2 Remedies for Default. In case of default as described in paragraph 11.1 Landlord shall have the right to the following remedies which are intended to be cumulative and in addition to any other remedies provided under applicable law:

(a) Landlord may at its option terminate the Lease by notice to Tenant. With or without termination, Landlord may retake possession of the Premises and may use or relet the Premises without accepting a surrender or waiving the right to damages. Following such retaking of possession, efforts by Landlord to relet the Premises shall be sufficient if Landlord follows its usual procedures for finding tenants for the space at rates not less than the current rates for other comparable space in the Building. If Landlord has other vacant space in the Building, prospective tenants may be placed in such other space without prejudice to Landlord's claim to damages or loss of rentals from Tenant.

(b) Landlord may recover all damages caused by Tenant's default which shall include an amount equal to rentals lost because of the default, Lease commissions paid for this Lease, and the unamortized cost of any tenant improvements installed by Landlord to meet Tenant's special requirements. Landlord may sue periodically to recover damages as they occur throughout the Lease term, and no action for accrued damages shall bar a later action for damages subsequently accruing. Landlord may elect in any one action to recover accrued damages plus damages attributable to the remaining term of the Lease. Such damages shall be measured by the difference between the rent under this Lease and the reasonable rental value of the Premises for the remainder of the term, discounted to the time of judgment at the prevailing interest rate on judgments.

(c) Landlord may make any payment or perform any obligation, which Tenant has failed to perform, in which case Landlord shall be entitled to recover from Tenant upon demand all amounts so expended, plus interest from the date of the expenditure at the rate of one-and-one-half percent per month. Any such payment or performance by Landlord shall not waive Tenant's default.

12.1 Surrender. On expiration or early termination of this Lease Tenant shall deliver all keys to Landlord and surrender the Premises vacuumed, swept, and free of debris and in the same condition as at the commencement of the term subject only to reasonable wear from ordinary use. Tenant shall remove all of its furnishings and trade fixtures that remain its property and repair all damage resulting from such removal. Failure to remove shall be an abandonment of the property, and Landlord may dispose of it in any manner without liability. If Tenant fails to vacate the Premises when required, including failure to remove all its personal property, Landlord may elect either: (i) to treat Tenant as a tenant from month to month, subject to the

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provisions of this Lease except that rent shall be one-and-one-half times the total rent being charged when the Lease term expired, and any option or other rights regarding extension of the term or expansion of the Premises shall no longer apply, or (ii) to eject Tenant from the Premises and recover damages caused by wrongful holdover.

13.1 Regulations. Landlord shall have the right but shall not be obligated to make, revise and enforce regulations or policies consistent with this Lease for the purpose of promoting safety, health (including moving, use of common areas and prohibition of smoking), order, economy, cleanliness, and good service to all tenants of the Building. All such regulations and policies shall be complied with as if part of this Lease.

14.1 Access. During times other than normal Building hours Tenant's officers and employees or those having business with Tenant may be required to identify themselves or show passes in order to gain access to the Building. Landlord shall have no liability for permitting or refusing to permit access by anyone. Landlord may regulate access to any Building elevators outside of normal Building hours. Landlord shall have the right to enter upon the Premises at any time by passkey or otherwise to determine Tenant's compliance with this Lease, to perform necessary services, maintenance and repairs or alterations to the Building or the Premises, or to show the Premises to any prospective tenant or purchasers. Except in case of emergency such entry shall be at such times and in such manner as to minimize interference with the reasonable business use of the Premises by Tenant.

14.2 Furniture and Bulky Articles. Tenant shall move furniture and bulky articles in and out of the Building or make independent use of the elevators only at times approved by Landlord following at least 24 hours written notice to Landlord of the intended move. Landlord will not unreasonably withhold its consent under this paragraph.

15.1 Notices. Notices between the parties relating to this Lease shall be in writing, effective when delivered, or if mailed, effective on the second day following mailing, postage prepaid, to the address for the party stated in this Lease or to such other address as either party may specify by notice to the other. Rent shall be payable to Landlord at the same address and in the same manner, but shall be considered paid only when received.

16.1 Subordination and Attornment. This Lease shall be subject to and subordinate to any mortgages, deeds of trust, or land sale contracts (hereafter collectively referred to as encumbrances) now existing against the Building. At Landlord's option this Lease shall be subject and subordinate to any future encumbrance hereafter placed against the Building (including the underlying land) or any modifications of existing encumbrances, and Tenant shall execute such documents as may reasonably be requested by Landlord or the holder of the encumbrance to evidence this subordination. If any encumbrance is foreclosed, then if the purchaser at foreclosure sale gives to Tenant a written agreement to recognize Tenant's Lease, Tenant shall attorn to such purchaser and this Lease shall continue.

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Landlord's Initials

Tenant's Initials

16.2 Transfer of Building. If the Building is sold or otherwise transferred by Landlord or any successor, Tenant shall attorn to the purchaser or transferee and recognize it as the Landlord under this Lease, and, provided the purchaser or transferee assumes all obligations hereunder, the transferor shall have no further liability hereunder.

16.3 Estoppels. Either party will within 10 days after notice from the other execute, acknowledge and deliver to the other party a certificate certifying whether or not this Lease has been modified and is in full force and effect; whether there are any modifications or alleged breaches by the other party; the dates to which rent has been paid in advance, and the amount of any security deposit or prepaid rent; and any other facts that may reasonably be requested. Failure to deliver the certificate within the specified time shall be conclusive upon the party of whom the certificate was requested that the Lease is in full force and effect and has not been modified except as may be represented by the party requesting the certificate. If requested by the holder of any encumbrance, or any ground Landlord, Tenant will agree to give such holder or Landlord notice of and an opportunity to cure any default by Landlord under this Lease.

17.1 Attorneys' Fees. In any litigation arising out of this Lease, the prevailing party shall be entitled to recover attorney's fees and expenses at trial and on any appeal. If Landlord incurs attorneys' fees because of a default by Tenant, Tenant shall pay all such fees whether or not litigation is filed.

18.1 Quiet Enjoyment. Landlord warrants that so long as Tenant complies with all terms of this Lease it shall be entitled to peaceable and undisturbed possession of the Premises free from any eviction or disturbance by Landlord. Neither Landlord nor its managing agent shall have any liability to Tenant for loss or damages arising out of the acts, including criminal acts, of other tenants of the Building or third parties, nor any liability for any reason which exceeds the value of its interest in the Building.

19.1 Additional Rent: Tax Adjustment. Whenever for any year the real property taxes levied against the Building and its underlying land exceed those levied for the **2019** tax year, then the monthly rental for the next succeeding calendar year shall be increased by one-twelfth of such tax increase times Tenant's proportionate share. "Real property taxes" as used herein means all taxes and assessments of any public authority against the Building and the land on which it is located, the cost of contesting any tax and any form of fee or charge imposed on Landlord as a direct consequence of owning or leasing the Premises, including but not limited to rent taxes, gross receipt taxes, leasing taxes, or any fee or charge wholly or partially in lieu of or in substitution for ad valorem real property taxes or assessments, whether now existing or hereafter enacted.

19.2 Additional Rent: Operating Expense Adjustment. Tenant shall pay as additional rent Tenant's proportionate share of the amount by which operating expenses for the Building increase over those experienced by Landlord during the calendar year **2020** (base year). Effective January 1 of each year Landlord shall estimate the amount, by which operating expenses are expected to increase, if any, over those incurred in the base year. Monthly rental for that year shall be increased by one-twelfth of Tenant's share of the estimated increase. Following the end of each calendar year, Landlord shall compute the actual increase in operating expenses and bill Tenant for any deficiency or credit Tenant with any excess collected. As used herein "operating expenses" shall mean

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all costs of operating and maintaining the Building as determined by standard real estate accounting practice, including, but not limited to: all water and sewer charges; the cost of natural gas and electricity provided to the Building; janitorial and cleaning supplies and services; administration costs and management fees; superintendent fees; security services, insurance premiums; licenses; permits for the operation and maintenance of the Building and all of its component elements and mechanical systems; the annual amortized capital improvement cost (amortized over such a period as Landlord may select and at a current market interest rate) for any capital improvements to the Building required by any governmental authority or those which have a reasonable probability of improving the operating efficiency of the Building.

19.3 Disputes. If Tenant disputes any computation of additional rent or rent adjustment under paragraphs 19.1 through 19.2 of this Lease, it shall give notice to Landlord not later than one (1) year after the notice from Landlord describing the computation in question, but in any event not later than thirty (30) days after expiration or earlier termination of this Lease. If Tenant fails to give such a notice, the computation by Landlord shall be binding and conclusive between the parties for the period in question. If Tenant gives a timely notice, the dispute shall be resolved by an independent certified public accountant selected by Landlord whose decision shall be conclusive between the parties. Each party shall pay one-half of the fee for making such determination except that if the adjustment in favor of Tenant does not exceed ten percent of the escalation amounts for the year in question, Tenant shall pay (i) the entire cost of any such third-party determination; and (ii) Landlord's out-of-pocket costs and reasonable expenses for personnel time in responding to the audit. Nothing herein shall reduce Tenant's obligations to make all payments as required by this Lease.

20.1 Complete Agreement; No Implied Covenants. This Lease and the attached Exhibits and Schedules if any, constitute the entire agreement of the parties and supersede all prior written and oral agreements and representations and there are no implied covenants or other agreements between the parties except as expressly set forth in this Lease. Neither Landlord nor Tenant is relying on any representations other than those expressly set forth herein.

20.2 Space Leased As Is. Unless otherwise stated in the Lease, the Premises are leased "As-Is" in the condition now existing with no alterations or other work to be performed by Landlord**.**

20.3 Captions. The titles to the paragraphs of this Lease are descriptive only and are not intended to change or influence the meaning of any paragraph or to be part of this Lease.

20.4 Nonwaiver. Failure by Landlord to promptly enforce any regulation, remedy or right of any kind under this Lease shall not constitute a waiver of the same and such right or remedy may be asserted at any time after Landlord becomes entitled to the benefit thereof notwithstanding delay in enforcement.

20.45 Brokers. Landlord is represented by John Bauder and Harrison Laird, CBRE, Inc..

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Landlord's Initials

Tenant's Initials

20.5 Substitution Space. Landlord shall have the right at any time during the Term of this Lease to require the Tenant to relocate to other space in the Building (hereinafter referred to as "Substitution Space"). The Substitution Space shall be of similar quality and have approximately the same rentable square footage as the Premises. If Landlord desires to exercise such right, Landlord shall give Tenant not less than ninety (90) days prior written notification that Tenant is to relocate to another space (the "Relocation Notice"). If Tenant refuses to accept the Substitute Space within ten (10) days of the date of the Relocation Notice, this Lease shall terminate on the day that is ninety (90) days from the date of the Relocation Notice. If Tenant accepts Substitute Premises, Landlord, at Landlord's sole expense, shall pay for all costs reasonably and directly related to the physical relocation of Tenant from Premises to Substitution Space, and all costs related to improving the space with leasehold improvements equal in all material respects to those then in Tenant's Premises. After such relocation, all terms, covenants, conditions, provisions, and agreements of this Lease shall continue in full force and effect and shall apply to the Substitution Space except that if the Substitution Space contains more square footage than the presently leased Premises, the monthly rental shall be increased proportionately and if the Substitution Space contains less square footage than the presently leased Premises, the monthly rental shall be decreased proportionately. If Tenant shall retain possession of the Premises or any part thereof following the date set for relocation or termination, Tenant shall be liable to Landlord, for each day of such retention, for double the amount of the daily rental for the last period prior to the date of such expiration or termination, plus actual damages incurred by Landlord resulting from delay by Tenant in surrendering the Premises, including, without limitation, any claims made against Landlord by any succeeding tenant to the Premises and Landlord's costs in taking any action to evict Tenant from the Premises.

20.6 Contingency. This Lease and all terms and conditions of this Lease are subject to and are not binding until a fully executed copy is delivered to the Tenant.

20.7 Early Termination: Tenant shall have the right to terminate this Lease after the 6th month and before the 12th month of the initial term, with at least 30 days prior written notice of the termination effective date to Landlord. Tenant shall have the right to terminate this Lease during the extended term with at least 60 days' prior written notice of the termination effective date to Landlord. The termination effective date shall be the last day of a calendar month.

20.8 Exhibits The following Exhibits are attached hereto and incorporated as part of this Lease:

Exhibit A: Legal Description
Exhibit B: Premises
Exhibit C: Work Agreement
Exhibit D: Rules & Regulations

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Landlord's Initials

Tenant's Initials

IN WITNESS WHEREOF, the duly authorized representatives of the parties have executed this Lease as of the day and year first written above.

LANDLORD:
3W TMOB Partners LLC and M & M Tacoma Investments IV LLC

By: DocuSigned by: Jeff Mincheff, Managing Member of Mincheff & Mincheff Investments IV LLC, agent for Landlord

Address for notices:
2222 NE Oregon Street, Suite 201
Portland, OR 97232

TENANT:
Seasons Hospice & Palliative Care of Pierce County, LLC

By: _____

Name: Todd Stern

Its: CEO

Address for notices:

6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attn: Legal Department

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_____
Landlord's Initials

_____
Tenant's Initials

THIS PAGE IS REQUIRED IF PROPERTY IS IN WASHINGTON, WITH A LEASE TERM LONGER THAN 12 MONTHS

LANDLORD ACKNOWLEDGMENTS

STATE OF _____)
COUNTY OF _____) ss:

I, the undersigned, a Notary Public, in and for the County and State aforesaid, do hereby certify that Jeff Mincheff is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to executed the instrument and acknowledged it as the managing member of Mincheff & Mincheff Investments IV LLC, to be free and voluntary act of such party for the uses and purposed mentioned in the instrument.

GIVEN under my hand and official seal this ____ day of _____, 20___.

Notary Public_____

Printed Name _____

Residing at: _____

My Commission Expires: _____

TENANT ACKNOWLEDGMENTS

STATE OF _____)
COUNTY OF _____) ss:

On this the ____ day of _____, 20__, before me a Notary Public duly authorized in and for the said County in the State aforesaid to take acknowledgments personally appeared _____ known to me to be _____ of _____, one of the parties described in the foregoing instrument, and acknowledged that as such officer, being authorized so to do, (s)he executed the foregoing instrument on behalf of said corporation by subscribing the name of such corporation by himself/herself as such officer and caused the corporate seal of said corporation to be affixed thereto, as a free and voluntary act, and as the free and voluntary act of said corporation, for the uses and purposes therein set forth.

IN WITNESS WHEREOF, I hereunto set my hand and official seal.

Notary Public_____

Printed Name _____

Residing at: _____

_____ _____
Landlord's Initials Tenant's Initials

EXHIBIT A

LEGAL DESCRIPTION

PARCEL "A"

PARCEL 2 OF CITY OF TACOMA BOUNDARY LINE ADJUSTMENT RECORDED DECEMBER 27, 1999 UNDER RECORDING NUMBER 9912275001, IN PIERCE COUNTY, WASHINGTON.

PARCEL "B"

TOGETHER WITH THOSE RIGHTS AS ESTABLISHED BY THAT CERTAIN FIVE-PARTY AGREEMENT RECORDED UNDER PIERCE COUNTY RECORDING NO. 2142567 AND AMENDED BY DOCUMENTS RECORDED UNDER RECORDING NOS. 8008040039, RECORDS OF PIERCE COUNTY, WASHINGTON.

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Landlord's Initials

Tenant's Initials

EXHIBIT B

PREMISES

Suites 55, 57, 81 and 85

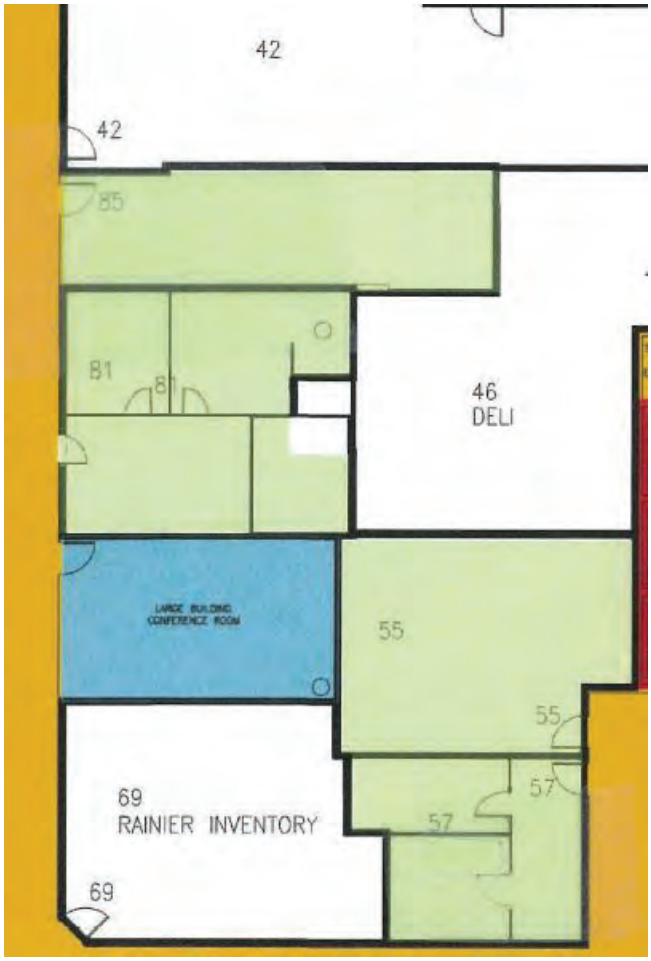

EXHIBIT C

WORK AGREEMENT

Tenant agrees to accept Premises in it's current "as-is" condition.

EXHIBIT D

RULES AND REGULATIONS

1. No sign, placard, picture, advertisement, name of notice shall be inscribed, displayed or printed or affixed on the Building or to any part thereof, or which is visible from the outside of the Building, without the written consent of Landlord, first had and obtained and Landlord shall have the right to remove any such sign, placard, picture, advertisement, name or notice without notice and at the expense of Tenant.

   All approved signs or lettering on doors shall be printed, affixed or inscribed at the expense of Tenant by a person approved by Landlord.

2. If a directory is located at the Building, it is provided exclusively for the display of the name and location of Tenant only and Landlord reserves the right to exclude any other names therefrom.

3. The sidewalks, passages, exits, entrances, and stairways in and around the Building shall not be obstructed by Tenant or used by it for any purpose other than for ingress to and egress from the Premises. The passages, exits, entrances, stairways, and roof are not for the use of the general public and Landlord shall in all cases retain the right to control and prevent access thereto by all persons whose presence in the judgment of Landlord shall be prejudicial to the safety, character, reputation and interests of the Building and its Tenants, provided that nothing herein contained shall be construed to prevent such access to person with whom Tenant normally deals in the ordinary course of Tenant's business unless such persons are engaged in illegal activities. Neither Tenant nor any employees or invitees of Tenant shall go upon the roof of the Building.

4. Tenant shall not be permitted to install any additional lock or locks on any door in the Building unless written consent of Landlord shall have first been obtained.

5. The toilets and urinals shall not be used for any purpose other than those for which they were constructed, and no rubbish, or other substances of any kind shall be thrown into them. Tenant shall be responsible for any breakage, stoppage or damage resulting from the violation of this rule by Tenant or its employees or invitees.

6. Tenant shall not overload the floor of the Premises or mark, drive nails, screw or drill into the partitions, woodwork or plaster or in any way deface the Premises or any part thereof.

7. Tenant shall not use, keep or permit to be used or kept any foul or noxious gas or substance in the Premises, or permit or suffer the Premises to be occupied or used in a manner offensive or objectionable to Landlord or other occupants of the Building by reason of noise, odors and/or vibrations, or interfere in any way with other Tenants or those having business therein.

8. The Premises shall not be used for any improper objectionable or immoral purposes.

9. Tenant shall not use or keep in the Premises or the Building any kerosene, gasoline, or inflammable or combustible fluid or material, or use any method of heating or air conditioning other than that supplied by Landlord.

10. Landlord will direct electricians as to the manner and location in which telephone and telegraph wires are to be introduced. No boring or cutting for wires will be allowed without the consent of Landlord. The location of telephones, call boxes and other office equipment affixed to the Premises shall be subject to the approval of Landlord.

11. Tenant shall not lay linoleum, tile, carpet or other similar floor covering so that the same shall be affixed to the floor of the Premises in any manner except as approved by Landlord. The expense of repairing any damage resulting from a violation of this rule or removal of any floor covering shall be done by Tenant.

12. Any window covering desired by Tenant shall be approved by Landlord.

13. Landlord reserves the right to exclude or expel from the Building any person who, in the judgment of Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of the Building.

14. Tenant shall not disturb, solicit, or canvass any occupant of the Building.

15. Without the written consent of Landlord, Tenant shall not use the name of the Building in connection with or in promoting or advertising the business of Tenant except as Tenant's address.

16. Tenant shall not permit any contractor or other person making any alterations, additions or installations within the Premises to use the hallways, lobby or corridors as storage or work areas without the prior consent of Landlord. Tenant shall be liable for and shall pay the expense of any additional cleaning or other maintenance required to be performed by Landlord as a result of the transportation or storage of materials or work performed within the Building by or for Tenant.

17. Tenant shall be entitled to use parking spaces as mutually agreed upon between Tenant and Landlord subject to such reasonable conditions ant regulations as may be imposed by Landlord. Tenant agrees that vehicles of Tenant or its employees or agents shall not park in driveways nor occupy parking spaces or other areas reserved for any use such as Visitors, Delivery, Loading, or other tenants. Landlord or its agents shall have the right to cause or be removed any car or Tenant, its employees or agents, that may be parked in unauthorized areas, and Tenant agrees to save and hold harmless Landlord, its agents and employees from any and all claims, losses, damages and demands asserted or arising in respect to or in connection with the removal of any such vehicle. Tenant, its employees, or agents shall not park campers, trucks or cars on the Building parking areas overnight or over weekends. Tenant will from time to time, upon request of Landlord, supply Landlord with a list of license plate numbers of vehicles owned or operated by its employees and agents.

18. Landlord reserves the right to make modifications hereto and such other and further rules and regulations as in its sole judgment may be required for the safety, care and cleanliness of the Premises and the Building and for the preservation of good order therein. Tenant agrees to abide by all such rules and regulations.

19. Canvassing, soliciting and peddling is prohibited in the Building and each Tenant shall cooperate to prevent the same.

20. Landlord is not responsible for the violation of any rule contained herein by any other Tenant.

21. Landlord may waive any one or more of these rules for the benefit of any particular Tenant, but no such waiver shall be construed as a waiver of Landlord's right to enforce these rules against any or all Tenants occupying the Building.

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Landlord's Initials

Tenant's Initials

First Amendment to Lease

January 27, 2021

This First Amendment Lease ("Amendment") is entered into by and between 3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common ("Landlord"), and Seasons Hospice & Palliative Care of Pierce County, LLC ("Tenant").

RECITALS

A. Landlord and Tenant entered into the Lease dated February 28, 2020 ("Lease") according to which Tenant leased from Landlord approximately 2,183 rentable square feet in Suite 85, which includes the combination of Suites 55, 57, 81 and 85, of the Tacoma Mall Office Building located at 4301 S. Pine Street, Tacoma, Washington and legally described in Exhibit A to the Lease ("Premises"), incorporated herein by this reference.

B. Tenant and Landlord desire to extend the initial term and amend the Lease as set forth below. Capitalized terms not defined herein shall have the same meaning as set forth in the Lease. The terms of this Amendment shall prevail in the event of any conflict or inconsistency between the terms of the Lease and the terms of this Amendment.

AMENDMENT

Term: The initial term of the Lease shall be extended to and including February 28, 2022. The option term stated in this lease, if exercised, will commence March 1, 2022 and continue to and including December 31, 2025.

Monthly Base Rent: The Monthly Base Rent for the initial term of the Lease will be $3,274.50.

Pre-Occupancy Relocation: The following Section 20.55, entitled "Pre-Occupancy Relocation", is hereby inserted immediately following Section 20.5, entitled "Substitution Space":

> Pre-Occupancy Relocation: Notwithstanding anything in Section 20.5 above to the contrary, Landlord shall have the right in its sole discretion to relocate the Premises at any time prior to Tenant physically occupying the Premises on no less than five (5) days' prior written notification to Tenant, provided the relocation space shall be no less than 2,000 rentable square feet. If the relocation space is less than 2,183 rentable square feet, the Monthly Base Rent will be proportionally reduced based on $18.00 per square foot per year. If the relocation space is larger than 2,183 rentable square feet, the Monthly Base Rent will be unaffected. In the event of any relocation according to this Section, the Premises will continue to be commonly known as Suite 85. Landlord shall not be liable to Tenant for any costs directly or indirectly related to a Pre-Occupancy Relocation.

ALL OTHER TERMS OF THE LEASE REMAIN UNCHANGED.

[INTENTIONALLY BLANK - SIGNATURES FOLLOW]

Approved and Accepted:

Landlord:	**Tenant:**
3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common	**Seasons Hospice & Palliative Care of Pierce County, LLC**
DocuSigned by:	DocuSigned by:
By: Jeff Mincheff	By: 0F05F639FFDE4EC...
Its: Managing Member of Mincheff & Mincheff Investments IV LLC, agent for Landlord	Its: Managing Member
1/28/2021	1/28/2021
Date	Date

LANDLORD ACKNOWLEDGMENTS

STATE OF _____)
COUNTY OF _____) ss:

I, the undersigned, a Notary Public, in and for the County and State aforesaid, do hereby certify that Jeff Mincheff is the person who appeared before me, and said person acknowledged that he signed this instrument, on oath stated that he was authorized to executed the instrument and acknowledged it as the managing member of Mincheff & Mincheff Investments IV LLC, to be free and voluntary act of such party for the uses and purposed mentioned in the instrument.

GIVEN under my hand and official seal this ____ day of _____, 200__.

Notary Public_____

Printed Name_____

Residing at:_____

My Commission Expires:_____

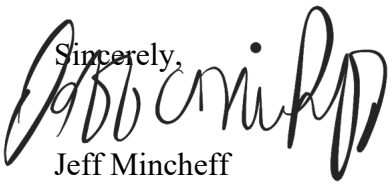
January 25, 2021

RE: Seasons Hospice & Palliative Care Lease

Dear Mr. Stern:

As you know, Seasons Hospice & Palliative Care of Pierce County, LLC ("Tenant") and 3W TMOB Partners LLC and M & M Tacoma Investments IV LLC (collectively, "Landlord") entered into a Lease dated February 28, 2020. Landlord acknowledges and agrees that Tenant shall be permitted to assign the Lease, consistent with the terms of the Lease, to an affiliate of Tenant including Seasons Hospice & Palliative Care of Pierce County Washington, LLC.

Sincerely,



Jeff Mincheff
(Managing Member of Mincheff & Mincheff Investments IV LLC, agent for Landlord)

Second Amendment to Lease

January 27, 2022

This Second Amendment Lease ("Amendment") is entered into by and between 3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common ("Landlord"), and Seasons Hospice & Palliative Care of Pierce County, LLC ("Tenant").

RECITALS

A. Landlord and Tenant entered into the Lease dated February 28, 2020, and First Amendment dated January 27, 2021 ("Lease") according to which Tenant leased from Landlord approximately 2,183 rentable square feet in Suite 85, which includes the combination of Suites 55, 57, 81 and 85, of the Tacoma Mall Office Building located at 4301 S. Pine Street, Tacoma, Washington and legally described in Exhibit A to the Lease ("Premises"), incorporated herein by this reference.

B. Tenant and Landlord desire to extend the initial term and amend the Lease as set forth below. Capitalized terms not defined herein shall have the same meaning as set forth in the Lease. The terms of this Amendment shall prevail in the event of any conflict or inconsistency between the terms of the Lease and the terms of this Amendment.

AMENDMENT

Term: The initial term of the Lease shall be extended to and including February 28, 2023. The option term stated in this lease, if exercised, will commence March 1, 2023 and continue to and including December 31, 2026, with the Base Rent increased to the then Fair Market Rate, but in no event less than the Base Rent of the preceding term increased by 3%, and with 3% annual increases through the extended term.

Monthly Base Rent: The Monthly Base Rent for the extended term through February 28, 2023, will be $3,274.50.

Early Termination: Section 20.7 (Early Termination) of the Lease is hereby deleted in its entirety and replaced with the following:

Tenant shall have the option to terminate and cancel the Lease between July 1, 2022 and February 28, 2023 (the "First Early Termination Date"), provided that Landlord receives written notice (the "First Termination Notice") from Tenant on or before the date that is at least 60 days prior to the First Early Termination Date stating that Tenant is electing to terminate this Lease pursuant to the terms and conditions of this Section. Tenant shall also have the option to terminate and cancel the Lease between March 1, 2023 and December 31, 2026 (the "Second Early Termination Date"), provided that Landlord receives written notice (the "Second Termination Notice") from Tenant on or before the date that is at least 120 days prior to the Second Early Termination Date stating that Tenant is electing to terminate this Lease pursuant to the terms and conditions of this Section. Tenant must pay an amount equal to unamortized costs associated with the extended term, including but not limited to leasing commissions, tenant improvements, and rent abatement, all amortized at a 6% annual rate ("Termination Fee") within thirty (30) days of Landlord's notice of such Termination Fee. Failure by Tenant to remit the Termination Fee within such thirty (30) days shall nullify Tenant's Early Termination option. The First and Second Early Termination Dates shall be the last day of a calendar month. If Tenant terminates the Lease in accordance with the terms of this Section, then the Lease shall automatically terminate and be of no further force or effect as of the applicable First or Second Early Termination Date, and

Landlord and Tenant shall be relieved of their respective obligations under this Lease as of the applicable First or Second Early Termination Date, except for those obligations which accrued prior to the applicable First or Second Early Termination Date, including, without limitation, the payment by Tenant of all amounts owed to Landlord up to and including the applicable First or Second Early Termination Date.

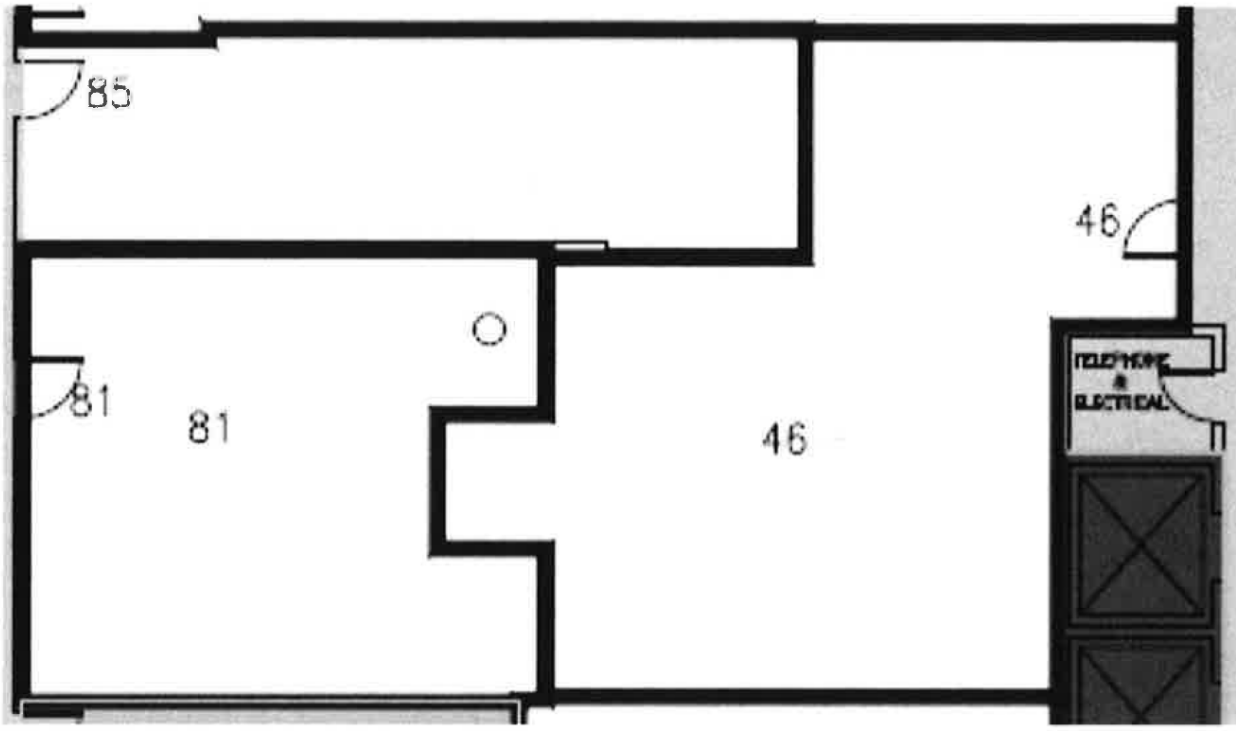
Relocation: A portion of the Premises, Suites 55 and 57, are relocated to Suite 46. Exhibit A floor plan shows the new Premises. The Base Rent and Rentable Square Footage remain unchanged. Landlord retains the right of Pre-Occupancy Relocations as containing in the First Amendment.

ALL OTHER TERMS OF THE LEASE REMAIN UNCHANGED.

Approved and Accepted:

Landlord:	**Tenant:**
3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common	**Seasons Hospice & Palliative Care of Pierce County, LLC**
DocuSigned by:	
By: Jeff Mincheff	By: Todd Stern
Its: Managing Member of Mincheff & Mincheff Investments IV LLC, agent for Landlord	Its: Managing Member
Jeff MINCHEFF	1/27/2022
Date	Date

Exhibit A



Third Amendment to Lease

March 14, 2022

This Third Amendment Lease ("Amendment") is entered into by and between 3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common ("Landlord"), and Seasons Hospice & Palliative Care of Pierce County, LLC ("Tenant").

RECITALS

A. Landlord and Tenant entered into the Lease dated February 28, 2020, First Amendment dated January 27, 2021 and Second Amendment dated January 27, 2022 ("Lease") according to which Tenant leased from Landlord approximately 2,183 rentable square feet in Suite 85, which includes the combination of Suites 46, 81 and 85, of the Tacoma Mall Office Building located at 4301 S. Pine Street, Tacoma, Washington and legally described in Exhibit A to the Lease ("Premises"), incorporated herein by this reference.

B. Tenant and Landlord desire to amend the Lease as set forth below. Capitalized terms not defined herein shall have the same meaning as set forth in the Lease. The terms of this Amendment shall prevail in the event of any conflict or inconsistency between the terms of the Lease and the terms of this Amendment.

AMENDMENT

Option Term:
In addition to the option term noted in the Second Amendment to extend the term through December 31, 2026 (the "First Option Term"), Tenant shall have an additional option term to extend the term two years commencing January 1, 2027 and continuing through December 31, AJ ~~2028~~ ~~2029~~ 2029 (the "Second Option Term"), with the same terms and conditions required for the Second Option Term as are required for the First Option Term.

DS DS 2023-Jan-27 | 13:00 PST

DS

1/27/2023

ALL OTHER TERMS OF THE LEASE REMAIN UNCHANGED.

Approved and Accepted:

Landlord:	**Tenant:**
3W TMOB Partners LLC and M & M Tacoma Investments IV LLC as tenants in common	**Seasons Hospice & Palliative Care of Pierce County, LLC**
By: Jeff Mincheff	Anthony Jackson By: Anthony Jackson
Its: Managing Member of Mincheff & Mincheff Investments IV LLC, agent for Landlord	Its: Managing Member
March 28, 2022 Date	3-25-2022 Date

Exhibit A

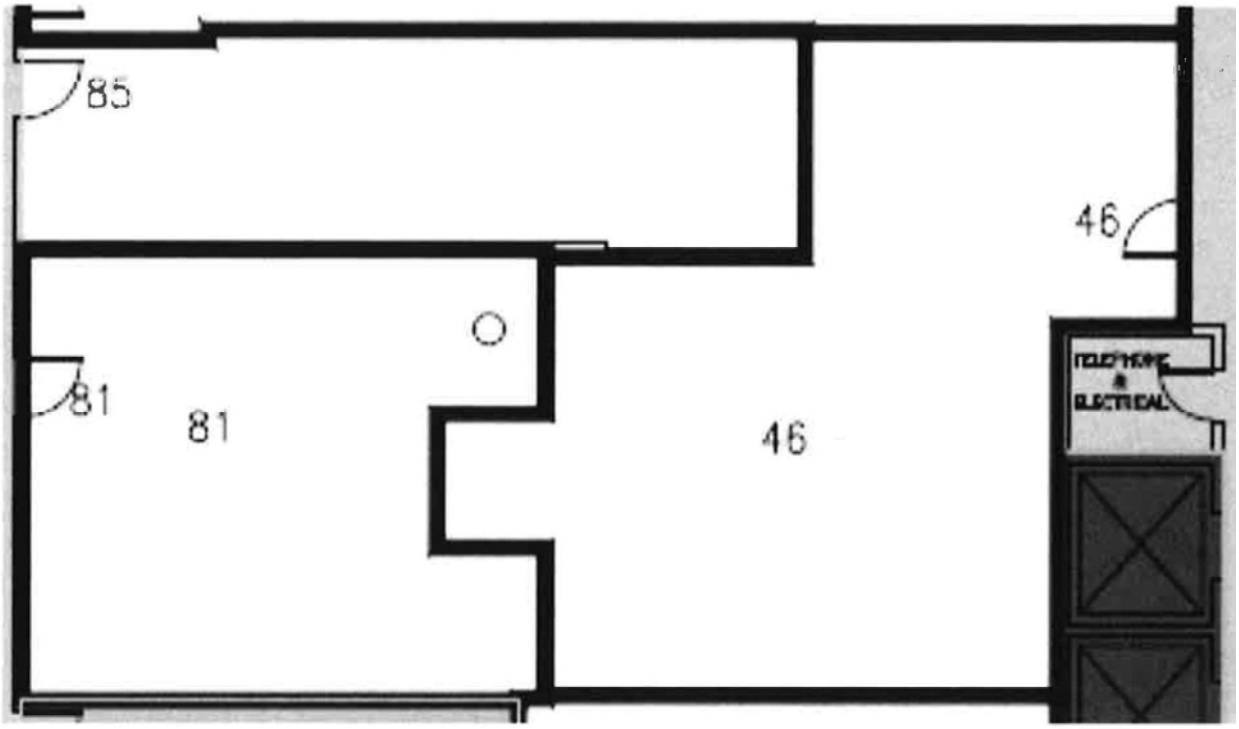


EXHIBIT 5

Sample *PharmSmart* Newsletter

Healthcare Professionals | Stories of Hope

PharmSmart: Catch me if you can! Management of DYSPNEA!

By AccentCare | November 30, 2020

" can't catch my breath!" How often do we hear th s from a pat ent w th an advanced ness? Dyspnea, def ned as an uncomfortab e abnorma awareness of breath ng, s one of the most common symptoms exper enced by pat ents at the end of fe. Not on y s t uncomfortab e for the pat ent, but t's d ff cu t for the fam y and careg vers to observe. However, dyspnea can occur at any stage of a deb tat ng d sease. t's essent a to understand how t may happen, how t presents, ts under y ng et o ogy, and, most mportant y, how to treat t.

What's the pathophysiology of dyspnea?

Dyspnea s character zed by the under y ng et o ogy and fee ng of a r hunger, there s an ncrease n the resp ratory dr ve ead ng to ncrease vent ator demand. Because there may a so be some form of obstruct on or restr ct ve ung d sease occurr ng, there s a decrease n vent ator capac ty and pu monary comp ance. The b d rect ona s gna s transm tted from the motor cortex to the sensory cortex and outgo ng motor command to the vent ator musc es ead to a cha n of command of chest wa t ghtness, back to the bra n stem, and to the sensory cortex.

What are the common symptoms or presentation of dyspnea?

A WHOLE ot of breath essness nc ud ng (but not m ted to):

- Rap d breath ng (tachypnea)
- Excess ve breath ng (hyperpnoea)
- Hypervent at on

- Shortness of breath
- Chest t ghtness
- Pa p tat ons
- Wheez ng
- Cough ng
- Pa n
- Fat gue

Mov ng forward w th the management and treatment of dyspnea, a comprehens ve assessment must be conducted to dent fy any under y ng d agnos s or et o og es that may be caus ng the prob em. Some examp e quest ons to start off, when d d the pat ent's symptoms start? Do the symptoms occur sudden y or on y when an offend ng factor s nvo ved? What makes the symptoms worse or better? How ong do the symptoms occur, or s t constant? These prob ng quest ons may ead to appropr ate tests to be conducted to dent fy an under y ng chron c ness and appropr ate y correct hypoxem a.

Suggested d agnost c tests nc ude the fo ow ng, genera y ear er n the d sease process:

- Arter a b ood gas to determ ne the pat ent's resp ratory ac d base status
- Pu se ox metry to eva uate for hypox a
- Chest rad ography to d scover any phys ca f nd ngs for suspected pu monary or g n
- Comp ete b ood count and e ectro ytes nc ud ng rena and hepat c funct on tests to eva uate for anem a, po ycythem a, eukocytos s, or neutropen a wh ch may ass st n d agnos s
- Sp rometry to detect a rf ow obstruct on

The next tab e prov des some examp es of d agnoses that dyspnea may occur n some d sorders.

Origin	Diagnoses
Respiratory	• Asthma • COPD • Pneumon a • Pu monary embo sm • Lung ma gnancy
Neuromuscular or Psychogenic	• Sp na cord dysfunct on • Chest trauma w th fracture • Myopathy and neuropathy • Phren c nerve para ys s
Cardiovascular	• Congest ve heart fa ure • Pu monary edema • Acute coronary syndrome • Pu monary hypertens on • Card ac arrhythm a • Va vu ar heart defect
Other Systemic Illnesses	• Anem a • Acute rena fa ure • C rrhos s • Seps s • Anaphy ax s • Ang oedema

The treatment of dyspnea shou d beg n by correct ng the under y ng cause of symptoms. For examp e, w th resp ratory d sorders such as asthma or chron c obstruct ve pu monary d sease (COPD), there s an ncrease n a rf ow res stance w th bronchoconstr ct on. C n c ans can ut ze d sease mod fy ng therap es to opt m ze the management of COPD and asthma. Treatments w th nha ed bronchod ators and cort costero ds have prov ded some mprovement n symptoms and reduce dyspnea. The fo ow ng tab e sts the pr mary steps n the management of dyspnea.

Identifying underlying etiology	**Perform comprehensive dyspnea assessment including physical, emotional, social, and spiritual aspects of symptoms**
Address reversible contributors	**Treat underlying cause to improve physical function**
Treat symptomatically	**Utilize non-pharmacological and pharmacological interventions**

What are non-pharmacological interventions to treat dyspnea?

A WHOLE host of mu t d sc p nary reg mens (but not m ted to):

- Pu monary rehab tat on
- Pat ent educat on of the psychosoc a sp r tua mpact of dyspnea anx ety cyc e
- Energy conservat on techn ques
- Cogn t ve behav ora therapy
- Re axat on techn ques
- Ga t a ds
- Acupuncture
- Fan/Med ca a r
- Oxygen and therapeut c room a r

Now, what are the pharmacological interventions to treat dyspnea?

OP O DS! Op o ds are the f rst ne pharmaco og ca treatment opt on for symptomat c refractory dyspnea. There are many formu at ons ava ab e for pat ents w th comp ex d et orders and d ff cu ty swa ow ng. Op o ds can be poss b e by mouth (tab et or so ut on), ntravenous nject on, subcutaneous nject on, and probab y recta adm n strat on. G v ng the op o d by nha at on seems ke t wou d be dea , but th s route of adm n strat on has ed to poorer resu ts and s not recommended. The mechan sm of act on s unc ear, but research suggests a reduct on n sens t v ty to hypercapn a and hypox a. Op o d se ect on and dos ng w be dependent on the pharmacok net cs and pat ent character st cs. The fo ow ng chart w prov de an overv ew of op o ds, nc ud ng pharmacok net cs and c n ca pear s, to cons der for pat ents w th organ dysfunct on.

Drug	Onset	Peak	Duration	Clinical Pearls
Morphine	PO: 15 min IV: 2-4 min	PO: 1.5-2 hrs IV: 15-20 min	PO: 4 hrs IV: 2 hrs	• Histamine re ease: Decreases BP, itching • Dose adjust or avoid in rena impairment
Hydrocodone	PO: 60 min	PO: 2 hrs	PO: 4-6 hrs	• Caution with PRN orders due to acetaminophen component
Oxycodone	PO: 15-30 min	PO: 1-2 hrs	PO: 4-6 hrs	• Safer in rena dysfunction

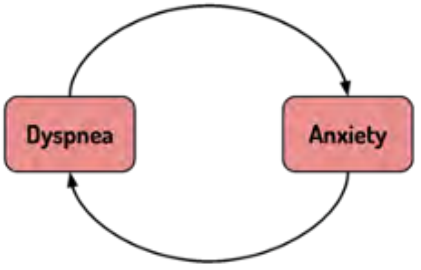
Hydromorphone	PO: 30 min IV: 2-3 min	PO: 60 min IV: 10-15 min	PO: 4-6 hrs IV: 2 hrs	• High potency, more euphoria • S ight y safer in rena dysfunction
Fentanyl	IV: 1-2 min	IV: 5 min	IV: 1-2 hrs	• Safe in rena and iver dysfunction

Wow! That's qu te a st! **What about side effects** we we a know there's a r sk w th us ng op o ds. f used correct y and safe y, t can be benef c a to treat pat ents w th refractory dyspnea. Let's cons der the common s de effects assoc ated w th op o d therapy:

- **Central Nervous System (CNS) depression** t s essent a to counse pat ents on CNS depress on, wh ch may affect the r menta and phys ca a ertness. Espec a y pat ents w th fa r sk, t s mperat ve to a ow pat ents to see how they may fee on the f rst few doses before they beg n the r norma da y act v t es.
- **Constipation** Cons der preventat ve measures such as co prescr b ng op o ds w th st mu ant axat ves; ncrease f ber and use of osmot c axat ves to reduce the r sk of const pat on.
- **Respiratory depression** as a B ack Box Warn ng, resp ratory depress on s a severe or fe threaten ng fata r sk. Counse ng pat ents to be c ose y mon tored, espec a y dur ng n t at on and dose esca at on. Some symptoms to observe are s ow or sha ow breath ng, dayt me s eep ness, b u sh co ored ps, f ngers or toes, or depress on.
- **Less common side effects** nc ude hypotens on, anaphy ax s and a ergy (f pat ent has a hypersens t v ty react on to other phenanthrene der vat ve op o d such as code ne, hydromorphone, oxycodone, or oxymorphone), gastro ntest na , hemato og c, neuro og c, and dermato og c effects.

The **significant drug interactions** we shou d pay attent on to w th op o ds and ncrease r sk of CNS depress on are as fo ows:

- Concom tant benzod azep ne or CNS depressant
- A coho
- Concom tant op o d agon sts
- Cannab s or re ated type products



Op o ds rema n f rst ne pharmacotherapy opt ons for dyspnea, and benzod azep nes shou d never be used as f rst ne monotherapy. A Cochrane system c rev ew found no benef t for benzod azep ne use for chron c dyspnea and found ts use was assoc ated w th an ncrease n morta ty r sk when used w th op o ds. However, benzod azep ne may be cons dered for pat ents w th concom tant anx ety w th dyspnea. A r hunger or shortness of breath often eads to anx ety, wh ch can comprom se or worsen resp ratory status by ncreas ng resp ratory demand and decrease pu monary comp ance. Some c n c ans have co prescr bed benzod azep nes for pat ents w th refractory anx ety and dyspnea. t s just cruc a to be VERY caut ous when start ng both agents at the same t me!

Bottom-line it for me! How would you approach a patient presenting with dyspnea?

- Dyspnea s the sensat on of uncomfortab e or d ff cu ty breath ng
- Determ ne the root cause of the dyspnea whether t s revers b e and use d sease mod fy ng treatment strateg es
- F rst ne of pharmacotherapy for dyspnea s op o ds
  - Op o d for dyspnea requ re ower doses than for pa n and t trate to owest effect ve dose
  - Supp ementa oxygen has on y shown benef t n pat ents w th hypox a

Ok, et's get rea w th a pat ent case. **Mr. Cookie** s a 73 year o d ma e w th atr a f br at on on warfar n, hyper p dem a, and end stage chron c obstruct ve pu monary d sease (COPD) who presents to the emergency department w th shortness of

breath, wheez ng, and progress ve fat gue over the past 7 days desp te ut z ng d sease d rected treatment. You beg n to start th nk ng of the next best treatment p an for Mr. Cook e.

What s the next step n Mr. Cook e's treatment p an?

1. Beg n goa s of care d scuss on and mmed ate y refer the pat ent to hosp ce
2. Start ow dose morph ne
3. Assess for anx ety and start ow dose orazepam
4. Perform further assessment to determ ne f under y ng et o ogy ex sts

Oh no, poor Mr. Cook e! Let's cons der ook ng at Mr. Cook e's extens ve past med ca h story may prompt further nvest gat on. So cho ce (A) s not a great cho ce because there may be revers b e causes to he p Mr. Cook e's symptoms. And a though op o ds are f rst ne therapy and ow dose morph ne may be cons dered for Mr. Cook e's pharmaco og ca treatment of symptomat c dyspnea, cho ce (D) s the best cho ce! Dur ng d agnos s, t's essent a to perform a comprehens ve phys ca , menta assessment to cons der f there s an under y ng et o ogy to address, nc ud ng anx ety. Therefore, cho ce C s not the best cho ce for Mr. Cook e's treatment p an.

Let's consider a few LAST multiple-choice questions for the road!

- Wh ch s cons dered as f rst ne pharmacotherapy for dyspnea?
  a. nha ed cort costero ds
  b. Op o ds
  c. Benzod azep nes
  d. Ant cho nerg cs

- Wh ch of the fo ow ng are resp ratory patterns of dyspnea? Se ect a that app y.
  a. ↑ vent atory demand
  b. ↑ vent atory capac ty
  c. ↑ a rway res stance
  d. ↓ pu monary comp ance

- Wh ch of the fo ow ng are TRUE regard ng the management of dyspnea n advanced ness?
  a. Educate pat ent th s s an expected symptom at the end of fe
  b. Ut ze non pharmaco og ca and pharmaco og ca ntervent ons to treat refractory dyspnea
  c. Most op o ds w reduce the sensat on of dyspnea
  d. Morph ne s frequent y used to treat dyspnea, but s not the best cho ce n advanced rena d sease
  e. A of the above are correct

Answers:

1. B
2. A, C, D
3. E

PharmSmart is a monthly article dedicated to best practices in drug management for patients nearing the end of life, with a little cheer and lightheartedness woven throughout. It is edited by Dr. Mary Lynn McPherson, PharmD. Dr. McPherson is the Executive Director of Advanced Post-Graduate Education in Palliative Care at University of Maryland. Dr. McPherson is a consultant pharmacist to Seasons, and answers complex medication

questions for our clinical teams at all hours of the day or night. She is a nationally-recognized expert in medication management for hospice and palliative care patients.

This edition of PharmSmart was written by Cindy Nguyen, PharmD.

Commun ty, D sease Progress on, Symptom Management

How Hosp ce Keeps Pat ents Home fo...

What a R sk bear ng Ent ty Shou d Ex...

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EXHIBIT 6

Sample Nursing Facility Services Agreement

NURSING FACILITY SERVICES AGREEMENT

THIS NURSING FACILITY SERVICES AGREEMENT ("Agreement") is effective on the ____ day of _____, 20___ (the "Effective Date") by and between Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Hospice") and _____ ("Facility").

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Facility is a duly licensed nursing facility that is certified to participate in the Medicare and/or Medicaid programs.

C. WHEREAS, the parties contemplate that from time to time individuals residing in Facility will need hospice care and individuals previously accepted into Hospice will need care in a nursing facility.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions.

(a) "Emergency Situation" means any natural or man-made event, situation, or disaster resulting in a challenge or disruption of normal healthcare services, including any event prompting the activation of an emergency management process or emergency operation plan.

(b) "Facility Services" means those personal care and room and board services provided by Facility as specified in the Plan of Care for a Hospice Patient, including but not limited to: (i) providing food, including individualized requests and dietary supplements; (ii) assisting with activities of daily living such as mobility and ambulation, dressing, grooming, bathing, transferring, eating and toileting; (iii) arranging and assisting in socializing activities; (iv) assisting in the administration of medicine; (v) providing and maintaining the cleanliness of Hospice Patient's room; (vi) supervising and assisting in the use of any durable medical equipment and therapies included in the Plan of Care; (vii) providing laundry and personal care supplies; (viii) providing health monitoring of general conditions; (ix) contacting family/legal representative for purposes unrelated to the terminal condition; (x) arranging for the provision of medications not related to the management of the terminal illness; and (xi) providing the usual and customary room furnishings provided to Facility residents, including but not limited to, beds, linens, lamps and dressers. In the case of Medicaid Eligible Hospice Patients, Facility Services shall include all services outlined in the Medicaid covered services rule, as may be amended from time to time.

(c) "Hospice Patient" means an individual who has elected, directly or through such individual's legal representative, to receive Hospice Services and is accepted by Hospice to receive Hospice Services.

(d) "Hospice Physician" means a duly licensed doctor of medicine or osteopathy employed or contracted by Hospice who, along with the Hospice Patient's attending physician (if any), is responsible for the palliation and management of a Hospice Patient's terminal illness and related conditions.

(e) "Hospice Services" means those services provided to a Hospice Patient that are reasonable and necessary for the palliation and management of such Hospice Patient's terminal illness and are specified in a Hospice Patient's Plan of Care. Hospice Services include: (i) nursing care and services by or under the supervision of a registered nurse; (ii) medical social services provided by a qualified social worker under the direction of a physician; (iii) physician services to the extent that these services are not provided by the attending physician; (iv) counseling services, including bereavement, dietary and spiritual counseling; (v) physical, respiratory, occupational and speech therapy services; (vi) home health aide/homemaker services; (vii) medical supplies; (viii) drugs and biologicals; (ix) use of medical appliances; and (x) medical direction and management of Hospice Patient.

(f) "Interdisciplinary Group" ("IDG") means a group of qualified individuals, including but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(g) "Medicaid Eligible Hospice Patient" means a Hospice Patient who either: is eligible for Medicaid benefits and who has elected to receive the Medicaid hospice benefit; or is eligible for both Medicaid and Medicare Part A benefits and who has elected the Medicare hospice benefit.

(h) "Medicare Eligible Hospice Patient" means a Hospice Patient who is eligible for Medicare Part A benefits, but who is not eligible for Medicaid benefits and who has elected to receive the Medicare Part A hospice benefit.

(i) "Other Facility Services" means all items and services provided by Facility which are not related to treatment of a Hospice Patient's terminal illness but specified in the Plan of Care.

(j) "Plan of Care" means a written care plan established, maintained, reviewed and modified, if necessary, at intervals identified by the IDG. The Plan of Care must reflect Hospice Patient and family goals and interventions based on the problems identified in the Hospice Patient assessments. The Plan of Care will reflect the participation of the Hospice, Facility and the Hospice Patient and family to the extent possible. Specifically, the Plan of Care includes: (i) an identification of the Hospice Services, including interventions for pain management and symptom relief, needed to meet such Hospice Patient's needs and the related needs of Hospice Patient's family; (ii) a detailed statement of the scope and frequency of such Hospice Services; (iii) measurable outcomes anticipated from implementing and coordinating the

Plan of Care; (iv) drugs and treatment necessary to meet the needs of the Hospice Patient; (v) medical supplies and appliances necessary to meet the needs of the Hospice Patient; and (vi) the IDG's documentation of the Hospice Patient's or representative's level of understanding, involvement and agreement with the Plan of Care. Hospice and Facility will jointly develop and agree upon a coordinated, interdisciplinary Plan of Care which is consistent with the hospice philosophy and is responsive to the unique needs of Hospice Patient and his or her expressed desire for hospice care. Hospice and Facility shall periodically conduct joint reviews of each Plan of Care as necessary to coordinate provision of Facility Services. The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care.

(k) "Private Pay Hospice Patient" means a Hospice Patient who is not eligible for the Medicare Part A hospice benefit, or the Medicaid hospice benefit, or if eligible, has revoked or elected not to receive the Medicare Part A hospice benefit and/or the Medicaid hospice benefit. This includes Hospice Patients with third party payors other than Medicare or Medicaid.

(l) "Purchased Hospice Services" means those Hospice Services specified in Exhibit A that are not core services under the Medicare Conditions of Participation for Hospice Care and that Hospice has elected to contract with Facility to provide.

(m) "Residential Hospice Care Day" means a day on which a Hospice Patient receives Facility Services, including the day of admission but excluding any days on which a Hospice Patient receives inpatient care and any other days on which Facility would not have received payment from Medicaid if the Hospice Patient had not been enrolled in hospice (*e.g.*, date of discharge, date of death).

(n) "Uncovered Items and Services" means those services provided by Facility which are not Hospice Services, Facility Services or Other Facility Services, including, but not limited to, telephone, guest trays and television hookup.

2. Responsibilities of Facility.

(a) Provision of Services.

(i) Facility Services. At the request of an authorized Hospice staff member, Facility shall admit Hospice Patients to Facility, subject to Facility's admission policies and procedures and the availability of beds. Facility shall immediately notify Hospice if Facility is unable to admit a Hospice Patient. Facility shall comply with Hospice Patient's Plan of Care and shall ensure Hospice Patients are kept comfortable, clean, well-groomed and protected from negligent and intentional harm including, but not limited to, accident, injury and infection. Facility's primary responsibility is to provide Facility Services based on each Hospice Patient's Plan of Care and ensure that the level of care provided is appropriately based on the individual Hospice Patient's needs. It is Facility's responsibility to provide Facility Services that meet the personal care and nursing needs that would have been provided by a Hospice Patient's primary caregiver at home in coordination with Hospice, and Facility shall perform Facility Services at

the same level of care provided to each Hospice Patient before hospice care was elected. While Facility's nursing personnel may, as specified by Facility, assist in administering prescribed therapies to Hospice Patients under the Plan of Care, such assistance may only be provided to the extent the activity is permitted by law and only to the extent that Hospice would routinely utilize the services of a Hospice Patient's family in implementing the Plan of Care. Notwithstanding the foregoing, in times of Hospice Patient crisis, Hospice may authorize and direct Facility staff to perform more sophisticated functions in order to ensure Hospice Patient comfort, and Hospice and Facility shall address potential crisis situations for individual Hospice Patients in the Plan of Care.

(ii) Availability. Facility shall be available to provide Facility Services 24 hours per day, 7 days per week and shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(iii) Purchased Hospice Services. At the request of an authorized Hospice staff member, Facility shall provide Hospice Patients with the Purchased Hospice Services identified in Exhibit A.

(iv) Notification of Services. Facility shall fully inform Hospice Patients of Facility Services, Other Facility Services and Uncovered Items and Services to be provided by Facility.

(b) Professional Standards and Credentials.

(i) Professional Standards. Facility shall ensure that all Facility Services are provided competently and efficiently. Facility Services shall meet or exceed the standards of care for providers of such services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements.

(ii) Credentials.

[a] Licensure. Facility represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses and certificates required by law to provide Facility Services. Upon Hospice's request, Facility shall provide Hospice with evidence of such licenses and certifications.

[b] Qualifications of Personnel. Personnel who provide Facility Services shall be reasonably acceptable to Hospice. Facility represents and warrants that personnel providing Facility Services: [i] are duly licensed, credentialed, certified, and/or registered as required under applicable state laws; and [ii] possess the education, skills, training and other qualifications necessary to provide Facility Services. Based on criminal background checks conducted by Facility, Facility personnel who have direct contact with Hospice Patients or have access to Hospice Patient records have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals. Upon Hospice's request, Facility shall provide Hospice with proof of an individual's qualifications to provide Facility Services.

[c] Disciplinary Action. Facility represents and warrants that neither it nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Facility or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[d] Exclusion from Medicare or Medicaid. Facility represents and warrants that neither Facility nor its personnel has been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid, nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law. Facility shall screen its personnel and contractors against the Office of Inspector General's List of Excluded Individuals and Entities ("LEIE") and the Government Services Administration's Excluded Parties List System upon hire or contracting, and on a monthly basis thereafter.

(c) Quality Assessment and Performance Improvement Activities. Facility shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include (i) data collection; (ii) reporting adverse patient events, analyzing their causes, and implementing preventative actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall provide Facility with a description of its quality assessment and performance improvement program and information on performance improvement projects. Third party payors may also impose their own utilization management or quality assurance requirements which Facility must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(d) Coordination of Care.

(i) General. Facility shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day.

(ii) Design of Plan of Care. In accordance with applicable federal and state laws and regulations, Facility shall coordinate with Hospice in developing a Plan of Care for each Hospice Patient. Hospice retains primary responsibility for determining each Hospice Patient's appropriate Plan of Care. Facility shall ensure that each Hospice Patient's care plan includes both the most recent Hospice Plan of Care and a description of the Facility Services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychosocial well-being as required by federal regulations.

(iii) Modifications to Plan of Care. Facility will assist with periodic review and modification of the Plan of Care. Facility will not make any modifications to the

Plan of Care without first consulting with Hospice. Hospice retains the sole authority for determining the appropriate course of hospice care provided to each Hospice Patient, including the determination to change the level of services provided.

(iv) Notification of Change in Condition. Facility shall immediately inform Hospice of any change in the condition of a Hospice Patient. This includes, without limitation, a significant change in a Hospice Patient's physical, mental, social or emotional status, clinical complications that suggest a need to alter the Plan of Care, a need to transfer the Hospice Patient to another facility, or the death of a Hospice Patient.

(v) Designated Facility Member. Facility shall designate a member of Facility's interdisciplinary team who is responsible for working with Hospice representatives to coordinate care to the Hospice Patient provided by Facility and Hospice. The designated interdisciplinary team member shall have a clinical background, function within their State scope of practice act, and have the ability to assess the Hospice Patient or have access to someone that has the skills and capabilities to assess the Hospice Patient. The designated team member shall be responsible for:

[a] Collaboration with Hospice. Collaborating with Hospice representatives and coordinating Facility's participation in Hospice's care planning process for those Hospice Patients receiving Facility Services;

[b] Communication with Providers. Communicating with Hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the Hospice Patient and family;

[c] Communication with Hospice. Ensuring that Facility communicates with Hospice Physician, the Hospice Patient's attending physician (if any), and other practitioners participating in the provision of care to the Hospice Patient as needed to coordinate the hospice care with the medical care provided by other physicians;

[d] Orientation. Ensuring that Facility provides orientation in the policies and procedures of Facility, including patient rights, appropriate forms, and record keeping requirements, to Hospice personnel furnishing care to Hospice Patients at Facility; and

[e] Information from Hospice. Obtaining the following information from Hospice:

[i] Plan of Care, Medications and Orders. The most recent Hospice Plan of Care, medication information and physician orders specific to each Hospice Patient;

[ii] Election Form. Each Hospice Patient's Hospice election form;

[iii] Certifications. Physician certification and recertification of the terminal illness specific to each Hospice Patient;

[iv] Contact Information. Names and contact information for Hospice personnel involved in hospice care of each Hospice Patient; and

[v] On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(e) Policies and Procedures. In providing services to Hospice Patients, Facility shall abide by Hospice's policies and procedures, palliative care protocols and Plans of Care, and shall review the hospice orientation video, which can be accessed at https://www.youtube.com/embed/pw-hPbKzKh4?rel=0.

(f) Assist with Surveys and Complaints. Facility shall be available during federal, state, local and other surveys to assist Hospice in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey deficiencies and providing clinical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Hospice, Facility shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Facility shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. Facility shall notify Hospice promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(g) Visiting and Access by Hospice.

(i) Visiting Privileges. Facility shall permit free access and unrestricted visiting privileges, including visits by children of any age, 24 hours per day, 7 days per week.

(ii) Visitor Accommodations. Facility shall provide adequate space, located conveniently to Hospice Patient, for private visiting among Hospice Patient, Hospice Patient's family members and any other visitors. Facility shall provide adequate accommodations for Hospice Patient's family members to remain with Hospice Patient up to 24 hours per day, and permit family members privacy following the death of a Hospice Patient.

(iii) Hospice Access to Facility. Facility shall permit employees, contractors, agents and volunteers of Hospice free and complete access to Facility 24 hours per day, as necessary, to permit Hospice to counsel, treat, attend and provide services to each Hospice Patient.

(iv) Hospice Physician. Facility shall grant full staff privileges to Hospice Physicians upon application and qualification for such privileges in accordance with Facility's requirements.

(h) Patient Transfer. Facility shall not transfer any Hospice Patient to another care setting without the prior approval of Hospice. If Facility fails to obtain the necessary prior approval, Hospice bears no financial responsibility for the costs of transfer or the costs of care provided in another setting.

(i) Physician Orders. If there are physician orders that are inconsistent with the Plan of Care or Hospice protocols, a registered nurse with Facility shall notify Hospice. An authorized representative of Hospice shall resolve differences directly with the physician and secure the necessary orders.

(j) Bereavement Services to Facility Staff. Facility shall be primarily responsible for providing any requested bereavement services to Facility staff after the death of a Hospice Patient who resided in Facility; provided, however, that Hospice may assist Facility in providing such bereavement services to grieving Facility staff members upon request from Facility.

(k) Emergency Situations. In the event of any Emergency Situation affecting Hospice, Facility shall cooperate with Hospice to admit Hospice patients to Facility, subject to the availability of beds. Facility shall provide Facility services to such Hospice patients during the Emergency Situation. The billing and payment procedures set forth in section 4 of this Agreement shall apply to such Facility services provided during any Emergency Situation. Facility shall use its best efforts to provide services under this section. However, Facility will not be expected to provide assistance unless Facility has determined it has sufficient resources to do so.

3. Responsibilities of Hospice.

(a) Admission to and Discharge from Hospice Program.

(i) Assessment. If a resident of Facility requests the provision of Hospice Services, Hospice shall perform an assessment of such resident and shall notify Facility, either orally or in writing, whether such resident is authorized for admission as a Hospice Patient. Hospice shall maintain adequate records of all such authorizations of admission.

(ii) Assessing Continued Eligibility. Hospice shall have sole authority for assessing a Hospice Patient's continued eligibility for Hospice Services and for discharging a Hospice Patient from Hospice.

(b) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall assume professional management responsibility for Hospice Services provided to Hospice Patients residing at Facility and their family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of the Plan of Care, authorization of all services and management of the care through IDG meetings. Hospice shall make arrangement for, and remain responsible for, any necessary continuous care or inpatient care related to a Hospice Patient's terminal illness and related conditions. Hospice

acknowledges that it is responsible for providing Hospice Services to Hospice Patients residing at Facility at the same level and to the same extent as if Hospice Patients were receiving care in their own homes.

(ii) Management of Hospice Services. Hospice shall retain professional management responsibility to ensure that Hospice Services are furnished in a safe and effective manner by qualified personnel in accordance with Hospice Patient's Plan of Care. Hospice Services shall be provided in a timely manner and shall meet the professional standards and principles that apply to individuals providing services in Facility.

(iii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice Patients, which shall include coordination of Facility Services. Hospice's IDG shall communicate with Facility's medical director, Hospice Patient's attending physician and other physicians participating in the care of a Hospice Patient as needed to coordinate Hospice Services with the medical care provided by other physicians. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Facility Services; [c] review of documentation; [d] evaluation of the response of a Hospice Patient to the Plan of Care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iv) Assessment of Facility Services. Hospice shall develop, maintain and conduct an ongoing, comprehensive assessment of the quality and appropriateness of Facility and the provision of Facility Services. Such assessments shall be conducted at least annually.

(v) Evaluation. Hospice will review and/or revise all contracts annually and will evaluate the contracted care, treatment, and services to determine whether they are being provided according to the contract and the level of safety and quality as needed by the Hospice Patient and family.

(c) Hospice Care Training. Hospice shall provide orientation and ongoing hospice care training to Facility's personnel as necessary to facilitate the provision of safe and effective care to Hospice Patients. Such orientation must include Hospice policies and procedures regarding methods of comfort, pain control and symptom management as well as principles about death and dying, individual responses to death, patient rights, appropriate forms and recordkeeping requirements.

(d) Designation of Hospice Representative. For each Hospice Patient, Hospice shall designate a registered nurse who will be responsible for coordinating and supervising services provided to a Hospice Patient and be available 24 hours per day, 7 days per week for consultation with Facility concerning a Hospice Patient's Plan of Care. In addition, for each Hospice Patient residing at Facility, Hospice shall designate a member of the Hospice Patient's IDG to provide overall coordination of care for such Hospice Patient. Such hospice representative shall monitor Facility and be available to provide information to Facility regarding the provision of Facility Services and to coordinate the periodic evaluation of patient progress and outcomes of care upon request. Further, the hospice representative shall be responsible for

communicating with Facility representatives and other health care providers who participate in the care of a Hospice Patient's terminal illness and related conditions to ensure quality of care for Hospice Patients and their families.

(e) Provision of Information. Hospice shall promote open and frequent communication with Facility and shall provide Facility with sufficient information to ensure that the provision of Facility Services under this Agreement is in accordance with the Hospice Patient's Plan of Care, assessments, treatment planning and care coordination. At a minimum, Hospice shall provide the following information to Facility for each Hospice Patient residing at Facility:

(i) Plan of Care, Medications and Orders. The most recent Plan of Care, medication information and physician orders specific to each Hospice Patient residing at Facility;

(ii) Election Form. The hospice election form and any advanced directives;

(iii) Certifications. Physician certifications and recertifications of terminal illness;

(iv) Contact Information. Names and contact information for Hospice personnel involved in providing Hospice Services; and

(v) On-Call System. Instructions on how to access Hospice's 24-hour on-call system.

(f) Policies and Procedures. Hospice shall provide Facility with copies of Hospice's policies and procedures applicable to the provision of Facility Services and shall meet with Facility to review such policies and procedures, as necessary.

(g) Physician Orders. All physician orders communicated by Hospice under this Agreement shall be in writing and signed by the applicable attending physician or Hospice Physician; provided, however, that in the case of urgent or emergency circumstances, such orders may be communicated orally by any such persons. Hospice shall maintain adequate records of all physician orders communicated in connection with the Plan of Care.

(h) Purchased Hospice Services. Hospice may purchase from Facility Purchased Hospice Services. The terms of such sale are delineated in Exhibit A.

(i) Notification of Hospice Services. Hospice shall fully inform Hospice Patient of the Hospice Services to be provided by Hospice and Purchased Hospice Services, if any, to be provided by Facility.

(j) Assist with Surveys and Complaints. Hospice shall be available during federal, state, local and other surveys to assist Facility in responding to surveyor questions and survey citations, attending exit conferences, drafting plans of correction for identified survey

deficiencies and providing medical expertise when necessary to appeal survey deficiencies. In the event of any complaint filed by or with respect to a Hospice Patient or any investigation initiated by any governmental agency or any litigation commenced against Facility, Hospice shall fully cooperate with Facility in an effort to respond to and resolve the same in a timely and effective manner. Hospice shall also cooperate fully with any insurance company providing protection to Facility in connection with investigations. Hospice shall notify Facility promptly of any inquiries, claims, and investigations and cooperate fully with the directions of Hospice with respect thereto.

(k) Summary of Hospice's Responsibilities. Exhibit B includes a chart that summarizes some of Hospice's major responsibilities to Hospice Patients under this Agreement. This chart is intended to provide examples of Hospice's responsibilities hereunder and is not exhaustive.

(l) Emergency Situations. In the event of any Emergency Situation affecting Facility, Hospice shall cooperate with Facility to provide services or supplies as Hospice is reasonably able. Facility shall reimburse Hospice for the cost of such services or supplies. Hospice shall provide Facility with an invoice for the costs, and Facility shall reimburse Hospice within 45 days of receipt of invoice. Hospice shall use its best efforts to provide services under this section. However, Hospice will not be expected to provide assistance unless Hospice has determined it has sufficient resources to do so.

4. Billing and Payment.

(a) Billing and Payment for Facility Services Provided to Medicaid Eligible Hospice Patients.

(i) Rates. Hospice shall pay Facility a fixed payment rate for each Residential Hospice Care Day provided to a Medicaid Eligible Hospice Patient excluding any days on which a Hospice Patient receives inpatient care and any other days on which Facility would not have received payment from Medicaid if the Hospice Patient had not been enrolled in hospice (*e.g.*, date of discharge, date of death). The fixed payment rate shall be one hundred percent (100%) of Facility's applicable then current Medicaid per diem rate that would have been paid by the Medicaid program to Facility if the Medicaid Eligible Hospice Patient had not elected to receive hospice care, less the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. Facility shall accept this rate as payment in full for Facility Services provided to such Medicaid Eligible Hospice Patient and shall not bill the Medicaid Eligible Hospice Patient or his/her family, representatives or any third party payor. Facility shall collect and retain the Medicaid Eligible Hospice Patient's required personal contribution amount, if any. The sharing of fees between a referring agency or individual and Hospice is prohibited.

(ii) Billing and Payment. Hospice utilizes a room and board software application to process payment for services provided by Facility hereunder. Facility agrees to utilize such application to facilitate payment (e.g., approving invoices, identifying Patient payor type, etc.). For Patients whose Medicaid benefits are pending, Facility shall notify Hospice within 5 days of the state's approval of such Patients' Medicaid benefit. Hospice shall pay Facility undisputed amounts within 30 days after Facility's approval of statements. Payment by

Hospice in respect to such bills shall be considered final, unless adjustments are requested in writing by Facility within 30 days of receipt of payment. Hospice shall have no obligation to pay Facility for any service if invoices are not approved for such service within 60 days following the date on which the service was rendered.

(b) Billing and Payment for Facility Services Provided to Medicare Eligible Hospice Patients and Private Pay Hospice Patients. Facility shall bill each Medicare Eligible Hospice Patient and Private Pay Hospice Patient (or such patient's third party payor, if applicable) for Facility Services at a rate agreed upon by Facility and such patient or his or her third party payor. Facility shall accept such payment as payment in full for Facility Services. Hospice will not be responsible for reimbursing Facility for any portion of the cost of Facility Services provided to a Medicare Eligible Hospice Patient or Private Pay Hospice Patient. Facility shall not seek payment from Hospice in the event of default of financial obligations on the part of a Medicare Eligible Hospice Patient, Private Pay Hospice Patient or such patient's third party payors. Hospice will, to the extent permitted by law, provide Facility with any information it may reasonably require to obtain payment from any payor or other permissible payment source.

(i) MCO and other eligible 3rd party payors billing is determined by the contract/regulations for that MCO or 3rd party.

(c) Billing and Payment for Purchased Hospice Services Provided to All Hospice Patients. Facility shall bill Hospice for Purchased Hospice Services provided to Hospice Patients at the rates agreed to by Facility and Hospice in Exhibit A. Facility shall accept these rates as payment in full for Purchased Hospice Services provided to Hospice Patients and shall not bill such patients, their family, representatives or any third party payor. Facility represents and warrants that all Purchased Hospice Services for Medicaid Eligible Hospice Patients are not included in the applicable, then-current Medicaid per diem rate that Facility would have received if the Medicaid Eligible Hospice Patient had not elected to receive Hospice Services. The billing and payment procedures set forth in section 4(a)(ii) of this Agreement shall apply.

(d) Billing and Payment for Other Services. Facility shall bill Hospice Patients or the third party payor, if applicable, for (i) Other Facility Services; (ii) Uncovered Items and Services; and (iii) care provided by Facility upon the request of a Hospice Patient which is not reasonable or necessary for palliation or management of the terminal illness and not rendered in accordance with the applicable Plan of Care. Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for the cost of these services. Facility shall not bill Medicare or Medicaid for care or services provided by Facility upon the request of a Hospice Patient which Hospice determines are related to the terminal illness or related conditions but not reasonable or medically necessary.

(e) Limitation on Hospice's Financial Responsibility. Except as specifically identified in this Agreement, Hospice shall bear no responsibility, obligation, or other liability to reimburse Facility for any charges, costs, expenses or other fees for services provided under this Agreement.

(f) Return of Money. Facility will return any monies to Hospice collected or received in error for the provision of services hereunder. Facility shall also be affirmatively obligated to return any money billed in error to Medicare, Medicaid, or any other payor for items and services to be paid for by Hospice pursuant to this Agreement, in accordance with such payor's or Hospice's requirements for return of such funds.

5. Insurance and Indemnification.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability insurance coverage in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations, but at no time shall the terms or coverage amounts of Facility's professional liability insurance be less than $1 million per claim and $3 million in the aggregate. Either party may request evidence of insurance from the other party and such other party shall provide such evidence to the requesting party in a timely manner. Each party shall ensure that the other party receives at least 30 days' notice prior to the termination of any insurance policy required by this Agreement.

(b) Indemnification. Each party ("Indemnifying Party") agrees to indemnify the other party, its directors, officers, employees, and agents (the "Indemnified Party") from and against any and all claims, suits, damages, fines, penalties, liabilities and expenses (including reasonable attorney's fees and court costs) resulting from or arising out of, any act or omission by the Indemnifying Party or any of its directors, officers, employees, or agents pertaining to the services hereunder, including but not limited to, gross negligence or willful misconduct. This section shall survive termination of this Agreement.

6. Records.

(a) Creation and Maintenance of Records. Each party shall prepare and maintain complete and detailed records concerning each Hospice Patient receiving Facility Services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Each party shall retain such records for a minimum of seven years from the date of discharge of each Hospice Patient or such other time period as required by applicable federal and state law. Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Hospice Patient, including evaluations, treatments, progress notes, authorizations to admission to Hospice and/or Facility, physician orders entered pursuant to this Agreement and discharge summaries. Each record shall document that the specified services are furnished in accordance with this Agreement and shall be readily accessible and systemically organized to facilitate retrieval by either party. Facility shall cause each entry made for Facility Services provided to be signed and dated by the person providing Facility Services.

(b) Financial Recordkeeping. Facility shall keep accurate books of accounts and records covering all transactions relating to this Agreement (the "Financial Records") at its principal place of business. Hospice and its duly authorized representatives, including any such independent public accountant or other auditor, shall have the right during regular business

hours and on reasonable written notice to Facility to examine Facility's Financial Records and to make copies thereof.

(c) Access by Hospice. Facility shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Facility relating to the provision of Facility Services, including but not limited to, clinical records and billing and payment records. This section shall survive the termination of this Agreement.

(d) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(i) and 42 C.F.R. § 420.300, et seq., Facility shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Facility carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12-month period, then Facility shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(e) Destruction of Records. Facility shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

7. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice Patients (collectively, "Patient Information") and may be required to disclose certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be subject to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

8. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one-year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason by providing at least 90 days' prior written notice to the other party. If this Agreement is terminated during the Initial Term, the parties shall not enter into an agreement for

the same or similar services for the duration of the Initial Term. This provision shall survive termination of this Agreement.

(ii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period.

(iii) Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(iv) Immediate Termination. Notwithstanding the above, either party may immediately terminate this Agreement if:

[a] Failure to Have Qualifications. A party or its personnel are excluded from any federal health program or no longer have the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Facility Services.

[b] Liquidation. A party commences or has commenced against it proceedings to liquidate, wind up, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. A party ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. A party fails to perform its duties under this Agreement and the other party determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. A party commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving the other party or a mutual patient of the parties.

(c) Effect of Termination on Availability of Facility Services. In the event this Agreement is terminated, Facility shall work with Hospice in coordinating the continuation of Facility Services to existing Hospice Patients and shall continue to provide Facility Services to Hospice Patients after this Agreement is terminated, if Hospice determines that removing Facility Services would be detrimental to Hospice Patients. In such cases, Facility Services shall

continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

9. Notification of Material Events. Either party shall immediately notify the other party's administrator of:

(a) Incident Reporting. Any of the following alleged incidents involving a Hospice Patient:

(i) mistreatment or neglect;
(ii) verbal, mental, sexual or physical abuse;
(iii) injuries of unknown source; or
(iv) misappropriation of patient property

(b) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against the party or its personnel.

(c) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program, including but not limited to, Medicare or Medicaid.

(d) Insurance. The cancellation or modification of any of the insurance coverage that the party is required to have under this Agreement.

(e) Liquidation. The commencement of any proceeding to liquidate, wind up, reorganize or seek protection, relief or a consolidation of Facility's or Hospice's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(f) Business Address Change. Any change in business address.

10. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion, disability, national origin or any other protected class in any manner prohibited by federal or state laws.

11. Independent Contractor. In performance of the services discussed herein, Hospice and Facility shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co-venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party. Hospice will not withhold taxes from any fees paid pursuant to this Agreement.

12. Use of Name or Marks. Neither Hospice nor Facility shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols, or marks of the other party in written

materials previously approved by the other party for the purpose of informing prospective Hospice Patients and attending physicians of the availability of the services described in this Agreement.

13. Miscellaneous Provisions.

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the state in which Hospice is located.

(e) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature, or as a waiver of any such provisions, rights or privileges hereunder.

(f) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns. There are no third party beneficiaries of or to this Agreement.

(g) No Third Party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(h) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not the party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(i) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither Facility nor Hospice shall receive any compensation or remuneration for referrals.

(j) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(k) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(l) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid, or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

TO: HOSPICE
Seasons Hospice & Palliative Care of Pierce County Washington, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attn: Executive Director

TO: FACILITY
_____
_____
_____
Attn: Administrator

(n) Entire Agreement. This Agreement, including all of the exhibits and addenda attached hereto, contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.

The parties have executed this Agreement as of the day, month and year first written above.

HOSPICE:	FACILITY:
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

EXHIBIT A
PURCHASED HOSPICE SERVICES

1. Purchased Hospice Services. The following services and items will be purchased, as needed, by Hospice from Facility on the terms set forth in this Exhibit A and elsewhere in the Agreement. The rates identified reflect fair market value, without regard to the volume and value of referrals.

   None contemplated at this time.

2. Authorized Personnel. The following hospice representatives are authorized to purchase or order items and services from Facility for Hospice Patients:

   - Hospice Director of Clinical Services;
   - Hospice Team Director; and
   - Hospice Executive Director

3. Billing and Payment. Billing and payment for Purchased Hospice Services shall be governed by this Agreement.

4. Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Purchased Hospice Services to ensure the provision of quality care. All Purchased Hospice Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care.

EXHIBIT B
SUMMARY OF RESPONSIBILITIES

ROLE	HOSPICE	FACILITY	N/A
Admitting Hospice Patients, Beginning Services	X		
Assessing Hospice Patients, Including Who is Responsible for the Initial and Ongoing Assessment	X		
Identifying the Individual(s) Responsible for the Care Planning Process	X		
Coordinating, Supervising, and Evaluating the Care and Services Provided	X		
Scheduling Visits or Hours	X		
Discharge Planning from Hospice	X		

EXHIBIT C
HOSPICE ADMISSION CRITERIA

1. The patient has a terminal prognosis of six months or less as certified by the patient's attending physician and the Hospice physician.

2. The patient or the patient’s health care power of attorney (where applicable) elects in writing to receive Hospice services.

3. The patient's attending physician, as named by the patient/family, provides written consent for patient to receive hospice services.

4. The patient/family understands Hospice's concept of care as being palliative and not curative in its goals.

5. The patient/family understands that Hospice retains responsibility for determining the appropriate location or treatment.

6. Race, color, creed, religion, gender, national origin, disability or sexual preference shall not be used as criteria for admission.

7. Final determination of eligibility for admission is made by Hospice.

EXHIBIT D

HOSPICE ROUTINE HOME CARE

On the basis of the needs of the patient and family as determined by Hospice and documented in the Patient's Plan of Care (Interdisciplinary Record of Care), the following services related to the management of the terminal illness will be provided to Hospice Patients residing at Facility:

1. Home visits by registered nurses with 24 hour availability.

2. Home visits by licensed practical nurses or licensed vocational nurses.

3. Home visits by social workers.

4. Home visits by chaplains.

5. Home visits by home health aides or homemakers.

6. Home visits by volunteers.

7. Family counseling services to family members during the time the Hospice Patient is receiving Hospice care with 24 hour availability.

8. Bereavement care and counseling for family members for as long as one year following the Hospice Patient's death.

9. Prescription medications, medical supplies and equipment provided directly or under arrangement between Hospice and Facility or others, if related to the Hospice Patient’s terminal illness.

10. Ancillary therapies related to the Hospice Patient's terminal illness including physical therapy, speech pathology, respiratory therapy, occupational therapy and nutritional counseling.

11. Laboratory services related to the Hospice Patient's terminal illness.

12. Training for Facility's staff in the use of Hospice protocols.

13. Counseling for Facility's staff to deal with personal grief and loss in connection with work with terminally ill patients.

RESPITE CARE ADDENDUM

THIS RESPITE CARE ADDENDUM is effective on the ___ day of _____, 20___ (the "Effective Date") and addends and is made part of the Nursing Facility Services Agreement ("Agreement") by and between Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Hospice") and _____ ("Facility") dated _____ (the "Agreement").

RECITAL

Hospice and Facility desire to modify the Agreement to address the provision of Respite Care to Hospice Patients.

AGREEMENTS

1. Definitions. Capitalized terms not otherwise defined in this Addendum shall have the meanings given to them in the Agreement.

(a) "Respite Care" means short-term inpatient care provided to a Hospice Patient when necessary to relieve a Hospice Patient's family members or other persons caring for the patient. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

(b) "Respite Care Day" means a day on which a Hospice Patient receives Respite Care from Facility, including the day of admission but excluding the day of discharge, unless the patient dies in Facility unless Medicaid does not reimburse for the day of death.

2. Responsibilities of Facility.

(a) Provision of Respite Care. At the request of an authorized Hospice staff member, Facility shall provide Respite Care to Hospice Patients in accordance with Facility's obligations to provide Facility Services to Hospice Patients under the Agreement, except as such obligations are superseded by this Addendum. Facility shall provide Hospice Patients with beds in Facility. While Facility does not guarantee the availability of any specific number of beds, it will make beds available to Hospice Patients on the same priority basis as its other patients.

(b) Medicare or Medicaid Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare and/or Medicaid programs.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all Hospice Patients and are furnished in accordance with each patient's Plan of Care. Each Hospice Patient must receive all nursing services as prescribed. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Respite Care furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Respite Care, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Respite Care to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance with the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Respite Care that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Respite Care furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Respite Care to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(c) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Respite Care to ensure the provision of quality care. All Respite Care must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all Respite Care identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Respite Care not identified in the Plan of Care.

4. Billing and Payment.

(a) Rates. Hospice shall pay Facility for Respite Care provided to Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients, Hospice Patients with a third-party payor who pays Hospice directly for Respite Care, and Hospice Patients who Hospice designates to receive Respite Care at Hospice's expense. Hospice shall pay Facility a fixed payment rate equal to _____, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility. Facility shall accept this rate as payment in full for each Respite Care Day and shall not bill such patients, their family, representatives or any third party payor. The rate represents fair market value and does not take into account the volume or value of referrals.

(b) Billing. The terms for billing for Respite Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative: _____.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above.

HOSPICE:	FACILITY:
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

GENERAL INPATIENT SERVICES ADDENDUM

THIS GENERAL INPATIENT SERVICES ADDENDUM is effective on the ___ day of _____, 20___ (the "Effective Date") and addends and is made part of the Nursing Facility Services Agreement ("Agreement") by and between Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Hospice") and _____ ("Facility") dated _____ (the "Agreement").

RECITAL

Hospice and Facility desire to modify the Agreement to address the provision of Inpatient Services to Hospice Patients.

AGREEMENTS

1. Definitions. Capitalized terms not otherwise defined in this Addendum shall have the meanings given to them in the Agreement.

(a) "General Inpatient Care Day" means a day on which a Hospice Patient receives Inpatient Services for pain control or symptom management which cannot be managed in other settings. Any portion of a 24 hour period, if less than 24 hours, shall constitute a General Inpatient Care Day and shall be compensated pursuant to this Agreement, except the day on which the Hospice Patient is discharged unless such patient dies as an inpatient.

(b) "Inpatient Services" means inpatient beds and related services that are available at, and provided by, Facility pursuant to its customary policies, including services necessary for pain control, or for symptom management. Such services include, without limitation, nursing, dietary, housekeeping, therapies, emergency, laboratory, radiology, respiratory, pharmacy, oxygen services and related ancillary services.

2. Responsibilities of Facility.

(a) Provision of Inpatient Services. At the request of an authorized Hospice staff member, Facility shall provide Inpatient Services to Hospice Patients in accordance with Facility's obligations to provide Facility Services to Hospice Patients under the Agreement, except as such obligations are superseded by this Addendum. Facility shall provide Hospice Patients with beds in Facility. While Facility does not guarantee the availability of any specific number of beds, it will make beds available to Hospice Patients on the same priority basis as its other patients.

(b) Medicare Certification. Facility represents and warrants that it is currently, and will at all times during the term of this Addendum remain, certified to participate in the Medicare program.

(c) Twenty-Four Hour Nursing Services. Facility shall provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's Plan of Care, and each shift shall include a registered nurse who provides direct

patient care. Each Hospice Patient must receive all nursing services as prescribed. For each shift, Facility will identify to Hospice in advance a charge nurse or other member of Facility's nursing staff who will respond to Hospice's requests for information concerning Hospice Patients.

(d) Home-Like Atmosphere. Facility shall provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort and privacy of patients.

(e) Discharge Summary. Facility shall provide Hospice with a copy of the discharge summary at the time of discharge.

(f) Inpatient Clinical Record. Facility shall maintain an inpatient clinical record for each Hospice Patient that includes a record of all Inpatient Services furnished and events regarding care that occurred at Facility. A copy of the inpatient clinical record shall be available to Hospice at the time of discharge.

(g) Implementation of Agreement. Facility shall designate an individual within the facility who shall be responsible for the implementation of the provisions of this Addendum and the Agreement ("Responsible Facility Representative"). The current Responsible Facility Representative is identified at the end of this Addendum. Facility shall notify Hospice if a new individual is designated as the Responsible Facility Representative.

3. Hospice Responsibilities.

(a) Provision of Plan of Care to Facility. Upon a Hospice Patient's admission to Facility for Inpatient Services, Hospice shall furnish a copy of the current Plan Care. Hospice shall specify the Inpatient Services to be furnished by Facility to such Hospice Patient.

(b) Verification of Regulatory Requirements. Hospice shall verify compliance the following requirements established by the Medicare Conditions of Participation for Hospice Care.

(i) Copy of Plan of Care. Hospice shall document in the patient's record that the Plan of Care has been provided to Facility and specify the Inpatient Services that Facility will furnish. Hospice shall periodically review Hospice Patients' records to verify that these requirements are met.

(ii) Patient Care Policies. Hospice shall verify that Facility has established patient care policies that are consistent with Hospice's policies and agrees to abide by the palliative care protocols and Plans of Care established by Hospice for its patients. Hospice shall review Facility's policies to determine their consistency with Hospice policies.

(iii) Inpatient Clinical Records. Hospice shall periodically review Hospice Patients' inpatient clinical records to determine that they include a record of all Inpatient Services furnished and events regarding care that occurred at Facility. Facility shall make inpatient clinical records available to Hospice at the time of discharge.

(iv) Copy of Discharge Summary. Hospice shall document in the patient's record that Facility provided a copy of the discharge summary at the time of discharge. Hospice shall periodically review Hospice Patients' records to verify that this requirement is met.

(v) Responsible Facility Representative. The Responsible Facility Representative is identified at the end of this Addendum. Facility shall immediately notify Hospice if a new Responsible Facility Representative is appointed, and shall inform Hospice of the name and contact information of the new Responsible Facility Representative. Hospice shall maintain a record of Responsible Facility Representatives.

(vi) Hospice Training. Facility shall provide Hospice with a list of Facility personnel who will be providing Inpatient Services to Hospice Patients, indicating whether each person has already been provided with hospice training. For personnel who have already received training, Facility shall provide Hospice with the names of the individuals who gave the training and a description of the training. For personnel who have not received hospice training, Hospice shall provide training, and shall document the names of the individuals who gave the training and a description of the training. Upon hiring new personnel who will be providing care to Hospice Patients, Facility shall notify Hospice and indicate whether the personnel have received hospice training and, if so, the names of the individuals who gave the training and a description of the training.

(c) Professional Management Responsibility. Hospice retains administrative and financial management, and oversight of staff and services related to all Inpatient Services to ensure the provision of quality care. All Inpatient Services must be authorized by Hospice, furnished in a safe and effective manner by qualified personnel, and delivered in accordance with the Plan of Care. Facility is authorized to provide all Inpatient Services identified in the Plan of Care. Facility shall seek authorization from designated Hospice personnel prior to providing Inpatient Services not identified in the Plan of Care.

4. Billing and Payment.

(a) Rates. Hospice shall pay Facility for Inpatient Services provided to Medicaid Eligible Hospice Patients, Medicare Eligible Hospice Patients, Hospice Patients with a third-party payor who pays Hospice directly for Inpatient Services, and Hospice Patients who Hospice designates to receive Inpatient Services at Hospice's expense. Hospice shall pay a fixed rate for each General Inpatient Care Day provided to such patients, except the day on which such patient is discharged from Facility, unless such patient dies while residing at Facility, unless Medicaid does not reimburse for the day of death. The fixed payment rate shall be _____ for each General Inpatient Care Day provided to such patients. Facility shall accept this rate as payment in full for each General Inpatient Care Day provided to such patients and shall not bill such patients, their family, representatives or any third party payor. The rate represents fair market value and does not take into account the volume or value of referrals.

(b) Billing. The terms for billing for General Inpatient Care shall be governed by the Agreement.

5. Responsible Facility Representative. Facility has identified the following individual as the Responsible Facility Representative _____.

6. Conflicts. This Addendum shall be subject to the terms and conditions of the Agreement; provided that, in the event of a conflict between the terms and conditions of this Addendum and the terms and conditions of the Agreement, the terms and conditions of this Addendum shall control. Except as specifically amended herein, all other terms and conditions of the Agreement shall remain in full force and effect.

The parties have executed this Addendum as of the day, month and year first written above.

HOSPICE:	FACILITY:
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____

EXHIBIT 7

Claritas Population Estimates for Washington By Zip Code, 2022-2027

ZipCode	State Name	County Name	Core Based Statistical Area Name	Geography Name	2022 Population, Age 65+	**2022 Total Population**	2027 Population, Age 65+	**2027 Total Population**
98303	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Anderson Island	475	**1,272**	560	**1,375**
98304	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Ashford	226	**937**	269	**995**
98321	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Buckley	2,742	**17,252**	3,420	**18,304**
98323	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Carbonado	98	**725**	135	**768**
98327	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Dupont	842	**11,087**	1,047	**12,113**
98328	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Eatonville	2,310	**11,992**	2,815	**12,867**
98329	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Gig Harbor	2,397	**12,329**	2,924	**13,137**
98330	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Elbe	56	**256**	69	**272**
98332	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Gig Harbor	4,863	**20,369**	5,833	**21,794**
98333	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Fox Island	1,068	**4,307**	1,304	**4,628**
98335	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Gig Harbor	6,814	**28,924**	8,033	**30,780**
98338	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Graham	4,992	**30,914**	6,225	**33,179**
98344	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Kapowsin	0	**0**	0	**0**
98348	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	La Grande	0	**0**	0	**0**
98349	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakebay	1,334	**7,663**	1,610	**8,160**
98351	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Longbranch	393	**1,435**	476	**1,531**
98352	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Sumner	0	**0**	0	**0**
98354	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Milton	1,256	**8,701**	1,551	**9,304**
98360	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Orting	2,100	**15,011**	2,532	**16,177**
98371	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Puyallup	4,679	**23,433**	5,494	**24,732**
98372	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Puyallup	4,775	**26,153**	5,694	**27,736**
98373	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Puyallup	3,562	**28,688**	4,492	**30,896**
98374	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Puyallup	6,334	**45,783**	7,810	**49,101**
98375	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Puyallup	3,198	**34,024**	4,177	**36,935**
98385	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	South Prairie	84	**489**	111	**517**
98387	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Spanaway	6,114	**51,693**	7,575	**55,304**
98388	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Steilacoom	1,570	**7,133**	1,767	**7,442**
98390	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Sumner	2,079	**11,938**	2,400	**12,665**
98391	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Bonney Lake	7,124	**55,120**	9,337	**58,791**
98394	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Vaughn	246	**1,026**	293	**1,095**
98395	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Wauna	0	**0**	0	**0**
98396	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Wilkeson	82	**422**	107	**447**
98397	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Longmire	0	**0**	0	**0**
98398	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Paradise Inn	0	**0**	0	**0**
98401	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98402	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	1,197	**8,298**	1,428	**8,842**
98403	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	1,376	**8,158**	1,634	**8,516**
98404	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	4,359	**36,286**	5,099	**38,491**
98405	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	3,622	**26,558**	4,227	**27,867**
98406	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	4,711	**22,921**	5,397	**23,945**
98407	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	5,035	**22,550**	5,828	**23,644**
98408	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	3,117	**20,546**	3,626	**21,479**
98409	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	2,860	**26,803**	3,487	**28,419**
98411	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98412	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98413	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98415	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98416	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	35	**996**	42	**1,000**
98417	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98418	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	1,393	**10,573**	1,649	**10,970**
98419	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98421	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	129	**1,236**	163	**1,280**
98422	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	3,677	**22,320**	4,574	**23,549**
98424	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Fife	1,247	**12,617**	1,578	**13,624**
98430	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Camp Murray	12	**145**	21	**156**
98431	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98433	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	153	**19,714**	247	**21,112**
98438	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	McChord AFB	1	**403**	1	**408**
98439	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakewood	245	**5,028**	322	**5,190**
98443	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	1,273	**5,523**	1,500	**5,727**
98444	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	4,532	**37,607**	5,280	**39,621**
98445	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	4,876	**34,180**	5,740	**36,460**
98446	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	2,107	**12,331**	2,526	**13,184**
98447	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	82	**1,352**	90	**1,378**
98448	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98464	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98465	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	1,567	**6,968**	1,774	**7,253**
98466	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	5,319	**29,114**	6,078	**30,546**
98467	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	University Place	2,997	**16,752**	3,533	**17,629**
98471	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98481	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98490	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98493	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Tacoma	0	**0**	0	**0**
98496	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakewood	0	**0**	0	**0**
98497	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakewood	0	**0**	0	**0**
98498	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakewood	5,892	**28,859**	6,704	**30,028**
98499	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Lakewood	4,962	**31,672**	5,707	**33,070**
98558	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	McKenna	102	**457**	122	**489**
98580	Washington	Pierce County	Seattle-Tacoma-Bellevue, WA Metro	Roy	2,488	**12,998**	3,085	**13,946**
	Total				141,179	**922,041**	169,522	**978,868**

EXHIBIT 8

Physician Aid-In-Dying Policies

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: *HOS 2-005*
		Effective Date: *01/01/13*
	Title: **HOSPICE AIDE SERVICES**	*Revised*: *02/15/22*
		Page: ***1** of **5***

POLICY:

Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group, prepares written patient care instructions for a hospice aide, and is responsible for the supervision of the hospice aide. The hospice aide meets the training, attitude, and skill requirements according to state and federal regulations.

Regulatory References: 418.100(c), 418.70, 418.76(g)(1-2), 418.76(g)(2)(iv), 418.76(g)(3-4), 418.76(k), 418.76(i)(2-3)
CHAP Standards: HCDT 1.I, HCDT 15.I, HCDT 16.I, HCDT 17.I, HCDT 18.I, HCDT 19.I, HCDT 20.I
TJC Standards: HR.01.06.01 EP 7, HR.01.05.01 EP 2, HR.01.01.01 EP 23, PC.01.03.01 EP 33, PC.02.01.03 EP 9

PURPOSE:

To specify the role of the hospice aide and/or homemaker in hospice care.

PROCEDURE:

1. The interdisciplinary group will identify the need for hospice aide services.

2. Hospice aide assignments, plan of care, and interventions shall be documented and included in the patient's clinical record.

3. Written patient care instructions for a hospice aide must be prepared by a registered nurse responsible for the delegation and supervision of the hospice aide.

4. Hospice aide duties provided by an aide may include:

   A. Assisting with personal hygiene, i.e., bathing, shampoo,

   B. Assisting with range of motion activities, ambulation, and exercises,

   C. Assisting with toileting, going into the bathroom, use of commode or bedpan,

   D. Assisting with meal preparation and feeding the patient,

E. Light housekeeping and/or linen changes,

F. Reporting changes in the patient's condition and needs to the Hospice RN, and

G. Other supportive tasks as assigned

5. If environmental support services (homemaker services) are needed to meet a patient's needs and, or family/caregiver, the environmental support tasks such as incidental household functions, shopping, etc., will be added to the patient's individualized Hospice Aide Care Plan.

6. Hospice aides document care provided in accordance with the hospice aide assignment and compliance with hospice policies and procedures.

7. Homemaker services may be included for routine care on an intermittent basis when non-hands-on care is required. Specifically, these activities would not be related to personal care; however, they would assist the primary family/caregiver to keep the patient at home.

8. Homemaker/chore services personnel provide the patient and family/caregiver with environmental support under professional supervision. These types of services could include:

   A. Housekeeping,

   B. Family/caregiver respite, and

   C. Meal preparation.

   Homemakers report all concerns about the patient or family to the IDG member coordinating homemaker services.

9. A hospice aide may also provide environmental support services.

10. The hospice coordinates the hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services they need.

State-Specific Requirements

Arizona: no additional requirements

California: no additional requirements

Colorado: 6 CCR 1011-1 6.19 Hospice Aide Services

The hospice shall ensure that hospice aides have successfully completed a state approved certified nurse aide (CNA) training program and are currently certified by the Colorado Department of Regulatory Agencies (DORA).

Connecticut:

19-13-D66

(p) "Homemaker-home health aide" means an unlicensed person who has successfully completed a training and competency evaluation program for the preparation of homemaker-home health aides approved by the department;

19-13-D 69

(D) An agency shall maintain at least the following staffing pattern during the regular workweek: One (1) full-time registered nurse for every fifteen (15), or less, full-time equivalent homemaker-home health aides on duty.

Delaware: no additional requirements

Florida: no additional requirements

Georgia: no additional requirements

Illinois: no additional requirements

Indiana: no additional requirements

Maryland: no additional requirements

Massachusetts: no additional requirements

Michigan: no additional requirements

Minnesota: 4664.0260 Home Health Aide Services

4. Supervision.
   A hospice provider must ensure that the home health aide services are supervised to verify that the services are adequately provided, identify problems, and assess the appropriateness to the patient's needs. The hospice provider must ensure that a registered nurse or physical therapist visits the hospice patient's home site at least every two weeks or more frequently based on the plan of care. The home health aide may or may not be present at the time of the supervisory visit.

Missouri: 19 CSR 30-35.010

A home health aide is not considered to have completed a training and competency program or a competency evaluation program if, since the individual's most recent completion of such program(s), there has been a continuous period of twenty-four (24) consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.

Mississippi: 113.07 Hospice Aide

3. Initial Orientation - The content of the basic orientation provided to the hospice aides shall include the following:
   a. Policies and objectives of the agency;
   b. Duties and responsibilities of a hospice aide;
   c. The role of the hospice aide as a member of the healthcare team;
   d. Emotional problems associated with terminal illness;
   e. The aging process;
   f. Information on the process of aging and behavior of the aged;
   g. Information on the emotional problems accompanying terminal illness;
   h. Information on terminal care, stages of death and dying, and grief;
   i. Principles and practices of maintaining a clean, healthy and safe environment;
   j. Ethics; and
   k. Confidentiality.

Nevada: no additional requirements

New Jersey: Section 8:42C-7.5 - Homemaker-home health aide services

(b) The hospice shall not employ an individual as a homemaker-home health aide unless the individual shall have completed a training program approved by the New Jersey Board of Nursing, shall be certified by the Board of Nursing in accordance with N.J.A.C. 13:37-4, and shall provide verification of current certification for inclusion in the hospice personnel record.

Oregon: no additional requirements

Pennsylvania: no additional requirements

Tennessee: 1200-08-27

(11) Home Health Aide/Hospice Aide Services. (a) The home health aide shall be assigned to a particular patient by a registered nurse. Written instructions for patient care shall be prepared by a registered nurse or therapist as appropriate.

Texas: Rule § 558.843 Hospice Aide Qualifications

(a) A hospice must use a qualified hospice aide to provide hospice aide services. A qualified hospice aide is a person who has successfully completed:

(1)a training program and competency evaluation program that complies with the requirements in subsections (c) and (d) of this section; or

(2) a competency evaluation program that complies with the requirements in subsection (d) of this section.

(b) A person who has not provided home health or hospice aide services for compensation in an agency during the most recent continuous period of 24 consecutive months must successfully complete the programs described in subsection (a)(1) of this section or the program described in subsection (a)(2) of this section before providing hospice aide services.

Washington, DC: no additional city regulations

Wisconsin: DHS 131.13

(2) Nurse Aide Services

6. Administering medications to patients if the aide has completed a state-approved medications administration course and has been delegated this responsibility in writing for the specific patient by a registered nurse.

POLICY:

Hospice aides have satisfactorily completed education and training programs consistent with federal and state regulations.

Regulatory References: CMS 418.76 (a); 418.76 (b); 418.76(b) (4); 418.76 (d); 418.76 (g) (3); 418.100(g)
CHAP Standards: HCDT 16.I HSRM 9.1 HSRM 11.I
TJC Standards: HR.01.05.01 EP 1, 4, 5; PC.02.01.03 EP 9; HR.01.05 EP 3, 5.

PURPOSE:

To outline a hospice aide training program to ensure the competence and skills of hospice aides.

PROCEDURE:

1. AccentCare shall hire only individuals as hospice aides who have completed a state-certified education and training program that meets all federal and state regulations.

2. If the individual has not been employed as a hospice or home health aide for a continuous period of 24 months since completing a program, then the individual shall not be considered to have completed a training and competency program.

3. There shall be a three (3) month introductory period for all new paraprofessional personnel. Successful completion of the probationary period shall be documented, dated, and signed by the employee and supervisor.

4. An RN shall conduct bi-weekly on-site supervisory visits during the initial eight (8) weeks of employment for all newly trained or hired hospice aides.

5. The organization shall perform an annual competency evaluation to ensure the competency of the hospice aide.

   A. The annual competency evaluation shall address the following topics:

      1) Communication skills, including the ability to read, write and verbally report clinical information to RN Case Manager, patient, caregivers, and other hospice staff *****
      2) Patient privacy/ confidentiality and respect for property

3) Observation, reporting, and documentation of patient status and care or service furnished
4) Taking and recording temperature, pulse, and respiration *****
5) Basic infection control procedures
6) Basic elements of body function and changes in body function that must be reported to an aide's Clinical Director
7) Maintenance of a clean, safe, and healthy environment
8) Recognizing emergencies and knowledge of emergency procedures
9) The physical and developmental characteristics of the populations served by the organization
10) Appropriate and safe techniques in performing personal hygiene and grooming tasks (bathing; bed-bath; sponge, tub, or shower bath; shampoo in sink, tub, or bed; nail and skin care; oral hygiene; toileting and elimination) *****
11) Safe transfer techniques and ambulation *****
12) Positioning and normal range of motion *****
13) Adequate nutrition and fluid intake
14) Recognize signs of abuse, neglect, and exploitation of patients, with knowledge of reporting procedures

B. Competency Evaluation

1) Those topics listed above indicated by an * asterisk require that the skill/task be evaluated by observing the aide's performance with a patient.
2) The remaining topics may be evaluated through oral or written examination, or after observation of the aide with a patient.

C. A hospice aide shall not be considered competent in any task in which they are evaluated as "unsatisfactory." The aide must not perform that task without direct supervision. The aide may perform the task that was evaluated as unsatisfactory after retesting in that area and receiving a satisfactory evaluation ban an RN.

D. A hospice aide shall not be considered to have successfully passed a competency evaluation if they had an "unsatisfactory" rating in more than one of the required areas.

6. The organization shall offer 12 hours of in-service training in a 12-month period. A qualified instructor shall provide the in-services and may occur while an aide provides patient care.

7. Additional training may be provided and documented when patients receive high technology or complex services.

8. The organization shall provide performance reviews (at least annually). The performance review shall address the areas/results of the competency evaluation.

9. The organization shall provide orientation about the hospice philosophy to all employees and contracted staff with patient and family contact.

10. Documentation in the Hospice Aide personnel file shall include:

    A. Successful completion of a training program
    B. In-service record reflecting twelve (12) hours of in-services in a 12-month period
    C. Annual Competency Evaluation
    D. Annual Performance Evaluation

11. Additional Documentation for Home Health Aide/Hospice Aide Continuing Education in California:

    A. All continuing education providers must be approved by the California Department of Public Health (CDPH), Training Program Review Unit (TPRU).
    B. California Home Health Aides/Hospice Aides: Must obtain twenty-four (24) hours of In-Service Training/CEUs within the certification period. Twelve (12) of the twenty-four (24) hours are required in each year of the two (2) year certification period.
    C. Aides may <u>not</u> use online CEUS to meet the renewal requirement.
    D. The following documentation is maintained in hard copy at the agency site and/or online for four (4) years. The records shall be immediately accessible to the Department upon request. Sign-in sheets
        1. Sign-in sheets
        2. Certificates
        3. Course content
            a. Course outline
            b. Course learning objectives
            c. Course curriculum
            d. Course examination
            e. Methods of teaching

State-Specific Requirements

Arizona: R9-10-612

5. A registered nurse:
   a. Assigns tasks in writing to a home health aide who is providing home health aide service to a patient,
   b. Provides direction for the home health aide services provided to a patient, and
   c. Verifies the competency of the home health aide in performing assigned tasks.

California: Article 1 Standards of Quality Hospice Care

Section 5.5 Hospice Aide/Homemaker Services.

2. Demonstrated experience as a Home Health/Hospice Aide or completion of an appropriate orientation and training program.

B. 4. The Homemaker shall have completed an appropriate orientation and training program.

Only CDPH-approved In-Service Training Programs and CDPH-approved CEU providers with a Nurse Assistant Certification Number (NAC#) are accepted.

CEU Provider Information
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph192.pdf

Continuing education submission form CDPH 282 A (8/19)
https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph283a.pdf

Colorado 6 CCR 1011-1 Chapter 21

6.19 Hospice Aide Services: The hospice shall ensure that hospice aides have successfully completed a state-approved certified nurse aide (CNA) training program and are currently certified by the Colorado Department of Regulatory Agencies (DORA).

7.9 Personnel: The hospice shall have a program for education and training that offers a minimum of 20 hours of education annually to enhance hospice related skills for all employees who provide direct patient care. The hospice shall maintain documentation of the annual education and training offered.

Connecticut: 19-13-D69. Services (d) Homemaker-Home Health Aide Service:

(1) An agency shall have written policies governing the delivery of homemaker-home health aide services.

(2) On and after January 1, 1993, no person shall furnish home health aide services on behalf of a home health care agency unless such person has successfully completed a training and competency evaluation program approved by the department.

(A) The commissioner shall adopt, and revise as necessary, a homemaker home health aide training program of not less than seventy-five (75) hours and competency evaluation program for homemaker-home health aides. The standard curriculum of the training program shall include the Department of Public Health Public Health Code 19-13-D69.

Delaware: 4468 Service to Patients

6.7 Inservice training and continuing education shall be offered on a regular basis. Documentation of this training and continuing education shall be maintained and available on request to the licensing authority.

Florida: 400.6045 Patients with Alzheimer's disease or other related disorders

A hospice licensed must provide the following staff training

(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders.

(b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease, or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

Georgia Rule 111-8-37-.18

(5)(c.) Personal care aides must receive at least 12 hours of continuing education annually regarding applicable aspects of hospice care and services.

Illinois: 210 ILCS 60/8 Sec. 8. General Requirements for hospice programs.
(o.) The hospice program shall provide an ongoing program for the training and education of its employees appropriate to their responsibilities.

Indiana: No additional requirements

Maryland: No additional requirements

Massachusetts: No additional requirements

Michigan: No additional requirements

Mississippi: Rule 1.18.3 The orientation and training curricula for hospice aides shall be detailed in a policies and procedures manual maintained by the hospice agency and provision of orientation and training shall be documented in the employee personnel record.

Rule 1.18.3 6. In-service Training – The hospice aide must have a minimum of 12 hours of appropriate in-service training annually. In-service training may be prorated for employees working a portion of the year. However, part-time employee who worked throughout the year must attend all twelve (12) hours of in-service training.

Rule 1.22.5 Hospice aide services shall be available and adequate to meet the needs of the patient. The hospice aide shall meet the federal and state training requirements.

Missouri: 19 CSR 30-35.010 Hospice Program Operations
Purpose:

12. Homemaker-a home health aide, volunteer, or other individual who assists the patient/family with light housekeeping chores.
13. Home health aide-a person who meets the training, attitude, and skill requirements specified in the Medicare home health program (42 CFR 484.36).

Nevada: No additional requirements

New Jersey: Section 8:42C-1.2 Definitions
"Homemaker-home health aide" means a person who has completed a training program approved by the New Jersey Board of Nursing and who is so certified by that Board in accordance with 45:11-23 et seq. and N.J.A.C. 13:37.

Oregon: 333-035-0050

(12) "Nurse's Aide" means a person certified as a nursing assistant under ORS 678.442 who has received special hospice training in accordance with CMS Conditions of Participation.

Pennsylvania: No additional requirements

Tennessee: 1200-08-27-.01

(30) Home Health Aide/Hospice Aide. A person who has completed a total of seventy-five (75) hours of training which included sixteen (16) hours of clinical training prior to or during the first three (3) months of employment and who is qualified to provide basic services, including simple procedures as an extension of therapy services, personal care regarding nutritional needs, ambulation and exercise, and household services essential to health care at home.

1200-08-27-.06

(11)(c.) There shall be continuing in-service programs on a regularly scheduled basis with on-the-job training during supervisor visits as issues are identified.

Texas: 558.842 Hospice Aide Services

(a) Hospice aide services must be provided by a hospice aide who meets the training and competency evaluation requirements, or the competency evaluation requirements specified in §558.843 of this subchapter (relating to Hospice Aide Qualifications).

(4) Hospice aide services must be consistent with a hospice aide's documented training and competency skills.

(e) An RN must make an annual on-site visit to the location where a hospice client is receiving care to observe and assess each hospice aide while the aide performs care.

558.843 Hospice Aide Qualifications

(2)(c.) A hospice aide training program must address each of the subject areas listed in paragraph (1) of this subsection through classroom and supervised practical training totaling at least 75 hours At least 16 hours must be devoted to supervised practical training. At least 16 hours of classroom training must be completed before the supervised practical training begins.

(6)(e.) A hospice aide must receive at least 12 hours of in-service training during each 12-month period.

558.845 Hospice Homemaker Qualifications

(2) is a qualified hospice aide as described in §558.843 of this subchapter (relating to Hospice Aide Qualifications).

(b) The orientation for a hospice homemaker must address the needs and concerns of a client and a client's family who are coping with a terminal illness.

Washington: WAC 246-335-615 Plan of operation.

The applicant or licensee must develop and implement a plan of operation which includes:

(13) Assuring direct care personnel, contractors and volunteers have training specific to the needs of the terminally ill patients and their families.

Washington, DC: No additional requirements

Wisconsin: DHS 131.31 Employees.

(2) General requirements. Prior to beginning patient care, every employee or contracted staff shall be oriented to the hospice program and the job to which he or she is assigned.

POLICY:

This agency's policy is to provide reasonable and necessary care to patients, comply with the state requirements as they apply to end-of-life care, and support patients who may wish to avail themselves of their legal right to pursue medical aid-in-dying (MAID) as their end-of-life option.

DEFINITIONS:

"Attending physician" – means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease. As defined within the law, this person is the prescriber of aid-in-dying medications.

"Consulting physician" – means a physician who is independent from the attending physician and is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

"Ingestion" – means any route of administration via the GI tract, e.g., oral, via NG or GT, or rectal.

"Self-administer" – means a qualified patient's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug.

PURPOSE:

To guide staff on the specific state-approved Medical Aid-in-Dying laws, which allow terminally ill, mentally capable state residents who are adults, 18 years or older, with a prognosis of six months or less the option to request from a medical or osteopathic physician or nurse practitioner (where applicable by law) medication that they can choose to self-administer to shorten their dying process. Each law generally outlines a process a person must legally follow and includes significant safeguards io protect persons from coercion. Information related to specific states can be found on SharePoint on the Physician Aid-in-Dying (P.A.D.) Hub: Physician Aid-in-Dying Hub (sharepoint.com).

PROCEDURE:

I. AccentCare will make information on its policy publicly available where required by applicable law.

II. All staff members in a state with a Medical Aid in Dying law, along with all Physicians and cALL Center staff, will be trained upon hire and annually. They are required to:

1. Understand the law of their state.
2. Understand the policy and process.
3. If not well-versed, be prepared to redirect to another clinician if a patient/family seeks information in a compassionate manner.
4. Show support to team members irrespective of their position on the law.

III. Care of Patients

Contractors and volunteers are included with staff.

1. Agencies that provide quality end-of-life care, symptom management, and services to all patients and families with the goal of providing excellent patient care, safe and comfortable dying, regardless of whether the patient chooses to participate in medical aid-in-dying in compliance with state regulations. Hospice team members are welcome to talk to patients about state-approved MAID laws and are encouraged to provide educational, emotional, and spiritual support to those considering this option. Discussion of laws regarding MAID, or availing of the law, would not be a reason to discharge an eligible patient from our services.

2. No staff member shall assist the patient in preparing or administering medical aid-in-dying medications.

3. This agency shall explore and evaluate patients' statements about all end-of-life options, including medical aid-in-dying, if they arise during intake and/or subsequent visits.

4. Patients who inquire about the option of securing the medical aid-in-dying medication shall be asked to contact their attending physician, which may be the Hospice/Palliative Medical Director. At the same time, the agency continues to provide standard services.

5. Staff who are aware that a patient is considering procuring medication for medical aid-in-dying shall inform the RN case manager and the Clinical Manager with notification to the hospice Regional Director of Patient Experience (RDPE) for guidance.

6. Patients who verbalize the intent to secure medical aid-in-dying medication shall be informed that this information will be shared with the care team for appropriate support. Staff shall maintain the patient's confidentiality and not disclose these details with the

patient's next of kin; however, as all of the laws preclude this without the patient's explicit consent.

7. Staff who are morally or ethically opposed to medical aid-in-dying shall have the option of transferring care responsibilities to other staff if their patient states intent to pursue medical aid-in-dying, without fear of retaliation.

8. If the patient chooses to pursue medical aid-in-dying as an option, the patient will be informed that the agency shall continue to provide reasonable and necessary physician-ordered services to the patient.

9. The patient is responsible for obtaining a physician who may fulfill their wishes for medical aid-in-dying.

10. If, upon arriving at a patient's home, a staff member discovers that the patient, who had not previously divulged their intention to utilize medical aid-in-dying medication, is in the process of taking or has taken the MAID medication, the staff member should notify their supervisor immediately. If a patient requests that staff be present when the aid-in-dying medication is self-administered, at least two team members must attend.

11. The Ethics Committee shall meet to review end-of-life policies and procedures, including review of updates to MAID statutes. When a challenging case presents itself, the Ethics Committee shall convene an ad hoc meeting to support the team.

12. At admission, staff shall inform patients of the AccentCare policy to provide standard home health, hospice, or palliative services to patients regardless of their stated interest or intent in pursuing medical aid-in-dying.

13. If a patient or family member wishes to discuss their state-approved MAID law, team members may provide education as available on SharePoint.
14. Team members shall maintain the confidentiality of patient requests, including next of kin under state law, if the patient identifies their wish for such.

15. The Hospice/Palliative Medical Director may serve, if they choose, as the attending or consulting physician as defined in the medical aid-in-dying regulations.

16. If the Hospice /Palliative Medical Director chooses not to be the attending for medical aid-in-dying, they may refer the patient to a community physician. The patient is responsible for obtaining a physician who may fulfill their wishes for aid-in-dying.
17. No employee, contractor, or volunteer of the agency may serve as a witness to the document serving to qualify the patient for medical aid-in-dying unless expressly permitted by law. The attending physician may never serve as a witness, per all statutes.

18. Anticipatory Grief and post-death Bereavement support shall be available to all families.

19. Prior to the patient's ingesting the medical aid-in-dying medication the staff shall assist the patient with the following routine care:
    a. Ensure the patient's Advance Directive forms (POLST/MOST) are complete and in the home.
        i) Team members will explain to the patient that the agency is required to follow state law with regard to life-sustaining treatment if a Do Not Resuscitate Order is not obtained.
    b. Encourage the patient to make funeral arrangements, including discussion of the disposition of body, if needed.
    c. Encourage the patient to complete any other end-of-life arrangements.
    d. Instruct caregivers to contact Agency at time of death.
    e. Identify next of kin who will be notified of the death if they will not be in attendance.
    f. Provide the patient and family members or other caregivers with information about safe disposal of medications.
    g. If the patient dies without self-administering the medical aid-in-dying medication and these medications are in the home, staff shall be deployed to the patient's residence to instruct and observe the family or caregiver with proper disposal of these medications safely according to policy.

20. Complete any additional documentation needed in the patient's chart, i.e., non-clinical notes, end-of-life notes, etc. The care team shall utilize MAID/PAD coordination notes in the electronic medical record system (HCHB). State laws have a confidentiality clause that restricts access to dialogue/discussion by anyone other than the patient and their medical team; as such, only the appropriate PAD coordination notes in Home Care Home Base may be utilized.

21. If a staff member arrives at a patient's home and finds that the patient has taken the medical aid-in-dying medication and has died, the staff member is to provide professional services as in any other cases and initiate the usual bereavement follow-up with the family or significant other(s).

IV. Patient Discussions Related to the Option of Medical Aid in Dying

1. Patients may want to discuss the option of medical aid-in-dying with staff, in which case staff shall respond to patient questions or statements regarding the end-of-life option with respect and compassion.

2. Where applicable by law, the hospice team members will inform the facility staff of any communications related to medical aid in dying.

3. If a hospice team member is aware that a formal request has been made to an attending/hospice physician, or the patient has initiated dialogue related to MAID, the Team Director, Regional Hospice Medical Director, and Regional Director of Patient Experience will be immediately notified.

4. When a patient/family has verbalized interest in this end-of-life option, staff, and volunteers, working with a patient/family shall:
    a. Obtain patient permission prior to communicating with a patient's family members, caregivers, or friends,
        i. While it is recommended that patients inform their families of their wishes around obtaining medical aid-in-dying medication, patients are not legally required to inform their families or caregivers of their wishes.
    b. Inquire about the patient's concerns, fears, symptoms, priorities, and care preferences.

V. Staff Presence at Time of Patient Death

1. Staff is not expected to remain in the home until the patient's death and may not be available.

2. If staff are present, the visit is an end-of-life visit in which symptom management, comfort, and supportive counseling are the focus.

VI. On-call and time of death instructions visit standards

1. Time of death visits shall be managed according to normal procedures with on-call staff making a determination according to the individual family needs and specific circumstances.
2. Agency staff shall inform on-call if they are aware that the patient is planning to ingest medical aid-in-dying medication during on-call hours. Documentation shall be placed in the EMR under the PAD communication note.
3. Time of death announcement to staff and volunteers shall not list information related to medical aid-in-dying.
   a. Notify the attending physician (by law) if they were not present at the time of death.
4. Patient's death certificate will list the underlying illness as the cause of death, pursuant to the law.
   A meeting may be held, consisting of involved team members and other national roles, to debrief and review the case. The Director of Clinical Operations should reach out to the Hospice Regional Director of Patient Experience to coordinate.

VII. Documentation related to requests for end-of-life medications

1. If patients have requested or obtained medical aid-in-dying medications, staff shall document:
   a. That the medical aid-in-dying medications have been dispensed and are in the patient's home.
   b. The specific medications dispensed for medical aid-in-dying for this patient, if known.
   c. Staff presence at time of death as a subsequent visit and/or death notes as with any hospice/palliative death.
   d. Time of death visit including:
      i. healthcare professional/staff presence
      ii. time of death
      iii. bereavement concerns
   e. Hospice team members present with the patient/family at the time of self-administration and subsequent death will document in the appropriate visit profile for

their discipline. Documentation will be completed in *PAD – Staff Present at Ingestion/Death* Documentation indicates:

i. Confirmation that patient presented with decisional capacity (within the discipline's scope of practice) prior to self-administering aid-in-dying medication.
ii. Medication (if known) and dose taken by the patient.
iii. Location/setting.
iv. All persons present and relationship to the patient.
v. Approximate time of death, if present.

f. If an attending physician or another licensed healthcare provider is present at death and ensure all state-required forms are completed and in the medical record.

VIII. Conscientious Objections and Personal Responsibility Related to Patients Requesting Medical Aid-in-Dying Medications

1. The agency recognizes that each patient care staff member including volunteers and physicians will need to thoughtfully consider whether it is within their ability, values, and beliefs to provide care for patients who are requesting medical aid-in-dying medications.
2. It is the staff member's responsibility to inform appropriate staff (Administrator or Team Director) of concerns or reluctance around caring for patients who are requesting medical aid-in-dying prescriptions. Staff members may request to be reassigned from the care of a person considering medical aid in dying.

State-Specific Requirements

Each state has specific forms, physician requirements, and required documentation.

In each state, the use of the law cannot affect the status of a patient's health, life, or annuity insurance policies.

Public Posting location for AccentCare https://www.accentcare.com/laws-regulations/

Arizona: no legislation

California: AB-15, ABX2-15 - End of Life Option Act passed in 2016. The law took effect on June 9, 2016. Later, SB 380 was signed by the Governor on October 5, 2021, which became effective on January 1, 2022.

1. Translators should be made available for non-English speakers.
   a. An interpreter whose services are provided shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person's estate upon death.
   b. Interpreters are required to complete a declaration form.
2. In January 2022, the law allowed the individual to make 2 oral requests a minimum of 48 hours apart, including a written request to their attending physician.
3. Physicians must instruct patients and provide a form for patients to document intent to use the medical aid-in-dying prescription 48 hours prior to use.
4. The physician must request that the patient notify his or her next of kin about the prescription request.
5. The patient must be informed that the medication should be taken in a private place with another person present.
6. The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.
   a. Only one of the two witnesses at the time the written request is signed may:
      1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.
      2) Own, operate, or be employed at a healthcare facility where the individual is receiving medical treatment or resides.
   b. The attending physician, consulting physician, or mental health specialist of the individual shall NOT be one of the witnesses.

7. Before prescribing an aid-in-dying drug, the attending physician shall:
   a. Determine the requesting adult has the capacity to make medical decisions,
      i) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.
      ii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
   b. Determine whether the requesting adult has a terminal disease,
   c. Determine the requesting adult has voluntarily made the request,
   d. Refer the individual to a consulting physician for a medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions.
   d. Determine whether the requesting adult is a qualified individual.
8. An individual may at any time withdraw or rescind their request for an aid-in-dying drug or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.
9. Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.
10. Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician follow up form to the State Department of Public Health.
11. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does NOT assist the qualified person in ingesting the aid-in-dying drug.
12. the information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.
13. A person who has custody or control of any unused aid-in-dying drugs prescribed after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposed of controlled substances, if none is available, shall dispose of it by lawful means in

accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

Resources available at: https://www.deathwithdignity.org/states/california/ or VSB End of Life Option Act (ca.gov)
Regulations: Health and Safety Code Division 1, Part 1.85, Section 443 to 443.22

Connecticut: no legislation

Colorado: Proposition 106 - End of Life Options Act, passed in November 2016 and took effect December 16, 2016

1. Health facilities must provide information about its policy related to medical-aid-in-dying
2. The cause of death for patient using the medical aid-in-dying option:
   a. The underlying terminal disease must be listed as the cause of death.
   b. The manner of death must be marked as "Natural."
   c. The cause of death section may not contain any language that indicates that the Colorado End-of-Life Options Act was used, such as:
      i. Suicide
      ii. Assisted suicide
      iii. Physician-assisted suicide
      iv. Death with Dignity
      v. Mercy killing
      vi. Euthanasia
      vii. Medication
3. An adult resident of Colorado may make a request to receive a prescription for the medical aid-in-dying medication if:
   a. The individual's attending physician has diagnosed the individual with a terminal illness with a prognosis of six months or less,
   b. The individual's attending physician has determined the individual has mental capacity,
   c. The individual has voluntarily expressed the wish to receive a prescription for medical aid-in-dying medication,
   d. The right to request medical aid-in-dying medication does not exist because of age or disability.
4. In order to receive a prescription for medical aid-in-dying medication and individual who satisfies the requirements, must make two oral requests, separated by at least 15 days, and a valid written request to their attending physician.
   a. To be valid, a written request for medical aid-in-dying medication must be:

i. Signed and dated by the individual seeking the medical aid-in-dying medication; and
ii. Witnessed by at least two individuals who, in the presence of the individual, attest to the best of their knowledge and belief that the individual is:
   1) Mentally capable;
   2) Acting voluntarily; and
   3) Not being coerced to sign the request.

b. Of the two witnesses to the written request, at least one must NOT be:
   i. Related to the individual by blood, marriage, civil union, or adoption;
   ii. An individual who at the time the request is signed, is entitled, under a will or by operation of law, to any portion of the individual's estate upon their death; or
   iii. An owner, operator, or employee of a health care facility where the individual is receiving medical treatment or is a resident.

c. Neither the individual's attending physician nor a person authorized as the individual's qualified power of attorney or durable medical power of attorney shall serve as a witness to the written request.

5. An attending physician shall not write a prescription for medical aid-in-dying medication unless the attending physician offers the qualified individual an opportunity to rescind the request for the medical aid-in-dying medication.
6. At any time, an individual may rescind their request for medical aid-in-dying medication without regard to the individual's mental state.
7. The attending physician shall:
   a. Make the initial determination of whether an individual requesting medical aid-in-dying medication has a terminal illness, has a prognosis of six months or less, is mentally capable, is making an informed decision and has made the request voluntarily.
   b. Refer the individual to a licensed mental health professional if the attending physician believes that the individual may not be mentally capable of making an informed decision.
   c. Counsel the individual on the importance of:
      i. Not taking the medical aid-in-dying medication in a public place,
      ii. Notifying their next of kin of the request for medical aid-in-dying medication,
      iii. Having another person present when the individual self-administers the medical aid-in-dying medication,
      iv. Safe-keeping and proper disposal of unused medical aid-in-dying medication.

8. Before an individual who is requesting medical aid-in-dying medication may receive a prescription, a consulting physician must:
   a. Examine the individual and their medical records,
   b. Confirm, in writing, to the attending physician:
      i. The individual has a terminal illness,
      ii. The individual has a prognosis of six months or less;
      iii. The individual is making an informed decision; and
      iv. That the individual is mentally capable or provide documentation that the consulting physician has referred the individual for further evaluation.
         1) A licensed mental health professional who evaluates an individual shall communicate in writing to the attending or consulting physician who requested the evaluation, his or her conclusions about whether the individual is mentally capable and making informed decisions.
         2) If the licensed mental health professional determines that the individual is not mentally capable of making informed decisions, the person shall not be deemed a qualified individual and the attending physician shall not prescribe medical aid-in-dying medication to the individual.
9. Unless otherwise prohibited by law, the attending physician or the hospice medical director shall sign the death certificate of a qualified individual who obtained and self-administered the aid-in-dying medication.
   a. When a death has occurred, the cause of death shall be listed as the underlying terminal illness and the death does not constitute grounds for post-mortem inquiry.
10. Physicians and health care providers shall provide medical services that meet or exceed the standard of care for end-of-life medical care.
11. If a health care provider is unable or unwilling to carry out an eligible individual's request and the individual transfers care to a new health care provider, the health care provider shall coordinate transfer of the individual's medical records to a new health care provider.
12. A person is not subject to civil or criminal liability or professional disciplinary action for acting in good faith, which includes being present when a qualified individual self-administers the prescribed medical aid-in-dying medication.
13. A health care facility or other health care provider shall not subject a physician, nurse, pharmacist, or other person to discipline, suspension, loss of license or privileges, or any other penalty or sanction for actions taken in good faith for refusing to act under this law.

14. A health care facility must notify patients in writing of its policy with regard to medical aid-in-dying. A health care facility that fails to provide advance notification to patients shall not be entitled to enforce such a policy.
15. A person who has custody or control of medical aid-in-dying medication dispensed that the terminally ill individual decides not to use or that remains unused after the terminally ill individual's death shall dispose of the unused medical aid-in dying medication either by:
    a. Returning the unused medical aid-in-dying medication to the attending physician who prescribed the medical aid in dying medication, who shall dispose of the unused medication in the manner required by law; or
    b. Lawful means in accordance with section 25-15-325 CRS or any other state or federally approved medication take-back program authorized under the federal secure and responsible drug disposal act of 2010, and regulations adopted pursuant to the federal act.

Resources available at: https://www.deathwithdignity.org/states/colorado/
Regulations: CRS 25-48-101 to 25-48-123

Delaware: no legislation

Florida: no legislation

Georgia: no legislation

Indiana: no legislation

Illinois: no legislation

Maryland: no legislation

Massachusetts: no legislation

Michigan: no legislation

Minnesota: no legislation

Mississippi: no legislation

Missouri: no legislation

Nevada: no legislation

New Jersey: A1054 - Aid in Dying for the Terminally Ill Act, signed into law April 12, 2019, and took effect on August 1, 2019.

1. At least 15 days shall elapse between the initial oral request and the second oral request,
2. The patient may submit the written request to the attending physician when the patient makes the initial oral request or at any time thereafter,
3. At least 48 hours shall elapse between the patient's initial oral request and the writing of the prescription
4. The attending physician must inform the patient of alternatives, including palliative care, hospice, and pain management options
5. All prescriptions for medical aid-in-dying must be reported to the state.
6. A valid written request for medication shall be in the form set forth by the state.
    a. The written request shall be signed and dated by the patient and witnessed by at least two individuals who, in the patient's presence, attest that, to the best of their knowledge and belief, the patient is capable and acting voluntarily to sign the request.
    b. At least one of the witnesses shall be a person who is NOT:
        i. A relative of the patient by blood, marriage, or adoption,
        ii. At the time the request is signed, entitled to any portion of the patient's estate upon the patient's death under any will or by operation of law,
        iii. An owner, operator, or employee of a health care facility, other than a long-term care facility where the patient is receiving medical treatment or is a resident.
        iv. The patient's attending physician at the time the request is signed shall NOT serve as a witness.
7. The attending physician shall ensure that all appropriate steps are carried out before writing a prescription for medication that a qualified terminally ill patient may choose to self-administer including such actions as are necessary to:
    a. Make the initial determination of whether a patient is terminally ill, is capable, and has voluntarily made the request,

b. Refer the patient to a consulting physician for medical confirmation of the diagnosis and prognosis, and determination that the patient is capable of acting voluntarily,
c. Refer the patient to a mental health care professional, if appropriate,
d. Inform that patient of the patient's opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind the request at the time the patient makes a second oral request, and
e. Fulfill the medical record documentation requirements.

8. A patient shall not be considered a qualified terminally ill patient until a consulting physician has:
   a. Examined that the patient and the patient's relevant medical records;
   b. Confirmed in writing, the attending physician's diagnosis that the patient is terminally ill, and
   c. Verified that the patient is capable, is acting voluntarily, and has made an informed decision to request medication, that if prescribed, the patient may choose to self-administer.
9. If, in the medical opinion of the attending or consulting physician, a patient may not be capable, the physician shall refer the patient to a mental health care professional to determine whether the patient is capable. A consulting physician who refers a patient to a mental health care professional shall provide written notice of the referral to the attending physician.
   a. If a patient has been referred to a mental health care professional, the attending physician shall not write a prescription for medication unless the attending physician has been notified in writing by the mental health care professional of that individual's determination that the patient is capable.
10. A qualified terminally ill patient shall not receive a prescription for medication unless the attending physician has recommended that the patient notify the patient's next of kin of the patient's request for medication, except that a patient who declines or is unable to notify the patient's next of kin shall not have the request for medication denied for that reason.
11. The qualified terminally ill patient shall make two oral requests and one written request for the medication to the patient's attending physician, subject to the following requirements:
    a. At least 15 days shall elapse between the initial oral request and the second oral request.
    b. At the time the patient makes the second oral request, the attending physician shall offer the patient an opportunity to rescind the request,

c. The patient may submit the written request to that the attending physician when the patient makes the initial oral request or at any time thereafter,
d. At least 15 days shall elapse between the patient's initial oral request and the writing of a prescription.
e. At least 48 hours shall elapse between the attending physician's receipt of the patient's written request and the writing of a prescription.

12. A qualified terminally ill patient may rescind the request at any time and in any manner without regard to the patient's mental state.
13. Any medication dispensed that a qualified terminally ill patient chooses not to self-administer shall be disposed of by lawful means, including, but not limited to, disposing of the medication consistent with State and federal guidelines concerning disposal of prescription medications, or surrendering the medication to a prescription medication drop-off receptacle. The patient shall designate a person who shall be responsible for the lawful disposal of the medication.
14. Reporting of information:
    a. No later than 30 days after the dispensing of medication, the physician or pharmacist who dispensed the medication shall file a copy of the dispensing record with the department.
    b. No later than 30 days after the date of the terminally ill patient's death, the attending physician shall transmit to the department such documentation of the patient's death as the director shall require.
    c. In the event that anyone is required to report information to the department provides an inadequate or incomplete report, the department shall contact the patient to request a complete report.
15. A person shall not be authorized to take any action on behalf of a patient by virtue of that person's designation as a guardian, except for communicating the patient's health care decisions to a health care provider if the patient so requests.
16. A person shall not be subject to civil or criminal liability or professional disciplinary action, or subject to censure, discipline, suspension, or loss of any licensure, certification, privileges, or membership, for any action taken in compliance with this law, including being present when a qualified terminally ill patient self-administers medication, or for the refusal to take any action or to otherwise participate in, a request for medication. A person who substantially complies in good faith shall be deemed to be in compliance with its provision.
17. If a health care professional is unable or unwilling to carry out a patient's request and the patient transfers care to a new health care professional or health care facility, the

prior health care professional shall transfer, upon request, a copy of the patient's relevant records to the new health care professional or health care facility.

18. Nothing in P.L.2019, c.59 shall be construed to:
    a. authorize a physician or any other person to end a patient's life by lethal injection, active euthanasia, or mercy killing, or any act that constitutes assisted suicide under any low of this state; or
    b. lower the applicable standard of care to be provided by a health care professional who participates in P.L.2019, c.59.

Resources available at: https://www.deathwithdignity.org/states/new-jersey/,
FAQs: https://nj.gov/health/advancedirective/documents/maid/MAID_FAQ.pdf
Regulations: P.L 2019 Chapter 59 C.26:16-1 to C.2A: 62-16 and revised statutes c.270 and J.J.S.2C:11-6

New Mexico: (H.B. 47) Elizabeth Whitefield End of Life Options Act

Signed into law on April 8, 2021, with an effective date of June 18, 2021.

2. Allows physicians, advanced practice registered nurses, and physician assistants to prescribe medical aid in dying medications.
3. Streamlined the waiting period for receiving aid-in-dying medication to 48 hours and provides the prescribing provider with the ability to waive the waiting period if a person is likely to die before the waiting period expires.
4. If a health care provider objects to participating in medical aid in dying they must:
    a. Inform the individual, and
    b. Refer the individual to either a health care provider who is willing to carry out the individual's request, or
    c. Refer the individual to an entity to assist the requesting individual in seeking medical aid in dying. Note: Clinicians can call the Doc2Doc consultation line at 800-247-7421 for a free consultation and information on end-of-life care with medical directors who have extensive medical aid in dying experience.
5. Criteria for End of Life Options Act:
    a. Must be 18 years of age or older (Adult)
    b. Diagnosed with a condition or illness that is incurable, irreversible, and likely to cause death within 6 months.
    c. Mentally capable of making an informed decision.
    d. Individuals must be physically capable of self-administering the life-ending medication.

e. Must be a resident of New Mexico
f. Individual acts voluntarily and without coercion

6. Two licensed healthcare providers, one of which must be a physician (MD or DO) must confirm the terminal illness.
   (i) Individuals enrolled in hospice are conserved terminal based on the standard of care and do not require a second confirmation if the prescribing provider is a physician.
7. If an individual has a recent history of a mental health disorder or an intellectual disability that could cause impaired judgment with regard to end-of-life medical decision making, or if, in the opinion of the prescribing health care provider or consulting health care provider, and individual currently has a mental health disorder or an intellectual disability that may cause impaired judgement with regard to end-of-life medical decision making, the individual shall not be determined to have capacity to make end-of-life decisions until the:
   a. Health care provider refers the individual for evaluation by a mental health professional with the training and expertise to assess a person with such a disorder or disability; and
   b. Mental health professional determines the individual to have capacity to make end-of-life decisions after evaluating the individual during one or more visits with the individual.
8. A person shall not be subject to criminal liability, licensing sanctions or other professional disciplinary action for:
   a. Participating, or refusing to participate, in medical aid in dying in good faith compliance with the End-of-Life Options Act.
   b. Being present with a qualified patient self-administers the prescribed medical aid in dying medication to end the qualified individual's life.

9. The individual must fill out the "Request to End My Life in a Peaceful Manner" form and present it to their qualified clinician. Link to the form https://endoflifeoptionsnm.org/wp-content/uploads/2021/07/REQUEST-FOR-MEDICATION-TO-END-MY-LIFE.pdf

Resources available at: https://deathwithdignity.org/states/new-mexico/
Regulation: NMSA 24-7C-3 to NMSA 24-7C-8, NMSA 24-1-43

Oklahoma: no legislation

Oregon: Ballot Measure 16 - Death with Dignity Act, voters approve the Act by ballot.

1. All prescriptions for medical aid-in-dying must be reported to the state.
2. A 48-hour waiting period is required before picking up prescribed medications.
3. The attending physician must inform the patient of alternatives, including palliative care, hospice, and pain management options.
4. The attending physician must request that the patient notify their next of kin of the prescription request.
5. On January 1, 2020, SB 579 went into effect that eliminates the 15-day waiting period between oral requests for patients who are fewer than 15 days from death.
6. For of the written request. A valid request for aid in dying medication shall be signed and dated by the patient and witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their knowledge and belief the patient is capable of acting voluntarily and is not being coerced to sign the request.
    a. One of the witnesses shall be a person who is NOT:
        i. A relative of the patient by blood, marriage, or adoption,
        ii. A person who at the time of the request is signed would be entitled to any portion of the state of the qualified patient upon death under any will or by operation of the law, or
        iii. An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
        iv. The patient's attending physician at the time the request is signed shall not be a witness.
7. The attending physician shall:
    a. Make the initial determination of whether a patient has a terminal disease, is capable, and has made the request voluntarily,
    b. Ensure that the patient is making an informed decision,
    c. Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is capable and acting voluntarily,
    d. Refer the patient for counseling, if appropriate,
    e. Recommend that the patient notify next of kin,
    f. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed, and not taking the medication in a public place.
    g. Inform the patient that they have an opportunity to rescind the request at any time and in any manner and offer the patient an opportunity to rescind at the time the patient makes the second oral request.

8. Consulting physician confirmation. Before a patient is qualified, a consulting physician shall examine the patient and their relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is capable, is acting voluntarily and has made an informed decision.
9. Counseling referral. If in the opinion of the attending physician or the consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient for counseling. No medication to end a patient's life in a humane and dignified manner shall be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgement.

Resources available at: https://www.deathwithdignity.org/states/oregon/
Regulations: ORS 127.800 to 127.895

Pennsylvania: no legislation

Texas: no legislation

Virginia: no legislation

Washington: Death with Dignity Act - Initiative 1000, approved November 8, 2008, and became effective on July 1, 2009

1. The Death with Dignity Act allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians.
2. A qualified patient means a competent adult who is a Washington resident suffering from a terminal illness that will lead to death within six months.
3. The qualified patient must sign and date the written request, at least two people must witness the signature, and at least one of whom is not related to the patient or employed by the health care facility. The patient's attending physician may not be a witness.
4. Waiting periods. The qualified patient must wait at least 15 days between their first and second oral requests.
5. When the qualified patient makes the second oral request, the attending physician must offer an opportunity to rescind that request.

6. A qualified patient may withdraw the request at any time and in any manner.
7. The qualified patient is encouraged to, but does not need to, notify next of kin.
8. The attending physician's responsibilities:
   a. Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily,
   b. Refer the patient for counseling, if in the opinion of the attending physician or consulting physician a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impairment.
   c. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed and not taking in a public place,
9. All prescriptions for medical aid-in-dying must be reported to the state.
10. The attending physician may sign the patient's death certificate which must list the underlying terminal disease as the cause of death
11. Any medication dispensed that was not self-administered shall be disposed of by lawful means.
12. All administrative required documentation shall be mailed or otherwise transmitted as allowed by the department no later than 30 calendar days after the writing of a prescription and dispensing of medication. Except that all documents required to be filed with the department by the prescribing physician after the death of the patient shall be mailed no later than 30 calendar days after the date of the patient.
    a. In the event that anyone required to report information to the department of health provides inadequate or incomplete report, the department shall contact the person to request a complete report.
13. A person shall not be subject to civil or criminal liability or professional disciplinary action for participating in good faith. This includes being present when a qualified patient takes the prescribed medication.

Resources available at: https://endoflifewa.org/
Regulations: RCW 70.245.010 to RCW 70.245.220

Washington D.C.: District of Columbia's Death with Dignity Act (D.C. law 21-182) was effective on February 18, 2017, and applicable as of June 6, 2017. This act allows terminally ill adults

seeking to voluntarily end their life, to request lethal doses of medication from licensed physicians(MD/DO) in the District**.**

To request a prescription for life-ending medication in D.C., a patient must be:

1. at least 18 years old a District of Columbia resident mentally capable of making and communicating health care decisions, and
2. diagnosed with a terminal disease that will result in death within six months.

A patient who meets the requirements above shall be prescribed aid-in-dying medication if:

- The patient makes two verbal requests to their attending physician at least 15 days apart.
- The patient gives a written request to the attending physician, signed in front of two qualified, adult witnesses.
    1. One of the witnesses shall be a person who is NOT:
        a. A relative of the patient by blood, marriage, or adoption
        b. At the time of the request is signed, entitled to any portion of the estate of the qualified patient upon death under any will or by operation of law, or
        c. An owner, operator, or employee of a health care facility where the qualified patient is receiving medical treatment or is a resident.
        d. The patient's attending physician at the time of the request shall not be a witness.

Responsibilities of the attending physician:

1. The prescribing doctor and one other doctor to confirm the patient's diagnosis and prognosis.
2. The prescribing doctor and one other doctor determine that the patient is capable of making medical decisions.
    a. If a consulting physician receives a referral for a patient from an attending physician, the consulting physician shall examine the patient and their relevant medical records to confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease.
    b. The consulting physician shall verify in writing, to the attending physician that the patient is capable, acting voluntarily, and has made an informed decision.

3. If, in the opinion of the attending physician or consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgement, either physician shall refer the patient to counseling.
    a. No covered medication shall be prescribed until the patient receives counseling and the psychiatrist or psychologist performing the counseling determines that the patient is not suffering from a disorder or depression causing impaired judgement.
4. The prescribing doctor confirms that the patient is not being coerced or unduly influenced by others when making the request.
5. The prescribing doctor informs the patient of any feasible alternatives to the medication, including care to relieve pain and keep the patient comfortable.
6. The prescribing doctor asks the patient to notify their next of kin of the prescription request. (The doctor cannot require the patient to notify anyone, however.)
7. The prescribing doctor offers the patient the opportunity to withdraw the request for aid-in-dying medication before granting the prescription.
8. Counsel the patient about the importance of having another person present when the patient takes a covered medication and of not taking a covered medication in a public place.
9. To use the medication, the patient must be able to ingest it on their own. A doctor or other person who administers the lethal medication may face criminal charges.
10. The physician completes the required forms. https://dchealth.dc.gov/node/1250671
11. If a health care provider is unable to or unwilling to carry out a patient's request for a covered medication and the patient transfers his or her care to a new health care provider, the prior health care provider shall transfer, upon request of the patient, a copy of the patient's relevant medical records to the new health care provider.

12. No person shall be subject to civil or criminal liability or professional disciplinary action for:
    a. Participating in good faith compliance with the law,
    b. Refusing to participate in providing a covered medication, or
    c. Being present when a qualified patient takes a covered medication
13. The Mayor shall issue rules to:
    a. Develop the form to collect the medical record information,
    b. Facilitate collection of the medical record information,
    c. Provide for the return of and safe disposal of unused covered medications,

d. Specify the recommended methods by which a qualified applicant, who so desires, may notify first responders of their intent to ingest a covered medication
e. Establish training opportunities for the medical community to learn about the use of covered medications by qualified patients seeking to die in a humane and peaceful manner, including best practices for prescribing the covered medication.

Freedom of Information Act exemption – The information collected by the Department shall not be a public record and may not be made available for inspection by the public , or any other law.

Resources including Educational Modules, Sample Physician Forms, and Physician Portal, available at: https://dchealth.dc.gov/page/death-dignity-act-2016
Regulations: DCCC 7-661.01 to 7-661.17

Wisconsin: no legislation

EXHIBIT 9

Bereavement Materials

Economic: Avoid hasty decisions about money and property. Seek advice before making any important financial decisions.

Personal belongings: Let go of your loved one's personal belongings when you are ready; don't allow others to rush you.

SEASONS HOSPICE & PALLIATIVE CARE®

Seasons Hospice offers a safe place to learn more about grief and loss and to provide mutual support for those experiencing the death of a loved one. For more information about our ongoing support groups, please call us a 800-570-8809.

Dear Friend,

At this very difficult time for you, we extend our deepest sympathies for your loss. We want you to know that your friends at Seasons Hospice are still here to support you in your bereavement journey.

Grief is a natural response to a significant change or loss in our lives. We all experience loss and grief.

Each person's grief is unique. Your relationship with your loved one, your culture, and other characteristics may impact your response.

Please know that grieving is hard work. It is a process that takes a lot of your time and energy. Talk about your feelings if you need to and please do not be afraid to ask for help. The staff at Seasons Hospice are just a phone call away, and we will continue to stay in touch with you over the coming months.

With sincere wishes for your peace and healing,

Seasons Hospice Staff and Volunteers
800-570-8809

GSI/IL-CHI/11-18

Certain reactions to the death of a loved one are so common that almost everyone experiences them. Hopefully, your knowledge about grief as a physical, intellectual, social, emotional and spiritual experience may make this period of loss less stressful and less frightening. You may be experiencing some of these reactions:

PHYSICAL

- Sobbing or being unable to cry, despite feeling choked up
- Tightness in the chest or throat, difficulty breathing, dizziness, dry mouth
- Loss of appetite
- Sleeplessness or numbness in hands and body
- Change in habits regarding drinking, smoking or other drug use(if excessive, please seek assistance)

Please do not neglect your health.
If needed, seek a physician's advice.

Shock and denial: Denying your loss, a kind of emotional numbness.

Anger: You may feel resentful.

Guilt: You may feel guilty for something done or not done, said or unsaid.

Depression: You may feel physically or emotionally drained, sometimes unable or not willing to perform routine tasks. You may be preoccupied, unable to concentrate and forgetful.

Loneliness: Increased responsibilities and changes in your social life can make you feel lonely and afraid; you may want to withdraw from friends and activities.

Spiritual: Some may find spiritual faith to be a source of comfort; others may find their spiritual connections difficult to maintain during this period.

Friends and family: Though often available early on, friends and family return to their own lives and may be less available for you later. Do not wait for them to guess your needs. Reach out and let them know how they can help. Set your own pace during your bereavement; don't let others tell you how you "should be."

SEASONS HOSPICE FOUNDATION

Seasons Hospice Foundation offers hope and support to the patients and families we are so privileged to serve. We strive to treat the whole person and their loved ones in ways that touch the human spirit – adding days to life and life to days. Our programs are made possible by your generosity.
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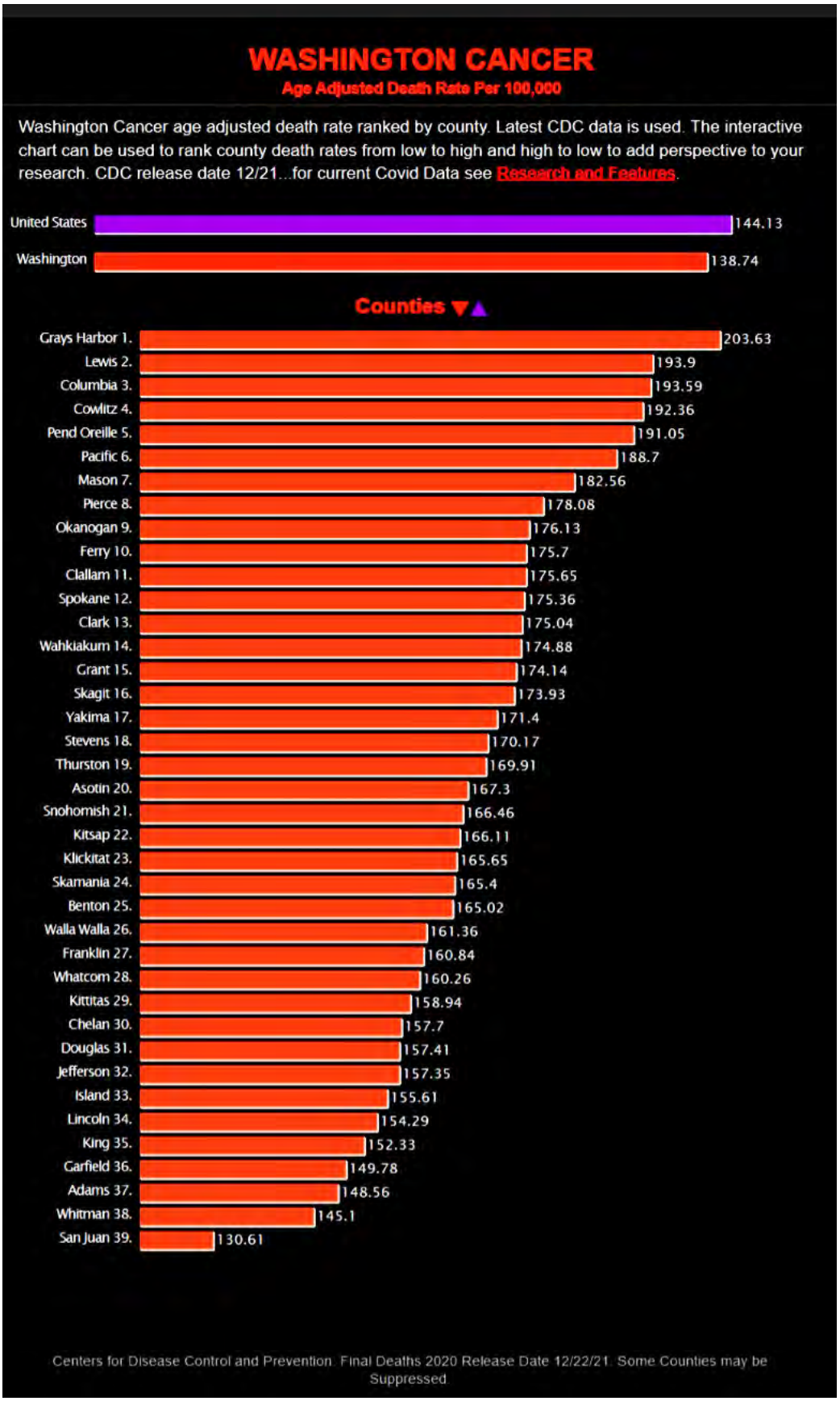
Throughout the year you will receive periodic mailings and calls from us, but we invite you to call us any time. We want you to know that we remain available to support you in your time of loss. We can be reached at bereavement@seasons.org or 480-606-1011.

Your friends at Seasons Hospice are thinking of you.

EXHIBIT 10

Mortality Data
(WHO Death Rates and DOH Statistics)



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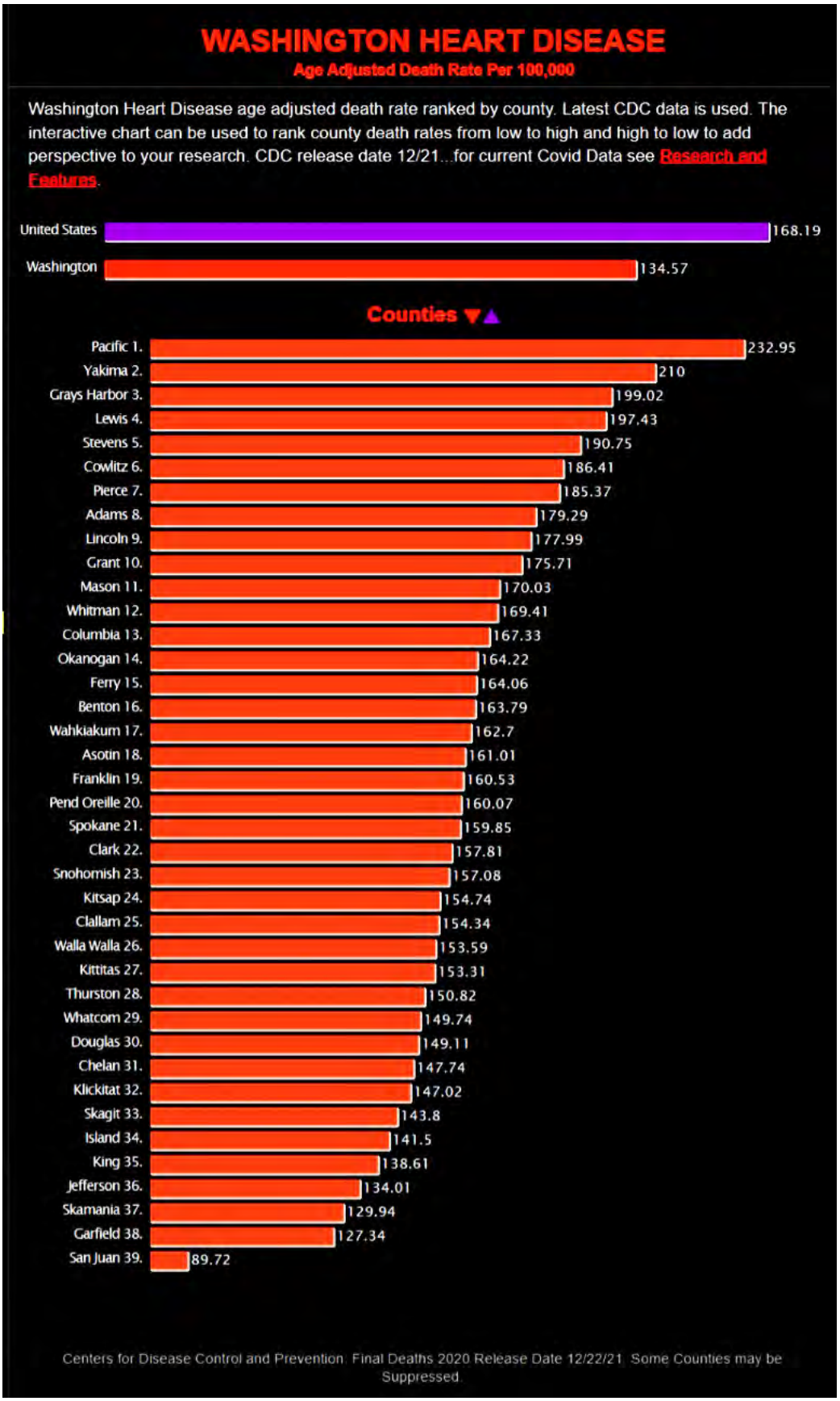

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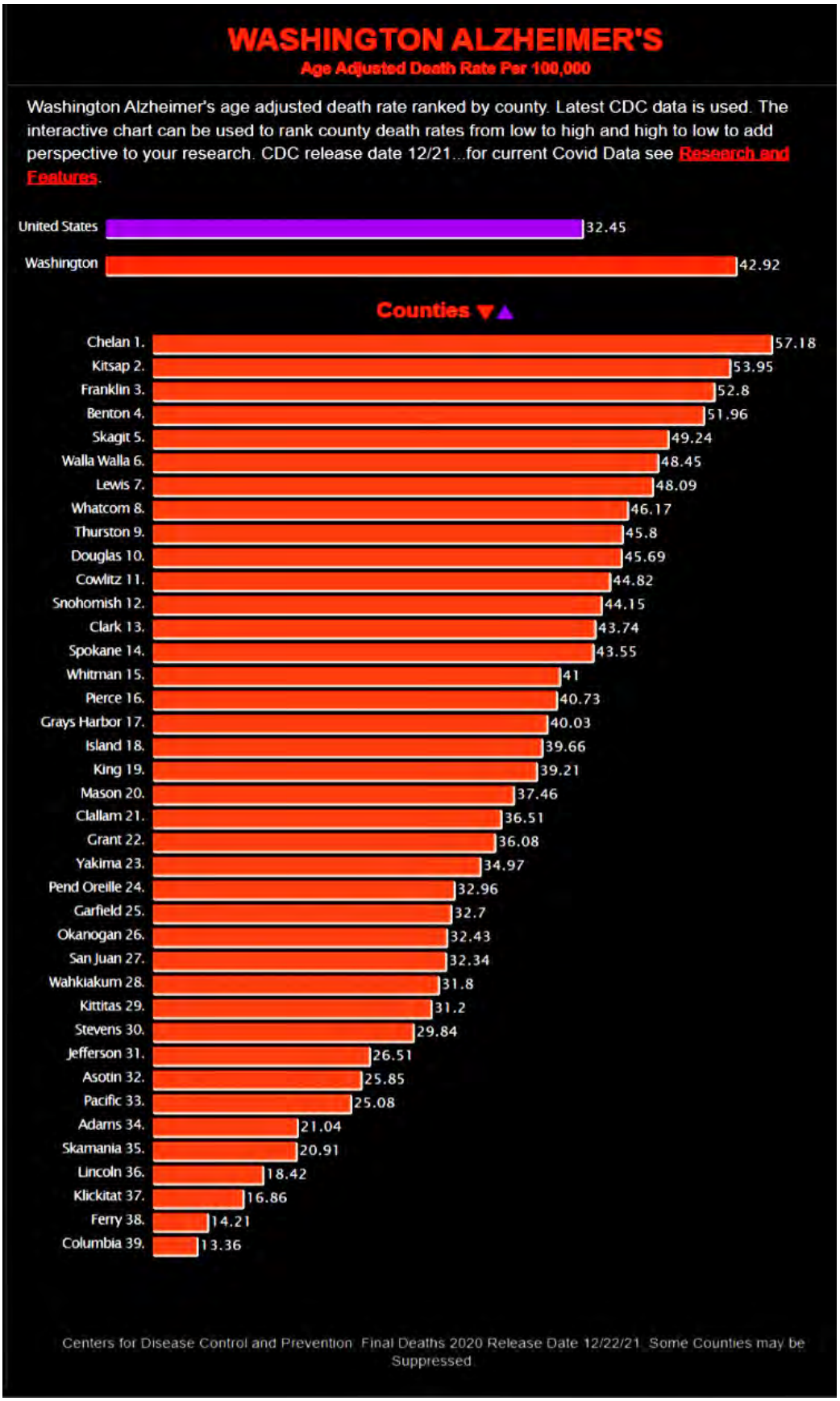

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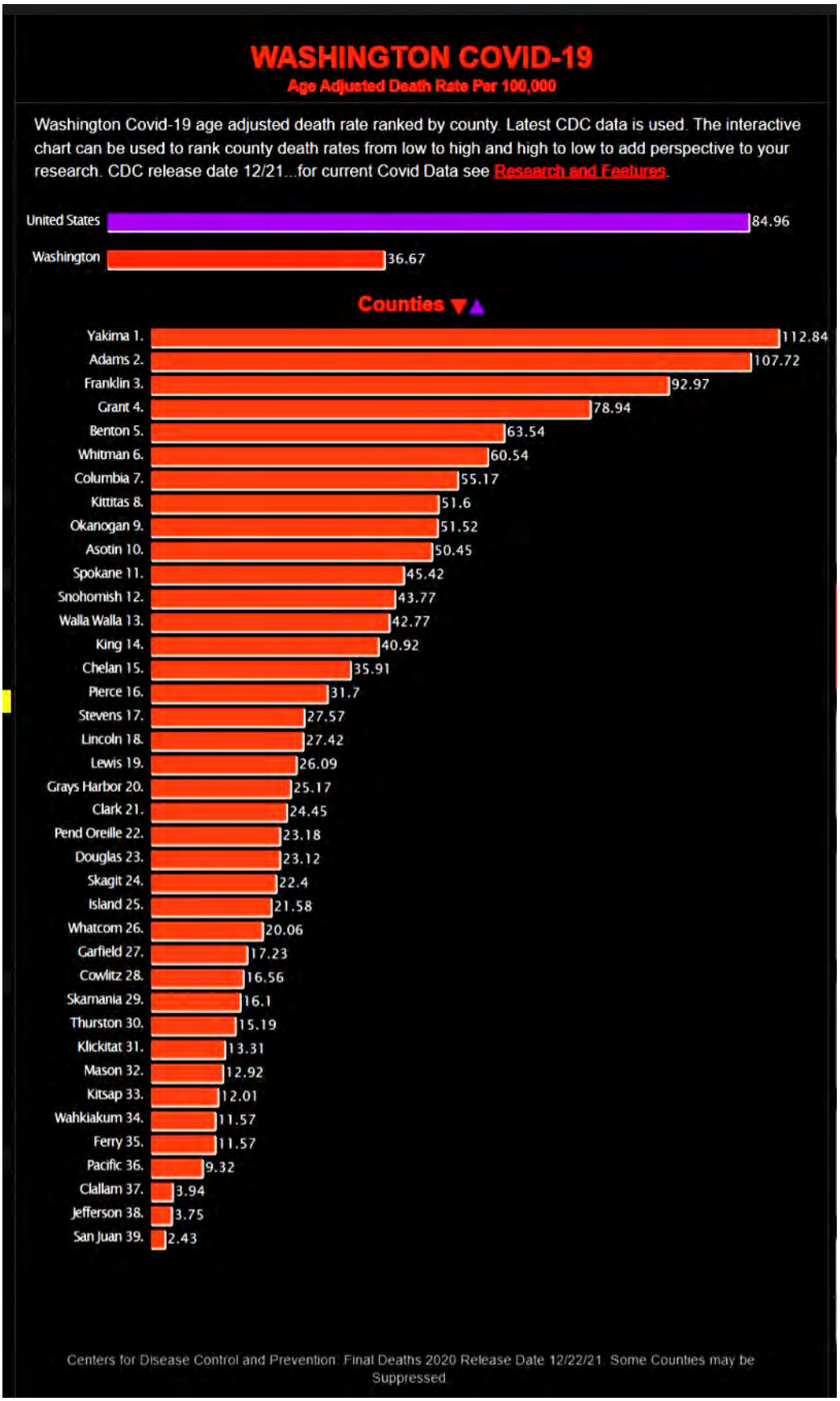

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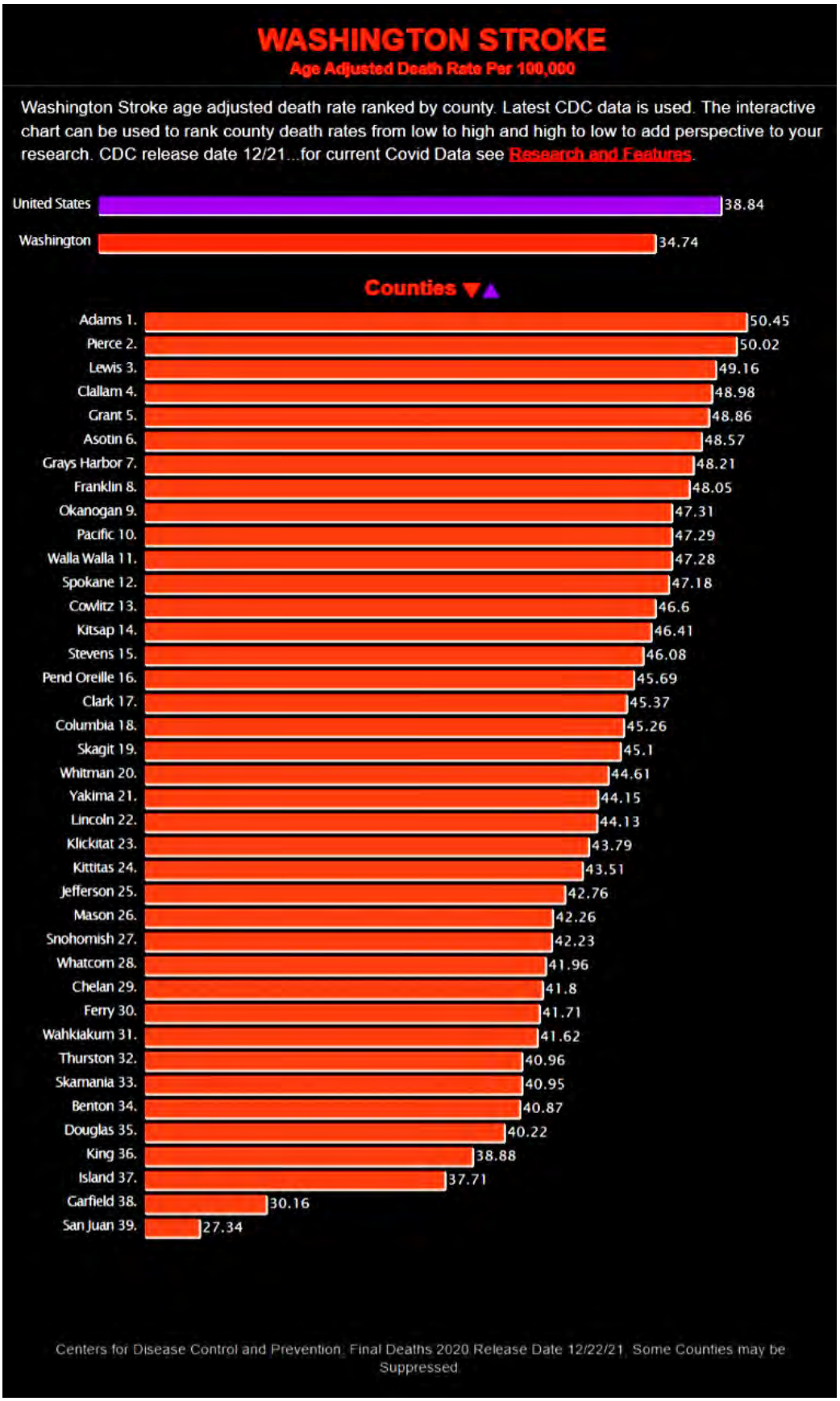

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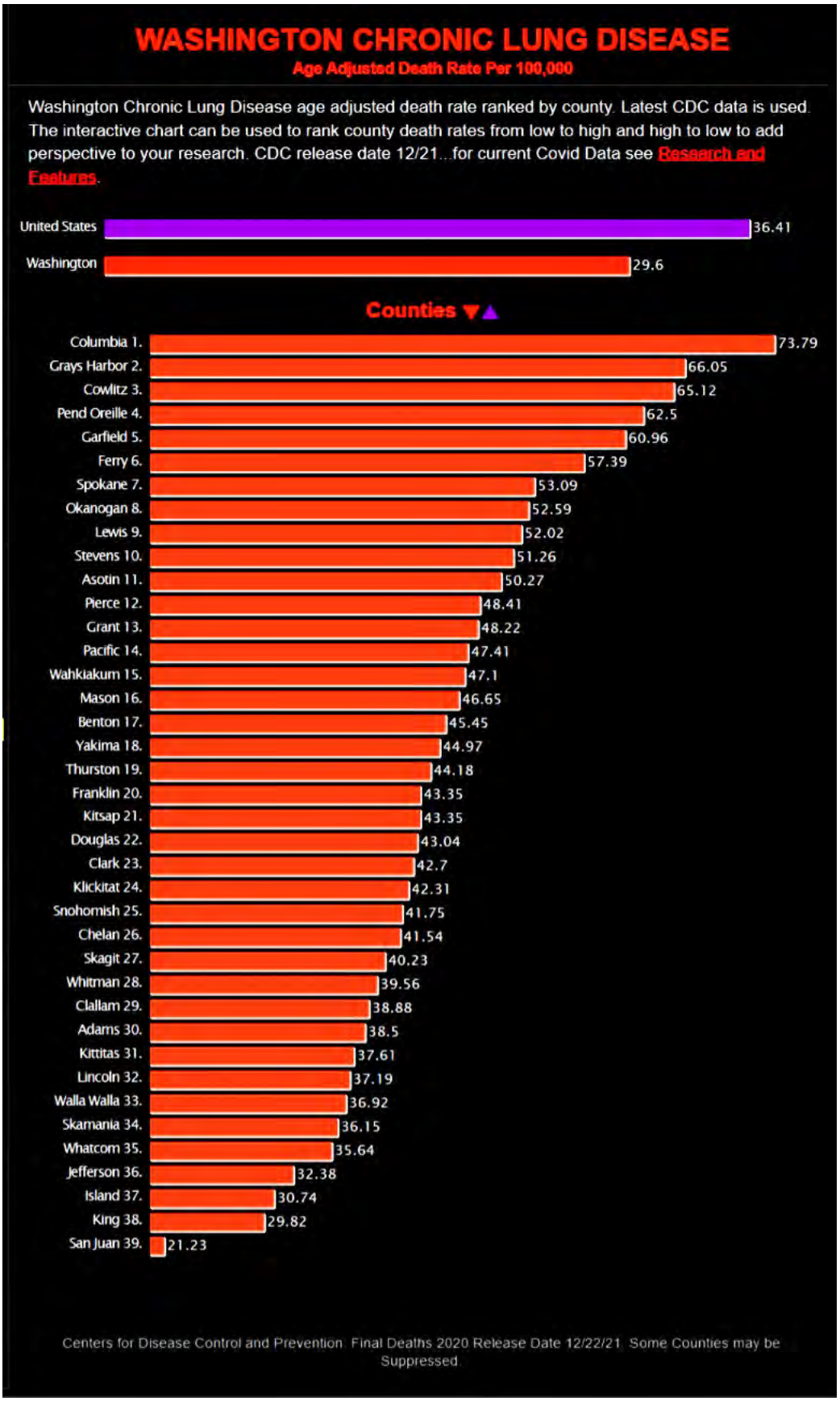

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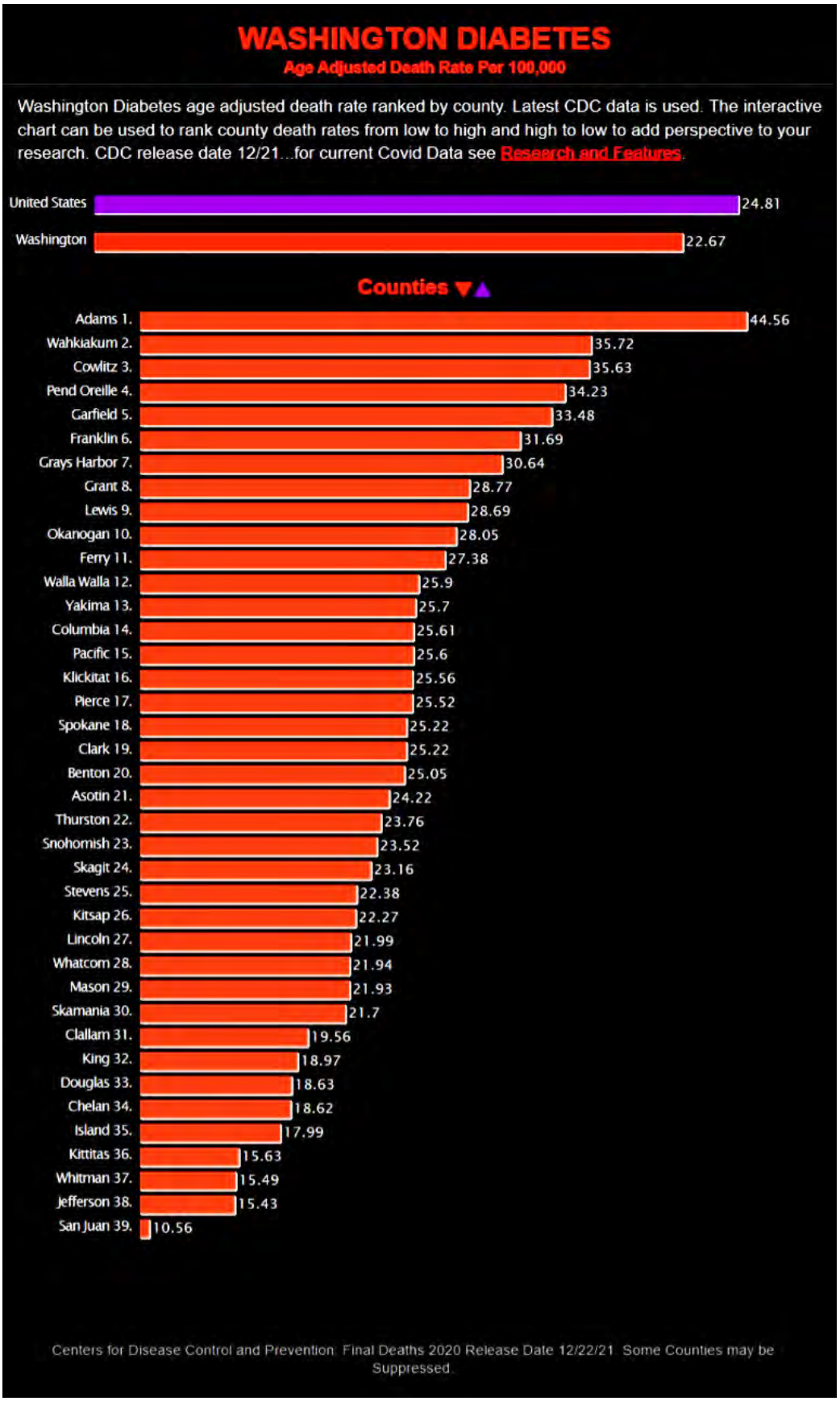

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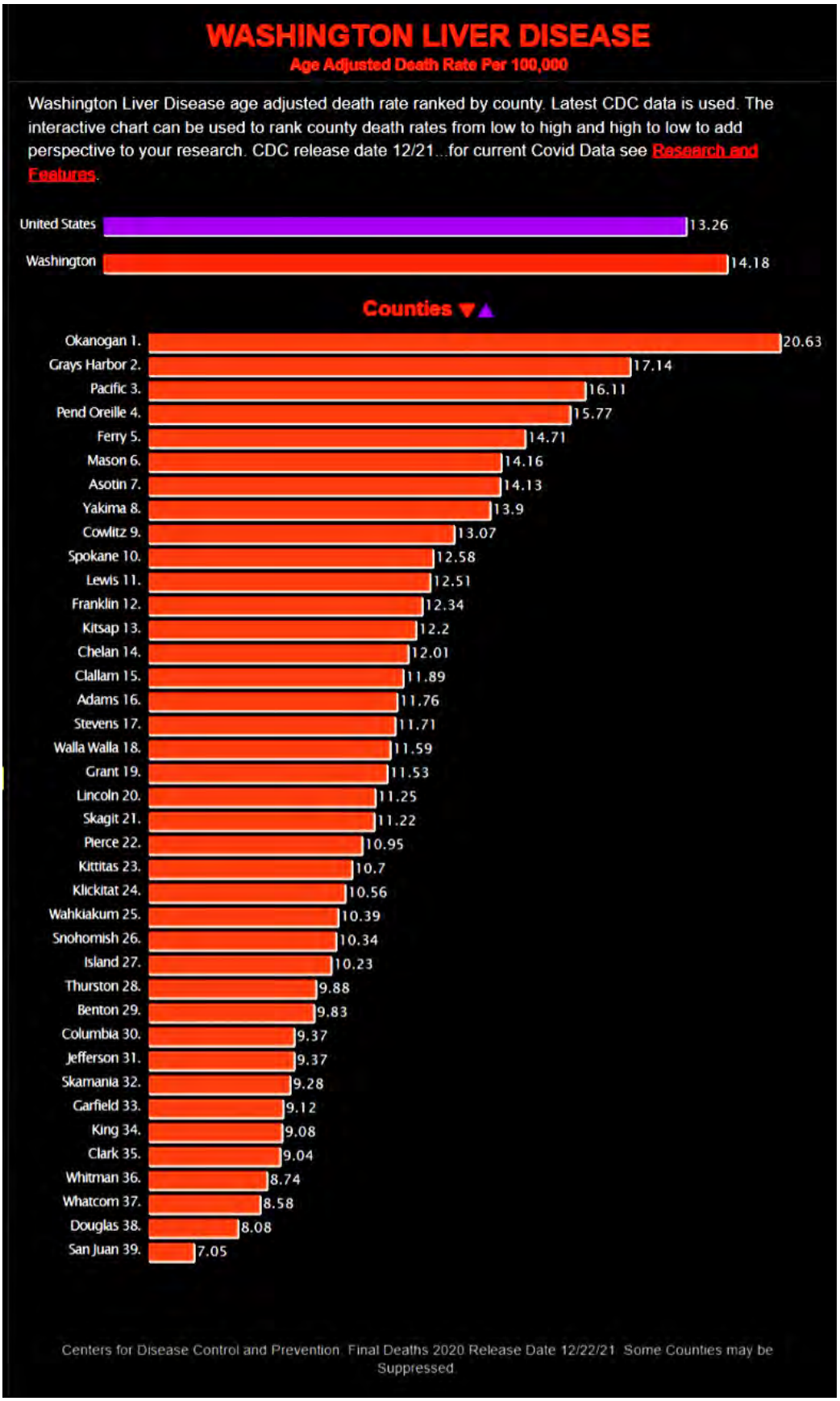

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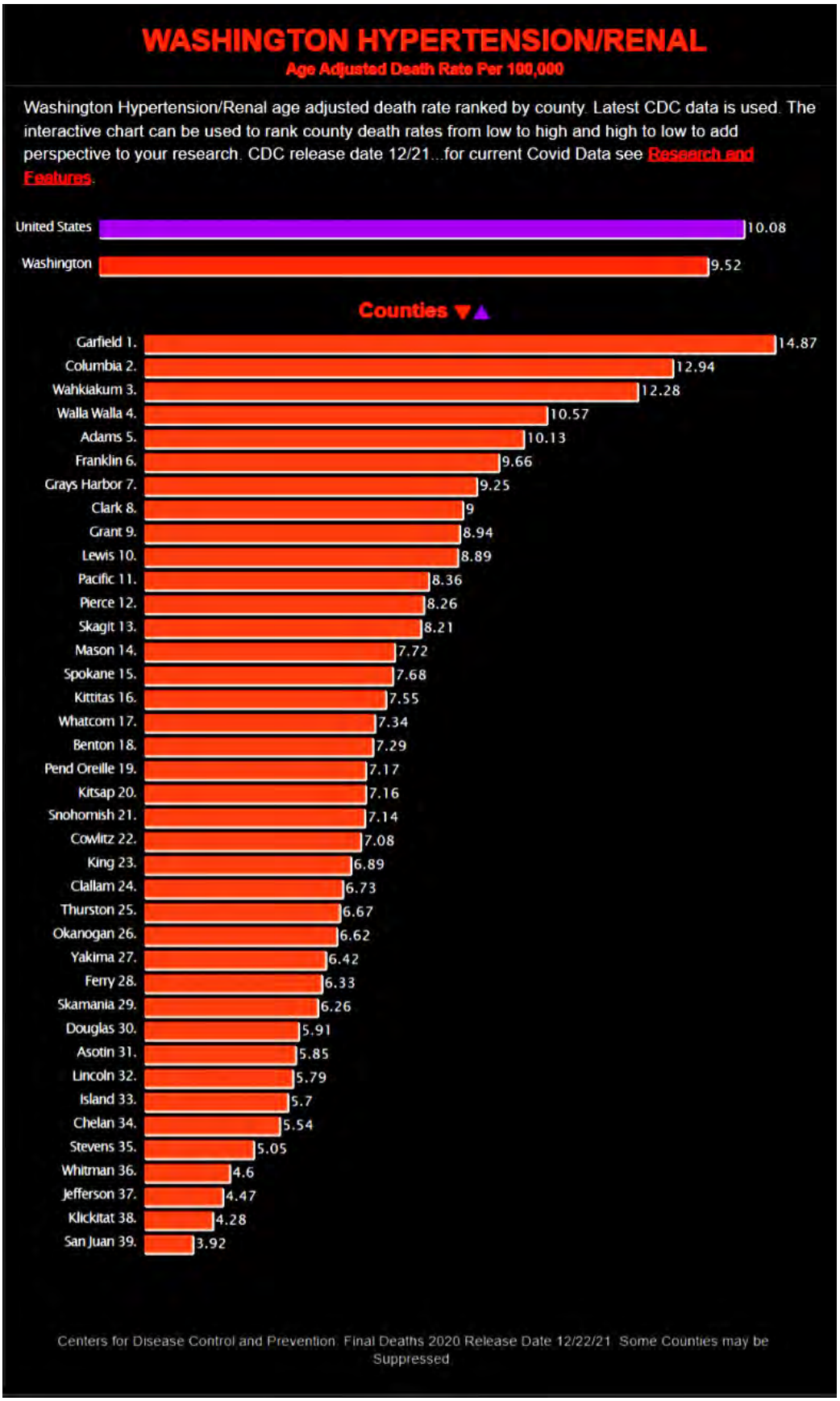

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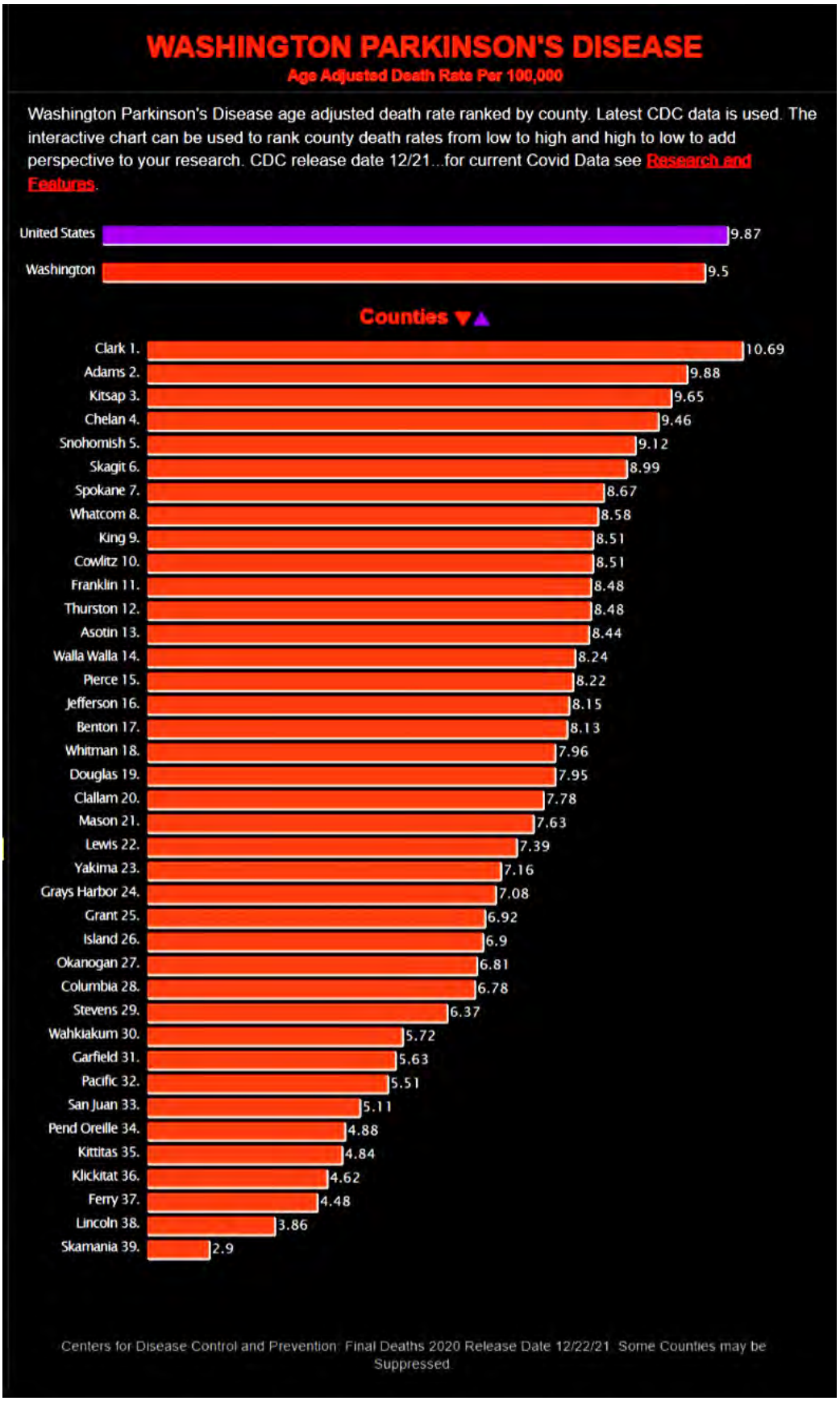

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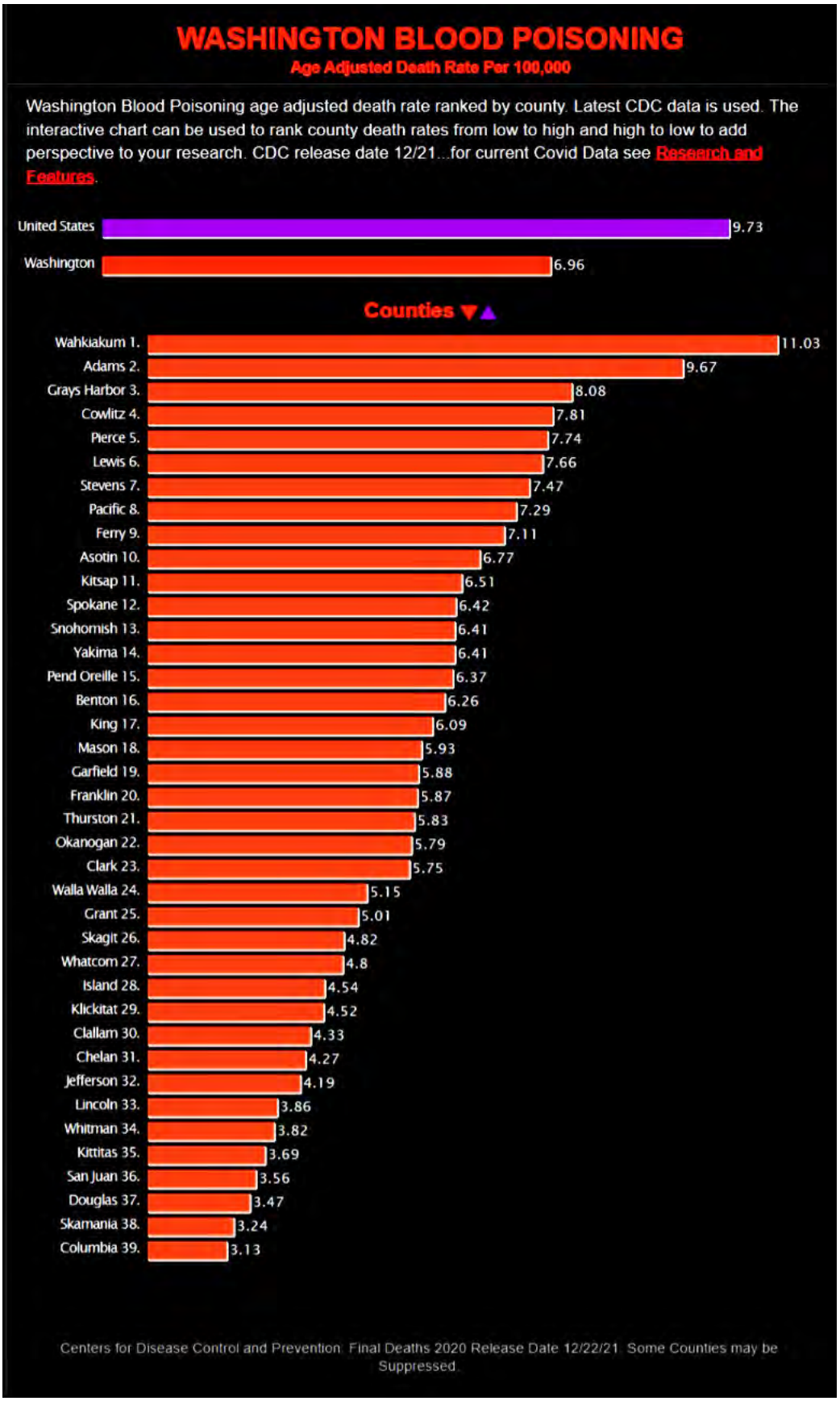

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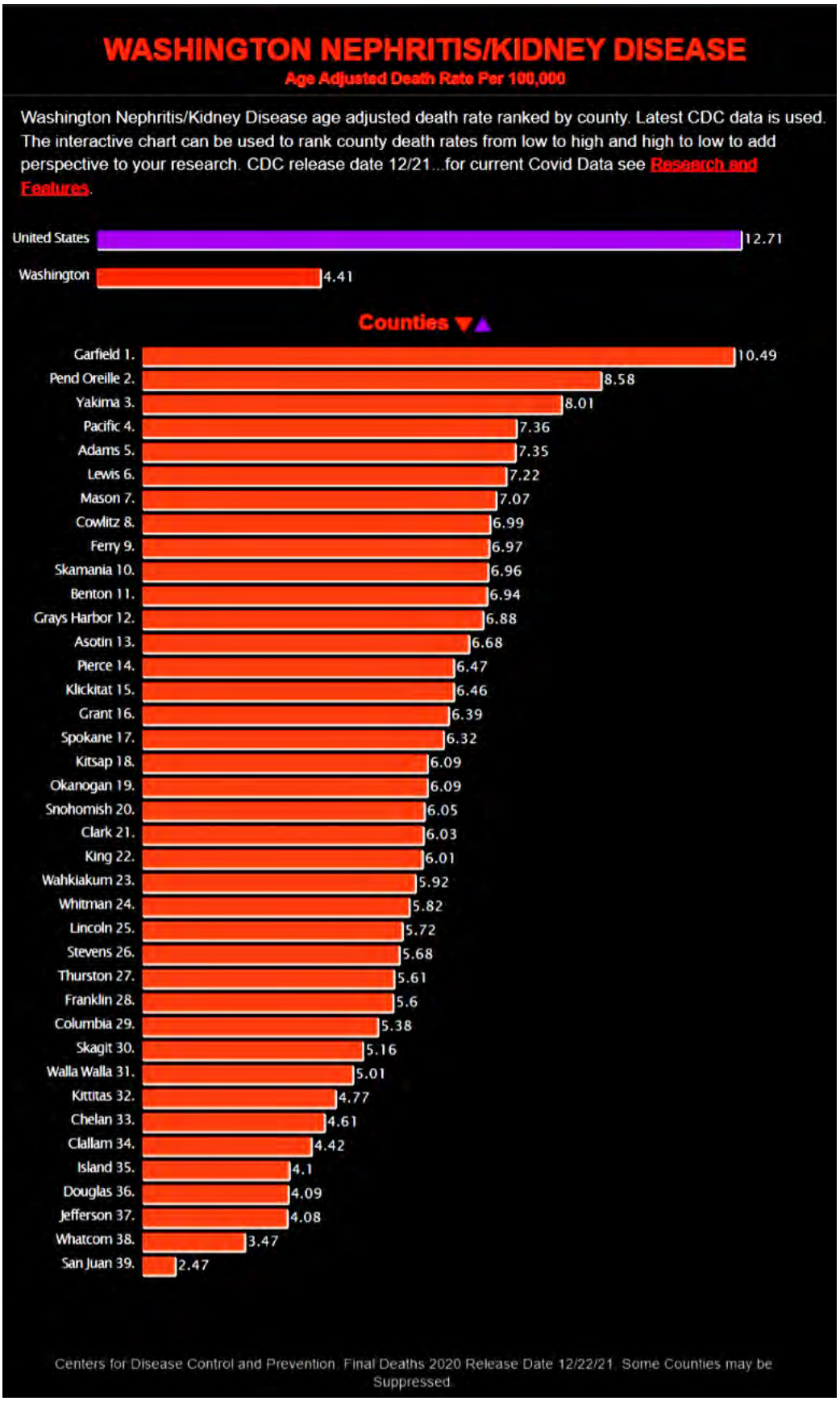

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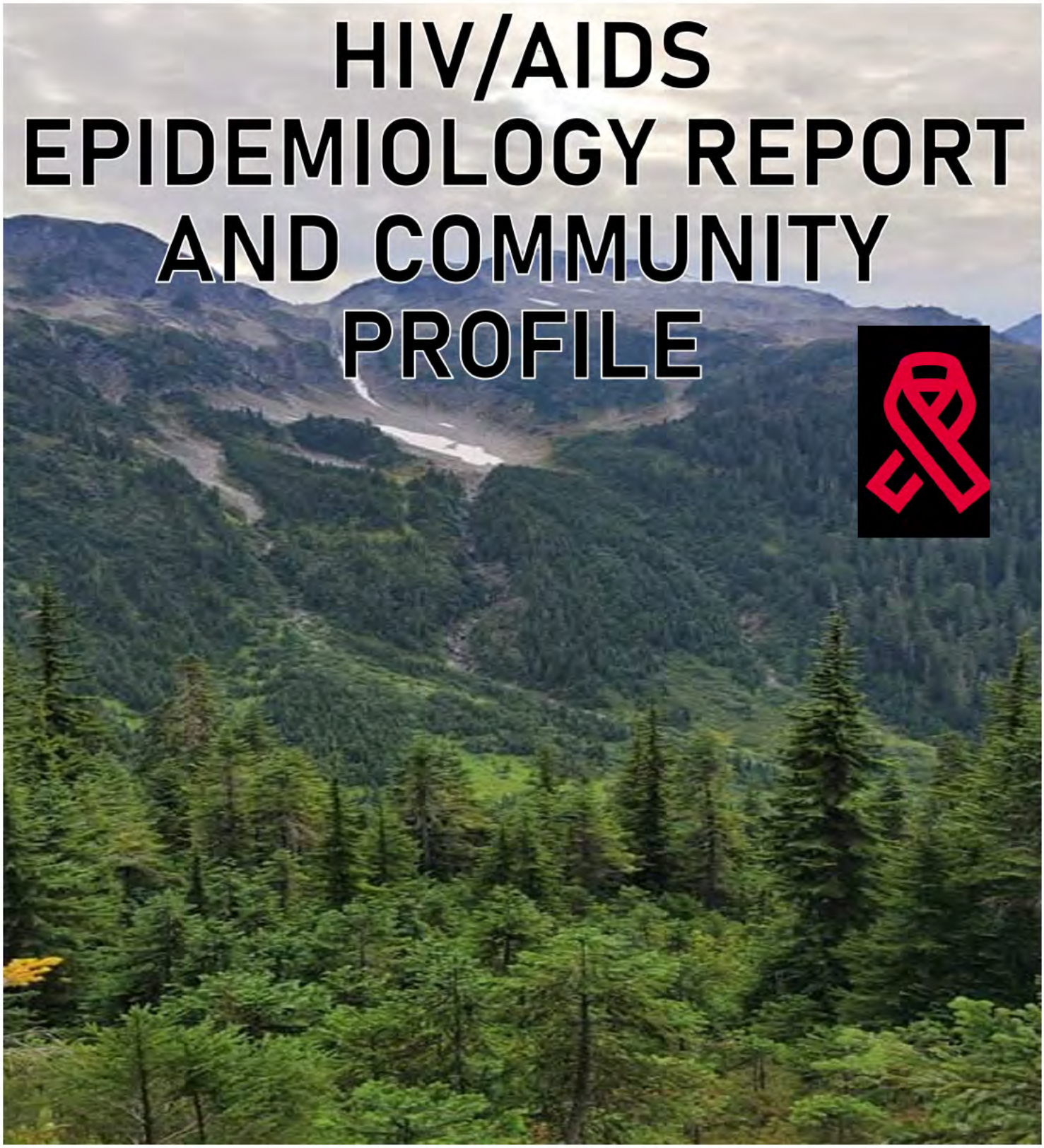
EXHIBIT 11

HIV/AIDS Epidemiology Report, 2021
Washington State HIV Surveillance Report, 2022 Edition

HIV/AIDS EPIDEMIOLOGY REPORT AND COMMUNITY PROFILE



2021

WASHINGTON STATE & KING COUNTY

HIV/AIDS EPIDEMIOLOGY REPORT AND COMMUNITY PROFILE

Contents

Acknowledgements

This 90th edition of the HIV/AIDS Epidemiology Report and Community Profile includes data available through July 2021. Public Health – Seattle & King County and the Infectious Disease Assessment Unit, Washington State Department of Health jointly produce this report. It is funded partly by a Centers for Disease Control and Prevention cooperative agreement for HIV/AIDS surveillance. We thank the medical providers caring for people with HIV/AIDS and the clinics and patients participating in epidemiologic projects. Their cooperation with public health department HIV/AIDS control efforts permits the collection of data included in this report – data which are used for further prevention and planning efforts. We also wish to acknowledge the outstanding assistance of our staff. Special thanks are due to Anna Berzkalns, Courtney Moreno, and Dr. Matthew Golden for reviewing the report, and Kaitlin Zinsli, UW PhD Student, for putting together this issue.

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Photo Credit

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HIV/AIDS Reporting Requirements

Detailed requirements for reporting of communicable diseases including HIV/AIDS are described in the Washington Administrative Code (WAC), section 246-101 (http://apps.leg.wa.gov/WAC/default.aspx?cite=246-101).

Washington health care providers are required to report all HIV infections, regardless of the date of the patient's initial diagnosis, to the health department. Providers are also required to report new diagnoses of AIDS in a person previously diagnosed with HIV infection. Local health department officials forward case reports to the Department of Health. Names are never sent to the federal government.

Laboratories are required to report evidence of HIV infection (i.e., positive HIV screening tests, p24 antigen detection, viral culture, and nucleic acid detection), all HIV viral load tests (detectable or not), and all CD4 counts in the setting of HIV infection. If the laboratory cannot distinguish tests (e.g., CD4 counts) performed due to HIV versus other diseases (e.g., cancer), the laboratory tests should be reported, and the health department will investigate. However, laboratory reporting does not relieve health care providers of their duty to report, as most of the critical information necessary for surveillance and follow-up is not available to laboratories.

For further information about HIV/AIDS reporting requirements, please call your local health department or the Washington State Department of Health at 888-236-3484. In King County, call 206-263-2000.

Suggested Citation

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Alternate Formats

- HIV/AIDS Epidemiology publications are online at: www.kingcounty.gov/hivepi
- Alternate formats provided upon request.
- To be included on the mailing list or for address corrections, please call 206-263-2000

Technical Note:

PAST DATA ESTIMATES MAY CHANGE: HIV surveillance data are dynamic with databases often being updated with new data, including data on characteristics of people living with HIV, laboratory results, and causes of death. Health departments may also change their definitions for defining outcomes, including new HIV diagnoses. These changes can affect current calculations of estimates from prior years. Thus, differences between reports for estimates for a given year are expected.

Definitions & Technical Notes

ACUTE HIV INFECTION: The earliest stage of HIV infection during which many people experience a flu-like illness occurring within 2 to 4 weeks of HIV infection. People with acute infection usually have a high viral load and are very contagious.

AIDS: The late stage of HIV infection that is characterized by a severely damaged immune system due to the virus. A person is considered to have AIDS if their CD4+ T-cell count falls below 200 cells per cubic millimeter of blood (or the percent of CD4+ lymphocytes is less than 14% if count is unavailable), or if they develop one or more opportunistic illness (OI).

CD4 COUNT: A measure of the number of CD4+ T cells in the bloodstream, the normal range of which is between 500-1,500 CD4+ T-cells per cubic millimeter of blood. HIV virus infects and kills CD4+ T cells, decreasing the strength of the immune system at fighting various infections and eventually leading the individual to develop AIDS (CD4 < 200 cells/mm3 or an OI). Through effective HIV treatment, CD4 count can rise to more normal levels.

EPIDEMIOLOGY: The branch of medicine which deals with the incidence, determinants, distribution, and possible control of diseases and other factors relating to health.

GENDER: The range of identities possible outside of and including the socially established categories of male and female.

HETEROSEXUAL CONTACT / PRESUMED HETEROSEXUAL CONTACT: This is an HIV risk transmission category defined at the national level, which is defined based on a person's sex assigned at birth and sex with an opposite sex partner. This category excludes men who have sex with men and people who inject drugs. To meet criteria for this category, persons must: (a) have an opposite sex partner living with HIV or at high risk of HIV (heterosexual contact) or (b) if female, report sex with a male partner and deny injection drug use (presumed heterosexual contact).

HIV VIRAL LOAD: The amount of HIV viral RNA is in the bloodstream. Higher amounts of HIV viral load have been linked to faster HIV progression and poorer outcomes. Through taking antiretroviral therapy (ART) medication, individuals can reach viral suppression, which is the presence of less than 200 copies of HIV per milliliter of blood. People with suppressed viral loads cannot transmit HIV sexually.

HIV: Human immunodeficiency virus (HIV) is the virus that causes AIDS. HIV puts people at higher risk for some types of infection and other medical problems by targeting the cells that help the body fight infection. Contact with specific bodily fluids - most commonly through condomless sex or sharing of injection drug equipment - allows the virus to spread between individuals.

HOMELESSNESS: Lacking a stable and safe place to live. This includes those who are unhoused, unsheltered, and sheltered, as well as those living in temporary settings due to lack of adequate economic resources.

INCIDENCE OR INCIDENT DIAGNOSES: Theoretically refers to newly acquired HIV in a time period, but the exact time of acquisition of HIV is often unknown, so incident diagnoses are a proxy. In WA State incident diagnoses exclude individuals reporting a positive HIV test 6 or more months before their first documented HIV (this is a new method with lower incidence relative to earlier reports). Incident diagnoses in King County exclude individuals first diagnosed with HIV outside WA State yet lacking documentation of that earlier diagnosis. Additionally, new HIV diagnoses in King County exclude people self-reporting an initial HIV diagnosis one year or more before an initial documented diagnosis.

LATINX: A gender inclusive description used throughout this report for Latina/Latino individuals.

MSM: An epidemiologic term defined as a man who has had at least one male sexual partner. Depending on the source and use of data, this may be defined as in the past 1 year, 5 years, since 1977, or during a man's lifetime. While this primarily includes MSM who identify as gay or bisexual, it also encompasses non-gay or bisexual identified MSM.

PLWH (PEOPLE LIVING WITH HIV): HIV-positive people presumed to be living in a jurisdiction at a certain point or period of time. Unless otherwise noted, this typically refers to people who have been diagnosed with HIV. This estimate excludes individuals lost to follow up (no reported laboratory test results for 10 or more years). To increase the precision of the King County care continuum we further exclude individuals who had no HIV-related laboratory results reported for 18 months or more and for whom we had some evidence of a relocation, but the relocation was not confirmed by the other jurisdiction.

POPULATION SIZES OF MEN WHO HAVE SEX WITH MEN (MSM) IN KING COUNTY: The Behavioral Risk Factor Surveillance Survey (BRFSS) contains an annual percent of adult men who report being gay or bisexual. This serves as a proxy for MSM status. Up through 2013 BRFSS suggested 5.7% of adult males were MSM. Starting in 2014, we took the average of the prior 2 years and estimate that the proportion of adolescent and adult males who are MSM increased to 6.7% in 2018.

PWID: Defined as an individual who has used a syringe to inject drugs that were not prescribed to them, or drugs that were prescribed but are used in a different way than as prescribed (e.g., to get high). This is primarily based on current injection drug use (IDU) but can also be based on recent or lifetime IDU.

SEX: For purposes of this report, refers to sex assigned at birth.

SURVEILLANCE: The continuous collection, analysis, and distribution of data regarding a health-related event.

TRANSGENDER MAN: Person who identifies as a man but was assigned female sex at birth.

TRANSGENDER WOMAN: Person who identifies as a woman but was assigned male sex at birth.

Executive Summary

Background

The HIV/AIDS Epidemiology Report & Community Profile is a longstanding joint effort between the Washington State Department of Health (WA DOH) and Public Health – Seattle & King County (PHSKC). Our goal each year is to provide a comprehensive summary and evaluation of efforts related to HIV/AIDS in our respective jurisdictions. The report includes HIV surveillance data, snapshots of key populations affected by HIV, and critical evaluations of each component of our program. We aim to answer these questions: What is the scope of the HIV epidemic in Washington State and King County? Who does the epidemic affect? and What are we doing to prevent HIV and ensure the successful treatment of people living with HIV?

In 2019, the U.S. Department of Health and Human Services released its Ending the HIV Epidemic (EHE) plan, which includes jurisdictions most impacted by HIV, including King County. The primary objective of EHE is to reduce the number of new HIV infections by 75% in 2025 and by 90% in 2030. This 2021 report – which includes data through the end of 2020 – focuses on each of the four pillars of EHE: 1) Diagnose, 2) Treat, 3) Prevent, and 4) Respond. Each pillar article includes data documenting progress toward meeting an EHE objective, including descriptions of ongoing local prevention activities. Our dashboard of key indicators reflects the goals and final assessment of the 2020 End AIDS Washington initiative, established in 2014.

Over the past decade, Washington State and King County have met numerous goals related to HIV prevention, treatment, and care. To our knowledge, King County was the first urban jurisdiction in the U.S. to meet the World Health Organization's 90-90-90 goals, including ensuring that 90% of all people living with HIV (PLWH) know of their infection, 90% of diagnosed people receive medical care, and that 90% of those in care are virally suppressed. Unfortunately, the past three years have presented significant challenges in maintaining this success. First, in 2018 there was a substantial increase in new HIV diagnoses among people who inject drugs (PWID), including a defined outbreak in north Seattle. Although that outbreak has been contained, the vulnerability that fostered the outbreak persists. Next, the COVID-19 pandemic that started in early 2020 has led to disruptions in HIV testing and access to care for some people living with HIV. We observed a slight worsening for many indicators this year, although the changes were not drastic. Because many of our core metrics (new diagnoses, linkage to care, retention in care, and viral suppression) are based on reported laboratory data, the 2020 numbers should be interpreted with caution. We are unable to determine if changes in indicators seen in 2020 were related to actual changes in transmission, ART

adherence, lack of access to testing or treatment, or changes in how treatment was provided (i.e., no labs).

EHE Pillar 1: Diagnose

In 2020, there were 359 new HIV diagnoses in Washington State, including 157 new HIV diagnoses in King County. These are the lowest numbers of diagnoses recorded since 1994, although it is not yet clear if this reflects a decline in the incidence of HIV transmission or a decline in HIV testing due to the COVID-19 pandemic. In both Washington State and King County, the majority of new HIV cases were among men who have sex men (MSM) including MSM who inject drugs (68% and 78%, respectively), while 3% and 2%, respectively, were among non-MSM PWID. New HIV diagnoses in both Washington State and King County were also disproportionately high among Black people (16% in Washington State and 17% in King County), given that only 7% and 4%, respectively, of residents are Black. At the state level, the proportion of new HIV diagnoses that were among Latinx people was disproportionately high (16% of cases vs. 10% of the population), although a similar pattern was not observed in King County (12% of cases vs. 13% of the population). Among both Black and Latinx populations, new HIV diagnoses disproportionately affect people born outside of the U.S.

In King County, we estimate that 94% of residents with HIV are aware of their status, which surpasses the national goal of 90% and approaches the local goal of 95%. The proportion of new HIV diagnoses that were identified "late" in 2019 – defined within one year of an AIDS diagnosis – was 22%, which is slightly higher than the PHSKC goal of <20%. PHSKC recommends annual HIV testing for sexually active MSM who are not in a long-term, mutually monogamous, HIV concordant relationship. Over 70% of MSM newly diagnosed with HIV reported testing in the prior two years, which reflects only a minor improvement over recent years. To continue to improve access to HIV testing for MSM and other populations at increased risk for HIV, PHSKC and WA DOH provide HIV testing at the PHSKC Sexual Health Clinic, community-based organizations, through syringe service outreach, and in King County jails.

EHE Pillar 2: Treat

People living with HIV on sustained antiretroviral therapy (ART) improve their own health outcomes and, if virally suppressed, cannot sexually transmit HIV to their partners. Both Washington State and King County have made tremendous progress toward meeting and exceeding ambitious goals related to HIV treatment and viral suppression. Likely due to the COVID-19 pandemic, there were some small declines among indicators related to HIV care and treatment in 2020 compared to 2019. At the state level, 85% of people diagnosed with HIV are in care and 79% are virally suppressed. These estimates are very close to meeting national goals (90% and 80%, respectively). In King County, 89% of people newly diagnosed with HIV were linked to care within one month (94% within 3 months), 88% of people diagnosed with HIV are in care, and 86% are estimated to be virally suppressed. (Note, due to COVID-19 related reductions in viral load testing in 2020, the 86% estimate of viral suppression includes people with no viral load reported in 2020 but had a suppressed viral load in both 2019 and the first half of 2021.) While King County continues to surpass the national one-month linkage to care and viral suppression goals, these indicators fell just below local goals for 2020. We continue to observe disparities in viral suppression with lower rates among people of color – particularly U.S.-born Black individuals – and PWID.

EHE Pillar 3: Prevent

The EHE initiative promotes two highly effective HIV prevention strategies: pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs). King County's PrEP implementation guidelines recommend PrEP use among MSM and transgender people who have sex with men based on specific criteria that identify people at elevated risk for HIV acquisition. Approximately 44% of MSM at elevated risk for HIV are currently on PrEP. This estimate is shy of King County's goal of 50% and has stalled during the COVID-19 pandemic. PrEP use data for transgender populations at higher risk for HIV is limited, but we estimate that 20-50% of transgender people at elevated risk for HIV are currently on PrEP. PrEP use among PWID is very low (<1%). King County supports several ongoing efforts to promote PrEP use, including running a large PrEP program at the PHSKC Sexual Health Clinic, offering PrEP to people receiving sexually transmitted infections (STI) partner services, partnering with community-based PrEP programs, and providing online resources. SSPs provide PWID with sterile syringes to reduce the risk of infectious disease (HIV and hepatitis C) transmission, as well as overdose prevention services, wound care, and linkages to treatment for substance use disorder. The PHSKC SSP's sites distributed over 5 million syringes in 2020, which is higher than any previous year. Across all SSPs in King County, we estimate that over 8.8 million syringes were distributed, which equates to 333 syringes per PWID per year. This is higher than the current World

Health Organization goal of 200, but below King County's goal of 365. Finally, condoms are not included in the EHE Prevent pillar but remain an important component of the PHSKC HIV/STI prevention toolkit. In 2020, PHSKC continued several condom distribution efforts to increase condom use among the populations with the highest incidence of HIV and other STI, including MSM and sexually active youth.

EHE Pillar 4: Respond

Pillar 4 of EHE promotes a rapid response to HIV outbreaks to get prevention and treatment services to PLWH who are part of clusters of linked infections, as well as the sex and needle sharing partners of these people. King County response efforts blend traditional epidemiologic and partner services investigations with molecular cluster identification using viral genetic sequencing techniques. When clusters are identified, PHSKC can employ focused interventions to expand HIV testing, HIV prevention, and linkage to HIV care for people living with HIV. Cluster identification has been used by PHSKC for many years, including the identification of the 2018 HIV outbreak among PWID in north Seattle. As of July 2021, King County had seven clusters, each with three to eleven linked members diagnosed with HIV in the past year; most clusters are largely comprised of MSM. The EHE initiative will permit us to develop additional services to help meet the needs of underserved populations in both north Seattle and south King County.

End AIDS Washington Goals

The End AIDS Washington initiative was announced on World AIDS Day (December 1) in 2014 to complement the National HIV/AIDS Strategy. The primary two goals were to reduce the rate of new HIV diagnoses by 50% and reduce disparities in health outcomes among people living with HIV. To achieve these goals, End AIDS Washington identified 11 recommendations and action items to remove barriers to prevention and care, reduce stigma, and increase access to needed services. Starting with the 2016 version of this report (which reported on data through 2015), we have included a dashboard of key indicators and tracked progress at the state and county level toward meeting each goal. Washington State used the 2020 End AIDS Washington goals in its dashboard, while King County used a combination of national and (typically higher) local goals for its indicators. For each goal, we have provided an annual assessment of whether the goal had been met, was on pace to be met, or had not been met. Because this report uses data from 2020, this dashboard is the final dashboard that will use the 2020 goals established in 2014. Next year's dashboard will be updated to reflect new goals. Unfortunately, the COVID-19 pandemic which started in the United States in early 2020 also affected access and use of HIV prevention and care services, and many indicators were negatively impacted. The outcomes for some goals which had previously been met slipped backward.

Although not all End AIDS Washington goals were met, Washington State and King County made at least some progress with nearly every indicator, and overall, local indicators in Washington State and King County exceeded national estimates. From 2014 to 2020, there was a 13% decline in the rate of new HIV diagnoses in Washington State, which did not reach the End AIDS Washington goal of 50%. King County had a 36% reduction in the rate of new diagnoses, which exceeded its local goal of 25%. Both jurisdictions were close to the goal of having 90% of people living with HIV in care: 85% in Washington State and 88% in King County. The state and national goals of 80% viral suppression among people living with HIV was met by Washington State in 2019 but the estimate of suppression slipped to 79% in 2020. In King County we estimated 86% of PLWH were suppressed, which met the national goal but not the local goal of 90%. Neither jurisdiction met their goal related to reducing HIV/AIDS mortality (25% reduction for Washington State and 33% reduction for King County), with little change over time at the state level and a 17% reduction at the county level. Finally, both jurisdictions made progress toward reducing disparities in viral suppression among people living with HIV. In Washington State, the state achieved its goal of reducing differences across racial/ethnic groups, specifically non-Latinx Black and foreign-born Latinx people living with HIV. In King County, there were relatively high levels of viral suppression across many key subpopulations, including foreign-born Black and Latinx populations, with a notable increase in viral suppression between 2014 and 2020 among transgender people living with HIV (71% to 81%). PWID in King County continue to have lower levels of viral suppression with 73% virally suppressed in 2020 (and 78% in 2014), likely due, at least in part, to reduced health care access due to the COVID-19 pandemic. Finally, King County had two ambitious goals related to HIV prevention. We estimate that 44% of MSM at high-risk for HIV are on PrEP, which does not quite reach the 50% goal, but is still a marker of success. In addition, across King County, we estimate that local SSPs distribute approximately 333 syringes per

PWID per year, which exceeds the WHO's 2030 goal of 300.

Conclusion

This HIV Epidemiology Report and Community Profile reports data primarily collected during the COVID-19 pandemic. The myriad challenges and barriers posed by this pandemic have affected the populations we serve and the community partners we support, and some of the recent progress made with respect to HIV-related outcomes has diminished. However, there is still much to celebrate with respect to progress made toward eliminating the HIV epidemic in Washington State and King County. EHE funding is actively being used to support an array of expanded services to diagnose, treat, prevent, and respond to the HIV epidemic. We remain optimistic that the immense progress that our community has made toward reducing HIV incidence and improving the lives and well-being of PLWH will continue.

WA State and King County HIV Goals and Evaluation Metrics: 2021 Dashboard

Washington State	2020 End AIDS Washington Goals[1]	WA State Data, 2014-2020		Outcome (See Key Below)
		2014	2020	
DIAGNOSE				
New HIV diagnoses, rate	↓50%	5.4/100,000	4.7/100,000 (↓13%)	✗
TREAT				
In HIV care among PLWH[2,3]	≥90%	85%	85%	✗
Viral suppression among PLWH[2]	≥80%	72%	79%	↑
Disparities in viral suppression among PLWH[2]				
All PLWH	Reference group	72%	79%	—
Non-Latina/o/x and Hispanic Black PLWH	Difference ≤ 4.0%	68%	76%	✓
Foreign-born Latina/o/x and Hispanic PLWH	Difference ≤ 5.2%	69%	78%	✓
HIV/AIDS mortality[2,4]	↓25% (1.6/100,000)	2.3/100,000 1.4/100 PWDH	2.3/100,000 1.2/100 PWDH	✗

King County	2020 Goals[1]		King County Data, 2014-2020		Outcome (See Key Below)
	National	King County	2014[5]	2020	
DIAGNOSE					
New HIV diagnoses, rate	↓25%	↓25%[6]	11.0/100,000	7.0/100,000 (↓36%)	✓
Know HIV status[6]	90%	≥95%	92%	94%	✗ ★
Late HIV diagnosis[7]	--	≤20%	24%	22%	✗
Recent HIV testing[8], MSM	--	≥75%	72%	72%	✗
TREAT					
Linked to care in 1 month[9]	85%	≥90%	88%	89%	↑ ★
Linked to care in 3 months[9]	--	95%[10]	92%	94%	↑
In HIV care among PLWH[2,3]	90%	95%	89%	88%	✗
Viral suppression among PLWH[2,11]	80%	90%	79%	86%	✗ ★
Viral suppression in 4 months[9, 12]	--	75%	51%	65%	✗

Abbreviations: PrEP, pre-exposure prophylaxis for HIV; PLWH, people living with diagnosed HIV; MSM, men who have sex with men.
Technical notes on following page.

Key:

✓ Goal met ↑ Goal currently not met, was met prior to the pandemic ✗ Goal not met ★ National goal was met, but the local goal has not been met

King County (continued)	2020 Goals[1]		King County Data, 2014-2020		Outcome (Key on prior page)
	National	King County	2014[5]	2020	
HIV/AIDS mortality[2,13,14]	↓33%	↓33% (0.8/100)	1.2/100 PWDH	1.0/100 PWDH	✗
Homelessness among PLWH[2,15]	<5%	<5%	12%	12%	✗
Disparities in viral suppression among PLWH					
Non-Latinx White	--	No difference between groups	81%	88%	✗
Non-Latinx Black, foreign-born			84%	86%	
Non-Latinx Black, U.S.-born			77%	79%	
Latinx, foreign-born			85%	88%	
Latinx, U.S.-born			81%	85%	
Transgender			71%	81%	
People who inject drugs			78%	73%	
PREVENT					
PrEP use, high-risk MSM[16]	--	≥ 50%	9%	44%	✗
Syringe coverage[17]	200/PWID	365/PWID	258/PWID[18]	333/PWID	✗ ★

Abbreviations: PrEP, pre-exposure prophylaxis for HIV; PLWH, people living with diagnosed HIV; MSM, men who have sex with men; PWID, people who inject drugs

Technical Notes to Dashboard

[1] All 2020 goals use 2014 as the baseline. Some of the goals are different between Washington State and King County due to King County establishing its goals prior to the release of the End AIDS Washington goals.
[2] Among people who have been diagnosed with HIV
[3] Defined as 1+ reported laboratory results (CD4, viral load, genotype) in a calendar year (see Treat article).
[4] Mortality data from 2019; WA mortality goal is based on HIV/AIDS mortality rate per 100,000 population; PHSKC mortality goal is based on HIV/AIDS mortality rate per 100 people living with HIV; for comparability between WA and PHSKC, both measures are provided for WA.
[5] Some 2014 estimates differ from previously published estimates due to enhanced methods and data cleaning efforts.
[6] Based partly on an estimation method developed by the University of Washington (see Treat article).
[7] AIDS within 1 year of HIV diagnosis, among people diagnosed in 2019.
[8] Among MSM with new HIV diagnoses in 2020 and a known testing history, last HIV test within prior 2 years (see Diagnose article).
[9] Among people with a new HIV diagnosis (see Treat article).
[10] The original King County goal of 85% was increased to 95% due to early achievement of this objective.
[11] Due to less viral load testing in 2020 due to the COVID-19 pandemic, viral suppression in 2020 was monitored over a longer time period (January 2019 through June 2021) if there was no viral load test reported in 2020.
[12] Goal established in 2017.
[13] Age-and lag-adjusted mortality rates per 100 people living with HIV/AIDS (see Treat article).
[14] 2019 mortality data are used as 2020 data are incomplete; it generally takes 21 months for 95% of deaths to be reported.
[15] Data on homelessness among people living with HIV come from three sources: (1) addresses reported with laboratory results in HIV surveillance data; (2) self-reported housing information from partner services interviews; and (3) data on housing status from Ryan White clients. Data on homelessness for people newly diagnosed with HIV comes from medical records and partner services interviews.
[16] In King County, "MSM at high risk for HIV" are defined as HIV-negative MSM with any: methamphetamine/popper use, 10+ sex partners, non-concordant condomless anal sex, bacterial STI diagnosis in the past year. The 2020 estimate of PrEP use among high-risk MSM is an average across multiple contemporaneous surveys (see Prevention article).
[17] Defined as the number of syringes provided by SSPs per PWID per year. There is no national goal, but the WHO has a benchmark of 200 syringes per PWID per year by 2020.
[18] This goal was first established in 2019.

HIV/AIDS DATA IN WASHINGTON STATE

TABLE 1-1. NEW HIV AND AIDS CASES, LATE HIV DIAGNOSES, AND LINKAGE TO CARE, BY DEMOGRAPHIC AND RISK CHARACTERISTICS, WA STATE, 2020

	New AIDS Cases Column			New HIV Cases Column			Late HIV Diagnoses[A]		Initial Linkage to HIV Care[B]	
	No.	%	Rate	No.	%	Rate	No.	Row %	No.	Row %
Total	154	100%	2.0	359	100%	4.7	85	24%	290	81%
Gender										
Cisgender women[C]	35	23%	0.9	48	13%	1.3	21	44%	39	81%
Cisgender men	115	75%	3.0	306	85%	8.0	63	21%	249	81%
Transgender women	3	2%	n/a	5	1%	n/a	1	20%	2	40%
Transgender men	1	1%	n/a	0	0%	n/a	0	0%	0	0%
Age at HIV diagnosis										
< 13	0	0%	0.0	0	0%	0.0	0	0%	0	0%
13-24	5	3%	0.4	15%	4.7	4	4	7%	43	80%
25-34	34	22%	3.2	127	35%	11.8	18	14%	104	82%
35-44	46	30%	4.6	84	23%	8.3	25	30%	64	76%
45-54	36	23%	3.9	46	13%	4.9	17	37%	39	85%
55-64	21	14%	2.2	37	10%	3.8	13	35%	29	78%
65+	12	8%	0.9	11	3%	0.9	8	73%	11	100%
Race/Ethnicity										
American Indian / Alaska Native	1	0%	1.1	6	2%	6.3	0	0%	3	1%
Asian	14	4%	1.9	30	8%	4.2	13	43%	25	83%
Black	32	28%	10.6	58	16%	19.2	17	29%	47	81%
Foreign-born[D,E]	23	16%	29.7	21	6%	27.2	13	62%	18	86%
U.S.-born[D,E]	6	12%	2.6	26	7%	11.2	3	12%	22	85%
Latina/o/x and Hispanic	25	18%	2.4	56	16%	5.5	12	21%	46	82%
Foreign-born[D,E]	10	10%	3.2	19	5%	6.1	4	21%	16	84%
U.S.-born[D,E]	9	4%	1.3	18	5%	2.6	2	11%	16	89%
Native Hawaiian / Pacific Islander	1	2%	1.8	4	1%	7.2	1	25%	3	75%
White	75	42%	1.5	190	53%	3.7	42	22%	154	81%
Multiple	6	6%	1.8	15	4%	4.4	0	0%	12	80%
Mode of Exposure										
Male / Male Sex (MSM)	66	43%	n/a	223	62%	n/a	39	17%	184	83%
People Who Inject Drugs (PWID)	12	8%	n/a	11	3%	n/a	3	27%	10	91%
MSM and PWID	15	10%	n/a	21	6%	n/a	2	10%	13	62%
Heterosexual Contact	20	13%	n/a	27	8%	n/a	11	41%	23	85%
Transfusion / Hemophiliac /Pediatric	2	1%	n/a	0	0%	n/a	0	0%	0	0%
No Identified Risk	39	25%	n/a	77	21%	n/a	30	39%	60	78%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021; **n/a** = Rate cannot be calculated due to no available population estimate. Population estimate for 2020 was extrapolated using previous estimates from years 2010-2019.

[A] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnoses.

[B] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnoses.

[C] Cisgender is presumed for those not known to be transgender.

[D] All race categories exclude Latino/a/x/Hispanic individuals. AI/AN = American Indian or Alaska Native, NHOPI = Native Hawaiian or Other Pacific Islander.

[E] Country of origin data are missing for approximately 19% and 34% of newly diagnosed cases among Black and Hispanics, respectively.

TABLE 1-2. NEW HIV CASES, INCLUDING LATE HIV DIAGNOSES AND LINKAGE TO CARE, BY COUNTY AND HEALTH DISTRICT (HD) OF RESIDENCE AT HIV DIAGNOSIS, WA STATE, 2020

County or Health District or Residence	New HIV Cases			Late HIV Diagnoses [A]		Initial Linkage to HIV Care [B]	
	No.	Col %	Rate	No.	Row %	No.	Row %
Adams Co.	2	1%	9.8	1	50%	2	100%
Asotin Co.	0	0%	0.0	0	0%	0	0%
Benton Co.	7	2%	3.4	1	14%	5	71%
Benton-Franklin HD	11	3%	3.6	1	9%	7	64%
Chelan Co.	1	0%	1.3	0	0%	0	0%
Chelan-Douglas HD	3	1%	2.4	0	0%	1	33%
Clallam Co.	1	0%	1.3	1	100%	1	100%
Clark Co.	23	6%	4.6	8	35%	21	91%
Columbia Co.	0	0%	0.0	0	0%	0	0%
Cowlitz Co.	1	0%	0.9	0	0%	0	0%
Douglas Co.	2	1%	4.6	0	0%	1	50%
Ferry Co.	0	0%	0.0	0	0%	0	0%
Franklin Co.	4	1%	4.1	0	0%	2	50%
Garfield Co.	0	0%	0.0	0	0%	0	0%
Grant Co.	2	1%	2.0	1	50%	2	100%
Grays Harbor Co.	1	0%	1.3	0	0%	0	0%
Island Co.	3	1%	3.5	0	0%	2	67%
Jefferson Co.	0	0%	0.0	0	0%	0	0%
King Co.	169[D]	47%	7.5	43	25%	141	83%
Kitsap Co.	4	1%	1.5	1	25%	2	50%
Kittitas Co.	1	0%	2.1	0	0%	0	0%
Klickitat Co.	1	0%	4.4	0	0%	1	100%
Lewis Co.	1	0%	1.2	0	0%	1	100%
Lincoln Co.	0	0%	0.0	0	0%	0	0%
Mason Co.	4	1%	6.1	0	0%	4	100%
Ne Tri-County HD	2	1%	3.0	0	0%	1	50%
Okanogan Co.	0	0%	0.0	0	0%	0	0%
Pacific Co.	0	0%	0.0	0	0%	0	0%
Pend Oreille Co.	1	0%	7.2	0	0%	1	100%
Pierce Co.	51	14%	5.7	11	22%	39	76%
San Juan Co.	2	1%	11.5	1	50%	2	100%
Skagit Co.	3	1%	2.3	1	33%	2	67%
Skamania Co.	0	0%	0.0	0	0%	0	0%
Snohomish Co.	23	6%	2.8	7	30%	17	74%
Spokane Co.	33	9%	6.3	3	9%	26	79%
Stevens Co.	1	0%	2.2	0	0%	0	0%
Thurston Co.	8	2%	2.7	1	13%	8	100%
Wahkiakum Co.	0	0%	0.0	0	0%	0	0%
Walla Walla Co.	1	0%	1.6	1	100%	1	100%
Whatcom Co.	3	1%	1.3	1	33%	3	100%
Whitman Co.	1	0%	2.0	1	100%	1	100%
Yakima Co.	5	1%	1.9	0	0%	5	100%
Total [C]	359	100%	4.7	85	24%	290	81%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

[A] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnoses.

[B] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnosis.

[C] Two cases did not have a reported county of diagnosis.

[D] Washington State and King County numbers may differ slightly due to differences in data cleaning, record access, or date of analysis.

TABLE 1-3. NEW HIV CASE COUNTS OVER TIME, BY DEMOGRAPHIC AND RISK CHARACTERISTICS, WA STATE, 2016-2020

	2016	2017	2018	2019	2020	2016-2020			
	No.	No.	No.	No.	No.	Total No.	Avg. No.	%	Rate
Total	370	375	401	408	359	1,913	383	100%	5.2
Gender									
Cisgender women	75	66	88	64	48	341	68	18%	1.8
Cisgender men	290	303	310	336	306	1545	309	81%	8.3
Transgender women	5	5	3	7	5	25	5	1%	n/a
Transgender men	0	1	0	1	0	2	0	0%	n/a
Age at HIV Diagnosis									
< 13	2	3	0	0	0	5	1	0%	0.1
13-24	63	59	54	61	54	291	58	15%	5.1
25-34	116	144	140	164	127	691	138	36%	13.3
35-44	78	62	92	77	84	393	79	21%	8.2
45-54	63	63	66	64	46	302	60	16%	6.4
55-64	36	35	41	31	37	180	36	9%	3.7
65+	12	9	8	11	11	51	10	3%	0.9
Race/Ethnicity									
American Indian / Alaska Native	9	5	3	3	6	26	5	1%	5.6
Asian	27	24	16	19	30	116	23	6%	3.6
Black	64	72	83	68	58	345	69	18%	24.6
Foreign-born[A,B]	27	37	43	29	21	157	31	8%	44.0
U.S.-born[A,B]	32	31	33	33	26	155	31	8%	14.8
Latina/o/x and Hispanic	63	80	71	96	56	366	73	19%	7.6
Foreign-born[A,B]	31	39	29	50	19	168	34	9%	11.0
U.S.-born[A,B]	27	34	30	28	18	137	27	7%	4.2
Native Hawaiian / Pacific Islander	4	3	5	3	4	19	4	1%	7.3
White	184	178	201	202	190	955	191	50%	3.8
Multiple	19	13	22	17	15	86	17	4%	5.4
Mode of Exposure									
Male / Male Sex (MSM)	193	211	199	240	223	1066	213	56%	n/a
People Who Inject Drugs (PWID)	28	19	43	41	11	142	28	7%	n/a
MSM and PWID	27	27	40	24	21	139	28	7%	n/a
Heterosexual Contact	53	38	52	38	27	208	42	11%	n/a
Transfusion / Hemophiliac /Pediatric	1	5	0	2	0	8	2	0%	n/a
No identified risk	68	75	67	63	77	350	70	18%	n/a

Table based on HIV surveillance data reported to the WA State Department of Health as of June, 30 2021.

n/a Rate cannot be calculated due to no available population estimate.

[A] Country of origin data are missing for approximately 19% and 34% of newly diagnosed cases among Black and Hispanics, respectively.

[B] Population estimate for 2020 was extrapolated using previous estimates from years 2010-2019.

TABLE 1-4. NEW HIV CASE COUNTS OVER TIME, BY COUNTY AND HEALTH DISTRICT (HD) OF RESIDENCE AT HIV DIAGNOSIS, WA STATE, 2016-2020

County and Health District of Residence	2016	2017	2018	2019	2020	2016-2020			
	No.	No.	No.	No.	No.	Total No.	Avg. No.	%	Rate
Adams Co.	0	0	0	1	2	3	1	0%	3.0
Asotin Co.	0	0	0	0	0	0	0	0%	0.0
Benton Co.	7	2	0	13	7	29	6	2%	2.9
Benton-Franklin HD	10	3	5	19	11	48	10	3%	3.3
Chelan Co.	6	1	3	2	1	13	3	1%	3.3
Chelan-Douglas HD	6	2	4	4	3	19	4	1%	3.2
Clallam Co.	2	2	5	2	1	12	2	1%	3.2
Clark Co.	18	24	21	28	23	114	23	6%	4.8
Columbia Co.	0	1	0	0	0	1	0	0%	4.8
Cowlitz Co.	2	4	1	3	1	11	2	1%	2.0
Douglas Co.	0	1	1	2	2	6	1	0%	2.8
Ferry Co.	0	0	0	0	0	0	0	0%	0.0
Franklin Co.	3	1	5	6	4	19	4	1%	4.1
Garfield Co.	0	0	0	0	0	0	0	0%	0.0
Grant Co.	0	0	4	2	2	8	2	0%	1.6
Grays Harbor Co.	1	4	0	2	1	8	2	0%	2.2
Island Co.	2	3	2	5	3	15	3	1%	3.6
Jefferson Co.	2	0	1	0	0	3	1	0%	1.9
King Co.	181	177	227	191	169[A]	945	189	49%	8.6
Kitsap Co.	7	9	9	9	4	38	8	2%	2.8
Kittitas Co.	1	0	1	2	1	5	1	0%	2.2
Klickitat Co.	0	1	0	0	1	2	0	0%	1.8
Lewis Co.	0	0	1	2	1	4	1	0%	1.0
Lincoln Co.	1	1	0	0	0	2	0	0%	3.7
Mason Co.	3	4	5	5	4	21	4	1%	6.6
NE Tri-County HD	1	0	0	1	2	3	1	0%	0.9
Okanogan Co.	1	0	0	1	0	2	0	0%	0.9
Pacific Co.	0	0	1	0	0	1	0	0%	0.9
Pend Oreille Co.	0	0	0	1	1	2	0	0%	3.0
Pierce Co.	42	41	49	53	51	236	47	12%	5.4
San Juan Co.	0	0	0	0	2	2	0	0%	2.4
Skagit Co.	7	4	3	3	3	20	4	1%	3.2
Skamania Co.	0	0	0	0	0	0	0	0%	0.0
Snohomish Co.	36	27	20	29	23	135	27	7%	3.4
Spokane Co.	26	22	17	26	33	124	25	6%	4.9
Stevens Co.	1	0	0	0	1	2	0	0%	0.9
Thurston Co.	8	10	8	6	8	40	8	2%	2.8
Wahkiakum Co.	0	0	0	0	0	0	0	0%	0.0
Walla Walla Co.	1	2	1	0	1	5	1	0%	1.6
Whatcom Co.	2	8	3	5	3	21	4	1%	1.9
Whitman Co.	0	0	3	0	1	4	1	0%	1.6
Yakima Co.	10	26	10	9	5	60	12	3%	4.7
Total	370	375	401	408	359	1913	383	100%	5.2

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

[A] Washington State and King County numbers may differ slightly due to differences in data cleaning, record access, or date of analysis.

TABLE 1-5. NEW CASES OF HIV INFECTION, BY CURRENT GENDER[A], RACE/ETHNICITY, AND HIV EXPOSURE CATEGORY, WA STATE, 2016-2020

Gender	Exposure Category	Asian		Black		Latina/o/x and Hispanic		Other		White	
		No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender Women	People Who Inject Drugs (PWID)	1	5%	3	2%	5	13%	6	25%	47	38%
	Heterosexual Contact	12	55%	72	55%	27	69%	11	46%	46	37%
	Transfusion / Hemophiliac /Pediatric	0	0%	4	3%	0	0%	0	0%	0	0%
	No Identified Risk	9	41%	52	40%	7	18%	7	29%	32	26%
	Total Women	22	100%	131	100%	39	100%	24	100%	125	100%
Cisgender Men	Male / Male Sex (MSM)	67	74%	122	58%	254	79%	70	69%	534	65%
	Injecting Drug Use (IDU)	2	2%	6	3%	5	2%	4	4%	63	8%
	MSM and IDU	0	0%	9	4%	12	4%	12	12%	101	12%
	Heterosexual Contact	0	0%	11	5%	12	4%	1	1%	16	2%
	Transfusion / Hemophiliac /Pediatric	0	0%	3	1%	0	0%	0	0%	1	0%
	No Identified Risk	21	23%	59	28%	38	12%	15	15%	107	13%
	Total Men	90	100%	210	100%	321	100%	102	100%	822	100%
Transgender Women	Male / Male Sex (MSM)	19	76%	-	-	-	-	-	-	-	-
	MSM and PWID	5	20%	-	-	-	-	-	-	-	-
	No Identified Risk	1	4%	-	-	-	-	-	-	-	-
	Total Transgender Women	25	100%	-	-	-	-	-	-	-	-

		Total	
		No.	%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020.

[A] Due to the small number of HIV cases reported among transgender men, further stratification is not possible.

TABLE 1-6. PREVALENT CASES OF HIV, INCLUDING ENGAGEMENT IN CARE AND VIRAL LOAD SUPPRESSION, BY DEMOGRAPHIC AND RISK CHARACTERISTICS, WA STATE, 2020

	Prevalent Cases of HIV			Engaged in Care [A]		Suppressed Viral Load [B]	
	No.	Column %	Prevalence per 100,000	No.	Row %	No.	Row %
Total	14,061	100%	183.7	12,004	85%	11,064	79%
Gender							
Cisgender women	2,176	15%	56.9	1,846	85%	1,678	77%
Cisgender men	11,744	84%	306.2	10,032	85%	9,278	79%
Transgender women	125	1%	n/a	112	90%	98	78%
Transgender men	16	0%	n/a	14	88%	10	63%
Current Age							
< 13	27	0%	2.2	23	85%	22	81%
13-24	288	2%	24.9	243	84%	201	70%
25-34	1,891	13%	175.4	1,524	81%	1,338	71%
35-44	2,796	20%	277.4	2,303	82%	2,067	74%
45-54	3,701	26%	398.0	3,154	85%	2,908	79%
55-64	3,837	27%	393.3	3,399	89%	3,215	84%
65+	1,521	11%	118.7	1,358	89%	1,313	86%
Race/Ethnicity							
American Indian / Alaska Native	130	1%	136.8	106	82%	89	68%
Asian	525	4%	73.0	452	86%	423	81%
Black	2,439	17%	807.0	2,047	84%	1,862	76%
Foreign-born [C,D]	1,048	7%	1,355.5	898	86%	842	80%
U.S.-born [C,D]	1,279	9%	552.8	1,060	83%	940	73%
Hispanic	2,154	15%	210.6	1,808	84%	1,660	77%
Foreign-born [C,D]	1,074	8%	342.3	891	83%	843	78%
U.S.-born [C,D]	894	6%	127.3	765	86%	688	77%
Native Hawaiian / Pacific Islander	64	0%	114.8	49	77%	44	69%
White	7,866	56%	153.5	6,795	86%	6,311	80%
Multiple	877	6%	260.2	741	84%	669	76%
Mode of Exposure							
Male / Male Sex (MSM)	8,633	61%	n/a	7,469	87%	6,997	81%
People Who Inject Drugs (PWID)	797	6%	n/a	646	81%	545	68%
MSM and PWID	1,256	9%	n/a	1,072	85%	938	75%
Heterosexual Contact	1,753	12%	n/a	1,493	85%	1,379	79%
Transfusion / Hemophiliac /Pediatric	186	1%	n/a	155	83%	137	74%
No identified risk	1,436	10%	n/a	1,169	81%	1,068	74%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.
n/a Prevalence per 100,000 cannot be calculated due to no available population estimate.
[A] Engaged in care = at least one reported CD4 or VL result within calendar year.
[B] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL.
[C] Country of origin data are missing for approximately 6% and 9% of newly living cases among Black and Hispanic people, respectively.
[D] Population estimate for 2020 was extrapolated using previous estimates from years 2010-2019.

TABLE 1-7. PREVALENT CASES OF HIV, INCLUDING ENGAGEMENT IN CARE AND VIRAL LOAD SUPPRESSION, BY COUNTY AND HEALTH DISTRICT (HD) OF CURRENT RESIDENCE, WA STATE, 2020

County or Health District of Residence	Prevalent Cases of HIV			Engaged in Care [A]		Suppressed Viral Load [B]	
	No.	Column %	Rate	No.	Row %	No.	Row %
Adams Co.	13	0%	63.6	10	77%	9	69%
Asotin Co.	18	0%	79.5	13	72%	12	67%
Benton Co.	191	1%	92.9	169	88%	112	59%
Benton-Franklin HD	277	2%	91.6	193	70%	132	48%
Chelan Co.	61	0%	76.6	51	84%	48	79%
Chelan-Douglas HD	90	1%	72.9	75	83%	68	76%
Clallam Co.	80	1%	104.2	68	85%	63	79%
Clark Co.	832	6%	166.7	676	81%	626	75%
Columbia Co.	3	0%	71.7	3	100%	3	100%
Cowlitz Co.	152	1%	137.6	125	82%	118	78%
Douglas Co.	29	0%	66.3	24	83%	20	69%
Ferry Co.	4	0%	50.6	2	50%	2	50%
Franklin Co.	86	1%	88.9	70	81%	55	64%
Garfield Co.	2	0%	89.9	2	100%	2	100%
Grant Co.	58	0%	57.9	51	88%	48	83%
Grays Harbor Co.	99	1%	132.5	81	82%	71	72%
Island Co.	106	1%	123.9	80	75%	74	70%
Jefferson Co.	46	0%	142.9	39	85%	38	83%
King Co.	7,074[C]	50%	312.9	6,166	87%	5,727	81%
Kitsap Co.	351	2%	128.9	300	85%	285	81%
Kittitas Co.	32	0%	66.5	26	81%	25	78%
Klickitat Co.	20	0%	87.8	17	85%	14	70%
Lewis Co.	64	0%	79.8	49	77%	44	69%
Lincoln Co.	6	0%	54.3	5	83%	5	83%
Mason Co.	74	1%	112.7	56	76%	53	72%
NE Tri-County HD	38	0%	56.1	29	76%	27	71%
Okanogan Co.	27	0%	62.6	18	67%	16	59%
Pacific Co.	35	0%	160.3	25	71%	24	69%
Pend Oreille Co.	11	0%	79.4	7	64%	7	64%
Pierce Co.	1,581	11%	175.5	1,268	80%	1,140	72%
San Juan Co.	22	0%	126.9	18	82%	17	77%
Skagit Co.	98	1%	75.1	85	87%	77	79%
Skamania Co.	5	0%	40.9	4	80%	4	80%
Snohomish Co.	1,229	9%	148.0	1,069	87%	1,015	83%
Spokane Co.	727	5%	139.1	631	87%	573	79%
Stevens Co.	23	0%	50.1	18	78%	16	70%
Thurston Co.	327	2%	112.4	278	85%	255	78%
Wahkiakum Co.	4	0%	95.0	3	75%	3	75%
Walla Walla Co.	53	0%	84.7	43	81%	41	77%
Whatcom Co.	250	2%	109.6	216	86%	202	81%
Whitman Co.	25	0%	49.5	22	88%	21	84%
Yakima Co.	243	2%	94.1	216	89%	199	82%
Total	14,061	100%	183.7	12,004	85%	11,064	79%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

[A] Engaged in care = at least one reported CD4 or VL result within calendar year.

[B] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL.

[C] Washington State and King County numbers may differ slightly due to differences in data cleaning, record access, or date of analysis.

TABLE 1-8. PREVALENT CASES OF HIV, BY CURRENT GENDER[A], RACE/ETHNICITY, AND HIV EXPOSURE CATEGORY, WA STATE, 2020

		Asian		Black		Latina/o/x/and Hispanic		Other		White	
Gender	Exposure Category	No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender Women	People Who Inject Drugs (PWID)	2	2%	38	4%	30	12%	41	26%	207	27%
	Heterosexual Contact	65	69%	551	60%	182	71%	95	59%	439	58%
	Transfusion / Hemophiliac /	3	3%	53	6%	7	3%	4	3%	22	3%
	No Identified Risk	24	26%	269	30%	38	15%	20	13%	85	11%
	Total Women	94	100%	911	100%	257	100%	160	100%	753	100%
Cisgender Men	Male / Male Sex (MSM)	307	73%	813	54%	1,414	76%	607	68%	5,395	76%
	People Who Inject Drugs	7	2%	77	5%	44	2%	43	5%	304	4%
	MSM and PWID	10	2%	91	6%	146	8%	135	15%	845	12%
	Heterosexual Contact	13	3%	173	11%	77	4%	36	4%	118	2%
	Transfusion / Hemophiliac /	3	1%	39	3%	9	0%	6	1%	38	1%
	No Identified Risk	83	20%	314	21%	170	9%	62	7%	360	5%
	Total Men	423	100%	1,507	100%	1,860	100%	889	100%	7,060	100%
Transgender Women	Male / Male Sex (MSM)	7	88%	18	100%	26	70%	14	74%	26	60%
	People Who Inject Drugs	0	0%	0	0%	1	3%	0	0%	0	0%
	MSM and PWID	0	0%	0	0%	9	24%	5	26%	15	35%
	No Identified Risk	1	13%	0	0%	1	3%	0	0%	2	5%
	Total Transgender Women	8	100%	18	100%	37	100%	19	100%	43	100%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

[A] Due to the small number of HIV cases reported as transgender men, further stratification is not possible.

TABLE 1-9. CHARACTERISTICS AND CARE OUTCOMES OF PEOPLE LIVING WITH HIV REPORTING ANY AMERICAN INDIAN OR ALASKA NATIVE RACE , 2016-2020

	New HIV Cases		Prevalent HIV Cases	
	No.	Column %	No.	Column %
Total	67	2%[A]	554	4%[A]
Gender				
Cisgender women	18	27%	101	18%
Cisgender men	48	72%	442	80%
Transgender women	0	0%	2	0%
Transgender men	1	1%	9	2%
Mode of Exposure				
Male / Male Sex (MSM)	29	43%	296	53%
People Who Inject Drugs	10	15%	64	12%
MSM and PWID	10	15%	83	15%
Heterosexual Contact	8	12%	73	13%
No Identified Risk / Other	10	15%	38	7%
Geography				
King County	32	48%	265	48%
Other Western Washington	19	28%	218	39%
Eastern Washington	16	24%	71	13%
Care Metrics				
Initial Linkage to HIV Care [B]	51	76%	n/a	n/a
Engaged in Care [C]	n/a	n/a	460	83%
Viral Suppression [D]	n/a	n/a	407	73%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.
N/A Rate cannot be calculated due to no available population estimate.
[A] Percentage of total Washington Cases.
[B] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnoses.
[C] Engaged in care = at least one reported CD4 or VL result within calendar year.
[D] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL.

TABLE 1-10. DEATHS AMONG CASES OF HIV INFECTION, BY DEMOGRAPHIC AND RISK CHARACTERISTICS, WA STATE, 1982-2019

	Deaths among Cases of HIV Infection 2019					1983-2018	
	No.	Column %	Mortality rate (per 100,000)	Case Fatality Rate (per 1,000)	Standard Mortality Ratio	No.	Column %
Total	172	100%	2.3	12.4	1.6	8,585	100%
Gender							
Cisgender women	26	15%	0.7	12.1	2.4	763	9%
Cisgender men	144	84%	3.8	12.4	1.5	7,800	91%
Transgender women	2	1%	n/a	16.7	0.0	22	0%
Transgender men	0	0%	n/a	0.0	0.0	0	0%
Current Age							
< 13	0	0%	0.0	0.0	0.0	19	0%
13-24	1	1%	0.1	3.3	5.2	101	1%
25-34	9	5%	0.8	4.9	4.1	1,750	20%
35-44	17	10%	1.7	6.2	3.2	3,056	36%
45-54	38	22%	4.1	9.7	2.5	2,075	24%
55-64	61	35%	6.3	16.6	1.9	1,079	13%
65+	46	27%	3.8	33.7	0.9	505	6%
Race/Ethnicity							
American Indian / Alaska Native	2	1%	2.1	14.7	n/a	135	2%
Asian	1	1%	0.1	2.1	n/a	97	1%
Black	22	13%	7.6	9.3	n/a	830	10%
Foreign-born [A]	5	3%	6.2	4.9	n/a	82	1%
U.S.-born [A]	17	10%	7.8	13.5	n/a	734	9%
Hispanic	21	12%	2.1	10.0	n/a	574	7%
Foreign-born [A]	6	3%	1.9	5.7	n/a	199	2%
U.S.-born [A]	14	8%	2.0	15.9	n/a	344	4%
Native Hawaiian / Pacific Islander	2	1%	3.7	32.3	n/a	20	0%
White	110	64%	2.2	14.1	n/a	6,618	77%
Multiple	14	8%	4.3	15.7	n/a	310	4%
Mode of Exposure							
Male / Male Sex (MSM)	76	44%	n/a	8.9	n/a	5,454	64%
People Who Inject Drugs (PWID)	29	17%	n/a	35.7	n/a	972	11%
MSM and PWID	27	16%	n/a	21.5	n/a	953	11%
Heterosexual Contact	17	10%	n/a	9.8	n/a	186	2%
Transfusion / Hemophiliac /Pediatric	1	1%	n/a	5.3	n/a	513	6%
No Identified Risk	22	13%	n/a	16.1	n/a	507	6%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

n/a Rate cannot be calculated due to no available population estimate.

[A] Country of origin data are missing for approximately 6% and 9% of living cases among Black and Hispanic people, respectively.

TABLE 1-11. PREVALENT CASES OF HIV, BY DEMOGRAPHIC AND RISK CHARACTERISTICS, WA STATE, 2016-2020

	2016		2017		2018		2019		2020	
	No.	Column %	No.	Column %	No.	Column %	No.	Column %	No.	Column %
Total	12,767	100%	13,267	100%	13,652	100%	13,862	100%	14,061	100%
Gender										
Cisgender women	1,856	15%	1,964	15%	2,078	15%	2,147	15%	2,176	15%
Cisgender men	10,792	85%	11,172	84%	11,439	84%	11,582	84%	11,744	84%
Transgender women	109	1%	120	1%	122	1%	120	1%	125	1%
Transgender men	10	0%	11	0%	13	0%	13	0%	16	0%
Current Age										
< 13	43	0%	43	0%	37	0%	30	0%	27	0%
13-24	307	2%	302	2%	297	2%	306	2%	288	2%
25-34	1,700	13%	1,783	13%	1,813	13%	1,832	13%	1,891	13%
35-44	2,625	21%	2,686	20%	2,763	20%	2,752	20%	2,796	20%
45-54	4,332	34%	4,240	32%	4,079	30%	3,902	28%	3,701	26%
55-64	2,848	22%	3,152	24%	3,538	25%	3,673	26%	3,837	27%
65+	912	7%	1,061	8%	1,225	9%	1,367	10%	1,521	11%
Race/Ethnicity										
American Indian / Alaska Native	128	1%	130	1%	133	1%	136	1%	130	1%
Asian	414	3%	436	3%	453	3%	485	3%	525	4%
Black	1,971	15%	2,125	16%	2,277	17%	2,369	17%	2,439	17%
Foreign-born [A]	754	6%	848	6%	955	7%	1,012	7%	1,048	7%
U.S.-born [A]	1,141	9%	1,198	9%	1,238	9%	1,262	9%	1,279	9%
Hispanic	1,798	14%	1,932	15%	2,018	15%	2,102	15%	2,154	15%
Foreign-born [A]	880	7%	952	7%	985	7%	1,054	8%	1,074	8%
U.S.-born [A]	788	6%	845	6%	884	6%	881	6%	894	6%
Native Hawaiian / Pacific Islander	51	0%	56	0%	61	0%	62	0%	64	0%
White	7,544	59%	7,704	58%	7,814	57%	7,813	56%	7,866	56%
Multiple	855	7%	878	7%	890	7%	889	6%	877	6%
Mode of Exposure										
Male / Male Sex (MSM)	7,878	62%	8,160	62%	8,355	61%	8,501	61%	8,633	61%
People Who Inject Drugs (PWID)	788	6%	780	6%	799	6%	812	6%	797	6%
MSM and PWID	1,234	10%	1,283	10%	1,300	10%	1,256	9%	1,256	9%
Heterosexual Contact	1,602	13%	1,670	13%	1,712	13%	1,737	13%	1,753	12%
Transfusion / Hemophiliac /Pediatric	165	1%	182	1%	182	1%	189	1%	186	1%
No Identified Risk	1,100	9%	1,192	9%	1,304	10%	1,367	10%	1,436	10%

Table based on HIV surveillance data reported to the WA State Department of Health as of June, 30 2021

[A] Population estimate for 2020 was extrapolated using previous estimates from years 2010-2019

TABLE 1-12. PREVALENT CASES OF HIV, BY COUNTY AND HEALTH DISTRICT (HD) OF RESIDENCE AT DIAGNOSIS, WA STATE. 2016-2020

County or Health District of Residence	2016		2017		2018		2019		2020	
	No.	Column %	No.	Row %	No.	Row %	No.	Row %	No.	Row %
Adams Co.	13	0%	11	0%	13	0%	14	0%	13	0%
Asotin Co.	24	0%	22	0%	22	0%	19	0%	18	0%
Benton Co.	126	1%	151	1%	171	1%	185	1%	191	1%
Benton-Franklin HD	193	2%	228	2%	254	2%	266	2%	277	2%
Chelan Co.	57	0%	57	0%	58	0%	62	0%	61	0%
Chelan-Douglas HD	73	1%	72	1%	74	1%	82	1%	90	1%
Clallam Co.	76	1%	77	1%	78	1%	83	1%	80	1%
Clark Co.	655	5%	701	5%	737	5%	769	6%	832	6%
Columbia Co.	7	0%	6	0%	4	0%	3	0%	3	0%
Cowlitz Co.	122	1%	142	1%	149	1%	148	1%	152	1%
Douglas Co.	16	0%	15	0%	16	0%	20	0%	29	0%
Ferry Co.	4	0%	4	0%	5	0%	6	0%	4	0%
Franklin Co.	67	1%	77	1%	83	1%	81	1%	86	1%
Garfield Co.	3	0%	3	0%	3	0%	2	0%	2	0%
Grant Co.	41	0%	40	0%	43	0%	50	0%	58	0%
Grays Harbor Co.	81	1%	94	1%	94	1%	91	1%	99	1%
Island Co.	82	1%	88	1%	98	1%	101	1%	106	1%
Jefferson Co.	36	0%	43	0%	50	0%	45	0%	46	0%
King Co.	6,806	53%	6,930	52%	7,019	51%	7,048	51%	7,074[A]	50%
Kitsap Co.	309	2%	328	2%	325	2%	344	2%	351	2%
Kittitas Co.	29	0%	29	0%	28	0%	32	0%	32	0%
Klickitat Co.	16	0%	18	0%	18	0%	20	0%	20	0%
Lewis Co.	56	0%	63	0%	67	0%	66	0%	64	0%
Lincoln Co.	8	0%	9	0%	5	0%	7	0%	6	0%
Mason Co.	68	1%	67	1%	68	0%	68	0%	74	1%
NE Tri-County HD	39	0%	41	0%	43	0%	44	0%	38	0%
Okanogan Co.	30	0%	29	0%	28	0%	29	0%	27	0%
Pacific Co.	29	0%	25	0%	29	0%	33	0%	35	0%
Pend Oreille Co.	12	0%	12	0%	10	0%	12	0%	11	0%
Pierce Co.	1,411	11%	1,444	11%	1,532	11%	1,557	11%	1,581	11%
San Juan Co.	23	0%	21	0%	23	0%	23	0%	22	0%
Skagit Co.	98	1%	99	1%	98	1%	98	1%	98	1%
Skamania Co.	5	0%	7	0%	6	0%	5	0%	5	0%
Snohomish Co.	1,038	8%	1,080	8%	1,155	8%	1,205	9%	1,229	9%
Spokane Co.	608	5%	634	5%	676	5%	688	5%	727	5%
Stevens Co.	23	0%	25	0%	28	0%	26	0%	23	0%
Thurston Co.	290	2%	329	2%	334	2%	334	2%	327	2%
Wahkiakum Co.	4	0%	4	0%	6	0%	4	0%	4	0%
Walla Walla Co.	54	0%	60	0%	57	0%	54	0%	53	0%
Whatcom Co.	182	1%	245	2%	243	2%	250	2%	250	2%
Whitman Co.	23	0%	25	0%	25	0%	28	0%	25	0%
Yakima Co.	235	2%	253	2%	248	2%	251	2%	243	2%
Total	12,767	100%	13,267	100%	13,652	100%	13,862	100%	14,061	100%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2021.

[A] Washington State and King County numbers may differ slightly due to differences in data cleaning, record access, or date of analysis.

FIGURE 1-1. HIV CARE CONTINUUM, WASHINGTON STATE 2020 (BASED ON DATA REPORTED THROUGH JUNE 2021)

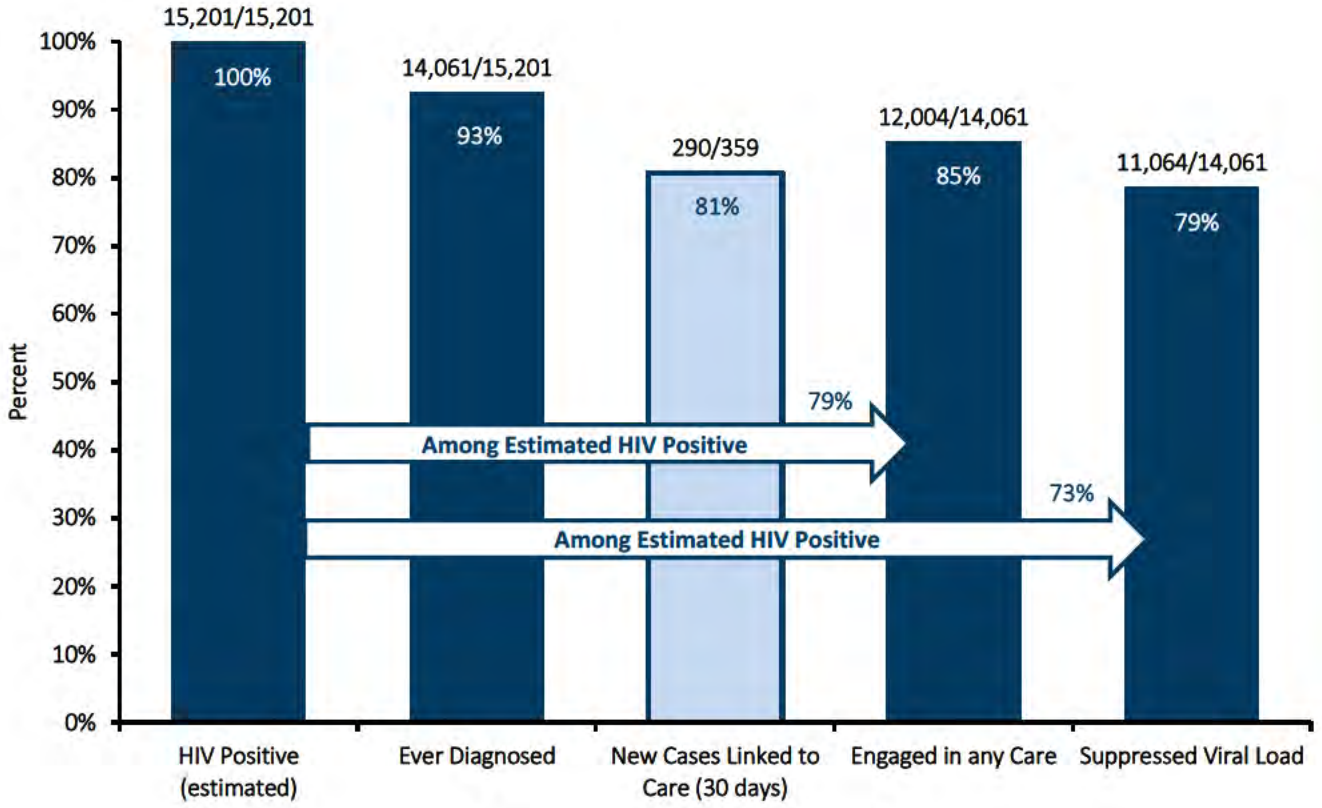
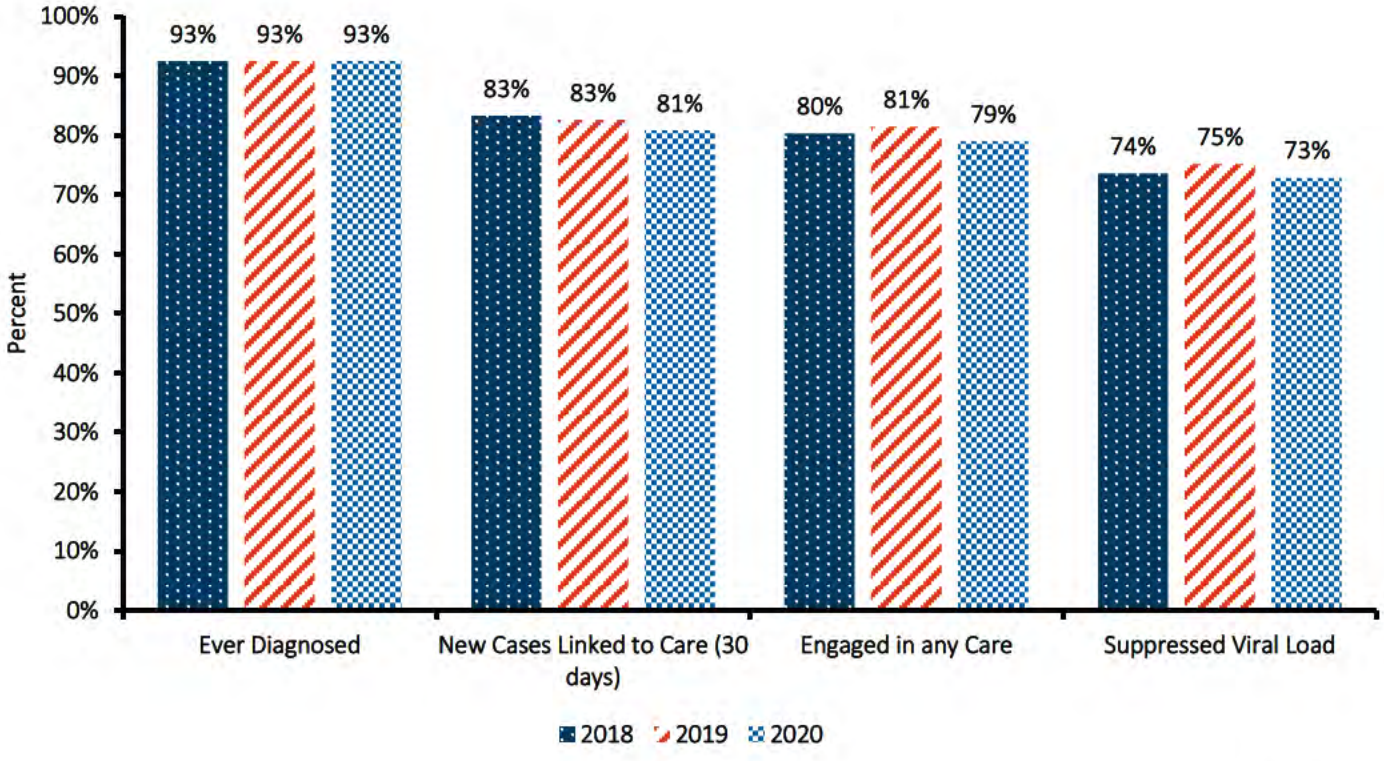


FIGURE 1-2. 2017-2019 THREE-YEAR TRENDS, WASHINGTON STATE HIV CARE CONTINUUM AS OF JULY, 2021



COVID-19 Vaccination Among People Living with HIV

Background and Aims

The Centers for Disease Control and Prevention (CDC) identified people living with HIV (PLWH) as a population with heightened risk from COVID-19.[1] With the distribution of vaccine underway, it is critically important to ensure that populations at increased risk of severe COVID-19 outcomes are being vaccinated and to identify subpopulations that may face particular obstacles to vaccination.

PLWH have been demonstrated to have more severe outcomes from COVID-19 than the general population. A 2021 systematic review of hospital-based case-control studies found that PLWH were 1.78 times more likely to die from COVID-19 than the general population.[2] As of 8/30/2021, only 64.3% of the eligible population in Washington was fully vaccinated from COVID-19, indicating that there are subpopulations that are not protected.[3] Many PLWH have regular access to a health care provider, while others face numerous barriers to healthcare access that may prevent them from seeking or being able to access the COVID-19 vaccine. Particular groups of PLWH, such as Black PLWH and PLWH who inject drugs, are at the intersection of overlapping epidemics that may make vaccination challenging.[4]

The purpose of this study was to estimate the proportion of PLWH who have been vaccinated against COVID-19, compare this proportion to the general population of Washington State, and identify subgroups of PLWH who have low vaccination rates. The Washington State Department of Health (WA DOH) and Public Health – Seattle & King County (PHSKC) have established service-delivery programs for PLWH and are well-positioned to contribute to vaccination efforts for PLWH. A more complete understanding of vaccine uptake would benefit these organizations' abilities to meet this population's needs.

Methods

We extracted name, date of birth, and COVID-19 vaccination date(s) from the WA DOH's Vaccine Registry for all people who received one or more doses of COVID-19 vaccine through June 7th, 2021. Vaccinated individuals were manually matched to identifiers from HIV surveillance data using LinkPlus software and an algorithmic filter to remove pairs with a low probability of being a true match.

The number and percent of PLWH who had received one or more doses of COVID-19 vaccine were tabulated for all PLWH and for sex, age, race/ethnicity, and HIV transmission category. A log-binomial model was used to estimate prevalence ratios and confidence intervals. We calculated the cumulative proportion of PLWH and other

Washingtonians who received one or more doses of COVID-19 vaccine by date and displayed this information in a time-series. We compared the final proportion using a chi-squared test. We calculated percentages using denominators from United States Census estimates of population eligible for the vaccine — above the age of 12 and HIV surveillance estimates from the WA DOH.[5,6]

Results

As of 6/7/2021, 9,468 PLWH had received one or more doses of COVID-19 vaccine, representing 66% of PLWH in Washington State. In comparison, 4,176,405 Washingtonians who were not living with diagnosed HIV received the vaccine, representing 64% of this population ($p<0.01$, Figure 2-1). Vaccine uptake was lowest among female PLWH; PLWH who are Black, Native Hawaiian or other Pacific Islander (NHOPI), or American Indian/Alaska Native (AI/AN); young PLWH; and PLWH who inject drugs (Table 2-1). Vaccine uptake was higher in King County than in other parts of the state.

Conclusions

Since arrival of the COVID-19 vaccine in December of 2020, at least 66% of PLWH have received one or more doses of the COVID-19 vaccine. This is comparable to the proportion of the general population that has been vaccinated in Washington state. Vaccine uptake was lowest among female PLWH, PLWH who are Black, NHOPI, or AI/AN; young PLWH, and PLWH who inject drugs.

This data suggests that campaigns to promote vaccination have been reasonably effective in reaching PLWH, although as a population at higher risk of COVID-19 morbidity, a higher rate of vaccination should be targeted. PLWH have had access to the vaccine for

Table 2-1: COVID Vaccination Status (One or More Doses) Among People Living with HIV by Demographic Categories, Washington State 6/7/2021

Attribute	Value	COVID-19 Vaccinated	All PLWH	Percent	Prevalence Ratio
Total	-	9,468	14,332	66%	-
Sex at Birth	Female	1,304	2,211	59%	0.87 (0.84-0.91)
	Male	8,164	12,111	67%	Reference
Race[A]	White	5,505	7,998	69%	Reference
	Black	1,474	2,487	59%	0.54 (0.52-0.56)
	Hispanic	1,389	2,211	63%	0.91 (0.88-0.95)
	Asian	398	531	75%	1.09 (1.03-1.15)
	NHOPI	35	64	55%	0.79 (0.64-0.99)
	AI/AN	77	139	55%	0.52 (0.43-0.62)
	Multiple Races	585	886	66%	0.96 (0.91-1.01)
Age in years	12-19	0	10	0%	-
	20-39	440	966	46%	0.78 (0.72-0.83)
	40-59	3,312	5,644	59%	Reference
	60-79	5,150	7,004	74%	1.25 (1.22-1.29)
	≥80	566	719	79%	1.34 (1.28-1.40)
Transmission Category	MSM	6,308	8,820	72%	Reference
	IDU	379	805	47%	0.66 (0.61-0.71)
	MSM+IDU	788	1,281	62%	0.86 (0.82-0.90)
	Heterosexual	1,070	1,782	60%	0.84 (0.81-0.87)
	NRR	823	1,456	57%	0.79 (0.75-0.82)
	Other	100	178	56%	0.79 (0.69-0.89)
Geography	King County	5,178	7115	73%	1.23 (1.20-1.26)
	Other	4,290	7228	59%	Reference

[A] Six PLWH were of unknown race and are not represented.

approximately three months longer than entire general population, suggesting that uptake may be slower.[7] There is scant literature on the uptake of the COVID-19 vaccine among other populations at high risk of COVID-19 morbidity.

The subpopulations of PLWH with low vaccination rates overlap those that are not engaged in HIV care more generally. Black PLWH (78% viral suppression), young PLWH (74% viral suppression among those between 25 and 34), and PLWH who inject drugs (75% viral suppression) have the lowest rates of viral suppression rates in the state (82% viral suppression overall).[5] This suggests that the factors affecting access to HIV care may also be barriers to vaccination. The population trends among PLWH are distinct from the general population, where females have a higher rate of vaccination and the racial differences are less pronounced.[3]

There is potential for misclassification and underestimation of vaccination rates if not all vaccinations are present in the vaccine registry. However, there is no evidence that this would differ according to HIV status or the demographic characteristics we investigated. The accuracy of our estimates of the vaccination rates among PLWH is also dependent on the accuracy of the Link Plus match.

The results of our analysis suggest that PLWH are being vaccinated at a rate comparable to the general population, but significant disparities remain. The WA DOH, PHSKC, and other HIV service providers should prioritize vaccine education and distribution to increase uptake in this high-risk population.

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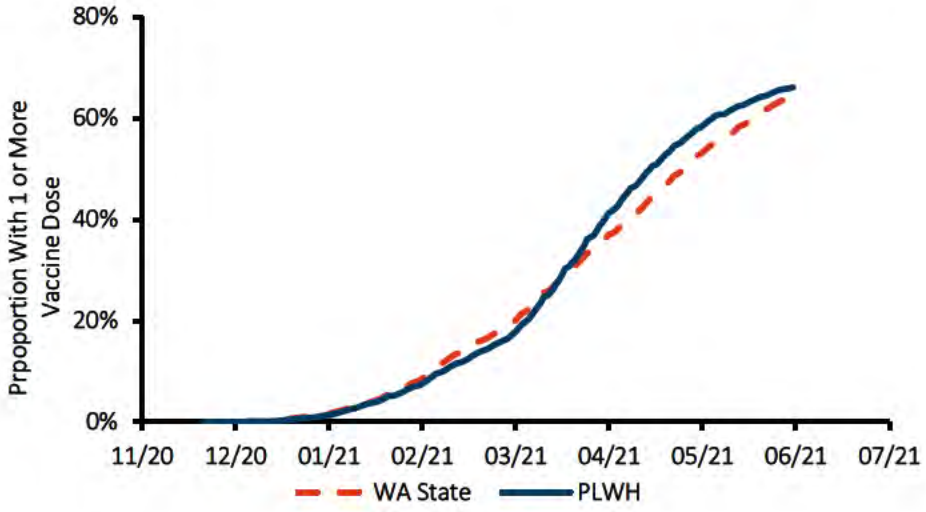
Contributed by Steven Erly, Kelly Naismith, and Jennifer Reuer

FIGURE 2-1: PROPORTION OF POPULATION (AGE 12+ YEARS) RECEIVING ONE OR MORE DOSES OF COVID-19 VACCINE BY HIV STATUS, WASHINGTON STATE, 6/7/2021



PLWH=People living with HIV

The Impact of the COVID-19 Pandemic on Core HIV Surveillance Metrics

Introduction

Standardized HIV metrics are the cornerstone of monitoring HIV prevention and care and allow public health professionals to plan, evaluate, and compare programs. The four most prominent HIV metrics, which are used across the United States, are the number of new diagnoses, the proportion of people newly diagnosed with HIV linked to care within 30 days of diagnosis, the proportion of people living with HIV (PLWH) engaged in care, and the proportion of PLWH virally suppressed. Three of these metrics - linkage to care, engagement in care, and viral suppression - have shown continual improvement over the preceding five years in Washington State, but declined markedly during the first year of the COVID-19 pandemic. Conversely, the number of new diagnoses in Washington state gradually increased from 2015 to 2019 but dropped precipitously in 2020.

The change in these metrics is noteworthy, but it isn't clear if they represent a change in HIV transmission and population viral load, access to HIV testing and care, or an artifact of the way the outcomes are measured, or some combination of these factors. The core HIV surveillance metrics are dependent on laboratory reporting and are only accurate if laboratory reporting presents a valid picture of HIV care quality. There is anecdotal evidence that many PLWH switched to telehealth in the beginning of the COVID-19 pandemic and were able to continue accessing medical care and antiretroviral therapy without routine laboratory monitoring. Concern about the safety of healthcare settings may have also led to a decrease in the amount of HIV diagnostic testing and new infections may have gone undetected. Individuals already experiencing barriers to care access may have found those barriers increased due to pandemic impacts.

To understand the relationship between the change in these metrics and changes in HIV prevention and care, it is necessary to examine the data in the context of multiple data sources. The purposes of this study were to: 1) quantify deviation from historical trends in core HIV metrics associated with the COVID-19 pandemic; 2) examine changes to the volume of electronic laboratory reporting (ELR) reporting and HIV testing during the same time period; and 3) identify commensurate changes in AIDS Drug Assistance Program (ADAP) data and demographic trends in new HIV diagnoses during 2020.

Methods

We compiled all HIV laboratory reports received by the Washington State Department of Health's (WA DOH) automated ELR system between 10/1/2019 (when the most recent ELR system was implemented) and 12/1/2020. This includes all positive HIV tests (antigen

and antibody), HIV genotype testing, HIV viral load testing, and CD4 tests related to HIV care. It also includes a relatively small number of CD4 tests that are performed for non-HIV conditions and are reported. We categorized tests as either "diagnostic" (HIV tests and genotypes) or "care" (viral load and CD4 tests) and displayed the number of reports as a time series. Washington also receives all HIV test results in Washington state from a nationwide laboratory, which prior unpublished work suggests are regionally and demographically representative of the population at high risk of HIV in the state. We calculated the number of tests performed by month between 10/1/2019 and 12/1/2020 and displayed these numbers as a time series. Finally, we extracted the number of new diagnoses by mode of transmission and the total number of PLWH from the Washington state HIV registry from 2016 through 2020. We also extracted the total number of ADAP clients and the number of ADAP clients who filled one or more antiretroviral (ART) prescription from the Washington Ryan White data system.

We calculated the proportion of people newly diagnosed with HIV who received a CD4 or viral load test within 30 days of diagnosis (linked to care in 30 days), the number PLWH who received a CD4 or viral load test in each calendar year (engaged in care), the number of PLWH who received a viral load test in a calendar year and whose final viral load result was less than or equal to 200 copies per mL (virally suppressed), and the number of ADAP clients who filled one or more ART prescription.

We presented the overall counts and percentages for each metric by year. We used a Poisson model to estimate the values for 2020 if trends from prior years had continued using a linear term for year. This model contained a term for calendar year and an indicator for the presence of the COVID pandemic in 2020. To assess the significance of the divergence of historical trends in 2020, we reported the p-value from the Wald statistic of the indicator variable.

Results

From 10/1/2019 to 12/1/2020, an average of 5,074 HIV labs were reported through the WA DOH ELR system per month. Of these 5,074, an average of 4,172 (82%) were HIV care labs and 902 (18%) were diagnostic labs. There was a large decrease in ELR reports in the beginning of 2020, centered in April of 2020, when there were only 3,044 labs (40% decrease). The decrease was equivalent between care (2,495 labs reported; 40% decrease) and diagnostic labs (549 labs reported; 40% decrease; **Figure 3-1**). There was a similar decrease in the volume of overall testing performed (**Figure 3-2**). While there was an increase in laboratory testing starting in May 2020, the volume of testing did not return to that seen at the end of 2019, much less increase to make up for testing missed in the spring. There was a significant deviation from historical trends in 2020 in engagement in care (projected 88%, actual 85%, p=0.03) and viral suppression (projected 83%, actual 79%, p<0.01), but not linkage to care (projected 83%, actual 81%, p=0.73) or viral suppression among those engaged in care (projected 93%, actual 92%, p=0.21). New HIV diagnoses were similarly depressed in total (projected 424, actual 359, p=0.03) and among people who inject drugs (PWID) (projected 52, actual 11, p<0.01), but not among men who have sex with men (MSM) (projected 245, actual 223, p=0.37). The percentage of ADAP clients who filled ART prescriptions exceeded what would be expected from prior years, but not significantly so (projected 80%, actual 82%, p=0.31, **Table 3-1**).

Discussion

During the 2020 COVID-19 pandemic, there were significant deviations from historical trends in the metrics of engagement in HIV care and viral suppression but not linkage to care or viral suppression among those engaged in care. The overall number of new HIV diagnoses in 2020 was significantly lower than predicted, as were the number of diagnoses among PWID but not MSM. There was a large decrease in the number of HIV labs performed in Washington at the beginning of 2020.

Taken together, the HIV care data point to a disconnect between the surveillance metrics and the ability of PLWH to access care. The consistency in the proportion of ADAP clients who filled an ART prescription and viral suppression among those engaged in care suggest that the ability to access care within these populations was not disrupted by the pandemic. The decrease in ELR volume at the beginning of the pandemic suggests that many people forewent routine laboratory testing, but this does not preclude access to ART.

The decrease in HIV testing during the pandemic suggests that the decrease in HIV diagnoses seen during 2020 may, at least in part, represent a lack of detection rather than a decrease in transmission. Although it is possible that some of this decline represents a change in

FIGURE 3-1. HIV LABS REPORTED THROUGH WASHINGTON STATE AUTOMATED ELECTRONIC LABORATORY SYSTEM BY MONTH AND TYPE, 10/2019-12/2020

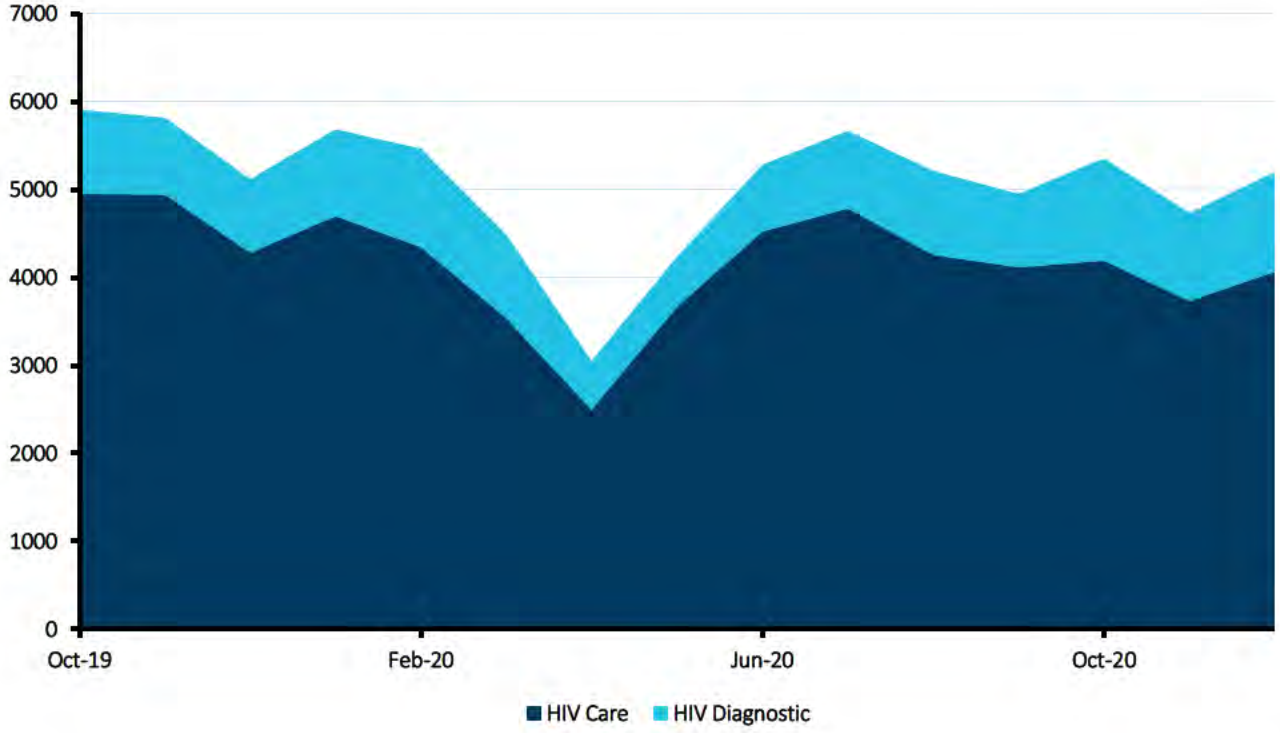


FIGURE 3-2. HIV TESTS REPORTED TO WASHINGTON STATE, 10/2019-12/2020

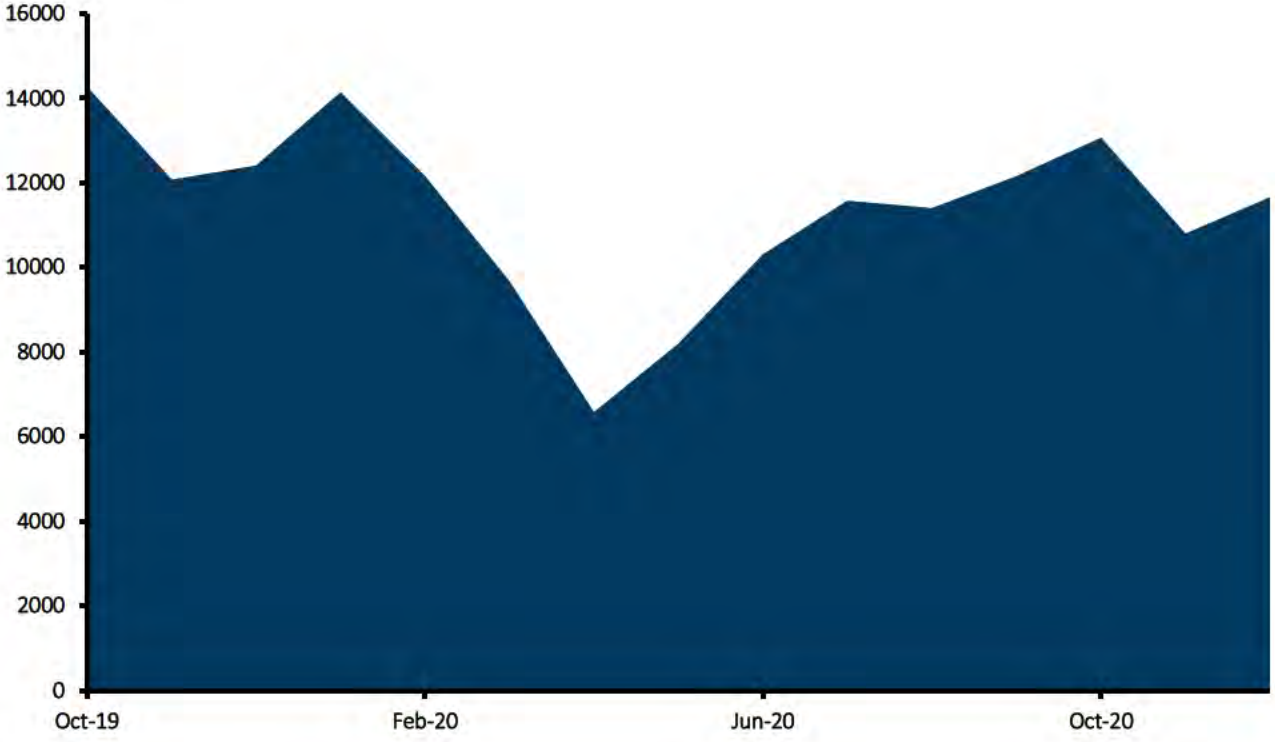


TABLE 3-1: HIV DIAGNOSES, CARE METRICS, AND ADAP UTILIZATION FOR WASHINGTON STATE, PROJECTED AND ACTUAL, 2016-2020

Metric[A]	2016	2017	2018	2019	2020 Actual	2020 Projected[B]	P-value
Prevalence	12,776	13,274	13,652	13,862	14,061	-	-
-Linkage to Care (30 Days)	302 (82%)	313 (83%)	334 (83%)	337 (83%)	290 (81%)	83% (73-90%)	0.73
-Engagement in Care	11,068 (87%)	11,526 (87%)	11,858 (87%)	12,198 (88%)	12,004 (85%)	88% (86-90%)	0.03
-Viral Suppression	9,783 (77%)	10,427 (79%)	10,863 (80%)	11,260 (81%)	11,064 (79%)	83% (81-85%)	<0.01
-Viral Suppression Among Those Engaged in Care	9,783 (88%)	10,427 (90%)	10,863 (92%)	11,260 (92%)	11,064 (92%)	93% (92-96%)	0.21
New HIV Diagnoses	370	375	401	408	359	424 (376-478)	0.03
-MSM Diagnoses	193	211	199	240	223	245	0.37
-IDU Diagnoses	28	19	43	41	11	52	<0.01
ADAP Enrollment	4,079	4,265	4,514	4,783	4,682	5,033 (4,858-5,215)	**<0.01**
# (%) of Clients with ART Fills	3,268 (80%)	3,416 (80%)	3,612 (80%)	3,806 (80%)	3,822 (82%)	80% (76-83%)	0.31

[A] Engaged in care defined as receiving one or more CD4 or viral load test in a calendar year. Virally suppressed defined as receiving one or more viral load in a calendar year and the final viral load result being less than or equal to 200 copies per mL. Linked to care defined as receiving a CD4 or viral load test within 30 days of HIV diagnosis

[B] Projected value and p-value from Poisson model with linear term for year and an indicator variable for the year 2020.

MSM=men who have sex with men; IDU = Injection drug users; ART=antiretroviral

risk behavior during the pandemic, the large median time between infection and treatment among PLWH (three years according to national estimates) suggests that any impact would occur on a much longer timescale that what was assessed here.[1] The contrast between the sharp decrease in new HIV diagnoses among PWID and small decrease among MSM is suggests that populations with greater barriers to HIV testing and care may have been more affected by the pandemic. The high level of linkage to care among individuals newly diagnosed may also support the idea that barriers were exacerbated during the earlier days of the pandemic. Indeed, there is data from syringe services programs that HIV testing stopped at many programs and has likely led to a decrease in HIV testing among PWID during the pandemic.[2,3]

There are a number of limitations to this study. Our projection of 2020 data relies on an assumption of linear trends, which may be an oversimplification. In particular, the number of new diagnoses and the proportion of PLWH who are virally suppressed among those who are engaged in care changed more at the beginning of our study time period than at the end, and the projections may be an overestimate of what would have been seen in 2020 if the pandemic had not occurred. There was also an outbreak of HIV among PWID in King County in 2018 and 2019 which likely inflated the expected number of new diagnoses attributed to injection drug use in 2020. The population of PLWH who are engaged in care or who use ADAP services are a subset of PLWH in the state who are successful in navigating medical systems, and their ability to access ART during the pandemic may not represent the experience of all.

The core HIV metrics defined by CDC are valuable tools for evaluating progress in the HIV epidemic and comparing jurisdictions. However, the evidence we present suggests that they do not accurately reflect the complex changes to healthcare that occurred during the COVID-19 pandemic. We suggest that the data from 2020 be interpreted with caution and that other sources of information be integrated in program decision-making.

Contributed by: Steven Erly, Jen Reuer, Leticia Campos

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WASHINGTON STATE HIV SURVEILLANCE REPORT 2022 EDITION

Washington State Department of Health

DOH 150-030

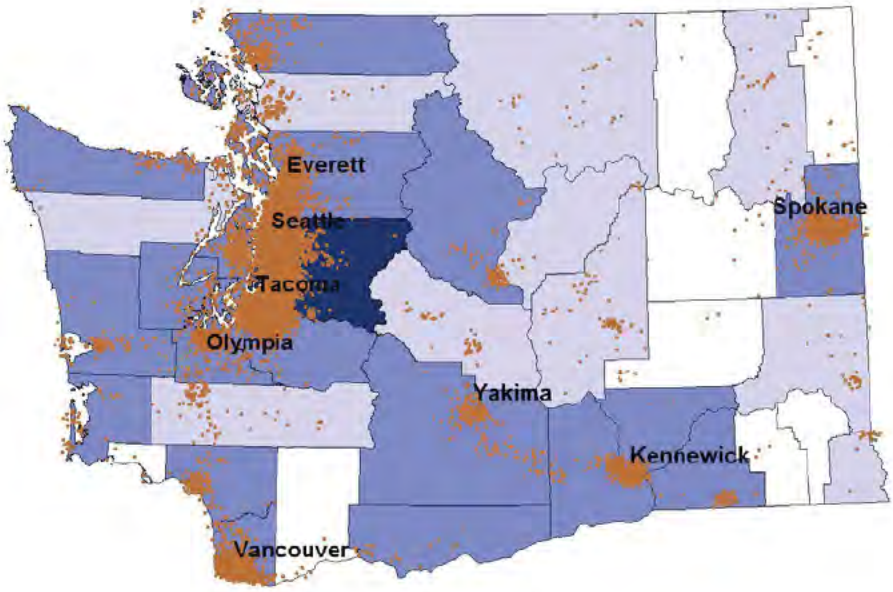
Office of Infectious Disease Assessment Unit (360) 236-3455 www.doh.wa.gov/HIVAIDSData

What's in this report?

HIV IN WASHINGTON: AN OVERVIEW

- In Washington, the first case of HIV was diagnosed in 1981.
- There are roughly 14,000 people living with HIV in Washington State, with about 400 new cases diagnosed each year.
- HIV has the largest impact on cisgender men, in particular cisgender men who have sex with men (MSM). On average, cisgender men make up 81% of the annual number of new cases, and male-male sex is the identified exposure in 63% of new cases.
- Just over half of all cases live in King County, which is the state's most populous and urban county.

Figure 1. Living HIV Cases and Prevalence Rates by County, 2021



Orange Dots = Location of Prevalent HIV Cases (Addresses Randomized Around Zip Code Centroid)

Prevalence Rate per 100,000
- Less than 90
- 90-180
- Greater than 180
- Rate Not Available

STATISTICS: NEW HIV CASES

Table 1. New HIV and AIDS Cases, Late HIV Diagnoses and Linkage to Care, by Demographic and Risk Characteristics, WA State, 2021

	New AIDS Cases			New HIV Cases			Late HIV Diagnoses[a]		Initial Linkage to HIV Care[b]	
	no.	column %	rate	no.	column %	rate	no.	row %	no.	row %
Total	185	100%	2.4	406	100%	5.2	92	23%	320	79%
Gender										
Cisgender men	151	82%	3.9	321	79%	8.3	78	24%	255	79%
Cisgender women	30	16%	0.8	71	17%	1.8	14	20%	55	77%
Transgender men	0	0%	n/a	3	1%	n/a	--	--	--	--
Transgender women	4	2%	n/a	11	3%	n/a	0	0%	7	64%
Age at HIV Diagnosis										
<15	0	0%	0.0	2	0%	0.1[NR]	--	--	--	--
15-24	12	6%	1.2[NR]	51	13%	5.3	6	12%	43	84%
25-34	42	23%	3.8	141	35%	12.9	19	13%	111	79%
35-44	56	30%	5.4	98	24%	9.4	31	32%	76	78%
45-54	39	21%	4.1	72	18%	7.7	21	29%	55	76%
55-64	28	15%	2.9	32	8%	3.3	12	38%	27	84%
65+	8	4%	0.6[NR]	10	2%	0.7[NR]	3	30%	7	70%
Race/ethnicity										
AI/AN	2	1%	2.2[NR]	8	2%	8.7[NR]	--	--	--	--
Asian	10	5%	1.3	18	4%	2.4	6	33%	14	78%
Black	39	21%	12.8	79	19%	25.9	19	24%	61	77%
Foreign-born[c]	18	10%	25.6	29	7%	41.2	12	41%	21	72%
U.S.-born[c]	17	9%	7.1	31	8%	13.0	4	13%	27	87%
LAT/HISP	44	24%	4.0	96	24%	8.7	23	24%	80	83%
Foreign-born[c]	21	11%	7.1	42	10%	14.2	9	21%	36	86%
U.S.-born[c]	15	8%	2.0[NR]	28	7%	3.7	6	21%	23	82%
NHOPI	1	1%	1.5[NR]	7	2%	10.8[NR]	--	--	--	--
White	77	42%	1.6	181	45%	3.7	40	22%	140	77%
Multiple	12	6%	2.4[NR]	17	4%	3.3	3	18%	15	88%
Mode of Exposure										
MSM	96	52%	n/a	217	53%	n/a	47	22%	172	79%
PWID	8	4%	n/a	23	6%	n/a	2	9%	18	78%
MSM/PWID	12	6%	n/a	34	8%	n/a	2	6%	24	71%
Heterosexual	24	13%	n/a	45	11%	n/a	10	22%	39	87%
Blood/pediatric	3	2%	n/a	2	0%	n/a	--	--	--	--
NIR	42	23%	n/a	85	21%	n/a	31	36%	66	78%

Abbreviations: AI/AN, American Indian or Alaska Native; LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NHOPI, Native Hawaiian or Other Pacific Islander; NIR, no identified risk; PWID, people who inject drugs

n/a Rate cannot be calculated due to no available population estimate

-- Due to the small number of HIV cases, the count and percentage based on the count is not shown

[NR] Not reliable, RSE ≥25

[a] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnosis

[b] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnosis

[c] Country of origin data are missing for approximately 10% and 38% of newly diagnosed cases among Black and LAT/HISP, respectively

STATISTICS: NEW HIV CASES (continued)

Table 2. New HIV Cases, including Late HIV Diagnoses and Linkage to Care, by County and Health District (HD) of Residence at HIV Diagnosis, WA State, 2021

County or Health District or Residence	New HIV Cases			Late HIV Diagnoses[a]		Initial Linkage to HIV Care[b]	
	no.	column %	rate	no.	row %	no.	row %
Adams Co.	0	0%	0.0	0	0%	0	0%
Asotin Co.	0	0%	0.0	0	0%	0	0%
Benton Co.	12	3%	5.7[NR]	5	42%	12	100%
Benton-Franklin HD	18	4%	5.8	6	33%	15	83%
Chelan Co.	5	1%	6.3[NR]	--	--	--	--
Chelan-Douglas HD	5	1%	4.0[NR]	--	--	--	--
Clallam Co.	5	1%	6.4[NR]	--	--	--	--
Clark Co.	26	6%	5.1	3	12%	20	77%
Columbia Co.	0	0%	0.0	0	0%	0	0%
Cowlitz Co.	6	1%	5.4[NR]	--	--	--	--
Douglas Co.	0	0%	0.0	0	0%	0	0%
Ferry Co.	1	0%	13.8[NR]	--	--	--	--
Franklin Co.	6	1%	6.1[NR]	--	--	--	--
Garfield Co.	0	0%	0.0	0	0%	0	0%
Grant Co.	1	0%	1.0[NR]	--	--	--	--
Grays Harbor Co.	4	1%	5.3[NR]	--	--	--	--
Island Co.	0	0%	0.0	0	0%	0	0%
Jefferson Co.	0	0%	0.0	0	0%	0	0%
King Co.	182	45%	8.0	40	22%	149	82%
Kitsap Co.	5	1%	1.8[NR]	--	--	--	--
Kittitas Co.	0	0%	0.0	0	0%	0	0%
Klickitat Co.	0	0%	0.0	0	0%	0	0%
Lewis Co.	4	1%	4.8[NR]	--	--	--	--
Lincoln Co.	1	0%	9.2[NR]	--	--	--	--
Mason Co.	3	1%	4.6[NR]	--	--	--	--
NE Tri-County HD	1	0%	1.5[NR]	--	--	--	--
Okanogan Co.	0	0%	0.0	0	0%	0	0%
Pacific Co.	0	0%	0.0	0	0%	0	0%
Pend Oreille Co.	0	0%	0.0	0	0%	0	0%
Pierce Co.	59	15%	6.4	12	20%	41	69%
San Juan Co.	0	0%	0.0	0	0%	0	0%
Skagit Co.	2	0%	1.5[NR]	--	--	--	--
Skamania Co.	0	0%	0.0	0	0%	0	0%
Snohomish Co.	30	7%	3.6	8	27%	22	73%
Spokane Co.	22	5%	4.1	6	27%	20	91%
Stevens Co.	0	0%	0.0	0	0%	0	0%
Thurston Co.	16	4%	5.4[NR]	3	19%	12	75%
Wahkiakum Co.	0	0%	0.0	0	0%	0	0%
Walla Walla Co.	1	0%	1.6[NR]	--	--	--	--
Whatcom Co.	3	1%	1.3[NR]	--	--	--	--
Whitman Co.	4	1%	9.0[NR]	--	--	--	--
Yakima Co.	8	2%	3.1[NR]	0	0%	6	75%
Total	406	100%	5.2	92	23%	320	79%

-- Due to the small number of HIV cases, the count and percentage based on the count is not shown

[NR] Not reliable, RSE ≥25

[a] Late HIV diagnoses = AIDS diagnoses within 12 months of HIV diagnoses

[b] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnosis

STATISTICS: NEW HIV CASES (continued)

Table 3. New HIV Case Counts over Time, by Demographic and Risk Characteristics, WA State, 2017-2021

	2017	2018	2019	2020	2021	2017-2021			
	no.	no.	no.	no.	no.	total no.	avg. no.	%	rate
Total	376	399	406	357	406	1944	389	100%	5.2
Gender									
Cisgender men	303	308	334	304	321	1570	314	81%	8.3
Cisgender women	67	88	64	48	71	338	68	17%	1.8
Transgender men	1	0	1	0	3	5	1	0%	n/a
Transgender women	5	3	7	5	11	31	6	2%	n/a
Age at HIV Diagnosis									
<15	4	0	1	0	2	7	1	0%	0.1[NR]
15-24	58	54	60	54	51	277	55	14%	5.0
25-34	144	138	163	125	141	711	142	37%	13.4
35-44	62	92	76	84	98	412	82	21%	8.3
45-54	64	66	64	46	72	312	62	16%	6.7
55-64	35	41	31	36	32	175	35	9%	3.6
65+	9	8	11	12	10	50	10	3%	0.8[NR]
Race/ethnicity									
AI/AN	4	2	2	5	8	21	4	1%	4.5[NR]
Asian	24	16	18	29	18	105	21	5%	3.1
Black	72	82	67	57	79	357	71	18%	24.7
Foreign-born[a]	37	43	29	20	29	158	32	8%	43.2
U.S.-born[a]	31	34	34	26	31	156	31	8%	14.3
LAT/HISP	80	71	95	56	96	398	80	20%	7.9
Foreign-born[a]	39	29	52	20	42	182	36	9%	11.9
U.S.-born[a]	34	30	29	20	28	141	28	7%	4.1
NHOPI	3	5	3	4	7	22	4	1%	8.0[NR]
White	177	198	201	189	181	946	189	49%	3.7
Multiple	16	25	20	17	17	95	19	5%	5.3
Mode of Exposure									
MSM	210	199	241	224	217	1091	218	56%	n/a
PWID	19	44	41	13	23	140	28	7%	n/a
MSM/PWID	27	39	23	21	34	144	29	7%	n/a
Heterosexual	38	50	38	27	45	198	40	10%	n/a
Blood/pediatric	5	2	2	0	2	11	2	1%	n/a
NIR	77	65	61	72	85	360	72	19%	n/a

Abbreviations: AI/AN, American Indian or Alaska Native; LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NHOPI, Native Hawaiian or Other Pacific Islander; NIR, no identified risk; PWID, people who inject drugs
n/a Rate cannot be calculated due to no available population estimate

[NR] Not reliable, RSE ≥25

[a] Country of origin data are missing for approximately 10% and 38% of newly diagnosed cases among Black and LAT/HISP, respectively

STATISTICS: NEW HIV CASES (continued)

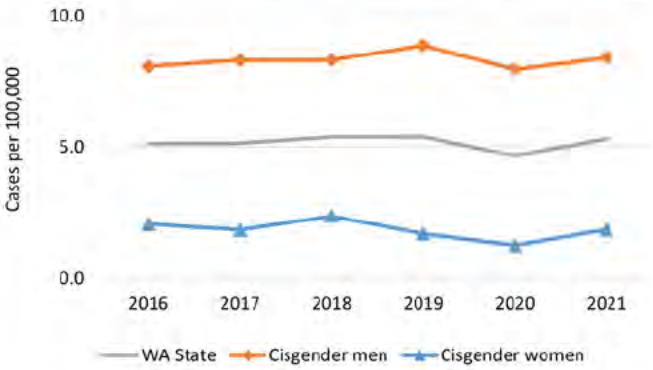
Table 4. New HIV Case Counts over Time, by County and Health District (HD) of Residence at HIV Diagnosis, WA State, 2017-2021

County and Health District of Residence	2017	2018	2019	2020	2021	2017-2021			
	no.	no.	no.	no.	no.	total no.	avg. no.	%	rate
Adams Co.	0	0	1	1	0	2	0	0%	2.0[NR]
Asotin Co.	0	0	0	0	0	0	0	0%	0.0
Benton Co.	2	0	13	6	12	33	7	2%	3.3
Benton-Franklin HD	0	0	0	0	0	0	0	0%	0.0
Chelan Co.	1	3	2	1	5	12	2	1%	3.1[NR]
Chelan-Douglas HD	0	0	0	0	0	0	0	0%	0.0
Clallam Co.	2	5	2	1	5	15	3	1%	3.9[NR]
Clark Co.	24	21	28	22	26	121	24	6%	4.9
Columbia Co.	1	0	0	0	0	1	0	0%	4.9[NR]
Cowlitz Co.	4	1	3	2	6	16	3	1%	2.9[NR]
Douglas Co.	1	1	2	2	0	6	1	0%	2.8[NR]
Ferry Co.	0	0	0	0	1	1	0	0%	2.6[NR]
Franklin Co.	1	5	6	4	6	22	4	1%	4.7
Garfield Co.	0	0	0	0	0	0	0	0%	0.0
Grant Co.	0	4	2	3	1	10	2	1%	2.0[NR]
Grays Harbor Co.	4	0	2	1	4	11	2	1%	3.0[NR]
Island Co.	3	2	5	3	0	13	3	1%	3.1[NR]
Jefferson Co.	0	1	0	0	0	1	0	0%	0.6[NR]
King Co.	178	226	189	167	182	942	188	48%	8.5
Kitsap Co.	9	9	9	4	5	36	7	2%	2.7
Kittitas Co.	0	1	2	1	0	4	1	0%	1.7[NR]
Klickitat Co.	1	0	0	1	0	2	0	0%	1.8[NR]
Lewis Co.	0	1	2	1	4	8	2	0%	2.0[NR]
Lincoln Co.	1	0	0	0	1	2	0	0%	3.7[NR]
Mason Co.	4	5	5	4	3	21	4	1%	6.5
NE Tri-County HD	0	0	0	0	0	0	0	0%	0.0
Okanogan Co.	0	0	1	0	0	1	0	0%	0.5[NR]
Pacific Co.	0	1	0	0	0	1	0	0%	0.9[NR]
Pend Oreille Co.	0	0	1	0	0	1	0	0%	1.5[NR]
Pierce Co.	41	49	53	52	59	254	51	13%	5.7
San Juan Co.	0	0	0	0	0	0	0	0%	0.0
Skagit Co.	4	3	3	5	2	17	3	1%	2.7
Skamania Co.	0	0	0	0	0	0	0	0%	0.0
Snohomish Co.	27	20	29	23	30	129	26	7%	3.2
Spokane Co.	22	16	26	32	22	118	24	6%	4.6
Stevens Co.	0	0	0	2	0	2	0	0%	0.9[NR]
Thurston Co.	10	8	6	8	16	48	10	2%	3.3
Wahkiakum Co.	0	0	0	0	0	0	0	0%	0.0
Walla Walla Co.	2	1	0	1	1	5	1	0%	1.6[NR]
Whatcom Co.	8	3	5	3	3	22	4	1%	2.0
Whitman Co.	0	3	0	1	4	8	2	0%	3.3[NR]
Yakima Co.	26	10	9	6	8	59	12	3%	4.6
Total	376	399	406	357	406	1944	389	100%	5.2

[NR] Not reliable, RSE ≥25

STATISTICS: NEW HIV CASES (continued)

Figure 2. New HIV Case Rates by Gender,* WA State, 2016-2021



*Rates for transgender populations not available due to small case counts

Figure 3. New HIV Case Rates by Age at Diagnosis, WA State, 2016-2021

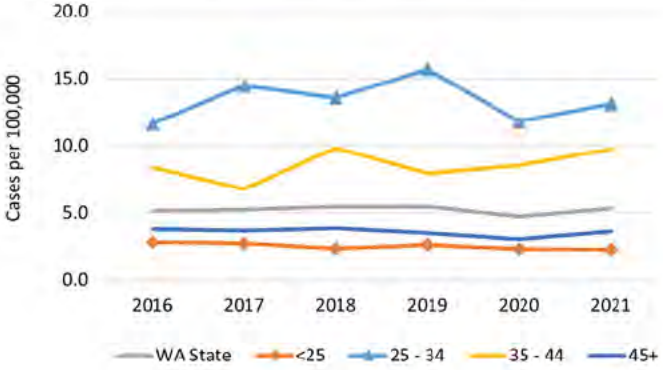


Figure 4. New HIV Case Rates among Black Persons by Nativity, WA State, 2016-2021

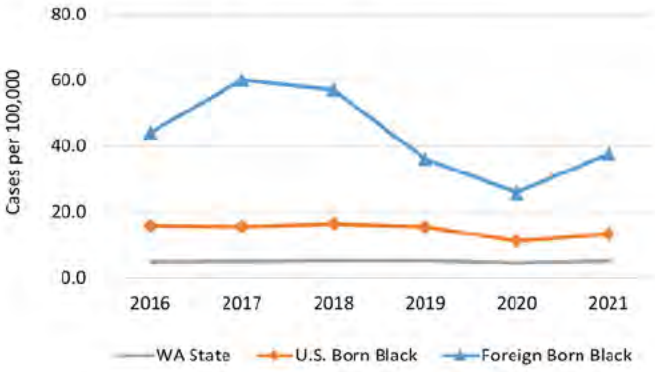


Figure 5. New HIV Case Rates among Latina/o/x and Hispanic (LAT/HISP) Persons by Nativity, WA State, 2016-2021

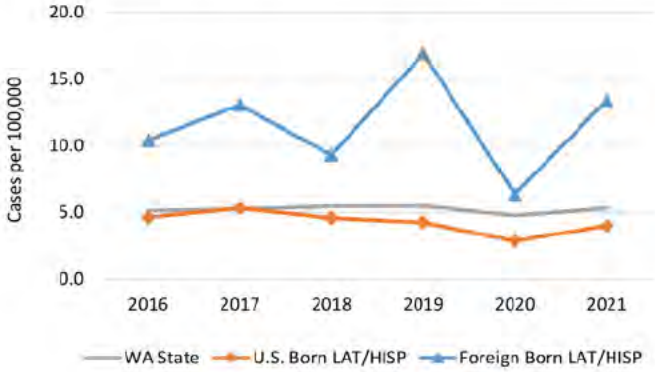
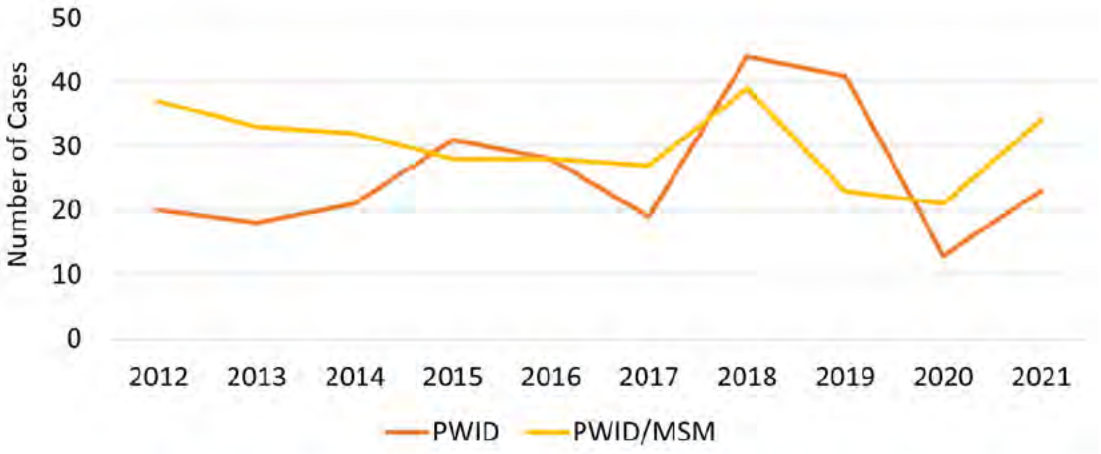


Figure 6. New HIV Case Counts among Persons who Inject Drugs (PWID) and PWID/MSM, WA State, 2012-2021



STATISTICS: NEW HIV CASES (continued)

Table 5. New Cases of HIV Infection, by Current Gender*, Race/Ethnicity, and HIV Exposure Category, WA State, 2017-2021

Gender	Exposure Category	Asian		Black		LAT/HISP		Other		White	
		No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender men	MSM	64	76%	128	58%	275	79%	76	74%	522	64%
	PWID	1	1%	8	4%	7	2%	3	3%	61	7%
	MSM and PWID	0	0%	8	4%	11	3%	11	11%	110	14%
	Heterosexual Contact	0	0%	10	5%	10	3%	1	1%	14	2%
	Blood/Pediatric	0	0%	3	1%	0	0%	0	0%	1	0%
	NIR	19	23%	63	29%	46	13%	12	12%	106	13%
	Total	84	100%	220	100%	349	100%	103	100%	814	100%
		Asian		**Black**		**LAT/HISP**		**Other**		**White**	
		No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender women	PWID	0	0%	4	3%	5	13%	8	29%	43	35%
	Heterosexual Contact	8	50%	64	49%	25	64%	14	50%	50	40%
	Blood/Pediatric	0	0%	5	4%	1	3%	0	0%	1	1%
	NIR	8	50%	58	44%	8	21%	6	21%	30	24%
	Total	16	100%	131	100%	39	100%	28	100%	124	100%
		Total									
		No.	%	No.	%	No.	%	No.	%	No.	%
Transgender women	Sex with men	26	84%	-	-	-	-	-	-	-	-
	Sex with men and PWID	4	13%	-	-	-	-	-	-	-	-
	NIR	1	3%	-	-	-	-	-	-	-	-
	Total	31	100%	-	-	-	-	-	-	-	-

Abbreviations: LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NIR, no identified risk; PWID, people who inject drugs
* Due to the small number of HIV cases reported as transgender men, they were not included in this table

Figure 7. New HIV Case Rates, WA State, 2012-2021

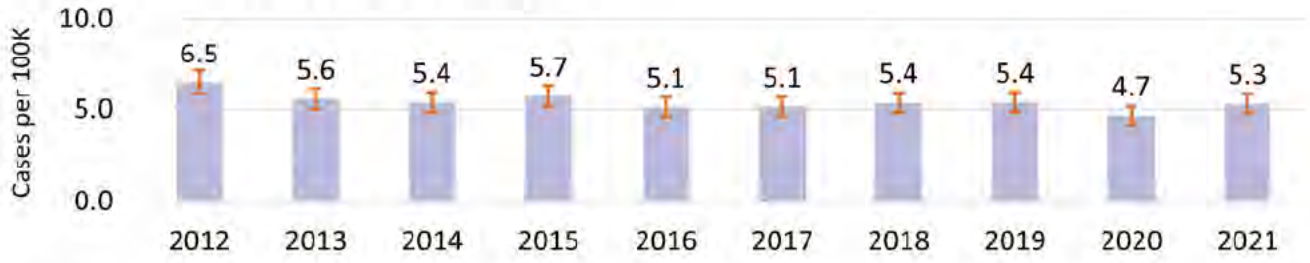
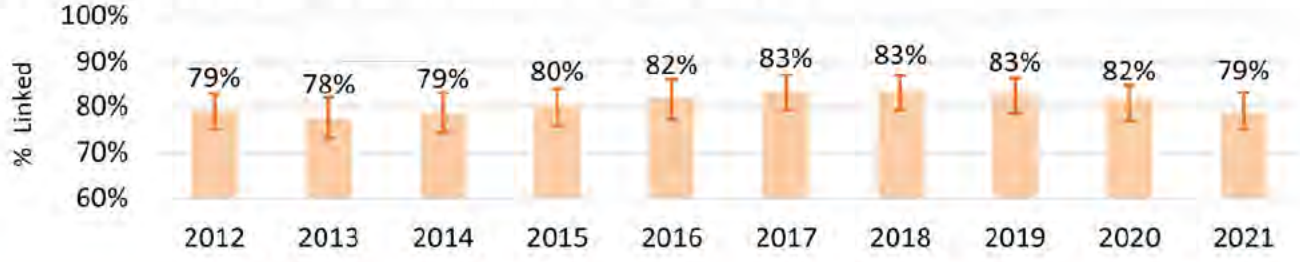


Figure 8. Linkage to Care among New HIV Cases, WA State, 2012-2021



STATISTICS: PREVALENT HIV CASES

Table 6. Prevalent Cases of HIV, Including Engagement in Care and Viral Load Suppression, by Demographic and Risk Characteristics, WA State, 2021

	Prevalent Cases of HIV			Engaged in Care[a]		Suppressed Viral Load[b]	
	no.	column %	rate	no.	row %	no.	row %
Total	14517	100%	186.9	12567	87%	11564	80%
Gender							
Cisgender men	2264	16%	58.2	1955	86%	1762	78%
Cisgender women	12083	83%	311.8	10465	87%	9674	80%
Transgender men	151	1%	n/a	130	86%	112	74%
Transgender women	19	0%	n/a	17	89%	16	84%
Current Age							
<15	35	0%	2.5	32	91%	31	89%
15-24	270	2%	27.8	232	86%	194	72%
25-34	1924	13%	175.6	1566	81%	1382	72%
35-44	2880	20%	277.3	2384	83%	2130	74%
45-54	3648	25%	387.8	3175	87%	2910	80%
55-64	4015	28%	410.7	3577	89%	3392	84%
65+	1745	12%	129.8	1601	92%	1525	87%
Race/ethnicity							
AI/AN	133	1%	144.6	110	83%	96	72%
Asian	547	4%	73.1	489	89%	465	85%
Black	2557	18%	839.4	2169	85%	1962	77%
Foreign-born[c]	1112	8%	1579.0	973	88%	918	83%
U.S.-born[c]	1319	9%	552.6	1089	83%	953	72%
LAT/HISP	2296	16%	207.9	1961	85%	1797	78%
Foreign-born[c]	1139	8%	384.5	968	85%	907	80%
U.S.-born[c]	955	7%	125.4	824	86%	744	78%
NHOPI	69	0%	106.7	50	72%	46	67%
White	7986	55%	161.5	6960	87%	6445	81%
Multiple	925	6%	181.6	824	89%	749	81%
Mode of Exposure							
MSM	8935	62%	n/a	7830	88%	7345	82%
PWID	809	6%	n/a	657	81%	556	69%
MSM/PWID	1274	9%	n/a	1107	87%	945	74%
Heterosexual	1790	12%	n/a	1554	87%	1420	79%
Blood/pediatric	201	1%	n/a	179	89%	157	78%
NIR	1508	10%	n/a	1240	82%	1141	76%

Abbreviations: AI/AN, American Indian or Alaska Native; LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NHOPI, Native Hawaiian or Other Pacific Islander; NIR, no identified risk; PWID, people who inject drugs
n/a Rate cannot be calculated due to no available population estimate

[a] Engaged in care = at least one reported CD4 or VL result within calendar year
[b] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL
[c] Country of origin data are missing for approximately 5% and 9% of prevalent cases among Black and LAT/HISP, respectively

STATISTICS: PREVALENT HIV CASES (continued)

Table 7. Prevalent Cases of HIV, including Engagement in Care and Viral Load Suppression, by County and Health District (HD) of Current Residence, WA State, 2021

County or Health District of Residence	Prevalent Cases of HIV			Engaged in Care[a]		Suppressed Viral Load[b]	
	no.	column %	rate	no.	row %	no.	row %
Adams Co.	13	0%	62.2[NR]	9	69%	8	62%
Asotin Co.	20	0%	88.9	16	80%	16	80%
Benton Co.	203	1%	96.9	166	82%	106	52%
Benton-Franklin HD	297	2%	96.5	252	85%	159	54%
Chelan Co.	75	1%	93.8	60	80%	53	71%
Chelan-Douglas HD	98	1%	79.3	78	80%	70	71%
Clallam Co.	87	1%	111.9	75	86%	66	76%
Clark Co.	868	6%	169.2	667	77%	617	71%
Columbia Co.	3	0%	75.9[NR]	--	--	--	--
Cowlitz Co.	159	1%	142.6	128	81%	117	74%
Douglas Co.	23	0%	52.8	18	78%	17	74%
Ferry Co.	3	0%	41.4[NR]	--	--	--	--
Franklin Co.	94	1%	95.6	86	91%	53	56%
Garfield Co.	0	0%	0.0	0	0%	0	0%
Grant Co.	59	0%	58.5	54	92%	50	85%
Grays Harbor Co.	109	1%	143.3	90	83%	82	75%
Island Co.	106	1%	121.7	81	76%	81	76%
Jefferson Co.	49	0%	148.0	39	80%	36	73%
King Co.	7211	50%	315.3	6443	89%	6004	83%
Kitsap Co.	365	3%	131.4	302	83%	287	79%
Kittitas Co.	37	0%	81.8	32	86%	29	78%
Klickitat Co.	22	0%	95.7	18	82%	17	77%
Lewis Co.	74	1%	89.5	61	82%	56	76%
Lincoln Co.	11	0%	100.9[NR]	9	82%	8	73%
Mason Co.	78	1%	118.6	62	79%	59	76%
NE Tri-County HD	41	0%	60.8	29	71%	28	68%
Okanogan Co.	27	0%	63.8	23	85%	22	81%
Pacific Co.	39	0%	166.5	30	77%	28	72%
Pend Oreille Co.	12	0%	89.1[NR]	6	50%	6	50%
Pierce Co.	1633	11%	175.9	1356	83%	1222	75%
San Juan Co.	20	0%	112.0	18	90%	18	90%
Skagit Co.	100	1%	76.9	88	88%	85	85%
Skamania Co.	6	0%	51.1[NR]	--	--	--	--
Snohomish Co.	1242	9%	148.2	1086	87%	1032	83%
Spokane Co.	786	5%	145.0	677	86%	600	76%
Stevens Co.	26	0%	55.6	21	81%	20	77%
Thurston Co.	347	2%	116.5	299	86%	260	75%
Wahkiakum Co.	5	0%	111.7[NR]	--	--	--	--
Walla Walla Co.	58	0%	93.4	46	79%	45	78%
Whatcom Co.	255	2%	112.7	227	89%	208	82%
Whitman Co.	29	0%	65.0	24	83%	23	79%
Yakima Co.	263	2%	101.9	237	90%	221	84%
Total	14517	100%	186.9	12567	87%	11564	80%

n/a Rate cannot be calculated due to no available population estimate
-- Due to the small number of HIV cases the count and percentage based on the count is not shown

[NR] Not reliable, RSE ≥25
[a] Engaged in care = at least one reported CD4 or VL result within calendar year
[b] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL

STATISTICS: PREVALENT HIV CASES (continued)

Table 8. Prevalent Cases of HIV, by Current Gender*, Race/Ethnicity, and HIV Exposure Category, WA State, 2021

Gender	Exposure Category	Asian		Black		LAT/HISP		Other		White	
		No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender men	MSM	327	74%	848	54%	1,516	76%	644	70%	5,481	76%
	PWID	6	1%	76	5%	46	2%	41	4%	312	4%
	MSM and PWID	11	2%	93	6%	153	8%	132	14%	855	12%
	Heterosexual Contact	12	3%	175	11%	74	4%	36	4%	118	2%
	Blood/Pediatric	4	1%	41	3%	9	0%	6	1%	39	1%
	NIR	84	19%	332	21%	184	9%	64	7%	361	5%
	Total	444	100%	1,565	100%	1,982	100%	923	100%	7,166	100%
		Asian		Black		LAT/HISP		Other		White	
		No.	%	No.	%	No.	%	No.	%	No.	%
Cisgender women	PWID	2	2%	37	4%	26	10%	45	26%	213	28%
	Heterosexual Contact	64	69%	572	59%	190	71%	102	59%	441	58%
	Blood/Pediatric	3	3%	60	6%	10	4%	4	2%	23	3%
	NIR	24	26%	297	31%	40	15%	23	13%	87	11%
	Total	93	100%	966	100%	266	100%	174	100%	764	100%
Transgender women	Sex with men	8	89%	21	95%	36	77%	21	78%	29	63%
	PWID	0	0%	0	0%	1	2%	0	0%	0	0%
	Sex with men and PWID	0	0%	1	5%	8	17%	6	22%	15	33%
	NIR	1	11%	0	0%	2	4%	0	0%	2	4%
	Total	9	100%	22	100%	47	100%	27	100%	46	100%

Abbreviations: LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NIR, no identified risk; PWID, people who inject drugs
* Due to the small number of HIV cases reported as transgender men, they were not included in this table

Figure 9. Living HIV Case Rates, WA State, 2012-2021

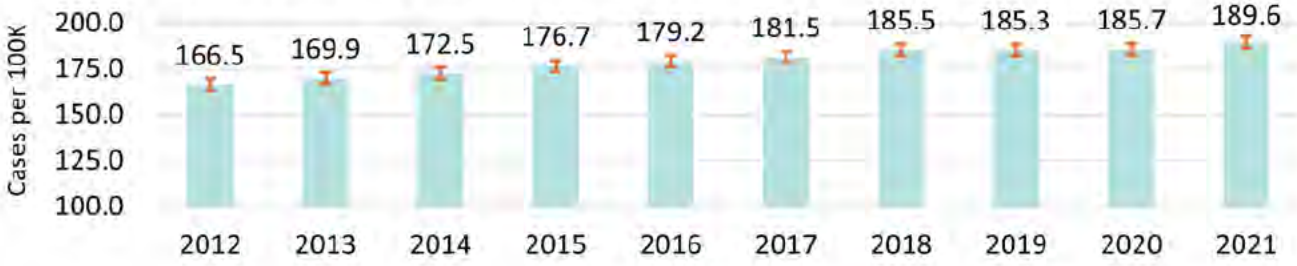


Figure 10. Virologic Suppression among Living HIV Cases, WA State, 2012-2021

STATISTICS: PREVALENT HIV CASES (continued)

Table 9. Prevalent Cases of HIV, by Demographic and Risk Characteristics, WA State, 2017-2021

	2017		2018		2019		2020		2021	
Total	no.	col %	no.	col %	no.	col %	no.	col %	no.	col %
	13376	100%	13780	100%	13984	100%	14218	100%	14517	100%
Gender										
Cisgender men Cisgender	11267	84%	11550	84%	11691	84%	11889	84%	12083	83%
women Transgender	1975	15%	2093	15%	2158	15%	2186	15%	2264	16%
men Transgender	12	0%	13	0%	13	0%	16	0%	19	0%
women	122	1%	124	1%	122	1%	127	1%	151	1%
Age at HIV Diagnosis										
<15	54	0%	54	0%	48	0%	40	0%	35	0%
15-24	301	2%	292	2%	301	2%	286	2%	270	2%
25-34	1803	13%	1837	13%	1860	13%	1924	14%	1924	13%
35-44	2707	20%	2781	20%	2767	20%	2825	20%	2880	20%
45-54	4266	32%	4114	30%	3923	28%	3733	26%	3648	25%
55-64	3180	24%	3471	25%	3711	27%	3882	27%	4015	28%
65+	1065	8%	1231	9%	1374	10%	1528	11%	1745	12%
Race/ethnicity										
AI/AN	126	1%	129	1%	132	1%	125	1%	133	1%
Asian	438	3%	454	3%	484	3%	524	4%	547	4%
Black	2133	16%	2289	17%	2381	17%	2455	17%	2557	18%
Foreign-born[a]	850	6%	958	7%	1016	7%	1052	7%	1112	8%
U.S.-born[a]	1203	9%	1248	9%	1271	9%	1292	9%	1319	9%
LAT/HISP	1954	15%	2045	15%	2126	15%	2194	15%	2296	16%
Foreign-born[a]	949	7%	980	7%	1048	7%	1081	8%	1139	8%
U.S.-born[a]	871	7%	918	7%	916	7%	934	7%	955	7%
NHOPI	55	0%	61	0%	61	0%	63	0%	69	0%
White	7744	58%	7863	57%	7859	56%	7936	56%	7986	55%
Multiple	921	7%	934	7%	936	7%	916	6%	925	6%
Mode of Exposure										
MSM	8238	62%	8447	61%	8598	61%	8757	62%	8935	62%
PWID	788	6%	810	6%	821	6%	806	6%	809	6%
MSM/PWID	1305	10%	1324	10%	1275	9%	1277	9%	1274	9%
Heterosexual	1668	12%	1710	12%	1735	12%	1758	12%	1790	12%
Blood/pediatric	191	1%	193	1%	200	1%	196	1%	201	1%
NIR	1186	9%	1296	9%	1355	10%	1424	10%	1508	10%

Abbreviations: AI/AN, American Indian or Alaska Native; LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NHOPI, Native Hawaiian or Other Pacific Islander; NIR, no identified risk; PWID, people who inject drugs
n/a Rate cannot be calculated due to no available population estimate

STATISTICS: PREVALENT HIV CASES (continued)

Table 10. Prevalent Cases of HIV, by County and Health District (HD) of Residence at HIV Diagnosis, WA State, 2017-2021

County and Health District of Residence	2017		2018		2019		2020		2021	
	no.	col %	no.	col %	no.	col %	no.	col %	no.	col %
Adams Co.	11	0%	13	0%	14	0%	13	0%	13	0%
Asotin Co.	23	0%	23	0%	19	0%	18	0%	20	0%
Benton Co.	160	1%	180	1%	194	1%	201	1%	203	1%
Benton-Franklin HD	238	2%	264	2%	275	2%	289	2%	297	2%
Chelan Co.	55	0%	56	0%	59	0%	61	0%	75	1%
Chelan-Douglas HD	70	1%	72	1%	78	1%	89	1%	98	1%
Clallam Co.	79	1%	81	1%	86	1%	84	1%	87	1%
Clark Co.	729	5%	767	6%	801	6%	869	6%	868	6%
Columbia Co.	6	0%	4	0%	3	0%	3	0%	3	0%
Cowlitz Co.	146	1%	153	1%	151	1%	155	1%	159	1%
Douglas Co.	15	0%	16	0%	19	0%	28	0%	23	0%
Ferry Co.	5	0%	5	0%	6	0%	4	0%	3	0%
Franklin Co.	78	1%	84	1%	81	1%	88	1%	94	1%
Garfield Co.	3	0%	3	0%	2	0%	2	0%	0	0%
Grant Co.	41	0%	44	0%	51	0%	59	0%	59	0%
Grays Harbor Co.	98	1%	98	1%	95	1%	103	1%	109	1%
Island Co.	91	1%	101	1%	105	1%	110	1%	106	1%
Jefferson Co.	46	0%	53	0%	48	0%	49	0%	49	0%
King Co.	6934	52%	7033	51%	7062	51%	7094	50%	7211	50%
Kitsap Co.	335	3%	331	2%	351	3%	358	3%	365	3%
Kittitas Co.	30	0%	29	0%	33	0%	33	0%	37	0%
Klickitat Co.	17	0%	17	0%	19	0%	20	0%	22	0%
Lewis Co.	65	0%	69	1%	68	0%	66	0%	74	1%
Lincoln Co.	9	0%	5	0%	7	0%	6	0%	11	0%
Mason Co.	67	1%	69	1%	69	0%	75	1%	78	1%
NE Tri-County HD	44	0%	45	0%	46	0%	41	0%	41	0%
Okanogan Co.	29	0%	28	0%	28	0%	27	0%	27	0%
Pacific Co.	25	0%	29	0%	33	0%	35	0%	39	0%
Pend Oreille Co.	14	0%	12	0%	14	0%	13	0%	12	0%
Pierce Co.	1465	11%	1554	11%	1575	11%	1605	11%	1633	11%
San Juan Co.	21	0%	23	0%	23	0%	22	0%	20	0%
Skagit Co.	97	1%	97	1%	96	1%	97	1%	100	1%
Skamania Co.	7	0%	6	0%	5	0%	5	0%	6	0%
Snohomish Co.	1079	8%	1154	8%	1207	9%	1232	9%	1242	9%
Spokane Co.	637	5%	680	5%	691	5%	731	5%	786	5%
Stevens Co.	25	0%	28	0%	26	0%	24	0%	26	0%
Thurston Co.	334	2%	341	2%	342	2%	336	2%	347	2%
Wahkiakum Co.	4	0%	6	0%	4	0%	4	0%	5	0%
Walla Walla Co.	62	0%	60	0%	56	0%	56	0%	58	0%
Whatcom Co.	251	2%	249	2%	254	2%	254	2%	255	2%
Whitman Co.	25	0%	26	0%	29	0%	26	0%	29	0%
Yakima Co.	258	2%	253	2%	257	2%	252	2%	263	2%
Total	13376	100%	13780	100%	13984	100%	14218	100%	14517	100%

STATISTICS: AMERICAN INDIAN/ALASKA NATIVE SPOTLIGHT

Demographic and care outcomes for people who identify as American Indian/Alaska Native (AI/AN) alone or with another race category are highlighted in the table below. This population has historically been underrepresented, as the majority of people who identify as AI/AN also have one or more other races indicated and therefore are placed in the multi-race category. Better reporting on AI/AN HIV data is important in order to address disparities in the rate of new diagnoses and care outcomes, and to ensure adequate prevention and treatment services and resources are available.

Table 11. Characteristics and Care Outcomes of People Living with HIV Reporting Any American Indian or Alaska Native Race, 2017-2021

	New HIV Cases		Prevalent HIV Cases, 2021	
	no.	column %	no.	column %
Total	64	3%[a]	565	4%[a]
Gender				
Cisgender men	39	61%	446	79%
Cisgender women	23	36%	104	18%
Transgender men	0	0%	2	0%
Transgender women	2	3%	13	2%
Mode of Exposure				
MSM	27	42%	309	55%
PWID	11	17%	64	11%
MSM/PWID	7	11%	80	14%
Heterosexual	11	17%	72	13%
NIR/Other	8	13%	40	7%
Geography				
King County	30	47%	266	47%
Other Western Washington	19	30%	226	40%
Eastern Washington	15	23%	73	13%
Care Metrics				
Initial Linkage to HIV Care[b]	52	81%	N/A	N/A
Engaged in Care[c]	N/A	N/A	490	87%
Viral Suppression[d]	N/A	N/A	436	77%

Abbreviations: MSM, people assigned male at birth who have sex with men; NIR, no identified risk; PWID, people who inject drugs

[a] Percentage of total Washington Cases
[b] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnoses
[c] Engaged in care = at least one reported CD4 or VL result within calendar year
[d] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL

STATISTICS: MORTALITY

Table 12. Deaths among Cases of HIV Infection, by Demographic and Risk Characteristics, WA State, 1984-2020

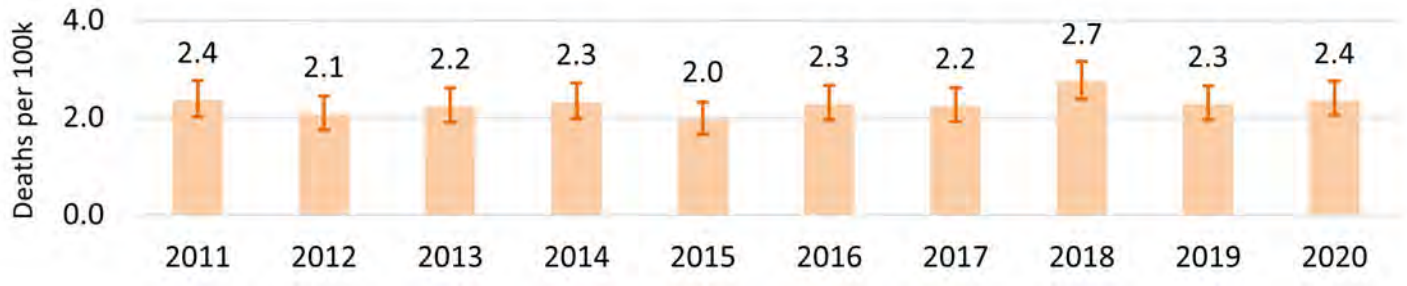
	2020					1984-2020	
Total	**no.**	**column %**	**Mortality rate (per 100,000)**	**case fatality rate (per 1,000)**	**standard mortality ratio**	**no.**	**column %**
	180	100%	2.4	12.7	1.5	8759	100%
Gender							
Cisgender men	148	82%	3.9	12.4	1.4	7942	91%
Cisgender women	31	17%	0.8	14.2	2.6	794	9%
Transgender men	0	0%	n/a	0.0	n/a	0	0%
Transgender women	1	1%	n/a	7.9[NR]	n/a	23	0%
Current Age							
<15	0	0%	0.0	0.0	0.0	19	0%
15-24	2	1%	0.2[NR]	6.7[NR]	11.3	103	1%
25-34	4	2%	0.4[NR]	2.1[NR]	1.9	1753	20%
35-44	18	10%	1.8	6.4	2.9	3071	35%
45-54	53	29%	5.7	14.2	3.4	2127	24%
55-64	52	29%	5.3	13.4	1.4	1130	13%
65+	51	28%	4.0	33.4	0.9	556	6%
Race/ethnicity							
AI/AN	6	3%	6.3[NR]	48.0[NR]	n/a	141	2%
Asian	1	1%	0.1[NR]	1.9[NR]	n/a	98	1%
Black	21	12%	6.9	8.6	n/a	851	10%
Foreign-born[a]	5	3%	6.5[NR]	4.8[NR]	n/a	82	1%
U.S.-born[a]	14	8%	6.1[NR]	10.8[NR]	n/a	734	8%
LAT/HISP	24	13%	2.3	10.9	n/a	597	7%
Foreign-born[a]	4	2%	1.3[NR]	3.7[NR]	n/a	199	2%
U.S.-born[a]	18	10%	2.6	19.3	n/a	343	4%
NHOPI	1	1%	1.8[NR]	15.9[NR]	n/a	21	0%
White	111	62%	2.2	14.0	n/a	6724	77%
Multiple	16	9%	4.7[NR]	17.5[NR]	n/a	326	4%
Mode of Exposure							
MSM	92	51%	n/a	10.5	n/a	5538	63%
PWID	21	12%	n/a	26.1	n/a	994	11%
MSM/PWID	29	16%	n/a	22.7	n/a	988	11%
Heterosexual	18	10%	n/a	10.2	n/a	529	6%
Blood/pediatric	2	1%	n/a	10.2	n/a	188	2%
NIR	18	10%	n/a	12.6	n/a	522	6%

Abbreviations: AI/AN, American Indian or Alaska Native; LAT/HISP, Latina/o/x and Hispanic; MSM, people assigned male at birth who have sex with men; NHOPI, Native Hawaiian or Other Pacific Islander; NIR, no identified risk; PWID, people who inject drugs
n/a Rate cannot be calculated due to no available population estimate

[NR] Not reliable, RSE ≥25
[a] Country of origin data are missing for approximately 5% and 9% of living cases among Black and LAT/HISP, respectively

STATISTICS: MORTALITY (continued)

Figure 11. Age-Adjusted HIV Death Rates, WA State, 2011-2020



STATISTICS: HIV CARE CONTINUA

Figure 12. HIV Care Continuum, WA State, 2021

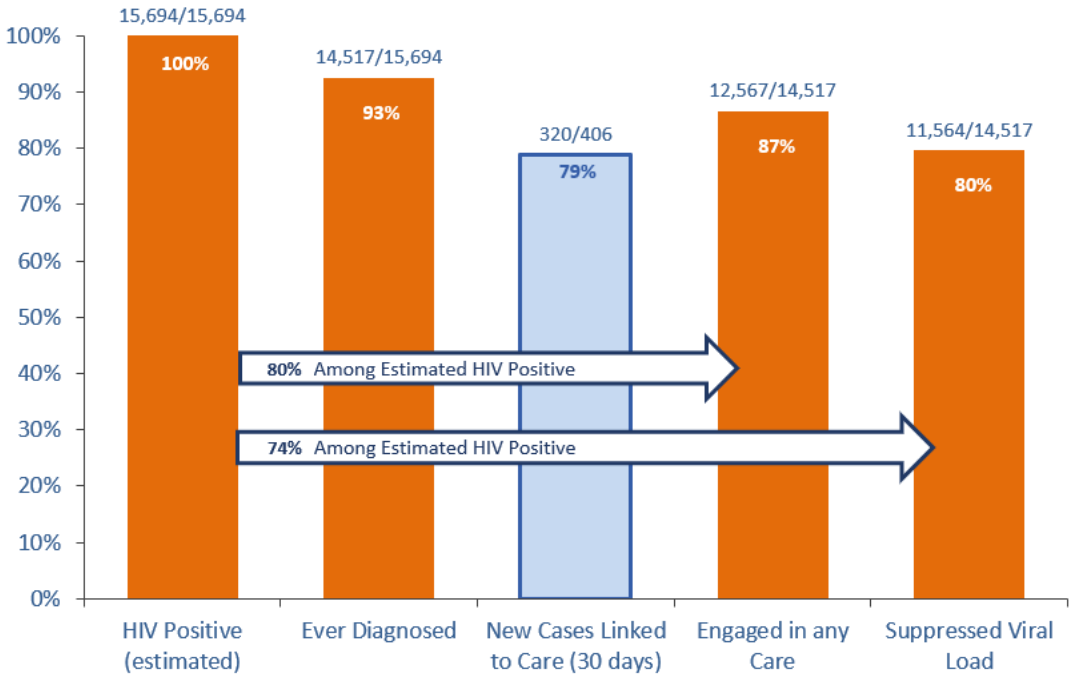
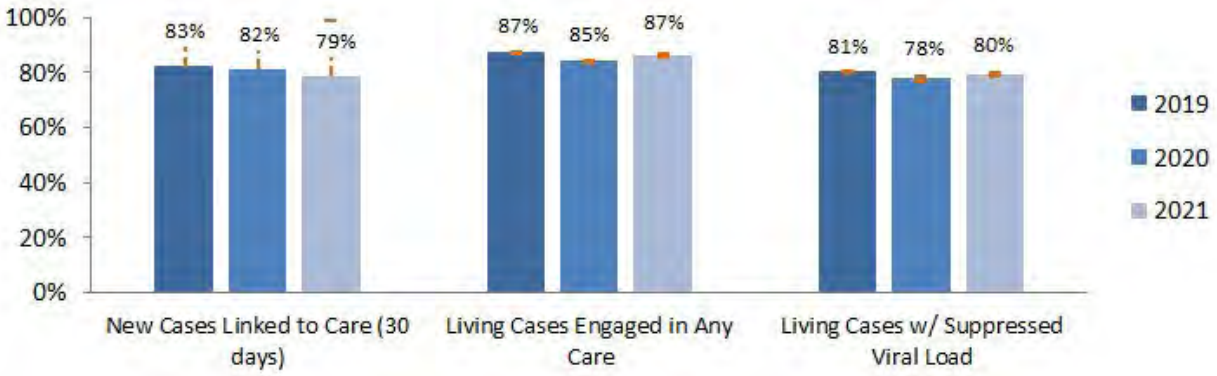
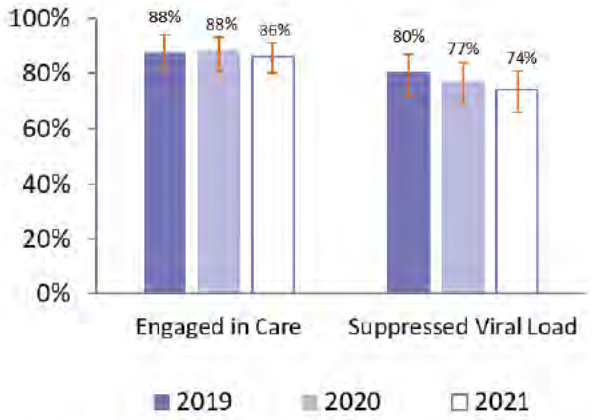


Figure 13. HIV Care Outcomes over Time, WA State, 2019-2021



STATISTICS: HIV CARE CONTINUA FOR END AIDS WASHINGTON PRIORITY POPULATIONS, WA state, 2019-2021

Figure 14. Transgender Women



*Linkage to care not shown due to small case counts

Figure 15. Young Adults (Ages 18-29)

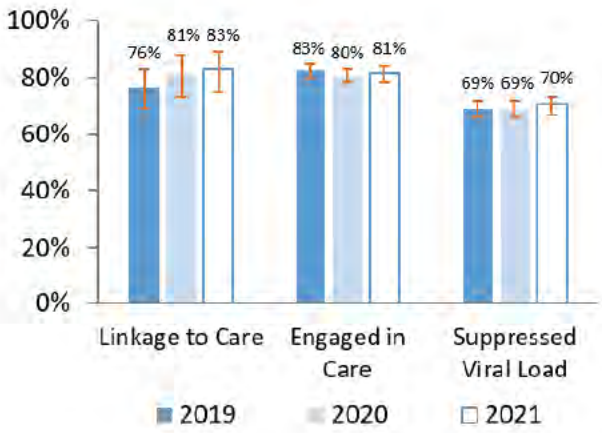


Figure 16. U.S.-Born Black

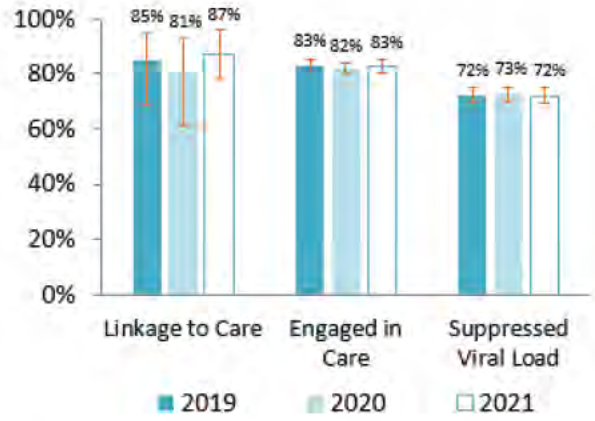


Figure 17. Foreign-Born Black

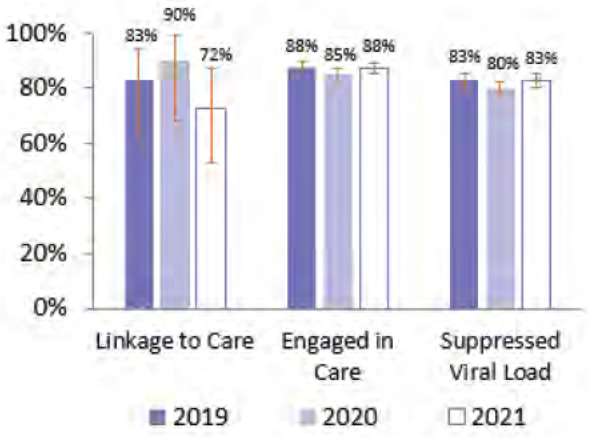


Figure 18. Foreign-Born Latina/o/x and Hispanic

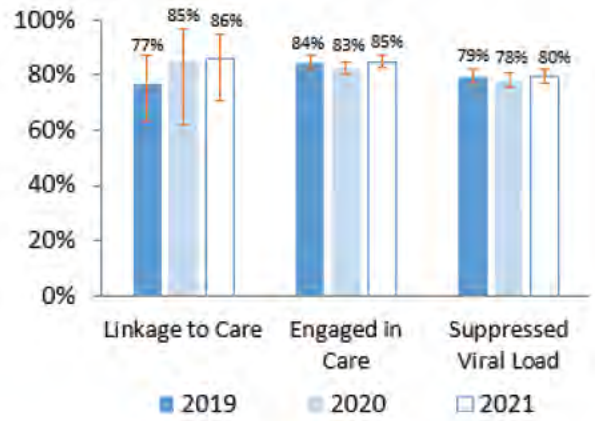
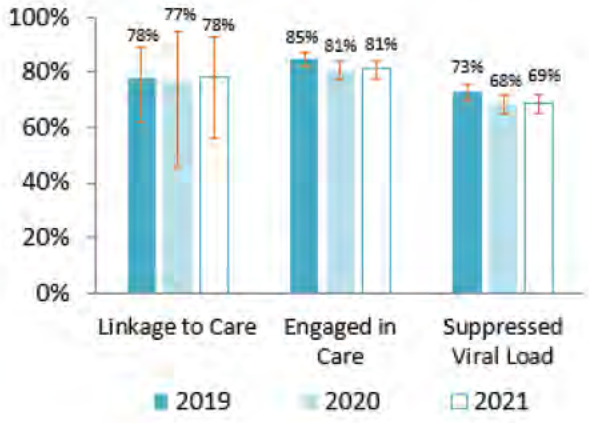


Figure 19. Persons who Inject Drugs



DEFINITIONS

AIDS: Acquired Immune Deficiency Syndrome. An advanced stage of HIV disease which is defined by the existence of certain opportunistic illnesses or other clinical outcomes. The presence of AIDS often suggests that a person has been HIV-positive for many years.

Age-Adjusted Death Rate: Age-adjustment is a statistical procedure which allows rates from different communities to be compared in way that controls for differences between each population's age structure. In this report, the age-adjusted rate of all-cause deaths per 100,000 people living with HIV is compared to the rate of all-cause deaths per 100,000 Washington State residents.

Blood Exposure: A mode of HIV exposure which involves the transfusion of human blood (or blood products) or the transplantation of human tissue.

Case: A person with HIV who has been diagnosed and reported to the health department while living in Washington. This report does not include the results of anonymous HIV testing.

Case Fatality Rate: The rate of HIV/AIDS related deaths per 1,000 people living with HIV within a calendar year.

CD4 Count: The concentration of a certain type of white blood cell circulating within a person's bloodstream. CD4 count (cells/μL) provides a good indication of a patient's stage of HIV disease.

Confidence Interval (CI): A range of values within which the true value is likely to exist based on a specified probability. In this report, we use 95% confidence intervals to describe the reliability of HIV diagnosis rates. Error bars on figures display the confidence interval.

Engaged in Care: The proportion of prevalent cases who have a CD4 test or viral load test within the calendar year of interest. HIV-related laboratory tests are indicative of an HIV-related medical visit. This is a key performance measure within the HIV care continuum.

HIV: Human Immunodeficiency Virus. The virus that causes HIV disease, including AIDS. HIV weakens a person's immune system by destroying T cells that fight disease and prevent infection.

HIV Care Continuum: A model that outlines the sequential stages of HIV medical care experienced by persons living with HIV, from diagnosis to virologic suppression. Also referred to as the HIV treatment cascade.

HIV Deaths: Deaths among resident, diagnosed cases of HIV. Reported death data has a one year lag due to the availability of sources of death data collected.

HIV Diagnosis Date: The earliest documented confirmed date when a person was diagnosed with HIV, with or without AIDS.

HIV Incidence: In Washington State, incident cases are defined as persons whose first HIV-indicated laboratory result or first diagnosis by a healthcare provider occurred while living in Washington. Cases with a self-reported positive test more than 6 months prior to the diagnosis date recorded by the Department of Health are not considered incident cases. Also referred to as **New HIV Case** in this report.

HIV Prevalence: A measure of disease frequency describing the number of persons living with HIV within a calendar year. Since not all persons living with HIV have been diagnosed or reported, we can only estimate HIV prevalence.

HIV Surveillance: The ongoing and systematic collection, evaluation, and dissemination of population-based information about people diagnosed and living with HIV and AIDS.

Injection Drug Use (IDU): The behavior of using needles, syringes, and other drug injection equipment to take drugs, usually without a prescription. The sharing of drug injection equipment is a common mode of HIV exposure.

Late HIV Diagnosis: An event in which a case is diagnosed with AIDS within 12 months of HIV diagnosis. A late HIV diagnosis suggests that a person has been infected for many years and was not routinely screened for HIV prior to diagnosis.

Linkage to Care: The proportion of new HIV cases who have a CD4 test or viral load test within 30 days from their date of HIV diagnosis.HIV-related laboratory tests are indicative of an HIV-related medical visit. This is a key performance measure within the HIV care continuum.

DEFINITIONS (continued)

Men Having Sex with Men (MSM): In this report, refers to men who report any history of man-man sex since 1977. Condomless anal intercourse between men is the most common mode of HIV exposure in the U.S.

Mode of Exposure: The manner in which a case was most likely to have been infected by HIV, based on reported HIV risk behaviors. A case can only be attributed to one mode of exposure, although re-categorization is possible as new information becomes available.

Mortality Rate: The rate of all-cause deaths among people living with HIV per 100,000 within a calendar year.

Pediatric Exposure: A mode of HIV exposure which involve children ages 12 and under. These cases are often the result of mother-to-child (or perinatal) transmission.

Person Who Injects Drugs (PWID): In this report, describes cases reporting any history of injection drug use (IDU) since 1977.

Prevalent HIV Case: A resident, diagnosed case of HIV within a specified time period. Prevalent cases can include persons who were originally diagnosed while living outside Washington state. Residency is based on vital status and address information collected and stored within the state's HIV surveillance registry. Also referred to as 'Ever Diagnosed' or 'people living with HIV.'

Relative Standard Error (RSE): RSE provides a measure of reliability for statistical estimates. When the RSE is large the estimate is imprecise and considered unreliable.

Standardized Mortality Ratio: The ratio between the observed number of deaths among people living with HIV to the expected number of deaths in the Washington State population.

Transgender: Refers to a person whose gender identity is not the same as their assigned sex at birth. Transgender women who have sex with men have higher risk for HIV infection compared to cisgender women.

Viral Load: This is the concentration of viral copies circulating within a person's blood plasma. Reducing viral load improves patient health and reduces their ability to infect others. Viral load can be reduced by HIV medication, and is a good indication of whether a person is receiving optimal HIV medical care.

Virologic Suppression: The reduction of a person's HIV viral load to ≤ 200 copies/mL. The proportion of living HIV cases who have achieved virologic suppression is a key performance measure within the HIV care continuum. Sometimes described as 'viral load suppression' or 'viral suppression.'

ACKNOWLEDGEMENTS AND CONTACT INFORMATION

Our thanks to the health providers who care for people with HIV/AIDS, to our local health jurisdiction partners, and to the medical laboratories - all of whom work diligently to ensure the timely and complete reporting of cases. These data are used to support the allocation of HIV prevention and care resources, to conduct program planning and evaluation, and to educate the public about the HIV epidemic in Washington.

For more information, or to receive a printed copy of this report, please contact:

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PO Box 47838, Olympia, WA 98504-7838
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ABOUT THIS PUBLICATION

This surveillance report reflects events occurring through December 31, 2021 and reported by June 30 2022, unless otherwise stated. Reports are published annually.

HIV REPORTING REQUIREMENTS

Detailed requirements for the reportng of communicable diseases including HIV/AIDS are described in the Washington Administrative Code (WAC), section 246-101 (http://apps.leg.wa.gov/WAC/default aspx?cite=246-101).

Washington health care providers are required to report all HIV cases, regardless of the date of the patient's initial diagnosis, to the health department. Providers are also required to report new diagnoses of AIDS in a person previously diagnosed with HIV. Local health department officials forward case reports to the state department of health. Names are never sent to the federal government.

Laboratories are required to report any evidence of HIV infection (i.e., positive western blot assays, p24 antigen detection, viral culture, and nucleic acid detection), all HIV viral load tests (detectable or not), and all CD4 counts in the setting of HIV infection. If the laboratory cannot distinguish tests, such as CD4 counts, done due to HIV versus other diseases (such as cancer), the CD4 counts should be reported and the health department will investigate. However, laboratory reporting does not relieve health care providers of their duty to report, as most of the critical information necessary for surveillance and follow-up is not available to laboratories.

For further information about HIV/AIDS reporting requirements, please call your local health department or the Washington State Department of Health at 888-367-5555. In King County, call 206-263-2000.

SUGGESTED CITATION

Infectious Disease Assessment Unit, Washington State Department of Health. Washington State HIV Surveillance Report, 2021 Edition.

ALTERNATIVE FORMATS

Electronic copies of this report are available at: https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/HIVAIDSData/SurveillanceReports

For people with disabilities, this document is available on request in other formats. To submit a request, please call 1-800-525-0127 (TDD/TTY 711).

EDITORIAL NOTES

Age categories were changed from < 13 and 13-24 to < 15 and 15-24 due to changes in available population data.

EXHIBIT 12

Point-In-Time Homeless Counts
Articles on Homelessness

2018 Point in Time Count | State Totals

		Emergency Shelter	Transitional Housing	Safe Haven	Total Sheltered	Unsheltered	TOTAL
Households with at least one adult and one child	**Households**	762	821	-	**1,583**	**217**	**1,800**
	Persons	2,549	2,615	-	**5,164**	**716**	**5,880**
Households with only children	**Households**	70	35	-	**105**	**163**	**268**
	Persons	74	45	-	**119**	**168**	**287**
Households without children	**Households**	4,849	1,293	41	**6,183**	**8,135**	**14,318**
	Persons	5,029	1,330	41	**6,400**	**9,737**	**16,137**
TOTAL	**Households**	5,681	2,149	41	**7,871**	**8,515**	**16,386**
	Persons	7,652	3,990	41	**11,683**	**10,621**	**22,304**
Subpopulations	**Chronically Homeless Individuals**	1,592	156	37	**1,785**	**4,029**	**5,814**
	Chronically Homeless Families	69	32	-	**101**	**860**	**961**
	Persons in Chronically Homeless Families	444	269	-	**713**	**1,076**	**1,789**
	Chronically Homeless Veteran Individuals	128	-	< 10	**129**	**401**	**530**
	Chronically Homeless Veteran Families	144	103	-	**247**	**193**	**440**
	Persons in CH Veteran Families	< 10	-	-	**< 10**	**172**	**172**
	Adults with a Serious Mental Illness	367	219	-	**586**	**910**	**1,496**
	Adults with a Substance Use Disorder	207	154	-	**361**	**563**	**924**
	Adults with HIV/AIDS	-	-	-	**-**	**-**	**-**
	Adult Victims of Domestic Violence	294	173	-	**467**	**164**	**631**
Veterans							
Households with adults and children	**Veteran Households**	23	22	-	45	**< 10**	**53**
	Veterans	23	22	-	45	**< 10**	**53**
Households without children	**Veteran Households**	442	260	< 10	703	**846**	**1,549**
	Veterans	451	260	< 10	712	**850**	**1,562**
Youth Households (under 25)							
Households	**Total numbers of households**	463	416	-	879	**1,037**	**1,916**
	Unaccompanied Youth households	407	302	-	709	**1,020**	**1,729**
	Parenting Youth Households	56	114	-	170	**17**	**187**
Persons	**Total number of persons**	602	570	-	1,172	**1,455**	**2,627**
	Persons in parenting youth household	153	261	-	414	**44**	**458**
	Persons in unaccompanied youth household	449	309	-	758	**1,411**	**2,169**

2018 Point in Time Count | County Totals

County	TOTAL Homeless (sheltered and unsheltered)							
	Households w/out minors		Households with minors		Households with only minors		TOTAL	
	Persons	Households	Persons	Households	Persons	Households	Persons	Households
Adams	< 10	< 10	0	0	0	0	< 10	< 10
Asotin	38	34	< 10	< 10	0	0	45	37
Benton-Franklin	94	91	62	20	< 10	< 10	163	118
Chelan-Douglas	318	305	155	50	< 10	< 10	474	356
Clallam	144	130	89	34	0	0	233	164
Clark	440	398	342	104	13	12	795	514
Columbia	< 10	< 10	< 10	< 10	0	0	< 10	< 10
Cowlitz	189	165	147	46	< 10	< 10	338	212
Ferry	0	0	0	0	0	0	0	0
Garfield	< 10	< 10	0	0	0	0	< 10	< 10
Grant	77	70	60	19	0	0	137	89
Grays Harbor	156	146	15	< 10	< 10	0	174	151
Island	108	102	54	16	< 10	< 10	167	122
Jefferson	56	55	< 10	< 10	0	0	59	56
King	9,312	8,023	2,624	782	176	174	12,112	8,979
Kitsap	303	257	141	40	< 10	< 10	445	298
Kittitas	23	23	< 10	< 10	0	0	28	24
Klickitat	26	25	< 10	< 10	0	0	33	27
Lewis	115	112	17	< 10	0	0	132	117
Lincoln	< 10	< 10	< 10	< 10	0	0	< 10	< 10
Mason	136	122	96	29	0	0	232	151
Okanogan	< 10	< 10	< 10	< 10	0	0	14	< 10
Pacific	57	48	16	< 10	0	0	73	52
Pend Oreille	< 10	< 10	11	< 10	0	0	12	< 10
Pierce	1,210	1,135	404	128	14	11	1,628	1,274
San Juan	46	42	11	< 10	0	0	57	46
Skagit	182	171	155	45	< 10	0	338	216
Skamania	< 10	< 10	< 10	< 10	0	0	11	< 10
Snohomish	582	561	246	74	30	24	858	659
Spokane	897	874	328	119	20	19	1,245	1,012
Stevens	29	25	14	< 10	0	0	43	29
Thurston	510	433	316	99	< 10	< 10	835	541
Wahkiakum	< 10	< 10	0	0	0	0	< 10	< 10
Walla Walla	130	129	51	17	0	0	181	146
Whatcom	571	501	241	67	< 10	< 10	816	572
Whitman	14	10	15	< 10	0	0	29	16
Yakima	348	305	229	67	< 10	< 10	578	373
TOTAL	**16,137**	**14,318**	**5,880**	**1,800**	**287**	**268**	**22,304**	**16,386**

2019 Point in Time Count | State Totals

		Emergency Shelter	Transitional Housing	Safe Haven	Total Sheltered	Unsheltered	TOTAL
Households with at least one adult and one child	**Households**	844	702		**1,546**	**203**	**1,749**
	Persons	2,694	2,253		**4,947**	**675**	**5,622**
Households with only children	**Households**	111	38		**149**	**76**	**225**
	Persons	112	42		**154**	**94**	**248**
Households without children	**Households**	5,504	1,274	43	**6,821**	**7704**	**14,525**
	Persons	5,573	1,305	43	**6,921**	**8831**	**15,752**
TOTAL	**Households**	6,459	2,014	43	**8,516**	**7983**	**16,499**
	Persons	8,379	3,600	43	**12,022**	**9600**	**21,622**
Subpopulations	**Chronically Homeless Individuals**	1592	156	37	**1785**	**4029**	**5,814**
	Chronically Homeless Families	69	32	0	**101**	**860**	**961**
	Persons in Chronically Homeless Families	444	269	0	**713**	**1076**	**1,789**
	Chronically Homeless Veteran Individuals	128	0	< 10	**129**	**401**	**530**
	Chronically Homeless Veteran Families	144	103	0	**247**	**193**	**440**
	Persons in CH Veteran Families	< 10	0	0	**< 10**	**172**	**172**
	Adults with a Serious Mental Illness	1487	572	11	**586**	**2365**	**2,951**
	Adults with a Substance Use Disorder	837	334	< 10	**361**	**1857**	**2,218**
	Adults with HIV/AIDS	22	25	0	**0**	**87**	**87**
	Adult Victims of Domestic Violence	351	336	0	**467**	**560**	**1,027**
Veterans							
Households with adults and children	**Veteran Households**	21	12	0	**33**	**14**	**47**
	Veterans	22	12	0	**34**	**14**	**48**
Households without children	**Veteran Households**	453	328	< 10	**781**	**951**	**1732**
	Veterans	453	329	< 10	**782**	**753**	**1535**
Youth Households (under 25)							
Households	**Total numbers of households**	520	377	< 10	**897**	**885**	**1782**
	Unaccompanied Youth households	463	289	< 10	**752**	**873**	**1625**
	Parenting Youth Households	57	88	0	**145**	**12**	**157**
Persons	**Total number of persons**	451	364	< 10	**815**	**952**	**1767**
	Persons in parenting youth household	354	257	< 10	**611**	**936**	**1547**
	Persons in unaccompanied youth household	97	107	0	**204**	**16**	**220**

2019 Point in Time Count | County Total

County	TOTAL Homeless (sheltered and unsheltered)							
	Households w/out minors		Households with minors		Households with only minors		TOTAL	
	Persons	Households	Persons	Households	Persons	Households	Persons	Households
Adams County	0	0	22	< 10	0	0	22	< 10
Asotin County	< 10	< 10	< 10	< 10	0	0	10	< 10
Benton County	71	69	73	22	< 10	< 10	152	99
Chelan County	285	274	104	31	< 10	< 10	391	307
Clallam County	130	125	64	22	< 10	< 10	196	149
Clark County	491	452	452	133	15	11	958	596
Columbia County	0	0	< 10	< 10	0	0	< 10	< 10
Cowlitz County	309	285	155	52	< 10	< 10	468	341
Douglas County	11	11	10	< 10	0	0	21	13
Ferry County	< 10	< 10	0	0	0	0	< 10	< 10
Franklin County	50	50	20	< 10	0	0	70	56
Garfield County	< 10	< 10	< 10	< 10	0	0	< 10	< 10
Grant County	77	64	71	20	0	0	148	84
Grays Harbor County	138	136	11	< 10	0	0	149	141
Island County	124	119	34	12	< 10	< 10	159	132
Jefferson County	65	55	27	10	10	10	102	75
King County	8,666	7,789	2,451	763	82	70	11,199	8,622
Kitsap County	361	338	114	35	< 10	< 10	480	377
Kittitas County	31	30	< 10	< 10	0	0	39	33
Klickitat County	< 10	< 10	11	< 10	0	0	14	< 10
Lewis County	127	125	33	10	< 10	< 10	161	136
Lincoln County	< 10	< 10	< 10	< 10	0	0	< 10	< 10
Mason County	172	162	98	29	< 10	< 10	273	194
Okanogan County	24	22	12	< 10	0	0	36	25
Pacific County	34	26	< 10	< 10	0	0	42	29
Pend Oreille County	10	< 10	21	< 10	0	0	31	16
Pierce County	1,095	1,063	375	113	16	14	1,486	1,190
San Juan County	55	54	11	< 10	< 10	< 10	67	59
Skagit County	161	156	133	39	< 10	< 10	296	197
Skamania County	16	15	< 10	< 10	< 10	< 10	25	18
Snohomish County	744	701	337	105	35	33	1,116	839
Spokane County	985	954	302	97	22	19	1,309	1,070
Stevens County	40	34	< 10	< 10	< 10	< 10	45	36
Thurston County	519	511	271	85	11	11	801	607
Wahkiakum County	< 10	< 10	< 10	< 10	0	0	13	< 10
Walla Walla County	149	149	< 10	< 10	12	12	163	162
Whatcom County	482	433	212	75	< 10	< 10	701	515
Whitman County	< 10	< 10	13	< 10	< 10	< 10	23	15
Yakima County	295	285	140	39	< 10	< 10	439	328
State Total	**15,752**	**14,525**	**5,622**	**1,749**	**247**	**223**	**21,621**	**16,497**

2020 Point in Time Count | State Totals

		Emergency Shelter	Transitional Housing	Safe Haven	Total Sheltered	Unsheltered	TOTAL
Households with at least one adult and one child	**Households**	781	767	-	**1,548**	**570**	**2,118**
	Persons	2,505	2,336	-	**4,841**	**1,891**	**6,732**
Households with only children	**Households**	68	26	-	**94**	**224**	**318**
	Persons	95	47	-	**142**	**308**	**450**
Households without children	**Households**	5,813	1,048	81	**6,942**	**7,888**	**14,830**
	Persons	5,933	1,112	81	**7,126**	**8,615**	**15,741**
TOTAL	**Households**	6,662	1,841	81	**8,584**	**10,506**	**17,266**
	Persons	8,533	3,495	81	**12,109**	**10,814**	**22,923**
Subpopulations	**Chronically Homeless Individuals**	2,268	-	67	**2,335**	**4,472**	**6,807**
	Chronically Homeless Families	66	-	-	**66**	**164**	**230**
	Persons in Chronically Homeless Families	258	-	-	**258**	**610**	**868**
	Chronically Homeless Veteran Individuals	196	-	25	**221**	**379**	**600**
	Adults with a Serious Mental Illness	1,478	344	44	**1,866**	**4,743**	**6,609**
	Adults with a Substance Use Disorder	1,146	252	27	**1,425**	**3,873**	**5,298**
	Adults with HIV/AIDS	15	18	-	**33**	**196**	**229**
	Adult Victims of Domestic Violence	829	338	< 10	**1,189**	**2,356**	**3,545**
Veterans	**Veteran Households**	554	269	39	862	**673**	**1,535**
	Veterans	558	269	39	866	**741**	**1,607**
Youth Households (under 25)							
Households	**Total numbers of households**	500	375	-	875	**772**	**1,647**
	Unaccompanied Youth households	457	286	-	743	**720**	**1,463**
	Parenting Youth Households	43	89	-	132	**52**	**184**
Persons	**Total number of persons**	620	520	-	1,140	**1,080**	**2,220**
	Persons in parenting youth household	129	219	-	348	**129**	**477**
	Persons in unaccompanied youth household	491	301	-	792	**951**	**1,743**

2020 Point in Time Count | County Totals

County	TOTAL Homeless (sheltered and unsheltered)							
	Households w/out minors		Households with minors		Households with only minors		TOTAL	
	Persons	Households	Persons	Households	Persons	Households	Persons	Households
Adams County	0	0	0	0	0	0	0	0
Asotin County	13	13	<10	<10	0	0	15	14
Benton County	50	50	81	23	<10	<10	138	79
Chelan County	229	215	92	30	16	<10	337	248
Clallam County	151	147	46	16	<10	<10	198	164
Clark County	536	491	372	120	<10	<10	916	619
Columbia County	<10	<10	10	<10	0	0	11	<10
Cowlitz County	244	223	81	28	<10	<10	328	252
Douglas County	12	12	<10	<10	0	0	21	15
Ferry County	<10	<10	0	0	0	0	<10	<10
Franklin County	44	44	<10	<10	<10	<10	52	48
Garfield County	<10	<10	<10	<10	0	0	<10	<10
Grant County	104	97	75	19	<10	<10	180	117
Grays Harbor County	92	91	15	<10	<10	0	108	95
Island County	105	94	24	<10	0	0	129	103
Jefferson County	119	112	20	<10	0	0	139	118
King County	7707	7222	3743	1190	301	210	11751	8622
Kitsap County	390	366	133	42	<10	<10	524	409
Kittitas County	<10	<10	<10	<10	<10	<10	15	14
Klickitat County	28	27	<10	<10	<10	<10	33	30
Lewis County	97	89	45	16	0	0	142	105
Lincoln County	0	0	0	0	0	0	0	0
Mason County	90	86	83	25	<10	<10	178	113
Okanogan County	55	49	11	<10	<10	<10	67	56
Pacific County	48	44	11	<10	<10	<10	60	48
Pend Oreille County	11	10	29	<10	<10	<10	42	20
Pierce County	1527	1445	358	113	12	12	1897	1570
San Juan County	55	55	10	<10	0	0	65	59
Skagit County	181	162	130	36	<10	0	314	198
Skamania County	36	35	<10	<10	0	0	43	37
Snohomish County	818	776	284	92	30	29	1132	897
Spokane County	1171	1118	363	104	25	22	1559	1244
Stevens County	35	33	<10	<10	0	0	42	34
Thurston County	672	645	310	95	13	<10	995	747
Wahkiakum County	<10	<10	0	0	0	0	<10	<10
Walla Walla County	123	122	<10	<10	<10	<10	140	128
Whatcom County	521	496	165	55	<10	<10	687	552
Whitman County	<10	<10	14	<10	<10	0	22	10
Yakima County	457	442	176	49	0	0	633	491
TOTAL	**15741**	**14830**	**6732**	**2118**	**450**	**318**	**22923**	**17266**

Pierce County
Human Services

2021 Homeless Point-In-Time Count Results
January 27, 2021

The Homeless Point-In-Time Count (PIT) is a one-day snapshot that captures the characteristics and situations of people living in the County without permanent housing. The Homeless PIT Count includes both sheltered individuals (those sleeping in emergency shelters or transitional housing) and unsheltered individuals (those sleeping outside or living in places that are not meant for human habitation). Due to the ongoing COVID pandemic there was no unsheltered survey conducted which caused our 2021 totals to be lower than previous years. This is not an indication of fewer people experiencing homelessness. Unsheltered surveys will resume in 2022.

The annual Homeless PIT Count occurs sometime in the last 10 days in January. Typically The Homeless PIT Count is carried out by outreach teams and volunteers who interview people using a standard survey (via a mobile app) that asks people where they slept the night before where their last residence was located what may have contributed to their loss of housing and what disabilities the individual may have. It also asks how long the individual has been homeless age and demographics and whether the person is a veteran and/or a survivor of domestic violence.

Like all surveys the Homeless PIT Count has limitations. Results from the count are influenced by the weather local encampment removal and relocation availability of overflow shelter beds the number of volunteers and the level of engagement of the people volunteers interview. Due to COVID restrictions and with caution for volunteers people experiencing homelessness and outreach staff the unsheltered count was not completed this year but will resume in 2022 for both the sheltered and unsheltered count.

Total Persons Counted	#	%
All Persons Total	**1005**	**100%**
Sheltered	1 005	100%
Unsheltered	0	0%

The HUD definition of "sheltered" includes ONLY shelters or transitional housing that report in HMIS.

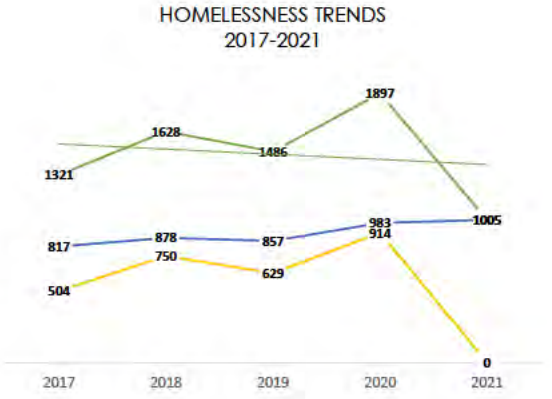
	Historical Data				
	2017	2018	2019	2020	2021
Total	**1321**	**1628**	**1486**	**1897**	**1005**
Sheltered*	817	878	857	983	1005
Unsheltered	504	750	629	914	0

Total Household Types Counted	#	% of Total Households Counted	Sheltered		Unsheltered	
			#	%	#	%
Total Households	**745**	**100%**	**745**	**100%**	**0**	**0%**
Households without Children	651	87%	651	87%	0	0%
Households with Children	83	11%	83	11%	0	0%
Households with only Children	11	2%	11	1%	0	0%

In this table only percentages represent percent of total households (i.e. not individuals).

Race	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
American Indian/Alaskan Native	44	4%	44	4%	0	0%
Asian	12	1%	12	1%	0	0 0%
Black/African Americans	211	21%	211	21%	0	0%
Multi- Racial	181	18%	181	18%	0	0%
Native Hawaiian/Other Pacific Islander	56	6%	56	6%	0	0%
White	501	50%	501	50%	0	0%

Ethnicity	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%



Non-Hispanic/Non-Latino	856	85%	856	85%	0	0%
Hispanic/Latino	149	15%	149	15%	0	0 0%

Age	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Under 18	223	22%	223	22%	0	0%
18-24 yr. old	70	7%	70	7%	0	0%
25-34 yr. old	138	14%	138	14%	0	0%
35-44 yr. old	196	19%	196	19%	0	0%
45-54 yr. old	130	13%	130	13%	0	0%
55-61 yr. old	162	16%	162	16%	0	0%
62+	86	9%	86	9%	0	0%

Gender	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Female	412	41%	412	41%	0	0%
Male	579	58%	579	58%	0	0%
Non-conforming	2	0%	2	0%	0	0%
Transgender	4	0%	4	0%	0	0%
Unknown	8	1%	8	1%	0	0%

Not all individuals answered this question.

Where People Stayed the Night Before the Count	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Abandoned Building	0	0%	0	0%	0	0%
Emergency Shelter	898	89%	898	89%	0	0%
Out of Doors (street tent etc.)	0	0%	0	0%	0	0%
Transitional Housing	107	11%	107	11%	0	0%
Vehicle	0	0%	0	0%	0	0%
Unknown	0	0%	0	0%	0	0%

Targeted Populations	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Chronically* Homeless Persons	265	26%	265	26%	0	0%
Adult Domestic Violence Survivor	243	24%	243	24%	0	0%
Veterans	84	8%	84	8%	0	0%
Unaccompanied Youth & Young Adults	92	9%	92	9%	0	0%

	Historical Data				
	2017	2018	2019	2020	2020
Chronically* Homeless Persons	276	403	364	223	265
Adult Domestic Violence Survivor	183	165	106	236	243
Veterans	134	135	134	95	84
Unaccompanied Youth & Young Adults	84	96	143	61	92

* HUD defines chronic homelessness as a person who has a disabling condition AND has either been continuously homeless for a year or more OR has had at least four homeless episodes totaling one year or more in the past three years.

Self-Reported Disabilities	Reported Disabilities		Sheltered		Unsheltered	
	#	% of Total Persons Counted	#	%	#	%
Mental Health	415	41%	415	41%	0	0%
Physical Disability	298	30%	298	30%	0	0%
Chronic Health Condition	300	30%	300	30%	0	0%
Substance Abuse	205	20%	205	20%	0	0%
Developmental Disability	110	11%	110	11%	0	0%
HIV/AIDS	8	0.8%	8	1%	0	0%

Individuals may offer multiple responses

Percentages represent percent of total persons and thus may not sum to 100%.

Last Reported Zip code	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Bonney Lake	4	0%	4	0%	0	0%
Buckley	2	0%	2	0%	0	0%
Carbonado	2	0%	2	0%	0	0%
Eatonville	1	0%	1	0%	0	0%
Fife	5	0%	5	0%	0	0%
Gig Harbor	3	0%	3	0%	0	0%
Graham	6	1%	6	1%	0	0%
Joint Base Lewis McChord	0	0%	0	0%	0	0%
Kapowsin	1	0%	1	0%	0	0%
King County	46	5%	46	5%	0	0%
Lakewood	74	7%	74	7%	0	0%
Milton	4	0%	4	0%	0	0%
Orting	3	0%	3	0%	0	0%
Outside Pierce	61	6%	61	6%	0	0%
Outside Washington	128	13%	128	13%	0	0%
Parkland	96	10%	96	10%	0	0%
Puyallup	16	2%	16	2%	0	0%
Roy	2	0%	2	0%	0	0%
South Hill	31	3%	31	3%	0	0%
Spanaway	31	3%	31	3%	0	0%
Steilacoom	2	0%	2	0%	0	0%
Sumner	5	0%	5	0%	0	0%
Tacoma	405	40%	405	40%	0	0%
University Place	17	2%	17	2%	0	0%
Unknown	59	6%	59	6%	0	0%
Wilkeson	1	0%	1	0%	0	0%

Not all individuals answered this question.

Income Sources	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Alimony	0	0%	0	0%	0	0%
Child Support	11	1%	11	1%	0	0%
General Assistance	27	3%	27	3%	0	0%
Income From Job	101	10%	101	10%	0	0%
No Resource	547	54%	547	54%	0	0%
Other	26	3%	26	3%	0	0%
Pension or Other Retirement	1	0%	1	0%	0	0%
Private Disability	0	0%	0	0%	0	0%
Retirement Income From Social Security	11	1%	11	1%	0	0%
SSDI	79	8%	79	8%	0	0%
SSI	161	16%	161	16%	0	0%
TANF	71	7%	71	7%	0	0%
Unemployment	27	3%	27	3%	0	0%
VA Non-Service	9	1%	9	1%	0	0%
VA Service	16	2%	16	2%	0	0%
Workers Comp	11	1%	11	1%	0	0%

Individuals may have more than one source of income. total persons and thus may not sum to 100%.

Primary Reason For Homelessness	#	% of Total Persons Counted	Sheltered		Unsheltered	
			#	%	#	%
Asked to leave home when turned 18	8	1%	8	1%	0	0%
Child Born During Homeless Episode	13	1%	13	1%	0	0%
Child reunifiying with homeless family	8	1%	7	1%	1	0%
Criminal activity	18	2%	18	2%	0	0%
Domestic Violence Victim & Fleeing domestic violence	90	9%	90	9%	0	0%
Eviction & Mortgage Foreclosure	84	8%	84	8%	0	0%
Family Crisis/Breakup	148	15%	148	15%	0	0%
Health/safety	61	6%	61	6%	0	0%
Loss of Child Care	0	0%	0	0%	0	0%
Loss of job	113	11%	113	11%	0	0%
Loss of public assistance	7	1%	7	1%	0	0%
Loss of transportation	6	1%	6	1%	0	0%
Medical condition	49	5%	49	5%	0	0%

Not all individuals answered this question.

Mental health	42	4%	42	4%	0	0%
Mortgage Foreclosure	3	0%	3	0%	0	0%
No affordable housing	114	11%	114	11%	0	0%
Release from institution	10	1%	10	1%	0	0%
Substance abuse	64	6%	64	6%	0	0%
Substandard housing	4	0%	4	0%	0	0%
Underemployment/low income	102	10%	102	10%	0	0%
Unknown	61	6%	61	6%	0	0%
Utility Shutoff	1	0%	1	0%	0	0%

2022 Point in Time Count | State Totals

		Emergency Shelter	Transitional Housing	Safe Haven	Total Sheltered	Unsheltered	TOTAL
Households with at least one adult and one child	**Households**	958	544	-	**1,502**	**618**	**2,120**
	Persons	3,120	1,726	-	**4,846**	**1,881**	**6,727**
Households with only children	**Households**	71	19	-	**90**	**444**	**534**
	Persons	71	19	-	**90**	**444**	**534**
Households without children	**Households**	6,341	1,089	55	**7,485**	**10,263**	**17,748**
	Persons	6,445	1,107	55	**7,607**	**10,584**	**18,191**
TOTAL	**Households**	7,370	1,652	55	**9,077**	**11,325**	**20,402**
	Persons	9,636	2,852	55	**12,543**	**12,909**	**25,452**
Subpopulations	**Chronically Homeless Individuals**	3,271	-	49	**3,320**	**4,946**	**8,266**
	Adults with a Serious Mental Illness	2,248	573	23	**2,844**	**4,591**	**7,435**
	Adults with a Substance Use Disorder	1,581	383	25	**1,989**	**4,672**	**6,661**
	Adults with HIV/AIDS	35	< 11	-	**39**	**16**	**55**
	Adult Victims of Domestic Violence	930	275	< 11	**1,207**	**317**	**1,524**
Veterans	**Veteran Households**	437	245	15	697	**810**	**1,507**
	Veterans	444	246	15	705	**864**	**1,569**
Youth Households (under 25)							
Households	**Total numbers of households**	1,518	417	11	1,946	**2,796**	**4,742**
	Unaccompanied Youth households	1,423	332	< 11	1,764	**2,793**	**4,557**
	Parenting Youth Households	95	85	< 11	182	**< 11**	**185**
Persons	**Total number of persons**	1,550	459	11	2,020	**1,056**	**3,076**
	Persons in parenting youth household	106	116	< 11	224	**< 11**	**230**
	Persons in unaccompanied youth household	1,444	343	< 11	1,796	**1,050**	**2,846**

2022 Point in Time Count | County Totals

County	TOTAL Homeless (sheltered and unsheltered)							
	Households w/out minors		Households with minors		Households with only minors		TOTAL	
	Persons	Households	Persons	Households	Persons	Households	Persons	Households
Adams County	0	0	0	0	0	0	0	0
Asotin County	71	63	24	< 11	0	0	95	*
Benton County	78	69	111	32	13	13	202	114
Chelan County	246	226	143	41	0	0	389	267
Clallam County	118	116	60	20	0	0	178	136
Clark County	785	695	632	198	21	21	1438	914
Columbia County	17	17	0	0	0	0	17	17
Cowlitz County	174	167	97	30	0	0	271	197
Douglas County	< 11	< 11	< 11	< 11	0	0	20	14
Ferry County	< 11	< 11	< 11	< 11	0	0	< 11	< 11
Franklin County	13	13	0	0	0	0	13	13
Garfield County	0	0	0	0	0	0	0	0
Grant County	223	217	63	21	0	0	286	238
Grays Harbor County	120	115	< 11	< 11	< 11	< 11	134	124
Island County	110	102	35	12	< 11	< 11	146	115
Jefferson County	112	104	18	< 11	0	0	130	*
King County	9327	9324	3592	1121	449	449	13368	10894
Kitsap County	444	415	111	37	< 11	< 11	*	*
Kittitas County	33	30	23	< 11	0	0	56	*
Klickitat County	< 11	< 11	< 11	< 11	0	0	13	< 11
Lewis County	102	100	18	< 11	0	0	120	*
Lincoln County	0	0	0	0	0	0	0	0
Mason County	135	132	103	35	0	0	238	167
Okanogan County	41	39	16	< 11	0	0	57	*
Pacific County	108	91	< 11	< 11	0	0	*	*
Pend Oreille County	< 11	< 11	< 11	< 11	0	0	18	11
Pierce County	1516	1443	331	106	< 11	< 11	*	*
San Juan County	50	41	< 11	< 11	0	0	*	*
Skagit County	216	203	98	31	0	0	314	234
Skamania County	24	24	0	0	0	0	24	24
Snohomish County	882	846	287	92	15	15	1184	953
Spokane County	1457	1413	290	90	< 11	< 11	*	*
Stevens County	31	27	19	< 11	0	0	50	30
Thurston County	484	471	170	61	< 11	< 11	*	*
Wahkiakum County	< 11	< 11	0	0	0	0	< 11	< 11
Walla Walla County	133	132	14	< 11	< 11	< 11	151	140
Whatcom County	573	553	258	83	< 11	< 11	*	*
Whitman County	< 11	< 11	< 11	< 11	0	0	11	< 11
Yakima County	529	524	163	50	0	0	692	574
TOTAL	**15741**	**14830**	**6732**	**2118**	**450**	**318**	25452	20402

Department of Commerce

Homelessness in Washington State

2018 Annual Report

December 2018
Report to the Legislature
Brian Bonlender, Director

Acknowledgements

Washington State Department of Commerce

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For people with disabilities, this report is available on request in other formats. To submit a request, please call 360-725-4000 (TTY 360-586-0772).

Table of Contents

Executive Summary

This annual report complements the Washington State Homeless Strategic Plan updated in 2018, and fulfills reporting requirements outlined in several chapters of the Homeless Housing and Assistance Act, including RCW 43.185c.010, 040, 045, 170, 340, and RCW 43.63A.305 and 311. New reporting requirements were added to the Act during the 2018 legislative session.

Despite a strong state economy, growing incomes, and above-average and improving family stability, Washington has the fifth highest prevalence of homelessness in the nation. The count of people living unsheltered has increased every year since 2013, and now totals over 10,000 people.

In most domains that drive homelessness, Washington is above average and improving, with the notable exception of rental price inflation. Rents have increased 30 percent in the last decade, primarily due to an undersupply of new units versus rapid population increases. Even with above-average income growth for lower-income households in Washington, it has not been enough to keep pace with rent inflation, resulting in more people with already tight budgets being pushed into homelessness.

Additional investments by the Legislature and performance improvements have moderated the impacts of this mismatch between rents and lower incomes, but forecasts show that rent increases and population growth-driven demand will outpace available funding. Washington's top tier performance-based contracting should continue to yield better outcomes with existing investments, but performance improvements do not add up to significant reductions in homelessness without additional investment and a solution to the undersupply of housing.

The Housing Opportunities Act (Chapter 85, Laws of 2018) added significant accountability, specific planning requirements and additional transparency, which is being implemented now. As part of this renewed effort, state, local governments and community partners are actively pursuing:

- Solutions to the housing supply problem.
- Improving performance.
- Quantifying the necessary level of investment to leave no person living outside.

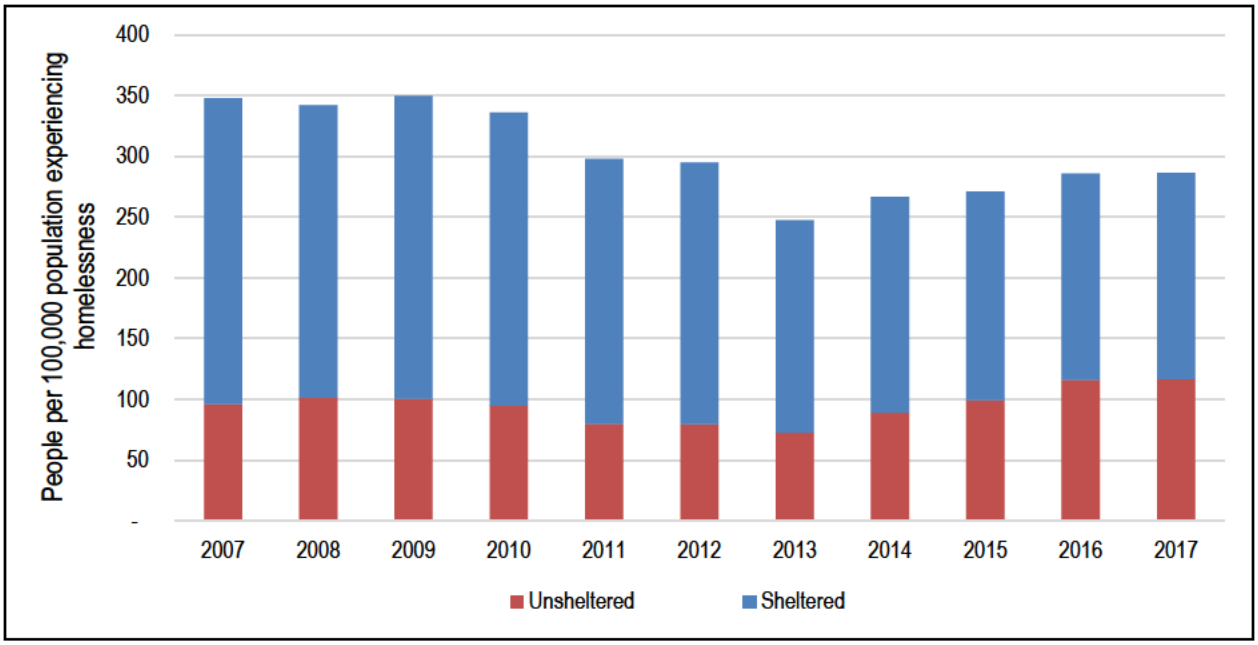
Complementing the department's broad effort to address homelessness, the Office of Homeless Youth, created through the Homeless Youth Prevention and Protection Act of 2015, continues its cross-systems partnership to work toward all young people having a safe and stable home and the support they need to thrive. The office's work around expanding services, best practices, data collection, performance management and coordinated entry implementation is integrated tightly with, and informed by, the larger overall effort to address homelessness in Washington.

Assessing the Current Conditions of Homelessness

Adult and Family Homelessness

Data-driven investments resulting from the 2006 Homelessness Housing and Assistance Act led to declines in homelessness through 2012. However, Washington's exceptionally strong economic growth without a matching increase in the housing supply contributed to a 30 percent rent inflation since 2012, moving Washington from having the 12th to the eighth highest rents in the nation. Concurrent with these rent increases, the count of people experiencing homelessness in Washington increased 26 percent, and Washington now has the fifth highest rate of homelessness in the nation, with over 10,000 people living unsheltered, and over 11,000 people living in temporary homeless housing.

Figure 1: Changes in Homelessness 2007-2017 per the Point-in-Time Count

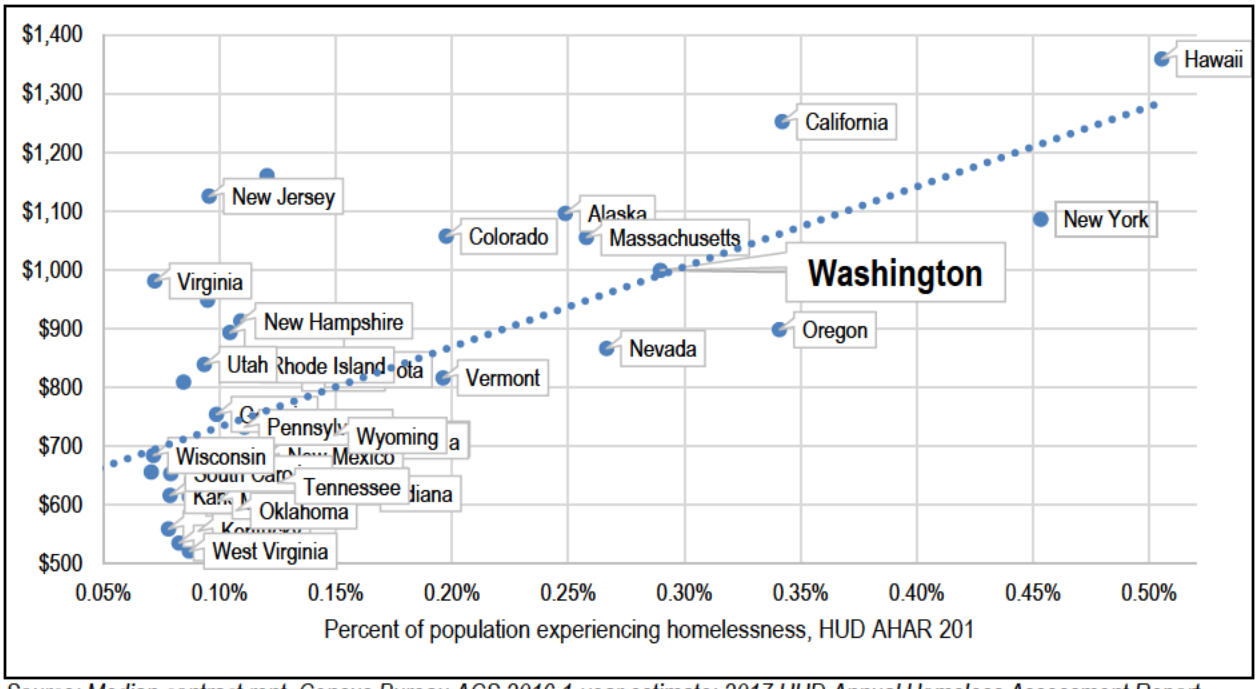


Source: Washington Annual Point in Time Count

Although Washington has an exceptionally high rate of homelessness, when compared to rent levels, Washington's rate of homelessness is average. The correlation between rent levels and homelessness (+0.66) is much stronger than other potential drivers of the increase. For example the correlation between homelessness and the supplemental poverty measure is counterintuitively negligible (+0.16), and states with large increases in opiate deaths actually experience a drop in the rate of homelessness. Washington experienced a below-average increase in opiate deaths during this time period when compared to other states.

Measures of family structure and stability are top tier in Washington and improving, and should be a countervailing force to the rent-driven increases in homelessness.

Figure 2: Median Rent and Percent of Population Experiencing Homelessness by State



Source: Median contract rent, Census Bureau ACS 2016 1-year estimate; 2017 HUD Annual Homeless Assessment Report.

Washington economic growth has been ranked first for two consecutive years, and now has the 10th highest per capita GDP among states. The lowest incomes (bottom quintile households) in Washington are ranked eighth in the nation, and the poverty rate is falling (now ranked 36th). The percentage of people working is increasing (now ranked 25th), and the percent of people collecting disability remains below the national average.

Addressing the Growing Need

Updates to the Homeless Housing and Assistance Act (Chapter 43.185C RCW) have positioned Washington as a national leader in state-driven performance contracts that have improved the efficiency of the existing homeless crisis response system investments. Legislatively required updates to local and state strategic plans will include an accounting of performance, policy, and resources changes necessary to leave no person living outside.

The plans will build off transparent, research-supported assumptions about the cost per successful intervention and related assumptions about reducing the number of people experiencing homelessness.

Newly available research and cross-jurisdictional performance data show that it is possible to reduce dramatically the number of people living outside, and a combination of lower rent inflation, improved performance, and adequate investment levels can bring Washington's performance in line with higher-performing peer states.

Youth and Young Adult Homelessness

At least 13,000 young people, ages 12 through 24, live on the street or in unsafe or unstable housing situations, and are on their own, without a parent or guardian. This often is referred to as "unaccompanied" homelessness.

Young people can experience homelessness for any number of reasons, including family dysfunction or conflict, rejection due to sexual orientation or gender identity, or economic instability that leads to separation from family. In short, young people become homeless when home is not safe, not supportive, or does not exist.

Some Young People are at Greater Risk of Homelessness

- Youth of color experience homelessness at much higher rates than the rest of the youth population. Black youth in Washington make up 24 percent of the homeless youth population, but represent only 6 percent of the total youth population.[1]
- Up to 40 percent of youth experiencing homelessness identify as LGBTQ, while only 3 to 5 percent of the U.S. population identifies as LGBTQ.[2]
- Approximately 1 in 4 youth who exit foster care and 1 in 3 exiting the juvenile or adult justice system experience homelessness. Nearly 1,200 youth and young adults exiting behavioral health inpatient treatment experienced homelessness in a single year (23 percent of those exiting).[3]
- Youth with less than a high school diploma or GED have a 346 percent higher risk of homelessness.[4]

Adolescence is a Unique Period that Demands a Tailored Approach

Experiencing homelessness during adolescence can have a profound and enduring impact on a person's life. Ages 12 through 24 are a key developmental window where significant changes are happening physically, emotionally, psychologically, and socially. The adolescent brain is plastic, meaning that it is malleable and highly sensitive to its environment. During times of heightened sensitivity (which occur during both early childhood and adolescence), the brain is more vulnerable to damage from physical harms, like drugs or environmental toxins, or psychological ones, like trauma and stress.[5] It is also more responsive to positive influences,

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[1] Washington State Department of Commerce, "Office of Homeless Youth 2016 Report to the Governor and Legislature," http://www.commerce.wa.gov/wp-content/uploads/2015/11/hau-ohy-report-2016-update.pdf

[2] Ray, N., "Lesbian, gay, bisexual and transgender youth: An epidemic of homelessness," (2006), http://www.thetaskforce.org/lgbt-youth-an-epidemic-of-homelessness/

[3] Mayfield, Jim et al., "Housing Status of Youth Exiting Foster Care, Behavioral Health and Criminal Justice Systems," (2017), https://www.dshs.wa.gov/ffa/rda/research-reports/housing-status-youth-exiting-foster-care-behavioral-health-and-criminal-justice-systems

[4] Chapin Hall, *Voices of Youth Count*, http://voicesofyouthcount.org/

[5] Steinberg, Lawrence, "Age of Opportunity, Lessons from the New Science of Adolescence," (2015)

making interventions that occur during this time significant in their influence on a young person's success and stability into adulthood. Simply put, the period of adolescence is our last best chance to put individuals on a positive pathway to a happy and fulfilling life.

The conditions under which young people enter into homelessness require that our response be more holistic rather than focused on housing alone. Young people typically lack work experience, have not completed their education, and do not have experience living independently so have not developed skills like budgeting, housekeeping, and job searching. Due to their age, they are at greater risk of victimization.[6]

The Office of Homeless Youth addresses youth homelessness through five key components identified in RCW 43.330.700 to prepare young people for a bright future:

1. Stable housing
2. Permanent connections
3. Family reconciliation
4. Education and employment
5. Social and emotional well-being

Washington Can Lead the Way

Working together, we can ensure that all young people have a safe and stable home and the support they need to thrive. Washington is positioned to lead the nation in making this vision a reality. The establishment of the Office of Homeless Youth in 2015 solidified the state's commitment to take a laser-like approach in addressing this issue. There is a strong movement of leaders, funders, and young people working together to end youth and young adult homelessness. Bold initiatives have recently launched including:

- A Way Home, Washington's Anchor Communities Initiative, to end youth and young adult homelessness in four communities by 2022.
- $12.5 million in U.S. Department of Housing and Urban Development (HUD) Youth Homelessness Demonstration Program grants for King, Snohomish, and the 23 most rural counties in the state.
- A partnership between the Department of Children, Youth, and Families and the Office of Homeless Youth to support families and youth in crisis and ensure that youth exit public systems of care into safe and stable housing.

Significant progress has been made on recommendations proposed in the Office of Homeless Youth's 2016 Report, including expanded access to Extended Foster Care, increased funding for housing and shelter, and policies to support the academic success of students experiencing homelessness. While progress was made, much work remains. Washington must remain steadfast in its commitment to prevent and end youth and young adult homelessness.

[6] National Network for Youth, "What Works to End Youth Homelessness?," (2015), https://www.nn4youth.org/wp-content/uploads/2015-What-Works-to-End-Youth-Homlessness.pdf

Challenges to Reducing Homelessness

There are broader system and administrative challenges to reducing homelessness in our state. The system challenges such as institutional discharges into homelessness, rising rents, and lack of affordable housing, coupled with growth management laws, fall outside of the capacity of local homeless crisis response system to make significant changes. Instead, those local crisis response systems work to improve efficiencies that sometimes can be seen only at the margins. Even after performance benchmarks are achieved, modeling shows that existing resources are inadequate to reach the goal of leaving no person living outside.

System Challenges

Increases in Rent

Rental rates may have stopped increasing in most counties, and in some, may be declining. However, the long-term structural balance may result in a chronic undersupply of housing, resulting in further excessive rent inflation and increases in homelessness. With chronic, excessive rent inflation, the need for more low-income housing rises and may make it difficult for state and local governments to keep pace with growing need.

Lack of Housing

According to a study by the National Low Income Housing Coalition, the U. S. has a shortage of 7.4 million affordable rental homes available to extremely low-income renter households, resulting in 35 affordable and available units for every 100 extremely low-income renter households.[7] The study also shows that Washington is no exception, with less than the national average. Because of the shortage of affordable and available homes, many lower-income households spend more on housing than they can afford sacrificing income for health care, food, transportation, childcare, and utilities.

Current Gaps in Youth and Young Adult System Limit Prevention and Pathways out of Homelessness

- Geographic gaps: Youth and young adults experience homelessness in every region of our state. Despite what many people assume, rates of youth homelessness are similar in rural and urban areas.[8] Yet while there are youth experiencing homelessness in all communities of the state, the resources to help them are not. There are no beds for homeless youth in half of the 39 counties in Washington.

[7] National Low Income Housing Coalition, "Out of Reach: The High Cost of Housing," (2018), http://nlihc.org/sites/default/files/oor/OOR_2018.pdf

[8] Chapin Hall, *Voices of Youth Count*, (2018), http://voicesofyouthcount.org/

- Lack of prevention services: Families experiencing conflict or disruption do not have access to the support needed to build resiliency and resolve challenges. They need access to robust crisis intervention, family counseling and reconciliation, and behavioral health services to prevent young people from having even a single experience of homelessness.
- Inadequate transition planning from public systems: Young people transitioning from public systems of care, such as foster care and the justice system, are leaving without the proper preparation and support to ensure their safety and stability.

Administrative Challenges

Statewide By-Name List

Identifying and prioritizing people experiencing homelessness is central to efficiently using limited resources. By-name lists are real-time lists of all people experiencing homelessness in a service area. A by-name list provides an ongoing snapshot of who is homeless and what their needs and preferences are. A well-implemented by-name list can also help service providers understand inflow into a homeless response system as people become homeless as well as outflow out of the system as people obtain permanent housing or leave a service area.

The HUD has made a positive long-term contribution to this initiative by releasing draft data standards governing the systems and procedures for coordinated entry, but release of final federal standards has delayed Commerce's ability to add new contract requirements. In the interim, Commerce has dedicated technical assistance staff to work with counties to strengthen their own procedures while we wait for the data standards and vendor updates to the Homeless Management Information System (HMIS). Homeless housing service providers use HMIS to collect and manage data gathered during the course of providing housing assistance to people experiencing homelessness.

Modeling Tools

Accurately quantifying the impact of performance improvements and investment levels is critical to developing meaningful local and state strategic plans. Existing tools to develop these estimates, built using hidden assumptions and calculations, are hard to use and understand given the inherent complexity of modeling flow of people through a system. Commerce has developed non-proprietary modeling tools with transparent underlying calculations and assumptions, but assisting local planning processes with understanding and using these tools will be a challenge for the department.

Homeless System Performance

Homeless System Performance Goals and Targets

Performance measures help evaluate the effectiveness of Homeless Crisis Response Systems as they work towards ending homelessness. Each performance measure has a target that is the level of desirable performance and is an indicator of a high-performing system. Commerce has identified the following as the most critical homeless system performance measures:

1. Prioritizing unsheltered homeless households.
2. Increasing exits to permanent housing.
3. Reducing returns to homelessness.
4. Reducing the length of time homeless.

Homeless Crisis Response Systems work to meet benchmarks for each performance measure. The benchmark is a short-term goal to improve performance. The benchmark is set using local data and indicates acceptable progress toward the target within a given timeframe.

Because homeless housing projects work together, performance is measured using system-wide data. This means data from all applicable homeless housing projects are included in the baseline data and in the performance results regardless of fund sources.

Prioritizing Unsheltered Homeless Households

In January 2016, Commerce introduced the first performance improvement requirement to the Consolidated Homeless Grant, which was to prioritize people experiencing unsheltered homelessness[9] for services and programs. At that time, only 41 percent of the people served were experiencing unsheltered homelessness, or had a history of unsheltered homelessness. Initially, grantees were required to increase the percent of people served who were experiencing unsheltered homeless to 35 percent. Most grantees exceeded the benchmark, and the statewide rate of service to people experiencing unsheltered homelessness increased to 57 percent.

As of July 2017, grantees are required to continue to increase the percentage of unsheltered homeless served or achieve functional zero. Functional zero means that the average number of housing placements keeps pace with the number of people experiencing homelessness.

[9] The Unsheltered Prioritization measurement includes any person who was unsheltered in the last two years, as measured in the Homeless Management Information System, by living situation (place not meant for habitation, e.g., vehicle, abandoned building, bus/train/subway station/airport, park, camping ground or anywhere outside), OR people indicating that they are currently fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions.

Additionally, grantees that are serving high levels of unsheltered homeless but have not achieved functional zero may assert that the county has met a high performance threshold, evaluated by Commerce, based on state and local administrative data, and qualitative data gathered from key stakeholders.

Improving Housing Outcomes

In July 2017, Commerce introduced additional performance improvement requirements to the Consolidated Homeless Grant with the aim of improving the housing outcomes of homeless crisis response systems. Commerce provided grantees with a menu of performance measures specific to intervention type (see table below). For each intervention type, grantees adopted the required performance measure(s), and at least one secondary performance measure. Using local data, they chose short-term improvement goals.

Performance measures and benchmarks are required to be included in sub-contracts for all Consolidated Homeless Grant and Emergency Shelter Grant funded housing interventions. However, grantees are encouraged to customize sub-grantee performance benchmarks according to past performance, facility type, or other variables. For example, to increase system-wide exits to permanent housing from emergency shelters, a grantee may require a high-performing, continuous-stay emergency shelter to reach 80 percent exits to permanent housing while a night-by-night shelter is required only to reach 30 percent exits to permanent housing. Regardless of how grantees pass performance improvement requirements to sub-grantees, performance measurement is system-wide.

Figure 3: Intervention Types, Performance Measures and Performance Targets

Intervention Type	Performance Measure (required measures are bold)	Performance Target
Emergency Shelter	**Increase Percent Exits to Permanent Housing**	At Least 50%
	Reduce Median Length of Stay	20 Days or Less
	Reduce Average Length of Stay	20 Days or Less
	Reduce Percent Return to Homelessness in 2 Years	Less than 10%
Transitional Housing	**Increase Percent Exits to Permanent Housing**	At Least 80%
	Reduce Median Length of Stay	90 Days or Less
	Reduce Average Length of Stay	90 Days or Less
	Reduce Percent Return to Homelessness in 2 Years	Less than 5%
Rapid Re-Housing	**Increase Percent Exits to Permanent Housing**	At Least 80%
	Reduce Percent Return to Homelessness in 2 Years	Less than 5%
Targeted Prevention	**Reduce Number of New Homeless**	Reduce Number
	Increase Percent served coming from institutional setting or temporarily staying with family or friends (doubled up)	At Least 80%
	Increase Percent served with past homelessness	At Least 80%
Permanent Supportive Housing	Increase Percent Exits to or Retention of Permanent Housing	At Least 95%

Monitoring and Communicating Performance

Commerce analyzes homeless system performance quarterly and annually to assess the degree to which systems are making progress on their benchmarks. Performance outcomes communicate through the "Washington State Homeless System Performance Reports." The reports provide information on critical homeless system performance measures and other contextual information about a community's homeless crisis response system.

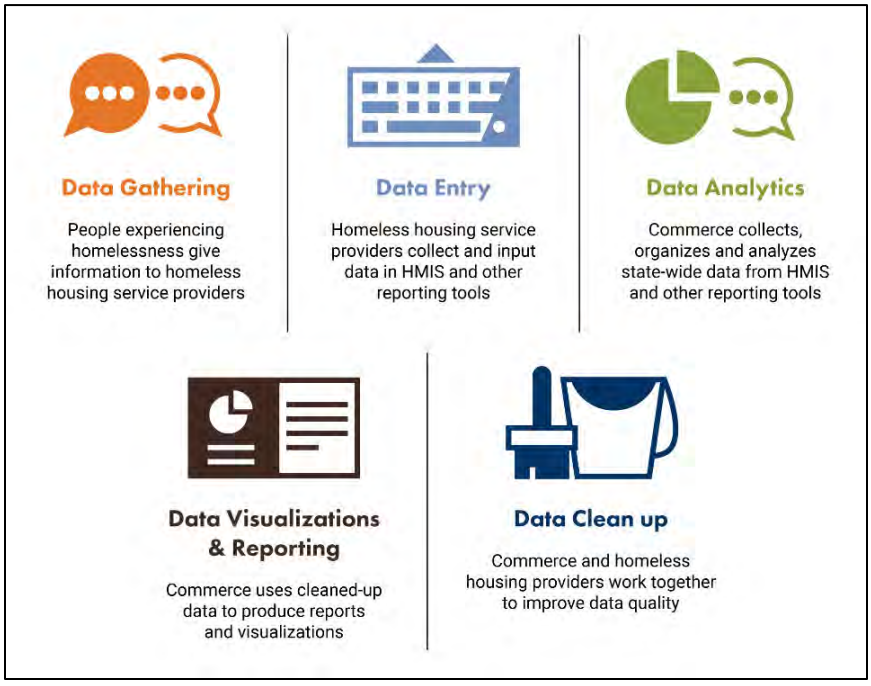
The reports:

- Identify evidence-based housing interventions that efficiently move people experiencing homelessness into permanent destinations.
- Provide communities with information regarding their progress towards locally established performance benchmarks.
- Evaluate if improvement strategies are having the intended impact.
- Highlight data quality.

Data Sources

The Homeless Management Information System (HMIS) is the data source for most of the information used in the "Washington State Homeless System Performance Reports." Homeless housing service providers use HMIS to collect and manage data gathered during the course of providing housing assistance to people experiencing homelessness. Other data sources include the annual County Expenditure Report, and the annual Point-In-Time Count.

Figure 4: Illustration of How HMIS Data is used for Reporting



Washington State Homeless System Performance Reports

The County Report Card and Year-to-Year Comparison provide annual performance outcome results for Washington as a whole, and for each county. Data from all homeless housing projects that participate in HMIS are included in these reports.

The County Report Card provides information by county on system-wide performance measures, including exits to permanent housing, returns to homelessness, length of time homeless, and cost per exit to permanent housing. The County Report Card is embedded in an interactive map that identifies performance outcome results for the reporting period.

The Year-to-Year Comparison table provides information by county on system-wide performance measures for each year.[10] It also includes contextual information such as Point-in-Time Count results and rental vacancy rates. The interactive table allows the viewer to see trends over time.

Dashboards provide performance outcome results for counties as a whole, for each agency, and for each project each quarter. The dashboards are organized by different types of interventions, and each dashboard includes a data quality component to help direct service providers ensure their data are accurate and complete. At this time, only counties that are included in the Balance of State Continuum of Care are included in project-type dashboards.

Rapid Re-Housing Dashboard:[11] Rapid Re-Housing projects aim to quickly move households from homelessness into permanent housing by providing move-in assistance, temporary rent subsidies, and housing-focused case management. Critical performance measures for Rapid Re-Housing projects include:

- Increasing exits to permanent housing.
- Reducing returns to homelessness.
- Decreasing time to move-in.

Temporary Housing Dashboard:[12] Temporary Housing projects include emergency shelters and transitional housing projects. Temporary housing interventions intend to provide short-term lodging to people experiencing homelessness. Participants will eventually leave the unit when they resolve their housing situation or at the maximum stay allowable by the project. Critical performance measures for temporary housing projects are:

- Increasing exits to permanent housing.

[10] https://public.tableau.com/profile/comhau#!/vizhome/WashingtonStateHomelessSystemPerformanceYeartoYearComparison-DRAFT/YeartoYearDashboard

[11] https://public.tableau.com/profile/comhau#!/vizhome/DRAFTWashingtonBalanceofStateHomelessSystemPerformanceRapidRe-HousingDashboard/RRHDashboard

[12] https://public.tableau.com/profile/comhau#!/vizhome/WashingtonBalanceofStateHomelessSystemPerformanceTemporaryHousingDashboard_0/ESTHDashboard

- Reducing returns to homelessness.
- Decreasing length of stay.

Homelessness Prevention Dashboard link:[13] Homelessness prevention projects intend to prevent homelessness for currently housed people by providing crisis resolution focused services and financial assistance if needed. Critical performance measures for homelessness prevention projects are reducing the number of new people entering the homeless system, and targeting assistance to those most likely to become homeless.

[13] https://public.tableau.com/profile/comhau#!/vizhome/WashingtonBalanceofStateHomelessSystemPerformanceHomelessPreventionDashboard/HPDashboard

Homeless System Performance Successes: Rural Washington

Homeless system performance in rural and mid-size counties in Washington improved in state fiscal year 2018 compared to state fiscal year 2017, with all Washington counties meeting their improvement goals on one or more of the homeless system performance measures.

- Exits to permanent housing increased from 47 percent to 50 percent overall.
- Exits to permanent housing improved among emergency shelter programs from 26 percent to 31 percent. The state target for exits to permanent housing from emergency shelters is 50 percent.
- Exits to permanent housing among rapid re-housing programs remained steady at 78 percent. The state target for exits to permanent housing from rapid re-housing programs is 80 percent.
- Households served by permanent housing-type projects, including rapid re-housing, are very unlikely to return to homelessness as compared to other intervention types with only 7 percent returning to homelessness after two years.
- The average length of stay in emergency shelter and transitional housing programs increased slightly from 101 days to 105 days.
- The average length of time homelessness increased overall from 221 days to 263 days, due to the prioritization of people experiencing unsheltered homelessness and chronically homeless households.
- The number of people experiencing homelessness for the first time decreased from 13,554 to 12,523.

The tables below highlight grantees in rural Washington that made the most progress on improving housing outcomes for emergency shelter and rapid re-housing.

Figure 5: Emergency Shelters – Improving Housing Outcomes

Top-Ten Improved Exits to Permanent Housing			
County or Region	**7/1/2016 - 6/30/2017**	**7/1/2017 - 6/30/2018**	**Change**
Asotin	26.92	64.29	37.37
Clallam	32.98	40.99	8.01
Cowlitz	26.67	44.75	18.08
Island	34.81	44.12	9.31
Lewis	43.9	50.39	6.49
Region Benton - Franklin	33.33	57.2	23.87
Region Ferry - Stevens	63.27	72.73	9.46
Region Grant - Adams	14.83	26.59	11.76
Thurston	16.96	31.56	14.6
Wahkiakum	45.5	75	29.5

Figure 6: Rapid Rehousing – Improving Housing Outcomes

Top-Ten Improved Exits to Permanent Housing			
County or Region	**7/1/2016 - 6/30/2017**	**7/1/2017 - 6/30/2018**	**Change**
Clallam	77.37	87.59	10.22
Cowlitz	68.93	79.47	10.54
Grays Harbor	74.55	76.7	2.15
Island	75.54	86.45	10.91
Okanogan	88.89	91.74	2.85
Pacific	50.96	64.29	13.33
Region Benton - Franklin	68.76	81.01	12.25
Region Columbia - Garfield	76.92	94.12	17.2
San Juan	66.67	100	33.33
Yakima	69.86	76.26	6.4

Strategies to Improve System Performance

Every community has different resources, strengths, and challenges and will need to take different actions to improve performance results. However, there are high-impact strategies that can improve performance in all communities. Nationally recognized strategies detailed below are best practices in homeless housing services and are a Consolidated Homeless Grant requirement or allowable activity.

Figure 7: Best Practice Strategies

Strategies for Improvement	Prioritize Unsheltered Homeless Households	Increase Exits to Permanent Housing	Reduce Returns to Homelessness	Reduce the Length of Time Homeless
Lower Barriers to Coordinated and Project Entry	✓	✓		✓
Deploy Progressive Engagement Service Models System-Wide		✓	✓	✓
Link Street Outreach to Coordinated Entry	✓	✓		✓
Provide Housing Focused Case Management		✓	✓	✓
Lower Barriers to Project Participation	✓	✓		✓
Provide Housing Search and Placement Services		✓	✓	✓
Target Homeless Prevention Assistance			✓	

Current State Plan Accomplishments

Homeless Strategic Plan Vision, Mission, and Guiding Principles

Commerce first published a strategic plan separate from the annual report in January 2017 and updated it again in 2018. The plan's vision and mission remain the same, and Commerce continues to address system goals.

Figure 8: Commerce's Homelessness Strategic Plan Vision, Mission and Guiding Principles

Vision
No person left living outside.
Mission
Support homeless crisis response systems that efficiently reduce the number of people living outside, and that when scaled appropriately can house all unsheltered people.
Guiding Principles
❖ All people deserve a safe place to live. ❖ Urgent and bold action is the appropriate response to people living outside. ❖ Interventions must be data driven and evidenced based.

Homeless Crisis Response System Goals and Progress

Commerce identified six homeless crisis response system goals to direct our work in 2017 and 2018.

- **Goal 1:** Effective and efficient coordinated access and assessment for services and housing.
- **Goal 2**: Effective and efficient crisis response system.
- **Goal 3**: Identification of policy changes and resources necessary to house all people living unsheltered.
- **Goal 4**: Quantifying what would reduce the number of new people becoming homeless.
- **Goal 5**: Transparent and meaningful accounting of state and local recording fee funds.
- **Goal 6**: Fair and equitable resource distribution.

Each goal included specific actions and timelines connected to a performance measure. Figures 9 through 14 below present the actions, timelines, and results of the work towards the six system goals identified above.

Figure 9: Goal 1 – Effective and Efficient Coordinated Access and Assessment for Services and Housing

Strategy 1.1: Improved Implementation of Coordinated Entry, Outreach & Statewide By-name List			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
1.1.1 Continue technical assistance to counties working to refine their coordinated entry systems and outreach strategies.	On-going	Biennial technical assistance and training plan.	Statewide training and technical assistance including webinars and site visits.
1.1.2 Develop a project plan for an active statewide by-name list in the state's Homeless Management Information System.	2018	Active statewide by-name list.	Project plan implemented and new Housing and Urban Development Coordinated Entry standards under review.
1.1.3 Continue to evaluate and score coordinated entry systems, including adding additional performance measures of coordinated entry and accessibility.	2019	Evaluated biennially by interdisciplinary team.	Project plan developed. Reviews will be completed in 2019.
1.1.4 Expand coordinated entry requirement for all homeless housing programs managed by recipients of, and sub recipients of, Commerce homeless funding.	Completed	Review during compliance monitoring.	Monitoring on-going.
1.1.5 Revise Consolidated Homeless Grants to include the new HUD coordinated entry requirements in 2018—2019 grants.	Completed	Updated Grant Guidelines.	Implemented

Figure 10: Goal 2 – Effective and Efficient Crisis Response System

Strategy 2.1: Promote Evidence-based Housing Interventions that Efficiently Move People Experiencing Homelessness into Permanent Destinations			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
2.1.1 Publish Homeless System Performance *County Report Card* with system performance measures: • Cost per successful exit to permanent housing. • Exits to permanent housing destinations. • Returns to homelessness. • Length of time homeless.	Annually	Post to Commerce website.	Posted on Commerce website. Next Report Card underway for posting in January 2019.

Actions in Support of Strategy	Timeline	Accountability	Progress Made
2.1.2 Publish Homeless System Performance *Project Report* with project level performance measures: • People served, exited • Exits to permanent housing destinations • Returns to homelessness • Length of stay	Quarterly	Post to Commerce website.	Posted on Commerce website. Quarterly dashboards posted for Rapid Rehousing, Temporary Housing and Prevention for all projects in every county.
2.1.3 Provide training on Trauma Informed Services, Mental Health First Aid, Low Barrier Conversion, Harm Reduction, Fair Housing, Progressive Engagement, best practices in serving survivors of domestic violence, and Coordinated Entry.	On-going	Biennial technical assistance and training plan.	Training on Trauma Informed Services, Mental Health First Aid started in 2018.
2.1.4 Explore contracting the next biennial 2019 - 2021 Consolidated Homeless Grant funds competitively based on performance.	2018	Procure performance consultant.	In discussions with consultant.
2.1.5 Explore promoting local prioritization of locally-controlled housing funding (recording fees and federal funds awarded to housing authorities) for priority populations in the 2019 homeless grants awarded from Commerce.	2018	Develop policy memo for stakeholder feedback.	Postponed until 2019.
2.1.6 Align homeless grant requirements with system performance measures and benchmarks plus require systems receiving Commerce funds to prioritize serving people who are unsheltered.	Completed	Consolidated Homeless Grant	Completed and being monitored.
2.1.7 Require systems receiving Commerce funds to use a service model that includes the following evidenced based best practices: 1) Access to continued housing assistance should not be contingent on unnecessary conditions. 2) Initial and frequent re-assessment to solve housing crises with minimal services needed. 3) Individualized services responsive to the needs of each household. 4) Voluntary participation in supportive services. 5) Rapid exits to permanent housing.	Completed	Consolidated Homeless Grant	Completed and being monitored.
2.1.8 Provide local homeless plan academy for county/local governments and introduce Local Plan Modeling Tool.	Completed	Local Plan Modeling Tool	Release draft in October 2018 and final by December 2018.

Figure 11: Goal 3 – Identification of Policy Changes and Resources Necessary to House all People Living Unsheltered

Strategy 3.1: Improve County Data Reporting			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
3.1.1 Contractually require data quality improvements in submission of Homeless Management Information System data and Annual Report submissions by Consolidated Homeless Grantees. Thresholds introduced in 2018 and required contractually in 2019.	Thresholds introduced in 2018 and required contractually in 2019.	Improved data quality scores in *Homeless System Performance Report Card.*	Ongoing
3.1.2 Contractually require best practices in administering the Point-in Time count by Consolidated Homeless Grantees.	Introduced in 2018 and required contractually in 2019.	Improved data quality scores in *Homeless System Performance Report Card.*	Postponed
3.1.3 Expand participation in statewide by name list in the Homeless Management Information System in cooperation with the Department of Social and Health Services and other entities in contact with people experiencing homelessness.	2018 - 2019	Improved data quality scores in *Homeless System Performance Report Card.*	Ongoing
Strategy 3.2: Develop Unmet Need Estimate to House all People Living Unsheltered			
3.2.1 Propose law and policy changes to support cross agency data sharing capacity.	On-going	Interagency Council on Homelessness.	On-going
3.2.2 Work with state agencies to determine the counts of people unsheltered whose housing is the direct responsibility of state agencies.	On-going	Interagency Council on Homelessness.	On-going
3.2.3 Develop unmet count based on statewide byname lists in the Homeless Management Information System.	On-going	Post to Commerce website.	Postponed until federal data standards are finalized.
3.2.4 Supplement Point-in-Time count with count derived from administrative data collected by the Department of Social and Health Services.	Twice annually	Post to Commerce website.	Posted on Commerce website.
3.2.5 Estimate policy and resource changes in resources necessary to leave no person living outside, based on contracted system performance targets and updated enumerations of people living outside.	January 2018	Update state Homeless Housing Strategic Plan to include updated resource gap calculations.	Underway

Figure 12: Goal 4 – Quantifying What Would Reduce the Number of New People Becoming Homeless

Strategy 4.1: Facilitate Identification of Policy and Resource Changes that Would Reduce the Number of New People Becoming Homeless			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
4.1.1 Engage local governments and service providers to solicit ideas on interventions and policy changes that would reduce the number of people becoming homeless.	2018	Commerce publishes literature review and model assumptions.	Ongoing
4.1.2 Review literature to quantify the impact of upstream interventions that could reduce the number of people at-risk of becoming homeless by increasing incomes, improving family stability, and reducing behavioral health problems.	2018	Commerce publishes literature review and model assumptions.	Ongoing

Figure 13: Goal 5 – Transparent Accounting of State and Local Recording Fee Funds

Strategy 5.1: Publish County Report Cards			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
5.1.1 Compile data from the Homeless Management Information System, contract compliance, spending, and other data sources to develop county reports cards.	Annually	Post to Commerce website.	Posted to Commerce website.
Strategy 5.2: Publish Spending and Performance Data for all Projects Funded by State and Local Recording Fees			
5.2.1 Commerce drafts annual report and presents to the Interagency Council on Homelessness and the Statewide Advisory Council on Homelessness.	Annually	Post to Commerce website.	Current
Strategy 5.3: Ensure Access to all Homeless Data			
5.3.1 Require counties not able to export client data to the state Homeless Management Information System by December 2016 to use the state Homeless Management Information System for direct data entry. Provide technical assistance to all data integration counties.	In progress.	All statewide data available to Commerce.	Postponed

Figure 14: Goal 6 – Fair and Equitable Resource Distribution

Strategy 6.1: Staff Development on System Disparities			
Actions in Support of Strategy	**Timeline**	**Accountability**	**Progress Made**
Identify training plan for staff development.	2018	Staff complete training in 2018.	Initial plan developed for 2018-2019.
Strategy 6.2: Examine System Disparities			
Identify components and timeframe for completing the work.	2018	Staff produce draft findings and recommend strategies in 2019.	Ongoing
Strategy 6.3: Produce Recommendations			
Include remedies in the future State Homeless Housing Strategic Plan.	2018	Updated Plan includes remedies.	Ongoing

Future Planning and Reporting

With the passage of the Washington Housing Opportunities Act (Chapter 85, Laws of 2018), Commerce has new state strategic plan and annual reporting requirements.

State Strategic Plan Timeline

Below is the timeline for meeting the new State Homeless Housing Strategic Plan and Local Homeless Plan requirements.

- Commerce will release updated Local Homeless Plan guidance by December 2018; updated plans are due from local governments to Commerce by December 2019.
- Commerce will produce an updated State Homeless Housing Strategic Plan by July 2019 and every five years thereafter.
- Commerce will evaluate and post local homeless plans on our website in 2020.
- Commerce will provide technical assistance to local governments whose local homeless plans do not meet state guidance in 2020.

Beginning in December 2019, Commerce will annually report an assessment of the state's performance in furthering the goals of the updated State Homeless Housing Strategic Plan and the performance of each local government in creating and executing a local homeless plan that meets the state guidance.

State Strategic Plan Content

Commerce will adopt the updated Federal Strategic Plan to Prevent and End Homelessness published by the U. S. Interagency Council on Homelessness and identify actions and timeline to achieve the objectives.

Additionally, and as required in recent legislation, Commerce will include the following in the State Strategic Plan in July 2019.

Performance measures:

- Short- and long-term goals to reduce homelessness.
- Analysis of services and programs at the state and county level.
- Identification of programs representing best practices and outcomes.
- Recognition of programs targeted to populations or geographic areas in recognition of diverse needs.
- New or innovative funding, programs and service strategies.
- Analysis of current drivers of homelessness.
- Implementation strategy with timelines outlining roles and responsibilities at the state and local level.

Commerce will consult with the following stakeholders in developing the updated State Homeless Housing Strategic Plan:

- State Consolidated Homeless Grant grantees:[14] The Consolidated Homeless Grant Program at Commerce uses state funds to support all 39 counties in maintaining an integrated system of housing assistance.
- Office of Homeless Youth:[15] The Office of Homeless Youth Prevention and Protection Programs leads the statewide efforts to reduce and prevent homelessness for youth and young adults.
- Washington State Balance of State Continuum of Care:[16] Commerce is the Collaborative Applicant for the Washington Balance of State Continuum of Care (BoS CoC). The BoS CoC's 34 small and medium-sized counties receive about $6 million annually for permanent and temporary housing projects funded by the U.S. Dept. of Housing and Urban Development Continuum of Care Program.
- Washington Low Income Housing Alliance (WLIHA) Homeless Advisory Committee:[17] WLIHA leads statewide advocacy efforts to ensure that all our residents thrive in safe, healthy, affordable homes. They do this through advocacy, education, and organizing.
- State Interagency Council on Homelessness:[18] The Interagency Council on Homelessness (as defined in RCW 43.185C.010) meets throughout the year to coordinate the state's response to homelessness, including guiding creation of the state strategic plan, and making budget and policy recommendations to the governor.
- State Advisory Council on Homelessness:[19] The State Advisory Council on Homelessness was created by executive order in 1994 to advise governors on homelessness issues. It includes 12 members who represent various stakeholder groups including business, philanthropy, youth, housing authorities and local governments.
- The Affordable Housing Advisory Board:[20] The Affordable Housing Advisory Board advises the Department of Commerce on housing and housing-related issues. There are 22 members representing a variety of housing interests around the state.

[14] https://www.commerce.wa.gov/serving-communities/homelessness/consolidated-homeless-grant/
[15] https://www.commerce.wa.gov/serving-communities/homelessness/office-of-youth-homelessness/
[16] https://www.commerce.wa.gov/serving-communities/homelessness/continuum-of-care/
[17] https://www.wliha.org/about-us/overview
[18] https://www.commerce.wa.gov/about-us/boards-and-commissions/homeless-councils/
[19] https://www.commerce.wa.gov/about-us/boards-and-commissions/homeless-councils/
[20] https://www.commerce.wa.gov/about-us/boards-and-commissions/affordable-housing-advisory-board/

Recommendations

- Identify and implement strategies to rein in excessive market rate housing price inflation.
- Increase funding for the Housing Trust Fund to increase the number of subsidized housing units available for low-income and special needs households.
- Provide additional funding for housing assistance to increase the capacity of the homelessness response system in Washington.

Appendix A: Organizational Outline

The Department of Commerce Housing Assistance Unit is divided into several offices in response to legislative requirements and responsibilities.

Figure 15: Offices Within the Housing Assistance Unit

Housing Assistance Unit				
Office of Family & Adult Homelessness	Office of Homeless Youth Prevention & Protection Programs	Office of Behavioral Health	Performance Office	Balance of State Continuum of Care and Reporting Office

The Office of Family and Adult Homelessness (OFAH) administers state and federal fund sources that are granted to local governments and nonprofits.

Figure 16: Fund Sources of Office of Family and Adult Homelessness Managed Grants

Grant	Fund Source
Consolidated Homeless Grant	Housing surcharge/document recording fee
Housing and Essential Needs	General fund state
Homeless Student Stability Program	General fund state
HOME Tenant Based Rental Assistance	Federal
Emergency Solutions Grant	Federal

You can learn more about the OFAH on the Commerce website at: www.commerce.wa.gov/serving-communities/homelessness/office-of-family-and-adult-homelessness/.

The Office of Homeless Youth (OHY) Prevention & Protection Programs administers state fund sources that are granted to local governments and nonprofits. These include:

- Crisis Residential Centers
- HOPE Centers
- Independent Youth Housing Program
- Street Youth Services
- Young Adult Shelter
- Youth Adult Housing Program

You can learn more about the OHY on the Commerce website at: www.commerce.wa.gov/ohy.

The Office of Behavioral Health administers the Landlord Mitigation Program and HUD 811 Project Rental Assistance Demonstration Grant. You can learn more about the Landlord Mitigation Program on the Commerce website at www.commerce.wa.gov/building-

infrastructure/housing/landlord-mitigation-program/ and the HUD 811 Project Rental Assistance Demonstration Grant at www.commerce.wa.gov/serving-communities/homelessness/hud-section-811-rental-assistance/.

The Performance Office produces the Homeless System Performance Reports and County Report Cards, dashboards on homeless interventions, and more. This office also leads compliance efforts with the low-barrier and coordinated entry requirements for Consolidated Homeless Grant grantees. You can learn more about how this office provides information on the homeless system performance on the Commerce website at: www.commerce.wa.gov/serving-communities/homelessness/homeless-system-performance/.

The Balance of State Continuum of Care and Reporting Office works with 34 counties represented in the Balance of Washington State Continuum of Care to submit a consolidated application for funding from the U.S. Department of Housing and Urban Development. You can read more about the Balance of State Continuum of Care on the Commerce website at: www.commerce.wa.gov/serving-communities/homelessness/continuum-of-care/.

In addition, this Office administers the state's Homeless Management Information System (HMIS). It provides front-end solutions for the Balance of State and King County Continuums, as well as data integration technology to bring the other continuum data into the statewide database. HMIS is the data source for most of the information used in our performance reports. Homeless housing service providers use HMIS to collect and manage data gathered during the course of providing housing assistance to people experiencing homelessness. You can read more about HMIS on the Commerce website at: https://www.commerce.wa.gov/serving-communities/homelessness/hmis/.

Appendix B: Homeless Housing Project Expenditure and Data Report

RCW 43.185c.045 requires that each county in Washington report all expenditures by funding sources (federal, state and local) for homeless housing projects in their community. Commerce combines expenditures data with Homeless Management Information System data to create an even more comprehensive report that not only reports expenditures but also links it to outcomes.

In state fiscal year 2018, 2,355 projects spent $255,040,669 assisting 152,068 households who were homeless or at imminent risk of homelessness. The table below summarizes the number of beds and cost per intervention.

Figure 17: Homeless Housing Project Expenditures for State Fiscal Year 2018

	Rapid Re-housing	Emergency Shelter	Transitional Housing	Homeless Prevention	Permanent Supportive Housing	Other Permanent Housing	Street Outreach	Services Only
Beds	4,452	20,349	6,660	7,163	12,818	4,010	4,116	20,005
Total Expenditures	$42,389,212	$50,102,694	$18,616,067	$27,169,538	$68,190,346	$16,451,556	$3,164,533	$18,334,842
Cost per day per Household	$49.30	$31.43	$30.11	$14.34	$30.67	$32.59	n/a	n/a
Cost per successful exit per Household	$9,527.81	$8,991.87	$14,658.32	$5,769.70	n/a	n/a	n/a	n/a

You can find the state fiscal year 2018 homeless housing projects expenditure and data report on our website at https://www.commerce.wa.gov/serving-communities/homelessness/state-strategic-plan-annual-report-and-audits/.

You can find out how the Performance Office uses the expenditure and data on our website at www.commerce.wa.gov/serving-communities/homelessness/homeless-system-performance/.

Appendix C: State Funded Homeless Housing Reports

Several RCWs require Commerce to report on expenditures, performance, and outcomes of state funds for the following:

- Consolidated Homeless Grant: RCW 434.285C.045
- Housing and Essential Needs: RCW 43.185C.220
- Homeless Student Stability Program: RCW 43.185C.340
- Independent youth housing program: RCW 43.63A.311

Commerce reports include the grant recipient and service area, expenditures, interventions and number of households assisted. They may also include additional specific information required in each RCW.

You can find the state fiscal year 2018 state funded homeless housing reports on our website at https://www.commerce.wa.gov/serving-communities/homelessness/state-strategic-plan-annual-report-and-audits/.

Appendix D: Landlord Sampling Report

RCW 43.185C.240 requires that Commerce develop a sampling method to obtain data and report by county on:

- Type of landlord receiving services.
- Number of households.
- Number of people in households.
- Number of payments.
- Total of payments.
- Number of households receiving eviction prevention payments.
- Number of people in households receiving eviction prevention payments.
- Number of eviction prevention payments.
- Total of eviction prevention payments.

You can find the state fiscal year 2018 Landlord Sampling Report on our website at https://www.commerce.wa.gov/serving-communities/homelessness/state-strategic-plan-annual-report-and-audits/.

Appendix E: Point-in-Time Count

RCW 43.185c.045 requires that Commerce report on the annual homeless point-in-time census conducted under RCW 43.185C.030. Each county is required to conduct an annual one-day survey of people who are without permanent housing. The 2018 count took place on Jan. 25, 2018, and the results were released in May 2018.

Count results by county are located on the Commerce website at: https://www.commerce.wa.gov/serving-communities/homelessness/annual-point-time-count/.

Homeless Persons' Memorial Day, 2006

The Hard, Cold Facts About the Deaths of Homeless People

Information from the National Health Care for the Homeless Council

Homelessness dramatically elevates one's risk of illness, injury and death.

For every age group, homeless persons are three times more likely to die than the general population. Middle-aged homeless men and young homeless women are at particularly increased risk.[1]

The average age of death of homeless persons is about 50 years, the age at which Americans commonly died in 1900.[2] Today, non-homeless Americans can expect to live to age 78.[3]

Homeless people suffer the same illnesses experienced by people with homes, but at rates three to six times higher.[4] This includes potentially lethal communicable diseases such as HIV/AIDS, tuberculosis and influenza, as well as cancer, heart disease, diabetes and hypertension.

Homeless persons die from illnesses that can be treated or prevented. Crowded, poorly-ventilated living conditions, found in many shelters, promote the spread of communicable diseases. Research shows that risk of death on the streets is only moderately affected by substance abuse or mental illness, which must also be understood as health problems. *Physical* health conditions such as heart problems or cancer are more likely to lead to an early death for homeless persons. The difficulty getting rest, maintaining medications, eating well, staying clean and staying warm prolong and exacerbate illnesses, sometimes to the point where they are life threatening.

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[1] O'Connell, Jim, MD. *Premature Mortality in Homeless Populations: A Review of the Literature* Nashville: National Health Care for the Homeless Council, December 2005. p.13. http://www.nhchc.org/PrematureMortalityFinal.pdf

[2] O'Connell, p. 13.

[3] National Center for Health Statistics, at http://www.cdc.gov/nchs/fastats/lifexpec.htm

[4] Wright JD. "Poor People, Poor Health: The health status of the homeless." In Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States*. New York: WW Norton & Co., 1990: 15–31.

Homeless persons die on the streets from exposure to the cold. In the coldest areas, homeless persons with a history of frostbite, immersion foot, or hypothermia have an eightfold risk of dying when compared to matched non-homeless controls.[5]

Homeless persons die on the streets from unprovoked violence, also known as hate crimes. For the years 1999 through 2005, the National Coalition for the Homeless has documented 472 acts of violence against homeless people by housed people, including 169 murders of homeless people and 303 incidents of non-lethal violence in 165 cities from 42 states and Puerto Rico.

Poor access to quality health care reduces the possibility of recovery from illnesses and injuries. Nationally, 71% of Health Care for the Homeless clients are uninsured,[6] as were 46.6 million other Americans in 2005.[7]

The National Health Care for the Homeless Council works to end the deadly conditions and injustices described above. We recognize and believe that

- *homelessness is unacceptable;*
- *every person has the right to adequate food, housing, clothing and health care;*
- *all people have the right to participate in the decisions affecting their lives;*
- *contemporary homelessness is the product of conscious social and economic policy decisions that have retreated from a commitment to insuring basic life necessities for all people; and*
- *the struggle to end homelessness and alleviate its consequences takes many forms, including efforts to insure adequate housing, health care, and access to meaningful work.*

To learn more, or to contribute to the work of the National Health Care for the Homeless Council, please visit www.nhchc.org or contact us at PO Box 60427, Nashville TN 37206-0427, (615) 226-2292, council@nhchc.org.

[5] O'Connell, p. 7.
[6] Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System 2004. http://www.bphc.hrsa.gov/hchirc/about/prog_successes.htm
[7] United States Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2005." http://www.census.gov/prod/2006pubs/p60-231.pdf

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RESEARCH ARTICLE Open Access

Examining mortality among formerly homeless adults enrolled in Housing First: An observational study

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Abstract

Background: Adults who experience prolonged homelessness have mortality rates 3 to 4 times that of the general population. Housing First (HF) is an evidence based practice that effectively ends chronic homelessness, yet there has been virtually no research on premature mortality among HF enrollees. In the United States, this gap in the literature exists despite research that has suggested chronically homeless adults constitute an aging cohort, with nearly half aged 50 years old or older.

Methods: This observational study examined mortality among formerly homeless adults in an HF program. We examined death rates and causes of death among HF participants and assessed the timing and predictors of death among HF participants following entry into housing. We also compared mortality rates between HF participants and (a) members of the general population and (b) individuals experiencing homelessness. We supplemented these analyses with a comparison of the causes of death and characteristics of decedents in the HF program with a sample of adults identified as homeless in the same city at the time of death through a formal review process.

Results: The majority of decedents in both groups were between the ages of 45 and 64 at their time of death; the average age at death for HF participants was 57, compared to 53 for individuals in the homeless sample. Among those in the HF group, 72 % died from natural causes, compared to 49 % from the homeless group. This included 21 % of HF participants and 7 % from the homeless group who died from cancer. Among homeless adults, 40 % died from an accident, which was significantly more than the 14 % of HF participants who died from an accident. HIV or other infectious diseases contributed to 13 % of homeless deaths compared to only 2 % of HF participants. Hypothermia contributed to 6 % of homeless deaths, which was not a cause of death for HF participants.

Conclusions: Results suggest HF participants face excess mortality in comparison to members of the general population and that mortality rates among HF participants are higher than among those reported among members of the general homeless population in prior studies. However, findings also suggest that causes of death may differ between HF participants and their homeless counterparts. Specifically, chronic diseases appear to be more prominent causes of death among HF participants, indicating the potential need for integrating medical support and end of life care in HF.

Keywords: Homelessness, Housing First, Health disparities, Vulnerability index, Death, Permanent supportive housing

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Background

Adults who experience prolonged homelessness have mortality rates 3 to 4 times that of the general population [1–3], and communities including New York City [4] and Philadelphia [5] have enacted surveillance systems to monitor and address mortality in this population. Injuries, substance abuse, heart disease, liver disease, and ill-defined conditions have been reported as accounting for the vast majority of deaths among individuals experiencing homelessness [1, 3]. Housing can protect against exposure to weather, infections, drugs, and violence experienced while living on the streets. There is some evidence that exiting homelessness to housing is associated with reduced risk of mortality [6], but whether access to housing affects health disparities, including mortality rates of individuals who have experienced long-term homelessness in particular, is unclear [7].

Housing First (HF) is an evidence-based practice that addresses homelessness by offering immediate access to housing while providing ongoing community-based support services [8]. HF has been adopted in multiple countries including the United States [9], Canada [10], Europe [11], and Australia [12], and effectively ends homelessness for people who have experienced a lifetime of cumulative adversity [13] and carry a significant disease burden based on multiple risk categories [14]. To date, however, there has been no research on premature mortality among formerly homeless adults who have enrolled in HF. In the United States, this gap in the literature exists despite research that suggests chronically homeless adults constitute an aging cohort; nearly half are aged 50 years old or older [15].

To begin to address this gap, the present study explored mortality among formerly homeless adults who moved into housing as part of an HF program in Philadelphia, PA. We examined death rates and causes of death among HF participants. We then compared HF participant mortality to two groups: members of the general population and the homeless population. We also compared the causes of death and characteristics of decedents in the HF program to a sample of adults identified as homeless at the time of death through formal review process in Philadelphia.

Methods

We used administrative records from the HF program to identify a cohort of 292 formerly homeless individuals who moved into a housing unit between September 2008, when the HF program first began operations, and October 2013. Individuals who had been admitted to the HF program but had not yet moved into housing were excluded from the study cohort, because these individuals could still be considered homeless. In 2014, HF medical and continuous quality improvement staff members reviewed and documented the events that preceded the death of all participants who died during the first 6 years of the program's operation (2008–2013) for purposes of program improvement. These data were used to ascertain the date and cause of death among HF participants. Members of the study cohort were followed prospectively from the initial date of their move to a housing unit until either their date of death or October 31, 2013; this observation period was measured in person-years.

We conducted analyses to examine mortality among HF participants from several perspectives. First, we calculated all-cause and cause-specific mortality rates, expressed as deaths per 100,000 person-years of observation, for the entire study cohort. Second, we used survival analysis methods to assess the risk and predictors of death following HF participants' move to housing. We estimated hazard functions and Kaplan-Meier survival curves to conduct descriptive analyses of the timing and occurrence of death following move to housing and fitted a Cox proportional hazards regression model to assess the relationship between HF participants' demographic characteristics (gender, race and age) and risk of death following move to housing.

Third, we calculated all-cause mortality rates among HF participants stratified by age and sex. We did not further stratify these age- and gender-specific mortality rates by cause due to sparse data. We used mortality rate ratios to compare the age- and sex-specific all-cause mortality rates among HF participants to members of the general population in Philadelphia between 2008 and 2013. To calculate these rate ratios, we divided the all-cause mortality rate among members of the study cohort by the corresponding rates in the general population. These values were adjusted for race using direct standardization, with the Philadelphia general population serving as the standard population. We calculated 95 % confidence intervals for these rate ratios using established methods [16]. We obtained mortality data for the Philadelphia general population (2008–2013) from the CDC Wide-ranging Online Data for Epidemiologic Research compressed mortality files regarding underlying cause of death [17].

Fourth, we compared mortality rates in our sample of HF participants to mortality rates of individuals experiencing homelessness as reported in prior studies. To achieve this, we identified published studies that provided mortality rates or information from which such rates could be calculated. We only included studies that were conducted in North America. We identified 10 studies [3, 6, 18–25] that met these criteria. We excluded three studies: one study [24] because it only reported data on homeless youths younger than 25; a second [18] because it grouped individuals living in emergency shelters with those living in rooming houses

and hotels; and a third [25] because it only reported information for individuals experiencing homelessness as part of a family with children. Following a previously employed approach for comparing mortality rates among homeless individuals across several studies [20, 23], we obtained or calculated age-specific all-cause mortality rates for each identified study using age groupings that were as similar as possible (younger, middle-aged, older). We then calculated mortality rate ratios by comparing the age-specific all-cause mortality rates observed among HF participants in the present study with those obtained or calculated from the identified studies. We calculated 95 % confidence intervals for these rate ratios when possible using published data. These rates and rate ratios were not adjusted for race.

Finally, we compared the causes of death and characteristics of decedents in the HF program with information on individuals identified as homeless at their time of death in Philadelphia using data from a report by the City of Philadelphia's Homeless Death Review Team [5]. Homeless status in the report is determined using the U.S. Department of Housing and Urban Development's definition of homelessness, which considers individuals to be homeless if they are residing in an emergency shelter or in a place not meant for human habitation (i.e., unsheltered or "street" homelessness). Although the report included sheltered and unsheltered decedents, it did not provide specific information about the living situation of decedents at the time of their death. The report, which identified 90 individuals who died while homeless during a 2-year period (2009 and 2010) that overlaps with the follow-up period for the HF participant cohort, provided demographic characteristics from the medical examiner's office that included age, gender, and race. The medical examiner also classified the manner of death as homicide, suicide, accidental, natural, or undetermined. A natural manner of death includes infectious diseases, cardiovascular or other chronic conditions, and cancers. The specific primary cause of death was also noted and included: specific disease (e.g., infectious, circulatory, respiratory), drug intoxication or alcoholism, injury (e.g., blunt force, gunshot wound), cancer, hyper- or hypothermia, HIV, or other. To facilitate comparisons, the demographic information and manner and cause of death among HF decedents were reclassified using categories reported in the City of Philadelphia's report. The report did not include information about the size of the overall homeless population in Philadelphia during 2009 and 2010, nor are we aware of another publicly available source that provides such information. As such, it was not possible to calculate mortality rates for the Philadelphia homeless population using data from the report; consequently, comparisons between the HF and homeless group were conducted using chi-square and Fisher's exact tests. The small number of deaths that occurred among HF participants during the same time frame as the City of Philadelphia's report (i.e., 2009 and 2010) precluded a comparison of deaths between the same groups during the same time period. Instead, we opted to compare HF deaths observed during the entire study period (i.e., 2008–2013) with those identified in the report. Study protocols were found to be exempt by the Pathways to Housing, Inc.'s institutional review board.

Results

Table 1 presents the characteristics of the 292 individuals in the overall HF participant cohort and decedents. The mean age at move to housing was 51.3, and roughly 80 % of the study cohort was between the ages of 45 and 74 at move to housing. The study cohort was predominantly male (70 %) and African American (68 %). The median duration of follow-up was 3.2 years, resulting in 1045 person-years of observation. Forty-one deaths occurred during the study period, with a mean age at death of 57.2 years. The majority of decedents were male (78 %) and African American (59 %).

As shown in Table 2, the crude mortality rate for the study cohort was 3916.1 deaths per 100,000 person-years. Disease of the circulatory system was the leading cause of death, accounting for 29.3 % of deaths in the study cohort. Cancer accounted for 22 % of deaths, whereas drugs or alcohol caused approximately 10 % of deaths. Kidney and respiratory disease caused about 5 % of deaths each, with diabetes, HIV, injury, and liver disease each accounting for about 2 % of deaths.

Figure 1 presents the estimated hazard function for death following HF participants' move to housing. The

Table 1 Characteristics of all Housing First participants in study cohort ($N = 292$) and decedents ($N = 41$)

	Overall	Decedents
	n (%)	*n* (%)
Gender		
Female	84 (28.8)	9 (22.0)
Male	207 (70.9)	32 (78.0)
Unknown	1 (0.3)	0 (0.0)
Age[a]		
19 44	58 (19.9)	4 (9.8)
45 64	213 (72.9)	32 (78.0)
65 74	21 (7.2)	5 (12.2)
Race		
Black	197 (67.5)	24 (58.5)
White	78 (26.7)	17 (41.5)
Other	17 (5.8)	0 (0.0)

[a]Figures in this row reflect *M* (range) at time of move to housing for the overall sample and at time of death for decedents

Table 2 Cause of death among Housing First decedents and crude mortality rates

Cause of death	Number of deaths	% of deaths	Crude mortality rate per 100,000 person years
All causes	41	100.0	3916.1
Circulatory system disease	12	29.3	1146.2
Cancer	9	22.0	859.6
Other	8	19.5	764.1
Drugs or alcohol	4	9.8	382.1
Kidney disease	2	4.9	191.0
Respiratory disease	2	4.9	191.0
Diabetes	1	2.4	95.5
HIV	1	2.4	95.5
Injury	1	2.4	95.5
Liver disease	1	2.4	95.5

hazard for death was highest in the period directly following participants' move to housing and then declined steeply and steadily thereafter. Among decedents, the median time to death following move to housing was 1.3 years, and 25 % of deaths occurred within the first 6 months following entry into housing. Kaplan-Meier 1-, 3-, and 5-year survival rates among all members of the HF participant cohort were 94.5 % (95 % CI 91.9–97.2 %), 88.3 % (95 % CI 84.6–92.3 %), and 82.9 % (95 % CI 77.9–88.2 %), respectively. Only age was a significant predictor in the Cox regression model, with those in the 65–74 age bracket having almost a five-fold increase (HR 4.8, 95 % CI 1.2–18.1) in the risk of death following their initial move to housing.

Table 3 presents age, gender, and overall all-cause mortality rates and rate ratios (RRs) comparing mortality rates in the HF participant cohort with those of the general population of Philadelphia. The all-cause mortality rate among male HF participants in the 45–64 age bracket was 4.7 times higher than in the general population (RR 4.7, 95 % CI 2.1–10.8). Estimates of the risk ratios for all other age and gender subgroups exceeded 1, but none of these differences was statistically significant. However, the all-cause mortality rates were higher for male HF participants (RR 4.4, 95 % CI 1.7–11.7) and all HF participants (RR 4.6, 95 % CI 1.6–13.2) relative to the Philadelphia general population.

Additional file 1 presents the results of comparisons of mortality rates observed among HF participants in the current study and the corresponding mortality rates for members of the homeless population in several North American cities reported in previously published studies. Point estimates of the mortality risk ratios show that mortality rates among HF participants in the present study were generally higher than those documented in prior studies for homeless individuals in similar age brackets. For most age and gender subgroups, these risk ratios suggest that mortality rates among HF participants in the present study were between 1.2 and 3 times

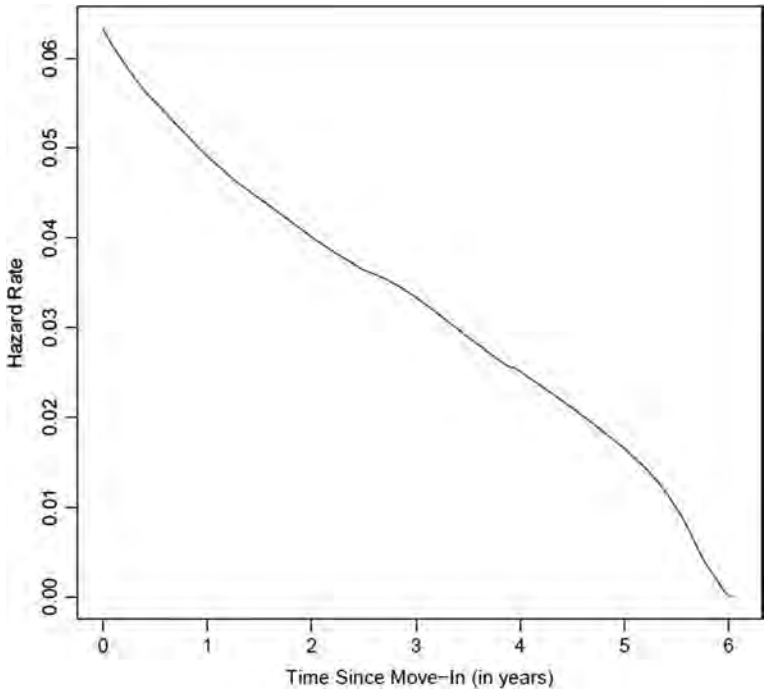

Fig. 1 Hazard function for death following move to housing among Housing First participants

Table 3 Mortality rates and rate ratios comparing Housing First participants and the general population in Philadelphia

	Deaths	Person Years of Observation	CR[a]	Race Adjusted RR[b]	95 % CI
Men					
25 44	2	114	1754.4	8.1	0.2, 334.7
45 64	26	554	4693.1	4.7	2.1, 10.8
65 74	4	56	7142.9	2.3	0.6, 9.2
All men[c]	32	725	4413.8	4.4	1.7, 11.7
Women					
25 44	1	76	1315.8	23.1	0, 10,988.9
45 64	5	195	2564.1	2.8	0.7, 11.2
65 74	3	49	6122.4	2.1	0.5, 9.8
All women[c]	9	320	2812.5	4.8	0.6, 39.1
Total[c]	41	1045	3923.4	4.6	1.6, 13.2

Abbreviations: CR, crude rate; CI, confidence interval; RR, rate ratio
[a]Deaths per 100,000 person years of observation
[b]Mortality rate ratios calculated by dividing the race adjusted mortality rates for the Housing First participant cohort by corresponding mortality rates in the Philadelphia general population. Race adjusted mortality rates were calculated using direct standardization with the Philadelphia general population during the study period (2003 2013) used as the standard population
[c]Mortality rate ratios also adjusted for age using direct standardization with the Philadelphia general population during the study period used as the standard population

higher than those among their homeless counterparts. However, in cases in which it was possible to conduct tests of statistical significance, the only significant difference in mortality rates was found in a comparison of middle-aged male HF participants, who had a increased risk of mortality (RR 2.2, 95 % CI 1.5–3.2) relative to homeless men in the same age bracket from a study using data from New York City [6].

Table 4 presents the comparison between the 41 HF participants who died during the first 6 years of the program's operation and the homeless decedents identified by the City of Philadelphia's Homeless Death Review Team during an overlapping 2-year time period. The majority of decedents in both the HF and homeless groups were between the ages of 45 and 64 at their time of death, although there were proportionally more decedents younger than 45 in the homeless group. Among those in the HF group, 78 % died from natural causes, compared to 49 % in the homeless group. This included 22 % of HF participants as opposed to 7 % in the homeless group who died from cancer. Among homeless adults, 40 % died from an accident, which was significantly more than the 12 % of HF participants who died from an accident. An infectious disease other than HIV caused more than 1 in 10 homeless deaths and hypothermia caused an additional 6 % of deaths; neither of these factors contributed to the death of HF participants.

Discussion

This study is the first to our knowledge to examine mortality among formerly homeless participants in an HF program. Overall, the results from this study are consistent with prior research on early mortality among populations that have experienced long-term homelessness [1, 20, 22] and suggest that adverse health outcomes associated with homelessness persist even after individuals obtain housing. Importantly, we found that risk of death among HF participants residing in housing was highest during the period immediately following their initial entry into housing. On one hand, this may reflect particularly heightened vulnerability and poor health in a certain segment of individuals who die shortly after entering housing. On the other hand, this finding may indicate that the period of transition into housing is one of elevated risk, during which it is of great importance to help individuals access needed health care and other services that may help prevent potentially avoidable deaths.

Comparisons of mortality rates among members of the HF study cohort with previously reported mortality rates in the homeless population in several North American cities also provide some evidence that formerly homeless HF participants have excess mortality in comparison to the more general homeless population. This finding is not entirely unexpected because individuals experiencing chronic homelessness, who have been shown to have more complex health and behavioral health problems than their homeless peers who are not chronically homeless [26], are the target population for HF programs. Put differently, HF program participants are typically members of the homeless population who have the highest risk of mortality. Future studies should contrast the mortality rates of HF participants with members of the homeless population who experience chronic homelessness. This would provide a better sense of the impact of HF on housing mortality, but such a comparison was not possible with available data. Thus, a more rigorous

Table 4 Comparison between decedents in a Housing First program in Philadelphia (2008 2013) and individuals identified as homeless at time of death in Philadelphia (2009 2010)

	Housing First	Homeless	
	n (%)	*n* (%)	*p*
Gender			.630
Male	32 (78.0)	75 (83.3)	
Female	9 (22.0)	15 (16.7)	
Age			.088
< 25	0 (0.0)	3 (3.3)	
25 34	1 (2.4)	5 (5.6)	
35 44	2 (4.9)	9 (10.0)	
45 54	10 (24.4)	34 (37.8)	
55 64	21 (51.2)	22 (24.4)	
65 74	7 (17.1)	14 (15.6)	
75+	0 (0.0)	3 (3.3)	
Manner of death			< .001
Accident	5 (12.2)	36 (40.0)	
Homicide	1 (2.4)	8 (8.9)	
Suicide	0 (0.0)	2 (2.2)	
Natural	32 (78.0)	44 (48.9)	
Other or unknown	3 (7.3)	0 (0.0)	
Cause of death			< .001
Drug or alcohol	4 (9.8)	23 (25.6)	
Circulatory system disease	12 (29.3)	21 (23.3)	
Injury	1 (2.4)	13 (14.4)	
HIV and infectious disease	1 (2.4)	12 (13.3)	
Cancer	9 (22.0)	6 (6.7)	
Hypothermia	0 (0.0)	5 (5.6)	
Respiratory disease	2 (4.9)	3 (3.3)	
Fire	0 (0.0)	3 (3.3)	
Diabetes	1 (2.4)	0 (0.0)	
Other	11 (26.8)	4 (4.4)	

assessment of the impact of HF on mortality is an important goal for future research.

Findings from this study with respect to the causes of death among HF participants are also noteworthy. Circulatory system disease was the leading cause of death among members of the HF study cohort, accounting for almost 30 % of deaths, followed by cancer, which accounted for 22 % of deaths in the study cohort. These two causes combined with kidney disease, respiratory disease, diabetes, HIV, and liver disease to account for 78 % of deaths in the HF study cohort. In contrast, drug- and alcohol-related causes and injury accounted for only 12 % of deaths. As a point of comparison, a recent study found drug overdose to be the leading cause of death among homeless adults in Boston [21], accounting for 17 % of deaths, with cancer and heart disease each accounting for about 16 % of deaths. Furthermore, the comparison of HF decedents with those identified by the Philadelphia Homeless Death Review Team shows that drug, alcohol, injury, and accident were more prominent causes of death in the latter group. Similarly, comparisons of the manner of death indicate that a much greater proportion of deaths among homeless decedents in Philadelphia were due to accident or homicide relative to members in the HF cohort. Taken together, these findings suggest that HF participants and their currently homeless counterparts may face different mortality-related risks.

Elevated rates of accidental deaths, homicide, and deaths from infectious diseases in the homeless group may reflect the fact that homelessness increases exposure to risks and unmet service needs, which supports the notion that HF may serve as a protective factor against some causes of death. Nonetheless, HF participants were more likely to die of natural causes, potentially reflecting underlying differences in the disease burden of these two groups, which could be explained by a growing practice in the United States known as *vulnerability indexing* wherein homeless individuals identified as having medical conditions placing them at the highest risk of death receive priority for placement in permanent housing programs [27]. This practice, which was implemented in Philadelphia starting in 2011, suggests that HF participants are more vulnerable to death than those who remain on the streets, in which case any evidence supporting the notion that HF serves as a protective factor is understated.

The high number of deaths in the HF group resulting from chronic diseases also suggests that HF providers may need to reorient their supportive service delivery models, which have traditionally focused on housing stability and behavioral health interventions, to increasingly focus on chronic disease management and end-of-life care [28, 29]. This may entail additional staff training on integrated care models [30, 31] to address client needs. Growing interest in the use of newly available Medicaid funds via the Affordable Care Act to offer supportive services in permanent supportive housing programs could present an important opportunity for HF programs to develop new service models [32]. It may also be important to provide increased support to help staff members handle the emotional impact of client deaths at a time when HF may have provided renewed hopes of recovery from chronic homelessness. Interventions designed for health care professionals who encounter patient deaths may be useful models [33].

This is the first study to consider premature mortality among formerly homeless adults who have enrolled in Housing First, an approach that has been adopted as the official policy of the United States to address chronic

homelessness [9] and is being implemented in multiple countries [10–12]. The use of death reviews conducted by medical professionals for both homeless adults and HF participants in the same city during the same time period is a strength of the study. The small sample size of the HF participant cohort represents a limitation of the study, particularly regarding comparisons of mortality rates among HF participants with those among members of the general population. Lack of more detailed information about the health conditions of HF participants at enrollment and other characteristics that may be related to mortality risk is also a serious limitation in the present study. Interpretation of the results of the comparison between HF decedents and those identified in Philadelphia Homeless Death Review study warrants caution for several reasons. First, because only three deaths occurred among HF participants during the time period covered in the Philadelphia Homeless Death Review report, it was necessary to compare HF decedents identified during a 6-year period with homeless decedents identified during a 2-year period. Moreover, because data on the size and characteristics of the overall Philadelphia homeless population during the time period were not covered by the report, it was not possible to calculate mortality rates in the homeless population during this time period and compare them to those observed among HF participants. Finally, the absence of information about whether homeless decedents identified in the death review report were eligible for or offered HF services represents a clear limitation.

Conclusions

HF may decrease mortality rates for adults who have experienced chronic homelessness by reducing exposure to risks while homeless that contribute to higher rates of deaths caused by accidents, homicide, and infectious diseases. This idea is further supported when considering that individuals who are most medically vulnerable are often prioritized for HF, which may also account for higher rates of HF participant deaths due to natural causes. Integrating medical support and end-of-life care in HF support services is needed, as is support for staff members who are working to promote recovery among highly vulnerable individuals.

Additional files

Additional file 1: Mortality rates and rate ratios comparing Housing First participants in study cohort and individuals experiencing homelessness. (DOCX 25 kb)

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

BFH originally drafted the article with input from TB, who conducted the analysis. BS collected data on Housing First enrollee deaths and provided feedback on the article. All authors approved the final article.

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Health Care and Homelessness

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Poor health is closely associated with homelessness. For families struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction.

PREVALENCE

The 2007 United States Census Bureau calculated that 45.7 million Americans (15.3% of the population) do not have health insurance. In 2007, 26.8 million people (18.1%) who worked part-time or full-time during the previous year were uninsured, including 21.1 million full-time workers. Whether or not Americans have health insurance is very closely tied to their incomes. Only 7.8% of people who have a yearly salary of $75,000 or higher are uninsured, compared to 24.5% of people with salaries under $25,000. In 2007, Medicaid covered 39.6 million people, which fortunately is an increase since 2006 (United States Census Bureau, 2007). However, Medicaid has numerous eligibility requirements, and many people do not qualify even if they live below the poverty line.

Of the 45.7 million uninsured Americans, 34.6 million identify as part of a family. There are 8.1 million children (11.0%) in the United States without health insurance. An estimated 10.5% of American children under the age of six do not have health insurance. This proportion is much higher for impoverished children: 17.6% of children below the poverty line lack health insurance (United States Census Bureau, 2007).

RELATIONSHIP TO HOMELESSNESS

Homelessness and health care are intimately interwoven. Poor health is both a cause and a result of homelessness. The National Health Care for the Homeless Council (2008) estimates that 70% of Health Care for the Homeless (HCH) clients do not have health insurance. Moreover, approximately 14% of people treated by homeless health care programs are children under the age of 15 (National Health Care for the Homeless Council, 2008).

Inadequate health insurance is itself a cause for homelessness. Many people without health insurance have low incomes and do not have the resources to pay for health services on their own. A serious injury or illness in the family could result in insurmountable expenses for hospitalizations, tests, and treatment. For many, this forces a choice between hospital bills or rent. According to the National Health Care for the Homeless Council (2008), half of all personal bankruptcies in the United States are caused by health problems.

Health care is even more of a problem for people who are already homeless. Homeless people are three to six times more likely to become ill than housed people (National Health Care for the Homeless Council,

2008). Homelessness precludes good nutrition, good personal hygiene, and basic first aid, adding to the complex health needs of homeless people. Additionally, conditions which require regular, uninterrupted treatment, such as tuberculosis and HIV/AIDS, are extremely difficult to treat or control among those without adequate housing.

Diseases that are common among the homeless population include heart disease, cancer, liver disease, kidney disease, skin infections, HIV/AIDS, pneumonia, and tuberculosis (O'Connell, 2005). People who live on the streets or spend most of their time outside are at high risk for frostbite, immersion foot, and hypothermia, especially during the winter or rainy periods. Although not many homeless deaths are specifically attributed to exposure-related causes such as frostbite, immersion foot, or hypothermia, the risk of death from other causes is increased eightfold in people who have experienced those conditions in the past (O'Connell, 2005).

Unfortunately, many homeless people who are ill and need treatment do not ever receive medical care. Barriers to health care include lack of knowledge about where to get treated, lack of access to transportation, and lack of identification (Whitbeck, 2009). Psychological barriers also exist, such as embarrassment, nervousness about filling out the forms and answering questions properly, and self-consciousness about appearance and hygiene when living on the streets. The most common obstacle to health care is the cost (Whitbeck, 2009). Without health care, many homeless people simply cannot pay. As a result, many homeless people utilize hospital emergency rooms as their primary source of health care. Not only is this not the most effective form of care for them, since it provides little continuity, it is also very expensive for hospitals and the government.

As a result of these factors, homeless people are three to four times more likely to die than the general population (O'Connell, 2005). This increased risk is especially significant in people between the ages of 18 and 54. Although women normally have higher life expectancies than men, even in impoverished areas, homeless men and women have similar risks of premature mortality. In fact, young homeless women are four to 31 times as likely to die early as housed young women (O'Connell, 2005). The average life expectancy in the homeless population is estimated between 42 and 52 years, compared to 78 years in the general population.

POLICY ISSUES

At present, there is one federally funded program, Health Care for the Homeless (HCH), that is designed specifically to provide primary health care to homeless persons. HCH projects are required to provide primary health care, substance abuse services, emergency care, outreach, and assistance in qualifying for housing. Many HCH projects also provide dental care, mental health treatment, supportive housing, and other services. In 2008, HCH programs were estimated to serve more than 740,000 homeless people per year (National Health Care for the Homeless Council). However, more health care services designed to serve the homeless are clearly needed, since HCH programs do not meet the needs of the majority of homeless Americans. In addition, lack of affordable housing complicates efforts to provide health care to homeless persons. Housing is the first form of treatment for homeless people with medical problems, protecting against illness and making it possible for those who remain ill to recover.

Universal access to affordable, high-quality and comprehensive health care is also essential in the fight to end homelessness. A health insurance system could reduce homelessness and help to prevent future episodes of homelessness, as well as ease the suffering of those on the streets. A universal health system would also reduce the fiscal impact and social cost of communicable diseases and other illnesses.

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Mortality Among Homeless Adults in Boston

Shifts in Causes of Death Over a 15-Year Period

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Background: Homeless persons experience excess mortality, but US-based studies on this topic are outdated or lack information about causes of death. To our knowledge, no studies have examined shifts in causes of death for this population over time.

Methods: We assessed all-cause and cause-specific mortality rates in a cohort of 28 033 adults 18 years or older who were seen at Boston Health Care for the Homeless Program from January 1, 2003, through December 31, 2008. Deaths were identified through probabilistic linkage to the Massachusetts death occurrence files. We compared mortality rates in this cohort with rates in the 2003-2008 Massachusetts population and a 1988-1993 cohort of homeless adults in Boston using standardized rate ratios with 95% confidence intervals.

Results: A total of 1302 deaths occurred during 90 450 person-years of observation. Drug overdose (n=219), cancer (n=206), and heart disease (n=203) were the major causes of death. Drug overdose accounted for one-third of deaths among adults younger than 45 years. Opioids were implicated in 81% of overdose deaths. Mortality rates were higher among whites than nonwhites. Compared with Massachusetts adults, mortality disparities were most pronounced among younger individuals, with rates about 9-fold higher in 25- to 44-year-olds and 4.5-fold higher in 45- to 64-year-olds. In comparison with 1988-1993 rates, reductions in deaths from human immunodeficiency virus (HIV) were offset by 3- and 2-fold increases in deaths owing to drug overdose and psychoactive substance use disorders, resulting in no significant difference in overall mortality.

Conclusions: The all-cause mortality rate among homeless adults in Boston remains high and unchanged since 1988 to 1993 despite a major interim expansion in clinical services. Drug overdose has replaced HIV as the emerging epidemic. Interventions to reduce mortality in this population should include behavioral health integration into primary medical care, public health initiatives to prevent and reverse drug overdose, and social policy measures to end homelessness.

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An estimated 2.3 to 3.5 million Americans experience homelessness annually,[1] and over 649 000 are homeless on a single night.[2] Homeless individuals have a high prevalence of physical illness, psychiatric disease, and substance abuse,[3-5] contributing to very high mortality rates in comparison with nonhomeless people.[6-17]

Despite the persistence of homelessness in the United States, the past decade has yielded few studies on mortality among homeless Americans, and information on causes of death in this population is sparse. In the most recent study that examined causes of death in a US-based homeless population, Hwang et al[7] analyzed data on 17 292 adults seen at Boston Health Care for the Homeless Program (BHCHP) in 1988 to 1993. This study documented the substantial toll of human immunodeficiency (HIV) infection, which was the leading cause of death among 25- to 44-year-olds and accounted for 18% of all deaths in the study cohort. Homicide was the principal cause of death for 18- to 24-year-olds, while heart disease and cancer were the leading causes among 45- to 64-year-olds.

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In view of interim advances in HIV treatment and expansion of federally funded Health Care for the Homeless clinical services, the mortality profile of homeless adults in the United States may have changed since 1988 to 1993; however, data to confirm this are lacking. A comprehen-

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sive reassessment of mortality and causes of death among homeless adults would provide a needed update on the health status of this vulnerable population and inform policy decisions and clinical practice priorities regarding the provision of health care and other services for this group of people.

Using methods similar to the 1988-1993 Boston mortality study,[7] we assessed overall and cause-specific mortality rates in a large cohort of adults who used services provided by BHCHP from 2003 to 2008. We compared these mortality rates with those of the general population of Massachusetts residents from 2003 to 2008 and to the cohort of homeless adults seen by BHCHP in 1988 to 1993. We also examined racial variations in mortality since prior studies of homeless individuals have found paradoxically higher death rates among whites than nonwhites.[6,12,18]

METHODS

PARTICIPANTS AND SETTING

We retrospectively assembled a cohort of all adults at least 18 years old who had an in-person encounter at BHCHP between January 1, 2003, and December 31, 2008. BHCHP serves more than 11 000 individuals annually in over 90 000 outpatient medical, oral health, and behavioral health encounters through a network of over 80 service sites based in emergency shelters, transitional housing facilities, hospitals, and other social service settings in greater Boston.[19,20] Patients must be homeless to enroll in services at BHCHP; no other eligibility requirements are imposed. Some patients elect to continue receiving care at BHCHP after they are no longer homeless. Owing to limitations in the data, we were unable to distinguish currently vs formerly homeless participants, so this study represents an analysis of adults who have ever experienced homelessness. We refer to this group as "homeless" for simplicity. Individuals were observed from the date of first contact within the study period until the date of death or December 31, 2008. We measured observation time in person-years. The Partners Human Research Committee approved this study.

ASCERTAINMENT OF VITAL STATUS

We used LinkPlus software (version 2.0; Centers for Disease Control and Prevention [CDC]) to cross-link the BHCHP cohort with the Massachusetts Department of Public Health (MDPH) death occurrence files for 2003 to 2008. LinkPlus is a probabilistic record linkage software program that uses expectation maximization algorithms and an array of linkage tools to compute linkage probability scores for possible record pairs based on the level of agreement and relative importance of various personal identifiers.[21] Our primary linkage procedure used first and last name, date of birth, and social security number (SSN); sensitivity analyses used sex and race with no additional linkages identified. There were minimal missing data for the core identifiers in the BHCHP cohort (0% for name and birth date, 9% for SSN). We manually reviewed record pairs achieving a probability score of 7 or higher[21] and generally accepted a record pair as a true linkage if it matched on one of the following National Death Index criteria[22] that were also used in the 1988-1993 BHCHP mortality study[7]: (1) SSN, (2) first and last name, month and year of birth ($\pm$1 year), or (3) first and last name, month, and day of birth. Two investigators (T.P.B. and B.C.P.) independently conducted the manual review with very high concordance and interrater reliability (κ=0.99). A third investigator (J.J.O.) adjudicated discrepancies.

CAUSES OF DEATH

We based causes of death on the *International Statistical Classification of Diseases, 10th Revision (ICD-10)* underlying cause of death codes in the MDPH mortality file (eTable; http://www.jamainternalmed.com). The MDPH translates death certificate entries into *ICD-10* cause of death codes using software developed by the National Center for Health Statistics (NCHS).[23] We defined "drug overdose" as drug poisoning deaths that were unintentional (codes X40-X44) or of undetermined intent (codes Y10-Y14).[24] We included undetermined intent drug poisonings in this definition because Massachusetts medical examiners made relatively frequent use of this category prior to a 2005 policy change at the Office of the Chief Medical Examiner requiring that most of these deaths be categorized as unintentional.[23,25] In addition, evidence suggests that poisonings of undetermined intent more closely resemble unintentional poisonings than suicidal poisonings.[26] For drug overdose deaths, we examined the multiple cause of death fields to ascertain which substances were implicated in each overdose. We classified deaths due to alcohol poisoning (codes X45, Y15) separately from drug overdose. Drug- and alcohol-related deaths could also be captured under the *ICD-10* underlying cause of death codes for mental and behavioral disorders due to psychoactive substance use (codes F10-F19), which we analyzed collectively as "psychoactive substance use disorders." These codes are generally intended for deaths related to a chronic pattern or sequel of substance abuse rather than acute poisoning.[27] Such deaths include those attributed to substance dependence (eg, chronic alcoholism), harmful substance use resulting in medical complications (eg, dilated cardiomyopathy, gastrointestinal hemorrhage, aspiration pneumonia), and substance withdrawal syndromes (eg, delirium tremens) (Robert N. Anderson, PhD, Chief, Mortality Statistics Branch, NCHS, written communication, June 22, 2012).

STATISTICAL ANALYSIS

We tabulated the leading causes of death overall and stratified by age and sex. We calculated mortality rates by dividing the number of deaths by the person-years of observation and expressed these rates as deaths per 100 000 person-years. Since the accuracy of the underlying cause of death may depend on whether a decedent underwent autopsy, we assessed the percentage of homeless decedents who underwent autopsy and used the χ^2 test to compare this with the percentage who underwent autopsy in the Massachusetts general population.

To compare our age- and sex-stratified findings with the 2003-2008 Massachusetts general population, we adjusted for race using direct standardization with weights chosen according to the racial breakdown in the general population. We then calculated overall and cause-specific mortality rate ratios by dividing the race-standardized mortality rates in the homeless cohort by the rates in the general population. We fitted 95% confidence intervals using conventional methods for standardized rate ratios.[28,29] We obtained mortality data for the 2003-2008 Massachusetts general population from the CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) underlying cause of death compressed mortality files.[30]

To compare our findings with the 1988-1993 BHCHP cohort, we directly standardized the overall and cause-specific mortality rates in the 2003-2008 cohort to match the age, sex, and race distribution of the 1988-1993 cohort. We limited this portion of the analysis to 18- to 64-year-olds to correspond to the age range analyzed in 1988 to 1993. From 1988 to 2008, BHCHP experienced substantial growth in the density and intensity of its clinical operations but did not change its core mission, geographical service area, target population, or eligibility requirements for pa-

Table 1. Characteristics of the Entire Study Cohort and the Decedents

Characteristic	No. (%)
Entire Cohort (n = 28 033)	
Age at index observation, mean (SD), y	41.0 (12.4)
18-24	3493 (12.5)
25-44	13 805 (49.3)
45-64	9924 (35.4)
65-84	793 (2.8)
≥85	18 (0.1)
Sex	
Male	18 612 (66.4)
Female	9421 (33.6)
Race/ethnicity	
White, non-Hispanic	11 912 (42.5)
Black, non-Hispanic	8066 (28.8)
Hispanic	5301 (18.9)
Other/unknown	2754 (9.8)
Decedents (n = 1302)	
Age at death, mean (range), y	51.2 (19.3-93.5)
Sex	
Male	1055 (81.0)
Female	247 (19.0)
Race	
White, non-Hispanic	784 (60.2)
Black, non-Hispanic	301 (23.1)
Hispanic	131 (10.1)
Other/unknown	86 (6.6)
Veteran	164 (12.6)
Place of death	
Hospital	683 (52.5)
Residence	352 (27.0)
Nursing home	129 (9.9)
Other	138 (10.6)
Autopsy performed	
Yes	495 (38.0)
No	807 (62.0)

tient enrollment.[20] To gauge the potential impact of this clinical expansion, we distinguished between natural and external causes of death (eTable)[27] because the former may be more responsive to traditional medical interventions. Since causes of death were classified according to *ICD-9* codes in the 1988-1993 cohort and *ICD-10* codes in the 2003-2008 cohort, we applied comparability ratios (CRs) (eTable) using methods outlined by the NCHS.[31-33] We used the CR for drug-induced deaths to analyze drug overdose mortality. We used the CR for alcohol-induced deaths to analyze mortality due to psychoactive substance use disorders since most of these deaths were alcohol-related.

To assess for racial differences in mortality, we compared the age-standardized all-cause mortality rates for white, black, and Hispanic adults, stratified by sex. We used SAS statistical software (version 9.3; SAS Institute Inc) and Microsoft Excel 2003 (Microsoft Corp) to conduct our analyses.

RESULTS

A total of 28 033 adults were followed for a median of 3.3 years, yielding 90 450 person-years of observation. The mean age at cohort entry was 41 years (**Table 1**). In comparison with the 1988-1993 cohort, individuals 45 years or older comprised a greater proportion of observation time (45% vs 29%). Two-thirds of participants were male, and 42.5% were white.

Table 2. Causes of Death and Crude Mortality Rates

Underlying Cause of Death[a]	Deaths, No. (% of Total)	Crude Rate per 100 000 Person-years (95% CI)
All causes	1302 (100)	1439.5 (1361.3-1517.7)
Drug overdose	219 (16.8)	242.1 (210.1-274.2)
Cancer	206 (15.8)	227.8 (196.6-258.9)
Trachea, bronchus, and lung	74 (5.7)	81.8 (63.2-100.5)
Liver and intrahepatic bile ducts	24 (1.8)	26.5 (15.9-37.1)
Colon, rectum, and anus	18 (1.4)	19.9 (10.7-29.1)
Esophagus	11 (0.8)	12.2 (5.0-19.3)
Pancreas	8 (0.6)	8.8 (2.7-15.0)
Heart disease	203 (15.6)	224.4 (193.6-255.3)
Psychoactive substance use disorder	99 (7.6)	109.5 (87.9-131.0)
Alcohol use disorder	71 (5.5)	78.5 (60.2-96.8)
Other substance use disorders	28 (2.2)	31.0 (19.5-42.4)
Liver disease	89 (6.8)	98.4 (78.0-118.8)
Chronic liver disease and cirrhosis	58 (4.5)	64.1 (47.6-80.6)
Other liver diseases	31 (2.4)	34.3 (22.2-46.3)
HIV	76 (5.8)	84.0 (65.1-102.9)
Ill-defined conditions	41 (3.1)	45.3 (31.5-59.2)
Suicide	36 (2.8)	39.8 (26.8-52.8)
Transport accident	26 (2.0)	28.7 (17.7-39.8)
Pedestrian injured in transport accident	15 (1.2)	16.6 (8.2-25.0)
Cerebrovascular disease	25 (1.9)	27.6 (16.8-38.5)
Diabetes mellitus	24 (1.8)	26.5 (15.9-37.1)
Other accidents	23 (1.8)	25.4 (15.0-35.8)
Sepsis	22 (1.7)	24.3 (14.2-34.5)
Homicide	21 (1.6)	23.2 (13.3-33.1)
Nephritis, nephrotic syndrome, and nephrosis	21 (1.6)	23.2 (13.3-33.1)
Events of undetermined intent	21 (1.6)	23.2 (13.3-33.1)
Chronic lower respiratory diseases	20 (1.5)	22.1 (12.4-31.8)
Viral hepatitis	18 (1.4)	19.9 (10.7-29.1)
Anoxic brain injury	12 (0.9)	13.3 (5.8-20.8)
Influenza and pneumonia	11 (0.8)	12.2 (5.0-19.3)
Metabolic disorders	8 (0.6)	8.8 (3.8-17.4)
Alcohol poisoning	6 (0.5)	6.6 (2.4-14.4)
All other causes	75 (5.8)	82.9 (64.2-101.7)

Abbreviation: HIV, human immunodeficiency virus.
[a]Causes of death are based on the *International Statistical Classification of Diseases, 10th Revision (ICD-10)*. See the eTable (http://www.jamainternalmed.com) for the *ICD-10* codes used to define each cause of death.

There were 1302 deaths during the study period, generating a crude mortality rate of 1439.5 deaths per 100 000 person-years. The mean age at death was 51 years (range, 19-93 years) (Table 1). Over 80% of decedents were male, and 60.2% were white. Most deaths occurred in a hospital. Overall, 38.0% of decedents in the study cohort underwent autopsy compared with 6.7% of decedents in the Massachusetts general population ($P < .001$).

MAJOR CAUSES OF DEATH

Drug overdose was the leading cause of death, accounting for 16.8% of all deaths in the cohort (**Table 2**). Opioids were implicated in 81% of overdose deaths; of these, heroin was identified in 13%, opioid analgesics in 31%, and other and unspecified narcotics in 60%. Cocaine contributed to 37% of overdose deaths, and 43% involved multiple substances. Alcohol was mentioned as a co-occurring substance in 32% of drug overdose deaths.

Table 3. Leading Causes of Death and Race-Adjusted Mortality Rate Ratios (RRs) by Age Group and Sex

25-44 Years				45-64 Years				65-84 Years			
Cause	No.	CR[a]	Race-Adjusted RR[b] (95% CI)	Cause	No.	CR[a]	Race-Adjusted RR[b] (95% CI)	Cause	No.	CR[a]	Race-Adjusted RR[b] (95% CI)
Men											
Drug overdose	92	346.9	16.0 (12.6-20.3)	Cancer	120	418.7	2.2 (1.8-2.8)	Cancer	38	1350.4	1.2 (0.8-1.7)
Heart disease	24	90.5	5.1 (3.1-8.4)	Heart disease	114	397.8	3.5 (2.8-4.3)	Heart disease	36	1279.3	1.4 (0.9-2.1)
Psychoactive substance use disorder	24	90.5	22.1 (14.0-34.9)	Drug overdose	80	279.1	17.5 (13.6-22.5)	Chronic lower respiratory disease	5	177.7	0.9 (0.3-2.5)
HIV	21	79.2	17.3 (10.1-29.8)	Psychoactive substance use disorder	59	205.9	19.6 (14.6-26.4)	Cerebrovascular disease	4	142.1	0.7 (0.2-2.5)
Suicide	15	56.6	7.1 (4.2-11.8)	Liver disease	58	202.4	7.7 (5.7-10.3)	Sepsis	4	142.1	1.1 (0.3-5.0)
All causes	252	950.1	8.6 (7.4-9.9)	All causes	670	2337.7	4.5 (4.1-4.9)	All causes	114	4051.3	1.1 (0.9-1.4)
Women											
Drug overdose	28	172.6	23.6 (15.2-36.6)	Cancer	28	326.4	1.9 (1.1-3.1)	Cancer	6	672.4	1.3 (0.5-3.0)
Heart disease	8	49.3	3.6 (1.2-11.1)	Heart disease	16	186.5	3.0 (1.5-6.1)	Heart disease	4	448.3	1.1 (0.4-3.2)
HIV	7	43.1	9.7 (2.9-32.4)	Drug overdose	14	163.2	21.2 (11.4-39.5)	Diabetes mellitus	3	336.2	5.8 (1.5-22.1)
Psychoactive substance use disorder	7	43.1	33.0 (13.0-83.7)	Liver disease	12	139.9	16.9 (9.2-30.9)	Suppressed[c]			
Liver disease	6	37.0	21.3 (8.4-53.9)	HIV	8	93.3	18.0 (6.1-52.5)	Suppressed[c]			
All causes	95	585.6	9.6 (7.4-12.4)	All causes	126	1469.0	4.5 (3.6-5.6)	All causes	21	2353.4	1.1 (0.7-1.8)

Abbreviations: CR, crude rate; HIV, human immunodeficiency virus.
[a] Deaths per 100 000 person-years of observation.
[b] Mortality RRs were calculated by dividing the race-adjusted mortality rates for the homeless cohort by the corresponding mortality rates in the general population of Massachusetts during the same years (2003-2008). Race adjustment was performed using direct standardization to match the racial and ethnic breakdown of the specified age and sex groups within the general population of Massachusetts.
[c] Suppressed owing to confidentiality concerns.

Cancer and heart disease were also major causes of death, each accounting for about 16% of deaths (Table 2). Malignant neoplasms of the trachea, bronchus, and lung comprised over one-third of all cancer deaths. Psychoactive substance use disorders caused nearly 8% of all deaths, and 72% of these were attributable to alcohol.

MORTALITY RATE RATIOS BY AGE AND SEX

Drug overdose was the leading cause of death among 25- to 44-year-old homeless men and women, accounting for 35% of deaths at rates 16- to 24-fold higher than those in the Massachusetts general population (**Table 3**). All-cause mortality rates for men and women in this age group were 8.6- and 9.6-fold higher than in the general population, respectively.

Cancer and heart disease were the leading causes of death among 45- to 64-year-old homeless adults, and the mortality rates for these causes were about 2- and 3-fold higher than in the general population, respectively. All-cause mortality rates in this age group were 4.5-fold higher than in the general population. Among 65- to 84-year-olds, overall and cause-specific mortality rates generally were not significantly different than in comparably aged adults in Massachusetts.

COMPARISON WITH 1988-1993 COHORT

The age-, sex-, and race-standardized mortality rate among 18- to 64-year-old adults in the current study was not significantly different than in the 1988-1993 BHCHP cohort (**Figure 1**). However, there were significant differences with respect to specific causes of death. A 3-fold increase in drug overdose deaths and a 2-fold increase in suicide deaths contributed to an 83% higher rate of deaths due to external causes in comparison with the 1988-1993 cohort. Despite a 2-fold increase in deaths due to psychoactive substance use disorders, significant reductions in deaths due to HIV and cirrhosis contributed to a 15% overall decrease in natural causes of death.

RACIAL VARIATIONS IN MORTALITY

White men had a significantly higher age-standardized mortality rate than black men (rate ratio [RR], 1.94 [95% CI, 1.66-2.28]) and Hispanic men (RR, 1.80 [95% CI, 1.47-2.21]). The age-standardized mortality rate in white women was substantially higher than in Hispanic women (RR, 3.81 [95% CI, 2.19-6.61]) and marginally higher than in black women (RR, 1.31 [95% CI, 0.99-1.74]). **Figure 2** juxtaposes these rates with those expected in the Massachusetts general population if it had the same age distribution as the homeless cohort.

COMMENT

Drug overdose was the leading cause of death in this cohort of currently and formerly homeless adults, occurring at substantially higher rates than in the Massachusetts general population. Despite comprising only 0.3% of the state's adult population, the study cohort accounted for 5% of all drug overdose deaths among Massachusetts adults in 2003 to 2008. Opioids contributed to over 80% of these deaths. Cancer and heart disease were the leading causes of death

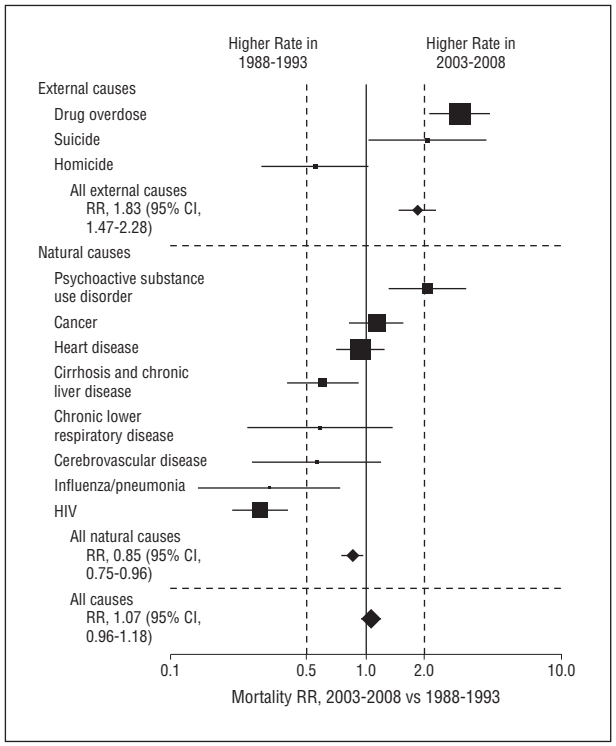

Figure 1. Mortality rate ratios (RRs) comparing cause-specific and overall mortality rates for the 2003-2008 and 1988-1993 homeless cohorts. Boxes are weighted in proportion to the total number of deaths owing to the specified cause. Prior to computing RRs, mortality rates from the 2003-2008 cohort were directly standardized to the age, sex, and race distribution of the 1988-1993 cohort. Differences between *International Classification of Diseases, Ninth Revision (ICD-9)* (1988-1993) and *ICD-10* (2003-2008) underlying cause of death codes were accounted for using comparability ratios from the National Center for Health Statistics. See the eTable for *ICD-9* and *ICD-10* codes and comparability ratios (http://www.jamainternalmed.com). HIV indicates human immunodeficiency virus.

among adults 45 years or older. In comparison with the general population, the greatest disparities in all-cause mortality occurred in the younger age groups.

There was no significant difference between the all-cause mortality rate in the 2003-2008 cohort compared with the 1988-1993 cohort. A 15% reduction in deaths owing to natural causes was offset by an 83% increase in deaths due to external causes. Although HIV-related deaths decreased considerably, we found a 3-fold increase in drug overdose deaths and 2-fold increases in deaths due to suicide and psychoactive substance use disorders.

Similar to findings in prior studies,[6,12,18] we found significantly higher mortality rates among white homeless adults in comparison with other racial groups, which differs from the pattern in the general population. This may reflect underlying racial differences in the pathways to homelessness. Evidence suggests that African Americans are more likely to be homeless because of structural factors, such as discrimination and poverty, while homelessness among whites is more heavily linked to personal factors such as mental illness, trauma, family dysfunction, and substance abuse,[34-36] placing these individuals at higher risk of death. This is supported by the finding that whites accounted for a particularly disproportionate percentage of deaths due to drug overdose (68%), substance use disorders (68%), and suicide (89%).

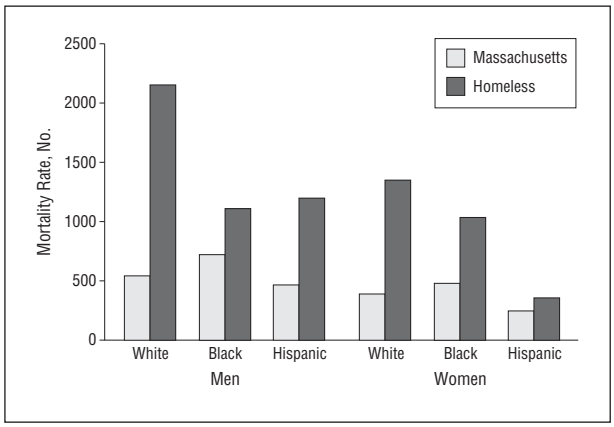

Figure 2. Race-specific age-standardized mortality rates for homeless adults and adults in the general population of Massachusetts (2003-2008), stratified by sex. Mortality rate is expressed as the number of deaths per 100 000 person-years of observation for the homeless cohort, and deaths per 100 000 for the Massachusetts general population. All mortality rates are directly standardized to match the age distribution of the homeless cohort using the following categories: 18 to 24, 25 to 34, 35 to 44, 45 to 54, 55 to 64, and 65 years or older. Owing to limitations in state data, the age-specific mortality rate for 20- to 24-year-old Massachusetts adults was used to estimate the rate for 18- to 24-year-old adults.

Our findings have implications for policymakers, public health professionals, and clinicians serving this population. The overall mortality pattern of homeless adults in this study demonstrates the substantial impact of substance abuse and mental illness, highlighting the need for integrated systems of care to address these complex issues. Interval increases in deaths due to drug overdose, psychoactive substance use disorders, and suicide suggest that chemical dependency counselors, psychiatrists, and other behavioral health specialists should be collocated with primary care practitioners serving this population. The dramatic rise in drug overdose deaths reflects a broader nationwide trend in drug poisoning mortality fueled largely by rising opioid-related deaths.[37-39] Such deaths are fundamentally preventable. The bulk of opioid overdoses were due to nonheroin substances, including opioid analgesics and other narcotics. Given the high prevalence of both chronic pain and addiction in homeless persons,[40] health care organizations serving this population may wish to develop standardized pain management protocols to help ensure safe, effective, and appropriate opioid prescribing. Efforts to curb prescription drug diversion should remain a national policy priority. Public health initiatives aiming to prevent and reverse opioid overdoses through education and the distribution of intranasal naloxone may also help reduce these deaths.[41,42] In addition to methadone maintenance programs, office-based buprenorphine treatment seems to be feasible in the setting of homelessness[43] and may be an effective option for addressing opioid dependence in this population.

The impact of alcohol and tobacco use is also apparent. Alcohol was the principal substance implicated in 72% of deaths owing to psychoactive substance use disorders and was a co-occurring substance in one-third of drug overdose deaths. The preponderance of deaths due to heart disease and cancer, particularly neoplasms of the trachea, bronchus, and lung, suggests a pressing need to address the 73% prevalence of cigarette smoking among homeless

adults.[44] The heavy burden of such deaths among the growing subset of individuals 45 years or older reinforces the need for primary care and preventive services that target the health issues of an aging homeless population.[45]

From 1988 to 2008, BHCHP substantially expanded the scope of its clinical services in greater Boston.[20] While causality cannot be determined, this expansion may partially explain the interim reduction in natural causes of death that may be more amenable to medical interventions than external causes. However, the lack of change in all-cause mortality is consistent with the fact that multiple factors other than health care influence population health.[46] Addressing the substantial mortality disparities in homeless populations will require not only clinical innovation and tailored health care services, but also creative public health programming combined with policy initiatives to address homelessness and other social determinants of health.

This study has certain limitations. We focused on adults who used Health Care for the Homeless clinical services in Boston. Our findings may not be generalizable to homeless individuals who avoid such services or to homeless adults in other cities. Our study included both currently and formerly homeless adults, which likely exerts a conservative bias on our findings since individuals who have exited homelessness may have lower mortality rates.[18] Finally, the accuracy of death certificates in identifying cause of death has been debated.[47] Death certificates have poor sensitivity but high specificity for identifying drug poisoning deaths,[48] implying a low likelihood for "false-positive" drug overdose deaths in our study. Death certificates also seem to be relatively accurate in identifying cancer deaths,[49,50] the second most common cause of death in this study. Furthermore, decedents in this study underwent autopsy at a 6-fold higher rate than decedents in the Massachusetts general population, providing some reassurance that the cause of death information is not less accurate, and may be more accurate, than for nonhomeless individuals.

In conclusion, drug overdose has replaced HIV as the emerging epidemic among homeless adults. While mortality rates due to certain causes have decreased in comparison with rates 15 years prior, we found substantial increases in addiction-related and mental health–related mortality rates among homeless adults, resulting in no overall change in mortality despite a major expansion in clinical services for this population. Findings suggest the need to integrate psychiatric and substance abuse services into primary medical care and to expand public health efforts to curb the growing problem of opioid-related deaths. The mortality disparity between homeless individuals and the general population, particularly among those who are youngest, underscores the need to address the social determinants of health through policy initiatives to eradicate homelessness.

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Homelessness, Unsheltered Status, and Risk Factors for Mortality: Findings From the 100 000 Homes Campaign

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Abstract

Objectives: People who live in unsheltered situations, such as the streets, often have poorer health, less access to health care, and an increased risk of premature mortality as compared with their sheltered counterparts. The objectives of this study were to (1) compare the characteristics of people experiencing homelessness who were sleeping primarily in unsheltered situations with those who were accessing homeless shelters and other sheltered situations, (2) identify correlates of unsheltered status, and (3) assess the relationship between unsheltered status and increased risk of mortality.

Methods: Using primary data collected as part of the 100 000 Homes Campaign—a national effort to help communities find homes for vulnerable and chronically homeless Americans—we estimated 2 generalized linear mixed models to understand the correlates of unsheltered status and risk factors for mortality. Independent variables included demographic characteristics; history of homelessness, incarceration, foster care, and treatment for mental illness or substance use; sources of income; and past and present medical conditions. The study sample comprised 25 489 people experiencing homelessness who responded to an assessment of their housing and health as part of the 100 000 Homes Campaign from 2008 to 2014.

Results: In the full model, the following characteristics were associated with unsheltered status: being a veteran (adjusted odds ratio [aOR] = 1.10); having <high school education (aOR = 1.09); accessing informal income (aOR = 2.37); and having a history of foster care (aOR = 1.14), chronic homelessness (aOR = 1.36 for 1-5 years, aOR = 1.95 for >5 years), incarceration (aOR = 1.32), or substance use (aOR = 1.10 for ever abusing drugs or alcohol, aOR = 1.13 for ever using intravenous drugs, aOR = 1.98 for drinking alcohol every day for past month). Being unsheltered (aOR = 1.12), being female (aOR = 1.22), or receiving entitlements (aOR = 1.63) increased respondents' odds of having risk factors for mortality.

Conclusions: These findings highlight the need to assertively reach out to vulnerable populations and provide interventions to assist them during their transition—for example, as they exit incarceration or age out of foster care. Such a response could prevent unsheltered homelessness and thereby address increased mortality risk. Connecting people with resources to increase their access to employment, benefits, and other sources of income is especially important.

Keywords

homeless, unsheltered, mortality

People living in unsheltered situations—staying at a primary nighttime residence not intended for human habitation (eg, streets, parks, cars, abandoned buildings)[1]—often report poorer health and more symptoms of physical illness than their sheltered counterparts.[2,3] Unsheltered people frequently have serious mental illness,[3-5] cognitive disorders,[6] substance use disorders,[5-8] co-occurring mental health and substance use conditions,[7] and chronic health conditions.[5,9] Although their needs are high, they tend to receive acute rather than preventive care[10] and less frequent outpatient encounters.[3,7]

Studies show that people living in unsheltered situations are at increased risk for premature death[11] and that those who

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died while in unsheltered situations had high rates of chronic medical illness, serious mental illness, substance use disorders, and acute care utilization.[12,13] These studies led to the identification of a set of conditions or characteristics that confer particularly high risk for premature death among people living in unsheltered situations.[14-16]

The most recent point-in-time estimates of homelessness indicate that 42.6% of the >350 000 single adults who were homeless in the United States on 1 day in January 2015 were living in unsheltered situations, including one-third of homeless veterans and two-thirds of chronically homeless people.[1] Although this number represents a 32.3% decline in unsheltered homelessness since 2007, the raw numbers indicate that unsheltered homelessness is still a concern.

Previous studies have assessed the correlates and predictors of unsheltered homelessness and premature mortality among homeless populations using small study samples, often limited to service users or people in a limited geographic area. Unsheltered populations present substantial challenges to data collection because they are often not identified as homeless in local homelessness management information systems, as is the case for people seeking shelter.[17] Data collected as part of the 100 000 Homes Campaign provide an opportunity to address these challenges. The 100 000 Homes Campaign was a national effort led by Community Solutions—a nonprofit focused on finding solutions to complex social problems—to help 186 communities find homes for 100 000 vulnerable and/or chronically homeless Americans from July 2010 through July 2014. A primary strategy of the 100 000 Homes Campaign was to identify, in each participating community, every person living on the streets or in shelters and assess their housing and health using standardized instruments administered by trained volunteer interviewers.[18]

Our study had 3 objectives: (1) to compare characteristics of people experiencing homelessness who were sleeping primarily in unsheltered situations with the characteristics of those who were accessing homeless shelters and other sheltered situations, (2) to identify correlates of unsheltered status, and (3) to assess the relationship between unsheltered status and increased risk of mortality.

Methods

Measures

This study used primary data collected as part of and prior to the 100 000 Homes Campaign from 2008 through 2014 in 96 communities to assess 2 characteristics of people experiencing homelessness: sheltered status and risk factors for mortality. Sheltered status was based on respondents' selection of 1 of 6 responses to the question "Where do you sleep most frequently?" Respondents who indicated any of the following unsheltered locations were classified as unsheltered: streets, car/van/recreational vehicle, subway/bus, and beach/riverbed. Sheltered locations included shelters. Respondents who listed only "other"—or listed "other" along with sheltered locations—were excluded from analyses because we could not rule out the possibility that they were unsheltered at least some of the time. This study was approved by the University of Pennsylvania Institutional Review Board.

The selection of risk factors for premature mortality was based on work conducted in Boston, Massachusetts, that identified a profile of people experiencing homelessness who were at high risk of premature death: sleeping in unsheltered situations for at least 6 months and having at least 1 high-risk condition.[14-16] The 100 000 Homes Vulnerability Index, which was used in the 100 000 Homes Campaign, assessed the following high-risk conditions through respondents' self-report[19]:

- Trimorbidity of substance use (past or present), severe mental illness (indicated by past involuntary commitment for psychiatric treatment), and chronic medical illness (indicated by past or present diagnosis of 2 or more of the following: heart disease, diabetes, asthma, emphysema, cancer, hepatitis C, tuberculosis)
- Intensive health care service use indicated by a hospitalization (past year) or frequent emergency department visits (3 or more visits in past 3 months)
- >60 years of age
- Living with HIV or AIDS
- Liver or kidney disease
- History of frostbite, hypothermia, or immersion foot

The survey also collected information on demographic characteristics (education, race, sex, age, veteran status), the duration and frequency of homelessness, history of incarceration or foster care, sources of income, history of mental health treatment, current alcohol abuse and history of other substance use and related treatment, and past and present medical conditions. "Active" income included on- and off-the-books employment; "passive" income was from pensions, benefits, and public assistance; and other informal income came from recycling, panhandling, and the drug and sex trades.[20] Because rates of unsheltered homelessness vary substantially by geographic region—based largely on climate—we assessed average temperature in January for each state in which a 100 000 Homes Campaign community was located.[1]

Sample

Many of the 96 communities that contributed data were missing survey data. Communities were excluded from this study if ≥50% of data were missing on the item assessing sheltered status, ≥50% of data were missing on 2 or more other variables, and ≥75% of data were missing on 1 or more other variables. These criteria applied to 34 of the 96 communities, reducing the sample size from 50 607 respondents in the 96 communities to 36 540 respondents in the remaining 62 communities. Only respondents with complete data on sheltered status and all key predictors were included in the analyses,

resulting in a final analytic sample of 25 489. Although the differences between included and excluded cases were substantial, driven largely by sample size, the differences were small.

Analyses

We used Pearson's χ^2 tests to assess differences in the characteristics of sheltered and unsheltered respondents. We conducted 2 multivariate analyses. First, to understand the correlates of unsheltered status, we fit a generalized linear mixed model with demographic, homelessness, mental/behavioral health, institutional, and income characteristics as fixed effects and community as a random effect. Second, to assess if unsheltered status and other correlates were associated with increased mortality risk, we fit a generalized linear mixed model of the likelihood of meeting 1 or more of the previously outlined 6 high-risk conditions as a function of unsheltered status and demographic, homelessness, institutional, and income characteristics. Each multivariate analysis controlled for average state temperature in January. We also conducted a corresponding univariate analysis, entering each correlate as a fixed effect, with community as a random effect. All analyses were conducted with SAS/STATA 9.4.[21]

Results

Characteristics

Of the 25 489 survey respondents, 13 761 (54.0%) reported sleeping most frequently in an unsheltered situation. Compared with their sheltered counterparts, unsheltered respondents were more frequently located in areas with warmer temperatures; were male and white or other/mixed race; had a history of military service, incarceration, or foster care; and reported use of drugs and alcohol and treatment related to substance use and mental health. Compared with sheltered respondents, unsheltered respondents were less likely to have more than a high school education and more likely to obtain income through informal sources. Unsheltered respondents reported substantially longer durations of homelessness but less frequent episodes of homelessness than sheltered respondents. Also, compared with sheltered respondents, unsheltered respondents reported higher rates of each high-risk condition measured by the Vulnerability Index, except for frequent hospitalizations, being >60 years of age, and living with HIV/AIDS. Unsheltered status was more common in areas with higher temperatures and among respondents with less than a high school education, those identifying as a mixed/other race or white, males, and those who reported being homeless for 5 or more years (Table 1).

Correlates of Unsheltered Status

Results of the generalized linear mixed model for unsheltered status indicated that respondents who identified as black or Hispanic, female or transgender, and ≥60 years of age had lower odds of sleeping in an unsheltered situation; those who reported less than a high school education and a history of military service had slightly higher odds of being unsheltered. Duration of homelessness was significantly related to sleeping in an unsheltered situation: the adjusted odds of being unsheltered was 1.36 for those who had been homeless 1 to 5 years and 1.95 for those who had been homeless more than 5 years. A history of incarceration and foster care also increased the risk of sleeping in an unsheltered situation (Table 2).

Respondents' use of alcohol and drugs and lack of treatment related to both substance use and mental health increased their likelihood of sleeping in an unsheltered situation. Respondents who reported drinking alcohol every day for a month, ever abusing alcohol or drugs, ever using drugs intravenously, and ever being hospitalized against their will had increased odds of sleeping in an unsheltered situation, whereas respondents who had ever been treated for substance abuse had lower odds of being unsheltered. Finally, respondents who reported receiving more formal sources of income (eg, entitlements) had lower odds of being unsheltered (Table 2).

Although the multivariate model attenuated some of the univariate effect sizes as expected, results were generally consistent between these sets of analyses. The only exception was the effect of past substance abuse treatment, with unadjusted odds of 1.21 in the univariate analysis and adjusted odds of 0.84 in the multivariate analysis (Table 2).

Correlates of Risk Factors for Mortality

Results of the generalized linear mixed model for risk factors for mortality indicated that respondents who were sleeping in an unsheltered situation had 12% higher adjusted odds of having at least 1 risk factor for mortality. Other correlates of increased risk of mortality included being female, having served in the military, being homeless for more than 5 years, and having previously been incarcerated. Self-identifying as black and receiving income related to employment protected against risk factors for increased mortality, whereas receiving income from entitlements and other informal sources increased the likelihood of endorsing risk factors for mortality. Results were relatively consistent between multivariate and univariate analyses (Table 3).

Discussion

Our finding that unsheltered respondents were significantly different from sheltered respondents is consistent with other studies finding that people living in unsheltered situations were more frequently veterans than nonveterans,[6,22] had a history of incarceration,[6] obtained lower levels of education,[10] had significant substance use histories,[6,7,22] and were persistently homeless more frequently.[5,10,17,23,24] In addition, unsheltered respondents more frequently reported a history of foster care and accessing informal income than not. Each of these characteristics was associated with unsheltered status among the study sample;

Table 1. Characteristics of respondents to the 100 000 Homes Vulnerability Index, by sheltered status: 2007 2014 (62 US communities; n = 25 489)[a]

Variable	Sheltered (n = 11 728)		Unsheltered (n = 13 761)			Unsheltered Rate (n = 13 761)[c]	
	No.	% (95% CI)	No.	% (95% CI)	*P* Value[b]	No.	% (95% CI)
Average state temperature in Jan, °F					<.001		
<25	2412	20.6 (19.8 21.3)	1272	9.2 (8.8 9.7)		1272	34.5 (33.0 36.1)
25 34	4014	34.2 (33.4 35.1)	3347	24.3 (23.6 25.0)		3347	45.5 (44.3 46.6)
35 44	1674	14.3 (13.6 14.9)	2084	15.1 (14.5 15.7)		2084	55.5 (53.9 57.0)
≥45	3628	30.9 (30.1 31.8)	7058	51.3 (50.5 52.1)		7058	66.0 (65.2 66.9)
Demographic characteristics							
Education					<.001		
<High school	3434	29.3 (28.5 30.1)	4801	34.9 (34.1 35.7)		4801	58.3 (57.2 59.4)
High school / GED / trade school	4901	41.8 (40.9 42.7)	5642	41.0 (40.2 41.8)		5642	53.5 (52.6 54.5)
Some college	2450	20.9 (20.2 21.6)	2438	17.7 (17.1 18.4)		2438	49.9 (48.5 51.3)
College graduate	943	8.0 (7.5 8.5)	880	6.4 (6.0 6.8)		880	48.3 (46.0 50.6)
Race/ethnicity					<.001		
Non Hispanic white	3860	32.9 (32.1 33.8)	5050	36.7 (35.9 37.5)		5050	56.7 (55.6 57.7)
Non Hispanic black	5471	46.6 (45.7 47.6)	5386	39.1 (38.3 40.0)		5386	49.6 (48.7 50.5)
Hispanic	1291	11.0 (10.4 11.6)	1508	11.0 (10.4 11.5)		1508	53.9 (52.0 55.7)
Mixed/other[d]	1106	9.4 (8.9 10.0)	1817	13.2 (12.6 13.8)		1817	62.2 (60.4 63.9)
Sex					<.001		
Male	8237	70.2 (69.4 71.1)	10 410	75.6 (74.9 76.4)		10 410	55.8 (55.1 56.5)
Female	3442	29.3 (28.5 30.2)	3298	24.0 (23.3 24.7)		3298	48.9 (47.7 50.1)
Transgender/other[e]	49	0.4 (0.3 0.5)	53	0.4 (0.3 0.5)		53	52.0 (42.3 61.7)
Age, y					.161		
18 29	1389	11.8 (11.3 12.4)	1497	10.9 (10.4 11.4)		1497	51.9 (50.0 53.7)
30 39	1803	15.4 (14.7 16.0)	2142	15.6 (15.0 16.2)		2142	54.3 (52.7 55.9)
40 49	3420	29.2 (28.3 30.0)	4089	29.7 (29.0 30.5)		4089	54.5 (53.3 55.6)
50 59	3978	33.9 (33.1 34.8)	4724	34.3 (33.5 35.1)		4724	54.3 (53.2 55.3)
≥60	1138	9.7 (9.2 10.2)	1309	9.5 (9.0 10.0)		1309	53.5 (51.5 55.5)
Served in US military	1779	15.2 (14.5 15.8)	2262	16.4 (15.8 17.1)	.006	2262	56.0 (54.4 57.5)
Homelessness characteristics							
Years spent homeless					<.001		
<1	3644	31.1 (30.2 31.9)	2557	18.6 (17.9 19.2)		2557	41.2 (40.0 42.5)
1 5	5603	47.8 (46.9 48.7)	6405	46.5 (45.7 47.4)		6405	53.3 (52.4 54.2)
>5	2481	21.2 (20.4 21.9)	4799	34.9 (34.1 35.7)		4799	65.9 (64.8 67.0)
Times homeless and rehoused in past 3 y	8509	72.6 (71.7 73.4)	9152	66.5 (65.7 67.3)		9152	51.8 (51.1 52.6)
<4	8509	72.6 (71.7 73.4)	9152	66.5 (65.7 67.3)		9152	51.8 (51.1 52.6)
≥4	1207	10.3 (9.7 10.8)	1331	9.7 (9.2 10.2)		1331	52.4 (50.5 54.4)
Not reported	2012	17.2 (16.5 17.8)	3278	23.8 (23.1 24.5)		3278	62.0 (60.7 63.3)
Institutional history							
Ever been incarcerated	8651	73.8 (73.0 74.6)	11 278	82.0 (81.3 82.6)	<.001	11 278	56.6 (55.9 57.3)
Ever been in foster care	1696	14.5 (13.8 15.1)	2385	17.3 (16.7 18.0)	<.001	2385	58.4 (56.9 60.0)
Income[f]							
Active (employment)	2880	24.6 (23.8 25.3)	2984	21.7 (21.0 22.4)	<.001	2984	50.9 (49.6 52.2)
Passive (entitlements)	7822	66.7 (65.8 67.5)	8474	61.6 (60.8 62.4)	<.001	8474	52.0 (51.2 52.8)
Other informal income	1220	10.4 (9.8 11.0)	3812	27.7 (27.0 28.4)	<.001	3812	75.8 (74.6 76.9)
Mental health							
Ever treated for mental health problems	6319	53.9 (53.0 54.8)	7389	53.7 (52.9 54.5)	.769	7389	53.9 (53.1 54.7)
Ever hospitalized against will	2257	19.2 (18.5 20.0)	3303	24.0 (23.3 24.7)	<.001	3303	59.4 (58.1 60.7)
Substance use							
Drank alcohol every day for past month	1196	10.2 (9.7 10.7)	3171	23.0 (22.3 23.7)	<.001	3171	72.6 (71.3 73.9)
Ever abused drugs or alcohol	7261	61.9 (61.0 62.8)	9438	68.6 (67.8 69.4)	<.001	9438	56.5 (55.8 57.3)
Ever used intravenous drugs	1852	15.8 (15.1 16.5)	2912	21.2 (20.5 21.8)	<.001	2912	61.1 (59.7 62.5)
Ever treated for drug or alcohol abuse	5291	45.1 (44.2 46.0)	6490	47.2 (46.3 48.0)	.001	6490	55.1 (54.2 56.0)
Increased mortality risk	6584	56.1 (55.2 57.0)	8155	59.3 (58.4 60.1)	<.001	8155	55.3 (54.5 56.1)
Trimorbidity	566	4.8 (4.4 5.2)	977	7.1 (6.7 7.5)	<.001	977	63.3 (60.9 65.7)
Substance abuse	7723	65.9 (65.0 66.7)	10 168	73.9 (73.2 74.6)	<.001	10 168	56.8 (56.1 57.6)

(continued)

Table 1. (continued)

Variable	Sheltered (n = 11 728)		Unsheltered (n = 13 761)			Unsheltered Rate (n = 13 761)[c]	
	No.	% (95% CI)	No.	% (95% CI)	*P* Value[b]	No.	% (95% CI)
Severe mental illness	2257	19.2 (18.5 20.0)	3303	24.0 (23.3 24.7)	<.001	3303	59.4 (58.1 60.7)
Chronic medical illness	2449	20.9 (20.1 21.6)	3362	24.4 (23.7 25.1)	<.001	3362	57.9 (56.6 59.1)
Health care service use	5245	45.7 (44.8 46.6)	6330	47.2 (46.3 48.0)	.017	6330	54.7 (53.8 55.6)
Hospitalization in past year	4716	41.2 (40.3 42.1)	5660	42.3 (41.4 43.1)	.076	5660	54.5 (53.6 55.5)
Frequent emergency room visits (≥3 in past 3 mo)	2014	17.5 (16.8 18.2)	2541	18.9 (18.2 19.6)	.004	2541	55.8 (54.3 57.2)
>60 y of age	899	7.7 (7.2 8.1)	1044	7.6 (7.1 8.0)	.813	1044	53.7 (51.5 55.9)
Living with HIV/AIDS	386	3.3 (3.0 3.6)	504	3.7 (3.4 4.0)	.101	504	56.6 (53.4 59.9)
Living with liver and/or kidney disease	1363	11.8 (11.2 12.4)	2050	15.1 (14.5 15.7)	<.001	2050	60.1 (58.4 61.7)
Ever had frostbite/hypothermia/immersion foot	742	6.4 (5.9 6.8)	1466	10.7 (10.2 11.3)	<.001	1466	66.4 (64.4 68.4)

Abbreviations: CI, confidence interval; GED, general equivalency diploma; HIV, human immunodeficiency virus.
[a]Data source: Community Solutions.[19]
[b]Based on Pearson's χ^2 test of significance to compare the difference between sheltered and unsheltered respondents.
[c]Unsheltered rate indicates the prevalence of people living in unsheltered situations who have each characteristic indicated in this table. Percentages are by row, with the denominator being the total number of sheltered and unsheltered respondents for each characteristic.
[d]Includes respondents self-identifying as Asian, Native Hawaiian / other Pacific Islander, Native American, mixed race, or other.
[e]Includes respondents self-identifying as transgender or other.
[f]Items reflect separate dichotomous variables, not mutually exclusive categories. Active income includes on- and off-the-books employment; passive income includes pensions, benefits, and public assistance; and other informal income includes income from recycling, panhandling, and the drug and sex trades.

however, other characteristics (ie, identifying as black, female, and >60 years of age) protected against unsheltered status. In univariate analyses, a history of substance abuse treatment was associated with increased odds of being unsheltered. In the multivariate model, however, respondents who indicated ever receiving treatment for substance abuse were more likely to be sheltered than those who had not received treatment, which perhaps reflects sheltered respondents' access to services or a function of the requirements for obtaining shelter.

The relationship between foster care and homelessness as an adult is well documented: compared with the general population, those who are homeless report a history of foster care 6 to 9 times more frequently.[25] Housing instability—characterized by running away from foster care or frequently transitioning among foster homes—is associated with an increased risk of homelessness among youth aging out of foster care, indicating a lack of social support or ability to access resources.[26] A history of foster care is also associated with longer durations of homelessness and younger age at first episode of homelessness,[27] as well as long-term difficulties related to mental health, chronic and acute health conditions, and employment difficulties that persist beyond middle age.[28] Although research has not linked foster care to unsheltered homelessness, experiences in adulthood that are related to a history of foster care are consistent with risk factors for unsheltered homelessness.

Respondents who were receiving entitlement income had almost 30% higher adjusted odds of being sheltered than those who were not receiving entitlement income, a finding that is consistent with research conducted among veterans experiencing homelessness that found that those receiving compensation related to service-connected disabilities were less likely to be unsheltered than those who were not receiving compensation[7] and less likely to be persistently homeless.[17] This relationship, which holds true even for families that are avoiding housing instability or eviction, may symbolize "uncertainty of income," making it difficult to budget or plan for accessing shelter, which usually comes with a price.[29] The finding that respondents accessing other informal income were significantly more likely to be unsheltered than those who were not accessing other informal income may be related to uncertainty of income, but it may also be a symptom of living in an unsheltered situation.

Compared with sheltered respondents, those living in unsheltered situations had higher odds of meeting Vulnerability Index criteria for increased risk of mortality. The correlates of increased risk of mortality were similar to what was found for unsheltered status, with 2 important differences: respondents receiving entitlements and women were less likely to be unsheltered but had greater odds of increased risk of mortality, 1.63 and 1.22, respectively. More certain income—such as that received through entitlements—may be related to the ability to budget for shelter; however, eligibility for these entitlements is based on disability, which likely contributes to recipients' risk of mortality.

To our knowledge, no studies have assessed mortality or mortality risk among unsheltered women, but a 2004 study of women staying in homeless shelters found that the mortality rate among women <45 years of age was 5 to 30 times higher than expected and about twice as high as expected among women ≥45 years of age.[30] Future research should examine the subpopulation of female respondents to identify factors associated with their increased risk of mortality—including the role of unsheltered status—and appropriate responses.

Table 2. Results of a mixed effects logistic regression model[a] assessing correlates of unsheltered status among respondents to the 100 000 Homes Vulnerability Index: 2007 2014 (62 US communities; n = 25 489)[b]

Variable	Unadjusted OR (95% CI)	*P* Value[c]	aOR[d] (95% CI)	*P* Value
Average state temperature in Jan, °F				
≥45	1 [Reference]		1 [Reference]	
<25	0.17 (0.07 0.43)	<.001	0.14 (0.06 0.35)	<.001
25 34	0.38 (0.19 0.75)	.006	0.39 (0.20 0.75)	.005
35 44	0.44 (0.17 1.11)	.081	0.50 (0.21 1.20)	.122
Education				
High school / GED / trade school	1 [Reference]		1 [Reference]	
<High school	1.18 (1.11 1.26)	<.001	1.09 (1.02 1.17)	.01
Some college	0.81 (0.75 0.88)	<.001	0.86 (0.79 0.93)	<.001
College graduate	0.72 (0.65 0.81)	<.001	0.81 (0.72 0.91)	<.001
Race/ethnicity				
Non Hispanic white	1 [Reference]		1 [Reference]	
Non Hispanic black	0.66 (0.62 0.71)	<.001	0.65 (0.61 0.70)	<.001
Hispanic	0.88 (0.80 0.97)	.013	0.83 (0.75 0.93)	<.001
Other/mixed[e]	1.06 (0.96 1.17)	.251	1.00 (0.90 1.11)	.964
Sex				
Male	1 [Reference]		1 [Reference]	
Female	0.76 (0.72 0.81)	<.001	0.89 (0.83 0.96)	.001
Transgender/other[f]	0.64 (0.42 0.99)	.045	0.62 (0.39 0.98)	.04
Age, y				
18 29	1 [Reference]		1 [Reference]	
30 39	1.08 (0.97 1.20)	.181	1.02 (0.91 1.14)	.717
40 49	1.08 (0.98 1.19)	.103	0.96 (0.86 1.06)	.404
50 59	1.03 (0.94 1.13)	.516	0.92 (0.83 1.02)	.106
≥60	0.87 (0.77 0.99)	.03	0.87 (0.76 0.99)	.036
Served in US military	1.09 (1.01 1.17)	.027	1.10 (1.01 1.19)	.025
Years spent homeless				
<1	1 [Reference]		1 [Reference]	
1 5	1.5 (1.40 1.61)	<.001	1.36 (1.26 1.46)	<.001
>5	2.46 (2.27 2.66)	<.001	1.95 (1.79 2.12)	<.001
Substance use				
Drank alcohol every day for past month	2.56 (2.37 2.77)	<.001	1.98 (1.82 2.15)	<.001
Ever abused drugs or alcohol	1.51 (1.42 1.60)	<.001	1.10 (1.02 1.19)	.012
Ever used intravenous drugs	1.48 (1.38 1.59)	<.001	1.13 (1.04 1.22)	.004
Ever treated for drug or alcohol abuse	1.21 (1.15 1.28)	<.001	0.84 (0.78 0.90)	<.001
Mental health				
Ever treated for mental health problems	1.05 (1.00 1.12)	.064	0.97 (0.91 1.04)	.442
Ever hospitalized against will	1.33 (1.24 1.42)	<.001	1.20 (1.11 1.29)	<.001
Institutional history				
Ever been incarcerated	1.73 (1.62 1.85)	<.001	1.32 (1.22 1.42)	<.001
Ever been in foster care	1.29 (1.20 1.40)	<.001	1.14 (1.05 1.24)	.002
Income[g]				
Active income (employment)	1.06 (0.99 1.13)	.113	0.94 (0.88 1.01)	.105
Passive income (entitlements)	0.75 (0.70 0.79)	<.001	0.78 (0.73 0.83)	<.001
Other informal income	3.14 (2.90 3.39)	<.001	2.37 (2.18 2.57)	<.001

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; GED, general equivalency diploma; OR, odds ratio.
[a]Mixed effects logistic regression model with community entered as a random effect.
[b]Data source: Community Solutions.[19]
[c]Based on Wald χ^2 test for significance to compare whether the predictor is associated with the outcome.
[d]Adjusted for all other variables in the table.
[e]Includes respondents self-identifying as Asian, Native Hawaiian / other Pacific Islander, Native American, mixed race, or other.
[f]Includes respondents self-identifying as transgender or other.
[g]Active income includes on- and off-the-books employment; passive income includes pensions, benefits, and public assistance; and other informal income includes income from recycling, panhandling, and the drug and sex trades.

Limitations

This study had several limitations. Because of missing data, a substantial portion of the original sample was excluded from analyses, which may affect the generalizability of the findings. In addition, there were significant—though not substantive—differences between respondents who were and were not

Table 3. Results of mixed effects logistic regression model[a] assessing risk factors for mortality among people responding to the 100 000 Homes Vulnerability Index: 2007 2014 (62 US communities; n = 25 489)[b]

Variable	Unadjusted OR (95% CI)	*P* Value[c]	aOR[d] (95% CI)	*P* Value
Unsheltered	1.21 (1.15 1.28)	<.001	1.12 (1.05 1.19)	<.001
Education				
<High school	1 [Reference]		1 [Reference]	
High school / GED / trade school	1.19 (1.12 1.26)	<.001	1.13 (1.06 1.20)	<.001
Some college	1.12 (1.04 1.20)	.002	1.11 (1.03 1.20)	.004
College graduate	1.25 (1.13 1.39)	<.001	1.29 (1.16 1.44)	<.001
Race/ethnicity				
Non Hispanic white	1 [Reference]		1 [Reference]	
Non Hispanic black	0.76 (0.71 0.81)	<.001	0.76 (0.71 0.81)	<.001
Hispanic	0.84 (0.76 0.92)	<.001	0.92 (0.83 1.01)	.083
Other/mixed[e]	0.95 (0.87 1.04)	.31	0.96 (0.88 1.06)	.435
Sex				
Male	1 [Reference]		1 [Reference]	
Female	1.16 (1.10 1.23)	<.001	1.22 (1.14 1.30)	<.001
Transgender/other[f]	1.49 (0.98 2.26)	.062	1.48 (0.97 2.27)	.069
Served in US military	1.26 (1.17 1.35)	<.001	1.27 (1.18 1.37)	<.001
Years spent homeless				
<1	1 [Reference]		1 [Reference]	
1 5	1.35 (1.26 1.43)	<.001	1.29 (1.21 1.38)	<.001
>5	1.83 (1.70 1.97)	<.001	1.65 (1.53 1.78)	<.001
Institutional history				
Ever been incarcerated	1.44 (1.36 1.53)	<.001	1.38 (1.29 1.48)	<.001
Ever been in foster care	1.15 (1.07 1.23)	<.001	1.06 (0.99 1.14)	.12
Income[g]				
Active income (employment)	0.55 (0.52 0.59)	<.001	0.61 (0.58 0.65)	<.001
Passive income (entitlements)	1.78 (1.69 1.88)	<.001	1.63 (1.54 1.73)	<.001
Other informal income	1.26 (1.18 1.35)	<.001	1.19 (1.11 1.28)	<.001

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; GED, general equivalency diploma; OR, odds ratio.
[a]Mixed effects logistic regression model with community entered as a random effect. The dependent variable was meeting at least 1 of 6 risk factors for mortality.
[a]Data source: Community Solutions.[19]
[c]Based on Wald χ^2 test for significance to compare whether the predictor is associated with the outcome.
[d]Adjusted for all other variables in the table.
[e]Includes respondents self-identifying as Asian, Native Hawaiian / other Pacific Islander, Native American, mixed race, or other.
[f]Includes respondents self-identifying as transgender or other.
[g]Active income includes on- and off-the-books employment; passive income includes pensions, benefits, and public assistance; and other informal income includes income from recycling, panhandling, and the drug and sex trades.

included in the final analytic sample, which may reflect selection bias. Second, we were unable to assess interrater reliability across interviewers and communities, which is a concern given that the level of training and experience among raters likely varied considerably. Third, the data were based on self-report, which may be unreliable, particularly as related to duration of homelessness, use of health care services, and medical conditions. Furthermore, the Vulnerability Index did not assess behavioral health conditions. Fourth, the data provided little information on respondents' sheltered status, which made it impossible to know about or control for the duration, frequency, and history of unsheltered status. Finally, due to the cross-sectional nature of the data, the results presented here cannot be used to infer causality.

Conclusion

This study identified several factors associated with increased odds that a person would be living in an unsheltered situation, be at increased risk of mortality, or both, including extended duration of homelessness, substance use, history of incarceration and foster care, lack of reliable income, and female sex. These findings highlight the need to reach out to these vulnerable populations and provide interventions that help people during their transition from incarceration to the community or as they age out of foster care. Connecting people with resources to increase their likelihood to obtain employment, access benefits, and find other sources of income is especially important.

Declaration of Conflicting Interests

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EXHIBIT 13

African American Council
Articles on Racial Disparity in Hospice

THE INCLUSION INITIATIVE

African American Council

Nicole McCann-Davis, National Director of Communications

Seasons Hospice & Palliative Care

The Why

Demographic	Nat'l Patients	SHPC Patients	SHPC Staff
African American	8.3%	14.99%	19.4%
Hispanic	2.1%	8.59%	17.4%
Asian	1.2%	1.54%	4.3%

Seasons Hospice & Palliative Care

AAC's Goal

- Educate our staff to ensure that all needs are being met
- Improve the community understanding of hospice and palliative care
- Provide care that respects what is most important to each individual

Seasons Hospice & Palliative Care

Educating Our Staff

- BD² Vignettes focused on supporting the African American family
- 60 second updates focused on inclusion
- Inclusion focused Case Management Recipe vignettes
- Sharing culturally appropriate holidays, facts, and traditions on Yammer and the flat screens

Seasons Hospice & Palliative Care

Improving the Community's Understanding

- The Inclusion Initiative – Baltimore
  - We anticipated 5-7 attendees
  - Final count – 16
  - Investment – $600

Seasons Hospice & Palliative Care

The Inaugural Inclusion Initiative Meeting

- *"Everybody wants to go to Heaven, but nobody wants to die. It's not so much the act of dying itself, but the things that are surrounding death: injustice, poverty, mistreatment, and evil...There's a sense that we won't be stopped by those things - our 'somehow theology.' Somehow, someway, we will get through this."*

  - Rev. Frank Jackson, Faith Presbyterian Church

Seasons Hospice & Palliative Care

Key Takeaways

- Lack of preparedness is a barrier
- Families want to feel genuinely cared for (not like it's just part of our job)
- If the family feels cared for and is truly supported, they will be loyal to the organization
- Supporting the family is equally, **if not more** important than the patient

Seasons Hospice & Palliative Care

On the horizon

- Updated Seasons.org page
- Baltimore and Illinois
- Adopt a hospice initiative
- Urban community college connections
- Inclusion Initiative events focused on preparation to decrease fear at the end of life
  - Getting your house in order
    - Advance Care Planning
    - Understanding life insurance
  - What is hospice and palliative care
    - Signs that your loved one may qualify for hospice
    - Questions to ask the doctor to advocate for yourself/your loved one

Seasons Hospice & Palliative Care

Virtual Mentor
American Medical Association Journal of Ethics
September 2006, Volume 8, Number 9: 613-616.

Op-ed
Racial disparities in hospice: moving from analysis to intervention
by Ramona L. Rhodes, MD, MPH

Hospice is a program designed to provide comfort—rather than curative—care to terminally ill patients and support to their families. Hospice services are provided by a multidisciplinary team of physicians, nurses, social workers, clergy and volunteers who work together to help patients and their families meet the challenges of end-of-life care. Hospice services can be provided in a variety of venues including the home, inpatient hospice facilities and long-term-care facilities. Several studies have documented the benefits of hospice to patients and their families. For example, in a randomized, controlled trial of terminally ill cancer patients and their primary care givers, Kane et al. found that patients enrolled in a hospice program experienced significantly less depression and expressed more satisfaction with care [1]. Furthermore, caregivers of hospice patients showed somewhat more satisfaction and less anxiety than did those of controls [1]. Bereaved family members told Teno and colleagues in a national study that loved ones who died at home with hospice services had reported fewer unmet needs and greater satisfaction with their experience [2]. Finally, Miller et al. observed that hospice enrollment improves pain assessment and management for nursing home residents [3]. The literature consistently finds that participation in a hospice program improves the quality of care patients receive at the end of life.

Since the inception of the Medicare hospice benefit, hospice services have been available to many patients. Despite these additional sources of funding and the evidence of improved quality of care at the end of life, African Americans and members of other ethnic minority groups consistently underutilize hospice. For example, in a secondary analysis of the 1993 National Mortality Followback Survey, Greiner et al. found that being African American was negatively associated with hospice use regardless of the patient's access to health care [4]. In a retrospective analysis of more than one million Medicare enrollees, Virnig and colleagues found that the rate of hospice use was significantly lower for blacks than for nonblacks [5]. Furthermore, even though blacks made up 12 percent of the population of the United States in 2004 they accounted for only 8.1 percent of hospice admissions for that year [6].

Several possible causes for racial disparity in hospice utilization have been proposed. Research has suggested, for instance, that lack of knowledge about hospice programs is a barrier to their use in the African American community [7]. Mistrust of the

health care system, conflicts between individuals' spiritual and cultural beliefs and the goals of hospice care, and preferences for aggressive life-sustaining therapies have also been suggested as causes [8-12]. Some believe that providers' conscious or unconscious stereotyping of their patients may also lead to disparities in health care [13]. Additionally, the prohibitive cost of health care, barriers to access and a culturally insensitive health care system have been thought to contribute [8]. Few of these reasons for underutilization of hospice services by African Americans and members of other minority and ethnic groups have been studied in depth.

When compared with use by Caucasian patients, not only do African Americans underutilize hospice, they also perceive the quality of end-of-life care differently. According to Welch et al. blacks were less likely to rate the care their family members received at the end of life as "excellent" or "very good." They were more likely to have concerns about being told what to expect when their loved one died and more likely to be distressed about the amount of emotional support they received from the health care team during their loved one's last days [14]. There were, however, marked decreases in the disparities noted in perceptions about the quality of care once patients enrolled in hospice, particularly with regard to overall satisfaction with services and attending to the needs of family members [15]. Hence, there is evidence that having hospice care leads to improvements in African Americans' perceptions of end-of-life care.

Though initiatives have been implemented in some areas, more culturally sensitive education is needed to increase awareness of hospice and its benefits. Some studies suggest that cultural diversity among hospice staff may influence diversity among hospice patients [11]. Consequently, hospice programs should strive to increase diversity not only among their patient populations but also among their employees and volunteers. Given that conflicts between cultural preferences and hospice goals are thought to inhibit its utilization, cultural sensitivity should be emphasized to all health care workers, particularly those who care for patients at the end of life. Interventions directed at these areas are sorely needed, as is evaluation of their effectiveness.

Access to hospice has been increasingly thought of as a public health matter. The right to quality care at the end of life is one that should be extended to everyone regardless of race, ethnic background or socioeconomic status. Barriers to hospice utilization should be researched and identified so that appropriate interventions can be conducted to overcome these obstacles. The evidence that hospice is underutilized by those of underserved communities is substantial, but few steps are being taken to understand and reverse this trend. The time has come for research to move from the analysis of disparities in end-of-life care and hospice utilization to identification of barriers and interventions to reverse the trend.

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controlled trial of hospice care. *Lancet*. 1984;2:890-892.
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Related articles
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FELLOWSHIP STORY SHOWCASE

Racial disparities in end-of-life care — how mistrust keeps many African Americans away from hospice

hospice care, end of life care, racial disparities, California

By JoAnn Mar

JoAnn Mar's report for KALW was produced as part of a larger project for the USC Annenberg Center for Health Journalism's 2018 California Fellowship. This story also ran in the Oakland Post.

Other stories in this series include:

Challenges and cultural barriers faced by Asians and Latinos at the end of life

Friday, November 16, 2018

Sharitta Berry was at Oakland's Highland Hospital when she got the bad news in early 2018. For several months, Berry was coughing heavily and struggling to breathe. Her doctors told her she has COPD, chronic obstructive pulmonary disease caused by years of heavy smoking and drug abuse. There is no cure for COPD and her condition is rapidly getting worse. The bad news hit her hard—she felt sad, scared, and depressed. The 52-year-old Berry needed to make an important decision. She could choose the comfort care provided by hospice. Or she could undergo invasive surgery and be attached to a ventilator for the rest of her life.

Berry's doctors tried to explain her options, but they were unable to communicate effectively with her and she couldn't reach a decision. At the heart of the communication breakdown was a deep lack of trust of the medical system—Berry, an African-American woman, did not trust what her doctors were telling her. "Gorillas, some of the doctors were all gorillas, said Berry's daughter Ashley Hunter, describing the recurring dreams her mother had about doctors, "Or they were like robotic. She was talking about doctors doing something to her."

Reasons for Racial Disparities at the End of Life— Poor Communication

Dr. Alexander Smith, UC San Francisco palliative care specialist and researcher

Communication skills and training in conducting sensitive, end-of-life conversations are essential for providing high-quality care to dying patients. However, studies have found that African Americans report lower quality interactions with their physicians, compared with white patients. In one study surveying 1816 participants by telephone in the late 1990s, African-American patients rated their visits with physicians as less participatory than whites. African Americans also report less satisfaction with the quality of communication, including the extent to which providers listen and share information. U.C. San Francisco palliative care researcher Dr. Alexander Smith conducted a multistate study of 803 terminally ill patients published in 2007. According to Smith, "We found that African-American patients reported significantly lower quality patient-physician relationships than white patients." Many African Americans are either unaware of hospice care or lack a clear understanding of what hospice is.

Home Hospice Can Provide a More Affordable, Less Painful Option to Hospitalization

The goal of home hospice is comfort and pain management, when cure is no longer possible. Curative, life-prolonging treatments such as surgeries and chemotherapy are stopped, and the focus shifts to quality of life. Hospice care focuses on the patient's physical, emotional, social, and spiritual needs. The patient spends his final days and weeks at home, taken care of by family members with the help of hospice nurses and volunteers to monitor his medications and comfort level. But far fewer African Americans utilize hospice compared to whites. Among Medicare beneficiaries who died in 2010, 45.8% of whites used hospice compared to 34% of African Americans.

Reaching Out to Dying African-American Patients

Berry's doctors finally brought in Dr. Jessica Zitter, a palliative care specialist, to help out. Rather than dominate the conversation with medical jargon, Zitter let Berry talk for a long time. Berry felt comfortable speaking with Zitter and soon, it became clear what Berry wanted.

"I said 'well, what do you think about being on a breathing machine?'" recounts Zitter. "And [Berry] said 'I'm afraid I wouldn't get off.' I said 'I'm afraid you wouldn't get off too.' And she said 'I don't want it.' And that was it—that was the answer."

Berry is now at home, receiving hospice care. Her daughter Ashley is her part-time caregiver, and is relieved that Berry did not choose aggressive life sustaining treatments. "My mama knows I don't like seeing her in the hospital," said Hunter, "She knows I'm more comfortable her being with me and closer to me."

Keeping Hope Alive—Cultural Differences in End-of-Life Decision-Making

If Berry had chosen to stay alive at all costs using heroic measures such as mechanical ventilators and feeding tubes, these aggressive treatments wouldn't cure the disease, just give her a little more time. Even though there's little chance of full recovery, African Americans are more likely than whites to choose life-sustaining measures. Minorities at the end of life are more likely to receive high-intensity, life-sustaining treatments. Dr. Zitter refers to a 2013 survey done by the Pew Center survey, which found "African Americans do tend to die more often on machinery in facilities, away from home in pain than white patients."

Keeping hope alive is a strong part of African-American culture and surviving difficult times. Hospital TV dramas like *ER* and *Grey's Anatomy* serve to reinforce the belief that medicine can cure most problems, even terminal illness.

"If you watch TV as most people do, you think 'hey yeah, if this happens to most people, bring me back. Restart my heart, go for it, 'cause it happens all the time on TV." says Dr. Alexander Smith. "Nobody wants the CPR, the chest compressions, the shocks, the breathing tubes. They want to like get back to their former selves, to go home. Not to live in the ICU on machines for a few days before dying."

A Long History of Unequal Treatment in Medical Services

Doing everything to stay alive is part of African-American culture that can be traced back to the days of slavery. The country's long history of racism and poverty included unequal access to medical care. To this day, some suspect that the health care system is limiting their treatment options. Others worry that choosing hospice means giving up hope or hastening death. Reverend Cynthia Carter Perrilliat, a minister at the Allen Temple Baptist Church in East Oakland, often encounters this fear among her congregants, who she says ask "Why should I trust that you're going to do the right thing for me?"

"Statistics will tell you that in communities of color, particularly African-American communities, they always say 'give me everything,'" says Perrilliat. "You know, all the treatment that there is, because typically we don't get the treatment we need."

Historic wrongs such as the Tuskegee syphilis experiments of the 1930's have only served to reinforce African-American mistrust of the medical system. "The U.S. government had ultimately a cure for syphilis but they did not provide that cure to these African-American men," said Perrilliat, "Unfortunately most of them died. It was a senseless death. It did not have to happen and frankly the powers that be, the government, did nothing about it."

Established racial disparities and discrimination have long been part of America's health care system from birth to death. Infant mortality rates are twice as high for African Americans compared to whites. White Americans live 3.5 years longer than African Americans. Research further indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services. Even at the end of life, racial disparities persist.Significantly fewer African Americans, Asians, and Latinos enrolled in hospice compared to whites.

Painful Consequences of Avoiding Hospice Care

But without the comfort care provided by hospice, African Americans at the end of life have less access to pain medication, especially if they live in low-income neighborhoods. "If they're under the care of hospice, hospice will bring the medication to that neighborhood," said Dr. Zitter, "But if you actually have to go and refill that prescription, it can be a real problem for people who don't have a car and who can't figure out how to get to a pharmacy somewhere else." Nearby pharmacies in some predominantly minority neighborhoods are less likely to stock adequate supplies of opioids.

For dying patients who opt for aggressive, life-prolonging treatments, palliative care1 is available to alleviate some of the physical pain. But Zitter says these heroic measures can immobilize frail patients, thus increasing their discomfort and suffering in their final days of life. "If I sit and think what that must feel like to be a dying person, unable to communicate on my back in an ICU or a ventilator facility with tubes surgically attached to my body with my arms tied down—to me, that's a fate I would never personally want," said Zitter.

The Faith Community and Its Potential Role in Reducing Racial Disparities in End-of-Life Care

Reverend Perrilliat had her own positive experience with hospice many years ago when her father died of cancer. She said the staff took good care of him—they were kind, caring, and compassionate. But she noticed that very few African Americans enrolled in hospice. Most

of them knew little about it and the medical staff was all white. "Why don't we see more health professionals that are people of color?" asked Perrilliat, "Asians, Latinos, African Americans—where are we in this mix? The light came on and immediately I saw it. This is ministry, this is ministry at the heart of it all."

Perrilliat realized that houses of worship needed to become more active in end-of-life care, to overcome the historical mistrust of the medical system. Seventy percent of African Americans are religious and churches are highly respected institutions. "The faith community frankly I think is one of the last bastions of resource out there for communities where there is still some level there of trust," said Perrilliat, "Trust is huge on this issue of advancing illness and aging and end of life. You really need to know you can get trusted information from trusted individuals that have no motives other than they want the best for you."

The Alameda County Care Alliance—A Faith-Health Partnership

The Allen Temple Baptist Church, one of the ACCA's hub churches

In 2014, Perrilliat partnered with five churches, and started the Alameda County Care Alliance, a faith-based non-profit providing critical support for predominantly African-American adults with advanced illness and their caregivers. It's considered the nation's first community-faith-health partnership of its kind. Ministers and faith leaders are trained to help their congregants prepare for the end of life and provide spiritual guidance and support related to their advanced illness.

At the heart of the ACCA's program is its navigation system. Community care navigators are trained to provide support and connect participants with needed resources such as transportation, meals, medical services, and hospice care.

"You have to have a heart for people, a desire to help," said Alexis Owens, one of the ACCA's navigators, "We want to make sure they know we're actively listening. We want them to trust us."

Owens grew up in Oakland and has deep roots in the city's faith community. One of her clients is 98-year-old Hannah Martin, who attends the same church. Since the death of her husband, Martin has suffered from grief, loneliness, high blood pressure, and hypertension and now, she's fallen behind on her bills, which causes added stress. "At one point, her PG&E and water bill had escalated quite a bit," said Owens, "We contacted those utility companies." Owens arranged a payment plan for her overdue bills and also helped with her transportation needs. "She's been right there when I needed her," said Martin, "She [took] me several times to the hospital, to meetings when I had to go to church. If I needed to go some place, I'd call on Alexis."

Each visit ends with a prayer. Owens holds Martin's hand and gives thanks and blessings to everyone who has helped her. As she nears the end of her life, Martin knows she can turn to Owens for help. "I just love Alexis because she's such a nice person," said Martin, "She's very, very helpful. She's someone you can talk to." Owens and the ACCA will connect her with hospice, comfort care, or whatever medical services she wants when the time comes.

The ACCA's Success and Plans for Expansion

In the last four years, the ACCA's hub churches have grown from five to fourteen. Its medical partners include Kaiser Permanente, U.C. Davis School of Nursing, and the Public Health Institute. "We got our first funding in 2014—in less than twelve months we had 550 people," said Perrilliat, "Year two our numbers practically doubled. We're well over 2,500, close to 3,000 plus folks now in our third year. So there's no lack of need, I promise you."

The ACCA hopes to reach beyond the African-American community and expand throughout the Bay Area and connect with other faith communities in the future. Major cities such as San Francisco, Los Angeles, Chicago, and New York have expressed interest in replicating the ACCA's navigator system. If the model spreads nationwide, it could go a long way in reducing racial disparities in end of life care.

1. To clarify, "palliative care" is not limited to hospice and is also used to address the physical pain, psycho-social suffering, and discomfort of those with advanced or life-threatening illness as well as those with terminal illness.

FELLOWSHIP STORY SHOWCASE

Challenges and cultural barriers faced by Asians and Latinos at the end of life

Asians, Latinos, hospice care, end of life care, racial disparities

By JoAnn Mar

JoAnn Mar's report for KALW was produced as part of a larger project for the USC Annenberg Center for Health Journalism's 2018 California Fellowship. This story also ran in the Oakland Post.

Other stories in this series include:

Racial Disparities in End-of-Life Care— How Mistrust Keeps Many African Americans Away from Hospice

KALW

Thursday, November 15, 2018

For Asians, Latinos, and other ethnic minorities, the end of life presents unique challenges. Language barriers and cultural traditions can often inhibit access to hospice, pain management, and comfort care.

Overcoming barriers and navigating cultural norms is not easy and requires health professionals and patients working together as equal partners.

The end of life is not easy for most Americans nearing death. The good news is that up to ninety percent of pain and suffering can be controlled. But the bad news is that over half of all dying Americans experience unwanted pain and suffering during their final days. And the numbers are even greater for people of color. African-Americans, Asians, and Latinos have less access to the pain medication and comfort care that hospice can provide at the end of life compared to whites.

Asians, Latinos, and other ethnic minorities whose second language is English face additional challenges. Language barriers and cultural traditions can inhibit awareness of and discussions about end-of-life options and are often compounded by poverty and lack of education.

The cultural taboo against openly discussing death

In many traditional Latino and Asian cultures, speaking openly about death is taboo, especially when a loved one is seriously ill. Among the Chinese, talking about death, especially with elders is considered disrespectful.

At a recent gathering, grief counselor Terri Daniel spoke with Chinese seniors residing at Mercy Housing, a low-income assisted-living community in San Francisco. The elders told Daniel they've spent a lot of time and thought setting up altars in honor of deceased ancestors and paying regular visits to the cemetery—but have not spent time making plans for their own deaths. Daniel asked how many of them have had end-of-life conversations with their children. Only six out of twenty-five seniors raised their hands. Fang Huang, resident services coordinator, said she and others at Mercy Housing have tried to encourage the elder residents to talk with their families and complete advance directives. When asked why they hadn't spoken with their families, one woman said they didn't want to discuss death with their children because they were afraid it would upset them. Another woman said, "My children are actually even more fearful than us."

Failure to plan for the end of life

Only one-third of Americans have completed an advance directive, a legal document that specifies a person's preferences for medical treatment in the event of a serious or terminal illness. Whites are more likely to have an advance directive than other racial and ethnic groups. Latinos and Asians are less likely than whites to discuss their end-of-life preferences or engage in advance care planning. Less than ten percent of Latinos have announced or written down their preferences about the kind of care they would want at the end of their lives.

These inequities have serious ramifications. Patients who engage in advance care planning (end-of-life conversations with family or health providers) are less likely to die in the hospital or to receive futile intensive care. Family members have fewer concerns and experience less emotional trauma if they have the opportunity to talk about their loved one's wishes. "Making sure that we talk to people and prepare people in advance for these serious illnesses—that's what we're trying to promote nation-wide," said Dr. Alexander Smith, one of the many concerned palliative care specialists in the Bay Area seeking to improve care at the end of life, "More importantly is understanding what their goals and values are. What type of life is worth living? What kind of trade-offs are they willing to make in order to have that type of life? These are the kinds of conversations that are very important and help family members prepare."

Poverty and the tendency to delay seeking treatment

Luis Hernandez' family did no planning around the end of life. Hernandez and his brother were raised by their single mother in the projects of Brooklyn, New York. "Death is not something we really talked about until it happened," said Hernandez. His mother had been complaining about pain for a long time, and he and his brother urged her to see a doctor. "My mom was always very scared of doctors and never wanting to go," said Hernandez, "No matter how many times me and my brother told her 'Go!' She said 'I'm scared they'll find something.'"

His mother waited too long. By the time she finally saw the doctor, she was diagnosed with stage four liver cancer. After emergency surgery, she got sicker and later died in the hospital. Because events moved so quickly, there was no time for Hernandez and his brother to talk with their mother and discuss hospice or alternatives to the aggressive medical interventions she received. "We're not rich white people," said Hernandez, "What time does she have when she has to work nine to six o'clock job? And even on weekends, she's working. Where do you find time to plan all of that out?"

Deportation threats may discourage end-of-life planning

In addition to poverty and lack of insurance, threats of deportation may cause undocumented immigrants to delay seeking medical help or plan for the end of life. Well-publicized cases of "hospital deportation" may further exacerbate fears among undocumented immigrants. "I'm concerned that the overall direction our country has taken, building the border wall, forced separation of families, will have serious consequences, in particular at the end of life," said Dr. Smith, "It takes very little to prevent accessing services until it's too late, until you're really suffering, until you're dying, until you're hospitalized in the intensive care unit."

Lack of health literacy as a barrier

In traditional Latino and Asian cultures, many families often treat illnesses using home remedies and for that reason, tend to delay seeing doctors and put off end-of-life planning. Many Chinese people will use traditional Chinese medicine first before seeing a doctor. Many Latinos and Asians also believe in fatalism—the idea that events such as serious illness or death are pre-determined by destiny—thus they tend to delay seeking treatment in the belief that medical intervention will not affect the outcome.

Misunderstandings around hospice

Hospice is a novel concept among many Asians and is often a misunderstood term among Latinos. Some Asians mistakenly believe that hospice is similar to nursing home care. Among Latinos, even medical professionals mistakenly translate "hospice" as "hospicio", which in Spanish, is a place for orphans, the destitute, or an asylum for the mentally ill. Compared to whites, fewer Latinos and Asians utilize hospice services and are more likely to die in the hospital.

Family members make end-of-life decisions for the patient

Family plays an important role in the end-of-life decision-making process in both Latino and Asian cultures. Personal autonomy is not highly valued among Chineseor Latinos--this runs counter to the individual-based paradigm prevalent in the American mainstream. Among Latino families, a male member, usually the oldest son or uncle, is responsible for making decisions on behalf of the dying family member. The expectation is that if the elected caregiver respects and loves the dying patient, they will insist the hospital "do everything" to keep the patient alive—this can mean another round of chemotherapy or multiple emergency room visits. The children of a Chinese parent will often advocate for aggressive, life-prolonging treatment out of a sense of filial duty.

Asian and Latino family members will often hide a poor prognosis from the dying relative. "Family may want to shield their loved one--'Don't tell mother that she has cancer. It's gonna make her depressed, she can't handle it psychologically'," said Dr. Smith, who has done extensive research on racial and ethnic disparities in end-of-life care. In Latin America, even physicians often do not disclose bad news or poor prognosis with their patients and are expected to keep up the patients' hope.

Failure to discuss end-of-life preferences can lead to poor outcomes

"In our own family, we don't talk about death definitively," said Julie Thai about her family in Vietnam, "We don't talk about it at all because we just love our family members so much that we talk about them as if they're still alive." Thai's parents emigrated to the United States after the Vietnam war, but they kept in close contact with the rest of the family that remained in Vietnam. Thai and her mother were close to Thai's 85-year old grandfather, who told them he wanted a natural death and did not want to be resuscitated. But his family in Vietnam did not have any conversations with him as he was nearing death. Thai's aunt and her cousin took charge of making decisions on his behalf. "I think everybody assumed they would be in charge of his care, that they would do what they felt was right for him," said Thai, "It was never talked about and that's why his needs were not met at the end of life."

When Thai's grandfather was taken to the hospital for the last time, her aunt asked the hospital to do everything to keep him alive. Hospital staff kept feeding him beef broth, even though he was a vegan. "He was very upset, he was crying, he was pulling the IVs out, he was spitting up the food," said Thai, "He just didn't want anything they were giving him." Despite the attempts to save his life, her grandfather went into cardiac arrest and he died twenty-four hours later. "He was caused more pain by them imposing these heroic measures on him, as opposed to just letting him go, which is what he would have wanted," said Thai.

Overcoming cultural barriers and taboos

Trained medical professionals and social workers can make a critical difference in reaching out to ethnic patients and their families and helping them prepare for the end of life. Professional translators are essential to assist medical staff and families and help them overcome language barriers and facilitate conversations with patients. "You should always have a professional interpreter for any serious conversation," said Dr. Alexander Smith, "You may think your Spanish is pretty good because you took it in college, but that does not rise to the level of professional translation." All too often, says Smith, so-called "ad-hoc interpreters" are used in place of professionals and this may lead to inaccurate translations. "For example, a family member may have their own agenda, trying to protect their loved one from a serious diagnosis, and they may not translate everything completely," said Smith, "Nurses, though they may speak the language, may not know how to translate the medical terminology into the other language."

Educational outreach and good communication also require special training in cultural humility—an awareness of the patient's values, beliefs, and traditions and a willingness to listen closely to the patient. Cultural humility can also mean becoming a student of the patient, forgoing the role of expert, and allowing him to become a full partner in his care. "You have to let the family lead," said hospice social worker Karen McCabe, "Instead of us taking the lead, 'oh, well we know all about this, we'll be right over, we'll tell you what to do.'"

McCabe works at Hospice of Santa Cruz County, which provides home hospice services to patients nearing the end of their lives. Santa Cruz County has a large number of farmworkers and one-third of the population is Latino. Twenty years ago, Latinos made up only three

percent of all hospice patients in Santa Cruz. Today, the number of Latinos in hospice has increased to eight percent, thanks to community outreach efforts by the Hospice of Santa Cruz.

McCabe says working with the family and overcoming their fear of hospice is key to providing the patient with good end-of-life care. For example, when explaining hospice, McCabe says she avoids confusing terminology like "hospicio" and instead tells families that hospice means getting all the care they want at home. "I explain that we're going to be bringing nurses into your home and we're going to be sending the medicines into your house and we need somebody in your family to be in charge of care and we're going to teach them what to do," he explains.

On Lok, the gold standard for end-of-life care

On Lok Senior Health Services was created in 1971 in San Francisco Chinatown by a group of Chinese elders who wanted an alternative to nursing homes. The founders believed that traditional models of care were not adequately meeting the needs of the elderly. Today, the majority of On Lok's seniors are low-income Chinese and Latinos living in three Bay Area counties.

On Lok provides low-income frail seniors with comprehensive services that allow them to stay at home. These services include home visits and clinical care, meal deliveries, transportation, and adult day care.

"Even though it's taboo, I usually say 'I'm your doctor and this is my job and I need to know what you want or what you don't want'," said Dr. Alana Shpal, a primary care physician at On Lok in San Francisco. "And I also bring up that if we don't discuss this now, it'll put their family in a harder place later on and that often helps because they see their family struggling to make a decision and they don't want to be a burden." She added, "I remind them that telling me is a gift they're giving their family members."

Shpal, who mostly works with Spanish speaking patients, says conversing with them can often be challenging, especially if cultural norms prohibit patient autonomy and discussing death. But thanks to the efforts of Shpal and other staff members, almost all of On Lok's participants have completed advance directives. "It's a crusade of mine, to have everyone document their end-of-life preferences," she says.

On Lok currently serves over 1,500 frail elders, and at the end of life, provides seniors with comfort care similar to hospice. On Lok's innovative program has now been replicated in thirty states.

Hope for the future

Julie Thai and her mother are still recovering from the shock of her grandfather's painful and protracted death. Thai is encouraging her parents to plan for the end of their lives and complete their advance directives, to avoid repeating the mistakes of her grandfather. She recently asked her mother about how she wants to die. "She's pretty comfortable talking about it," said Thai, "She says 'Just let me go.'"

Following the death of her grandfather, Thai graduated from medical school. She's now a doctor in Flint, Michigan, specializing in family medicine and geriatrics and is trained to help seniors plan for the end of their lives. By having open, honest conversations, Thai hopes to honor her patients' wishes. In particular, she wants to reach out to patients bound by culture who can't talk openly about death. Efforts like Thai's could have a big impact by reducing racial disparities in end-of-life care.

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Closing the Gap in Hospice Utilization for the Minority Medicare Population

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Abstract

Background: Medicare spends about 20% more on the last year of life for Black and Hispanic people than White people. With lower hospice utilization rates, racial/ethnic minorities receive fewer hospice-related benefits such as lesser symptoms, lower costs, and improved quality of life. For-profit hospices have higher dropout rates than nonprofit hospices, yet target racial/ethnic minority communities more through community outreach. This analysis examined the relationship between hospice utilization and for-profit hospice status and conducted an economic analysis of racial/ethnic minority utilization. **Method**: Cross-sectional analysis of 2014 Centers for Medicare & Medicaid Services (CMS), U.S. Census, and Hospice Analytics data. Measures included Medicare racial/ethnic minority hospice utilization, for-profit hospice status, estimated cost savings, and several demographic and socioeconomic variables. **Results**: The prevalence of for-profit hospices was associated with significantly increased hospice utilization among racial/ethnic minorities. With savings of about $2,105 per Medicare hospice enrollee, closing the gap between the White and racial/ethnic minority populations would result in nearly $270 million in annual cost savings. **Discussion**: Significant disparities in hospice use related to hospice for-profit status exist among the racial/ethnic minority Medicare population. CMS and state policymakers should consider lower racial/ethnic minority hospice utilization and foster better community outreach at all hospices to decrease patient costs and improve quality of life.

Keywords

hospice, Medicaid/Medicare, health care disparity, race/ethnicity

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Introduction

On average, one quarter of individual Medicare expenditures take place during the patient's last year of life (Riley & Lubitz, 2010), with end-of-life Medicare costs for Black people exceeding those for White people by 20% (Byhoff, Harris, Langa, & Iwashyna, 2016). Several studies have examined why such racial disparities in spending exist, pointing some of the causes to geographic, sociodemographic, and morbidity differences (Baicker, Chandra, Skinner, & Wennberg, 2004; Hanchate, Kronman, Young-Xu, Ash, & Emanuel, 2009; Kelley et al., 2011). Through patient interviews, Martin et al. (2011) found racial/ethnic minorities were more likely than White people to expend their financial resources to extend life. Medicare expenditure data showed Black and Hispanic people were significantly more likely than White people to be admitted to the intensive care unit. Black people were also more likely to receive more intensive procedures such as resuscitation and cardiac conversion, mechanical ventilation, and gastrostomy for artificial nutrition (Hanchate et al., 2009).

An alternative to pursuing costly, life-sustaining strategies for terminally ill patients is enrolling in hospice. Hospice care uses a team-oriented medical approach and emphasizes pain management and emotional support for the patient with a life expectancy of 6 months or less. Most hospice care takes place in the patient's home (56% of hospice care) or a nursing facility (42% of hospice care) (National Hospice and Palliative Care Organization, 2018) and provides support to the patient's family. Benefits from such care include lower costs, lesser symptoms, and a higher quality of life (Institute of Medicine, 1997; Kelley, Deb, Du, Aldridge Carlson, & Morrison, 2013; Steinhauser et al., 2000). Two surveys conducted by Gallup 4 years apart both showed 9 out of 10 terminally ill patients with less

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than 6 months to live would prefer to be cared for at home (Institute of Medicine, 1997). American Hospice Foundation (n.d., para. 2) cites two common reasons patients choose hospice care: (a) to stay at home and (b) avoid curative treatments that are painful or require hospitalization.

A recent analysis of Medicare's new payment structure that began in January 2016 showed hospice enrollment would still provide the potential for cost savings. Medicare's new payment structure, designed to align payments with service costs and ensure quality care in the last days of life, consists of a two-tiered per diem structure with payments increasing through Days 1 to 60 then decreasing for Days 61 and beyond. The last 7 days of life may have add-on payments retrospectively (Taylor et al., 2018).

Racial/ethnic minority hospice utilization has been found to be lower than that of the White population (Haines et al., 2018; Hardy et al., 2011; Ramey & Chin, 2012) when controlling for other socioeconomic factors such as income, area population, education, and age. Pan, Abraham, Giron, LeMarie, and Pollack (2015) showed Asian and Hispanic people were less familiar than White people with hospice services. In that study, most of the Asian and Hispanic respondents were open to receiving information about hospice in the future and reported they would tell friends and family members about hospice (Pan et al., 2015). One variable that relates to a greater number of racial/ethnic minorities receiving information about hospice is hospice ownership status. For-profit hospices tend to engage in greater community outreach to low-income and racial/ethnic minority communities than nonprofit hospices (Aldridge et al., 2014; Stevenson, Grabowski, Keating, & Huskamp, 2016). Stevenson et al. (2016) found this relationship persisted despite its chain status. With the growth in the proportion of hospices having for-profit ownership from 5% in 1990 to over 60% in 2014, it is important to compare measures such as utilization between hospices with different ownership status.

This study compares hospice utilization by racial/ethnic minorities between for-profit and nonprofit hospices, examining whether there is an association between the proportion of Medicare racial/ethnic minority patients enrolling in hospice per state and the proportion of for-profit hospices in that state. Also included are estimated projected cost savings if racial/ethnic minority Medicare hospice utilization levels were to increase to that of the White Medicare hospice utilization levels.

Method

Data Sources

The 2014 hospice utilization data were obtained from the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Data Warehouse (CCW; 2018), a database that has 100% of Medicare enrollment and fee-for-service claims data. CCW was launched to aid researchers in analyzing CMS data to help improve quality of care, decrease health care costs, and curb medical utilization for chronically ill Medicare beneficiaries. CCW contains 17 years' worth of data and includes enrollment/eligibility, assessment data, and fee-for-service institutional and noninstitutional claims. The U.S. Census Medicare beneficiary data (U.S. Census Bureau, 2015) are obtained from the March 2015 Current Population Survey Annual Social and Economic Supplement based on 2014 data.

Data for the percentage of individuals identifying as religious in 2014 were obtained from the Pew Research Center (Smith et al., 2015), whereas the measures for the 2014 per capita state income levels and 2010 education levels were accessed from the Bureau of Economic Analysis (2018) and the American Community Survey (U.S. Census Bureau, n.d.), respectively. Data on 2014 hospice by owner type and state-level racial/ethnicity measures were obtained from Hospice Analytics (2018) and the Kaiser Family Foundation (n.d.), respectively. The authors used Taylor et al.'s (2018) estimated cost savings per hospice enrollee based on the updated 2016 Medicare hospice payment structure. Taylor et al.'s study derived its findings from 2009 to 2010 Medicare claims data from North Carolina Medicare beneficiaries (N = 36,035).

Measures

The independent variable of for-profit hospice prevalence was calculated by the total amount of for-profit hospices per 10,000 Medicare beneficiaries for each state. The same calculation was used for nonprofit hospice prevalence for each state. Medicare beneficiaries include Medicare Advantage and fee-for-service beneficiaries. The percentage of individuals identifying as religious, the percentage of adults with at least a high school education, per capita income, and the percentage of racial/ethnic minorities within a state were included as covariates in the statistical model to control for state-level socioeconomic factors. The racial/ethnic minority hospice utilization disparity measure was calculated by dividing the percentage of racial/ethnic minorities using hospice by the percentage of racial/ethnic minorities enrolled in Medicare for each state. States were assigned a "1" if they possessed less of a disparity between racial/ethnic minority hospice Medicare patients and overall racial/ethnic minority Medicare enrollees compared with the median of all states (states with a value above 0.70) and a "0" otherwise.

For the projected cost savings from closing the gap between White and racial/ethnic minority Medicare hospice utilization, the breakdown by ethnicity followed the Kaiser Family Foundation Medicare beneficiary categories of Black, White, Hispanic, and Other. The Other category included Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and

Table 1. Descriptive Statistics of Independent Variables.

Variable	Definition	*M* (*SD*)
Prevalence of for-profit hospices	Ratio of for-profit hospices per 10,000 Medicare beneficiaries	0.59 (0.67)
Prevalence of nonprofit hospices	Ratio of nonprofit hospices per 10,000 Medicare beneficiaries	0.65 (0.63)
Per capita income	Average per capita income per state (in thousands)	$45.65 (7.72)
Percentage religious	Percentage state population stating they are religious	0.77 (0.06)
Percentage racial/ethnic minority	Percentage of state population identified as non-White	0.31 (0.16)
High school education or higher	Percentage with high school degree or higher	0.87 (0.03)

Note. Calculations were performed by state.

people of two or more races (Kaiser Family Foundation, 2017). To calculate the Medicare hospice participation rate by ethnicity, Medicare hospice beneficiaries within each racial group (CCW, 2018) were divided by the total number of Medicare beneficiaries within the same year (Kaiser Family Foundation, 2017). Then, the number of additional hospice enrollees necessary to match the higher White hospice utilization rate was calculated. Next, the projected mean cost savings of $2,105 per hospice enrollee (Taylor et al., 2018) was applied to estimate the potential cost savings from closing the racial/ethnic minority hospice utilization gap.

Analysis

Multivariate logistic regression was performed with the dependent variable being a dichotomous measure of whether or not a state had a relatively large racial/ethnic minority hospice usage gap. The independent variables of the study included the prevalence of for-profit and nonprofit hospices within a state as well as state-level socioeconomic measures of religiosity, racial/ethnic diversity, income, and education. All 50 U.S. states and Washington, D.C., were included in the analysis. StataSE version 15 (StataCorp LP, College Station, TX, USA) was utilized for statistical analyses.

Results

State Variable Summary Statistics

Table 1 displays the descriptive statistics of the study independent variables across the 50 states plus Washington, D.C. States tended to have more nonprofit hospices (0.65 per 10,000 state Medicare beneficiaries) versus for-profit hospices (0.59 per 10,000 state Medicare beneficiaries). In 2014, states on average had per capita incomes of $45,650 with 77% of the population stating they were religious, and 31% of the population representing non-White racial/ethnic categories as defined by the Kaiser Family Foundation (n.d.). In addition, 87% of the population earned a high school education or higher. The hospice utilization disparity was the dependent variable of focus. Nineteen states were assigned a "1" indicating that their minority hospice utilization disparity was below the national median.

Table 2. Multivariate Logistic Regression Results (*N* = 51).

	Coefficient	*SE*	*p*-value
Constant	−0.30	13.50	.98
Prevalence of for-profit hospices*	1.93	0.72	.01
Prevalence of nonprofit hospices	−0.69	0.77	.37
Per capita income	−0.03	0.06	.65
Percentage religious	−1.20	6.22	.85
Non-White population	2.78	2.63	.29
Education—high school graduate	0.27	15.55	.99

Note. Calculations were performed by state. χ^2 (6, *N* = 51) = 17.76, *p* = .007.
*Significant at the 5% level.

Statistical Results. Based on the logistic regression analysis displayed in Table 2, the prevalence of for-profit hospices was positively associated with racial/ethnic minority Medicare beneficiary hospice utilization, χ^2 (6, $N = 51$) = 17.76, $p = .007$. As the prevalence of for-profit hospices per Medicare beneficiary increases within a state, the probability increases that a state would have a lower than average hospice utilization gap between racial/ethnic minorities and the White population. No other coefficients were found to be significant.

The economic analysis found if racial/ethnic minority Medicare hospice utilization were to equal that of the current White Medicare hospice utilization, it would result in an estimated savings of nearly $270 million per year (Table 3).

Discussion

This study indicates a positive association exists between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices. An estimated nationally representative annual savings of nearly $270 million in projected annual savings would result from closing the Medicare hospice utilization gap between racial/ethnic minority and White Medicare beneficiaries.

The finding of the positive relationship between the prevalence of for-profit hospices and racial/ethnic minority Medicare utilization is not surprising given previous research showed for-profit hospices engage in greater community outreach to racial/ethnic minorities and low-income communities than nonprofit hospices

Table 3. Estimated Cost Savings From Closing Medicare Hospice Utilization Gap.

	White	Black	Hispanic	Other[a]	Total
Medicare beneficiaries[b]	38,505,300	5,160,600	4,137,400	2,742,900	50,546,200
Hospice beneficiaries[c]	1,112,625	107,461	68,776	43,499	1,332,361
Hospice beneficiaries/Medicare beneficiaries	2.89%	2.08%	1.66%	1.59%	2.64%
Racial/ethnic minority enrollment that closes disparity		41,656	50,776	35,758	
Estimated cost savings from closing disparity[d]		$87,686,851	$106,882,881	$75,270,839	$269,840,571

[a]Other includes Asians, Native Hawaiians and Pacific Islanders, American Indians, Aleutians, Eskimos, and people of two or more races.
[b]*Source*. Kaiser Family Foundation (2017).
[c]*Source*. Chronic Conditions Data Warehouse (CCW; 2018).
[d]*Source*. Utilizes Taylor et al.'s (2018) cost savings estimate of $2,105 per beneficiary.

(Aldridge et al., 2014; Stevenson et al., 2016). Prior research showed that both lower income and lower education were associated with lower rates of hospice care enrollment and at-home hospice death when holding other covariates constant (Barclay, Kuchibhatla, Tulsky, & Johnson, 2013; Jenkins et al., 2011; Silveira, Connor, Goold, McMahon, & Feudtner, 2011). The current study did not find significant relationships between state-level education and income measures and the minority hospice utilization gap. That said, the correlations in the individual-level studies between lower socioeconomic status and lower hospice utilization are not surprising given the significant role social determinants of health plays in end-of-life care decisions (Koroukian et al., 2017). A potential strategy for increasing hospice enrollment among groups across socioeconomic levels is to include offering short bouts of increased emotional and physical support for the patient and/or caregiver(s) during times of crisis in end-of-life care (Barclay et al., 2013). In addition, given informational materials hospices provide are not written at a level understood by most Americans (Kehl & McCarty, 2012), hospices should also focus on developing materials that comply with the Clear Communication initiative established by the National Institutes of Health. Clear Communication involves incorporating plain language and new technologies with accessible formats and content, all grounded in cultural respect (National Institutes of Health, n.d., para. 1).

Although policies targeting increased hospice enrollment levels for low-income populations with no specific focus on racial/ethnic minority populations would contribute to the economic savings discussed in this article, prior research has indicated that they would not eliminate the racial disparities within hospice enrollment. Brown et al. (2018) showed the effects of race/ethnicity on the intensity of end-of-life care are only partly mediated by other social determinants of health. Another study showed removing racial and ethnic disparities is complex and sometimes well-intended reform initiatives might inadvertently reinforce racial/ethnic disparities (Alegria, Alvarez, Ishikawa, DiMarzio, & McPeck, 2016). Strategies hospices could use for specifically addressing racial disparities in hospice utilization may include offering materials in languages spoken by the targeted racial/ethnic minorities (Kehl & McCarty, 2012; Young, 2014) and employing bilingual and bicultural clinicians or trained staff who act as interpreters and provide cultural context for the clients' beliefs and behaviors (Jackson & Gracia, 2014; Substance Abuse and Mental Health Services Administration, 2016).

This study estimated a projected savings of around $270 million annually from increasing the Medicare racial/ethnic minority hospice usage rate to that of the White population. Several studies have estimated the higher end-of-life expenditures among racial/ethnic minority groups (Baicker et al., 2004; Byhoff et al., 2016; Hanchate et al., 2009; Kelley et al., 2011) and savings from hospice utilization, in general (Kelley et al., 2013; Taylor et al., 2018; Taylor, Ostermann, Van Houtven, Tulsky, & Steinhauser, 2007). However, to the authors' knowledge, no other study has estimated the cost savings that could result from closing the hospice utilization gap. In addition to achieving cost savings, increasing Medicare racial/ethnic minority hospice use could potentially improve patient quality of care (Meier, 2011). As Livne (2014) states, "Limiting spending means helping people face their imminent death and avoiding prolonged aggressive treatment; in the context of hospice, it becomes a way of caring" (p. 906).

For terminally ill Medicare patients, hospice often provides a lower cost care option emphasizing quality of life that meets patients' preconceived wishes for end-of-life care (e.g., dying at home and being comfortable/without pain) (Kelley et al., 2013; Taylor et al., 2018; Teno et al., 2004; Wright et al., 2010; Zuckerman, Stearns, & Sheingold, 2016). Why racial/ethnic minority populations utilize this option less is subject to much discussion and debate (Elliott, Alexander, Mescher, Mohan, & Barnato, 2016; Pan et al., 2015). A systematic review of hospice use of Black people cited multiple factors contributing to relatively lower hospice utilization levels, including lack of hospice awareness, monetary concerns, mistrust of the health care system, a conflict in value with hospice care, and expected lack of racial/ethnic minority staff within hospice care (Washington, Bickel-Swenson, & Stephens, 2008). Alternately, Koss and Baker (2017) reported findings that question the common assertion that mistrust of the

health system by Black older adults contributes to lower rates of advance care planning (a practice associated with receiving hospice care earlier and longer) (Bischoff, Sudore, Miao, Boscardin, & Smith, 2013; Teno, Gruneir, Schwartz, Nanda, & Wetle, 2007). Adams, Horn, and Bader (2007) emphasized the lack of access to health services prior to hospice admission for the U.S. Hispanic population as a significant reason for lower hospice use by that group.

Simply closing the gap on hospice enrollment will not eliminate racial disparities observed within hospice care. Research finds once in hospice care, Black people experience higher levels of disenrollment, often to pursue costly, more invasive end-of-life treatment (Aldridge, Canavan, Cherlin, & Bradley, 2015; Johnson, Kuchibhatla, & Tulsky, 2008). Research in this area is ongoing with one study finding, on average, Black and Hispanic people tended to enroll in hospices that provided a lower quality of care. However, within a particular hospice, Black and Hispanic people receive care that is similar to that of White people (Price, Parast, Haas, Teno, & Elliott, 2017). In contrast, another study found disparities existed between the quality of care for Black and White people within the same hospice setting (Rizzuto & Aldridge, 2018). Barclay et al. (2013) found Black people enrolled in hospice were also less likely to die at home compared with White people even when accounting for other socioeconomic factors such as income, location, and education. The explanation for the lower rate of at-home deaths for Black hospice patients is inconclusive, with some studies suggesting potential differences in culture, caretaker support, and hospice care communication may be contributors (Barclay et al., 2013).

This article discusses potential advantages (e.g., quality of life, lesser symptoms, and cost savings) from closing the current gap between racial/ethnic minority and White Medicare hospice utilization (Institute of Medicine, 1997; Kelley et al., 2013; Steinhauser et al., 2000). Recent research based on national survey data shows the disparities in health care access between Black and Hispanic people and White people have significantly narrowed from 2013 to 2015 after the passage of the Affordable Care Act (ACA). In addition to reducing racial and ethnic disparities, the ACA was associated with increased access for all three groups examined—Black, Hispanic, and White people, partly through Medicaid expansion (Hayes, Riley, Radley, & McCarthy, 2017). The racial and ethnic disparity within hospice is slightly different given that all citizens over 65 years of age, at least in theory, have access to hospice via their automatic Medicare enrollment. The disparities seen in hospice go beyond insurance accessibility or income (Harris et al., 2017; Ornstein et al., 2016). The hospice community outreach efforts discussed above (e.g., access improvements, materials at a lower reading level) would likely improve participation among people of all racial and ethnic backgrounds, including White people. Such increased enrollment across all racial and ethnic Medicare groups has the potential for even greater improvements in health and cost outcomes than addressed in this analysis.

This research has some limitations. First, due to a lack of variation estimates in the existing literature, it was assumed a similar proportion of Medicare beneficiaries would be eligible for hospice care across all racial groups. There is also the possibility the racial/ethnic minority Medicare beneficiaries, who would comprise the additional hospice enrollees, would have a different average length of stay, disease prevalence estimates, and disenrollment rates. The authors chose not to project these statistics because of the uncertainty as to the types of patients (e.g., diagnoses) greater hospice community outreach to racial/ethnic minorities would most attract. Second, this research is limited to state-level data. Future research is recommended examining the relationship between racial/ethnic minority Medicare hospice utilization and the prevalence of for-profit hospices that include additional variables of hospice utilizers such as metropolitan status (e.g., rural vs. urban), gender, and income.

Another limitation is for-profit hospices have been shown to have higher levels of dementia patients compared with nonprofit hospices (Wachterman, Marcantonio, Davis, & McCarthy, 2011). Studies suggest dementia hospice patients have higher costs compared with nonhospice counterparts on account of relatively longer hospice stays and fewer invasive end-of-life treatments for this type of disease regardless of a patient's hospice status (Taylor et al., 2018; Zuckerman et al., 2016). Another risk is enrolling patients in hospice too early, increasing chances of live discharge which research has shown is positively associated with both hospice profit margins and the proportion of patients from racial/ethnic minority groups (Dolin et al., 2017; Stevenson et al., 2016). If for-profit hospices improve racial/ethnic minority hospice enrollment by focusing solely on dementia patients and/or engage in too early enrollment practices—both of which are practices more associated with for-profit hospices than nonprofit hospices (Dolin et al., 2017; Stevenson et al., 2016)—and nonprofit hospices do not improve their racial/ethnic minority recruiting efforts across all primary diagnosis levels, the estimated cost savings discussed in this article could be overstated. Policymakers should be aware of this potential issue and ensure racial/ethnic minority hospice recruitment programs encourage hospice use across all eligible diseases. In addition, mechanisms should be in place to monitor both for-profit and nonprofit hospices to ensure quality of care remains paramount in decisions about recruiting and care.

Conclusion

With average per capita end-of-life medical spending in the last year of life at $80,000 in the United

States—comprising a larger fraction of its gross domestic product than that for all eight other countries examined in a 2017 study (French et al., 2017), implementing strategies to increase the inclusiveness of all racial/ethnic groups to hospice may be one way Medicare can simultaneously lessen its financial burden and improve the quality of life for its beneficiaries. This research finds a positive association between the prevalence of for-profit hospices and racial/ethnic minority Medicare hospice utilization, highlighting a potential business ownership model to further examine when developing strategies for racial/ethnic minority Medicare enrollees' inclusion in hospice care. With the potential to provide nearly $270 million in annual cost savings while also improving health outcomes, further research on specific programs that successfully reduce the racial/ethnic minority hospice enrollment gap is paramount. In addition, collaboration between hospices, health systems, and community organizations is needed to reduce the disparities between racial/ethnic minority and White Medicare beneficiary hospice utilization.

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EXHIBIT 14

Claritas Population Estimates for Washington by County, 2022-2027

Geography Code (Concatenated Geography Code)	FIPS State Code	FIPS County Code	Core Based Statistical Area Code	State Name	County Name	**2022 Total Population**	2022 Population, Age 18+	2022 Population, Age 21+	2022 Population, Age 65+
53001	53	001	36830	Washington	Adams County	**20,498**	13,316	12,374	2,469
53003	53	003	30300	Washington	Asotin County	**23,033**	18,484	17,766	5,782
53005	53	005	28420	Washington	Benton County	**211,545**	156,334	148,011	34,454
53007	53	007	48300	Washington	Chelan County	**79,515**	61,241	58,394	16,498
53009	53	009	38820	Washington	Clallam County	**79,088**	65,934	63,819	25,124
53011	53	011	38900	Washington	Clark County	**510,999**	394,101	375,238	87,285
53013	53	013	99953	Washington	Columbia County	**4,131**	3,394	3,276	1,228
53015	53	015	31020	Washington	Cowlitz County	**113,378**	87,847	83,913	23,206
53017	53	017	48300	Washington	Douglas County	**44,623**	33,324	31,586	8,482
53019	53	019	99953	Washington	Ferry County	**7,909**	6,576	6,320	2,337
53021	53	021	28420	Washington	Franklin County	**99,896**	68,885	64,532	10,346
53023	53	023	99953	Washington	Garfield County	**2,293**	1,803	1,737	609
53025	53	025	34180	Washington	Grant County	**101,833**	72,381	67,965	15,046
53027	53	027	10140	Washington	Grays Harbor County	**76,864**	61,425	59,004	18,039
53029	53	029	36020	Washington	Island County	**87,561**	71,348	68,645	23,055
53031	53	031	99953	Washington	Jefferson County	**33,203**	29,351	28,691	13,142
53033	53	033	42660	Washington	King County	**2,325,075**	1,859,870	1,780,050	337,458
53035	53	035	14740	Washington	Kitsap County	**277,195**	221,139	211,122	54,315
53037	53	037	21260	Washington	Kittitas County	**50,452**	41,842	37,716	9,072
53039	53	039	99953	Washington	Klickitat County	**23,234**	18,861	18,178	5,993
53041	53	041	16500	Washington	Lewis County	**83,281**	65,562	62,823	18,683
53043	53	043	99953	Washington	Lincoln County	**11,295**	8,908	8,527	3,045
53045	53	045	43220	Washington	Mason County	**69,155**	55,749	53,634	16,896
53047	53	047	99953	Washington	Okanogan County	**43,347**	33,322	31,866	10,036
53049	53	049	99953	Washington	Pacific County	**23,140**	19,625	19,051	7,769
53051	53	051	99953	Washington	Pend Oreille County	**14,383**	11,701	11,257	4,046
53053	53	053	42660	Washington	Pierce County	**930,715**	714,591	679,624	141,924
53055	53	055	99953	Washington	San Juan County	**17,833**	15,660	15,250	6,554
53057	53	057	34580	Washington	Skagit County	**133,619**	104,993	100,506	30,206
53059	53	059	38900	Washington	Skamania County	**12,363**	10,171	9,802	2,911
53061	53	061	42660	Washington	Snohomish County	**850,697**	661,226	632,637	130,049
53063	53	063	44060	Washington	Spokane County	**538,406**	420,964	398,922	95,396
53065	53	065	44060	Washington	Stevens County	**47,040**	37,329	35,782	11,782
53067	53	067	36500	Washington	Thurston County	**300,863**	237,479	227,029	57,249
53069	53	069	99953	Washington	Wahkiakum County	**4,514**	3,772	3,637	1,537
53071	53	071	47460	Washington	Walla Walla County	**62,480**	49,610	46,199	12,350
53073	53	073	13380	Washington	Whatcom County	**235,667**	190,333	178,692	44,982
53075	53	075	39420	Washington	Whitman County	**50,513**	42,756	35,017	5,741
53077	53	077	49420	Washington	Yakima County	**256,765**	182,115	171,015	37,478
				Washington	Total	**7,858,401**	6,153,322	5,859,607	1,332,574

County Name	2027 Population, Age 18+	2027 Population, Age 65+	2022 Population, Hispanic/Latino, White Alone	2022 Population, Hispanic/Latino, Black/African American Alone	2022 Population, Hispanic/Latino, American Indian/Alaskan Native Alone	2022 Population, Hispanic/Latino, Asian Alone	2022 Population, Hispanic/Latino, Native Hawaiian/Pacific Islander Alone
Adams County	14,226	2,819	5,503	76	347	32	2
Asotin County	19,386	6,597	644	5	53	5	0
Benton County	168,543	40,455	21,756	295	457	108	50
Chelan County	64,652	19,122	7,833	74	232	22	13
Clallam County	69,505	28,561	2,637	59	474	22	13
Clark County	425,654	105,084	27,590	708	1,156	403	211
Columbia County	3,495	1,364	197	0	16	0	0
Cowlitz County	92,756	27,071	4,598	99	297	40	32
Douglas County	35,736	9,750	6,168	59	154	19	1
Ferry County	6,831	2,638	159	13	72	0	0
Franklin County	75,254	12,367	18,473	184	239	68	21
Garfield County	1,823	670	36	0	2	1	0
Grant County	77,229	17,214	18,086	366	404	35	22
Grays Harbor County	64,160	20,567	3,430	55	432	49	7
Island County	74,421	26,334	4,469	140	180	117	37
Jefferson County	31,011	14,977	850	14	87	7	2
King County	1,990,223	409,553	104,210	4,857	4,496	2,860	584
Kitsap County	232,375	63,980	13,696	510	819	499	211
Kittitas County	44,927	11,021	2,061	39	64	23	2
Klickitat County	20,081	6,960	1,051	11	61	6	3
Lewis County	68,915	21,576	4,071	50	174	31	20
Lincoln County	9,368	3,434	285	6	21	0	0
Mason County	59,000	19,514	3,195	82	620	64	21
Okanogan County	34,797	11,390	3,035	37	374	18	5
Pacific County	20,649	8,839	887	18	85	5	1
Pend Oreille County	12,395	4,630	382	3	36	0	0
Pierce County	760,874	170,435	48,241	4,002	2,712	1,533	599
San Juan County	16,708	7,545	563	7	41	3	2
Skagit County	111,390	35,102	10,204	177	629	73	60
Skamania County	10,853	3,426	582	3	39	0	0
Snohomish County	706,953	162,247	43,554	1,296	2,002	932	198
Spokane County	446,966	113,070	19,742	580	1,384	268	144
Stevens County	39,436	13,504	1,130	0	236	5	10
Thurston County	254,325	67,965	15,261	574	874	375	159
Wahkiakum County	4,048	1,762	169	5	11	2	0
Walla Walla County	52,143	14,145	7,355	91	184	30	10
Whatcom County	203,436	52,769	11,289	221	969	161	52
Whitman County	45,391	6,724	1,977	48	64	42	7
Yakima County	190,964	41,529	47,836	707	1,833	247	76
Total	6,560,899	1,586,710	463,205	15,471	22,330	8,105	2,575

County Name	2022 Population, Hispanic/Latino, Some Other Race Alone	2022 Population, Hispanic/Latino, Two or More Races	**Total 2022 Hispanic**	2022 Population, Not Hispanic/Latino, White Alone	2022 Population, Not Hispanic/Latino, Black/African American Alone	2022 Population, Not Hispanic/Latino, American Indian/Alaskan Native Alone	2022 Population, Not Hispanic/Latino, Asian Alone
Adams County	7,286	505	**13,751**	6,119	147	99	157
Asotin County	266	158	**1,131**	20,434	175	340	238
Benton County	24,180	4,033	**50,879**	142,692	3,248	1,389	6,755
Chelan County	14,064	1,094	**23,332**	52,569	467	605	838
Clallam County	1,801	648	**5,654**	64,403	766	3,580	1,524
Clark County	20,945	5,860	**56,873**	387,902	11,087	3,768	25,710
Columbia County	86	54	**353**	3,402	29	52	62
Cowlitz County	4,977	1,261	**11,304**	93,163	1,138	1,649	1,687
Douglas County	8,119	565	**15,085**	27,446	233	394	399
Ferry County	134	42	**420**	5,713	64	1,203	84
Franklin County	34,000	1,893	**54,878**	38,057	2,160	509	2,161
Garfield County	75	28	**142**	1,987	0	14	82
Grant County	23,599	2,132	**44,644**	52,402	953	865	942
Grays Harbor County	3,703	783	**8,459**	59,933	985	3,302	1,011
Island County	1,993	1,055	**7,991**	67,368	2,743	668	4,372
Jefferson County	229	206	**1,395**	29,030	359	576	668
King County	99,825	24,144	**240,976**	1,299,373	157,268	13,069	478,346
Kitsap County	5,553	3,624	**24,912**	207,034	8,260	3,732	14,427
Kittitas County	2,244	404	**4,837**	41,723	546	532	1,082
Klickitat County	1,483	230	**2,845**	18,942	137	461	213
Lewis County	4,277	764	**9,387**	67,981	691	1,188	1,101
Lincoln County	85	66	**463**	10,147	74	204	63
Mason County	3,254	772	**8,008**	54,287	955	2,061	787
Okanogan County	5,422	617	**9,508**	27,197	332	4,540	506
Pacific County	1,379	158	**2,533**	18,642	215	482	451
Pend Oreille County	111	116	**648**	12,573	99	459	196
Pierce County	41,331	15,387	**113,805**	596,094	66,728	10,741	64,368
San Juan County	575	116	**1,307**	15,516	126	147	252
Skagit County	13,106	1,688	**25,937**	97,343	1,197	2,090	2,995
Skamania County	234	71	**929**	10,628	73	193	135
Snohomish County	38,638	9,221	**95,841**	561,845	31,916	8,751	106,357
Spokane County	8,934	4,988	**36,040**	446,462	10,234	7,761	12,889
Stevens County	368	273	**2,022**	40,241	267	2,413	395
Thurston County	9,034	4,442	**30,719**	217,801	10,208	4,026	18,876
Wahkiakum County	62	54	**303**	3,815	28	62	93
Walla Walla County	5,638	786	**14,094**	43,769	1,228	513	1,052
Whatcom County	9,820	2,395	**24,907**	181,237	2,510	5,987	11,429
Whitman County	1,085	423	**3,646**	38,955	1,198	323	4,222
Yakima County	77,312	6,151	**134,162**	102,913	2,184	9,172	3,133
Total	475,227	97,207	**1,084,120**	5,167,138	321,028	97,920	770,058

County Name	2022 Population, Not Hispanic/Latino, Native Hawaiian/Pacific Islander Alone	2022 Population, Not Hispanic/Latino, Some Other Race Alone	2022 Population, Not Hispanic/Latino, Two or More Races	**2022 Total Non-Hispanic**	2027 Population, Hispanic/Latino, White Alone	2027 Population, Hispanic/Latino, Black/African American Alone	2027 Population, Hispanic/Latino, American Indian/Alaskan Native Alone
Adams County	14	16	195	**6,747**	6,051	84	382
Asotin County	61	12	642	**21,902**	784	7	64
Benton County	393	294	5,895	**160,666**	25,424	346	534
Chelan County	133	80	1,491	**56,183**	8,632	81	256
Clallam County	118	124	2,919	**73,434**	3,112	70	559
Clark County	4,545	738	20,376	**454,126**	33,424	859	1,401
Columbia County	102	9	122	**3,778**	226	0	18
Cowlitz County	464	69	3,904	**102,074**	5,280	114	340
Douglas County	89	56	921	**29,538**	6,965	67	174
Ferry County	30	8	387	**7,489**	191	16	87
Franklin County	173	114	1,844	**45,018**	20,411	203	264
Garfield County	0	4	64	**2,151**	42	0	2
Grant County	103	99	1,825	**57,189**	20,146	407	450
Grays Harbor County	242	74	2,858	**68,405**	3,892	62	490
Island County	354	118	3,947	**79,570**	5,505	172	222
Jefferson County	79	66	1,030	**31,808**	1,018	18	104
King County	18,540	5,555	111,948	**2,084,099**	117,698	5,487	5,078
Kitsap County	2,488	453	15,889	**252,283**	16,246	604	972
Kittitas County	105	62	1,565	**45,615**	2,397	45	74
Klickitat County	33	16	587	**20,389**	1,172	11	69
Lewis County	184	78	2,671	**73,894**	4,698	58	200
Lincoln County	17	5	322	**10,832**	353	7	27
Mason County	270	88	2,699	**61,147**	3,822	99	742
Okanogan County	67	42	1,155	**33,839**	3,417	42	421
Pacific County	34	14	769	**20,607**	1,037	21	99
Pend Oreille County	19	26	363	**13,735**	456	4	44
Pierce County	15,820	1,600	61,559	**816,910**	56,693	4,703	3,187
San Juan County	26	39	420	**16,526**	660	8	48
Skagit County	419	176	3,462	**107,682**	11,394	197	702
Skamania County	34	8	363	**11,434**	702	4	46
Snohomish County	5,844	1,419	38,724	**754,856**	50,345	1,499	2,314
Spokane County	3,409	681	20,930	**502,366**	23,771	698	1,667
Stevens County	82	77	1,543	**45,018**	1,365	0	285
Thurston County	2,795	481	15,957	**270,144**	18,394	691	1,053
Wahkiakum County	11	5	197	**4,211**	224	7	15
Walla Walla County	209	55	1,560	**48,386**	8,062	100	201
Whatcom County	596	415	8,586	**210,760**	13,309	261	1,143
Whitman County	120	46	2,003	**46,867**	2,411	59	78
Yakima County	231	303	4,667	**122,603**	52,614	778	2,017
Total	58,253	13,525	346,359	**6,774,281**	532,343	17,889	25,829

County Name	2027 Population, Hispanic/Latino, Asian Alone	2027 Population, Hispanic/Latino, Native Hawaiian/Pacific Islander Alone	2027 Population, Hispanic/Latino, Some Other Race Alone	2027 Population, Hispanic/Latino, Two or More Races	**2027 Total Hispanic**	2027 Population, Not Hispanic/Latino, White Alone	2027 Population, Not Hispanic/Latino, Black/African American Alone
Adams County	35	2	8,014	556	**15,124**	5,596	197
Asotin County	6	0	324	193	**1,378**	20,879	217
Benton County	128	58	28,256	4,712	**59,458**	145,507	3,825
Chelan County	24	15	15,499	1,207	**25,714**	53,503	611
Clallam County	26	15	2,124	765	**6,671**	66,553	872
Clark County	488	255	25,374	7,099	**68,900**	399,967	12,475
Columbia County	0	0	98	62	**404**	3,365	38
Cowlitz County	46	37	5,715	1,449	**12,981**	96,057	1,422
Douglas County	22	2	9,168	639	**17,037**	27,830	308
Ferry County	0	0	161	49	**504**	5,825	85
Franklin County	76	23	37,567	2,092	**60,636**	38,511	2,524
Garfield County	2	0	88	33	**167**	1,977	0
Grant County	39	25	26,288	2,374	**49,729**	52,733	1,071
Grays Harbor County	57	7	4,202	889	**9,599**	61,074	1,103
Island County	145	46	2,454	1,299	**9,843**	68,488	3,295
Jefferson County	7	2	273	246	**1,668**	30,243	420
King County	3,231	660	112,747	27,268	**272,169**	1,291,737	175,534
Kitsap County	591	251	6,585	4,299	**29,548**	211,851	9,242
Kittitas County	27	1	2,609	470	**5,623**	43,857	641
Klickitat County	7	3	1,655	256	**3,173**	19,798	184
Lewis County	35	24	4,935	881	**10,831**	69,753	852
Lincoln County	0	0	105	82	**574**	10,383	98
Mason County	77	26	3,894	924	**9,584**	55,985	1,126
Okanogan County	21	6	6,104	694	**10,705**	27,168	431
Pacific County	6	2	1,614	185	**2,964**	19,164	288
Pend Oreille County	0	0	133	139	**776**	13,053	124
Pierce County	1,800	703	48,574	18,084	**133,744**	606,621	73,807
San Juan County	4	1	674	136	**1,531**	16,115	165
Skagit County	81	68	14,634	1,885	**28,961**	100,604	1,475
Skamania County	0	0	281	84	**1,117**	10,986	89
Snohomish County	1,077	229	44,660	10,659	**110,783**	566,657	39,105
Spokane County	322	173	10,757	6,005	**43,393**	462,882	11,460
Stevens County	6	13	445	329	**2,443**	41,552	327
Thurston County	452	192	10,888	5,353	**37,023**	223,089	12,027
Wahkiakum County	4	0	82	71	**403**	3,867	39
Walla Walla County	34	11	6,180	861	**15,449**	44,403	1,350
Whatcom County	190	62	11,578	2,824	**29,367**	187,193	2,853
Whitman County	50	9	1,323	517	**4,447**	39,957	1,437
Yakima County	271	83	85,034	6,765	**147,562**	98,241	2,420
Total	9,387	3,004	541,096	112,435	**1,241,983**	5,243,024	363,537

County Name	2027 Population, Not Hispanic/Latino, American Indian/Alaskan Native Alone	2027 Population, Not Hispanic/Latino, Asian Alone	2027 Population, Not Hispanic/Latino, Native Hawaiian/Pacific Islander Alone	2027 Population, Not Hispanic/Latino, Some Other Race Alone	2027 Population, Not Hispanic/Latino, Two or More Races	**2027 Total Non-Hispanic**
Adams County	112	186	18	15	231	**6,355**
Asotin County	375	298	73	13	749	**22,604**
Benton County	1,411	7,740	478	303	6,975	**166,239**
Chelan County	652	974	154	82	1,684	**57,660**
Clallam County	3,716	1,791	136	128	3,232	**76,428**
Clark County	4,109	29,657	5,497	773	23,388	**475,866**
Columbia County	55	80	144	9	147	**3,838**
Cowlitz County	1,797	1,797	592	72	4,396	**106,133**
Douglas County	441	462	107	57	1,078	**30,283**
Ferry County	1,216	99	42	8	417	**7,692**
Franklin County	570	2,501	211	117	2,187	**46,621**
Garfield County	19	104	0	5	81	**2,186**
Grant County	903	1,017	127	100	1,996	**57,947**
Grays Harbor County	3,486	1,034	275	76	3,190	**70,238**
Island County	721	4,873	346	122	4,451	**82,296**
Jefferson County	551	772	89	70	1,098	**33,243**
King County	12,805	574,208	20,501	5,884	126,738	**2,207,407**
Kitsap County	3,848	15,633	2,651	470	17,781	**261,476**
Kittitas County	613	1,205	130	66	1,833	**48,345**
Klickitat County	471	258	40	17	631	**21,399**
Lewis County	1,309	1,330	224	81	3,058	**76,607**
Lincoln County	225	74	23	5	383	**11,191**
Mason County	2,149	830	297	92	3,018	**63,497**
Okanogan County	4,673	645	88	43	1,249	**34,297**
Pacific County	511	466	43	15	855	**21,342**
Pend Oreille County	457	258	21	27	392	**14,332**
Pierce County	11,424	72,834	18,551	1,673	69,649	**854,559**
San Juan County	178	288	32	41	469	**17,288**
Skagit County	2,102	3,472	540	183	3,956	**112,332**
Skamania County	215	154	46	8	401	**11,899**
Snohomish County	8,718	127,553	7,250	1,495	44,448	**795,226**
Spokane County	8,367	14,390	4,204	713	23,881	**525,897**
Stevens County	2,501	476	91	81	1,676	**46,704**
Thurston County	4,486	21,726	3,234	504	18,323	**283,389**
Wahkiakum County	69	128	13	4	243	**4,363**
Walla Walla County	548	1,215	235	57	1,758	**49,566**
Whatcom County	6,379	13,603	659	435	9,801	**220,923**
Whitman County	348	4,602	131	48	2,305	**48,828**
Yakima County	9,347	3,539	275	295	5,002	**119,119**
Total	101,877	912,272	67,568	14,187	393,150	**7,095,615**

EXHIBIT 15

Letter of Intent for Seasons Hospice & Palliative Care of Pierce County Washington, LLC

accentCare.

Reimagining care, together.

www.accentcare.com

December 14, 2022

Eric Hernandez, Program Manager
Certificate of Need Program
Office of Community Health Systems
Washington Department of Health
111 Israel Road, S.E.
Tumwater, WA 98501

Via Email: ERIC.HERNANDEZ@DOH.WA.GOV
FSLCON@DOH.WA.GOV

RE: Letter of Intent

Dear Mr. Hernandez,

Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Seasons Pierce County") hereby submits this letter of intent to apply for a certificate of need to establish a hospice agency. The applicant is an affiliate of AccentCare, Inc. In accordance with WAC 246-310-080, please find the following information:

1. Description of Services Provided. Seasons proposes to establish a Medicare and Medicaid certified hospice agency.

2. Estimated Cost of the Proposed Project. The estimated cost of the proposed hospice agency is $120,000.00.

3. Identification of Service Area. The service area of the hospice agency will be Pierce County, Washington.

Thank you for your support. We look forward to one day serving hospice patients in Pierce County, Washington. Please feel free to contact me with any questions or concerns.

Sincerely,

DocuSigned by:
Russell Hilliard
97DFC127E73B4CF...

Russell Hilliard, PhD, LCSW, LCAT, MT-BC, CHRC, CHC
Senior Vice President of Market Expansion Initiatives
RUSSELLHILLIARD@ACCENTCARE.COM

EXHIBIT 16
Proxy Data Used in Projections

Projections of the Population Age 65 and Over for Growth Management
2017 GMA Projections - Medium Series

	Census		Estimate		Projection												
	2010		2015		2020		2025		2030		2035		2040				
	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	Count	Percentage	CAGR	2026	2027
Washington	827,677	12.31	1,027,652	14 55	1,279,195	16.75	1,534,834	18 98	1,751,105	20 59	1,896,603	21.32	1,997,565	21 61	2.67%	1,575,838	1,617,937
Adams	1,915	10.23	1,773	9.13	2,341	11.35	2,549	11.76	2,722	11 92	2,905	11.98	3,058	12 20	1.32%	2,583	2,617
Asotin	4,172	19.29	5,041	22 90	6,005	26.50	6,853	29 51	7,461	31 64	7,582	31.82	7,503	31 35	1.71%	6,971	7,090
Benton	20,586	11.75	26,328	13 96	32,150	15.95	38,267	17.74	43,366	19 01	46,393	19.33	48,431	19 33	2.53%	39,236	40,230
Chelan	11,175	15.42	13,746	18 32	16,408	20.80	19,626	23 84	21,987	25.76	23,143	26.29	23,614	26 09	2.30%	20,077	20,538
Clallam	17,189	24.07	19,934	27.44	22,267	29.81	25,436	33.10	27,162	34 52	27,262	34.03	26,697	32 99	1.32%	25,772	26,113
Clark	48,710	11.45	64,524	14 28	82,125	16.44	99,929	18.49	116,677	20 23	130,324	21.30	142,656	22.17	3.15%	103,074	106,319
Columbia	937	22.98	1,102	26 94	1,269	31.34	1,357	34 25	1,448	37 00	1,402	36.22	1,308	34 34	1.31%	1,375	1,393
Cowlitz	15,805	15.43	18,863	18 09	22,969	21.09	26,721	23 80	29,129	25.42	30,139	25.87	30,501	25 92	1.74%	27,186	27,659
Douglas	5,443	14.16	6,450	16.13	8,358	19.05	9,899	21.15	11,142	22 57	11,902	22.99	12,588	23.12	2.39%	10,136	10,379
Ferry	1,428	18.91	1,876	24 33	2,241	28.66	2,482	31.49	2,578	32.42	2,503	31.39	2,312	29.18	0.76%	2,501	2,520
Franklin	5,696	7.29	7,499	8 60	9,610	9.64	11,977	10 53	14,287	11 21	16,844	11.77	19,981	12 60	3.59%	12,407	12,852
Garfield	506	22.33	595	26 33	658	29.67	714	32.78	767	35 53	716	33.82	668	32.44	1.44%	724	735
Grant	10,531	11.82	12,395	13 20	15,477	15.08	18,446	16 62	21,023	17.72	23,033	18.27	25,029	18 82	2.65%	18,935	19,437
Grays Harbor	11,849	16.28	14,005	19.16	16,653	22.62	19,051	25 53	20,522	27 08	20,670	27.24	20,370	26 95	1.50%	19,337	19,626
Island	14,439	18.39	18,086	22.44	20,777	24.72	23,952	27.44	26,210	29.17	27,021	29.33	26,470	28 02	1.82%	24,387	24,831
Jefferson	7,842	26.25	10,244	33.17	11,924	36.53	13,919	40 69	15,114	41 69	15,449	40.01	14,978	37 55	1.66%	14,150	14,385
King	210,679	10.91	254,219	12 38	324,660	14.55	390,213	16 57	447,783	18 09	492,243	19.01	525,440	19 53	2.79%	401,102	412,295
Kitsap	33,296	13.26	45,652	17 68	55,878	20.25	67,414	23 22	76,539	25 22	80,827	25.79	81,866	25 36	2.57%	69,148	70,926
Kittitas	5,212	12.74	6,464	15.15	7,943	16.92	9,557	19.14	10,651	20 29	11,171	20.34	11,465	20.10	2.19%	9,766	9,980
Klickitat	3,625	17.84	4,792	22 82	6,088	28.10	6,987	31 93	7,485	33.73	7,558	34.13	7,451	33 98	1.39%	7,084	7,182
Lewis	13,076	17.33	15,166	19.78	17,219	21.46	19,608	23 50	21,161	24.77	21,505	24.59	21,363	23 96	1.54%	19,909	20,215
Lincoln	2,197	20.79	2,619	24.43	2,959	27.49	3,360	30 83	3,460	31 67	3,367	30.86	3,170	29 22	0.59%	3,380	3,400
Mason	11,112	18.31	13,528	21.75	16,499	24.40	19,841	27.43	22,332	29.18	23,407	28.90	23,914	28.14	2.39%	20,316	20,802
Okanogan	7,070	17.19	8,773	20 96	10,901	25.30	12,445	28.19	13,131	29 30	13,038	28.76	12,692	27 82	1.08%	12,579	12,715
Pacific	5,183	24.78	6,095	28.74	6,910	32.42	7,533	34 98	7,733	35 69	7,543	34.67	7,090	32.44	0.53%	7,573	7,612
Pend Oreille	2,485	19.11	3,195	24.13	4,107	29.51	4,768	33.19	5,115	35 29	5,055	34.49	4,817	32 92	1.41%	4,835	4,904
Pierce	87,785	11.04	108,983	13.13	136,114	15.10	167,652	17 52	195,143	19.47	215,302	20.57	229,186	21.10	3.08%	172,821	178,150
San Juan	3,657	23.19	4,875	30.13	5,991	35.78	6,907	39 37	7,399	40 67	7,422	39.50	7,220	37 68	1.39%	7,003	7,100
Skagit	18,876	16.15	22,735	18 85	29,168	22.32	34,899	25 26	39,609	26 97	42,566	27.41	44,569	27 05	2.56%	35,794	36,712
Skamania	1,596	14.42	2,158	18 88	2,798	23.24	3,422	27 22	3,915	30.10	4,070	30.40	4,103	29 94	2.73%	3,515	3,611
Snohomish	73,544	10.31	95,788	12 64	125,219	14.87	159,013	17 68	191,668	20 05	216,909	21.48	235,698	22 28	3.81%	165,065	171,348
Spokane	60,969	12.94	73,817	15.12	91,361	17.68	107,906	19 99	121,926	21 60	129,007	22.13	133,078	22 23	2.47%	110,575	113,309
Stevens	7,516	17.27	9,454	21.47	11,837	25.83	13,723	28 99	14,492	29 92	14,480	29.32	14,185	27.79	1.10%	13,873	14,026
Thurston	32,764	12.99	42,459	15 88	52,832	17.95	63,170	19 96	71,511	21 29	77,380	21.83	82,039	22.13	2.51%	64,756	66,383
Wahkiakum	1,015	25.52	1,254	31 51	1,565	39.07	1,641	42 08	1,659	43 52	1,609	42.98	1,487	40 06	0.22%	1,645	1,648
Walla Walla	8,778	14.93	10,757	17.74	11,068	17.84	12,479	19 59	13,301	20.45	13,523	20.32	13,506	20 02	1.28%	12,639	12,802
Whatcom	26,640	13.24	33,950	16.18	42,640	18.50	50,526	20 57	57,443	21 93	61,903	22.48	64,981	22 61	2.60%	51,839	53,187
Whitman	4,257	9.51	4,370	9 25	5,815	11.84	6,781	13 53	7,408	14.46	7,783	14.93	7,948	15 07	1.78%	6,902	7,025
Yakima	28,122	11.56	34,088	13 64	38,391	14.60	43,811	15 94	48,646	16 92	51,647	17.32	54,133	17 60	2.12%	44,738	45,684

Notes:
Totals may not add due to rounding.
Data should not be considered accurate to the last digit.
The 2015 age-sex distribution is from the Small Area Demographic Estimates model: 20171222_R04_VM.
OFM - Forecasting & Research | January 2018

MDCR HOSPICE 3

Medicare Hospices: Utilization and Program Payments for Medicare Beneficiaries, by Area of Residence, Calendar Year 2020

Area of Residence	Total Part A Enrollees	Total Persons With Utilization	Total Covered Days of Care	Covered Days of Care Per Person With Utilization	Covered Days of Care Per 1,000 Part A Enrollees	Total Program Payments	Program Payments Per Person With Utilization	Program Payments Per Covered Day	Program Payments Per Part A Enrollee	Discharged Dead
All Areas	62,498,751	1,728,004	128,294,027	74.24	2,053	$22,445,345,674	$12,989	$175	$359	1,272,769
United States	61,211,371	1,717,193	127,279,840	74.12	2,079	22,331,382,511	13,005	175	365	1,266,370
Alabama	1,056,359	36,717	3,519,842	95.86	3,332	$512,197,144	$13,950	$146	$485	24,223
Alaska	104,078	1,238	70,489	56.94	677	13,461,998	10,874	191	129	957
Arizona	1,359,840	45,779	3,787,163	82.73	2,785	635,912,153	13,891	168	468	32,061
Arkansas	645,494	18,482	1,319,783	71.41	2,045	207,049,181	11,203	157	321	14,013
California	6,281,323	173,506	15,124,890	87.17	2,408	3,243,058,593	18,691	214	516	111,234
Colorado	927,390	24,856	1,854,413	74.61	2,000	326,817,936	13,148	176	352	18,437
Connecticut	689,967	17,160	966,402	56.32	1,401	196,736,849	11,465	204	285	13,721
Delaware	214,919	6,562	504,396	76.87	2,347	93,407,206	14,235	185	435	4,716
District of Columbia	92,795	1,697	127,661	75.23	1,376	22,966,763	13,534	180	248	1,179
Florida	4,674,019	146,263	10,865,100	74.28	2,325	2,013,048,589	13,763	185	431	108,101
Georgia	1,754,062	54,135	4,528,226	83.65	2,582	730,155,866	13,488	161	416	38,583
Hawaii	280,787	6,595	498,348	75.56	1,775	98,450,225	14,928	198	351	4,734
Idaho	349,019	10,052	803,443	79.93	2,302	128,595,846	12,793	160	368	7,266
Illinois	2,246,603	62,084	3,681,879	59.30	1,639	658,663,901	10,609	179	293	49,786
Indiana	1,282,040	38,197	2,641,024	69.14	2,060	437,303,266	11,449	166	341	29,414
Iowa	637,145	19,927	1,182,948	59.36	1,857	191,652,465	9,618	162	301	15,906
Kansas	545,607	17,683	1,248,534	70.61	2,288	199,500,809	11,282	160	366	13,384
Kentucky	931,126	22,575	1,173,940	52.00	1,261	208,653,195	9,243	178	224	18,501
Louisiana	882,812	27,786	2,204,934	79.35	2,498	333,500,927	12,002	151	378	20,240
Maine	345,665	9,195	631,385	68.67	1,827	109,675,767	11,928	174	317	7,019
Maryland	1,056,328	26,479	1,653,041	62.43	1,565	293,132,447	11,070	177	278	20,662
Massachusetts	1,351,220	33,557	2,275,089	67.80	1,684	440,128,762	13,116	193	326	25,615
Michigan	2,099,433	61,736	4,191,603	67.90	1,997	691,299,322	11,198	165	329	47,795
Minnesota	1,045,280	30,655	2,152,831	70.23	2,060	383,391,705	12,507	178	367	23,312
Mississippi	609,478	19,174	1,645,053	85.80	2,699	246,183,990	12,839	150	404	13,203
Missouri	1,246,928	37,468	2,693,055	71.88	2,160	426,142,467	11,374	158	342	28,373
Montana	237,051	5,279	315,647	59.79	1,332	51,307,883	9,719	163	216	4,021
Nebraska	353,434	9,894	644,694	65.16	1,824	105,578,152	10,671	164	299	7,799
Nevada	546,759	15,075	1,089,229	72.25	1,992	209,107,613	13,871	192	382	10,878
New Hampshire	307,435	7,464	524,721	70.30	1,707	93,152,966	12,480	178	303	5,668
New Jersey	1,622,244	39,117	2,369,564	60.58	1,461	462,992,296	11,836	195	285	30,793
New Mexico	427,346	11,438	974,650	85.21	2,281	154,020,527	13,466	158	360	8,164
New York	3,652,873	52,682	2,860,719	54.30	783	582,705,061	11,061	204	160	41,080
North Carolina	2,028,204	56,136	4,054,157	72.22	1,999	687,505,024	12,247	170	339	42,154
North Dakota	133,840	2,581	149,191	57.80	1,115	23,120,649	8,958	155	173	2,041
Ohio	2,368,612	81,840	5,907,287	72.18	2,494	997,235,895	12,185	169	421	62,871
Oklahoma	753,140	25,776	2,206,477	85.60	2,930	330,476,505	12,821	150	439	18,253
Oregon	885,544	23,345	1,521,826	65.19	1,719	291,531,799	12,488	192	329	18,018
Pennsylvania	2,765,923	76,285	4,912,592	64.40	1,776	833,584,749	10,927	170	301	59,500
Rhode Island	222,702	6,633	452,856	68.27	2,033	85,034,836	12,820	188	382	5,094
South Carolina	1,101,105	33,476	2,749,017	82.12	2,497	438,861,232	13,110	160	399	24,155
South Dakota	180,149	4,132	229,426	55.52	1,274	35,759,812	8,654	156	199	3,318
Tennessee	1,382,574	39,413	2,918,954	74.06	2,111	448,076,306	11,369	154	324	29,730
Texas	4,275,461	137,787	12,112,368	87.91	2,833	1,956,865,743	14,202	162	458	95,688
Utah	412,009	14,820	1,365,940	92.17	3,315	219,193,674	14,790	160	532	10,048
Vermont	151,220	3,381	254,940	75.40	1,686	43,860,066	12,973	172	290	2,457
Virginia	1,540,473	39,930	2,901,726	72.67	1,884	477,619,236	11,961	165	310	29,878
Washington	1,397,182	30,517	1,888,675	61.89	1,352	364,251,082	11,936	193	261	23,293
West Virginia	442,495	11,440	758,341	66.29	1,714	121,896,157	10,655	161	275	8,856
Wisconsin	1,200,220	37,213	2,676,659	71.93	2,230	459,353,925	12,344	172	383	28,574
Wyoming	113,659	1,981	94,712	47.81	833	17,203,952	8,684	182	151	1,604
Territories, Possessions, and Other										
Puerto Rico	750,096	10,203	973,738	95.44	1,298	$107,253,318	$10,512	$110	$143	5,969
Virgin Islands	19,974	359	26,921	74.99	1,348	4,196,041	11,688	156	210	242
American Samoa	4,715	12	126	10.50	27	42,940	3,578	341	9	12
Guam	17,598	109	6,881	63.13	391	1,119,534	10,271	163	64	80
Northern Mariana Islands	2,624	15	884	58.93	337	151,421	10,095	171	58	*
Foreign Countries	492,105	112	5,607	50.06	11	1,194,055	10,661	213	2	86
Unknown	268	*	†	†	†	†	†	†	†	*

* Counts between 1 and 10 have been suppressed because of CMS rules to protect the privacy of beneficiaries.
† Counts have been cross-suppressed to prevent the recalculation of suppressed counts between 1 and 10.

NOTES The total Medicare Part A enrollee counts and calculated 'per Part A enrollee' rates are based on enrollees in Original Medicare and Medicare Advantage/Other Health Plans combined, because once a beneficiary enrolled in Medicare Advantage/Other Health Plans elects the hospice benefit, his or her Medicare benefits revert to fee-for-service. This table limits the reporting of hospice days to utilization days occurring within the specified calendar year and may not reflect all of a beneficiary's utilization days for an entire hospice episode of care. As a result, the 'covered days of care per person with utilization' calculation may be understated since utilization days that occur prior to the specified calendar year and/or utilization days that occur after the specified calendar year are not included in the calculation. Counts and amounts may not sum to totals because of rounding.

SOURCE Centers for Medicare & Medicaid Services, Office of Enterprise Data and Analytics, CMS Chronic Conditions Data Warehouse.

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	Final FY21 Dec Actual	Final FY22 Jan Actual	Final FY22 Feb Actual	Final FY22 Mar Actual	Final FY22 Apr Actual	Final FY22 May Actual	Final FY22 Jun Actual	Final FY22 Jul Actual	Final FY22 Aug Actual	Final FY22 Sep Actual	Final FY22 Oct Actual	Final FY22 Nov Actual	Final FY22 Dec Actual
Gross Revenue	(141,029)	267,937	289,595	387,639	276,836	277,424	247,752	234,795	260,801	246,377	312,344	363,404	0
Revenue Adjustments	4 945	(10 565)	(24 568)	(39 406)	1 088	(21 168)	(30 050)	(11 083)	(16 067)	(5 441)	(17 491)	(18 996)	0
Net Revenue	**(136,084)**	**257,372**	**265,026**	**348,233**	**277,924**	**256,257**	**217,702**	**223,712**	**244,733**	**240,936**	**294,852**	**344,408**	**0**
COS Wages	88,672	82,175	82,162	81,699	67,058	66,190	70,242	78,860	61,523	58,351	52,501	65,176	0
Benefits	0	17,633	23,520	16,363	17,669	19,149	11,775	18,198	14,260	12,180	8,309	12,651	0
Contract Labor	17,498	14,077	3,670	20,845	4,190	4,752	9,504	9,471	6,988	84,159	26,136	28,084	0
Medical Supplies	3,830	2,495	3,233	2,981	2,276	1,893	1,893	2,321	2,145	1,667	1,762	2,436	0
COS Other	(34,958)	1,354	3,602	(11,626)	1,129	(6,957)	1,103	(3,753)	1,879	4,161	(7,515)	7,984	0
53000 - Mileage Reimbursement	3,048	3,460	3,210	3,918	2,866	2,558	2,836	2,809	2,107	171	1,272	5,047	0
59180 - Pharmacy	6,666	7,456	6,827	10,419	7,909	6,272	5,580	5,965	6,638	6,031	6,894	9,980	0
59190 - DME	7,974	7,918	6,471	7,701	6,378	6,177	5,711	5,149	6,668	6,325	5,830	6,013	0
59825 - General Inpatient Expense	4,450	0	0	6,300	21,700	15,000	13,800	12,900	6,276	6,046	9,114	7,423	0
Cost of Sales	**97,180**	**136,567**	**132,696**	**138,600**	**131,175**	**115,034**	**122,443**	**131,920**	**108,484**	**179,092**	**104,302**	**144,793**	**0**
Gross Margin	**(233,264)**	**120,805**	**132,331**	**209,633**	**146,749**	**141,222**	**95,259**	**91,792**	**136,250**	**61,844**	**190,550**	**199,614**	**0**
Gross Margin %	*171.4%*	*46.9%*	*49.9%*	*60.2%*	*52.8%*	*55.1%*	*43.8%*	*41.0%*	*55.7%*	*25.7%*	*64.6%*	*58.0%*	*0.0%*
Salaries	72,159	51,416	53,379	52,017	65,690	39,416	44,413	47,635	49,911	54,478	54,276	42,820	0
Admin Benefits	22,921	5,039	12,968	12,703	13,233	11,220	8,105	11,378	12,065	13,970	10,734	11,382	0
Rent/Facilities	10,254	8,839	8,075	10,035	9,055	8,907	9,151	9,261	8,744	8,677	11,516	9,035	0
Outside Services/Consulting	0	120	0	138	0	0	210	0	0	0	0	0	0
Technology	281	1,242	1,885	1,332	841	2,809	2,014	1,668	1,304	(936)	3,550	(123)	0
Travel and Entertainment	1,013	83	472	655	1,001	1,392	1,127	2,238	2,068	2,092	2,062	704	0
Telecommunications	6,242	3,278	5,601	4,566	3,904	5,543	4,750	5,806	7,304	5,794	3,638	2,398	0
Recruiting and Human Capital	975	0	325	339	278	646	384	482	1,348	(420)	1,011	292	0
Legal	349	413	0	0	(138)	0	0	0	0	0	0	0	0
Marketing	4,253	2,932	(2,642)	268	108	1,122	359	7,543	384	843	12,817	1,145	0
Insurance Expense	1,783	856	555	555	555	691	694	694	691	535	660	660	0
Office Related	2,606	1,935	2	1,553	493	4,752	776	934	956	3,404	6,184	8,157	0
Other G&A Expenses	280	195	103	293	482	442	(424)	(390)	2,359	735	(1,578)	(199)	0
Other Allocated	66,447	0	0	0	0	0	0	0	0	0	0	0	0
86000 - Stock-Based Compensation	0	0	0	0	0	0	0	0	0	0	0	0	0
G&A Expenses	**189,563**	**76,348**	**80,723**	**84,455**	**95,501**	**76,940**	**71,559**	**87,248**	**87,134**	**89,172**	**104,871**	**76,270**	**0**
G&A %	*-139.3%*	*29.7%*	*30.5%*	*24.3%*	*34.4%*	*30.0%*	*32.9%*	*39.0%*	*35.6%*	*37.0%*	*35.6%*	*22.1%*	*0.0%*
Center Contribution	**(422,828)**	**44,457**	**51,607**	**125,178**	**51,248**	**64,282**	**23,700**	**4,543**	**49,116**	**(27,328)**	**85,679**	**123,344**	**0**
Contribution Margin %	*310.7%*	*17.3%*	*19.5%*	*35.9%*	*18.4%*	*25.1%*	*10.9%*	*2.0%*	*20.1%*	*-11.3%*	*29.1%*	*35.8%*	*0.0%*
Admits - HP	11	43	32	27	21	29	30	27	26	23	31	38	19
Average Patient Census	45	46	45	47	42	39	36	34	36	34	36	43	43
Patient Days	1,385	1,413	1,257	1,465	1,253	1,209	1,094	1,069	1,104	1,005	1,123	1,294	1,326
Imputed LOS	125.9	32.9	39.3	54.3	59.7	41.7	36.5	39.6	42.5	43.7	36.2	34.1	69.8
Net Revenue PPD	($98.26)	$182.15	$210.84	$237.68	$221.79	$211.96	$198.98	$209.24	$221.68	$239.74	$262.61	$266.18	$0.00
COS Wages PPD	$64.02	$58.16	$65.36	$55.76	$53.51	$54.75	$64.20	$73.76	$55.73	$58.06	$46.76	$50.37	$0.00
Contract Labor PPD	$12.63	$9.96	$2.92	$14.23	$3.34	$3.93	$8.69	$8.86	$6.33	$83.74	$23.28	$21.71	$0.00
Lab Costs PPD	$0.20	$0.00	$0.00	$0.14	$0.05	$0.04	$0.13	$0.00	$0.37	$0.00	$0.00	$0.00	$0.00
Patient Transportation PPD	$0.21	$0.69	$0.21	($4.86)	($1.96)	$0.00	$2.23	$0.02	$1.88	$0.00	$0.00	$0.00	$0.00
Medical Supplies PPD	$2.77	$1.77	$2.57	$2.03	$1.82	$1.57	$1.73	$2.17	$1.94	$1.66	$1.57	$1.88	$0.00
Pharmacy Supplies PPD	$4.81	$5.28	$5.43	$7.11	$6.31	$5.19	$5.10	$5.58	$6.01	$6.00	$6.14	$7.71	$0.00
DME Supplies PPD	$5.76	$5.60	$5.15	$5.26	$5.09	$5.11	$5.22	$4.82	$6.04	$6.29	$5.19	$4.65	$0.00
Consumables PPD	$13.74	$13.33	$13.36	$9.68	$11.31	$11.90	$14.41	$12.59	$16.25	$13.95	$12.90	$14.24	$0.00
Room and Board PPD	($26.96)	($0.44)	$2.14	($3.86)	$2.12	($6.33)	($0.43)	($4.26)	($0.93)	$3.93	($6.81)	$5.83	$0.00
Auto and Mileage PPD	$2.20	$2.45	$2.55	$2.67	$2.29	$2.12	$2.59	$2.63	$1.91	$0.17	$1.13	$3.90	$0.00
COS PPD	$70.17	$96.65	$105.57	$94.60	$104.68	$95.15	$111.91	$123.39	$98.26	$178.20	$92.90	$111.90	$0.00
OPEX Wages PPD	$52.10	$36.39	$42.47	$35.50	$52.42	$32.60	$40.59	$44.55	$45.21	$54.21	$48.34	$33.09	$0.00
OPEX PPD	$136.87	$54.03	$64.22	$57.64	$76.21	$63.64	$65.40	$81.61	$78.93	$88.73	$93.40	$58.95	$0.00

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	Final FY22 Dec Budget	F/(U) Var	F/(U) Var %	Final FY22 Dec YTD Actual	Final FY22 Dec YTD Budget	F/(U) Var	F/(U) Var %	Final FY22 Dec Actual	2+10 FY22 Dec Forecast	F/(U) Var	F/(U) Var %	Final FY22 Dec YTD Actual	Final FY21 Dec YTD Actual	F/(U) Var	F/(U) Var %
Gross Revenue	318,752	(318,752)	-100.0%	3,164,903	3,450,624	(285,721)	-8.3%	0	363,682	(363,682)	-100.0%	3,164,903	4,022,936	(858,034)	-21.3%
Revenue Adjustments	(4 727)	4 727	100.0%	(193 747)	(27 638)	(166 109)	-601.0%	0	0	0		(193 747)	(21 414)	(172 333)	-804.8%
Net Revenue	**314,025**	**(314,025)**	**-100.0%**	**2,971,156**	**3,422,986**	**(451,830)**	**-13.2%**	**0**	**363,682**	**(363,682)**	**-100.0%**	**2,971,156**	**4,001,522**	**(1,030,367)**	**-25.7%**
COS Wages	94,042	94,042	100.0%	765,936	1,044,541	278,605	26.7%	0	92,078	92,078	100.0%	765,936	1,049,984	284,048	27.1%
Benefits	17,370	17,370	100.0%	171,707	196,434	24,728	12.6%	0	24,968	24,968	100.0%	171,707	0	(171,707)	
Contract Labor	6,311	6,311	100.0%	211,877	69,428	(142,448)	-205.2%	0	7,209	7,209	100.0%	211,877	174,981	(36,896)	-21.1%
Medical Supplies	3,100	3,100	100.0%	25,103	34,296	9,193	26.8%	0	4,250	4,250	100.0%	25,103	42,453	17,351	40.9%
COS Other	2,991	2,991	100.0%	(8,639)	34,516	43,155	125.0%	0	8,965	8,965	100.0%	(8,639)	22,525	31,164	138.4%
53000 - Mileage Reimbursement	2,675	2,675	100.0%	30,254	30,355	101	0.3%	0	4,941	4,941	100.0%	30,254	41,773	11,519	27.6%
59180 - Pharmacy	8,854	8,854	100.0%	79,969	97,409	17,440	17.9%	0	9,618	9,618	100.0%	79,969	127,702	47,733	37.4%
59190 - DME	7,857	7,857	100.0%	70,342	86,149	15,807	18.3%	0	10,339	10,339	100.0%	70,342	112,429	42,087	37.4%
59825 - General Inpatient Expense	6,086	6,086	100.0%	98,559	66,555	(32,004)	-48.1%	0	6,086	6,086	100.0%	98,559	37,783	(60,776)	-160.9%
Cost of Sales	**149,285**	**149,285**	**100.0%**	**1,445,107**	**1,659,684**	**214,577**	**12.9%**	**0**	**168,452**	**168,452**	**100.0%**	**1,445,107**	**1,609,629**	**164,522**	**10.2%**
Gross Margin	**164,740**	**(164,740)**	**-100.0%**	**1,526,049**	**1,763,301**	**(237,253)**	**-13.5%**	**0**	**195,230**	**(195,230)**	**-100.0%**	**1,526,049**	**2,391,893**	**(865,844)**	**-36.2%**
Gross Margin %	*52.5%*	*-52.5%*		*51.4%*	*51.5%*	*-0.2%*		*0.0%*	*53.7%*	*-53.7%*		*51.4%*	*59.8%*	*-8.4%*	
Salaries	43,441	43,441	100.0%	555,449	502,189	(53,261)	-10.6%	0	37,185	37,185	100.0%	555,449	778,576	223,126	28.7%
Admin Benefits	10,182	10,182	100.0%	122,797	116,264	(6,533)	-5.6%	0	9,162	9,162	100.0%	122,797	372,664	249,867	67.0%
Rent/Facilities	9,769	9,769	100.0%	101,296	114,767	13,471	11.7%	0	8,482	8,482	100.0%	101,296	122,686	21,390	17.4%
Outside Services/Consulting	0	0		468	0	(468)		0	120	120	100.0%	468	1,174	706	60.1%
Technology	1,702	1,702	100.0%	15,586	12,833	(2,753)	-21.5%	0	2,706	2,706	100.0%	15,586	3,741	(11,845)	-316.6%
Travel and Entertainment	416	416	100.0%	13,896	4,880	(9,015)	-184.7%	0	339	339	100.0%	13,896	14,844	948	6.4%
Telecommunications	2,966	2,966	100.0%	52,582	34,028	(18,554)	-54.5%	0	4,440	4,440	100.0%	52,582	53,455	873	1.6%
Recruiting and Human Capital	798	798	100.0%	4,684	8,805	4,121	46.8%	0	325	325	100.0%	4,684	5,228	543	10.4%
Legal	0	0		275	0	(275)		0	0	0		275	12,091	11,816	97.7%
Marketing	1,264	1,264	100.0%	24,879	13,978	(10,901)	-78.0%	0	761	761	100.0%	24,879	18,842	(6,037)	-32.0%
Insurance Expense	787	787	100.0%	7,146	9,064	1,918	21.2%	0	555	555	100.0%	7,146	11,504	4,358	37.9%
Office Related	2,044	2,044	100.0%	29,146	22,859	(6,287)	-27.5%	0	969	969	100.0%	29,146	29,244	98	0.3%
Other G&A Expenses	142	142	100.0%	2,018	1,574	(444)	-28.2%	0	149	149	100.0%	2,018	1,530	(488)	-31.9%
Other Allocated	0	0		0	0	0		0	0	0		0	728,234	728,234	100.0%
86000 - Stock-Based Compensation	0	0		0	0	0		0	0	0		0	0	0	
G&A Expenses	**73,511**	**73,511**	**100.0%**	**930,222**	**841,240**	**(88,982)**	**-10.6%**	**0**	**65,194**	**65,194**	**100.0%**	**930,222**	**2,153,813**	**1,223,591**	**56.8%**
G&A %	*23.4%*	*23.4%*		*31.3%*	*24.6%*	*-6.7%*		*0.0%*	*17.9%*	*17.9%*		*31.3%*	*53.8%*	*22.5%*	
Center Contribution	**91,229**	**(91,229)**	**-100.0%**	**595,827**	**922,061**	**(326,235)**	**-35.4%**	**0**	**130,036**	**(130,036)**	**-100.0%**	**595,827**	**238,080**	**357,747**	**150.3%**
Contribution Margin %	*29.1%*	*-29.1%*		*20.1%*	*26.9%*	*-6.9%*		*0.0%*	*35.8%*	*-35.8%*		*20.1%*	*5.9%*	*14.1%*	
Admits - HP	14	(5)	-35.7%	346	157	189	120.4%	19	18	1	3.1%	346	176	170	96.6%
Average Patient Census	48	5	10.9%	40	45	(5)	-10.7%	43	58	(15)	-26.3%	40	55	(14)	-26.5%
Patient Days	1,488	162	10.9%	14,612	16,371	(1,759)	-10.7%	1,326	1,798	(472)	-26.3%	14,612	19,887	(5,275)	-26.5%
Imputed LOS	106.3	36.5	34.3%	42.2	104.3	62.0	59.5%	69.8	97.6	27.8	28.5%	42.2	113.0	70.8	62.6%
Net Revenue PPD	$211.04	($211.04)	-100.0%	$203.34	$209.09	($5.75)	-2.8%	$0.00	$202.27	($202.27)	-100.0%	$203.34	$201.21	$2.12	1.1%
COS Wages PPD	$63.20	$63.20	100.0%	$52.42	$63.80	$11.39	17.8%	$0.00	$51.21	$51.21	100.0%	$52.42	$52.80	$0.38	0.7%
Contract Labor PPD	$4.24	$4.24	100.0%	$14.50	$4.24	($10.26)	-241.9%	$0.00	$4.01	$4.01	100.0%	$14.50	$8.80	($5.70)	-64.8%
Lab Costs PPD	$0.17	$0.17	100.0%	$0.06	$0.17	$0.11	65.6%	$0.00	$0.17	$0.17	100.0%	$0.06	$0.14	$0.08	56.9%
Patient Transportation PPD	$0.60	$0.60	100.0%	($0.26)	$0.60	$0.86	143.4%	$0.00	$0.60	$0.60	100.0%	($0.26)	$0.41	$0.67	163.7%
Medical Supplies PPD	$2.08	$2.08	100.0%	$1.72	$2.09	$0.38	18.0%	$0.00	$2.36	$2.36	100.0%	$1.72	$2.13	$0.42	19.5%
Pharmacy Supplies PPD	$5.95	$5.95	100.0%	$5.47	$5.95	$0.48	8.0%	$0.00	$5.35	$5.35	100.0%	$5.47	$6.42	$0.95	14.8%
DME Supplies PPD	$5.28	$5.28	100.0%	$4.81	$5.26	$0.45	8.5%	$0.00	$5.75	$5.75	100.0%	$4.81	$5.65	$0.84	14.8%
Consumables PPD	$14.08	$14.08	100.0%	$11.80	$14.08	$2.28	16.2%	$0.00	$14.23	$14.23	100.0%	$11.80	$14.76	$2.95	20.0%
Room and Board PPD	$0.00	$0.00		($0.74)	$0.00	$0.74		$0.00	$2.98	$2.98	100.0%	($0.74)	($0.29)	$0.45	152.5%
Auto and Mileage PPD	$1.80	$1.80	100.0%	$2.07	$1.85	($0.22)	-11.7%	$0.00	$2.75	$2.75	100.0%	$2.07	$2.10	$0.03	1.4%
COS PPD	$100.33	$100.33	100.0%	$98.90	$101.38	$2.48	2.4%	$0.00	$93.69	$93.69	100.0%	$98.90	$80.94	($17.96)	-22.2%
OPEX Wages PPD	$29.19	$29.19	100.0%	$38.01	$30.68	($7.34)	-23.9%	$0.00	$20.68	$20.68	100.0%	$38.01	$39.15	$1.14	2.9%
OPEX PPD	$49.40	$49.40	100.0%	$63.66	$51.39	($12.28)	-23.9%	$0.00	$36.26	$36.26	100.0%	$63.66	$108.30	$44.64	41.2%

Comparison of AccentCare Hospice Oregon Service Area with Pierce County, Washington

Fact	Fact Note	Multnomah County, Oregon	Clackamas County, Oregon	Washington County, Oregon	Pierce County, Washington
Population Estimates, July 1 2022, (V2022)		NA	NA	NA	NA
Population Estimates, July 1 2021, (V2021)		803,377	422,537	600,811	925,708
Population estimates base, April 1, 2020, (V2022)		NA	NA	NA	NA
Population estimates base, April 1, 2020, (V2021)		815,428	421,401	600,372	921,130
Population, percent change - April 1, 2020 (estimates base) to July 1, 2022, (V2022)		NA	NA	NA	NA
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)		-1.50%	0.30%	0.10%	0.50%
Population, Census, April 1, 2020		815,428	421,401	600,372	921,130
Population, Census, April 1, 2010		735,334	375,992	529,710	795,225
Persons under 5 years, percent		4.70%	4.90%	5.30%	6.10%
Persons under 18 years, percent		18.00%	21.20%	21.90%	23.20%
Persons 65 years and over, percent		14.30%	19.10%	14.30%	14.40%
Female persons, percent		50.30%	50.30%	50.10%	49.80%
White alone, percent		78.60%	88.00%	78.60%	73.10%
Black or African American alone, percent	(a)	6.00%	1.30%	2.70%	8.00%
American Indian and Alaska Native alone, percent	(a)	1.50%	1.10%	1.20%	1.80%
Asian alone, percent	(a)	8.20%	5.20%	12.20%	7.40%
Native Hawaiian and Other Pacific Islander alone, percent	(a)	0.70%	0.30%	0.60%	1.80%
Two or More Races, percent		5.00%	4.00%	4.80%	7.90%
Hispanic or Latino, percent	(b)	12.70%	9.50%	17.60%	12.20%
White alone, not Hispanic or Latino, percent		68.10%	79.90%	63.20%	63.90%
Veterans, 2017-2021		35,054	24,485	28,450	83,506
Foreign born persons, percent, 2017-2021		13.50%	8.50%	17.90%	10.20%
Housing units, July 1, 2021, (V2021)		368,029	172,527	240,499	365,340
Owner-occupied housing unit rate, 2017-2021		54.70%	71.40%	61.10%	64.40%
Median value of owner-occupied housing units, 2017-2021		$437,600	$452,200	$439,300	$369,300
Median selected monthly owner costs -with a mortgage, 2017-2021		$2,119	$2,191	$2,151	$2,041
Median selected monthly owner costs -without a mortgage, 2017-2021		$726	$726	$721	$697
Median gross rent, 2017-2021		$1,394	$1,447	$1,541	$1,444
Building permits, 2021		3,547	1,803	3,096	6,072
Households, 2017-2021		339,228	159,553	226,412	335,969
Persons per household, 2017-2021		2.34	2.6	2.61	2.65
Living in same house 1 year ago, percent of persons age 1 year+, 2017-2021		83.10%	86.90%	84.90%	82.80%
Language other than English spoken at home, percent of persons age 5 years+, 2017-2021		19.60%	12.20%	24.90%	15.30%
Households with a computer, percent, 2017-2021		95.80%	95.90%	97.20%	96.00%
Households with a broadband Internet subscription, percent, 2017-2021		91.30%	90.70%	93.50%	91.70%
High school graduate or higher, percent of persons age 25 years+, 2017-2021		92.40%	94.30%	93.00%	92.10%

Source: www.census.gov "Quick Facts Reports"
Accessed 01/18/2023

Bachelor's degree or higher, percent of persons age 25 years+, 2017-2021		47.20%	38.90%	45.60%	28.40%
With a disability, under age 65 years, percent, 2017-2021		9.30%	7.70%	7.30%	9.50%
Persons without health insurance, under age 65 years, percent		7.20%	6.20%	6.60%	6.80%
In civilian labor force, total, percent of population age 16 years+, 2017-2021		70.00%	63.80%	69.00%	63.40%
In civilian labor force, female, percent of population age 16 years+, 2017-2021		67.00%	58.00%	62.70%	59.60%
Total accommodation and food services sales, 2017 ($1,000)	(c)	3,605,374	877,858	1,417,379	1,944,983
Total health care and social assistance receipts/revenue, 2017 ($1,000)	(c)	9,879,704	2,861,945	4,422,133	7,449,203
Total transportation and warehousing receipts/revenue, 2017 ($1,000)	(c)	3,635,264	504,777	808,382	2,030,314
Total retail sales, 2017 ($1,000)	(c)	11,927,713	5,737,739	11,937,536	13,775,903
Total retail sales per capita, 2017	(c)	$14,759	$13,893	$20,166	$15,641
Mean travel time to work (minutes), workers age 16 years+, 2017-2021		26.1	28.1	24.9	32.8
Median household income (in 2021 dollars), 2017-2021		$76,290	$88,517	$92,025	$82,574
Per capita income in past 12 months (in 2021 dollars), 2017-2021		$44,675	$45,140	$44,362	$39,036
Persons in poverty, percent		12.40%	8.40%	8.60%	8.20%
Total employer establishments, 2020		27,656	12,209	15,865	18,783
Total employment, 2020		460,467	147,405	293,095	279,552
Total annual payroll, 2020 ($1,000)		25,871,419	7,942,942	21,149,216	14,297,082
Total employment, percent change, 2019-2020		1.50%	-0.20%	1.00%	3.20%
Total nonemployer establishments, 2019		75,076	33,502	41,301	49,937
All employer firms, Reference year 2017		22,393	10,018	12,715	14,484
Men-owned employer firms, Reference year 2017		11,765	5,245	6,680	7,098
Women-owned employer firms, Reference year 2017		5,176	1,921	2,590	2,789
Minority-owned employer firms, Reference year 2017		2,656	962	1,850	2,340
Nonminority-owned employer firms, Reference year 2017		17,009	8,019	9,213	10,439
Veteran-owned employer firms, Reference year 2017		1,012	651	745	913
Nonveteran-owned employer firms, Reference year 2017		18,456	8,177	10,289	11,556
Population per square mile, 2020		1,891.20	225.3	828.9	552.2
Population per square mile, 2010		1,704.90	201	731.4	476.3
Land area in square miles, 2020		431.16	1,870.67	724.27	1,667.96
Land area in square miles, 2010		431.3	1,870.32	724.23	1,669.51
FIPS Code		"41051"	"41005"	"41067"	"53053"
NOTE: FIPS Code values are enclosed in quotes to ensure leading zeros remain intact.					
Value Notes					
None					
Fact Notes					
(a)	Includes persons reporting only one race				

Source: www.census.gov "Quick Facts Reports"
Accessed 01/18/2023

(c)	Economic Census - Puerto Rico data are not comparable to U.S. Econor				
(b)	Hispanics may be of any race, so also are included in applicable race ca				
Value Flags					
-	Either no or too few sample observations were available to compute ar				
F	Fewer than 25 firms				
D	Suppressed to avoid disclosure of confidential information				
N	Data for this geographic area cannot be displayed because the number				
FN	Footnote on this item in place of data				
X	Not applicable				
S	Suppressed; does not meet publication standards				
NA	Not available				
Z	Value greater than zero but less than half unit of measure shown				

Source: www.census.gov "Quick Facts Reports"
Accessed 01/18/2023

AccentCare's Start Up Experience
Most Recent Ten Years

SEASONS' RECENT START-UP EXPERIENCE

		Year 1				Admission	Year 2				Admission	Year 3			
Program	**Start Date**	**Admissions**	**Patient Days**	**ALOS**	**ADC**	**Growth**	**Admissions**	**Patient Days**	**ALOS**	**ADC**	**Growth**	**Admissions**	**Patient Days**	**ALOS**	**ADC**
Denver CO	Apr-16	151	7,083	47	19	-7%	141	12,315	87	34	83%	258	21,107	82	58
Las Vegas NV	Dec-15	129	6,632	51	18	27%	164	14,681	90	40	-27%	119	11,895	100	33
Portland OR	Nov-14	165	9,052	55	25	5%	173	19,028	110	52	24%	214	22,464	105	62
New Jersey	Jul-14	164	7,060	43	19	53%	251	16,255	65	45	63%	408	17,846	44	49
CA-Sacramento	Aug-17	58	2,388	41	7	183%	164	11,512	70	32	40%	229	19,181	84	53
CA-San Jose	May-13	188	8,976	48	25	86%	349	19,967	57	55	44%	503	39,955	79	109
CA-San Bernardino	Oct-12	204	15,052	74	41	77%	361	29,863	83	82	23%	445	44,323	100	121
TX-Houston	Aug-12	144	6,977	48	19	63%	235	22,418	95	61	43%	336	34,692	103	95
FL-Broward	Jan-15	182	10,115	56	28	358%	833	29,744	36	81	18%	981	41,450	42	114
FL-Tampa	Jun-17	245	13,029	53	36	138%	582	41,665	72	114	118%	1,269	83,898	66	230
FL-Pinellas	Apr-18	284	14,598	51	40	149%	708	52,156	74	143	6%	753	57,247	76	157
FL-Pasco	Apr-20	238	13,277	56	36	16%	277	23,671	85	65					
CA-Oakland	May-20	81	4,054	50	11	30%	105	9,275	88	25					
Average		**172**	**9,099**	**53**	**25**	**110%**	**360**	**24,509**	**68**	**67**	**32%**	**476**	**33,681**	**71**	**92**
Median		**165**	**8,976**	**51**	**25**	**52%**	**251**	**19,967**	**74**	**55**	**41%**	**372**	**28,578**	**83**	**78**

		First 6 Months			
Program	**Start Date**	**Admissions**	**Patient Days**	**ALOS**	**ADC**
Denver CO	2016-02	66	1,848	28	10
Las Vegas NV	2015-01	51	1,908	37	10
Portland OR	2014-09	60	1,786	30	10
New Jersey	Jul-14	59	2,144	36	12
CA-Sacramento	Aug-17	19	494	26	3
CA-San Jose	May-13	90	3,364	37	18
CA-San Bernardino	Oct-12	105	5,032	48	27
TX-Houston	Aug-12	56	2,034	36	11
FL-Broward	Jan-15	12	1,733	144	9
FL-Tampa	Jun-17	82	3,581	44	20
FL-Pinellas	June 2020	81	2,888	36	16
FL-Pasco	Apr-20	94	3,650	39	20
CA-Oakland	May-20	29	883	30	5
Average		**62**	**2,437**	**39**	**13**
Median		**60**	**2,034**	**34**	**11**

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WAC246-310-290(8)(a) Step 1:

Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.

WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2019	3,712
2020	3,680
2021	3,893
	average: 3,762

Deaths ages 0-64	
Year	Deaths
2019	14,047
2020	16,663
2021	18015
	average: 16,242

Use Rates	
0-64	23.16%
65+	58.07%

Hospice admissions ages 65+	
Year	Admissions
2019	26,175
2020	27,957
2021	27,884
	average: 27,339

Deaths ages 65+	
Year	Deaths
2019	44,159
2020	46,367
2021	50,717
	average: 47,081

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
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WAC246-310-290(8)(b) Step 2:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	2019	2020	2021	2019-2021 Average Deaths
Adams	35	20	23	**26**
Asotin	54	56	43	**51**
Benton	346	555	536	**479**
Chelan	137	224	256	**206**
Clallam	186	195	185	**189**
Clark	887	1,043	1,078	**1,003**
Columbia	7	7	11	**8**
Cowlitz	294	314	401	**336**
Douglas	63	42	45	**50**
Ferry	20	19	21	**20**
Franklin	123	100	110	**111**
Garfield	5	5	4	**5**
Grant	197	186	208	**197**
Grays Harbor	251	209	236	**232**
Island	167	110	116	**131**
Jefferson	72	68	54	**65**
King	3,275	4,456	4,892	**4,208**
Kitsap	557	454	489	**500**
Kittitas	90	78	88	**85**
Klickitat	46	42	50	**46**
Lewis	210	205	186	**200**
Lincoln	25	15	24	**21**
Mason	167	143	168	**159**
Okanogan	119	88	92	**100**
Pacific	66	55	59	**60**
Pend Oreille	31	41	55	**42**
Pierce	1,911	2,364	2,574	**2,283**
San Juan	20	18	24	**21**
Skagit	229	269	334	**277**
Skamania	19	26	25	**23**
Snohomish	1,533	1,587	1,563	**1,561**
Spokane	1,143	1,634	1,842	**1,540**
Stevens	112	86	114	**104**
Thurston	525	628	763	**639**
Wahkiakum	11	10	7	**9**
Walla Walla	118	150	138	**135**
Whatcom	394	457	443	**431**
Whitman	47	51	59	**52**
Yakima	555	653	699	**636**

65+				
County	2019	2020	2021	2019-2021 Average Deaths
Adams	93	59	92	**81**
Asotin	222	186	188	**199**
Benton	1,154	1,522	1,610	**1,429**
Chelan	626	785	870	**760**
Clallam	955	777	906	**879**
Clark	2,987	3,205	3,705	**3,299**
Columbia	52	43	43	**46**
Cowlitz	951	968	1,100	**1,006**
Douglas	270	160	174	**201**
Ferry	64	58	63	**62**
Franklin	313	263	261	**279**
Garfield	21	11	24	**19**
Grant	508	455	523	**495**
Grays Harbor	659	558	590	**602**
Island	642	505	504	**550**
Jefferson	338	273	295	**302**
King	10,213	11,186	11,896	**11,098**
Kitsap	1,811	1,714	1,832	**1,786**
Kittitas	266	241	241	**249**
Klickitat	160	113	164	**146**
Lewis	722	653	723	**699**
Lincoln	89	75	76	**80**
Mason	548	408	461	**472**
Okanogan	358	277	324	**320**
Pacific	265	177	239	**227**
Pend Oreille	125	101	119	**115**
Pierce	5,002	5,608	6,264	**5,625**
San Juan	127	94	91	**104**
Skagit	1,018	1,068	1,190	**1,092**
Skamania	87	47	56	**63**
Snohomish	4,081	4,278	4,478	**4,279**
Spokane	3,545	4,322	4,810	**4,226**
Stevens	345	248	304	**299**
Thurston	1,908	2,007	2,285	**2,067**
Wahkiakum	53	18	25	**32**
Walla Walla	450	522	595	**522**
Whatcom	1,461	1,481	1,674	**1,539**
Whitman	219	226	278	**241**
Yakima	1,451	1,675	1,644	**1,590**

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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WAC246-310-290(8)(c) Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2019-2021 Average Deaths	Projected Patients: 23.16% of Deaths
Adams	26	6
Asotin	51	12
Benton	479	111
Chelan	206	48
Clallam	189	44
Clark	1,003	232
Columbia	8	2
Cowlitz	336	78
Douglas	50	12
Ferry	20	5
Franklin	111	26
Garfield	5	1
Grant	197	46
Grays Harbor	232	54
Island	131	30
Jefferson	65	15
King	4,208	975
Kitsap	500	116
Kittitas	85	20
Klickitat	46	11
Lewis	200	46
Lincoln	21	5
Mason	159	37
Okanogan	100	23
Pacific	60	14
Pend Oreille	42	10
Pierce	2,283	529
San Juan	21	5
Skagit	277	64
Skamania	23	5
Snohomish	1,561	362
Spokane	1,540	357
Stevens	104	24
Thurston	639	148
Wahkiakum	9	2
Walla Walla	135	31
Whatcom	431	100
Whitman	52	12
Yakima	636	147

65+		
County	2019-2021 Average Deaths	Projected Patients: 58.07% of Deaths
Adams	81	47
Asotin	199	115
Benton	1,429	830
Chelan	760	442
Clallam	879	511
Clark	3,299	1,916
Columbia	46	27
Cowlitz	1,006	584
Douglas	201	117
Ferry	62	36
Franklin	279	162
Garfield	19	11
Grant	495	288
Grays Harbor	602	350
Island	550	320
Jefferson	302	175
King	11,098	6,445
Kitsap	1,786	1,037
Kittitas	249	145
Klickitat	146	85
Lewis	699	406
Lincoln	80	46
Mason	472	274
Okanogan	320	186
Pacific	227	132
Pend Oreille	115	67
Pierce	5,625	3,266
San Juan	104	60
Skagit	1,092	634
Skamania	63	37
Snohomish	4,279	2,485
Spokane	4,226	2,454
Stevens	299	174
Thurston	2,067	1,200
Wahkiakum	32	19
Walla Walla	522	303
Whatcom	1,539	893
Whitman	241	140
Yakima	1,590	923

Sources:
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WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this

0-64								
County	Projected Patients	2019-2021 Average Population	2022 projected population	2023 projected population	2024 projected population	2022 potential volume	2023 potential volume	2024 potential volume
Adams	6	18,303	18,622	18,787	18,953	6	6	6
Asotin	12	16,655	16,540	16,485	16,429	12	12	12
Benton	111	169,475	172,638	174,249	175,861	113	114	115
Chelan	48	62,401	62,562	62,611	62,661	48	48	48
Clallam	44	52,389	52,027	51,821	51,615	43	43	43
Clark	232	416,817	426,529	431,158	435,786	238	240	243
Columbia	2	2,782	2,710	2,675	2,640	2	2	2
Cowlitz	78	85,859	85,769	85,695	85,621	78	78	78
Douglas	12	35,487	36,080	36,356	36,633	12	12	12
Ferry	5	5,582	5,506	5,470	5,435	5	5	5
Franklin	26	90,186	94,784	97,124	99,465	27	28	28
Garfield	1	1,561	1,522	1,502	1,483	1	1	1
Grant	46	87,144	89,322	90,403	91,485	47	47	48
Grays Harbor	54	57,008	56,401	56,122	55,844	53	53	53
Island	30	63,219	63,296	63,312	63,328	30	30	30
Jefferson	15	20,688	20,550	20,463	20,377	15	15	15
King	975	1,903,445	1,930,192	1,941,913	1,953,635	988	994	1000
Kitsap	116	219,729	221,192	221,771	222,349	117	117	117
Kittitas	20	38,918	39,556	39,827	40,097	20	20	20
Klickitat	11	15,572	15,304	15,168	15,033	10	10	10
Lewis	46	62,955	63,327	63,491	63,654	47	47	47
Lincoln	5	7,807	7,698	7,644	7,591	5	5	5
Mason	37	51,050	51,672	51,946	52,221	37	38	38
Okanogan	23	32,211	31,991	31,896	31,800	23	23	23
Pacific	14	14,424	14,242	14,161	14,081	14	14	14
Pend Oreille	10	9,813	9,727	9,684	9,642	10	10	10
Pierce	529	763,798	774,696	779,475	784,253	536	540	543
San Juan	5	10,782	10,707	10,684	10,661	5	5	5
Skagit	64	101,410	102,236	102,586	102,935	65	65	65
Skamania	5	9,238	9,205	9,186	9,168	5	5	5
Snohomish	362	714,698	726,273	731,019	735,765	367	370	372
Spokane	357	425,148	428,033	429,326	430,619	359	360	361
Stevens	24	34,006	33,841	33,766	33,690	24	24	24
Thurston	148	241,186	246,235	248,602	250,970	151	152	154
Wahkiakum	2	2,448	2,368	2,332	2,295	2	2	2
Walla Walla	31	50,924	51,075	51,121	51,168	31	31	31
Whatcom	100	187,499	190,722	192,178	193,633	102	102	103
Whitman	12	43,282	43,322	43,330	43,337	12	12	12
Yakima	147	224,364	227,147	228,473	229,798	149	150	151

Sources:
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WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

65+								
County	Projected Patients	2019-2021 Average Population	2022 projected population	2023 projected population	2024 projected population	2022 potential volume	2023 potential volume	2024 potential volume
Adams	47	2,317	2,424	2,466	2,507	49	50	51
Asotin	115	5,997	6,344	6,514	6,683	122	125	129
Benton	830	32,170	34,597	35,820	37,044	892	924	955
Chelan	442	16,445	17,695	18,339	18,982	475	492	510
Clallam	511	22,323	23,535	24,168	24,802	538	553	567
Clark	1,916	82,139	89,247	92,807	96,368	2,081	2,164	2,248
Columbia	27	1,264	1,304	1,322	1,339	28	28	28
Cowlitz	584	22,945	24,470	25,220	25,971	623	642	661
Douglas	117	8,334	8,974	9,283	9,591	126	130	135
Ferry	36	2,233	2,337	2,386	2,434	37	38	39
Franklin	162	9,627	10,557	11,030	11,504	178	186	194
Garfield	11	658	680	692	703	11	11	12
Grant	288	15,469	16,665	17,258	17,852	310	321	332
Grays Harbor	350	16,636	17,612	18,092	18,571	370	380	390
Island	320	20,809	22,047	22,682	23,317	339	348	358
Jefferson	175	11,945	12,722	13,121	13,520	187	193	198
King	6,445	324,334	350,881	363,992	377,102	6,972	7,232	7,493
Kitsap	1,037	55,965	60,492	62,800	65,107	1,121	1,164	1,206
Kittitas	145	7,952	8,589	8,911	9,234	156	162	168
Klickitat	85	6,062	6,448	6,627	6,807	90	92	95
Lewis	406	17,241	18,175	18,652	19,130	428	439	451
Lincoln	46	2,963	3,119	3,200	3,280	49	50	51
Mason	274	16,524	17,836	18,504	19,173	296	307	318
Okanogan	186	10,862	11,519	11,827	12,136	197	202	207
Pacific	132	6,897	7,159	7,284	7,408	137	139	142
Pend Oreille	67	4,090	4,371	4,504	4,636	71	74	76
Pierce	3,266	136,408	148,729	155,037	161,344	3,561	3,712	3,863
San Juan	60	5,978	6,357	6,541	6,724	64	66	68
Skagit	634	29,121	31,460	32,607	33,753	685	710	735
Skamania	37	2,797	3,048	3,172	3,297	40	42	43
Snohomish	2,485	125,510	138,737	145,495	152,254	2,747	2,880	3,014
Spokane	2,454	91,294	97,979	101,288	104,597	2,633	2,722	2,811
Stevens	174	11,804	12,591	12,969	13,346	185	191	196
Thurston	1,200	52,830	56,967	59,035	61,102	1,294	1,341	1,388
Wahkiakum	19	1,549	1,595	1,611	1,626	19	19	19
Walla Walla	303	11,141	11,632	11,915	12,197	317	324	332
Whatcom	893	42,586	45,794	47,372	48,949	961	994	1,027
Whitman	140	5,783	6,201	6,395	6,588	150	155	159
Yakima	923	38,465	40,559	41,643	42,727	974	1,000	1,026

Sources:
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WAC246-310-290(8)(e) Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2022 potential volume	2023 potential volume	2024 potential volume	Current Supply of Hospice Providers	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*	2024 Unmet Need Admissions*
Adams	56	56	57	**51.33**	4	5	6
Asotin	134	137	140	**96.33**	37	41	44
Benton	1,005	1,038	1,070	**994.00**	11	44	76
Chelan	523	540	557	**741.41**	(219)	(201)	(184)
Clallam	582	596	610	**492.75**	89	103	118
Clark	2,319	2,405	2,490	**2,751.75**	(433)	(347)	(261)
Columbia	29	30	30	**38.33**	(9)	(9)	(8)
Cowlitz	701	720	739	**855.33**	(154)	(135)	(116)
Douglas	138	142	147	**195.33**	(58)	(53)	(49)
Ferry	42	43	44	**33.00**	9	10	11
Franklin	205	213	222	**190.33**	14	23	32
Garfield	12	12	13	**7.00**	5	5	6
Grant	357	368	380	**277.33**	79	91	102
Grays Harbor	423	433	443	**363.08**	60	70	80
Island	369	379	388	**443.67**	(75)	(65)	(55)
Jefferson	202	207	213	**201.33**	0	6	12
King	7,960	8,227	8,493	**8,727.96**	(768)	(501)	(235)
Kitsap	1,237	1,280	1,323	**1,305.08**	(68)	(25)	18
Kittitas	176	182	188	**161.33**	15	21	27
Klickitat	100	103	105	**158.80**	(58)	(56)	(54)
Lewis	475	486	497	**439.67**	35	46	58
Lincoln	54	55	56	**23.33**	30	32	33
Mason	333	345	356	**512.08**	(179)	(167)	(156)
Okanogan	220	225	230	**199.33**	20	26	31
Pacific	151	153	155	**66.00**	85	87	89
Pend Oreille	81	83	85	**67.33**	14	16	18
Pierce	4,097	4,252	4,406	**4,156.74**	(59)	95	249
San Juan	69	71	73	**92.00**	(23)	(21)	(19)
Skagit	750	775	800	**764.67**	(15)	10	35
Skamania	45	47	49	**38.67**	7	8	10
Snohomish	3,114	3,250	3,386	**4,288.02**	(1,174)	(1,038)	(902)
Spokane	2,992	3,082	3,172	**3,120.75**	(128)	(38)	52
Stevens	209	215	220	**145.67**	64	69	74
Thurston	1,445	1,493	1,542	**1,829.19**	(384)	(336)	(287)
Wahkiakum	21	21	22	**13.67**	8	8	8
Walla Walla	348	356	364	**283.00**	65	73	81
Whatcom	1,062	1,096	1,130	**1,317.08**	(255)	(221)	(187)
Whitman	162	167	172	**139.67**	23	27	32
Yakima	1,123	1,149	1,176	**1,214.67**	(92)	(65)	(38)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

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WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	**2022 Unmet Need Admissions***	**2023 Unmet Need Admissions***	**2024 Unmet Need Admissions***	**Statewide ALOS**	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***	**2024 Unmet Need Patient Days***
Adams	4	5	6	**61.89**	260	316	372
Asotin	37	41	44	**61.89**	2,317	2,516	2,716
Benton	11	44	76	**61.89**	692	2,710	4,728
Chelan	(219)	(201)	(184)	**61.89**	(13,529)	(12,457)	(11,385)
Clallam	89	103	118	**61.89**	5,506	6,393	7,280
Clark	(433)	(347)	(261)	**61.89**	(26,780)	(21,480)	(16,181)
Columbia	(9)	(9)	(8)	**61.89**	(550)	(528)	(507)
Cowlitz	(154)	(135)	(116)	**61.89**	(9,552)	(8,374)	(7,195)
Douglas	(58)	(53)	(49)	**61.89**	(3,569)	(3,295)	(3,022)
Ferry	9	10	11	**61.89**	560	606	652
Franklin	14	23	32	**61.89**	887	1,422	1,956
Garfield	5	5	6	**61.89**	326	337	347
Grant	79	91	102	**61.89**	4,907	5,625	6,343
Grays Harbor	60	70	80	**61.89**	3,735	4,343	4,951
Island	(75)	(65)	(55)	**61.89**	(4,624)	(4,020)	(3,416)
Jefferson	0	6	12	**61.89**	19	378	737
King	(768)	(501)	(235)	**61.89**	(47,516)	(31,022)	(14,528)
Kitsap	(68)	(25)	18	**61.89**	(4,193)	(1,528)	1,136
Kittitas	15	21	27	**61.89**	936	1,308	1,681
Klickitat	(58)	(56)	(54)	**61.89**	(3,612)	(3,463)	(3,313)
Lewis	35	46	58	**61.89**	2,170	2,874	3,578
Lincoln	30	32	33	**61.89**	1,884	1,960	2,036
Mason	(179)	(167)	(156)	**61.89**	(11,059)	(10,360)	(9,661)
Okanogan	20	26	31	**61.89**	1,265	1,587	1,909
Pacific	85	87	89	**61.89**	5,232	5,375	5,517
Pend Oreille	14	16	18	**61.89**	851	982	1,113
Pierce	(59)	95	249	**61.89**	(3,672)	5,880	15,432
San Juan	(23)	(21)	(19)	**61.89**	(1,425)	(1,311)	(1,197)
Skagit	(15)	10	35	**61.89**	(921)	637	2,196
Skamania	7	8	10	**61.89**	420	521	622
Snohomish	(1,174)	(1,038)	(902)	**61.89**	(72,664)	(64,234)	(55,804)
Spokane	(128)	(38)	52	**61.89**	(7,943)	(2,371)	3,200
Stevens	64	69	74	**61.89**	3,931	4,271	4,611
Thurston	(384)	(336)	(287)	**61.89**	(23,774)	(20,777)	(17,780)
Wahkiakum	8	8	8	**61.89**	468	477	486
Walla Walla	65	73	81	**61.89**	4,030	4,507	4,984
Whatcom	(255)	(221)	(187)	**61.89**	(15,763)	(13,667)	(11,571)
Whitman	23	27	32	**61.89**	1,394	1,684	1,973
Yakima	(92)	(65)	(38)	**61.89**	(5,700)	(4,036)	(2,372)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

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WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***	**2024 Unmet Need Patient Days***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**2024 Unmet Need ADC*†**
Adams	260	316	372	1	1	1
Asotin	2,317	2,516	2,716	6	7	7
Benton	692	2,710	4,728	2	7	13
Chelan	(13,529)	(12,457)	(11,385)	(37)	(34)	(31)
Clallam	5,506	6,393	7,280	15	18	20
Clark	(26,780)	(21,480)	(16,181)	(73)	(59)	(44)
Columbia	(550)	(528)	(507)	(2)	(1)	(1)
Cowlitz	(9,552)	(8,374)	(7,195)	(26)	(23)	(20)
Douglas	(3,569)	(3,295)	(3,022)	(10)	(9)	(8)
Ferry	560	606	652	2	2	2
Franklin	887	1,422	1,956	2	4	5
Garfield	326	337	347	1	1	1
Grant	4,907	5,625	6,343	13	15	17
Grays Harbor	3,735	4,343	4,951	10	12	14
Island	(4,624)	(4,020)	(3,416)	(13)	(11)	(9)
Jefferson	19	378	737	0	1	2
King	(47,516)	(31,022)	(14,528)	(130)	(85)	(40)
Kitsap	(4,193)	(1,528)	1,136	(11)	(4)	3
Kittitas	936	1,308	1,681	3	4	5
Klickitat	(3,612)	(3,463)	(3,313)	(10)	(9)	(9)
Lewis	2,170	2,874	3,578	6	8	10
Lincoln	1,884	1,960	2,036	5	5	6
Mason	(11,059)	(10,360)	(9,661)	(30)	(28)	(26)
Okanogan	1,265	1,587	1,909	3	4	5
Pacific	5,232	5,375	5,517	14	15	15
Pend Oreille	851	982	1,113	2	3	3
Pierce	(3,672)	5,880	15,432	(10)	16	42
San Juan	(1,425)	(1,311)	(1,197)	(4)	(4)	(3)
Skagit	(921)	637	2,196	(3)	2	6
Skamania	420	521	622	1	1	2
Snohomish	(72,664)	(64,234)	(55,804)	(199)	(176)	(152)
Spokane	(7,943)	(2,371)	3,200	(22)	(6)	9
Stevens	3,931	4,271	4,611	11	12	13
Thurston	(23,774)	(20,777)	(17,780)	(65)	(57)	(49)
Wahkiakum	468	477	486	1	1	1
Walla Walla	4,030	4,507	4,984	11	12	14
Whatcom	(15,763)	(13,667)	(11,571)	(43)	(37)	(32)
Whitman	1,394	1,684	1,973	4	5	5
Yakima	(5,700)	(4,036)	(2,372)	(16)	(11)	(6)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

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WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**2024 Unmet Need ADC*†**	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	6	7	7	FALSE	FALSE
Benton	2	7	13	FALSE	FALSE
Chelan	(37)	(34)	(31)	FALSE	FALSE
Clallam	15	18	20	FALSE	FALSE
Clark	(73)	(59)	(44)	FALSE	FALSE
Columbia	(2)	(1)	(1)	FALSE	FALSE
Cowlitz	(26)	(23)	(20)	FALSE	FALSE
Douglas	(10)	(9)	(8)	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	2	4	5	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	13	15	17	FALSE	FALSE
Grays Harbor	10	12	14	FALSE	FALSE
Island	(13)	(11)	(9)	FALSE	FALSE
Jefferson	0	1	2	FALSE	FALSE
King	(130)	(85)	(40)	FALSE	FALSE
Kitsap	(11)	(4)	3	FALSE	FALSE
Kittitas	3	4	5	FALSE	FALSE
Klickitat	(10)	(9)	(9)	FALSE	FALSE
Lewis	6	8	10	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	(30)	(28)	(26)	FALSE	FALSE
Okanogan	3	4	5	FALSE	FALSE
Pacific	14	15	15	FALSE	FALSE
Pend Oreille	2	3	3	FALSE	FALSE
Pierce	(10)	16	42	***TRUE***	***1***
San Juan	(4)	(4)	(3)	FALSE	FALSE
Skagit	(3)	2	6	FALSE	FALSE
Skamania	1	1	2	FALSE	FALSE
Snohomish	(199)	(176)	(152)	FALSE	FALSE
Spokane	(22)	(6)	9	FALSE	FALSE
Stevens	11	12	13	FALSE	FALSE
Thurston	(65)	(57)	(49)	FALSE	FALSE
Wahkiakum	1	1	1	FALSE	FALSE
Walla Walla	11	12	14	FALSE	FALSE
Whatcom	(43)	(37)	(32)	FALSE	FALSE
Whitman	4	5	5	FALSE	FALSE
Yakima	(16)	(11)	(6)	FALSE	FALSE

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

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Department of Health
2022-2023 Hospice Numeric Need Methodology
290(7)(b) Agencies

Release Year	2022
Supply year 1	2019
Supply year 3	2021
Statewide ALOS	61.89
Default Admits = 35 ADC	206.4

			Supply Years						
			2019		2020		2021		
Provider	**County**	**Certificate Year**	**Survey**	**# Used**	**Survey**	**# Used**	**Survey**	**# Used**	**Notes**
Wesley Homes Hospice	King	2017	91	206.4					Third year 2019
Heart of Hospice	Klickitat	2017	26	206.4					Third year 2019
Envision Hospice	Thurston	2018	24	206.4	25	206.4			Third year 2020
Olympic Medical Center	Clallam	2019	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2021
Providence Health & Services	Clark	2019	*none*	206.4	*none*	206.4	18	206.4	Third year 2021
Envision Hospice	King	2019	*none*	206.4	77	206.4	74	206.4	Third year 2021
Continuum Care of Snohomish	Snohomish	2019	*none*	206.4	143	206.4	342	342.0	Third year 2021
Envision Hospice	Snohomish	2019	*none*	206.4	*none*	206.4	1	206.4	Third year 2021
Glacier Peak Healthcare (Alpha)	Snohomish	2019	*none*	206.4	31	206.4	117	206.4	Third year 2021
Heart of Hospice	Snohomish	2019	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2021
Symbol Healthcare (Puget Sound Hospice)	Thurston	2019	*none*	206.4	6	206.4	19	206.4	Third year 2021
Continuum Care of King	King	2020	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2022
Envision Hospice	Kitsap	2020	*none*	206.4	*none*	206.4	61	206.4	Third year 2022
EmpRes Healthcare Group	Whatcom	2020	*none*	206.4	*none*	206.4	26	206.4	Third year 2022
The Pennant Group (Puget Sound Hospice)	Grays Harbor	2021	*none*	206.4	*none*	206.4	6	206.4	Third year 2023
EmpRes Healthcare Group	King	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Seasons	King	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
The Pennant Group (Puget Sound Hospice)	Mason	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Seasons	King	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
The Pennant Group (Puget Sound Hospice)	Mason	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Providence Health & Services	Pierce	2021	*none*	206.4	*none*	206.4	2	206.4	Third year 2023
Envision Hospice	Pierce	2021	*none*	206.4	*none*	206.4	121	206.4	Third year 2023
EmpRes Healthcare Group	Snohomish	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Seasons	Snohomish	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
MultiCare Health	Thurston	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Bristol Hospice	Thurston	2021	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2023
Stride Health Care	Chelan	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
The Pennant Group	King	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
Y.B.G. Healthcare	King	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
Continuum Care of Snohomish	Pierce	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
The Pennant Group	Pierce	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
Seasons	Pierce	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024
Seasons	Spokane	2022	*none*	206.4	*none*	206.4	*none*	206.4	Third year 2024

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Hospice Capacity Admission Calculations

0-64 Total Admissions by County				65+ Total Admissions by County				Actual Survey Admits Not Adjusted For Newly Approved All Agencies				Actual Survey Admits Only Under Default 290(7)(b) Newly Approved Only				Count of Newly Approved Agencies Only Under Default 290(7)(b) Newly Approved Only				Default Adjustments Only Under Default 290(7)(b) Newly Approved Only				Adjusted Admits Includes Adjustment for 290(7)(b) Agencies All Agencies			
Sum of 0-(	Column Labels			Sum of 65	Column Labels																						
Row Labe	2019	2020	2021	Row Labe	2019	2020	2021	County	2019	2020	2021	County	2019	2020	2021	2019	2020	2021	2019	2020	2021	County	2019	2020	2021	Average
Adams	8	4	4	Adams	54	48	36	Adams	62	52	40	Adams							-	-	-	Adams	62.00	52.00	40.00	**51.33**
Asotin	9	24	9	Asotin	71	84	92	Asotin	80	108	101	Asotin							-	-	-	Asotin	80.00	108.00	101.00	**96.33**
Benton	103	132	107	Benton	837	973	830	Benton	940	1,105	937	Benton							-	-	-	Benton	940.00	1,105.00	937.00	**994.00**
Chelan	28	32	53	Chelan	385	421	686	Chelan	413	453	739	Chelan				1	1	1	206.4	206.4	206.4	Chelan	619.41	659.41	945.41	**741.41**
Clallam	23	24	24	Clallam	234	283	271	Clallam	257	307	295	Clallam	0	0	0	1	1	1	206.4	206.4	206.4	Clallam	463.41	513.41	501.41	**492.75**
Clark	287	297	308	Clark	2060	2238	2464	Clark	2,347	2,535	2,772	Clark	0	0	18	1	1	1	206.4	206.4	206.4	Clark	2,553.41	2,741.41	2,960.41	**2751.75**
Columbia	3	3	3	Columbia	25	50	31	Columbia	28	53	34	Columbia							-	-	-	Columbia	28.00	53.00	34.00	**38.33**
Cowlitz	121	94	116	Cowlitz	735	707	793	Cowlitz	856	801	909	Cowlitz							-	-	-	Cowlitz	856.00	801.00	909.00	**855.33**
Douglas	19	17	23	Douglas	130	170	227	Douglas	149	187	250	Douglas							-	-	-	Douglas	149.00	187.00	250.00	**195.33**
Ferry	5	3	6	Ferry	25	28	32	Ferry	30	31	38	Ferry							-	-	-	Ferry	30.00	31.00	38.00	**33.00**
Franklin	26	34	17	Franklin	166	194	134	Franklin	192	228	151	Franklin							-	-	-	Franklin	192.00	228.00	151.00	**190.33**
Garfield	1	3	0	Garfield	4	7	6	Garfield	5	10	6	Garfield							-	-	-	Garfield	5.00	10.00	6.00	**7.00**
Grant	45	40	27	Grant	236	254	230	Grant	281	294	257	Grant							-	-	-	Grant	281.00	294.00	257.00	**277.33**
Grays Harl	41	27	2	Grays Harl	212	186	8	Grays Harbor	253	213	10	Grays Harbor			6	1	1	1	206.4	206.4	206.4	Grays Harbor	459.41	419.41	210.41	**363.08**
Island	43	54	68	Island	341	375	450	Island	384	429	518	Island							-	-	-	Island	384.00	429.00	518.00	**443.67**
Jefferson	26	17	15	Jefferson	181	194	171	Jefferson	207	211	186	Jefferson							-	-	-	Jefferson	207.00	211.00	186.00	**201.33**
King	765	889	812	King	6315	7131	6592	King	7,080	8,020	7,404	King	91	77	74	7	6	6	1,444.9	1,238.5	1,238.5	King	8,433.90	9,181.49	8,568.49	**8727.96**
Kitsap	173	96	389	Kitsap	1074	921	704	Kitsap	1,247	1,017	1,093	Kitsap		0	61	1	1	1	206.4	206.4	206.4	Kitsap	1,453.41	1,223.41	1,238.41	**1305.08**
Kittitas	16	12	15	Kittitas	169	157	115	Kittitas	185	169	130	Kittitas							-	-	-	Kittitas	185.00	169.00	130.00	**161.33**
Klickitat	12	12	13	Klickitat	90	87	82	Klickitat	102	99	95	Klickitat	26			1			206.4	-	-	Klickitat	282.41	99.00	95.00	**158.80**
Lewis	50	47	38	Lewis	362	401	421	Lewis	412	448	459	Lewis							-	-	-	Lewis	412.00	448.00	459.00	**439.67**
Lincoln	3	6	5	Lincoln	22	22	12	Lincoln	25	28	17	Lincoln							-	-	-	Lincoln	25.00	28.00	17.00	**23.33**
Mason	34	43	37	Mason	193	263	347	Mason	227	306	384	Mason			0	1	1	1	206.4	206.4	206.4	Mason	433.41	512.41	590.41	**512.08**
Okanogan	27	31	19	Okanogan	171	167	183	Okanogan	198	198	202	Okanogan							-	-	-	Okanogan	198.00	198.00	202.00	**199.33**
Pacific	15	12	2	Pacific	98	69	2	Pacific	113	81	4	Pacific							-	-	-	Pacific	113.00	81.00	4.00	**66.00**
Pend Oreil	4	17	12	Pend Oreil	65	49	55	Pend Oreille	69	66	67	Pend Oreille							-	-	-	Pend Oreille	69.00	66.00	67.00	**67.33**
Pierce	556	425	322	Pierce	3170	2714	2310	Pierce	3,726	3,139	2,632	Pierce			123	5	5	5	1,032.1	1,032.1	1,032.1	Pierce	4,758.07	4,171.07	3,541.07	**4156.74**
San Juan	6	8	5	San Juan	73	89	95	San Juan	79	97	100	San Juan							-	-	-	San Juan	79.00	97.00	100.00	**92.00**
Skagit	77	70	85	Skagit	705	607	750	Skagit	782	677	835	Skagit							-	-	-	Skagit	782.00	677.00	835.00	**764.67**
Skamania	1	3	4	Skamania	33	37	38	Skamania	34	40	42	Skamania							-	-	-	Skamania	34.00	40.00	42.00	**38.67**
Snohomisl	342	361	514	Snohomisl	2214	2636	3580	Snohomish	2,556	2,997	4,094	Snohomish	0	174	118	6	6	5	1,238.5	1,238.5	1,032.1	Snohomish	3,794.49	4,061.49	5,008.07	**4288.02**
Spokane	342	362	368	Spokane	2333	2648	2690	Spokane	2,675	3,010	3,058	Spokane				1	1	1	206.4	206.4	206.4	Spokane	2,881.41	3,216.41	3,264.41	**3120.75**
Stevens	20	21	31	Stevens	126	128	111	Stevens	146	149	142	Stevens							-	-	-	Stevens	146.00	149.00	142.00	**145.67**
Thurston	115	129	107	Thurston	947	1070	923	Thurston	1,062	1,199	1,030	Thurston	24	31	19	4	4	3	825.7	825.7	619.2	Thurston	1,863.66	1,993.66	1,630.24	**1829.19**
Wahkiaku	0	3	3	Wahkiaku	7	11	17	Wahkiakum	7	14	20	Wahkiakum							-	-	-	Wahkiakum	7.00	14.00	20.00	**13.67**
Walla Wal	41	41	41	Walla Wal	242	242	242	Walla Walla	283	283	283	Walla Walla							-	-	-	Walla Walla	283.00	283.00	283.00	**283.00**
Whatcom	138	80	113	Whatcom	995	978	1054	Whatcom	1,133	1,058	1,167	Whatcom		0	26	1	1	1	206.4	206.4	206.4	Whatcom	1,339.41	1,264.41	1,347.41	**1317.08**
Whitman	12	12	15	Whitman	77	128	175	Whitman	89	140	190	Whitman							-	-	-	Whitman	89.00	140.00	190.00	**139.67**
Yakima	175	195	161	Yakima	998	1190	925	Yakima	1,173	1,385	1,086	Yakima							-	-	-	Yakima	1,173.00	1,385.00	1,086.00	**1214.67**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/61.89 ALOS = 206.4 default admissions
206.4 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Includes one or more proxies for new agencies, survey year predates approval.

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kindred Hospice	IHS.FS.60308060	Spokane	2019	23	248
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169
Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613

Sources:
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Department of Health
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Survey Data

Agency Name	License Number	County	Year	0-64	65+
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	1	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
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Agency Name	License Number	County	Year	0-64	65+
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Whatcom Hospice	IHS.FS.00000471	Whatcom	2020	80	978
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2020	29	252
Alpha Hospice	IHS.FS.61032013	Snohomish	2021	6	111
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2021	9	92
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2021	0	6
Astria Hospice	IHS.FS.60097245	Yakima	2021	3	52
Bristol Hospice - Thurston, LLC	IHS.FS.61211200	Thurston	2021	0	0
Central Washington Home Care Services	IHS.FS.00000250	Chelan	2021	53	686
Central Washington Home Care Services	IHS.FS.00000250	Douglas	2021	19	209
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2021	73	558
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2021	1	14
Community Home Health/Hospice	IHS.FS.60547198	Clark	2021	57	425
Continuum Care of King LLC	IHS.FS.61058934	King	2021	0	0
Continuum Care of Snohomish, LLC	IHS.FS.61010090	Snohomish	2021	36	306
Continuum Care of Snohomish, LLC	IHS.FS.61010090	King	2021	9	309
Eden Hospice at Whatcom County	IHS.FS.61117985	Whatcom	2021	2	24
Eden Hospice at Whatcom County	IHS.FS.61117985	Skagit	2021	0	1
Enhabit Hospice	IHS.FS.61165576	Douglas	2021	4	18
Enhabit Hospice	IHS.FS.61165576	Grant	2021	2	5
Enhabit Hospice	IHS.FS.61165576	Okanogan	2021	19	183
Enhabit Hospice	IHS.FS.61165576	Lincoln	2021	0	0
Enhabit Hospice	IHS.FS.61165576	Ferry	2021	0	0
Enhabit Hospice	IHS.FS.61165576	Chelan	2021	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2021	0	1
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2021	1	73
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2021	6	55
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2021	8	113
Envision Hospice of Washington, LLC	IHS.FS.60952486	Thurston	2021	1	22
EvergreenHealth	IHS.FS.00000278	King	2021	259	2082
EvergreenHealth	IHS.FS.00000278	Snohomish	2021	67	627
EvergreenHealth	IHS.FS.00000278	Island	2021	0	4
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2021	356	371
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2021	141	1081
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2021	31	387
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2021	2	2

Sources:
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Agency Name	License Number	County	Year	0-64	65+
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2021	2	2
HEART OF HOSPICE	IHS.FS.60741443	Clark	2021	0	0
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2021	3	20
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2021	2	22
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2021	0	0
Heartlinks	IHS.FS.00000369	Benton	2021	17	205
Heartlinks	IHS.FS.00000369	Yakima	2021	15	224
Heartlinks	IHS.FS.00000369	Franklin	2021	1	9
Horizon Hospice	IHS.FS.00000332	Spokane	2021	36	520
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2021	14	162
Hospice of Spokane	IHS.FS.00000337	Spokane	2021	317	1899
Hospice of Spokane	IHS.FS.00000337	Stevens	2021	31	111
Hospice of Spokane	IHS.FS.00000337	Ferry	2021	6	32
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2021	12	55
Hospice of Spokane	IHS.FS.00000337	Lincoln	2021	1	2
Kaiser Permanente	IHS.FS.00000353	Clark	2021	37	408
Kaiser Permanente	IHS.FS.00000353	Cowlitz	2021	4	7
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2021	42	281
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2021	11	138
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2021	21	156
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2021	5	63
Kittitas Valley Healthcare Hospice	IHS.FS.00000320	Kittitas	2021	15	115
Klickitat Valley Health - Hospice	IHS.FS.00000361	Klickitat	2021	3	28
Kline Galland Hospice	IHS.FS.60103742	King	2021	42	410
Memorial Home Care Services	IHS.FS.00000376	Yakima	2021	143	649
Multicare Hospice	IHS.FS.60639376	King	2021	21	141
Multicare Hospice	IHS.FS.60639376	Pierce	2021	145	914
Multicare Hospice	IHS.FS.60639376	Kitsap	2021	16	140
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2021	24	271
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2021	1	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2021	19	221
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2021	12	47
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2021	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2021	31	282
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Spokane	2021	15	271
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Whitman	2021	15	175
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2021	1	116
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2021	0	0
PeaceHealth Southwest Hospice	IHS.FS.60331226	Clark	2021	213	1614
PeaceHealth Southwest Hospice	IHS.FS.60331226	Cowlitz	2021	39	228
PeaceHealth Southwest Hospice	IHS.FS.60331226	Skamania	2021	0	1
PeaceHealth Southwest Hospice	IHS.FS.60331226	Wahkiakum	2021	2	3
Providence Hospice	IHS.FS.60201476	Klickitat	2021	7	34
Providence Hospice	IHS.FS.60201476	Skamania	2021	2	15
Providence Hospice	IHS.FS.60201476	Clark	2021	1	17
Providence Hospice of Seattle	IHS.FS.00000336	King	2021	402	2664
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2021	1	1
Providence Hospice Snohomish	IHS.FS.00000418	Island	2021	7	36
Providence Hospice Snohomish	IHS.FS.00000418	Snohomish	2021	387	2378
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2021	75	600
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2021	25	300
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2021	19	200
Puget Sound Hospice	IHS.FS.61032138	Thurston	2021	0	19
Puget Sound Hospice	IHS.FS.61032138	Mason	2021	0	0
Puget Sound Hospice	IHS.FS.61032138	Pierce	2021	0	0
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2021	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2021	22	111
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2021	5	95
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2021	85	749
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2021	13	94
Tri Cities Chaplaincy	IHS.FS.00000456	Benton	2021	90	625
Tri Cities Chaplaincy	IHS.FS.00000456	Franklin	2021	16	125
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2021	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2021	3	31
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2021	4	36
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2021	25	225
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2021	4	10
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2021	4	129
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2021	6	44
Whatcom Hospice	IHS.FS.00000471	Whatcom	2021	111	1030
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2021	39	299

Sources:
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Department of Health

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*Preliminary Death Data Updated October 3, 2022**

	0-64			65+		
County	**2019**	**2020**	**2021**	**2019**	**2020**	**2021**
ADAMS	35	20	23	93	59	92
ASOTIN	54	56	43	222	186	188
BENTON	346	555	536	1154	1522	1610
CHELAN	137	224	256	626	785	870
CLALLAM	186	195	185	955	777	906
CLARK	887	1043	1078	2987	3205	3705
COLUMBIA	7	7	11	52	43	43
COWLITZ	294	314	401	951	968	1100
DOUGLAS	63	42	45	270	160	174
FERRY	20	19	21	64	58	63
FRANKLIN	123	100	110	313	263	261
GARFIELD	5	5	4	21	11	24
GRANT	197	186	208	508	455	523
GRAYS HARBOR	251	209	236	659	558	590
ISLAND	167	110	116	642	505	504
JEFFERSON	72	68	54	338	273	295
KING	3,275	4456	4892	10213	11186	11896
KITSAP	557	454	489	1811	1714	1832
KITTITAS	90	78	88	266	241	241
KLICKITAT	46	42	50	160	113	164
LEWIS	210	205	186	722	653	723
LINCOLN	25	15	24	89	75	76
MASON	167	143	168	548	408	461
OKANOGAN	119	88	92	358	277	324
PACIFIC	66	55	59	265	177	239
PEND OREILLE	31	41	55	125	101	119
PIERCE	1,911	2364	2574	5002	5608	6264
SAN JUAN	20	18	24	127	94	91
SKAGIT	229	269	334	1018	1068	1190
SKAMANIA	19	26	25	87	47	56
SNOHOMISH	1,533	1587	1563	4081	4278	4478
SPOKANE	1,143	1634	1842	3545	4322	4810
STEVENS	112	86	114	345	248	304
THURSTON	525	628	763	1908	2007	2285
WAHKIAKUM	11	10	7	53	18	25
WALLA WALLA	118	150	138	450	522	595
WHATCOM	394	457	443	1461	1481	1674
WHITMAN	47	51	59	219	226	278
YAKIMA	555	653	699	1451	1675	1644

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0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,303
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,655
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	169,475
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,401
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,389
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	416,817
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,782
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,859
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,487
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,582
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	90,186
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,561
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	87,144
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,008
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,219
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,688
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,903,445
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	219,729
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,918
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,572
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,955
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,807
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	51,050
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,211
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,424
Pend Oreil	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,813
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	763,798
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,782
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	101,410
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,238
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	714,698
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	425,148
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,006
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	241,186
Wahkiakur	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,448
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,924
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	187,499
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,282
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	224,364

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,317
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,997
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	32,170
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	16,445
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	22,323
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	82,139
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,264
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,945
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	8,334
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,233
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,627
Garfield	595	607	620	633	645	658	669	680	692	703	714	658
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	15,469
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,636
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,809
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,945
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	324,334
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	55,965
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,952
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	6,062
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	17,241
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,963
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	16,524
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,862
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,897
Pend Oreil	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	4,090
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	136,408
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,978
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	29,121
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,797
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	125,510
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	91,294
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,804
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	52,830
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,549
Walla Wall	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,141
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	42,586
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,783
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	38,465

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Adams** ***Select from drop down menu***

Adams County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,303
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,317

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		35	20	23				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	26							
Projected patient deaths: 23.16%	**3**	6							
Average population (OFM)	**4**	18,303							
Projected population	**N/A**		18,160	18,291	18,456	18,622	18,787	18,953	**Steps 2-4**
Potential volume	**N/A**		6	6	6	6	6	6	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		93	59	92				**Ages 65+**
Average deaths (2019-2021)	**2**	81							
Projected patient deaths: 58.07%	**3**	47							
Average population (OFM)	**4**	2,317							
Projected population	**N/A**		2,227	2,341	2,383	2,424	2,466	2,507	**Steps 2-4**
Potential volume	**N/A**		45	48	49	49	50	51	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		51	54	55	56	56	57	**All Ages**
Current capacity (DOH survey)	**N/A**	51							
Unmet need	**5**		**0**	**2**	**3**	**4**	**5**	**6**	
Unmet need patient days (statewide ALOS)	**6**	61.89	3	149	205	260	316	372	
Unmet Average Daily Census (ADC)	**7**		0	0	1	1	1	1	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Asotin** ***Select from drop down menu***

Asotin County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,655
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,997

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		54	56	43				Ages 0 - 64
Average deaths (2019-2021)	2	51							
Projected patient deaths: 23.16%	3	12							
Average population (OFM)	4	16,655							
Projected population	N/A		16,715	16,652	16,596	16,540	16,485	16,429	Steps 2-4
Potential volume	N/A		12	12	12	12	12	12	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		222	186	188				Ages 65+
Average deaths (2019-2021)	2	199							
Projected patient deaths: 58.07%	3	115							
Average population (OFM)	4	5,997							
Projected population	N/A		5,812	6,005	6,175	6,344	6,514	6,683	Steps 2-4
Potential volume	N/A		112	116	119	122	125	129	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		124	127	131	134	137	140	All Ages
Current capacity (DOH survey)	N/A	96							
Unmet need	5		**27**	**31**	**34**	**37**	**41**	**44**	
Unmet need patient days (statewide ALOS)	6	61.89	1,691	1,918	2,117	2,317	2,516	2,716	
Unmet Average Daily Census (ADC)	7		5	5	6	6	7	7	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Benton** ***Select from drop down menu***

Benton County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	169,475
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	32,170

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		346	555	536				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	479							
Projected patient deaths: 23.16%	3	111							
Average population (OFM)	4	169,475							
Projected population	N/A		167,984	169,415	171,026	172,638	174,249	175,861	
Potential volume	N/A		110	111	112	113	114	115	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		1,154	1,522	1,610				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	1,429							
Projected patient deaths: 58.07%	3	830							
Average population (OFM)	4	32,170							
Projected population	N/A		30,986	32,150	33,373	34,597	35,820	37,044	
Potential volume	N/A		799	829	861	892	924	955	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		909	940	973	1,005	1,038	1,070	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	994							
Unmet need	5		**(85)**	**(54)**	**(21)**	**11**	**44**	**76**	
Unmet need patient days (statewide ALOS)	6	61.89	(5,260)	(3,343)	(1,325)	692	2,710	4,728	
Unmet Average Daily Census (ADC)	7		(14)	(9)	(4)	2	7	13	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Chelan** ***Select from drop down menu***

Chelan County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,401
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	16,445

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		137	224	256				Ages 0 - 64
Average deaths (2019-2021)	2	206							
Projected patient deaths: 23.16%	3	48							
Average population (OFM)	4	62,401							
Projected population	N/A		62,227	62,463	62,512	62,562	62,611	62,661	Steps 2-4
Potential volume	N/A		48	48	48	48	48	48	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		626	785	870				Ages 65+
Average deaths (2019-2021)	2	760							
Projected patient deaths: 58.07%	3	442							
Average population (OFM)	4	16,445							
Projected population	N/A		15,876	16,408	17,052	17,695	18,339	18,982	Steps 2-4
Potential volume	N/A		426	441	458	475	492	510	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		474	488	506	523	540	557	All Ages
Current capacity (DOH survey)	N/A	741							
Unmet need	5		**(268)**	**(253)**	**(236)**	**(219)**	**(201)**	**(184)**	
Unmet need patient days (statewide ALOS)	6	61.89	(16,568)	(15,672)	(14,600)	(13,529)	(12,457)	(11,385)	
Unmet Average Daily Census (ADC)	7		(45)	(43)	(40)	(37)	(34)	(31)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Clallam** ***Select from drop down menu***

Clallam County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,389
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	22,323

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		186	195	185				Ages 0 - 64
Average deaths (2019-2021)	2	189							
Projected patient deaths: 23.16%	3	44							
Average population (OFM)	4	52,389							
Projected population	N/A		52,494	52,439	52,233	52,027	51,821	51,615	Steps 2-4
Potential volume	N/A		44	44	44	43	43	43	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		955	777	906				Ages 65+
Average deaths (2019-2021)	2	879							
Projected patient deaths: 58.07%	3	511							
Average population (OFM)	4	22,323							
Projected population	N/A		21,800	22,267	22,901	23,535	24,168	24,802	Steps 2-4
Potential volume	N/A		499	509	524	538	553	567	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		542	553	567	582	596	610	All Ages
Current capacity (DOH survey)	N/A	493							
Unmet need	5		**50**	**60**	**75**	**89**	**103**	**118**	
Unmet need patient days (statewide ALOS)	6	61.89	3,076	3,733	4,620	5,506	6,393	7,280	
Unmet Average Daily Census (ADC)	7		8	10	13	15	18	20	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Clark** ***Select from drop down menu***

Clark County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	416,817
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	82,139

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		887	1,043	1,078				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	1,003							
Projected patient deaths: 23.16%	3	232							
Average population (OFM)	4	416,817							
Projected population	N/A		411,278	417,273	421,901	426,529	431,158	435,786	
Potential volume	N/A		229	232	235	238	240	243	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		2,987	3,205	3,705				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	3,299							
Projected patient deaths: 58.07%	3	1,916							
Average population (OFM)	4	82,139							
Projected population	N/A		78,605	82,125	85,686	89,247	92,807	96,368	
Potential volume	N/A		1,833	1,915	1,998	2,081	2,164	2,248	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		2,062	2,148	2,233	2,319	2,405	2,490	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	2,752							
Unmet need	5		**(689)**	**(604)**	**(518)**	**(433)**	**(347)**	**(261)**	
Unmet need patient days (statewide ALOS)	6	61.89	(42,666)	(37,378)	(32,079)	(26,780)	(21,480)	(16,181)	
Unmet Average Daily Census (ADC)	7		(117)	(102)	(88)	(73)	(59)	(44)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Columbia** ***Select from drop down menu***

Columbia County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,782
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,264

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		7	7	11				Ages 0 - 64
Average deaths (2019-2021)	2	8							
Projected patient deaths: 23.16%	3	2							
Average population (OFM)	4	2,782							
Projected population	N/A		2,822	2,780	2,745	2,710	2,675	2,640	Steps 2-4
Potential volume	N/A		2	2	2	2	2	2	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		52	43	43				Ages 65+
Average deaths (2019-2021)	2	46							
Projected patient deaths: 58.07%	3	27							
Average population (OFM)	4	1,264							
Projected population	N/A		1,236	1,269	1,287	1,304	1,322	1,339	Steps 2-4
Potential volume	N/A		26	27	27	28	28	28	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		28	29	29	29	30	30	All Ages
Current capacity (DOH survey)	N/A	38							
Unmet need	5		(10)	(10)	(9)	(9)	(9)	(8)	
Unmet need patient days (statewide ALOS)	6	61.89	(635)	(593)	(572)	(550)	(528)	(507)	
Unmet Average Daily Census (ADC)	7		(2)	(2)	(2)	(2)	(1)	(1)	Steps 5-8
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Cowlitz** ***Select from drop down menu***

Cowlitz County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,859
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,945

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		294	314	401				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	336							
Projected patient deaths: 23.16%	3	78							
Average population (OFM)	4	85,859							
Projected population	N/A		85,817	85,917	85,843	85,769	85,695	85,621	
Potential volume	N/A		78	78	78	78	78	78	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		951	968	1,100				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	1,006							
Projected patient deaths: 58.07%	3	584							
Average population (OFM)	4	22,945							
Projected population	N/A		22,148	22,969	23,719	24,470	25,220	25,971	
Potential volume	N/A		564	585	604	623	642	661	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		642	663	682	701	720	739	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	855							
Unmet need	5		**(213)**	**(192)**	**(173)**	**(154)**	**(135)**	**(116)**	
Unmet need patient days (statewide ALOS)	6	61.89	(13,210)	(11,910)	(10,731)	(9,552)	(8,374)	(7,195)	
Unmet Average Daily Census (ADC)	7		(36)	(33)	(29)	(26)	(23)	(20)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Douglas** ***Select from drop down menu***

Douglas County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,487
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	8,334

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		63	42	45				Ages 0 - 64
Average deaths (2019-2021)	2	50							
Projected patient deaths: 23.16%	3	12							
Average population (OFM)	4	35,487							
Projected population	N/A		35,130	35,527	35,803	36,080	36,356	36,633	Steps 2-4
Potential volume	N/A		11	12	12	12	12	12	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		270	160	174				Ages 65+
Average deaths (2019-2021)	2	201							
Projected patient deaths: 58.07%	3	117							
Average population (OFM)	4	8,334							
Projected population	N/A		7,976	8,358	8,666	8,974	9,283	9,591	Steps 2-4
Potential volume	N/A		112	117	122	126	130	135	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		123	129	133	138	142	147	All Ages
Current capacity (DOH survey)	N/A	195							
Unmet need	5		**(72)**	**(66)**	**(62)**	**(58)**	**(53)**	**(49)**	
Unmet need patient days (statewide ALOS)	6	61.89	(4,454)	(4,115)	(3,842)	(3,569)	(3,295)	(3,022)	
Unmet Average Daily Census (ADC)	7		(12)	(11)	(11)	(10)	(9)	(8)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Ferry** ***Select from drop down menu***

Ferry County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,582
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,233

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		20	19	21				Ages 0 - 64
Average deaths (2019-2021)	2	20							
Projected patient deaths: 23.16%	3	5							
Average population (OFM)	4	5,582							
Projected population	N/A		5,628	5,577	5,541	5,506	5,470	5,435	Steps 2-4
Potential volume	N/A		5	5	5	5	5	5	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		64	58	63				Ages 65+
Average deaths (2019-2021)	2	62							
Projected patient deaths: 58.07%	3	36							
Average population (OFM)	4	2,233							
Projected population	N/A		2,168	2,241	2,289	2,337	2,386	2,434	Steps 2-4
Potential volume	N/A		35	36	37	37	38	39	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		39	41	41	42	43	44	All Ages
Current capacity (DOH survey)	N/A	33							
Unmet need	5		**6**	**8**	**8**	**9**	**10**	**11**	
Unmet need patient days (statewide ALOS)	6	61.89	399	468	514	560	606	652	
Unmet Average Daily Census (ADC)	7		1	1	1	2	2	2	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Franklin** ***Select from drop down menu***

Franklin County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	90,186
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,627

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		123	100	110				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	111							
Projected patient deaths: 23.16%	3	26							
Average population (OFM)	4	90,186							
Projected population	N/A		88,012	90,102	92,443	94,784	97,124	99,465	
Potential volume	N/A		25	26	26	27	28	28	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		313	263	261				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	279							
Projected patient deaths: 58.07%	3	162							
Average population (OFM)	4	9,627							
Projected population	N/A		9,188	9,610	10,083	10,557	11,030	11,504	
Potential volume	N/A		155	162	170	178	186	194	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		180	187	196	205	213	222	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	190							
Unmet need	5		**(11)**	**(3)**	**6**	**14**	**23**	**32**	
Unmet need patient days (statewide ALOS)	6	61.89	(658)	(181)	353	887	1,422	1,956	
Unmet Average Daily Census (ADC)	7		(2)	(0)	1	2	4	5	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Garfield** ***Select from drop down menu***

Garfield County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,561
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Garfield	595	607	620	633	645	658	669	680	692	703	714	658

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		5	5	4				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	5							
Projected patient deaths: 23.16%	3	1							
Average population (OFM)	4	1,561							
Projected population	N/A		1,581	1,560	1,541	1,522	1,502	1,483	
Potential volume	N/A		1	1	1	1	1	1	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		21	11	24				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	19							
Projected patient deaths: 58.07%	3	11							
Average population (OFM)	4	658							
Projected population	N/A		645	658	669	680	692	703	
Potential volume	N/A		11	11	11	11	11	12	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		12	12	12	12	12	13	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	7							
Unmet need	5		**5**	**5**	**5**	**5**	**5**	**6**	
Unmet need patient days (statewide ALOS)	6	61.89	293	305	316	326	337	347	
Unmet Average Daily Census (ADC)	7		1	1	1	1	1	1	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Grant** ***Select from drop down menu***

Grant County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	87,144
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	15,469

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		197	186	208				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	197							
Projected patient deaths: 23.16%	3	46							
Average population (OFM)	4	87,144							
Projected population	N/A		86,033	87,158	88,240	89,322	90,403	91,485	
Potential volume	N/A		45	46	46	47	47	48	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		508	455	523				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	495							
Projected patient deaths: 58.07%	3	288							
Average population (OFM)	4	15,469							
Projected population	N/A		14,861	15,477	16,071	16,665	17,258	17,852	
Potential volume	N/A		276	288	299	310	321	332	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		321	333	345	357	368	380	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	277							
Unmet need	5		**44**	**56**	**68**	**79**	**91**	**102**	
Unmet need patient days (statewide ALOS)	6	61.89	2,724	3,470	4,188	4,907	5,625	6,343	
Unmet Average Daily Census (ADC)	7		7	9	11	13	15	17	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Grays Harbo** ***Select from drop down menu***

Grays Harbor County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Grays Harbor	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,008
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Grays Harbor	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,636

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		251	209	236				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	232							
Projected patient deaths: 23.16%	**3**	54							
Average population (OFM)	**4**	57,008							
Projected population	**N/A**		57,387	56,958	56,679	56,401	56,122	55,844	**Steps 2-4**
Potential volume	**N/A**		54	54	53	53	53	53	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		659	558	590				**Ages 65+**
Average deaths (2019-2021)	**2**	602							
Projected patient deaths: 58.07%	**3**	350							
Average population (OFM)	**4**	16,636							
Projected population	**N/A**		16,123	16,653	17,133	17,612	18,092	18,571	**Steps 2-4**
Potential volume	**N/A**		339	350	360	370	380	390	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		393	404	414	423	433	443	**All Ages**
Current capacity (DOH survey)	**N/A**	363							
Unmet need	**5**		**30**	**41**	**51**	**60**	**70**	**80**	
Unmet need patient days (statewide ALOS)	**6**	61.89	1,856	2,520	3,127	3,735	4,343	4,951	
Unmet Average Daily Census (ADC)	**7**		5	7	9	10	12	14	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Island** ***Select from drop down menu***

Island County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,219
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,809

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		167	110	116				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	131							
Projected patient deaths: 23.16%	3	30							
Average population (OFM)	4	63,219							
Projected population	N/A		63,114	63,264	63,280	63,296	63,312	63,328	
Potential volume	N/A		30	30	30	30	30	30	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		642	505	504				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	550							
Projected patient deaths: 58.07%	3	320							
Average population (OFM)	4	20,809							
Projected population	N/A		20,239	20,777	21,412	22,047	22,682	23,317	
Potential volume	N/A		311	319	329	339	348	358	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		341	349	359	369	379	388	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	444							
Unmet need	5		**(103)**	**(94)**	**(84)**	**(75)**	**(65)**	**(55)**	
Unmet need patient days (statewide ALOS)	6	61.89	(6,348)	(5,832)	(5,228)	(4,624)	(4,020)	(3,416)	
Unmet Average Daily Census (ADC)	7		(17)	(16)	(14)	(13)	(11)	(9)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Jefferson** ***Select from drop down menu***

Jefferson County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,688
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,945

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		72	68	54				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	65							
Projected patient deaths: 23.16%	**3**	15							
Average population (OFM)	**4**	20,688							
Projected population	**N/A**		20,705	20,722	20,636	20,550	20,463	20,377	**Steps 2-4**
Potential volume	**N/A**		15	15	15	15	15	15	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		338	273	295				**Ages 65+**
Average deaths (2019-2021)	**2**	302							
Projected patient deaths: 58.07%	**3**	175							
Average population (OFM)	**4**	11,945							
Projected population	**N/A**		11,588	11,924	12,323	12,722	13,121	13,520	**Steps 2-4**
Potential volume	**N/A**		170	175	181	187	193	198	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		185	190	196	202	207	213	**All Ages**
Current capacity (DOH survey)	**N/A**	201							
Unmet need	**5**		**(16)**	**(11)**	**(5)**	**0**	**6**	**12**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(1,004)	(698)	(339)	19	378	737	
Unmet Average Daily Census (ADC)	**7**		(3)	(2)	(1)	0	1	2	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **King** ***Select from drop down menu***

King County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,903,445
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	324,334

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		3,275	4,456	4,892				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	4,208							
Projected patient deaths: 23.16%	**3**	975							
Average population (OFM)	**4**	1,903,445							
Projected population	**N/A**		1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	**Steps 2-4**
Potential volume	**N/A**		965	976	982	988	994	1000	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		10,213	11,186	11,896				**Ages 65+**
Average deaths (2019-2021)	**2**	11,098							
Projected patient deaths: 58.07%	**3**	6,445							
Average population (OFM)	**4**	324,334							
Projected population	**N/A**		310,572	324,660	337,771	350,881	363,992	377,102	**Steps 2-4**
Potential volume	**N/A**		6,171	6,451	6,711	6,972	7,232	7,493	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		7,136	7,427	7,694	7,960	8,227	8,493	**All Ages**
Current capacity (DOH survey)	**N/A**	8,728							
Unmet need	**5**		**(1,592)**	**(1,301)**	**(1,034)**	**(768)**	**(501)**	**(235)**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(98,515)	(80,505)	(64,010)	(47,516)	(31,022)	(14,528)	
Unmet Average Daily Census (ADC)	**7**		(270)	(220)	(175)	(130)	(85)	(40)	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kitsap** ***Select from drop down menu***

Kitsap County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	219,729
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	55,965

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		557	454	489				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	500							
Projected patient deaths: 23.16%	**3**	116							
Average population (OFM)	**4**	219,729							
Projected population	**N/A**		218,538	220,035	220,614	221,192	221,771	222,349	**Steps 2-4**
Potential volume	**N/A**		115	116	116	117	117	117	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		1,811	1,714	1,832				**Ages 65+**
Average deaths (2019-2021)	**2**	1,786							
Projected patient deaths: 58.07%	**3**	1,037							
Average population (OFM)	**4**	55,965							
Projected population	**N/A**		53,833	55,878	58,185	60,492	62,800	65,107	**Steps 2-4**
Potential volume	**N/A**		997	1,035	1,078	1,121	1,164	1,206	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		1,113	1,151	1,194	1,237	1,280	1,323	**All Ages**
Current capacity (DOH survey)	**N/A**	1,305							
Unmet need	**5**		**(193)**	**(154)**	**(111)**	**(68)**	**(25)**	**18**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(11,916)	(9,522)	(6,857)	(4,193)	(1,528)	1,136	
Unmet Average Daily Census (ADC)	**7**		(33)	(26)	(19)	(11)	(4)	3	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kittitas** ***Select from drop down menu***

Kittitas County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,918
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,952

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		90	78	88				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	85							
Projected patient deaths: 23.16%	**3**	20							
Average population (OFM)	**4**	38,918							
Projected population	**N/A**		38,453	39,015	39,286	39,556	39,827	40,097	**Steps 2-4**
Potential volume	**N/A**		20	20	20	20	20	20	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		266	241	241				**Ages 65+**
Average deaths (2019-2021)	**2**	249							
Projected patient deaths: 58.07%	**3**	145							
Average population (OFM)	**4**	7,952							
Projected population	**N/A**		7,647	7,943	8,266	8,589	8,911	9,234	**Steps 2-4**
Potential volume	**N/A**		139	145	150	156	162	168	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		159	164	170	176	182	188	**All Ages**
Current capacity (DOH survey)	**N/A**	161							
Unmet need	**5**		**(3)**	**3**	**9**	**15**	**21**	**27**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(159)	192	564	936	1,308	1,681	
Unmet Average Daily Census (ADC)	**7**		(0)	1	2	3	4	5	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Klickitat** ***Select from drop down menu***

Klickitat County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,572
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	6,062

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		46	42	50				Ages 0 - 64
Average deaths (2019-2021)	2	46							
Projected patient deaths: 23.16%	3	11							
Average population (OFM)	4	15,572							
Projected population	N/A		15,702	15,575	15,439	15,304	15,168	15,033	Steps 2-4
Potential volume	N/A		11	11	11	10	10	10	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		160	113	164				Ages 65+
Average deaths (2019-2021)	2	146							
Projected patient deaths: 58.07%	3	85							
Average population (OFM)	4	6,062							
Projected population	N/A		5,829	6,088	6,268	6,448	6,627	6,807	Steps 2-4
Potential volume	N/A		81	85	87	90	92	95	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		92	96	98	100	103	105	All Ages
Current capacity (DOH survey)	N/A	159							
Unmet need	5		**(67)**	**(63)**	**(61)**	**(58)**	**(56)**	**(54)**	
Unmet need patient days (statewide ALOS)	6	61.89	(4,130)	(3,911)	(3,762)	(3,612)	(3,463)	(3,313)	
Unmet Average Daily Census (ADC)	7		(11)	(11)	(10)	(10)	(9)	(9)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lewis** ***Select from drop down menu***

Lewis County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,955
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	17,241

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		210	205	186				Ages 0 - 64
Average deaths (2019-2021)	2	200							
Projected patient deaths: 23.16%	3	46							
Average population (OFM)	4	62,955							
Projected population	N/A		62,700	63,001	63,164	63,327	63,491	63,654	Steps 2-4
Potential volume	N/A		46	46	47	47	47	47	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		722	653	723				Ages 65+
Average deaths (2019-2021)	2	699							
Projected patient deaths: 58.07%	3	406							
Average population (OFM)	4	17,241							
Projected population	N/A		16,808	17,219	17,697	18,175	18,652	19,130	Steps 2-4
Potential volume	N/A		396	406	417	428	439	451	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		442	452	463	475	486	497	All Ages
Current capacity (DOH survey)	N/A	440							
Unmet need	5		**2**	**12**	**24**	**35**	**46**	**58**	
Unmet need patient days (statewide ALOS)	6	61.89	150	763	1,467	2,170	2,874	3,578	
Unmet Average Daily Census (ADC)	7		0	2	4	6	8	10	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lincoln** ***Select from drop down menu***

Lincoln County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,807
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,963

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	**2**		25	15	24				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	21							
Projected patient deaths: 23.16%	**3**	5							
Average population (OFM)	**4**	7,807							
Projected population	**N/A**		7,864	7,805	7,751	7,698	7,644	7,591	**Steps 2-4**
Potential volume	**N/A**		5	5	5	5	5	5	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	**2**		89	75	76				**Ages 65+**
Average deaths (2019-2021)	**2**	80							
Projected patient deaths: 58.07%	**3**	46							
Average population (OFM)	**4**	2,963							
Projected population	**N/A**		2,891	2,959	3,039	3,119	3,200	3,280	**Steps 2-4**
Potential volume	**N/A**		45	46	48	49	50	51	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	**5**		50	51	53	54	55	56	**All Ages**
Current capacity (DOH survey)	**N/A**	23							
Unmet need	**5**		**27**	**28**	**29**	**30**	**32**	**33**	
Unmet need patient days (statewide ALOS)	**6**	61.89	1,669	1,733	1,808	1,884	1,960	2,036	
Unmet Average Daily Census (ADC)	**7**		5	5	5	5	5	6	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

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2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Mason** ***Select from drop down menu***

Mason County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	51,050
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	16,524

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		167	143	168				Ages 0 - 64
Average deaths (2019-2021)	2	159							
Projected patient deaths: 23.16%	3	37							
Average population (OFM)	4	51,050							
Projected population	N/A		50,632	51,122	51,397	51,672	51,946	52,221	Steps 2-4
Potential volume	N/A		37	37	37	37	38	38	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		548	408	461				Ages 65+
Average deaths (2019-2021)	2	472							
Projected patient deaths: 58.07%	3	274							
Average population (OFM)	4	16,524							
Projected population	N/A		15,905	16,499	17,167	17,836	18,504	19,173	Steps 2-4
Potential volume	N/A		264	274	285	296	307	318	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		301	311	322	333	345	356	All Ages
Current capacity (DOH survey)	N/A	512							
Unmet need	5		**(211)**	**(201)**	**(190)**	**(179)**	**(167)**	**(156)**	
Unmet need patient days (statewide ALOS)	6	61.89	(13,089)	(12,456)	(11,757)	(11,059)	(10,360)	(9,661)	
Unmet Average Daily Census (ADC)	7		(36)	(34)	(32)	(30)	(28)	(26)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Okanogan** ***Select from drop down menu***

Okanogan County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,211
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,862

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		119	88	92				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	100							
Projected patient deaths: 23.16%	**3**	23							
Average population (OFM)	**4**	32,211							
Projected population	**N/A**		32,364	32,183	32,087	31,991	31,896	31,800	**Steps 2-4**
Potential volume	**N/A**		23	23	23	23	23	23	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		358	277	324				**Ages 65+**
Average deaths (2019-2021)	**2**	320							
Projected patient deaths: 58.07%	**3**	186							
Average population (OFM)	**4**	10,862							
Projected population	**N/A**		10,475	10,901	11,210	11,519	11,827	12,136	**Steps 2-4**
Potential volume	**N/A**		179	186	192	197	202	207	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		202	209	215	220	225	230	**All Ages**
Current capacity (DOH survey)	**N/A**	199							
Unmet need	**5**		**3**	**10**	**15**	**20**	**26**	**31**	
Unmet need patient days (statewide ALOS)	**6**	61.89	178	620	942	1,265	1,587	1,909	
Unmet Average Daily Census (ADC)	**7**		0	2	3	3	4	5	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pacific** ***Select from drop down menu***

Pacific County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,424
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,897

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		66	55	59				Ages 0 - 64
Average deaths (2019-2021)	2	60							
Projected patient deaths: 23.16%	3	14							
Average population (OFM)	4	14,424							
Projected population	N/A		14,545	14,403	14,322	14,242	14,161	14,081	Steps 2-4
Potential volume	N/A		14	14	14	14	14	14	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		265	177	239				Ages 65+
Average deaths (2019-2021)	2	227							
Projected patient deaths: 58.07%	3	132							
Average population (OFM)	4	6,897							
Projected population	N/A		6,747	6,910	7,035	7,159	7,284	7,408	Steps 2-4
Potential volume	N/A		129	132	134	137	139	142	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		143	146	148	151	153	155	All Ages
Current capacity (DOH survey)	N/A	66							
Unmet need	5		**77**	**80**	**82**	**85**	**87**	**89**	
Unmet need patient days (statewide ALOS)	6	61.89	4,763	4,947	5,090	5,232	5,375	5,517	
Unmet Average Daily Census (ADC)	7		13	14	14	14	15	15	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pend Oreille** ***Select from drop down menu***

Pend Oreille County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Pend Oreille	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,813
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Pend Oreille	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	4,090

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		31	41	55				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	42							
Projected patient deaths: 23.16%	**3**	10							
Average population (OFM)	**4**	9,813							
Projected population	**N/A**		9,859	9,812	9,769	9,727	9,684	9,642	**Steps 2-4**
Potential volume	**N/A**		10	10	10	10	10	10	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		125	101	119				**Ages 65+**
Average deaths (2019-2021)	**2**	115							
Projected patient deaths: 58.07%	**3**	67							
Average population (OFM)	**4**	4,090							
Projected population	**N/A**		3,925	4,107	4,239	4,371	4,504	4,636	**Steps 2-4**
Potential volume	**N/A**		64	67	69	71	74	76	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		74	77	79	81	83	85	**All Ages**
Current capacity (DOH survey)	**N/A**	67							
Unmet need	**5**		**7**	**10**	**12**	**14**	**16**	**18**	
Unmet need patient days (statewide ALOS)	**6**	61.89	408	589	720	851	982	1,113	
Unmet Average Daily Census (ADC)	**7**		1	2	2	2	3	3	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pierce** ***Select from drop down menu***

Pierce County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	763,798
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	136,408

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:										
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		1,911	2,364	2,574				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	2,283							
Projected patient deaths: 23.16%	**3**	529							
Average population (OFM)	**4**	763,798							
Projected population	**N/A**		756,339	765,139	769,918	774,696	779,475	784,253	**Steps 2-4**
Potential volume	**N/A**		524	530	533	536	540	543	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		5,002	5,608	6,264				**Ages 65+**
Average deaths (2019-2021)	**2**	5,625							
Projected patient deaths: 58.07%	**3**	3,266							
Average population (OFM)	**4**	136,408							
Projected population	**N/A**		130,688	136,114	142,422	148,729	155,037	161,344	**Steps 2-4**
Potential volume	**N/A**		3,129	3,259	3,410	3,561	3,712	3,863	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		3,653	3,789	3,943	4,097	4,252	4,406	**All Ages**
Current capacity (DOH survey)	**N/A**	4,157							
Unmet need	**5**		**(504)**	**(368)**	**(214)**	**(59)**	**95**	**249**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(31,193)	(22,775)	(13,224)	(3,672)	5,880	15,432	
Unmet Average Daily Census (ADC)	**7**		(85)	(62)	(36)	(10)	16	42	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**1**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **San Juan** ***Select from drop down menu***

San Juan County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,782
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,978

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		20	18	24				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	21							
Projected patient deaths: 23.16%	**3**	5							
Average population (OFM)	**4**	10,782							
Projected population	**N/A**		10,863	10,753	10,730	10,707	10,684	10,661	**Steps 2-4**
Potential volume	**N/A**		5	5	5	5	5	5	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		127	94	91				**Ages 65+**
Average deaths (2019-2021)	**2**	104							
Projected patient deaths: 58.07%	**3**	60							
Average population (OFM)	**4**	5,978							
Projected population	**N/A**		5,768	5,991	6,174	6,357	6,541	6,724	**Steps 2-4**
Potential volume	**N/A**		58	61	62	64	66	68	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		63	65	67	69	71	73	**All Ages**
Current capacity (DOH survey)	**N/A**	92							
Unmet need	**5**		**(29)**	**(27)**	**(25)**	**(23)**	**(21)**	**(19)**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(1,789)	(1,653)	(1,539)	(1,425)	(1,311)	(1,197)	
Unmet Average Daily Census (ADC)	**7**		(5)	(5)	(4)	(4)	(4)	(3)	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Skagit** ***Select from drop down menu***

Skagit County Only

Population information (OFM)

Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	101,410
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	29,121

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		229	269	334				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	277							
Projected patient deaths: 23.16%	3	64							
Average population (OFM)	4	101,410							
Projected population	N/A		100,807	101,537	101,887	102,236	102,586	102,935	
Potential volume	N/A		64	64	65	65	65	65	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		1,018	1,068	1,190				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	1,092							
Projected patient deaths: 58.07%	3	634							
Average population (OFM)	4	29,121							
Projected population	N/A		27,881	29,168	30,314	31,460	32,607	33,753	
Potential volume	N/A		607	635	660	685	710	735	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		671	699	725	750	775	800	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	765							
Unmet need	5		**(94)**	**(65)**	**(40)**	**(15)**	**10**	**35**	
Unmet need patient days (statewide ALOS)	6	61.89	(5,800)	(4,038)	(2,479)	(921)	637	2,196	
Unmet Average Daily Census (ADC)	7		(16)	(11)	(7)	(3)	2	6	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
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Methodology By County

COUNTY: **Skamania** ***Select from drop down menu***

Skamania County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,238
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,797

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		19	26	25				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	23							
Projected patient deaths: 23.16%	3	5							
Average population (OFM)	4	9,238							
Projected population	N/A		9,248	9,242	9,223	9,205	9,186	9,168	
Potential volume	N/A		5	5	5	5	5	5	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		87	47	56				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	63							
Projected patient deaths: 58.07%	3	37							
Average population (OFM)	4	2,797							
Projected population	N/A		2,670	2,798	2,923	3,048	3,172	3,297	
Potential volume	N/A		35	37	38	40	42	43	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		41	42	44	45	47	49	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	39							
Unmet need	5		**2**	**4**	**5**	**7**	**8**	**10**	
Unmet need patient days (statewide ALOS)	6	61.89	115	218	319	420	521	622	
Unmet Average Daily Census (ADC)	7		0	1	1	1	1	2	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Snohomish** ***Select from drop down menu***

Snohomish County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	714,698
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	125,510

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		1,533	1,587	1,563				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	1,561							
Projected patient deaths: 23.16%	**3**	362							
Average population (OFM)	**4**	714,698							
Projected population	**N/A**		705,787	716,781	721,527	726,273	731,019	735,765	**Steps 2-4**
Potential volume	**N/A**		357	363	365	367	370	372	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		4,081	4,278	4,478				**Ages 65+**
Average deaths (2019-2021)	**2**	4,279							
Projected patient deaths: 58.07%	**3**	2,485							
Average population (OFM)	**4**	125,510							
Projected population	**N/A**		119,333	125,219	131,978	138,737	145,495	152,254	**Steps 2-4**
Potential volume	**N/A**		2,362	2,479	2,613	2,747	2,880	3,014	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		2,719	2,842	2,978	3,114	3,250	3,386	**All Ages**
Current capacity (DOH survey)	**N/A**	4,288							
Unmet need	**5**		**(1,569)**	**(1,446)**	**(1,310)**	**(1,174)**	**(1,038)**	**(902)**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(97,079)	(89,523)	(81,093)	(72,664)	(64,234)	(55,804)	
Unmet Average Daily Census (ADC)	**7**		(266)	(245)	(222)	(199)	(176)	(152)	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Spokane** ***Select from drop down menu***

Spokane County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	425,148
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	91,294

WAC 246-310-290(8)(a) Step 1:

		2019	2020	2021	Average	Use Rate
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	**2**		1,143	1,634	1,842				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	1,540							
Projected patient deaths: 23.16%	**3**	357							
Average population (OFM)	**4**	425,148							
Projected population	**N/A**		423,256	425,447	426,740	428,033	429,326	430,619	**Steps 2-4**
Potential volume	**N/A**		355	357	358	359	360	361	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	**2**		3,545	4,322	4,810				**Ages 65+**
Average deaths (2019-2021)	**2**	4,226							
Projected patient deaths: 58.07%	**3**	2,454							
Average population (OFM)	**4**	91,294							
Projected population	**N/A**		87,852	91,361	94,670	97,979	101,288	104,597	**Steps 2-4**
Potential volume	**N/A**		2,361	2,456	2,544	2,633	2,722	2,811	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	**5**		2,716	2,812	2,902	2,992	3,082	3,172	**All Ages**
Current capacity (DOH survey)	**N/A**	3,121							
Unmet need	**5**		**(405)**	**(308)**	**(218)**	**(128)**	**(38)**	**52**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(25,036)	(19,086)	(13,514)	(7,943)	(2,371)	3,200	
Unmet Average Daily Census (ADC)	**7**		(69)	(52)	(37)	(22)	(6)	9	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
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Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Stevens** ***Select from drop down menu***

Stevens County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,006
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,804

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		112	86	114				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	104							
Projected patient deaths: 23.16%	3	24							
Average population (OFM)	4	34,006							
Projected population	N/A		34,109	33,992	33,917	33,841	33,766	33,690	
Potential volume	N/A		24	24	24	24	24	24	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		345	248	304				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	299							
Projected patient deaths: 58.07%	3	174							
Average population (OFM)	4	11,804							
Projected population	N/A		11,360	11,837	12,214	12,591	12,969	13,346	
Potential volume	N/A		167	174	180	185	191	196	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		191	198	204	209	215	220	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	146							
Unmet need	5		**46**	**53**	**58**	**64**	**69**	**74**	
Unmet need patient days (statewide ALOS)	6	61.89	2,822	3,250	3,590	3,931	4,271	4,611	
Unmet Average Daily Census (ADC)	7		8	9	10	11	12	13	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
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Vital Statistics Death Data for Years 2019-2021
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2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Thurston** ***Select from drop down menu***

Thurston County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	241,186
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	52,830

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		525	628	763				Ages 0 - 64
Average deaths (2019-2021)	2	639							
Projected patient deaths: 23.16%	3	148							
Average population (OFM)	4	241,186							
Projected population	N/A		238,190	241,500	243,867	246,235	248,602	250,970	Steps 2-4
Potential volume	N/A		146	148	150	151	152	154	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		1,908	2,007	2,285				Ages 65+
Average deaths (2019-2021)	2	2,067							
Projected patient deaths: 58.07%	3	1,200							
Average population (OFM)	4	52,830							
Projected population	N/A		50,757	52,832	54,900	56,967	59,035	61,102	Steps 2-4
Potential volume	N/A		1,153	1,200	1,247	1,294	1,341	1,388	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		1,299	1,348	1,397	1,445	1,493	1,542	All Ages
Current capacity (DOH survey)	N/A	1,829							
Unmet need	5		**(530)**	**(481)**	**(433)**	**(384)**	**(336)**	**(287)**	
Unmet need patient days (statewide ALOS)	6	61.89	(32,809)	(29,767)	(26,770)	(23,774)	(20,777)	(17,780)	
Unmet Average Daily Census (ADC)	7		(90)	(81)	(73)	(65)	(57)	(49)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
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2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Wahkiakum** ***Select from drop down menu***

Wahkiakum County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Wahkiakum	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,448
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Wahkiakum	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,549

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		11	10	7				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	9							
Projected patient deaths: 23.16%	**3**	2							
Average population (OFM)	**4**	2,448							
Projected population	**N/A**		2,498	2,441	2,405	2,368	2,332	2,295	**Steps 2-4**
Potential volume	**N/A**		2	2	2	2	2	2	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		53	18	25				**Ages 65+**
Average deaths (2019-2021)	**2**	32							
Projected patient deaths: 58.07%	**3**	19							
Average population (OFM)	**4**	1,549							
Projected population	**N/A**		1,503	1,565	1,580	1,595	1,611	1,626	**Steps 2-4**
Potential volume	**N/A**		18	19	19	19	19	19	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		20	21	21	21	21	22	**All Ages**
Current capacity (DOH survey)	**N/A**	14							
Unmet need	**5**		**7**	**7**	**7**	**8**	**8**	**8**	
Unmet need patient days (statewide ALOS)	**6**	61.89	406	449	459	468	477	486	
Unmet Average Daily Census (ADC)	**7**		1	1	1	1	1	1	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Walla Walla** ***Select from drop down menu***

Walla Walla County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Walla Walla	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,924
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Walla Walla	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,141

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		118	150	138				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	135							
Projected patient deaths: 23.16%	**3**	31							
Average population (OFM)	**4**	50,924							
Projected population	**N/A**		50,763	50,981	51,028	51,075	51,121	51,168	**Steps 2-4**
Potential volume	**N/A**		31	31	31	31	31	31	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		450	522	595				**Ages 65+**
Average deaths (2019-2021)	**2**	522							
Projected patient deaths: 58.07%	**3**	303							
Average population (OFM)	**4**	11,141							
Projected population	**N/A**		11,006	11,068	11,350	11,632	11,915	12,197	**Steps 2-4**
Potential volume	**N/A**		300	301	309	317	324	332	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		331	333	340	348	356	364	**All Ages**
Current capacity (DOH survey)	**N/A**	283							
Unmet need	**5**		**48**	**50**	**57**	**65**	**73**	**81**	
Unmet need patient days (statewide ALOS)	**6**	61.89	2,962	3,075	3,552	4,030	4,507	4,984	
Unmet Average Daily Census (ADC)	**7**		8	8	10	11	12	14	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Whatcom** ***Select from drop down menu***

Whatcom County Only													
Population information (OFM)													
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
0 - 64	Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	187,499
Ages	**County**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2019-2021 Avgerage**
65 +	Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	42,586

WAC 246-310-290(8)(a) Step 1:						
		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 0 - 64	**Hospice unduplicated admissions**	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	**2020**	**2021**	**Average**	**Use Rate**
Ages 65 +	**Hospice unduplicated admissions**	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Planning area historical resident deaths (OFM)	**2**		394	457	443				**Ages 0 - 64**
Average deaths (2019-2021)	**2**	431							
Projected patient deaths: 23.16%	**3**	100							
Average population (OFM)	**4**	187,499							
Projected population	**N/A**		185,418	187,812	189,267	190,722	192,178	193,633	**Steps 2-4**
Potential volume	**N/A**		99	100	101	102	102	103	

Ages 65+	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
PA historical resident deaths (OFM)	**2**		1,461	1,481	1,674				**Ages 65+**
Average deaths (2019-2021)	**2**	1,539							
Projected patient deaths: 58.07%	**3**	893							
Average population (OFM)	**4**	42,586							
Projected population	**N/A**		40,902	42,640	44,217	45,794	47,372	48,949	**Steps 2-4**
Potential volume	**N/A**		858	895	928	961	994	1,027	

All Ages	**Step**	**Result**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	
Combined age cohorts	**5**		957	995	1,029	1,062	1,096	1,130	**All Ages**
Current capacity (DOH survey)	**N/A**	1,317							
Unmet need	**5**		**(360)**	**(322)**	**(289)**	**(255)**	**(221)**	**(187)**	
Unmet need patient days (statewide ALOS)	**6**	61.89	(22,291)	(19,955)	(17,859)	(15,763)	(13,667)	(11,571)	
Unmet Average Daily Census (ADC)	**7**		(61)	(55)	(49)	(43)	(37)	(32)	**Steps 5-8**
Agency needed (ADC > 35)	**8**	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Whitman** ***Select from drop down menu***

Whitman County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,282
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,783

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		47	51	59				Ages 0 - 64 Steps 2-4
Average deaths (2019-2021)	2	52							
Projected patient deaths: 23.16%	3	12							
Average population (OFM)	4	43,282							
Projected population	N/A		43,222	43,308	43,315	43,322	43,330	43,337	
Potential volume	N/A		12	12	12	12	12	12	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		219	226	278				Ages 65+ Steps 2-4
Average deaths (2019-2021)	2	241							
Projected patient deaths: 58.07%	3	140							
Average population (OFM)	4	5,783							
Projected population	N/A		5,526	5,815	6,008	6,201	6,395	6,588	
Potential volume	N/A		134	141	145	150	155	159	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		146	153	158	162	167	172	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	140							
Unmet need	5		**6**	**13**	**18**	**23**	**27**	**32**	
Unmet need patient days (statewide ALOS)	6	61.89	381	815	1,105	1,394	1,684	1,973	
Unmet Average Daily Census (ADC)	7		1	2	3	4	5	5	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

Department of Health
2022-2023 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Yakima** ***Select from drop down menu***

Yakima County Only													
Population information (OFM)													
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
0 - 64	Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	224,364
Ages	County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2019-2021 Avgerage
65 +	Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	38,465

WAC 246-310-290(8)(a) Step 1:						
		2019	2020	2021	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,712	3,680	3,893	**3,762**	**23.16%**
	Total deaths	14,047	16,663	18015	**16,242**	

		2019	2020	2021	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	26,175	27,957	27,884	**27,339**	**58.07%**
	Total deaths	44,159	46,367	50,717	**47,081**	

WAC 246-310-290(8)(a) Steps 2-8:									
Ages 0-64	Step	Result	2019	2020	2021	2022	2023	2024	
Planning area historical resident deaths (OFM)	2		555	653	699				Ages 0 - 64
Average deaths (2019-2021)	2	636							
Projected patient deaths: 23.16%	3	147							
Average population (OFM)	4	224,364							
Projected population	N/A		222,774	224,497	225,822	227,147	228,473	229,798	Steps 2-4
Potential volume	N/A		146	147	148	149	150	151	

Ages 65+	Step	Result	2019	2020	2021	2022	2023	2024	
PA historical resident deaths (OFM)	2		1,451	1,675	1,644				Ages 65+
Average deaths (2019-2021)	2	1,590							
Projected patient deaths: 58.07%	3	923							
Average population (OFM)	4	38,465							
Projected population	N/A		37,530	38,391	39,475	40,559	41,643	42,727	Steps 2-4
Potential volume	N/A		901	921	948	974	1,000	1,026	

All Ages	Step	Result	2019	2020	2021	2022	2023	2024	
Combined age cohorts	5		1,047	1,069	1,096	1,123	1,149	1,176	All Ages
Current capacity (DOH survey)	N/A	1,215							
Unmet need	5		**(168)**	**(146)**	**(119)**	**(92)**	**(65)**	**(38)**	
Unmet need patient days (statewide ALOS)	6	61.89	(10,376)	(9,028)	(7,364)	(5,700)	(4,036)	(2,372)	
Unmet Average Daily Census (ADC)	7		(28)	(25)	(20)	(16)	(11)	(6)	Steps 5-8
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2019-2021
Vital Statistics Death Data for Years 2019-2021
Prepared by DOH Program Staff

EXHIBIT 17

Policies Referenced in Application

POLICY:

The patient or their legal representative (when the patient is not competent or of legal age) must sign a consent to participate in a hospice program prior to receiving care.

PURPOSE:

To delineate the process for informing patients and families/caregivers regarding hospice services and obtaining signed consent for hospice care.

Regulatory Reference: 418.104(a)(6)
CHAP Reference: HSIM 3.I
TJC Reference: RC.02.01.01 EP 4

PROCEDURE:

1. The admitting hospice staff shall review the form with the patient and family/caregiver so that there is an understanding of:
   a. the philosophy and goals,
   b. services provided by the program,
   c. the focus of hospice,
   d. the benefit periods based on the source of fee,
   e. The services of the interdisciplinary group, with the registered nurse as the Case Manager, and any requirements to use services contracted by the hospice.

2. The signed consent is maintained in the medical record, and the patient is given a copy of the consent with other required notices.

FOR A PATIENT NOT ABLE TO UNDERSTAND AND SIGN THE CONSENT

1. Suppose a patient has been adjudged incompetent or lacking capacity under state law by a court of proper jurisdiction. In that case, the patient's rights may be exercised by the person appointed by the state court to act on the patient's behalf.

2. Since the patient's consent must be signed prior to the initiation of patient care, arrangements must be made to obtain consent and the confirming signature before the initiation of patient care.

3. If a state court has not adjudged a patient incompetent, the patient may designate a representative who may exercise the patient's rights.

4. If a patient has been adjudged to lack legal capacity under state law by a court of proper jurisdiction, the patient may exercise their rights to the extent allowed by court order.
   a. The patient's authorized representative will be available for the admission visit: If the patient cannot understand the rights and the nature and consequences of proposed treatments, the clinician shall explain the patient's rights, proposed treatment, and goals to their authorized representative and ask the patient's representative to sign the consent before the initiation of the patient's care.

   b. The patient's authorized representative will not be available at the time of the patient's admission: The designee in intake contacts the patient's representative before the initiation of patient care to explain the rights and responsibilities, obtain verbal consent and transmit the consent for signature by the authorized representative before the initiation of patient care. The representative will be instructed to sign the consent, retain a copy for their records and return the signed consent by fax, electronically, or overnight mail for filing in the patient's record.

   c. The patient's authorized representative planned to be available when the patient's admission but is not present: The clinician contacts the authorized representative to explain that the patient consent for treatment must be signed before patient care may begin. The representative will be instructed to sign the consent, retain a copy for their records and return the signed consent by fax, electronically, or overnight mail for filing in the patient's record.

   d. The patient authorized representative is educated regarding the patient's admission handbook.

   e. A legal surrogate may consent to the admission for hospice care of a non-decisional individual who does not have a valid power of attorney for health care, a legal guardian, or other legal representatives. The following individuals, in the following order of priority, may consent to admission for hospice care. If there is more than one individual at the highest available level of priority, any person of the level of priority may consent to

hospice if no other individual of the same level of priority disagrees with the proposed admission.

1) The spouse of the non-decisional individual;
2) An adult child of the non-decisional individual;
3) A parent of the non-decisional individual;
4) An adult sibling of the non-decisional individual;
5) A grandparent of the non-decisional individual;
6) An adult grandchild of the non-decisional individual;
7) An adult close friend of the non-decisional individual;
8) A member of the ethics committee of a facility at which the non-decisional individual resides or is receiving treatment when the ethics committee agrees that hospice care is appropriate for the incapacitated individual.
9) Two non-hospice physicians who agree that hospice care is appropriate for the non-decisional individual.

f. An individual who consents to an admission for the non-decisional individual may make health care decisions to the same extent as a guardian of the person may authorize expenditures related to health care to the same extent as a guardian of the state may, until the earlies of the following:
   1) Death or discharge of the non-decisional individual from hospice care,
   2) Appointment of a guardian for the non-decisional individual.

5. Before care is provided, the patient shall be advised of:
   a. The difference of palliative rather than curative nature of hospice care,
   b. The type and frequency of visits/services proposed to be furnished and any limitations on these services, including the availability of spiritual counseling for the patient and family,
   c. Alternatives to hospice services,
   d. The patient/family rights and responsibilities,

e. The right to receive an election statement addendum listing any conditions, items, services, and drugs that the hospice determines to be unrelated to the terminal illness and related conditions that would not be covered by the hospice; and the right to an immediate advocacy process through the Beneficiary and Family-Centered Care Quality Improvement Organization.
f. The impact of the election of Medicare Hospice Benefit on eligibility for reimbursement by Medicare for other health care services (if the patient is a Medicare Beneficiary),
g. The patient's right to revoke the hospice benefit at any time,
h. The options of a durable power of attorney for health care, advance directive or "do not resuscitate" orders in accordance with applicable law,
i. The levels of care available (routine, continuous care, respite and inpatient-acute),
j. Supervision by hospice of all services provided,
k. The availability of services 24 hours a day / 7 days a week and how to contact on-call staff,
l. The fees for services, the extent to which payment for services may be expected from any third party payer, and the charges for the services the patient may have to pay in the absence of reimbursement by any third-party payer, and
m. The hospice's criteria for discharging the individual from the hospice program.

6. The consent forms will include the following:
   a. A statement that the hospice will be providing the care and services,
   b. The patient/representative's identification of the attending physician,
   c. The patient/representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the patient's terminal illness,
   d. An acknowledgment that certain Medicare services are waived by the election of the hospice benefit,
   e. Acknowledgement that the patient or patient's representative has received a written copy of the Patient's Rights and Responsibilities,
   f. The effective date of the election, which will be the first day of hospice care or a later date (but shall not be earlier than the date of the election statement),

g. A disclosure of overlapping ownership of the hospice and the facility in which the patient resides, if applicable,

h. A complete statement enumerating all charges for services, materials, and equipment which shall, or maybe, furnished to the patient during the period of hospice care,

i. The prepayment and refund policies and in the case of third-party payment, an exact statement of responsibility in the event of retroactive denial (the patient shall be notified in writing of any changes in third party coverage prior to implementation of such changes),

j. The signature of the patient or representative and the date of the signature, and

k. The reason why the patient did not sign their own consents (if applicable).

l. The hospice shall not admit any persons under the age of eighteen (18) years without a signed parent/guardian consent.

m. The consents and election statement may be signed up to fourteen (14) days before the start of care. The hospice does not accept verbal consent for hospice care. Faxed, scanned, or emailed consents are acceptable.

State-Specific Requirements

Arizona: no state requirements

California: no state requirements

Colorado: no additional state requirements

Connecticut: no additional state requirements

Delaware: no additional state requirements

Florida: no additional state requirements

Georgia: no additional state requirements

Illinois: no additional state requirements

Indiana: no additional state requirements

Maryland: no additional state requirements

Massachusetts: no additional state requirements

Michigan: no additional state requirements

Minnesota: no additional state requirements

Mississippi: no additional state requirements

Missouri: 19 CSR 30-35-(C) Consent for Hospice Care.

1. A patient who wishes to receive hospice care, shall sign a consent form for hospice services.
2. The consent form shall include the following:
   A. Identification of the particular hospice that will provide care to the patient;
   B. The patient's or representative's acknowledgment that s/he has been advised and has an understanding of the palliative nature of hospice care as it relates to the patient's terminal illness;
   C. The specific type of care and services that may be provided as hospice care during the course of the illness.

Nevada: no additional state requirements

New Jersey: no additional state requirements

Oregon: no additional state requirements

Pennsylvania: no additional state requirements

Tennessee: no additional state requirements

Texas: no additional state requirements

Washington: no additional state requirements

Washington DC: no additional municipal requirements

Wisconsin: no additional state requirements

POLICY:

AccentCare is committed to protecting patient rights and empowering patients to exercise those rights without discrimination or reprisal. This agency informs patients and caregivers of their patient rights to provide guidelines to make care decisions and support active participation in care planning.

A patient may designate someone to act as their representative. On behalf of the patient, this representative may exercise any of the rights provided by the policies and procedures established by the agency.

The Agency staff shall assist with a complete understanding of patient rights. All policies will be available to agency personnel, patients, their representatives, other organizations, and the interested public.

Regulatory Reference: 418.52
CHAP Standards: HPFC 1.D; HPFC 2.D; HPFC 3.I; HPFC 4.1; HPFC 5.I; HPFC 7.D; HPFC 8.D; HPFC 9.D
TJC Standards: RI.01.01.03; RI.01.02.01; RI.01.03.01; RI.01.04.01; RI.01.05.01; RI.01.06.03; RI.01.06.05; RI.01.06.09; RI.01.07.01; RI.02.01.01

PURPOSE:

Ensure that patients, caregivers, and staff are aware of the Bill of Rights.

PROCEDURE:

A. Employees and volunteers shall receive training about patient rights during orientation and annually.

B. The Agency shall obtain the patient's or representative's signature to verify they have received and understand this information.

C. A list of the patients' rights and responsibilities is printed in the Admission Booklet. The list of rights and responsibilities will be redistributed to patients or their representatives following any revisions or modifications.

D. The Patient Bill of Rights statement supports the patient's right to exercise the following as well as any additional, specific state patient rights and responsibilities:

Dignity and Respect:

1. To access and receive services regardless of age, disability, national origin, ancestry, gender, gender identity and/or expression, sexual orientation, or payment source.
2. To be free from mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source and misappropriation of patient property.
3. To have their personal property and person treated with respect.

Notification and Information:

1. To receive a copy of this notice of rights and responsibilities.
2. To be knowledgeable of the patient's right to exercise their rights at any time.
3. Before providing care, patients shall be informed verbally and in writing of their rights and responsibilities in a language and manner that they understand and prefer.
4. To receive information about the services covered under the hospice benefit, the scope of services that hospice will provide, and specific limitations on those services.
5. To understand that the patient or patient's designated representative is authorized to exercise their rights.
6. Receive in writing, before the start of care, the telephone numbers for the State Hotline and the CHAP/TJC Hotline, including hours of operation and the purpose of the hotlines to receive complaints or questions about the organization.
7. Be informed about the mode of care delivery, including telecommunications, when applicable.
8. The Agency shall not request nor obtain any waiver of the patient's rights.
9. Be informed about the identity and role of the employee, contracted staff, or volunteer who will provide care, treatment, or services.

Participation and Quality Care:

1. To participate in developing their hospice plan of care and service plans.
2. To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

Confidentiality:

1. To have a confidential clinical record.
2. To know that the hospice organization maintains confidential treatment of their personal and medical records.
3. Accessing or releasing the patient's information and clinical records is permitted following 45CFR parts 160 and 164.

Decision Making:

1. To be given written notice upon admission of the patient's decision-making rights.
2. To facilitate their own health care decisions and receive comprehensive informed consent.
3. To refuse care or medical treatment.
4. To make an advance health care directive.
5. To be advised that AccentCare complies with Subpart 1 of 42 CFR 489 and to be informed and given written information concerning the hospice's policies on advance directives, including a description of an individual's right under applicable state law and how the organization implements such rights.
6. To choose their attending physician.
7. To be assured that the hospice program will not condition the provision of care or otherwise discriminate against a patient based on whether or not they have executed an advance directive.

Financial Information:

1. To receive information addressing any beneficial relationship between the organization and referring entities.
2. To be informed verbally and in writing of billing and reimbursement methodologies before the start of care and as changes occur, including fees for services/products, direct pay responsibilities, and notification of insurance coverage.

3. To know that the hospice program does not discontinue or reduce care provided to a Medicare or Medicaid beneficiary patient because of the patient's inability to pay for that care.

Complaints or Grievances:

1. To be informed that a patient has the right to voice complaints or grievances to the organization regarding treatment, care, or service without fear of discrimination or reprisal.
2. To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone providing services on behalf of hospice and not be subject to discrimination or reprisal for exercising their rights.
3. To receive written information describing the organization's grievance procedure, including contact information, contact phone number, hours of operations, and mechanisms for communicating problems.
4. To have their complaints heard and addressed. Also, to receive an investigation by the hospice of complaints from the patient, family, or guardian regarding treatment or care, and to have staff document the existence of the complaint and the resolution of the complaint.

The patient has the right to expect that hospice will:

1. Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source, and misappropriation of patient property, by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees, contracted staff, and volunteers to the hospice administrator.

2. Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified.

3. Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency.

4. Ensure that verified violations are investigated and reported to State and local bodies having jurisdiction (including the state survey and certification agency) within five (5) working days of becoming aware of the violation. If state requirements are more stringent, then state requirements take precedence.

The rights of the patient are executed by the patient or designee as follows:

1. Suppose a patient has been adjudged incompetent under state law by a court of proper jurisdiction. In that case, the patient's rights are exercised by the person appointed according to state law to act on the patient's behalf.

2. Suppose a state court has not adjudged a patient incompetent. In that case, any legal representative designated by the patient following state law may exercise the patient's rights to the extent state law allows.

3. If allowed by state law, the physician or psychiatrist can determine a patient's decisional capacity or incapacity.

FOR A PATIENT NOT ABLE TO UNDERSTAND AND SIGN THE CONSENT

1. If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the patient's rights may be exercised by the person appointed by the state court to act on the patient's behalf.

2. Since the patient's consent must be signed before the initiation of patient care, arrangements must be made to obtain consent and the confirming signature before the initiation of patient care.

3. If a state court has not adjudged a patient incompetent, the patient may designate a representative who may exercise the patient's rights.

4. If a patient has been adjudged to lack legal capacity under state law by a court of proper jurisdiction, the patient may exercise their rights to the extent allowed by court order.
    a. **The patient's authorized representative will be available for the admission visit:** If the patient cannot understand the rights and the nature and consequences of proposed treatments, the clinician shall explain the patient's rights, proposed

treatment, and goals to their authorized representative and ask the patient's representative to sign the consent before the initiation of the patient's care.

b. **The patient's authorized representative will not be available at the time of the patient's admission:** The designee in intake contacts the patient's representative before the initiation of patient care to explain the rights and responsibilities, obtain verbal consent, and transmit the consent for signature by the authorized representative before the initiation of patient care. The representative shall be instructed to sign the consent, retain a copy for their records and return the signed consent by fax, electronically, or overnight mail for filing in the patient's record.

c. **The patient's authorized representative planned to be available at the time of the patient's admission but is not present:** The clinician contacts the authorized representative to explain that the patient consent for treatment must be signed before patient care can begin. The representative will be instructed to sign the consent, retain a copy for their records and return the signed consent by fax, electronically, or overnight mail for filing in the patient's record.

d. **The patient authorized representative is educated regarding the patient's admission handbook, including the home health plan of care.**

State-Specific Requirements

Arizona: R9-10-610. Patient Rights

A. An administrator shall ensure that:
   1. The requirements in subsection (B) and the patient rights in subsection (C) are conspicuously posted on the premises;
   2. At the time of admission, a patient or the patient's representative receives a written copy of the requirements in subsection (B) and the patient rights in subsection (C); and
   3. Policies and procedures include:
      a. How and when a patient or the patient's representative is informed of patient rights in subsection (C), and
      b. Where patient rights are posted as required in subsection (A)(1).

B. An administrator shall ensure that:
   1. A patient is treated with dignity, respect, and consideration;
   2. A patient is not subjected to:
      a. Abuse;
      b. Neglect;
      c. Exploitation;
      d. Coercion;
      e. Manipulation;
      f. Sexual abuse;
      g. Sexual assault;
      h. Seclusion;
      i. Restraint;
      j. Retaliation for submitting a complaint to the Department or another entity; or
      k. Misappropriation of personal and private property by the hospice's personnel members, employees, volunteers, or students; and
   3. A patient or the patient's representative:
      a. Except in an emergency, either consents to or refuses treatment;
      b. May refuse or withdraw consent for treatment before treatment is initiated;
      c. Except in an emergency, is informed of proposed treatment alternatives, associated risks, and possible complications;
      d. Consents to photographs of the patient before the patient is photographed, except that a patient may be photographed when admitted to a hospice for identification and administrative purposes;
      e. Except as otherwise permitted by law provides written consent to the release of information in the patients:

i. Medical record, or ii. Financial records;

f. Is informed of:
   i. The components of hospice services provided by the hospice;
   ii. The rates and charges for the components of hospice services before the components are initiated and before a change in rates, charges, or;
   iii. The hospice's policy on health care directives; and
   iv. The patient complaint process; and

g. Is informed that a written copy of rates and charges, as required in A.R.S. § 36-436.03, may be requested.

C. A patient has the following rights:
1. Not to be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status, or diagnosis;
2. To receive treatment that supports and respects the patient's individuality, choices, strengths, and abilities;
3. To receive privacy in treatment and care for personal needs;
4. To review, upon written request, the patient's own medical record according to A.R.S. §§ 12-2293, 12-2294, and 12-2294.01;
5. To receive a referral to another health care institution if the hospice inpatient facility is not authorized or not able to provide physical health services needed by the patient;
6. To participate or have the patient's representative participate in the development of, or decisions concerning treatment;
7. To participate or refuse to participate in research or experimental treatment; and
8. To receive assistance from a family member, the patient's representative, or other individual in understanding, protecting or exercising the patient's rights.

California: Article 1 Section 6.6

A. Rights and Responsibilities

1. Written policies regarding the rights and responsibilities of patients shall be established and made available to the patient, guardian, next-of-kin, sponsoring agency or representative payee, and the public. Such policies shall ensure that each patient receiving care shall have the following rights and responsibilities:

a. To be fully informed, as evidenced by the patient's or his/he appointed representative's, written acknowledgment prior to or at the time of admission of these rights and of all rules and regulations governing patient conduct.

b. To be fully informed, prior to or at the time of admission, of services available in the hospice and of related charges, including any charges for services not covered under Titles XVIII or XIX of the Social Security Act.
c. To be fully informed by a physician of his or her medical condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management, and to refuse to participate in experimental research.
d. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
e. To be advised of what services are to be rendered and by what discipline, e.g., Registered Nurse, counselor, chaplain, etc.
f. To be advised, in advance, of any change in treatment.
g. To be assured confidential treatment of personal and clinical records and to approve or refuse their release to any individual outside the hospice, except in the case of transfer to another health facility, or as required by law or third party payment contract.
h. To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
i. To not be subjected to verbal or physical abuse of any kind and to be informed that corporal punishment is prohibited.
j. To be informed by the licensee of the provisions of the law regarding complaints and procedures for registering complaints confidentially, including, but not limited to, the address and telephone number of the local district office of the Department.
k. To be informed of the provisions of law pertaining to advanced directives, including withdrawal or withholding of treatment and/or life support.
l. To be assured that the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

Connecticut: 19-13-D78. Patient's bill of rights and responsibilities

An agency shall have a written bill of rights and responsibilities governing agency services, which shall be made available and explained to each patient or representative at the time of admission. Such explanation shall be documented in the patient's clinical record. The bill of rights shall include but not be limited to:

(a) A description of available services, unit charges, and billing mechanisms. Any changes in such must be given to the patient orally and in writing as soon as possible but no

later than thirty (30) working days from the date the agency becomes aware of a change;

(b) Policy on uncompensated care;

(c) Criteria for admission to service and discharge from service;

(d) Information regarding the right to participate in the planning of the care to be furnished, the disciplines that will furnish care, the frequency of visits proposed and any changes in the care to be furnished, the person supervising the patients' care and the manner in which that person may be contacted;

(e) Patient responsibility for participation in the development and implementation of the home health care plan;

(f) Right of the patient or designated representative to be fully informed of patients' health condition, unless contraindicated by a physician in the clinical record

(g) Right of the patient to have his or her property treated with respect;

(h) Explanation of confidential treatment of all patient information retained in the agency and the requirement for written consent for release of information to persons not otherwise authorized under law to receive it;

(i) Policy regarding patient access to the clinical record;

(j) Explanation of grievance procedure and right to file a grievance without discrimination or reprisal from the agency regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing agency services;

(k) Procedure for registering complaints with the commissioner and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints or questions about local home health agencies;

(l) Agency's responsibility to investigate complaints made by a patient, patient's family, or guardian regarding treatment or care provided or that fails to be provided and lack of respect for the patient's property by anyone providing agency services. The agency complaint log shall include the date, nature, and resolution of the complaint.

Colorado: 6 CCR 1011-1 Chapter 21

Section 5 Patient Rights and Responsibilities

5.1 Upon admission, each hospice patient/family, shall receive a copy of the Hospice Patient's Bill of Rights and Responsibilities.

5.2 There shall be written documentation of receipt of the copy of the patient rights and responsibilities.

5.3 By written declaration, the hospice shall affirm the following patient rights and responsibilities:

a. The right to be informed of the hospice concept, admission criteria, services to be provided, options available, and any charges which may be incurred.
b. The right to participate in developing the patient plan of care.
c. The right to expect that all records be confidential.
d. The right to refuse service or withdraw from the program at any time.
e. The responsibility is to provide accurate information which may be useful to the hospice in delivering appropriate care.
f. The right to express a grievance without fear of reprisal.

5.4 Hospice responsibilities shall include but not be limited to:
a. Providing quality care to individuals regardless of race, religion, sex, age, and/or physical or mental disabilities or ability to pay;
b. Training all employees and volunteers adequately for the type of service they provide;
c. Providing care that is ethical, is in the best interest of the patient, and is respectful of the patient/family life values, religious preference, dignity, individuality, privacy in treatment and personal needs; and
d. Assuring special attention to patients who are infants, small children, and adolescents in regard to their right to privacy, choice, and dignity.

Delaware: Title 16 4468

5.5 The hospice program must establish written policies regarding the rights and responsibilities of patients, and these policies and procedures are to be made available to patient/family or patient/guardian. The rights of patients shall be consistent with Titles 16 and 31 of the Delaware Code and the Department of Health and Social Services Regulations regarding Patient's Rights

Florida: 400.60695

(3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.

Georgia: 111-8-37-.10 Patient and Family Rights

(1) The hospice must ensure that patients and their families receive hospice care and palliative care for persons with advanced and progressive diseases, when offered, in a manner that respects and protects their dignity and ensures all patients' rights to:

(a) Participate in the hospice voluntarily and sever the relationship with the hospice at any time;
(b) Receive only the care and services to which the patient and/or the patient's family have consented;
(c) Receive care in a setting and manner that preserves the patient's dignity, privacy, and safety to the maximum extent possible;
(d) Receive hospice care in a manner that neither physically nor emotionally abuses the patient nor neglects the patient's needs;
(e) Receive care free from unnecessary use of restraints;
(f) Receive education in the availability and use of the hospice's grievance process for all patients;
(g) Communicate grievances, concerns, or complaints to the hospice for prompt resolution;
(h) Refuse any specific treatment from the hospice without severing the relationship with the hospice;
(i) Choose their own private attending physician, so long as the physician agrees to abide by the policies and procedures of the hospice;
(j) Exercise the religious beliefs and generally recognized customs of their choice, not in conflict with health and safety standards, during the course of their hospice treatment and exclude religion from their treatment if they so choose;
(k) Have their family unit, legal guardian, if any, and their patient representative present any time during an inpatient stay, unless the presence of the family unit, legal guardian if any, or patient representative poses a risk to the patient or others;
(l) Participate in the development of the patient's plan of care and any changes to that plan;
(m)Have maintained as confidential any medical or personal information about the patient;
(n) Continue hospice care and not be discharged from the hospice during periods of coordinated or approved appropriate hospital admissions;
(o) Be provided with a description of the hospice care provided and levels of care to which the patient is entitled depending upon whether the patient is terminally ill or suffering from advanced and progressive disease, and any charges associated with such services;
(p) Review, upon request, copies of any inspection report completed by the Georgia Department of Community Health within the two years preceding the request;
(q) Make self-determination concerning medical care, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services;

(r) Continue to receive appropriate hospice care when terminally ill without regard for the ability to pay for such care; and

(s) Have communication of information provided in a method that is effective for the patient. If the hospice cannot provide communications in a method that is effective for the patient, attempts to provide such shall be documented in the patient's medical record.

(2) The hospice must provide to the patient, the patient's representative, and/or the patient's legal guardian oral and written explanations of the rights of the patient and the patient's family unit while receiving hospice care for the terminally ill and palliative care for persons with advanced and progressive diseases. The explanation of rights must be provided at the time of admission into the hospice.

(3) At the time of admission, the hospice must provide the patient, the patient's representative, and the patient's legal guardian the contact information, including the website address of the Georgia Department of Community Health, for reporting complaints about hospice care to the Department.

(4) The hospice shall post the following information in a public area at the facility:

(a) A copy of the patient rights as outlined in Rule 111-8-37-.10(1) in a public area at the facility; and

(b) Contact information, including the website address of the Georgia Department of Community
Health, for reporting complaints about hospice care to the Department.

Illinois: 210 ILCS 60/8

Sec. 8. General Requirements for hospice programs.

(h) The hospice program shall clearly define its admission criteria. Decisions on admissions shall be made by a hospice care team and shall be dependent upon the expressed request and informed consent of the patient or the patient's legal guardian. For purposes of this Act, "informed consent" means that a hospice program must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the patient's illness has been obtained for every hospice patient, either from the patient or from the patient's representative.

Indiana: No additional requirements

Maryland: 10.07.21.21 Patient's Rights.

A. The hospice care program shall provide the patient or representative with written notice of the patient's rights in advance of furnishing care. Documentation verifying

receipt of and understanding of this information shall be included as part of the patient's record.

B. The patient has the right to:
(1) Be treated with consideration and respect for individual dignity;
(2) Confidentiality in all aspects of service or treatment;
(3) Privacy;
(4) Be free from physical or mental abuse;
(5) Participate in the planning of the patient's hospice care;
(6) Formulate advance directives as provided under State law;
(7) Have all personal property treated with respect;
(8) Refuse care and services, including continued participation in the hospice care program;
(9) Be informed of short-term inpatient care options available for pain control, management, and respite;
(10) Be informed of the hospice care program's discharge policy;
(11) Make complaints or grievances to the hospice care program, government agencies, or other persons without threat or fear of retaliation; and
(12) Be informed orally and in writing, before care is initiated, of the extent to which payment may be expected from the patient, third-party payers, and any other source of funding known to the hospice care program.

C. The hospice care program shall ensure that all employees and volunteers respect the rights of a patient.

Massachusetts: No additional requirements

Michigan: R325.13104 Patient/family unit rights and responsibilities
Rule 104
(1) A hospice shall adopt written policies and procedures to implement the rights and responsibilities of the patient/family unit as provided by sections 20201 (1) and (2) and 20202 of the code, MCL 333.20201 and 333.20202.
(2) A hospice shall post policies and procedures described in subrule (1) of this rule in a public place inside the hospice and distribute them to a patient/family unit at the time of admission and if requested thereafter.
(3) A hospice shall assure that information transmitted to a patient/family unit will be communicated in a manner that will reasonably ensure that the information is understood by the patient/family unit.
(4) The procedures to initiate, investigate, and resolve complaints must include all of the following:

(a) A statement that a patient/family unit may complain to the hospice about any condition, event, or procedure in the hospice without citing a specific violation of the code or rules.

(b) A procedure for submitting written complaints to the hospice. The procedure includes assisting a complainant in reducing an oral complaint to writing, when the oral complaint is not resolved to the satisfaction of the complainant.

(c) The title, location, and telephone number of the hospice staff responsible for receiving complaints and conducting complaint investigations and a procedure for how the patient/family unit contacts that individual, as well as contact information for filing a complaint with the department.

(d) A hospice shall investigate complaints within 5 working days following receipt of a complaint by the hospice and the hospice shall deliver to the complainant a written report of the results of the investigation within 15 working days following receipt of the complaint.

(e) A mechanism to appeal the matter to the hospice administrator if the complainant is not satisfied with the investigation or resolution of the complaint.

(5) A hospice shall maintain written complaints and investigations for 3 years.

Minnesota: 144A.751

Subdivision 1. Statement of rights. An individual who receives hospice care has the right to:

(1) Receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated;

(2) Receive care and services according to a suitable hospice plan of care, subject to accepted hospice care standards, and take an active part in creating and changing the plan and evaluating care and services.

(3) Be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequence of these choices, including the consequences of refusing care;

(4) Be told in advance, whenever possible, of any change in the hospice plan of care and to take an active part in any change;

(5) Refuse any services or treatments;

(6) Know, in advance, any limits to the services available from a provider and the provider's grounds for termination of services;

(7) Know, in advance, of receiving care whether the hospice services may be covered by health insurance, medical assistance, Medicare, or other health programs in which the individual is enrolled;
(8) Receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services;
(9) Know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services;
(10) Choose freely among available providers and change providers after services have begun, within the limits of health insurance, medical assistance, Medicare, or other programs;
(11) Have personal, financial, and medical information kept private and be advised of the provider's policies and procedures regarding disclosure of such information.
(12) Be allowed access to records and written information from records according to sections 144.291 to 144.298;
(13) Be served by people who are properly trained and competent to perform their duties;
(14) Be treated with courtesy and respect and to have the patient' property treated with respect;
(15) Voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property;
(16) Be free from physical and verbal abuse;
(17) Reasonable, advance notice of changes in services or charges, including at least 10 days advance notice of the termination of a service by a provider, except in cases where:
    i) The recipient of services engages in conduct that alters the conditions of employment between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing hospice services;
    ii) An emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement, and that cannot be safely met by the hospice provider; or
    iii) The recipient is no longer certified as terminally ill;
(18) A coordinated transfer when there will be a change in the provider of services;

(19) Know who to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;
(20) Know the name and address of the state or county agency to contact for additional information or assistance;
(21) Assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation; and
(22) Have pain and symptoms managed to the patient's desired level of comfort.

144A.751 Subdivision 2.

Interpretation and enforcement of rights. The rights under this section are established for the benefit of individuals who receive hospice care. A hospice provider may not require a person to surrender these rights as a condition of receiving hospice care. A guardian or conservator or, when there is no guardian or conservator, a designated person may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving hospice care, persons providing hospice care, or hospice providers licensed under section 144A.753.

Mississippi: Rule 1.19.9 Patient Rights and Responsibilities

1. Be cared for by a team of professionals who provide health quality comprehensive hospice services as needed and appropriate for patient/family;
2. Have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, seven days a week;
3. Receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual orientation, place of residence, or the ability to pay for the services rendered;
4. Be fully informed regarding the patient's status in order to participate in the POC. The hospice professional team will assist the patient/family in identifying which services and treatments will help attain these goals;
5. Be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;
6. Refuse any treatment without severing his/her relationship with the hospice;
7. Choose his/her private physician as long as the attending physician agrees to abide by the policies of the hospice program;
8. Be treated with respect and dignity;

9. Confidentiality with regard to the provision of services and all client records, including information concerning patient/family health status, as well as social and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent and/or as required by law;
10. Voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and
11. Be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.
12. The patient has the responsibility to:
    a. Participate in developing the POC and update as his or her condition/needs change;
    b. Provide hospice with his/her accurate and complete health information;
    c. Remain under a physician's care while receiving hospice services; and
    d. Assist hospice staff in developing and maintaining a safe environment in which patient care can be provided.

Missouri: 19 CSR 30-35.010

(F) Patient Rights. The hospice shall have a written statement of patient rights which shall include, but need not be limited to, those specified herein:
1. Each patient of a hospice program shall be informed in writing of his/her rights as recipients of hospice services;
2. The hospice shall document that it has informed patients of their rights in writing and shall protect and promote the exercise of these rights; and
3. The patient's family, representative, or guardian may exercise the patient's rights when all reasonable efforts to communicate with the patient have failed. These rights shall include:
    A. The patient and family's right for respect of property and person;
    B. The right to voice grievances regarding treatment or care that is, or fails to be, furnished or regarding lack of respect of property by anyone who is furnishing services on behalf of the hospice and the patient/family shall not be subjected to discrimination or reprisal for doing so;
    C. The right to be informed about his/her care alternatives available from the hospice and payment resources;
    D. The right to participate in the development of the plan of care and planning changes in the care;
    E. The right to be informed in advance about the care to be furnished;

F. The right to be informed in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished;
G. The right to be informed in advance of any change in the plan of care before the change is made;
H. The right to the confidentiality of the clinical records maintained by the hospice and to be informed of the hospice's policy for disclosure of clinical records;
I. The right to be informed in writing of the extent to which payment may be required from the patient and any changes in liability within thirty (30) days of the hospice becoming aware of the new amount of the liability; and
J. The right to access the Missouri home health and toll-free hospice hotline and to be informed of its telephone number, the hours of operations, and its purpose for the receipt of complaints and questions regarding hospice services

Nevada: No additional requirements

New Jersey:

Section 8:42C-5.1 - Policies and procedures

(a) The hospice shall establish and implement written policies and procedures regarding the rights of patients and the implementation of these rights as set forth in (b) below. A complete statement of these rights, including the right to file a complaint with the Department, shall be conspicuously posted in the facility and shall be distributed to all staff and contracted personnel. These patient rights shall be made available in any language which is spoken as the primary language by more than ten (10) percent of the population in the hospice program's service area.

(b) Each patient shall be entitled to the following rights, none of which shall be abridged or violated by the hospice or any of its staff:

1. To treatment and services without discrimination based on race, age, religion, national origin, sex, sexual preferences, handicap, diagnosis, ability to pay, or source of payment;
2. To be given a verbal and written notice in a language and manner that the patient understands, prior to the initiation of care, of these patient rights and any additional policies and procedures established by the agency involving patient rights and responsibilities. If the patient is unable to respond, the notice shall be given to a family member or an individual who is a legal representative of the patient.

i. The hospice shall obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.
ii. If a patient has been adjudged incompetent under State law by a court with jurisdiction, the rights of the patient are exercised by the person appointed pursuant to State law to act on the patient's behalf.
iii. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law;

3. To receive information about the services covered under the hospice benefit and to receive information about the scope of services that the hospice will provide and specific limitations on those services;
4. To be informed in writing of the following:
   i. The services available from the hospice;
   ii. The names and professional status of personnel providing and/or responsible for care;
   iii. The frequency of home visits to be provided;
   iv. The hospice's daytime and emergency telephone numbers; and
   v. Notification regarding the filing of complaints with the Department's 24-hour Complaint Hotline at 1-800-792-9770 or in writing to the Office of Assessment and Survey.
5. To receive, in terms that the patient understands, an explanation of his or her plan of care, expected results, and reasonable alternatives. If this information would be detrimental to the patient's health, or if the patient is not able to understand the information, the explanation shall be provided to a family member or an individual who is a legal representative of the patient and documented in the patient's medical record;
6. To receive, as soon as possible, the services of a translator or interpreter to facilitate communication between the patient and health care personnel.
   i. Hospices shall make efforts to secure a professional, objective interpreter for hospice-patient communications, including those involving the notice of patient rights

(c.) The hospice shall ensure that all verified violations involving anyone furnishing services on behalf of the hospice are reported to State and local authorities having jurisdiction within five (5) working days of becoming aware of the violation.

Oregon: No additional requirements

Pennsylvania: No additional requirements

Tennessee: 1200-08-27-.12 Patient rights

(1) Each patient has at least the following rights:

a. To privacy in treatment and personal care;

b. To be free from mental and physical abuse. Should this right be violated, the agency must notify the Department within five (5) business days. Suspected abuse of a patient shall be reported immediately to the Tennessee Department of Human Services, Adult Protective Services as required by T.C.A. § 71-6-101 et seq.;

c. To have appropriate assessment and management of pain;

d. To be involved in the decision making of all aspects of their care;

e. To refuse treatment. The patient must be informed of the consequences of that decision. A refusal and its reason must be reported to the physician and documented in the medical record;

f. To refuse experimental treatment and drugs. The patient's or health care decision maker's written consent for participation in research must be obtained and retained in the medical record; and

g. To have their records kept confidential and private. Written consent by the patient must be obtained prior to the release of information except to persons authorized by law. If the patient lacks capacity, written consent is required from the patient's health care decision-maker. The agency must have policies to govern access and duplication of the patient's record.

(2) Each patient has a right to self-determination, which encompasses the right to make choices regarding life-sustaining treatment, including resuscitative services. This right of self-determination may be effectuated by an advance directive.

Texas: 558.282 Client Rights

f. A client has the following rights:

(1) A client has the right to be informed in advance about the care to be furnished, the plan of care, expected outcomes, barriers to treatment, and any changes in the care to be furnished. The agency must ensure that written informed consent specifying the type of care and services that may be provided by the agency has been obtained for every client, either from the client or their legal representative. The client or the legal representative must sign or mark the consent form.

(2) A client has the right to participate in planning the care or treatment and in planning a change in the care or treatment.

(A) An agency must advise or consult with the client or legal representative in advance of any change in the care or treatment.

(B) A client has the right to refuse care and services.

(C) A client has the right to be informed before care is initiated of the extent to which payment may be expected from the client, a third-party payer, and any other source of funding known to the agency.

(3) A client has the right to have assistance in understanding and exercising the client's rights. The agency must maintain documentation showing that it has complied with the requirements of this paragraph and that the client demonstrates an understanding of the client's rights.

(4) A client has the right to exercise rights as a client of the agency.

(5) A client has the right to have the client's person and property treated with consideration, respect, and full recognition of the client's individuality and personal needs.

(6) A client has the right to be free from abuse, neglect, and exploitation by an agency employee, volunteer, or contractor.

(7) A client has the right to confidential treatment of the client's personal and medical records.

(8) A client has the right to voice grievances regarding treatment or care that is or fails to be furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the agency and must not be subjected to discrimination or reprisal for doing so.

h. In the case of a client adjudged incompetent, the rights of the client are exercised by the person appointed by law to act on the client's behalf.

i. In the case of a client who has not been adjudged incompetent, any legal representative may exercise the client's rights to the extent permitted by law.

Washington: WAC 246-335-635

Bill of rights.

A hospice agency at the time of admission must provide each patient, designated family member, or legal representative with a written bill of rights affirming each patient's right to:

(1) Receive effective pain management and symptom control and quality services from the hospice agency for services identified in the plan of care;

(2) Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services;

(3) A statement advising of the right to ongoing participation in the development of the plan of care;

(4) Choose his or her attending physician;

(5) A statement advising of the right to have access to the department's listing of licensed hospice agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations;
(6) A listing of the total services offered by the hospice agency and those being provided to the patient;
(7) Refuse specific services;
(8) The name of the individual within the hospice agency responsible for supervising the patient's care and the manner in which that individual may be contacted;
(9) Be treated with courtesy, respect, and privacy;
(10) Be free from verbal, mental, sexual, and physical abuse, neglect, exploitation, discrimination, and the unlawful use of restraint or seclusion;
(11) Have property treated with respect;
(12) Privacy and confidentiality of personal information and health care related records;
(13) Be informed of what the hospice agency charges for services, to what extent payment may be expected from health insurance, public programs, or other sources, and what charges the patient may be responsible for paying;
(14) A fully itemized billing statement upon request, including the date of each service and the charge. Agencies providing services through a managed care plan are not required to provide itemized billing statements;
(15) Be informed about advanced directives and POLST and the agency's scope of responsibility;
(16) Be informed of the agency's policies and procedures regarding the circumstances that may cause the agency to discharge a patient;
(17) Be informed of the agency's policies and procedures for providing back-up care when services cannot be provided as scheduled;
(18) A description of the agency's process for patients and family to submit complaints to the hospice agency about the services and care they are receiving and to have those complaints addressed without retaliation;
(19) Be informed of the department's complaint hotline number to report complaints about the licensed agency or credentialed health care professionals; and
(20) Be informed of the DSHS end harm hotline number to report suspected abuse of children or vulnerable adults.
(21) The hospice agency must ensure that the patient rights under this section are implemented and updated as appropriate.

Washington D.C.: Title 44, Chapter 5, 44-504 Rules

(4) A statement of patients', clients', and residents' rights and responsibilities for each type of facility and agency, including the right to non-discrimination in treatment or access to services based on reasons prohibited by Unit A of Chapter 14 of Title 2.

Wisconsin: DHS 131.19 Patient rights

(1) General Information. A hospice shall provide each patient and patient's representative, if any, with a written statement of the rights of patients before services are provided and shall fully inform each patient and patient's representative, if any, of all of the following:

(a) Those patient rights and all hospice rules and regulations governing patient responsibilities, which shall be evidenced by written acknowledgment provided by the patient, if possible, or the patient's representative, if any, prior to receipt of services.

(b) The right to prepare an advance directive.

(c) The right to be informed of any significant change in the patient's needs or status.

(d) The hospice's criteria for discharging the individual from the program.

(2) Rights of Patients. In addition to rights to the information under sub. (1), each patient shall have all of the following rights:

(a) To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

(b) To participate in planning care and in planning changes in care.

(c) To select or refuse care or treatment.

(d) To choose his or her attending physician.

(e) To confidential treatment of personal and clinical record information and to approve or refuse the release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third party payment contract.

(f) To request and receive an exact copy of one's clinical record.

(g) To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source and misappropriation of patient property.

(h) To be free from restraints and seclusion except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care.

(i) To be treated with courtesy, respect, and full recognition of the patient's dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements, and the care of personal needs.

(j) To privately communicate with others without restrictions.

(k) To receive visitors at any hour, including small children, and to refuse visitors.

(l) To be informed prior to admission of the types of services available from the hospice, including contracted services and specialized services for unique patient groups such as children.

(m) To be informed of those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services.

accentCare.	*Manual*:	**HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*:	*C 2.4*
	Title:	**AVAILABILITY OF SERVICES - ACCEPTANCE, ADMISSION, ONGOING AND DISCHARGE**	*Effective Date*:	*9/12*
			Revised:	*12/19*
			Page:	***1** of **2***

POLICY:

It is the policy of this agency that all patients, regardless of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin have the right to receive the same quality of care throughout the organization and to have access to the home health resources they need to meet their health care needs.

PURPOSE:

To ensure uniform quality of patient care and service for all patients throughout the organization and to ensure that patients have access to the resources they need to meet their health care needs.

PROCEDURE:

1. Patients are accepted for treatment with a reasonable expectation that their medical, nursing, rehabilitative, and social needs can be met adequately by the Agency in the patient's residence.

2. The agency does not discriminate against an individual based on whether or not the individual has executed an Advance Directive.

3. The agency will maintain a clinical record review process and an internal audit process to ensure that agency policies and procedures are followed by all personnel, whether employed or through contract.

4. The care and resources the patient receives, as well as the skill level and training of organization personnel, will be based on the professional standards of care and practice of recognized authorities and the needs of the patients served.

5. The agency maintains specific policies regarding admission criteria, ongoing care and discharge in its program-specific policy and procedure manual.

6. The start of care assessment visit must be performed on the start of care date ordered by the physician, within 48 hours of the referral, within 48 hours of the patient's return home from hospitalization of 24 hours for more for other than for tests, or within 48 hours after the election of hospice care unless the physician, patient or representative request a different SOC/ROC assessment date.

7. Additional initial discipline assessments will be provided within five business days of the start of care or on the physician-ordered date. For hospice, the comprehensive assessment will be completed no later than 5 calendar days after the election of hospice care.

8. Routine visits will be performed on weekends or after regular business hours, if required, by the type of care ordered (e.g., daily wound care, every 12 hour IV medication administration) or to meet the patient's need (e.g., visiting when a specific family member is available for wound care instruction).

9. A registered nurse is available by phone after regular business hours and may make an urgent need visit.

10. The agency utilizes a collaborative approach to patient care that consists of soliciting the patient and family's participation in the care planning process, communication with the patient's physician, and coordinating care among the disciplines and clinicians providing care.

SECTION 504 GRIEVANCE PROCEDURE

POLICY:

This agency does not discriminate based on disability and follows an internal grievance procedure providing prompt and equitable resolution of complaints alleging any action prohibited by Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) or the U.S. Department of Health and Human Services regulations implementing the Act.

Any person who believes she or he has been subjected to discrimination based on disability may file a grievance under this procedure. It is against the law to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

REFERENCE: Section 504 states, in part, that "no otherwise qualified handicapped individual…shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance…"

DEFINITION: The Section 504 Coordinator is the Human Resources Business Partner for the agency.

PROCEDURE:

1. Grievances must be submitted to the Section 504 Coordinator within thirty (30) days from the date the person filing the grievance becomes aware of the alleged discriminatory action.
2. A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
3. The Section 504 Coordinator, or her/his designee, shall conduct an investigation of the complaint. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 504 Coordinator will maintain the files and records relating to such grievances.

4. The Section 504 Coordinator shall issue a written decision on the grievance no later than 30 days after its filing.
5. The person filing the grievance may appeal the decision of the Section 504 Coordinator by writing to the Chief People Officer within 15 days of receiving the Section 504 Coordinator's decision.
6. The Chief People Officer shall issue a written decision in response to the appeal no later than 30 days after its filing.
7. The availability and use of this grievance procedure does not prevent a person from filing a complaint of discrimination based on disability with the U.S. Department of Health and Human Services, Office of Civil Rights, or at the Regional Offices for Civil Rights.
8. In case of questions, please contact the Section 504 Coordinator for the agency or the support center at 1-866-339-9844.

Offices for Civil Rights

Office for Civil Rights Headquarters / U.S. Department of Health & Human Services

Hubert H. Humphrey Building, 200 Independence Avenue, S.W. Room 509F, Washington, D.C. 20201 Phone: 1-800-368-1019 or TDD number 1-800-537-7697 Email: ocrmail@hhs.gov

Regional Offices for Civil Rights

Region 1 Includes: Connecticut, Massachusetts, and New Hampshire
John F. Kennedy Federal Building, Government Center Room 1875, Boston, MA 02203

Region 2 Includes: New Jersey and New York
Jacob Javits Federal Building, 26 Federal Plaza Suite 3312, New York, NY 10278

Region 3 Includes: Delaware, District of Columbia, Maryland, Pennsylvania, and Virginia
801 Market Street, Suite 9300, Philadelphia, PA 19107

Region 4 Includes: Florida, Georgia, Mississippi, and Tennessee
Sam Nunn Atlanta Federal Center, 61 Forsyth St. SW, Suite 16T70, Atlanta, GA 30303

Region 5 Includes: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin
233 N. Michigan Ave., Suite 240, Chicago, IL 60601

Region 6 Includes: New Mexico, Oklahoma, and Texas
1301 Young Street, Suite 106, Dallas, TX 75202

Region 7 Includes: Missouri and Nebraska
601 East 12 h Street, Room 353, Kansas City, MO 64106

Region 8 Includes: Colorado
1961 Stout Street Room 08-148 Denver, CO 80294

Region 9 Includes: Arizona, California, and Nevada
90 7 h Street, Suite 4-100, San Francisco, CA 94103

Region 10 Includes: Oregon and Washington
701 5 h Avenue, Suite 1600 MS-01, Seattle, WA 98104

DISSEMINATION OF SECTION 504 NON-DISCRIMINATION POLICY

For the purposes of complying with the rules and regulations set forth and enforced by the Office for Civil Rights, this agency informs the public, patients, and employees that the agency does not discriminate on the basis of age, disability, national origin, ancestry, gender, gender identity and/or expression, sexual orientation, or source of payment.

Regulatory reference: Rehabilitation Act of 1973 - Section 504, American Disabilities Act of 1990
CHAP standards: Core CI.5c, CI.5d
TJC standards: RI.01.01.01 EP 6, 9, RI.01.01.03 EP 1, 2, 3

This agency disseminates the nondiscrimination statement in the following ways:

<u>For the General Public:</u>

- A copy of the nondiscrimination statement is available at the agency location for visitors, clients/patients to view.
- The nondiscrimination statement is printed in the company brochure and is routinely distributed to patients, referral sources, and the community.

- The nondiscrimination statement is included in newspaper advertisements for the agency.

For the Patients:

- The nondiscrimination statement is included in the patient's admissions information.
- The nondiscrimination statement is discussed with patients during initial home visit/admission to care.
- A copy of the nondiscrimination statement is available upon request.

For the Employees:

- The nondiscrimination statement is included in employee advertisements.
- The nondiscrimination statement is included in the employee handbook.
- The nondiscrimination statement is discussed and distributed during employee orientation.
- A copy of the nondiscrimination statement is available at the agency location.

POLICY:

It is the policy of this agency to monitor and report information related to adverse events that endanger the health and safety of patients and/or employees and predispose the organization to real or potential liability.

Regulatory References: Home Health – 484.50 (c.)(2), 484.50 (e.)(2), 484.65 (c.)(1)(iii)
Hospice – 418.58(a)(2), 418.58 (c.)(2), 418.58(c.)(3), 418.58(e.)(2)
CHAP Standard: Core - CII.7I
CHAP Standards: Home Health - PCC.8.I, PCC.8.I.M1, CQI.2.D, CQI.2.D.M2, CQI.3.I.M2, CQI.3.I.M3, CQI.3.I.M4, IM.6.I
CHAP Standards: Hospice – HPFC 8.D, HSIC 8.I, HQPI 1.D, HQPI 4.I, HQPI 7.I
TJC Standards: Home Health - RC.02.01.01 EP 2, 25; APR.04.01.01 EP 27; LD.03.09.01 EP 12
TJC Standards: Hospice - RC.02.01.01 EP 2; PC.01.02.01 EP 6, 11; LD.03.09.01 EP 12; PI.01.01.01. EP 24; LD.04.03.03 EP 22

PURPOSE:

This policy provides a process that allows for early identification, immediate investigation, expeditious response, and determination of whether the incident is categorized as an adverse or sentinel event. To evaluate trends and develop action plans to resolve problems as quickly as possible, and to reduce the risk of similar incidents occurring in the future.

DEFINITION:

Serious Adverse Event or Sentinel Event: is an unanticipated occurrence involving death, serious physical or psychological injury, or the risk thereof.

Adverse Event: Injury or unintended harm to a patient resulting by an act of commission or omission, rather than by the underlying disease or condition of the patient.

PROCEDURES:

1. Incident Reports are completed on all occurrences as set forth below:

    a. Sentinel or serious adverse events include but not limited to:
        i. Unexpected death not resulting from the patient's medical condition,
        ii. Loss of a body part,
        iii. Partial loss of body function or blindness,
        iv. Suicide, threats or attempts of suicide,

v. Burns, fractures, concussions, or head injuries
vi. Criminal acts including, rape or assault leading to temporary or permanent harm to a patient or staff member,
vii. Delay of treatment that resulted in a life-threatening event, serious injury to the patient,
viii. Failure to communicate critical laboratory results to physician in a timely manner,
ix. Injury or harm to the patient resulting from care involving medication use, whether in provision of or omission of care.
x. Patient death or serious injury associated with a patient fall during patient care,
xi. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care. This includes home oxygen administration, as part of the home care services, regardless of whether a member of staff was present.

b. Adverse events include, but are not limited to:
   i. Provision of care errors including, but not limited to staff member fails to report significant findings or medication errors.
   ii. Unusual occurrences including, but not limited to:
      1) A patient safety event that did reach the patient and did not result in serious harm,
      2) A patient safety event that did not reach the patient (i.e., close-call),
   iii. Vehicular crashes, including, but not limited to motor vehicle accident while on company business involving personal or company-owned vehicle.
   iv. Other types of accidents or injury, but not limited to staff incidents that require treatment, lost days of work, hospitalization.
   v. Safety hazards, including, but not limited to unsafe situation in the home; any suspected abuse, neglect, or exploitation to/of patients.
   vi. Falls, witnessed and un-witnessed.

c. Whenever any equipment, supply or component used for servicing a patient malfunctions, or is improperly operating either as a result of an inherent problem with the equipment; e.g., this would include, but not be limited to settings, improper hook-up, tracheostomy/gastrostomy tube malfunctioning, oxygen delivery, or wound care equipment. (See Medical Device Reporting.)

d. Whenever paramedics are involved with a patient at home with the employee present and paramedic actions are in contrast to advance directives.

e. Damage to the property of a patient or caregiver is damaged or stolen, e.g., money or jewelry stolen, furniture damaged or equipment stolen.

f. Other similar incidents.

2. An incident is to be reported by the person who observed or heard about the incident and documented electronically, as soon possible, through the online reporting portal or in the electronic medical record's quality improvement (QI) event report.

3. The Director of Patient Care Services/Clinical Manager, and/or designated appropriate management staff will, review and investigate all incidents, collect data, analyze for trends and patterns, implement corrective action plans when necessary, and evaluates the outcomes of the action plans.

4. Incident reports are to be forwarded to corporate risk management. Any incident involving corporate compliance infractions are forwarded to the compliance department.
   a. An incident report is added to Riskonnect/Clearsight by the person observing or hearing about the incident within 48 hours.
   b. Go to the following link to access Riskonnect/Clearsight: https://www.riskonnectclearsight.com/Enterprise/login.cmdx?noAuthentication=2&ReturnUrl=%252fEnterprise%252fDefault.aspx

5. If the incident is categorized as a "serious adverse or sentinel event," the Administrator, Vice President of Clinical Services, and Regional Vice President are notified immediately. The Regional Vice President/VP of Clinical Services will notify the Chief Nursing Officer, and VP of Quality as indicated, and may conduct any additional analysis and involve the Compliance Department/Legal Department or designee to ensure that thorough follow-up has occurred.

6. Incidents are reported to state authorities, if required, according to state regulations.

7. The agency is to report an incident to the payer, if required, and follow the payer's reporting policy and/or using the payer's incident reporting form, e.g., Regional Centers in California.

8. If the investigation of the incident indicates a potential or actual liability claim against the company, the Vice President/Risk Management/Legal Department is notified.

9. All sentinel or serious adverse events require a comprehensive analysis and corrective action plan within 30 days of the event or within 30 days of becoming aware of the event. It should identify system vulnerabilities so that they can be eliminated or mitigated.
   a. The analysis will focus on systems and processes, not solely on individual performance and include patients, family, or patient representatives when appropriate to ensure a thorough understanding of the facts.

b. Include individuals most closely involved in the processes and systems under review,
c. Be consistent and answer all obvious questions,
d. Identify who is responsible for implementation, when the action will be implemented, how the effectiveness of the actions will be evaluated, and how actions will be sustained.

10. As part of the agency's Quality Assurance Performance Improvement (QAPI) process adverse patient events are analyzed to determine causes and preventive actions to be implemented that lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of any patient.

11. Risk Management distributes reports generated from the reporting portal to the Regional Vice President/ Administrator who will distribute the reports to the Executive Directors/Administrators in the region. Copies of these reports are maintained by the agency.

12. The Administrator or Designee reviews the log of incident reports and present trends and a quarterly summary of all incidents (C 2.7.9.3) to the Quality Assurance Performance Improvement (QAPI) Committee for review and action as indicated.

13. No incident report shall be filed in the patient's clinical record.

14. Serious injury or death resulting from an equipment failure or malfunction must also be reported to the Food and Drug Administration and the equipment manufacturer – refer to "Medical Device Reporting" and "Advice about Voluntary FDA Reporting".

State-Specific Requirement

Arizona: Hospice -no additional requirements

California: Home Health - no additional requirements

Hospice: Section 6.4 Unusual Occurrences

(B)(1) Occurrences that threaten the welfare, safety or health of patients or program personnel shall be reported to the Department. These occurrences include, but are not limited to:

a. Poisonings
b. Death from unnatural causes
c. Fires
d. Patient injury as a result of medical or nursing malfeasance or nonfeasance
e. Criminal misconduct by a program employee or agent committed upon a patient

(B)(2) The report shall be made by the next Department workday either by telephone (and confirmed in writing) or in person to the Department. An incident report shall be maintained by the hospice for one (1) year.

(B)(3) The program shall report alleged misconduct listed above to the appropriate licensing board of the individual involved. The program shall furnish other pertinent information related to such occurrences as the Department may require.

(B)(4) Criminal misconduct shall be reported to the appropriate law enforcement agency.

Colorado: Home Health and Hospice - no additional requirements

Connecticut: Hospice – no additional requirements

Delaware: Hospice – no additional requirements

Florida: Home Health and Hospice - no additional requirements

Georgia: Home Health no additional requirements

Hospice - 0601 Reports to the Department 290-9-43-.06(1) Patient Incidents Requiring Report. This paragraph takes effect three months after the Department provides written notification of the effective date to all hospices.

0602 290-9-43-.06(1)(a)1. The hospice shall report to the Department, on forms provided by the Department, within 24 hours or the next business day whenever any of the following incidents involving patients occurs or the hospice has reasonable cause to believe that an incident involving a patient has occurred:

1. Any death of a hospice patient not related to the natural course of the patient's terminal illness or any identified underlying condition;

2. Any patient rape that occurs in a residential or inpatient hospice facility or in a patient's home at the time a hospice employee or volunteer is in the patient's home;
3. Any assault on a patient by a hospice employee or volunteer, or any abuse or neglect of a patient by a hospice employee or volunteer;
4. Any serious injury to a patient resulting from the malfunction or intentional or accidental misuse of patient care equipment; and
5. In a residential or inpatient hospice facility, any time a patient cannot be located, where there are circumstances that place the health, safety, or welfare of the patient or others at risk and the patient has been missing for more than eight hours.

0607 Reports to the Department
290-9-43-.06(1)(b) The hospice, through its peer review committee, shall submit the reports of patient incidents listed in subparagraph
(a) of this paragraph to be received and retained in confidence by the Department together with any documentation generated by the Department of its initial review of the reported incident.

0608 Reports to the department
290-9-43-.06(1)(c) Reports of patient incidents shall include:
1. The name of the hospice, the name of the administrator or site manager, and a contact telephone number for information related to the report;
2. The date of the incident and the date the hospice became aware of the incident;
3. The type of incident, with a brief description of the incident; and
4. Any immediate corrective or preventative action taken by the hospice to ensure against the replication of the incident.

The information provided in the report should be sufficient for the Department to understand what took place, and why the facility determined the incident to require report. For reporting forms and information regarding online incident reporting, go to the ORS website: www.ors.dhr.georgia.gov

0612 Reports to the department 290-9-43-.06(1)(d) The hospice shall conduct an internal investigation of any of the patient incidents listed in subparagraph (a) of this paragraph and shall complete and retain on-site a written report of the results of the investigation within 45 days of the discovery of the incident. The complete report shall be available to the Department for inspection at the hospice office and shall contain at least:
1. An explanation of the circumstances surrounding the incident, including the results of a root cause analysis or any other system analysis;
2. Any findings or conclusions associated with the review; and

3. A summary of any actions taken to correct identified problems associated with the incident and to prevent recurrence of the incident, and also any changes in procedures or practices resulting from the investigation.

Illinois: Home Health and Hospice - no additional requirements

Indiana: Home Health and Hospice - no additional requirements

Massachusetts: Home Health - no additional requirements

Hospice – 105 CMR 141.201

(F) Incident Reporting.

(1) All incidents seriously affecting the health or safety of patients resulting from acts or omissions of hospice program employees, including those working for the hospice through a contract arrangement with another organization, and volunteers shall be recorded and reported accurately to the Department within seven (7) days of the occurrence. Such reports shall be made in a format prescribed by the Department (MA DOH).

(2) A hospice inpatient facility shall also report immediately any of the following which occurs on premises covered by its license:

(a) death that is unanticipated, not related to the natural course of the patient's illness or underlying condition, or that is the result of an error or other incident as specified in guidelines of the Department;

(b) full or partial evacuation of the facility for any reason;

(c) fire;

(d) suicide;

(e) serious criminal acts;

(f) pending or actual strike action by its employees, and contingency plans for operation of the program or facility; or

(g) any other serious incident or accident as specified in guidelines of the Department.

(3) A hospice program shall make available to the Department all information that may be relevant to the Department's investigation of any incident or complaint, regardless of how reported to the Department.

(4) A hospice program shall make all reasonable efforts to facilitate the Department's attempts to interview any and all potential witnesses who may have information relevant to the Department's investigation of any incident or complaint, regardless of how reported to the Department.

(G) Patient Abuse, Mistreatment, Neglect or Misappropriation of Property. In accordance with 105. CMR 155.00 Hospice administrators and workers shall immediately report to the Department any suspected instance(s) of hospice patient abuse, mistreatment, neglect, or misappropriation of hospice patient property.

(H) Grievance Procedure.

(1) The hospice patient has the right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment that has been furnished as well that which has not been furnished.

(2) The hospice program must promptly acknowledge and actively work to resolve all oral and written patient grievances.

Michigan: Home Health and Hospice - no additional requirements

Minnesota:

Home Health 144A.4794

Subdivision 3 Contents of the client record.

(9) Documentation of incidents involving the client and actions taken in response to the needs of the client including reporting to the appropriate supervisor or health care professional.

Hospice: Hospice Chapter 4664.0190

Subpart 3 F. A hospice provider must ensure that each hospice patient's record contains documentation on the day of occurrence of any significant change in the patient's status or any significant incident and any actions by staff in response to the change or incident.

Mississippi: Home Health - no additional requirements

Missouri: Hospice - no additional requirements

Nebraska: Home Health - Title 175 14-004.07

Notification: An applicant or licensee must notify the Department in writing, by mail, electronic mail, or facsimile:

7. Within 24 hours if the home health agency has reason to believe that a patient death was due to abuse or neglect by staff.

Nevada: Hospice - no additional requirements

New Jersey: Hospice

Section 8:42C-3.8 - Reportable events.

(c) The facility shall report to the Department every serious preventable adverse event that occurs in the facility, pursuant to N.J.A.C. 8:43E-10.

Section 8:43E-10.6 Reporting of serious preventable adverse events

(a)(2)Adult and pediatric day health care services facilities and facilities that provide home-based services, that is, home health care facilities, hospice facilities, assisted living residences, comprehensive personal care homes, and assisted living programs, shall report only those serious preventable adverse events that are within the control of the facility or directly caused by, or related to, services of the facility.

(b) A facility shall notify the Department, or the Department of Human Services, as applicable, of the occurrence of an event subject to mandatory reporting, pursuant to (a) above, no later than five (5)business days after the facility discovers the occurrence of the event.

1. If a facility does not have all the information required pursuant to (c) below for a complete report, the facility shall submit a partial report on a serious preventable adverse event within the time specified in (b) above, and shall then update this initial partial report as soon as the other information required pursuant to (c) below becomes available.

(c) A facility shall submit, pursuant to (a) above, the form provided at subchapter Appendix A, incorporated herein by reference, which includes the following information:

1. The facility name, license number, and address, and the name and title of the person submitting the report;
2. A brief description of the event, including the impact on the patient or resident;
3. The date and time the event occurred;
4. Where the patient or resident was when the event occurred;
5. The date and time the facility became aware of the event;
6. How the event was discovered;
7. The patient or resident's billing and medical record number, date of admission or ambulatory encounter, demographic information, and, for inpatients, whether the patient was admitted directly, by transfer, or through the emergency department;
8. The type of serious preventable adverse event, using the categories provided at (e) through (j) below;
9. The immediate corrective actions the facility took to eliminate or reduce the adverse impact of the event and to prevent future similar events;
10. If the facility previously submitted a partial report on the event pursuant to (b)1 above, the report number assigned to the prior report by the Department; and

11. If the facility previously submitted a report on the event containing incorrect information, the report number assigned to the prior report by the Department and the correct information.

(d) Facilities shall report the information required pursuant to (c) above by means of telefacsimile using the form provided in subchapter Appendix A.

1. The telefacsimile number to which facilities are to submit event reports to the Department is (609) 530-4850.
2. The telephone number facilities may use to obtain additional information concerning the event report and form is (609) 530-7473.

(f) Patient or resident care management-related events include, but are not limited to:

1. Patient or resident death, loss of body part, disability, or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with:
   - a medication error (such as errors involving the wrong drug, wrong dose, wrong patient or resident, wrong time, wrong rate, wrong preparation, or wrong route of administration);
   - with hypoglycemia, the onset of which occurs while the patient or resident is being cared for in the health care facility;
   - Stage III or IV pressure ulcers acquired after admission of the patient or resident to a health care facility.
   - Progression from stage II to stage III is excluded from the meaning of above, provided that stage II was recognized and documented upon admission

(g) Environmental events include, but are not limited to:

1. Patient or resident death, loss of body part, disability, or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with:
   - an electric shock while being cared for in a health care facility,
   - incidents in which a line designated for oxygen or other gas to be delivered to a patient or resident contains the wrong gas or is contaminated by toxic substances;
   - a burn incurred from any source while in a health care facility;
   - associated with a fall while in a health care facility; and
   - the use of restraints or bedrails while in a health care facility

(h) Product or medical device-related events include, but are not limited to:

1. Patient or resident death, loss of body part, disability, or loss of bodily function lasting more than seven days or, in the case of a non-residential health care facility, still present at discharge, associated with:

- use of generally detectable contaminated drugs, medical devices, or biologics provided by the health care facility, regardless of the source of contamination or product;
- the use or function of a medical device in patient or resident care in which the device is used or functions other than as intended, including, but not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators;
- Intravascular air embolism that occurs while the patient or resident is in the facility
- use of a new or reprocessed single-use device in patient or resident care in which the device is used or functions other than as intended.

(j) Patient or resident protection-related events include, but are not limited to:

3. Patient or resident suicide or attempted suicide while in a health care facility
   i. does not include deaths or disability resulting from self-inflicted injuries that were the reason for admission to the health care facility

(k) A facility shall submit to the Department a root cause analysis of every serious preventable adverse event subject to mandatory reporting pursuant to (a) above no later than 45 days after the submission of the initial report of the event using the form provided at subchapter Appendix B, incorporated herein by reference.

New Mexico: Home Health 7.28.2.41 Incidents

A. Reporting: All home health agencies licensed pursuant to these regulations must report to the licensing authority any of the following, which has, or could threaten the health, safety and welfare of the patient/clients or staff:
   (1) any serious incident or unusual occurrence;
   (2) injuries of unknown origin or known, suspected or alleged incidents of patient/client abuse, neglect, exploitation, or mistreatment by staff or person(s) contracted by the home health agency.

B. Documentation: The agency is responsible for documenting all incidents, within five (5) days of the incident, and having on file the following:
   (1) a narrative description of the incident;
   (2) evidence contact was made to the licensing authority;
   (3) results of the facility's investigation;
   (4) the facility action if any.

New York: Home Health - no additional requirements

Ohio: Home Health - no additional requirements

Oklahoma: Home Health - no additional requirements

Oregon: Home Health and Hospice - no additional requirements

Pennsylvania:

The agency shall report all incidents of possible abuse, neglect, and exploitation to the Event Reporting System (ERS) https://sais.health.pa.gov/Incidents/facilitylogin.asp

Home Health and Hospice - PART IV. Ch. 51 General Information 28 § 51.3

(e) If a healthcare facility is aware of information, which shows that the facility does not comply with any of the Department's regulations, which are applicable to that healthcare facility, and that the noncompliance seriously compromises quality assurance or patient safety, it shall immediately notify the Department in writing of its noncompliance. The notification shall include sufficient detail and information to alert the Department as to the reason for the failure to comply and the steps, which the health care facility shall take to bring it into compliance with the regulation.

(f) If a health care facility is aware of a situation or the occurrence of an event at the facility, which could seriously compromise quality assurance or patient safety, the facility shall immediately notify the Department in writing. The notification shall include sufficient detail and information to alert the Department as to the reason for its occurrence and the steps which the health care facility shall take to rectify the situation.

(g) For purposes of subsections (e) and (f), events, which seriously compromise quality assurance or patient safety, include, but are not limited to, the following:

(1) Deaths due to injuries, suicide, or unusual circumstances.
(2) Deaths due to malnutrition, dehydration, or sepsis.
(3) Deaths or serious injuries due to a medication error.
(4) Elopements.
(5) Transfers to a hospital as a result of injuries or accidents.
(6) Complaints of patient abuse, whether or not confirmed by the facility.
(7) Rape.
(8) Surgery performed on the wrong patient or on the wrong body part.
(9) Hemolytic transfusion reaction.
(10) Infant abduction or infant discharged to the wrong family.
(11) Significant disruption of services due to disaster such as fire, storm, flood or other occurrence.
(12) Notification of termination of any services vital to the continued safe operation of the facility or the health and safety of its patients and personnel, including, but not limited to, the anticipated or actual termination of electric, gas, steam heat, water, sewer, and local exchange telephone service.

(13) Unlicensed practice of a regulated profession.
(14) Receipt of a strike notice.

(h) A health care facility shall send the written notification required under subsections (a)—(f) to the director of the division in the Department responsible for the licensure of the health care facility.

Home Health - 28 §601.13. Responsibilities of Home Health Care Agency owners.

(c) The owner, administrator, or designee shall immediately report, by telephone to the Department and by a written follow-up report as soon as possible, a catastrophic incident, such as fire or flood, or an incident which may cause interruption or cessation of the delivery of services or another interruption of home health care Agency services which would affect the health and safety of the patients.

Hospice – no additional requirements

Tennessee: Home Health 1200-08-26-.11 and Hospice 1200-08-27-.11

Records and Reports.

(2) The agency providing home health services shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.
(3) The agency providing home health services shall report the following incidents to the Department of Health in accordance with T.C.A. § 68-11-211.
(a) Strike by staff at the facility;
(b) External disasters impacting the facility;
(c) Disruption of any service vital to the continued safe operation of the home care organization providing home health services or to the health and safety of its patients and personnel; and
(d) Fires at the home care organization providing home health services that disrupt the provision of patient care services or cause harm to the patients or staff, or that are reported by the facility to any entity, including but not limited to a fire department charged with preventing fires.
(4) The agency shall retain legible copies of the following records and reports for thirty-six (36) months following their issuance. They shall be maintained in a single file and shall be made available for inspection during normal business hours to any person who requests to view them:
(a) Department licensure and fire safety inspections and surveys;
(b) Federal Health Care Financing Administration surveys and inspections, if any;
(c) Orders of the Commissioner or Board, if any; and
(d) Comptroller of the Treasury's audit report and finding if any.

Texas: Home Health and Hospice 558.249 Self-Reported Incidents of Abuse, Neglect, and Exploitation

(a) The following words and terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.
  (1) Abuse, neglect, and exploitation of a client 18 years of age and older have the meanings assigned by the Texas Human Resources Code, 48.002.
  (2) Abuse, neglect, and exploitation of a child have the meanings assigned by the Texas Family Code, 261.401.
  (3) Employee means an individual directly employed by an agency, a contractor, or a volunteer.
  (4) Cause to believe means that an agency knows, suspects, or receives an allegation regarding abuse, neglect, or exploitation.

(b) An agency must adopt and enforce a written policy relating to the agency's procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency.

(c) If an agency has cause to believe that a client served by the agency has been abused, neglected, or exploited by an agency employee, the agency must report the information immediately, meaning within 24 hours, to:
  (1) the Department of Family and Protective Services (DFPS) at 1-800-252-5400, or through the DFPS secure website at www.txabusehotline.org; and
  (2) TXHHS at 1-800-458-9858.

558.250 Agency Investigations

(a) Written policy.
  (1) An agency must adopt and enforce a written policy relating to the agency's procedures for investigating complaints and reports of abuse, neglect, and exploitation.
  (2) The policy must meet the requirements of this section.

(b) Reports of abuse, neglect, and exploitation (ANE).
  (1) Immediately upon witnessing the act or upon receipt of the allegation, an agency must initiate an investigation of known and alleged acts of ANE by agency employees, including volunteers and contractors.
  (2) An agency must complete HHSC's Provider Investigation Report form and include the following information:
    (B) incident date;
    (C) the alleged victim;
    (D) the alleged perpetrator;
    (E) any witnesses;
    (F) the allegation;

(G) any injury or adverse affect;
(H) any assessments made;
(I) any treatment required;
(J) the investigation summary; and
(K) any action taken

(3) An agency must send the completed HHSC's Provider Investigation Report form to HHSC Complaint Intake Unit no later than the 10th day after reporting the act to the Department of Family and Protective Services and HHSC.

(c) Agency complaint investigations.

(1) An agency must investigate complaints made by a client, a client's family or guardian, or a client's health care provider, in accordance with this subsection, regarding:
(A) treatment or care that was furnished by the agency;
(B) treatment or care that the agency failed to furnish; or
(C) a lack of respect for the client's property by anyone furnishing services on behalf of the agency.

(2) An agency must:
(A) document receipt of the complaint and initiate a complaint investigation within 10 days after the agency's receipt of the complaint; and
(B) document all components of the investigation.

(d) Completing agency investigations. An agency must complete the investigation and documentation within 30 days after the agency receives a complaint or report of abuse, neglect, and exploitation, unless the agency has and documents reasonable cause for a delay.

(e) Retaliation

(1) An agency may not retaliate against a person for filing a complaint, presenting a grievance, or providing, in good faith, information relating to home health, hospice, or personal assistance services provided by the agency.

(2) An agency is not prohibited from terminating an employee for a reason other than retaliation.

Virginia: Home Health - no additional regulations

Washington: Hospice - no additional regulations

Washington D.C.: Hospice - no additional regulations

Wisconsin: Hospice DHS 131.39

Fire safety. (8) Fire report. All incidents of fire in a hospice shall be reported to the department within 72 hours. Note: Online fire reporting is available at: Health Care Facility Report F-62500 at: https://www.dhs.wisconsin.gov/publications/p01729.pdf.

accentCare.

PATIENT INCIDENT REPORT – Tracking Log C 2.7.9.2

Agency/Site:_____

Month:_____ Year:_____

Date /Type of Incident	Name of Person Reporting	DATE NC DENT FOLLOW UP RESOLVED

04/01/22

accentCare.

PATIENT INCIDENT REPORT – Summary C 2.7.9.3

Office/Site:_____

Month:_____ Year:_____

Type of Incident	TOTALS	%
Fall_____Without staff present ____With staff present		
Abuse/ Neglect/Exploitation		
Infection occurring after admission		
Medication error/problem		
Adverse medication reaction		
Lab error/problem		
Equip/Medical device problem		
Omission of care/Missed visit/Delay in		
Care given without orders		
Loss/theft/breakage of patient property		
Decubitus ulcer __New (after admission) ___Changed (worsening)		
Patient accident/injury		
Emergency (Ambulance or 911 required)		
Unexpected death		
I.V. problem		
Other		
TOTAL		

11/01/21

POLICY:

Patients and family/caregivers will receive information on an emergency management plan during the initial visit.

PURPOSE:

To provide guidelines for specific instruction and information for patients and family/caregivers in relation to emergency preparedness and actions to take in the event of a natural disaster and/or emergency.

Regulation references: State Operations Manual Appendix Z (CoP for Hospices 418.113 & CoP for Home Health Agencies 484.22)
CHAP Standard: Home Health- EP.1.D; Hospice- HSEP1.I; HSEP 2.D; HSEP 3.D; HSEP 4.D; HSEP 5.D; HSEP 6.I; HSEP 7.I

PROCEDURE:

1. As part of the comprehensive assessment, the patient and family/caregiver will be assessed regarding their emergency management plan for the home, and any special needs will be noted.
2. The patient's and family/caregiver's understanding will be assessed on an ongoing basis. Instruction will be in accordance with applicable organization policies, including, but not limited to, "Emergency Management Plan."
3. The patient and family/caregiver will be assessed and instructed regarding the components of an emergency preparedness/natural disaster plan that will include, but not be limited to:
    a. Emergency phone access, including ambulance, police, fire, gas, electric, water
    b. Emergency supplies, including food, water, heat, light, day to day necessities, and needed medical supplies
    c. Disaster follow up, including battery-powered access to local radio stations
    d. Procedures to follow if care is disrupted by a natural disaster
    e. Actions to take in preparation and during natural disasters, such as flood, storms or earthquakes
    f. Actions to take in case of fire
    g. Evacuation plans for the home

4. Written information will be presented and reviewed, based on patient and family/caregiver knowledge, skills, and identified needs.
5. The Case Manager will document all patient and family/caregiver education information in the clinical notes. Noncompliance and/or lack of understanding will be documented, and a plan for instruction will be developed as part of the plan of care.
6. The Emergency Preparedness Policy (EP-1) in the Safety First Manual requires the Emergency Preparedness Plan (EPP) and Communication Plan are reviewed annually by each provider.

State-Specific Requirements

Arizona: Hospice R9-10-616
Emergency and Safety Standards for a Hospice Inpatient Facility

A. An administrator of a hospice inpatient facility shall ensure that:
   1. A disaster plan is developed, documented, maintained in a location accessible to personnel members and other employees, and, if necessary, implemented that includes:
      a. When, how, and where patients will be relocated, including:
         i. Instructions for the evacuation or transfer of patients,
         ii. Assigned responsibilities for each employee and personnel member, and
         iii. A plan for providing continuing services to meet patient's needs;
      b. How each patient's medical record will be available to individuals providing services to the patient during a disaster;
      c. A plan to ensure each patient's medication will be available to administer to the patient during a disaster; and
      d. A plan for obtaining food and water for individuals present in the hospice inpatient facility or the hospice inpatient facility's relocation site during a 22 disaster;
   2. The disaster plan required in subsection (A)(1) is reviewed at least once every 12 months;
   3. Documentation of a disaster plan review required in subsection (A)(2) is created, is maintained for at least 12 months after the date of the disaster plan review, and includes:
      a. The date and time of the disaster plan review;
      b. The name of each personnel member, employee, or volunteer participating in the disaster plan review;
      c. A critique of the disaster plan review; and
      d. If applicable, recommendations for improvement;
   4. A disaster drill for employees is conducted on each shift at least once every three months and documented; and
   5. An evacuation path is conspicuously posted on each hallway of each floor of the hospice inpatient facility.

California:

Home Health: Title 22 747.21 Written Administrative Policies.

(a) Administrative policies shall be established and implemented by the agency.

(b) These policies and procedures shall be reviewed and revised as necessary. The policies and procedures shall be made available upon request to patients or their representatives and to Department representatives.

(c) These policies and procedures shall include, but not be limited to:

(1) A plan to handle medical emergencies.

(8) An emergency preparedness plan designed to provide continuing care/service in the event of an emergency that would result in the interruption of patient care services.

Hospice Section 6.2 Administrative Policies

1. Written administrative policies shall be developed and shall be reviewed as necessary and, if indicated, revised. These policies shall be made available to patients/families or their agents upon request.
2. These policies shall include, but not be limited to:

l. A written policy and plan that addresses patient care during a disaster.

Colorado:

Home Health: 6 CCR 1011-1 Chapter 26 Section 6.12 Emergency preparedness

(A) The home care agency (HCA) shall have a written emergency preparedness plan that is designed to manage consumers' care and services in response to the consequences of natural disasters or other emergencies that disrupt the agency's ability to provide care and services or threatens the lives or safety of its consumers.

(B) At a minimum, an agency's written emergency preparedness plan shall include the following:

(1) Provisions for the management of all staff who are designated to be involved in emergency measures, including the assignment of responsibilities and functions. All staff shall be informed of their duties and be responsible for implementing the emergency preparedness plan.

(2) Education for consumers, caregivers and families on how to handle care and treatment, safety and/or well-being during and following instances of natural (tornado, flood, blizzard, fire, etc.) and other disasters or other similar situations appropriate to the needs of the consumer.

(3) Adequate staff education on emergency preparedness so that staff safety is assured.

(C) The agency shall review its emergency preparedness plan after any incident response and on an annual basis, and incorporate into policy any substantive changes.

Hospice: 6 CCR 1011-1 Chapter 21

Section 11: Hospice Inpatient Facility

11.2 Environment (A) Safety Management (2) The facility shall have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan shall be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.

Connecticut: Home Care including Hospice 19-13-D72

Patient care policies

(F) Emergency plan and procedures to be followed to assure patient safety in the event agency services are disrupted due to civil or natural disturbances, e.g., hurricanes, snowstorms, etc.

Delaware: Hospice –Title 16 Delaware Administrative Code, Division of Public Health

4468 Delivery of Hospice Services 5.0 - Patient Care Policies

5.1.8 A written policy denoting care of patients:

5.1.8.1 In an emergency.

Florida:

Home Health: 400.492 Provision of services during an emergency.

Each home health agency shall prepare and maintain a comprehensive emergency management plan that is consistent with the standards adopted by national or state accreditation organizations and consistent with the local special needs plan. The plan shall be updated annually and shall provide for continuing home health services during an emergency that interrupts patient care or services in the patient's home. The plan shall include the means by which the home health agency will continue to provide staff to perform the same type and quantity of services to their patients who evacuate to special needs shelters that were being provided to those patients prior to evacuation.

The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters, including: notifying staff when emergency response measures are initiated; providing for communication between staff members, county health departments, and local emergency management agencies,

including a backup system; identifying resources necessary to continue essential care or services or referrals to other organizations subject to written agreement; and prioritizing and contacting patients who need continued care or services.

(1) Each patient record for patients who are listed in the registry established pursuant to s. 252.355 shall include a description of how care or services will be continued in the event of an emergency or disaster. The home health agency shall discuss the emergency provisions with the patient and the patient's caregivers, including where and how the patient is to evacuate, procedures for notifying the home health agency in the event that the patient evacuates to a location other than the shelter identified in the patient record, and a list of medications and equipment which must either accompany the patient or will be needed by the patient in the event of an evacuation.

(2) Each home health agency shall maintain a current prioritized list of patients who need continued services during an emergency. The list shall indicate how services shall be continued in the event of an emergency or disaster for each patient and if the patient is to be transported to a special needs shelter, and shall indicate if the patient is receiving skilled nursing services and the patient's medication and equipment needs. The list shall be furnished to county health departments and to local emergency management agencies, upon request.

(3) Home health agencies shall not be required to continue to provide care to patients in emergency situations that are beyond their control and that make it impossible to provide services, such as when roads are impassable or when patients do not go to the location specified in their patient records. Home health agencies may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients. Home health agencies shall demonstrate a good faith effort to comply with the requirements of this subsection by documenting attempts of staff to follow procedures outlined in the home health agency's comprehensive emergency management plan, and by the patient's record, which support a finding that the provision of continuing care has been attempted for those patients who have been identified as needing care by the home health agency and registered under s. 252.355, in the event of an emergency or disaster under subsection (1).

(4) Notwithstanding the provisions of s. 400.464(2) or any other provision of law to the contrary, a home health agency may provide services in a special needs shelter located in any county

Home Health 400.506

(e) The comprehensive emergency management plan required by this subsection is subject to review and approval by the county health department. During its review, the county health department shall contact state and local health and medical stakeholders when necessary. The county health department shall complete its review to ensure that the plan complies with the criteria in the Agency for Health Care Administration rules within 90 days after receipt of the plan and shall either approve the plan or advise the nurse registry of necessary revisions. If a nurse registry fails to submit a plan or fails to submit requested information or revisions to the county health department within 30 days after written notification from the county health department, the county health department shall notify the Agency for Health Care Administration. The agency shall notify the nurse registry that its failure constitutes a deficiency, subject to a fine of $5,000 per occurrence. If the plan is not submitted, information is not provided, or revisions are not made as requested, the agency may impose the fine.

Home Health: 59A-8.027 Emergency Management Plans.

(1) Pursuant to section 400.492, F.S., each home health agency shall prepare and maintain a written comprehensive emergency management plan, in accordance with criteria shown in the "Comprehensive Emergency Management Plan (CEMP)," AHCA Form 3110-1022, Revised March 2013, incorporated by reference (http://www.flrules.org/Gateway/reference.asp?No=Ref-02767). This document is available from the Agency for Health Care Administration at http://ahca.myflorida.com/MCHQ/Emergency_Activities/index.shtml and shall be used as the format for the home health agency's emergency management plan. The plan shall describe how the home health agency establishes and maintains an effective response to emergencies and disasters.

(2) The plan, once completed, will be forwarded electronically for approval to the contact designated by the Department of Health.

(3) The agency shall review its emergency management plan on an annual basis and make any substantive changes.

Hospice - 400.605 Administration; forms; fees; rules; inspections; fines.—

(1) The agency shall by rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:

(h) Components of a comprehensive emergency management plan, developed in consultation with the Department of Health and the Division of Emergency Management.

400.610 Administration and management of a hospice.—

(b)1 Prepare and maintain a comprehensive emergency management plan that provides for continuing hospice services in the event of an emergency that is consistent with local special needs plans. The plan shall include provisions for ensuring continuing care to hospice patients who go to special needs shelters. The plan shall include the means by which the hospice provider will continue to provide staff to provide the same type and quantity of services to their patients who evacuate to special needs shelters, which were being provided to those patients prior to evacuation.

The plan is subject to review and approval by the county health department, except as provided in subparagraph 2. During its review, the county health department shall contact state and local health and medical stakeholders when necessary. The county health department shall complete its review to ensure that the plan complies with criteria in rules of the agency within 90 days after receipt of the plan and shall either approve the plan or advise the hospice of necessary revisions. Hospice providers may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the provider to reach its clients.

A hospice shall demonstrate a good faith effort to comply with the requirements of this paragraph by documenting attempts of staff to follow procedures as outlined in the hospice's comprehensive emergency management plan and to provide continuing care for those hospice clients who have been identified as needing alternative caregiver services in the event of an emergency.

Georgia: No Home Health state requirements

Hospice: Rule 111-8-37-.06 Reports to the Department

(a) The hospice must report in an acceptable format to the Department whenever any of the following events involving hospice operations occur or when the hospice becomes aware that any such events are likely to occur, to the extent that such events 622

expected to cause or cause a significant disruption of care for hospice patients:

1. An external disaster or other community emergency situation; or
2. An interruption of services vital to the continued safe operation of a hospice facility, such as telephone, electricity, gas, or water services.

(b) The hospice must make a report of the event within twenty-four hours or by the next regular business day from when the reportable event occurred or from when the hospice has reasonable cause to anticipate that the event is likely to occur. The report must include:

1. The name of the hospice, the name of the hospice administrator or site manager, and a contact telephone number for information related to the report;
2. The date of the event, or the anticipated date of the event, and the anticipated duration, if known;
3. The anticipated effect on care and services for hospice patients; and
4. Any immediate plans the hospice has made regarding patient management during the event.

(c) Within 45 days of the discovery of the event, the hospice must complete an internal evaluation of the hospice's response to the event where opportunities for improvement related to the hospice's disaster preparedness plan were identified. The hospice must make changes to the disaster preparedness plan as appropriate. The complete report must be available to the Department for inspection at the hospice office.

Rule 111-8-37-.11 Disaster Preparedness

(1) Every hospice must have a current disaster preparedness plan that addresses potential situations where services to patients may be disrupted and outlines appropriate courses of action in the event a local or widespread disaster occurs including communications with patients and their families and emergency management agencies.

(2) The disaster preparedness plan must include at a minimum plans for the following emergency situations:

(a) Local and widespread severe weather emergencies or natural disasters, such as floods, ice or snow storms, tornados, hurricanes, and earthquakes;

(b) Interruption of service of utilities, including water, gas, or electricity, either within the facility or patients' homes or within a local or widespread area; and

(c) Coordination of continued care in the event of an emergency evacuation of the area.

(3) If the hospice offers residential and/or inpatient services, in addition to the procedures specified in paragraph (2) of this rule, the plan must also include:
(a) Fire safety and evacuation procedures and procedures for the provision of emergency power, heat, air conditioning, food, and water; and
(b) Plans for the emergency transport or relocation of all or a portion of the hospice patients, should it be necessary, in vehicles appropriate to the patients' conditions when possible, including written agreements with any facilities, which have agreed to receive the hospice's patients in such situations, and notification of the patients' representatives.

(4) The hospice must have plans to ensure sufficient staffing and supplies to maintain safe patient care during the emergency situation.

(5) The plan must be reviewed and revised annually, as appropriate, including any related written agreements.

(6) Disaster preparedness plans for hospice care facilities must be rehearsed at least quarterly. Rehearsals must be document-ted to include staff and patient participants, a summary of any problems identified, and the effectiveness of the rehearsal. In the event an actual disaster occurs in any given quarter, the hospice may substitute the actual disaster's response in place of that quarter's rehearsal.

(7) Hospices must include emergency management agencies in the development and maintenance of their disaster preparedness plans and also provide copies of such plans to those agencies as requested.

(8) The Department may suspend any requirements of these rules and the enforcement of any rules where the Governor of the State of Georgia has declared that a state of emergency or disaster exists as a result of a public health emergency.

Illinois:

Home Health – Section 245.71 Qualifications and Requirements for Home Service Workers
(d)(9) Recognizing emergencies and initiating emergency procedures, including basic first aid and implementation of a client's emergency preparedness plan

Hospice – No state requirements

Indiana: Hospice - No state requirements

Maryland: No state requirements

Massachusetts: Home Health and Hospice **-** No state requirements

Michigan: Home Health or Hospice – No state requirements

Minnesota:

Home Health 144A.479 Subd. 12.
Disaster planning and emergency preparedness plan. The home care provider must have a written plan of action to facilitate the management of the client's care and services in response to a natural disaster, such as flood and storms, or other emergencies that may disrupt the home care provider's ability to provide care or services. The licensee must provide adequate orientation and training of staff on emergency preparedness.

Hospice – 4664.0140
Every person who provides direct care, supervision of direct care, or management services for a licensee must complete an orientation training to hospice requirements that include handling of emergencies and use of emergency services.

4664.0500 Subpart 2 A residential hospice facility must maintain a written plan that specifies actions and procedures for responding to emergency situation such as fire, sever weather or a missing person. The plan must be developed with assistance and advice of at least the local fire or rescue authority or any other appropriate resource persons. An accident or incident report must be maintained for at least one year.

Mississippi:

Home Health 41-71-13 Rule 46.20.1-2 & Hospice 41-85-7 Rule 1.48.1 , Rule 1.48.2
The licensed entity shall develop and maintain a written preparedness plan utilizing the "All Hazards" approach to emergency and disaster planning. The plan must include procedures to be followed in the event of any act of terrorism or man-made or natural disaster as appropriate for the specific geographical location. The final draft of the Emergency Operations Plan (EOP), will be reviewed by the Office of Emergency Preparedness and Response, Mississippi State Department of Health, or their designates, for conformance with the "All Hazards Emergency Preparedness and Response Plan." Particular attention shall be given to critical areas of concern which may arise during any "all hazards" emergency whether required to evacuate or to sustain in place. Additional plan criteria or a specified EOP format may be required as deemed necessary by the Office of Emergency Preparedness and Response.

The six (6) critical areas of consideration are:

a. Communications - Facility status reports shall be submitted in a format and a frequency as required by the Office of EOP
b. Resources and Assets
c. Safety and Security
d. Staffing
e. Utilities
f. Clinical Activities

Emergency Operations Plans (EOPs) must be exercised and reviewed annually or as directed by the Emergency Preparedness and Response. Written evidence of current approval or review of provider EOPs, by the Office of Emergency Preparedness and Response, shall accompany all applications for facility license renewals.

Missouri: Hospice -19 CSR 30-35

30-35.20 Hospice Inpatient Facility - (3)(B) Disaster Preparedness

1. The hospice shall have a written plan, annually rehearsed with staff, which includes procedures to be followed in the event of an internal or external disaster and for the care of casualties arising from disasters.

Nebraska: Home Health 175 NAC 14

14-006.12 Disaster Preparedness- The home health agency must establish and implement disaster preparedness plans and procedures to ensure that:

1. Patients and families are educated on how to handle patient care and treatment, safety, and well-bing during and following instances of natural (tornado, flood, ect.) and other disasters, or other similar situations; and
2. How staff is educated on disaster preparedness and staff safety is assured.

Nevada:

Hospice NAC 449.0187 Requirements for operation of facility for hospice care. (NRS 449.0302**)**

A facility for hospice care must comply with the following requirements:

8. A written plan of the procedures to be followed during a local disaster, a widespread disaster or a disaster, which occurs within the facility for hospice care, must be adopted. The plan must:
   (a) Provide procedures designed to protect each patient and to care for any casualty, which may arise from such a disaster;
   (b) Be reviewed and the procedures set forth therein rehearsed by all members of the staff at least once in each quarter of the year; and
   (c) Be approved by the Division

New Mexico: Home Health - no state requirements

New Jersey: Hospice – Section 8:42 C-11.12 Emergency preparedness in inpatient hospice care units

(a) A unit shall have a written emergency preparedness plan.

1. Inpatient hospice care providers shall annually train all staff on the requirements of the written emergency preparedness plan.
2. Inpatient hospice care providers shall train all new staff members on the requirements of the written emergency preparedness plan within 30 days of commencement of duties within the unit.

(b) If a unit is located within a licensed healthcare facility and inpatient hospice care provider shall coordinate emergency preparedness plans and drills with the licensed healthcare facility in which the unit is located.

(c.) Inpatient hospice care providers shall conduct at least one drill of the emergency preparedness plan every month.

1. These 12 drills shall be conducted on a rotating basis to ensure that four drills occur during each working shift on an annual basis.
2. At least eight of the 12 drills shall be fire drills, and the remainder of the drills shall address other emergency preparedness situations.

New York: Home Health 766.9 (c.) and 763.11 a (10)

The governing authority or operator, as defined in Part 700 of this Title, of a licensed home care services agency shall: ensure the development of a written emergency plan which is current and includes procedures to be followed to assure health care needs of patients continue to be met in emergencies that interfere with delivery of services, and orientation of all employees to their responsibilities in carrying out such a plan.

Pennsylvania: Hospice - no state requirements

Oklahoma: Home Health - no state requirements

Oregon: Home Health and Hospice - no state requirements

Tennessee: Home Health 1200-08-26.14 Disaster Preparedness & Hospice 1200-08-27-.14

(1) All agencies shall establish and maintain communications with the local office of the Tennessee Emergency Management Agency. This includes the provision of the information and procedures that are needed for the local comprehensive emergency plan. The agency shall cooperate, to the extent possible, in area disaster drills and local

emergency situations.

(2) A file of documents demonstrating communications and cooperation with the local agency must be maintained.

Texas:
Home Health Rule 558.256 Emergency Preparedness Planning and Implementation

(a) An agency must have a written emergency preparedness and response plan that comprehensively describes its approach to a disaster that could affect the need for its services or its ability to provide those services. The written plan must be based on a risk assessment that identifies the disasters from natural and man-made causes that are likely to occur in the agency's service area. With the exception of a freestanding hospice inpatient unit, DADS does not require an agency to physically evacuate or transport a client.

(b) Agency personnel that must be involved with developing, maintaining, and implementing an agency's emergency preparedness and response plan include:
(1) the administrator;
(2) the supervising nurse, if the agency is required to employ or contract with a supervising nurse as required by §558.243 of this subchapter (relating to Administrative and Supervisory Responsibilities);
(3) the agency disaster coordinator; and
(4) the alternate disaster coordinator.

(c) An agency's written emergency preparedness and response plan must:
(1) designate, by title, an employee, and at least one alternate employee to act as the agency's disaster coordinator;
(2) include a continuity of operations business plan that addresses emergency financial needs, essential functions for client services, critical personnel, and how to return to normal operations as quickly as possible;
(3) include how the agency will monitor disaster-related news and information, including after hours, weekends, and holidays, to receive warnings of imminent and occurring disasters;
(4) include procedures to release client information in the event of a disaster, in accordance with the agency's written policy required by §97.301(a)(2) of this subchapter (relating to Client Records); and
(5) describe the actions and responsibilities of agency staff in each phase of emergency planning, including mitigation, preparedness, response, and recovery.

(d) The response and recovery phases of the plan must describe:
(1) the actions and responsibilities of agency staff when warning of an emergency is not provided;
(2) who at the agency will initiate each phase;
(3) a primary mode of communication and alternate communication or alert systems in the event of telephone or power failure; and
(4) procedures for communicating with:
(A) staff;
(B) clients or persons responsible for a client's emergency response plan;
(C) local, state, and federal emergency management agencies; and
(D) other entities including DADS and other healthcare providers and suppliers.

(e) An agency's emergency preparedness and response plan must include procedures to triage clients that allow the agency to:
(1) readily access recorded information about an active client's triage category in the event of an emergency to implement the agency's response and recovery phases, as described in subsection (d) of this section; and (2) categorize clients into groups based on:
(A) the services the agency provides to a client;
(B) the client's need for continuity of the services the agency provides; and
(C) the availability of someone to assume responsibility for a client's emergency response plan if needed by the client.

(f) The agency's emergency preparedness and response plan must include procedures to identify a client who may need evacuation assistance from local or state jurisdictions because the client:
(1) cannot provide or arrange for his or her transportation; or
(2) has special health care needs requiring special transportation assistance.

(g) If the agency identifies a client who may need evacuation assistance, as described in subsection (f) of this section, agency personnel must provide the client with the amount of assistance the client requests to complete the registration process for evacuation assistance if the client:
(1) wants to register with the Transportation Assistance Registry, accessed by dialing 2-1-1; and
(2) is not already registered, as reported by the client or legally authorized representative.

(h) An agency must provide and discuss the following information about emergency preparedness with each client:
  (1) the actions and responsibilities of agency staff during and immediately following an emergency;
  (2) the client's responsibilities in the agency's emergency preparedness and response plan;
  (3) materials that describe survival tips and plans for evacuation and sheltering in place; and
  (4) a list of community disaster resources that may assist a client during a disaster, including the Transportation Assistance Registry available through 2-1-1 Texas, and other community disaster resources provided by local, state, and federal emergency management agencies. An agency's list of community disaster resources must include information on how to contact the resources directly or instructions to call 2-1-1 for more information about community disaster resources.

(i) An agency must orient and train employees, volunteers, and contractors about their responsibilities in the agency's emergency preparedness and response plan.

(j) An agency must complete an internal review of the plan at least annually, and after each actual emergency response, to evaluate its effectiveness and to update the plan as needed.

(k) As part of the annual internal review, an agency must test the response phase of its emergency preparedness and response plan in a planned drill if not tested during an actual emergency response. Except for a freestanding hospice inpatient unit, a planned drill can be limited to the agency's procedures for communicating with staff.

(l) An agency must make a good faith effort to comply with the requirements of this section during a disaster. If the agency is unable to comply with any of the requirements of this section, it must document in the agency's records attempts of staff to follow procedures outlined in the agency's emergency preparedness and response plan.

(m) An agency is not required to continue to provide care to clients in emergency situations that are beyond the agency's control and that make it impossible to provide services, such as when roads are impassable or when a client relocates to a place unknown to the agency. An agency may establish links to local emergency operations centers to determine a mechanism by which to approach specific areas within a disaster area in order for the agency to reach its clients.

(n) If written records are damaged during a disaster, the agency must not reproduce or recreate client records except from existing electronic records. Records reproduced from existing electronic records must include:
(1) the date the record was reproduced;
(2) the agency staff member who reproduced the record; and
(3) how the original record was damaged.

(o) Notwithstanding the provisions specified in Division 2 of this subchapter (relating to Conditions of a License), no later than five working days after an agency temporarily relocates a place of business, or temporarily expands its service area resulting from the effects of an emergency or disaster, an agency must notify and provide the following information to the DADS Home and Community Support Services Agencies licensing unit:
(1) if temporarily relocating a place of business:
(A) the license number for the place of business and the date of relocation;
(B) the physical address and phone number of the location; and
(C) the date the agency returns to a place of business after the relocation; or

(2) if temporarily expanding the service area to provide services during a disaster:
(A) the license number and revised boundaries of the service area;
(B) the date the expansion begins; and
(C) the date the expansion ends.

(p) An agency must provide the notice and information described in subsection (o) of this section by fax or email. If fax and email are unavailable, the agency may notify the Texas Health and Human Services Commission (HHSC) licensing unit by telephone, but must provide the notice and information in writing as soon as possible. If communication with the DADS licensing unit is not possible, the agency must provide the notice and information by fax, e-mail, or telephone to the designated survey office.

Hospice Rule 558.871 Physical Environment in a Hospice Inpatient Unit
(1) A hospice inpatient unit must address real or potential threats to the health and safety of the clients, others, and property.
(2) In addition to §558.256 of this chapter (relating to Emergency Preparedness Planning and Implementation), a hospice inpatient unit must have a written disaster preparedness plan that addresses the core functions of emergency management as described in subparagraphs (A) - (G) of this paragraph. The facility must maintain documentation of compliance with this paragraph.

Wisconsin:

Hospice Subchapter V — Physical Environment, DHS 131.37 Physical plant

(24) EMERGENCY PLAN

(a) Each hospice shall have a written plan posted in a conspicuous place, which specifies procedures for the orderly evacuation of patients in case of an emergency. The plan shall include an evacuation diagram. The evacuation diagram shall in addition be posted in a conspicuous place in the facility.

(b) The licensee, administrator and all staff who work in the hospice facility shall be trained in all aspects of the emergency plan.

(c) The procedures for exiting or taking shelter in the event of a fire, tornado, flooding or other disaster to be followed for patient safety shall be clearly communicated by the staff to the patients within 72 hours after admission and practiced at least quarterly by staff.

SEVERE WEATHER/EARTHQUAKES

1. Have emergency equipment and medical supplies readily available.
2. Close all drapes.
3. Move away from windows.
4. CLOSE exit doors.
5. Go to inside room of building with no windows, if available.
6. Do not enter damaged portions of the building until instructed.
7. Monitor weather bulletins/radio announcements.
8. Do not exit building until instructed.

REMAIN CALM. DO NOT PANIC.

TORNADOS

- Listen to local radio and TV for updated storm information.
- Tornado WATCH means a tornado is possible in your area.
- Tornado WARNING means a tornado has been sighted and may be headed for your area. Go to safety immediately.
- Be alert to changing weather conditions. Blowing debris or the sound of an approaching freight train may alert you a tornado is approaching.
- Go to the basement right away.
- If there is no basement go to the lowest floor possible.
- Stay in a hallway or small room in the center of the building (closets or bathrooms best).
- Do not attempt to open exterior windows or doors.
- Keep away from windows, doors, and glass.
- Cover up with blankets, sheets or curtains or get under heavy furniture.
- If you live in a mobile home, go to a sturdy building nearby.

FIRE

- Make sure everyone in the house knows about the fire – shout and get everyone together
- Get everyone out. Use your family's planned escape route.
- Don't delay to save valuables.
- Crawl on the floor if there's smoke, as the air is cleaner near the floor.
- Put your nose as low as possible, as smoke is toxic and can kill you.
- As you exit, open only the doors you need to and close any open doors.
- Feel doors with the back of your hand before you open them. If they're warm, don't open them.
- If escaping with others, stay together if you can.

FLOODS

(Flood warnings, alerts, or an actual flood)

***Precautions before the flood*:**

1. Make sure emergency supplies and equipment are readily available.
2. Do not touch any electrical equipment unless it is dry.

***Precautions if evacuation of building is ordered*:**

1. Travel only routes designated.
2. Do not try to cross a stream or other water areas unless you are sure it is safe.
3. Monitor local radio broadcast.
    A. Watch for fallen trees, live wires, etc.
    B. Watch for washed-out roads, earth slides, broken water lines, etc.
    C. Watch for areas where rivers, lakes, or streams may flood suddenly.

***After the flood*:**

1. Do not enter the building until an all-clear has been given.
2. Do not use any open flame devices until the building has been inspected for possible gas leaks.
3. Do not turn on any electrical equipment that may have gotten wet.
4. Shovel out mud while it is still moist.

***Flash floods*:**

1. Remember, flash floods can happen without warning.

2. When a flash flood warning is issued, take immediate action.

FOLLOW ALL INSTRUCTIONS ISSUED WITHOUT DELAY

SNOW EMERGENCY

(Snow emergency or winter storms)

1. Keep a one (1) to two (2) week supply of heating fuel, food, and water on hand in case of isolation at home.

2. Keep your car properly serviced, with snow tires and filled with gas.

3. Keep emergency supplies in the car: container of sand, shovel, windshield scraper, tow chain or rope, flares, blanket and flashlight.

4. Dress appropriately – wear several layers of loose, lightweight, warm clothing, mittens, and winter headgear to cover head and face.

5. Carry a cellular phone (if available).

6. Drive with all possible caution. If caught in a blizzard, seek refuge immediately. Keep car radio on for weather information

7. If your car breaks down—turn flashers on or hang a cloth from the radio aerial; stay in your car. If your car is stuck in snow or traffic jam and car is running, crack windows to prevent carbon monoxide poisoning and keep exhaust pipe free of snow. If engine is not running, you do not need to crack windows.

* See Safety Manual – Section 2: Emergency Preparedness for Evacuation Handout

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: *HOS 2-003*
		Effective Date: *01/01/13* *05/15/21*
	Title: **INTERDISCIPLINARY GROUP MEMBERSHIP AND RESPONSIBILITIES**	*Page*: ***1** of **2***

POLICY:

The interdisciplinary group will engages with patients and families to ensure that the care and services provide respect and respond to individual preferences and goals of the terminally ill individuals and the needs of their families.

When there is more than one (1) interdisciplinary group, the hospice will designate in advance the group responsible for program oversight and the establishment of policies that govern the day-to-day provision of hospice care and services.

Regulatory references: 418.56(a)(2); 418.56; 418.106(f)(2); 418.106(d)
CHAP Standards: HCPC 2.D; HCPC 3.I; HCPC 18.I; HCPC 20.I; HCPC 22.I; HCDT 28.I; HCDT 34.I

PURPOSE:

To define the membership and responsibilities of the interdisciplinary group.

PROCEDURE:

1. The hospice interdisciplinary group membership includes at a minimum:

   A. Physician
   B. Registered nurse
   C. Social worker
   D. Pastoral or other counselors
   E. Volunteer Coordinator

2. Additional members may include:

   A. Physical therapist
   B. Occupational therapist
   C. Speech therapist
   D. Registered dietician
   E. Pharmacist

F. Home care aide/homemaker

G. Volunteer

3. The interdisciplinary group responsibilities include but are not limited to:

A. Participation in the establishment of the plan of care, in consultation with the patient's attending physician, for each patient admitted to the hospice service

B. Participation in the periodic review and updating of the plan of care for each patient receiving hospice services

C. Provision or supervision of hospice care and services

D. Establishment of policies and procedures governing the day-to-day provision of hospice care and services

E. Reviewing and resolving conflict of care and ethical issues

F. Provision of on-going support for and techniques to avoid overstepping boundaries

G. Planning for community education regarding hospice services

H. Participating in performance improvement activities

I. The hospice ensures that each patient and the primary caregiver(s) receive education and training as appropriate for their responsibilities in the plan of care.

J. The hospice ensures instruction to the patient and/or caregivers on the proper handling of medical equipment and/or supplies.

K. The IDG determines the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in their home.

POLICY:

AccentCare shall admit a patient with a terminal illness that meets the admission criteria without discrimination on the basis of age, disability, national origin, ancestry, gender, gender identity, and/or expression, sexual orientation, or source of payment.

In addition, patients shall be accepted for care based on the need for hospice services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence within the organization's financial and service capabilities, mission, and applicable law and regulations.

Regulatory Regulations 418.102(b)(1-5), 418.102(d), 418.54(c)-(c)(1-5)
CHAP Standards: HCPC 4.I, HCPC 11.I
TJC Standards: PC.01.01.01 EP 48, PC.01.02.01 EP 34, PC.01.02.01 EP 7

PURPOSE:

To establish standards and a process by which a patient can be evaluated and accepted for admission within 24 hours of the inquiry unless the patient, family, referral source, or physician/provider requests a later date.

PROCEDURE:

1. Referrals may be taken by any hospice staff member 24 hours a day, 7 days a week.
2. All requests for admission to the Open Access program shall have their treatments reviewed and approved by the Clinical Leadership prior to admission. See Hospice Protocol 2065 Open Access Admission and Management.
3. Hospice may meet with the patient and/or family to provide hospice information without a physician's order. However, a physician's order may be obtained prior to accessing the patient's medical record or performing a physical assessment unless a patient or their legal representative has given authorization to release the medical record or agreed to a physical assessment. A physician's order to evaluate is valid for up to 30 days.
4. To be admitted to AccentCare Hospice, the patient must meet the following Admission Criteria:
   A. The patient must be under the care of a physician or non-physician provider. This individual may be an employee or contractor of the hospice if requested by the patient or their legal representative. The patient's physician (or non-physician provider) must

order and approve the provision of hospice care and be willing to sign the death certificate.

B. The hospice Medical Director and attending physician (if any) reviews the clinical information for the patient being evaluated for admission and provides written certification that the patient's prognosis is for a life expectancy of six (6) months or less if the illness runs its normal course based on their clinical judgment and standard clinical prognosis guidelines developed from the local coverage determinations.

C. At admission, the patient, if applicable, shall identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual who are independent in their activities of daily living (ADLs) shall require a specific plan to be developed at the time of admission with the social worker.

D. The patient or the legal representative shall agree to hospice services.

E. The focus of care desired must be palliative versus curative. Pediatric palliative/hospice patients may maintain concurrent curative care, per the Affordable Care Act, section 2302 (Concurrent Care for Children). Other hospice patients may maintain concurrent curative care if permitted by applicable law and payor source.

F. The patient or legal representative shall agree to the plan of care, complete the election of hospice benefit and sign any other required consent form to initiate hospice care.
   1) The date on the hospice election statement shall be the official service start date.
   2) The signed hospice election statement shall be filed in the patient's clinical record and a copy provided to the patient or legal representative.

G. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be their private home, a family member's home, a skilled nursing facility, or other living arrangements.

H. The patient must reside within the geographical area that the AccentCare agency services.

5. The organization shall utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices to determine eligibility for admission to the program. If the patient's attending physician does not make the service request, they must be consulted before the evaluation visit/initiation of services.

6. The Admissions Coordinator or designee shall assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source or based on the information regarding the patient's condition or as ordered by the physician (or other non-physician providers).

7. Assignment of appropriate hospice personnel to conduct the initial assessment of the patient's eligibility for admission will be based on:

   A. Patient's geographical location;

   B. Complexity of patient's hospice care needs/level of care required;

   C. Hospice personnel's education and experience;

   D. Hospice personnel's unique training and/or competence to meet patient's needs;

   E. Urgency of the identified need for assessment;

   F. Any state-specific regulations.

8. The initial visit shall be made within the time frame requested by the referral source and according to organization policy or as ordered by the physician (or non-physician provider). The initial visit shall be completed at the place where hospice care will be provided, which may include the hospital, SNF, ALF, or the patient's home. The purpose of the initial patient visit shall be to:

   A. Explain the hospice philosophy of care with the patient and family/caregiver as a unit of care;

   B. Explain the patient's rights and responsibilities and grievance procedure;

   C. Provide the patient with a copy of AccentCare notice of privacy practices;

   D. Assess the family/caregiver's willingness or ability to provide care;

   E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home;

   F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services provided under the Medicare/Medicaid hospice benefit;

   G. Review appropriate forms and obtain needed patient or legal representative signatures, if applicable. Once their agreement to receive hospice services has been confirmed and the patient has been admitted to hospice;

H. Provide services as needed and ordered by a physician (or non-physician provider) and documented into the hospice care plan;

I. Give patient information about durable power of attorney for health care if the patient has not already completed one.

9. During the initial assessment visit, the admitting clinician shall assess the patient's eligibility for hospice services with the patient's attending physician, the clinical supervisor, and the hospice Medical Director.

10. If eligibility criteria are met, the patient and family/caregiver shall be provided with a Family Education booklet or various educational materials relating to hospice care that includes sufficient information on:

A. Nature and goals of care and/or service;

B. Hours during which care or service are available (physician, nursing, care team support, medication, and cALL Center are available 24 hours/day). All other services are available to meet individual patient care needs;

C. Access to care after hours;

D. Costs to be borne by the patient, if any, for care;

E. Hospice mission and scope of care provided directly and those provided through contractual agreement;

F. Safety information;

G. Infection control information;

H. Emergency preparedness plans;

I. Available community resources;

J. Complaint/grievance process;

K. Advance directives;

L. Availability of spiritual counseling in accordance with faith/secular preference;

M. Hospice personnel to be involved in care;

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes;

11. The hospice staff shall document in the clinical record that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

12. The patient and family/caregiver, after review, shall be allowed to either accept or refuse services.

13. The patient shall be considered admitted to Hospice after:

    A. Admission, consent, and Election of Benefits are completed and signed;

    B. The nursing assessment is complete;

    C. The physician orders are obtained;

    D. The plan of care is initiated;

    E. The hospice physician has approved the admission.

    Arizona: Before admitting an individual as a patient, the hospice shall obtain:
    1) The name of the attending physician, and
    2) Documentation that the individual is terminally ill, provided by:
        a. The individual's attending physician; and
        b. The hospice Medical Director or a physician member of the hospice IDG.

    Connecticut: Any delay in the start of service shall require prior notification to the patient and family. Such notification shall include the anticipated start of service date and the plan while the patient is on the waiting list.

14. Refusal of services shall be documented in the clinical record. Notification of the Clinical Manager/Team Director, attending physician, and referral source shall be completed and documented in the clinical record.

15. The hospice registered nurse shall complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy)

16. The hospice registered nurse shall contact at least one (1) other member of the interdisciplinary group for input into the care plan prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the care plan within two (2) days of the start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient shall be performed no later than 5 calendar days after the election of hospice care by both the registered nurse case manager and the social worker. A plan of care shall be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires shall be considered and respected in developing the plan of care. (See "Comprehensive Assessment" Policy)

18. A clinical record shall be initiated for each patient admitted for hospice services.

19. If a patient does not meet the admission criteria or cannot be cared for by AccentCare, the Clinical Manager/Team Director shall be notified, and appropriate referrals to other sources of care are made on behalf of the patient.

20. The following individuals shall be notified of non-admits:
    A. Patient
    B. Physician
    C. Referral source (if not a physician)

21. A record of non-admits is kept for statistical purposes, with the date of referral, date of assessment, patient name, services required, physician, the reason for non-admit, referral to other hospice care facilities, etc.

State-Specific Requirements

Arizona:

R9-10-607 Admission

A. Before admitting an individual as a patient, an administrator shall obtain:
   1. The name of the individual's physician;
   2. Documentation that the individual has a diagnosis by a physician that indicates that the individual has specific, progressive, normally irreversible disease that is likely to cause the individual's death in six (6) months or less; and
   3. Documentation from the individual's representative acknowledging that:
      a. Hospice services include palliative care and supportive care and are not curative, and
      b. The individual or individual's representative has received a list of services to be provided by the hospice.

B. At the time of admission, a physician or registered nurse shall:
   1. The name of the individual's physician;
   2. As applicable, obtain informed consent or general consent.

C. Before or at the time of admission, a personnel member qualified according to policies and procedures shall assess the social and psychological needs of a patient's family, if applicable.

California: no additional state requirements

Colorado: 6 CCR 1011-1 Chapter 21

6.2 Admission Criteria

(A) Upon admission to the hospice there shall be an evaluation of the patient's immediate needs related to their terminal condition. An initial plan of care shall be developed based upon the results of the immediate needs evaluation.

(B) An initial assessment of the patient's physical, psychosocial, spiritual and emotional status related to the patient's terminal illness and related conditions shall be completed by a registered nurse within forty-eight (48) hours.

6.6 Except as set forth in paragraph (A) below, the interdisciplinary group (in collaboration with the individual's attending physician or nurse practitioner) shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 30 calendar days.

Connecticut:

19-13-D72 Patient care policies

(a)(1) Conditions on admission:

(B) A home assessment by the primary care nurse or, when delegated by the supervisor of clinical services, by other professional staff, to determine that the patient can be cared for safely in the home.

(D) Circumstances which render a patient ineligible for agency services, including by not limited to level of care needs which make care at home unsafe, kinds of treatments agency will not accept, payment policy and limitations on condition of admission, if any;

(E) Plan for referral of patients not accepted for care;

(F) Any delay in the start of service shall require prior notification to the patient. Such notification shall include the anticipated start of service date and the agency's plan while the patient is on the waiting list.

(b)(G)(i) The hospice program shall assure coordination and continuity of the plan of care, 24 hours per day, seven days per week from the time of admission to the hospice program throughout the course of the patient's illness until death or discharge

Delaware:

Title 16, Section 4468

5.3 Admission to a hospice is limited to the following:

5.3.1 Patient in the terminal state of illness whose survival is anticipated to be less than six (6) months.

5.3.2 Patients who are no longer receiving treatment for cure.

5.3.3 The patient and physician agree that palliative care is appropriate.

5.3.4 The patient or the patient's legal guardian choose hospice care.

5.3.5 A hospice program shall not admit any persons under the age of eighteen (18) without a signed Parent/guardian consent.

5.3.6 Each hospice program must have a policy and procedure regarding informed consent agreement.

5.3.7 At the time of admission to the hospice and thereafter, a patient/family must be under the care of a physician who shall be responsible for medical care.

5.3.8 Admission is limited to those patients who have a family member, or designated person who is able and willing to assume the role of primary caregiver.

Florida:

Chapter 400, Florida Statutes, Part IV, Hospices

400.6095 Patient admission

(1) Each hospice shall make its services available to all terminally ill persons and their families without regard to age, gender, national origin, sexual orientation, disability, diagnosis, cost of therapy, ability to pay, or life circumstances. A hospice shall not

impose any value or belief system on its patients or their families and shall respect the values and belief systems of its patients and their families.

(2) Admission to a hospice program shall be made upon a diagnosis and prognosis of terminal illness by a physician licensed pursuant to chapter 458 or chapter 459 and shall be dependent on the expressed request and informed consent of the patient.

(3) At the time of admission, the hospice shall inquire whether advance directives have been executed pursuant to chapter 765, and if not, provide information to the patient concerning the provisions of that chapter. The hospice shall also provide the patient with information concerning patient rights and responsibilities pursuant to s. 381.026.

(4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.

Georgia:

Rule 111-8-37-.14 Admissions

(1) Admissions. The hospice must not admit any patients unless the hospice believes that it is capable of meeting the care needs of the patients. The hospice must have written criteria that address the eligibility for admission into home hospice care, residential, or inpatient hospice care and palliative care for persons with advanced and progressive diseases, if such palliative care is offered.

(2) Terminally Ill Patient Admissions for Home Care. The hospice program offered to terminally ill patients in their homes must admit only patients that meet the following minimum criteria:

(a) The patient has a referral from a physician who has personally evaluated the patient and diagnosed the patient as terminally ill, where the medical prognosis is less than six months of life if the terminal illness takes its normal course, and in need of hospice care;

(b) The patient has received from the hospice an initial assessment, performed by an appropriate representative of the hospice care team, that reflects a reasonable expectation that the patient's medical, nursing, and psychological needs can be met adequately by the hospice and further reflects that the patient has a need for and can benefit from hospice care;

(c) The patient has been given a description of the scope of services and has personally or through an authorized patient representative given informed consent in writing to receive hospice care;

(d) The patient has been certified in writing by the hospice to have an anticipated life expectancy of six months or less if the terminal illness takes its normal course;

(e) The patient lives within the hospices service area; and

(f) The patient has identified a primary caregiver. In the absence of a primary caregiver, the hospice must develop a detailed plan for meeting the daily care and safety needs of the patient.
(g) The hospice must ensure the development of an initial plan of care, within 24 hours of admission to the hospice, based on the initial assessment and with appropriate input from a physician or registered nurse to meet the immediate needs of the patient.
(h) The hospice must ensure that no terminally ill patient is excluded from participation in or denied benefits of any hospice care because of an inability to pay for such hospice care.

Illinois: Section 280.2030 Policies and Procedures
b) The hospice program shall clearly define its admission criteria. Decisions on admission shall be made by a hospice care team and shall be dependent upon the expressed request and informed consent of the patient or the patient's legal guardian. For purposes of the Act and this Part, "informed consent" means that a hospice program must demonstrate respect for an individual's rights by ensuring that an informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the patient's illness has been obtained for every hospice patient, either from the patient or from the patient's representative. (Section 8(h) of the Act)

Indiana: no additional requirements

Maryland: 10.07.21.07 Policies and Procedures
The hospice care program shall adopt and implement written policies and procedures for: (K) Admission, transfer and discharge, including criteria to be used for each.

Massachusetts: 105 CMR 141.00 Licensure of hospice programs
141.208 Admissions
(A) The hospice shall establish written admission criteria and policies which shall include an assessment of the patient's/family's desire and need for hospice service, and any eligibility limitations of a patient who does not have a designated primary caregiver.
(B) Admission to a hospice shall be limited to patients
(1) who are terminally ill with a limited life expectancy,
(2) who are no longer receiving treatment for cure,
(3) who along with the physician and family agree that palliative care is appropriate, and
(4) who have elected to receive hospice care.

(C) Each hospice shall define in writing the term "limited life expectancy" in its admission policies.
(D) The patient, or a representative of the patient's family unit if the patient is not able, must sign an informed consent agreement

Michigan: no additional requirements

Minnesota:
4664.0060 Acceptance of patients
Subpart 1. - Acceptance of hospice patients. No licensee shall accept a person as a hospice patient unless the licensee has staff sufficient in qualifications and numbers to adequately provide the hospice services described in Minnesota Statutes, section 144A.75, subdivision 8.

144A.75, Subdivision 8
"Hospice services" or "hospice care" means palliative and supportive care and other services provided by an interdisciplinary team under the direction of an identifiable hospice administration to terminally ill hospice patients and their families to meet the physical, nutritional, emotional, social, spiritual, and special needs experienced during the final stages of illness, dying, and bereavement, or during a chronic, complex, and life-threatening illness contributing to a shortened life expectancy for hospice patients who meet the criteria in subdivision 6, clause (2). These services are provided through a centrally coordinated program that ensures continuity and consistency of home and inpatient care that is provided directly or through an agreement.

Mississippi: 41-85-7 Subchapter 19
Rule 1.19.1 Patient care standard
1. Patient Certification –To be eligible for hospice care, an individual, or his/her representative, must sign an election statement with a licensed hospice; the individual must have a certification of terminal illness and must have a plan of care (POC) which is established before services are provided.
2. Admission criteria – The hospice shall have written policies to be followed in making decisions regarding the acceptance of patients for care. Decisions are based upon medical, physical, and psychosocial information provided by the patient's attending physician, the patient/family and the interdisciplinary group. The admission criteria shall include:
   a. The ability of the agency to provide core services on a 24-hour basis and provide for or arrange for non-core services on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the

palliation and management of terminal illness and related conditions;
b. Certification of terminal illness signed by the attending physician and the medical director of the agency upon admission and recertification;
c. A documented assessment of the patient/family needs and desires for hospice services;
d. Informed consent signed by patient or representative who is authorized in accordance with state law to elect the hospice care, which will include the purpose and scope of hospice services.

3. Admission Procedure – Patients are to be admitted only upon the order of the patient's attending physician.
4. An assessment visit shall be made by a registered nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family.
5. Documentation at admission will be retained in the clinical record and shall include:
    a. Signed consent forms;
    b. Documented evidence that a patient's rights statement has been given or explained to the patient and/or family;
    c. Clinical data including physician's order for care;
    d. Patient Release of Information;
    e. Orientation of the patient/care giver, which includes:
        i. Advanced directives;
        ii. Agency services;
        iii. Patient's rights; and
        iv. agency contact procedures;
    f. Certification of terminal illness signed by the medical director and attending physician.

Missouri: no additional requirements

Nevada: no additional requirements

New Jersey: N.J Administrative Code
Section 8:42C-6.3 Policies and Procedures
(a)(1) Admissions criteria shall be based solely upon the patient's needs and the ability of the facility to meet safely the medical, nursing, and social needs of the patient.

Oregon: no additional requirements

Pennsylvania: no additional requirements

Tennessee: 1200-08-27-.05 Admissions

(1) The hospice service program shall have a policy to admit only patients who meet the following criteria:
   (a) Has been diagnosed as terminally ill;
   (b) Has been certified by a physician, in writing, to have an anticipated life expectancy of six (6) months or less;
   (c) Has personally or through a representative voluntarily requested admission to, and been accepted by, a licensed hospice service organization; and
   (d) Has personally or through a representative, in writing, given informed consent to receive hospice care; or
   (e) Is a non-hospice patient that has been determined to need palliative care only.

(2) Patients shall be accepted to receive hospice services on the basis of a reasonable expectation that the patient's medical, nursing, and psychosocial needs can be met adequately by the organization in the patient's regular or temporary place of residence.

(3) Care shall follow a written plan of care established and reviewed by the attending physician, the medical director or physician designee, and the interdisciplinary group prior to providing care. Care shall continue under the supervision of the attending physician.

(4) The agency staff shall determine if the patient's needs can be met by the organization's services and capabilities.

(5) Every person admitted for care or treatment to any agency covered by these rules shall be under the supervision of a physician as defined in this chapter who holds a license in good standing. The name of the patient's attending physician shall be recorded in the patient's medical record.

(6) The agency staff shall obtain the patient's written consent for hospice services.

(7) The signed consent form shall be included with the patient's individual clinical record.

(8) A diagnosis must be entered in the admission records of the agency for every person admitted for care or treatment.

Texas: Rule 558.810 Hospice Initial Assessment

(a) A hospice RN must complete an initial assessment of a client where hospice services will be delivered within 48 hours after the election of hospice care, unless the client's physician, the client, or the client's legal representative requests that the initial assessment be completed in less than 48 hours.

(b) The initial assessment must assess a client's immediate physical, psychosocial, and emotional status related to the terminal illness and related conditions. The information

gathered must be used by the hospice to begin the plan of care and to provide care and services to treat a client's and a client's family's immediate care and support needs.

Washington: WAC 246-335-620 Delivery of Services

(3) Initial patient assessment completed by a registered nurse within seven (7) calendar days of receiving and accepting a physician or practitioner referral for hospice services. Longer time frames are permitted when one or more of the following is documented:
- (a) Longer time frame for completing the initial patient assessment is requested by physician or practitioner;
- (b) Longer time frame for completing the initial patient assessment is requested by the patient, designated family member, or legal representative; or
- (c) Initial patient assessment was delayed due to agency having challenges contacting the patient, designated family member, or legal representative.

Washington, DC: no additional licensing requirements

Wisconsin: DHS 131.17 Admission

(1) Program description. A hospice shall have a written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that includes all of the following:
- (a) Clearly define the philosophy of the program;
- (b) Limit admission to individuals with terminal illness as defined under DHS 131.13(24);
- (c) Clearly define the hospice's limits in providing services and the settings for service provision;
- (d) Ensure protection of patient rights;
- (e) Provide clear information about services available for the prospective patient and his or her representative, if any;
- (f) Allow and individual to receive hospice services whether or not the individual has executed an advance directive.

(3) Initial determination
- (a) The hospice employee shall, based on the needs described by the person seeking admission or that person's representative, if any, or both, make an initial determination whether or not the hospice is generally able to meet those needs.
- (b) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to referring source alternative programs that may meet the described needs.

(4) Patient acknowledgement and hospice acceptance. The person seeking admission to the hospice shall be recognized as being admitted after:

(a) Completion of the assessment.

(b) Completion of a service agreement in which:

1. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.
2. The hospice agrees to provide care for the person.
3. The person or the person's representative, if any, authorizes services in writing.

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: *HOS 2-030*
	Title: **THE PLAN OF CARE**	*Effective Date*: *01/01/13* *Revised*: *07/25/22*
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POLICY: This Agency designates an interdisciplinary team group that, in consultation with the patient's attending physician, prepares a written plan of care (POC) for each patient that is regularly reviewed.

Regulatory Reference: 418.56 (b to d); 418.112 (b & d)
CHAP Standards: HCPC 18.I; HCPC 19.I; HCPC 20.I; HCPC 21.I; HCPC 22.I; HCPC 23.D; HSRF 3.I; HSRF.4.I; HSRF.6.I
TJC Standards: PC.01.03.01 EP 5, 13, 16, 18, 32; PC.02.03.01 EP 4; RC.02.01.01 EP 6, 22; LD.04.03.03 EP 31; PC.02.03.01 EP 4; PC.01.03.01 EP 13, PC.02.01.01 EP 1; PC.01.03.01 EP 40, 41, 42

PURPOSE: To develop a plan of care that specifies the hospice care and services necessary to meet the specific needs of the patient and family identified in the comprehensive assessment relative to the terminal illness and associated conditions.

PROCEDURE:

1. A written individualized patient and family/caregiver care plan will be established and maintained for each individual admitted to the hospice program.

2. The Case Manager (or admitting registered nurse) shall complete the initial assessment and initiate the care plan development after the consent forms are signed. See HOS2-044 "Initial Hospice Assessment" Policy.

3. The patient and family/caregiver are encouraged to participate in developing and updating the plan of care.

4. This care plan must be initiated at the start of care. See HOS 2 045 "Comprehensive Assessment" Policy and HOS 2-046 "Ongoing Comprehensive Assessments" Policy.

5. The Case Manager (or admitting registered nurse) will notify the attending physician and a core member of the interdisciplinary group of the initial assessment findings, identifying patient needs and the recommended services to meet those needs. The plan of care will be reviewed before care is delivered.

6. Orders for the start of care will be verbally received by the Case Manager (or hospice registered nurse) from the attending physician (or another non-physician provider) and documented on the plan of care/physician order form.

7. The care plan will identify the patient's needs and services to meet those needs, including managing pain and discomfort and symptom relief. It must state, in detail, the scope and frequency of services needed to meet the patient's and family/caregiver's needs.

8. The care plan will be provided to both the attending physician and the hospice Medical Director for approval of verbal orders and certification of the terminal illness signatures.

9. Each patient will be monitored for their response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals.

10. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing comprehensive assessments, and analysis of patient response to care against goals and outcomes.

11. The plan of care will be reviewed and revised as frequently as deemed necessary, but not less often than every 15 days, by the interdisciplinary group, with input from the attending physician, the patient, and the family/caregiver, based on ongoing comprehensive assessments of the patient and family/caregiver. A review of the care plan will be documented in the clinical record. Revision dates will be noted on the plan of care.

12. A change in the patient's condition may result in a revision of the plan of care before implementing the new service.

13. As needed, the patient and family/caregiver will receive written instructions regarding treatments or aspects of care that will be the responsibility of the patient and family/caregiver to provide or follow through.

14. All appropriate hospice staff will have access to the care plan.

15. Care provided to the patient will be in accordance with the plan of care.

16. The written plan of care will contain, but will not be limited to, the following:

A. Diagnosis

B. Identify of patient and family/caregiver needs, including physical, psychosocial, cognitive, cultural, spiritual, nutritional, functional, educational, and counseling.

C. Reduction in risk factors

D. Functional limitations

E. Mental status

F. Safety measures to protect against abuse, injury, infection, or infectious disease, as appropriate

G. Nutritional requirements

H. Prognosis

I. DME and medical supplies necessary to meet patient needs

J. Frequency of services

K. Placement at the appropriate level of care and referrals as needed for counseling, additional disciplines, volunteers, and adjunctive services

L. Individualized interventions to assist with end-of-life care

M. Patient and family/caregiver educational needs and assessment of their ability to learn and understand teaching and their ability to safely self-administer drugs and biologicals

N. Statement of treatment goals

O. Interdisciplinary group assessment of needs

P. Pain and symptom management interventions

Q. Drugs and treatments (including allergies)

R. Physician-directed instruction to patient and family/caregiver

S. Physician (or another non-physician provider) orders

T. Identification of advance directives

U. Measurable outcomes anticipated from implementing and coordinating the plan of care.

V. Patient or representative's level of understanding, involvement, and agreement with the plan of care

W. The plan of care may include services provided by telecommunications. Telehealth visits may consist of telephone (audio only) or two-way audio-video technology devices. This service may supplement the patient's care plan and shall not substitute any in-person home visits ordered by the physician or non-physician practitioner. The care plan will include a specific frequency or a range of visits that span the certification period. The care plan (goals or interventions) shall describe how this service will meet the patient's needs.

State-Specific Regulations

Arizona: R9-10-608

A. An administrator shall ensure that a plan of care is developed for each patient:
   1. Based on the:
      a. Assessment of the:
         i. Patient; and
         ii. Patient's family, if applicable.
      b. Hospice service agency's or inpatient hospice facility's scope of service.
   2. With participation from a:
      a. Physician,
      b. Registered nurse, and
      c. Another personnel member as designated in R9-10-612 (A)(4); and
   3. That includes:
      a. The patient's diagnosis.
      b. The patient's health care directives.
      c. The patient's cognitive awareness of self, location, and time.
      d. The patient's functional abilities and limitations.
      e. Goals for pain control and symptom management.
      f. The type, duration, and frequency of services to be provided to the patient and, if applicable, the patient's family.
      g. Treatments the patient is receiving from a health care institution or health care professional other than the hospice, if applicable.
      h. Medications ordered for the patient.
      i. Any known allergies.
      j. Nutritional requirements and preferences; and
      k. Specific measures to improve the patient's safety and protect the patient against injury.

B. An administrator shall ensure that:
   1. A request for participation in a patient's care plan is made to the patient or patient's representative.
   2. An opportunity for participation in the patient's care plan is provided to the patient, patient's representative, or patient's family; and
   3. The request in subsection B1 and the opportunity in subsection B2 are documented in the patient's record.

C. An administrator shall ensure that:

1. Hospice services are provided to a patient, and if applicable, the patient's family according to the patient's care plan.
2. A patient's care plan is reviewed and updated:
   a. Whenever there is a change in the patient's condition that indicates a need for a change in the type, duration, or frequency of services being provided.
   b. If the patient's physician orders a change in the care plan; and
   c. At least every 30 calendar days; and
3. A patient's physician authenticates the care plan with a signature within 14 calendar days after the care plan is initially developed and whenever the care plan is reviewed or updated.

California:

Article 3 Plan of Care

Section 3.1 Assessments

Comprehensive assessments are conducted and developed to identify the patient's need for care and the need for medical, nursing, social, emotional, and spiritual care that includes the palliation and management of the terminal illness and related medical conditions.

A. The program's representative makes and initial contact to determine the immediate care and support needs of the patient. The initial contact occurs as soon as possible after the receipt of the referral for care.
B. Following the consent of the patient, the program must conduct a comprehensive assessment.
C. A comprehensive assessment includes input from members of the interdisciplinary team. Information regarding the outcome of the assessment, which may be contained in one or more assessment documents, is located in the plan of care or elsewhere in the clinical record. The outcome of the comprehensive assessment forms the basis for the goals and interventions contained in the plan of care. The following information is evaluated as part of the comprehensive assessment document.
   1. The patient's physical condition, including functional ability and mental status.
   2. The patient's pain and other symptoms and the level of discomfort and symptom relief.
   3. A review of the patient's drug profile, including over-the-counter drugs.
   4. The patient's and family's social and emotional well-being.
   5. The patient's spiritual orientation and needs.

6. Imminence of death.
7. Any other information necessary to develop an effective interdisciplinary plan of care.

Section 3.2 Content of the Plan

All services furnished to patients must follow a written plan of care established by the interdisciplinary team in collaboration with the attending physician.

A. Each patient's written plan of care reflects planned interventions based on the problems identified in the comprehensive or continuing assessments. It ensures that care and services are appropriate to each patient's / family's specific needs.
B. The plan of care includes but is not limited to:
   1. Interventions to facilitate the management of pain and symptoms.
   2. Frequency and mix of services necessary to meet the patient / family specific needs identified in the comprehensive assessment.
   3. Measurable outcomes that the program anticipates will occur as a result of implementing and coordinating the plan of care.
   4. Drugs and treatments necessary to meet the needs of the patient as identified in the assessment.
   5. Medical supplies and appliances necessary to meet the needs of the patient identified in the assessment.
   6. Patient's / family's goals, understanding, agreement and involvement with the plan as they desire.
   7. Anticipated discharge and bereavement care needs of the family.

Section 3.4 Review of the plan

A. The plan must be reviewed and revised by the interdisciplinary group according to the program's policies in collaboration with the attending physician.

Section 3.5 Coordination of the plan

A. The program must maintain a system of communication and integration of services, whether provided directly or under arrangement that ensures the identification of patient needs and the ongoing liaison of all disciplines providing care.
B. The program identifies the level of coordination necessary to deliver safe and appropriate care to the patient at home or in the inpatient setting and involves the patient / family, as they desire, in coordination of care efforts.

Colorado:

CCR 1011-1 Chapter 21

Section 6.2 Admission Criteria

B. An initial assessment of the patient's physical, psychosocial, spiritual, and emotional status related to the patient's terminal illness and related conditions shall be completed by a registered nurse within forth-eight (48) hours.

Section 6.4 An individualized written plan of care shall be developed to reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and include but not limited to:

A. Interventions to manage pain and symptoms.
B. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
C. Measurable outcomes anticipated from implementing and coordinating the plan of care.
D. Drugs and interventions necessary to meet the needs of the patient.
E. Medical supplies and appliances necessary to meet the needs of the patient.
F. Coordination of care.
G. Patient / family understanding and agreement with the plan of care, and
H. When applicable, plans to meet the special needs of patients who are infants, children, and adolescents.

Section 6.5 A designated registered nurse shall coordinate the overall plan of care for each patient.

Section 6.6 The interdisciplinary group (in collaboration with the individual's attending physician or nurse practitioner) shall review, revise, and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care.

Section 8.5 Administration of medication and biologicals

A. The interdisciplinary group, as part of the review of the plan of care, shall determine the ability of the patient and/or family to safely self-administer medications and biologicals to the patient in his or her home.

Connecticut: Sec. 19a-495-6j

(c) The comprehensive assessment shall be updated as frequently as the condition of the patient requires, but not less than once every fourteen calendar days.

(h) The patient-centered plan of care shall include, but not be limited to:

1. Pertinent diagnosis and prognosis,
2. Interventions to facilitate the management of pain and other symptoms
3. Measurable targeted outcomes anticipated from implementing and coordinating the patient centered plan of care
4. A detailed statement of the patient and family needs addressing the:
   A. Physical, psychological, social, and spiritual needs
   B. The scope of services required
   C. The frequency of services
   D. The need for respite or general inpatient care
   E. Nutritional needs
   F. Drugs and biological products
   G. Management of pain and control of other symptoms, and
   H. Management of grief
5. Drugs and treatments necessary to meet the needs of the patient
6. Medical supplies and appliances necessary to meet the needs of the patient
7. The interdisciplinary team's documentation of the patient's and family's understanding, involvement, and agreement with the patient centered plan of care, and
8. Such other relevant modalities of care and services as may be appropriate to meet individual patient and family care needs

Delaware: Title 16

3.3 The interdisciplinary team shall have the following responsibilities:

3.3.2 Develop the care plan for the patient/family. The patient care coordinator will be responsible for assuring the implementation and ongoing review of the plan of care.

3.3.3 Hold an interdisciplinary care team meeting at least semimonthly or more often if needed to review and update the care plan.

3.3.4 Emphasize prevention and control of pain and other distressing symptoms.

6.2.3 Patient/physician encounters shall be at a frequency not less than described in the written plan of care or as otherwise required to meet demonstrated patient/family needs.

6.8.3 The patient care plan will give direction to the care given in meeting the physiological, sociological, and spiritual needs of patient/family. The plan will identify those caregivers who will be participating in this plan. The plan will specifically address maintenance of patient independence and control.

6.8.4 The plan will be recorded in ink and maintained as part of the patient/family record.

6.8.7 The plan of care must be prepared within three (3) days of the patient's admission to the home care component of the hospice program and within two (2) days of admission to the inpatient component of the hospice program.

Florida:

59A-38.005 Coordinated Care Program

(2) The administrator shall be responsible for ensuring the development, documentation and implementation of a current plan that delineates cooperative planning, decision-making and documentation by the disciplines represented the members of hospice care team and which provides the staff with methods of meeting collective and individual responsibilities as outlined and assigned in the plan of care for each patient and family unit.

(e.) Methods to ensure that the patient and the patient's family shall, insofar as practical, define the needs to be addressed in the plan of care, provide significant information and assistance in developing and implementing an effective plan of care, and have access to the written plan of care upon request.

59A-38.008 Medical Direction

(b.) Duties of the medical director shall include:

(3) Assisting in developing and medically validating the plan of care for each patient and family unit with the coordination of the patient's attending physician(s).

400.6095 Plan of Care

(4) The admission process shall include a professional assessment of the physical, social, psychological, spiritual, and financial needs of the patient. This assessment shall serve as the basis for the development of a plan of care.

(5) Each hospice, in collaboration with the patient and the patient's primary or attending physician, shall prepare and maintain a plan of care for each patient, and the care provided to a patient must be in accordance with the plan of care. The plan of care shall be made a part of the patient's medical record and shall include, at a minimum:

(a.)Identification of the primary caregiver, or an alternative plan of care in the absence of a primary caregiver, to ensure that the patient's needs will be met.

(b.) The patient's diagnosis, prognosis, and preferences for care.
(c.) Assessment of patient and family needs, identification of the services required to meet those needs, and plans for providing those services through the hospice care team, volunteers, contractual providers, and community resources.
(d.) Plans for instructing the patient and family in patient care.
(f.) A description of how needed care and services will be provided in the event of an emergency.

(6) The hospice shall provide an ongoing assessment of the patient and family needs, update the plan of care to meet changing needs, coordinated the care provided with the patient's primary or attending physician, and document services provided.

Georgia:

Rule 111-8-37-.14

(2)(G) The hospice must ensure the development of an initial plan of care, within 24 hours of admission to the hospice, based on the initial assessment and with appropriate input from a physician or registered nurse to meet the immediate needs of the patient.

Rule 111-8-37-.15 Assessment and the Plan of Care

(3) The appropriate members of the hospice care team must provide a comprehensive assessment, as dictated by the identified needs of the patient, no later than five (5) days after admission that includes at least medical, nursing, psychosocial, and spiritual evaluations of the patient, as well as the capability of the family unit in meeting the care needs of the patient and the need for bereavement services.

(4) Based on the results of the assessment of the patient, the hospice care team must:
a. Establish the plan of care; and
b. Provide and supervise hospice care and services in accordance with accepted standards of care and the plan of care.

(5) The hospice care team must establish and maintain a written plan of care for each patient prior to providing care.
a. The plan of care must be developed with the input of the patient, the patient's family unit if designated by the patient, the patient's caregivers where the patient resides in a licensed facility, and the patient's representative, if any.
b. The plan of care must detail the scope and frequency of services to be provided to meet the needs of the patient and the patient's family unit.
c. The hospice care team must meet as a group to review each terminally ill patient's plan of care. The plan of care must be reviewed and updated as the

patient's condition changes, and as additional services needs are identified. The plan of care for terminally ill patients must be reviewed and updated at intervals of no more than 15 days. All reviews and updates shall be documented in the patient's medical record. Plans of care for patients receiving palliative care who have not been determined to be terminally ill will be reviewed and updated as the patient's condition changes or the patient requests additional services.

d. Documentation of plan of care review for the terminally ill patient must include a record of those participating and must include evidence of the attending physician's opportunity to review and approve of any revised plans of care. In the absence of the attending physician's written approval of the revised plan of care, the revised plan of care must have the written approval of the medical director.

Illinois:

210 ILCS Hospice Program Licensing Act
Section 3. Definitions (a)(10)
(c-5) A hospice patient's plan of care must be established and maintained for each individual admitted to a hospice care program, and the services provided to an individual must be in accordance with the individual's plan of care. The plans of care must be established and maintained in accordance with the standards for certification under the Medicare program set forth in the Conditions of Participation in 42 CFR Part 418.
(l) The hospice program must maintain professional management responsibility for hospice care and ensure that services are furnished in a safe and effective manner by persons meeting the qualifications as defined in this Act and in accordance with the patient's plan of care.

Title 77 Part 280 Hospice Programs
280.2010 Hospice Services (3)
A. Each hospice shall ensure that there is a written plan of care for each patient. The hospice care team shall complete an assessment of the care needs and evaluate the ability of the patient to be cared for in his/her place of residence.
B. The plan shall be updated based on the ongoing assessments by the hospice care team.
C. The patient care plan shall provide for involvement of the family and others in treatment.

D. Each hospice providing services to a patient in both the home setting and the inpatient setting shall have written policies and procedures to share the written plan of care between both settings to facilitate continuity of care.

Indiana: No additional requirements

Maryland: 10.07.21.10

A. The interdisciplinary team shall develop a written plan of care for each patient and family. The plan of care shall reflect current standards of practice. The hospice care program shall document the attending physician's participation in the development, revision, and overall approval of the plan of care.
B. The interdisciplinary plan of care shall reflect continuing communication between the attending physician and other members of the interdisciplinary team. The interdisciplinary plan of care shall be reviewed, and revised, if necessary, at least:
    1. Every 14 days after admission for home-based hospice services; and
    2. Every 7 days after admission for inpatient hospice services.
C. The interdisciplinary plan of care shall recognize the patient's and family's psychological, social, religious, and cultural values.
D. The interdisciplinary plan of care shall reflect efforts that the hospice care program staff and volunteers have made to:
    1. Maximize patient independence.
    2. Deliver services at the convenience of the patient, family, and caregiver.
    3. Arrange respite services for caregivers.
    4. Bridge gaps in the patient's caregiving network; and
    5. Adapt the home environment to meet the patient's physical needs.
E. The interdisciplinary plan of care shall be based on the initial assessments conducted by interdisciplinary care team members.
F. The hospice care program shall encourage the patient and family to participate in developing and implementing the interdisciplinary plan of care.
G. Contents. The interdisciplinary plan of care shall include, at a minimum:
    1. Identification of patient and family problems and needs.
    2. Identification of realistic and achievable goals, objectives, and outcomes.
    3. The frequency and mix of services, including bereavement needs.
    4. The level of care to be provided.
    5. Prescribed medication and treatments; and
    6. Required medical equipment.

Massachusetts:

141.202 Plan of Care / Assessments

A. The hospice shall develop a comprehensive written plan of care by an interdisciplinary hospice care team and if applicable, the patient's attending physician or primary care provider, prior to provision of services. The initial plan of care shall be developed within three (3) days of admission by at least three members of the interdisciplinary team as defined by 105 CMR 141.203, including a registered nurse and the medical director. The initial plan of care shall be reviewed and ratified by the full interdisciplinary team at their next scheduled meeting.
B. The patient / family shall be permitted, and end encouraged to actively participate in the care planning process and the provision of care. Such participation shall be documented in the patient / family record.
C. The plan of care shall include but not be limited to:
    1. pertinent diagnosis and prognosis.
    2. identification of the physical, psychological, social, economic, and spiritual status of the patient / family.
    3. need for inpatient care (respite or general), nutritional needs, medication needs, need for management of discomfort and symptom control, and need for management of grief.
    4. plan to address identified needs including scope of services required.
    5. identification of anticipated frequency of services needed.
    6. designation of the primary caregiver or alternate plan to provide 24-hour care and support in the patient's home.
    7. identification of the person responsible for coordinating care.
    8. plans instructing the patient / family or designated caregiver in patient care.
    9. plans for support and care at the time of death.
    10. plans for providing bereavement care to family.

D. The comprehensive plan of care shall reflect the changing care needs of the patient / family and be reviewed and revised as necessary but at least twice a month by the interdisciplinary care team. These reviews shall be documented in the patient / family record.

141.207 Pharmaceutical Services and Medications

F. The primary caregivers and each drug and biological they are instructed to administer must be specified in the patient's plan of care.

Michigan:

R 325.13 Rule 112 Patient records.

1. The hospice shall keep and maintain a record that is in compliance with section 20175 of the code, MCL 333.20175
2. Each patient's record shall include the following:
   a. Physician certification and recertification of terminal illness
   b. Copy of advance directives or notation that the patient declined.
   c. Physician orders
   d. The initial and updated plan of care, assessments, and clinical notes.

R 325.13 Rule 304 Nursing services

4. The hospice interdisciplinary group shall complete a comprehensive assessment not later than 5 calendar days after the election of hospice care. The comprehensive assessment shall identify the patient's immediate physical, psychosocial, emotional, and spiritual needs related to the terminal illness.
5. The development of a comprehensive patient care plan for each hospice patient/family unit shall commence within 24 hours of admission.
6. The patient care plan shall be established by the hospice interdisciplinary care team.
7. The plan of care shall include problems, interventions, and goals specific to the patient/family unit and all medications, medical equipment, and other pertinent items used by the patient. The plan of care shall be revised or updated every 15 days or as the needs of the patient/family unit change.

Minnesota:

4664.0110

Subpart 1. Plan of Care. Each hospice patient and hospice patient's family must have a current and up-to-date written plan of care. The plan of care must be based on the assessments described in part 4664.0100 and developed by the interdisciplinary team, medical director or designee, and the attending physician prior to providing hospice care. The plan of care must be developed with the active participation of the hospice patient or the hospice patient's responsible person. The plan of care must:

A. Reflect the current individualized needs of the hospice patient and the hospice patient's family based on the current assessments.
B. Address the palliative care of the hospice patient, including medication side effects, and monitoring.

C. Include a description and frequency of hospice services needed to meet the hospice patient's and hospice patient family's needs. Services must include bereavement counseling for the hospice patient's family for up to one year following the death of the patient; and
D. Include identification of the persons or categories of persons who are to provide hospice services.

Subpart 2. Implementation. A hospice provider must ensure that hospice services are provided according to the plan of care.
Subpart 3. Copy of plan of care. A hospice provider must provide the hospice patient or the responsible person a copy of the initial plan of care. Changes to the plan of care must be made available to the patient or responsible person upon request.

4664.0120
Subpart 1. Reassessment. Each hospice patient and hospice patient's family shall be reassessed based on their individualized needs.
Subpart 2. Review of plan of care. A plan of care must be reviewed and updated at intervals as specified in the plan, by the attending physician, medical director, and the interdisciplinary team. The reviews must be documented.

Mississippi: 41-85-7
Rule 1.19.2 Plan of Care (POC) – Within 48 hours of the admission, a written plan of care must be developed for each patient / family by a minimum of two IDT members and approved by the full IDT and the Medical Director at the next meeting. The care provided to an individual must be in accordance with the POC.
1. The IDT member who assesses the patient's needs must meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician.
2. At a minimum the POC will include the following:
   a. An assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief.
   b. In detail, the scope and frequency of services needed to meet the patient's and family's needs. The frequency of services established in the POC will be sufficient to effectively manage the terminal diagnosis of the patient, provide appropriate amounts of counseling to the family, and meet or exceed nationally accepted hospice standards of practice.

c. Identification of problems with realistic and achievable goals and objectives.
d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions.
e. Patient / family understanding, agreement, and involvement with the POC; and
f. Recognition of the patient / family's physiological, social, religious, and cultural variables and values.

3. The POC must be maintained on file as part of the individual's clinical record. Documentation of updates shall be maintained.
4. The hospice will designate a registered nurse to coordinate the implementation of the POC for each patient.

Rule 1.19.3 Review and Update of the Plan of Care

1. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT and the attending physician.
2. Agency shall have policy and procedures for the following:
   a. The attending physician's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician.
   b. Physician orders must be signed and dated in a timely manner but must be received before billing is submitted for each patient.
3. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

Missouri: 19 CSR 30-35

D. Plan of Care

1. A written plan of care must be established for each patient by the interdisciplinary group with the attending physician involvement.
2. The plan shall be established within seven (7) days of admission.
3. The care provided to a patient shall be in accordance with the plan.
4. The plan shall include:
   A. Identification of the patient's /family's problems and needs.

B. The scope and frequency of services needed to meet the patient's and family's needs and by whom the services will be provided, prescribed, and required equipment, supplies, medications, treatments, and the level of care.
C. Realistic and achievable goals; and
D. All physician orders.

5. The plan shall be reviewed and updated by the interdisciplinary group at a minimum of every two (2) weeks. These reviews shall be documented in the patient record.
6. Documentation on the plan of care shall reflect the changing needs of the patient/family and the services required to meet those needs.

Nevada: NAC 449.0186 Requirements for the plan of care

1. The medical director of a program of hospice care shall cause a written plan of care to be established for each patient in the program. Any person who furnishes care for the patient shall adhere to the plan.
2. A plan of care must:
   a. Be established by the physician of the patient or by the medical director of the program of hospice care, and the interdisciplinary team, which provides the hospice care.
   b. Include an assessment of the needs of the patient and identify the services required by the patient, which must include the management of discomfort and relief of symptoms of the patient.
   c. State the scope and frequency of each service to be provided to the patient and the members of his or her family; and
   d. Be reviewed and updated at intervals that are specified in the plan by the person who established the plan. The review must be documented in writing.

New Jersey: N.J. Admin. Code 8:42C

8:42C-6.1 Role of the interdisciplinary team

(b.)The interdisciplinary team shall be responsible for:

1. Participation in the plan of care, which shall be:
   i. Initiated and implemented when the patient is admitted.
   ii. Coordinated and maintained by the interdisciplinary team.
   iii. Inclusive of, but not limited to, the patient's diagnosis, patient goals, means of achieving goals, and care and treatment to be provided.
   iv. Current and available to all personnel providing patient care; and
   v. Included in the patient's medical/health record.
2. Provision and supervision of all hospice care and services.

3. Periodic review and updating of the plan of care for each individual receiving hospice care; and
4. Establishment of policies governing the day-to-day provision of hospice care.

(c.) The hospice shall ensure that each patient and the primary caregiver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

Oregon: No additional requirements

Pennsylvania: No additional requirements

Tennessee: 1200-08-27-.06

(2) Plan of Care. A written plan of care must be established and maintained for each patient admitted to a hospice program and the care provided must be in accordance with the plan.

a. Establishment of plan. The plan must be established by the attending physician, the medical director or the physician's designee and the interdisciplinary group prior to providing care.
b. Review of plan. The plan must be reviewed and updated as the patient's condition changes, but at intervals of no more than fifteen (15) days, by the attending physician, the medical director or the physician's designee and interdisciplinary group. These reviews must be documented.
c. Content of the plan. The plan must include an assessment of the individual's needs and identification of the hospice services required, including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

Texas:

558.821 Hospice Plan of Care

a. A hospice must designate and interdisciplinary team (IDT) to prepare a written plan of care for a client in consultation with the client's attending practitioner, if any, the client or the client's legal representative, and the primary caregiver, if any of them so desire.
b. The IDT must develop an individual written plan of care for each client. The plan of care must reflect client and family goals and intervention based on the problems identified in the initial, comprehensive, and updated comprehensive assessments.

c. The hospice must provide care and services to a client and the client's family in accordance with and individualized written plan of care stablished by the hospice IDT.
d. The client's plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions. The plan of care must include:
   (1) interventions to manage pain and symptoms.
   (2) a detailed statement of the scope and frequency of services necessary to meet the specific client and family needs.
   (3) measurable outcomes anticipated from implementing and coordinating the plan of care.
   (4) drugs and treatments necessary to meet the needs of the client.
   (5) medical supplies and equipment necessary to meet the needs of the client; and
   (6) the IDT's documentation in the client record of the client's or the client's legal representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's policies.
e. The hospice must ensure that the client and the client's primary caregiver receives education and training provided by hospice staff as appropriate to the client's and the client's primary caregiver's responsibilities for providing the care and services specified in the plan of care.

558.822 Review of the Hospice Plan of Care
a. A hospice interdisciplinary team, in collaboration with a client's attending practitioner, if any must review, revise, and document the individualized plan of care as frequently as the client's condition requires, but no less than every 15 days.
b. A revised plan of care must include information from the client's updated comprehensive assessment and must note the client's progress toward outcomes and goals specified in the plan of care.

Washington: WAC 246-335-640 Hospice Plan of Care
Except as provided in subsection (5) of this section, the licensee must:
(1) Develop and implement a written hospice plan of care for each patient with input from the authorizing practitioner, appropriate interdisciplinary team members, and the patient, designated family member, or legal representative;
(2) Ensure each plan of care is developed by appropriately trained or credentialed agency personnel and is based on a patient and family assessment;

(3) Ensure the hospice plan of care includes:
(a) Current diagnoses and information on health status;
(b) Goals and outcome measures which are individualized for the patient;
(c) Symptom and pain management;
(d) Types and frequency of services to be provided;
(e) Palliative care, if applicable;
(f) Use of telehealth or telemedicine, if applicable;
(g) Home medical equipment and supplies used by the patient;
(h) Orders for treatments and their frequency to be provided and monitored by the licensee;
(i) Special nutritional needs and food allergies;
(j) Orders for medications to be administered and monitored by the licensee including name, dose, route, and frequency;
(k) Medication allergies;
(l) The patient's physical, cognitive and functional limitations;
(m) Patient and family education needs pertinent to the care being provided by the licensee;
(n) Indication that the patient has a signed advanced directive or POLST, if applicable. Include resuscitation status according to advance directives or POLST, if applicable; and
(o) The level of medication assistance to be provided.
(4) Develop and implement a system to:
(a) Ensure and document that the plan of care is reviewed by the appropriate interdisciplinary team members within the first week of admission and every two (2) weeks thereafter;
(b) Ensure the plan of care is signed or authenticated and dated by appropriate agency personnel and the authorizing practitioner;
(c) Ensure the signed or authenticated plan of care is returned to the agency within sixty days from the initial date of service;
(d) Inform the authorizing practitioner regarding changes in the patient's condition that indicates a need to update the plan of care;
(e) Obtain approval from the authorizing practitioner for additions and modifications; and
(f) Ensure all verbal orders for modification to the plan of care are immediately documented in writing and signed or authenticated and dated by an agency individual authorized within the scope of practice to receive the order and signed

or authenticated by the authorizing practitioner and returned to the agency within sixty days from the date the verbal orders were received.

(5) Hospice agencies providing a one-time visit for a patient may provide the following written documentation in lieu of the hospice plan of care requirements in subsection (3) of this section:

(a) Patient's name, age, current address, and phone number;

(b) Confirmation that the patient was provided a written bill of rights under WAC 246-335-635;

(c) Patient consent for services to be provided;

(d) Authorizing practitioner orders; and

(e) Documentation of services provided.

Washington, DC: no additional licensing requirements

Wisconsin: DHS 131.21 Plan of Care

(1) General Requirements. A written plan of care shall be established and maintained for each patient admitted to the hospice program and the patient's family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.

(2) Initial Plan of Care.

(a) The hospice shall develop an initial plan of care that does all of the following:

1. Defines the services to be provided to the patient and the patient's family.

2. Incorporates physician orders and medical procedures.

(b) The initial plan of care shall be developed upon conclusion of the assessment under s. DHS 131.20 (1) (a).

(c) The initial plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team.

(d) The registered nurse shall immediately record and sign a physician's oral orders and shall obtain the physician's countersignature within 20 business days.

(3) Plan of Care

(a) Integrated plan of care. The hospice core team shall develop an integrated plan of care for the new patient within 5 days after the admission. The core team shall use the initial plan of care as a basis for team decision-making and shall update

intervention strategies as a result of core team assessment and planning collaboration.

(b) Content of the plan of care. The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions, including all of the following:

1. Interventions to manage pain and symptoms.
2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
3. Measurable outcomes anticipated from implementing and coordinating the plan of care.
4. Drugs and treatment necessary to meet the needs of the patient.
5. Medical supplies and appliances necessary to meet the needs of the patient.
6. The interdisciplinary group's documentation of the patient's or representative, if any, level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

(c) Review of the plan of care. The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, shall review, revise, and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care. The hospice interdisciplinary group shall primarily meet in person to review and revise the individualized plan of care.

(d) Bereavement plan of care. The hospice core team shall review and update the bereavement plan of care, at minimum:

1. Fifteen calendar days following a patient's death.
2. Within 60 calendar days following the patient's death.
3. As often as necessary based on identified family needs.
4. At the termination of bereavement services.

(e) Contents of the bereavement plan of care. The bereavement plan of care shall include all of the following:

1. The family and caregiver's specific needs or concerns.
2. Intervention strategies to meet the identified needs.

3. Employees responsible for delivering the care.
4. Established timeframes for evaluating and updating the interventions.
5. The effect of the intervention in meeting established goals.

(f) Record of notes. The core team shall develop a system for recording and maintaining a record of notes within the plan of care.

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: HOS 2-042
		Effective Date: 01/01/13
	Title: **PROVISION OF CARE TO RESIDENTS OF SNF/NF OR ICF/MR**	*Revised*:
		Page: ***1*** *of* ***4***

POLICY:

Hospice services including physician, nursing, social work, counselors, medical supplies, durable medical supplies and drugs will be directly provided by hospice. Other services may be provided. A designated interdisciplinary group member is responsible for the coordination of services. Hospice will assume responsibility for professional management of the SNF/NF or ICF/MR resident's hospice services provided, in accordance with the hospice plan of care and the hospice CoPs and make any arrangements for hospice-related inpatient care in a participating Medicare/Medicaid facility.

PURPOSE:

To ensure the coordination of care provided to residents of SNF/NF or ICF/MR.

PROCEDURE:

The organization provides hospice care to residents of an SNF/NF or ICF/MR and will abide by the following standards:

1. Medicare patients receiving hospice services are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.

2. The organization will assume responsibility for professional management of the resident's hospice services provided.

3. The organization and SNF/NF or ICF/MR will have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by the authorized representatives of the hospice and facility before the provision of services. The written agreement must include at least the following:

    A. The manner in which the parties will communicate with each other and document such communications to ensure the needs of patients are addressed and met 24 hours a day.

    B. A provision that the hospice is notified if:

        1. A significant change in a patient's physical, mental, social;, or emotional status occurs

2. Clinical complications appear that suggest a need to alter the plan of care

3. A need to transfer the patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care related to the terminal illness and related conditions

4. Patient dies

C. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

D. An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs at the same level of care before hospice care was elected.

E. An agreement that it is hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the resident were in his or her own home.

F. A delineation of the hospice's responsibilities, which include, but are not limited to the following:

1. Providing medical direction and management

2. Providing nursing, counseling (including spiritual, dietary and bereavement), social work

3. Providing medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with terminal illness

4. Provision of other hospice services that are necessary for care related to the terminal status and related conditions

G. A provision that the hospice may use SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent

that the hospice would routinely use the services of a patient's family in implementing the plan of care.

H. A provision that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

I. A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.

4. A written plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this plan of care. The plan of care must:

   A. Identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions

   B. Reflect the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible

   C. Document any hospice approved changes in the plan of care and that changes were discussed with the patient or representative, and SNF/NF or ICF/MR representatives.

5. The organization will designate a member of each interdisciplinary group that is responsible for a patient who is a resident of the SNF/NF or ICF/MR. The designated member is responsible for:

   A. Providing overall coordination of hospice care of the resident with the facility representatives

   B. Communicating with the facility representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family

6. The organization will ensure that the interdisciplinary group communicates with the SNF/NF or ICF/MR Medical Director, the patient's attending physician, and other physicians participating in the provision of care as needed to coordinate the hospice care with the medical care provided by other physicians.

7. The organization will provide the SNF/NF or ICF/MR the following information specific to each patient:

   A. The most recent plan of care

   B. Hospice election form and Advance Directives

   C. Physician certification and recertification of the terminal illness

   D. Names and contact information for hospice personnel involved in hospice care

   E. Instructions on how to access the hospice's 24-hour on-call system

   F. Hospice medication information

   G. Hospice physician and attending physician (if any) orders

8. The organization assures orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the following:

   A. Hospice philosophy

   B. Hospice policies and procedures regarding methods of comfort, pain control, symptom management, and postmortem care

   C. Principles about death and dying and individual responses to death

   D. Patient rights

   E. Appropriate forms and record keeping requirements

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: *HOS 2-082*
		Effective Date: *01/01/13*
	Title: **DISCHARGE FROM HOSPICE PROGRAM**	*Revised*: *05/01/21*
		Page: ***1** of **14***

POLICY:

To ensure patients receive needed care and services at discharge.

AccentCare will provide service to a patient and family/caregiver as long as the patient remains terminally ill and lives in the designated service area. The organization will not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the inability to pay.

Planned discharges require the agency to complete a summary of the patient's care. Discharge/Transfer forms are completed for patients transferring to another healthcare agency.

Regulatory requirements: Chapter 2 SOM Section 2082; 418.100 (d); 418.104 (e.)(1-3); 418.108 (c.)(3); 418.28
CHAP standards: HCDT 37.D; HCDT 38.I; HCDT 39.I; HCDT 40.I; HCDT 41.I; HCIC 5.D; HSIM3.I

Discharge Criteria

1. The Medical Director and/or attending physician will determine the patient is not hospice-appropriate according to standard clinical criteria for determining disease prognosis of six (6) months or less.
2. Patient moves out of the service area of AccentCare or transfers to another hospice.
3. The patient and family/caregiver request discharge.
4. Hospice determines the patient needs to be discharged for cause. This is defined as when a patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.
5. Environment is determined to be unsafe for the patient and/or staff.
6. The patient or family/caregiver refuses to allow the hospice physician or nurse practitioner to have the required face-to-face encounter (prior to third and subsequent benefit periods).

PURPOSE:

To establish standards and a process by which patients are discharged from the hospice program.

PROCEDURE:

1. Hospice will obtain a written physician order from the hospice medical director for discharge prior to discharging a patient for any reason. If the patient has an attending physician involved in their care, that physician shall be consulted prior to discharge and given the opportunity to participate in discharge planning.

2. Patients will not be discharged due to isolated incidences of seeking emergency treatment or for using necessary hospice services.

3. The hospice interdisciplinary group will develop a discharge plan.

4. Discharge planning includes plans for any necessary family counseling, patient education, other services, community referrals, and agency notification (if any) before the patient is discharged.

5. The Case Manager will ensure that necessary paperwork is completed at the time of discharge. Complete the Discharge/Transfer Summary, if applicable. If appropriate, a signed revocation form will be completed. A written physician order to discharge is received, if appropriate.

6. If the patient is transferring to another healthcare agency or facility, additional documentation to be sent includes:

    A. A summary of the patient's stay including treatments, symptoms, and pain/symptom management
    B. The patient's current plan of care
    C. The patient's latest physician orders
    D. Other documentation facilitating continuity of care and/or requested by the attending physician or receiving facility.

7. If a patient is transferred to another Medicare / Medicaid certified facility, a copy of the hospice discharge summary and a copy of the hospice clinical record (if requested) is sent to the receiving facility.

8. If a patient revokes the election of hospice care or is discharged from hospice, a copy of the hospice discharge summary and a copy of the hospice clinical record (if requested) is sent to the attending physician.

9. All related documentation will be filed in the patient's clinical record. Documentation in the clinical record is complete for discharge record filing within 30 days of discharge.

10. Before discharging a patient for cause, a serious effort to resolve the problem(s) presented by the patient's behavior and, or situation must be made and documented in the patient's clinical record. Hospice will advise the patient that a discharge for cause is being considered, presenting alternative suggestions and referrals for care before ending service.

11. If the environment is determined unsafe for the patient and/or staff, the following steps will be taken:

    A. Provide written recommendations to patient and family/caregiver and physician to resolve the unsafe situation.
    B. Refer to the social worker for assistance with placement planning.
    C. Consult with adult/child protective services and document.
    D. Consider referrals to other agencies.
    E. A formal letter will be provided to the patient and/or his/her representative that includes the organization's concern, recommendations, and consequences if concerns are not resolved and potential discharge date. A copy will be provided to the attending physician.

State-Specific Regulations

Arizona: R9-10-603

C. The administrator shall ensure that:
   2. Policies and procedures for hospice services are established, documented, and implemented to protect the health and safety of a patient that:
      a. Cover patient screening, admission, transfer, discharge planning, and discharge.

California: CA Hospice & Palliative Association - Section 6.2 Policies

A. Administrative Policies
   e. A policy for discharge of patients. Criteria for discharge may include:
      1. Death of the patient,
      2. The patient's condition has changed so he/she is no longer considered eligible for services,
      3. The patient and family or attending physician requests discharge,
      4. The patient/family is unwilling to comply with the plan of care, and consistently acts in a way that compromises standards of care,
      5. Issues of staff safety cannot be resolved,
      6. The patient moves from the geographic area served by the program,
      7. The patient and family elects to receive care from another provider,
      8. Subject to applicable contracts, state and federal law, payment sources are exhausted, and the program is fiscally unable to provide free or part-cost care,
      9. The program is closing

Section 6.3 Record-keeping requirements

   2. Discharge
      a. Discharge notes and summary of all program services, if other than by death shall include:
         (1) Summary of the patient's physical, mental, spiritual and emotional status at the time of discharge.
         (2) Method of initiation of discharge, i.e., by physician, hospice, patient and/or family.
         (3) Date and reason for termination of service
         (4) Extent to which treatment goals were obtained
         (5) Referrals made, if necessary
         (6) Documentation of notification of the termination of services to patient,

family and physician
(7) Transfer notes, if appropriate

b. Discharge notes and summary of all program services, if discharged by death shall include:
(1) Date and location of death
(2) Extent to which treatment goals were obtained, including pain and symptom management
(3) Degree of emotional support extended to family and significant others
(4) Bereavement services plan
(5) Disposition of Schedule II drugs

Colorado: 6 CCR 1011-1 Chapter 21

Section 6.7 (B) At the time of discharge, the hospice shall provide pertinent clinical records and any other documentation that may be requested to assist in post-discharge continuity of care.

Section 10.7 (A)(3) The hospice patient's inpatient clinical record includes all aspects of the patient's care, condition and services furnished during the patient's inpatient stay. A copy of the inpatient facility's discharge summary shall be provided to the hospice at the time of the discharge. A copy of the inpatient facility's complete clinical record shall be available to the hospice.

Connecticut: 19-13-D72 Patient Care Policies

B. Patient Care Standards
An agency shall develop and implement written policies and procedures for all hospice services provide which include:
(i) A description of the objectives and scope of each service to be provided, both directly and by contract which assures the continuity of care from the time of admission to the hospice program throughout the course of the patient's illness until death or discharge. Such services shall include coordination of inpatient care agreements for care as needed in inpatient settings.
(ii) Admission criteria for accepting a patient family for hospice services which includes, but is not limited to, a statement of a physician's or the medical director's clinical judgement regarding the normal course of the individual's illness and a requirement that patients will not be discharged from the hospice program solely as a result of an admission to an inpatient setting with which the hospice program has a coordination of inpatient care agreement.

Delaware: Title 16 Health and Safety Code - 4468 Delivery of Hospice Services

5.1.9 Every hospice shall develop written policies pertaining to the services they provide. Such policies include criteria for discharge from hospice programs

Florida: Chapter 400 Florida Statutes – Part IV Hospices

400.6095 7. In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.

Georgia: Rule 111-8-37-.14

6. Discharge Requirements
   a. Once a hospice admits a patient who is terminally ill for hospice care, the hospice at its discretion must not discharge the patient unless either the patient freely and voluntary requests the discharge or the hospice determines that an involuntary discharge is necessary in accordance with these rules.
   b. No hospice is permitted to require or demand that a terminally ill patient request voluntary discharge from the hospice or require or demand a hospice patient to execute a request for voluntary discharge from the hospice as a condition for admission or continued care.
   c. In situations where the hospice identifies issues where the safety of the terminally ill patient, the patient's family unit, or a hospice staff member or volunteer is compromised, the hospice must make every effort to resolve the issues before considering the option of involuntary discharge.
      1. All such efforts for resolution by the hospice must be documented in the patient's record.
      2. If involuntary discharge is the elected option, the hospice must give no less than 14 days' notice of discharge to the terminally ill patient and the patient's representative, except in cases of imminent danger or immediate peril to the terminally ill patient, other terminally ill patients, or staff.
      3. The hospice must notify the Department of the pending involuntary discharge of a terminally ill patient at the time of patient notification.
   d. No terminally ill patient receiving hospice care may be discharged due to inability to pay for the hospice services.
   e. No hospice is permitted to discontinue hospice care for a terminally ill patient, nor discharge or transfer the patient, during a period of coordinated or approved appropriate hospital admission for the treatment of conditions related to the

patient's terminal illness or any other condition.

f. Hospices must assist in coordinating continued care should any hospice patient be transferred or discharged from the hospice.

Illinois: no requirements

Indiana: no requirements

Maryland: 10.07.21.12 Transfer or Discharge

D. The hospice care program shall document the specific reasons for transferring or discharging a patient from its program. These reasons may include:
   1. The patient moves from the service area;
   2. There is a change in terminal status;
   3. The patient and family are unwilling to comply with the interdisciplinary plan of care or consistently act in a way, which compromises the standards of care;
   4. Issues of patient safety cannot be resolved; or
   5. Issues of staff safety cannot be resolved; or
   6. Patient and family desire for discharge

E. The hospice care program shall prepare a written discharge summary, which shall be provided, to the patient or the patient's family before the patient's discharge.

F. Before discharge, the hospice care program shall assess the patient's and family's continuing care needs and make referrals to appropriate services.

Massachusetts: no requirements

Michigan: no requirements

Minnesota: 4664.0060

Subpart 2. Discontinuance of services. If the licensee discharges or transfers a hospice patient for any reason, then:

A. The reason for discharge or transfer must be documented in the clinical record. The documentation must include:
   (1) The reason why the transfer or discharge is necessary; and
   (2) Why the patient's needs cannot be met by the licensee, if the patient continues to need hospice services;

B. A written notice must be given to the hospice patient or responsible person at least 10 days in advance of termination of service by the hospice provider, except according

to Minnesota Statutes, section 144A. 751, subdivision 1, clause (17), and must include the information required under item D, and the name, address, and telephone number of the Office of the Ombudsman for Older Minnesotans. A copy of the discharge notice shall be placed in the clinical record;

C. if the hospice patient's health has improved sufficiently that the patient no longer needs the services of the licensee, the hospice patient's physician must document that the discharge is appropriate; and

D. Before discharge, the hospice provider must give the hospice patient or the responsible person a written list of providers that provide similar services in the hospice patient's geographical area and must document that the list was provided.

Mississippi: Rule 1.19.4 Coordination and Continuity of Care

1. An assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services.

10. When the patient is admitted to a setting where hospice care cannot be delivered, hospice adheres to standards, policies and procedures on transfer and discharge and facilitates the patient's transfer to another care provider.

Rule 1.19.8 Discharge/Revocation/Transfer

1. Discharge- The patient shall be discharged only in the following circumstances;
   a. The patient is determined to no longer be terminally ill with a life expectancy of six months or less;
   b. Patient relocates from the hospice's geographically defined service area;
   c. If the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the problem must be documented in detail in the patient's clinical record; and
   d. If the patient enters a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the patient chooses not to transfer to a facility with which the hospice has a contract, or to a hospice with which the SNF has a contract), the hospice shall then discharge the patient.
   e. The hospice must clearly document reasons for discharge.

2. Revocation- Occurs when the patient or representative makes a decision to discontinue receiving hospice services:
   a. A recipient may revoke hospice care at any time;

b. If a patient or representative chooses to revoke from hospice care, the patient must sign a statement, which states that he or she is aware of the revocation and stating why revocation is chosen. The effective date of discharge cannot be earlier than the signed revocation date.

3. Noncompliance- When a patient is noncompliant; the hospice must counsel the patient/family on the option to revoke any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:
   a. The patient seeks or receives curative treatment for the illness;
   b. The patient seeks treatment related to the terminal illness in a facility that does not have a contract with the hospice; or
   c. The patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice.
4. Transfer- The hospice must document the reason for such transfer and an appropriate discharge plan/summary is to be written. Appropriate continuity of care is to be arranged prior to such transfer.

Missouri: Title 19 - Division 30 - Chapter 35 (19 CSR 30-35)

(C.)(3) The hospice shall have written policies for hospice patient discharge, which identify specific circumstances in with the patient, is discharged.

A. The hospice shall immediately notify the patient or representative and shall include the date that the discontinuance is effective.
B. Patient's/family's continuing care needs, if any, are assessed at discharge, and the patient/family are referred to appropriate resources.

(C.)(4) The physician shall be notified in all instances of discontinuance of hospice care and such notification shall be documented in the patient record.

Nevada: no requirements

New Jersey: Section 8: 42C-6.3 Policies and procedures

a. The hospice shall establish written policies and procedures governing patient care that are reviewed at least annually by the advisory group, revised as needed, and implemented. The written policies and procedures shall include at least the following:
   1. Criteria for admission, discharge, and readmission of patients. Admissions criteria shall be based solely upon the patient's needs and the ability of the facility to meet the medical, nursing, and social needs of the patient. Discharge policies shall preclude punitive discharge.

Oregon: no requirements

Pennsylvania: no requirements

Tennessee:

1200-08-27-.05

11. No patient shall be involuntarily discharged without a written order from the attending physician or the medical director stating that the patient does not meet hospice criteria, or through other legal processes, and timely notification of next of kin and/or the authorized representative.
12. When a patient is discharged, a summary of the significant findings and events of the patient's care, the patient's condition on discharge and the recommendation and arrangements for future care, if any, is required.

1200-08-27-.06 (6) Continuation of care. An organization providing hospice services must assist in coordinating continued care should the patient be transferred or discharged from the hospice program or the organization.

7. (e.) The medical record must include a record of all inpatient services and events. A copy of the discharge summary must be provided to the hospice and, if requested, a copy of the medical record is to be provided to the hospice.
15. (a) Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.

Texas: Title 26 – Part 1- Chapter 558 – Subchapter C

Rule 558.295 Client Transfer or Discharge Notification Requirements

a. Except as provided in subsection (e.) of this section, and agency intending to transfer or discharge a client must:
   1. provide written notification to the client or the patient's parent, family, spouse, significant other, or legal representative; and
   2. notify the client's attending physician or practitioner if he is involved in the agency's care of the client.
b. An agency must ensure delivery of the written notification no later than five (5) days before the date on which the client will be transferred or discharged.
c. The agency must deliver the required notice by hand or by mail.
d. If the agency delivers the written notice by mail:

1. the notice must be mailed at least eight (8) working days before the date of discharge or transfer; and
2. the agency must speak with the client by telephone or in person to ensure the client's knowledge of the transfer or discharge at least five (5) days before the date of discharge or transfer.

e. An agency may transfer or discharge a client without proper notice required by subsection (b) of this section:
   1. upon the client's request;
   2. if the client's medical needs require transfer, such as a medical emergency;
   3. in the event of a disaster when the client's health and safety is at risk in accordance with provisions of 558.256 of this chapter (relating to Emergency Preparedness Planning and Implementation);
   4. for the protection of staff or a client after the agency has made documented reasonable effort to notify the client, the client's family and physician, and appropriate state or local authorities of the agency's concerns for staff or client safety, and in accordance with agency policy;
   5. according to physician orders; or
   6. if the client fails to pay for services, except as prohibited by federal law.

f. An agency must keep the following in the client's file:
   1. a copy of the written notification provided to the client or the client's parent, family, spouse, significant other, or legal representative;
   2. documentation of the personal contact with the client if the required notice was delivered by mail; and
   3. documentation that the client's attending physician or practitioner was notified of the date of discharge.

Rule 558.859 Hospice Discharge or Transfer of Care

a. If a hospice transfers the care of a client to another facility or agency, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the receiving facility or agency.

b. If a client revokes the election of hospice care, or is discharged by the hospice for any reason listed in subsection (d) of this section, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the client's attending practitioner.

c. A hospice discharge summary must include:
   1. a summary of the client's stay, including treatments, symptoms, and pain

management,
2. the client's current plan of care;
3. the client's latest physician orders; and
4. any other documentation needed to assist in post-discharge continuity of care or that is requested by the attending practitioner or receiving facility or agency.

d. In addition to the requirements in 558.295 of this chapter (relating to Client Transfer and Discharge Notification Requirements), a hospice may discharge a client if:
   1. the client moves out of the hospice's service area or transfers to another hospice;
   2. the hospice determines that the client is no longer terminally ill; or
   3. the hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that the behavior of the client or other person in the client's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the client or ability of the hospice to operate effectively is seriously impaired.

e. Before a hospice seeks to discharge a client for cause, the hospice must:
   1. advise the client that a discharge for cause is being considered;
   2. make a reasonable effort to resolve the problems presented by the client's behavior or situation;
   3. document in the client's record the problems and efforts made by the hospice to resolve the problems; and
   4. ascertain that the client's proposed discharge is not due to the client's use of necessary hospice services.

f. Before discharging a client for any reason listed in subsection (d) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If the client has an attending practitioner involved in the client's care, the attending practitioner should be consulted before discharge and the practitioner's review and decision should be included in the discharge note.

g. A hospice must have a discharge planning process that addresses the possibility that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as terminally ill. A client's discharge planning must include any necessary family counseling, client education or other services before the hospice discharges the client based on a decision by the hospice medical director or physician designee that the client is no longer terminally ill.

Wisconsin: Chapter DHS 131

131.18 Discharge

2. Written policy. The hospice shall have a written policy that details the manner in which the hospice is able to end its obligation to a patient. This policy shall be provided to the patient or patient's representative, if any, as part of the acknowledgement and authorization process at the time of the patient's admission. The policy shall include all of the following as a basis for discharging a patient:
    a. The hospice may discharge a patient:
        1. Upon the request or with the informed consent of the patient or patient's representative.
        2. If the patient elects care or other than hospice care at any time.
        3. If the patient elects active treatment, inconsistent with the role of palliative hospice care.
        4. If the patient moves out of the geographical area served by the hospice or into a facility that does not have a contact with the hospice.
        5. If the patient requests services in a setting that exceeds the limitations of the hospice's authority.
        6. For nonpayment of charges, following reasonable opportunity to pay any deficiency.
        7. For the patient's safety and welfare or the safety and welfare of others, if the hospice determines that the behavior of the patient or other persons in the patient's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.
        8. If the hospice determines that the patient is no longer terminally ill.
        b. The hospice shall do all of the following before it seeks to discharge a patient whose behavior or the behavior of other persons in the patient's home, is disruptive, abusive, or uncooperative to the extent that the delivery of care to the patient or the ability of the hospice is seriously impaired:
            1. Advise the patient that a discharge for cause is being considered.
            2. Make a serious effort to resolve the problem or problems presented by the patient's behavior or situation.
            3. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.
            4. Document the matter and enter this documentation into the patient's clinical record.

3. Notice
   a. When a patient is being discharged for a reason given in sub. (2) (a) 1,2,3,4,5,7, or 8, the hospice shall give written notice of the discharge to the patient or patient's representative, if any, a family representative and the attending physician.
   b. When a patient is being discharged for the reason given in sub. (2) (a) 6., the hospice shall give written notice of the discharge at least fourteen (14) days prior to the date of discharge, and indicate a proposed date for pre-discharge planning. The written notice shall be given to the patient or patient's representative, if any, a family representative and the attending physician.
4. Planning - The hospice shall conduct the pre-discharge planning with the patient or patient's representative and review the need for discharge, assess the effect of discharge on the patient, discuss alternative placements and develop a comprehensive discharge plan.

accentCare.	*Manual*: **HOSPICE**	*Policy Number*: *HOS 2-083*
		Effective Date: *01/01/13*
	Title: **DISCHARGE SUMMARY**	*Revised*: *05/15/21*
		Page: ***1** of **6***

POLICY:

All patients discharged from service and from hospice will have a discharge summary completed and filed in the clinical record.

PURPOSE:

To define the requirements for documentation of a discontinuation of service and when patients are discharged from hospice.

Regulatory requirements: Chapter 2 SOM Section 2082; 418.100 (d); 418.104 (e.)(1-3); 418.108 (c.)(3); 418.28
CHAP standards: HCDT 37.D; HCDT 38.I; HCDT 39.I; HCDT 40.I; HCDT 41.I; HCIC 5.D; HSIM3.I

PROCEDURE:

1. Hospice personnel who provide care will complete a discharge summary at the time the discipline is discontinued, which may include, as appropriate:

   A. The date of discharge, the date the physician and patient informed of discharge
   B. The reason for discharge, including the name of the organization to which the patient is being transferred, if applicable
   C. A summary of a patient stays including treatments, and pain/symptom management
   D. Continuing symptom management needs
   E. A summary of the care or services provided
   F. The patient's current plan of care
   G. The patient's latest physician orders

2. The discharge summary and other relevant clinical record documents will be completed and filed in the patient's medical record within 30 days of discharge.

3. A copy of the discharge summary will be provided to the patient's attending physician. If the physician or receiving facility requests additional information, additional documentation facilitating the patient's continuity of care will be provided.

4. Hospice will complete all necessary audits to determine the completeness of the patient's clinical record within 30 days of discharge date. The discharge record will be organized according to policy for clinical records contents and removed from the active files.

State-Specific Regulations

Arizona: No additional requirements

California: CA Hospice & Palliative Association

Section 6.3 Record-keeping requirements

2. Discharge
   a. Discharge notes and summary of all program services, if other than by death shall include:
      (1) Summary of the patient's physical, mental, spiritual and emotional status at the time of discharge.
      (2) Method of initiation of discharge, i.e., by physician, hospice, patient and/or family.
      (3) Date and reason for termination of service
      (4) Extent to which treatment goals were obtained
      (5) Referrals made, if necessary
      (6) Documentation of notification of the termination of services to patient, family and physician
      (7) Transfer notes, if appropriate

   b. Discharge notes and summary of all program services, if discharged by death shall include:
      (1) Date and location of death
      (2) Extent to which treatment goals were obtained, including pain and symptom management
      (3) Degree of emotional support extended to family and significant others
      (4) Bereavement services plan
      (5) Disposition of Schedule II drugs

Colorado: 6 CCR 1011-1 Chapter 21

Section 6.7 (B) At the time of discharge, the hospice shall provide pertinent clinical records and any other documentation that may be requested to assist in post-discharge continuity of care.

Section 10.7 (A)(3) The hospice patient's inpatient clinical record includes all aspects of the patient's care, condition and services furnished during the patient's inpatient stay.

A copy of the inpatient facility's discharge summary shall be provided to the hospice at the time of the discharge. A copy of the inpatient facility's complete clinical record shall be available to the hospice.

Delaware: No additional requirements

Florida: Chapter 400 Florida Statutes – Part IV Hospices

400.6095 7. In the event a hospice patient chooses to be discharged or transferred to another hospice, the hospice shall arrange for continuing care and services and complete a comprehensive discharge summary for the receiving provider.

Georgia: No additional requirements

Illinois: No requirements

Indiana: No requirements

Maryland: 10.07.21.12 Transfer or Discharge

E. The hospice care program shall prepare a written discharge summary, which shall be provided, to the patient or the patient's family before the patient's discharge.

Massachusetts: No additional requirements

Michigan: No additional requirements

Minnesota: No additional requirements

Mississippi: Rule 1.19.8 Discharge/Revocation/Transfer

4. Transfer- The hospice must document the reason for such transfer and an appropriate discharge plan/summary is to be written. Appropriate continuity of care is to be arranged prior to such transfer.

Missouri: No additional requirements

Nevada: No additional requirements

New Jersey: No additional requirements

Oregon: No additional requirements

Pennsylvania: No additional requirements

Tennessee:

1200-08-27-.05

12. When a patient is discharged, a summary of the significant findings and events of the patient's care, the patient's condition on discharge and the recommendation and arrangements for future care, if any, is required.

1200-08-27-.06 (6) Continuation of care. An organization providing hospice services must assist in coordinating continued care should the patient be transferred or discharged from the hospice program or the organization.

7. (e) The medical record must include a record of all inpatient services and events. A copy of the discharge summary must be provided to the hospice and, if requested, a copy of the medical record is to be provided to the hospice.

15. (a) Clinical notes shall be written the day on which service is rendered and incorporated no less often than weekly; copies of summary reports shall be sent to the physician; and a discharge summary shall be dated and signed within 7 days of discharge.

Texas: Title 26 – Part 1- Chapter 558 – Subchapter C

Rule 558.859 Hospice Discharge or Transfer of Care

a. If a hospice transfers the care of a client to another facility or agency, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the receiving facility or agency.

b. If a client revokes the election of hospice care, or is discharged by the hospice for any reason listed in subsection (d) of this section, the hospice must provide a copy of the hospice discharge summary and, if requested, a copy of the client's record to the client's attending practitioner.

c. A hospice discharge summary must include:
   1. a summary of the client's stay, including treatments, symptoms, and pain management,
   2. the client's current plan of care;
   3. the client's latest physician orders; and
   4. any other documentation needed to assist in post-discharge continuity of care or

that is requested by the attending practitioner or receiving facility or agency.

d. In addition to the requirements in 558.295 of this chapter (relating to Client Transfer or Discharge Notification Requirements), a hospice may discharge a client if:
   1. the client moves out of the hospice's service area or transfers to another hospice;
   2. the hospice determines that the client is no longer terminally ill; or
   3. the hospice determines, under a policy set by the hospice for addressing discharge for cause, that the behavior of the client or other person in the client's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the client or the ability of the hospice to operate effectively is seriously impaired.

e. Before a hospice seeks to discharge a client for cause, the hospice must:
   1. advise the client that a discharge for cause is being considered;
   2. make a reasonable effort to resolve the problems presented by the client's behavior or situation;
   3. document in the client's record the problems and efforts made by the hospice to resolve the problems; and
   4. ascertain that the client's proposed discharge is not due to the client's use of necessary hospice services.

f. Before discharging a client for any reason listed in subsection (d) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If the client has an attending practitioner involved in the client's care, the attending practitioner should be consulted before discharge and the practitioner's review and decision should be included in the discharge note.

g. A hospice must have a discharge planning process that addresses the possibility that a client's condition might stabilize or otherwise change such that the client cannot continue to be certified as terminally ill. A client's discharge planning must include any necessary family counseling, client education or other services before the hospice discharges the client based on a decision by the hospice medical director or physician designee that the client is no longer terminally ill.

Wisconsin: No additional requirements

accentCare.	*Manual*: **HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*: *C 3.2*
		Effective Date: *12/97*
	Title: **CONTRACTS FOR CLINICAL SERVICES**	*Revised*: *04/01/22*
		Page: ***1** of **3***

POLICY:

It is the policy of this Agency to provide qualified care and services to meet the needs of the patients served. When care and services are provided through a contracted source, the Executive Director/Administrator is responsible to ensure patients receive the same level of performance from that source as from the organization itself. These contracted services will be defined by a written agreement before individuals from that source will be permitted to provide services on behalf of the organization.

Regulatory Reference: Home Health- 484.50 (e.)(2); 484.65(a)(1); 484.80(h)(5); 484.40
Hospice- 418.52 (b)(4); 418.56 (a)(1) & (c.)(2); 418.60(c); 418.62(b-c); 418.64(a) & (b)(3); 418.76 (c.)(2); 418.102; 418.106 (a) & (f)(2-3); 418.108(c 1-6); 418.114 (a) & (b3)& (d); 418.58; 418.64(b)(3); 418.78(e.); 418.100 (e.) & (g); 418.110 (i) & (n)(1);418.112 (b)

CHAP Standards: Home Health- PCC.8.I.M1; CQI.1.I.M1; LG.4.I.M3; LG 12.D; LG 12.D.M 1 to 4; IM.4.I.M3
Hospice- HPFC 7.D; HCPC 2.D; HCDT 2.I; HCDT 3.I; HCDT 5.I; HCDT 7.D; HCDT 28.I; HSIC 5.D; HSIC 28.I; HSRM3.I; HSRM 15.I: HSRM 16.I; HSRM 21.I; HIPC 1.D; HQPI 1.D; HSLG 10.I; HSLG 15.D; HSLG 18.I

TJC Standards: LD.04.03.03 EP20; LD.04.03.09 EP 4, EP5, EP6, EP7

PURPOSE:

To ensure the provision of clinical services and maintain an adequate number of qualified professionals to provide professional services.

PROCEDURE:

1. The Executive Director/Administrator determines when contractual arrangements are needed to provide adequate, qualified patient care providers.
2. The Executive Director/Administrator or designee gets approval for the contractor from the Regional Vice President (RVP).
3. The Legal Department is informed, and a Legal Department representative or designee negotiates the contract terms with the contractor.

4. The Contractor and the Executive Director/Administrator completes and signs the appropriate negotiated written contract.

5. The Contractor will not directly bill the patient or any health insurance program for services furnished to any Agency patient.

6. The Contractor and Agency will adhere to all the terms of the written contract, in particular; relating to billing, payment of services, and communication with Agency staff, adhering to Agency policies and procedures and providing/coordinating patient care services, and complying with Title VI of the Civil Rights Act of 1964. The Contractor and Agency will enter into a Business Associate Agreement.

7. The quality of service provided by the Contract personnel will be reviewed periodically. If the service meets Agency standards, the contract may be renewed or continued. The Executive Director/Administrator, with the assistance of other organization personnel, will monitor, evaluate, and audit the contracted services to ensure that they are being provided according to the contract and CHAP/TJC standards, if applicable. In addition, the review will:
   a. Formally assess the quality of services provided by the contracted provider,
   b. Determine pertinence of agreement to current practice,
   c. Extend or modify the terms of the agreement,
   d. Negotiate new terms as necessary,
   e. Terminate the contract, if necessary.

8. Validation of the contract evaluation will be documented and include:
   a. Date of review,
   b. Participating parties,
   c. Continuing relevance of the contract to the provision of care.

9. The written agreement will stipulate the following:
   a. Service to be provided or statement of work
   b. Contractor is required to perform work in accordance with the applicable policies and procedures which shall be provided
   c. Contractor assures the education, training, qualifications, and identification of personnel designated to provide care
   d. Contractor participates in education training, and education records are maintained separately

e. Mechanisms for the contractor to participate in performance improvement activities, as applicable
f. Procedures for scheduling visits and periodic patient evaluation
g. Procedures for submission of required patient-related documentation that verifies the provision of services by the written service contract
h. Procedures for the submission of invoices and related information and reimbursement for care provided
i. Effective dates of the contract including terms of renewal or termination.

10. All contracted staff shall have proof of a COVID-19 vaccine card or a letter for a medical or religious exemption. Documentation shall be submitted directly to the agency and/or loaded into AMN/ShiftWise system.

11. Agency leaders shall take steps to improve contracted services that do not meet expectations.

    Improvement efforts shall include the following:

    a. Increase monitoring of the contracted services
    b. Provide consultation or training to the contractor
    c. Renegotiate the contract terms
    d. Apply defined penalties, if needed
    e. Terminate the contract if the contractor does not improve performance.

POLICY:

It is the policy of this Agency to obtain fair reimbursement for services rendered to all patients

PURPOSE:

To provide guidelines to be considered when establishing patient eligibility for uncompensated or discounted services for uninsured or underinsured indigent and charity patients.

PROCEDURE:

1. Requirements for Consideration of Indigent or Charity Services

    a. The client must not be Medicare or Medicaid eligible and not covered under any commercial insurance policy if they are Medicaid eligible but have not completed the paperwork, they do not qualify of Indigent or Charity Care.
    b. The client must fill out a Confidential Financial Statement, which will be provided to him/her at the time of admission to AccentCare. Once completed, the form shall be submitted to the Executive Director for calculating referencing the current US federal poverty guidelines.
    c. The patient and/or staff member working with the patient shall document his or her income by available information in his/her possession, such as W-2 form, pay stub, tax return or other similar documentation containing income.
    d. Based on the calculation from the Confidential Financial Statement, if the client's monthly income falls below 125% of the federal poverty level they will receive all services at no charge.
    e. If based on the calculation the client's monthly income falls within the charity care (at or below 125% of poverty level) and indigent care ceiling (above 200% of poverty level), the patient will be eligible for a mutually agreeable fee payment to be negotiated by the Executive Director.

2. The Executive Director or designee will notify the client in writing immediately after processing the Confidential Financial Statement with the reduced, if at all, per visit charge and will follow up with a phone call to confirm.

3. Victims of assault must press charges or initial legal action as appropriate against their assailant to be considered eligible for indigent services.

4. Approval for Indigent Care: Based on published rates usually in quarter one of the new year.

    - Patients meeting guidelines for consideration for indigent or charity care may be prospectively approved by the Executive Director for care up to $1000.
    - If the amount of services exceeds $5000, the approval of the Regional Vice President or designee should be obtained.
    - A log of pre-approved indigent or charity patients and amount of charges for discounted services to such patient shall be maintained at the Agency.

State-Specific Requirements

Arizona:
Hospice – no indigent care State requirements
No certificate of need law.

California:
Home Health and Hospice -no indigent care State requirements
No certificate of need law.

Colorado:
Home Health and Hospice -no indigent care State requirements
No certificate of need law.

Connecticut:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but no certificate of need requirements of home health or hospice agencies.
https://portal.ct.gov/OHS/Pages/Certificate-of-Need

Delaware:
Hospice – no indigent care State requirements
No certificate of need law.
Has certificate of need law, but no certificate of need requirements of home health or hospice agencies.
https://dhss.delaware.gov/dhss/dhcc/hrb/dhrbhome.html

Florida:
Home Health - no indigent care State requirements
Has certificate of need law required for establishment of hospice or hospice inpatient facility.
https://ahca.myflorida.com/mchq/con_fa/index.shtml

Georgia:
Home Health - Has certificate of need and established indigent care State requirements
https://dch.georgia.gov/divisionsoffices/office-health-planning/certificate-need-con
Like all home health agencies in the State of Georgia, the Agency has made a commitment to either provide Indigent/Charity care at a certain level or make payments to the State of Georgia in an equivalent amount to fund Indigent/Charity care in the State of Georgia. This

commitment was made as part of the certificate of need application. Reporting of Indigent/Charity care provided by the Agency shall be credited to the commitment as reported to the Georgia Department of Community Health. In the event that Indigent/Charity care provided by the Agency has not been previously allocated or reported, it may be carried over and applied to subsequent commitment periods. Any difference between the Indigent/Charity care reported by the Agency and the commitment made by the Agency will be funded upon periodic request by the State of Georgia.
Hospice: no indigent care State requirements

Illinois:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but no requirements for establishment of home health or hospice agencies.
https://www2.illinois.gov/sites/hfsrb/conprogram/pages/default.aspx

Indiana:
Home Health and Hospice – no indigent care State requirements
No certificate of need law.

Maryland:
Hospice – no indigent care State requirements
Has certificate of need law. Required for establishment of home health or hospice agencies.
https://mhcc.maryland.gov/mhcc/Pages/hcfs/hcfs_con/hcfs_con.aspx

Massachusetts:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but no requirements for establishment of home health or hospice agencies.
https://www.mass.gov/service-details/don-guidelines-and-policy-advisories

Michigan:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but no requirements for establishment of home health or hospice agencies.
https://www.michigan.gov/mdhhs/0 5885 7-339-71551_2945_5106--- 00.html

Minnesota:
Home Health and Hospice – no indigent care State requirements
No certificate of need law.

Mississippi:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law required for establishment of home health agencies.
http://www.msdh.state.ms.us/msdhsite/_static/30 0 84.html

Missouri:
Home Health – no indigent care State requirements
Has certificate of need law, but not required for establishment of home health or hospice agencies.
https://health.mo.gov/information/boards/certificateofneed/

Nebraska:
Home Health– no indigent care State requirements
Has certificate of need law but, not required for establishment of home health or hospice agencies.
http://dhhs.ne.gov/licensure/Documents/Facilities-NebraskaHealthCareCertificateOfNeedAct.pdf

Nevada:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but not required for establishment of home health or hospice agencies.
http://dpbh.nv.gov/Programs/Certificate_of_Need/Certificate_of_Need_-_Home/

New Jersey:
Home Health– no indigent care State requirements
Has certificate of need law. Required for establishment of home health agencies.
https://www.nj.gov/health/healthfacilities/certificate-need/

New Mexico:
Home Health - Home Health and Hospice – no indigent care State requirements
No certificate of need law.

New York: Home Health – no indigent care State requirements
Has certificate of need law required for establishment of home health and hospice agencies.
https://www.health.ny.gov/facilities/cons/

Ohio:
Home Health– no indigent care State requirements
Has certificate of need law, but no requirement for establishment of home health or hospice agencies.
http://codes.ohio.gov/oac/3701-12

Oklahoma:
Home Health– no indigent care State requirements
Has certificate of need law but, no requirement for establishment of home health or hospice agencies.
https://oklahoma.gov/health/protective-health/health-resources-development-service/health-facility-systems-.html

Oregon:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law, but no requirement for establishment of home health or hospice agencies.
https://www.oregon.gov/oha/ph/ProviderPartnerResources/HealthcareProvidersFacilities/CertificateNeed/Pages/index.aspx

Pennsylvania:
Hospice – no indigent care State requirements
No certificate of need law.

Tennessee:
Home Health and Hospice – no indigent care State requirements
Has certificate of need law. Required for establishment of home health or hospice agencies.
https://www.tn.gov/health/health-program-areas/health-planning/certificate-of-need.html

Texas:
Home Health and Hospice – no indigent care State requirements
No certificate of need law.

Wisconsin:
Hospice – no indigent care State requirements
https://docs.legis.wisconsin.gov/statutes/statutes/150

Each year in January, the Census Bureau updates the U.S. Federal Poverty Guidelines Used to Determine Financial Eligibility for Certain Federal Programs. Search by entering the "year" and "federal poverty guidelines."

https://aspe.hhs.gov/poverty-guidelines

The 2022 poverty guidelines are in effect as of
Federal Register Notice, ...February 1, 2022 - Full text.

2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA		
PERSONS IN FAMILY/HOUSEHOLD	**POVERTY GUIDELINE**	**125%**
For families/households with more than 8 persons, add $4,720 for each additional person.		
1	$13,590	$16,987
2	$18,310	$22,887
3	$23,030	$28,787
4	$27,750	$34,687
5	$32,470	$40,587
6	$37,190	$46,487
7	$41,910	$52,387
8	$46,630	$58,287

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CONFIDENTIAL FINANCIAL STATEMENT

NAME OF HEAD OF HOUSEHOLD	PLACE OF EMPLOYMENT			
STREET	CITY	STATE	ZIP	PHONE

PLEASE LIST SPOUSE AND DEPENDENTS UNDER AGE 18

NAME	DATE OF BIRTH	NAME	DATE OF BIRTH
SELF		DEPENDENT	
SPOUSE		DEPENDENT	
DEPENDENT		DEPENDENT	
DEPENDENT		DEPENDENT	

ANNUAL HOUSEHOLD INCOME

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business self-employment, and dependents				
Rent, interest, dividend and other income				
Total Income				

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CONFIDENTIAL FINANCIAL STATEMENT

ANNUAL HOUSEHOLD EXPENSE

SOURCE	SELF	SPOUSE	OTHER	TOTAL
Rent/Mortgage				
Groceries				
Utilities				
Auto (gas/repairs)				
Phone/Mobile Phone				
Cable/Internet				
Entertainment				
Clothing				
Childcare				
Child Support				
Alimony				
Medications				
Physicians				
Hospital				
Other Medical Care				
Home Equity Loan				
Other Loan (s)				
Vehicle Loan (s)				
Credit Card (s)				
Insurance (s)				
Other				
Other				
Other				
Total Expenses				

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CONFIDENTIAL FINANCIAL STATEMENT

I certify that the family size and income information I have provided on this form is correct. Copies of tax returns, pay stubs, and other information verifying income may be required before a discount is approved.

Name (Print) _____

_____

S gnature Date

AGENCY USE ONLY

SOURCE	YES	NO
Identification/Address: Driver's License, Birth Certificate, Employment ID, Social Security Card or Other		
Income: Prior Year Tax Return, Three Most Recent Pay Stubs, or Other		
Insurance: Insurance Card(s)		
Medicaid: Application Made or Evidence of Rejection		

Calculate Income: _____

125% of Poverty Level:_____(Below 125% or below is no fee)

200% of Poverty Level:_____(between 125% through 200% fee is adjusted)

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CONFIDENTIAL FINANCIAL STATEMENT

Patient Name_____

Visit Rate _____

Notification of Patient: ❑ Call Date _____ ❑ Written Date _____

Approved By: _____

POLICY:

It is the policy of AccentCare, Inc. to utilize financial and operational tools and reports to monitor financial components, ensure the availability of adequate funding, provide appropriate and timely reports to all levels within the organization, and ensure compliance with generally accepted accounting standards.

Regulatory References: Home Health - 484.105(a), 484.105(h)(1-4)
CHAP References: Home Health - FS.2.I, FS.2.I.M1, FS.2.I.M2; Hospice HSLG.6.I
TJC References: LD.04.01.03 EP 1

PURPOSE:

To assist the organization in providing operational, financial information to senior management and the Governing Body.

PROCEDURE:

1. Senior management is provided with monthly agency reports to monitor the financial performance of the organization's operations which may include:
    a. Financial reports with documented variances
    b. Admissions and discharges by payer source
    c. Visits by discipline and payer
    d. Patients by diagnostic category and length of stay
    e. Bad debt and indigent care
    f. Results of internal and external billing
    g. Denials of payment by source

h. Cost per episode/visit/product

i. Billing by the payer

j. Accounts receivable by the payer

k. Aged receivables by the payer

l. Bad debt allowances

m. Accounts payable by the vendor

n. Aged payables by the vendor

2. Monthly financial statements will contain key financial ratios and show a reasonable match between revenue and expense line items, including at least:

   a. Net income/operating revenues

   b. Reconciliation of budget to actual results of operations

   c. Days of revenue and receivables

   d. Cost per visit analysis

3. Senior management will review the reports for variances and trends to evaluate the organization's performance and make current and informed decisions to ensure financial viability.

4. Customary financial controls are followed, including:

   a. Annual review of the budget.

   b. Each Financial Department monitors adherence to financial policies and procedures, which may include:

1. Budgeting
2. Billing/claim submission
3. Cash receipts
4. Payment posting
5. Approval process for adjustments and write-offs
6. Collection/follow-up
7. Accounts Payable
8. Payroll

c. An annual external audit by a qualified accounting professional.

POLICY:

The Governing Body ensures its quality assurance and performance improvement program (QAPI) is defined, followed, and evaluated annually by delegating leadership and management of the program to the Executive Director/Administrator and appointing a multidisciplinary hospice Professional Advisory Committee (PAC).

Regulatory references: 418.52; 418.60(b)(1); 418.62(c.)
CHAP standards: HQPI 1.D; HQPI 2. I; HQPI 3. I; HQPI 4. I; HQPI 5. I; HQPI 6. I; HQPI 7. I; HQPI 8. I; HQPI 9. I
TJC standards: P.01.01.01 EP 1, EP2, EP 12, EP 13, EP 23, EP 24; PI.02.01.01 EP 4, EP 8; PI.03.01.01 EP 1, EP 2, EP 9

PURPOSE:

To establish an effective Quality Assurance/Performance Improvement (QAPI) Program, outline roles, and responsibilities, and establish patient outcomes as the primary focus of the organization's performance improvement activities.

PROCEDURE:

1. The Hospice agency's performance improvement activities shall:
   A. Reflect the complexity of its organization and services
   B. Focus on high-risk, high-volume, problem-prone areas, and adverse patient events
   C. Consider incidence, prevalence, and severity of problems in those areas
   D. Measures, analyzes, and tracks quality indicators to monitor program effectiveness, patient safety, and quality of care
   E. Involve all hospice services, including those services furnished under contract or arrangement
   F. Utilize quality indicator data to identify opportunities and priorities for improvement, taking action to demonstrate improvement in hospice/palliative performance.

2. Patient-focused quality assurance and improvement activities include:
   A. Comprehensive assessment and care planning; notification of significant changes to the agreed plan of care, scheduling of service, and efforts to ensure continuity of care by designated staff,
   B. Patient teaching and levels of understanding,

C. Determination of patient's discharge readiness,
D. Use of findings from satisfaction surveys completed by the patient and, or family,
E. Clinical record reviews that are routinely conducted,
F. Safety issues,
G. Evaluation of systems designed to support clinical operations,
H. Compliance with standards of clinical practice,
I. Reprioritization of performance improvement activities,
J. Integration of administrative, clinical, and support functions.

3. Performance improvement results are tracked, trended, analyzed, and used by the hospice agency to address problem issues, improve the quality of care and patient safety, and shall be incorporated into program planning and process design.

4. Actions aimed at performance improvement shall be taken, and, after implementing those actions, the hospice shall measure its success and track performance to ensure that improvements are sustained.

5. The number/scope of performance improvement projects conducted annually is based on the needs of the hospice's population and internal agency needs. It shall reflect the scope, complexity, and past performance of the hospice's services and operations.

6. Senior Management and Executive Director/Administrator shall:
   A. Participate in educational activities to increase his/ her level of understanding and ability to implement performance improvement activities. (i.e., seminars, periodicals, industry benchmarking, etc.)
   B. Set expectations for performance improvement and manage processes to improve performance by utilizing available resources (i.e., NHPCO resources/tools)
   C. Adopt a structured framework for performance improvements. This problem-solving approach will stress the interrelationship of quality services provided, management activities, and sound business practices applicable to the organization's mission, culture, strategic objectives, resources, agency's operations, practice standards, staff skills and competencies.
   D. Identify and set specific outcomes /priorities for improvement, adjusting priorities in response to unusual or urgent events.
   E. Allocate resources for assessing and improving the organization's performance by:
      1. Assigning agency personnel to participate in performance improvement activities

2. Provide adequate time for agency personnel to participate in performance improvement activities
3. Create and maintain information systems and data management processes to support collecting, managing, and analyzing data to improve performance
4. Provide agency personnel training in effective approaches and methods of assessment and improvement
5. Utilize appropriate statistical techniques to analyze/display data (run charts, scatter diagrams, Pareto charts, fishbone diagrams, process flowcharts, etc.)

7. Senior Management and Executive Director/Administrator shall ensure that the infection control program is an integral part of the organization's safety and performance improvement program by:
   A. Participating in the design and implementation of the infection control program
   B. Establishing a process for ongoing assessments of the risks for acquisition and transmission of infectious agents

8. Performance improvement results, including trends identified through performance improvement measurement and analysis, will be reported to the Governing Body on a consistent and periodic basis.

9. Agency personnel, including contractors, shall:
   A. Be involved in performance improvement activities
   B. Promote communication and coordination of performance improvement activities, as well as contribute to those activities
   C. Forward relevant information regarding performance improvement activities to senior management /managers/coordinators responsible for performance improvement

D. Take action on recommendations generated through performance improvement activities

State-Specific Requirements

Arizona:

R9-10-604 Quality Management

An administrator shall ensure that:

1. A plan is established, documented, and implemented for an ongoing quality management program that, at a minimum, includes:
   a. A method to identify, document, and evaluate incidents;
   b. A method to collect data to evaluate services provided to patients;
   c. A method to evaluate the data collected to identify a concern about the delivery of services related to patient care;
   d. A method to make changes or take action as a result of the identification of a concern about the delivery of services related to patient care; and
   e. The frequency of submitting a documented report required in subsection (2) to the governing authority; and
2. A documented report is submitted to the governing authority that includes:
   a. An identification of each concern about the delivery of services related to patient care, and
   b. Any change made or action taken as a result of the identification of a concern about the delivery of services related to patient care; and
3. The report required in subsection (2) and the supporting documentation for the report are maintained for at least 12 months after the date of the report is submitted to the governing authority.

R9-10-613 Medication services

A. An administrator shall ensure that policies and procedures for medication services:
   2. Specify a process for review through the quality management program of:
      a. A medication error, and
      b. An adverse reaction to a medication

California: Section 6.5 Quality Assessment and Performance Improvement

A. Each program shall have an organized system for assessing and improving the quality of care and services. This system shall be designed to improve performance on a systematic and continuous basis. The system shall consist of planned and measurable mechanisms for data collection, analysis and a process for improvement within specified time frames.

B. The organization shall implement performance improvement processes that routinely assess and improve all services provided directly and by written agreement.
C. Each organization shall have a written plan reviewed and revised at least annually for improving the organization's performance. This plan shall include, but not be limited to, assessment and improvement of the quality and efficiency of governance; management; and clinical and support processes.
D. The organization must have a process for assessing employee competency; measuring consumer satisfaction; and investigating, addressing, and documenting complaints and grievances.
E. The hospice administrator is responsible for performance improvement.
F. Each hospice will conduct a review of quality improvement and performance improvement policies at least annually. This review will be by a group composed of at least the following:
    1. The Administrator
    2. The hospice Medical Director
    3. The Patient Care Coordinator or Director of Patient Care Services
    4. A hospice Social Worker or Counselor
G. All performance improvement activities will be documented on a quarterly basis and maintained on file.
H. Utilization review shall include criteria for each discipline providing care. Criteria shall include:
    1. Appropriateness of the level of care to protect health and safety of patients.
    2. Timeliness of care
    3. Adequacy of care to meet patients' needs
    4. Appropriateness of specific services provided
    5. Whether standards of practice for patient care were observed
I. The program shall provide to make provision for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact.

Colorado: 6 CCR 1011-1 Chapter 21

Section 4.5 The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program that complies with 6 CCR 1011-1, Chapter 2, Part 4. In addition, the hospice's governing body shall ensure that the program:

A. Reflects the complexity of its organization and services;
B. Involves all hospice services (including those services furnished under contract or under arrangement);

C. Focuses on indicators related to improved palliative outcomes, and
D. Takes actions to demonstrate improvement in hospice performance.

Section 4.6 The hospice shall maintain documented evidence that its quality assessment and performance improvement program has been implemented and is functioning effectively.

Connecticut:

19-13-D68 General Requirements

C. Professional Advisory Committee

1. There shall be a professional advisory committee, appointed by the governing authority, consisting of at least one physician, one public health nurse, one therapist representing at least one of the skilled therapy services provided by the agency, and one social worker. Representatives appointed to the professional advisory committee shall be active practice in their professions, or shall have been active within the last five (5) years. No member of the professional advisory committee shall be an owner, stockholder, employee of the agency, or related to same, including by marriage. However, provision may be made for employees to serve on the professional advisory committee as ex officio members only, without voting power.
2. The functions of the professional advisory committee shall be to participate in the agency's quality assurance program to the extent defined in the quality assurance program policies and to recommend at least annually review agency policies on:
   a. Scope of services offered;
   b. Admission and discharge criteria;
   c. Medical and dental supervision and plans of treatment
   d. Clinical records;
   e. Personnel qualifications;
   f. Quality assurance activities;
   g. Standards of care;
   h. Professional issues especially as they relate to the delivery of service and findings of the quality assurance program.
3. The professional advisory committee shall hold at least two (2) meetings annually.
4. Written minutes shall document dates of the meetings, attendance, agenda, and recommendations. The minutes shall be presented, read and accepted at the next regular meeting of the governing authority of the agency following the

professional advisory committee meeting. These minutes shall be available at any time to the commissioner.

19-13-D72

C. A hospice program shall have a written quality improvement plan and program which guides the hospice program toward improving organizational performance and achieving the desired outcomes for patient families.
D. A hospice program shall appoint a pharmacist, a volunteer and members of other professional disciplines as appropriate to the agency's Professional Advisory Committee.

19-13-D76 Quality Assurance Program

A. An agency shall have a written quality assurance program, which shall include but not be limited to the following components:
    1. Program evaluation;
    2. Quarterly clinical record review;
    3. Annual documentation of clinical competence;
    4. Annual process and outcome record audits.
B. The professional advisory committee or a committee appointed by the governing authority and at least one person from administrative or supervisory staff shall implement, monitor and integrate the various components of the agency's quality assurance program.
C. The committee and staff designated pursuant to regulation 19-13-D76 (b) shall:
    1. Annually analyze and summarize, in writing, all findings and recommendations of the quality assurance program;
    2. Present written reports of the findings of each component or a written summary report of the findings of the quality assurance program to the professional advisory committee and to the governing authority;
    3. Monitor implementation of the recommendations and actions directed by the governing authority based on said report(s);
    4. Within one hundred twenty (120) days of action on the report(s) by the governing authority, report in writing to the governing authority, administration and professional advisory committee the progress in the implementation of the recommended actions;
    5. Ensure that a copy of the annually quality assurance report(s) and the progress report on implementation are maintained by the agency.

D. The program evaluation shall include, but not be limited to:
   1. The extent to which the agency's objectives, policies and resources are adequate to maintain programs and services appropriate to community, patient and family needs;
   2. The extent to which the agency's administrative practices and patterns for delivery of services achieve efficient and effective community, patient and family services in a five (5) year cycle.

E. At least quarterly, health professionals in active practice, representing at least the scope of the agency's home health care services shall review a sample of active and closed clinical records to assure that agency policies are followed in providing services. No person involved directly in service to a patient or family shall participate in the review of that patient or family's clinical record.
   1. At least once in each calendar quarter, the agency shall select records for review by a random sampling of all therapeutic cases. The agency's sampling methodology shall be defined in its quality assurance program policies and procedures after approval by the commissioner. The sample of clinical records reviewed each quarter shall be according to the following ratios:
      A. Eighty (80) or less cases; eight (8) records;
      B. Eighty-one (81) or more cases, ten percent (10%) of caseload for the quarter to a maximum of twenty-five (25) records. One review form describing the areas to be assessed shall be completed for each record reviewed.

Delaware: Title 16 Chapter 4468

4.7.3 Governing authority shall prepare an annual review and program evaluation which should include, but not be limited to the following, and should be available upon request to the licensing agency:
   1. Review and reevaluation of the program objectives
   2. Evaluation of the appropriateness of the scope of services offered
   3. Review of admission, discharge and patient care policies and procedures
   4. Annual review of a random sample of patient/family records and written evaluation on quality of services provided
   5. Annual review of staffing qualifications, responsibilities and needs

Florida: 59A-38.006 Quality Assurance and Utilization Review (QAUR)/Assessment and Performance Improvement (QAPI) Committee and Plan.

Pursuant to section 400.610(2), F.S., each hospice must appoint a committee, which must develop, document and implement a comprehensive quality assurance and

utilization review plan, also referred to as a quality assessment and performance improvement plan. The QAUR/QAPI plan must be in accordance with quality assessment and performance improvement (QAPI) standards incorporated within the Medicare Conditions for Participation, 42 C.F.R., Part 418, and must include goals and objectives, provisions for identifying and resolving problems, methods for evaluating the quality and appropriateness of care, and the effectiveness of actions taken to resolve identified problems. The QAUR/QAPI plan must establish a process for revising policies, procedures and practices when reviews have identified problems. The QAUR/QAPI committee must review the QAUR/QAPI plan and report findings and recommendations to the governing body annually. Dated and signed minutes of those meetings of the governing body at which QAUR/QAPI findings and recommendations are presented must be kept in an administrative file.

(1) The QAUR/QAPI committee must be composed of individuals who are trained, qualified, supervised and supported by review procedures and written criteria related to treatment outcomes. These review procedures and written criteria must be established with involvement from physicians, and shall be evaluated and updated annually by the QAUR/QAPI committee.

(2) An incident or accident report shall be required in every instance of error in treatment, adverse reaction to treatment or medication, or injury to the patient. All of these incident or accident reports shall be reviewed by the QAUR/QAPI committee.

(3) The QAUR/QAPI committee must audit patient records, including interdisciplinary care records, on a regular and periodic basis. All records must be stored in secured areas to protect patient confidentiality.
   (a) Active patient records shall be kept at the main office, a satellite office, a hospice residential facility or a hospice inpatient facility.
   (b) The master record may be moved to storage in a secure and accessible location after termination of bereavement services or a minimum of one year after the patient's death.

(4) The QAUR/QAPI committee shall assist the administrator in developing, documenting and implementing a formal training and orientation program for individuals conducting utilization review activities.

(5) Activities undertaken by the QAUR/QAPI committee must demonstrate a systematic collection, review, and evaluation of information and must result in proposed actions to correct any identified problems. The information used by the QAUR/QAPI committee must include:
   (a) Care provided in alternate settings and by contracted entities;

(b) Services provided by professional and volunteer staff;
(c) Evaluations by the patient and the patient's family of care provided by the hospice;
(d) Incident reports;
(e) Complaints received from patients and their families;
(f) High-risk, high-volume and problem-prone activities that would have a significant impact on patients, staff or the organization, even if adverse incidents occur infrequently. For example, high-risk activities may include review and evaluation of protocols for containment of communicable diseases, emergency evacuations and continuity of operations; high-volume activities might include collection of information regarding administration of medications; lastly, identifying problem-prone activities might include deterioration or malfunction of equipment, including security of information systems, disposal of contaminated materials or other bio-medical waste; and,
(g) Appropriateness of team services and levels of care measured by whether:

1. The plan of care was directly related to the identified physical and psychosocial needs of the patient and the patient's family;
2. Services, medications and treatments prescribed were in accordance with the current hospice plan of care; and,
3. The hospice care was primarily a home-care program that utilized inpatient hospice care on a short-term or respite basis only.

(6) The QAUR/QAPI committee shall periodically review the accessibility of hospice services and the quality of those services.
(7) The QAUR/QAPI committee shall make recommendations to the administrator and the governing body for resolving identified problems and for improving patient and family care.

Georgia:

Rule 111-8-37-.07 Governing Body

G. The Governing body will appoint an individual to assume overall responsibility for a quality assurance, utilization, and peer review program for monitoring and evaluating the quality and level of patient care in the hospice on an ongoing basis.

Rule 111-8-37-.09 Quality Management

(1) The hospice must appoint an interdisciplinary quality management committee that reflects the hospice's scope of services. The committee must develop and implement a comprehensive, effective and ongoing quality management, utilization, and peer

review program that evaluates, maintains and improves the quality of patient care provided, including the appropriateness of the level of service received by patients, and submits required patient incident reports to the Department.

(2) The quality management, utilization, and peer review program must establish and use written criteria as the basis to evaluate the provision of patient care. The written criteria must be based on accepted standards of care and must include, at a minimum, systematic reviews of:
   (a) Appropriateness of admissions, continued stay, and discharge;
   (b) Appropriateness of professional services and level of care provided;
   (c) Effectiveness of pain control and symptom relief;
   (d) Patient injuries, such as those related to falls, accidents, and restraint use;
   (e) Errors in medication administration, procedures, or practices that compromise patient safety;
   (f) Infection control practices and surveillance data;
   (g) Patient and family complaints and on-call logs;
   (h) Inpatient hospitalizations;
   (i) Staff adherence to the patients' plans of care; and
   (j) Appropriateness of treatment.

(3) Findings of the quality management utilization, and peer review program must be utilized to correct identified problems, revise hospice policies, and improve the care of patients.

(4) There must be an ongoing evaluation of the quality management, utilization, and peer review committee to determine its effectiveness, with the results of the evaluation presented at least annually for review and appropriate action to the medical staff and the governing body.

Illinois:

Section 280.2090 Quality Assurance Program

a) The hospice program must conduct a quality assurance program in accordance with the standards for certification under the Medicare program set forth in the Conditions of Participation in 42 CFR 418. (Section 8(m) of the Act)

b) Each hospice shall establish a written quality assurance plan for review of the services delivered. The plan must include:
   1) A process for identification of quality assurance issues. The person or persons responsible for coordinating quality assurance shall review all summaries of individual assessments at least quarterly and prepare a written report addressing

any problems with care, treatment services, availability of services, and methods of care delivery.

2) A system to report to the governing body findings and recommendations for improving the quality of care delivered. The quality assurance reports shall be reviewed by the hospice administrator and the governing body.
3) The minutes of the meetings of the governing body, which shall indicate that the reports have been reviewed at least annually.

Indiana: No additional requirements

Maryland: No additional requirements

Massachusetts: 105 CMR 141.210 Quality Assurance

A. The hospice shall develop and implement, through an interdisciplinary committee, an ongoing quality assurance program. One member of the committee shall be designated to be responsible for coordinating quality assurance.
B. The quality assurance program shall include and evaluation of all services, including any services provided to patients under contractual arrangements. The hospice shall offer contracted hospice providers the opportunity to participate in the quality assurance program.
C. Each hospice shall establish a written quality assurance plan for review of services delivered. The plan shall include:
    1. A procedure for evaluating care provided on individual cases. At least quarterly, members of professional disciplines representing at least the scope of the hospice program shall review a 10% sample of both active and inactive clinical records of care delivered to hospice patients and families. A written summary shall be prepared for each individual review commenting on the amount and kind of care delivered and including statements addressing any unmet needs.
    2. A process for program evaluation and the identification of problems. At least quarterly, all summaries of individual reviews shall be reviewed by the person responsible for coordinating quality assurance. A written report will be prepared addressing any identified problems with care, treatment, availability of services, and methods of care delivery.
    3. A system to report to the governing body the findings and recommendations for improving the quality of care delivered. The quality assurance reports shall be submitted to the hospice administrator and governing body. There shall be

evidence in the governing body's meeting minutes that the reports have been reviewed by the governing body at least annually.

Michigan: R 325.13106 Governing body.

Rule 106. (1) A hospice shall have an organized governing body that assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvements.

Minnesota:

144A.753 Licensure, Subdivision 2

(6) Utilize an ongoing system of quality assurance.

Chapter 4664

4664.0160 Quality assurance. A hospice provider must conduct an ongoing, integrated, self-assessment of the quality and appropriateness of hospice care provided, including inpatient care, home care, and hospice services provided under contract. The findings shall be used by the hospice provider to correct identified problems and to revise hospice policies if necessary. The licensee shall establish and implement a written quality assurance plan that requires the licensee to:

A. Monitor and evaluate two or more selected components of its services at least once every twelve months; and
B. Document the collection and analysis of data and the action taken as a result

Mississippi: Miss. Code Ann. 41-85-7

Rule 1.20.5 Quality Assurance

1. The hospice shall conduct an ongoing, comprehensive integrated self-assessment quality improvement process (inclusive of inpatient care, home care and respite care) which evaluates not only the quality of care provided, but also the appropriateness care/services provided and evaluations of such services. Findings shall be documented and used by the hospice to correct identified problems and to revise hospice policies.
2. The hospice shall have written plans, policies and procedures addressing quality assurance.
3. The hospice shall designate, in writing, and individual responsible for the coordination of the quality improvement program.
4. The hospice shall conduct quality improvement meetings quarterly, at a minimum.

5. The Hospice's written plan for continually assessing and improving all aspects of operations must include:
   a. Goals and objectives
   b. A system to ensure systematic, objective quarterly reports. Documentation must be maintained to reflect that such reports were reviewed with the IDT, the Medical Director, the Governing Body and distributed to appropriate areas;
   c. The method for evaluating the quality and appropriateness of care;
   d. A method for resolving identified problems; and
   e. Application to improving the quality of patient care.
6. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data, which at a minimum, includes:
   a. Services provided by professional and volunteer staff;
   b. Outcome audits of patient charts;
   c. Reports from staff, volunteers, and clients about services;
   d. Concerns or suggestion for improvement in services;
   e. Organizational review of the hospice program;
   f. Patient/family evaluations of care; and
   g. High-risk, high-volume and problem-prone activities
7. The quality improvement plan must be reviewed at least annually and revised as appropriate.
8. When problems are identified in the provision of hospice care, there shall be evidence of corrective actions, including ongoing monitoring, revisions of policies and procedures, educational intervention and changes in the provision of services.
9. The effectiveness of actions taken to improve services or correct identified problems must be evaluated/documented.

Missouri: No additional requirements

Nevada: No additional requirements

New Jersey: 8:42C-3.4 Policy and procedure manual

a. The hospice shall establish, implement and review at least annually, a policy and procedure manual for the organization of the hospice.
   2. The manual shall include:
      iii. A description of the quality assurance program for patient care and staff performance

Oregon: No additional requirements

Pennsylvania: No additional requirements

Tennessee: 1200-08-27-.06

9. Performance Improvement Program. Each agency must conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of past and present care provided, including inpatient care and contract services. The written performance improvement plan findings are to be used by the hospice to determine the appropriateness and effectiveness of the care provided and to ascertain that professional policies are followed in providing these services. The objectives of those responsible for the performance improvement program are as follows:
    a. To assist the agency in using its personnel and facilities to meet individual and community needs;
    b. To identify and correct problems and/or deficiencies which undermine the quality of care and least to waste of agency and personnel resources;
    c. To help the agency make critical judgements to regarding the quality and quantity of its services through self-examination;
    d. To provide opportunities to evaluate the effectiveness of agency policies and when necessary to make recommendations to the administration as to controls or changes needed to assure high standards of patient care.
    e. To provide data needed to satisfy state licensure and federal certification requirements; and
    f. To establish criteria to measure the effectiveness and efficiency of the hospice services provided to patients.

Texas:

Rule 558.287 Quality Assessment and Performance Improvement

(a) Quality Assessment and Performance Improvement (QAPI) Program.

(1) An agency must maintain a QAPI Program that is implemented by a QAPI Committee. The QAPI Program must be ongoing, focused on client outcomes that are measurable, and have a written plan of implementation. The QAPI Committee must review and update or revise the plan of implementation at least once within a calendar year, or more often if needed. The QAPI Program must include:

(A) A system that measures significant outcomes for optimal care. The QAPI Committee must use the measures in the care planning and coordination of

services and events. The measures must include the following as appropriate for the scope of services provided by the agency:

(i) An analysis of a representative sample of services furnished to clients contained in both active and closed records;

(ii) A review of:

(I) Negative client care outcomes;

(II) Complaints and incidents of unprofessional conduct by licensed staff and misconduct by unlicensed staff;

(III) Infection control activities;

(IV)Medication administration and errors; and

(V) Effectiveness and safety of all services provided, including:

(-a-) the competency of the agency's clinical staff;

(-b-) the promptness of service delivery; and

(-c-) the appropriateness of the agency's responses to client complaints and incidents;

(iii) A determination that services have been performed as outlined in the individualized service plan, care plan, or plan of care; and

(iv) An analysis of client complaint and satisfaction survey data; and

(B) An annual evaluation of the total operation, including services provided under contract or arrangement.

(i) An agency must use the evaluation to correct identified problems and, if necessary, to revise policies.

(ii) An agency must document corrective action to ensure that improvements are sustain over time.

(2) An agency must immediately correct identified problems that directly or potentially threaten the client care and safety.

(3) QAPI documents must be kept confidential and be made available to HHSC staff upon request.

(b) QAPI Committee membership. At a minimum, the QAPI Committee must consist of:

(1) The administrator;

(2) The supervising nurse or therapist, or the supervisor of an agency licensed to provide personal assistance services; and

(3) An individual representing the scope of services provided by the agency.

(c) Frequency of QAPI Committee meeting. The QAPI Committee must meet twice a year or more often if needed.

Rule 558.813 Hospice Client Outcome Measures

(a) The comprehensive assessment must include data elements that allow the hospice to measure client outcomes. The hospice must measure and document data in the same way for all clients.

(b) The data elements must:

(5) Be used in the aggregate for the hospice's quality assessment and performance improvement program.

Washington: WAC 246-335-655 Quality Improvement Program

Every hospice licensee must develop and operationalize a quality improvement program to ensure the quality of care and services provided throughout all approved service areas including, at a minimum:

(1) A complaint process that includes a procedure for the receipt, investigation, and disposition of complaints regarding services provided;

(2) A method to identify, monitor, evaluate, and correct problems identified by patients, families, personnel, contractors, or volunteers; and

(3) A system to assess patient satisfaction with the overall services provided by the agency.

Washington D.C.: no additional requirements

Wisconsin: DHS 131.22 Quality assessment and performance improvement.

(1) Program Standards.

(a) The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.

(b) The hospice's governing body shall ensure that the program reflects the complexity of its organization and services, involves all hospice services including those services furnished under contract or arrangement, focuses on indicators related to improved palliative outcomes, and takes actions to demonstrate improvement in hospice performance.

(c) The hospice shall maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to the department.

(2) Program Scope.

(a) The program shall at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

(b) The hospice shall measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.

(3) Program Data.

(a) The program shall use quality indicator data, including patient care, and other relevant data, in the design of its program.

(b) The hospice shall use the data collected to do all of the following:

1. Monitor the effectiveness and safety of services and quality of care.
2. Identify opportunities and priorities for improvement.

(c) The frequency and detail of the data collection shall be approved by the hospice's governing body.

(4) Program Activities.

(a) The hospice's performance improvement activities shall include all of the following:

1. Focus on high risk, high volume, or problem-prone areas.
2. Consider incidence, prevalence, and severity of problems in those areas.
3. Affect palliative outcomes, patient safety, and quality of care.

(b) Performance improvement activities track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

(c) The hospice shall take actions aimed at performance improvement and, after implementing those actions. The hospice shall measure its success and track performance to ensure that improvements are sustained.

(5) Performance Improvement Projects. The hospice shall develop, implement, and evaluate performance improvement projects.

(a) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, and shall reflect the scope, complexity, and past performance of the hospice's services and operations.

(b) The hospice shall document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.

(6) Executive Responsibilities. The hospice's governing body is responsible for ensuring all of the following:

(a) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.

(b) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

(c) That one or more individuals who are responsible for operating the quality assessment and performance improvement program are designated.

accentCare.	*Manual*:	**HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*:	*C 1.6.1*
			Effective Date:	*05/00*
	Title:	**FACILITATING COMMUNICATION FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY AND/OR SENSORY DEFICITS**	*Revised*:	*1/18/19*
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POLICY:

It is the policy of this agency not to discriminate against any person because of language, cultural beliefs and practices, or sensory and communication impediment and to ensure meaningful communication with Limited English Proficiency (LEP) and sensory deficits patients/clients and their authorized representatives and an equal opportunity to participate in our services, activities, programs, and other benefits. The agency will consistently and clearly communicate with patients/clients in a language or form they can reasonably understand.

Personnel will treat all patients/clients with respect and dignity and will use forms of communication appropriate to meet the patient's/client's needs.

The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc.

All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

If services cannot be secured, the patient/client will be notified in advance so that they are free to choose another agency.

Regulatory References: Title VI of the Civil Rights Act of 1964, Section 504 of the 1973 Rehabilitation Act HH CoP §484.50 (a).

PURPOSE:

To ensure that patients/clients are treated with respect and dignity, receive culturally sensitive care and, despite the limited command of the English language and/or communication, speech, and hearing impairments, have access to appropriate resources and interpretive assistance to benefit from the services of the agency, and consistently and clearly receive information in a language or form they can reasonably understand.

PROCEDURE – LEP:

1. Language assistance will be provided through the use of competent bilingual staff, staff interpreters, contracts, or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services.

2. Identifying LEP Persons and their language: The initial assessment determines the patient's/client's communication ability and identifies medical problems from the patient's point of view including cultural beliefs or practices which may influence the outcome of the plan of care. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. If there is any question regarding the patient's/client's ability to communicate adequately with agency staff, a translator will be secured. The agency will promptly identify the language and communication needs of the LEP person. If necessary, staff will use a language identification card (or "I speak cards," available online at www.lep.gov) or posters to determine the language. In addition, when records are kept of past interactions with patients or family members, the language used to communicate with the LEP person will be included as part of the record.

3. Obtaining A Qualified Interpreter: In the event that an interpreter is needed, the agency will contact the appropriate bilingual staff member to determine if that employee who speaks the needed language is available and is qualified to interpret. If available, this staff member will be assigned to interpret and/or provide care.

4. Obtaining an Outside Interpreter: If a bilingual staff or staff interpreter is not available or does not speak the needed language a 24/7 translator line will be used. See C 1.6.2 for specific information about the calling procedure for the Stratus Language Line (877-746-4674).

5. Using Family or Friend as Interpreter: Some LEP persons may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the LEP

person will not be used as interpreters unless specifically requested by that individual and after the LEP person has understood that an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the patient's medical record. If the LEP person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest will be considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided to the LEP person. Other clients/patients/residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

6. Maintaining Language Resources: The agency administrator or designee is responsible to maintain a list of Local Agencies and Resources Which Meet Cultural, Language, and Special Needs as C 1.6.3 and a list of staff with language skills as C 1.6.4.

7. Providing Written Translations: When translation of vital documents is needed, each agency will submit documents for translation into frequently-encountered languages to the Forms Committee.
   a. Original documents being submitted for translation will be in final, approved form with updated and accurate legal and medical information.
   b. Facilities will provide translation of other written materials, if needed, as well as written notice of the availability of translation, free of charge, for LEP individuals.

8. Providing Notice To LEP Persons: The agency will inform LEP persons of the availability of language assistance, free of charge, by providing written notice in languages LEP persons will understand. At a minimum, notices will be provided in the admission packet and outreach brochures.

9. All patients will receive a copy of:
   a. Patient/Client Rights and Responsibilities
   b. Advance Directives Information

These forms will be provided in appropriate languages as available. If there is a need to interpret these forms in another language, an interpreter will be secured, at no cost to the patient.

10. Monitoring Language Needs and Implementation: On an ongoing basis, the agency's QAPI and Annual Evaluation process will review of the language access needs of patients based on changes in demographics, monitor the implementation of this policy, review and update policy and as necessary and review complaints filed by LEP persons and feedback from patients and community organizations.

11. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge.

12. Staff Education: Our staff represents a diverse mix of cultures, languages, ethnic backgrounds, and countries of origin. Our staff is expected to care for our patients who also have different cultural backgrounds, languages, and beliefs. To facilitate giving culturally competent care to our patients, all staff receive education regarding cultural diversity as part of the orientation process. All staff are educated to this policy, use of the resource lists in C 1.6.4, use of the telephone interpreter's line in 1.6.2, and the language skills of staff in 1.6.3.

PROCEDURE – SENSORY DEFICIT

1. The initial assessment determines the patient's/client's communication ability and identifies medical problems from the patient's point of view including cultural beliefs or practices which may influence the outcome of the plan of care. Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the Agency in the patient's place of residence. The admitting clinician interviewing the patient and/or family ascertains the patient's preferred

methods of communication, i.e., paper and pencil, lip-reading, sign language, and/or electronic devices (personal digital assistant, computer).

2. When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or requests an auxiliary aid or service, staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations. If there is any question regarding the patient's/client's ability to communicate adequately with agency staff, a translator or communication aids will be secured. A sign-language interpretation agency for the deaf and hard of hearing is available at the Stratus Language Line (877-746-4674). The agency provides notice of the availability of and procedure for requesting auxiliary aids and services through notices in our admission packet.

3. For visually impaired patient/client:
   a. The admitting clinician will read aloud all documents normally provided to the patient/client and ascertain that the person has heard and understands what was read. The admitting clinician will document this in the clinical record.
   b. Staff will communicate the information contained in written materials concerning treatment, benefits, services, and consent to treatment forms by talking or reading out loud to persons who are blind or who have low vision.
   c. The following documents are distributed in large print: Patient Consent, Advance Beneficiary Notices and Expedited Notice of Non-Medicare Coverage.
   d. Other written documents can also be made available as needed in alternate formats, including large print. In addition, staff members are available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.
   e. For the following auxiliary aids and services, staff will contact the Director of Patient Care Services (DPCS) who is responsible to provide the aids and services in a timely manner which may include reformatting into large print or other effective methods that help make visually delivered materials available to individuals who are blind or who have low vision.

f. If the agency is not able to access the appropriate resources to meet the patient's communication needs, the agency will refer the patient to another provider.

4. For the communicatively impaired patient/client:
   a. The admitting clinician interviewing the patient/client and/or family ascertains the patient's/client's preferred methods of communication, i.e., paper and pencil, lip-reading, sign language and/or electronic devices (personal digital assistant, computer).
   b. With physician approval, patients/clients with expressive or receptive language deficits may benefit from a consultation with a speech therapist to determine appropriate, effective use of assistive devices such as flashcards, communication boards, etc.
   c. With physician approval a referral to a speech therapist may be appropriate to establish effective use of assistive devices for patients who have other barriers to communication including tracheostomies and/or are ventilator dependence.
   d. If the agency is not able to access the appropriate resources to meet the patient's communication needs, the agency will refer the patient to another provider.

5. For the hearing impaired patient/client:
   a. If the preferred method is sign language, the admitting clinician or case manager will contact the resource providing a sign language interpreter and establish a plan for ongoing communications. See C 1.6.4.
   b. Hearing or communicatively impaired patients who have access to TTD instruments can call the State relay service at 711 (the universal state relay service number) to communicate with someone at the agency.
   c. Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy, and conflict of interest should be considered. If

the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services should be provided.

NOTE: Other patients or residents will **not** be used to interpret, in order to ensure confidentiality of information and accurate communication.

d. If the agency is not able to access the appropriate resources to meet the patient's communication needs, the agency will refer the patient to another provider.

6. For the patients with speech impairments
   a. Various aids and services are available to facilitate communication, including communications concerning programs services, treatment and benefits, and consent forms
   b. For the following auxiliary aids and services, staff will contact the DPCS who is responsible to provide the aids and services in a timely manner such as writing materials and other communication aids that help to ensure effective communication by individuals with speech impairments
   c. If the agency is not able to access the appropriate resources to meet the patient's communication needs, the agency will refer the patient to another provider.

7. For the patients with manual impairments:
   a. Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or other effective methods that help to ensure effective communication by individuals with manual impairments.
   b. For the following auxiliary aids and services, staff will contact the DPCS who is responsible to provide the aids and services in a timely manner such as writing materials and other communication aids that help to ensure effective communication by individuals with speech impairments.
   c. If the agency is not able to access the appropriate resources to meet the patient's communication needs, the agency will refer the patient to another provider.

accentCare.	*Manual*: **HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*: *C 1.4*
		Effective Date: *12/97*
	Title: **POLICY DEVELOPMENT AND STANDARDS OF PRACTICE**	*Revised*: *04/01/22*
		Page: ***1** of **3***

POLICY:

It is the policy of this Agency to follow a written process for participation in policy decisions affecting the organization. The Governing Body has the ultimate authority to delegate to senior management the development of administrative and clinical policies to maintain current, up-to-date policies and procedures manuals for clinical personnel to utilize in the provision of patient care and service. AccentCare is committed to providing care and services in compliance with acceptable professional standards and all state and federal laws and regulations.

PURPOSE:

Ensure that patient care and services are guided by current and relevant clinical policies and procedures. Clinical policies and procedures shall be created or revised according to state practice act, state/federal guidelines, and current clinical practice.

PROCEDURE:

1. Clinical policies and procedures manuals may be developed internally utilizing relevant and current professional practice guidelines or may be purchased commercially. Purchased manuals shall be individualized to the organization's practice.

2. Policies and procedures are written in a standardized format and conform to state and federal regulations and accreditation standards.

3. Senior management has the authority and responsibility to make decisions that affect patient care and services and develop, approve, review and revise policies delegated by the Governing Body. Recommendations for clinical policies and procedures may be completed by the Professional Advisory Committee, the Medical Director, or a clinician with recognized and documented expertise in a specific clinical arena.

4. On an annual basis, the Professional Advisory Committee (PAC) reviews the following policies:
   A. Administrative/operational

B. Clinical policies and procedures
C. Governance
D. Patient rights
E. Performance improvement/clinical record reviews
F. Clinical care
G. Infection control
H. Safety/risk management
I. Financial control
J. Personnel management

Policies form the framework for planning, delivery, and evaluation of care and services provided by the agency. The Professional Advisory Committee documents the review and recommendations as part of the Annual Agency Evaluation process. Final approval shall be by the Governing Body.

5. All physicians and clinicians shall be licensed in the state where they provide care.

6. Care will be provided in a coordinated, effective, appropriate, cost-conscious, and safe manner in accordance with Accent Care's goals, objectives, and philosophy.

7. The same set of services will be provided to patients and families living in a facility as are provided to patients and families living in their own homes.

8. The Agency shall employ an adequate amount of staff to meet the needs of patients and families accepted for care. When possible, services shall be provided by the same clinician for continuity of care.

9. Administrative policies, clinical policies and procedures, professional journals, and discipline-specific practice guidelines shall be accessible to personnel.

10. All revisions will be assigned effective date and, if appropriate, a revised date noted on the policy.

11. Policy or process changes made as a result of senior management meetings shall be distributed to the Agency administrators and department managers.

12. Administrators and department managers are responsible for educating affected personnel, providing access to policies and procedures, reporting, and incorporating the changes into the performance improvement program.

13. Clinical practice standards are developed by professional organizations such as, but not limited to the following, acceptable guides of practice for patient care staff:
    A. AHCPR sponsored Clinical Practice Guidelines
    B. American Nurses Association
    C. American Physical Therapy Association
    D. American Occupation Therapy Association
    E. American Speech-Language-Hearing Association (ASHA)
    F. National Association of Social Workers
    G. Association of Professionals in Infection Control
    H. Infusion Nurses Society
    I. Wound and Ostomy Care Nurse's Society
    J. VNAA Nursing Procedure Manual
    K. Infection Prevention and Control Program
    L. Center for Disease Control
    M. American Psychiatric Nurse Association

accentCare.	*Manual*:	**HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*:	*C 2.5.4*
			Effective Date:	*12/97*
	Title:	**SAFEGUARDING PROTECTED HEALTH INFORMATION (PHI) AND RELEASE OF MEDICAL INFORMATION**	*Revised*:	*02/15/22*
			Page:	***1** of **3***

POLICY:

It is the policy of this agency to safeguard patient confidentiality as it relates to access, duplication, and dissemination of information contained in patient clinical records.

Regulatory References: Code of Federal Regulations - 45 CFR Parts 160, 162, and 164; HH CoP - 484.110(e.); 484.50(c.)(6); 418.52 (c)(5)
CHAP Standards: Home Health IM.4.I; Hospice HSIM 5.I
TJC Standards: IM.02.01.01 EP 3, EP 6; IM.02.01.03 EP 5, EP 9

PURPOSE:

To safeguard the clinical record information against loss or unauthorized use and ensure the patient's written authorization is received for release of information not authorized by law. The Agency will follow proper procedures to ensure that only the minimum amount of protected health information (PHI) necessary to accomplish the specific purpose of a use or disclosure is used or disclosed.

PROCEDURE:

1. The patient is asked to sign a release statement included in the consent for service upon admission that is kept in the patient's medical record. This consent allows the patient's medical record and medical information to be released consistent with HIPAA policy H-10 for the following activities or operations:
   a. Treatment activities: The agency discloses the patient's PHI to physicians and other authorized health care providers, such as a nursing home or hospital, who need access to the patient's medical information.
   b. Payment activities on behalf of the patient.
   c. Health Care Operations activities such as QAPI.
   d. Treatment, Payment, and Health Care Operations of Other Covered Entities.

2. Copies of the necessary patient authorization forms are in the HIPAA Policy and Procedure Manual. The patient or authorized representative signs the HIPAA "Authorization to Use and/or Disclose Protected Health Information" and/or "Authorization for Sharing Information with Family and Friends" following the "Instructions for Authorization."

3. Protected Health Information is released as specified below:

a. Attending Physician and patient's	Release of information without patient's authorization health care providers
b. Worker's Compensation	Release of information without patient's authorization
c. Government Agencies	Release of information without patient's authorization
d. Medicare/Intermediaries and third payers	Release of information without patient's party authorization
e. Accreditation Organizations	Release of information without patient's authorization
f. State and Federal regulatory agencies	Release of information without patient's authorization
g. FBI and All Law Enforcement in accordance with state or federal law or national security	Release of information without patient's authorization
h. Attorneys, Insurance Brokers/Agents	Requires patient's authorization
i. Subpoenas Corporate	Subpoenas honored after approval from Legal/Compliance Dept.
j. Patient or Family authorization	Requires patient's verbal and/or & written from patient

4. Patients or patients' authorized representatives may request copies of the patient's medical record in writing according to HIPAA privacy practices.
   a. Written, signed, and dated requests for medical records are forwarded to the privacy officer or designee for review and action.
   b. After the request is reviewed for compliance with HIPAA regulations regarding the release and tracking of medical records:

i. The medical record is sent free of charge via overnight mail to the patient, or patient's authorized representative
ii. Delivery at the next scheduled home visit or within four business days, whichever comes first.

c. When the patient is transferred to another Agency, a transfer summary will be forwarded with the patient's consent to the receiving Agency.
d. The patient's authorized representative shall include the patient's legal guardian, power of attorney, or health care proxy.

5. Released protected health information is tracked using the "Account of Disclosures Log form as well as the AccentCare "Facility Log for Acct. of Disclosures."

6. Protected health information (PHI) may be sent in sealed, addressed envelopes with return addresses via the United States Postal Service.

7. Contact the legal department if there is a question if PHI may be released.

8. Unless prohibited by law or regulation, the Agency may charge for reproducing the patient's medical record.

9. Confidentiality of information via fax process is maintained with a fax confidentiality statement.

10. Protected health information (PHI) may only be sent on AccentCare's secure intranet. PHI may NOT be sent via email on the internet. Plans of Care and other pertinent PHI will be emailed via AccentCare's secure intranet to the clinician's AccentCare email box on a timely basis to be used exclusively for the treatment of the patient. No PHI may be transmitted via text messaging from any phone. PHI may be transmitted via a voice message.

11. The clinician who takes PHI into the field is responsible to safeguard the information by:
    a. Taking the minimal amount of information necessary to give care safely,
    b. Obscuring any PHI that is not necessary for patient care, securing material with PHI out of sight and in a trunk, if available, and
    c. Keeping material with PHI under the control of the clinician.

accentCare.	*Manual*: **HOME HEALTH / HOME CARE / HOSPICE**	*Policy Number*: *C 4.3*
		Effective Date: *3/12*
	Title: **CONSUMER / COMMUNITY REPRESENTATIVE ACKNOWLEDGEMENT OF HIPAA PRIVACY AND PHI SECURITY**	*Revised*: *01/01/20*
		Page: ***1** of **1***

The Professional Advisory Committee (PAC) includes the Agency's management team (Administrator, Director of Professional Care Services), at least one physician, and appropriate representation from other professional disciplines provided, and at least one member who is neither an owner nor an employee of the Agency, as specified in state regulations. Members should be individuals who are aware of the needs of the community related to the population served.

I_____, am aware of the AccentCare Notice of Privacy Practices and have reviewed the following policies:

- C 2.5.4 Safeguarding Protected Health Information (PHI)
- H 010 AccentCare Notice of Privacy Practices (HIPAA Policy Manual)

I am aware of the importance of PHI and will abide by AccentCare's privacy and security policies and procedures as a requirement of my role in the Quality Improvement meetings /Professional Advisory Committee.

CONSUMER / COMMUNITY REPRESENTATIVE
(Print Name)

_____

SIGNATURE

_____

DATE

_____

POLICY:

AccentCare shall provide training and education to allow personnel to learn new skills and improve/expand knowledge related to hospice care. It may include information regarding the organization's professional standards of care/practice, performance improvement monitoring results, patient care techniques/resources updates, and safety/infection control requirements.

Regulatory Reference: 418.100(g)(1-3), 418.76(d)(1-2), 418.76(j), 418.78(a)
CHAP Standards: HSRM 14.I, HSRM 15.I, HSRM 17.I, HSRM 18.I, HSRM 31.I, HSIC 5.D
TJC Standards: HR.01.04.01 EP 3, 21; HR.01.05.01. EP 3, 5; HR.01.05.03. EP 1, 2 5, 9, 11, 12; HR.01.06.01 EP 1, 5, 6, 17; HR.01.01.01 EP 23, 24

PURPOSE:

To delineate organization policies for in-service education programs designed to increase competence in hospice care.

PROCEDURE:

1. Ongoing training/continuing education is provided for all hospice direct care staff, including volunteers, contract employees, and personnel who will provide the patient's care during a short-term inpatient stay. The training may include, but is not limited to:

   A. Hospice philosophy, goals, and services;

   B. Protection of patient and family/caregiver rights, including confidentiality (HIPAA);

   C. Knowledge of Advance Directives and power of attorney;

   D. Communication and documentation skills;

   E. Interdisciplinary group approach to care with the registered nurse as care coordinator;

   F. Physiological, psychosocial, and spiritual aspects of terminal care;

   G. Protocols to deal with grievances and issues of ethical concern;

   H. Respect for cultural diversity and special communication needs;

   I. Bereavement care;

J. Family dynamics and crisis management;

K. Concepts of palliative versus curative care;

L. Procedures for responding to medical emergencies and patient's death;

M. Processes for communicating with the hospice staff;

N. On-call protocols;

O. Safety policies and procedures;

P. Infection control;

Q. Areas of potential conflict of interest;

R. Quality assessment performance improvement process;

S. "Staff request not to participate in aspects of care when faced with conflicting cultural, ethical or religious beliefs;" and

T. Any state-specific training requirements.

2. The organization shall maintain a written description of the in-service training provided during the previous 12 months. Records shall include a written description of the training and the name of the individual providing the training.

3. An in-service log shall be kept tracking the number of in-service hours the aides (CNAs/HHAs) have obtained on a cumulative basis.

OTHER:

Refer to HR 11 – Introductory / Orientation Period

POLICY:

AccentCare shall provide training and education to allow personnel to learn new skills and improve/expand knowledge related to hospice care. It may include information regarding the organization's professional standards of care/practice, performance improvement monitoring results, patient care techniques/resources updates, and safety/infection control requirements.

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CHAP Standards: HSRM 14.I, HSRM 15.I, HSRM 17.I, HSRM 18.I, HSRM 31.I, HSIC 5.D
TJC Standards: HR.01.04.01 EP 3, 21; HR.01.05.01. EP 3, 5; HR.01.05.03. EP 1, 2 5, 9, 11, 12; HR.01.06.01 EP 1, 5, 6, 17; HR.01.01.01 EP 23, 24

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   D. Communication and documentation skills;

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OTHER:

Refer to HR 11 – Introductory / Orientation Period

State-Specific Requirements

Arizona: R9-10-606. Personnel

A. An Administrator shall ensure that:
   5. Personnel receive in-service education according to criteria established in hospice policies and procedures;
   6. In-service education documentation for a personnel member includes:
      a. The subject matter,
      b. The date of the in-service education, and
      c. The signature of each individual who participated in the in-service education;

B. An administrator shall ensure that record is maintained for each personnel member, employee, volunteer, or student that includes:
   1. The individual's name, date of birth, and contact telephone number;
   2. The individual's starting date of employment or volunteer service and, if applicable, the ending date; and
   3. Documentation of:
      a. The individual's qualifications, including skills and knowledge applicable to the individual's job duties;
      b. The individual's education and experience applicable to the individual's job this document contains duties;
      c. The individual's completed orientation and in-service education as required by policies and procedures.

California: no additional requirements

Colorado: 6 CCR 1011- 6.15 The hospice shall maintain a volunteer program which meets the operational needs of the hospice and demonstrates overall coordination of volunteer services. The program shall include recruitment, orientation, training, supervision, monitoring and evaluation

Connecticut:

19-13-D71. Personnel policies

(a) An agency shall have written personnel policies which include but are not limited to:
   (2) In-service education policy which provides an annual average of at least one (1) hour per month for each employee serving patients. The in-service education shall include current information regarding drugs and treatments; specific service procedures and techniques; recognized professional standards, criteria and

classification of clients served. Agencies that employ homemaker-home health aides shall ensure that homemaker-home health aides attend in-service sessions. The in-service education program shall be provided under the supervision of the supervisor of clinical service or a designated registered nurse who possesses a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of home health care. On and after January 1, 1993 any home health care agency that utilizes a homemaker-home health aide from a placement agency or from a nursing pool shall maintain sufficient documentation to demonstrate these requirements are met.

19-13-D72 Patient care policies

(b) (B) An agency shall develop and implement written policies and procedures for all hospice services provided which include:

(vii) For hospice employees, six hours of the annual in-service education requirements in accordance with Section 19-13- D71(a)(2) of these regulations shall address topics related to hospice care. The agency shall ensure, as part of its coordination of inpatient care agreement with an inpatient setting, that all direct service staff receive in-service education including two hours specific to hospice care. The in-service education shall include current information regarding drugs and treatments, specific service procedures and techniques, pain and symptom management, psychosocial and spiritual aspects of care, interdisciplinary team approach to care, bereavement care, acceptable professional standards, and criteria and classification of clients served;

Delaware: TITLE 16 Section 4468 Delivery of Hospice Services

3.0 Hospice Care

3.2.4 A volunteer will be qualified to participate in the hospice program after completion of a structured orientation and training program.

Florida: 400.6045 Patients with Alzheimer's disease or other related disorders; staff training requirements; certain disclosures.— (1) A hospice licensed under this part must provide the following staff training:

(a) Upon beginning employment with the agency, each employee must receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders.

(b) In addition to the information provided under paragraph (a), employees who are expected to, or whose responsibilities require them to, have direct contact with

participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least 1 hour within the first 3 months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

(c) In addition to the requirements of paragraphs (a) and (b), an employee who will be providing direct care to a participant who has Alzheimer's disease or a dementia-related disorder must complete an additional 3 hours of training within 9 months after beginning employment. This training must include, but is not limited to, the management of problem behaviors, information about promoting the patient's independence in activities of daily living, and instruction in skills for working with families and caregivers.

(d) For certified nursing assistants, the required 4 hours of training shall be part of the total hours of training required annually.

(e) For a health care practitioner as defined in s. 456.001, continuing education hours taken as required by that practitioner's licensing board shall be counted toward the total of 4 hours.

(f) For an employee who is a licensed health care practitioner as defined in s. 456.001, training that is sanctioned by that practitioner's licensing board shall be considered to be approved by the Department of Elderly Affairs.

(g) The Department of Elderly Affairs or its designee must approve the required 1-hour and 3-hour training provided to employees or direct caregivers under this section. The department must consider for approval training offered in a variety of formats. The department shall keep a list of current providers who are approved to provide the 1-hour and 3-hour training. The department shall adopt rules to establish standards for the employees who are subject to this training, for the trainers, and for the training required in this section.

(h) Upon completing any training described in this section, the employee or direct caregiver shall be issued a certificate that includes the name of the training provider, the topic covered, and the date and signature of the training provider. The certificate is evidence of completion of training in the identified topic, and the employee or direct caregiver is not required to repeat training in that topic if the employee or direct caregiver changes employment to a different hospice or to a home health agency, assisted living facility, nursing home, or adult day care center.

Georgia:

111-8-37-.08

(3) The hospice administrator must ensure that the hospice:

(e) Provides an orientation, training, and supervision program for every employee and volunteer that addresses hospice care and palliative care for persons with advanced and progressive diseases, when offered, and the performance of the specific job to which the employee or volunteer is assigned;

111-8-37-.13 Human Resources

(1) All persons providing services for a hospice must be qualified by education, training, and experience to carry out all duties and responsibilities assigned to them

(4) The hospice must have an effective annual training and education program for all staff and volunteers who provide hands on care to patients that addresses at a minimum:
(a) Emerging trends in infection control;
(b) Recognizing abuse and neglect and reporting requirements;
(c) Patient rights; and
(d) Palliative care.

Illinois: 210 ILCS 60/8 Sec. 8. General Requirements for hospice programs.

(o) The hospice program shall provide an ongoing program for the training and education of its employees appropriate to their responsibilities.

Indiana: no additional requirements

Massachusetts:

105 CMR 141.201

(E) Administrative Records.

(1) Each hospice shall maintain current, complete and accurate administrative records.

(d) personnel records for each employee, including evidence of any required license or registration number, documentation of any specialty certification, documentation of initial training and ongoing annual training on dementia care consistent with the requirements of 105 CMR 150.024 and 150.025 for employees providing direct care to nursing home residents, education and job experience. A hospice agency is not required to train an employee, consistent with the requirements of 105 CMR 150.024: Staff Qualifications and Training and 105 CMR 150.025: Content of Training, if the employee has completed the required training at a different location, provided the initial training and any ongoing training is documented in the personnel record.

141.204 Required Patient Care Services

(F) Direct Service Volunteer Services.

(2) The hospice shall designate a coordinator of volunteer services who shall develop and implement a direct service volunteer program, coordinate the orientation, education, support and supervision of direct service volunteers, define the roles and responsibilities of direct service volunteers, and coordinate the utilization of direct service volunteers with other hospice staff.
(3) The coordinator of volunteer services shall document successful completion of a training and orientation program for all direct service volunteers.
(4) The orientation and training program for direct service volunteers shall address at least the following:
(a) the hospice program's goals and services;
(b) confidentiality and protection of patients/families rights;
(c) procedures for responding to such situations as medical emergencies or deaths;
(d) the physiological and psychological aspects of terminal disease;
(e) family dynamics, coping mechanisms, and psychosocial and spiritual issues surrounding terminal disease, death, and bereavement;
(f) general communication skills.

Maryland: Sec. 10.07.21.08. E. Personnel Records.
For all employees, volunteers, and contractual staff, the administrator shall ensure that there is:
(1) An accurate, complete, and current personnel record that includes:
(d) Documentation of all required training;
G. Orientation and Training.
(1) The hospice care program shall ensure that all licensed staff receive orientation and training, which includes at a minimum:
(a) The purpose and philosophy of hospice care;
(b) The skills necessary to provide for the physical care of the patient;
(c) The skills necessary to provide for the psychosocial and spiritual needs of the patient and family; and
(d) The need and importance of maintaining professional boundaries with the patient and the patient's family.
(2)(a) Any volunteer who provides direct patient care receives appropriate orientation and at least 16 hours of training which includes, at a minimum:
(i) The purpose and philosophy of hospice care;
(ii) The role of the volunteer in hospice;
(iii) Concepts of death and dying;
(iv) Communication skills;

(v) Care and comfort measures;
(vi) The physical, psychosocial, and spiritual issues related to death and dying;
(vii)The concept of the hospice family;
(viii)Patient rights;
(ix) Confidentiality;
(x) Bereavement;
(xi) Infection control;
(xii)Safety; and
(xiii) Stress management

(3) Training shall be specifically tailored to ensure that staff is capable of providing care to meet the individual needs of patients

Michigan: no additional requirements

Minnesota: 44664.0140 Orientation to Hospice Requirements.

Subpart 1. Orientation training. Every individual applicant for a license and every person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation training to hospice requirements before providing hospice services to hospice patients. The orientation need only be completed once. The orientation training must include the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.75 to 144A.755;
B. handling of emergencies and use of emergency services;
C. reporting the maltreatment of vulnerable minors and adults under Minnesota Statutes, sections 626.556 and 626.557;
D. the hospice bill of rights;
E. handling of patients' complaints and reporting of complaints to the Office of Health Facility Complaints;
F. services of the Office of the Ombudsman for Older Minnesotans; and
G. hospice philosophy and the physical, spiritual, and psychosocial aspects of hospice care.

Subp. 2. Sources of orientation training. The orientation training required by this part may be provided by the licensee or may be obtained from other sources. The commissioner shall provide a curriculum and materials that may be used to present the orientation training.

Subp. 3. Verification and documentation. Each licensee shall retain evidence that the required orientation training has been completed by each person specified in subpart 1

664.0150 Employee Performance Review and In-Service Training

Subp. 2. In-service training. In-service training must address care of the terminally ill and special needs of the hospice patient and the hospice patient's family, as determined by the hospice staff and the interdisciplinary team.

Subp. 9. Training and competency

A. For each person who performs home health aide services, a licensee must comply with this subpart.
B. For every 12 months of employment or contracted services, a person who performs home health aide services must complete at least 12 hours of in-service training in topics relevant to the provision of hospice services.
C. A hospice provider must retain documentation that it has complied with this part and must provide documentation to persons who have completed the in-service training.

4664.0180 Volunteer Services

Subp. 5. Training. A hospice provider must ensure that each volunteer completes a volunteer training course before performing any volunteer services. The volunteer training course may be combined with other training, must be consistent with the specific tasks that volunteers perform, and must include the following topics:

A. the orientation required by part 4664.0140;

4664.0300 Personnel Records

Subpart 1. Personnel records.

B. records of training required by this chapter.

Mississippi: TITLE 15 Part III Subpart 01 Part V 111 Personnel Policies

111.01 Personnel Policies - Each licensed hospice agency shall adopt and enforce personnel policies applicable and available to all full and part-time employees. These policies shall include but not be limited to the following:

3. Orientation to the hospice and appropriate continuing education.

Missouri: 19 CSR 30-35

(J) Volunteers

4. The hospice shall provide task-appropriate orientation and training consistent with acceptable standards of hospice practice, that includes at a minimum:
   A. Hospice philosophy, goals, and services;
   B. The volunteer role in hospice;
   C. Confidentiality;
   D. Instruction in the volunteer's particular duties and responsibilities;

E. Whom to contact if in need of assistance or instruction regarding the performance of their specific duties and responsibilities; and
F. Documentation and record-keeping as related to the volunteer's duties.

6. The hospice shall document orientation and ongoing in-services.

(M) Employee Training and Orientation.

(a) At a minimum, the training required shall address the following areas:
I. An overview of Alzheimer's disease and related dementias;
II. Communicating with persons with dementia;
III. Behavior management;
IV. Promoting independence in activities of daily living; and
V. Understanding and dealing with family issues.

(b) Employees or independent contractors who do not provide direct care for, but may have daily contact with, persons with Alzheimer's disease or related dementias shall receive dementia-specific training that includes at a minimum:
I. An overview of Alzheimer's disease and related dementias; and
II. Communicating with persons with dementia.

(c) Dementia-specific training about Alzheimer's disease and related dementias shall be incorporated into orientation for new employees with direct patient contact and independent contractors with direct patient contact. The training shall be provided annually and updated as needed.

C. Ongoing in-service training shall include a broad range of topics that reflect identified educational needs.
D. The hospice shall document initial orientation and in-service topics presented.

2. Volunteers are exempt from these provisions, except for dementia-specific training as specified at 19 CSR 30-35.010 (2)(M)1.B.(XLII), as their orientation and inservice requirements are defined in 19 CSR 30-35.010(2)(J)4., 5., and 6.
3. Contract employees shall receive orientation to dementia-specific training as specified at 19 CSR 30-35.010(2)(M)1.B.(XIII), confidentiality, hospice philosophy, and to their specific job duties.

New Jersey: Section 8:42C-3.6 – Staffing

(b) The hospice shall develop and implement a staff orientation and a staff education plan, including plans for each service and designation of the person(s) responsible for training.

Nevada:

NRS 449.0151

"Medical facility" includes:

4. An agency to provide nursing in the home;
5. A facility for intermediate care;
6. A facility for skilled nursing;
7. A facility for hospice care.

NRS 449.103 Regulations requiring training related specifically to cultural competency for any agent or employee of a facility.

1. To enable an agent or employee of a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed who provides care to a patient or resident of the facility to more effectively treat patients or care for residents, as applicable, the Board shall, by regulations, require such a facility to conduct training specifically to cultural competency for any agent or employee of the facility who provides care to a patient or resident of the facility so that such an agent or employee may better understand patients or residents who have different cultural backgrounds, including, without limitation, patients or residents who are:
   (a) From various gender, racial and ethnic backgrounds;
   (b) From various religious backgrounds;
   (c) Persons with various sexual orientations and gender identities or expressions;
   (d) Children and senior citizens;
   (e) Persons with a mental or physical disability; and
   (f) Part of any other population that such an agent or employee may need to better understand, as determined by the Board.
2. The training relating specifically to cultural competency conducted by a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed pursuant to subsection 1 must be provided through a course or program that is approved by the Department of Health and Human Services.

NRS 449.104 Regulations to ensure patients or residents are identified in accordance with their gender identity or expression. The Board shall adopt regulations that require a medical facility, facility for the dependent or facility which is otherwise required by regulations adopted by the Board pursuant to NRS 449.0303 to be licensed :

1. Develop policies to ensure that a patient or resident is addressed by his or her preferred name and pronoun and in accordance with his or her gender identity or expression;
2. Adapt electronic records to reflect the gender identities or expressions of patients or residents with diverse gender identities or expressions, including without limitation:

(a) If the facility is a medical facility, adapting health records to meet the medical needs of patients or residents with diverse sexual orientations and gender identities or expressions, including without limitation, integrating information concerning sexual orientation and gender identity or expression into electronic systems for maintaining health records; and

(b) If the facility is a facility for the dependent or other residential facility, adapting electronic records to include:

(1) The preferred name and pronoun and gender identity or expression of a resident; and

(2) Any other information prescribed by regulation of the Board.

Oregon: Rule 333-035-0050 Definitions As used in OAR chapter 333, division 35, the following definitions apply: (12)"Nurse's Aide" means a person certified as a nursing assistant under ORS 678.442 (Certification of nursing assistants) who has received special hospice training in accordance with CMS Conditions of Participation.

Pennsylvania: no additional requirements

Tennessee: Rule 1200-08-27-.06

(5) Volunteers.

(a) Training. The hospice program must provide appropriate orientation and training that is
consistent with acceptable standards of hospice practice

(7) Short Term Inpatient Care. Short term inpatient care is available for pain control, symptom management and respite services, and if not provided directly, must be provided under a legally binding written agreement that meets the requirements of subparagraph (b) of this paragraph in a licensed nursing home, hospital, or residential hospice which meets the following minimum requirements:

(g) The hospice shall retain responsibility for appropriate hospice care training of the personnel who provide the care under the agreement.

(11) Home Health Aide/Hospice Aide Services. Home Health Aide Services must be available and adequate in frequency to meet the needs of the patients.

(c) There shall be continuing in-service programs on a regularly scheduled basis with on the-job training during supervisor visits as issues are identified.

Texas:

RULE §558.843 Hospice Aide Qualifications

(1) A training program and competency evaluation program that complies with the requirements in subsections (c) and (d) of this section;

(3) An agency must maintain documentation that demonstrates that its hospice aide training program meets the requirements in this subsection. Documentation must include a description of how additional skills, beyond the basic skills listed in paragraph (1) of this subsection, are taught and tested if the agency requires a hospice aide to perform more complex tasks.

RULE §558.844 Hospice Homemaker Services

(b) The training for a hospice homemaker must include:

(1) assisting in maintaining a safe and healthy environment for a client and the client's family; and (2) providing homemaker services to help the client and the client's family to carry out the treatment plan.

RULE §558.851 Hospice Services Provided by a Licensed Person

(b) A licensed person providing hospice services directly or under contract must:

(2) participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.

RULE §558.857 Hospice Staff Training

In addition to the requirements in §558.245 of this chapter (relating to Staffing Policies), a hospice must:

(5) maintain a written description of the in-service training provided during the previous 12 months.

RULE §558.863 Hospice Short-term Inpatient Care

(7) the hospice retains responsibility for ensuring that the training of personnel who will be providing the client's care in the facility has been provided and that a description of the training and the names of those giving the training are documented.

Washington:

WAC 246-335-615 Plan of operation.

(13) Assuring direct care personnel, contractors and volunteers have training specific to the needs of the terminally ill patients and their families;

WAC 246-335-645 Supervision of hospice services.

(3) The licensee shall ensure the director of clinical services and the designated alternate completes a minimum of ten (10) hours of training annually. Written documentation of trainings must be available upon request by the department. Training may include a combination of topics related to clinical supervision duties and the delivery of hospice services. Examples of appropriate training include, but are not limited to:

(a) Agency sponsored in-services;
(b) Community venues;
(c) Community classes;
(d) Conferences;
(e) Seminars;
(f) Continuing education related to the director's health care professional credential, if applicable

Washington, DC: § 44-505(a) (3) Standards for the construction and operation of each type of facility and agency, including standards governing: employee and volunteer training.

Wisconsin:

DHS 131.25 Core services. (a) Bereavement services. a. Orientation and training to individuals providing bereavement services to ensure that there is continuity of care.

DHS 131.27 Volunteers. Prior to beginning patient care, a volunteer shall have the training for the duties to which he or she is assigned.

DHS 131.31 Employees.
(4) Duties. Hospice employees or contracted staff may be assigned only those duties for which they are capable, as evidenced by documented training or possession of a license or certificate.
(5) Continuous Training. A program of continuing training directed at maintenance of appropriate skill
levels shall be provided for all hospice employees providing services to patients and their families.
b) Personnel records shall include evidence of qualifications, licensure, performance evaluations and continuing training, and shall be kept up-to-date.

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E. Personnel Records. For all employees, volunteers, and contractual staff, the administrator shall ensure that there is: (d) Documentation of all required training.

F. Outside Agreements. If a hospice care program utilizes the services of an outside entity to provide certain hospice services, the hospice care program shall enter into a written agreement with that entity which includes at a minimum: (4) A plan to ensure that any

individual providing services under this section shall have at least comparable training to that required by this regulation.

G. Orientation and Training.

(1) The hospice care program shall ensure that all licensed staff receive orientation and training, which includes at a minimum:

(a) The purpose and philosophy of hospice care;

(b) The skills necessary to provide for the physical care of the patient;

(c) The skills necessary to provide for the psychosocial and spiritual needs of the patient and family; and

(d) The need and importance of maintaining professional boundaries with the patient and the patient's family.

(a) Any volunteer who provides direct patient care receives appropriate orientation and at least 16 hours of training which includes, at a minimum:

(i) The purpose and philosophy of hospice care;

(ii) The role of the volunteer in hospice;

(iii) Concepts of death and dying;

(iv) Communication skills;

(v) Care and comfort measures;

(vi) The physical, psychosocial, and spiritual issues related to death and dying;

(vii) The concept of the hospice family

(viii) Patient rights;

(ix) Confidentiality;

(x) Bereavement;

(xi) Infection control;

(xii) Safety; and

(xiii) Stress management; and

(b) A volunteer, other than those specified in §G(2)(a) of this regulation, receives appropriate orientation regarding the volunteer's role in the hospice care program.

(3) Training shall be specifically tailored to ensure that staff is capable of providing care to meet the individual needs of patients.

(4) The hospice care program shall provide continuing in-service education for all employees and volunteers providing direct patient services at least:

(a) Once a year for volunteers; and

(b) Four times a year for employees.

POLICY:

It is the policy of the agency to develop, implement and maintain an effective, ongoing data driven Quality Assurance Quality Improvement Program (QAPI) in order to improve agency performance that includes an agency evaluation to provide the basis for future planning.

Regulatory References: HH §484.65 (a-e), 484.75(b), § 418.58, 418.62(c)
CHAP Standards: Home Health- CQI.1.I.M1, M2; CQI.2.D; CQI.2.D.M1, M2, M3; CQI.3.I.M1, M2, M3, M4; CQI.5.I; CQI.5.I.M2; CQI.6.S; Hospice – HQPI 1.D; HQPI 2.I; HQPI 3.I; HQPI 4.I; HQPI 5.I; HQPI 6.I; HQPI 7.I; HQPI 8.I; HQPI 9.I
TJC Standards: P.01.01.01 EP 1, EP2, EP 12, EP 13, EP 23, EP 24; PI.02.01.01 EP 4, EP 8; PI.03.01.01 EP 1, EP 2, EP 9

PURPOSE:

The purpose of QAPI is to use measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, quality of care, the agency's management, and business functions while adhering to state and federal regulatory requirements. The QAPI program covers all services and programs offered, including those provided under contract or arrangement.

DEFINITION:

Consumer - A consumer may be any individual in the community outside the Agency, regardless of whether he or she has been the recipient of or is eligible to receive home health or hospice services.

OVERVIEW:

The Governing Body ensures that the QAPI program reflects the complexity of the agency and its services. The program involves all the agency services including those services provided under contract, focuses on measurable indicators related to improved outcomes, includes the use of emergent care services, hospital admissions, and re-admissions, and takes actions that address the agency's performance across the spectrum of care, including the prevention and reduction of medical errors. The agency documents the performance of a QAPI indicator on standard templates.

PROCEDURE:

1. The goals of the QAPI Program are accomplished in various ways, including, but not limited to measuring, analyzing, and tracking quality indicators, including adverse patient events,

and other aspects of performance that enable the agency to assess processes of care, services, and operations.

2. Components of the program include:
   a. Quarterly reviews of a stratified sample of patient clinical records,
   b. Annual review of overall agency functioning,
   c. Group of professional personnel called the Professional Advisory Committee (PAC),
   d. Agency QAPI Committee, and
   e. Written QAPI Program including the quality improvement plan and guidelines manual to outline how the design, measurement, assessment, and improvement activities will be accomplished and ensure compliance with state and federal regulations.

3. Reports of the activities including the results of the agency evaluations and QAPI programs are provided to the governing body at least annually.
4. "Contracted clinical staff must participate in AccentCare's QAPI Program or Performance Improvement Activities. Participation in QAPI may include participation in data collection, record reviews, QAPI Committee Meeting attendance, Performance Improvement Projects (PIP), providing recommendations for agency improvement to QAPI Committee or PIP workgroup, taking actions to improve performance, reporting adverse events, analyzing their causes, and implementing preventative actions, and to remain knowledgeable of agency performance improvement projects and take actions to improve performance.
5. Agency clinical/licensed staff must participate in AccentCare's QAPI Program or Performance Improvement Activities in accordance with their job descriptions.
6. The program utilizes quality indicator data, including measures derived from the OASIS/HIS assessments, where applicable.
7. Reports of the activities including the results of the agency evaluations and QAPI programs are provided to the governing body at least annually.
8. QAPI improvement activities focus on:
   a. High risk, high volume, or problem-prone areas,
   b. Incidence, prevalence, and severity of problems areas,
   c. Developing an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients,
   d. Use of emergent care services,
   e. Hospital admissions and readmissions,
   f. Performance across the spectrum of care, including the prevention and reduction of medical errors,

g. Indicators related to improved palliative outcomes including the needs of the population served,
h. Include surveillance, identification, prevention, and control of infectious and communicable disease, and
i. Collects data on significant medication errors and adverse drug reactions.

9. Hospice measures, analyzes, and tracks quality indicators of performance that enable the assessment of:
   a. Process of care,
   b. Hospice services,
   c. Operations,
   d. Adverse events.

10. Performance improvement activities track, analyze, and implement preventive/improvement activities for adverse patient events. Adverse patient events are analyzed to determine their causes, and preventative actions are implemented. QAPI activities lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients.
11. Improvement and corrective actions that are implemented measure the success of improvement success and track performance to ensure that improvements are sustained.
12. Reports of the activities including the results of the agency evaluations and QAPI programs are provided to the governing body at least annually. One or more individual(s) is appointed by the governance as responsible for operating the QAPI program. The frequency and detail of the data collection are approved by the governance.
13. The agency administrator/ED reports any Fraud, Waste, or Abuse to the Compliance Department.
14. The agency shall follow the procedures and guidelines for clinical record review, Professional Advisory Committee, and Annual Agency Evaluation as written in the QAPI program in order to meet the requirements of this policy.
15. The annual evaluation shall be performed by the agency's Professional Advisory Committee (or a subcommittee of this group), agency staff, and consumers in accordance with the agency's written QAPI program. The aspects of the annual evaluation do not have to be done at the same time or by the same evaluators. Patient care services are evaluated by providers and consumers.

16. The annual evaluation report:
    a. Validates the inclusion of a service/product (scope of services)
    b. Reviews the following components: risk management, human resources, financial and operational policies
    c. Analyzes and explains variances from the usual patterns of performance
    d. Assesses the extent to which the agency's programs are appropriate, adequate, effective, and efficient
    e. Is presented to advisory and governing bodies as appropriate
    f. Is retained as an administrative record

Equal Employment Opportunity

Functional Owner:	HR	Last Revision Date:		
Policy Number:	HR-4	Effective Date:	01.01.2022	Approved By:

Company Overview

AccentCare, Inc. (the "Company") is a healthcare organization. This policy applies to all employees of the Company, its subsidiaries, and affiliates (referred to as "AccentCare" throughout) unless otherwise noted.

Purpose

To promote a positive and productive work environment for our employees and to ensure compliance with all federal, state and local laws that regulate equality in employment.

Scope

All employees of the Company, contractors and vendors with whom we partner to support employment and/or decisions related to selection.

General

The Company is committed to providing equal employment opportunities (EEO) to all employees and applicants for employment without regard to age, color, disability, ethnicity, family or marital status, gender identity or expression, national origin, ancestry, physical and mental ability, political affiliation, race, religion, sexual orientation, socio-economic status, veteran status, and other characteristics that make them unique or any other basis protected by federal, state, or local law. The Company expressly prohibits any form of workplace discrimination or harassment on the basis of any of the aforementioned or any other basis protected by federal, state, or local law.

The Company complies with applicable laws governing non-discrimination in employment in every location in which the Company has facilities. This policy applies to all terms and conditions of employment, including, but not limited to, hiring, placement, promotion, transfer, layoff, termination, recall, leaves of absence, compensation, and training.

Procedures

The Company leadership (e.g., supervisor, manager, director, etc.) will follow the policy in all employment actions, ensuring decisions remove any form of bias based on any of the items listed under "General" or that violate the law. The Company has zero tolerance for any violation of this policy. Should circumstances require an investigation or uncover the need for corrections and/or

other remedial action, Human Resources will coordinate with the appropriate leadership to make the necessary corrections or remedies up to and including terminating the employment of individuals in breach of the EEO and/or other referenced policies.

Reference(s):

- Anti-harassment, Discrimination, & Retaliation
- Diversity, Equity, Inclusion, & Belonging
- Standards of Conduct & Workplace Behaviors

Change Control Log:

Revision Date	Type of Revision	Version Number	Approved/Issued By

Introductory / Orientation Period

Functional Owner:	HR	Last Revision Date:		
Policy Number:	HR-11	Effective Date:	01.01.2022	Approved By:

Company Overview

Accent Care, Inc. (the "Company") is a healthcare organization. These policies apply to employees of the Company, its subsidiaries, and affiliates as outlined under Scope.

Purpose

Outline the company's introductory/orientation period for newly hired employees or an employee moving into a new role for the first time. Clarify expectations with regard to onboarding, performance, and support.

Scope

This policy applies to all employees.

Definition(s) / Key Terms

Term	Definition
Introductory Period	Initial period spanning from the first day of employment in a new position/role to the ninetieth (90) day in the role.
On-boarding	The process through which new employees acquire the necessary knowledge, skills, and behaviors to become effective organizational members.
Orientation	The process of introducing new hires to their jobs, employees, and the organization.
New Hire	Individuals who accept an offer of employment with the Company, begin employment and are classified as an employee for the first time within the Company.

General

The introductory period enables new employees to assimilate into their new position and responsibilities, while also providing management an adequate opportunity to evaluate the employee's ability to meet communicated performance standards. The first ninety (90) days of continuous employment with Company, the Introductory Period, is a learning experience.

Employees go through a defined onboarding process specific to their role. They learn to perform their job duties and responsibilities, get acquainted with their employees and management, and familiarize themselves with the Company in general including policies, procedures, and operating protocols. This initial period of employment is the "Introductory Period".

As part of the onboarding experience, employees receive an Orientation and review of the Company's standards, policies, values and practices, and completion of all new hire documents as required by federal, state, and/or local regulations. An orientation program is provided to thoroughly prepare a new employee in the performance of their duties and responsibilities; it helps provide a positive work experience that supports their success.

Introductory / Orientation Period Provisions

1. The Company will review the employee's job performance, reliability, execution and approach toward their assigned responsibilities and evaluate continuation of their employment. Once an Introductory Period is completed, the employee's manager may complete a written review of the employee's performance up to that point. The Company will continue to review overall job performance throughout the employee's tenure.

2. The existence of an introductory period does not in any way alter the Company's at-will employment policy. At-will employment allows the Company and the employee to terminate the employment relationship at any time with or without notice, and with or without cause, regardless of the completion of the introductory period.

3. If an employee is absent from work more than three (3) days during the Introductory Period, the Company may choose to extend the Introductory Period as necessary to give the employee an opportunity to demonstrate their ability to effectively do the job. The Company reserves the right to extend the Introductory Period in other cases as well, where warranted based on overall performance and the circumstances.

Orientation Procedure

1. The new hire orientation content for all personnel will include the following as applicable and appropriate to the care and service provided:
   a. General Company information including the organization's vision, mission and passions.
   b. Care and services provided by the company/agency/center.
   c. Review of the specific organization chart, including the lines of authority and responsibility.
   d. Working hours, attendance guidelines, and reporting expectations.

e. Job related responsibilities and skills as outlined in the job description.
f. Compliance training including code of conduct, confidentiality of organizational and patient Information /HIPAA regulations, documentation standards and the Company reporting process.
g. Infection prevention and control within the organization and the homecare setting (applicable roles only).
h. Performance standards.
i. OSHA training and compliance.
j. Medical Device reporting, if agency CHAP certified
k. The Company adherence to the Equal Employment Opportunity (EEO) and Americans with Disabilities Act (ADA) Requirements.
l. Grievance Procedure.
m. Ethical issue identification and resolution.
n. Sexual Harassment Protection.
o. Compensation and benefits information.
p. Unemployment and workers' compensation.
q. Collective bargaining information, as applicable.
r. Family/State Medical Leave Act.

2. The hiring manager or designee will ensure orientation to and accurate completion of all new hire documents during the orientation period and completion of all required compliance training.
3. All employee files will be maintained in electronic format in the HR system or kept in a secured area designated by the manager/administrator.
4. Each line of business/type of care will provide a new hire orientation program specific to its care or service requirements.
   a. During orientation, the supervisor will be responsible for evaluating the knowledge and skills of the personnel being oriented. Any areas of concern will be brought to the immediate attention of the new personnel. Appropriate guidance or training will be provided as needed.
   b. The introductory period will be 90 days, during which time the orientation process may be extended.

OVERVIEW OF ORIENTATION FOR CLINICAL PERSONNEL

1. The orientation process for all clinical personnel will consist of didactic and practical components. Observation in a lab or patient setting will be performed by the supervisor or assigned preceptors to assess the skills demonstrated by new or reassigned personnel as well as reinforce information presented during didactic sessions.
2. The supervisor or assigned personnel will orient newly assigned employees or volunteers to their responsibilities, patient needs, and care specifics when patient assignments change. Orientation may be provided in the patient's home and consist of record review and instructions either written or verbal.
3. Orientation of current employees assigned to new job classifications will include, as applicable:
   a. Lines of authority and responsibility,
   b. Working hours,
   c. Job responsibilities and skills as outlined in the job description,
   d. Documentation responsibilities.
4. The orientation process for contract personnel will consist of the following:
   a. For a contracting organization or vendor, the contractor will assign one member of the organization to be oriented to the agency's policies, procedures, compliance requirements, documentation requirements and other agency information presented during orientation. The contractor's appointee will be responsible for orienting other contract personnel from that organization provided to the agency.
   b. For independent contractors a preceptor or other clinician will be assigned to complete the orientation process.

Reference(s):

- Attendance
- Standards of Conduct

Change Control Log:

Revision Date	Revision Description(s)	Version Number	Approved / Issued By

Tuition Reimbursement

Functional Owner:	HR	Last Revision Date:		
Policy Number:	HR-46	Effective Date:	01.01.2022	Approved By:

Company Overview

Accent Care, Inc. (the "Company") is a healthcare organization. These policies apply to employees of the Company, its subsidiaries, and affiliates.

Purpose

Provide employees with tuition benefits toward their education and career advancement.

Scope

This policy applies to all employees of the Company who meet eligibility requirements.

General

It is the policy of AccentCare to encourage all employees to improve their effectiveness in their job performance and to prepare themselves for future career opportunities with the Company. AccentCare has established program for eligible regular full-time and part-time employees to receive reimbursement toward tuition at accredited educational institutions or programs according to the conditions established in this policy

Eligibility

The following eligibility criteria apply to employees who wish to participate in the program:

- Regular Full-time employees must have a minimum of one (1) year continuous employment and be in good standing to be eligible and apply for reimbursement.
- Regular part-time employees must have completed at least 1040 hours of employment in the past year and be in good standing to be eligible and apply for reimbursement.
- Employees must be actively employed with AccentCare for the duration of the course for which reimbursement is requested and at the time reimbursement if requested.
- Regular Full Time Employees are defined as regularly scheduled over 32 hours per week and Regular Part Time Employees are defined as regularly scheduled 21-31 hours per week

Application Procedure

Prior to enrolling in course(s)

1. Review eligibility and program guidelines of Tuition policy
2. Complete Tuition Application
3. Obtain approval of your manager and department VP
4. Email completed application with all required approvals and course information to Tuition@accentcare.com
5. Watch for an email from Tuition@accentcare.com confirming approval or denial of your application
6. If approved enroll in your course(s).

Program Guidelines

- For pre-approved courses in an accredited educational institution or program, eligible employees may receive tuition reimbursement of 100% up to $2,500 for full-time employees and 100% up to $1,000 for part-time employees per fiscal year.
- Employees must secure a passing grade of a minimum of "C" or obtain a certification to receive reimbursement.
- Employees are required to take advantage of any discounts or other subsidies that may be available to them which would cover expenses qualifying for tuition reimbursement. AccentCare will provide tuition reimbursement only to the extent that expenses are not covered by discounts, subsidies, grants, scholarships, or other services.
- Courses must be approved by your manager prior to enrolling and Courses must be scheduled outside of normal business hours
- All employees receiving reimbursement under this program are obligated to remain employed by AccentCare for a period of twelve (12) months from the date of reimbursement.
- Employees leaving AccentCare prior to the 12-month period (as stated above), will be required to repay AccentCare any amount received through this program. The amount owed will be deducted from any money due to the employee, including their wages (in compliance with all applicable laws and regulations).

Criteria for Eligible Courses

COLLEGE COURSES CRITERIA (All 3 criteria required)

1. Course (s) must be through an accredited school
2. Courses should be related to employees' current position with AccentCare or prepare the employee for a higher position or a change in career field with AccentCare.
3. Pre-requisite courses outside the major course of study (e.g., completion of an undergraduate statistics course in order to be allowed to register for the graduate course). Requests for approval of these courses must be submitted with written justification from the educational institute.

CERTIFICATE PROGRAM CRITERIA (Criteria # 1 or #2 required and # 3 required)

1. Health care related courses in accredited technical or trade schools leading to certification in a field that will prepare the employee for a higher position or career field within AccentCare.
2. Courses and exams for professional certifications from an organization that will enhance skills in current classification or prepare the employee for a higher position or change in career field with AccentCare. (examples: CPA, SHRM, PMP)
3. All certificate courses must be taken at accredited institutions that issue a pass/fail grade or rating of completed and college credit is received.

REIMBURSEMENT PROCEDURE FOR ELIGIBLE COURSE(S)

1. Using the Workday Expense Process submit the following with your request: A copy of approved Tuition Application
2. A copy of final grades from the educational institution
3. A copy of tuition cost (must show actual tuition cost only for course work) A copy of certification and confirmation of passing exam (as applicable) Information on any grants received for tuition.
4. The expense request with documents shown above must be submitted no later than 60 days from completion of course work to be considered
5. Non-Reimbursable Costs through this Policy:

- Textbooks
- Service fees
- Admission fees
- Activity fees
- Out-of-State Resident fees/courses
- Membership fees
- Recertification fees Licensure fees
- Registration fees
- Course audits

- Seminars/workshops CEU courses

Change Control Log:

Revision Date	Type of Revision	Version Number	Approved/Issued By

END · OF · LIFE

Helping With Comfort and Care

NATIONAL INSTITUTE ON AGING ■ ✦ ✶ ✸ NATIONAL INSTITUTES OF HEALTH
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
783

National Institute on Aging
Office of Communications and Public Liaison
Bethesda, MD 20892-2292
www.nia.nih.gov

End of Life

Helping With Comfort and Care

Empty-handed I entered the world,
Barefoot I leave it.
My coming, my going
Two simple happenings
That got entangled.

— Kozan Ichikyo (d. 1360)

Introduction

At the end of life, each story is different. Death comes suddenly, or a person lingers, gradually failing. For some older people, the body weakens while the mind stays alert. Others remain physically strong, and cognitive losses take a huge toll. But for everyone, death is inevitable, and each loss is personally felt by those close to the one who has died.

End-of-life care is the term used to describe the support and medical care given during the time surrounding death. Such care does not happen just in the moments before breathing finally stops and a heart ceases to beat. An older person is often living, and dying, with one or more chronic illnesses and needs a lot of care for days, weeks, and sometimes even months.

End of Life: Helping With Comfort and Care hopes to make the unfamiliar territory of death slightly more comfortable for everyone involved. This publication is based on research, such as that supported by the National Institute on Aging, part of the National Institutes of Health. This research base is augmented with suggestions from practitioners with expertise in

helping individuals and families through this difficult time. Throughout the booklet, the terms comfort care, supportive care, and palliative care are used to describe individualized care that can provide a dying person the best quality of life until the end. Most of the stories in this booklet are fictitious, but they depict situations that reflect common experiences at the end of life.

When a doctor says something like, "I'm afraid the news is not good. There are no other treatments for us to try. I'm sorry," it may close the door to the possibility of a cure, but it does not end the need for medical support. Nor does it end the involvement of family and friends. There are many places and a variety of ways to provide care for an older person who is dying. Such care often involves a team. If you are reading this, then you might be part of such a team.

Helping With Comfort and Care provides an overview of issues commonly facing people caring for someone nearing the end of life. It can help you to work with health care providers to complement their medical and caregiving efforts. The booklet does not replace the personal and specific advice of the doctor, but it can help you make sense of what is happening and give you a framework for making care decisions.

Providing Comfort

at the End • of • Life

Comfort care is an essential part of medical care at the end of life. It is care that helps or soothes a person who is dying. The goal is to prevent or relieve suffering as much as possible while respecting the dying person's wishes.

You are probably reading this because someone close to you is dying. Is it a parent or grandparent, your husband or wife, a favorite aunt or uncle, your best friend? You wonder what will happen. You want to know how to give comfort, what to say, what to do. At the same time, you're possibly unsure about what is needed, worried about doing the wrong thing, or afraid of being there—or not being there—at the moment of death.

You might be giving day-to-day care to the dying person, chosen to make health care decisions, or a close family member or friend who wants to help. You would like to know how to make dying easier—how to help ensure a "good death," with treatment consistent with the dying person's wishes.

A "good death" might mean something different to you than to someone else. Your sister might want to know when death is near so she can have a few last words with the people she loves and take care of personal matters. Your husband might want to die quickly and not linger. Perhaps your mother has said she would like to be at home when she dies, while your father wants to be in a hospital where he can receive treatment for his illness until the very end. Some people want to be surrounded by family and friends; others want to be alone. Of course, often one doesn't get to choose, but having your end-of-life wishes followed, whatever they are, and being treated with respect while dying are common hopes.

Generally speaking, people who are dying need care in four areas—physical comfort, mental and emotional needs, spiritual issues, and practical tasks. In this chapter you will find a number of ways you can be of help to someone who is dying. Always remember to check with the health care team to make sure these suggestions are appropriate.

Comfort needs near the end of life:

- Physical Comfort
- Mental and Emotional Needs
- Spiritual Issues
- Practical Tasks

Physical Comfort

There are ways to make a person who is dying more comfortable. Discomfort can come from a variety of problems. For each there are things you or a health care provider can do, depending on the cause. For example, a dying person can be uncomfortable because of:

- Pain
- Breathing problems
- Skin irritation
- Digestive problems
- Temperature sensitivity
- Fatigue

Pain. Watching someone you love die is hard enough, but thinking that person is also in pain makes it worse. Not everyone who is dying experiences pain, but there are things you can do to help someone who does. Experts believe that care for someone who is dying should focus on relieving pain without worrying about possible long-term problems of drug dependence or abuse. Don't be afraid of giving as much pain medicine as is prescribed by the doctor. Pain is easier to prevent than to relieve, and overwhelming pain is hard to manage. Try to make sure that the level of pain does not "get ahead" of pain-relieving medicines. If the pain is not controlled, ask the doctor or nurse to arrange for consultation with a pain management specialist.

Struggling with severe pain can be draining. It can make it hard for families to be together in a meaningful way. Pain can affect mood—being in pain can make someone seem angry or short-tempered. Although

What about morphine?

Morphine is an opiate, a strong drug used to treat serious pain. Sometimes, morphine is also given to ease the feeling of shortness of breath. You might have heard that giving morphine leads to a quicker death. Is that true? Most experts think this is unlikely, especially if increasing the dose is done carefully. Successfully reducing pain and/or concerns about breathing can provide needed comfort to someone who is close to dying.

understandable, irritability resulting from pain might make it hard to talk, hard to share thoughts and feelings.

Breathing problems. Shortness of breath or the feeling that breathing is difficult is a common experience at the end of life. The doctor might call this *dyspnea (disp-NEE-uh)*. Worrying about the next breath can make it hard for important conversations or connections. Try raising the head of the bed, opening a window, using a vaporizer, or having a fan circulating air in the room. Sometimes, the doctor suggests extra oxygen, given directly through the nose, to help with this problem.

People very near death might have noisy breathing called a *death rattle*. This is caused by fluids collecting in the throat or by the throat muscles relaxing. It might help to try turning the person to rest on one side. There is also medicine that can be prescribed to help clear this up. But not all noisy breathing is a death rattle. And, it may help to know that this noisy breathing is usually not upsetting to the person dying, even if it is to family and friends.

Skin irritation. Skin problems can be very uncomfortable. With age, skin becomes drier and more fragile naturally, so it is important to take extra care with an older person's skin. Gently applying alcohol-free lotion can relieve dry skin as well as be soothing.

Dryness on parts of the face, such as the lips and eyes, can be a common cause of discomfort near death. A lip balm could keep this from getting worse. A damp cloth placed over closed eyes might relieve dryness. If the inside of the mouth seems dry, giving ice chips, if the person is conscious, or wiping the inside of the mouth with a damp cloth, cotton ball, or a specially-treated swab might help.

Sitting or lying in one position puts constant pressure on sensitive skin, which can lead to painful bed sores (sometimes called pressure ulcers). When a bed sore first forms, the skin gets discolored or darker. Watch carefully for these discolored spots, especially on the heels, hips, lower back, and back of the head. Turning the person from side to back and to the other side every few hours may help prevent bed sores. Or try putting a foam pad under an area like a heel or elbow to raise it off the bed and reduce pressure. A special mattress or chair cushion might also help. Keeping the skin clean and moisturized is always important. A bed sore that won't heal probably needs treatment by a wound specialist.

Digestive problems. Nausea, vomiting, constipation, and loss of appetite are common end-of-life complaints. The causes and treatments for these symptoms are varied, so talk to a doctor or nurse right away. There are medicines that can control nausea or vomiting or relieve constipation.

If someone near death wants to eat, but is too tired or weak, you can help with feeding. If loss of appetite is a problem, encourage eating by gently offering favorite foods in small amounts. Or try serving frequent, smaller meals rather than three big ones. But, don't force a person to eat. Going without food and/or water is generally not painful, and eating can add to discomfort. Losing one's appetite is a common and normal part of dying. A conscious decision to give up food can be part of a person's acceptance that death is near.

Temperature sensitivity. People who are dying may not be able to tell you that they are too hot or too cold, so watch for clues. For example, someone who is too warm might repeatedly try to remove a blanket. You can take off the blanket and try a cool cloth on his or her head. If a person is hunching his or her shoulders, pulling the covers up, or even shivering—those could be signs of cold. Make sure there is no draft, raise the heat, and add another blanket, but avoid electric blankets because they can get too hot.

Fatigue. It is common for people nearing the end of life to feel tired and have little or no energy. Keep activities simple. For example, a bedside commode can be used instead of walking to the bathroom. A shower stool can save a person's energy, as can switching to sponging off in bed.

Medical tests and treatments can be uncomfortable and can drain the strength of a person who is dying. Some may no longer be necessary and can be stopped, as one woman's family learned. At eighty, Catherine had already been in a nursing home for two years since her stroke. Her health began to fail quickly, and she was no longer able to communicate her wishes. Her physician, Dr. Jones, told her family she was dying. He said that medical

tests, physical therapy, and IVs (intravenous tubes inserted into a vein with a needle to give medicine or fluids) were no longer really needed and should be stopped since they might be causing Catherine discomfort. Dr. Jones also said that checking vital signs (pulse, blood pressure, temperature, and breathing rate) was interrupting her rest and would no longer be done regularly.

Then Catherine developed pneumonia. Her family asked about moving her to the hospital. The doctor explained that Catherine could get the same treatment—antibiotics, if chosen, and oxygen—in the familiar surroundings of her nursing home. Besides, he said a move could disturb and confuse her. The family agreed to leave Catherine in the nursing home, and she died two days later surrounded by those close to her. Experts suggest that moving someone to a different place, like a hospital, close to the time of death, should be avoided if possible.

Mental and Emotional Needs

Complete end-of-life care also includes helping the dying person manage any mental and emotional distress. Someone nearing the end of life who is alert might understandably feel depressed or anxious. Encouraging conversations about feelings might be beneficial. You might want to contact a counselor, possibly one familiar with end-of-life issues. If the depression or anxiety is severe, medicine might provide relief.

A dying person might also have some specific fears and concerns. He or she may fear the unknown or worry about those left behind. Some people are afraid of being alone at the very end. This feeling can be made worse by the understandable reactions of family, friends, and even the medical team. For example, when family and friends do not know how to help

or what to say, sometimes they stop visiting. Or, someone who is already beginning to grieve may withdraw. Doctors may become discouraged because they can't cure their patient and feel helpless. Some seem to avoid a dying patient. This can add to a dying person's sense of isolation. If this appears to be happening, try to discuss your concerns with the family, friends, or the doctor.

The simple act of physical contact—holding hands, a touch, or a gentle massage—can make a person feel connected to those he or she loves. It can be very soothing. Warm your hands by rubbing them together or running them under warm water.

Try to set the kind of mood that is most comforting for the dying person. What has he or she always enjoyed? For example, Bill loved a party, so it was natural for him to want to be surrounded by family and friends when he was dying. Ellen always preferred spending quiet moments with one or two people at a time, so she was most comfortable with just a few visitors. Some experts suggest that when death is very near, music at low volume and soft lighting are soothing. In fact, near the end of life, music therapy might improve mood, help with relaxation, and lessen pain. Listening to music might also evoke memories those present can share. For some people, keeping distracting noises like televisions and radios to a minimum is important.

Spiritual Issues

People nearing the end of life may have spiritual needs as compelling as their physical concerns. Spiritual needs involve finding meaning in one's life and ending disagreements with others, if possible. The dying person

might find peace by resolving unsettled issues with friends or family. Visits from a social worker or a counselor may also help. Many people find solace in their faith. Praying, talking with someone from one's religious community (such as a minister, priest, rabbi, or Muslim cleric), reading religious text, or listening to religious music may bring comfort.

Family and friends can talk to the dying person about the importance of their relationship. For example, adult children can share how their father has influenced the course of their lives. Grandchildren can let their grandfather know how much he has meant to them. Friends can relate how they value years of support and companionship. Family and friends who can't be present could send a recording of what they would like to say or a letter to be read out loud.

Sharing memories of good times is another way some people find peace near death. This can be comforting for everyone. Some doctors think it is possible that even if a patient is unconscious, he or she might still be able to hear; it is probably never too late to say how you feel or to talk about fond memories.

Always talk to, not about, the person who is dying. When you come into the room, it is a good idea to identify yourself, saying something like "Hi, Bob. It's Mary, and I've come to see you." Another good idea is to have someone write down some of the things said at this time—both by and to the one dying. In time, these words might serve as a source of comfort to family and friends. People who are looking for ways to help may welcome the chance to aid the family by writing down what is said.

There may come a time when a dying person who has been confused suddenly seems clear-thinking. Take advantage of these moments, but understand that they might be only temporary, not necessarily a sign he or she is getting better.

Practical Tasks

There are many practical jobs that need to be done at the end of life—both to relieve the dying person and to support the caregiver. Everyday tasks can be a source of worry for someone who is dying, and they can overwhelm a caregiver. Taking over small daily chores around the house—such as answering the door, picking up the mail or newspaper, writing down phone messages, doing a load of laundry, feeding the family pet, taking children to soccer practice, picking medicine up from the pharmacy—can provide a much needed break for caregivers.

A dying person might be worried about who will take care of things when he or she is gone. Offering reassurance—"I'll make sure your African violets are watered," "Jessica has promised to take care of Bandit," "Dad, we want Mom to live with us from now on"—might provide a measure of peace. Reminding the dying person that his or her personal affairs are in good hands can also bring comfort.

Everyone may be asking the family "What can I do for you?" It helps to make a specific offer. Say to the family "Let me help with …" and suggest something like bringing meals for the caregivers, paying bills, walking the dog, or babysitting. If you're not sure what to offer, talk to someone who has been through a similar situation. Find out what kind of help was useful. If you want to help, but can't get away from your own home, you could schedule other friends or family to help with small jobs or to bring in meals. This can allow the immediate family to give their full attention to the dying person.

If you are the primary caregiver, try to ask for help when you need it. Don't hesitate to suggest a specific task to someone who offers to help.

Friends and family are probably anxious to do something for you and/or the person who is dying, but they may be reluctant to repeatedly offer when you are so busy.

Setting up a phone tree or computer *listserv* for the family to contact friends and other relatives can reduce the number of calls to the house. A listserv is a way to send the same message to a large group of people through email. Some families set up a website where they can share news, thoughts, and wishes. These can all save close family members from the emotional burden of answering frequent questions about how their loved one is doing.

Questions to Ask

This section has described what family and friends can do to provide comfort and ease to someone nearing the end of life. Here are some questions to help you learn more about what you might do.

Ask the doctor in charge:

1. Since there is no cure, what will happen next?
2. Why are you suggesting this test or treatment?
3. Will the treatment bring physical comfort?
4. Will the treatment speed up or slow down the dying process?
5. What can we expect to happen in the coming days or weeks?

Ask the caregiver:

1. How are you doing? Do you need someone to talk with?
2. Would you like to go out for an hour or two? I could stay here while you are away.

3. Who has offered to help you? Do you want me to work with them to coordinate our efforts?
4. Can I help, maybe … walk the dog, answer the phone, go to the drug store or the grocery store, or watch the children (for example)…for you?

To Learn More

About Comfort Care:

- *For more detailed information:*
  Caring Connections (National Hospice and Palliative Care Organization)
  www.caringinfo.org ◆ 800-658-8898 (toll-free)

- *For information about caring for wounds:*
  American Academy of Wound Management
  www.aawm.org ◆ 202-457-8408

- *For online tips for family caregivers:*
  Center for Caregiver Training
  www.caregiving101.org

- *For "Patient/Family Teaching Sheets" with caregiving tips:*
  Hospice and Palliative Nurses Association
  www.hpna.org

- *For a music therapist:*
  American Music Therapy Association
  www.musictherapy.org ◆ 301-589-3300

- *For information about managing pain:*
  American Academy of Pain Medicine
  www.painmed.org ◆ 847-375-4731

Death does not sound a trumpet.

— African proverb

Finding Care

at the End • of • Life

Decades ago, most people died at home, but medical advances have changed that. Today, most Americans are in hospitals or nursing homes at the end of their lives. Some people enter the hospital to get treated for an illness. Some may already be living in a nursing home. Increasingly, people are choosing hospice care at the end of life.

There is no "right" place to die. And, of course, where we die is not usually something we get to decide. But, if given the choice, each person and/or his or her family should consider which type of care makes the most sense, where that kind of care can be provided, whether family and friends are available to help, and, of course, how they will manage the cost.

Hospitals and Nursing Homes

George is sixty-four and has a history of congestive heart failure. One night he is taken to the hospital with chest pain. George and those closest to him had previously decided that, no matter what, the doctor should try to do everything medically possible to extend George's life. So, when

George needed care, he went to a hospital, where doctors and nurses are available around-the-clock. Hospitals offer a full range of treatment choices, tests, and other medical care. If George's heart continues to fail, the hospital intensive care unit (ICU) or coronary care unit (CCU) is right there. Although hospitals have rules, they can sometimes be flexible. If George's doctor thinks he is not responding to treatment and is dying, the family can ask for relaxed visiting hours. If George's family wants to bring personal items from home, they can ask the staff if there are space limitations or if disinfection is needed. Whether George is in the ICU, CCU, or a two-bed room, his family can ask for more privacy.

Who pays for care at the end of life?

How to pay for care at the end of life depends on the type and place of care and the kind of insurance. Medicare, Medicaid, private medical insurance, long-term care insurance, Veterans Health Administration (if VA-eligible), or the patient and his or her family are common sources of payment.

See *To Learn More* at the end of this section for links and telephone numbers for services that are Federal government programs.

In a hospital setting, there is always medical staff available who know what needs to be done for someone who is dying. This can be very reassuring for that person, as well as for family and friends.

More and more people are in nursing homes at the end of life. In a nursing home, nursing staff is also always present. A nursing home, sometimes

The doctor wants to move my relative to the ICU. What can we expect?

The ICU (intensive care unit) and CCU (coronary care unit) are types of critical care units, that is, they are parts of a hospital where more seriously ill patients can benefit from specially-trained staff that have quick access to advanced equipment. The medical staff in ICUs and CCUs closely monitor and care for a small number of patients. Doctors who work in these units are called *intensivists.*

Patients in the ICU or CCU are often connected to monitors that check breathing, heart rate, pulse, blood pressure, and oxygen levels. An IV (intravenous) tube may supply medicines, fluids, and/or nutrition. Another tube called a Foley catheter may take urine out of the body; a tube through the nose or stomach area may provide nutrition and remove unwanted fluids. A breathing tube through the mouth or trachea (windpipe) may be attached to a ventilator or respirator to help with breathing. Often these external supports—designed to be used for a short time—will maintain vital functions while the body heals.

But sometimes, even with intensive care, the body can't heal, and organs start to fail. When this happens, survival is unlikely. In this case, the health care team might talk to the family—and the patient if he or she is conscious—about considering whether or not to continue intensive treatment.

called a skilled nursing facility, has advantages and disadvantages for end-of-life care. Unlike a hospital, a doctor is not in the nursing home all the time. But, plans for end-of-life care can be arranged ahead of time, so that when the time comes, care can be provided as needed without first consulting a doctor. If the dying person has lived in the facility for a while, the staff and family have probably already established a relationship. This can make the care feel more personalized than in a hospital. As in a hospital, privacy may be an issue. You can ask if arrangements can be made to give your family more time alone when needed.

Home

Home is likely the most familiar setting for someone who needs end-of-life care. Family and friends can come and go freely. Care at home can be a big job for family and friends—physically, emotionally, and financially. But, there are benefits too, and it is often a job they are willing to take on. Hiring a home nurse is an option for people who need additional help.

In order to make comfort care available at home, you will have to arrange for services (such as visiting nurses) and special equipment (like a hospital bed or bedside commode). Health insurance might only cover these services or equipment if they have been ordered by a doctor. Work with the doctor to decide what is needed to support comfort care at home. If the dying person is returning home from the hospital, sometimes a hospital discharge planner, often a social worker, can help with the planning. Your local Area Agency on Aging might be able to recommend other sources of help (see page 30 to learn how to contact your Area Agency on Aging).

A doctor has to be available to oversee the patient's care at home—he or she will arrange for new services, adjust treatment, and order medicines as needed. It is important to follow the doctor's plan in order to make the dying person as comfortable as possible. Talk with the doctor if you think a treatment is no longer helping.

Palliative Care and Hospice

Doctors can provide treatment to seriously ill patients in the hopes of a cure for as long as possible. These patients also receive symptom care or *palliative care.* For example, in time George developed anemia along with his heart failure. Managing the anemia can improve some of the symptoms troubling George. It might also make it easier for him to do things like get dressed or bathe on his own. Treating his anemia is part of palliative care.

Recently, the term palliative care has come to mean more than just treating symptoms. In the United States, palliative care now often refers to a comprehensive approach to improving the quality of life for people who are living with potentially fatal diseases. It provides support for family members, very similar to the more familiar concept of hospice care.

In a palliative care program, a multidisciplinary health care team works with both the patient and family to provide any support—medical, social, and emotional—needed to live with a possibly fatal illness. The health care team may be made up of doctors, nurses, therapists, counselors, social workers, and others as needed.

Who can benefit from palliative care?

Palliative care is not just for people who might die soon. It is a resource for anyone with a long-term disease that will, in time, probably cause their death. These include heart failure, chronic obstructive pulmonary disease, or Parkinson's disease. The organized services available through palliative care could also be helpful to any older person having a lot of general discomfort and disability very late in life.

Palliative care can be provided in hospitals, nursing homes, outpatient palliative care clinics, certain other specialized clinics, or at home. Medicare covers some of the treatments and medicine. Veterans may be eligible for palliative care through the Department of Veterans Affairs. Private health insurance might pay for some services. Health insurance providers can answer questions about what they will cover.

In palliative care, you aren't asked to make a choice between treatment that might cure a terminal disease and comfort care. In time, if the doctor believes the patient is not responding to treatment and is likely to die within 6 months, there are two possibilities. Palliative care could transition to hospice care. Or, the palliative care could continue, with increasing emphasis on comfort care and less focus on medical treatment aimed at a cure.

That is what happened with Jack, retired from the U.S. Air Force, who was diagnosed with chronic obstructive pulmonary disease at age seventy. As the disease progressed and breathing became more difficult, Jack wanted to explore experimental treatments to slow the disease. Through the palliative care provided by the Veterans Health Administration, while receiving treatment for his pulmonary disease, Jack was also able to receive the comfort care and emotional support he needed to cope with his health problems. The palliative care program also provided help around the house and other support for Jack's wife, making it easier for her to care for Jack at home.

At some point, curative medical treatment may no longer make sense—it might not help or may actually make the patient more uncomfortable. *Hospice* is designed for this situation. The patient beginning hospice care understands that his or her illness is not responding to medical attempts to cure it or to slow the disease's progress. The hospice approach to end-of-life care is similar to palliative care, in that it provides comprehensive comfort care to the dying person as well as support to his or her family, but, in hospice, attempts to cure the person's illness are stopped.

Hospice is an approach to care, and so it is not tied to a specific place. It can be offered in two types of settings—at home or in a facility such as a nursing home, hospital, or even in a separate hospice center. Hospice care brings together a team of people with special skills—among them nurses, doctors, social workers, spiritual advisors, and trained volunteers. Everyone works together with the person who is dying, the caregiver,

and/or the family to provide the medical, emotional, and spiritual support needed. A member of the hospice team visits regularly and is always available by phone—24 hours a day, 7 days a week.

It is important to remember that stopping treatment specifically aimed at curing an illness does not mean discontinuing all treatment. A good example is an older person with cancer. If the doctor determines that the cancer is not responding to chemotherapy and the patient chooses to enter into hospice care, then the chemotherapy will stop, but other medical care may continue. For example, if the person has high blood pressure, he or she will still get medicine for that.

Choosing hospice does not have to be a permanent decision. For example, Delores was eighty-two when she learned that her kidneys were failing. She thought that she had lived a long, good life and didn't want to go through dialysis, so Delores began hospice care. A week later she learned that her granddaughter was pregnant. Delores changed her mind about using hospice care and left to begin dialysis in the hopes of one day holding her first great-grandchild.

Similar to Delores, real-life humorist and *Washington Post* columnist Art Buchwald, age eighty-one, decided against the kidney dialysis suggested by his doctor. Buchwald entered hospice in February 2006, expecting to die of kidney disease within a few weeks. It was big news when his condition stabilized. When it became clear death was not imminent, Buchwald left hospice. He spent the summer in Martha's Vineyard and died in January 2007.

Some Differences Between Palliative Care and Hospice

	PALLIATIVE CARE	HOSPICE
Who can be treated?	Anyone with a serious illness	Anyone with a serious illness whom doctors think has only a short time to live, often less than 6 months
Will my symptoms be relieved?	Yes, as much as possible	Yes, as much as possible
Can I continue to receive treatments to cure my illness?	Yes, if you wish	No, only symptom relief will be provided
Will Medicare pay?	It depends on your benefits and treatment plan	Yes, it pays all hospice charges
Does private insurance pay?	It depends on the plan	It depends on the plan
How long will I be cared for?	This depends on what care you need and your insurance plan	As long as you meet the hospice's criteria of an illness with a life expectancy of months, not years
Where will I receive this care?	◆ Home ◆ Assisted living facility ◆ Nursing home ◆ Hospital	◆ Home ◆ Assisted living facility ◆ Nursing home ◆ Hospice facility ◆ Hospital

Art Buchwald on leaving the hospice:

- I maintained everyone has to die—I still do. The hospice gives a person the opportunity to die with dignity. It provides care, help, and as much comfort as possible.
- In spite of the fact that I've been staying in a hospice, I'm not going to heaven immediately. My doctor informs me that I can stop over on Martha's Vineyard on the way there.

Art Buchwald, *Too Soon to Say Goodbye,* (New York: Random House, 2006).

Eighty-year-old Annie had advanced lung cancer and asked for help through a hospice program, so she could stay in the home she had lived in for more than 40 years. A hospice team helped her family and friends with caregiving and everyday activities. They arranged *respite care* for Annie's family—once she went into a facility for a few days to give her husband a break. Respite care can be for as short as a few hours or for as long as several weeks. After Annie died, hospice continued to support her family offering bereavement counseling for a year.

Hospice care was a relief for Annie who didn't want to be a burden to her relatives in her last days. Hospice services also greatly reduced the stress of caregiving for Annie's family. In fact, a widow or widower is less likely to die within 18 months after the death of a spouse if that spouse received hospice services. This was true for Annie's husband who weathered the sadness of her loss without having his health decline. Families of people who received care through a hospice program are also more satisfied with

What does the hospice "6-month requirement" mean?

Some people misinterpret their doctor's suggestion to consider hospice. They think it means death is very near. But that's not always the case. Sometimes people don't begin hospice care soon enough to take full advantage of the help it offers. Perhaps they wait too long to begin hospice; they are too close to death. Or, some people are not eligible for hospice care soon enough to receive its full benefit. In the United States, older people can receive hospice care through Medicare if their health care provider thinks they have less than 6 months to live. Doctors have a hard time predicting how long an older, frail person will live. Health often declines slowly, and some people might need a lot of help with daily living for more than 6 months before they die. Talk to the doctor if you think a hospice program might be helpful. If he or she agrees, but thinks it is too soon for Medicare to cover the services, then you can investigate how to pay for the services that are needed.

What happens if someone under hospice care lives longer than 6 months? If the doctor continues to certify that that person is still close to dying, Medicare can continue to pay for hospice services. It is also possible to leave hospice care for a while and then later return if the health care provider still believes that the patient has less than 6 months to live.

end-of-life care than are those of people who did not have hospice services. Hospice recipients are more likely to have their pain controlled and less likely to undergo tests or be given medicines they don't need than people who don't use hospice care.

Before Annie died, she chose to receive hospice care and agreed to give up treatment, such as chemotherapy and radiation, to try to cure her lung cancer. But she continued to receive comfort care and counseling. If Annie had changed her mind, she could have left hospice care and received treatment for her cancer.

Questions to Ask

Choosing among the different options for care at the end of life can be difficult. Here are some questions that might help you determine what is best for you and your family.

1. How long is this person expected to live?
2. What kind of end-of-life care is needed?
3. Is the most likely caregiver able to give that kind of care?
4. Where would the person who is dying want to have this end-of-life care—a facility or at home, for example?
5. What is the best place to get the type of care he or she wants?
6. Who will pay for this care?
7. Can children, grandchildren, friends, pet, etc., visit whenever they want?
8. Is there a good chance that treatment in an intensive care unit will reverse the dying process, or instead draw it out?

To Learn More

About Hospice or Palliative Care:

- American Hospice Foundation
  www.americanhospice.org • 800-347-1413 (toll-free)
- Center to Advance Palliative Care
  www.getpalliativecare.org • 212-201-2670
- Centers for Medicare & Medicaid Services
  www.medicare.gov • 800-633-4227 (toll-free)
- Department of Veterans Affairs
  www.va.gov • 877-222-8387 (toll-free)
- National Hospice and Palliative Care Organization
  www.nhpco.org • 800-658-8898 (toll-free)
- Visiting Nurse Associations of America
  www.vnaa.org • 617-737-3200

To contact your Area Agency on Aging:

- Eldercare Locator
  www.eldercare.gov • 800-677-1116 (toll-free)

While I thought that I was learning how to live,
I have been learning how to die.

— Leonardo da Vinci (1452-1519)

DEMENTIA

AT THE END • OF • LIFE

As they reach the end of life, people suffering from conditions like Alzheimer's disease (AD) or Parkinson's disease can present special problems for caregivers. People live with these diseases for years, becoming increasingly disabled. Because they do not die soon after they are diagnosed, it can be hard to think of these as terminal diseases. But they do contribute to death.

Illnesses like Alzheimer's disease make it difficult for those who want to provide supportive care at the end of life to know what is needed. Because people with advanced dementia can no longer communicate, they cannot share their concerns. Is Uncle Bert refusing food because he is not hungry or because he's confused? Why does Grandma Ruth seem agitated? Is she in pain and needs medication to relieve it, but can't tell you?

As these conditions progress, they also obstruct efforts to provide emotional or spiritual comfort. How can you let Grandpa know how much his life has meant to you? How do you make peace with your mother if she no longer knows who you are? Someone who has severe memory loss might not take spiritual comfort from sharing family memories or understand when others express what an important part of their life this person has

been. Palliative care or hospice can be helpful in many ways to families of people with dementia.

Sensory connections—targeting someone's senses, like hearing, touch, or sight—can bring comfort to people with Alzheimer's disease. Being touched or massaged and listening to music, "white" noise, or sounds from nature seem to soothe some people and lessen their agitation.

When an illness like Alzheimer's disease is first diagnosed, if everyone understands that there is no cure, then plans for the end of life can be made before thinking and speaking abilities fail and people can no longer legally complete documents like advance directives. That didn't happen in Ethel's family. She had been forgetful for years, but even after her family knew that AD was the cause of her forgetfulness, they never talked about what the future would bring. As time passed and the disease eroded Ethel's memory and her ability to think and speak, she became less and less able to share her concerns and desires with those close to her. This made it hard for her daughter Barbara to know what Ethel needed or wanted. Barbara's decisions, therefore, had to be based on what she knew about her mom's values and priorities, rather than on what Ethel actually said she would like.

Quality of life is an important issue when making health care decisions for people with Alzheimer's disease. For example, there are medicines available that might slow the progression of this devastating disease for a short time in some patients, generally early in the illness. However, in more advanced AD, some caregivers might not want these drugs prescribed. They may believe that the quality of life is already so diminished and that the medicine is unlikely to make a difference. If the drug has serious side effects, they are even more likely to decide against it.

End-of-life care decisions are more complicated for caregivers if the dying person has not expressed the kind of end-of-life care he or she would prefer. Someone newly diagnosed with Alzheimer's disease might not be able to imagine the later stages of the disease. Ethel was like that. She and Barbara never talked about things like feeding tubes, machines that help with breathing, antibiotics for pneumonia, or transfers to the hospital. So when doctors raised some of these questions, Barbara didn't know how to best reflect her mother's wishes. When making care decisions for someone else near the end of life, it is important to consider how a treatment will benefit the person and what the side effects and risks might be. Sometimes you might decide to try the health care team's suggestion for a short time. Other times you might decide that the best choice is to do nothing.

Alzheimer's disease and similar conditions often progress slowly and unpredictably. Experts suggest that signs of the final stage of Alzheimer's disease include some of the following:

- Being unable to move around on one's own
- Being unable to speak or make oneself understood
- Needing help with most, if not all, daily activities
- Eating problems such as difficulty swallowing or no appetite

Because of their unique experience with what happens at the end of life, hospice and palliative care experts might also be of help identifying when someone in the final stage of Alzheimer's disease is beginning to die.

Caring for people with Alzheimer's disease at home can be demanding and stressful for the family caregiver. Depression is a problem for some family caregivers, as is fatigue, because many feel they are always "on call."

More than half of one group of family caregivers reported cutting back on work hours or giving up their jobs because of the demands of caregiving. Most of those family members taking care of dying Alzheimer's disease patients at home expressed relief when death happened—for themselves and for the person who died. It is important to realize such feelings are normal. Hospice—whether used at home or in a facility—gives family caregivers needed support near the end of life, as well as help with their grief, both before and after their family member dies.

Questions to Ask

You will want to understand how the available medical options presented by the health care team fit into your family's particular needs. You might want to ask questions such as:

1. How will the approach the doctor is suggesting affect your relative's quality of life? Will it make a difference?
2. If considering hospice for your relative with Alzheimer's disease, does the facility have special experience with people with dementia?

To Learn More

About Dementia and Caregiving for People With Dementia:

- Alzheimer's Disease Education and Referral Center
  www.nia.nih.gov/alzheimers • 800-438-4380 (toll-free)
- Alzheimer's Association
  www.alz.org • 800-272-3900 (toll-free)

Understanding
Health Care Decisions

It can be overwhelming to be asked to make health care decisions for someone who is dying and no longer able to make his or her own decisions. It is even more difficult if you do not have written or even verbal guidance (see pages 58-61). How do you decide what type of care is right for someone? Even when you have written documents, some decisions still might not be clear.

Two approaches might be useful. One is to put yourself in the place of the person who is dying and try to choose as he or she would. That is called *substituted judgment.* Sheila's ninety-year-old mother, Esther, was in a coma after having a major stroke. The doctor said damage to Esther's brain was widespread and she needed to be put on a breathing machine (ventilator) or she would probably die. The doctor asked Sheila if she wanted that to be done. Sheila remembered how her mother disapproved when an elderly neighbor was put on a similar machine after a stroke. She decided to say no, and her mother died peacefully a few hours later. Some experts believe that decisions should be based on substituted judgment whenever possible, but decision-makers sometimes combine that with another method.

The other approach, known as *best interests,* is to decide what would be best for the dying person. Jim's father, Sam, is eighty and has lung cancer, as well as advanced Parkinson's disease. He is in a nursing facility and doesn't seem to recognize Jim when he visits. Sam's doctor suggested that surgery to remove part of a lung might slow down the course of the cancer and give Sam more time. But, Jim thought, "What kind of time? What would that time do for Dad?" Jim decided that putting his dad through surgery and recovery was not in Sam's best interests.

If you are making decisions for someone at the end of life and trying to use one of these approaches, it may be helpful to think about the following:

- Has the dying person ever talked about what he or she would want at the end of life?
- Has he or she expressed an opinion about how someone else was being treated?
- What were his or her values in life? What gave meaning to life? Maybe it was being close to family—watching them grow and making memories together. Perhaps just being alive was the most important thing.

As a decision-maker without specific guidance from the dying person, you need as much information as possible on which to base your actions. You might ask the doctor:

- What can we expect to happen in the next few hours, days, or weeks?
- Why is this new test being suggested?
- Will it change the current treatment plan?
- Will a new treatment help my relative get better?

- How would the new treatment change his or her quality of life?
- Will it give more quality time with family and friends?
- How long will this treatment take to make a difference?
- If we choose to try this treatment, can we stop it at any time? For any reason?
- What are the side effects of the approach you are suggesting?
- If we try this new treatment and it doesn't work, what then?
- If we don't try this treatment, what will happen?
- Is the improvement we saw today an overall positive sign or just something temporary?

It is a good idea to have someone with you when discussing these issues with medical staff. Having someone take notes or remember details can be very useful during this emotional time. If you are unclear about something you are told, don't be afraid to ask the doctor or nurse to repeat it or to say it another way that does make sense to you. Do not be reluctant to keep asking questions until you have all the information you need to make decisions. Make sure you know how to contact a member of the medical team if you have a question or if the dying person needs something. You may want to get pager numbers, email, or cell phone numbers.

Sometimes the whole family wants to be involved in every decision. Maybe that is the family's cultural tradition. Or, maybe the person dying did not pick one person to make health care choices before becoming unable to do so. That is not unusual, but it is probably a good idea to choose one person to be the spokesperson and the contact person when dealing with medical staff. The doctor and nurses will appreciate answering questions from only one person. Even if one family member is named as

the decision-maker, it is a good idea, as much as possible, to have family agreement about the care plan. If you can't agree on a care plan, a decision-maker, or even a spokesperson, the family might need to hire a mediator, someone trained to bring people with different opinions to a common decision. (See *To Learn More* on page 46.) In any case, as soon as possible after the doctor says the patient is dying, the family should try to discuss with the medical team what approach to end-of-life care they want for their family member. That way, decision making for crucial situations can be planned and does not have to be done quickly.

Issues You May Face

Maybe you are now faced with making end-of-life choices for someone close to you. You've thought about that person's values and opinions, and you've asked the health care team to explain the treatment plan and what you can expect to happen. But there are other issues that you need to understand in case they arise. What if the dying person starts to have trouble breathing and a doctor says a ventilator might be needed? Maybe one family member wants the health care team to "do everything" to keep this relative alive. What does that involve? Or, what if family members can't agree on end-of-life care, or they disagree with the doctor? What happens then?

Here are some common end-of-life issues like those—they will give you a general understanding and may help in your conversations with the doctors.

If we say "do everything," what does that mean? This means that if someone is dying, all measures that might keep vital organs working will be tried—for example, using a machine to help with breathing (ventilator)

or starting dialysis for failing kidneys. Such life support can sometimes be a temporary measure that allows the body to heal itself and begin to work normally again. It is not intended to be used indefinitely in someone who is dying. "Doing everything" does not include medical treatments intended to cure a medical condition, such as surgery or chemotherapy.

What can be done if someone's heart stops beating (cardiac arrest)? CPR (cardiopulmonary resuscitation) can sometimes restart a stopped heart. It is most effective in people who were generally healthy before their heart stopped. In CPR, the doctor repeatedly pushes on the chest with great force and periodically puts air into the lungs. Electric shocks (called defibrillation) may also be used to restart the heart, and some medicines might also be given. Although not usually shown on television, the force required for CPR can cause broken ribs or a collapsed lung. Often, CPR does not succeed, especially in an elderly person who is already failing.

What if someone needs help breathing or completely stops breathing (respiratory arrest)? Sometimes doctors suggest using a ventilator (a respirator or breathing machine)—the machine forces the lungs to work. Initially, this involves *intubation,* putting a tube attached to a ventilator down the throat into the trachea or windpipe. Because this tube can be quite uncomfortable, people are often sedated. If the person needs ventilator support for more than a few days, the doctor will probably suggest a *tracheotomy,* sometimes called a "trach" (rhymes with "make"). This tube is then attached to the ventilator. This is more comfortable than a tube down the throat and may not require sedation. Inserting the tube into the trachea is a bedside surgery. A tracheotomy can carry risks, including collapsed lung, plugged tracheotomy tube, or bleeding.

How can I be sure the medical staff knows that we don't want efforts to restore a heart beat or breathing? As soon as the decision that medical staff should not do CPR or other life-support procedures is made by the patient or the person making health care decisions, the doctor-in-charge should be told of this choice. The doctor will then write this on the patient's chart using terms such as DNR (Do Not Resuscitate), DNAR (Do Not Attempt to Resuscitate), or DNI (Do Not Intubate). If end-of-life care is given at home, a special "non-hospital DNR," signed by a doctor, is needed. This ensures that if emergency medical technicians (EMTs) are called to the house, they will respect your wishes. Without a non-hospital DNR, in many places EMTs are required to perform CPR and similar techniques when called to a home. Hospice staff can help determine whether a medical condition is part of the normal dying process or something that needs the attention of EMTs. DNR orders do not stop all treatment. They only mean that CPR and a ventilator will not be used. These orders are not permanent—they can be changed if the situation changes.

What about pacemakers (or similar devices)—should they be turned off? A pacemaker is a device implanted under the skin on the chest that keeps a heartbeat regular. It will not keep a dying person alive. Some people have an implantable cardioverter defibrillator (ICD) under the skin. This is a pacemaker that also shocks the heart back into regular beats when needed. The ICD should be turned off at the point when life support is no longer wanted. This can be done without surgery.

What if the doctor suggests a feeding tube? If a patient can't or won't eat or drink, even when spoon fed, the doctor might suggest a feeding tube. While recovering from an illness, a feeding tube can be helpful. But

at the end of life, a feeding tube might cause more discomfort than not eating. As death approaches, loss of appetite is common. Body systems start shutting down, and fluids and food are not needed as before. Some experts believe that at this point few nutrients are absorbed from any type of nutrition, including that received through a feeding tube.

If tube feeding is going to be tried, there are two methods that can be used. In the first, a feeding tube, known as a nasogastric or NG tube, is threaded through the nose down to the stomach to give nutrition for a short time. Sometimes the tube is uncomfortable. If so, the doctor might try a smaller, child-sized tube. Someone with an NG tube might try to remove it. This usually means the person has to be restrained, which could mean binding his or her hands to the bed. If tube feeding is required for an extended time, then a gastric or G tube is put directly into the stomach through an opening made in the side or abdomen. This second method is also called a PEG tube for percutaneous endoscopic gastrostomy tube. These carry risks of infection, pneumonia, and nausea.

Some people try tube feeding for a short time to see if it makes a difference, while keeping open the option of removing the tube if there is no improvement. Talk to the doctor about how the feeding tube could help and how long it makes sense to try it.

Refusing food might be a conscious decision—a part of the dying person's understanding that death is near. The decision-maker should think carefully about doing something that might be against the dying person's wishes.

Should someone dying be sedated? Sometimes very near the end of life, the doctor might suggest sedation to manage symptoms that are not

responding to treatment and still make the patient uncomfortable. This means using medicines to put the patient in a sleep-like state. Sedation doesn't cause a person to die more quickly. Many doctors suggest continuing to use comfort care measures like pain medicine even if the dying person is sedated. Sedatives can be stopped at any time. A person who is sedated may still be able to hear what you are saying—so try to keep speaking directly to, not about, him or her. Do not say things you would not want the patient to hear.

What about antibiotics? Antibiotics are medicines that fight infections caused by bacteria. Lower respiratory infections, such as pneumonia, are often caused by bacteria and are common in older people who are dying. If someone is already dying when the infection began, giving antibiotics is probably not going to prevent death but might make the person feel more comfortable. Tom was eighty-three and had lived in a nursing home for several years with advanced Parkinson's disease when he choked on some food causing him to inhale a small amount into his lungs. As a result, Tom developed aspiration pneumonia. The doctors assured his wife that they could keep Tom comfortable without antibiotics, but she wanted them to try treating his pneumonia. He died a few days later despite their efforts.

Is refusing treatment legal? Choosing to stop treatment that is not curing or controlling an illness or deciding not to start a new treatment is completely legal—whether the choice is made by someone who is dying or by the one making health care decisions. Some people think this is like allowing death to happen. The law does not consider refusing such treatment to be either suicide or euthanasia, sometimes called "mercy killing."

What happens if the doctor and I have different opinions about care for someone who is dying? Sometimes medical staff, the patient, and family members disagree about a medical care decision. This can especially be a problem when the dying person can't tell the doctors what kind of end-of-life care he or she wants. For example, the family might want more active treatment, like chemotherapy, than the doctors think will be helpful. If there is an advance directive (see page 58) explaining the patient's preferences, those guidelines should determine care. Without the guidance of an advance directive, if there is disagreement about medical care, it may be necessary to get a second opinion from a different doctor or to consult the ethics committee or patient representative, also known as an ombudsman, of the hospital or facility. An arbitrator (mediator) can sometimes assist people with different views to agree on a plan. (See *To Learn More* on page 46.)

The doctor does not seem familiar with our family's views about dying. What should we do? America is a rich melting pot of religions, races, and cultures. Ingrained in each tradition are expectations about what should happen as a life nears its end. It is important for everyone involved in a patient's care to understand how each family background may alter expectations, needs, and choices. You may come from a different background than the doctor you are working with. You might be used to a different approach to talking about what is happening or making health care decisions at the end of life than the medical staff is. For example, many health care providers look to a single person—the dying person or his or her chosen representative—for important health care decisions at the end of life. But, in some cultures the entire immediate family takes on that role, something American doctors might not expect. It is helpful to

discuss your personal and family traditions with your doctors and nurses. Don't be reluctant to say what you want. Each person—each family—is entitled to the end-of-life care that best matches their beliefs and rituals. Make sure you understand how the available medical options presented by the health care team fit into your family's desires for end-of-life care.

If there are religious or cultural customs surrounding death that are important to you, tell the health care providers with whom you are working. Knowing that these practices will be honored could ease the dying person. Telling the medical staff ahead of time may also help avoid confusion and misunderstanding when death occurs.

Questions to Ask

Here are some examples of the kinds of questions you might want to ask the medical staff caring for the dying person:

1. What is the care plan?
2. If we try using the ventilator to help with breathing and decide to stop, how will that be done?
3. If we try the treatment plan you are suggesting and then decide to stop, what will happen?
4. If my family member is dying, why does he or she have to be connected to all those tubes and machines? Why do we need more tests?
5. What is the best way for our family to work with the care staff?
6. How can I make sure I get a daily update on my family member's condition?
7. Will you call me if there is a change in his or her condition?

Things to Share

Make sure the health care team knows what is important to your family surrounding the end of life. You might say:

1. In my religion, we … (then describe your religious traditions regarding death).
2. Where we come from … (tell what customs are important to you at the time of death).
3. In our family when someone is dying, we prefer … (describe what you hope to have happen).

To Learn More

About Decisions You Might Need to Make:

- Society of Critical Care Medicine
  www.sccm.org ◆ **847-827-6869**

- Family Caregiver Alliance
  www.caregiver.org ◆ **800-445-8106 (toll-free)**

About Family Mediation:

- Association for Conflict Resolution
  www.acrnet.org ◆ **202-464-9700**

We understand death for the first time when
he puts his hand upon one whom we love.

— Madame deStael (1766-1817)

What Happens

When Someone Dies

When death comes suddenly, there is little time to prepare. On the other hand, watching an older person become increasingly frail may mean that it's hard to know when the end of life begins because changes can happen so slowly. But if you do know death is approaching and understand what will happen, then you do have a chance to plan. Listen carefully to what doctors and nurses are saying. They may be suggesting that death could be soon.

Just as each life is unique, so is each death. But, there are some common experiences very near the end:

- Shortness of breath, known as *dyspnea*
- Depression
- Anxiety
- Tiredness and sleepiness
- Mental confusion
- Constipation or incontinence
- Nausea
- Refusal to eat or drink

Each of these symptoms, taken alone, is not a sign that someone is dying. But, for someone with a serious illness or declining health, these might suggest that that person is nearing the end of life.

In addition, closer to death, the hands, arms, feet, or legs may be cool to the touch. Some parts of the body may become darker or blue-colored. Breathing and heart rates may slow. In fact, there may be times when the person doesn't breathe for many seconds, known as *Cheyne-Stokes breathing*. Some people hear a death rattle. That is noisy breathing that makes a gurgling or rattling sound. Finally, the chest stops moving, no air comes out of the nose, and there is no pulse. Eyes that are open can seem glassy.

Should there always be someone in the room with a dying person?

Staying close to someone who is dying is often called "keeping a vigil." It can be comforting for the caregiver to always be there, but it can also be tiring and stressful. Unless your cultural or religious traditions require it, do not feel that you must stay with the person all the time. You need to eat and rest. If there are other family members or friends around, try taking turns sitting in the room. Some people almost seem to "prefer" to die alone. They appear to slip away just when visitors leave. Of course, experts have no way to prove that's what happened.

After death, there may still be a few shudders or movements of the arms or legs. There could even be an uncontrolled cry because of muscle movement in the voice box. Sometimes there will be a release of urine or stool, but usually only a small amount since so little has probably been eaten in the last days of life.

Calling 911 or not?

When there is a medical emergency, such as a heart attack, stroke, or serious accident, we know to call 911. But if a person is dying at home and does not want CPR, calling 911 is not necessary. In fact, a call to 911 could cause confusion. Many places require EMTs (emergency medical technicians) who respond to 911 calls to perform CPR if someone's heart has stopped. Consider having a "non-hospital DNR" (see page 41) if the person is dying at home.

Things to Do

After Someone Dies

Immediately following death, nothing has to be done. Take the time you need to start the grieving process. Some people want to stay in the room with the body; others prefer to leave. You might want to have someone make sure the body is lying flat before the joints become stiff and cannot be moved. This *rigor mortis* begins sometime during the first hours after death.

After the death, how long you can stay with the body may depend on where death happens. If it is at home, there is no need to move the body right away. If your religious, ethnic, or cultural background requires any special customs soon after death, there should be time for that now. If the death is likely to happen in a facility, such as a hospital or nursing home, discuss any important customs or rituals with the staff early on, if possible. That will allow them to plan so that you can have the appropriate time with the body.

Some families want time to sit quietly with the body, console each other, and maybe share memories. You could ask a member of your religious

community or a spiritual counselor to come. If you have a list of people to notify, this is the time to call those who might want to come and see the body before it is moved.

As soon as possible, the death must be "pronounced" by someone in authority like a doctor in a hospital or nursing facility or a hospice nurse. This person also fills out the forms certifying the cause, time, and place of death. These steps will make it possible for an official death certificate to be prepared. This legal form is necessary for many reasons, including life insurance and financial and property issues. If hospice is helping, a plan for what happens after death is already in place. If death happens at home without hospice, try to talk with the doctor, local medical examiner (coroner), your local health department, or a funeral home representative in advance about how to proceed.

Arrangements should be made to pick up the body as soon as the family is ready. Usually this is done by a funeral home. The hospital or nursing facility, if that is where death takes place, may call the funeral home for you. If at home, you will need to contact the funeral home directly or ask a friend or family member to do that for you.

The doctor may ask if you want an *autopsy.* This is a medical procedure conducted by a specially-trained physician to learn more about what caused death. For example, if the person who died was believed to have Alzheimer's disease, a brain autopsy will allow for a definitive diagnosis. If your religion or culture objects to autopsies, talk to the doctor. Some people planning a funeral with a viewing worry about having an autopsy, but the physical signs of an autopsy are usually hidden by clothing.

What about organ donation?

At some time before death or right after it, the doctor may ask about donating organs such as the heart, lungs, pancreas, kidneys, cornea, liver, and skin. Organ donation allows healthy organs from someone who dies to be transplanted into living people who need them. People of any age can be an organ donor. The person who is dying may have already indicated they would like to be an organ donor. Some states include it on the driver's license. If not, the decision has to be made quickly. There is no cost to the donor's family for this "gift of life." If the person has requested a do-not-resuscitate (DNR) order, but wants to donate organs, he or she might have to indicate that the desire to donate supersedes the DNR. That is because it might be necessary to use machines to keep the heart beating until the medical staff is ready to use the donated organs.

To Learn More

About Funerals:

- AARP
  www.aarp.org • 888-687-2277 (toll-free)
- Federal Trade Commission
  www.ftc.gov/bcp/conline/edcams/funerals • 877-382-4357 (toll-free)

About Organ Donation:

- Donate Life America
  www.shareyourlife.org • 804-782-4920
- Living Bank
  www.livingbank.org • 800-528-2971 (toll-free)

Getting Help

for Your Grief

Losing someone close to you can make you feel sad, lost, alone, and maybe even angry. You greatly miss the person who has died—you want them back. You might have also been so busy with caregiving that it now seems you have nothing to do. This can add to your feelings of loss. This is all part of grieving, a normal reaction to the loss of someone you love.

There are many ways to grieve and to learn to accept this loss. Try not to ignore your grief. Support may be available until you can manage your grief on your own. It is especially important to get help with your loss if you feel overwhelmed, consumed, or very depressed by it.

Family and friends can be a great support. They are grieving too, and some people find that sharing memories is one way you can help each other. Feel free to talk about the one who is gone. Sometimes people hesitate to bring up the loss or mention the dead person's name as they worry this can be hurtful. But everyone may find it helpful to talk directly about their loss. Shortly after Carol's husband Doug died, her friends started coming over with dinners as well as memories to share. They would sit around Carol's dining table for hours remembering Doug's humor and

kindness. Soon Doug's friends were joining them with their own recollections. It was so like old times that it almost seemed Doug had just stepped out of the room. Those evenings together helped Carol, as well as the others, start to heal after their loss.

Sometimes people find grief counseling makes it easier to work through their sorrow. There are grief counselors who will talk with you one-on-one. Regular talk therapy can help people learn to accept a death and, in time, create a new life. There are also support groups where grieving people help each other. These groups can be specialized—parents who have lost children or people who have lost spouses, for example—or they can be just generally for anyone learning to manage grief. Check with religious groups, a local hospital, hospice groups, or your doctor to find support groups in your area.

An essential part of hospice is providing grief counseling to the family of someone who was under their care. Even if hospice was not used before the death, you can ask hospice workers for bereavement support at this time. If the death happened at a nursing home or hospital, there is often a social worker you can ask for resources that can help. The funeral home might also be able to suggest where you can find counseling.

Remember to take good care of yourself. You might know that grief affects how you feel emotionally, but you may not realize that it can also have physical effects. The stress of the death and your grief could even make you sick. Eat well, exercise, get enough sleep, and get back to doing things you used to enjoy, like going to the movies, walking, or reading. Accept offers of help or companionship from friends and family. It's good for you and for them.

Let major decisions wait, if possible.

Try to delay major life decisions until you are feeling better. You don't want to decide to make a big change like selling your home or leaving your job when you are grieving and perhaps not thinking clearly.

To Learn More

About Dealing With Grief:

- AARP
  www.aarp.org • 888-687-2277 (toll-free)

- American Hospice Foundation
  www.americanhospice.org • 800-347-1413 (toll-free)

Planning for

End-of-Life Care Decisions

Because of advances in medicine, each of us, as well as our families and friends, may face many decisions about the dying process. As hard as it might be to face the idea of your own death, you might take time to consider how your individual values relate to your idea of a good death. By deciding what end-of-life care best suits your needs when you are healthy, you can help those close to you make the right choices when the time comes. This not only respects your values, but also allows those closest to you the comfort of feeling as though they can be helpful.

There are several ways to make sure others know the kind of care you want when dying.

Talking About End-of-Life Wishes

The simplest, but not always the easiest, way is to talk about end-of-life care before an illness. Discussing your thoughts, values, and desires will help people who are close to you to know what end-of-life care you want.

For example, you could discuss how you feel about using life-prolonging measures or where you would like to be cared for. For some people, it makes sense to bring this up at a small family gathering. Others may find that telling their family they have made a will (or updated an existing one) provides an opportunity to bring up this subject with other family members. Doctors should be told about these wishes as well. As hard as it might be to talk about your end-of-life wishes, knowing your preferences ahead of time can make decision making easier for your family. You may also have some comfort knowing that your family can choose what you want.

On the other hand, if your parents are aging and you are concerned about what they want, you might introduce the subject. You can try to explain that having this conversation will help you care for them and do what they want. You might start by talking about what you think their values are, instead of talking about specific treatments. Try saying something like, "when Uncle Walt had a stroke and died, I thought you seemed upset that his kids wanted to put him on a respirator." Or, "I've always wondered why Grandpa didn't die at home. Do you know?" Encourage your parents to share the type of care they would choose to have at the end of life, rather than what they don't want. There is no right or wrong plan, only what they would like. If they are reluctant to have this conversation, don't force it, but try to bring it up again at a later time.

Advance Directives and Other Documents

Written instructions letting others know the type of care you want if you are seriously ill or dying are called *advance directives.* These include a living will and health care power of attorney. A *living will* records your

end-of-life care wishes in case you are no longer able to speak for yourself. You might want to talk with your doctor or other health care provider before preparing a living will. That way you will have a better understanding of what types of decisions might need to be made. Make sure your doctor and family have seen your living will and understand your instructions.

Because a living will cannot give guidance for every possible situation, you probably want to name someone to make care decisions for you if you are unable to do so for yourself. You might choose a family member, friend, lawyer, or someone in your religious community. You can do this either in the advance directives or through a *durable power of attorney for health care* that names a *health care proxy*, who is also called a *representative, surrogate, agent,* or *attorney-in-fact.* "Durable" means it remains in effect even if you are unable to make decisions. A durable power of attorney for health care is useful if you don't want to be specific—if you would rather let the health care proxy evaluate each situation or treatment option independently. A durable power of attorney for health care is also important if your health care proxy, the person you want to make choices for you, is not a legal member of your family. Of course, you should make sure the person and alternate(s) you have named understand your views about end-of-life care. If you don't name someone, the state you live in probably has an order of priority based on family relationships to determine who decides for you. A few states let people name a health care proxy by telling their doctor, without paperwork.

Don't confuse a durable power of attorney for health care with a *durable power of attorney.* The first is limited to decisions related to health care, while the latter covers decisions regarding property or financial matters.

A lawyer can prepare these papers, or you can do them yourself. Forms are available from your local or State government, from private groups, or on the Internet. (See *To Learn More* on page 61.) Often these forms need to be *witnessed.* That means that people who are not related to you watch as you sign and date the paperwork and then sign and date it themselves as proof that the signature is indeed yours. Make sure you give copies to your primary doctor and your health care proxy. Have copies in your files as well. Hospitals might ask for a copy when you are admitted, even if you are not seriously ill.

Sometimes people change their mind as they get older or after they become ill. Review the decisions in your advance directives from time to time and make changes if your views or your health needs have changed. Be sure to discuss these changes with your health care proxy and your doctor. Replace all copies of the older version with the updated ones, witnessed and signed if appropriate.

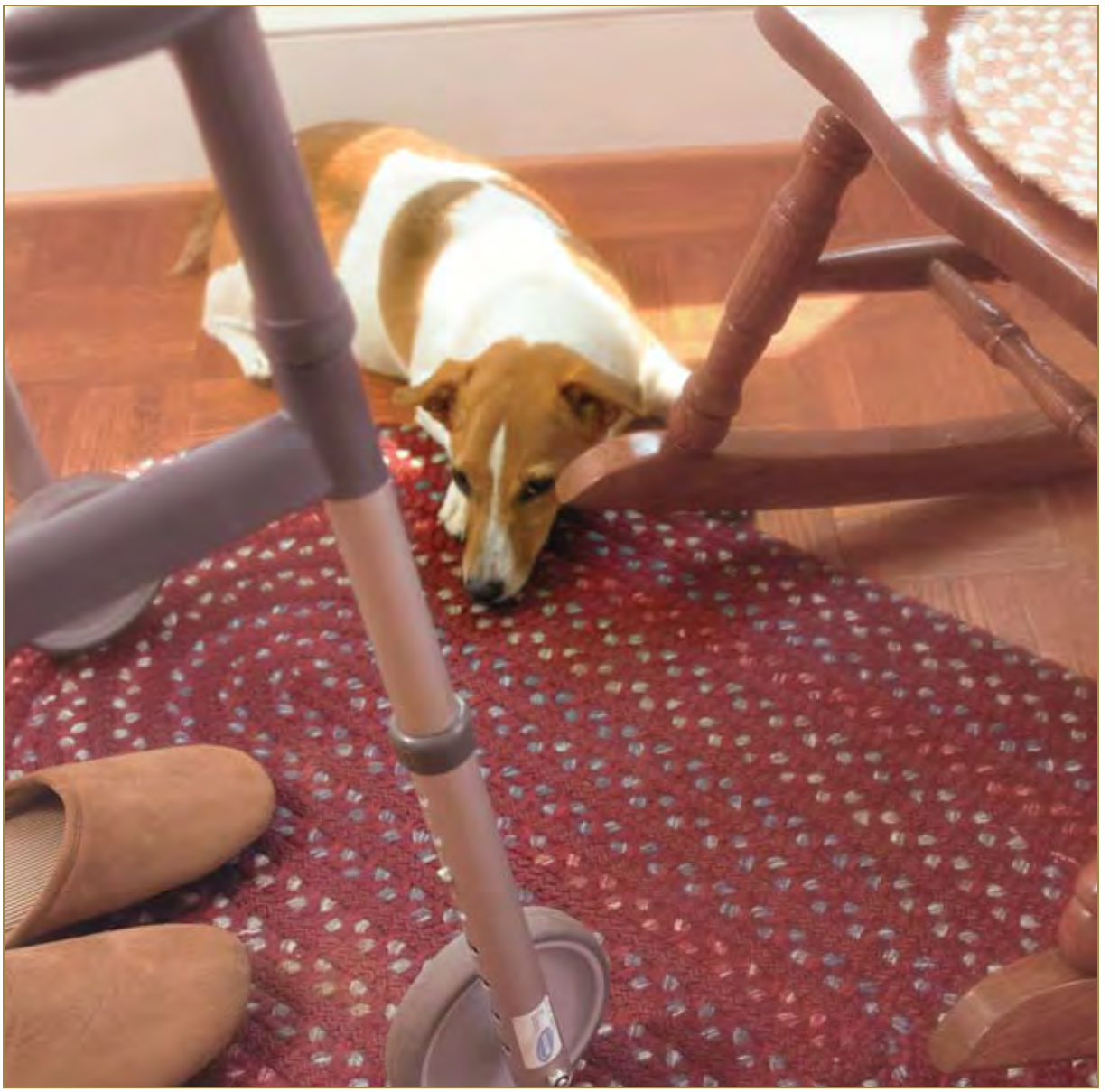
You should also give permission to your doctors and insurance companies to share your personal information with your health care proxy. This lets that person discuss your case with your doctor and handle insurance issues that may come up.

Do you live in one state, but spend a lot of time in another? Maybe you live in the north and spend winter months in a southern state. Or possibly your children and grandchildren live in a different state and you visit them often. Because states' rules and regulations may differ, make sure your forms are legal in both your home state and the state you travel to often. If not, make an advanced directive with copies for that state also. And make sure your family there has a copy.

To Learn More

About Advance Directives and Living Wills:

- American Bar Association
  www.abanet.org • 800-285-2221 (toll-free)
- Caring Connections (National Hospice and Palliative Care Organization)
  www.caringinfo.org • 800-658-8898 (toll-free)
- Medlineplus.gov
  www.medlineplus.gov, go to: Advance Directives
- National Cancer Institute
  www.cancer.gov • 800-422-6237 (toll-free)



They are not dead who live in the hearts they leave behind.

— Tuscarora saying

Closing Thoughts

Many Americans have little experience with someone who is dying. But, when the time comes, unless the death is unexpected and quick, there are choices to be made. These may not be easy. But planning ahead and working with the health care team can help you provide needed comfort.

You will probably remember for a long time what you do for someone who is dying. Realize that this is a difficult time for you too. Caring for someone at the end of life can be physically and emotionally exhausting. In the end, accept that there may be no perfect death, just the best you can do for the one you love. And the pain of losing someone close to you may be softened a little because, when they needed you, you did what you could.

Resources

If you are interested in learning more about any of the topics in this booklet, here are some other resources for you to explore. Some of these are also listed in the *To Learn More* section found at the end of most chapters.

AARP
601 E Street, NW
Washington, DC 20049
888-687-2277 (toll-free)
www.aarp.org

Aging with Dignity
Box 1661
Tallahassee, FL 32302
888-594-7437 (toll-free)
www.agingwithdignity.org

Alzheimer's Association
225 N. Michigan Avenue, Floor 17
Chicago, IL 60601
800-272-3900 (toll-free)
www.alz.org

American Academy of Pain Medicine
4700 W. Lake
Glenview, IL 60025
847-375-4731
www.painmed.org

American Academy of Wound Management
1155 15th Street, NW, Suite 500
Washington, DC 20005
202-457-8408
www.aawm.org

American Bar Association
321 N. Clark Street
Chicago, IL 60610
800-285-2221 (toll-free)
www.abanet.org

American Geriatrics Society Foundation for Health in Aging
Empire State Building
350 Fifth Avenue, Suite 801
New York, NY 10118
800-563-4916 (toll-free)
www.healthinaging.org

American Hospice Foundation
2120 L Street, NW, Suite 200
Washington, DC 20037
800-347-1413 (toll-free)
www.americanhospice.org

American Music Therapy Association
8455 Colesville Road, Suite 1000
Silver Spring, MD 20910
301-589-3300
www.musictherapy.org

Association for Conflict Resolution
1015 18th Street, NW, Suite 1150
Washington, DC 20036
202-464-9700
www.acrnet.org

Beth Israel Medical Center
Department of Pain Medicine and Palliative Care
First Avenue at 16th Street
New York, NY 10003
877-620-9999 (toll-free)
www.stoppain.org

Caring Connections
(See National Hospice and Palliative Care Organization)

Center for Caregiver Training
1320 Divisadero Street
San Francisco, CA 94115
415-563-9286
www.caregiving101.org

Centers for Medicare and Medicaid Services
800-633-4227 (toll-free)
www.medicare.gov

Center for Practical Bioethics
Harzfeld Building
1111 Main Street, Suite 500
Kansas City, MO 64105
800-344-3829 (toll-free)
www.practicalbioethics.org

Center to Advance Palliative Care
1255 Fifth Avenue, Suite C-2
New York, NY 10029
212-201-2670
www.getpalliativecare.org

Compassion and Choices
Box 101810
Denver, CO 80250
800-247-7421 (toll-free)
www.compassionandchoices.org

Department of Veterans Affairs
Veterans Benefits Administration
Veterans Health Administration
810 Vermont Avenue, NW
Washington, DC 20420
VA benefits:
800-827-1000 (toll-free)
To speak with a health care benefits counselor:
877-222-8387 (toll-free)
www.va.gov

Donate Life America
700 North 4th Street
Richmond, VA 23219
804-782-4920
www.shareyourlife.org

Eldercare Locator
800-677-1116 (toll-free)
www.eldercare.gov

Family Caregiver Alliance
180 Montgomery Street, Suite 1100
San Francisco, CA 94104
800-445-8106 (toll-free)
www.caregiver.org

Federal Trade Commission
CRC-240
Washington, DC 20580
877-382-4357 (toll-free)
www.ftc.gov

Growth House
www.growthhouse.org

Hospice and Palliative Nurses Association
One Penn Center West, Suite 229
Pittsburgh, PA 15276
412-787-9301
www.hpna.org

Hospice Association of America
228 Seventh Street, SE
Washington, DC 20003
202-546-4759
www.nahc.org/HAA

Hospice Foundation of America
800-854-3402 (toll-free)
www.hospicefoundation.org
www.hospicedirectory.org

Hospice Net
Suite 51
401 Bowling Avenue
Nashville, TN 37205
www.hospicenet.org

Living Bank
Box 6725
Houston, TX 77265
800-528-2971 (toll-free)
www.livingbank.org

National Alliance for Hispanic Health
Cuidando con Cariño/ Compassionate Care HelpLine
1501 Sixteenth Street, NW
Washington, DC 20036
877-658-8896 (toll-free)
www.hispanichealth.org

National Cancer Institute
Public Inquiries Office
6116 Executive Boulevard
Room 3036A
Bethesda, MD 20892
800-422-6237 (toll-free)
www.cancer.gov

National Hospice and Palliative Care Organization
1700 Diagonal Road, Suite 625
Alexandria, VA 22314
800-658-8898 (toll-free)
www.caringinfo.org
www.nhpco.org

National Institute of Nursing Research
31 Center Drive, Rm. 5B-10
Bethesda, MD 20892
866-910-3804 (toll-free)
www.ninr.nih.gov

National Library of Medicine
www.medlineplus.gov
Health Topics
Search for:
"Advance Directives"
"Bereavement"
"End-of-Life Issues"
"Hospice Care"
"Organ Donation"
"Pain"

Palliative Care Policy Center
www.medicaring.org

Robert Wood Johnson Foundation
Box 2316
College Road East and Route 1
Princeton, NJ 08543
877-843-7953 (toll-free)
www.lastacts.org

Society of Critical Care Medicine
500 Midway Drive
Mt. Prospect, IL 60056
847-827-6869
www.sccm.org

Visiting Nurse Associations of America
99 Summer Street, Suite 1700
Boston, MA 02110
617-737-3200
www.vnaa.org

Well Spouse Association
63 West Main Street, Suite H
Freehold, NJ 07728
800-838-0879 (toll-free)
www.wellspouse.org

The National Institute on Aging (NIA) is part of the nation's principal medical research agency, the National Institutes of Health. NIA promotes healthy aging by conducting and supporting biomedical, social, and behavioral research and public education.

To learn more about Alzheimer's disease, contact NIA's ADEAR Center at:

Alzheimer's Disease Education and Referral (ADEAR) Center
Box 8250
Silver Spring, MD 20907-8250
800-438-4380 (toll-free)
www.nia.nih.gov/alzheimers

For more information on health and aging, contact:

National Institute on Aging Information Center
Box 8057
Gaithersburg, MD 20898-8057
800-222-2225 (toll-free)
800-222-4225 (TTY/toll-free)
www.nia.nih.gov
www.nia.nih.gov/Espanol

To sign up for regular email alerts about new publications and other information from the NIA, go to www.nia.nih.gov/HealthInformation.

Visit NIHSeniorHealth (www.nihseniorhealth.gov), a senior-friendly website from the National Institute on Aging and the National Library of Medicine. This website has health information for older adults. Special features make it simple to use. For example, you can click on a button to have the text read out loud or to make the type larger.

Send comments, suggestions, or ideas to:
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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EXHIBIT 18

Pro Forma Financial Statements and Assumptions

UPDATED FOR JANUARY 2023 APPLICATION

Estimated Operating Rev and Expenses

			Yr ending Dec 31		
	1/1/24 - 6/30/24	7/1/24-12/31/24	2025	2026	2027
REVENUES					
Patient Service Charges					
Medicare		$153,111	$571,234	$875,683	$1,091,159
Medicare Managed Care		$357,259	$1,332,880	$2,043,260	$2,546,038
Medicaid		$5,609	$20,924	$32,076	$39,970
Health Options (BHP)		$11,217	$41,848	$64,152	$79,938
Charity Care		$5,608	$20,924	$32,076	$39,969
Private Pay		$8,413	$31,386	$48,114	$59,954
Third Party Insurance		$16,825	$62,773	$96,229	$119,908
Other (Champus, VA)		$2,804	$10,463	$16,039	$19,984
Total Patient Service Charges		**$560,846**	**$2,092,433**	**$3,207,629**	**$3,996,920**
Revenue Deductions					
Medicare		$13,990	$52,193	$80,011	$99,699
Medicare Managed Care		$48,873	$182,339	$279,520	$348,300
Medicaid		$1,022	$3,813	$5,845	$7,284
Health Options (BHP)		$2,243	$8,370	$12,830	$15,988
Charity Care		$5,608	$20,924	$32,076	$39,969
Private Pay		$6,730	$25,109	$38,492	$47,963
Third Party Insurance		$841	$3,139	$4,811	$5,995
Other (Champus, VA)		$701	$2,616	$4,010	$4,996
Total Revenue Deductions		**$80,009**	**$298,503**	**$457,595**	**$570,194**
Net Patient Service Revenues					
Medicare		$139,121	$519,041	$795,672	$991,461
Medicare Managed Care		$308,386	$1,150,541	$1,763,740	$2,197,738
Medicaid		$4,587	$17,111	$26,231	$32,686
Health Options (BHP)		$8,973	$33,479	$51,322	$63,950
Charity Care		$0	$0	$0	$0
Private Pay		$1,683	$6,277	$9,623	$11,991
Third Party Insurance		$15,984	$59,635	$91,418	$113,912
Other (Champus, VA)		$2,103	$7,847	$12,029	$14,988
Total Net Patient Service Revenues		**$480,837**	**$1,793,930**	**$2,750,034**	**$3,426,726**
Non-operating Revenues		$11,010	$41,160	$63,062	$78,557
TOTAL REVENUES		**$491,847**	**$1,835,090**	**$2,813,097**	**$3,505,283**
variance to 2022 application		($6,891)	$44,913	$150,659	$205,875

			Yr ending Dec 31		
EXPENSES	**1/1/24 - 6/30/24**	**7/1/24-12/31/24**	**2025**	**2026**	**2027**
Advertising	$2,000	$7,500	$15,000	$15,000	$15,000
Allocated Costs	$0	$0	$0	$0	$0
Depreciation & Amortization		$6,085	$12,071	$12,071	$12,071
Dues and Subscriptions		$2,500	$5,000	$5,000	$5,000
Education and Training		**$779**	**$2,907**	**$4,457**	**$5,553**
Employee Benefits	$26,453	$70,429	$176,759	$194,384	$219,284
Equipment Rental		$0	$0	$0	$0
Information Technology/Computers		$33,110	$19,580	$19,580	$19,580
Insurance		**$1,302**	**$4,859**	**$7,449**	**$9,282**
Interest		$0	$0	$0	$0
Legal and Professional		**$801**	**$2,988**	**$4,581**	**$5,708**
Licenses and Fees		$19,476	$20,444	$23,194	$25,944
Medical Supplies		**$31,303**	**$116,793**	**$179,038**	**$223,092**
Payroll Taxes		**$30,519**	**$76,595**	**$84,233**	**$95,023**
Postage		**$100**	**$374**	**$574**	**$715**
Purchased Services (Utilities, other)		$34,678	$129,378	$198,332	$247,135
Rental/Lease	$61,114	$20,844	$42,729	$44,011	$45,331
Repairs and Maintenance		**$230**	**$858**	**$1,316**	**$1,639**
Salaries and Wages (DNS, RN, OT, clerical, etc.)	$176,350	$469,523	$1,178,392	$1,295,892	$1,461,892
Supplies		**$778**	**$2,903**	**$4,450**	**$5,545**
Telephone/Pagers		**$4,889**	**$18,243**	**$27,965**	**$34,846**
Service Fees	$30,000	$60,000	$60,000	$60,000	$60,000
Washington State B&O Taxes (1.4% of total revenue)		$7,378	$27,526	$42,196	$52,579
Travel (patient care, other)		**$5,063**	**$18,890**	**$28,958**	**$36,083**
TOTAL EXPENSES	**$295,916**	**$807,288**	**$1,932,291**	**$2,252,680**	**$2,581,303**
		1.50%	1.50%	1.50%	1.50%
Contributions to AccentCare Hospice Foundation			$12,500	$25,000	$50,000
NET INCOME	**($295,916)**	**($315,441)**	**($109,701)**	**$535,417**	**$873,980**

Global Assumptions					
Inflation Rates	1.000				
Patient Charges	1.000				
Government Payers	1.000				
Salaries and Wages	1.000				
Medical Supplies	1.000				
Project Year 1 Ending Date		**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Fringe Benefit Percentage (excluding Gov't)		15.0%	15.0%	15.0%	15.0%
Payroll Taxes		6.5%	6.5%	6.5%	6.5%

Patient Days by Setting				
Projected Patient Days	2,236	8,344	12,791	15,938
ADC	6	23	35	44

Percentage by Setting	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Routine	98.0%	98.0%	98.0%	98.0%
Continuous Care	0.2%	0.2%	0.2%	0.2%
Respite	0.3%	0.3%	0.3%	0.3%
GIP	1.5%	1.5%	1.5%	1.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Payer Mix by Patient Day				
	12/31/2024	**12/31/2025**	**12/31/2026**	**12/31/2027**
Medicare	27.3%	27.3%	27.3%	27.3%
Medicare Managed Care	63.7%	63.7%	63.7%	63.7%
Medicaid	1.0%	1.0%	1.0%	1.0%
Health Options (BHP)	2.0%	2.0%	2.0%	2.0%
Charity Care	1.0%	1.0%	1.0%	1.0%
Private Pay	1.5%	1.5%	1.5%	1.5%
Third Party Insurance	3.0%	3.0%	3.0%	3.0%
Other (Champus, VA)	0.5%	0.5%	0.5%	0.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Workpaper 4: Patient Days by Setting by Payer				
	12/31/2024	**12/31/2025**	**12/31/2026**	**12/31/2027**
Medicare				
Routine	598	2,232	3,422	4,264
Continuous Care	1	5	7	9
Respite	2	7	10	13
GIP	9	34	52	65
Total Medicare	**611**	**2,278**	**3,492**	**4,351**
Medicare Managed Care				
Routine	1,396	5,209	7,985	9,950
Continuous Care	3	11	16	20
Respite	4	16	24	30
GIP	21	80	122	152
Total Medicare Managed Care	**1,425**	**5,315**	**8,148**	**10,153**

Medicaid				
Routine	22	82	125	156
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	2	2
Total Medicaid	**22**	**83**	**128**	**159**
Health Options (BHP)				
Routine	44	164	251	312
Continuous Care	0	0	1	1
Respite	0	1	1	1
GIP	1	3	4	5
Total Medicaid	**45**	**167**	**256**	**319**
Charity Care				
Routine	22	82	125	156
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	2	2
Total Charity Care	**22**	**83**	**128**	**159**
Private Pay				
Routine	33	123	188	234
Continuous Care	0	0	0	0
Respite	0	0	1	1
GIP	1	2	3	4
Total Private Pay	**34**	**125**	**192**	**239**
Third Party Insurance				
Routine	66	245	376	469
Continuous Care	0	1	1	1
Respite	0	1	1	1
GIP	1	4	6	7
Total Third Party Insurance	**67**	**250**	**384**	**478**
Other (Champus, VA)				
Routine	11	41	63	78
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	1	1
Total Other	**11**	**42**	**64**	**80**
ALL PAYERS				
Routine	2,192	8,177	12,535	15,619
Continuous Care	4	17	26	32
Respite	7	25	38	48
GIP	34	125	192	239
TOTAL ALL PAYERS	**2,236**	**8,344**	**12,791**	**15,938**

Patient Charges

Base Time Period	**10/1/22 to 9/30/23**
Routine	$232
Continuous Care	$1,693
Respite	$537
GIP	$1,216

Source: Palmetto GBA - https://palmettogba.com/palmetto/jmhhh.nsf/DID/REF87R0NS3

	12/31/2024	**12/31/2025**	**12/31/2026**	**12/31/2027**
Inflation Factors	1.000	1.000	1.000	1.000
Inflation-adjusted Charges				
Routine	$232	$232	$232	$232
Continuous Care	$1,693	$1,693	$1,693	$1,693
Respite	$537	$537	$537	$537
GIP	$1,216	$1,216	$1,216	$1,216
Projected Patient Charges	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Medicare				
Routine	$138,922	$518,299	$794,535	$990,043
Continuous Care	$2,067	$7,713	$11,824	$14,733
Respite	$984	$3,669	$5,625	$7,009
GIP	$11,138	$41,553	$63,700	$79,374
Total Medicare	**$153,111**	**$571,234**	**$875,683**	**$1,091,159**
Medicare Managed Care				
Routine	$324,152	$1,209,364	$1,853,913	$2,310,100
Continuous Care	$4,824	$17,997	$27,589	$34,378
Respite	$2,295	$8,562	$13,125	$16,354
GIP	$25,988	$96,957	$148,632	$185,206
Total Medicare Managed Care	**$357,259**	**$1,332,880**	**$2,043,260**	**$2,546,038**
Medicaid				
Routine	$5,089	$18,985	$29,104	$36,266
Continuous Care	$76	$283	$433	$540
Respite	$36	$134	$206	$257
GIP	$408	$1,522	$2,333	$2,907
Total Medicaid	**$5,609**	**$20,924**	**$32,076**	**$39,970**

Health Options (BHP)				
Routine	$10,177	$37,970	$58,207	$72,530
Continuous Care	$151	$565	$866	$1,079
Respite	$72	$269	$412	$513
GIP	$816	$3,044	$4,667	$5,815
Total Health Options (BHP)	**$11,217**	**$41,848**	**$64,152**	**$79,938**
Charity Care				
Routine	$5,089	$18,985	$29,104	$36,265
Continuous Care	$76	$283	$433	$540
Respite	$36	$134	$206	$257
GIP	$408	$1,522	$2,333	$2,907
Total Charity Care	**$5,608**	**$20,924**	**$32,076**	**$39,969**
Private Pay				
Routine	$7,633	$28,478	$43,656	$54,398
Continuous Care	$114	$424	$650	$810
Respite	$54	$202	$309	$385
GIP	$612	$2,283	$3,500	$4,361
Total Private Pay	**$8,413**	**$31,386**	**$48,114**	**$59,954**
Third Party Insurance				
Routine	$15,266	$56,956	$87,312	$108,796
Continuous Care	$227	$848	$1,299	$1,619
Respite	$108	$403	$618	$770
GIP	$1,224	$4,566	$7,000	$8,722
Total Third Party Insurance	**$16,825**	**$62,773**	**$96,229**	**$119,908**
Other (Champus, VA)				
Routine	$2,544	$9,493	$14,552	$18,132
Continuous Care	$38	$141	$217	$270
Respite	$18	$67	$103	$128
GIP	$204	$761	$1,167	$1,454
Total Other	**$2,804**	**$10,463**	**$16,039**	**$19,984**
ALL PAYERS				
Routine	$508,873	$1,898,530	$2,910,383	$3,626,531
Continuous Care	$7,573	$28,253	$43,311	$53,968
Respite	$3,603	$13,441	$20,604	$25,674
GIP	$40,797	$152,209	$233,332	$290,747
TOTAL ALL PAYERS	**$560,846**	**$2,092,433**	**$3,207,629**	**$3,996,920**

Net Revenues by Payer and Patient Setting

Part 1: Net Per Diem Revenues

Medicare			**% 1-60 days**	**% 1-60 days**	**Blended Rate**
Routine	$232.18	$183.47	52%	48%	$208.80
Continuous Care	$1,693.04				$1,693.04
Respite	$536.95				$536.95
GIP	$1,216.14				$1,216.14

Source: Final FY 2022 Hospice Rates CMS

Inflation-adjusted Rates	
Inflation Amount	1.000
Effective Date	9/30/2020

Inflation Factor	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Compound Inflation	1.000	1.000	1.000	1.000
Inflation-adjusted Medicare Rates				
Routine	$208.80	$208.80	$208.80	$208.80
Continuous Care	$1,693.04	$1,693.04	$1,693.04	$1,693.04
Respite	$536.95	$536.95	$536.95	$536.95
GIP	$1,216.14	$1,216.14	$1,216.14	$1,216.14

It is assumed that reimbursement rates for Medicare Managed Care and Medicaid will follow the Medicare methodology with discounts from the Medicare rates.

	12/31/2024	**12/31/2025**	**12/31/2026**	**12/31/2027**
Medicare Managed Care Discount	5%	5%	5%	5%
Medicaid Discount	10%	10%	10%	10%
Medicare Managed Care Rates				
Routine	$198.36	$198.36	$198.36	$198.36
Continuous Care	$1,608.39	$1,608.39	$1,608.39	$1,608.39
Respite	$510.10	$510.10	$510.10	$510.10
GIP	$1,155.33	$1,155.33	$1,155.33	$1,155.33
Medicaid Rates				
Routine	$187.92	$187.92	$187.92	$187.92
Continuous Care	$1,523.74	$1,523.74	$1,523.74	$1,523.74
Respite	$483.26	$483.26	$483.26	$483.26
GIP	$1,094.53	$1,094.53	$1,094.53	$1,094.53
Other Payers Percentage of Charges Collected				
Healthy Options (BHP)	80%	80%	80%	80%
Charity Care	0%	0%	0%	0%
Private Pay	20%	20%	20%	20%
Third Party Insurance	95%	95%	95%	95%
Other	75%	75%	75%	75%

For payers other than Medicare, Medicare Managed Care, and Medicaid, net revenues are computed as a percentage of charges.

Per Diem Collections

	12/31/2024	12/31/2025	12/31/2026	12/31/2027
Health Options (BHP)				
Routine	$185.74	$185.74	$185.74	$185.74
Continuous Care	$1,354.43	$1,354.43	$1,354.43	$1,354.43
Respite	$429.56	$429.56	$429.56	$429.56
GIP	$972.91	$972.91	$972.91	$972.91
Charity Care				
Routine	$0.00	$0.00	$0.00	$0.00
Continuous Care	$0.00	$0.00	$0.00	$0.00
Respite	$0.00	$0.00	$0.00	$0.00
GIP	$0.00	$0.00	$0.00	$0.00
Private Pay				
Routine	$46.44	$46.44	$46.44	$46.44
Continuous Care	$338.61	$338.61	$338.61	$338.61
Respite	$107.39	$107.39	$107.39	$107.39
GIP	$243.23	$243.23	$243.23	$243.23
Third Party Insurance				
Routine	$220.57	$220.57	$220.57	$220.57
Continuous Care	$1,608.39	$1,608.39	$1,608.39	$1,608.39
Respite	$510.10	$510.10	$510.10	$510.10
GIP	$1,155.33	$1,155.33	$1,155.33	$1,155.33
Other				
Routine	$174.14	$174.14	$174.14	$174.14
Continuous Care	$1,269.78	$1,269.78	$1,269.78	$1,269.78
Respite	$402.71	$402.71	$402.71	$402.71
GIP	$912.11	$912.11	$912.11	$912.11

Percentage of GIP Revenues to be paid to outside providers

	12/31/2024	12/31/2025	12/31/2026	12/31/2027
GIP Charges	$1,216.14	$1,216.14	$1,216.14	$1,216.14
Contract Percentage	85%	85%	85%	85%
Contract Payments	$1,033.72	$1,033.72	$1,033.72	$1,033.72
GIP Days	34	125	192	239
GIP Contract Payments	$34,678	$129,378	$198,332	$247,135

Part 2: Aggregated Net Revenues

	12/31/2024	12/31/2025	12/31/2026	12/31/2027
Medicare				
Routine	$124,933	$466,105	$714,524	$890,345
Continuous Care	$2,067	$7,713	$11,824	$14,733
Respite	$984	$3,669	$5,625	$7,009
GIP	$11,138	$41,553	$63,700	$79,374
Total Medicare	**$139,121**	**$519,041**	**$795,672**	**$991,461**
Medicare Managed Care				
Routine	$276,934	$1,033,200	$1,583,861	$1,973,597
Continuous Care	$4,583	$17,097	$26,210	$32,659
Respite	$2,180	$8,134	$12,469	$15,537
GIP	$24,689	$92,110	$141,201	$175,946
Total Medicare Managed Care	**$308,386**	**$1,150,541**	**$1,763,740**	**$2,197,738**
Medicaid				
Routine	$4,119	$15,366	$23,556	$29,352
Continuous Care	$68	$254	$390	$486
Respite	$32	$121	$185	$231
GIP	$367	$1,370	$2,100	$2,617
Total Medicaid	**$4,587**	**$17,111**	**$26,231**	**$32,686**
Health Options (BHP)				
Routine	$8,142	$30,376	$46,566	$58,024
Continuous Care	$121	$452	$693	$863
Respite	$58	$215	$330	$411
GIP	$653	$2,435	$3,733	$4,652
Total Health Options (BHP)	**$8,973**	**$33,479**	**$51,322**	**$63,950**
Charity Care				
Routine	$0	$0	$0	$0
Continuous Care	$0	$0	$0	$0
Respite	$0	$0	$0	$0
GIP	$0	$0	$0	$0
Total Charity Care	**$0**	**$0**	**$0**	**$0**
Private Pay				
Routine	$1,527	$5,696	$8,731	$10,880
Continuous Care	$23	$85	$130	$162
Respite	$11	$40	$62	$77
GIP	$122	$457	$700	$872
Total Private Pay	**$1,683**	**$6,277**	**$9,623**	**$11,991**
Third Party Insurance				
Routine	$14,503	$54,108	$82,946	$103,356
Continuous Care	$216	$805	$1,234	$1,538
Respite	$103	$383	$587	$732
GIP	$1,163	$4,338	$6,650	$8,286
Total Third Party Insurance	**$15,984**	**$59,635**	**$91,418**	**$113,912**
Other (Champus, VA)				
Routine	$1,908	$7,120	$10,914	$13,599
Continuous Care	$28	$106	$162	$202
Respite	$14	$50	$77	$96
GIP	$153	$571	$875	$1,090
Total Other (Champus, VA)	**$2,103**	**$7,847**	**$12,029**	**$14,988**
TOTAL ALL PAYERS	$480,837	$1,793,930	$2,750,034	$3,426,726
Charity Care Discount	$5,608	$20,924	$32,076	$39,969

Start Up Costs

Prior to placing the Project in service, the following investments and expenditures will be made and incurred.

Pre-opening Rental Expenses
The Applicant will execute its lease agreements and make rental payments prior to initiating services

Monthly Rental Expense (included in Income Statement)

2022 Rental	$40,473
First Six Months of 2024	$20,641
Projected Pre-opening Rental Expense	**$61,114**

Advertising Costs
Pre-opening advertising costs will consist of advertising for skilled staff to be hired in connection with the project

Projected Advertising Costs	**$2,000**

Pre-opening Hiring Costs
It is assumed that all management positions will be filled 2 months prior to the opening of the hospice.
All Staff positions will be filled one month prior to the opening of the hospice.

Annual Salary for Administrative Positions	$596,750
Annual Salary for Other Positions	$570,000
Two Months Salary Supervisor	$99,458
One Month Salary Other	$47,500
Pre-opening Medical Director Fee	$2,500
Total Pre-opening Salary	**$149,458**
Benefit Percentage (Does not apply to Med Direct	20.0%
Total Pre-opening Salary + Benefits + Stipend	**$179,350**

The Capital costs associated with furnishing the office space with furniture and communications equipment
is included in the project costs and will be expensed via the depreciation schedules set forth in this application

Total Pre-opening Expenses	**$242,464**

Rental Security Deposit	**$3,000**

Rental Worksheet

	2021	2022 (old app)	2023 (new app)
Rental Rate Base per Square Foot	$0.00	$18.00	$18.54
Add-on for Utilities	$0.00	$0.00	$0.00
Add-on for Property Taxes	$0.00	$0.00	$0.00
Total Rent per Square Foot			**$18.54**
Square Feet			2,183
Months			12
Rent Expense			$40,473
Rent			$40,473
Utilities			$0
Property Taxes			$0
Total			**$40,473**

Computation of Weighted Rental Expense

Inflation factor 1.03

	2023	**Jan-Jun 2024**	**Jul-Dec 2024**	**2025**	**2026**	**2027**
Jan	$3,373	$3,373		$3,474	$3,578	$3,685
Feb	$3,373	$3,373		$3,474	$3,578	$3,685
Mar	$3,373	$3,474		$3,578	$3,685	$3,796
Apr	$3,373	$3,474		$3,578	$3,685	$3,796
May	$3,373	$3,474		$3,578	$3,685	$3,796
Jun	$3,373	$3,474		$3,578	$3,685	$3,796
Jul	$3,373		$3,474	$3,578	$3,685	$3,796
Aug	$3,373		$3,474	$3,578	$3,685	$3,796
Sep	$3,373		$3,474	$3,578	$3,685	$3,796
Oct	$3,373		$3,474	$3,578	$3,685	$3,796
Nov	$3,373		$3,474	$3,578	$3,685	$3,796
Dec	$3,373		$3,474	$3,578	$3,685	$3,796
Total Rental Expense	**$40,473**	**$20,641**	**$20,844**	**$42,729**	**$44,011**	**$45,331**
Price per SF	$18.54	$9.46	$9.55	$19.57	$20.16	$20.77

Other Expense assumptions/considerations.

Worksheet 7:

Non-salary and other costs are based on the experience of AccentCare Hospice and Palliative Care of Oregon. The grid below summarizes patient days for this facility for Calendar Year 2022. The figures in this grid are used to compute the fixed and per diem variable non-salary costs for the project.

Patient Setting	**Patient Days**	**2020 Breakout**
Routine	15,885	97.03%
Respite	4	0.02%
GIP	483	2.95%
Continuous Care	0	0.00%
Total	**16,371**	**100.00%**

Physician Fees	$80,761
Patient Days	16,371
Per Diem Physician Fees	**$4.93**
Other Revenue Inflation Factors	1.00
Other Revenue Per Diem (all years)	$4.93

		12/31/2024	**12/31/2025**	**12/31/2026**	**12/31/2027**
Projected Patient Days (Pierce)		2,236	8,344	12,791	15,938
Projected Non-operating Revenue		$11,010	$41,160	$63,062	$78,557
	NOR/Patient day	*$4.92*	*$4.93*	*$4.93*	*$4.93*

Projected Staffing

	Current FTE		**First Six Months**		**Year 1**	
Staff	**FTE**	**Contracted**	**FTE**	**Contracted**	**FTE**	**Contracted**
RN			2.000		3.000	
LPN						
Hospice Aide			1.000		2.000	
Nursing Total			**3.000**	**0.000**	**5.000**	**0.000**
Admin			3.000		4.000	
Medical Director				0.030		0.030
Medical Director Contracted				0.200		0.200
DNS						
Business Clerical			3.000		4.000	
Admin Total			**6.000**	**0.230**	**8.000**	**0.230**
PT				0.015		0.015
OT				0.011		0.011
Speech Therapist				0.025		0.025
Clinical Nutritionist			0.100		0.100	
Med Social Worker			1.000		1.000	
Pastoral/Other Counselor (Chaplain)			1.000		1.000	
Volunteers						
Other: Music Therapy			1.000		1.000	
Others Total			**3.100**	**0.051**	**3.100**	**0.051**
TOTAL STAFFING			**12.100**	**0.281**	**16.100**	**0.281**

Staffing and Salary Levels

AccentCare follows a corporate staffing model in member hospice. The staffing levels shown below are the levels indicated for the census levels projected for the pr
three years of operations.

	12/31/2024	12/31/2025	12/31/2026	12/31/2027
Calendar Days	**184**	**366**	**365**	**365**
Patient Days	2,236	8,344	12,791	15,938
ADC	6	23	35	44

Department	**FTEs**	**FTEs**	**FTEs**	**FTEs**
Admissions Department	0.000	0.000	0.000	1.000
Business Development Department	2.000	3.000	3.000	3.000
Business Operations - Leadership	1.000	1.000	1.000	1.000
Chaplain	1.000	1.000	1.000	1.000
Executive Director	1.000	1.000	1.000	1.000
Hospice Aide	1.000	2.000	3.000	4.000
Music Therapy	1.000	1.000	1.000	1.000
Nursing	2.000	3.000	4.000	5.000
Physician Leadership (Medical Director)	0.030	0.030	0.030	0.030
Physician Team Support	0.200	0.200	0.200	0.200
Social Work	1.000	1.000	1.000	1.000
PT	0.015	0.015	0.015	0.015
OT	0.011	0.011	0.011	0.011
Speech Therapist	0.025	0.025	0.025	0.025
Clinical Nutritionist	0.100	0.100	0.100	0.100
Team Assistant	1.000	1.000	1.000	1.000
Team Director	1.000	1.000	1.000	1.000
Volunteer Department	0.000	1.000	1.000	1.000
TOTAL	**12.381**	**16.381**	**18.381**	**21.381**

		Annual Salary per FTE		
Department	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Admissions Department	$0	$0	$0	$48,500
Business Development Department	$77,500	$77,500	$77,500	$77,500
Business Operations - Leadership	$82,000	$82,000	$82,000	$82,000
Chaplain	$65,500	$65,500	$65,500	$65,500
Executive Director	$107,000	$107,000	$107,000	$107,000
Hospice Aide	$32,500	$32,500	$32,500	$32,500
Music Therapy	$58,500	$58,500	$58,500	$58,500
Nursing	$85,000	$85,000	$85,000	$85,000
Physician Leadership (Medical Director)	$250,000	$250,000	$250,000	$250,000
Physician Team Support	$250,000	$250,000	$250,000	$250,000
Social Work	$68,500	$68,500	$68,500	$68,500
PT	$93,700	$93,700	$93,700	$93,700
OT	$94,200	$94,200	$94,200	$94,200
Speech Therapist	$96,000	$96,000	$96,000	$96,000
Clinical Nutritionist	$68,000	$68,000	$68,000	$68,000
Team Assistant	$35,750	$35,750	$35,750	$35,750
Team Director	$87,500	$87,500	$87,500	$87,500
Volunteer Department	$0	$52,000	$52,000	$52,000
Effective Date	12/31/2023			
Inflation Rate		1.00		
Inflation Factor	1.00	1.00	1.00	1.00

No inflation adjustment is made

	TOTAL SALARIES (NOT INCL BENEFITS)			
Portion of Year	**50%**	**100%**	**100%**	**100%**
Department	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Admissions Department	$0	$0	$0	$48,500
Business Development Department	$78,137	$232,500	$232,500	$232,500
Business Operations - Leadership	$41,337	$82,000	$82,000	$82,000
Chaplain	$33,019	$65,500	$65,500	$65,500
Executive Director	$53,940	$107,000	$107,000	$107,000
Hospice Aide	$16,384	$65,000	$97,500	$130,000
Music Therapy	$29,490	$58,500	$58,500	$58,500
Nursing	$85,699	$255,000	$340,000	$425,000
Physician Leadership (Medical Director)	$3,781	$7,500	$7,500	$7,500
Physician Team Support	$25,205	$50,000	$50,000	$50,000
Social Work	$34,532	$68,500	$68,500	$68,500
PT	$709	$1,406	$1,406	$1,406
OT	$522	$1,036	$1,036	$1,036
Speech Therapist	$1,210	$2,400	$2,400	$2,400
Clinical Nutritionist	$3,428	$6,800	$6,800	$6,800
Team Assistant	$18,022	$35,750	$35,750	$35,750
Team Director	$44,110	$87,500	$87,500	$87,500
Volunteer Department	$0	$52,000	$52,000	$52,000
Total	**$469,523**	**$1,178,392**	**$1,295,892**	**$1,461,892**

The Expenses shown below are additional projections of costs for telecommunications, EMR, and Software Licenses. The telecommunications and EMR expenses ar
for Information Technology and Computers. The amount for Licenses is included in the expense projection for Licenses and Fees.

Telecommunications and EMR			**Six Months Ending**			
	10%					
Information Technology and Computers	**Unit Cost (2022)**	**Unit Cost (2023)**	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Toshiba Protégé x20W-D Lap Top	$1,400	$1,540	6	2	2	2
Samsung S8 Cell Phone	$700	$770	6	2	2	2
Lenovo Think Center M7 10Q Computer	$700	$770	4	1	1	1
Monitor	$150	$165	6	2	2	2
Desk Phone	$300	$330	6	2	2	2
Internet Charges	$8,400	$9,240	1	1	1	1
Telecom Charges	$3,600	$3,960	1	1	1	1
Total						

			Six Months Ending			
Licenses	**Unit Cost**	**Unit Cost**	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Windows 365 & Related	$540	$594	4	1	1	1
EMR Costs Operating	$3,500	$3,850	1	1	1	1
EMR Costs Incremental	$2,500	$2,750	3	4	5	6
Total						

TOTAL

Licenses & Fees for state and local licenses			$5,000	$5,000	$5,000	$5,000

Payroll Taxes - same as 2022 application

Postage - based on % of revenue for OR

Purchased Services
same description as 2022 application….

Projection of Purchased Services Expenses		Six Months Ending 12/31/2024	12/31/2025	12/31/2026	12/31/2027
GIP Days		34	125	192	239
Projected GIP per Diem Charge		$1,216	$1,216	$1,216	$1,216
Projected GIP per Diem Charge Contract Payment	85%	$1,034	$1,034	$1,034	$1,034
		$0.00	$0.00	$0.00	$0.00
Total Purchased Services		**$34,678**	**$129,378**	**$198,332**	**$247,135**

Source: "Forecast-Pierce" tab and 2022 application

2023 APPLICATION (UPDATED)	6 months			
Pierce County	**2024**	**2025**	**2026**	**2027**
Seasons' Share of Unmet Patients	23.0%	39.0%	39.0%	39.0%
Seasons' Hospice Patients	**57**	**157**	**207**	**258**
Seasons' Share of Total Volume	1.3%	3.5%	4.4%	5.3%
ALOS	**39**	**53**	**61.89**	**61.89**
Seasons' Patient Days	**2,236**	**8,344**	**12,791**	**15,938**
Seasons' Share of Unmet Days	14.5%	33.4%	39.0%	39.0%
Seasons' ADC	**6**	**23**	**35**	**44**
Seasons' Share of Unmet Census	14.5%	33.4%	39.0%	39.0%

Revenue and Expenses for AccentCare Pierce County
Initial Partial Year and First Three Calendar Years

REVENUE	7/1/24 - 12/31/24	CY 2025	CY 2026	CY 2027
Patient Service Charges				
Medicare and Medicare Managed Care	$510,370	$1,904,114	$2,918,943	$3,637,198
Medicaid & Medicaid Managed Care	$5,609	$20,924	$32,076	$39,970
Health Options (BHP)	$11,217	$41,848	$64,152	$79,938
Charity Care	$5,608	$20,924	$32,076	$39,969
Private Pay	$8,413	$31,386	$48,114	$59,954
Third Party Insurance	$16,825	$62,773	$96,229	$119,908
Other (Champus, VA)	$2,804	$10,463	$16,039	$19,984
Total Patient Service Charges	**$560,846**	**$2,092,433**	**$3,207,629**	**$3,996,920**
Revenue Deductions				
Medicare and Medicare Managed Care	$62,863	$234,532	$359,530	$447,999
Medicaid & Medicaid Managed Care	$1,022	$3,813	$5,845	$7,284
Health Options (BHP)	$2,243	$8,370	$12,830	$15,988
Charity Care	$5,608	$20,924	$32,076	$39,969
Private Pay	$6,730	$25,109	$38,492	$47,963
Third Party Insurance	$841	$3,139	$4,811	$5,995
Other (Champus, VA)	$701	$2,616	$4,010	$4,996
Total Revenue Deductions	**$80,009**	**$298,503**	**$457,595**	**$570,194**
Net Patient Service Revenue				
Medicare and Medicare Managed Care	$447,507	$1,669,582	$2,559,412	$3,189,199
Medicaid & Medicaid Managed Care	$4,587	$17,111	$26,231	$32,686
Health Options (BHP)	$8,973	$33,479	$51,322	$63,950
Charity Care	$0	$0	$0	$0
Private Pay	$1,683	$6,277	$9,623	$11,991
Third Party Insurance	$15,984	$59,635	$91,418	$113,912
Other (Champus, VA)	$2,103	$7,847	$12,029	$14,988
Total Net Patient Service Revenue	**$480,837**	**$1,793,930**	**$2,750,034**	**$3,426,726**
Non-operating Revenue	**$11,010**	**$41,160**	**$63,062**	**$78,557**
TOTAL REVENUE	**$491,847**	**$1,835,090**	**$2,813,097**	**$3,505,283**

EXPENSES	7/1/24 - 12/31/24	CY 2025	CY 2026	CY 2027
Advertising	$7,500	$15,000	$15,000	$15,000
Allocated Costs	$0	$0	$0	$0
Depreciation & Amortization	$6,085	$12,071	$12,071	$12,071
Dues and Subscriptions	$2,500	$5,000	$5,000	$5,000
Education and Training	$779	$2,907	$4,457	$5,553
Employee Benefits	$70,429	$176,759	$194,384	$219,284
Equipment Rental	$0	$0	$0	$0
Information Technology/Computers	$33,110	$19,580	$19,580	$19,580
Insurance	$1,302	$4,859	$7,449	$9,282
Interest	$0	$0	$0	$0
Legal and Professional	$801	$2,988	$4,581	$5,708
Licenses and Fees	$19,476	$20,444	$23,194	$25,944
Medical Supplies	$31,303	$116,793	$179,038	$223,092
Payroll Taxes	$30,519	$76,595	$84,233	$95,023
Postage	$100	$374	$574	$715
Purchased Services (Utilities, other)	$34,678	$129,378	$198,332	$247,135
Rental/Lease	$20,844	$42,729	$44,011	$45,331
Repairs and Maintenance	$230	$858	$1,316	$1,639
Salaries and Wages (DNS, RN, OT, clerical, etc.)	$469,523	$1,178,392	$1,295,892	$1,461,892
Supplies	$778	$2,903	$4,450	$5,545
Telephone/Pagers	$4,889	$18,243	$27,965	$34,846
Services Fees	$60,000	$60,000	$60,000	$60,000
Washington State B&O Taxes	$7,378	$27,526	$42,196	$52,579
Travel (patient care, other)	$5,063	$18,890	$28,958	$36,083
TOTAL EXPENSES	$807,288	$1,932,291	$2,252,680	$2,581,303
Contributions to AccentCare Hospice Foundation		$12,500	$25,000	$50,000
NET INCOME	**($315,441)**	**($109,701)**	**$535,417**	**$873,980**

Balance Sheet and Statement of Cash Flows for AccentCare Pierce County
Initial Partial Year and First Three Calendar Years

BALANCE SHEET

Current Assets	**12/31/2022**	**1/1/24 - 6/30/24**	**7/1/24 - 12/31/24**	**CY 2025**	**CY 2026**	**CY 2027**
Cash	$2,000,000	$1,609,457	$1,262,730	$1,036,007	$1,445,033	$2,241,499
Accounts Receivable	$0	$0	$80,079	$298,775	$458,007	$570,704
Total Current Assets	**$2,000,000**	**$1,609,457**	**$1,342,810**	**$1,334,782**	**$1,903,040**	**$2,812,203**
Long-term Assets						
Land						
Buildings						
Equipment		$106,700	$106,700	$106,700	$106,700	$106,700
Security Deposit		$3,000	$3,000	$3,000	$3,000	$3,000
Total Long-term Assets		**$109,700**	**$109,700**	**$109,700**	**$109,700**	**$109,700**
Less Accumulated Depreciation			$6,085	$18,157	$30,228	$42,299
Net Long-term Assets		**$109,700**	**$103,615**	**$91,543**	**$79,472**	**$67,401**
Total Assets	**$2,000,000**	**$1,719,157**	**$1,446,424**	**$1,426,326**	**$1,982,512**	**$2,879,604**
Liabilities and Equity						
Current Liabilities						
Accounts Payable	$0	$172	$10,803	$29,743	$39,727	$47,140
Salaries Payable	$0	$14,902	$47,539	$119,312	$131,209	$148,017
Current Portion of Long-term Debt	$0	$0	$0	$0	$0	$0
Debt	$0	$0	$0	$0	$0	$0
Total Current Liabilities	**$0**	**$15,074**	**$58,342**	**$149,055**	**$170,936**	**$195,157**
Long-term Debt	$0	$0	$0	$0	$0	$0
Total Liabilities	**$0**	**$15,074**	**$58,342**	**$149,055**	**$170,936**	**$195,157**
Equity	**$2,000,000**	**$1,704,084**	**$1,388,082**	**$1,277,270**	**$1,811,577**	**$2,684,446**
Liabilities Plus Equity	**$2,000,000**	**$1,719,157**	**$1,446,424**	**$1,426,326**	**$1,982,512**	**$2,879,604**

STATEMENT OF CASH FLOWS

	12/31/2022	**1/1/24 - 6/30/24**	**7/1/24 - 12/31/24**	**CY 2025**	**CY 2026**	**CY 2027**
Net Income	$0	($295,916)	($315,441)	($109,701)	$535,417	$873,980
Less Depreciation	$0	$0	$5,525	$10,961	$10,961	$10,961
Decrease (Increase) in Accounts Receivable	$0	$0	($80,079)	($218,696)	($159,232)	($112,697)
Increase (Decrease) in Accounts Payable	$0	$15,074	$43,269	$90,713	$21,881	$24,221
Net Cash Flow from Operations	**$0**	**($280,843)**	**($346,727)**	**($226,724)**	**$409,026**	**$796,466**
Purchase of Property, Plant, and Equipment	$0	($106,700)	$0	$0	$0	$0
Security Deposit	$0	($3,000)	$0	$0	$0	$0
Payment of Long-term Debt	$0	$0	$0	$0	$0	$0
Net Cash Flow from Investing	**$0**	**($109,700)**	**$0**	**$0**	**$0**	**$0**
Contribution of Capital	$2,000,000	$0	$0	$0	$0	$0
Beginning Cash	$0	$2,000,000	$1,609,457	$1,262,730	$1,036,007	$1,445,033
Ending Cash	**$2,000,000**	**$1,609,457**	**$1,262,730**	**$1,036,007**	**$1,445,033**	**$2,241,499**

*** Please note that AccentCare does not provide or develop Balance Sheet or Cash Flow statements at the facility level, and AccentCare does not routinely use facility level Cash Flow statements as part of its financial assessment when evaluating new market opportunities/business ventures. However, for the purposes of this Application, AccentCare has prepared a Balance Sheet and Cash Flow statement.*

Financial Assumptions for AccentCare Pierce County Hospice CON Application

Patient Days

We have assumed patient day breakout by setting as follows and based on our experience in running hospice operations around the country.
This breakout will be the same for each payer source (breakout for patient days by payer is below).

Routine	98.0%
Continuous Care	0.2%
Respite	0.3%
GIP	1.5%
TOTAL	**100.0%**

Similarly, we are assuming a payer mix by patiend days as follows, also based on our experience around the country.

Medicare	27.3%
Medicare Managed Care	63.7%
Medicaid	1.0%
Health Options (BHP)	2.0%
Charity Care	1.0%
Private Pay	1.5%
Third Party Insurance	3.0%
Other (Champus, VA)	0.5%
TOTAL	**100.0%**

Revenue

Patient Care Revenues: Revenues are forecast on the basis of the Applicant's historical experience in other services area. Charges are set to be generally consistent with expected Medicare reimbursement by level of service. In order to reflect patient care services rendered, charges assessed to charity care patients and to bad debts are initially recorded as private pay revenue. The allowances for charity care and bad debts are deducted from the gross revenues projected for the private pay payor group. All payor groups are projected to access the four categories of patient care routine, continuous care, respite, and GIP in the same distribution. Non-Operating Revenues: Non-Operating r evenues are billings for physician services outside of the Medicare hospice benefit. The amount shown is based on the experience of the AccentCare-Affiliated program AccentCare Hospice and Palliative Care of Oregon.

Non-Operating Revenues: Non-Operating revenues are billings for physician services outside of the Medicare hospice benefit.
The amount shown is based on the experience of the AccentCare-Affiliated program AccentCare Hospice and Palliative Care of Oregon.

Net Patient Service Revenues: Net Patient service revenues by payor are computed as follows:
Medicare: Medicare Net patient service revenues are forecast on the basis of the October 2022 Medicare rates applicable to the Applicant's proposed service area.
For purposes of computing the blended routine care rate, it is assumed that 52 percent of the routine patient days delivered at the proposed hospice will be reimbursed at the rate applicable to days 1 – 60. The balance of the projected patient days will be reimbursed at the rate applicable to days 61 and beyond.
This mix of routine days is based on the experience of SHCM with start-up programs.
Medicare Managed Care: It is assumed that managed care providers will negotiate and average discount of 5 percent below the published Medicare rates.
Medicaid: It is assumed that net reimbursement for Medicaid patients will be approximately 10 percent lower than published rates for Medicare patients.

Also consistent with our 2022 application, for payers other than Medicare, Medicare Managed Care, and Medicaid, net revenues are computed as a percentage of charges. Please see below.

Other Payers Percentage of Charges Collected	**All Years**
Healthy Options (BHP)	80%
Charity Care	0%
Private Pay	20%
Third Party Insurance	95%
Other	75%

For patient charges by setting, we are using the Palmetto GBA, LLC website, which is sourced by CMS data. (https://palmettogba.com/palmetto/jmhhh.nsf/DID/REF87R0NS3)
For Pierce County beginning from October 1, 2022 to September 30, 2023, the following rates by setting exist.
Please note that we will keep these rates for each year throughout the projected time period, that is, we will NOT inflate or decrease them.

Routine	$232
Continuous Care	$1,693
Respite	$537
GIP	$1,216

Expenses

Utilizing our Oregon operations and 2022 financial statements as a proxy, the below expenses are based on percent of revenue and consistent with our Oregon operations.

Expense	**% of Revenue (OR)**	Notes
Education and Training	0.16%	
Insurance	0.26%	
Legal and Professional	0.16%	
Medical Supplies	6.36%	
Postage	0.02%	
Repairs and Maintenance	0.05%	
Supplies	0.16%	
Telephones / Pagers	0.99%	
Travel	1.03%	

Otherwise, other expense item assumptions are below.

Advertising:
Advertising costs are based on the 2020 experience of AccentCare Hospice and Palliative Care of Oregon, which was $14,154. No inflation adjustment has been made to this amount.
Advertising costs are treated as fixed and do not respond to changes in clinical volume. For the purposes of this application, we assume $15,000 per year beginning in 2025

and half that amount from July to December of 2024. An advertising budget of $2,000 is also included in the pre-opening expenditures.

Allocated Costs:
Allocated costs are not accounted for in this model, consistent with our other markets and are therefore $0 throughout the time period.

Depreciation and Amortization:
Depreciation and Amortization is computed on the basis of the capital assets to be acquired in connection with this project. Depreciation is forecast on a straight-line basis. The depreciation table is within the capital expenditures breakout. **see "Cost Estimates" tab**

Dues and Subscriptions:
We have projected the cost of dues and subscriptions based on its experience with other start-up programs. It is assumed that this line item is not sensitive to increases in clinical volume. No inflation adjustment is made to this amount.

Education and Training:
Education and Training expenses are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022. This inclues Education/Training and Employee Relation Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Employee Benefits:
Employee benefits are projected to equal 15% of salaries and wages. This percentage does not include provision for Employed FICA contributions, which are forecast under the caption of Payroll Taxes.

Equipment Rental:
Consistent with our 2022 application, we are allocating $0 in annual expenses to equipment rental.

Information Technology / Computers:
The budget for this line item reflects the acquisition of the costs of purchasing computer hardware, cell phones, computer monitors, desk phones and applicable charges for internet connections and telecom charges. Such charges will be incurred as staffing levels require. For this reason, the largest expense is in year one. Internet and telecom charges are fixed, others are incremental. The schedule of acquisitions and expenses is shown below and we have increased unit cost 10% compared to our 2022 application.

			Six Months Ending				Six Months Ending			
Information Technology and Compu	**Unit Cost (2022)**	**Unit Cost (2023)**	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**	12/31/2024	12/31/2025	12/31/2026	12/31/2027
Toshiba Protégé x20W-D Lap Top	$1,400	$1,540	6	2	2	2	$9,240	$3,080	$3,080	$3,080
Samsung S8 Cell Phone	$700	$770	6	2	2	2	$4,620	$1,540	$1,540	$1,540
Lenovo Think Center M7 10Q Compu	$700	$770	4	1	1	1	$3,080	$770	$770	$770
Monitor	$150	$165	6	2	2	2	$990	$330	$330	$330
Desk Phone	$300	$330	6	2	2	2	$1,980	$660	$660	$660
Internet Charges	$8,400	$9,240	1	1	1	1	$9,240	$9,240	$9,240	$9,240
Telecom Charges	$3,600	$3,960	1	1	1	1	$3,960	$3,960	$3,960	$3,960
Total							**$33,110**	**$19,580**	**$19,580**	**$19,580**

Insurance:
Insurance expenses are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022.
Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Interest
We are assuming no interest expense at the local/facility level,

Licenses and Fees
Licenses and Fees include a $5,000 annual provision for state and local licenses. In addition to this amount, the following computer software and licensing fees are projected in connection with the office computer equipment to be acquired in connection with the project.

			Six Months Ending				Six Months Ending			
Licenses	**Unit Cost**	**Unit Cost**	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**	**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
Windows 365 & Related	$540	$540	4	1	1	1	$2,376	$594	$594	$594
EMR Costs Operating	$3,500	$3,500	1	1	1	1	$3,850	$3,850	$3,850	$3,850
EMR Costs Incremental	$2,500	$2,500	3	4	5	6	$8,250	$11,000	$13,750	$16,500
Total							**$14,476**	**$15,444**	**$18,194**	**$20,944**

Medical Supplies:
Medical Supplies are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022. These expenses include Clinical Supplies, DME Expense, and Pharmacy Costs. Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Payroll Taxes:
Payroll Taxes are projected to equal 6.5 percent of Salaries and Wages.

Postage:
Postage expenses are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022.
Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Purchased Services:
Purchased services consist of the fees paid to hospitals and nursing homes that provide inpatient services on a subcontracted basis to the Applicant's projected hospice inpatients.
It is assumed that these facilities will be paid an amount to 85 percent of the Medicare GIP per diem rate.

		Six Months Ending			
Projection of Purchased Services Expenses		**12/31/2024**	**12/31/2025**	**12/31/2026**	**12/31/2027**
GIP Days		34	125	192	239
Projected GIP per Diem Charge		$1,216	$1,216	$1,216	$1,216
Projected GIP per Diem Charge Contr	85%	$1,034	$1,034	$1,034	$1,034
Total Purchased Services		**$34,678**	**$129,378**	**$198,332**	**$247,135**

Rental/Lease:
The amount shown under rental and lease expense represents the costs of leasing the office space from which the proposed hospice will conduct its operations.
The lease amounts are documented in the Appendices to this application. The rental amount is inclusive of utilities and property taxes.

Repairs and Maintenance:
The Applicant estimates that repairs and maintenance will be relatively minor expenditures in its early years of operations, but has included a budget on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022. Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Salaries and Wages:
Salaries and Wages Salaries and wages are detailed in **Tables 22 and 23** of this application. Staffing levels are based on the projected daily census of the proposed hospice and AccentCare sta
Salary expense for the pre-opening period includes provisions for pre-opening hiring of staff to permit orientation and training before clinical operations commence.

Supplies:
Expenses specific to Supplies (for example, office supplies) are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022.
Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Telephones/Pagers:
The expenses included in this line item include the Information Systems and Call Center expenses at of AccentCare Hospice and Palliative Care of Oregon in 2020.
Also as indicated above, we assume that these expenses will correlate to our projected revenue.

Service Fees:
Service Fees consist of the management fee paid by the Applicant to AccentCare. This fee is fixed at $60,000 per year.

Washington State B&O Taxes:
This tax is computed as 1.5 percent of Revenues.

Travel:
Expenses specific to Travel are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2022.
Also as indicated above, we assume that these expenses will correlate to our projected revenue.

EXHIBIT 19

Medical Director Agreement
Dr. Balakrishnan Natarajan Credentials
Physician Independent Contractor Agreement

MEDICAL DIRECTOR AGREEMENT

This MEDICAL DIRECTOR AGREEMENT ("Agreement") is effective on the 1st day of January, 2021 (the "Effective Date") by and between Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Seasons") and Balakrishnan Natarajan, M.D. ("Physician").

RECITALS

A. WHEREAS, Seasons operates a licensed hospice program, or is seeking such licensure, to provide hospice and palliative care and related services that focus primarily on improving the quality of life of terminally-ill patients and their families; and

B. WHEREAS, Seasons desires to employ Physician, and Physician desires to be so employed, to provide Services for Seasons in accordance with the terms and conditions of this Agreement.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions. Capitalized terms not otherwise defined herein shall have the following meanings:

(a) "Applicable Laws" means all federal, state, and local laws, rules, and regulations applicable to Seasons, Physician, or the Services to be performed by Physician pursuant to this Agreement, as amended from time to time. For the purposes of this Agreement, Applicable Laws shall include, but not be limited to, the Social Security Act, the Medicare hospice regulations, and applicable state hospice licensure and Medicaid laws, rules, and regulations.

(b) "Approval" means any and all federal, state, and local governmental and regulatory approval, authorization, license, or permit; Medicare and Medicaid and other provider and supplier number or registration including, but not limited to, Federal Drug Enforcement Agency ("DEA") registrations and state equivalents, if any; and certifications required by Applicable Laws.

(c) "Attending Physician" means a duly licensed doctor of medicine or osteopathy who is identified by a Patient or his or her legal representative upon the election of Hospice Services as having the most significant role in the determination and delivery of the Patient's medical care.

(d) "Patient" means an individual who has been duly admitted and accepted by Seasons to receive Hospice Services.

(e) "Hospice Services" means those services and items that are reasonable and necessary for the palliation and management of a Patient's terminal illness and related conditions as specified in such Patient's Plan of Care.

(f) "Interdisciplinary Group" ("IDG") means Seasons' group of qualified individuals, including but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(g) "Medical Director" means an employee or contractor of Seasons who is designated as Seasons' Medical Director, and who has overall responsibility for Seasons' medical component in accordance with Applicable Laws.

(h) "Plan of Care" means a written care plan established, maintained, and modified, as necessary, for each Patient receiving Hospice Services by the IDG which includes (i) an assessment of the Patient's needs; (ii) an identification of the Hospice Services appropriate to meet the needs of the Patient and his or her family; and (iii) details concerning the scope and frequency of such Hospice Services.

(i) "Services" means the Hospice Services set forth in the attached exhibits, administrative services, and other physician services provided to Seasons or Patients.

2. Employment. Seasons hereby employs Physician to provide Services for Seasons during the Term of this Agreement and in accordance with the terms and conditions set forth herein, and Physician hereby agrees to be so employed by Seasons.

3. Physician's Responsibilities.

(a) Hospice Services. In furtherance of Physician's duties and responsibilities hereunder, Physician shall provide Hospice Services in accordance with the provisions of the exhibits attached hereto.

(b) Extent of Services. Physician shall be available for on-call consultations, assistance, and decisions regarding patient care on a schedule and at times as agreed upon by Seasons and Physician.

(c) Supervision. As an employee of Seasons, for services Physician provides on behalf of Seasons, Physician shall at all times be subject to the general administrative control and supervision of Seasons, and for administrative purposes shall report directly to the Executive Director of Seasons, or such other individual appointed by Seasons.

(d) Seasons Policies and Procedures. Physician shall follow and at all times comply with Seasons' policies and procedures, which will remain available for review at Seasons offices.

(e) Documentation. Physician shall prepare and maintain accurate and complete reports and other documentation with respect to the performance of the Services provided hereunder, including medical records and time reports (collectively, "Documentation"), in accordance with sound medical practice, Applicable Laws, Seasons policies and procedures, and other reasonable requirements of Seasons. Physician shall provide a signed medical record entry at the time each medical service is provided by Physician to a Patient. All Documentation shall remain the exclusive property of Seasons and Physician shall not have any ownership interest in Documentation of Seasons records. This section shall survive termination of this Agreement with respect to Documentation of Services provided prior to termination. Failure to comply with this section shall be grounds for immediate termination. Any such termination shall not relieve Physician of the obligation to complete Documentation.

(f) Drug Use. Physicians will be free from the influence of alcohol or illegal substances while providing Services under this Agreement.

(g) Nurse Practitioner Supervision. If requested by Seasons, Physician shall provide supervision of Seasons nurse practitioners, including executing a collaborative agreement if required by state law.

4. Representations, Warranties, and Covenants of Physician. Physician represents, warrants, and covenants to Seasons, upon execution of Agreement and continuously throughout the Term of this Agreement, as follows:

(a) Approvals. Physician possesses and shall maintain in full force and effect at all times all Approvals necessary to perform the Services under this Agreement. Physician has not: (i) had any license to practice medicine in any state, DEA Registration Number, any state-issued authorization to prescribe controlled substances or other Approval suspended, relinquished, terminated, restricted, revoked, or voluntarily surrendered; (ii) been disciplined by any licensing board, state or local society, or specialty board; (iii) had entered against Physician a final judgment in, or settled, a malpractice or similar action during the past 5 years; or (iv) had his or her medical staff privileges at any hospital or medical facility revoked, suspended, relinquished, terminated, or restricted. If any of the events described in this section should occur during the Term of this Agreement, Physician shall provide Seasons with immediate written notice thereof. Physician holds the Medicare provider number, the National Provider Identifier, and the DEA registration number that appear beneath Physician's signature below.

(b) Program Exclusion. Physician has not been convicted of a criminal offense related to, and has not been debarred, excluded, or suspended from participation in, any federal health care program (as defined in Section 1128B of the Social Security Act (42 U.S.C.

1320a-7b(f))) or state health care program (as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(h)).

(c) Compliance with Applicable Laws and Policies, Standard of Care. Physician shall perform all Services hereunder in accordance with: (i) all Applicable Laws; (ii) Seasons policies and procedures; and (iii) generally recognized standards of care and the codes of ethics and/or professional conduct of the professional associations of which Physician is a member.

(d) Board Certification. Physician shall be board certified as agreed to by Physician and Seasons in writing, and shall promptly furnish Seasons with evidence of such board certification upon request.

(e) Continuing Medical Education. Physician shall do all things reasonably necessary to maintain the Approvals and board certification referred to in this section including attending continuing medical education programs in accordance with licensure or certification requirements and Seasons policies and procedures.

5. Seasons' Responsibilities. Seasons retains full professional management responsibility and authority over, and control of, all aspect of Seasons business and operations that may not legally be carried on by persons or entities other than Seasons including, but not limited to, the responsibility for planning, coordinating, and providing Hospice Services for Patients and their families. Nothing in this Agreement shall be construed to delegate to Physician any professional management or other responsibility or authority that may only be exercised by Seasons under Applicable Laws.

6. Compensation and Benefits. In consideration for Services provided by Physician under this Agreement, Physician shall be paid in accordance with, and subject to, the terms and conditions set forth in the exhibits attached hereto. Seasons reserves the right to withhold payment if a Physician fails to provide Documentation of such Services and/or any Services cannot be billed by Seasons due to failure of Physician to complete Documentation, where permitted by state law. Seasons reserves the right to recoup payment if a Physician fails to provide Services as required under this Agreement, where permitted by state law. Should Physician receive any overpayment, Physician shall immediately notify Seasons of such overpayment. The amounts to be paid by Seasons to Physician pursuant to this Agreement have been determined through good faith bargaining, in an arm's length process, to be fair market value for the performance of the duties, responsibilities, and obligations of Physician specified herein. No amount paid hereunder is intended to be a direct or indirect, covert or overt offer, inducement, or payment for referrals of patients or services. Physician will be eligible to receive benefits in accordance with, and subject to, the terms and conditions of Seasons policies and procedures for full-time or part-time employees, as applicable to Physician.

7. Confidentiality and Non-Solicitation.

(a) Confidentiality. Physician acknowledges and agrees that in the performance of the Services hereunder Physician will receive or have access to the Confidential Information (as defined below) of Seasons. Physician shall hold all such Confidential Information in strict confidence, and shall not disclose any such Confidential Information to any third party, at any time during the Term of this Agreement or after the termination of this Agreement. The provisions of this section shall not apply to the extent that such Confidential Information: (i) is in the public domain through no fault of Physician; (ii) is lawfully acquired by Physician from a third party under no obligation of confidence to Seasons; or (iii) is required by Applicable Law by any governmental or judicial body to be disclosed; provided, however, that upon receiving notice of a required disclosure under this clause, Physician shall promptly notify Seasons of such required disclosure in writing. Such Confidential Information shall not otherwise be used to the detriment of Seasons in any manner and all Confidential Information provided by Seasons to Physician, including all copies and extracts thereof, will be returned to Seasons immediately upon its request. For purposes of this Agreement, the term "Confidential Information" shall mean any and all confidential and proprietary information relating to the business and operation of Seasons, including but not limited to, information with respect to Seasons' existing and contemplated services, products, trade secrets, know how, research and development, formulas, models, compilations, processes, inventions, computer code generated or developed, software or programs, related documentation, business and financial methods or practices, plans, pricing, operating margins, marketing, merchandising and selling techniques and information, customer lists, details of customer agreements, sources of supply, employee compensation and benefit plans, patients, patient records and data, and other confidential information relating to Seasons policies and procedures, operating strategies, expansion strategies or business strategies or other confidential or proprietary information of Seasons.

(b) Non-Solicitation of Patients, Customers, and Suppliers. Physician agrees that during the Term of this Agreement, Physician shall not directly or indirectly through another person or entity, solicit the trade, business, or care of any patient, prospective patient, customer, prospective customer, referral source, prospective referral source, supplier, or prospective supplier of Seasons for any business or other purpose competitive with the business of Seasons (i.e., hospice and palliative care). Physician further agrees that for 1 year following termination of this Agreement, Physician shall not directly or indirectly through another person or entity, solicit the trade, business or care of any patients, customers, referral sources or suppliers, or prospective patients, customers, referral sources or suppliers, of Seasons for any business or purpose competitive with the business of Seasons (i.e., hospice and palliative care); provided however, that the foregoing shall not be construed (i) to interfere with or prohibit a patient's or prospective patient's freedom of choice, or (ii) to prohibit Physician's solicitation of any patient who was a patient of Physician prior to such time as the patient became a Patient of Seasons.

(c) Non-Solicitation of Employees. Physician agrees that, during the Term of this Agreement and for 1 year following termination of this Agreement, Physician shall not

directly or indirectly through another person or entity, solicit or induce, or attempt to solicit or induce, any employee of Seasons to leave Seasons for any reason whatsoever, or hire (in any capacity) any person who was an employee of Seasons at any time during the 6 month period immediately prior to the date on which such hiring would take place (it being conclusively presumed by the parties so as to avoid any disputes under this section that any such hiring within such 6 month period is in violation of this section).

(d) Injunctive Relief. Physician agrees that in the event of any breach by Physician of any of the covenants or agreements contained in this section, Seasons would suffer substantial and irrevocable damage and would encounter extreme difficulty in attempting to prove the actual amount of damages suffered by Seasons as a result of such breach, and Seasons would not have an adequate remedy at law in such event and, therefore, in addition to any other remedy Seasons may have at law or in equity in the event of any such breach, Seasons shall be entitled to seek and receive specific performance and temporary, preliminary and permanent injunctive relief from any breach of any of the covenants or agreements of this Agreement from any court of competent jurisdiction without the necessity of proving the amount of any actual damages to it resulting from such breach. This section shall survive termination of this Agreement.

8. Insurance. Seasons shall at all times during the Term of this Agreement maintain professional liability insurance and general liability insurance (including contractual liability for this Agreement) with minimum separate limits of $1,000,000 per occurrence and $3,000,000 in the aggregate, to cover claims arising from the acts or omissions of Physician in his or her performance of the Services under this Agreement. Such coverages may be maintained by Seasons on a claims-made basis with Seasons' purchase of tail end coverage to insure claims occurring during the Term of this Agreement, or may be maintained by Seasons' on an occurrence basis. This section shall survive termination of this Agreement. PHYSICIAN ACKNOWLEDGES AND AGREES THAT THE PROFESSIONAL LIABILITY AND OTHER INSURANCE PROVIDED HEREUNDER DOES NOT COVER PHYSICIAN'S ACTIVITIES WHICH ARE OUTSIDE THE SCOPE OF THIS AGREEMENT AND NOT PERFORMED FOR THE BENEFIT OF SEASONS, AND THAT PHYSICIAN MUST OBTAIN SEPARATE PROFESSIONAL LIABILITY AND OTHER INSURANCE FOR SUCH OUTSIDE ACTIVITIES.

9. Term and Termination.

(a) Term of Agreement. The initial term of this Agreement shall commence on the date first above written and shall continue for a period of 1 year (the "Initial Term"). Upon the expiration of the Initial Term, this Agreement shall automatically renew for additional consecutive renewal terms of 1 year each (each a "Renewal Term"), unless earlier terminated in accordance with the terms hereof. The "Term" of this Agreement shall mean and include the Initial Term, together with any Renewal Terms, until terminated as provided herein. In the event a party does not desire to renew this Agreement, it shall provide written notice of non-renewal to

the other Party not less than 30 days prior to the expiration of the Initial Term or any Renewal Term, as the case may be.

(b) Termination for Cause.

(i) If Physician is in default of any material term, condition, representation, or warranty under this Agreement, or fails to perform in any material respect any of the Services hereunder, and such default or failure is not cured within 30 days following its receipt of notice of default or failure, then Seasons may, after the expiration of such 30 day period, terminate this Agreement upon written notice to Physician.

(ii) Seasons may terminate this Agreement in the event of Physician's (i) loss or suspension of any Approval, or (ii) failure to qualify for coverage under Seasons' insurance policy. Such termination shall be effective immediately upon written notice of termination to Physician. Physician shall immediately notify Seasons in writing of the occurrence or threat of occurrence of any of the events specified in this section.

(iii) Seasons may terminate this Agreement if it determines in its sole discretion that continuation of this Agreement may be detrimental to the operations of Seasons, or could jeopardize the health or welfare of any Patient. Such termination shall be effective immediately upon written notice of termination to Physician.

(c) Suspension. In lieu of termination, Seasons may suspend the operation of this Agreement at any time upon the occurrence of any of the events giving rise to Seasons' right to terminate this Agreement pursuant to the sections above or upon Seasons' determination in its sole discretion that there is probable cause to believe that any of such events may have occurred.

(d) Death or Disability of Physician. This Agreement shall automatically terminate upon Physician's death or disability, as reasonably determined by Seasons in its sole discretion and in accordance with all Applicable Laws.

(e) Termination without Cause. Either party may terminate this Agreement without cause upon not less than 60 days prior written notice of termination to the other party.

(f) Effect of Termination or Suspension. If this Agreement is terminated or suspended, Physician shall immediately cease providing any Services hereunder unless Seasons notifies Physician that he or she shall continue to provide Services in accordance with this Agreement until a successor is named, in which event Seasons shall continue to reimburse Physician in accordance with this Agreement. This provision shall survive termination of this Agreement.

10. Notification of Material Events. Physician shall immediately notify Seasons of:

(a) Incident Reporting. Any incident involving a Patient including mistreatment or neglect; verbal, mental, sexual, or physical abuse; injuries of an unknown source; or misappropriation of patient property.

(b) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against Physician.

(c) Exclusion. Any threatened, proposed, or actual exclusion of Physician or its personnel from any government program including, but not limited to, Medicare or Medicaid.

11. General Provisions.

(a) Nondiscrimination. Physician shall perform the Services hereunder without unlawful discrimination on the basis of race, color, religion, national origin, sex, ancestry, disability, or any other basis protected by law.

(b) Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment which is caused, directly or indirectly, by acts of nature, military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, strikes, or other work interruptions beyond the reasonable control of either party. However, both parties shall make good faith efforts to perform their respective obligations under this Agreement in the event of any such circumstances.

(c) Medical Judgment. The parties agree that Seasons shall not control the professional judgment, treatment, or medical services rendered by Physician, and the responsibility for the aforementioned shall rest solely with Physician.

(d) Notices. Any notice, demand, request, consent, or approval required or permitted hereunder shall be in writing and shall be delivered (i) personally; (ii) by certified mail, return receipt requested, postage prepaid; or (iii) by overnight courier, to the address indicated below or to such other address as may be designated in writing by any party from time to time:

If to Seasons:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: President

With a copy to:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: Legal Department

If to Physician:

Balakrishnan Natarajan, M.D.
540 Mills St.
Hinsdale, IL 60521

All such communications shall be deemed to have been received by the intended recipient (i) 3 business days following deposit in the United States Mail if sent by certified mail; (ii) on the day actually received if delivered personally; or (iii) on the next business day if sent by overnight courier.

(e) No Third-Party Beneficiaries. This Agreement shall not confer any rights or remedies upon any person other than Seasons and Physician and their respective successors and permitted assigns.

(f) Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State where Seasons is located without giving effect to any choice or conflict of law provision or rule (whether of the State where Seasons is located or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State where Seasons is located**.**

(g) Amendments and Waivers. No amendment of any provision of this Agreement, and no postponement, or waiver of any such provision or of any default, misrepresentation, or breach of warranty or covenant hereunder, whether intentional or not, shall be valid unless such amendment, postponement, or waiver is in writing and signed by or on behalf of Seasons and Physician. No such amendment, postponement, or waiver shall be deemed to extend to any prior or subsequent matter, whether or not similar to the subject-matter of such amendment, postponement, or waiver. No failure or delay on the part of Seasons or Physician in exercising any right, power, or privilege under this Agreement shall operate as a waiver thereof nor shall any single or partial exercise of any right, power, or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, power, or privilege.

(h) Succession and Assignment. This Agreement shall be binding upon and inure to the benefit of Seasons and Physician and their respective heirs, executors, successors and permitted assigns. No party may assign this Agreement or any of such party's rights, interests, or obligations hereunder without the prior approval of the other party hereto, except that Seasons

may assign its rights, interests, and obligations hereunder, in whole or in part, to any of its affiliates.

(i) Legal Compliance. Nothing contained in this Agreement will require Physician to admit or refer any patients to Seasons as a precondition to receiving the benefits set forth herein. In the event that either party determines, with the documented advice of qualified legal counsel, that compliance with the terms of this Agreement by either party would pose a clear and present risk of causing a party of violating an Applicable Law of any kind, including but not limited to laws relating to relationships between referral sources or relating to availability of reimbursement to Seasons from governmental payers, the party will provide notice of the potential violation and proposed modifications to the Agreement to remediate the potential violation and for the 15 day period after the other party received the foregoing notice and the parties will negotiate in good faith for an appropriate amendment to this Agreement. If the parties are not able to agree within that time, either party may terminate this Agreement immediately on written notice to the other party. Such notice shall not be deemed an admission by either party that a violation of an Applicable Law has occurred.

(j) Construction. Seasons and Physician have participated jointly in the negotiation and drafting of this Agreement. If an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by Seasons and Physician and no presumption or burden of proof shall arise favoring or disfavoring Seasons or Physician because of the authorship of any of the provisions of this Agreement. Any reference to any Applicable Law shall be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise. Each representation, warranty, and covenant contained herein shall have independent significance. If Seasons or Physician breaches in any respect any representation, warranty, covenant, or other obligation contained herein or created hereby, the fact that there exists another representation, warranty, covenant, or obligation relating to the same subject matter (regardless of the relative levels of specificity) which has not been breached shall not detract from or mitigate the consequences of such breach. The rights and remedies expressly specified in this Agreement are cumulative and are not exclusive of any rights or remedies which any party would otherwise have. The article and section headings hereof are for convenience only and shall not affect the meaning or interpretation of this Agreement.

(k) Severability. The invalidity or unenforceability of one or more of the provisions of this Agreement in any situation in any jurisdiction shall not affect the validity or enforceability of any other provision hereof or the validity or enforceability of the offending provision in any other situation or jurisdiction.

(l) Entire Agreement; Counterparts. This Agreement (including the appendix and exhibits attached hereto and the documents referred to herein) constitutes the entire agreement among the parties and supersedes any prior understandings, agreements or representations by or among the parties, written or oral, to the extent they relate to the subject

matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. It shall not be necessary in making proof of this Agreement to produce or account for more than one such counterpart.

(m) Prevailing Party. If any litigation, including arbitration, arises as a result of the terms, conditions, or provisions of this Agreement, the prevailing party shall be entitled to recover reasonable attorneys' fees at all pre-trial, trial and appellate levels, as well as all costs and expenses.

(n) Waiver of Jury Trial. **EACH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES TRIAL BY JURY IN CONNECTION WITH ANY ACTION OR PROCEEDING INSTITUTED UNDER OR RELATING TO THIS AGREEMENT, OR ANY OTHER DOCUMENT EXECUTED PURSUANT TO THIS AGREEMENT, OR IN CONNECTION WITH ANY COUNTERCLAIM RESULTING FROM ANY SUCH ACTION OR PROCEEDING.**

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement as of the date first written above.

SEASONS:	PHYSICIAN:
By: 	By: 
Name: Todd Stern	Name: Balakrishnan Natarajan, MD
Title: CEO	Title: Physician

EXHIBIT A

MEDICAL DIRECTOR SERVICES

1. Responsibilities. As Medical Director, Physician shall have overall responsibility for the medical component of Hospice Services. Such responsibilities include:

(a) Clinical Care Quality.

(i) Patient Care. Physician shall review the quality of and provide medical expertise on pain and symptom management to admission and Patient care staff. Physician shall interact with Attending Physicians as necessary regarding pain and symptom management issues and issues involving Patient prognosis. Physician shall periodically attend home care team meetings and rounds in inpatient units.

(ii) Plan of Care. Physician shall assure the quality of initial and comprehensive Plans of Care.

(iii) Terminal Illness. Physician shall provide medical expertise and assure appropriate evaluation and certification of terminal prognosis of Patients to admission and Patient care staff. Physician shall also review recertifications of terminal prognosis.

(iv) Face-to-Face Encounters. Prior to a Patient's third and subsequent re-certifications, Physician shall ensure a face-to-face encounter with the Patient to gather clinical findings that support continued hospice care and also attest that such a visit took place, all in the manner required under Applicable Laws.

(v) Revocation and Discharge. Physician shall review hospice revocations and relevant discharges by Patients, including discharges for extended prognosis.

(vi) Documentation. Physician shall ensure the accuracy of Documentation of Services provided pursuant to the Agreement.

(vii) Collaboration. Physician shall actively participate in formal quality improvement functions and on the quality improvement committee. Physician shall also actively participate in ethics committee and IDG meetings.

(b) Supervision of Team Physicians.

(i) Hiring and Orientation. Physician shall interview and participate in the hiring and contracting of team physicians with the clinical director. Physician shall orient team physicians as to clinical responsibilities and the principles of palliative care.

(ii) Quality. Physician shall periodically review the quality of clinical care provided by the team physicians. Physician shall also periodically review the quality of the Documentation of visits made by the team physicians.

(iii) Participation and Support. Physician shall ensure proper team physician participation and support in team meetings. Physician shall also ensure proper team physician support to the hospice nurse, Patient care manager/team manager, and other clinical team members. Physician shall participate with the Patient care manager/team manager in the yearly formal evaluation of the team physician. Physician shall ensure that a physician on-call rotation is established so that there is team physician support available 24 hours-a-day, 7 days-a-week.

(c) Management.

(i) Meetings. Physician shall participate as an active member of the local/regional management team (including the budget process, strategic planning, etc.) and actively participate in leadership and operations meetings.

(ii) Audits and Denials. Physician shall participate in responding to audits and denials from third party insurance and intermediaries (e.g., Medicare), if requested.

(iii) Credentialing. Physician shall ensure that all contracted physicians, including team physicians and consulting physicians, are properly credentialed via Seasons' credentialing process. Physician shall serve on Seasons' credentialing committee.

(d) Community Relations. Physician shall educate community physicians on the principles of palliative care. Physician shall provide resource and consultative support to community physicians in palliative care, and attend and present at medical staff and other medical community conferences on palliative care. Physician shall serve as a liaison between Seasons and community physicians including making regular contacts with practicing physicians to introduce hospice, to educate physicians regarding individuals for whom hospice may be appropriate, and to answer clinical and other concerns of physicians with respect to hospice. Physician shall assist in introducing Seasons to long term care providers, managed care providers, hospitals, and others. Physician shall conduct educational seminars, in services, and presentations to physicians, nurses, and other health care audiences whose support for and understanding of hospice is integral to assuring that hospice services are made accessible to patients and families.

(e) Education and Research. Physician shall assist in the development of and actively participate in clinical training for all Patient care and admissions personnel. Physician shall actively participate in medical and nursing education programs on palliative medicine that may be provided by Seasons to medical and nursing colleges in the community. Physician shall assist in the development of and actively participate in research protocols on both the local and

corporate level. Physician shall be a member of and participate in professional organizations related to palliative medicine.

(f) Other. Physician shall fulfil other duties, as may be assigned by the Executive Director, including performing the duties of a team physician when necessary.

(g) Requirements and Qualifications.

(i) Principles of Hospice Care. Physician shall have knowledge of the principles and practice of primary medical care, with at least a working knowledge of hospice and palliative care, with particular emphasis on control of symptoms associated with terminal illness.

(ii) Collaboration. Physician shall have the ability to work collaboratively with Patients' Attending Physicians to effectively implement the hospice program. Physician shall also have the ability to work collaboratively with Seasons' employees and volunteers as part of the IDG.

2. Title. Physician's title shall be Medical Director.

3. Compensation.

(a) Compensation Prior to Licensure. In consideration for the Medical Director Services provided by Physician hereunder prior to Seasons becoming licensed as a hospice provider, Seasons will pay Physician a one-time payment of $2,500.00. Physician shall provide such Medical Director Services upon Seasons' request.

(b) Compensation After Licensure. In consideration for the Medical Director Services provided by Physician hereunder once Seasons is licensed as a hospice provider, Seasons will pay Physician $7,500.00 annually, paid in biweekly installments. Physician shall provide approximately 1 hour of Medical Director Services per week, which may vary from week to week.

4. Payment in Full. Physician shall accept such compensation as payment in full for all Medical Director Services provided by Physician hereunder, and shall not seek or accept additional compensation from Patients or their families or representatives, Medicare, Medicaid, or any other or third-party payors.

5. Right to Payment. Physician's right to payment from Seasons for Medical Director Services under this exhibit will not be contingent on Seasons' ability to collect the amounts billed to Patients, Medicare, Medicaid, or third-party payors, unless any inability to collect is through fault of Physician.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

1/25/2023

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for Natarajan, Balakrishnan .

This site is a Primary Source for Verification of Credentials.

Credential Number:	MD61027396
Credential Type:	Physician And Surgeon License
First Credential Date:	03/24/2020
Last Renewal Date:	01/04/2021
Credential Status:	ACTIVE
Current Expiration Date:	02/28/2023
Enforcement Action:	No

The Washington Department of Health presents this information as a service to the public.

The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, the mere presence of such information does not imply a practitioner is not competent or qualified.

This site provides disciplinary actions taken and credentials denied for failure to meet qualifications. If the Enforcement Action is listed as a No, there has been no disciplinary action. It allows viewing and downloading of related legal documents since July 1998. Contact our Public Records Office for information on actions before July 1998. This information comes directly from our database. It is updated daily.

PHYSICIAN INDEPENDENT CONTRACTOR AGREEMENT

This PHYSICIAN INDEPENDENT CONTRACTOR AGREEMENT ("Agreement") is effective on the ____ day of _____, 20__ (the "Effective Date") by and between Seasons Hospice & Palliative Care of Pierce County Washington, LLC ("Seasons") and _____ ("Group").

RECITALS

A. WHEREAS, Seasons operates a licensed hospice program, or is seeking such licensure, to provide hospice and palliative care and related services that focus primarily on improving the quality of life of terminally-ill patients and their families; and

B. WHEREAS, Seasons desires to engage Group, and Group desires to be so engaged, to provide Services for Seasons in accordance with the terms and conditions of this Agreement.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Definitions. Capitalized terms not otherwise defined herein shall have the following meanings:

(a) "Applicable Laws" means all federal, state, and local laws, rules, and regulations applicable to Seasons, Group, Group Physicians, or the Services to be performed by Group pursuant to this Agreement, as amended from time to time. For the purposes of this Agreement, Applicable Laws shall include, but not be limited to, the Social Security Act, the Medicare hospice regulations, and applicable state hospice licensure and Medicaid laws, rules, and regulations.

(b) "Approval" means any and all federal, state, and local governmental and regulatory approval, authorization, license, or permit; Medicare and Medicaid and other provider and supplier number or registration including, but not limited to, Federal Drug Enforcement Agency ("DEA") registrations and state equivalents, if any; and certifications required by Applicable Laws.

(c) "Attending Physician" means a duly licensed doctor of medicine or osteopathy who is identified by a Patient or his or her legal representative upon the election of Hospice Services as having the most significant role in the determination and delivery of the Patient's medical care.

(d) "Patient" means an individual who has been duly admitted and accepted by Seasons to receive Hospice Services or Non-Hospice Palliative Care Services.

(e) "Hospice Services" means those services and items that are reasonable and necessary for the palliation and management of a Patient's terminal illness and related conditions as specified in such Patient's Plan of Care.

(f) "Interdisciplinary Group" ("IDG") means Seasons' group of qualified individuals, including but not limited to: a doctor of medicine or osteopathy; a registered nurse; a social worker; and a pastoral or other counselor.

(g) "Medical Director" means an employee or contractor of Seasons who is designated as Seasons' Medical Director, and who has overall responsibility for Seasons' medical component in accordance with Applicable Laws.

(h) "Non-Hospice Palliative Care Services" means palliative care services provided to Patients by Seasons.

(i) "Plan of Care" means a written care plan established, maintained, and modified, as necessary, for each Patient receiving Hospice Services by the IDG which includes (i) an assessment of the Patient's needs; (ii) an identification of the Hospice Services appropriate to meet the needs of the Patient and his or her family; and (iii) details concerning the scope and frequency of such Hospice Services.

(j) "Services" means the Hospice Services and Non-Hospice Palliative Care Services set forth in the attached exhibits, administrative services, and other physician services provided by Group or Physician.

2. Engagement. Seasons hereby engages Group, through its physicians, to provide Services for Seasons during the Term of this Agreement and in accordance with the terms and conditions set forth herein, and Group hereby agrees to be so engaged. Only the Group physicians specifically identified in Appendix 1 ("Physician" or "Physicians") are authorized to perform or provide Services for or on behalf of Seasons pursuant to this Agreement. A Physician may be added to Appendix 1 upon written notification by Seasons to Group, and Group's written approval of such addition. Seasons may remove a Physician from Appendix 1 at any time.

3. Group's Responsibilities.

(a) Hospice Services and Non-Hospice Palliative Care Services. In furtherance of Physician's duties and responsibilities hereunder, Physician shall provide Hospice Services and Non-Hospice Palliative Care Services in accordance with the provisions of the exhibits attached hereto.

(b) Extent of Services. Group shall make Physicians available for on-call consultations, assistance, and decisions regarding patient care on a schedule and at times as agreed upon by Seasons and Group.

(c) Supervision. Group shall at all times be subject to the general administrative control and supervision of Seasons, and for administrative purposes Physicians shall report directly to Seasons' Executive Director or such other individual appointed by Seasons.

(d) Hospice Policies and Procedures. Group shall follow and at all times comply with Seasons' policies and procedures, which have been made available to Group and will remain available for review at Seasons offices.

(e) Documentation. Group shall prepare and maintain accurate and complete reports and other documentation with respect to the performance of the Services provided hereunder, including medical records and time reports (collectively, "Documentation"), in accordance with sound medical practice, Applicable Laws, Seasons' policies and procedures, and other reasonable requirements of Seasons. Group shall provide a signed medical record entry at the time each medical service is provided by Physician to a Patient. All Documentation shall remain the exclusive property of Seasons and Group shall not have any ownership interest in Documentation of Seasons or Seasons' records. This section shall survive termination of this Agreement with respect to Documentation of Services provided prior to termination. Failure to comply with this section shall be grounds for immediate termination. Any such termination shall not relieve Physician of the obligation to complete Documentation.

(f) Drug Use. Physicians will be free from the influence of alcohol or illegal substances while providing Services under this Agreement.

(g) Nurse Practitioner Supervision. If requested by Seasons, Physician shall provide supervision of Seasons nurse practitioners, including executing a collaborative agreement if required by state law.

4. Representations, Warranties, and Covenants of Group. Group represents, warrants, and covenants to Seasons, upon execution of Agreement and continuously throughout the Term of this Agreement, as follows:

(a) Approvals. Group and Physicians possess and shall maintain in full force and effect at all times all Approvals necessary to perform the Services under this Agreement. Group and Physicians have not: (i) had any license to practice medicine in any state, DEA Registration Number, any state-issued authorization to prescribe controlled substances or other Approval suspended, relinquished, terminated, restricted, revoked, or voluntarily surrendered; (ii) been disciplined by any licensing board, state or local society, or specialty board; (iii) had entered against Group or Physician a final judgment in, or settled, a malpractice or similar action during the past 5 years; or (iv) had his or her medical staff privileges at any hospital or medical facility revoked, suspended, relinquished, terminated, or restricted. If any of the events

described in this section should occur during the Term of this Agreement, Group shall provide Seasons with immediate written notice thereof.

(b) Program Exclusion. Group and Physicians have not been convicted of a criminal offense related to, and have not been debarred, excluded, or suspended from participation in, any federal health care program (as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(f))) or state health care program (as defined in Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b(h)).

(c) Compliance with Applicable Laws and Policies, Standard of Care. Group and Physicians shall perform all Services hereunder in accordance with: (i) all Applicable Laws; (ii) Seasons' policies and procedures; and (iii) generally recognized standards of care and the codes of ethics and/or professional conduct of the professional associations of which Group or Physicians are a member.

(d) Board Certification. Physician shall be board certified as agreed to by Group and Seasons in writing, and Group shall promptly furnish Seasons with evidence of such board certification upon request.

(e) Continuing Medical Education. Group and Physicians shall do all things reasonably necessary to maintain the Approvals and board certification referred to in this section including attending continuing medical education programs in accordance with licensure or certification requirements and Seasons' policies and procedures.

5. Seasons' Responsibilities. Seasons retains full professional management responsibility and authority over, and control of, all aspects of Seasons' business. Seasons retains full professional management responsibility and authority over, and control of, all aspect of Seasons' business and operations that may not legally be carried on by persons or entities other than Seasons including, but not limited to, the responsibility for planning, coordinating, and providing Hospice Services for Patients and their families. Nothing in this Agreement shall be construed to delegate to Group any professional management or other responsibility or authority that may only be exercised by Seasons under Applicable Laws.

6. Compensation; No Benefits. In consideration for the Services provided by Group under this Agreement, Group shall be paid in accordance with, and subject to, the terms and conditions set forth in the exhibits attached hereto. Seasons reserves the right to withhold payment if a Physician fails to provide Documentation of such Services and/or any Services cannot be billed by Seasons due to failure of Physician to complete Documentation. Seasons reserves the right to recoup payment if a Physician fails to provide Services as required under this Agreement. Should Group receive any overpayment, Physician and/or Group shall immediately notify Seasons of such overpayment. The amounts to be paid by Seasons to Group and Physicians pursuant to this Agreement have been determined through good faith bargaining, in an arm's length process, to be fair market value for the performance of the duties, responsibilities, and obligations of Group specified herein. No amount paid hereunder is intended to be a direct or indirect, covert or overt offer, inducement, or payment for referrals of patients or services. In recognition of its status as an independent contractor, neither Group nor

any Physician shall be entitled to receive from Seasons any vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind, and Seasons will not withhold for taxes from Group's fees paid pursuant hereto. Group shall be fully responsible for all vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind, for all Physicians, and shall make all state and federal estimated or final tax payments due on account of all compensation received by Group pursuant to this Agreement.

7. Confidentiality and Non-Solicitation.

(a) Confidentiality. Group acknowledges and agrees that in the performance of the Services hereunder Group and Physicians will receive or have access to the Confidential Information (as defined below) of Seasons. Group and Physicians shall hold all such Confidential Information in strict confidence, and shall not disclose any such Confidential Information to any third party, at any time during the Term of this Agreement or after the termination of this Agreement. The provisions of this section shall not apply to the extent that such Confidential Information: (i) is in the public domain through no fault of Group; (ii) is lawfully acquired by Group from a third party under no obligation of confidence to Seasons; or (iii) is required by Applicable Law by any governmental or judicial body to be disclosed; provided, however, that upon receiving notice of a required disclosure under this clause, Group shall promptly notify Seasons of such required disclosure in writing. Such Confidential Information shall not otherwise be used to the detriment of Seasons in any manner and all Confidential Information provided by Seasons to Group or Physicians, including all copies and extracts thereof, will be returned to Seasons immediately upon its request. For purposes of this Agreement, the term "Confidential Information" shall mean any and all confidential and proprietary information relating to the business and operation of Seasons, including but not limited to, information with respect to Seasons' existing and contemplated services, products, trade secrets, know how, research and development, formulas, models, compilations, processes, inventions, computer code generated or developed, software or programs, related documentation, business and financial methods or practices, plans, pricing, operating margins, marketing, merchandising and selling techniques and information, customer lists, details of customer agreements, sources of supply, employee compensation and benefit plans, patients, patient records and data, and other confidential information relating to Seasons policies and procedures, operating strategies, expansion strategies or business strategies or other confidential or proprietary information of Seasons.

(b) Non-Solicitation of Patients, Customers, and Suppliers. Group agrees that during the Term of this Agreement, Group shall not directly or indirectly through another person or entity, solicit the trade, business, or care of any patient, prospective patient, customer, prospective customer, referral source, prospective referral source, supplier, or prospective supplier of Seasons for any business or other purpose competitive with the business of Seasons. Group further agrees that for 1 year following termination of this Agreement, Group shall not directly or indirectly through another person or entity, solicit the trade, business, or care of any patients, customers, referral sources or suppliers, or prospective patients, customers, referral sources or suppliers, of Seasons for any business or purpose competitive with the business of

Seasons; provided however, that the foregoing shall not be construed (i) to interfere with or prohibit a patient's or prospective patient's freedom of choice, or (ii) to prohibit Group's solicitation of any patient who was a patient of Group prior to such time as the patient became a Patient of Seasons.

(c) Non-Solicitation of Employees. Group agrees that, during the Term of this Agreement and for 1 year following termination of this Agreement, Group shall not directly or indirectly through another person or entity, solicit or induce, or attempt to solicit or induce, any employee of Seasons to leave Seasons for any reason whatsoever, or hire (in any capacity) any person who was an employee of Seasons at any time during the 6 month period immediately prior to the date on which such hiring would take place (it being conclusively presumed by the parties so as to avoid any disputes under this section that any such hiring within such 6 month period is in violation of this section).

(d) Injunctive Relief. Group agrees that in the event of any breach by Group of any of the covenants or agreements contained in this section, Seasons would suffer substantial and irrevocable damage and would encounter extreme difficulty in attempting to prove the actual amount of damages suffered by Seasons as a result of such breach, and Seasons would not have an adequate remedy at law in such event and, therefore, in addition to any other remedy Seasons may have at law or in equity in the event of any such breach, Seasons shall be entitled to seek and receive specific performance and temporary, preliminary and permanent injunctive relief from any breach of any of the covenants or agreements of this Agreement from any court of competent jurisdiction without the necessity of proving the amount of any actual damages to it resulting from such breach. This section shall survive termination of this Agreement.

8. Insurance. Seasons shall at all times during the Term of this Agreement maintain professional liability insurance and general liability insurance (including contractual liability for this Agreement) with minimum separate limits of $1,000,000 per occurrence and $3,000,000 in the aggregate, to cover claims arising from the acts or omissions of Physician in his or her performance of the Services under this Agreement. Such coverages may be maintained on a claims-made basis with purchase of tail end coverage to insure claims occurring during the Term of this Agreement, or may be maintained on an occurrence basis. This section shall survive termination of this Agreement. GROUP AND PHYSICIAN ACKNOWLEDGE AND AGREE THAT THE PROFESSIONAL LIABILITY AND OTHER INSURANCE PROVIDED HEREUNDER DOES NOT COVER PHYSICIAN'S ACTIVITIES WHICH ARE OUTSIDE THE SCOPE OF THIS AGREEMENT AND NOT PERFORMED FOR THE BENEFIT OF SEASONS, AND THAT PHYSICIAN OR GROUP MUST OBTAIN SEPARATE PROFESSIONAL LIABILITY AND OTHER INSURANCE FOR SUCH OUTSIDE ACTIVITIES.

9. Indemnification. Group agrees to indemnify Seasons, its directors, officers, employees, and agents from and against any and all claims, suits, damages, fines, penalties, liabilities and expenses (including reasonable attorney's fees and court costs) resulting from or arising out of, any claimed act or omission by Group or any of its directors, officers, employees, or agents pertaining to the Services hereunder, including but not limited to, gross negligence or willful misconduct. This section shall survive termination of this Agreement.

10. Term and Termination.

(a) Term of Agreement. The initial term of this Agreement shall commence on the date first above written and shall continue for a period of 1 year (the "Initial Term"). Upon the expiration of the Initial Term, this Agreement shall automatically renew for additional consecutive renewal terms of 1 year each (each a "Renewal Term"), unless earlier terminated in accordance with the terms hereof. The "Term" of this Agreement shall mean and include the Initial Term, together with any Renewal Terms, until terminated as provided herein. In the event a party does not desire to renew this Agreement, it shall provide written notice of non-renewal to the other Party not less than 30 days prior to the expiration of the Initial Term or any Renewal Term, as the case may be.

(b) Termination for Cause.

(i) If Group is in default of any material term, condition, representation, or warranty under this Agreement, or fails to perform in any material respect any of the Services hereunder, and such default or failure is not cured within 30 days following its receipt of notice of default or failure, then Seasons may, after the expiration of such 30 day period, terminate this Agreement upon written notice to Group.

(ii) Seasons may terminate this Agreement in the event of Group or Physician's (i) loss or suspension of any Approval, or (ii) failure to qualify for coverage under Seasons' insurance policy. Such termination shall be effective immediately upon written notice of termination to Group. Group shall immediately notify Seasons in writing of the occurrence or threat of occurrence of any of the events specified in this section.

(iii) Seasons may terminate this Agreement if it determines in its sole discretion that continuation of this Agreement may be detrimental to the operations of Seasons, or could jeopardize the health or welfare of any Patient. Such termination shall be effective immediately upon written notice of termination to Group.

(c) Suspension. In lieu of termination, Seasons may suspend the operation of this Agreement at any time upon the occurrence of any of the events giving rise to Seasons' right to terminate this Agreement pursuant to the sections above or upon Seasons' determination in its sole discretion that there is probable cause to believe that any of such events may have occurred.

(d) Termination without Cause. Either party may terminate this Agreement without cause upon not less than 60 days prior written notice of termination to the other party.

(e) Effect of Termination or Suspension. If this Agreement is terminated or suspended, Group shall immediately cease providing any Services hereunder unless Seasons notifies Group that it shall continue to provide Services in accordance with this Agreement until a successor is named, in which event Seasons shall continue to reimburse Group in accordance with this Agreement. This provision shall survive termination of this Agreement.

11. Notification of Material Events. Group shall immediately notify Seasons of:

(a) Incident Reporting. Any incident involving a Patient including mistreatment or neglect; verbal, mental, sexual, or physical abuse; injuries of an unknown source; or misappropriation of patient property.

(b) Licensure Actions. Any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, or action by federal or state officials against Group or its personnel.

(c) Exclusion. Any threatened, proposed, or actual exclusion of Group or its personnel from any government program including, but not limited to, Medicare or Medicaid.

12. HIPAA. Group Physicians are under the direct control of Seasons for the provision of physician services hereunder and are, therefore, considered part of Seasons' workforce, as defined in by the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation") under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

13. General Provisions.

(a) Nondiscrimination. Group shall perform the Services hereunder without unlawful discrimination on the basis of race, color, religion, national origin, sex, ancestry, disability, or any other basis protected by law.

(b) Force Majeure. Neither party shall be liable nor deemed to be in default for any delay or failure in performance under this Agreement or other interruption of service or employment which is caused, directly or indirectly, by acts of nature, military authority, acts of public enemy, war, accidents, fires, explosions, earthquakes, floods, failure of transportation, machinery or supplies, vandalism, strikes, or other work interruptions beyond the reasonable control of either party. However, both parties shall make good faith efforts to perform their respective obligations under this Agreement in the event of any such circumstances.

(c) Medical Judgment. The parties agree that Seasons shall not control the professional judgment, treatment, or medical services rendered by Physicians, and the responsibility for the aforementioned shall rest solely with Physicians.

(d) Notices. Any notice, demand, request, consent, or approval required or permitted hereunder shall be in writing and shall be delivered (i) personally; (ii) by certified mail, return receipt requested, postage prepaid; or (iii) by overnight courier, to the address indicated below or to such other address as may be designated in writing by any party from time to time:

If to Seasons:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: President

With a copy to:

Seasons Hospice & Palliative Care of Pierce County Washington, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: Legal Department

If to Group:

_____
_____
_____
Attention: _____

With a copy to Physician:

_____
_____
_____

All such communications shall be deemed to have been received by the intended recipient (i) 3 business days following deposit in the United States Mail if sent by certified mail; (ii) on the day actually received if delivered personally; or (iii) on the next business day if sent by overnight courier.

(e) No Third-Party Beneficiaries. This Agreement shall not confer any rights or remedies upon any person other than Seasons and Group and their respective successors and permitted assigns.

(f) Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State where Seasons is located without giving effect to any choice or conflict of law provision or rule (whether of the State where Seasons is located or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State where Seasons is located**.**

(g) Amendments and Waivers. No amendment of any provision of this Agreement, and no postponement, or waiver of any such provision or of any default, misrepresentation, or breach of warranty or covenant hereunder, whether intentional or not, shall be valid unless such amendment, postponement, or waiver is in writing and signed by or on behalf of Seasons and Group. No such amendment, postponement, or waiver shall be deemed to extend to any prior or subsequent matter, whether or not similar to the subject-matter of such

amendment, postponement, or waiver. No failure or delay on the part of Seasons or Group in exercising any right, power, or privilege under this Agreement shall operate as a waiver thereof nor shall any single or partial exercise of any right, power, or privilege hereunder preclude any other or further exercise thereof or the exercise of any other right, power, or privilege.

(h) Succession and Assignment. This Agreement shall be binding upon and inure to the benefit of Seasons and Group and their respective heirs, executors, successors and permitted assigns. No party may assign this Agreement or any of such party's rights, interests, or obligations hereunder without the prior approval of the other party hereto, except that Seasons may assign its rights, interests, and obligations hereunder, in whole or in part, to any of its affiliates.

(i) Legal Compliance. Nothing contained in this Agreement will require Group to admit or refer any patients to Seasons as a precondition to receiving the benefits set forth herein. In the event that either party determines, with the documented advice of qualified legal counsel, that compliance with the terms of this Agreement by either party would pose a clear and present risk of causing a party of violating an Applicable Law of any kind, including but not limited to laws relating to relationships between referral sources or relating to availability of reimbursement to Seasons from governmental payers, the party will provide notice of the potential violation and proposed modifications to the Agreement to remediate the potential violation and for the 15 day period after the other party received the foregoing notice and the parties will negotiate in good faith for an appropriate amendment to this Agreement. If the parties are not able to agree within that time, either party may terminate this Agreement immediately on written notice to the other party. Such notice shall not be deemed an admission by either party that a violation of an Applicable Law has occurred.

(j) Construction. Seasons and Group have participated jointly in the negotiation and drafting of this Agreement. If an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted jointly by Seasons and Group and no presumption or burden of proof shall arise favoring or disfavoring Seasons or Group because of the authorship of any of the provisions of this Agreement. Any reference to any Applicable Law shall be deemed also to refer to all rules and regulations promulgated thereunder, unless the context requires otherwise. Each representation, warranty, and covenant contained herein shall have independent significance. If Seasons or Group breaches in any respect any representation, warranty, covenant, or other obligation contained herein or created hereby, the fact that there exists another representation, warranty, covenant, or obligation relating to the same subject matter (regardless of the relative levels of specificity) which has not been breached shall not detract from or mitigate the consequences of such breach. The rights and remedies expressly specified in this Agreement are cumulative and are not exclusive of any rights or remedies which any party would otherwise have. The article and section headings hereof are for convenience only and shall not affect the meaning or interpretation of this Agreement.

(k) Severability. The invalidity or unenforceability of one or more of the provisions of this Agreement in any situation in any jurisdiction shall not affect the validity or

enforceability of any other provision hereof or the validity or enforceability of the offending provision in any other situation or jurisdiction.

(l) Entire Agreement; Counterparts. This Agreement (including the appendix and exhibits attached hereto and the documents referred to herein) constitutes the entire agreement among the parties and supersedes any prior understandings, agreements or representations by or among the parties, written or oral, to the extent they relate to the subject matter hereof. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument. It shall not be necessary in making proof of this Agreement to produce or account for more than one such counterpart.

(m) Prevailing Party. If any litigation, including arbitration, arises as a result of the terms, conditions, or provisions of this Agreement, the prevailing party shall be entitled to recover reasonable attorneys' fees at all pre-trial, trial and appellate levels, as well as all costs and expenses.

(n) Waiver of Jury Trial. **EACH PARTY IRREVOCABLY AND UNCONDITIONALLY WAIVES TRIAL BY JURY IN CONNECTION WITH ANY ACTION OR PROCEEDING INSTITUTED UNDER OR RELATING TO THIS AGREEMENT, OR ANY OTHER DOCUMENT EXECUTED PURSUANT TO THIS AGREEMENT, OR IN CONNECTION WITH ANY COUNTERCLAIM RESULTING FROM ANY SUCH ACTION OR PROCEEDING.**

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement as of the date first written above.

SEASONS:

By: _____
Name: _____
Title: _____

GROUP:

By: _____
Name: _____
Title: _____

PHYSICIAN ACKNOWLEDGMENT:

By: _____
Name: _____

APPENDIX 1

GROUP PHYSICIANS

Only the Group Physicians specifically identified below are authorized to perform or provide Services for or on behalf of Seasons pursuant to this Agreement. A Physician may be added to this appendix upon written notification by Seasons to Group, and Group's written approval of such addition. Seasons may remove a Physician from this appendix at any time.

Group Physician: _____

_____
Medicare Provider Number

_____
National Provider Identifier

_____
DEA Registration Number

_____
Telephone Number

_____
Board Certification

EXHIBIT A

PHYSICIAN SERVICES

1. Responsibilities.

(a) Patient Visit Services.

(i) Visits. Physician shall provide Patient Visit Services which may include Hospice Services or Non-Hospice Palliative Visit Services. Patient Visit Services may include, as appropriate:

[1] Evaluating the individual's need for pain and symptom management, including the eligibility for hospice care on initial admission and recertification;
[2] Counseling the individual regarding hospice and other care options;
[3] Advising the individual regarding advanced care planning;
[4] Ordering tests and initiating treatment as appropriate and necessary;
[5] Providing face-to-face visits as needed;
[6] Acting as an Attending Physician as needed;
[7] Liaising between the IDG, the Attending Physician, and the patient and family;
[8] Managing Patient's medications; and
[9] Participating in an on-call rotation, if requested by Seasons, and if on-call, being available to staff 24 hours per day.

(ii) Relationship with Attending Physician. Physician shall provide Patient Visit Services at the written or verbal request of a Patient's Attending Physician or other appropriate source and will document such request in the Patient's medical record. If an individual other than the Attending Physician requests Patient Visit Services, Physician should communicate with the Attending Physician, with the Patient's permission, to the extent necessary to ensure continuity of care. If a Physician is the Attending Physician to a Patient, then the Physician may furnish Patient Visit Services directly to the Patient.

(iii) Documentation. Physician shall submit Documentation of Patient Visit Services provided under this exhibit to Seasons in accordance with Seasons' policies and protocols.

(iv) Inpatient Visits. If Physician is providing inpatient visits, Physician shall:

[1] Create a Plan of Care for each Patient at the inpatient unit, including discussing general inpatient care criteria and potential discharge plans with the IDG, patient, and family;
[2] Sign death certificates, as applicable;
[3] Participate in the evaluation and certification or recertification of the terminal prognosis, as applicable;
[4] Establish consistent times for daily rounds, including RNs, team directors, and social workers, and prepare staff for daily rounds;
[5] Conduct daily rounding on each patient receiving general inpatient care;
[6] Establish a schedule for physician coverage at the inpatient unit;
[7] Provide education to IDG during rounds, and conduct in-services for newly hired staff;
[8] Promote physician collaboration on Patients;

[9] Conduct daily billing;
[10] Ensure the eligibility for general inpatient care is documented; and
[11] Provide after-hours call coverage at the inpatient unit on days on which inpatient visits are made.

(b) Team Physician Services.

(i) Interdisciplinary Group. Physician shall communicate regularly with the Medical Director and other members of the IDG, and actively participate for the full duration of the IDG meeting, as applicable, to provide clinical leadership guidance and medical expertise to the other members of the IDG. Physician shall participate in IDG quality improvement activities.

(ii) Coverage and Availability. Physician shall participate in an on-call schedule to provide 24 hour a day, 7-day a week coverage of physician services. Physician shall be available by telephone during usual business hours to address specific patient management and/or physician relations issues. Physician shall be accessible to family members to provide information about the medical management and prognosis of Patients, ensuring patient confidentiality where necessary.

(iii) Patient Care. Physician shall review Patients' medication regimens for adverse reactions, inappropriate usage, and inappropriate duration. Physician shall provide for the general medical needs of Patients covered by the IDG to the extent that these needs are not met by the Attending Physician, including but not limited to: (i) writing prescriptions, including prescriptions for controlled substances, when applicable, when the Attending Physician chooses not to or is not licensed to do so; (ii) signing death certificates; and (iii) accepting full responsibility for the care of the Patient if the Attending Physician does not desire to provide care to the Patient.

(iv) Plan of Care. Physician shall participate in the development of the initial Plan of Care as a member of the IDG. Physician shall also participate in the development, implementation, and ongoing revision of the Plan of Care. If a Patient is receiving the general inpatient level of care, Physician shall review the Patient’s eligibility for continued inpatient management.

(v) Terminal Illness. For Patients receiving Hospice Services, Physician shall participate in the evaluation and certification or recertification of the terminal prognosis for Patients covered by the IDG of which Physician is a member at indicated intervals. Physician shall provide medical expertise on an on-going and timely basis to admission and care staff on issues and challenges involving evaluation of terminal prognosis and pain and symptom management. Physician shall interact with Attending Physicians and referring physicians regarding issues and challenges involving determination of terminal prognosis and pain and symptom management.

(vi) Revocation and Discharge. Physician shall intervene proactively, as required, when there is a possible revocation of hospice care, or discharge from hospice care for extended prognosis or other relevant discharge. Physician shall review all revocations and relevant discharges with the other members of the IDG, medical director, and other team members, as required.

(vii) Face-to-Face Encounters. Prior to a Patient’s third and subsequent re-certifications, Physician shall ensure that a physician or nurse practitioner has a face-to-face encounter with such Patients to gather clinical findings that support continued hospice care and also attest that such a visit took place, all in the manner required under Applicable Laws.

(viii) Documentation. Physician shall provide accurate and timely records and submit Documentation of all Team Physician Services provided hereunder.

(c) Requirements and Qualifications.

(i) Principles of Hospice Care. Physician shall have knowledge of the principles and practice of primary medical care, with at least a working knowledge of hospice and palliative care, with particular emphasis on control of symptoms associated with terminal illness.

(ii) Collaboration. Physician shall have the ability to work collaboratively with Patients' Attending Physicians to effectively implement the hospice program. Physician shall also have the ability to work collaboratively with Seasons' employees and volunteers as part of the IDG.

2. Title. Physician's title shall be Associate Medical Director.

3. Compensation. In consideration for the Services provided by Physician hereunder, Seasons will pay Group $50,000.00 annually, paid in biweekly installments. Physician shall provide approximately 8 hours of Services per week, which may vary from week to week.

4. Compensation in Full. Group shall accept such compensation as payment in full for all Services provided by Physician hereunder, and shall not seek or accept additional compensation from Patients or their families or representatives, Medicare, Medicaid, or any other third-party payor.

5. Billing and Collection. All billings for Services rendered by Physician shall be performed by Seasons, in its name, utilizing its provider number and for its benefit, and all funds received shall be deposited in the accounts of Seasons. Physician will cooperate with Seasons to facilitate such billing submissions. Physician and Group shall not separately bill for any professional or other services rendered pursuant to this Agreement, and hereby assign to Seasons all such rights. Physician and Seasons shall execute and deliver such reassignment of benefits forms and such managed care credentialing and provider participation applications as Seasons shall reasonably request. Seasons shall be entitled to collect all accounts receivable generated by Physician.

6. Right to Payment. Group's right to payment from Seasons for Services under this exhibit will not be contingent on Seasons' ability to collect the amounts billed to Patients, Medicare, Medicaid, or third-party payors, unless any inability to collect is through fault of Physician.

EXHIBIT 20

Commitment of Funding

accentCare.

Reimagining care, together.

www.accentcare.com

January 20, 2023

Mr. Eric Hernandez
Manager - Certificate of Need
Department of Health - Community Health Systems
111 Israel Road, S.E.
Tumwater, WA 98501-5447

RE: Seasons Hospice & Palliative Care of Pierce County Washington, LLC
Certificate of Need Application to Establish a Hospice Agency in Pierce County

Dear Mr. Hernandez:

As Chief Financial Officer of AccentCare, Inc. (the parent organization of Seasons Hospice & Palliative Care of Pierce County Washington, LLC) and Horizon Acquisition Co., Inc., my letter expresses commitment to the funds for the development and operation of the applicant's proposed hospice program.

The attached audited financial statements for Seasons Hospice & Palliative Care of Pierce County Washington, LLC dated February 24, 2021 reflect the start-up period for this new entity created on December 28, 2020. The balance sheet shows $2,000,000 in cash with which to establish the proposed hospice agency.

To further demonstrate access to capital, the attached Consolidated Financial Statements for Horizon Acquisition Co., Inc. and Subsidiaries for the years ended December 31, 2021 and 2020 demonstrates available capital of approximately $22 million in cash and cash equivalents.

AccentCare, Inc. is pleased to commit funding for the proposed hospice agency to serve residents of Pierce County.

Sincerely,

Ryan Solomon
Chief Financial Officer

Attachments

CONSOLIDATED FINANCIAL STATEMENTS

Horizon Acquisition Co., Inc. and subsidiaries

Years Ended December 31, 2021 and 2020
With Report of Independent Registered Public Accounting Firm

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Ernst & Young LLP
One Victory Park
2323 Victory Avenue
Suite 2000
Dallas, TX 75219

Tel: +1 214 969 8000
Fax: +1 214 969 8587
ey.com

Building a better working world

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholder and the Board of Directors of Horizon Acquisition Co., Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Horizon Acquisition Co., Inc. and subsidiaries (the Company) as of December 31, 2021 and 2020, the related consolidated statements of operations, comprehensive (loss) income, stockholder's equity, and cash flows for the years then ended, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2021 and 2020, and the results of its operations and its cash flows for the years then ended in conformity with U.S. generally accepted accounting principles.

Adoption of ASU No. 2016-02

As discussed in Note 2 to the consolidated financial statements, the Company changed its method of accounting for leases in 2021 due to the adoption of ASU No. 2016-02, *Leases (Topic 842)*, and subsequent amendments to the initial guidance by ASU 2017-13, ASU 2018-10, ASU 2018-11, and ASU 2018-20.

Basis for Opinion

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB and in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits, we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Ernst & Young LLP

We have served as the Company's auditor since 2010.

April 15, 2022

HORIZON ACQUISITION CO., INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except share and par value amounts)

	As of December 31,	
	2021	2020
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 21,579	$ 56,331
Restricted cash	242	244
Patient accounts receivable, net	240,094	238,111
Prepaid expenses	11,009	14,171
Other current assets	5,167	6,544
Total current assets	278,091	315,401
Property and equipment, net	51,179	52,860
Operating lease right of use assets	72,687	—
Goodwill	1,693,814	1,554,652
Intangible assets	264,234	376,105
Other assets	11,382	5,825
Total assets	$ 2,371,387	$ 2,304,843
LIABILITIES AND STOCKHOLDER'S EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 12,949	$ 17,412
Accrued payroll and related benefits	71,206	71,993
Accrued expenses	78,130	76,766
Current portion of long-term obligations	8,690	8,800
Current portion of operating lease liabilities	23,743	—
Income taxes payable	337	393
Other current liabilities	32,231	28,716
Total current liabilities	227,286	204,080
Long-term obligations, less current portion	1,230,721	1,113,869
Operating lease liabilities, less current portion	52,176	—
Deferred tax liability, net	64,265	72,845
Other long-term liabilities	26,552	46,185
Total liabilities	1,601,000	1,436,979
Noncontrolling interests - redeemable	48,435	48,098
Commitments and contingencies - Note 11		
STOCKHOLDER'S EQUITY		
Horizon Acquisition Co., Inc. stockholder's equity:		
Common stock, $0.01 par value - 1,000 shares authorized; 1,000 shares issued and outstanding as of December 31, 2021 and 2020	—	—
Additional paid-in capital	786,715	783,480
Accumulated deficit	(148,750)	(16,928)
Accumulated other comprehensive income (loss)	2,191	(887)
Total Horizon Acquisition Co., Inc. stockholder's equity	640,156	765,665
Noncontrolling interests - non-redeemable	81,796	54,101
Total stockholder's equity	721,952	819,766
Total liabilities and stockholder's equity	$ 2,371,387	$ 2,304,843

See accompanying notes to the consolidated financial statements.

HORIZON ACQUISITION CO., INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF OPERATIONS
(Amounts in thousands, except share amounts and per share data)

	For the Years Ended December 31,	
	2021	2020
Net service revenue	$ 1,562,069	$ 932,802
Other operating income	2,978	16,908
Total revenues	1,565,047	949,710
Cost of service, excluding depreciation and amortization	825,823	520,776
General and administrative expenses:		
Salary and benefits	450,689	253,622
Stock-based compensation	7,553	1,347
Other	202,430	112,523
Depreciation and amortization	29,550	14,113
Asset impairment	108,194	637
Total operating expenses	1,624,239	903,018
(Loss) income from operations	(59,192)	46,692
Other income (expense):		
Interest income	258	233
Interest expense	(80,377)	(38,694)
Loss from extinguishments of debt	(2,097)	—
Other (expense) income, net	(59)	410
Total other expense, net	(82,275)	(38,051)
(Loss) income before income tax (benefit) expense and noncontrolling interests	(141,467)	8,641
Income tax (benefit) expense	(6,839)	5,789
Net (loss) income	(134,628)	2,852
Less: Net (loss) income attributable to noncontrolling interests	(1,884)	2,125
Net (loss) income attributable to Horizon Acquisition Co., Inc.	$ (132,744)	$ 727
Loss per share		
Basic	$ (133,722.39)	$ (280.51)
Diluted	$ (133,722.39)	$ (280.51)
Weighted average shares outstanding:		
Basic	1,000	1,000
Diluted	1,000	1,000

See accompanying notes to the consolidated financial statements.

HORIZON ACQUISITION CO., INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME
(Amounts in thousands)

	For the Years Ended December 31,	
	2021	2020
Net (loss) income	$ (134,628)	$ 2,852
Unrealized gain (loss) on cash flow hedges, net of tax expense	3,078	(887)
Comprehensive (loss) income	(131,550)	1,965
Less: Comprehensive (loss) income attributable to noncontrolling interests	(1,884)	2,125
Comprehensive loss attributable to Horizon Acquisition Co., Inc.	$ (129,666)	$ (160)

See accompanying notes to the consolidated financial statements.

HORIZON ACQUISITION CO., INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDER'S EQUITY
(Amounts in thousands, except common stock shares)

	Common Stock		Additional Paid-In Capital	Accumulated Deficit	Accumulated Comprehensive Loss	Noncontrolling Interest	Total Equity	Redeemable Noncontrolling Interest
	Shares	Amount						
Balance, December 31, 2019	1,000	$ —	$ 424,922	$ (17,655)	$ —	$ 53,728	$ 460,995	$ 23,993
Capital contribution	—	—	359,917	—	—	—	359,917	—
Return of capital	—	—	(1,489)	—	—	—	(1,489)	—
Stock-based compensation	—	—	1,347	—	—	—	1,347	—
Other comprehensive loss	—	—	—	—	(887)	—	(887)	—
Noncontrolling interest distribution	—	—	—	—	—	(834)	(834)	(670)
Noncontrolling interest acquired	—	—	—	—	—	—	—	22,640
Net income	—	—	—	727	—	1,207	1,934	918
Adjust noncontrolling interest to redemption value	—	—	(1,217)	—	—	—	(1,217)	1,217
Balance, December 31, 2020	1,000	—	783,480	(16,928)	(887)	54,101	819,766	48,098
Capital contribution	—	—	750	—	—	—	750	—
Stock-based compensation	—	—	7,553	—	—	—	7,553	—
Other comprehensive loss	—	—	—	—	3,078	—	3,078	—
Noncontrolling interest distribution	—	—	—	—	—	(1,702)	(1,702)	(790)
Sale of a noncontrolling interest	—	—	(940)	—	—	29,202	28,262	—
Net (loss) income	—	—	—	(132,744)	—	195	(132,549)	(2,079)
Adjust noncontrolling interest to redemption value	—	—	(4,128)	922	—	—	(3,206)	3,206
Balance, December 31, 2021	1,000	$ —	$ 786,715	$ (148,750)	$ 2,191	$ 81,796	$ 721,952	$ 48,435

See accompanying notes to the consolidated financial statements.

HORIZON ACQUISITION CO., INC. and SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	For the Years Ended December 31,	
	2021	**2020**
CASH FLOWS FROM OPERATING ACTIVITIES:		
Net (loss) income	$ (134,628)	$ 2,852
Adjustments to reconcile net (loss) income to net cash (used in) provided by operating activities:		
Depreciation and amortization	29,550	14,113
Stock-based compensation	7,553	1,347
Deferred income taxes	(8,363)	4,102
Loss on extinguishment of debt	2,097	—
Asset impairment	108,194	637
Amortization of deferred financing charges	6,309	2,753
Amortization of operating lease right of use assets	25,339	—
Changes in assets and liabilities, net of acquisitions:		
Accounts receivable	8,745	(14,031)
Prepaid expenses	3,465	(1,099)
Other current assets	1,343	5,223
Other long-term assets	2,896	(2,190)
Income tax payable	(56)	—
Accounts payable	(5,251)	(3,137)
Accrued expenses	(4,992)	(18,471)
Other current liabilities	(20,779)	18,451
Other long-term liabilities	(23,431)	15,878
Accrued payroll and related expenses	(787)	(10,874)
Net cash (used in) provided by operating activities	(2,796)	15,554
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase of property and equipment, net of acquisitions	(14,692)	(9,307)
Acquisitions of businesses, net of cash acquired	(148,486)	(787,740)
Net cash used in investing activities	(163,178)	(797,047)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Repayment of long-term debt	(885,592)	(3,550)
Proceeds from debt issuance	879,913	677,000
Proceeds from revolver	150,000	103,500
Repayment of revolver	(35,000)	(103,500)
Costs associated with debt issuance	(2,131)	(20,811)
Payments under finance lease obligations	(2,228)	—
Proceeds from sale of a noncontrolling interest	28,000	—
Proceeds from capital contributions	750	—
Distributions to noncontrolling interest	(2,492)	(1,504)
Proceeds from acquisition related capital contributions	—	176,768
Net cash provided by financing activities	131,220	827,903
Net (decrease) increase in cash, cash equivalents and restricted cash	(34,754)	46,410
Cash, cash equivalents and restricted cash at beginning of period	56,575	10,165
Cash, cash equivalents and restricted cash at end of period	$ 21,821	$ 56,575

HORIZON ACQUISITION CO., INC. and SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	For the Years Ended December 31,	
	2021	**2020**
Supplemental cash flow information:		
Cash paid for income taxes	3,030	2,339
Cash paid for interest	67,370	42,165
Noncash activity:		
Fixed assets acquired included in accounts payable	811	263
Equity units in the parent for acquisition of business	—	181,658

See accompanying notes to the consolidated financial statements.

1. NATURE OF OPERATIONS, CONSOLIDATION AND PRESENTATION OF FINANCIAL STATEMENTS

Nature of Operations and Organization

On June 19, 2019, Horizon Merger Sub, Inc., a subsidiary of Horizon Acquisition Co., Inc. (together with its consolidated subsidiaries, referred to herein as "we," "us," "our," or the "Company"), a Delaware corporation, completed the merger with and into Pluto Acquisition I, Inc. (the "Merger") which resulted in the Company acquiring all of the outstanding stock of Pluto Acquisition I, Inc. The Company is a wholly owned subsidiary of the Horizon Group Holdings, L.P. (the "Parent").

Horizon Acquisition Co., Inc. is a multi-state provider of home health, hospice, and personal care services, which are provided on both a private-pay and third-party payor basis. Our home health services assist patients transitioning from a hospital, nursing facility, or outpatient facility to the home, with licensed clinical workers providing various combinations of skilled nursing and therapy services, as well as paraprofessional services. Our hospice services are designed to provide a wide variety of services to terminally ill patients and their families through a multidisciplinary group that typically includes a patient manager, skilled nursing staff, home health aides, a chaplain, and specially trained volunteers. Our personal care services assist clients with the daily tasks of living, including bathing, dressing, light housekeeping, grocery shopping, and medication monitoring. As of December 31, 2021, we operated 147 home health, 95 hospice, and 73 personal-care care centers in 31 states.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Use of Estimates

The preparation of and presentation of the Company's financial statements in conformity with U.S. generally accepted accounting principles ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts in the Company's accompanying consolidated financial statements and notes to the consolidated financial statements. Actual results could differ from those estimates.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Company and all of its wholly owned subsidiaries, as well as any majority-owned subsidiaries over which the Company exercises control. Additionally, we consolidate investments when the entity is a variable interest entity and we are the primary beneficiary or if we have controlling interest in the entity, which is generally ownership in excess of 50%. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our consolidated financial statements. All intercompany balances and transactions have been eliminated in consolidation.

Reclassifications

Reclassifications of certain accrued expenses and other liabilities and salary and benefits and other have been made to our prior period financial information to conform to the current year presentation and are not material to our consolidated financial statements. Such reclassifications had no impact on our reported net (loss) income or stockholder's equity. Additionally, the Company has classified redeemable noncontrolling interests as temporary equity in accordance with guidance applicable to public registrants of the Securities and Exchange Commission.

Revenue Recognition

The Company accounts for revenue from contracts with customers in accordance with Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, and as such, we recognize revenue in the period in which we satisfy our performance obligations under our contracts by transferring our promised services to our customers in amounts that reflect the consideration to which we expect to be entitled in exchange for providing patient care, which are the transaction prices allocated to the distinct services. The Company's cost of obtaining contracts is not material.

The Company generally has one performance obligation per contract; a promise to perform defined health services to the client on either a "per visit," "per episode," or "per diem" basis. While the Company provides separate services that each have unique stand-alone value, the Company's promise is to provide a combined output to their patients (skilled home health care, hospice care, personal care services, etc.). As a result, the Company does not need to allocate consideration. The Company satisfies its performance obligations over time given consumers simultaneously receive and consume the benefits provided by the Company's performance as it performs. As a result, the Company provides services and recognizes revenue in the same period the services are performed (i.e., on a daily basis).

The Company records net patient service revenue on an accrual basis for the transaction price based on gross charges for services provided, reduced by estimates for explicit and implicit price concessions. Adjustments are recorded for the difference between the Company's standard rates and the contracted rates to be realized from patients, third-party payors, and others for services provided (explicit price concessions). Some clients are covered under medical benefit programs through non-contracted payors, which provides less visibility into the final expected reimbursement rate at the time service is rendered. In addition, an insurance company, individual, state programs, or Medicare may still deny part, or all, of the claim, or the patient's stay might be shorter than expected. The revenue earned under arrangements with government programs is determined under complex rules and regulations that could subject a health care entity to the potential for retrospective adjustments in the future. As a result, revenue from contracts with patients that are paid by third party payors typically contain a variable element that requires health care providers to estimate the cash flows ultimately expected to be received for services provided (implicit price concessions). Implicit price concessions include amounts that change based on the occurrence or nonoccurrence of certain events, even if a transaction price seems fixed based on the terms of the contract. The amount of consideration can vary because one or more of, but not limited to, the following: contractual allowances, refunds, or credits. Implicit price concessions are recorded for self-pay, uninsured patients, and other payors by major payor class based on our historical collection experience, aged accounts receivable by payor, and current economic conditions. The Company assesses its ability to collect for the health care services provided at the time of patient authorization based on the Company's verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs.

The Company derives revenue from the following revenue streams: Home Health Medicare Episodic, Home Health Non-Medicare Episodic, Home Health Non-Medicare Non-Episodic, Hospice, and Personal Care Services ("PCS").

Revenue by payor class as a percentage of total net service revenue was as follows:

	For the Years Ended December 31,	
	2021	2020 [1]
Home Health		
Medicare	28 %	37 %
Private Pay	2 %	4 %
Other	12 %	13 %
Total Home Health	42 %	54 %
Hospice		
Medicare	30 %	9 %
Other	4 %	— %
Total Hospice	34 %	9 %
Personal Care		
Medicaid	20 %	31 %
Private Pay	2 %	4 %
Other	2 %	2 %
Total Personal Care	24 %	37 %
	100 %	100 %

[1] During 2021, the Company identified misstatements of the previously presented 2020 revenues by payor class as a percentage of total net service revenue. These 2020 misstatements are not considered material and have been corrected in the current table.

Home Health Revenue Recognition

Medicare Revenue

The Company assists patients transitioning from a hospital, nursing facility, or outpatient facility to their homes, with licensed clinical workers providing various combinations of skilled nursing and therapy services, as well as paraprofessional services.

The Centers for Medicare and Medicaid Services ("CMS") uses a case-mix adjustment methodology referred to as the Patient-Driven Groupings Model ("PDGM"), which better aligns payment with patient care needs and ensures that clinically complex and ill beneficiaries have adequate access to home health care. PDGM uses 30-day periods of care rather than the previous 60-

day episodes of care as the unit of payment, eliminates the use of the number of therapy visits provided in determining payment, and relies more heavily on clinical characteristics and other patient information.

Our revenue recognition is based on the reimbursement we are entitled to for each 30-day payment period based on the established Federal Medicare home health payment rate for a 30-day period of care. As the Company provides home health services to patients on a scheduled basis over the episode of care in a manner that approximates a pro rata pattern, revenue for the episode of care is recognized over a 30-day period, using a calendar day prorated method.

PDGM uses timing, admission source, functional impairment levels, and principal and other diagnoses to case-mix adjust payments. The case-mix adjusted payment for a 30-day period of care is subject to additional adjustments based on certain variables including, but not limited to: (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits provided was less than the established threshold, which ranges from two to six visits and varies for every case-mix group under PDGM; (c) a partial payment if a patient transferred to another provider or from another provider before completing the 30-day period of care; and (d) the applicable geographic wage index. Payments for routine and non-routine supplies are now included in the 30-day payment rate.

Medicare rates are based on the severity of the patient's condition, service needs and goals, and other factors relating to the cost of providing services and supplies, bundled into an episode of care, not to exceed 60 days. An episode starts the first day that a billable visit is performed and ends 60 days later or upon discharge, if earlier, with multiple continuous episodes allowed.

Prior to January 1, 2021, a portion of reimbursement from each Medicare episode, referred to as a request for anticipated payment ("RAP"), was billed near the start of each 30-day period of care, and cash was typically received before all services were rendered. Any cash received from Medicare for a RAP for a 30-day period of care that exceeded the associated revenue earned was recorded to deferred revenue in accrued expenses within our Consolidated Balance Sheets. The upfront payment for RAPs was 20% in 2020. CMS fully eliminated all upfront payments associated with RAPs effective January 1, 2021. As of December 31, 2020, the balance was approximately $0.6 million which was subsequently amortized into revenue.

Non-Medicare Revenue

Episodic-based revenue. The Company recognizes Non-Medicare Episodic revenue ratably (daily) in a similar manner as Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms, which generally range from 90% to 100% of Medicare rates.

Non-episodic-based revenue. Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per visit rates. Explicit revenue adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue. Implicit revenue adjustments are also made for non-episodic revenue based on our historical experience to reflect the estimated transaction price. We receive a minimal amount of our net service revenue from patients who either are self-insured or are obligated for an insurance co-payment.

Hospice Revenue Recognition

Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are predetermined daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care, and respite care. Routine care accounted for 86% and 97% of our total Medicare hospice service revenue for the years ended December 31, 2021 and 2020, respectively. There are two separate payment rates for routine care: payments for the first 60 days of care and payments for care beyond 60 days. In addition to the two routine rates, we may also receive a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse or medical social worker for patients in a routine level of care.

The performance obligation is the delivery of hospice services to the patient, as determined by a physician, each day the patient is on hospice care.

We make adjustments to Medicare revenue for implicit revenue adjustments, which include our inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these implicit revenue adjustments based on our historical experience, which primarily includes a historical collection rate of over 89% on Medicare claims, and record it during the period services are rendered.

Additionally, our hospice service revenue is subject to certain limitations on payments from Medicare, which are considered variable consideration. We are subject to an inpatient cap limit and an overall Medicare payment cap for each provider number. We monitor these caps on a provider-by-provider basis and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in accrued expenses within our Consolidated Balance Sheets. Providers are required to self-report and pay their estimated cap liability by February 28th of the following year. As of December 31, 2021 and 2020, we settled our Medicare hospice reimbursements for all fiscal years through October 31, 2019 and 2018, respectively. As of December 31, 2021 and 2020, we have recorded $2.5 million and $5.5 million, respectively, for estimated amounts due back to Medicare in accrued expenses for the Federal cap years.

Non-Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per day rates, as applicable. Explicit revenue adjustments are recorded for the difference between our standard rates and the contractual rates to be realized from patients, third party payors, and others for services provided and are deducted from gross revenue to determine our net service revenue. We also make implicit adjustments to non-Medicare revenue based on our historical experience to reflect the estimated transaction price.

PCS Revenue Recognition

Net service revenues are generated by providing personal care services directly to patients based on authorized hours, visits, or units determined by the relevant agency, at a rate that is either contractual or fixed by legislation. The Company assists clients with the daily tasks of living, including bathing, dressing, light housekeeping, grocery shopping, and medication monitoring and we receive payment for providing such services from payors, including state and local governmental agencies, managed care organizations, commercial insurers and private consumers. Net service revenue is recognized at the time services are rendered based on gross charges for the services provided, reduced by estimates for explicit and implicit revenue adjustments.

Other - Government Grants

In the absence of specific guidance to account for government grants under U.S. GAAP, we account for government grants in accordance with International Accounting Standard ("IAS") 20, *Accounting for Government Grants and Disclosure of Government Assistance*, and as such, we recognize grant income on a systematic basis in line with the recognition of expenses or the loss of revenues for which the grants are intended to compensate. We recognize grants once both of the following conditions are met: (1) we are able to comply with the relevant conditions of the grant and (2) the grant will be received. See Note 3, *Impact of Novel Coronavirus Pandemic (*"COVID-19"*)*, for additional information on our accounting for government funds received under the Coronavirus Aid, Relief and Economic Security Act ("CARES Act").

Cash, Cash Equivalents and Restricted Cash

Cash and cash equivalents include all highly liquid instruments purchased with an original maturity of three months or less. The Company's restricted cash is held in escrow for participation agreements and is not available for ordinary business use. The following table summarizes the balances related to the Company's cash, cash equivalents, and restricted cash (in thousands):

	As of December 31,	
	2021	2020
Cash and cash equivalents	$ 21,579	$ 56,331
Restricted cash	242	244
Cash, cash equivalents, and restricted cash	$ 21,821	$ 56,575

Patient Accounts Receivable

Accounts receivable are stated at estimated net realizable value from services rendered at their estimated transaction price, which includes explicit and implicit revenue adjustments based on the amounts expected to be due from payors. Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors, and patients. Management continually monitors and adjusts, as necessary, allowances associated with its receivables and only records a provision for bad debts when there is a subsequent, adverse change to a payor's ability to pay. Accounts are written off when collection efforts have been exhausted.

Concentration of Credit Risk

Patient accounts receivables are primarily short-term receivables arising from services the Company provides in its various lines of business, as described above, and are considered unsecured obligations. Credit risk can be affected by the general

economic climate, the state of the health care industry, and the financial status of the Company's customers. The Company is exposed to group concentrations of credit risk, as its customer base consists primarily of contracts that relate to various state programs and Medicare. The gross patient accounts receivable balance as of December 31, 2021 and 2020, related to these state programs was approximately $26.4 million and $17.7 million, respectively, and related to Medicare was approximately $141.7 million and $126.6 million, respectively.

The Company also has contractual arrangements with third-party payors and individual patients. The credit risk from other payors is limited due to the significance of Medicare as the primary payor. The Company believes the credit risk associated with its Medicare accounts is limited due to (i) the historical collection rate from Medicare and (ii) the fact that Medicare is a U.S. government payor. The Company does not believe that there are any other significant concentrations from any particular payor that would subject it to any significant credit risk in the collection of patient accounts receivable. The Company has multiple contracts with managed care organizations that vary by state. The loss of any one state contract would not have a material adverse effect on the continuing operations of the Company.

Capitalized Software Implementation Costs

In a hosting arrangement that is a service contract, the Company capitalizes costs for implementation activities in the application development stage, depending on the nature of the costs. Capitalized software implementation costs are amortized using the straight-line method over the term of the hosting arrangement, which is the fixed, non-cancelable term of the arrangement, plus any reasonably certain renewal periods. The capitalized implementation costs are included in Prepaid expenses and Other assets in the Consolidated Balance Sheets, and the amortization expense related to these costs are primarily included in Other operating expenses in the Consolidated Statements of Operations. The useful lives utilized for capitalized software implementation costs range from three to six years.

Capitalized implementation costs included in Prepaid expenses and Other assets in the Consolidated Balance Sheets was $1.4 million and $0.7 million, respectively, as of December 31, 2021. Amortization of internal-use software implementation costs included in Other operating expenses in the Consolidated Statements of Operations was $2.5 million for the year ended December 31, 2021. As 2021 was the first year of implementation, accumulated amortization is $2.5 million for the year ended December 31, 2021. Prior year activity was included in Property and equipment, net on the Consolidated Balance Sheets.

Property and Equipment

Property and equipment is stated at cost and depreciated on a straight-line basis over the estimated useful lives of the assets or life of the lease, if shorter. Additionally, we have internally developed computer software for our own use. Additions and improvements (including interest costs for construction of qualifying long-lived assets) are capitalized. Maintenance and repair expenses are charged to expense as incurred. The cost of property and equipment sold or disposed of and the related accumulated depreciation are eliminated from the property and related accumulated depreciation accounts, and any gain or loss is credited or charged to other general and administrative expenses.

We assess the impairment of a long-lived asset group whenever events or changes in circumstances indicate that the asset's carrying value may not be recoverable. Factors we consider important that could trigger an impairment review include but are not limited to the following:

- A significant change in the extent or manner in which the long-lived asset group is being used.
- A significant change in the business climate that could affect the value of the long-lived asset group.
- A significant change in the market value of the assets included in the asset group.

If we determine that the carrying value of long-lived assets may not be recoverable, we compare the carrying value of the asset group to the undiscounted cash flows expected to be generated by the asset group. If the carrying value exceeds the undiscounted cash flows, an impairment charge is indicated. An impairment charge is recognized to the extent that the carrying value of the asset group exceeds its fair value.

We generally provide for depreciation over the following estimated useful lives:

Property and Equipment	Estimated Useful Lives
Furniture and equipment	3 to 10 years
Computer equipment and software	3 to 6 years
Buildings	20 to 30 years
Leasehold improvements	Lesser of lease term or expected useful life

The following table summarizes the balances related to the Company's property and equipment (in thousands):

	As of December 31,	
	2021	2020
Furniture and equipment [(1)]	$ 27,977	$ 18,598
Computer equipment and software	42,283	37,595
Building and leasehold improvements	14,455	11,370
Land	5,688	4,184
Construction-in-progress	3,502	2,507
Property and equipment, gross	93,905	74,254
Less: accumulated depreciation [(1)]	(42,726)	(21,394)
Property and equipment, net	$ 51,179	$ 52,860

(1) Includes finance leases consisting of $1.5 million of office equipment (net of $1.1 million of accumulated depreciation) and $8.6 million of service vehicles (net of $1.9 million of accumulated depreciation) at December 31, 2021 and capitalized leases consisting of $2.3 million of office equipment (net of $1.8 million accumulated depreciation) and $2.8 million of service vehicles (net of $0.5 million of accumulated depreciation) at December 31, 2020.

Depreciation, inclusive of finance lease depreciation, was $23.1 million for the year ended December 31, 2021 and $13.6 million for the year ended December 31, 2020.

Leases

The Company determines if an arrangement contains a lease at inception and recognizes a lease liability and a right-of-use ("ROU") asset for all leases, including operating leases, with a term greater than twelve months on the balance sheet. We have historically entered into operating leases for our locations, our corporate headquarters and certain equipment with initial terms of one to ten years. We recognize rent expense on a straight-line basis over the lease term. Certain of the Company's leases include termination options and renewal options for periods ranging from one to five years. Renewal options generally are not considered in determining the lease term, and payments associated with the option years are excluded from lease payments unless we are reasonably certain to exercise the renewal option.

The operating lease liabilities are calculated using the present value of lease payments. If available, we use the rate implicit in the lease to discount lease payments to present value; however, most of our leases do not provide a readily determinable implicit rate. Therefore, we use our incremental borrowing rate to discount the lease payments based on information available at the lease commencement date in determining the present value of lease payments. We have lease agreements that contain both lease and non-lease components. For real estate leases, we account for lease components together with non-lease components (e.g., common-area maintenance). Certain leases require the Company to pay a portion of real estate taxes, utilities, building operating expenses, insurance and other charges in addition to rent. In addition, the Company has elected the practical expedient related to the short-term lease exemption, whereby leases with initial terms of one year or less are not capitalized and instead expensed generally on a straight-line basis over the lease term.

Operating lease assets are valued based on the initial operating lease liabilities plus any prepaid rent, reduced by tenant improvement allowances. Operating lease assets are tested for impairment in the same manner as our long-lived assets.

We have finance leases covering certain office equipment and several vehicles. For these finance leases, we recognize amortization expense from the amortization of the right-of-use asset and interest expense on the related lease liability. Finance lease balances are included in Property and equipment, net on our Consolidated Balance Sheets. See Note 8 for additional information related to leases.

On January 1, 2021, we adopted Accounting Standard Update ("ASU") 2016-02, *Leases (Topic 842)* using the modified retrospective transition method. Results for the reporting period beginning January 1, 2021 are presented under Topic 842, while prior period amounts were not adjusted and continue to be reported in accordance with our historical accounting under Topic 840, *Leases*. See the *Recent Accounting Pronouncements* section below for further discussion.

Debt Issuance Costs

The Company amortizes debt issuance costs over the term of the respective credit agreements through interest expense, unless the debt is extinguished, in which case unamortized balances are immediately expensed. As of December 31, 2021 and 2020, the Company had unamortized deferred debt issuance costs and debt discounts of approximately $27.6 million and $35.0 million, respectively, $26.6 million and $34.0 million of which is reflected within Long-term debt and $1.0 million and $1.0 million of which is reflected within Other assets on the Consolidated Balance Sheets. See Note 7, *Long-Term Obligations* for further discussion.

Fair Value of Financial Instruments

The fair value of a financial instrument is the amount at which the instrument could be exchanged in an orderly transaction between two willing parties. This amount is determined based on an exit price approach, which contemplates the price that would be received to sell an asset (or paid to transfer a liability) in an orderly transaction between market participants at the measurement date. It also includes disclosures about fair value measurements, which prioritize the inputs to valuation techniques used to measure fair value.

The classification of a financial instrument within the valuation hierarchy is based upon the transparency of inputs to the valuation of an asset or liability on the measurement date. The three levels of the hierarchy in order of priority of inputs to the valuation technique are defined as follows:

- Level 1 – Observable quoted market prices in active markets for identical assets or liabilities
- Level 2 – Observable inputs other than Level 1, such as quoted prices in active markets for similar assets or liabilities, quoted prices for identical or similar assets or liabilities in markets that are not active, or inputs other than quoted prices that are observable for the asset or liability
- Level 3 – Unobservable inputs for the asset or liability that are significant to the fair value of the assets or liabilities

The Company utilizes the best available information in measuring fair value, on a recurring and nonrecurring basis.

Business Combinations

We account for acquisitions using the acquisition method of accounting in accordance with ASC 805, *Business Combinations.* Acquisitions are accounted for as purchases and are included in our consolidated financial statements from their respective acquisition dates. Assets acquired and liabilities assumed, if any, are measured at fair value on the acquisition date using the appropriate valuation method. Goodwill generated from acquisitions is recognized for the excess of the purchase price over tangible and identifiable intangible assets. In determining the fair value of identifiable intangible assets, we use various valuation techniques including discounted cash flow analysis, the income approach, or the cost approach, which may require us to make estimates and assumptions surrounding projected revenues and costs, future growth, and discount rates.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test, which is performed as of October 1st of each year. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount. The Company's reporting units consist of Home Health, Hospice, and Personal Care. These events or circumstances include, but are not limited to, a significant adverse change in the business environment, regulatory environment, or legal factors.

During 2021 and 2020, we performed a quantitative assessment to determine if the fair values of the reporting units were less than the carrying values by using the income and market valuation approaches. The assumptions utilized include unobservable inputs and are considered Level 3 measurements. Based on this valuation, the carrying value of the reporting units were less than fair value and the goodwill associated with our reporting unit was not considered at risk of impairment as of October 1, 2021 and 2020. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that

the fair value of any of our reporting units would be less than its carrying amount. The Company has not recognized any goodwill impairment charges in 2021 or 2020 related to the annual impairment testing.

Intangible assets consist of certificates of need, licenses, acquired names and non-compete agreements. We amortize non-compete agreements on a straight-line basis over their estimated useful lives, which are generally two to three years. Our indefinite-lived intangible assets are reviewed for impairment annually or more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the intangible asset below its carrying amount. We test indefinite-lived intangible assets for impairment either through a qualitative assessment similar to our evaluation for goodwill, or by performing a quantitative test. Our quantitative test estimates the fair values of the assets based on estimated future earnings derived from the assets using the relief from royalty method of the income approach and is performed on a non-recurring basis. This discounted cash flow model involves judgmental assumptions, including forecasted future cash flows from estimated royalty rates and the asset's weighted average cost of capital. The weighted average cost of capital factors in the relevant risk associated with business-specific characteristics and the uncertainty of achieving projected cash flows. These assumptions are unobservable inputs and are considered Level 3 measurements. Impairment is recognized as the excess of the indefinite-lived intangible asset's carrying amount over its fair value. During 2021 and 2020, we performed a quantitative assessment to determine if the fair value of our indefinite-lived intangible assets were less than the carrying values. Based on the 2020 assessment, the carrying value of our indefinite-lived intangible assets were less than the fair values. During 2021, the Company made a strategic decision to rebrand the Company utilizing the AccentCare trade name (the "2021 Rebranding"). Prior to the 2021 Rebranding, the Company had used local branding related to its acquired entities. In connection with the 2021 Rebranding, the majority of the subsidiaries of the Company were renamed AccentCare, with transition of branding occurring through the end of 2021. As a result, the Company evaluated non-AccentCare trade name indefinite-lived assets by performing a quantitative impairment test using the method described above. As a result of this test, we recognized an impairment charge of $108.2 million for the year ended December 31, 2021. Other than the impairment resulting from the 2021 Rebranding, there have been no material developments, events, changes in operating performance, or other circumstances that would cause remaining intangible asset values to be less than their carrying amounts. See Note 6, *Goodwill and Intangible Assets*, for further discussion.

Noncontrolling Interests

Noncontrolling interests represent the portion of equity in a subsidiary not attributable, directly or indirectly, to the Company. The Company's accompanying consolidated financial statements include all assets, liabilities, revenues, and expenses at their consolidated amounts, which include the amounts attributable to the Company and the noncontrolling interests. The Company recognizes as a separate component of equity and earnings the portion of income or loss attributable to noncontrolling interests based on the portion of the entity not owned by the Company.

The Company classifies noncontrolling interests of its joint ventures based upon a review of the legal provisions governing the redemption of such interests. In each of the Company's joint ventures, those provisions are embodied within the joint venture's operating agreement. For joint ventures with operating agreement provisions that establish a contingent obligation or obligation at the option of the third party for the Company to purchase the third-party partners' noncontrolling interests other than as a result of events that lead to a liquidation of the joint venture, such noncontrolling interests are classified as redeemable noncontrolling interests in temporary equity. The Company's joint ventures that are classified as redeemable noncontrolling interests are subject to operating agreement provisions that could require the Company to purchase the noncontrolling partners' interest upon the occurrence of certain triggering events, including two consecutive years of losses, loss of state license or certification, material breach of obligations, suspension or exclusion from participation in any federal or state health care program, or taking actions that may affect tax status or the passage of time, typically after three to ten years. These triggering events and the related repurchase provisions are specific to each redeemable noncontrolling joint venture since the triggering of a repurchase obligation for any one redeemable noncontrolling interest in a joint venture does not necessarily impact any of the other redeemable noncontrolling interests in other joint ventures. Upon the occurrence of a triggering event requiring the purchase of a redeemable noncontrolling interest, the Company would be required to purchase such noncontrolling partners' interest based on a valuation methodology set forth in the applicable operating agreement. Further, such operating agreements do not limit the amount that the Company could be required to pay for the noncontrolling interest. For joint ventures with operating agreement provisions that do not establish an obligation for the Company to purchase the third-party partners' noncontrolling interests (e.g., where the Company has the option, but not the obligation, to purchase the third-party partners' noncontrolling interests), such noncontrolling interests are classified as nonredeemable noncontrolling interests in permanent equity.

Noncontrolling interests are initially recorded at their fair value as of the closing date of the transaction establishing the joint venture. Such fair values are determined using various accepted valuation methods, including the income approach, the market approach, the cost approach, or a combination of one or more of these approaches. A number of facts and circumstances concerning the operation of the joint venture are evaluated for each transaction, including (but not limited to) the ability to

choose management, control over acquiring or liquidating assets, and control over the joint venture's strategy and direction, in order to determine the fair value of the noncontrolling interest.

Subsequent to the closing date of the transaction establishing the joint venture, recorded values for both redeemable and nonredeemable noncontrolling interests are adjusted at the end of each reporting period for (a) comprehensive income (loss) that is attributed to the noncontrolling interest, which is calculated by multiplying the noncontrolling interest percentage by the comprehensive income (loss) of the joint venture's operations during the reporting period, (b) dividends paid to the noncontrolling interest partner during the reporting period, and (c) any other transactions that increase or decrease the Company's ownership interest in the joint venture, as a result of which the Company retains its controlling interest.

Additionally, the Company recognizes changes in the redemption value of its redeemable noncontrolling interest immediately as they occur and the carrying value of the noncontrolling interest is adjusted to equal what the redemption amount would be as if redemption were to occur at the end of the reporting date based on the conditions that exist as of that date. The amount presented in temporary equity is no less than the initial amount reported in temporary equity for the redeemable noncontrolling interest.

Sale of a Noncontrolling Interest

During the year ended December 31, 2021, the Company sold 40% of its limited liability company interest in Seasons Hospice & Palliative Care of Delaware, LLC to Christiana Care Health System, Inc. for total proceeds of $28.0 million.

(Loss) Earnings Per Share

Basic loss per share is calculated by dividing the net earnings (loss) attributable to common stockholders by the weighted-average number of common shares outstanding for the period without consideration of potential dilutive securities. Diluted loss per share is also computed by dividing the net earnings (loss) attributable to common stockholders by the sum of the weighted average number of common shares plus the potential dilutive effects of potential dilutive securities outstanding during the period. Potential dilutive securities are excluded from diluted earnings or loss per share if the effect of such inclusion is antidilutive. Share-based compensation is awarded in securities of the Company's Parent and the Seasons entity as mentioned in Note 10. As these awards are not redeemable in the Company's securities, they are not included in the calculation of dilutive securities. For the years ended December 31, 2021 and 2020 there was no difference in the number of shares used to calculate basic and diluted shares outstanding because there was only one class of stock and there were no potentially dilutive securities.

The following reflects the Company's net (loss) income used in the basic and diluted per share computations (amounts in thousands except per share data):

	For the Years Ended December 31,	
	2021	2020
Basic loss per share:		
Numerator for basic loss per share:		
Net (loss) income	$ (134,628)	$ 2,852
Less: Net (loss) income attributable to noncontrolling interests	(1,884)	2,125
Less: adjustments to redemption value	978	1,008
Net loss attributable to Horizon Acquisition Co., Inc.	(133,722)	(281)
Numerator for basic loss per share	(133,722)	(281)
Denominator for basic loss per share:		
Weighted average shares outstanding	1,000	1,000
Horizon Acquisition Co., Inc. stockholders:		
Basic loss per share	$ (133,722.39)	$ (280.51)
Diluted loss per share:		
Numerator for diluted loss per share:		
Net loss attributable to Horizon Acquisition Co., Inc.	(133,722)	(281)
Numerator for diluted loss per share	(133,722)	(281)
Denominator for diluted loss per share:		
Weighted average shares outstanding	1,000	1,000
Horizon Acquisition Co., Inc. stockholders:		
Diluted loss per share	$ (133,722.39)	$ (280.51)

Share-Based Compensation

The Company recognizes compensation expense for all share-based compensation awarded to employees using the fair-value-based method. The calculated grant-date fair value of each award is amortized to Share-based compensation expense over the award's vesting period for service awards and recognized upon the achievement of certain performance targets for performance-based awards. The Company accounts for forfeitures as they occur.

Variable Interest Entities

The Company evaluates arrangements and relationships with other entities, including investments in other associations in accordance with the accounting standard related to consolidation of variable interest entities. This guidance requires the Company to identify variable interests (contractual, ownership or other financial interests) in other entities and whether any of those entities in which the Company has a variable interest, meets the criteria of a variable interest entity. An entity is considered to be a variable interest entity when its total equity investment at risk is not sufficient to permit the entity to finance its activities without additional subordinated financial support, or its equity investors, as a group, lack the characteristics of having a controlling financial interest. In making this assessment, the Company considers the potential that the arrangements and relationships with other entities to provide subordinated financial support, the potential for the Company to absorb losses or rights to residual returns of an entity, the ability to directly or indirectly make decisions about the entity's activities and other factors.

If an entity that the Company has a variable interest in meets the criteria of a variable interest entity, the Company must determine whether the Company is the primary beneficiary of that entity. The primary beneficiary is the entity that has the power to direct the activities of the variable interest entity that most significantly impact the variable interest entity's economic performance, and the obligation to absorb losses or the right to receive benefits from the variable interest entity that could be potentially significant to the variable interest entity. If the Company is determined to be the primary beneficiary of (has controlling financial interest in) a variable interest entity, then the Company would be required to consolidate that entity. In certain situations, it may be determined that power is shared among multiple unrelated parties such that no one party has the power to direct the activities of a variable interest entity that most significantly impact the variable interest entity's economic performance (decisions about those activities require the consent of each of the parties sharing power). In accordance with the

accounting guidance prescribed by consolidation of variable interest entities, if the determination is made that power is shared among multiple unrelated parties, then no party is the primary beneficiary.

Income Taxes

The Company accounts for income taxes using the asset and liability method. Deferred income taxes are recognized based on the differences between the financial statement basis and the tax basis of assets and liabilities using the enacted statutory rates in effect for the year in which the differences are expected to reverse. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. The provision for income taxes represents the tax payable for the period and the change during the period in Deferred tax assets and liabilities. Uncertain tax positions must be more likely than not to occur before a tax benefit is recognized in the financial statements. The benefit to be recorded is the amount most likely to be realized assuming a review by tax authorities having all relevant information and applying current conventions. The Company recognizes interest and penalties on uncertain tax positions in Income tax expense.

Advertising Costs

The Company expenses advertising costs as incurred. Advertising expense for the years ended December 31, 2021 and 2020 was $2.4 million and $0.7 million, respectively.

Recent Accounting Pronouncements

Recently Adopted

Leases

In February 2016, the Financial Accounting Standards Board ("FASB") issued ASU 2016-02, *Leases (Topic 842)*, and subsequent amendments to the initial guidance ASU 2017-13, ASU 2018-10, ASU 2018-11, and ASU 2018-20 (collectively, "ASU 2016-02"). ASU 2016-02 amends the existing accounting standards for lease accounting, including requiring lessees to recognize most leases on their balance sheets and making targeted changes to lessor accounting. The new guidance also requires additional disclosures about leases. The Company adopted the requirements of the new standard as of January 1, 2021 using the optional transition method. As part of our adoption, we elected the package of practical expedients, permitted under the new guidance, which, among other things, allowed the Company to continue utilizing historical classifications of leases. In addition, we elected not to separate non-lease components for our real estate leases.

The adoption of the new standard resulted in the recognition of right-of-use assets of approximately $73.6 million and lease liabilities of approximately $75.3 million, which is reflected net of existing prepaid rents of $0.6 million, deferred rents of $0.9 million, and favorable and unfavorable lease intangible assets of $0.8 million, as of January 1, 2021. The standard did not materially impact our Consolidated Statements of Operations or Cash Flows.

Credit Losses

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments—Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments* ("ASU 2016-13"). ASU 2016-13 changes the impairment model for most financial assets and certain other instruments. Under the new standard, entities holding financial assets and net investment in leases that are not accounted for at fair value through net income are to be presented at the net amount expected to be collected. An allowance for credit losses will be a valuation account that will be deducted from the amortized cost basis of the financial asset to present the net carrying value at the amount expected to be collected on the financial asset. The Company adopted this standard effective January 1, 2021. We have reviewed our provision for doubtful accounts process as required by ASU 2016-13 and concluded that adoption of the new standard did not have a significant impact on our results of operations or liquidity.

Income Taxes

In December 2019, the FASB issued ASU 2019-12, *Simplifying the Accounting for Income Taxes* ("ASU 2019-12"), which removes certain exceptions to the general principles of ASC *Income Taxes (Topic 740)*, and adds guidance to reduce complexity in accounting for income taxes. The Company adopted this standard effective January 1, 2021.

Provisions related to general intra-period tax allocations, the calculation of income taxes for interim periods, the accounting for interim period effects on changes in tax law or rates and step-up basis of goodwill will be adopted on a prospective basis. The provision applicable to changes in accounting for franchise taxes calculated using the greater of two calculations—one based on income, and one based on non-income items (e.g., capital, revenue, etc.) will be applied on a modified retrospective approach. The adoption of this ASU did not have a material impact on the Company's consolidated financial statements.

Implementation Costs

In August 2018, the FASB issued ASU 2018-15, *Customer's Accounting for Implementation Costs Incurred in a Cloud Computing Arrangement That Is a Service Contract*, an update to ASC *Subtopic 350-40 - Intangibles - Goodwill and Other - Internal-Use Software* ("ASU 2018-15"). The amendments in ASU 2018-15 align the requirements for capitalizing implementation costs incurred in a hosting arrangement that is a service contract with the requirements for capitalizing implementation costs incurred to develop or obtain internal-use software. The Company adopted ASU 2018-15 prospectively as of January 1, 2021, and the adoption of this standard resulted in these costs being recorded in Prepaid expenses and Other assets on the Consolidated Balance Sheets and amortized over the life of the contract.

Pending Accounting Pronouncements

Government Assistance

In November 2021, the FASB issued ASU 2021-10, *Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance.* The amendments in this update require disclosures about transactions with a government that have been accounted for by analogizing to a grant or contribution accounting model to increase transparency about (1) the types of transactions, (2) the accounting for the transactions, and (3) the effect of the transactions on an entity's financial statements. This amendment is effective for annual reporting periods beginning after December 15, 2021 for all entities and can be applied either retrospectively or prospectively, and early adoption is permitted. The Company is evaluating the impact of adopting the new standard on the consolidated financial statements.

Business Combinations

In October 2021, the FASB issued ASU 2021-08, *Business Combinations (Topic 805): Accounting for Contract Assets and Contract Liabilities from Contracts with Customer*, which addresses diversity and inconsistency related to the recognition and measurement of contract assets and contract liabilities acquired in a business combination. The amendments in this update require that an acquirer recognize and measure contract assets and contract liabilities acquired in a business combination in accordance with Topic 606, *Revenue from Contracts with Customers*. This amendment is effective for annual reporting periods beginning after December 15, 2022, including interim periods within those annual reporting periods for public business entities, and for fiscal years beginning after December 15, 2023 for all other entities, and can be applied either retrospectively or prospectively. An entity should apply the amendments prospectively to business combinations occurring on or after the effective date of the amendment. Early adoption is permitted for all entities, including adoption in an interim period. The Company is evaluating the impact of adopting the new standard on the consolidated financial statements.

3. IMPACT OF NOVEL CORONAVIRUS PANDEMIC ("COVID-19")

In March 2020, the World Health Organization declared COVID-19 a pandemic. As a healthcare at home company, we have been, and will continue to be, impacted by the effects of COVID-19; however, we remain committed to carrying out our mission of caring for our patients. We will continue to monitor closely, the impact of COVID-19 on all aspects of our business, including the impacts to our employees, patients, and suppliers; however, at this time, we are unable to estimate the ultimate impact the pandemic will have on our consolidated financial condition, results of operations, or cash flows.

On March 27, 2020, the CARES Act was signed into legislation. The CARES Act provides for $178.0 billion to healthcare providers, including hospitals on the front lines of the COVID-19 pandemic. Of this total allocated amount, $30.0 billion was distributed immediately to providers based on their proportionate share of Medicare fee-for-service reimbursements in 2020. Healthcare providers were required to sign an attestation confirming receipt of the Provider Relief Fund ("PRF") funds and agree to the terms and conditions of payment. Our home health, hospice and personal care segments received approximately $25.7 million from the first $30.0 billion of funds distributed to healthcare providers in April 2020. We returned these funds and then applied for funds based on COVID-19 expenses and lost revenues for which the Company received $16.4 million from June to October 2020. We also acquired approximately $2.6 million of PRF funds in connection with our acquisitions during 2020. Under the terms and conditions for receipt of the payment, we are allowed to use the funds to cover lost revenues and health care costs related to COVID-19, and we are required to properly and fully document the use of these funds in reports to the U.S. Department of Health and Human Services ("HHS"). HHS issued new guidance in June 2021 noting that PRF funds can be used towards lost revenues or expenses attributable to COVID-19 through December 31, 2021 with any unutilized funds as of December 31, 2021 being subject to recapture by the government.

On December 16, 2021, HHS started Phase 4 General Distribution payments of an additional $17.0 billion to healthcare providers. The Company applied for Phase 4 funds based on changes in revenues and expenses for the period from July 1, 2020 to March 31, 2021 for AccentCare New York and Alliance for Health. On December 16, 2021, the Company's subsidiaries,

AccentCare New York and Alliance for Health received a combined $0.8 million in Phase 4 PRF funds. Funds received during Phase 4 can be used towards lost revenues or expenses attributable to COVID-19 through December 31, 2022 with any unutilized funds as of December 31, 2022 being subject to recapture by the government.

As of December 31, 2021, the Company has utilized all PRF funds received from the CARES Act. Funds utilized are reflected in Other operating income within our Consolidated Statements of Operations. In summary, the total funds that we have received from the CARES Act PRF as of December 31, 2021, consist of the following (amounts in thousands):

Funds utilized through December 31, 2020	$	16,908
Funds utilized from January 1, 2021 to December 31, 2021		2,978
	$	19,886

The CARES Act also provides for the temporary suspension of the automatic 2% reduction of Medicare claim reimbursements (sequestration) for the period May 1, 2020 through December 31, 2020 and the deferral of the employer share of social security tax (6.2%), effective for payments due after the enactment date. The suspension of the automatic 2% reduction of Medicare claim reimbursement increased our net service revenue by $18.3 million for the year ended December 31, 2021 and $8.6 million for the period May 1, 2020 through December 31, 2020. Fifty percent of the deferred payroll taxes were paid by December 31, 2021 with the remaining amounts due on December 31, 2022. As of December 31, 2021, we had deferred $17.9 million of social security taxes; this amount is included in Other current liabilities within our Consolidated Balance Sheets. As of December 31, 2020, we had deferred $36.7 million of social security taxes; half of this amount is included in Other current liabilities and the remaining half is included in Other long-term liabilities within our Consolidated Balance Sheets.

In December 2020, Congress passed additional COVID-19 relief legislation as part of the Consolidated Appropriations Act 2021. The legislation extended the suspension of sequestration through March 31, 2021. In December 2021, Congress passed legislation to provide full relief from the 2% Medicare sequestration cut for both participating providers and non-participating providers from January 1, 2022 through the end of March 2022. From April 2022 through June 2022 a 1% sequestration cut will be in effect, with the full 2% cut resuming thereafter.

4. ACQUISITIONS

2021 Transaction

Southeastern Acquisition

On June 10, 2021, the Company entered into an equity purchase agreement with Southeastern Holding, LLC, Southeastern Intermediate Holdings, LLC, and Southeastern Holdings, LLC (*"*Southeastern*"*). Per the purchase agreement, the final purchase price was $145.0 million plus closing cash and an acquired investment of $7.1 million, and subsequent working capital adjustments of $1.6 million for total consideration of $153.7 million. The transaction closed on June 15, 2021. The Company incurred $1.9 million of transaction fees in association with the Southeastern acquisition. These expenses are reflected in Other general and administrative expenses in the accompanying Consolidated Statements of Operations. The acquisition was a strategic decision to expand the business in the northeast.

The Company's acquisition of Southeastern was accounted for in accordance with ASC 805, and the resulting goodwill and intangibles were accounted for under ASC 350, *Accounting for Goodwill (Topic 350)* ("ASC 350"). The purchase price was allocated to the target company's net tangible and identified intangible assets based on estimated fair values. The excess of the purchase price over the aggregate fair value of the net assets acquired was allocated to goodwill and is primarily attributable to the Company's operating model and capabilities that are expected to facilitate continued growth by the Company. In total, $139.3 million of goodwill and intangible assets were acquired in the Southeastern Acquisition, all of which is amortizable for tax purposes.

The following table summarizes the preliminary allocation of the purchase price to the estimated fair values of assets acquired and liabilities assumed at the date of the acquisition (in thousands):

Consideration transferred:		
Cash	$	153,772
Recognized amount of identified assets acquired and liabilities assumed:		
Cash and cash equivalents		6,022
Mutual fund investment		1,103
Patient accounts receivable		10,343
Prepaid expenses and other current assets		302
Property and equipment		1,111
Operating lease right of use asset		1,670
Intangible assets		3,500
Accounts payable and accrued expenses		(4,313)
Operating lease liability		(1,785)
Total identifiable assets, net		17,953
Goodwill		135,819
Total purchase price	$	153,772

The results of operations of Southeastern are included in the Consolidated Statements of Operations since the date of the acquisition. The Company is in the process of reviewing the fair value of the assets acquired and liabilities assumed. The final valuation of the working capital assets acquired and liabilities assumed was not complete as of December 31, 2021, but will be finalized within the allowable measurement period. The fair value measurement of tangible and intangible assets and liabilities as of the acquisition date is based on significant inputs not observed in the market and thus represents a Level 3 fair value measurement, as defined under ASC 820, *Fair Value Measurement* ("ASC 820"). The valuation was assessed with the assistance of a valuation specialist.

The trade name was assigned a three year life. The licenses are indefinite-lived assets and, therefore, not subject to amortization. Trade names are valued using the relief from royalty method, a form of the income approach and are considered a defensive intangible asset. Licenses are valued based on replacement cost, a cost approach.

Southeastern's revenue and net income amounts are included in the Company's Consolidated Statement of Operations from the date of the acquisition to the period ended December 31, 2021 are $40.5 million and $5.1 million, respectively. The following pro forma financial information presents the Company's operating results as if the Southeastern acquisition had occurred on January 1, 2020 (amounts in thousands):

	For the Years Ended December 31,	
	2021	**2020**
	(unaudited)	**(unaudited)**
Pro forma revenue	$ 1,597,030	$ 949,711
Pro forma net (loss) income	(134,144)	$ 289

The pro forma financial information above adjusts for the effects of material business combination items, including depreciation and amortization of acquired assets and interest expense and the corresponding income tax effects of each. These pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the operating results of the Company that would have been achieved had the Southeastern acquisition actually taken place on January 1, 2020. In addition, these results are not intended to be a projection of future results and do not reflect events that may occur after the acquisition, including, but not limited to, revenue enhancements, cost savings or operating synergies that the combined company may achieve as a result of the acquisition.

2020 Transactions

Seasons Companies Acquisition

On October 30, 2020, the Company entered into an equity purchase agreement with Seasons Rollover Holdings, LLC and Seasons Healthcare Management Holdings, Inc. (*"*Seasons*"*). As part of this transaction, the Company acquired three commonly owned groups of companies: Seasons Hospice Group & Affiliates, Gareda, LLC, and Health Resource Solutions, LCC (collectively referred to as the *"*Seasons Companies*"*). Prior to the transaction, the Seasons Companies operated independently of each other. Per the purchase agreement, the final purchase price was $732.9 million plus closing cash of $39.5 million, $181.7 million of equity units in the Parent and a subsequent $0.3 million working capital adjustment, for total consideration of $954.4 million. The transaction closed on December 21, 2020. The Company incurred $12.3 million of transaction fees in association with the Seasons Companies acquisition. These expenses are reflected in Other general and administrative expenses in the accompanying Consolidated Statements of Operations. The acquisition was a strategic decision to grow the hospice line of business.

The Company's acquisition of the Seasons Companies was accounted for in accordance with ASC 805, and the resulting goodwill and intangibles were accounted for under ASC 350. The purchase price was allocated to the target Company's net tangible and identified intangible assets based on estimated fair values. The excess of the purchase price over the aggregate fair value of the net assets acquired was allocated to goodwill and is primarily attributable to the Company's operating model and capabilities that are expected to facilitate continued growth by the Company. Certain portions of the goodwill and intangible assets acquired are amortizable for tax purposes. In total, $908.3 million of goodwill and intangible assets were acquired in the Seasons acquisition. Of that total, $663.3 million is amortizable for tax purposes.

The following table summarizes the final allocation of the purchase price to the estimated fair values of assets acquired and liabilities assumed at the date of the acquisition (in thousands):

Consideration transferred:		
Cash	$	772,751
Equity units in parent		181,658
Fair value of total consideration exchanged		954,409
Recognized amount of identified assets acquired and liabilities assumed:		
Cash and cash equivalents		39,536
Patients accounts receivable		103,241
Prepaid expense		2,746
Other current assets		1,688
Property and equipment		31,251
Intangible assets		104,788
Other assets		391
Accounts payable		(17,287)
Accrued payroll and related benefits		(41,939)
Accrued expenses		(48,668)
Income taxes payable		(28)
Other current liability		(4,896)
Deferred tax liability, net		(6,209)
Other long-term liabilities		(4,180)
Total identifiable assets, net		160,434
Noncontrolling interest - redeemable in subsidiaries		(9,510)
Goodwill		803,485
Total purchase price	$	954,409

The associated results of operations of the Seasons Companies are included in the Consolidated Statements of Operations since the date of the acquisition. The final valuation of the working capital assets acquired and liabilities assumed was complete as of December 21, 2021. Based on available information obtained by the Company during the year ended December 31, 2021, the Company recorded certain measurement period adjustments to the acquisition accounting for the Seasons Companies, resulting in an decrease to Accounts receivable of $1.6 million, an increase in Accrued expenses of $1.0 million, an increase to Property and equipment of $0.7 million, and an increase to Other current liability of $0.7 million, with a corresponding increase to Goodwill of $2.6 million during the period. The fair value measurement of tangible and intangible assets and liabilities as of the acquisition date is based on significant inputs not observed in the market and thus represents a Level 3 fair value measurement, as defined under ASC 820. The valuation was assessed with the assistance of a valuation specialist.

The certain trade name, certificates of need and licenses are indefinite-lived assets and, therefore, not subject to amortization. Certain acquired definite-lived trade names were determined to have a twenty year useful life. Trade names are valued using the relief from royalty method, a form of the income approach. Certificates of need are valued using the replacement cost approach based on registration fees and opportunity costs. In the case of states with a moratorium in place, the certificate of need are valued using the Greenfield method. Licenses are valued based recent licenses sales, or the market approach. In the case of states with a moratorium in place, the licenses are valued using the multi-period excess earnings method. Noncontrolling interest is recorded at fair value. Noncontrolling interest is a Level 3 fair value measurement. The fair value was determined by the contribution and then applying a discount rate. The equity units in the parent consist of 94,960 units with a fair value of $1,913 per unit for a total of $181.7 million. These units are a Level 3 fair value measurement. The fair value was determined by historical information and market multiples.

The amounts of revenue and income of the Seasons Companies included in the Company's Consolidated Statements of Operations from the date of the acquisition to the year ended December 31, 2020, were $15.0 million and $1.2 million, respectively. The following pro forma financial information presents the Company's operating results as if the Seasons Companies acquisition had occurred on January 1, 2020 (amounts in thousands):

	For the Year Ended December 31, 2020
	(unaudited)
Pro forma revenue	$ 1,425,750
Pro forma net loss	(23,571)

The pro forma financial information above adjusts for the effects of material business combination items, including depreciation and amortization of acquired assets and interest expense and the corresponding income tax effects of each. These pro forma results have been prepared for comparative purposes only and do not purport to be indicative of the operating results of the Company that would have been achieved had the Seasons Companies acquisition actually taken place on January 1, 2020. In addition, these results are not intended to be a projection of future results and do not reflect events that may occur after the acquisition, including, but not limited to, revenue enhancements, cost savings or operating synergies that the combined company may achieve as a result of the acquisition.

Fairview Acquisition

On September 1, 2020, the Company entered into an asset purchase agreement with Fairview Health Services, Fairview Home Care and Hospice, HealthEast Care System, HealthEast St. Joseph's Hospital, all Minnesota nonprofit corporations (collectively *"*Fairview*"*). Fairview is engaged in the business of delivering home care and hospice services in Minnesota. Total aggregate purchase price for this transaction was $68.9 million, of which $13.1 million represents the value of a 20% equity interest in Fairview retained by the seller, and $54.9 million cash consideration and a $0.3 million subsequent working capital adjustment. The Company incurred $0.5 million of transaction fees in association with the Fairview acquisition. These expenses are reflected in Other general and administrative expenses in the accompanying Consolidated Statements of Operations. The acquisition was a strategic decision to grow the home health and hospice line of business.

The Company's acquisition of Fairview was accounted for in accordance with ASC 805, and the resulting goodwill and intangibles were accounted for under ASC 350. The purchase price was allocated to Fairview's net tangible and identified intangible assets based on estimated fair values. The excess of the purchase price over the aggregate fair value of the net assets acquired was allocated to goodwill and is primarily attributable to the Company's operating model and capabilities that are expected to facilitate continued growth by the Company. The goodwill and intangible assets acquired were deductible for tax purposes. In total, $53.6 million of goodwill and intangible assets were acquired in the Fairview Acquisition. Of that total, $43.2 million is amortizable for tax purposes.

The following table summarizes the final allocation of the purchase price to estimated fair values of assets acquired and liabilities assumed as a result of the acquisition (in thousands):

Consideration transferred:		
Cash	$	55,221
Recognized amount of identified assets acquired and liabilities assumed:		
Patients accounts receivable		15,341
Prepaid expenses		45
Property and equipment, net		115
Intangible assets		4,670
Accrued expenses		(585)
Deferred tax liability, net		(188)
Total identifiable assets, net		19,398
Noncontrolling interest - redeemable in subsidiaries		(13,130)
Goodwill		48,953
Total purchase price	$	55,221

The associated results of operations of Fairview are included in the Consolidated Statements of Operations since the date of the acquisition. The final valuation of the working capital assets acquired and liabilities assumed was complete as of September 30, 2021. Based on available information obtained by the Company during the year ended December 31, 2021, the Company recorded certain measurement period adjustments to the acquisition accounting for Fairview, resulting in a $0.3 million decrease to net working capital with a corresponding increase to Goodwill of $0.3 million during the period. The fair value measurement of tangible and intangible assets and liabilities as of the acquisition date is based on significant inputs not observed in the market and thus represents a Level 3 fair value measurement, as defined under ASC 820. The valuation was assessed with the assistance of a valuation specialist.

The certificates of need and licenses are indefinite-lived assets and, therefore, not subject to amortization. Trade names were determined to have a fifteen year useful life and are valued using the relief from royalty method, a form of the income approach. Certificates of need are valued using the replacement cost approach based on registration fees and opportunity costs. In the case of states with a moratorium in place, the certificate of need are valued using the Greenfield method. Licenses are valued based on a replacement cost approach. Noncontrolling interest is recorded at fair value. Noncontrolling interest is a Level 3 fair value measurement. The fair value is determined by the percentage of ownership of enterprise value with any necessary discount.

5. VARIABLE INTEREST ENTITIES

For legal entities where the Company has a financial relationship, the Company evaluates whether it has a variable interest and determines if the entity is considered a variable interest entity (“VIE”). If the Company concludes an entity is a VIE and the Company is the primary beneficiary, the entity is consolidated. The primary beneficiary analysis is a qualitative analysis based on power and benefits. A reporting entity has a controlling financial interest in a VIE and must consolidate the VIE if it has both power and benefits. It must have the power to direct the activities that most significantly impact the VIE’s economic performance and the obligation to absorb losses of the VIE that potentially could be significant to the VIE or the right to receive benefits from the VIE that potentially could be significant to the VIE.

Certain states prohibit the “corporate practice of medicine,” which restricts the Company from owning medical practices which directly employ physicians and from exercising control over medical decisions by physicians. In these states, the Company enters into long-term management agreements with medical practices that are owned by licensed physicians, which, in turn, employ or contract with physicians who provide professional medical services. Based on the provisions of the management agreements, the medical practices are variable interest entities for which the Company is the primary beneficiary. Under such management agreements, creditors lack recourse against the Company for debts incurred by the VIE.

As of December 31, 2021 and 2020, the total assets of the Company’s variable interest entities were $1.9 million and $0.2

million, respectively, and are principally comprised of patient accounts receivable. As of December 31, 2021 and 2020, the total liabilities of these variable interest entities were $1.7 million and $1.8 million, respectively, and are principally comprised of accounts payable and accrued expenses. The Company's variable interest entities have obligations payable for services received under the aforementioned management agreements of $5.5 million and $3.2 million as of December 31, 2021 and 2020, respectively; these intercompany balances are eliminated in consolidation.

6. GOODWILL AND INTANGIBLES

The following is a summary of goodwill balances and activity (in thousands):

	Home Health	Hospice	Personal Care	Total
Balance as of December 31, 2019	$ 547,646	$ 98,657	$ 59,246	$ 705,549
Acquisitions	67,572	759,222	22,309	849,103
Balance as of December 31, 2020	615,218	857,879	81,555	1,554,652
Acquisitions	131,028	4,791	—	135,819
Remeasurement adjustments[1]	82	2,790	471	3,343
Balance as of December 31, 2021	$ 746,328	$ 865,460	$ 82,026	$ 1,693,814

(1) See Note 4, *Acquisitions* for further discussion of remeasurement adjustments.

The following table provides information regarding the Company's other intangible assets, which are included in the accompanying Consolidated Balance Sheets (in thousands):

	Trade Names [2]	Certificates of Need	Medicare Licenses	Non-Compete Covenant [3]	Favorable Leases	Total	Unfavorable Leases
Balance as of December 31, 2019	$ 170,900	$ 82,865	$ 10,500	$ 1,565	$ 150	$ 265,980	$ —
Additions	66,194	38,493	5,700	—	986	111,373	(1,914)
Amortization	—	—	—	(536)	(412)	(948)	395
Write-offs[1]	—	—	(300)	—	—	(300)	—
Balance as of December 31, 2020	237,094	121,358	15,900	1,029	724	376,105	(1,519)
Acquisitions	1,600	—	1,900	—	—	3,500	—
Amortization	(6,038)	—	—	(449)	—	(6,487)	—
Impairment	(108,160)	—	—	—	—	(108,160)	—
Adoption of ASU 2016-02[4]	—	—	—	—	(724)	(724)	1,519
Balance as of December 31, 2021	$ 124,496	$ 121,358	$ 17,800	$ 580	$ —	$ 264,234	$ —

(1) During 2020, the Company recognized a disposal of $0.3 million related to Medicare licenses associated with our Home Health segment that were returned due to closed locations and is included in Asset impairment on the Company's Consolidated Statement of Operations. The Company completed its annual impairment analysis and noted no other impairments.

(2) As of December 31, 2021, the weighted average remaining amortization period of our amortizable trade names was 4.0 years. Accumulated amortization associated with our amortizable trade names totaled $6.0 million as of December 31, 2021. There was no accumulated amortization associated with our trade names for the year ended December 31, 2020 as these were previously indefinite-lived intangible assets. The value of our indefinite-lived trade names was $92.8 million and $237.1 million as of December 31, 2021 and 2020, respectively.

(3) As of December 31, 2021, the weighted average remaining amortization period of our non-compete covenants was 1.7 years. Accumulated amortization associated with our non-compete covenants totaled $2.3 million and $1.8 million as of December 31, 2021 and 2020, respectively.

(4) With the adoption of ASU 2016-02, the Company's favorable and unfavorable lease balances were reclassified to Operating lease right of use asset which is included on the Company's Consolidated Balance Sheets.

In July 2021, the Company made a strategic decision to rebrand the Company utilizing the AccentCare trade name. In connection with the 2021 Rebranding, certain subsidiaries of the Company were renamed AccentCare, with transition of branding occurring through the end of 2021. As a result, the Company evaluated certain non-AccentCare trade name indefinite-lived assets by performing a quantitative impairment test of those intangible assets, as described in Note 2 - *Summary of Significant Accounting Policies*. As a result of this test, we recognized an impairment charge of $108.2 million for the year ended December 31, 2021. For segment purposes, the impairment of intangible asset is included in our Corporate segment. Following the impairment, the remaining useful life of the impacted trade names was estimated to be three years.

The estimated aggregate amortization expense related to intangible assets for each of the five succeeding years is as follows (in thousands):

	Intangible Asset Amortization
2022	$ 11,749
2023	11,633
2024	5,846
2025	281
2026	281
Thereafter	2,486
Total	$ 32,276

7. LONG-TERM OBLIGATIONS

The Company's long-term obligations consisted of the following (in thousands):

	As of December 31,	
	2021	2020
Term loans:		
2019 1st lien term loan	$ —	$ 349,675
2019 2nd lien term loan	130,000	130,000
2020 incremental 1st lien term loan	—	525,000
2020 incremental 2nd lien term loan	152,000	152,000
2021 term loan	868,995	—
ABL credit facility	115,000	—
Debt issuance cost and debt discount, net of amortization	(26,584)	(34,006)
Total long-term obligations, net	1,239,411	1,122,669
Less current portion:		
Term loans	(8,690)	(8,800)
Long-term obligations, excluding current portion	$ 1,230,721	$ 1,113,869

As of December 31, 2021 and 2020, long-term obligations are reflected net of unamortized debt issuance costs and debt discounts of $26.6 million and $34.0 million, respectively. Amortization of debt issuance costs and debt discounts for the years ended December 31, 2021 and 2020 was $6.3 million and $2.7 million, respectively.

Annual future principal payment obligations for long-term debt were as follows as of December 31, 2021 (in thousands):

2022	$ 8,690
2023	8,690
2024	8,690
2025	8,690
2026	1,231,235
Total	$ 1,265,995

2021 Term Loan

On June 21, 2021, the Company entered into an agreement which provided for a $873.4 million term loan (the "2021 Term Loan"). The proceeds were utilized to pay off the existing Incremental First Lien Term Loan and the First Lien Term Loan. The 2021 Term Loan has quarterly principal payments of 0.25% of the original principal balance, and a maturity date of June 20, 2026. The 2021 Term Loans bear interest at a rate per annum equal to the base rate (either London Interbank Offered Rate ("LIBOR") or Alternate Base Rate) plus an applicable margin based on the Company's Moody's and S&P corporate rating ranging from 3.75% to 4.00% per annum for LIBOR based loans or 2.75% to 3.00% for Alternate Base Rate loans. At December 31, 2021 the interest rate calculated on the 2021 Term Loan was 4.09% with an outstanding balance of $869.0 million.

The Company incurred fees of $1.3 million related to the 2021 Term Loan which were expensed as incurred. Previously capitalized debt issuance costs of $0.7 million were written off as a loss on debt extinguishment on the Consolidated Statements of Operations.

The Company's outstanding debt carries a restrictive covenant for leverage ratios. The Company was in compliance with the covenants under all of its outstanding debt through the years ended December 31, 2021.

ABL Credit Facility

On June 15, 2021, the Company amended the ABL credit facility to increase the availability by $75.0 million to a total of $225.0 million availability. The Company incurred an arrangement fee of $0.2 million for the incremental increase in availability. The arrangement fee will be treated as debt issuance costs and amortized proportionality over the term of the ABL Facility on an effective interest rate basis. The debt issuance costs are included in Other assets in the Consolidated Balance Sheets. There was no change to the maturity date related to the increase in availability.

The Company had an outstanding balance under the 2020 ABL credit facility at December 31, 2021 of $115.0 million at an average interest rate of 1.95%. The Company had no outstanding balance under the ABL credit facility at December 31, 2020.

2020 Credit Agreement

On December 21, 2020, the Company executed agreements (the "2020 Credit Agreement") which amended the 2019 Credit Agreement (as defined below) to provide financing for the Seasons Companies Acquisition. The Company entered into two new term loans, a $525.0 million incremental first lien term loan (the "Incremental First Lien Term Loan") and a $152.0 million incremental second lien term loan (the "Incremental Second Lien Term Loan"), collectively the "2020 Incremental Term Loans." The 2019 ABL and Revolver were also amended. The availability under the ABL credit agreement was increased to $150.0 million and there were no changes in availability to the $40.0 million revolver. The 2020 Incremental Term Loans are collateralized by substantially all of the Company's assets.

Incremental First Lien Term Loan

The $525.0 million Incremental First Lien Term Loan provided for quarterly principal and interest payments, with the remaining principal balance due at maturity on June 20, 2026. The base rate per annum was equal to the highest of: (a) NYFRB Rate plus the 0.50% applicable margin (b) the LIBOR plus 1.0%, and (c) the Wall Street Journal Prime Rate for an Asset Based Rate ("ABR") loan. The interest rate of the Incremental First Lien Term Loan was calculated using LIBOR base rate and then adding an applicable percentage relative to the base rate. The applicable percentage per annum was equal to: (i) 3.75% to 4.00% in the case of an ABR loan or (ii) 4.75 to 5.00% in the case of a LIBOR loan. There is a LIBOR floor of 0.50%. The outstanding balance on the Incremental First Lien Term Loan was $525.0 million at December 31, 2020. The 2020 Incremental First Term Loan was refinanced in association with the 2021 Term Loan.

A total of $1.5 million of debt issuance costs were capitalized as deferred financing costs in association with the Incremental First Lien Term Loan. Additionally, a debt discount of $14.5 million was recorded in association with the Incremental First Lien Term Loan. The debt discount is recorded as a contra liability account and amortized over the life of the loan to interest expense.

Incremental Second Lien Term Loan

The $152.0 million Incremental Second Lien Term Loan provides for quarterly interest payments, with the full principal balance due on June 20, 2027. The interest rate of the Incremental Second Lien Term Loan is calculated using a base rate and then adding an applicable percentage relative to the base rate. The base rate per annum is equal to the highest of: (a) NYFRB Rate plus the 0.50% applicable margin, (b) the LIBOR plus 1.0%, and (c) the Wall Street Journal Prime Rate for an ABR loan.

The interest rate of the Incremental Second Lien Term Loan was calculated using LIBOR base rate. The base rate per annum is equal to LIBOR for in the case of a LIBOR loan. The applicable percentage per annum is equal to: (i) 7.75% in the case of an ABR loan or (ii) 8.75% in the case of a LIBOR loan. There is a LIBOR floor of 0.75%. As of December 31, 2021 and 2020, the interest rate on the Incremental Second Lien Term Loan was 9.96% and 9.50%, respectively, and the outstanding balance was $152.0 million.

Debt issuance costs of $0.3 million were expensed and a debt discount of $3.8 million was recorded in association with the Incremental Second Lien Term Loan. The debt discount is recorded as a contra liability account and amortized over the life of the loan to interest expense.

ABL Credit Facility

As part of the 2020 Credit Agreement, the availability under the 2019 ABL credit facility increased to $150.0 million. The terms of the 2020 ABL credit facility did not change from the terms of the 2019 ABL credit facility. Debt issuance costs of $1.0 million were capitalized in association with this transaction and are being amortized to interest expense proportionally over the terms of the respective loan using the effective interest rate method.

2019 Credit Agreement

During 2019, the Company entered into a credit agreement (the "2019 Credit Agreement") upon completion of the Merger. As part of the 2019 Credit Agreement, the Company entered into two term loans, collectively the "Term Loan Facilities." The first lien term loan was for $355.0 million (the "First Lien Term Loan") and a second lien term loan for $130.0 million (the "Second Lien Term Loan") over a respective seven-year and eight-year initial terms. The 2019 Credit Agreement also includes a $40.0 million revolving credit facility (the "Revolver"). Additionally, the lenders have extended credit under the ABL Credit Agreement (the "2019 ABL") in the form of an asset-based revolving facility in an initial aggregate principal amount of $75.0 million. The 2019 Credit Agreement is collateralized by substantially all of the Company's assets. The First Lien Term Loan has payment priority over the Second Lien Term Loan.

First Lien Term Loan

The $355.0 million First Lien Term Loan provided for quarterly principal and interest payments, with the remaining principal balance due at maturity on June 20, 2026. The interest rate of the First Lien Term Loan is calculated using a base rate and then adding an applicable percentage relative to the base rate.The base rate is equal to the highest of: (a) NYFRB Rate plus the 0.50% applicable margin (b) the London Interbank Offered Rate (LIBOR) plus 1.0%, and (c) the Wall Street Journal Prime Rate for an ABR loan. The base rate of the First Lien Term Loan was calculated using LIBOR base rate. The applicable percentage per annum equal to: (i) 4.00% in the case of an Asset Based Rate (ABR) loan or (ii) 5.00% in the case of a LIBOR loan. As of December 31, 2021, there was no outstanding balance on the First Lien Term Loan as a result of being paid off from the the 2021 Term Loan previously mentioned. As of December 31, 2020, the interest rate on the 2019 First Lien Term Loan was 5.15% with an outstanding balance of $349.7 million.

On February 4, 2021, the Company refinanced the First Lien Term Loan. This refinance amended the interest rate from 5.00% to 4.50% on LIBOR loans. No other terms were amended. The Company incurred $0.5 million in debt issuance costs of which $0.1 million were expensed and the remaining were capitalized as deferred financing costs and are amortized proportionality over the terms of the respective loans on an effective interest rate basis. Previously capitalized debt issuance costs of $1.3 million were written off as a loss on debt extinguishment on the Consolidated Statements of Operations. The First Lien Term Loan was subsequently refinanced in association with the 2021 Term Loan.

Second Lien Term Loan

The $130.0 million Second Lien Term Loan provides for quarterly interest payments, with the full principal balance due at maturity on June 20, 2027. The interest rate of the Second Lien Term Loan is calculated using a base rate and then adding an applicable percentage relative to the base rate. The base rate is equal to the highest of: (a) NYFRB Rate plus the 0.50% applicable margin, (b) the LIBOR plus 1.0%, and (c) the Wall Street Journal Prime Rate for an ABR loan. The base rate per annum is equal to LIBOR for in the case of a LIBOR loan. The applicable percentage per annum equal to: (i) 7.75% in the case of an ABR loan or (ii) 8.75% in the case of a LIBOR loan. As of December 31, 2021 and 2020, the interest rate on the 2019 Second Lien Term Loan was 9.96% and 9.50%, respectively, with an outstanding balance of $130.0 million.

Revolving Credit Facility

As part of the 2019 Credit Agreement, the lender made available a $40.0 million revolving loan, which may be used to issue letters of credit. The interest rate of the Revolver is calculated using a base rate and then adding an applicable percentage

relative to the base rate. The base rate per annum is equal to the highest of: (a) NYFRB Rate plus the 0.50% applicable margin, (b) LIBOR plus 1.0%, and (c) the Wall Street Journal Prime Rate for an ABR loan. The base rate per annum is equal to LIBOR for in the case of a LIBOR loan. The applicable rate is equal to the rate per annum set forth by the First Lien Leverage Ratio and ranging from: (i) 2.50% to 3.00% in the case of an ABR loan or (ii) 3.50% to 4.00% in the case of a LIBOR loan.

The Company did not have an outstanding balance under the 2020 Revolving Credit Facility as of December 31, 2021 or 2020. The Company had utilized $21.6 million and $23.2 million of the availability related to Letters of Credit issued to the Company's workers' compensation programs as of December 31, 2021 and 2020, respectively. These standby letters of credit benefit the Company's third-party insurer for its high deductible workers' compensation insurance program. The amount of the letters of credit is negotiated annually in conjunction with the insurance renewals. There were no amounts drawn down on the letters of credit as of December 31, 2021 or 2020.

ABL Credit Facility

As part of the 2019 Credit Agreement, $75.0 million was made available to the Company in the form of an asset-based revolving facility. The terms of the agreement provided for quarterly principal commencing June 30, 2021 and interest payments commencing June 30, 2019, with the remaining principal balance due at maturity on June 20, 2024. Borrowings under the ABL credit facility bear interest at a rate per annum equal to LIBOR for the interest period in effect plus an applicable margin set forth by the Average Historical Excess Availability and ranging from: (i) 0.75% to 1.25% in the case of an ABR loan or (ii) 1.75% to 2.25% in the case of a LIBOR loan.

8. LEASES

The Company's current leases have expiration dates through 2030. We recognize rent expense on a straight-line basis over the lease term. The Company's lease agreements do not contain any material residual value guarantees or material restrictive covenants.

Amounts reported in the Consolidated Balance Sheets as of December 31, 2021 for our operating leases are as follows (amounts in thousands):

	As of December 31, 2021
Operating lease ROU assets	$ 72,687
Current portion of operating lease liabilities	23,743
Operating lease liabilities, less current portion	52,176
Total operating lease liabilities	$ 75,919

Amounts reported in the Consolidated Balance Sheets as of December 31, 2021 for finance leases are included in the table below. The finance lease ROU assets are included in Property and equipment, net of accumulated depreciation on our Consolidated Balance Sheets. The finance lease liabilities are included in Other current liabilities and Other long-term liabilities on our Consolidated Balance Sheets.

	As of December 31, 2021
Finance lease ROU assets	$ 10,115
Accumulated amortization	(3,006)
Finance lease ROU assets, net	$ 7,109
Current installments of obligations under finance leases	$ 2,112
Long-term portion of obligations under finance leases	4,628
Total finance lease liabilities	$ 6,740

Lease Costs

Components of lease cost were as follows (in thousands):

	Income Statement Classification	For the Year Ended December 31, 2021
Operating lease cost	Other general and administrative	$ 28,642
Finance lease cost:		
Amortization of finance lease assets	Depreciation and amortization	1,849
Interest on finance lease liabilities	Interest expense, net	253
Variable lease cost	Other general and administrative	3,054
Short-term lease cost	Operating expense	7,131
Total		$ 40,929

Lease Term and Discount Rate

Weighted average remaining lease terms and discount rates were as follows:

	As of December 31, 2021
Weighted-average remaining lease term (years)	
Operating leases	4.2 years
Finance leases	3.2 years
Weighted-average discount rate	
Operating leases	4.4 %
Finance leases	4.7 %

Supplemental cash flows information

Supplemental cash flow information related to leases was as follows (in thousands):

	For the Year Ended December 31, 2021
Cash paid for amounts included in the measurement of lease liabilities:	
Operating cash flows for operating leases	$ 27,149
Operating cash flows for finance leases	248
Financing cash flows for finance leases	2,228
ROU assets obtained in exchange for lease liabilities:	
Operating leases	98,829
Finance leases	5,136
Reductions to ROU assets resulting from reductions to lease obligations:	
Operating leases	346
Finance leases	252

Maturity of Lease Liabilities

Maturities of lease liabilities as of December 31, 2021 were as follows (in thousands):

	Operating			Capital		
	Equipment	Facility	Total	Fleet	Equipment	Total
2022	$ 64	$ 26,645	$ 26,709	$ 2,144	$ 227	$ 2,371
2023	—	19,965	19,965	2,000	140	2,140
2024	—	13,583	13,583	1,805	70	1,875
2025	—	10,156	10,156	778	46	824
2026	—	5,529	5,529	—	14	14
Thereafter	—	8,217	8,217	—	—	—
Total undiscounted lease payments	$ 64	$ 84,095	$ 84,159	$ 6,727	$ 497	$ 7,224
Less: imputed interest			(8,240)			(484)
Total lease liabilities			$ 75,919			$ 6,740

As of December 31, 2020, minimum lease payments under non-cancelable operating leases by period were expected to be as follows (in thousands):

	Operating		Capital	
Year ending December 31:	Equipment	Facility	Fleet	Equipment
2021	$ 4	$ 24,274	$ 1,138	$ 336
2022	4	18,548	996	114
2023	4	13,441	847	56
2024	4	9,558	589	7
2025	4	7,102	—	1
Thereafter	—	10,161	—	—
Total commitments:	$ 20	$ 83,084	$ 3,570	$ 514

Rent expense under all operating leases for the year ending December 31, 2020 was $13.2 million.

9. INCOME TAXES

The Company files income tax returns in the U.S. federal jurisdiction and various state jurisdictions. The Company's provision for income taxes was as follows (in thousands):

	For the Year Ended	
	December 31, 2021	December 31, 2020
Current income taxes:		
Federal	$ —	$ (269)
State	1,524	1,956
	1,524	1,687
Deferred income taxes:		
Federal	$ (8,720)	$ 3,297
State	357	805
	(8,363)	4,102
Provision for income taxes	$ (6,839)	$ 5,789

A reconciliation of the U.S. federal statutory tax rate (using a statutory tax rate of 21%) to the Company's effective tax rate of 4.84% was as follows (in thousands):

	For the Year Ended	
	December 31, 2021	December 31, 2020
Expected income tax (benefit) expense at statutory rate	$ (29,707)	$ 1,815
State taxes	(4,226)	1,265
Return-to-accrual	(1,051)	(1,192)
Deferred tax adjustments	(416)	(646)
Federal tax credits	—	79
Stock-based compensation	1,586	283
Transaction costs	—	346
Noncontrolling interest	181	(653)
Other	(28)	161
Valuation allowance	26,822	4,331
Income tax (benefit) expense	$ (6,839)	$ 5,789

The components of deferred tax assets (liabilities) were as follows (in thousands):

	As of December 31,	
	2021	2020
Deferred tax assets:		
Net operating loss carryforwards and credits	$ 32,711	$ 24,191
Accrued expenses	18,739	16,473
Employer payroll tax deferral	3,516	7,544
Partnership basis	3,044	8,575
Unrealized loss	231	223
Interest expense limitation	18,287	5,441
Allowance for bad debts	3,619	3,015
Transaction costs	1,961	2,979
Lease liabilities	16,192	—
Intangible assets	2,253	—
Other	2,325	333
Less: valuation allowance	(85,126)	(68,631)
	17,752	143
Deferred income tax liabilities:		
Intangible assets	(64,544)	(72,936)
Right of use assets	(15,589)	—
Other	(1,884)	(52)
	(82,017)	(72,988)
Deferred tax liability, net	$ (64,265)	$ (72,845)

As of December 31, 2021 and 2020, the Company has net federal operating loss carry forwards of $109.9 million and $84.1 million, respectively. The net operating losses of $39.1 million generated before December 31, 2017 will begin to expire in 2032. The net operating losses of $70.8 million generated after December 31, 2017 can be carried forward indefinitely. As of both December 31, 2021 and 2020, the Company had federal tax credits of $2.1 million. The tax credits can be carried forward indefinitely.

As of December 31, 2021 and 2020, the Company has state operating loss carryforwards totaling $114.6 million and $74.2 million, respectively. These losses will begin to expire in 2027.

As a result of the Merger and pursuant to Internal Revenue Code Sections 382 and 383, the use of certain portions of the Company's net operating loss and credit carryforwards will be subject to an annual limitation. A review of preliminary calculations of this limitation shows that projected net operating loss and credit carryforward utilization at December 31, 2021 are significantly less than the potential limitation. Any further ownership changes could affect the Company's ability to utilize current net operating losses and credit carryforwards.

Based on the Company's operating results in recent years and the inherent uncertainty associated with the realization of future income, the Company has provided a valuation allowance of $85.1 million and $68.6 million as of December 31, 2021 and 2020, respectively. The valuation allowance increased $16.5 million during the year ended December 31, 2021. The valuation allowance is required as it is more likely than not that a portion of the deferred tax assets may not be realized. Net activity in the valuation allowance for the years ended December 31, 2021 and 2020 includes purchase price adjustments related to acquisitions.

The Company and its subsidiaries file income tax returns in the U.S. Federal jurisdiction and various state jurisdictions. Management has evaluated the Company's tax positions for all income tax jurisdictions. After analyzing the evidence and facts, management has concluded that it is appropriate to record no liabilities related to uncertain tax positions for the years ended December 31, 2021 and 2020.

The Company's open years for Internal Revenue Service ("IRS") examination purposes due to normal statute of limitation are 2018, 2019, and 2020. However, since the Company has net operating loss carryforwards, the IRS has the ability to make adjustments to items that originate in a year otherwise barred by the statute of limitations under Section 6501 of the Internal Revenue Code of 1986, as amended, in order to redetermine tax for an open year to which those items are carried. Therefore, in a year in which a net operating loss deduction was claimed, the IRS may examine the year in which the net operating loss was generated and adjust it accordingly for purposes of assessing additional tax in the year the net operating loss was claimed. The Company is not currently under examination by any federal or state tax agency.

10. SHARE-BASED COMPENSATION

At December 31, 2021 and 2020, there were 1,000 shares of common stock at $0.01 par value issued and outstanding. Pursuant to the Company's certificate of incorporation, each holder of common stock shall have one vote for each share of common stock held by such holder. In connection with the Seasons Companies acquisition, the Company's Parent issued $181.7 million of additional equity to its investors and the Company used the associated funds to complete the acquisition.

The Parent adopted an equity incentive plan on June 20, 2019 and awards share based compensation to employees and Board Members of the Company under the Horizon Group Holdings, L.P. 2019 Management Incentive Plan (the "Horizon Incentive Plan"). The vesting requirements are a mixture of time-based vesting and performance-based vesting. The time-based value of the incentive units will be recognized as expense ratably over a five-year vesting period. The Company's performance-based awards vest based upon the achievement of certain performance targets. Forfeitures are recognized as they occur. No expense was recognized during the years ended December 31, 2021 and 2020 for the performance awards, as the probability of meeting these targets was zero. The Company recognized $4.6 million and $1.3 million of compensation expense related to the Horizon Incentive Plan, for the years ended December 31, 2021 and 2020, respectively.

The following table provides a summary of the activity related to the Horizon Incentive Plan:

	Time Based Incentive Units	Performance Based Incentive Units	Total Incentive Units	Weighted Average Grant Date Fair Value Per Unit
Incentive units outstanding - December 31, 2020	19,454	27,235	46,689	$ 932
Granted	9,450	12,418	21,868	843
Forfeited	(859)	(1,508)	(2,367)	607
Incentive units outstanding - December 31, 2021	28,045	38,145	66,190	$ 733
Incentive units vested and unvested - December 31, 2021				
Unvested units	18,871	38,145	57,016	$ 738
Vested units	9,174	—	9,174	702
Incentive units outstanding - December 31, 2021	28,045	38,145	66,190	$ 733

Total awards available to be granted under the Horizon Incentive Plan are 69,101 units as of December 31, 2021. The Company uses the Monte Carlo pricing model to estimate the fair value of our incentive units. The fair value of the time-based units that vested during 2021 and 2020 totaled $4.3 million and $1.4 million, respectively. The time-based incentive units granted during the year ended December 31, 2021 vest over a five-year service period. As of December 31, 2021, total unrecognized compensation expense related to unvested time-based incentive units was $16.7 million, which is expected to be recognized over a weighted average remaining period of 2.5 years.

The performance-based incentive units granted during the year ended December 31, 2021 vest over a five-year service period based upon the achievement of certain performance targets. The compensation expense related to the performance-based incentive units is recognized over the vesting period when the achievement of the performance conditions becomes probable. The total compensation cost for the performance-based incentive units is determined based on the most likely outcome of the performance condition and the number of awards expected to vest. As of December 31, 2021, total unrecognized compensation expense related to unvested performance-based incentive units was $24.2 million.

In connection with the Seasons Companies Acquisition, the seller received a portion of the purchase price consideration in the form of equity in the Company's Parent. The seller formed a new entity designed to hold the rollover equity units in the Company's Parent. The seller's new entity adopted an equity incentive plan (the "Seasons Incentive Plan") on December 21, 2020 and awarded 2,827 incentive units, with a weighted average grant date fair value of $5,136, to employees of the Company under the terms of the Amended and Restated Limited Liability Company Agreement of Seasons Rollover Holdings LLC. The Seasons Incentive Plan and the Horizon Incentive Plan are in effect concurrently. The Seasons Incentive Plan units vest in annual tranches over a five-year period. The value of the incentive units will be recognized as expense ratably over a five-year vesting period. The Company recognized $2.9 million and $21 thousand of compensation expense related to the Seasons Incentive Plan for the years ended December 31, 2021 and 2020.

The following table provides a summary of the activity related to the Seasons Incentive Plan:

	Incentive Units	Weighted Average Grant Date Fair Value Per Unit
Incentive units outstanding - December 31, 2020	2,827	$ 5,136
Forfeited	(36)	5,136
Incentive units outstanding - December 31, 2021	2,791	$ 5,136
Incentive units vested and unvested - December 31, 2021		
Unvested	2,233	$ 5,136
Vested	558	5,136
Incentive units outstanding - December 31, 2021	2,791	$ 5,136

The fair value of the incentive units that vested during 2021 was $2.9 million. The total unrecognized compensation cost related to the Seasons Incentive Plan was $11.4 million which is expected to be recognized over a weighted average remaining period of 3.9 years. Total awards granted under the Seasons Incentive Plan were 2,827, of which 2,791 units were outstanding as of December 31, 2021 and 2,827 were outstanding at December 31, 2020.

11. COMMITMENTS AND CONTINGENCIES

Guarantees and Indemnities

The Company is Parent of the wholly-owned subsidiary, Seasons Hospice and Palliative Care of Massachusetts, LLC, which is a guarantor of Seasons Hospice Foundation's (the "Foundation") bank debt totaling $3.0 million as of December 31, 2021, consisting of a construction loan that is collateralized by the property and assignment of rents under the lease agreement with Seasons Hospice and Palliative Care of Massachusetts, LLC. The loan is due April 2026. The Company would be required to repay the outstanding debt of the Foundation if the Foundation failed to perform under the debt agreement and was found to be in default on the loan. As of December 31, 2021 the risk of default by the Foundation was remote.

The Company indemnifies its directors and officers to the maximum extent permitted under the law. The Company has not recorded any liability for these guarantees and indemnities in the accompanying Consolidated Balance Sheets. The maximum amount of potential future payments under such guarantees and indemnities is not determinable.

Legal

The Company is subject to extensive federal, state, and local government regulations relating to licensure, conduct of operations, ownership and expansion of services, and reimbursement for services. As such, in the ordinary course of business, the Company's operations are continuously subject to state and federal regulatory scrutiny, supervision, and control. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits, and surveys, some of which may be non-routine. While the Company believes it is in substantial compliance with the applicable laws and regulations, the Company also believes there has been, and will continue to be, an increase in governmental investigations of health care providers.

Adverse determinations in legal proceedings or governmental investigations, currently asserted or arising in the future could have a material adverse effect on the Company. In addition to the matter discussed above, the Company is subject to legal claims incurred in the normal course of business that, in the opinion of management, should not have a material effect on the consolidated results of operations or financial position.

Insurance

We are obligated for certain costs associated with our insurance programs, including employee health, workers' compensation and professional liability. While we maintain various insurance programs to cover these risks, we are self-insured for a substantial portion of our potential claims. We recognize our obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. The Company has recognized an estimated liability using actuarial methods based upon its historical claims experience, and the Company has purchased stop-loss coverage limits. The claims reserve is based on the best data available to the Company at the time the estimate is made; however, the estimate is subject to a significant degree of inherent variability. The estimate is continually monitored and reviewed, and, as the reserve is adjusted, the difference is reflected in current operations. While the ultimate amount of the Company's insurance related liabilities are dependent on future developments, the Company is of the opinion that the associated liabilities recognized in the accompanying consolidated financial statements are adequate to cover such claims. The amounts accrued below represent our total estimated liability for individual claims that are less than our noted insurance coverage amounts, which can include outstanding claims and claims incurred but not reported.

The following table presents details of our insurance programs, including amounts accrued for the periods indicated (amounts in thousands) in our liabilities in our Consolidated Balance Sheets:

		As of December 31,	
		2021	2020
Type of Insurance	**Balance Sheet Classification**		
Health insurance	Accrued payroll and related benefits	$ 4,874	$ 6,978
Workers' compensation	Accrued expenses	639	—
	Other current liabilities	10,724	7,145
	Other long-term liabilities	17,876	19,809
		34,113	33,932

The Company insures for professional and general liability claims under a claims-made policy. Under the policy, insurance premiums cover only those claims actually reported during the policy term. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims related to occurrences during the policy term but reported subsequent to the policy's termination may be uninsured. The Company is not aware of any potential professional and general liability claims whose settlement would have a material adverse effect on the Company's consolidated financial position.

Our health insurance has an exposure limit of $0.5 million for any individual covered life. Our workers' compensation insurance has a retention limit of $0.5 million per incident and our professional liability insurance has a retention limit of $75,000 and $50,000 per incident for claims against Horizon Acquisition Co., Inc. and $0.3 million limit for claims against Seasons for the years ended December 31, 2021 and 2020, respectively.

12. BENEFIT PLANS

The Company's defined contribution plan covers most full-time and regular, part-time employees and allows for up to a 25% discretionary Company match and limits employee contributions to the lesser of 75% of their pretax income or the applicable IRS limits per calendar year. For the years ended December 31, 2021 and 2020, the Company elected not to make a matching contribution. Through previous acquisitions, there is a defined contribution plan where the contribution matching was grandfathered in for those certain employees impacted by that acquisition. As a result, the Company matched $2.4 million and $1.8 million in contributions associated with those employees for the years ended December 31, 2021 and 2020, respectively.

The Company provides a non-qualified, deferred compensation plan for select employees. Unlike a qualified plan, the Company is not required to fund the benefits payable under the Plan. Deferred amounts are set aside in a trust, which is subject to the Company's general creditors. Participants can defer up to 90% of their base salary and up to 100% of bonuses, commissions, and excess 401(k) contributions. The Company may also make discretionary contributions on behalf of employees. For the years ended December 31, 2021 and 2020, plan assets totaled $4.1 million (inclusive of $2.5 million in cash surrender value of an insurance contract) and $1.8 million (inclusive of $1.5 million in cash surrender value of an insurance contract), respectively, and plan liabilities totaled $4.0 million and $3.4 million, respectively.

13. FAIR VALUE

Interest Rate Swaps

On July 14, 2020, the Company entered into two fixed interest rate swap agreements with an effective date of July 31, 2020 and a maturity date of July 31, 2023 for a total notional amount of $385.9 million. On January 7, 2021, the Company amended one of its interest rate swaps to reduce the notional value from $192.6 million to $157.2 million, totaling $349.8 million in notional value. The fair value of these assets is determined on a recurring basis.

Deferred Compensation Plan Assets

The Company provides a non-qualified, deferred compensation plan for select employees. Deferred amounts are set aside in a trust and are invested in mutual funds at current market rates. The fair value of these assets is determined on a recurring basis.

The assets and liabilities measured at fair value related to the Company's interest rate swaps, excluding accrued interest, and deferred compensation plan were as follows (in thousands):

			As of December 31,	
			2021	2020
	Balance Sheet Classification	Fair Value Hierarchy	Fair Value	Fair Value
Deferred compensation plan assets	Other assets	Level 2	$ 1,571	$ 1,785
Interest rate swap, current portion	Prepaid expenses	Level 2	612	—
Interest rate swap, non-current portion	Other assets	Level 2	1,629	—
Interest rate swap, current portion	Other current liability	Level 2	—	575
Interest rate swap, non-current portion	Other long-term liability	Level 2	—	312

Financial Instruments

The Company's financial instruments include cash and cash equivalents, accounts receivable, accounts payable, accrued expenses, and long-term obligations. Management believes that the carrying value of cash and cash equivalents, accounts receivable, accounts payable, and accrued expenses approximates fair value due to their short-term maturities. Management believes the carrying value of long-term obligations approximates fair value based on the variable interest rate of the long-term debt.

Non-Recurring Valuations

The Company has certain trade name intangible assets which were valued on a non-recurring basis for the year ended December 31, 2021. See Note 2 - *Summary of Significant Accounting Policies (Goodwill and Other Intangible Assets)* and Note 6 - *Goodwill and Intangibles*.

14. DERIVATIVE INSTRUMENTS

As discussed in Note 13, *Fair Value*, on July 14, 2020, the Company entered into two fixed interest rate swap agreements with an effective date of July 31, 2020 and a maturity date of July 31, 2023. The Company's interest rate swap agreements are executed for risk management and are not held for trading purposes. The objective of the interest rate swap agreements is to mitigate interest rate risk associated with future changes in interest rates. To accomplish this objective, the interest rate swap agreements are intended to hedge the variable cash flows on a portion of the Company's floating-rate debt, initially expected to be the Company's term loan under its floating rate First Lien Credit Agreement. The interest rate swap agreements entitle the Company to receive, at specific intervals, a variable rate of interest based on LIBOR in exchange for the payment of a fixed rate of interest throughout the life of the agreement, without exchange of the underlying notional amount.

The Company designated its interest rate swap agreements as cash flow hedges and accounts for the underlying activity in accordance with hedge accounting. The interest rate swaps are presented at fair value within other current liabilities and other long-term liabilities in the Consolidated Balance Sheets. In accordance with hedge accounting, the gains and losses on interest rate swaps that are designated as cash flow hedges are recorded as a component of Accumulated other comprehensive (loss) income, net of related income taxes, and reclassified into Interest expense in the Consolidated Statements of Comprehensive (Loss) Income in the same periods during which the hedge transactions affect earnings and reflected in cash flows from operations on the Consolidated Statements of Cash Flows. As of December 31, 2021, the amount expected to be reclassified from Accumulated other comprehensive (loss) income into Interest expense during the next twelve months was approximately $0.6 million. No significant amounts were excluded from the assessment of cash flow hedge effectiveness as of December 31, 2021.

The following table presents the effects of hedge accounting on Accumulated other comprehensive (loss) income for the interest rate contracts designated as cash flow hedges (in thousands):

	Interest Rate Swaps
Balance at December 31, 2019	$ —
Amount of loss recognized in AOCI	(1,112)
Less: Amount reclassified to interest expense	225
Balance at December 31, 2020	(887)
Amount of gain recognized in AOCI	2,392
Less: Amount reclassified from AOCI to interest expense	686
Balance at December 31, 2021	$ 2,191

15. SEGMENT INFORMATION

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health services assist patients transitioning from a hospital, nursing facility, or outpatient facility to the home, with licensed clinical workers providing various combinations of skilled nursing and therapy services, as well as paraprofessional services. Our hospice services are designed to provide a wide variety of services to terminally ill patients and their families through a multidisciplinary group that typically includes a patient manager, skilled nursing staff, home health aides, a chaplain, and specially trained volunteers. Our personal care services assist clients with the daily tasks of living, including bathing, dressing, light housekeeping, grocery shopping, and medication monitoring. The Corporate column in the following tables consists of costs relating to executive management and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration. Additionally, depreciation and amortization, including amortization and impairment charges of acquired intangible assets are included in the Corporate column as we do not allocate these assets or costs to the reportable segments. The accounting policies of the segments are the same as those described in Note 2.

The Company's Chief Operating Decision Maker ("CODM") evaluates performance and allocates resources based on the contribution margin of the reportable segments, which includes an allocation of corporate expenses directly attributable to the specific segment and includes revenues and all other costs directly attributable to the specific segment. Segment assets are not reviewed by the Company's CODM and therefore are not disclosed below (amounts in thousands).

	For the Year Ended December 31, 2021				
	Home Health	Hospice	Personal Care	Corporate	Total
Net service revenue	$ 656,743	$ 525,594	$ 379,732	$ —	$ 1,562,069
Other operating income	349	1,801	828	—	2,978
Cost of service, excluding depreciation and amortization	(297,253)	(237,981)	(290,589)	—	(825,823)
General and administrative expenses	(209,794)	(184,940)	(53,827)	(212,111)	(660,672)
Contribution margin	150,045	104,474	36,144	(212,111)	78,552
Depreciation and amortization					(29,550)
Asset impairment					(108,194)
Operating expenses [(1)]					(1,624,239)
Operating loss					$ (59,192)

(1) Operating expenses includes Cost of service, excluding depreciation and amortization, General and administrative expenses, Asset impairment and Depreciation and amortization.

	For the Year Ended December 31, 2020 [1]				
	Home Health	Hospice	Personal Care	Corporate	Total
Net service revenue	$ 500,643	$ 84,852	$ 347,307	$ —	$ 932,802
Other operating income	2,204	687	14,017	—	16,908
Cost of service, excluding depreciation and amortization	(216,271)	(38,686)	(265,819)	—	(520,776)
General and administrative expenses	(151,908)	(29,657)	(50,754)	(135,173)	(367,492)
Contribution margin	134,668	17,196	44,751	(135,173)	61,442
Depreciation and amortization					(14,113)
Asset impairment					(637)
Operating expenses [2]					(903,018)
Operating income					$ 46,692

[1] During 2021, the Company determined the presentation of the 2020 segment information omitted contribution margin, which is a significant measure reviewed by the CODM, and had previously allocated depreciation and amortization to the segments. These misstatements are not considered material and have been corrected in the current presentation.

[2] Operating expenses includes Cost of service, excluding depreciation and amortization, General and administrative expenses, Asset impairment and Depreciation and amortization.

16. REGULATORY MATTERS

All health care providers are required to comply with a significant number of laws and regulations at the federal and state government levels. These laws are extremely complex, and, in many instances, providers do not have the benefit of significant regulatory or judicial interpretation as to how to interpret and/or apply these laws and regulations. The U.S. Department of Justice and other federal and state agencies are increasing resources dedicated to regulatory investigations and compliance audits of health care providers. As a health care provider, the Company is subject to these regulatory efforts. Health care providers that do not comply with these laws and regulations may be subject to civil or criminal penalties, fines, the loss of their licenses, or restrictions on their ability to participate in various federal and state health care programs. This would have a material adverse effect on the Company's results of operations and cash flows. Further, there is a reasonable possibility that recorded estimates can change by a material amount in the future due to any future changes in these laws and regulations or the interpretations thereof. The Company endeavors to conduct business in compliance with all applicable laws and regulations and believes that it is in compliance with all applicable laws and regulations. The Company is not aware of any material pending or threatened investigations involving allegations of potential wrongdoing.

17. RELATED PARTY TRANSACTIONS

The Company's related party disclosures below resulted primarily from the transactions of the Seasons Companies that were acquired in December 2020. Prior to this, the Company's transactions with related parties were not significant.

In some cases, the Company delivers hospice services to patients in a nursing home and the room and board charges owed to the nursing home are reimbursable by CMS. For the year ended December 31, 2021, the Company incurred costs from related parties of approximately $8.1 million, for nursing home reimbursable room and board charges from nursing homes in which stockholders and/or their family members own an interest. At December 31, 2021, the Company had Accounts payable and Accrued expenses to these related parties of approximately $0.2 million.

For the year ended December 31, 2021, the Company incurred costs from related parties of approximately $0.7 million on the Consolidated Statements of Comprehensive (Loss) Income related to Advent International, an investor of Horizon Acquisition Co., Inc., for accounting, consulting, travel, and board fees incurred on behalf of the Company. At December 31, 2021, $0.1 million of such expense was included in Accrued expenses on the Consolidated Balance Sheets.

For the year ended December 31, 2021, the Company incurred costs from related parties of approximately $12.0 million for leasing durable medical equipment ("DME") from a DME hub service provider in which stockholders and/or their family members own an interest. At December 31, 2021, the Company had accounts payable and accrued expenses to these related parties of approximately $1.0 million.

In addition, the Company incurred costs of approximately $0.3 million of ambulance service from Lifeline Ambulance, which shares an investor with Seasons; $0.8 million of rent from Miami Jewish Health Systems, which is a minority shareholder of Seasons; $0.3 million of rent from 606 Potter Road, LLC, which is owned by a minority shareholder of Seasons; and $0.6 million of rent, from IMR Oak Creek OPCO, LLC, a minority interest holder in one of Seasons' subsidiaries, for the year ended December 31, 2021.

Seasons Hospice Foundation

The Company has amounts due from Seasons Hospice Foundation (the "Foundation"), a not-for-profit organization. Certain management employees of the Company participate on the Board of Directors for the Foundation. The receivable is non-interest bearing and due on demand. The balance as of December 31, 2021 was less than $1,000.

The Company contributed approximately $0.3 million for the year ended December 31, 2021 to the Foundation, which is included within Other expenses in the accompanying Consolidated Statements of Operations.

Seasons Hospice and Palliative Care of Massachusetts ("Massachusetts"), LLC, a wholly-owned subsidiary of the Company, paid approximately $0.5 million for rents under a lease agreement with Seasons Hospice Foundation during the year ended December 31, 2021. Future minimum annual payments under this lease are $0.5 million in 2022, with annual rent escalation of 3% per year.

18. SUBSEQUENT EVENTS

The Company evaluates the impact of subsequent events, which are events that occur after the balance sheet date, but before the consolidated financial statements are issued, for potential recognition in the consolidated financial statements as of the balance sheet date or disclosure in the consolidated financial statements. The Company has evaluated the impact of subsequent events through April 15, 2022, representing the date at which the consolidated financial statements were available to be issued.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC

Financial Report

February 24, 2021

Seasons Hospice & Palliative Care of Pierce County Washington, LLC

Contents

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Independent Auditor's Report

To the Member
Seasons Hospice & Palliative Care
of Pierce County Washington, LLC

We have audited the accompanying financial statements of Seasons Hospice & Palliative Care of Pierce County Washington, LLC (the "Company"), which comprise the balance sheet as of February 24, 2021 and the related statements of member's equity and cash flows for the period from December 28, 2020 (date of inception) through February 24, 2021, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Seasons Hospice & Palliative Care of Pierce County Washington, LLC as of February 24, 2021 and the results of its operations and its cash flows for the period from December 28, 2020 (date of inception) through February 24, 2021 in accordance with accounting principles generally accepted in the United States of America.

Plante & Moran, PLLC

March 5, 2021

Seasons Hospice & Palliative Care of Pierce County Washington, LLC

Balance Sheet

February 24, 2021

Assets	
Current Assets - Cash	**$ 2,000,000**
Liabilities and Member's Equity	
Liabilities	$ -
Member's Equity	2,000,000
Total liabilities and member's equity	**$ 2,000,000**

See notes to financial statements.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC

Statement of Member's Equity

Period from December 28, 2020 (Date of Inception) through February 24, 2021

Balance - December 28, 2020	$ -
Member contribution	2,000,000
Balance - February 24, 2021	**$ 2,000,000**

See notes to financial statements.

Seasons Hospice & Palliative Care of Pierce County Washington, LLC

Statement of Cash Flows

Period from December 28, 2020 (Date of Inception) through February 24, 2021

Cash Flows Provided by Financing Activities - Member contribution	$ 2,000,000
Net Increase in Cash	2,000,000
Cash - Beginning of period	-
Cash - End of period	**$ 2,000,000**

See notes to financial statements.

Note 1 - Nature of Business

Seasons Hospice & Palliative Care of Pierce County Washington, LLC (the "Company") was formed as a limited liability company under Delaware law on December 28, 2020.

The Company plans to develop a new hospice program in Pierce County, Washington.

The Company has not begun operations as of the date of the financial statements, and its activities have been limited to its formation and preparation for the application for a certificate of need (CON) for the Washington State Department of Health.

Note 2 - Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Cash

The Company maintains cash balances with a financial institution. Accounts at the institution are insured by the Federal Deposit Insurance Corporation up to $250,000. The Company evaluates the financial institutions with which it deposits funds; however, it is not practical to insure all cash deposits. The Company has not experienced any losses in such accounts and believes it is not exposed to any significant credit risk on its cash.

Income Taxes

Pursuant to provisions of the Internal Revenue Code, the Company has elected to be taxed as a limited liability corporation (LLC). Generally, the income of an LLC is not subject to federal income tax at the entity level, but rather the members are required to include a pro rata share of the Company's taxable income or loss in their personal income tax returns, irrespective of whether distributions have been paid. Accordingly, no provision for federal income taxes has been made in the accompanying financial statements. The Company is not subject to income taxes in the state of Washington.

Subsequent Events

The financial statements and related disclosures include evaluation of events up through and including March 5, 2021, which is the date the financial statements were available to be issued.

EXHIBIT 21

Articles on Hospice Cost Savings

JOURNAL OF PALLIATIVE MEDICINE
Volume 18, Number 5, 2015

DOI: 10.1089/jpm.2015.0014

Cost Savings Associated with Expanded Hospice Use in Medicare

Brian W. Powers, AB,[1] Maggie Makar, BS,[2] Sachin H. Jain, MD, MBA,[3] David M. Cutler, PhD,[4,6] and Ziad Obermeyer, MD, MPhil[2,3,5]

Dear Editor:

Despite mounting evidence that hospice provides high-value, high-quality care, many eligible Medicare beneficiaries do not enroll, and lengths of hospice stay remain short. Policymakers have considered changes to Medicare policies to encourage hospice use, but there are persistent concerns about the impact of expanding services on the long-term financial solvency of the program. In this study we simulated impact of increased hospice use among Medicare beneficiaries with poor-prognosis cancer on overall Medicare spending.

Methods

Using previously described methods,[1] we identified 18,165 fee-for-service Medicare beneficiaries who died in 2011 with a diagnosis of poor-prognosis cancer and matched them with similar patients who died without hospice. We constructed a regression model to estimate *difference in weekly costs* between matched hospice and nonhospice beneficiaries, as a function of age, sex, HRR, comorbidity, and time from diagnosis to death. Using coefficients from this model we estimated costs for all beneficiaries with poor-prognosis cancers (including those who were not matched, $n = 86{,}851$) at the beneficiary-week level, under hypothetical scenarios of increased hospice uptake. Specifically, we varied fraction of beneficiaries enrolled in hospice (assigning a random sample of $f = 20\%, 40\%, \ldots, 100\%$ of all beneficiaries to hospice) and length of hospice stay (setting length to $w = 2, 4, 8, \ldots, 24$ weeks for all those assigned to hospice). We summed these differences to estimate total savings under each scenario among patients with poor-prognosis cancer in the 20% sample, and multiplied by five to create national estimates.

Results

Estimated annual cost savings nationally ranged from $316 million (20% uptake, 4-week duration) to $2.43 billion (100% uptake, 24-week duration) (see Table 1). Currently, 60% of Medicare beneficiaries with poor-prognosis cancer receive hospice care, with average stay of under two weeks.[1] Broadening enrollment to 80% of all patients, the fraction who express preferences for end-of-life care directed at symptom management[2] would generate savings of $940 million. Medicare guidelines allow six months of hospice benefit, but physician opinion[3] and literature on disability trajectories[4] suggest that three months would be a reasonable duration. At current levels of 60% hospice uptake, extending hospice length to 12 weeks saves $1.34 billion annually. Together, increased uptake (80%) and duration (12 weeks) would save $1.79 billion.

Discussion

Under realistic scenarios of expanded hospice use for Medicare beneficiaries with poor-prognosis cancer, the program could save $1.79 billion annually. Clinical leaders

Table 1. Annual Cost Savings from Increased Hospice Uptake (Millions of Dollars)[a]

	Duration of hospice stay (weeks)						
Hospice uptake (%)	**2**	**4**	**8**	**12**	**16**	**20**	**24**
20	237	316	411	446	466	484	487
40	469	630	825	890	935	965	970
60	705	940	1235	1340	1395	1445	1455
80	940	1260	1645	1785	1860	1925	1940
100	1175	1570	2060	2230	2330	2410	2430

[a]Each cell shows the annual cost savings realized in a hypothetical counterfactual scenario with a given level of hospice uptake for a given number of weeks, based on the modeled differences in cost from the matched cohort.

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seeking to improve care for terminally ill patients and policy makers seeking to reduce low-value health spending may find common ground in supporting increased uptake and duration of hospice services.

Focusing on a population with poor-prognosis cancer had advantages and limitations. Restricting our analysis allowed us to focus on patients for whom hospice would be considered standard of care, and for whom reasonable estimates of ideal uptake and length of hospice stay were available. Cancer represents only a fraction of all individuals who receive hospice care albeit the largest single group and these results cannot be generalized to other populations. We focused exclusively on cost, and were unable to accurately account for the quality of hospice care received.

Author Disclosure Statement

Funding for this study was from NIH (Common Fund/Office of the Director), DP5 OD012161 (PI: Obermeyer). The funders had no role in the design and conduct of the study, in the collection, analysis, and interpretation of the data, and in the preparation, review, or approval of the manuscript.

ZO had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: ZO, DC, BP, SHJ; acquisition, analysis or interpretation of data: all authors; drafting of the manuscript: BP, MM, ZO; critical revision of the manuscript for important intellectual content: all authors; statistical analysis: ZO, MM, DC; obtained funding: ZO, DC; administrative, technical, or material support: ZO, DC; study supervision: ZO, DC, SHJ.

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Hospice Leads To Better Care, Lower Costs At End Of Life: JAMA

December 7, 2014 Hospice and Palliative Care, Politics and Law No Comments

Clinicians in ICU. Courtesy WikiMedia Commons.

Terminally ill patients enrolled in hospice care have lower rates of hospitalization, intensive care unit admission and invasive procedures at the end of life, according to an extensive new study published in the *Journal of the American Medical Association*. Hospice patients also incur significantly lower medical costs than non-hospice patients.

Researchers, led by **Dr. Ziad Obermeyer**, an emergency medicine physician at Brigham & Women's Hospital, studied hospice and non-hospice patients using a nationally representative sampling of Medicare fee-for-service beneficiaries who died in 2011. Some 18,000 patients with poor-prognosis cancers (brain, pancreatic, metastatic malignancies) enrolled in hospice care before death were matched to an equal number of similar patients who died without hospice support. Median hospice stay was 11 days.

The average costs of care for patients in their last year of life in the non-hospice group was $71,517, compared to $62,819 for those enrolled in hospice; savings totaled close to $9,000. The study also revealed a huge disparity: 74 percent of patients in the non-hospice group died in a hospital or nursing home, compared to just 14 percent of hospice patients. Recent studies indicate the vast majority of Americans wish to die at home, but rarely do.

Dr. Ziad Obermeyer, lead researcher

"While enrolled in hospice, beneficiaries were hospitalized less, received less intensive care, underwent fewer procedures and were less likely to die in hospitals and skilled nursing facilities," researchers write. "Over similar periods before death, most non-hospice beneficiaries were admitted to hospitals and ICUs for acute conditions not directly related to their poor-prognosis cancer. Such care is unlikely to fit with the preferences of most patients."

Hospice care is designed to help comfort the seriously ill near the end of life, and it has become increasingly popular in recent years – reaching nearly $14 billion in payments during 2011. The Medicare hospice benefit, established in 1982 to help patients pay for care, is usually provided only to those with a life expectancy of six months or less.

The findings also highlight the importance of frank, honest discussion between doctors and patients about goals of care. The Centers for Medicare and Medicaid Services is debating the risks and benefits of reimbursing physicians for end of life discussions, proposals removed from President Obama's Affordable Care Act.

Dr. Joan Teno, associate director of the Center for Gerontology and Health Care Research at Brown University Medical School, says that the cost savings associated with hospice care are much less important than the health benefits it provides seriously ill patients.

"A key policy concern is if hospice saves money, should health care policy promote increased hospice access? Perhaps an even larger policy issue involves the role of costs and not quality in driving U.S. health policy in care of the seriously ill and those at the close of life," she writes in an accompanying editorial. "The general expectation is that persons who choose to enroll in hospice should not die in an acute care hospital, and their hospital expenditures should be less than if they were not enrolled in hospice."

A recent study led by Teno suggests some newer for-profit hospice programs have accepted patients too early and discharged others when the costs of caring for them rose. Nearly 20 percent of U.S. hospice patients are discharged before death, and not-for-profit and government-run hospices have lower rates of discharge than newer for-profit programs, according to the findings published in the *Journal of Palliative Medicine*.

"Dying patients are a vulnerable population and often are impoverished, frail, older, and cognitively impaired," she adds. "As both private insurers and Medicare change the financial incentives in health care from doing 'more' to 'less,' there is an increased need for transparency and accountability."

Newswire

Advance Care Planning

Caregiving

Health Care

Hospice and Palliative Care

Life Choices

Politics and Law

Reuters Health: LMM Reports

Society and Culture

Treatments and Illness

Voices in Bioethics: LMM Commentary

Wire

Hospice and Palliative Care

Kindness Made Audible: Threshold Choir Comforts Patients Nearing Death

Disney Screens New 'Star Wars' Film For Terminally Ill Fan

NO-SHAVE NOVEMBER: Police Department Raises Funds For Hospice That Cared For Fellow Officer

Utah Hospice Hosts Wedding For Residents Who Fell In Love

'End Game' Is The Documentary Film America Needs

Biden Praises Hospice Nurses: 'You Do God's Work'

South Carolina Governor Signs Bill To Explore Palliative Care

Hospices Are Among America's Most Important Care Providers

'Cold And Heartless' Hospice: Former Passages Employees Still Hurting

Evaluation of the Medicare Care Choices Model

ANNUAL REPORT 3

Contract # HHSM-500-2014-000261/T0005

OCTOBER 2020

SUBMITTED TO:
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About this Report

This report represents the views of Abt Associates and its partners. Abt Associates is solely responsible for any errors contained within it.

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In partnership with:

Brown University

General Dynamics Information Technology

L&M Policy Research

Oregon Health & Science University

RAND Corporation

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Executive Summary

Under current Medicare policy, beneficiaries who elect the Medicare hospice benefit (MHB) must forgo coverage for non-hospice services intended to treat their terminal condition. Due in part to this policy, fewer than half of all beneficiaries elect MHB at the end of life. Of those who do choose hospice, many elect MHB less than a week before death—too late to experience the full benefit of hospice care. In 2016, the Center for Medicare & Medicaid Innovation at the Centers for Medicare & Medicaid Services (CMS) implemented the Medicare Care Choices Model (MCCM).

Three Key Findings

- MCCM led to a 25 percent decrease in total Medicare expenditures, which generated $21.5 million in net savings between January 1, 2016 and September 30, 2019, largely by reducing inpatient care through increased use of MHB by the 3,603 Medicare beneficiaries who enrolled in the model and died during this period.
- Beneficiaries in MCCM elected MHB nearly a week earlier and at a rate that was 20 percentage points higher than the comparison group.
- MCCM hospices provided high-quality care to most enrollees, and most caregivers were highly satisfied with the care received through the model and transitions to MHB. At the same time, the documentation of comprehensive assessments and advance care planning discussions varied widely across hospices.

MCCM tests the impact of giving eligible beneficiaries the option to receive supportive services from participating hospices while continuing to receive treatment for their terminal condition. Medicare beneficiaries who enroll in MCCM receive care coordination and case management, nursing and medical social services, hospice aide care, volunteer services, and bereavement counseling for enrollees and their caregivers. A side-by-side comparison of MCCM, MHB, and the Medicare home health benefit is in **Appendix Section A**.

Medicare beneficiaries are eligible for MCCM if they have one or more of the following diagnoses: cancer, congestive heart failure, chronic obstructive pulmonary disease, or human immunodeficiency virus/acquired immunodeficiency syndrome. Another requirement is a prognosis of six months or less to live if the disease runs its expected course.

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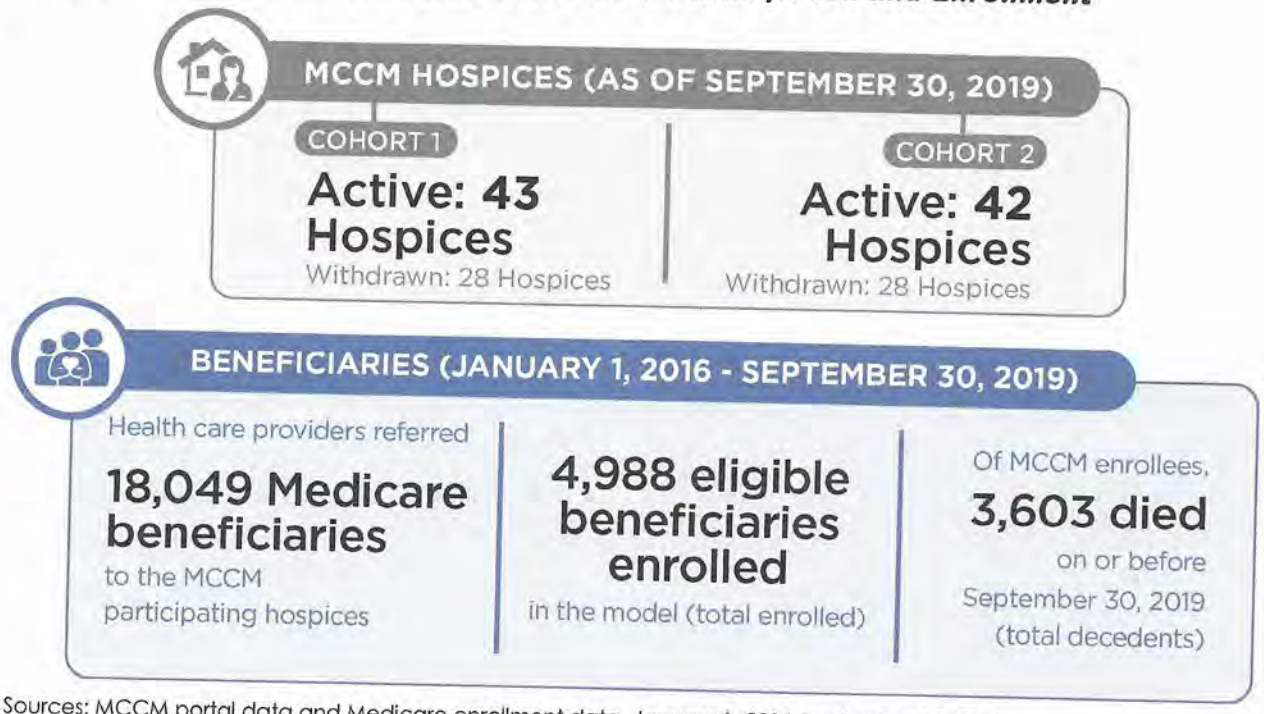
Beneficiaries also must be enrolled in Medicare Parts A and B and must have had at least 3 Medicare-covered office visits and 1 hospital encounter during the 12 months before enrollment. A hospital encounter can be an emergency department visit, observational stay, or inpatient admission. Beneficiaries must live in a traditional home (not a long-term care facility), and must not have elected MHB in the past 30 days.

Hospices participating in MCCM receive $400 per-beneficiary, per-month to cover supportive services and care coordination activities they provide to MCCM beneficiaries ($200 if enrolled less than 15 days during the first month). CMS randomized participating hospices into two cohorts: cohort 1 implemented the model beginning on January 1, 2016 and cohort 2 began on January 1, 2018.

As of September 30, 2019, 85 hospices (60 percent of the 141 participating hospices) remained in MCCM. **Exhibit ES.1** shows cumulative MCCM participation and enrollment.

Exhibit ES.1 Overview of Cumulative MCCM Participation and Enrollment



Sources: MCCM portal data and Medicare enrollment data, January 1, 2016-September 30, 2019.

The percentage of referred beneficiaries eligible for MCCM and the percentage of enrollees grew significantly between 2016 and the first three quarters of 2019. This increase reflected the relaxation of MCCM-eligibility requirements in 2016, the start of cohort 2 in 2018, and refined marketing practices. Out of the 85 active hospices, nine enrolled half of all beneficiaries served by the model.

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This report provides further information on the services hospices provided MCCM beneficiaries, the experiences that MCCM beneficiaries and their caregivers reported, the quality of MCCM care, and the frequency of transitions from MCCM to MHB. The report also provides updated information about the health status of MCCM enrollees and the care they received before MCCM enrollment, CMS payments to hospices, and the effect of MCCM on the use of Medicare-covered services and Medicare expenditures. Below we summarize important findings from each section of Annual Report 3.

What Are the Pathways to MCCM Enrollment?

Marketing MCCM. MCCM hospices worked throughout the model performance period to identify MCCM-eligible beneficiaries and increase enrollment, in part by developing marketing materials that drew distinctions between the goals of MCCM and MHB, and clarified the model's eligibility requirements.

Health and functional status before MCCM enrollment. In the 12 months before they enrolled in MCCM, beneficiaries had high rates of chronic illnesses in addition to the 4 MCCM-qualifying diagnoses. Less than 20 percent of beneficiaries were functionally independent at MCCM enrollment, while almost 50 percent needed some assistance. At enrollment, 77 percent lived with another person who presumably helped the enrollee live in a traditional home, as required for MCCM eligibility.

Use of Medicare-covered services before MCCM enrollment. In the 12 months before they enrolled in MCCM, beneficiaries used Medicare-covered services at higher rates, with use becoming more frequent closer to enrollment as their illnesses worsened. Over 60 percent of beneficiaries had an inpatient admission during the 90 days before MCCM enrollment. About 70 percent had one or more ambulance transports, emergency department visits, observational stays, and/or inpatient admissions during this time. Fewer than 2 percent of beneficiaries used no services during the 90 days before enrollment in the model. The last paid claims before MCCM enrollment were indicative of beneficiaries' urgent need for medical care: an emergency department visit without an inpatient admission (15 percent), an emergency department visit with an inpatient admission (27 percent), an ambulance transport (8 percent), and/or an observational stay (1 percent).

Potential importance of hospital-focused referral networks. The frequency and sequencing of hospital encounters that we observed were indicative not only of high medical need at the end of life but also the frequent use of hospital care in the one to three months before enrollment. These patterns suggest that hospitals may have played an important role in the referral of beneficiaries to MCCM. The potential advantages of hospital-focused referral networks are that their members may be familiar with beneficiaries' health status, have access to medical record documentation that supports certification of a six-month terminal illness, and enables verification of the use of physician visits and hospital care during the year before enrollment, as required for MCCM eligibility.

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How Does MCCM Affect Transitions to MHB?

Reasons enrollees left MCCM. Over 79 percent of the beneficiaries who enrolled in MCCM and subsequently left, stated that electing MHB was their reason for MCCM discharge. Only 12 percent of enrollees died while enrolled in the model, and less than 5 percent of enrollees left for other reasons.

Timing of transitions to MHB. Overall, 84 percent of MCCM decedents transitioned to MHB after an average of 14 weeks (99 days) in MCCM and about 7 weeks (46 days) before death. Less than 10 percent of enrollees transitioned to MHB during the last 2 days of life. On average, MCCM decedents with a diagnosis of cancer transitioned to MHB 87 days after enrolling in the model, which was 26 days sooner than enrollees with a diagnosis of chronic obstructive pulmonary disease and 33 days sooner than enrollees with congestive heart failure. This difference could arise because beneficiaries with cancer were more seriously ill when they enrolled in MCCM, and may reflect the unpredictable disease trajectory of these other illnesses.

Caregiver perceptions of MCCM. Caregivers of MCCM enrollees who transitioned to MHB reported experiences of care in MHB that were generally similar to those reported by caregivers of comparison beneficiaries with regard to how well the MCCM hospice team communicated with caregivers, provided help in a timely manner, treated the beneficiary with respect, provided emotional and spiritual support, and trained family members/caregivers to care for the beneficiary. The exception was care for pain in MHB, which caregivers perceived was worse for enrollees who transitioned to MHB from MCCM.

How Does MCCM Affect Utilization of Care and Medicare Expenditures?

Net savings to Medicare due to MCCM. The extent to which MCCM enrollment decreases utilization of care and Medicare expenditures at the end of life is a key focus of this evaluation. For MCCM to result in net savings for Medicare, the model needs to reduce total Medicare expenditures enough to cover the per-month payments to MCCM hospices. We estimated that MCCM reduced total Medicare expenditures by approximately $26 million, while CMS paid out $4.6 million in per-beneficiary, per-month payments to MCCM hospices for 3,603 decedents enrolled between January 1, 2016 and September 30, 2020. The difference in these values amounts to total net savings of $21.5 million. These results imply a 25 percent net reduction, or $5,962 per decedent.

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MCCM effects on total per-decedent Medicare expenditures. Gross Medicare savings during the last 90 days of life was $9,874 per decedent, representing a spending reduction of 29 percent compared to a group of similar beneficiaries residing in MCCM hospice markets during the baseline period, as shown in **Exhibit ES.2**.

Exhibit ES.2 Per Decedent Savings from MCCM Was Greatest During the Last 90 Days of Life

Sources: Medicare Enrollment Database and Master Beneficiary Summary File January 1, 2012-September 30, 2019.

Notes: This exhibit shows estimates of the impact of MCCM on Medicare expenditures for 3,608 MCCM enrollees who died on or before September 30, 2019. Percent saving equals the impact estimate divided by expenditures for similar beneficiaries residing in MCCM markets during the baseline period.

The magnitude of these savings was substantially larger than per-decedent savings during the last 30 and 180 days of life of $8,014 (40 percent) and $8,061 (16 percent), respectively. This implies that the period around the last 90 days of life may be a "sweet spot" when there is enough time to educate Medicare beneficiaries about the potential benefits of MHB and enroll them, before the time when inpatient care begins to increase at the end of life.

Drivers of MCCM impacts. Virtually all of the estimated impact of MCCM on total spending during the last 30 days of life was attributable to reductions in inpatient spending for enrolled decedents who transitioned to MHB. MCCM decedents were 20 percentage points more likely than comparison decedents to enroll in MHB. This difference represents a one-third increase relative to the comparison group. MCCM decedents who transitioned to MHB were enrolled in MHB an average of a week longer than the comparison group. When including beneficiaries who enrolled in MCCM more than a year before death to our analytic sample, we found that MCCM decedents transitioned two weeks earlier on average than comparison decedents. Total estimated expenditure reductions during the last 30 days of life were $9,268 for the 84 percent subgroup of decedents who transitioned to MHB and $346 for those who remained enrolled in MCCM.

How Does MCCM Affect the Quality of Care Experienced by MCCM Enrollees and Their Caregivers?

Assessing patient needs, screening, and managing symptoms. CMS expected MCCM hospices to assess symptoms of shortness of breath, pain, emotional concerns, and bowel obstruction soon after enrollment; and at least once every 15 days thereafter. The goal is to identify symptoms and address them effectively. MCCM hospices documented an average of two monthly assessments for each enrollee, consistent with expected practice. Participating hospices documented symptom screenings for the majority of enrollees. Rates of symptom

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relief among those with documented screenings exceeded 90 percent. Caregivers likewise reported that enrollees received timely attention and adequate pain relief.

However, there is room for improvement: MCCM hospices documented only 1 of 2 types of assessments during the first 5 days of enrollment for 28 percent of enrollees and no assessments for 9 percent of enrollees. To address this issue, CMS has been working with the MCCM implementation contractor to communicate MCCM reporting requirements and make it easier to correct portal data. MCCM hospices documented the administration of twice-monthly assessments to only half of MCCM enrollees. While we do not know how many undocumented assessments were actually performed, they may be difficult to administer to enrollees who continue to receive life-prolonging treatment.

Shared decision making. Hospice staff perceived shared decision making as important and a way to promote the effectiveness of MCCM care. About 90 percent of caregivers for MCCM decedents who transitioned to MHB indicated that the transition happened at the right time, beneficiaries or caregivers were involved as much as they wanted to be in the MHB decision, and the beneficiary made the decision free of pressure from the MCCM team. These results show that MCCM is achieving its goal of facilitating person-focused transitions to MHB through shared decision making.

Advance care planning. Having discussions about advance care planning is one indicator of whether MCCM hospices are engaging in shared decision making with enrolled beneficiaries. Overall, hospices documented advance care planning with an average of 68 percent of enrollees. However, hospices varied widely in the percentage of enrollees with a documented advance care planning discussion. For example, 4 hospices documented advance care planning discussions with more than 90 percent of enrollees, while 15 hospices documented these discussions with less than 50 percent of enrollees.

Bereavement counseling. Documentation of bereavement services suggests that the practice is rare, with hospices reporting only 321 encounters with 206 (4 percent) enrollees. A variety of qualified staff including nurses, care coordinators, social workers, clergy, and bereavement counselors performed the documented services.

Evaluation Limitations

Representativeness of MCCM hospices and enrollees. MCCM is a voluntary model and we know that participating hospices differ in ways from those that did not volunteer with regard to geography, size, and operational characteristics, as described in **Appendix Section F.2.** Likewise, MCCM decedents were more likely to live in urban areas and less likely to be dually eligible for Medicare and Medicaid compared to MCCM-eligible decedents living in comparison market areas. These differences are shown in **Appendix Section F.3.** Findings in this report may therefore not be generalizable to all Medicare hospices and beneficiaries who are seriously ill with MCCM diagnoses.

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Focus on decedents. The sample for the impact analyses we present in this report includes only decedents. Estimating impacts for a cohort of decedents allowed us to account for important, but unobserved, characteristics associated with both disease trajectory and end-of-life outcomes. Thus, the findings we present in **Section 4** do not provide a full picture of enrollee experiences in the model and resulting outcomes (e.g., total time in MCCM, services received, metrics related to death, cumulative costs), and do not account for the effects of MCCM on post-enrollment survival time.

Accounting for unobserved variation in disease trajectories. We used a stratified approach to weighting the comparison group that allowed us to account for important, but unobserved, decedent-level characteristics associated with both disease trajectory and end-of-life outcomes, as described in **Appendix Section F.3**. Because this method assesses health status at similar points in time relative to the date of death for MCCM and comparison decedents, our method represents an improvement over methods that randomly assign pseudo enrollment dates to comparison group members. Even so, the predictive power of the detailed set of health status measures we used to weight comparison decedents may not fully control for unobserved differences between MCCM and comparison decedents that affect utilization and expenditure outcomes, such as beneficiary preferences and clinical characteristics, quality of care, and access to care.

Similarity of MCCM and comparison decedents. This report presents estimates of the impact of MCCM on utilization and Medicare expenditures in **Section 4** based on cumulative experiences of MCCM decedents relative to those of a comparison group of Medicare decedents who resided in market areas served by a group of matched hospices. We used statistical modeling to ensure the similarity of the decedent groups based on demographics, use of Medicare-covered services, and the presence of serious illness and frailty at the end of life. Nonetheless, there may be important, but unobserved, differences between MCCM and comparison decedents on factors that influence end-of-life outcomes, such as quality of care and preferences for life-prolonging treatment.

Accuracy and completeness of the MCCM portal. Hospices report a variety of data used to conduct this evaluation in the MCCM portal, including referrals, beneficiary characteristics, enrollment duration, and quality of care, as described throughout this report. Although the capabilities of the portal improved over time, missing information and changes over time in the content of MCCM service and activity data limited our ability to provide a complete, longitudinal picture of enrollees' experiences receiving care from MCCM hospices.

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EXHIBIT 22

CMS Hospice Payment Rate Information

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11542	**Date: August 4, 2022**
	Change Request 12832

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 05, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the hospice payment rates, hospice wage index, and Pricer for FY 2023. The CR also updates the FY 2023 hospice aggregate cap amount. These updates apply to Publication (Pub) 100-04, Chapter 11, section 30.2.

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 11542	Date: August 4, 2022	Change Request: 12832

NOTE: This Transmittal is no longer sensitive and is being re-communicated August 05, 2022. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for Fiscal Year (FY) 2023

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

I. GENERAL INFORMATION

A. Background: Payment rates for hospice care, the hospice cap amount, and the hospice wage index are updated annually.

The law governing payment for hospice care requires annual updates to the hospice payment rates. Payment rates are updated annually according to section 1814(i)(1)(C)(ii)(VII) of the Social Security Act ("the Act"), which requires CMS to use the inpatient hospital market basket, adjusted for Multifactor Productivity (MFP) and other adjustments as specified in the Act, to determine the hospice payment update percentage.

The hospice cap amount is updated annually in accordance with § 1814(i)(2)(B) of the Act and provides for an increase (or decrease) in the hospice cap amount. For accounting years that end after September 30, 2016 and before October 1, 2025, the hospice cap is updated by the hospice payment update percentage. After FY 2025, the annual update to the cap amount would have reverted to the original methodology that updates the cap amount by the Consumer Price Index (CPI). However, the FY 2022 hospice final rule finalized the extension of the current calculation (i.e., hospital market basket reduced for multifactor productivity instead of the consumer price index) for updating the hospice cap amount through FY 2030 in accordance with division CC section 404 of the Consolidated Appropriations Act of 2021.

The hospice wage index is used to adjust payment rates to reflect local differences in wages. The hospice wage index is updated annually as discussed in hospice rulemaking.

Section 3004 of the Affordable Care Act (ACA) amended the Act to authorize a quality reporting program for hospices. Section 1814(i)(5)(A)(i) of the Act requires that beginning with FY 2014 and each subsequent FY, the Secretary shall reduce the market basket update by 2 percentage points for any hospice that does not comply with the quality data reporting requirements with respect to that FY.

B. Policy: FY 2023 Hospice Payment Rates

The hospice payment update percentage for FY 2023 is based on the inpatient hospital market basket update of 4.1 percent. Due to the requirements at sections 1886(b)(3)(B)(xi)(II) and 1814(i)(1)(C)(v) of the Act, the inpatient hospital market basket update for FY 2023 of 4.1 percent must be reduced by a MFP adjustment as mandated by Affordable Care Act (currently estimated to be 0.3 percentage point for FY 2023). In effect, the hospice payment update percentage for FY 2023 is 3.8 percent.

The FY 2023 hospice payment rates are effective for care and services furnished on or after October 1, 2022, through September 30, 2023. The hospice payment rates are discussed further in Pub. 100-04, Medicare Claims Processing Manual, Chapter 11, Processing Hospice Claims, section 30.2.

The FY 2023 hospice payment rates are shown in Tables 1 and 2 of the attachment.

Hospice Inpatient and Aggregate Caps

In the FY 2016 Hospice Wage Index and Payment Rate Update final rule (80 FR 47142), we finalized aligning the cap accounting year, for both the inpatient cap and the hospice aggregate cap, with the federal FY beginning in 2017. Therefore, the 2023 cap year will start on October 1, 2022 and end on September 30, 2023.

For the inpatient cap for the 2023 cap year, we will calculate the percentage of all hospice days that were provided as inpatient days (General Inpatient Care (GIP) and Respite Care) from October 1, 2022 through September 30, 2023.

The hospice cap amount for the 2023 cap year is equal to the FY 2022 cap amount ($31,297.61) updated by the FY 2023 hospice payment update percentage of 3.8 percent. As such, the FY 2023 cap amount is $32,486.92.

Hospice Wage Index

The FY 2023 Hospice final rule finalizes the application of a permanent 5-percent cap on any decrease to a geographic area's wage index from its wage index in the prior year, regardless of the circumstances causing the decline beginning in FY 2023. That is, we finalized that a geographic area's wage index for FY 2023 and subsequent years, would not be less than 95 percent of its wage index calculated in the prior FY.

The revised payment rates and wage index will be incorporated in the Hospice Pricer and forwarded to the Medicare contractors. The wage index will **not** be published in the Federal Register but will be available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/index.html.

Hospice Labor Shares

The FY 2022 Hospice final rule revised the labor shares used to wage-adjust hospice payments for each level of care. The revised labor share for Routine Home Care is 66.00 percent and corresponding the non-labor share is 34.00 percent. The revised labor share for Continuous Home Care is 75.20 percent and the corresponding non-labor share is 24.80 percent. The revised labor share for Inpatient Respite Care is 61.00 percent and the corresponding non-labor share is 39.00 percent. The revised labor share for GIP Care is 63.50 percent and the corresponding non-labor share is 36.50 percent.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
12832.1	Medicare systems shall apply the FY 2023 rates for claims with dates of service on or after October 1, 2022 through September 30, 2023.					X				Hospice Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12832.2	Medicare systems shall install the new Hospice Pricer software.					X				Hospice Pricer
12832.3	Medicare systems shall use a table of wage index values associated with Core Based Statistical Area (CBSA) codes for FY 2023 hospice payment calculation.					X				Hospice Pricer
12832.4	Contractors shall calculate hospices' aggregate cap amounts for the FY 2023 cap year, starting on October 1, 2022 and ending on September 30, 2023, based on the cap amount of $32,486.92.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12832.5	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.			X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chantelle Caldwell, 410-786-8743 or chantelle.caldwell@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

Table 1: FY 2023 Hospice Payment Rates for Hospices that Submit the Required Quality Data

Code	Do Submit Quality	FY 2023 payment rates	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$211.34	$139.48	$71.86
651	Routine Home Care (days 61+)	$167.00	$110.22	$56.78
652	Continuous Home Care Full Rate = 24 hours of care. Hourly rate=$63.42	$1,522.04	$1,144.57	$377.47
655	Inpatient Respite Care	$492.10	$300.18	$191.92
656	General Inpatient Care	$1,110.76	$705.33	$405.43

Table 2: FY 2023 Hospice Payment Rates for Hospices that <u>DO NOT</u> Submit the Required Quality Data

Code	Do not Submit Quality	FY 2023 payment rates	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$207.27	$136.80	$70.47
651	Routine Home Care (days 61+)	$163.78	$108.09	$55.69
652	Continuous Home Care Full Rate = 24 hours of care. Hourly rate=$62.20	$1,492.72	$1,122.53	$370.19
655	Inpatient Respite Care	$482.62	$294.40	$188.22
656	General Inpatient Care	$1,089.36	$691.74	$397.62

EXHIBIT 23

Health Resources and Services Administration Workforce Statistics

Discipline	MUA/P ID	Service Area Name	Designation Type	Primary State Name	County	Index of Medical Underservice Score	Status	Rural Status	Designation Date	Update Date
Primary Care	03678	PIERCE SERVICE AREA	Medically Underserved Area	Washington	Pierce County, WA	61.2	Designated	Partially Rural	07/08/1982	07/08/1982

Component State Name	Component County Name	Component Name	Component Type	Component GEOID	Component Rural Status
Washington	Pierce	Pierce	Single County	53053	Non-Rural

HPSA Name	Designation Type	HPSA Discipl ne Class	HPSA Score	HPSA Status	HPSA Designation Date	HPSA Designation Last Update	# of FTE Short	HPSA Designation Population	Address	City	ZIP	Rural Status	County
Wash ngton Co ect ons Cente fo Women (WCCW)	Co ect onal Fac l ty	Mental Hea th	15	Des gnated	08/10/2007	12/10/2021	0.43	1857	9601 Bujac ch Rd NW	G g Ha bo	98332-8300	Non-Ru al	P e ce County, WA
ICE - Tacoma No thwest Detent on Cente	Co ect onal Fac l ty	Mental Hea th	3	Des gnated	08/24/2004	12/31/2018	0.57	5136	1623 E J St Apt Su	Tacoma	98421-1602	Non-Ru al	P e ce County, WA
ICE - Tacoma No thwest Detent on Cente	Co ect onal Fac l ty	Dental Health	6	Des gnated	09/15/2010	12/31/2018	2.82	5136	1623 E J St Ste	Tacoma	98421-1602	Non-Ru al	P e ce County, WA
ICE - Tacoma No thwest Detent on Cente	Co ect onal Fac l ty	P ma y Ca e	12	Des gnated	08/24/2004	12/31/2018	2.98	2983	1623 E J St Apt Su	Tacoma	98421-1602	Non-Ru al	P e ce County, WA
Commun ty Hea th Ca e	Fede a ly Qual f ed Hea th Cente	Mental Hea th	20	Des gnated	12/02/2003	09/11/2021		116319	1148 B oadway Ste 100	Tacoma	98402-3518	Non-Ru al	P e ce County, WA
Commun ty Hea th Ca e	Fede a ly Qual f ed Hea th Cente	Dental Health	25	Des gnated	12/02/2003	09/11/2021		116319	1148 B oadway Ste 100	Tacoma	98402-3518	Non-Ru al	P e ce County, WA
Commun ty Hea th Ca e	Fede a ly Qual f ed Hea th Cente	P ma y Ca e	20	Des gnated	12/02/2003	09/11/2021		116319	1148 B oadway Ste 100	Tacoma	98402-3518	Non-Ru al	P e ce County, WA
Longb anch	Geog aph c HPSA	Mental Hea th	16	Des gnated	10/20/2017	09/08/2021	1.82	36424				Non-Ru al	P e ce County, WA
Longb anch	Geog aph c HPSA	Dental Health	16	Des gnated	10/20/2017	09/08/2021	5.5175	36424				Non-Ru al	P e ce County, WA
Bonney Lake/Buckley Se v ce A ea	Geog aph c HPSA	P ma y Ca e	15	Des gnated	10/16/2017	09/08/2021	20 94	104077				Pa t ally Ru al	P e ce County, WA
Longb anch	Geog aph c HPSA	P ma y Ca e	15	Des gnated	10/20/2017	09/08/2021	9.41	36424				Non-Ru al	P e ce County, WA
Eatonv lle/Roy	Geog aph c HPSA	P ma y Ca e	15	Des gnated	10/16/2017	09/08/2021	7.39	29358				Non-Ru al	P e ce County, WA
LI - West P e ce/Tacoma Se v ce A ea	HPSA Popula on	P ma y Ca e	16	Des gnated	11/09/2021	11/09/2021	30 06	90662				Non-Ru al	P e ce County, WA
Takop d Ind an Health Cente	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	Mental Hea th	18	Des gnated	10/26/2002	09/11/2021		65020	2209 E 32nd St	Tacoma	98404-4922	Non-Ru al	P e ce County, WA
Puyallup T bal Integ at ve Med c ne	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	Mental Hea th	18	Des gnated	08/18/2019	09/11/2021		65493	3700 Pac f c Hwy E	F fe	98424-1148	Non-Ru al	P e ce County, WA
Takop d Ind an Health Cente	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	Dental Health	19	Des gnated	10/26/2002	09/11/2021		65020	2209 E 32nd St	Tacoma	98404-4922	Non-Ru al	P e ce County, WA
Puyallup T bal Integ at ve Med c ne	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	Dental Health	18	Des gnated	08/18/2019	09/11/2021		65493	3700 Pac f c Hwy E	F fe	98424-1148	Non-Ru al	P e ce County, WA
Takop d Ind an Health Cente	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	P ma y Ca e	17	Des gnated	10/26/2002	09/11/2021		50001	2209 E 32nd St	Tacoma	98404-4922	Non-Ru al	P e ce County, WA
Puyallup T bal Integ at ve Med c ne	Ind an Hea th Se v ce, T bal Health, and U ban Ind an Health O gan zat ons	P ma y Ca e	17	Des gnated	08/18/2019	09/11/2021		50886	3700 Pac f c Hwy E	F fe	98424-1148	Non-Ru al	P e ce County, WA
Spec al Comm tment Cente	State Mental Hosp tal	Mental Hea th	20	Des gnated	08/14/2013	08/06/2021		196	1715 Lafayette St	Ste lacoom	98388-1327	Non-Ru al	P e ce County, WA
LI-West Tacoma-Lakewood A ea	HPSA Popula on	P ma y Ca e	15	P oposed Fo W thd awal	07/28/2020	09/10/2021	23 33	69995				Non-Ru al	P e ce County, WA
LI-East Tacoma Se v ce A ea	HPSA Popula on	P ma y Ca e	15	P oposed Fo W thd awal	07/28/2020	09/10/2021	19 35	58058				Non-Ru al	P e ce County, WA
Weste n State Hosp tal	State Mental Hosp tal	Mental Hea th	0	W thd awn	06/28/2012	06/25/2019			9601 Ste lacoom Blvd SW	Lakewood	98498-7212	Non-Ru al	P e ce County, WA
McNe l Island Co ect ons Cente	Co ect onal Fac l ty	Mental Hea th	3	W thd awn	10/22/2007	04/23/2013	0		1403 Comme c al St	Ste lacoom	98388-1305	Non-Ru al	P e ce County, WA
Met opol tan Development Counc l	Fede a ly Qual f ed Hea th Cente	Mental Hea th	10	W thd awn	12/02/2003	06/25/2019			622 Tacoma Ave S Ste 6	Tacoma	98402-2319	Non-Ru al	P e ce County, WA
Met opol tan Development Counc l	Fede a ly Qual f ed Hea th Cente	Dental Health	10	W thd awn	12/02/2003	06/25/2019			622 Tacoma Ave S Ste 6	Tacoma	98402-2319	Non-Ru al	P e ce County, WA
WA Co ect onal Cente fo Women	Co ect onal Fac l ty	Dental Health	12	W thd awn	02/16/1994	06/27/2013	1.54		9601 Bujac ch Rd NW	G g Ha bo	98332-8300	Non-Ru al	P e ce County, WA
Med ca d El g ble - South P e ce County	HPSA Popula on	Dental Health	0	W thd awn	06/28/1993	11/03/2011	6.6	101914					P e ce County, WA
McNe l Island Co ect onal Cente	Co ect onal Fac l ty	Dental Health	0	W thd awn	05/26/1982	06/29/2012	0.5		1403 Comme c al St	Ste lacoom	98388-1305	Non-Ru al	P e ce County, WA
Low Income - Easts de Tacoma	HPSA Popula on	P ma y Ca e	0	W thd awn	02/23/1996	11/03/2011	0	0					P e ce County, WA
Low Income - Lakewood (Southwest P e ce County)	HPSA Popula on	P ma y Ca e	0	W thd awn	02/23/1996	11/03/2011	0	0					P e ce County, WA
Wash ngton Co ect onal Cente fo Women	Co ect onal Fac l ty	P ma y Ca e	6	W thd awn	02/12/1990	06/27/2013	0.95		9601 Bujac ch Rd NW	G g Ha bo	98332-8300	Non-Ru al	P e ce County, WA
McNe l Island Co ect ons Cente	Co ect onal Fac l ty	P ma y Ca e	6	W thd awn	05/26/1982	04/23/2013	1.25		1403 Comme c al St	Ste lacoom	98388-1305	Non-Ru al	P e ce County, WA
Met opol tan Development Counc l	Fede a ly Qual f ed Hea th Cente	P ma y Ca e	5	W thd awn	12/02/2003	06/25/2019			622 Tacoma Ave S Ste 6	Tacoma	98402-2319	Non-Ru al	P e ce County, WA
Med cal Ind. Popula on - P e ce	HPSA Popula on	P ma y Ca e	0	W thd awn	03/16/1984	10/02/1995		22700					P e ce County, WA
Longb anch	Geog aph c HPSA	P ma y Ca e	12	W thd awn	04/28/1978	07/02/2018	3.21	14717					P e ce County, WA
Woodland/Cowl tz East	Geog aph c HPSA	P ma y Ca e	0	W thd awn	09/28/2001	05/20/2002		8786					Cowl tz County, WA | P e ce County, WA
Buckley/Enumclaw Se v ce A ea	Geog aph c HPSA	P ma y Ca e	10	W thd awn	09/12/2001	07/02/2018	8.14	46324					P e ce County, WA
Eatonv lle/Roy	Geog aph c HPSA	P ma y Ca e	10	W thd awn	09/12/2001	07/02/2018	6.52	29133					P e ce County, WA

Supply and Demand Projections of the Nursing Workforce: 2014-2030

July 21, 2017

U.S. Department of Health and Human Services

Health Resources and Services Administration

Bureau of Health Workforce

National Center for Health Workforce Analysis

About the National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis (the National Center) informs public and private-sector decision-making on the U.S. health workforce by expanding and improving health workforce data and its dissemination to the public, and by improving and updating projections of supply of and demand for health workers. For more information about the National Center, please visit our website at http://bhw.hrsa.gov/healthworkforce/index.html.

Suggested citation:

U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. 2017. National and Regional Supply and Demand Projections of the Nursing Workforce: 2014-2030. Rockville, Maryland.

Contents

Supply and Demand Projections of the Nursing Workforce: 2014-2030

Overview

This report presents projections of supply of and demand for registered nurses (RNs) and licensed practical/vocational nurses (LPNs) in 2030, with 2014 serving as the base year. These projections highlight the inequitable distribution of the nursing workforce across the United States, as recent research[1,2] shows that nursing workforce represents a greater problem with distribution across states than magnitude at the national level. Projections were developed using the Health Resources and Services Administration's (HRSA) Health Workforce Simulation Model (HWSM).

The HWSM is an integrated microsimulation model that estimates current and future supply of and demand for health workers in multiple professions and care settings. While the nuances of modeling supply and demand differ for individual health professions, the basic framework remains the same. The HWSM assumes that demand equals supply in the base year.[3] For supply modeling, the major components (beyond common labor-market factors like unemployment) include characteristics of the existing workforce in a given occupation; new entrants to the workforce (e.g., newly trained workers); and workforce participation decisions (e.g., retirement and hours worked patterns). For demand modeling, the major components include population demographics; health care use patterns (including the influence of increased insurance coverage); and demand for health care services (translated into requirements for full-time equivalents (FTEs)).

Important limitations for these workforce projections include an underlying model assumption that health care delivery in the future (projected until 2030) will not change substantially from

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025*. Rockville, Maryland, 2014.

[2] PI Buerhaus, DI Auerbach, DO Staiger, U Muench "Projections of the long-term growth of the registered nurse workforce: A regional analysis". Nursing Economics, 2013

[3] Ono T, Lafortune G, Schoenstein M. "Health workforce planning in OECD countries: a review of 26 projection models from 18 countries." *OECD Health Working Papers, No. 62*. France: OECD Publishing; 2013: 8-11.

the way health care was delivered in the base year (2014) and that there will be stability in the current rates of health care utilization. In addition, the supply model assumes that current graduation rates and workforce participation pattern will remain unchanged in the future (2030). Changes in any of these factors may significantly impact both the supply and demand projections presented in this report. Alternative supply and demand scenarios were developed to explore the impact of such changes. A detailed description of the HWSM can be found in the accompanying technical document available at http://bhw.hrsa.gov/healthworkforce/index.html.

Key Findings

Registered Nurses

Substantial variation across states is observed for RNs in 2030 through the large differences between their projected supply and demand.

- Looking at each state's 2030 RN supply minus its 2030 demand reveals both shortages and surpluses in RN workforce in 2030 across the United States. Projected differences between each state's 2030 supply and demand range from a shortage of 44,500 FTEs in California to a surplus of 53,700 FTEs in Florida.
- If the current level of health care is maintained, seven states are projected to have a shortage of RNs in 2030, with four of these states having a deficit of 10,000 or more FTEs, including California (44,500 FTEs), Texas (15,900 FTEs), New Jersey (11,400 FTEs) and South Carolina (10,400 FTEs).
- States projected to experience the largest excess supply compared to demand in 2030 include Florida (53,700 FTEs) followed by Ohio (49,100 FTEs), Virginia (22,700 FTEs) and New York (18,200 FTEs).

Licensed Practical/Vocational Nurses

Projected changes in supply and demand for LPNs between 2014 and 2030 vary substantially by state.

- Thirty-three states are projected to experience a shortage - a smaller growth in the supply of LPNs relative to their state-specific demand for LPNs. States projected to experience the largest shortfalls of LPNs in 2030 include Texas, with a largest projected deficit of 33,500 FTEs, followed by Pennsylvania with a shortage of 18,700 FTEs.

- In seventeen states where projected LPN supply exceeds projected demand in 2030, Ohio exhibits the greatest excess supply of 4,100 FTEs, followed by California with 3,600 excess FTEs.

Background

Health care spending is approximately 18 percent of the U.S. economy (GDP). Nursing is the single largest profession in the entire U.S. health care workforce with RNs and LPNs making up the two largest occupations in this profession.[4] RNs and LPNs perform a variety of patient care duties and are critical to the delivery of health care services across a wide array of settings, including ambulatory care clinics, hospitals, nursing homes, public health facilities, hospice programs, and home health agencies. Distinctions are made among different types of nurses according to their education, role, and the level of autonomy in practice.

LPNs typically receive training for a year beyond high school and, after passing the national NCLEX-PN exam, become licensed to work in patient care. LPNs provide a variety of direct care services including administration of medication, taking medical histories, recording symptoms and vital signs, and other tasks as delegated by RNs, physicians, and other health care providers.[5,6]

RNs usually have a bachelor's degree in nursing, a two year associate's degree in nursing, or a diploma from an approved nursing program. They must also pass a national exam, the NCLEX-RN, before they are licensed to practice.[7,8,9] RN responsibilities involve work that is more

[4] U.S. Department of Labor, Bureau of Labor Statistics. (2012). *Occupational Outlook Handbook, 2012-13 Edition*. Washington, D.C.: GPO, U.S. Bureau of Labor Statistics. Retrieved from http://www.bls.gov/ooh/healthcare/registered-nurses.htm; http://www.bls.gov/ooh/healthcare/licensed-practical-and-licensed-vocational-nurses htm

[5] Mueller, C., Anderson, R., McConnel, E. (2012). Licensed Nurse Responsibilities in Nursing Homes: A Scope-of-Practice Issue. *Journal of Nursing Regulation*. 3(1): 13-20.

[6] Lubbe, J., Roets, L. (2014) Nurses' Scope of Practice and the Implication for Quality Nursing Care, *Journal of Nursing Scholarship*. 46(1): 58-64.

[7] Sochalski, J., & Weiner, J. (2011). Health care system reform and the nursing workforce: Matching nursing practice and skills to future needs, not past demands. The *future of nursing: Leading change, advancing health*, 375-400.

[8] Pittman, P., & Forrest, E. (2015). The changing roles of registered nurses in Pioneer Accountable Care Organizations. *Nursing outlook*, *63*(5), 554-565.

[9] Anderson, D. R., & St Hilaire, D. (2012). Primary care nursing role and care coordination: An observational study of nursing work in a community health center. *Online journal of issues in nursing*, *17*(2), E1.

complex and analytical than that of LPNs. RNs provide a wide array of direct care services, such as administering treatments, care coordination, disease prevention, patient education, and health promotion for individuals, families, and communities. RNs may choose to obtain advanced clinical education and training to become Advanced Practice Nurses (who usually have a master's degree, although some complete doctoral-level training) and often focus in a clinical specialty area.[10,11] Advanced Practice Registered Nurses are not included in the analysis presented here, but are covered in separate reports.[12] [13]

The historical relationship between nurse supply and demand in the U.S. has been cyclical, with periodic shortages of nurses where demand outstrips available supply, followed by periods of overproduction which lead to nursing surpluses. This cycle necessitates regular monitoring of the nursing workforce, and thus, periodic updates of HRSA's workforce projections. This report updates HRSA's estimates provided in the 2014 report on the nursing workforce.[14]

According to HRSA's 2014 report, state-level variation had been observed in projections of nursing supply relative to demand. Nurse shortage or surplus appear to reflect local conditions, such as the number of new graduates from nursing schools. Nurses tend to practice in states where they have been trained. The 2014 report demonstrated that nursing shortages represent a problem with workforce distribution across states rather than magnitude at the national level. As such, this report focuses on the inequitable distribution of nursing workforce across states as oppose to a national-level projections.

[10] Blegen, M. A., Goode, C. J., Park, S. H., Vaughn, T., & Spetz, J. (2013). Baccalaureate education in nursing and patient outcomes. *Journal of Nursing Administration*, *43*(2), 89-94.

[11] Hamric, A. B., Hanson, C. M., Tracy, M. F., & O'Grady, E. T. (2013) *Advanced practice nursing: An integrative approach*. Elsevier Health Sciences.

[12] U.S. Department of Health and Human Services, Health Resources and Services Administration,. *National and Regional Projections of Supply and Demand for Primary Care Practitioners: 2013-2025*. National Center for Health Workforce Analysis. Rockville, Maryland, 2016.

[13] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *Health Workforce Projections: Certified Nurse Anesthetists.* Rockville, Maryland, 2016.

[14] U.S. Department of Health and Human Services, Health Resources and Services Administration, National Center for Health Workforce Analysis. *The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025.* Rockville, Maryland, 2014.

Results

Future supply of and demand for nurses will be affected by a host of factors, including population growth, the aging of the nation's population, overall economic conditions, expanded health insurance coverage, changes in health care reimbursement, geographic location, and health workforce availability. The HWSM is an integrated microsimulation model that estimates supply of and demand for health workers in multiple professions and care settings, and accounts for these factors when adequate data are available to estimate their impact.[15]

For supply modeling, the major components include characteristics of the existing workforce in the occupation, new entrants to the workforce (e.g., newly trained workers); and workforce decisions (e.g., retirement, hours worked patterns, and migration across states); as well as common labor-market factors like unemployment and wage rates. For the national demand modeling, the HWSM assumes that RN and LPN demand at the national level equals supply in 2014, consistent with standard workforce research methodology, in the absence of documented evidence of a substantial imbalance between national supply and demand in the base year (2014).[16] The state-level demand estimates assumes state-level RN and LPN demand in 2014 equals supply, to project future demand for each state to provide a level of care consistent with what was provided in 2014 in that state. Over the projection period, the model assumes that current national patterns of supply and demand, such as newly trained workers, retirement, hours worked patterns and health care use, remain unchanged within each demographic group (as defined by age, sex, etc.).

All supply and demand estimates and projections are reported as FTEs, where one FTE is defined as 40 hours per week. This measure standardizes the definition of FTE over time and across health occupations. Previous nurse workforce projections define FTE as estimated average hours worked among nurses working at least 20 hours, which is 37.3 for both RNs and LPNs in

[15] For additional information about the HWSM, please see "About the Model" on the last page of this report.

[16] HRSA's 2014 report modeled a scenario where each state was in equilibrium in the base year—which scenario models whether each state's future nurse supply will be adequate to maintain nursing care at a level of care consistent with the state's 2012 staffing levels.

this study. Consequently, the supply and demand numbers presented in this report are slightly lower than in previous nursing workforce projection reports.

Alternative supply and demand scenarios presented in this report show the sensitivity of projections to changes in key supply and demand determinants and assumptions. The alternative supply scenarios modeled include the impacts of graduating 10 percent more or 10 percent fewer nurses annually than the status quo. The alternative demand scenario reflects a potential change in health care delivery focusing on population health and preventive care.[17]

Trends in RN Supply and Demand

At the national level, the projected growth in RN supply (39 percent growth) is expected to exceed growth in demand (28 percent growth) resulting in a projected excess of about 293,800 RN FTEs in 2030.

The estimation of RN supply starts from approximately 2,806,100 RN FTEs that were active in the U.S. workforce in 2014. The number of graduates from U.S. nursing programs has steadily increased from approximately 68,800 individuals in 2001 to nearly 158,000 in 2015. Between 2014 and 2030, about 2,282,500 new RN FTEs will enter the workforce (assuming new RNs will graduate at the current rate), an estimated 1,043,500 RN FTEs will leave the workforce, and a decline in about 149,500 RN FTEs is associated with reduced work hours as the nurse workforce ages. This net growth of about 1,089,500 RN FTEs will result in a national RN workforce of 3,895,600 FTEs by 2030.

The demand for RNs is projected to be 2,806,100 in 2014 and will increase to 3,601,800 in 2030 (an increase of 795,700 FTEs between 2014 and 2030), based on current health care utilization and staffing patterns and assuming the national RN demand equaled supply in 2014. Growth in disease burden attributable to changing patient demographics contributes to an increased demand of about 776,400 RNs. HRSA's HWSM reflects increased insurance coverage associated with

[17] IHS Markit Inc., *The Complexities of Physician Supply and Demand: Projections from 2013 to 2025*. Prepared for the Association of American Medical Colleges. Washington, DC: Association of American Medical Colleges; 2015.

Medicaid expansion and insurance marketplaces. This expanded insurance coverage accounts for projected demand of an additional 19,300 RNs between 2014 and 2030.

Across states, projected differences between supply and demand for RNs in 2030 vary considerably. The demand estimates for each state in Exhibit 1 reflect the number of RN FTEs required to provide a level of care consistent with what was provided in 2014 in that state, given each state's demographics and the prevalence of health risk factors.

Looking at each state's 2030 RN supply minus their 2030 demand reveals both state-level shortages and surpluses. The most severe shortage is seen in California, where the undersupply is estimated to be 44,500 RN FTEs, while the largest surplus is seen in Florida, with an estimated oversupply of 53,700 RN FTEs. Among the seven states that have estimated 2030 shortages, four states have shortages of more than 10,000 RN FTEs including California, followed by Texas (15,900 fewer FTEs), New Jersey (11,400 fewer FTEs) and South Carolina (10,400 fewer FTEs). Meanwhile, three states have a surplus of more than 20,000 RN FTEs, including Florida, followed by Ohio (with 49,100 more FTEs), and Virginia (with 22,700 FTEs).

Exhibit 1: Baseline and Projected Supply of and Demand for Registered Nurses by State: 2014 and 2030

	2014	2030			
Region and State	**Supply/ Demand[a]**	**Supply**	**Demand**	**Difference[b]**	**Adequacy[c]**
Northeast					
Connecticut	34,000	43,500	40,000	3,500	8.8%
Maine	14,600	21,200	16,500	4,700	28.5%
Massachusetts	73,200	91,300	89,300	2,000	2.2%
New Hampshire	15,500	21,300	20,200	1,100	5.4%
New Jersey	81,700	90,800	102,200	(11,400)	(11.2%)
New York	174,100	213,400	195,200	18,200	9.3%
Pennsylvania	133,200	168,500	160,300	8,200	5.1%
Rhode Island	11,000	15,000	12,500	2,500	20.0%
Vermont	6,000	9,300	6,800	2,500	36.8%
Midwest					
Illinois	116,300	143,000	139,400	3,600	2.6%
Indiana	62,900	89,300	75,300	14,000	18.6%
Iowa	32,500	45,400	35,300	10,100	28.6%
Kansas	29,500	47,500	34,900	12,600	36.1%
Michigan	91,600	110,500	104,400	6,100	5.8%

Region and State	2014	2030			
	Supply/ Demand [a]	Supply	Demand	Difference [b]	Adequacy [c]
Minnesota	56,200	71,800	68,700	3,100	4.5%
Missouri	59,600	89,900	73,200	16,700	22.8%
Nebraska	20,300	24,700	21,200	3,500	16.5%
North Dakota	7,600	9,900	9,200	700	7.6%
Ohio	122,800	181,900	132,800	49,100	37.0%
South Dakota	10,300	11,700	13,600	(1,900)	(14.0%)
Wisconsin	58,100	78,200	72,000	6,200	8.6%
South					
Alabama	68,000	85,100	79,800	5,300	6.6%
Arkansas	28,400	42,100	32,300	9,800	30.3%
Delaware	9,600	14,000	12,800	1,200	9.4%
Distr. of Columbia [d]	1,800	8,800	2,300	6,500	282.6%
Florida	170,600	293,700	240,000	53,700	22.4%
Georgia	77,200	98,800	101,000	(2,200)	(2.2%)
Kentucky	44,900	64,200	53,700	10,500	19.6%
Louisiana	40,600	52,000	49,700	2,300	4.6%
Maryland	58,700	86,000	73,900	12,100	16.4%
Mississippi	29,100	42,500	35,300	7,200	20.4%
North Carolina	90,000	135,100	118,600	16,500	13.9%
Oklahoma	32,500	46,100	40,600	5,500	13.5%
South Carolina	36,900	52,100	62,500	(10,400)	(16.6%)
Tennessee	61,000	90,600	82,200	8,400	10.2%
Texas	180,500	253,400	269,300	(15,900)	(5.9%)
Virginia	67,900	109,200	86,500	22,700	26.2%
West Virginia	18,800	25,200	20,800	4,400	21.2%
West					
Alaska	16,400	18,400	23,800	(5,400)	(22.7%)
Arizona	65,700	99,900	98,700	1,200	1.2%
California	277,400	343,400	387,900	(44,500)	(11.5%)
Colorado	41,900	72,500	63,200	9,300	14.7%
Hawaii	10,900	19,800	16,500	3,300	20.0%
Idaho	11,200	18,900	15,300	3,600	23.5%
Montana	9,600	12,300	12,100	200	1.7%
Nevada	18,300	33,900	25,800	8,100	31.4%
New Mexico	15,900	31,300	21,600	9,700	44.9%
Oregon	30,400	41,100	38,600	2,500	6.5%
Utah	20,000	33,500	29,400	4,100	13.9%
Washington	56,700	85,300	79,100	6,200	7.8%
Wyoming	4,200	8,300	5,500	2,800	50.9%

Notes: The model assumes increased insurance coverage associated with Medicaid expansion and insurance marketplaces, together with year 2014 health care use and delivery patterns. Numbers may not sum to totals due to rounding.

[a] The projections assume that each state's supply and demand are equal in 2014.

[b] Difference = 2030 projected supply – demand.

[c] Adequacy = 100 * (projected supply – projected demand)/(projected demand); a negative adequacy indicates a shortage (i.e., supply is less than demand) while a positive adequacy indicates a surplus (i.e., supply is greater than demand); adequacies associated with 2030 projected shortages are highlighted in blue.
[d] Starting supply for Washington D.C. is based on small sample size in the American Community Survey so supply estimates might be unreliable.

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In addition to presenting RN shortages and surpluses by state, Exhibit 1 shows measures of adequacy (last column). For the purpose of this report, adequacy is defined as the projected 2030 state-level provider shortage or surplus expressed as a percentage of that state's 2030 provider demand. Adequacy is interpreted as follows:

- A negative adequacy indicates a 2030 shortage and reflects the percentage of 2030 demand that is unmet.
- A positive adequacy indicates a 2030 surplus and reflects the size of the projected surplus relative to the projected demand.

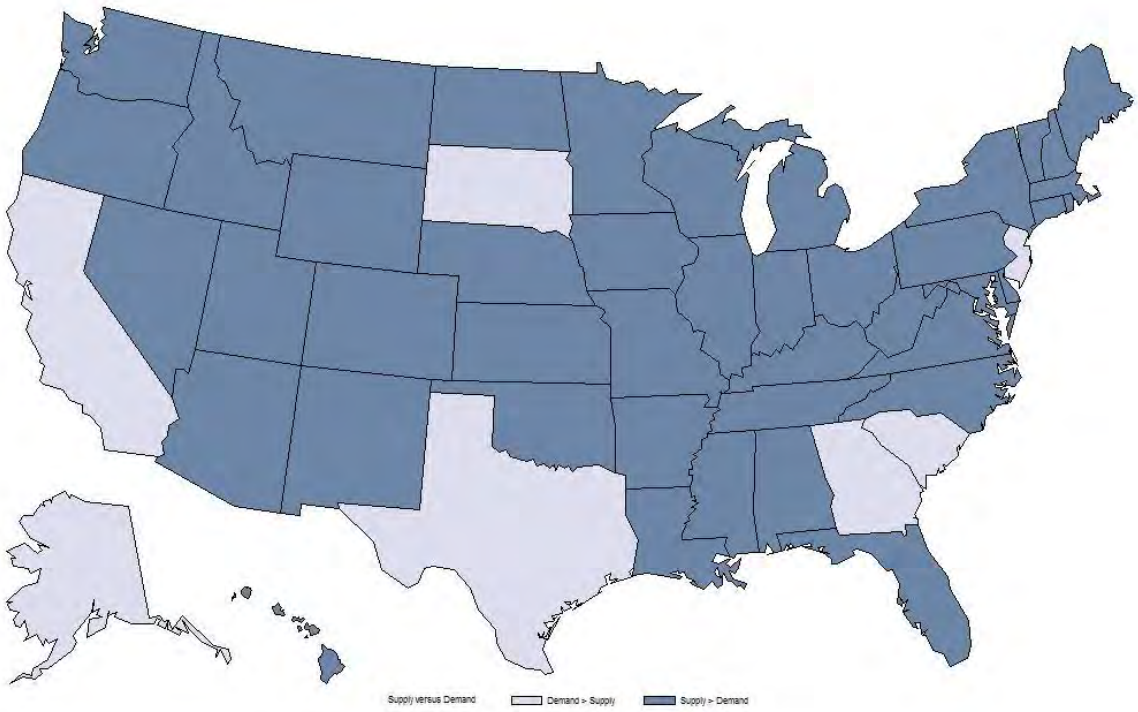
Expressing each 2030 state-level shortage or surplus as a percentage of the state's 2030 demand helps to inform comparisons of differences between supply and demand across states by considering how the size of each state's surplus or shortage relates to that state's underlying provider demand.

Based on the adequacies shown in Exhibit 1, the excessive 2030 supply for RNs is greatest in Wyoming (except Washington D.C.[18]), where the projected RN shortage is 51 percent of projected demand. The unmet 2030 RN demand is lowest in Arizona, where the projected shortage is about 1 percent of projected demand. As noted above, 2030 RN supply is lower than demand in 7 states, with shortage ranging from 2 percent of RN demand in Georgia to 23 percent of demand in Alaska.

Mapping the states with unmet demand in 2030 illustrates the geographic distribution of RN shortages projected across the United States (Exhibit 2).

[18] Washington D.C. shows the largest percentage of surplus. However, starting supply for Washington D.C. is based on small sample size in the American Community Survey so supply estimates might be unreliable.

Exhibit 2: RN Supply versus Demand, by State, 2030



Trends in LPN Supply and Demand

Approximately 809,700 LPN FTEs were active in the U.S. workforce in 2014. The number of first time LPN NCLEX-PN takers from U.S. nursing programs steadily increased from approximately 34,600 individuals in 2001 to a peak of slightly over 66,800 by 2010 before declining to about 47,000 in 2016. Trending forward to 2030 using current supply determinants (such as rates of entry and attrition from the profession) there will be 784,100 new LPN FTEs in the workforce and an estimated 493,500 LPN FTEs will leave the workforce. In addition, supply will decrease by approximately 83,600 LPN FTEs based on change in average hours worked. The net growth of about 207,000 new LPN FTEs by 2030 will result in a national workforce supply of approximately 1,016,700 LPN FTEs, an increase of 26 percent.

Assuming LPN demand equals supply in 2014 at the national level, by 2030 LPN demand is projected to reach 1,168,200 LPN FTEs, an increase of 358,500 (44 percent). Growth in demand is driven primarily by a growing and aging population, resulting in increased health service needs in nursing homes, residential care and hospital settings. The impact of expanded insurance

coverage associated with Medicaid expansion and insurance marketplaces is relatively small (4,100 FTEs).

At the national level, the demand for LPNs is projected to start growing faster than supply starting in about 2022. By 2030, a projected national shortage of about 151,500 LPN FTEs (13 percent of 2030 demand) could develop. That possibility notwithstanding, the risk associated with an LPN shortfall of this magnitude is limited because LPNs can be trained more quickly and at lower cost than RNs.

Exhibit 3 presents future state-level supply and demand for services if states were to continue providing a level of nursing care consistent with what the state provided in 2014. Under this scenario, substantial variation across states is observed in projected differences between supply and demand for LPNs. Overall, 33 states are projected to see that their LPN supply will be outpaced by demand by 2030 – including 14 states in the South, 7 in the Midwest, and 6 each in the West and Northeast. States with relatively large projected shortfalls are mostly in the South: Texas, with a largest projected deficit of 33,500 LPN FTEs, and other 6 states (North Carolina, Georgia, Florida, Alabama, Maryland, and Tennessee) with project deficits between 8,300 and 11,700 FTEs. Other states with larger projected shortfalls include Pennsylvania in the Northeast with a shortage of 18,700 FTEs and Indiana in the Midwest with a shortage of 7,000 FTEs. Among the other 18 states, Ohio exhibits the greatest projected excess supply of 4,100 FTEs by 2030, followed by California with 3,600 FTEs.

Exhibit 3: Baseline and Projected Supply of and Demand for Licensed Practical Nurses by State: 2014 and 2030

	2014	2030			
Region and State	**Supply/ Demand[a]**	**Supply**	**Demand**	**Difference[b]**	**Adequacy[c]**
Northeast					
Connecticut	9,600	11,000	13,200	(2,200)	(16.7%)
Maine	2,000	3,400	2,600	800	30.8%
Massachusetts	14,400	16,500	20,100	(3,600)	(17.9%)
New Hampshire	4,700	4,700	7,500	(2,800)	(37.3%)
New Jersey	19,400	30,500	27,400	3,100	11.3%
New York	52,400	58,900	62,500	(3,600)	(5.8%)
Pennsylvania	49,300	48,600	67,300	(18,700)	(27.8%)

Region and State	2014	2030			
	Supply/ Demand[a]	Supply	Demand	Difference[b]	Adequacy[c]
Rhode Island	2,000	2,300	2,400	(100)	(4.2%)
Vermont	1,800	2,500	2,400	100	4.2%
Midwest					
Illinois	26,500	34,400	37,100	(2,700)	(7.3%)
Indiana	19,900	19,900	26,900	(7,000)	(26.0%)
Iowa	7,900	13,000	9,900	3,100	31.3%
Kansas	8,400	14,400	11,400	3,000	26.3%
Michigan	21,500	24,800	28,100	(3,300)	(11.7%)
Minnesota	16,200	24,700	23,000	1,700	7.4%
Missouri	20,000	23,200	28,100	(4,900)	(17.4%)
Nebraska	6,200	6,000	6,500	(500)	(7.7%)
North Dakota	2,500	3,900	3,400	500	14.7%
Ohio	42,500	54,900	50,800	4,100	8.1%
South Dakota	2,100	2,800	3,200	(400)	(12.5%)
Wisconsin	12,600	16,300	18,000	(1,700)	(9.4%)
South					
Alabama	22,200	20,500	30,100	(9,600)	(31.9%)
Arkansas	12,200	17,800	15,600	2,200	14.1%
Delaware	2,900	4,200	4,500	(300)	(6.7%)
Distr. of Columbia[d]	900	1,800	1,300	500	38.5%
Florida	54,200	73,600	83,900	(10,300)	(12.3%)
Georgia	26,300	25,800	36,300	(10,500)	(28.9%)
Kentucky	12,600	14,400	17,200	(2,800)	(16.3%)
Louisiana	18,400	20,700	25,500	(4,800)	(18.8%)
Maryland	13,300	11,300	19,700	(8,400)	(42.6%)
Mississippi	9,900	11,800	14,200	(2,400)	(16.9%)
North Carolina	22,900	24,400	35,100	(10,700)	(30.5%)
Oklahoma	14,800	18,400	20,800	(2,400)	(11.5%)
South Carolina	8,000	8,200	12,900	(4,700)	(36.4%)
Tennessee	24,000	29,600	37,900	(8,300)	(21.9%)
Texas	70,900	80,900	114,400	(33,500)	(29.3%)
Virginia	25,500	32,200	36,600	(4,400)	(12.0%)
West Virginia	7,600	10,900	9,800	1,100	11.2%
West					
Alaska	1,700	2,000	3,100	(1,100)	(35.5%)
Arizona	9,100	12,200	15,800	(3,600)	(22.8%)
California	72,000	121,000	117,400	3,600	3.1%
Colorado	6,900	10,400	12,500	(2,100)	(16.8%)
Hawaii	2,300	4,700	4,300	400	9.3%
Idaho	2,500	4,300	4,100	200	4.9%
Montana	2,300	2,800	3,400	(600)	(17.6%)
Nevada	3,200	4,200	5,200	(1,000)	(19.2%)

Region and State	2014	2030			
	Supply/ Demand [a]	Supply	Demand	Difference [b]	Adequacy [c]
New Mexico	3,000	4,900	4,900	0	0.0%
Oregon	3,100	4,900	4,600	300	6.5%
Utah	2,900	6,700	5,000	1,700	34.0%
Washington	11,200	13,600	18,700	(5,100)	(27.3%)
Wyoming	1,000	1,800	1,600	200	12.5%

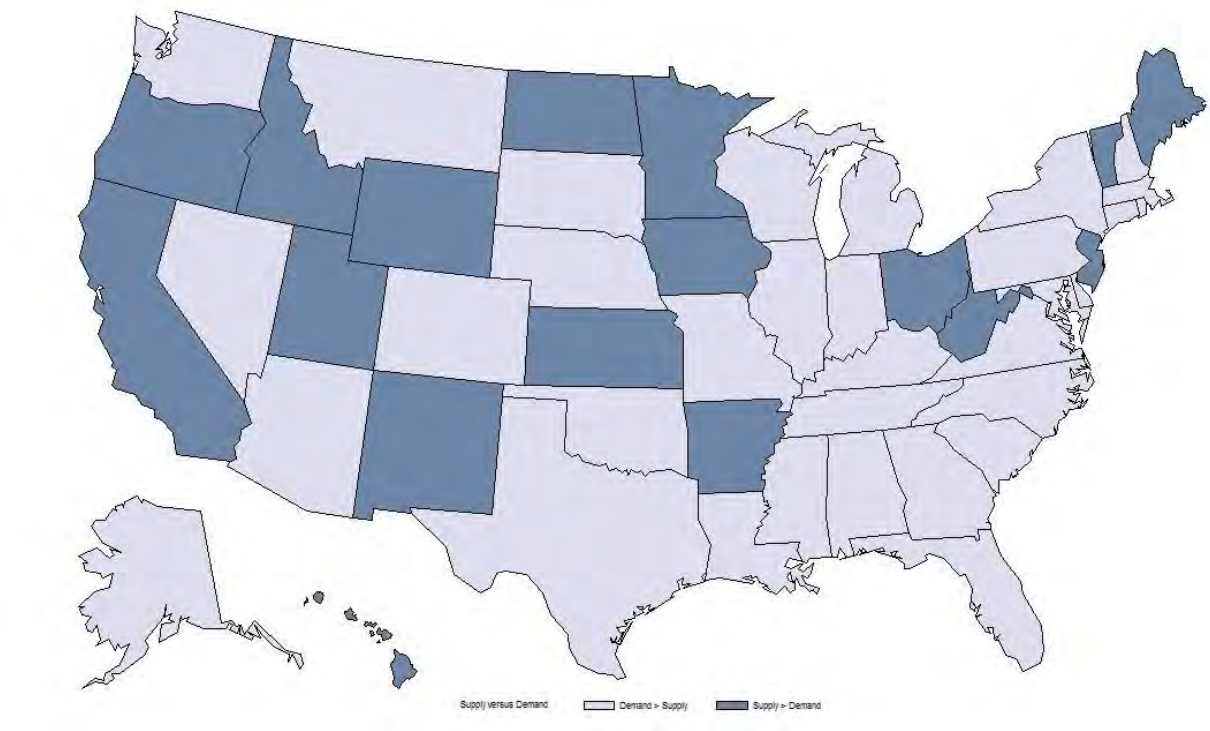
Notes: The model assumes increased insurance coverage associated with Medicaid expansion and insurance marketplaces, together with year 2014 health care use and delivery patterns. Numbers may not sum to totals due to rounding.
[a] The projections assume that each state's supply and demand are equal in 2014.
[b] Difference = 2030 projected supply – demand.
[c] Adequacy = 100 * (projected supply – projected demand)/(projected demand); a negative adequacy indicates a shortage (i.e., supply is less than demand) while a positive adequacy indicates a surplus (i.e., supply is greater than demand); adequacies associated with 2030 projected shortages are highlighted in blue.
[d] Starting supply for Washington D.C. is based on small sample size in the American Community Survey so supply estimates might be unreliable.

As shown in Exhibit 3, 2030 adequacy for LPNs ranges from more than 34 percent surplus of 2030 demand in Utah (except Washington D.C.[19]) to about 43 percent shortage of 2030 demand in Maryland.

Exhibit 4 maps the 33 states with projected unmet LPN demand in 2030.

[19] Washington D.C. shows the largest percentage of surplus. However, starting supply for Washington D.C. is based on small sample size in the American Community Survey so supply estimates might be unreliable.

Exhibit 4: LPN Supply versus Demand, by State, 2030



Strengths and Limitations

The model that was used to develop the supply and demand projections presented in this report relies on a microsimulation approach. Microsimulation techniques provide greater flexibility and granularity than the traditional cohort based approaches.

Major strengths of the current HWSM include:

- Application of a consistent approach to analyzing supply and demand across practitioner type, and U.S. state.
- Incorporation of current demographic and health data of sufficient size and representativeness to provide reliable estimates of key population characteristics.
- Consideration not only of population growth and changing demographics across the United States for both supply and demand, but also of the effects of changes in policy (such as expanded health insurance coverage) on demand.

HRSA's Health Workforce Simulation Model operates under many assumptions regarding the current status and future trends in health care utilization and workforce supply. The HRSA model, like most other health workforce projection models, assumes that the national labor market for nurses is currently in balance (i.e., supply and demand in the base year are equal) as indicated by the paucity of recent studies suggesting high vacancy rates and difficulties hiring nurses.[20] Therefore, the results in this report reflect future changes in the nursing workforce relative to a balanced 2014 baseline. The supply projections presented here illustrate what future supply is likely to be if the production of nurses from nursing programs remains consistent with the current level. However, there have historically been large swings in enrollment and the resulting labor supply, which, if repeated in the future, would affect the results reported here.

State-level projections require assumptions about the geographic mobility of nurses. Nurse migration patterns presented here suggest that nurses tend to practice in states where they have been trained. As a result, a number of states are projected to have a shortage of RNs in 2030 despite the fact that, on a national level, there is projected to be an excess of RNs. If migration were optimal (i.e., nurses were able and willing to migrate to states where the in-state supply did not meet demand), then the larger state-level nursing surpluses would be driven to areas of greater need and every state would show a relative surplus of RNs in 2030. This accentuates the fact that nursing shortages currently (and in 2030) represent a problem with workforce distribution rather than magnitude. Although there is evidence that some very specialized settings may be facing nurse shortages,[21] this report looks at the nursing profession as a whole and does not look at individual nursing specialty areas (e.g., public health, home health care, etc.) or sites of practice (e.g., hospitals, nursing homes, ambulatory settings, etc.).

The baseline demand projections account for increased utilization of health care services due to expanded insurance coverage. However, policy changes in this arena may have an effect on nursing demand not examined by this analysis, and that such changes are difficult to anticipate. Also, because of the uncertainties in its effects on staffing patterns and the evolving roles of different health professionals on care teams, changes in health care service delivery currently are

[20] Ono, T., Lafortune, G., Schoenstein, M. (2013). Health workforce planning in OECD countries: a review of 26 projection models from 18 countries**.** *OECD Health Working Papers, No. 62*. France: OECD Publishing; 2013:8-11.

[21] American Association of Colleges of Nursing. (2014). *Nursing shortage fact sheet.* Retrieved from http://www.aacn nche.edu/media-relations/fact-sheets/nursing-shortage.

not incorporated into the model. In addition, if the growing emphasis on care coordination, preventive services, and chronic disease management in care delivery models leads to a greater need for nurses, this report may underestimate the projected nurse demand. Likewise, improved care coordination could reduce demand for nurses in hospital settings.

Discussion and Conclusions

Using the most recent data available on the nurse education pipeline, labor supply, and retirement patterns, HRSA's Health Workforce Simulation Model projected a national RN excess of about 8 percent of demand, and a national LPN deficit of 13 percent by 2030. However, because these national estimates mask large geographic disparities in adequacy of supply, it is important to examine and focus on state-level projections.

For RNs, the state-level projections show both projected deficits of RNs in a number of states, and large variations in oversupply in other states. The variation ranges from a deficit of 44,500 FTEs in California to excess supply of 53,700 FTEs in Florida.

Similarly, national estimates of LPNs in 2030 obscure the considerable spread in state estimates, which range from a deficit of 33,500 FTEs in Texas to an excess supply of 4,100 FTEs in Ohio. These findings underscore the potential complexity of ensuring adequate nursing workforce supply across the United States.

While the projections presented here are directionally consistent with findings in recent studies on RN supply,[22, 23] historical experience demonstrates how sensitive enrollment in training programs and the resulting labor supply of nurses are to the job market and economic

[22] Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2014). Registered nurses are delaying retirement, a shift that has contributed to recent growth in the nurse workforce. *Health Affairs*, *33*(8), 1474-1480.

[23] Auerbach, D. I., Buerhaus, P. I., & Staiger, D. O. (2011). Registered nurse supply grows faster than projected amid surge in new entrants ages 23–26.*Health Affairs*, *30*(12), 2286-2292.

conditions.[24, 25] Alternative supply scenarios modeled show that graduating 10 percent more/fewer RNs annually than the status quo would increase/decrease the RN supply in 2030 by slightly over 200,000 FTEs. Similarly, graduating 10 percent more/fewer LPNs annually than the status quo would increase/decrease the LPN supply in 2030 by around 58,000 FTEs

Looking to the future, many factors will continue to affect demand for and supply of nurses including demand for health services broadly and within specific health care settings.[26] To date, the insurance reform has expanded the number of people with health insurance coverage and encouraged new value-based models of care. With an emphasis on disease management and prevention and redirecting care from institutional to community- and home-based settings, these models are providing new opportunities and roles for nurses within the health care delivery system.[27] For example, under a scenario that reflects a health care delivery with increased focus on preventive care and population health such as a medical home model with appropriate counseling and improved adherence to medications (e.g., statins, antihypertensives, metformin and other medications), an increase in the demand for RNs could be seen. This scenario assumed a 2016 intervention that 1) sustained a 5 percent reduction in body weight for people who were overweight or obese; 2) improved uncontrolled hypertension, high cholesterol, and high blood glucose levels; and 3) eliminated smoking. Model outcomes suggest that achieving these lifestyle and clinical goals would result in significant reduction in disease prevalence by 2030. However, achieving these population health goals would also cause reduction in mortality such that a greater number of people would require care. Under such a scenario, HWSM estimates that the demand for RNs would be about 105,800 FTE higher than the current RN demand projected in 2030 (3,601,800 FTEs).

On the other hand, emerging care delivery models such as Accountable Care Organizations could change the way that RNs and LPNs deliver service, but there is currently insufficient information

[24] Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2009). The recent surge in nurse employment: Causes and implications. *Health Affairs*, *28*(4), w657-w668.

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to project the extent to which these new delivery models will materially affect the demand for nurses.

As the health care system continues to evolve in response to shifting financial incentives and economic pressures, efforts to improve care access and quality, and changes in federal and state policies, the net effects of these and other factors on supply and demand projections will continue to be researched—with some policies and trends anticipated to increase nurse demand while others may decrease demand. HRSA will continue to update supply and demand projections as changes emerge in workforce supply and demand determinants.

About the Model

The results presented in this report come from HRSA's Health Workforce Simulation Model, which is an integrated health professions projection model that estimates the current and future supply of and demand for health care providers.

The supply component of the Model simulates workforce decisions for each provider based on his or her demographics and profession, along with the characteristics of the local or national economy and the labor market. The starting supply, plus new additions to the workforce, minus attrition provides an end of year supply projection, which becomes the starting supply for the subsequent year. This cycle is repeated through 2030. The basic file that underlies the supply analysis contains individual records of the RNs and LPNs in the workforce from the American Community Survey (ACS) and the state licensure data.

Demand projections for health care services in different care settings are produced by applying regression equations for individuals' health care use on the projected population. The current nurse staffing patterns by care setting are then applied to forecast the future demand for nurses. The population database used to estimate demand consists of records of individual characteristics of a representative sample of the entire U.S. population derived from the ACS, National Nursing Home Survey, and the Behavioral Risk Factor Surveillance System. Using the Census Bureau's projected population and the Urban Institute's state-level estimates of the impact of the healthcare reform on insurance coverage,[1, 2] the Model simulates future populations with expected demographic, socioeconomic, health status, health risk and insurance status.

This Model makes projections at the state level, which are then aggregated to the national level. A detailed description of the Model can be found in the accompanying technical documentation available at http://bhw.hrsa.gov/healthworkforce/index.html.

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NEWS

The Nurse-Case Scenario

One of the biggest threats to public health both in the South Sound and beyond isn't an influenza pandemic or the rise in opioid addiction. It's the shortage of nurses.

Written By Todd Matthews

Kim Giglio has worked in healthcare for 25 years, long enough for her industry to experience big, headline-grabbing milestones — from the completion of the Human Genome Project in 2003 to the passage of the Affordable Care Act in 2010.

But for Giglio, director of talent acquisition at MultiCare Health System in Tacoma, the biggest industry change has been more personal and firsthand: namely, a deepening paucity in the number of trained nurses available to work in hospitals, clinics, and other healthcare facilities.

"The bottom line is that I've been involved in nurse recruiting long enough, and I've seen about three nursing shortages," explained Giglio. "But this one is different. This one is more severe, and it feels like it's going to be longer."

For Giglio, who is tasked with hiring qualified nurses to assist physicians and care for patients at MultiCare, a nursing shortage has made her job acutely challenging.

Between October 2017 and September 2018, MultiCare accounted for a majority of the 107,000 unique job postings in Pierce County, according to data compiled by University of Washington Tacoma's Urban Studies Department. Of all those MultiCare postings, there were 9,600 unique job postings for registered nurses by occupation.

"Being a healthcare recruiter is not for the faint of heart right now," said Giglio, who noted the company's

people, making it the county's second largest private employer). "I happen to be an economics geek, so I'm fascinated by workforce economics. This is a great example of that, and I love it. But it is challenging. The supply of registered nurses is not even close to being enough to meet 100 percent of the demand."

Giglio's observation is not anecdotal.

The U.S. Department of Health & Human Services estimates that by 2025, Washington state will be 1,200 licensed practical nurses (LPNs) and 7,000 registered nurses (RNs) short of the numbers needed to meet employment demands.

The Washington Center for Nursing (WCN) reports the number of LPNs per 100,000 people in the state dropped 28 percent, from 209 to 135, between 2008 and 2018. Meanwhile, the number of RNs per 100,000 people in Washington state rose just 1.5 percent, from 962 to 977, during that same period.

Farther south, in counties that include Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum, the number of RNs per 100,000 people dropped from 915 in 2008 to 904 in 2018, according to the Washington Center for Nursing.

Add an aging and retiring nurse workforce to an aging population, and you have what healthcare professionals often describe as "the perfect storm."

How did the nursing industry arrive at this point?

For starters, the average age of nurses in Washington has been pegged at around 45 years old for the past decade, according to the WCN, and healthcare professionals locally and nationwide have braced for a wave of older and aging Baby Boomer-era nurses to retire. An exodus of retiring nurses was anticipated in 2008, but a deep U.S. recession meant many of those nurses chose to remain in the workforce and ride out the economic downturn.

Fast-forward 10 years: The economy is healthy, and aging nurses are revisiting their original retirement plans.

"Now that things are a little bit more stable in the economy, we are seeing nurses retire who maybe worked longer," said Gerianne Babbo, professor and associate dean of nursing at Olympic College in Bremerton. "That's kind of catching up to us."

Another factor is education. From as far south as Longview to as far north as Tacoma, the South Sound has a robust portfolio of more than a dozen colleges and universities that offer a range of programs for aspiring

LPNs and RNs. A challenge, however, is finding active nurses willing to obtain teaching credentials and join the faculty at one of these educational institutions — all while taking a cut in their salaries.

Babbo at Olympic College noted new graduates, right out of college, often earn more money than their

more money to help support that," she explained. "I have several faculty (members) who work a second job."

During her first 12 years as a faculty member at Olympic College, Babbo said, she worked part-time on weekends, holidays, and summers as an emergency room nurse to supplement her salary.

It's an issue Dianne Nauer, executive director of nursing at Bates Technical College in Tacoma, knows uncomfortably well. Nauer said she lost quality teachers who returned to the nursing industry after, say, a spouse lost his or her job, and it was suddenly difficult to support a family on a salary that earned 50 to 60 percent of what could be earned while working as a nurse in a hospital.

"We have to pay faculty better," said Nauer.

A different set of challenges exists for nursing school students.

Teri Moser Woo, professor and director of nursing at Saint Martin's University in Lacey, recently conducted an informal survey of nursing school programs from Tacoma, down to Centralia, and out to Grays Harbor, and found that, annually, approximately 300 people who want to pursue a career in nursing are turned away because there aren't enough faculty to teach them. Similarly, she found waiting lists of several hundred people hoping to get into many nursing programs.

Another hurdle arises once students are admitted into a nursing program and work toward completing their coursework — specifically, finding a hospital or healthcare facility with the capacity to onboard nurses in training. The state Department of Health's nursing commission requires students to complete a portion of their training in "clinical placement settings," such as hospitals, clinics, and other healthcare facilities.

With a shortage of nurses, it's difficult for a healthcare facility's already-busy nurses to take the time to carefully manage and train nursing school students in clinical settings.

"Finding clinical placements is extremely difficult," said Babbo at Olympic College.

According to Giglio, MultiCare can host only roughly 500 aspiring registered nurses in clinical settings annually, and has to turn applicants away. MultiCare would take on more students, but the company needs to balance the training of students, the training of newly hired nursing school graduates, and the workloads of experienced nurses who already are caring for patients.

"I know that our neighbors (CHI Franciscan Health) down the street do their part, as well," said Giglio. "We are part of a consortium of schools and other healthcare employers who work together to share the load in providing quality clinical experiences for the students. We train hundreds

SOUTH SOUND NURSING SCHOOLS

A healthy list of options exists for South Sound residents interested in pursuing nursing careers. Whether you aspire to become an LPN or RN, or already work as a nurse but want to continue your education and advance your career, here are some local colleges and universities to get you started.

Bates Technical College (Tacoma)
batestech.edu

Clover Park Technical College (Tacoma)
cptc.edu

Centralia College (Centralia)
centralia.edu

Grays Harbor College (Aberdeen)

greenriver.edu

Olympic College (Bremerton)
olympic.edu

Pacific Lutheran University (Tacoma)
plu.edu

Peninsula College (Port Angeles) pencol.edu

Pierce College (Puyallup)
pierce.ctc.edu

Saint Martin's University (Lacey)
stmartin.edu

South Puget Sound Community College (Olympia)
spscc.edu

Tacoma Community College (Tacoma)
tacomacc.edu

UW Tacoma (Tacoma)
tacoma.uw.edu

[illegible] healthcare facilities. For example, a nurse might work 12 hours per week at a hospital ICU and 24 hours per week in, say, a long-term care facility or even in a call center assisting nurses by phone (see "A Career Caregiver," down below).

Working fewer than 40 hours per week in different locations and environments can keep the work interesting for nurses, while also allowing for work-life balance in a job that is often physically and emotionally draining.

"We would love it if all of our nurses worked (full-time) in our units," said Giglio. "But that's one of the beauties of nursing. It's an incredibly flexible field. Nurses have a lot of options, which is why we are all competing so heavily for them. They are in the driver's seat."

So, where is the relief?

For the past several years, a coalition of nursing organizations (Washington Center for Nursing, Washington State Nursing Care Quality Assurance Commission, Council on Nursing Education in Washington State, and others) has championed the Action Now! initiative, which aims, chiefly, to lobby legislators in Olympia to increase salaries for nursing school program faculty, as well as the funding for the programs.

Increasing the pay for nurse faculty could encourage more nurses to become educators. Similarly, ramping up the funding for nursing school programs could help reduce waiting lists, and possibly increase the number of clinical placements in healthcare facilities.

Saint Martin's University in Lacey is in the process of developing a traditional, four-year nursing baccalaureate program that, if approved, could begin accepting students later this year and graduate four dozen nurses annually. The move aims to make an effort to address the South Sound nursing shortage.

As far as luring more nurses to our region, it's not uncommon for large hospitals to offer incentives such as signing bonuses and student loan repayments to bolster their nursing workforces. According to Giglio, certain units at MultiCare offer signing bonuses of between $2,500 and $5,000 — with some units offering bonuses of $10,000. The company also offers a loan-repayment program of up to $20,000 over a five-year period.

The company recruits nurses throughout the United States, and even sometimes internationally. And even so-called "agency" or "travel" nurses who work on a kind of freelance basis to support core staff are sometimes hired on at MultiCare.

Martin's Universiy. "People think, 'This isn't my problem.' But it is your problem if you go to the emergency room and there's no one to take care of you. This is a safety issue for all of us that need nursing care. It's an important issue to address."

A Career Caregiver

Not everyone's reasons for becoming a nurse are the same, but we wanted to learn more about what it's like to pursue a career in this field of healthcare. Puyallup resident Andrew Lehman, 49, has worked as a nurse in the South Sound for 20 years, offering care in settings that range from rehabilitation centers to Intensive Care Units. Lehman shared some of his insights and experiences as he reflected on his nursing career.

I was in the Army for five years and worked as a helicopter mechanic. I joined the Army knowing that I didn't want to waste my time with college until I figured out what I wanted to do. In the Army, it just came to me that I wanted to work in the medical field. I saw the human body as a very complicated machine, and I've always liked how everything works together.

Headshot courtesy Andrew Lehman.

I started out as a rehabilitation nurse at (MultiCare) Good Samaritan Hospital (in Puyallup), working with patients going through physical therapy, or recovering from brain and spinal cord injuries, as well as orthopedic surgery.

I was fortunate. Every step of the way, I was trained by people who were much more experienced than me. They passed their knowledge on. It doesn't matter how long you are doing it; you are always learning new stuff. Even after 20 years, I know that I will still be learning things for a long time to come.

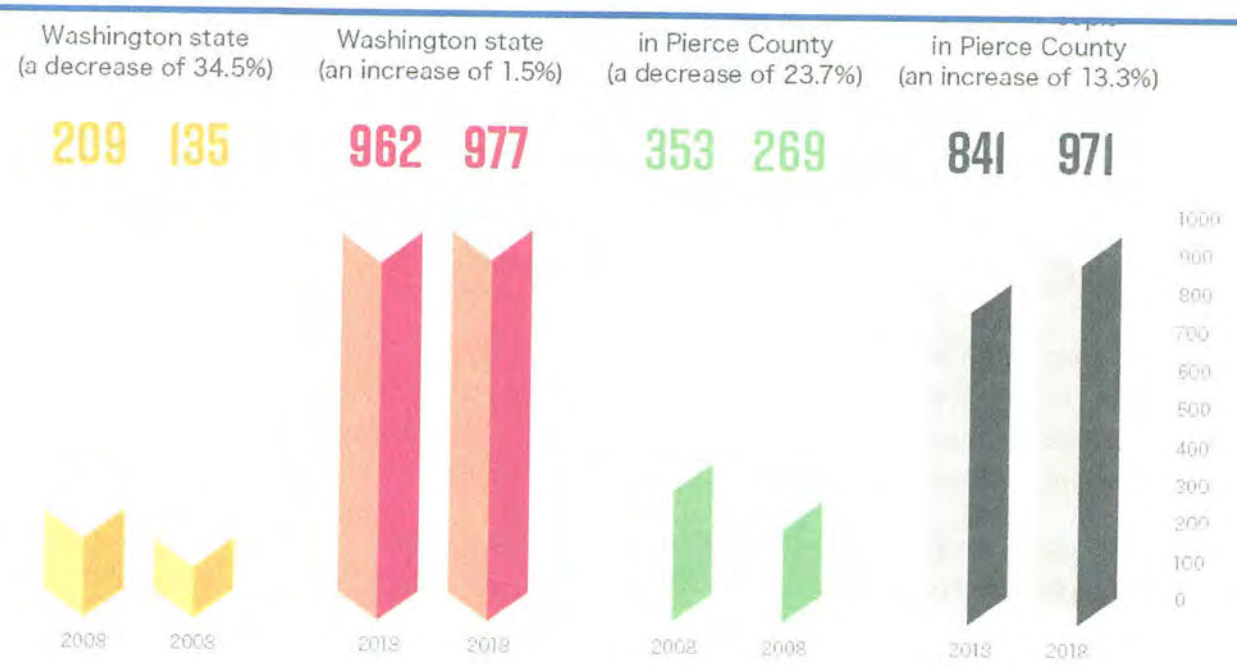
Now I work two jobs: one as a nurse at a hospital ICU in Olympia, and one as a nurse at a virtual acute care unit in Tacoma. Nurses from multiple hospitals contact us with questions or problems that need to be solved. Experienced nurses help new nurses figure out what to do with their patients.

People who haven't done nursing think there are one or two kinds of nurses out there. There are different kinds of nursing. You can be a dialysis nurse, medical/surgical nurse, emergency room nurse. There are nurses who work in ambulance transport. There are flight nurses who fly in helicopters. There are many different options for people who go into nursing. You don't have to do the same thing your entire career.

As corny as it sounds, even if you have a bad day as a nurse, at least you help people. It's a very rewarding profession. It's also intellectually and emotionally challenging. That's what drew me toward nursing — I basically get to do something interesting, but I also get to help people. — *As told to Todd Matthews*

Taking the pulse of nursing's workforce shortage

The U.S. Department of Health & Human Services estimates that **by 2025**, Washington state will be **1,200 licensed practical nurses (LPNs) and 7,000 registered nurses (RNs)** short of the numbers needed to meet employment demands.



statistics source: Source: the U.S. Department of Health & Human Services; CENTER FOR HEALTH WORKFOrCE STUDENTs/the Washington Center for Nursing (WCN)

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Nursing Shortage

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Definition/Introduction

Nurses are a critical part of healthcare and make up the largest section of the health profession. According to the World Health Statistics Report, there are approximately 29 million nurses and midwives globally, with 3.9 million of those individuals in the United States. Estimates of upwards of one million additional nurses will be needed by 2020.[1][2]

According to The American Nurses Association (ANA), more registered nurse jobs will be available through 2022 than any other profession in the United States. According to an article in the Nursing Times, The US Bureau of Labor Statistics projects that 11 million additional nurses are needed to avoid a further shortage. Employment opportunities for nurses are projected to grow at a faster rate (15%) than all other occupations from 2016 through 2026.

Issues of Concern

The nursing profession continues to face shortages due to a lack of potential educators, high turnover, and inequitable workforce distribution. The causes related to the nursing shortage are numerous and issues of concern.[3][4][5][6][7][8] Some potential reasons are explored below.

Aging Population

On the whole, the population is aging, with the baby boom generation entering the age of increased need for health services. Currently, the United States has the highest number of Americans over the age of 65 than any other time in history. In 2029, the last of the baby boomer generation will reach retirement age, resulting in a 73% increase in Americans 65 years of age and older, 41 million in 2011 compared to 71 million in 2019.

As the population ages, the need for health services increases. The reality is that older persons do not typically have one morbidity that they are dealing with, but more often have many diagnoses and comorbidities that require them to seek treatment. The population is surviving longer, as a whole, causing an increased use of health services as well. Many disease processes that were once terminal are now survivable for the long-term. Treating these long-term illnesses can strain the workforce.

Aging Work Force

Like the populations they serve, the nursing workforce is also aging. There are currently approximately one million registered nurses older than 50 years, meaning one-third of the workforce could be at retirement age in the next 10 to 15 years. This number includes nurse faculty, and that presents its own unique problem, training more nurses with fewer resources. Nursing faculty are experiencing a shortage, which leads to enrollment limitations, limiting the number of nurses that a nursing school can generate. Decreased and limited faculty can cause fewer students, and the overall quality of the program and classes can decline.

Nurse Burnout

Some nurses graduate and start working and then determine the profession is not what they thought it would be. Others may work a while and experience burnout and leave the profession.[9] Turnover in nursing seems to be leveling off, but only after years of steady climbing in rates. Currently, the national average for turnover rates is 8.8 % to 37.0%, depending on geographic location and nursing specialty.

Career and Family

Adding to the shortage problem is that nursing is still majority female, and often during childbearing years, nurses will cut back or leave the profession altogether. Some may eventually return, but others may move to a new job.

Regions

Current shortages and potential growth can be confusing when looking at regions and areas of the United States separately. Some regions have a surplus of nurses and lower growth potential, while other areas struggle to fulfill the local population's basic needs as a whole.

Nursing shortage amounts can vary greatly depending on the region of the country as well. Higher shortages are seen in different areas depending on the specialty of nursing. Some areas have real deficits when looking at critical care nurses, labor and delivery, and other specialties.

Growth

The fastest growth potential in the United States is projected for the West and Mountain regions, with slower growth in the Northeast and Midwest. A higher need is seen in areas that have high retirement populations. Despite these differences, every state is projected to have at least an 11% growth through 2022.

Violence in the Healthcare Setting

Violence in the healthcare setting plays a role in the nursing shortage, the ever-present threat of emotional or physical abuse, adding to an already stressful environment. Job satisfaction and work effort affected negatively, as the physical and emotional insults take a toll on the well-being of the healthcare professional physically and emotionally.[10] Emergency department and psychiatric nurses at a higher risk due to their patient population.

A study conducted in Poland between 2008 to 2009 concluded that nurses represent the profession most vulnerable to aggression in the workplace regarding a healthcare setting. Verbal abuse in the form of being spoken to by a person using loud vocal tones was the most common form of violence nurses were subjected to. The inpatient nurses suffered more insults than those in an outpatient setting.

Health care workers are at high risk of violence in all parts of the world, with between 8% and 38% suffering some form of violence in their career.

Clinical Significance

All of these potential reasons nurses choose to leave the profession add to nursing turnover, thus affecting staffing ratios. Staffing ratios are of clinical concern.[11]

Staffing Ratios

Bedside nurses, actually deciding acceptable nurse-patient ratios instead of managers, will lead to better job satisfaction, higher retention rates, and less desire to leave their chosen profession. Appropriate staffing levels will decrease errors, increase patient satisfaction, and improve nurse retention rates.

Nursing shortages lead to errors, higher morbidity, and mortality rates. In hospitals with high patient-to-nurse ratios, nurses experience burnout, dissatisfaction, and the patients experienced higher mortality and failure-to-rescue rates than facilities with lower patient-to-nurse ratios. Some states have begun to pass legislation to limit patient-to-nurse ratios. Despite this, when staffing is short, ratios go up to meet the need.

Nursing, Allied Health, and Interprofessional Team Interventions

Technology

The introduction of the Electronic Medical Record (EMR) and other technological advances can also affect nurses staying in the profession. While some specialties such as nursing informatics are booming, that adds to the shortage problem by removing nurses from direct patient care areas. Some seasoned nurses struggle with the technology and remove themselves from the profession at an earlier rate.

Empowerment

Organizations must be creative in meeting the needs of nurses while providing the best and safest care to the patients. An environment that empowers and motivates nurses is necessary to rejuvenate and sustain the nursing workforce. Empowerment in autonomy in staffing ratio decisions considering high volume and acuity levels will lead to less burnout and a strong desire to leave the workforce. Many organizations have endorsed and sought after the Magnet Certification to provide superior nursing processes and a high level of safety, quality, and patient satisfaction.[12]

Review Questions

- Access free multiple choice questions on this topic.
- Comment on this article.

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EXHIBIT 24

Article Regarding Impact of COVID-19

COVID-19 INTENSIFIES THE NATIONAL NURSING SHORTAGE

For years, national nursing leaders and health care experts warned of a looming nursing shortage... Add a global pandemic, and that shortage is here.

NEARLY EVERY STATE in the country is in dire need of nurses. Yet, the solutions are obvious. The only way out of this crisis is through a massive investment in our country's nursing education infrastructure and personnel.

According to the American Nurses Association (ANA):

> "By 2022, there will be far more registered nurse jobs available than any other profession, at more than 100,000 per year. With more than 500,000 seasoned RNs anticipated to retire by 2022, the U.S. Bureau of Labor Statistics projects the need for 1.1 million new RNs for expansion and replacement of retirees, and to avoid a nursing shortage."

With the national nursing shortage already exacerbated by the COVID-19 pandemic, immediate steps must be taken to ensure we retain our current nursing workforce while investing in expansion of our state's nursing schools.

Stop the bleeding: Retain current nurses

First and foremost, hospitals and other health care facilities must immediately invest in retaining our current nursing workforce. Burnout associated with COVID-19 working conditions and post-traumatic stress disorder is leading to an exodus of nurses. Some nurses are choosing to retire; others are abandoning hometown hospitals for more lucrative traveler positions. Some nurses are leaving the profession altogether. Now is the time to double down on retention strategies to keep the nurses who have kept our hospitals, long-term care facilities, public health departments and schools running for more than 18 months of the pandemic.

"Wage wars" for nurses are intensifying the current crisis by creating an unstable market that prioritizes travel nurses over local nurses. During last fall's coronavirus surge, some hospitals offered $6,000, $8,000 or even $10,000 per week to travel nurses. In-house bedside nurses in those same facilities were making far less for doing the same work. This situation has left long-term, community-based nurses feeling undervalued and underpaid.

PHOTO: STOCKSY / SKY-BLUE CREATIVE

A lesson from history

This isn't the first-time the U.S. has faced a massive nursing shortage – one that threatened to shut down civilian hospitals within our country's borders. During World War II, so many nurses left to support the war effort that hospitals within the states were left in a dire shortage. As part of the war effort, the U.S. created the Cadet Nurse Corps to recruit and train new nurses – all women.

Nurses in the U.S. Cadet Nurse Corps helped save and support stateside health care and went on to serve long careers in our state's hospitals, long-term care facilities and nursing schools.

The U.S. and Washington state are capable of building back our national nursing workforce. The only way out of this crisis is through a massive investment in our country's nursing education infrastructure and personnel.

Washington state leads the way

In 2019, the Washington State Legislature demonstrated its commitment to addressing the impending nursing shortage by investing $40 million to increase nurse educator salaries in community and technical colleges. Now that shortage has arrived, throwing many of our local hospitals and long-term care facilities into a staffing crisis – one that is being felt by nurses and patients alike.

That initial investment is working. Applications are increasing for vacant nursing faculty positions at nursing schools throughout the state, and those positions are being filled faster. In turn, this has allowed many programs to increase the number of slots for nursing students, meaning they are accepting more qualified applicants and graduating more new nurses.

Even with this initial investment, our state's nursing schools are still turning away hundreds of qualified applicants due to limited enrollment slots. Last spring, Vicky Hertig, dean of nursing at Seattle Colleges, told the Senate Health & Long Term Care Committee that her program is still turning away 300 qualified applicants each year due to limited enrollment slots.

The roadmap to alleviate the nursing shortage is clear: As a country, we have done it before. We must make a significant investment in nursing education and grow our own Washington nurses who want to serve their communities. Stealing nurses from other states is no longer a viable option; every state has a nursing shortage.

> **"Nurse shortages are a long-standing issue, but because of COVID, it is anticipated to grow even more by next year. Nurses and other health workers are overworked, and they are exhausted from the pandemic."**
>
> DR. ERNEST GRANT, PRESIDENT OF ANA, TOLD ABC NEWS ON MAY 21, 2021

These are the steps we must take immediately to increase new nurses in Washington state:

- Invest in our nursing schools to create more student enrollment slots.
- Place emphasis on investing in those nursing schools that graduate more diverse nurses.
- Provide adequate student support programs, such as tutoring and child care.
- Ensure hospitals and other practices are providing adequate clinical placements.
- Streamline the number of hours required for clinical placements.
- Increase funding for the health profession loan repayment program and focus on nursing.
- Create student loan forgiveness for graduate school nurses who commit to three years teaching in a Washington state nursing program.

WSNA looks forward to discussing these solutions with the Washington State Legislature and other partners. The time to invest in nursing education is now. We can't wait. ■

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EXHIBIT 25

AccentCare Continuing Education Documentation

COMMUNITY EDUCATION

The Seasons Hospice & Palliative Care vision statement directs us in part to "increase the community's awareness of hospice as part of the continuum of care." As a community-based provider, we want to be able to offer our care partners first-class education that will ultimately lead to better care and outcomes our shared patients. We understand that time and resources are never in abundance, and so we're pleased to offer a variety of virtual online courses that fit the needs and schedules of those we work alongside.

We are an accredited provider of CE and CME through *ANCC*, *ASWB*, *AAFP*, and *NAB*. Not all courses qualify for each type of credit, so please check each page for specific details. All in our community are welcome to attend and/or view, regardless of whether CE or CME can be awarded.

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CULTURAL CONSIDERATIONS FOR SUPPORTING BLACK/AFRICAN AMERICAN PATIENTS AT THE END OF LIFE

PARTNERING WITH INFORMAL CAREGIVERS TO PROVIDE BEST PRACTICE MEDICATION MANAGEMENT

PROFESSIONAL BOUNDARIES IN HOSPICE & PALLIATIVE CARE

DETERMINING LEVELS OF CARE IN HOSPICE

THE CLINICAL PATH OF COVID-19

ETHICS IN HOSPICE & PALLIATIVE CARE

ADVANCED CARE PLANNING AND CULTURAL CONSIDERATIONS IN THE TIME OF COVID-19

CARE OF THE PATIENT WITH DEMENTIA

RESILIENCY AND SELF-CARE FOR THE HEALTHCARE WORKER: WHAT TO DO IN THE FACE OF THE COVID-19 PANDEMIC?

SUPPORT THROUGH THE COVID-19 PANDEMIC: HOW HEALTHCARE WORKERS CAN STILL CREATE CONNECTIONS IN A TIME OF SOCIAL DISTANCING

WORKING WITH FAMILIES WHO CHALLENGE US

COMMUNICATING WITH PATIENTS & FAMILIES ABOUT END-OF-LIFE CARE

The following courses are not available for credit

NURSING AIDE EDUCATION: COVID-19 AND PTSD: SELF-CARE WHILE MANAGING SYMPTOMS OF PTSD IN PATIENT CARE

THIS IS HARD: MY FACILITY IS IN LOCKDOWN AND I AM STRUGGLING!

Questions? Email us at *communityeducation@seasons.org* and we'll be happy to assist.

There are no fees or costs for attending or viewing any session or attaining credit hours. Participants must register before the listed start time on each live session to be eligible for credit. There are no refunds, and the courses may only be offered at the listed time. If a live course has to be cancelled, Seasons will attempt to inform registrants in a timely manner, and to provide alternative arrangements if possible. To complete a course, registrants must attend or view the entire hour-long session and complete a brief post-activity survey. Participants will receive their CE/CME certificate via email within 24 hours of successful completion of the post-activity survey. Please see each registration page for system requirements. Reach out to communityeducation@seasons.org with questions, concerns, or accessibility requests.

ASWB *Seasons Healthcare Management Inc., dba Seasons Hospice & Palliative Care #1237, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Seasons Hospice & Palliative Care maintains responsibility for courses offered above. ACE provider approval period: 1/20/2019-1/20/2022.*

Seasons Hospice & Palliative Care is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. Provider Number: P0355

AAFP *Seasons is approved to offer select CME listed on this page via the American Academy of Family Physicians.*

SEARCH BY LOCATION

- Practical tips for being apart yet together during the holidays
- Coping During the Holidays and a Pandemic: 9 Strategies from A Grief & Bereavement Expert
- How to Support a Grieving Loved One via Text: According to a Grief and Bereavement Expert
- A Message to Our Community: Advancing Our Culture of Equity
- Broken Heart Syndrome on the Rise During Pandemic: A Conversation with Dr. Balu Natarajan, MD & Joshua Magariel, LCSW

Search for:

SEARCH

The Seasons family consists of Seasons Healthcare Management, Seasons Hospice & Palliative Care, Seasons Hospice Foundation, and Seasons Medical Group.

Founded in 1997, Seasons Hospice & Palliative Care is one of the largest hospice providers in the nation.

LEARN MORE ABOUT US

SOCIAL

Strategies to Feel Empowered Amidst Moral Distress

January 12, 2021 at 2pm ET / 11am PT

It doesn't take almost a full year of an ongoing pandemic for healthcare professionals to know that their work environment is wrought with complexity. Whether it be a challenging setting, a intricate system, or team dynamics – healthcare workers work through morally distressing situations across the care continuum daily. Join Seasons Hospice & Palliative Care director of quality and training Lindsey Haugen as she outlines current literature and shares suggested strategies to feel empowered while navigating moral distress and moral resiliency.

This course will help administrators, clinicians, & facility staff:

- Describe changes in "moral distress" definitions
- List common contributors to psychological distress that can lead to moral distress
- Illustrate two strategies in addressing and reducing moral distress
- Translate current events in healthcare

This course is eligible for one hour of CE/CME for RNs, Social Workers, MDs, NPs, Physician Assistants, and Long Term Care Administrators. If you have questions about this course please email *communityeducation@seasons.org*.

Presenter

LINDSEY HAUGEN, MSW

NATIONAL DIRECTOR, QUALITY AND TRAINING, SEASONS HOSPICE & PALLIATIVE CARE

Register for this Course

Email*

To ensure you receive registration confirmation, we recommend using a personal email address as some healthcare employer email systems block or filter external email.

First name* Last name*

Phone number*

Company Name* I work for a*

Please Select

Job Title I am a*

Please Select

Please select your nearest Seasons Hospice & Palliative Care Location*

If you are not located near one of these locations, please select "I do not have a nearby Seasons Hospice Location."

Please Select

I'm applying for the following type of CE/CME:*

- ○ RN, LPN, or LVN
- ○ Social Work
- ○ Long Term Care Administrator

SEASONS HOSPICE & PALLIATIVE CARE

Lindsey earned her dual bachelor's degrees in psychology and women's studies from Loyola University of Chicago. She went on to earn her Master of Social Work from Loyola University School of Social Work where she completed her graduate clinical training at Northwestern Memorial Hospital Geriatric Outpatient Clinic and the Prentice Women's Hospital - Neonatal Intensive Care Unit in Chicago, Illinois. Lindsey is a licensed clinical social worker. Since 2007, Lindsey has been part of the Seasons Hospice & Palliative Care national network with special responsibilities related to inpatient hospice, clinical supervision, quality measures and continuous improvement, interdisciplinary groups, ethics, and leadership. She began with a role as an inpatient school worker and has had opportunities in promotion across leadership positions in supportive care, education and quality. Presently, Lindsey serves the National organization as the Director of Quality & Training. She celebrates the completion of her graduate work at Northwestern University in healthcare quality and patient safety this year. Her capstone work centered on suicide prevention in the hospice setting. In 2020, Lindsey was confirmed to NHPCO's Next Generation Leadership council that empowers young leaders to provide input and guidance to assist NHPCO in meeting the needs of young professionals in hospice and palliative care, while developing the next generation of hospice leaders. Lindsey resides in Portland, Oregon.

- ○ Physician, Nurse Practitioner, or Physician Assistant
- ○ I am not taking this course for credit

REGISTER

Seasons Healthcare Management Inc., dba Seasons Hospice & Palliative Care #1237, is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved as ACE providers. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. Seasons Hospice & Palliative Care maintains responsibility for this course. ACE provider approval period: 1/20/2019-1/20/2022.

Social workers completing this course receive 1 hour of continuing education credits. Seasons Hospice & Palliative Care is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation. Provider # P0355.
This activity is pending approval for one hour of CME via the American Academy of Family Physicians.
This activity is approved for one hour of CE via the National Association of Long Term Care Administrator Boards.

CE: CULTURAL CONSIDERATIONS FOR SUPPORTING BLACK/AFRICAN AMERICAN PATIENTS AT THE END OF LIFE

Cultural Considerations for Supporting Black/African American Patients at the End of Life

This course is eligible for 1 credit hour of CE/CME for RN's, LPN's, LVN's, MDs, DOs, PAs, NPs, Social Workers, and Long Term Care Administrators.

Instructions

To earn CE/CME/NAB credit for this offering, you must enter in your information on the video below to obtain access, and then watch to the end of the video. Please plan on setting aside one whole hour to watch the video, as you must watch in one sitting. You may pause and restart the video, but if you close the page, you will have to begin the training again.

Your Certificate

Once the video has finished, you will be able to access our 5-10 minute post-event survey which will allow you to enter in your information to receive your certificate. Please email *communityeducation@seasons.org* with questions.

Course Description:

The African American community utilizes hospice care at significantly lower rates than other groups in the United States. This course will help attendees identify barriers to care for Black/African American patients and families, give examples of possible communication norms and considerations of imminent dying and at death, and use best practices and considerations for advance care planning with Black/African American patients and families.

Presenter Information:

- Nicole McCann-Davis is the National Director of Communications and Multicultural Affairs for Seasons Hospice & Palliative Care. Since joining Seasons in 2016, Nicole has helped to further develop Seasons' cultural inclusion efforts and education for staff and the many communities we serve. Prior to joining Seasons, Nicole worked in the television production industry before joining McDonald's Corporation in an internal communications role. Nicole was first introduced to hospice as a volunteer. Nicole earned her Bachelor of Science from Columbia College Chicago, and her Master of Communications from Northwestern University. She currently serves as a board member of the Seasons Hospice Foundation, and holds a Certificate in Diversity and Inclusion Leadership from Cornell University.

CE: THE CLINICAL PATH OF COVID-19

The Clinical Path of COVID-19

This course is eligible for 1 credit hour of CE for RN's, LPN's, LVN's, and Social Workers.

Instructions

To earn CE credit for this offering, you must enter in your information on the video below to obtain access, and then watch to the end of the video. Please plan on setting aside one whole hour to watch the video, as you must watch in one sitting. You may pause and restart the video, but if you close the page, you will have to begin the training again.

Your Certificate

Once the video has finished, you will be able to access our 5-10 minute post-event survey which will allow you to enter in your information to receive your certificate. Please email *communityeducation@seasons.org* with questions.

Course Description:

Clinicians have come a long way in a few short months in their understanding of how COVID-19 affects the body. Join Seasons Hospice & Palliative Care for 1 hour of Continuing Education that discusses recent research, clinical care considerations, and CDC guidelines for the discontinuation of isolation in various settings.

Presenter Information:

- Donna Hyatt, Vice President of Quality and Field Compliance for Seasons Hospice & Palliative Care
- Jennifer Nycz, MSN, RN, CHPN, Senior Vice President of Clinical Operations for Seasons Hospice & Palliative Care
- Dr. Balu Natarajan, MD, Chief Medical Officer for Seasons Hospice & Palliative Care and the President of Seasons Medical Group

CE: ADVANCED DIRECTIVES & CULTURAL CONSIDERATIONS IN THE TIME OF COVID-19

Advanced Directives & Cultural Considerations in the Time of COVID-19

This course is eligible for 1 credit hour of CE for RN's, LPN's, LVN's, and Social Workers.

Instructions

To earn CE credit for this offering, you must enter in your information on the video below to obtain access, and then watch to the end of the video. Please plan on setting aside one whole hour to watch the video, as you must watch in one sitting. You may pause and restart the video, but if you close the page, you will have to begin the training again.

Your Certificate

Once the video has finished, you will be able to access our 5-10 minute post-event survey which will allow you to enter in your information to receive your certificate. Please email *communityeducation@seasons.org* with questions.

Course Description:

As the coronavirus pandemic nears its peak around the United States, clinicians and healthcare workers in all settings will need to have the skills to guide patients through creating advance care plans that fit their wishes, beliefs, and circumstances. One of the key considerations to facilitating advance care planning discussions is a firm understanding of the impact that COVID-19 is having on different communities and cultures. Join Seasons for an engaging hour-long look at how to facilitate advance directive conversations in a time of coronavirus.

Presenter Information:

- Joshua Magariel, LCSW, National Director of Patient Experience at Seasons Hospice & Palliative Care.
- Nicole McCann-Davis, National Director of Communications and Multicultural Affairs for Seasons Hospice & Palliative Care

CE: SUPPORT THROUGH THE COVID-19 PANDEMIC

How Healthcare Workers Can Still Create Connections in a Time of Social Distancing

This course is eligible for 1 credit hour of CE for RN's, LPN's, LVN's, and Social Workers.

Instructions

To earn CE credit for this offering, you must enter in your information on the video below to obtain access, and then watch to the end of the video. Please plan on setting aside one whole hour to watch the video, as you must watch in one sitting. You may pause and restart the video, but if you close the page, you will have to begin the training again.

Your Certificate

Once the video has finished, you will be able to access our 5-10 minute post-event survey which will allow you to enter in your information to receive your certificate. Please email *communityeducation@seasons.org* with questions.

Course Description:

Social distancing is helping limit the spread of the COVID-19, but for seniors and those who live alone it can present challenges from lack of interaction and isolation. Healthcare workers can help support this vulnerable community by finding ways to mitigate the implications of social distancing and recognize capacity to overcome barriers to care. Attendees will: 1) Will identify differences between social distancing, spatial distancing, and emotional distancing 2) Will understand potential risk areas (emotional, physical, cognitive, spiritual) for patients and families, and their relationship to trauma and complicated grief responses 3) Will learn creative ways to mitigate the implications of social distancing and recognize capacity to overcome barriers to care The information presented was accurate as of the time of the original presentation (4/3/20), but the situation with the Coronavirus is rapidly changing and we encourage healthcare professionals to continue to work with their local hospice teams to ensure they are following the most up-to-date guidance and best practice.

Presenter Information:

Yelena Zatulovsky, LCAT, LPMT, MA, MT-BC, CCLS, HPMT, Vice President of Patient Experience at Seasons Hospice & Palliative Care
Rev. Travis C. Overbeck, M.Div., Chaplain at Seasons Hospice & Palliative Care

CE: THIS IS HARD! MY FACILITY IS IN LOCKDOWN AND I'M STRUGGLING

This is Hard! My Facility is in Lockdown and I'm Struggling

This is an informational course and is not offered for credit.

Course Description:

Assisted Living Facilities and Skilled Nursing Facilities are entering their third month of COVID-19 lockdown. Staff can feel burned out and filled with worry about how to best support their residents and patients, many of whom are missing their families who cannot visit. Join experts from Seasons Hospice & Palliative Care for a 30-minute session that will go over some helpful resiliency tips for all professionals who work in the facility setting, as well as concrete ways you can support your patients and residents through the distancing required by coronavirus.

Presenter Information:

- Yelena Zatulovsky, LCAT, MA, MT-BC, CCLS, HPMT, is the Vice President of Patient Experience at Seasons Hospice & Palliative Care.
- Sarah McKinnon, MA, is the Senior Vice President of Employee Engagement and Organizational Design

38:43

Please *click here to view a copy of the slides.*

Click here for the Resiliency Worksheet referenced in the presentation.

Please email *communityeducation@seasons.org* with questions.

WEBINAR: COVID-19 & PTSD

COVID-19 & PTSD: Preserving Self-Care While Managing Symptoms of PTSD During Patient Care

This is an informational course and is not offered for credit. This course can be completed by everyone, but is recommended for CNAs.

Course Description:

Certified Nursing Aides and Home Health Aides are a critical part of the post-acute care team. Their love, tenderness, and tireless care make all the difference for those who are seriously ill. We want to thank and honor our Nursing Assistant heroes! This course is focused on their mental health and the mental health of their patients and residents.

Presenter Information:

- Roberta Gule, BSN, RN, CHPN, Learning and Development-RN Training Specialist at Seasons Hospice & Palliative Care

Welcome to Seasons Hospice & Palliative Care's On-Demand Continuing Education Platform

Email address *

Next

Step 1 of 2

Please *click here to view a copy of the slides.*

Please email *communityeducation@seasons.org* with questions.

State Specific Orientation & Annual Education

Instructions:
State Specific Orientation and Annual Education requirements are available in a catalog on Seasons University or the Learning & Development Page on Seasons Connect. This will streamline access to these requirements and materials for all staff. The catalog is broken into two categories: Orientation and In-service Education. Scroll through to the chart to see what training is required for your state.

Employees

State	Policy Name/Number	Frequency	Location	Education Requirement	Course Name
AZ	In-Service Education / Staff Development Policy 814	Annually	SU	A minimum of wo clock hours annually in pallia ive care	DG: Case Managemen Vigne es
	Orientation Period Policy 804	Orientation	SU	Narcan Training	AZ Narcan S anding Educa ion Narcan Pa ien Educa ion-AZ
CA	Orientation Period Policy 207	Orientation	SU	Physician Aide in Dying	California End of Life Op ion Ac
	Orientation Period Policy 821	Orientation, Biannually	SU	Harassmen Preven ion Training for Supervisors & Volun eer Coordina ors	Workplace Harassmen Manager Comple e
	In-Service Education / Staff Development Policy 814	Annually, Quarterly	SU	Quar erly in-service educa ion programs o i s employees and volun eers who have direc pa ien con ac . Annual raining on he Seasons Hospice workplace violence preven ion plan.	Ca alogs available: • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA • NHPCO Webinars
CO	In-Service Education / Staff Development Policy 814	Annually	SU	A minimum of 20 hours of educa ion annually o enhance hospice rela ed skills for all employees who provide direc pa ien care.	Ca alogs available: • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA • NHPCO Webinars
	Orientation Period Policy 207	Orientation	SU	Physician Aide in Dying	Colorado End of Life Op ions Ac
CT	Orientation Period Policy 804	Orientation, Annually	SU	The Homemaker or Hospice Aide shall be provided wi h en (10) hours of orien a ion prior o he individual providing homemaker or hospice aide services.	Hospice Aide Orien a ion
	Orientation Period Policy 804		A rainceu *See access instructions on page 5*	Training and educa ion on Alzheimer's Disease/Demen ia symp oms and care o all s aff providing direc care, upon employmen and annually hereaf er.	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni
	Orientation Period Policy 821	Orientation, Biannually	SU	Harassmen Preven ion Training for Supervisors & Volun eer Coordina ors	Workplace Harassmen Manager Comple e
	In-Service Education / Staff Development Policy 814	Orientation, Annually, Monthly	SU	Each employee serving pa ien s will receive an average of a leas one (1) hour of in-service educa ion per mon h o include: • curren informa ion regarding drugs and rea men • specific service procedures and echniques • recognized professional s andards • cri eria and classifica ion of pa ien s serviced. • Six (6) hours of he annual in-service educa ion requiremen shall address opics rela ed o hospice care.	Ca alogs available: • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA • NHPCO Webinars
DE	Orientation Period Policy 821	Orientation and every two tears for all staff	SU	Harassmen Preven ion Training	or all Supervisors and managers: Workplace Harassmen Manager Comple e or S aff: Workplace Harassmen Employee Comple e

State Specific Orientation & Annual Education

Employees

State	Policy Name/Number	Frequency	Location	Education Requirement	Course Name
FL	Orientation Period Policy 804	Orientation	A rainceu *See access instructions on page 5	Each employee will receive basic wri en informa ion abou in erac ing wi h persons who have Alzheimer's disease or demen ia-rela ed disorders. Addi ional educa ion will be provided o employees who are expec ed o, or whose responsibili ies require hem o, have direc con ac wi h par icipan s who have Alzheimer's disease or demen ia-rela ed disorders.	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni *All direct patient care staff must complete both the 3 unit and 1 unit education.*
	In-Service Education / Staff Development Policy 814	Semi-Annually	SU	24 hours of in-service raining every o her year for cer ified nursing assis an s during mon hly HHA educa ion and/or Annual Review ma erials ha will include: • *bloodborne pathogens* • *infection control* • *domestic violence* • *medical record documentation and legal aspects appropriate to nursing assistants* • *resident rights* • *communication with cognitively impaired clients* • *CPR skills* • *medical error prevention and safety.*	Annual Review Presen a ion Ca alogs Available: HA Mon hly Educa ion
GA	In-Service Education / Staff Development Policy 814	Annual	SU	Annual raining and educa ion program for all s aff and volun eers who provide direc care o pa ien s ha addresses, a a minimum: • *emerging trends in infections control* • *recognizing abuse and neglect and reporting requirements* • *patient rights* • *palliative care*	Annual Presen a ion DG: Case Managemen Vigne es
L	Orientation Period Policy 804	Orientation, Annually	SU	All direc pa ien care s aff have o comple e 6 hours of raining wi hin he firs 60 days of employmen	CMS Hand in Hand: A Training Series for Nursing Homes
	In-service Education/Staff Development Policy 814	Annually	SU	Alzheimer's Services Supervisor mus comple e 8 hours of raining annually All direc pa ien care s aff have o comple e 3 hours of raining each year	CMS Hand in Hand: A Training Series for Nursing Homes
	In-Service Education / Staff Development Policy 814	Orientation	SU	All employees shall a end in-service educa ion programs per aining o heir assigned du ies a leas annually. Wri en records of program con en and personnel a ending each session shall be main ained.	Annual Presen a ion <u>Ca alogs available:</u> • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA • NHPCO Webinars
MO	Orientation Period Policy 804	Orientation, Annually	A rainceu *See access instructions on page 5	Demen ia-specific raining abou Alzheimer's disease and rela ed demen ias o heir employees and hose persons working as independen con rac ors who provide direc care o or may have daily con ac wi h residen s, pa ien s, clien s or consumers wi h Alzheimer's disease or rela ed demen ia.	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni
	In-Service Education / Staff Development Policy 814	Annually	A rainceu *See access instructions on page 5	Demen ia-specific raining abou Alzheimer's disease and rela ed demen ias shall be incorpora ed in o orien a ion for new employees wi h direc pa ien con ac and independen con rac ors wi h direc pa ien con ac .	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni

State Specific Orientation & Annual Education

Employees

State	Policy Name/Number	Frequency	Location	Education Requirement	Course Name
M	Orientation Protocol 3004	Orientation	SU	Emergency Drug Box M	Emergency Drug Box
NJ	Orientation Period Policy 804	Annually	SU	Access o approved programs in Human Trafficking Handling and Response Training for employees who have direc con ac and / or in erac ion wi h facili y pa ien s and / or visi ors of facili y pa ien s.	Recognizing and Responding o Human Trafficking in a Heal hcare Con ex
	Orientation Period Policy 207	Orientation	SU	Physician Aide in Dying	New Jersey Aide in Dying for he Terminally ll Ac
	In-Service Education / Staff Development Policy 814	Other	SU	Seasons Hospice shall develop and implemen a s aff educa ion plan, including plans for each service and designa ion of he person(s) responsible for raining.	
OR	Orientation Period Policy 207	Orientation	SU	Physician Aide in Dying	Dea h wi h Digni y
TX	Orientation Period Policy 804	Orientation, Annually	Pre-Hire Checklis	All personnel who are direc care s aff and who have direc con ac wi h pa ien s (employed or under con rac) will sign a s a emen ha hey have read, unders and and will comply wi h all applicable company policies.	Pre-Hire Checklis
	Administrator and Alternate Administrator Training Policy 6016		See policy	The adminis ra or and al erna e adminis ra or are required o comple e con inuing educa ion hours per 97.259 of he Texas Licensing S andards (see pro ocol 6016 Adminis ra or and Al erna e Adminis ra or Training – Texas Only).	Refer o Policy 6016 for specific requiremen s

State Specific Orientation & Annual Education

Volunteers

State	Policy Name/Number	Frequency	Location	Education Requirement	Course Name
CA	In-Service Education / Staff Development Policy 814	Annually, Quarterly	SU	Quar erly in-service educa ion programs o i s employees and volun eers who have direc pa ien con ac . Annual raining on he Seasons Hospice workplace violence preven ion plan.	Ca alogs available: • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA • NHPCO Webinars
CT	In-Service Education / Staff Development Policy 814	Orientation, Annually, Monthly	SU	Each employee serving pa ien s will receive an average of a leas one (1) hour of in-service educa ion per mon h o include: • curren informa ion regarding drugs and rea men • specific service procedures and echniques • recognized professional s andards • cri eria and classifica ion of pa ien s serviced. Six (6) hours of he annual in-service educa ion requiremen shall address opics rela ed o hospice care.	Ca alogs available: • Continuing Education • Enclara Pharmacy • HA Monthly Education • HPNA NHPCO Webinars
	Orientation Period Policy 804		A rainceu *See access instructions on page 5	Training and educa ion on Alzheimer's Disease/Demen ia symp oms and care o all s aff providing direc care, upon employmen and annually hereaf er.	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni
GA	In-Service Education / Staff Development Policy 814	Annual	SU	Annual raining and educa ion program for all s aff and volun eers who provide direc care o pa ien s ha addresses, a a minimum: • *emerging trends in infections control* • *recognizing abuse and neglect and reporting requirements* • *patient rights* *palliative care*	Annual Presen a ion DG: Case Managemen Vigne es
MO	Orientation Period Policy 804	Orien a ion, Annually	A rainceu *See access instructions on page 5	Demen ia-specific raining abou Alzheimer's disease and rela ed demen ias o heir employees and hose persons working as independen con rac ors who provide direc care o or may have daily con ac wi h residen s, pa ien s, clien s or consumers wi h Alzheimer's disease or rela ed demen ia.	ADRD for Nursing Homes, and Hospice, 3 Uni s • ADRD for Nursing Homes, and Hospice, 1 Uni
TX	Orientation Period Policy 804	Orien a ion, Annually	Pre-Hire Checklis	All personnel who are direc care s aff and who have direc con ac wi h pa ien s (employed or under con rac) will sign a s a emen ha hey have read, unders and and will comply wi h all applicable company policies.	Pre-Hire Checklis

Contractors

State	Policy Name/Number	Frequency	Location	Education Requirement	Course Name
MO	Orientation Period Policy 804	Orien a ion, Annually	A rainceu *See access instructions on page 5	Demen ia-specific raining abou Alzheimer's disease and rela ed demen ias o heir employees and hose persons working as independen con rac ors who provide direc care o or may have daily con ac wi h residen s, pa ien s, clien s or consumers wi h Alzheimer's disease or rela ed demen ia.	ADRD for Nursing Homes, and Hospice, 3 Uni s • ADRD for Nursing Homes, and Hospice, 1 Uni
	In-Service Education / Staff Development Policy 814	Orien a ion, Annually	A rainceu *See access instructions on page 5	Demen ia-specific raining abou Alzheimer's disease and rela ed demen ias shall be incorpora ed in o orien a ion for new employees wi h direc pa ien con ac and independen con rac ors wi h direc pa ien con ac .	ADRD for Nursing Homes, and Hospice, 3 Uni s ADRD for Nursing Homes, and Hospice, 1 Uni
TX	Orientation Period Policy 804	Orien a ion, Annually	Pre-Hire Checklis	All personnel who are direc care s aff and who have direc con ac wi h pa ien s (employed or under con rac) will sign a s a emen ha hey have read, unders and and will comply wi h all applicable company policies.	Pre-Hire Checklis

Alzheimer's Disease and Dementia Training:

This training is required to be completed within the first 90 days of hire for staff in CT, FL, and MO. For staff located in CT and MO this training must also be complete annually.

Instructions for course access

Our vendor's training is online and can be found on the link below:

https://www.atrainceu.com/

- To gain access to the course(s) on the Home Page, click on State-Mandated Training, and from drop-down box select All State-Mandated Training Courses. Click on course name to open the course and follow instructions from that point.
  - Staff with direct patient contact need to click on the course titled "ADRD for Nursing Homes, and Hospice, 3 Units".
  - Staff with indirect patient contact (ex: on the phone) need to click on the course titled "ADRD for Nursing Homes, and Hospice, 1 Unit".
- Study course and when ready complete the quiz and evaluation.
- To get to the quiz you must register as a new user or login.
- The register/login boxes are found on the course last page. Click the correct box supply info and once it is complete you will be directed to the quiz.
  - When requested to fill out personal Information make sure you add Florida license info if you wish courses reported to CE-Broker.
- When you reach payment and order section enter code SHA2 in discount code box and click apply to the order. The price discount will be reflected in your order.
  - Before completing the order you will need to fill in billing information. Using own personal date is okay.
- Once all course requirements are completed you will be directed to your activities. There is PDF copy of your certificate you can access to print and save.
- You will be sent several completion emails.
- You can always return to your certificate by logging into your account. Your certificates will be found under **My Activities.**

Human Trafficking: Required in NJ only:

Instructions for course access

There are 2 approved options to choose from for this training requirement.

1. The first approved training program is the online, web-based training offered by the National Human Trafficking Resource Center (NHTRC) called "Modern Day Slavery in America: Recognizing and Responding to Human Trafficking in a Healthcare Context" (February 2016), which is available at https://traffickingresourcecenter.org/audience/service-providers. This training is available without charge, and requires no special equipment or software other than a computer with speakers and internet access. The running time of the presentation is approximately 30 minutes.

2. The second approved training program is called, "Stop. Observe. Ask. Respond to Human Trafficking (SOAR): A Training for Health Care and Social Service Providers," which was developed by the Administration for Children and Families and the Office on Women's Health of the United States Department of Health and Human Services. See http://www.acf.hhs.gov/endtrafficking/initiatives/soar. The SOAR training informs health care and social services professionals how to identify, treat, and respond appropriately to potential victims of human trafficking who present in health care or social services settings. The training is a more in-depth alternative to the NHTRC training described above and has the advantage of offering healthcare professionals continuing education and continuing medical education credits through the provider. The three-hour course is offered without cost through either a traditional in-person classroom setting, or a live presentation in a scheduled online virtual classroom.

EXHIBIT 26

Checkster Quality Survey Tool

Checkster

Pulse Checkup - PREVIEW MODE

1. In order to provide the best possible work environment, what is the top area on which Seasons needs to focus? *

- ○ Benefits
- ○ Compensation
- ○ Culture
- ○ Job Expectations
- ○ Management
- ○ Training
- ○ Technology
- ○ Work / Life Balance

2. Additional Comments (Optional):

3. Select up to two solutions that you believe would improve work/culture at your program. *

- ☐ Internal Communication
- ☐ Increased Employee Recognition
- ☐ Opportunities for Growth
- ☐ Additional Training & Development
- ☐ Team Building

4. Additional Comments (Optional):

5. Select up to three barriers that prevent you from doing your job as well as you'd like. *

- [ ] Insufficient Training
- [ ] Lack of Support
- [ ] Poor Work / Life Balance
- [ ] Technology Issues
- [ ] High Work Load
- [ ] Travel / Commute / Coverage Area
- [ ] Insufficient Communication with Management
- [ ] Staffing

6. Additional Comments (Optional):

7. Would you recommend Seasons to care for your loved one? *

- ( ) Yes
- ( ) No

8. If you answered "No" to the question above, how can Seasons improve?

9. Would you refer a good friend to join the Seasons team? *

- ( ) Yes
- ( ) No

10. If you answered "No" to the question above, how can Seasons improve?

11. How supported do you feel by your team? *

- Very Supported
- Somewhat Supported
- Unsupported

12. Additional Comments (Optional):

13. Do you feel supported by your direct supervisor? *

- Very Supported
- Somewhat Supported
- Unsupported

14. Additional Comments (Optional):

15. Do you trust your Leadership team? *

- Yes
- Somewhat
- No

16. Additional Comments (Optional):

17. Do you believe Leadership takes Ownership of creating the best possible work environment? *

- Yes
- Somewhat
- No

18. Additional Comments (Optional):

19. Do you believe Seasons is delivering on their Mission, Vision and Values? *

- Yes
- Somewhat
- No

20. Additional Comments (Optional):

21. What is your job title? (Optional)

22. Please select your location: *

AZ	CA - Campbell
CA - LA	CA - Orange
CA - Sacramento	CA - San Bernardino
CA - San Diego	CO
CT	DE
FL -Broward	FL - Miami
GA	IL
IN	MD
MA	MI
MO	National
NV	NJ
OR	PA
TX - Grapevine	TX - Houston
TX - San Antonio	WI

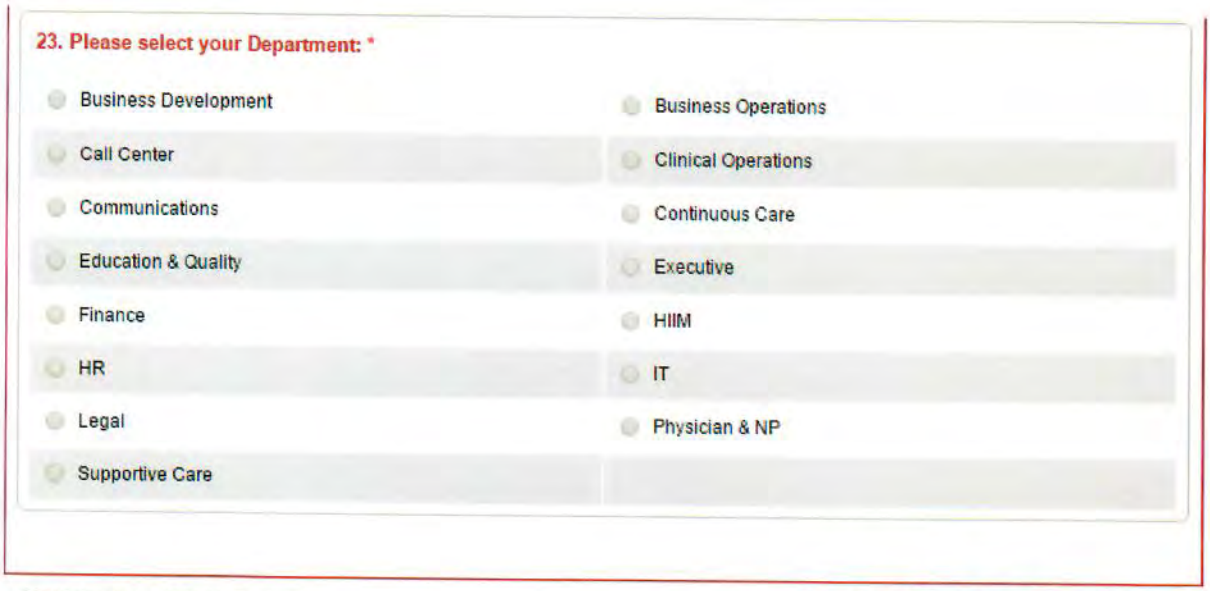

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EXHIBIT 27

Surveys of Seasons Hospice Agencies Requiring Corrective Action Plans, 2020-2022

Final Accreditation Report

Seasons Hospice & Palliative Care of New Jersey, LLC
2147 Route 27 South, Suite 101
Edison, NJ 08817

Organization Identification Number: 560935
Unannounced Full Event: 9/15/2020 - 9/18/2020

Program Surveyed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	09/15/2020 - 09/18/2020	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

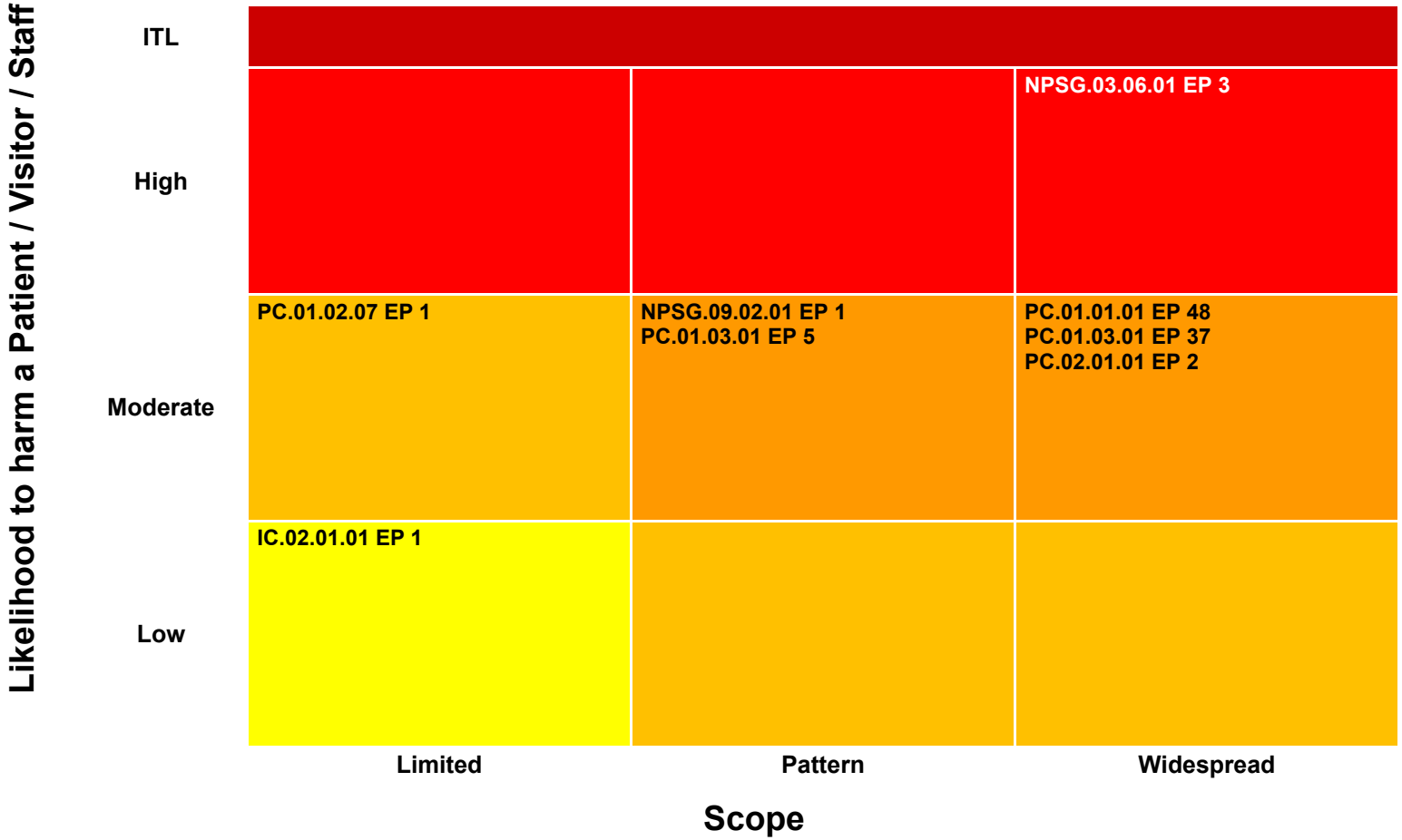
The Joint Commission
What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
IC.02.01.01	1	Low / Limited	§418.60 (a)	L579		✓
NPSG.03.06.01	3	High / Widespread				✓
NPSG.09.02.01	1	Moderate / Pattern				✓
PC.01.01.01	48	Moderate / Widespread	§418.102 (b)	L667		✓
PC.01.02.07	1	Moderate / Limited	§418.52 (c)(1)	L512		✓
PC.01.03.01	37	Moderate / Widespread	§418.64 (d)(1)(iv)	L596	✓	✓
	5	Moderate / Pattern				✓
PC.02.01.01	2	Moderate / Widespread	§418.64	L588	✓	✓

The Joint Commission
SAFER™ Matrix

Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.102	L665	Standard	OME
Hospice	§418.102(b)	L667	Standard	OME/PC.01.01.01/EP48
Hospice	§418.52	L501	Standard	OME
Hospice	§418.52(c)(1)	L512	Standard	OME/PC.01.02.07/EP1
Hospice	§418.60	L577	Standard	OME
Hospice	§418.60(a)	L579	Standard	OME/IC.02.01.01/EP1
Hospice	§418.64	L587	Standard	OME
Hospice	§418.64	L588	Condition	OME/PC.02.01.01/EP2
Hospice	§418.64(d)(1)(iv)	L596	Standard	OME/PC.01.03.01/EP37

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.02.01.01	1	Low Limited	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . The organization did not implement its infection prevention and control activities. During home visit 3 it was observed that the nurse did not cleanse her hands after removing gloves and before donning new pair of gloves per agency policy, before cleaning her stethoscope. This was confirmed by the Director of Clinical Services.	§418.60(a)	Standard
NPSG.03.06.01	3	High Widespread	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 6 of 10 patient records reviewed, The organization did not compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. During review of medical records it was noted that in the records associated with home visits 1, and 2 and in records 4, 6, 8, and 9 there was not a medication reconciliation documented at each visit per agency policy. For example, in record 8 there was no medication reconciliation of visits 2, 3, 4 ,5 6, 7 or 8. These findings were confirmed by the Director of Clinical Operations.		
NPSG.09.02.01	1	Moderate Pattern	Assess the patient's risk for falls.	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 2 of 10 patient records reviewed, The organization did not assess the patient's risk for falls. During review of patient records, it was noted that records 3 and 6 did not have a fall risk assessment documented at admission per agency policy. This was confirmed by the Director of Clinical Operations.		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.01.01	48	Moderate Widespread	For hospices that elect to use The Joint Commission deemed status option: The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course. Note: The determination of the patient's life expectancy considers the following factors: - The primary terminal condition - Related diagnoses, if any - Current subjective and objective medical findings - Current medication and treatment orders - Information about the medical management of the patient's conditions unrelated to the terminal condition	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 13 of 13 patient records reviewed, The medical director or physician designee did not review the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course. During review of patient records it was noted that the records associated with home visits 1, 2 and 3 and records 4-10 did not contain certification of terminal illness signed by the attending physician in addition to the hospice physician. The certification of terminal illness was only signed by the hospice physician at admission. This finding was confirmed by the Director of Clinical Operations.	§418.102(b)	Standard
PC.01.02.07	1	Moderate Limited	The organization has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . The organization did not assess the patient's pain. During review of patient records, it was noted that in the record associated with home visit 3, there was no pain assessment conducted at admission. The patient was admitted to hospice at a GIP level of care for pain management and was on morphine IV for pain management. This was confirmed by the Director of Clinical Operations.	§418.52(c)(1)	Standard
PC.01.03.01	5	Moderate Pattern	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 5 of 10 patient records reviewed, The written plan of care was not based on the patient's goals and the time frames, settings, and services required to meet those goals. During review of patient records it was noted that there were no documented time frames for reaching goals in the records associated with home visits 1 and 2 and records 1, 7, and 9. These findings were confirmed by the Director of Clinical Operations.		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	37	Moderate Widespread	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery. Note: Bereavement counseling is a required hospice service but is not reimbursable.	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 16 of 16 patient records reviewed, The hospice did not develop a bereavement plan of care that specifies the type of services to be offered and the frequency of service delivery. During review of patient records it was revealed that in the records associated with home visits 1,2, and 3, and records 1-10 and discharged records 1-3 there was no bereavement plan of care. These findings were confirmed by the Director of Clinical Operations.	§418.64(d)(1)(iv)	Standard
PC.02.01.01	2	Moderate Widespread	Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation. For home health agencies that elect to use The Joint Commission deemed status option: All home health services must also be provided in accordance with current clinical practice guidelines.	1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site . In 8 of 10 patient records reviewed, The organization did not provide care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation. During review of patient records, it was noted that in the record associated with home visit 2 aide visits were ordered 3 x week and in one week only two visits were provided. Also, in record 1 nurse visits were ordered for 7 x week and in one week only 6 visits were provided. Record 4 had aide visits ordered 5 x week and visits were missed in weeks 1, 2 and 4 of the cert period. Record 6 had nursing ordered 1-3 x week and had no visits documents for a 2 week period. Record 7 had aide ordered 5 x week and one week had a missed visit. Record 8 had aide ordered 5 x week and in the 4th and 5th weeks of the cert period only 4 visits were provided. In records 9 and 10 nursing was ordered 1-2 x week and there were no visits in one week. These findings were confirmed by the Director of Clinical Services.	§418.64	Condition

The Joint Commission

Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§418.52 Patient's Rights	L501	The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.
§418.52(c)(1) Rights of the patient	L512	(1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;
§418.60 Infection control	L577	§418.60 Condition of participation: Infection control.
§418.60(a) Prevention	L579	§418.60(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
§418.64 Core Services	L587	§418.64 Condition of participation: Core services.
§418.64(d)(1)(iv) Counseling services	L596	(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204 (c).
§418.102 Medical director	L665	The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.
§418.102(b) Initial certification of terminal illness	L667	§418.102(b) Standard: Initial certification of terminal illness. The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient’s life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination:
§418.64 Core Services	L588	A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
IC.02.01.01	1	The organization implements the infection prevention and control activities it has planned.	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.
NPSG.03.06.01	3	Maintain and communicate accurate patient medication information.	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient's risk for falls.
PC.01.01.01	48	The organization accepts the patient for care, treatment, or services based on its ability to meet the patient's needs.	For hospices that elect to use The Joint Commission deemed status option: The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course. Note: The determination of the patient's life expectancy considers the following factors: - The primary terminal condition - Related diagnoses, if any - Current subjective and objective medical findings - Current medication and treatment orders - Information about the medical management of the patient's conditions unrelated to the terminal condition
PC.01.02.07	1	The organization assesses and manages the patient's pain.	The organization has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	37	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery.

The Joint Commission

Standard	EP	Standard Text	EP Text
			Note: Bereavement counseling is a required hospice service but is not reimbursable.
PC.02.01.01	2	The organization provides care, treatment, or services for each patient.	Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation. For home health agencies that elect to use The Joint Commission deemed status option: All home health services must also be provided in accordance with current clinical practice guidelines.

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Joint Commission Health Care Organization

Organization ID: 560935-Seasons Hospice & Palliative Care of New Jersey, LLC
2147 Route 27 South, Suite 101 Edison, NJ 08817

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 11/23/2020

Home Care Accreditation Program IC.02.01.01 EP 1
Likelihood: Low Scope: Limited

Standard Text: The organization implements the infection prevention and control activities it has planned.

EP Text: The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.

Finding(s): 1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
The organization did not implement its infection prevention and control activities. During home visit 3 it was observed that the nurse did not cleanse her hands after removing gloves and before donning new pair of gloves per agency policy, before cleaning her stethoscope. This was confirmed by the Director of Clinical Services.

Assigning Accountability

The Director of Clinical Operations is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

All nurses, including on call and admissions, signed acknowledgments by Oct 1 with attached P&P and expectations.

All nurses, including on call and admissions, received training utilizing the video WHO: How to Handwash.

All nurses, including on call and admissions, effectively demonstrated hand hygiene with donning/doffing gloves during Back to Bedside (B2B) visits, a joint supervisory patient visit between clinical staff and a clinical assessor to assure competency, through leadership utilization of the Hand Hygiene Checklist and PPE Checklist.

Joint supervisory visits (B2Bs) were scheduled for each nurse (including admission and on-call) by October 8 and completed by November 1 for all full time nurses. Visits for resource and clinical support nurses were completed by November 13.

Immediate feedback was provided for any employee who was unable to demonstrate correct infection

control technique; with a repeat B2B scheduled and completed by November 15.

Q. All corrective actions described above were completed by

Nov 15, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

B2B visits/chart audits related to infection control will be conducted.

The Infection Control Program of 2021, which is due by January 25, 2021, will set the annual infection control goals for the site based on trends from the B2B visits and chart audits and infection control reporting data.

Q. What is the frequency of the monitoring activities?

Infection control will be addressed during B2B visits, of which the site has fourteen B2Bs required monthly for the ESC and at least 2 per month ongoing,

Q. What data will be collected from these activities?

Proper hand hygiene and donning/doffing of PPE will be assessed during B2B visits.

Q. To who, and how often, will this data be reported?

Trends will be reported in leadership meetings monthly by the DCO/Infection Control Officer and in QAPI meetings quarterly.

Trends will be utilized to establish goals for the 2021 Infection Control Program, which is due by January 25, 2021.

Home Care Accreditation Program NPSG.03.06.01 EP 3
Likelihood: High Scope: WideSpread

Standard Text: Maintain and communicate accurate patient medication information.

EP Text: Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies.Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual,

identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 6 of 10 patient records reviewed, The organization did not compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. During review of medical records it was noted that in the records associated with home visits 1, and 2 and in records 4, 6, 8, and 9 there was not a medication reconciliation documented at each visit per agency policy. For example, in record 8 there was no medication reconciliation of visits 2, 3, 4 ,5 6, 7 or 8. These findings were confirmed by the Director of Clinical Operations.

Assigning Accountability

The DCO is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Director of Nursing/Nurse Administrator
Director of Clinical Services

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

The Director of Clinical Operations is performing chart reviews during joint supervisory visits as required by protocol 8049A Back to the Bedside and care plan reviews at each Interdisciplinary Group (IDG) meetings.

The Regional Director of Clinical Operations (RDCO) includes discussion of findings in monthly supervisory meetings with the DCO.

The Executive Director (ED) and DCO review trends during monthly Leadership and quarterly QAPI meetings.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Discussion occurred between regional and site leadership and identified the nursing visit note did not have a clear indication not standard location to record that medication reconciliation was completed. The note indicated if there were changes, or no changes, in the patient's medication regimen only.

The DCO, Executive Director (ED) and Regional Director of Clinical Operations (RDCO) scheduled and assured completion of joint supervisory (Back to the Bedside - B2B) visits for every nurse including on

call and admissions to identify barriers to med rec & to ensure implementation of process for executing/documenting medication reconciliation at each nursing visit.

Chart reviews using the Plan of Correction (POC) audit tool were conducted by Quality and Field Compliance (QFC) to assess for notation of medication reconciliation completed for each visit.

Q. All corrective actions identified below must be completed prior to submission

Training for all nurses was provided regarding Protocol 3019 Medication Reconciliation, the complete medication reconciliation process using a skills checklist, and acknowledgement of education.

The DCO and Regional Director of Quality and Field Compliance (RDQFC) educated all nurses to indicate "medication reconciliation completed" in the visit summary for each visit where med rec was completed and reviewed the need for all visits to include a complete medication reconciliation.

Joint supervisory visits (B2Bs)completed for all full time nurses by November 1, 2020 & ensured medication reconciliation was occurring in all visits. During each B2B visit the clinical assessor completed the medication skills checklist to identify any areas that need follow up/remediation.

QFC chart reviews of five per week were reviewed with the clinical team and any chart that did not include documentation of medication reconciliation completion were referred to the DCO who provided individualized education with the nurse to ensure compliance.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

Trends from B2B visits/chart audits related to medication reconciliation will be reviewed at monthly Leadership Meetings and at quarterly QAPI meetings. Action Plans will be implemented to address identified trends and progress will be documented in quarterly QAPI meeting minutes. Trends that persist beyond 3 months will be considered as a performance improvement project (quality indicator action plan) in order to identify root cause(s) and implement a sustainable solution.

Q. What is the frequency of the monitoring activities?

The DCO will conduct chart reviews to confirm med reconciliation is documented as a part of each joint supervisory visit (B2B visit). At least 2 B2Bs will be performed every month per protocol 8049A Back to Bedside. The Hospice Physician will review medications & medication changes during bi-weekly IDG meetings.

Q. What data will be collected from these activities?

Documentation of medication reconciliation in the nurse visit summary will be assessed during each chart review. Joint supervisory visits (B2Bs) will assess the medication reconciliation process, as well as documentation of medication reconciliation for each nurse. IDG review by Hospice Physician will ensure that medication changes are captured and that meds are routinely reviewed for side effects, contraindications, & effectiveness.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates on joint visits, chart audits, and trends during both meetings. QFC staff will review minutes for both meetings and suggest performance improvement projects for trends that persist for more than 3 months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends, RDQFC will review data in ongoing plan of correction calls which will occur weekly until initial items are resolved and then monthly until plan of correction is complete.

Home Care Accreditation Program NPSG.09.02.01 EP 1
Likelihood: Moderate Scope: Pattern

Standard Text: Reduce the risk of falls.

EP Text: Assess the patient's risk for falls.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 2 of 10 patient records reviewed, The organization did not assess the patient's risk for falls. During review of patient records, it was noted that records 3 and 6 did not have a fall risk assessment documented at admission per agency policy. This was confirmed by the Director of Clinical Operations.

Assigning Accountability

The Director of Clinical Operations DCO is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Director of Nursing/Nurse Administrator
Director of Clinical Services

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

The Director of Clinical Operations performs a chart review during the first week of a patient's start of hospice care to include a review of the fall risk assessment required at admission. DCO also reviews care plana during Interdisciplinary Group (IDG) meetings. DCO will complete supervisory joint visits (at least 2 every month) to ensure fall risk assessment are being performed and documented, DCO will report results and trends at monthly leadership and quarterly QAPI meetings.

The Regional Director of Clinical Operations (RDCO) will review trends during monthly supervisory meetings with the DCO and support performance improvement projects for trends that persist for more than 3 months.

The ED will review trends in monthly leadership meetings and quarterly QAPI meetings and will monitor corrective actions if needed.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Regional and site leadership determined knowledge gaps related to EMR for completion of falls risk assessment on all admissions and recertifications. Admission nurse and field staff required education on compliance with Protocol 2017 Fall Prevention, Policy 212 Patient/Family Assessment, and Policy 213 Patient/Family Reassessment and where these items are documented in the EMR. Admission nurse staffing is lower than anticipated and this has played a role in this issue since field nurses have been called upon to complete admissions without sufficient training in entering this data into the EMR. Strategic recruitment is ongoing and additional training and support has been provided to the current nurses who are completing admissions.

Q. All corrective actions identified below must be completed prior to submission

Training for policy and protocol provided by October 10, with all nurses signing acknowledgement for education as well as expectations.

All nurses received and reviewed the Fall Risk Assessment and Care Plan Review documents which provide detailed instructions on how to complete these items in the EMR.

Joint supervisory visits (B2Bs) for all full time nurses were completed by November 1, and for all nurses and clinical support nurse by November 13.

DCO began reviewing each plan of care at admission and recert for fall risk assessment and acuity scales on October 10.

RDQFC assured that 5 Chart reviews were completed each week looking at each item identified in the ESC plan of correction. Each B2B visit includes a chart review that also reviewed the fall risk assessment & acuity scales for an admission or recertification visit.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

DCO will review each admission and recertification when locking the plan of care in the EMR. DCO will specifically monitor the fall risk assessment and acuity scales during these reviews.

Joint Supervisory visits (B2Bs) for admissions and recertifications will include observation of fall risk assessment and a chart review to ensure the documentation of same.

Q. What is the frequency of the monitoring activities?

IDG meeting reviews will occur biweekly for all admissions and recertifications.

Admissions will have fall risk acuity reviewed in IPOCs as admissions occur.

At least 2 joint supervisory visits (B2Bs) will be made each month.

Q. What data will be collected from these activities?

Staff compliance with fall risk assessment completion on all admissions and recertifications will be collected from IDG review and IPOC review.

Performance of fall risk assessment for admissions and recertifications will be assessed during B2B and associated chart review.

Q. To who, and how often, will this data be reported?

Leadership team will review trend report during monthly Leadership meetings and quarterly QAPI meetings.

RDCO will review trends during monthly supervisory meetings with DCO and will support performance improvement projects for trends that persist beyond 3 months on current action plan.

Home Care Accreditation Program PC.01.01.01 EP 48
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization accepts the patient for care, treatment, or services based on its ability to meet the patient's needs.

EP Text: For hospices that elect to use The Joint Commission deemed status option: The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course.Note: The determination of the patient's life expectancy considers the following factors:- The primary terminal condition - Related diagnoses, if any - Current subjective and objective medical findings - Current medication and treatment orders - Information about the medical management of the patient's conditions unrelated to the terminal condition

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 13 of 13 patient records reviewed, The medical director or physician designee did not review the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course. During review of patient records it was noted that the records associated with home visits 1, 2 and 3 and records 4-10 did not contain certification of terminal illness signed by the attending physician in addition to the hospice physician. The certification of terminal illness was only signed by the hospice physician at admission. This finding was confirmed by the Director of Clinical Operations.

Assigning Accountability

The Executive Director ED is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Administrative Director

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Ed will review requirements and process improvement needs with the physician group

The Director of Business Operations (DBO) assures completion of training acknowledgement for each physician, and reviews the finance audit trends which includes all items necessary for billing.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Regional and site leadership determined a review was needed with all physicians and admission staff on Protocol 2074 Physician Certification Statement, Policy 211 Certification & Recertification, and Protocol 2011 Sign On and Consent Process. The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course.

Q. All corrective actions identified below must be completed prior to submission

Training and education provided by October 10. MD, Team physicians, and admission staff signed acknowledgements post review of P&P related to certification, and expectations for same.

Training provided to all nurses who may complete an admission, Med Dir, and team doctors using Risky Business Certification infographic, and Risky Business videos Verbal Certification and Sources of Certification.

All current and new physicians received training about the Medicare requirement for narrative certification of terminal illness and will sign a form which explains this regulation, attesting to the physician's understanding and intent to comply.

The original signed and dated form is filed with the physician's contract or in their HR file.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

Per CMS Final Rule of 2009, the narrative certification must:
a.be composed by the physician performing the certification or recertification
b.include, under the physician's signature, a statement indicating that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient's medical record, or if applicable, examination of the patient
c.be signed by either the attending physician or the hospice medical director who composed the clinical narrative.
d.be displayed on the 485/POC

The physician that has composed and signed the CTI must also sign the Hospice Certification and Recertification Plan of Treatment

Team Assistants (TAs) will prepare the CTI form for the physician along with the certifications and re-certifications, for all patients, regardless of payer source.

The hospice physician will compose the brief narrative statement during IDG and sign and date the form. At the same time he/she signs the 485 or Recertification.

The TA will verify completion of the form by checking it off on the chart audit tool in HomeWorks.

The TA will file the form in the Medical Record.

Signature dates for signed 485 and re-certifications, will not be entered into HomeWorks until the 485 and the CTI are both signed.

Telephone order (verbal order) must be in the computer even before the actual signature at team. For Recertifications this date must be within 15 days before or within 2 days after the recertification period.

The process for verbal certification of terminal illness requires that the nurse dialog with the Attending physician (AMD) and the Hospice physician (HMD) during the admission process to attain verbal confirmation from the MDs regarding terminality. This information is added to each Admission Summary and is part of the IDG summary for each Admission.

Finance staff will not submit billing until they have verified that they have received both the completed and signed 485 and the new CTI form.

Finance staff will audit 100% of certs and recerts to make sure that all certification documents have been completed with all required fields prior to billing a claim.

Q. What is the frequency of the monitoring activities?

TAs will conduct process for all admissions and recertifications as they occur. TAs will identify issues in processes to DBO.

DBO will monitor finance audits monthly.

Q. What data will be collected from these activities?

Verification of completion and signature of CTI, 485.

Certification documentation completion prior to submission for billing.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates/trends on CTI and 485 completion as well as finance audit information during both meetings. QFC staff will review minutes for both meetings and suggest performance improvement projects for trends that persist for more than 3 months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends. RDQFC will review data in ongoing plan of correction calls which will occur weekly until initial items are resolved and then monthly until plan of correction is complete

Standard Text: The organization assesses and manages the patient's pain.

EP Text: The organization has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
The organization did not assess the patient's pain. During review of patient records, it was noted that in the record associated with home visit 3, there was no pain assessment conducted at admission. The patient was admitted to hospice at a GIP level of care for pain management and was on morphine IV for pain management. This was confirmed by the Director of Clinical Operations.

Assigning Accountability

The DCO is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

Training on Protocol 2082 Pain Management and Protocol 2044a General Inpatient, Nursing Manual page 100, and Head to Toe Assessment- Demo video provided by October 10. All nurses signed acknowledgements with attached P&P and expectations.

Calendar of joint supervisory visits (B2B visits) created and coordinated with regional directors to address gaps in knowledge, skills and attitude.

All full time nurses' B2Bs completed by November 1, round two completed by November 15. B2B visits will confirm that complete pain assessment & documentation occurred at the time of the visit. Immediate feedback and additional support/training provided if needed to confirm mastery.

RDQFC assured five chart reviews completed each week using the POC audit tool. All B2B patients received chart review. Feedback provided to any staff member who fails to document pain assessments and pain care plan when indicated. Action steps to address these omissions implemented.

All completed B2B and chart audits are posted to the evidence folder.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

Chart reviews in biweekly IDGs will identify pain assessment and care plan documentation and completion.

B2Bs will be conducted at minimum twice monthly to observe and assess completion of pain assessment, and documentation.

Q. What is the frequency of the monitoring activities?

Chart reviews in biweekly IDGs will identify pain assessment and care plan documentation and completion.

B2Bs will be conducted at minimum twice monthly to observe and assess completion of pain assessment, and documentation

Q. What data will be collected from these activities?

Pain assessment completion/documentation for all patients and care plan completion based on pain assessment results.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates on joint visits, chart audits, and trends during both meetings. QFC staff will review minutes for both meetings and suggest performance improvement projects for trends that persist for more than 3 months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends. RDQFC will review data in ongoing plan of correction calls which will occur weekly until initial items are resolved and then monthly until plan of correction is complete.

Home Care Accreditation Program PC.01.03.01 EP 5
Likelihood: Moderate Scope: Pattern

Standard Text: The organization plans the patient's care.

EP Text: The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 5 of 10 patient records reviewed, The written plan of care was not based on the patient's goals and the time frames, settings, and services required to meet those goals. During review of patient records it was noted that there were no documented time frames for reaching goals in the records associated with home visits 1 and 2 and records 1, 7, and 9. These findings were confirmed by the Director of Clinical Operations.

Assigning Accountability

The DCO is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Director of Nursing/Nurse Administrator
Director of Clinical Services
Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Regional Director of Patient Experience (RDPE)

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

DCO will assure chart reviews in biweekly IDGs, and joint supervisory visits (B2Bs) at minimum twice monthly.

RDCO will review DCO activities and discuss in monthly supervisory meetings with DCO.

RDPE will reiew DCO activities with Supportive Care (SC) team members, and provide continuing support to SC team for care planning action steps.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Discussion was held between regional and site leadership to determine knowledge gaps in areas of care planning measurable and time bound goals for patients/families. Staff education and training on Policy 214 Plan of Care was required, as well as ongoing review of care plans during biweekly IDGs.

Q. All corrective actions identified below must be completed prior to submission

Training provided by October 10 for IDG members review of Care Plans resources on the L&D Hub specifically on editing care plans. All IDG members who create care plans will sign acknowledgements and review P&P and expectations.

All active patients will have a care plan update before October 20 to reflect measurable goals/time frames.

Each patient on active census had care plan review in IDG prior to Nov. 1 through process of DCO/designee reviewing three care plans in their entirety during each IDG and editing for measurable goals/time frames, based on assessment and discussion of IDG members.

Each new admission will have their care plan reviewed and edited for measurable goals/time frames based on assessment and discussion of IDG members during first IDG.

RDQFC ensured five Chart reviews completed each week using the POC audit tool. Feedback provided by DCO/RDPE to any staff member who fails to update/create care plans with time frames and action steps to address the omission will be implemented.

All completed chart audits will be posted to the evidence folder.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

DCO reviewed three patient care plans in their entirety during biweekly IDGs.

Five weekly chart reviews using POC audit tool were completed.

Q. What is the frequency of the monitoring activities?

DCO reviewed three patient care plans in their entirety during biweekly IDGs.

Five weekly chart reviews using POC audit tool were completed.

Q. What data will be collected from these activities?

Review all care plans in chart audits to ensure that each has measurable goals with identified time frames.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates on chart reviews and trends during both meetings. QFC staff will review minutes for both meetings and suggest performance improvement projects for trends that persist for more than three months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends. RDQFC will review data in ongoing plan of correction calls which will occur

weekly until initial items are resolved and then monthly until plan of correction is complete.

Home Care Accreditation Program PC.01.03.01 EP 37
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization plans the patient's care.

EP Text: For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery.Note: Bereavement counseling is a required hospice service but is not reimbursable.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 16 of 16 patient records reviewed, The hospice did not develop a bereavement plan of care that specifies the type of services to be offered and the frequency of service delivery. During review of patient records it was revealed that in the records associated with home visits 1,2, and 3, and records 1-10 and discharged records 1-3 there was no bereavement plan of care. These findings were confirmed by the Director of Clinical Operations.

Assigning Accountability

The Regional Director of Patient Experience RDPE is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Director of Clinical Services
Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Regional Director of Patient Experience (RDPE)

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

DCO will confirm that there is an IDG death/bereavement summary documented for any patient that died since previous IDG meeting. This will include the bereavement risk at time of death (low, medium, or high).

National/Regional Director of Patient Experience will review bereavement committee mtg minutes and address identified issues related to care plans

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

RDPE reviewed and discussed with site leadership and regional leadership gaps between expected practice identified in Protocol 2026 Bereavement Services and Policy 203 Bereavement Services.and actual practice. Support and education needed for SC team, and bereavement coordinator new to responsibilities. Review of death with documented bereavement summaries needed in IDG with identification of risk by IDG members.

Q. All corrective actions identified below must be completed prior to submission

All SC staff reviewed protocol 2026 and policy 203 and the steps involved from admission through release from bereavement. Training for all supportive care staff included review of the Bereavement Hub; Case Management Vignettes Bereavement at Admission, Bereavement, Anticipatory Grief, and Time of Death and Onward; the bereavement section (pages 61-64) of the SC Manual; and the PowerPoint Updated Bereavement Process for NJ-CNJ by October 10. Acknowledgements of education and expectations were signed by all SC staff and uploaded to the evidence binder.

Bereavement Risk assessments completed within five days of admission by RN and/or SW.

During IDG meetings, the DCO confirmed that there is an IDG death/bereavement summary documented for any patient that died since previous IDG meeting. This inclued the bereavement risk at time of death (low, medium, or high).

Assigned Supportive Care member completed an Outreach Assessment within 7 days of each patient death to assess/document bereavement risk level.

A bereavement plan of care (POC) was initiated for all identified primary bereaved clients. The POC is inclusive of all scheduled, attempted, and completed contacts found under Counseling Attendance in the Deyta documentation system (also known as the bereavement record). The plan of care was individualized based upon the client's request for participation in bereavement programs/services.

The Bereavement Committee also reviews patients, caregivers, and family members for higher anticipatory grief risk factors during the monthly meeting.

The monthly Bereavement Committee Meeting reviewed all deaths since the last meeting and confirmed that an Outreach assessment was completed within 7 days of patient's death and that a bereavement risk level was documented.

Bereavement Committee reviewed all high-risk bereaved during monthly meetings and reviewed audit data.

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The monthly Bereavement Committee Meeting will review all deaths since the last meeting and confirm that an Outreach assessment was completed within 7 days of patient's death and that a bereavement risk level was documented.

Bereavement Committee will review monthly all high-risk bereaved during monthly meetings and review audit data.

In biweekly IDGs, the DCO will review all patient deaths since prior IDG to assure documentation of the bereavement/death summary with bereavement risk level assigned.

Q. What is the frequency of the monitoring activities?

The monthly Bereavement Committee Meeting will review all deaths since the last meeting and confirm that an Outreach assessment was completed within 7 days of patient's death and that a bereavement risk level was documented with POC.

Bereavement Committee will review monthly all high-risk bereaved during monthly meetings and review audit data.

In biweekly IDGs, the DCO will review all patient deaths since prior IDG to assure documentation of the bereavement/death summary with bereavement risk level assigned.

Q. What data will be collected from these activities?

Completion of bereavement/death summaries inclusion of bereavement risk assessment.

Compliance with outreach assessments, bereavement risk level following death, and completion of bereavement POC.

Review of high risk bereaved.

Trends and updates on bereavement risk levels, POCs, and any needed action plans.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates on IDG trends, bereavement chart audits and trends during both meetings. QFC staff will

review minutes for both meetings and suggest performance improvement projects for trends that persist for more than 3 months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends, Regional Director of Quality & Field Compliance will review data in ongoing plan of correction calls which will occur weekly until initial items are resolved and then monthly until plan of correction is complete.

Home Care Accreditation Program PC.02.01.01 EP 2
Likelihood: Moderate Scope: WideSpread

Standard Text: The organization provides care, treatment, or services for each patient.

EP Text: Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation.For home health agencies that elect to use The Joint Commission deemed status option: All home health services must also be provided in accordance with current clinical practice guidelines.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of New Jersey, LLC (2147 Route 27 South, Suite 101, Edison, NJ) site .
In 8 of 10 patient records reviewed, The organization did not provide care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation. During review of patient records, it was noted that in the record associated with home visit 2 aide visits were ordered 3 x week and in one week only two visits were provided. Also, in record 1 nurse visits were ordered for 7 x week and in one week only 6 visits were provided. Record 4 had aide visits ordered 5 x week and visits were missed in weeks 1, 2 and 4 of the cert period. Record 6 had nursing ordered 1-3 x week and had no visits documents for a 2 week period. Record 7 had aide ordered 5 x week and one week had a missed visit. Record 8 had aide ordered 5 x week and in the 4th and 5th weeks of the cert period only 4 visits were provided. In records 9 and 10 nursing was ordered 1-2 x week and there were no visits in one week. These findings were confirmed by the Director of Clinical Services.

Assigning Accountability

The DCO is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Chief Executive Officer
Director of Nursing/Nurse Administrator
Director of Clinical Services
Administrative Director

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Executive Director will review visit compliance and trends in site leadership meetings and QAPI meetings.

The RDCO will review trends during monthly supervisory meetings with DCO.

DCO will review visit strings report assuring compliance with ordered visits, or directing needed rescheduling or scheduling of visits.

The DBO will ensure TA scheduling of Hopsice Aide (HA) visits appropriate to ordered frequencies, and will ensure process to have paper notes documented in EMR and filed within seven days of receipt.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Review of the visit string order compliance by site and regional leadership identified gaps in scheduling process, knowledge deficits for ordering of visit strings according to Protocol 2022a HA and SN Visit Orders/Protocol 2022b SC Visit Orders Protocol/ 2022 Visit Strings, and use of scheduler module. Paper documentation completed was not reflected in EMR and filed timely.

Q. All corrective actions identified below must be completed prior to submission

All IDG members including HA scheduler reviewed training for the scheduling module along with Protocol 2022, 2022a, 2022b by October 10. All IDG members completed signed acknowledgements for training material and P&P, which acknowledged expectations of performance.

All IDG members including HA scheduler will use the scheduling module and create visit orders for the entire cert period for all patients.

PRN visits will only be used for unscheduled visits.

No visits will be documented on paper without prior authorization from a supervisor/Administrator on Call. The Team Assistant/DBO will ensure that paper documentation is recorded in EMR and filed within 7 days of receipt.

RDQFC reviewed the Visit String Compliance Report daily and reported to site to ensure visits are made. If any visits are outstanding on Thursday, DCO/DBO for HAs will check to ensure that a visit is scheduled before the end of the Medicare week. The DCO will check to ensure visits scheduled for nursing and SC.

Each IDG meeting, visit orders and visits made will be reviewed and missed visits will be reviewed with the physician and documented in the IDG summary

Q. All corrective actions described above were completed by

Nov 13, 2020

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The DCO will assess the visit string compliance report on weekly basis to assure ordered visits are scheduled.

Reports for use of scheduling module will be reviewed monthly.

DBO will ensure that paper documentation is posted to EMR within seven days of receipt.

Q. What is the frequency of the monitoring activities?

The DCO will assess the visit string compliance report on weekly basis to assure ordered visits are scheduled.

Reports for use of scheduling module will be reviewed monthly.

DBO will ensure that paper documentation is posted to EMR within seven days of receipt.

Q. What data will be collected from these activities?

Use of scheduling module by staff and TA scheduling HA visits.

Visits being conducted at ordered frequency for each discipline.

Paper documentation only being received as approved, and processed as per POC.

Q. To who, and how often, will this data be reported?

Leadership meetings are held monthly and QAPI meetings quarterly. Site leadership will receive updates on use of scheduler, compliance with ordered visit strings, and trends during both meetings. QFC staff will review minutes for both meetings and suggest performance improvement projects for trends that persist for more than three months. QFC staff attend QAPI or review the minutes each quarter and assist to identify action steps based on identified trends. RDQFC will review data in ongoing plan of correction calls which will occur weekly until initial items are resolved and then monthly until plan of correction is complete.

Final Accreditation Report

Seasons Hospice & Palliative Care of New Jersey, LLC
2147 Route 27 South, Suite 101
Edison, NJ 08817

Organization Identification Number: 560935
60-day Evidence of Standards Compliance Submitted: 11/23/2020

ESC Programs Reviewed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	11/23/2020	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score
Hospice	§418.102	L665	Compliant
Hospice	§418.102(b)	L667	Compliant
Hospice	§418.52	L501	Compliant
Hospice	§418.52(c)(1)	L512	Compliant
Hospice	§418.60	L577	Compliant
Hospice	§418.60(a)	L579	Compliant
Hospice	§418.64	L587	Compliant
Hospice	§418.64	L588	Compliant
Hospice	§418.64(d)(1)(iv)	L596	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
IC.02.01.01	Compliant
NPSG.03.06.01	Compliant
NPSG.09.02.01	Compliant
PC.01.01.01	Compliant
PC.01.02.07	Compliant
PC.01.03.01	Compliant
PC.02.01.01	Compliant

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
IC.02.01.01	1	The organization implements the infection prevention and control activities it has planned.	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.
NPSG.03.06.01	3	Maintain and communicate accurate patient medication information.	Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, does the comparison. (See also HR.01.06.01, EP 1)
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient's risk for falls.
PC.01.01.01	48	The organization accepts the patient for care, treatment, or services based on its ability to meet the patient's needs.	For hospices that elect to use The Joint Commission deemed status option: The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient's life expectancy is six months or less if the illness runs its normal course. Note: The determination of the patient's life expectancy considers the following factors: - The primary terminal condition - Related diagnoses, if any - Current subjective and objective medical findings - Current medication and treatment orders - Information about the medical management of the patient's conditions unrelated to the terminal condition
PC.01.02.07	1	The organization assesses and manages the patient's pain.	The organization has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	37	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery.

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Standard	EP	Standard Text	EP Text
			Note: Bereavement counseling is a required hospice service but is not reimbursable.
PC.02.01.01	2	The organization provides care, treatment, or services for each patient.	Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation. For home health agencies that elect to use The Joint Commission deemed status option: All home health services must also be provided in accordance with current clinical practice guidelines.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Final Accreditation Report

Seasons Hospice, Inc.
606 Potter Road
Des Plaines, IL 60016

Organization Identification Number: 200236
Unannounced Full Event: 3/9/2021 - 3/11/2021

Program Surveyed
Home Care

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Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	03/09/2021 - 03/12/2021	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

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What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.02.01	12	Low / Limited				✓
	4	High / Limited				✓
EC.02.05.07	5	High / Pattern				✓
EC.02.06.01	1	Low / Pattern				✓
EQ.01.04.01	6	High / Pattern				✓
IC.01.04.01	2	Low / Widespread	§418.60 (b)(2)(ii)	L581	✓	✓
	3	Low / Limited	§418.60 (b)(2)(ii)	L581	✓	✓
	4	Low / Widespread	§418.60 (b)(2)(ii)	L581	✓	✓
IC.02.01.01	2	Moderate / Pattern	§418.60 (a)	L579	✓	✓
LD.01.03.01	12	High / Widespread	§418.100 (b)	L651	✓	✓
MM.05.01.11	2	Moderate / Pattern				✓
NPSG.09.02.01	2	Moderate / Limited				✓
NPSG.15.02.01	1	Moderate / Widespread				✓
PC.01.02.03	26	Moderate / Pattern	§418.54 (b)	L523		✓

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Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
PC.01.03.01	18	Moderate / Pattern	§418.56 (c)(2)	L547	✓	✓
			§418.56 (c)(1)	L546	✓	✓
			§418.56 (c)(4)	L549	✓	✓
	33	Moderate / Limited	§418.76 (g)(1)	L625		✓
	5	Low / Widespread	§418.56 (c)	L545	✓	✓
PC.02.01.01	1	Moderate / Limited	§418.56 (e)(2)	L555	✓	✓
PC.02.03.01	10	Moderate / Widespread	§418.60 (c)	L582	✓	✓
PC.04.02.01	3	Moderate / Limited	§418.104 (e)(1)(i)	L682		✓
	4	Moderate / Limited	§418.104 (e)(1)(i)	L682		✓
RC.02.01.01	2	Low / Limited	§418.104 (a)(3)	L674		✓
RI.01.02.03	1	Moderate / Limited	§418.112 (a)	L761		✓

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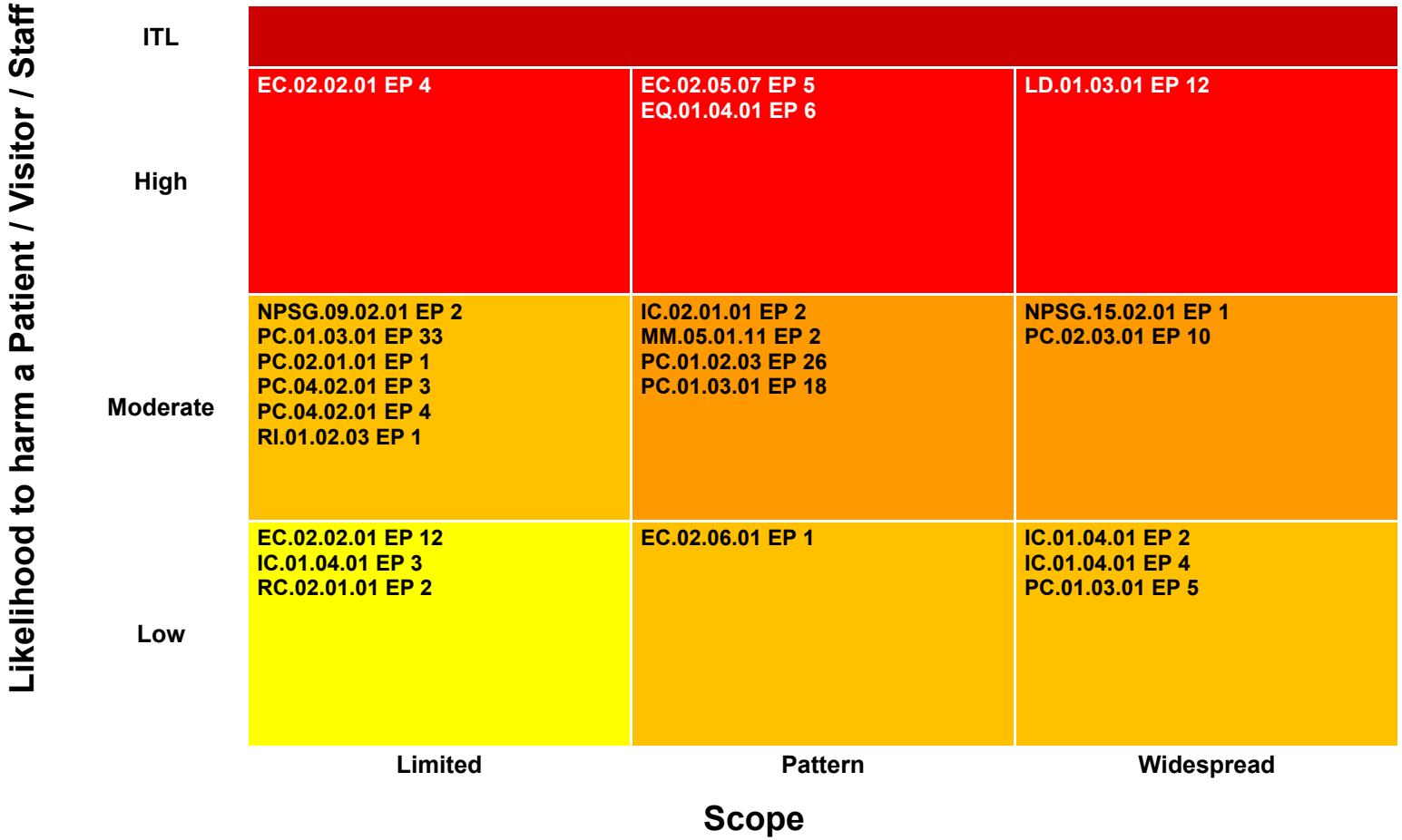
SAFER™ Matrix

Program: Home Care



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The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.100	L649	Condition	OME
Hospice	§418.100(b)	L651	Condition	OME/LD.01.03.01/EP12
Hospice	§418.104	L670	Standard	OME
Hospice	§418.104(a)(3)	L674	Standard	OME/RC.02.01.01/EP2
Hospice	§418.104(e)(1)(i)	L682	Standard	OME/PC.04.02.01/EP3 OME/PC.04.02.01/EP4
Hospice	§418.112	L760	Standard	OME
Hospice	§418.112(a)	L761	Standard	OME/RI.01.02.03/EP1
Hospice	§418.54	L520	Standard	OME
Hospice	§418.54(b)	L523	Standard	OME/PC.01.02.03/EP26
Hospice	§418.56	L538	Condition	OME
Hospice	§418.56(c)	L545	Standard	OME/PC.01.03.01/EP5
Hospice	§418.56(c)(1)	L546	Standard	OME/PC.01.03.01/EP18
Hospice	§418.56(c)(2)	L547	Standard	OME/PC.01.03.01/EP18
Hospice	§418.56(c)(4)	L549	Standard	OME/PC.01.03.01/EP18
Hospice	§418.56(e)(2)	L555	Standard	OME/PC.02.01.01/EP1
Hospice	§418.60	L577	Condition	OME
Hospice	§418.60(a)	L579	Standard	OME/IC.02.01.01/EP2
Hospice	§418.60(b)(2)(ii)	L581	Standard	OME/IC.01.04.01/EP2 OME/IC.01.04.01/EP3 OME/IC.01.04.01/EP4
Hospice	§418.60(c)	L582	Standard	OME/PC.02.03.01/EP10
Hospice	§418.76	L607	Standard	OME
Hospice	§418.76(g)(1)	L625	Standard	OME/PC.01.03.01/EP33

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.02.01	4	High Limited	The organization implements its procedures in response to hazardous material and waste spills or exposures. (See also IC.02.01.01, EP 2)	1) Observed in Tracer Activities at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 1 of 3 Life Safety Code Tracers, during a tour of the Naperville freestanding inpatient unit it was noted by the nurse surveyor that a gallon jug of “TB Cide” was open on the janitor’s cart. There no eyewash available in the event of an exposure to the chemical as required per the SDS sheet. The nearest eye wash station was in the warming kitchen on the other side of the unit. This was verified by the Inpatient Unit Clinical Director.		
EC.02.02.01	12	Low Limited	The organization labels hazardous materials and waste. * Labels identify the contents and hazard warnings. (See also IC.02.01.01, EP 6) Footnote *: The Occupational Safety and Health Administration’s (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.	1) Observed in Individual Tracer at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 1 of 5 home visits conducted, the organization did not label hazardous materials. In HV #2, the Surveyor noted the nurse had disinfecting wipes in a non-labeled bag. Per the Bag Technique policy, the cleaning wipes needed to be labeled and have a biohazard label on the bag. This was confirmed with the Executive Director.		
EC.02.05.07	5	High Pattern	At least monthly, the organization tests each emergency generator under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)	1) Observed in Tracer Activities at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 1 of 3 Life Safety Coder Tracers, For the Napierville freestanding inpatient unit it was noted by the surveyor that monthly emergency generator tests have not been done over the last twelve months. The organization had an outside vendor taking care of all of the emergency generator testing however, after the Covid-19 Pandemic hit they failed to continue to provide the service. This was verified with Leadership.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.06.01	1	Low Pattern	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, or services provided. (See also MC.05.02.01, EP 1)	1) Observed in Tracer Activities at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 1 of 3 Life Safety Code Tracers, during a tour of the Naperville freestanding inpatient unit it was noted by the nurse surveyor that there were stained ceiling tiles in the last patient room on the first hallway and in the middle of the second hallway down from the warming kitchen. This was verified by the Inpatient Unit Clinical Director.		
EQ.01.04.01	6	High Pattern	For any equipment that would threaten a patient's health if it were to fail or malfunction, the organization provides or arranges for either backup equipment, equipment repair, or equipment replacement.	1) Observed in Tracer Activities at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 1 of 3 Life Safety Coder Tracers, during a tour of the Naperville freestanding inpatient unit it was noted by the nurse surveyor that there were no back up E-Tanks on the unit for patients receiving oxygen if needed in the event of an emergency. This was verified by the Inpatient Unit Clinical Director.		
IC.01.04.01	2	Low Widespread	The organization's written infection prevention and control goals include the following: Limiting unprotected exposure to pathogens.	1) Observed in Data Session at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . The Surveyor noted the organization's written infection prevention and control goals did not include limiting unprotected exposure to pathogens as evidenced by the organization was not able to produce this documentation at the time of survey. This was confirmed with the Executive Director.	§418.60(b)(2)(ii)	Standard
IC.01.04.01	3	Low Limited	The organization's written infection prevention and control goals include the following: Limiting the spread of infections associated with procedures.	1) Observed in Data Session at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . The Surveyor noted the organization's written infection prevention and control goals did not include limiting the spread of infections associated with procedures as evidenced by the organization was not able to produce this documentation at the time of survey. This was confirmed with the Executive Director.	§418.60(b)(2)(ii)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.01.04.01	4	Low Widespread	The organization's written infection prevention and control goals include the following: Limiting the spread of infections associated with the use of medical equipment, devices, and supplies.	1) Observed in Data Session at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . The Surveyor noted the organization's written infection prevention and control goals did not include limiting the spread of infections associated with the use of medical equipment, devices, and supplies as evidenced by the organization was not able to produce this documentation at the time of survey. This was confirmed with the Executive Director.	§418.60(b)(2)(ii)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.02.01.01	2	Moderate Pattern	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4) Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings).	1) Observed in Tracer Visit at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 2 of 3 IPU patient tracer visits, it was observed by the Nurse Surveyor that the organization did not implement the infection prevention and control activities it had planned. For example, during IPUV#1/RR#15 (Napier) during a medication pass the registered nurse missed several opportunities to perform hand hygiene. She did not perform hand hygiene upon entering the medication room. She then looked at the medication administration record, pulled medication out of the medication dispenser, drew medication into a syringe and prepared a normal flush syringe all without performing hand hygiene. She then went to the patient's room and donned gloves without performing hand hygiene and administered the medication. She did perform hand hygiene after doffing the gloves. Additionally, the nurse prepared a normal saline flush for the patient from a multi-dose bottle that was used for all patients on the unit. It is against CDC guidelines to use a multi-dose vial of normal saline in an inpatient setting. IPUV#2/RR#14 (Holy Cross) the nurse surveyor observed two staff registered nurses providing care to and incontinent patient. They performed hand hygiene upon entry to room and gloves were donned. The patient's diaper was wet and soiled. The nurses performed peri care and cleaned the patient. Neither nurse changed their gloves nor performed hand hygiene after performing the care. They then put a clean diaper on patient and repositioned him. One nurse put the call light close to the patient, the other nurse went into wardrobe. Prior to leaving room they removed their gloves and washed their hands with soap and water. Agency policy was to hand sanitize between tasks, clean and dirty, and before donning gloves. This was verified by the Clinical Inpatient Unit Director.	§418.60(a)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LD.01.03.01	12	High Widespread	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program.	1) Observed in Tracer Activities at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews: - §418.100 and 418.56, 418.60.	§418.100(b)	Condition
MM.05.01.11	2	Moderate Pattern	The organization dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. (See also MC.01.01.03, EP 3; MC.05.01.01, EPs 4 and 6) Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications.	1) Observed in Tracer Activities at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . In 2 of 3 Inpatient Tracer Visits, during observation of a medication pass it was noted by the nurse surveyor that for IPUV#1RR#15 (Naperville) the nurse drew up the required 2mg of Morphine from the ampule and then disposed of the ampule with the remaining medication into the sharps container. For IPUV#13 (Swedish) the nurse drew the required amount of Haldol out of the ampule and then disposed of the vial with the wasted medication still in it into the sharps container. This was verified by the Inpatient Clinical Director.		
NPSG.09.02.01	2	Moderate Limited	Implement interventions to reduce falls based on the patient's assessed risk.	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 2 of 20 patient records reviewed, the organization did not implement interventions to reduce falls based on the patient's assessed risk. In HV #1 and RR #4, the Surveyor noted the patient was identified at risk for falls; however, the plan of care did not include interventions to address the fall risk. This was confirmed with the Senior Director Clinical Operations.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
NPSG.15.02.01	1	Moderate Widespread	Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: - Whether there are smoking materials in the home - Whether or not the home has functioning smoke detectors Note: Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required. - Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5)	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 6 of 8 patient records reviewed where the patient received oxygen therapy, the organization did not assess oxygen safety risk assessment. In HV #1, the Surveyor noted the nurse did not perform the oxygen safety assessment at the initial visit when the patient was assessed to be on oxygen. The oxygen safety assessment was performed by the chaplain on the 4th day of service; however, the safety assessment did not assess if the patient had functioning smoke detectors. This was confirmed with the Senior Director Clinical Operations. In HV #4 and RR #3, the Surveyor noted the organization did not document the complete oxygen safety assessment and only documented by exception. This was confirmed with the Senior Director Clinical Operations. In RR #2 and RR #5, the Surveyor noted the oxygen safety assessment did not include assessment of functioning smoke detectors. This was confirmed with the Senior Director Clinical Operations..		
				2) Observed in Record Review at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . the nurse surveyor noted that for RR#11 oxygen was ordered on admission, and for RR#12 oxygen was ordered about three weeks after admission. In both records, the home oxygen safety assessment form was not completed per agency protocol. This was verified by the Associate Executive Director.		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.02.03	26	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: The hospice's interdisciplinary group, in consultation with the patient's attending physician, if any, completes the comprehensive assessment no later than five calendar days after the election of hospice care.	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 3 of 20 patient records reviewed, the hospice interdisciplinary group did not complete the comprehensive assessment no later than 5 calendar days after the election of benefit. In HV #1, the Surveyor noted the medical social worker did not contact the patient until 6 days after the election of benefit. There was no documentation as to why the contact was delayed. The actual visit did not happen until 13 days after the election of benefit per the request of the daughter. This was confirmed with the Senior Director Clinical Operations. In HV #3, the Surveyor noted the spiritual assessment was not completed by the chaplain. There was no documentation the patient refused or the interdisciplinary group determined the patient did not require the evaluation. This was confirmed with the Senior Director Clinical Operations.	§418.54(b)	Standard
				2) Observed in Record Review at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . the nurse surveyor noted that for RR#7, the Chaplain did not complete the comprehensive assessment within five calendar days of the election of hospice care. There was no documentation in the electronic medical record to indicate why this was not completed. This was verified by the This was verified by the Associate Executive Director.	§418.54(b)	Standard
PC.01.03.01	5	Low Widespread	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 17 of 20 patient records reviewed, the written plan of care was not based on the patient's goals and the time frames, setting and services required to meet those goals. In HV #1, HV #2, HV #3, HV #4, HV #5, RR #1, RR #2, RR #3, RR #4 and RR #5, the Surveyor noted the plan of care goals did not include time frames. In addition, in HV #1 and RR #2, the plan of care included the following non-measurable goal: pain is currently managed at a level acceptable to patient. This was confirmed with the Senior Director Clinical Operations.	§418.56(c)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2) Observed in Record Review at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . the nurse surveyor noted that the goals were not measurable. In RR#6, RR#7, RR#8, RR#9, RR#10, RR#11, and RR#12, none of the goals had a target date of completion. This was verified by the Associate Executive Director.	§418.56(c)	Standard
PC.01.03.01	18	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 5 of 20 patient records reviewed, the plan of care did not include a detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. In HV #1, the Surveyor noted the chaplain visit frequency included prn visits; however, there was no indication given for these visits. This was confirmed with the Senior Director Clinical Operations. In HV #2, the Surveyor noted the plan of care included a visit frequency for the medical social worker; however, there were no goals or interventions on the plan of care for the medical social worker. This was confirmed with the Senior Director of Clinical Operations. In HV #3, HV #5, and RR #3, the Surveyor noted the plan of care included prn visits in the visit frequency for the skilled nurse; however, there was no indication given. This was confirmed with the Senior Director of Clinical Operations.	§418.56(c)(2)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 3 of 20 patient records reviewed, the plan of care did not include interventions to manage pain and symptoms. In HV #1, the Surveyor noted the patient was identified as having pain; however, there was no intervention identified to address pain except evaluation. In addition, the patient was identified as having dysphagia; however, the plan of care did not include interventions to address this patient identified need. This was confirmed with the Senior Director Clinical Operations. In HV #3, the Surveyor noted the patient was identified as having edema this certification period; however, the plan of care did not include interventions to address this identified need. In RR #2, the Surveyor noted the patient was identified as having pain; however, the only intervention was evaluation. In addition, the patient was identified as having anxiety and depression; however, the plan of care did not include interventions to address these identified needs. This was confirmed with the Senior Director Clinical Operations.	§418.56(c)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				3) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 5 of 20 patient records reviewed, the plan of care did not include all drugs and treatment necessary to meet the needs of the patient. In HV #1, the Surveyor noted the plan of care indicated "may irrigate foley with NS"; however, the plan of care did not specify frequency or volume. In addition, the plan of care indicated "Change catheter every 30 days and prn"; however, there was no indication provided of when to activate the prn order. This was confirmed with the Senior Director Clinical Operations. In HV #4, the Surveyor noted the current plan of care did not include orders for oxygen. This was confirmed with the Senior Director Clinical Operations. In RR #2, the Surveyor noted the plan of care included wound care and the frequency included prn; however, there was no indication given for the prn order. This was confirmed with the Senior Director Clinical Operations. In RR #5, the Surveyor noted the oxygen order did not specify the method of delivery. This was confirmed with the Senior Director Clinical Operations.	§418.56(c)(4)	Standard
				4) Observed in Record Review at Seasons Hospice Inc. (2195 W. Diehl Road, Naperville, IL) site . the nurse surveyor noted that for RR#11 the order for oxygen therapy was incomplete. The order read “oxygen 2-5 liters per minute”. There was no route of administration nor any indication if the oxygen was PRN or continuous. Additionally, the patient was diabetic and on insulin. The careplan did not address his diabetes. This was verified by the Associate Executive Director.	§418.56(c)(4)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	33	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.	1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . In 1 of 8 patient records reviewed where the patient received aide services, a registered nurse did not prepare written patient care instructions for the hospice aide. In RR #2, the Surveyor noted the aide plan of care did not include oxygen precautions; however, the patient was on oxygen. This was confirmed with the Senior Director Clinical Operations.	§418.76(g)(1)	Standard
PC.02.01.01	1	Moderate Limited	The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.	1) Observed in Record Review at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 2 of 20 patient records reviewed, the organization did not provide the patient with care, treatment or services according to his or her individualized plan of care. In HV #1, the Surveyor noted the plan of care visit frequency for the chaplain indicated 1 week 2 effective the fifth week of service; however, there was no visit was made the fifth or sixth week of service. This was confirmed with the Senior Director of Clinical Operations. In HV #3, the Surveyor noted the plan of care indicated a visit frequency for the chaplain effective the seventh week of the current certification period of 1 week 2, 1 every 2 week 2, 1 every 3 week 3; however, the patient was not seen the eighth week of service and the tenth week of service. This was confirmed with the Senior Director Clinical Operations.	§418.56(e)(2)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.03.01	10	Moderate Widespread	Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following: - An explanation of the plan for care, treatment, or services - Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency - Basic health practices and safety - Information on the safe and effective use of medications. (See also MM.06.01.01, EP 9; MM.06.01.03, EP 3) - Nutrition interventions (for example, supplements) and modified diets - Infection prevention and control - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on personal hygiene and grooming - Information on oral health - Basic physical and structural home safety - Information on the safe and effective use of medical equipment or supplies provided by the organization - Information on the storage, handling, and access to medical gases and supplies - Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Information on the use of restraint (See also PC.01.02.07, EP 8; PC.01.03.01, EP 55) Note: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health organization must provide infection control education to patients and caregivers.	1) Observed in Individual Tracer at Seasons Hospice, Inc. (6880 Frontage Road, Suite 100, Burr Ridge, IL) site . In 5 of 5 home visits conducted, the organization did not develop with the patient/family an individualized emergency management plan. In all the home visits conducted, the Surveyor noted the organization did not develop and individualized emergency management plan with the patient/family as evidenced by there was no copy in the patient's home or in the clinical record. This was confirmed with the Executive Director.	§418.60(c)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.04.02.01	3	Moderate Limited	The organization provides a written discharge summary to the patient's physician in accordance with law and regulation. For hospices that elect to use The Joint Commission deemed status option: Law and regulation require that the hospice inform the attending physician of the availability of a discharge summary. The discharge summary is provided to the physician upon the physician's request and includes the patient's medical and health status at the time of discharge. For home health agencies that elect to use The Joint Commission deemed status option: A completed discharge summary is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient (if any) after discharge from the organization within five business days of the patient's discharge. (See also RC.02.01.01, EP 3)	1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . In 1 of 2 patient records reviewed where the patient was discharged from hospice services, the organization did not complete and discharge summary. In RR #1, the Surveyor noted the discharge summary was not completed at the time of the patient's revocation. This was confirmed with the Senior Director of Clinical Services.	§418.104(e)(1)(i)	Standard
PC.04.02.01	4	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: If the care of the patient is transferred to another Medicare/Medicaid-certified facility, the hospice provides the receiving facility with a copy of the hospice discharge summary and, if requested, a copy of the patient's clinical record.	1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . In 1 of 2 discharged records reviewed, the hospice did not provide the hospital with a discharge summary. In RR #2, the Surveyor noted the patient was transferred to the hospital; however, a copy of the discharge summary was not sent to the hospital. This was confirmed with the Senior Director Clinical Operations.	§418.104(e)(1)(i)	Standard
RC.02.01.01	2	Low Limited	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s) - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status	1) Observed in Individual Tracer at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . In 1 of 5 patient records reviewed, the patient record did not contain an accurate medication profile. In HV #2, the Surveyor noted the medication profile indicated Bisacodyl 10 mg daily; however, the patient was actually taking the medication every three days. Second example, the medication profile included miralax daily; however, the patient's daughter-in-law stated the patient had not taken this medication for over one month. This was discussed with the Executive Director.	§418.104(a)(3)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23; RC.02.01.01, EP 3) Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.			

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
RI.01.02.03	1	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: The organization respects the patient's right to elect and revoke hospice care, in accordance with Medicare hospice regulations. Note: Further information about electing and revoking hospice care can be found in 42 CFR 418.20, 418.21, 418.24, 418.28, and 418.30.	1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site . In 1 of 2 patient records reviewed where the patient revoked hospice services, the organization did not respect the patient's right to revoke hospice care. In RR #1, the Surveyor noted the staff documented the patient went to the hospital and revoked the hospice benefit; however, there was no revocation statement in the clinical record. There was no documentation of an attempt to get the revocation statement signed. This was confirmed with the Senior Director Clinical Operations.	§418.112(a)	Standard

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Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§418.54 Initial and Comprehensive Assessment of the Patient	L520	§418.54 Condition of participation: Initial and comprehensive assessment of the patient.
§418.54(b) Time frame for completion of the comprehensive assessment	L523	§418.54(b) Standard: Time frame for completion of the comprehensive assessment. The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.
§418.60 Infection control	L577	§418.60 Condition of participation: Infection control.
§418.60(a) Prevention	L579	§418.60(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
§418.60(b)(2)(ii) Control	L581	(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
§418.60(c) Education	L582	§418.60(c) Standard: Education. The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.
§418.100 Organization and administration of services	L649	The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.
§418.100(b) Governing body and administrator	L651	§418.100(b) Standard: Governing body and administrator. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.
§418.56 Interdisciplinary group, care planning, and coordination of services	L538	The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

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CoP	Tag	CoP Standard text
§418.56(c) Content of the plan of care	L545	The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
§418.56(c)(1) Content of the plan of care	L546	(1) Interventions to manage pain and symptoms.
§418.56(c)(2) Content of the plan of care	L547	(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
§418.56(c)(4) Content of the plan of care	L549	(4) Drugs and treatment necessary to meet the needs of the patient.
§418.56(e)(2) Coordination of services	L555	(2) Ensure that the care and services are provided in accordance with the plan of care.
§418.76 Hospice Aide and Homemaker Services	L607	§418.76 Condition of participation: Hospice aide and homemaker services.
§418.76(g)(1) Hospice aide assignments and duties	L625	(1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
§418.104 Clinical Records	L670	§418.104 Condition of participation: Clinical records.
§418.104(a)(3) Content	L674	(3) Responses to medications, symptom management, treatments, and services.
§418.104(e)(1)(i) Discharge or transfer of care	L682	(i) The hospice discharge summary; and
§418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR.	L760	In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/MR must abide by the following additional standards.
§418.112(a) Resident eligibility, election, and duration of benefits	L761	§418.112(a) Standard: Resident eligibility, election, and duration of benefits Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/MR are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
EC.02.02.01	4	The organization manages risks related to hazardous materials and waste.	The organization implements its procedures in response to hazardous material and waste spills or exposures. (See also IC.02.01.01, EP 2)
EC.02.02.01	12	The organization manages risks related to hazardous materials and waste.	The organization labels hazardous materials and waste. * Labels identify the contents and hazard warnings. (See also IC.02.01.01, EP 6) Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.
EC.02.05.07	5	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization tests each emergency generator under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)
EC.02.06.01	1	The organization establishes and maintains a safe, functional environment.	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, or services provided. (See also MC.05.02.01, EP 1)
EQ.01.04.01	6	The organization provides patients with emergency maintenance, replacement, or backup of medical equipment, when needed.	For any equipment that would threaten a patient's health if it were to fail or malfunction, the organization provides or arranges for either backup equipment, equipment repair, or equipment replacement.
IC.01.04.01	2	Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.	The organization's written infection prevention and control goals include the following: Limiting unprotected exposure to pathogens.
IC.01.04.01	3	Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.	The organization's written infection prevention and control goals include the following: Limiting the spread of infections associated with procedures.
IC.01.04.01	4	Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.	The organization's written infection prevention and control goals include the following: Limiting the spread of infections associated with the use of medical equipment, devices, and supplies.
IC.02.01.01	2	The organization implements the infection prevention and control activities it has planned.	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4) Note: Standard precautions are infection prevention and control measures

Standard	EP	Standard Text	EP Text
			to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings).
LD.01.03.01	12	Governance is ultimately accountable for the safety and quality of care, treatment, or services.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program.
MM.05.01.11	2	The organization safely dispenses medications.	The organization dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. (See also MC.01.01.03, EP 3; MC.05.01.01, EPs 4 and 6) Note 1: Dispensing practices and recordkeeping include antidiversion strategies. Note 2: This element of performance is also applicable to sample medications.
NPSG.09.02.01	2	Reduce the risk of falls.	Implement interventions to reduce falls based on the patient's assessed risk.
NPSG.15.02.01	1	Identify risks associated with home oxygen therapy such as home fires.	Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: - Whether there are smoking materials in the home - Whether or not the home has functioning smoke detectors Note: Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required. - Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5)
PC.01.02.03	26	The organization assesses and reassesses the patient and his or her condition according to defined time frames.	For hospices that elect to use The Joint Commission deemed status option: The hospice's interdisciplinary group, in consultation with the patient's attending physician, if any, completes the comprehensive assessment no later than five calendar days after the election of hospice

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Standard	EP	Standard Text	EP Text
			care.
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	18	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs
PC.01.03.01	33	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.
PC.02.01.01	1	The organization provides care, treatment, or services for each patient.	The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.
PC.02.03.01	10	The organization provides patient education and training based on each patient's needs and abilities.	Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following: - An explanation of the plan for care, treatment, or services - Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency - Basic health practices and safety - Information on the safe and effective use of medications. (See also MM.06.01.01, EP 9; MM.06.01.03, EP 3) - Nutrition interventions (for example, supplements) and modified diets - Infection prevention and control - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on personal hygiene and grooming - Information on oral health - Basic physical and structural home safety - Information on the safe and effective use of medical equipment or supplies provided by the organization - Information on the storage, handling, and access to medical gases and supplies - Information on the identification, handling, and safe disposal of

Standard	EP	Standard Text	EP Text
			hazardous medications and infectious wastes - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Information on the use of restraint (See also PC.01.02.07, EP 8; PC.01.03.01, EP 55) Note: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health organization must provide infection control education to patients and caregivers.
PC.04.02.01	3	When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.	The organization provides a written discharge summary to the patient's physician in accordance with law and regulation. For hospices that elect to use The Joint Commission deemed status option: Law and regulation require that the hospice inform the attending physician of the availability of a discharge summary. The discharge summary is provided to the physician upon the physician's request and includes the patient's medical and health status at the time of discharge. For home health agencies that elect to use The Joint Commission deemed status option: A completed discharge summary is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient (if any) after discharge from the organization within five business days of the patient's discharge. (See also RC.02.01.01, EP 3)
PC.04.02.01	4	When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.	For hospices that elect to use The Joint Commission deemed status option: If the care of the patient is transferred to another Medicare/Medicaid-certified facility, the hospice provides the receiving facility with a copy of the hospice discharge summary and, if requested, a copy of the patient's clinical record.
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s) - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services

Standard	EP	Standard Text	EP Text
			- Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23; RC.02.01.01, EP 3) Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.
RI.01.02.03	1	For Medicare-certified hospices: The organization respects the patient's right to elect his or her hospice care.	For hospices that elect to use The Joint Commission deemed status option: The organization respects the patient's right to elect and revoke hospice care, in accordance with Medicare hospice regulations. Note: Further information about electing and revoking hospice care can be found in 42 CFR 418.20, 418.21, 418.24, 418.28, and 418.30.

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Joint Commission Health Care Organization

Organization ID: 200236-Seasons Hospice, Inc.
606 Potter Road Des Plaines, IL 60016

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 8/31/2021

Home Care Accreditation Program PC.01.03.01 EP 5
Likelihood: Low Scope: Pattern

Standard Text: The organization plans the patient's care.

EP Text: The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.

Finding(s): 1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site .
In 2 of 4 patient records reviewed, In 2 of 4 patient records reviewed, During RR#1 and RR# 4's patient records review, it was noted the organization had not ensured the written plan of care was based on the patient's goals and the time frames required to meet those goals. For example: review of RR# 1's plan of care revealed multiple goals with no time frames. During Review of RR# 4's recertification plan of care revealed goals with no time frames. In addition, RR# 4's plan of care included a non-measurable goal for pain goal that stated the patient's pain would be managed at a level acceptable to patient. This was discussed and reviewed with Leadership and validated.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

Training will be assigned to all Leadership and Field staff on how to use the Plan of Correction Update Order to add individualized, measurable goals with time frames to the plan of care in our learning management system.

Q. All corrective actions described above were completed by

Aug 24, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The Learning management system will show 100% compliance on the training transcript. The team director, clinical director, or member of the learning and development team will complete 3 supervisory visits per week to observe and provide immediate feedback on identified areas of improvement. The supervising staff will complete a Plan of Care audit with each supervisory visit to meet 80% compliance or better weekly until the threshold is maintained for 4 consecutive weeks. After the threshold is met, the leadership team will complete supervisory visits monthly per protocol for ongoing monitoring and immediate feedback.

Q. What is the frequency of the monitoring activities?

Monitoring will be weekly until the threshold is met and monthly thereafter.

Q. What data will be collected from these activities?

The audits will show compliance with having individualized, measurable goals with time frames.

Q. To who, and how often, will this data be reported?

The Senior Director Clinical Director will report trending data to the senior leadership team weekly and to the QAPI committee quarterly to create action plans on identified trends for ongoing improvement.

Home Care Accreditation Program PC.02.03.01 EP 10
Likelihood: Moderate Scope: Limited

Standard Text: The organization provides patient education and training based on each patient's needs and abilities.

EP Text: Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following:- An explanation of the plan for care, treatment, or services- Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency- Basic health practices and safety- Information on the safe and effective use of medications. (See also MM.06.01.01, EP 9; MM.06.01.03, EP 3)- Nutrition interventions (for example, supplements) and modified diets- Infection prevention and control- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management- Information on personal hygiene and grooming- Information on oral health- Basic physical and structural home safety- Information on the safe and effective use of medical equipment or supplies provided by the organization- Information on the storage, handling, and access to medical gases and supplies- Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes- Habilitation or rehabilitation techniques to help the patient reach maximum independence- Information on the use of restraint(See also PC.01.02.07, EP 8; PC.01.03.01, EP 55)Note: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization must provide infection control education to patients and caregivers.

Finding(s): 1) Observed in Record Review at Seasons Hospice, Inc. (606 Potter Road, Des Plaines, IL) site .

In 1 of 4 patient records reviewed, In 1 of 4 patient records reviewed, During RR# 4's patient record review, it was noted the organization had not ensured it developed an individual emergency plan with the patient/family. For example: review of RR# 4's patient record revealed no emergency plan or documentation an emergency plan had been developed with the patient/family. This was discussed and reviewed with Leadership and validated.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

There was a formalized organizational change made by adding a carbon copy Emergency preparation form to all admission booklets. All admission staff and Clinical staff were trained on the use of the emergency preparation form in June 2021. After analysis of the root cause of this finding, it was discovered that our monitoring process was insufficient. The program initiated a new process for ongoing monitoring of process as follows: the Team Assistant will verify attachment of the Emergency Preparation form to the medical record prior to the IDG meeting for all Admissions and Recerts. The Team Assistant will add a notation on the IDG agenda of completion of the form. The IDG will review missing Emergency forms and develop a plan to obtain them at team meetings. The Team Director will ensure missing forms are obtained by the next meeting.

Q. All corrective actions described above were completed by

Aug 24, 2021

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The Team Director will oversee the process weekly at IDG meeting by reviewing the attached emergency preparation forms to the medical record on the IDG agenda. The clinical leadership will continue to monitor emergency preparation form completions at the bedside during routine supervisory visits.

Q. What is the frequency of the monitoring activities?

Monitoring will be completed weekly.

Q. What data will be collected from these activities?

Compliance with having a completed individualized plan attached to the medical record for each home patient.

Q. To who, and how often, will this data be reported?

The Senior Director Clinical Director will report trending data weekly to the senior leadership team and to the QAPI committee quarterly to create action plans on identified trends for ongoing improvement.

Final Accreditation Report

Seasons Hospice, Inc.
606 Potter Road
Des Plaines, IL 60016

Organization Identification Number: 200236
60-day Evidence of Standards Compliance Submitted: 8/31/2021

ESC Programs Reviewed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	8/31/2021	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score
Hospice	§418.56	L538	Compliant
Hospice	§418.56(c)	L545	Compliant
Hospice	§418.60	L577	Compliant
Hospice	§418.60(c)	L582	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
PC.01.03.01	Compliant
PC.02.03.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.02.03.01	10	The organization provides patient education and training based on each patient's needs and abilities.	Based on the patient's condition and assessed needs, the education and training provided to the patient by the organization include the following: - An explanation of the plan for care, treatment, or services - Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency - Basic health practices and safety - Information on the safe and effective use of medications. (See also MM.06.01.01, EP 9; MM.06.01.03, EP 3) - Nutrition interventions (for example, supplements) and modified diets - Infection prevention and control - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management - Information on personal hygiene and grooming - Information on oral health - Basic physical and structural home safety - Information on the safe and effective use of medical equipment or supplies provided by the organization - Information on the storage, handling, and access to medical gases and supplies - Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes - Habilitation or rehabilitation techniques to help the patient reach maximum independence - Information on the use of restraint (See also PC.01.02.07, EP 8; PC.01.03.01, EP 55) Note: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization must provide infection control education to patients and caregivers.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	261641	A. BUILDING _____ B. WING _____	C 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE AND PALLIATIVE CARE OF MISSOURI, L	3660 S GEYER ROAD - SUITE 120 SAINT LOUIS, MO 63127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS A complaint investigation MO00185723 was completed on 06/30/2021 at Seasons Hospice and Palliative Care of Missouri. The complaint is substantiated. One or more of the allegations reported are verified and deficiencies were cited that are related to the allegations being investigated. The agency census was 170. One condition-level deficiency was identified during this survey at §418.112, Hospice that Provide Hospice Care to Residents of a SNF/NF.	L 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with state and federal laws.	
L 759	RESIDENTS OF SNF/NF OR ICF/MR CFR(s): 418.112 This CONDITION is not met as evidenced by: Based on policy review, record review, and interview the hospice provider failed to maintain professional management of core services (nursing service) of a patient residing in a skilled nursing facility (SNF). (L762) The effect of this practice results in the provider's inability to effectively provide care and services to patients' residing in a SNF.	L 759	All Clinical Leaders and all nurses will be assigned training in Season's University by 7/14/21 on the following: • policy 233 Hospice Care to Residents in a facility • Policy 214 Plan of Care • Protocol 2005 Wound Care • Protocol 2076 Long-term Care Facility Charts • Policy 212 Patient and Family Assessment • Policy 213 Patient and Family Reassessment • Dermarite wound care training hub • Use of facility Integration form • Editing Pathways	7/26/21
L 762	PROFESSIONAL MANAGEMENT CFR(s): 418.112(b) The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to §418.100 and §418.108.	L 762		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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L 762	Continued From page 1 This STANDARD is not met as evidenced by: Based on policy review, record review, and interview the hospice provider failed to maintain professional management of hospice core services (nursing service) in one of two patient records (Patient/Record #2) for patients residing in a skilled nursing facility (SNF). Findings included: Review of the agency policy titled "Wound Care Protocol", last updated 05/11/2017 showed in part the following: - "The nurse will assess wounds at least every 7 days per the Lippincott Procedure Manual, in coordination with the facility nurse or other caregivers"; - Staging of a pressure injury will be included in the documentation in the electronic medical record (EMR); - The nurse will coordinate with the physician, Interdisciplinary Group, caregivers, and facility nurses to develop a wound care plan appropriate to the patient's or decision maker's wound care goals; - The nurse will obtain a physician's order which will include wound treatment orders (including frequency) and medications, both scheduled and PRN; and - The nurse will review orders with facility staff, caregivers, and/or family to promote collaborative communication. RECORD/PATIENT #2: Review of the patient's hospice admissions document showed that the patient was admitted to hospice services on 02/11/2021 for protein	L 762	**Monitoring** Supervisory visit of a patient with a wound will be complete by ED/DC/TD with each RN for 100% nursing supervision by 8/31/21. The Supervisory visit will ensure a complete and accurate assessment and facility collaboration are done on every visit per policies and protocols: • policy 233 Hospice Care to Residents in a facility • Policy 214 Plan of Care • Protocol 2005 Wound Care • Protocol 2076 Long-term Care Facility Charts • Policy 212 Patient and Family Assessment • Policy 213 Patient and Family Reassessment An audit will be completed with each supervisory visit for a goal of 80% compliance or better. Immediate feedback will be provided to staff and follow up visits will be made with the RN who does not meet the 80% compliance every 2 weeks until the goal is achieved. All patients with wounds (100%) will be audited during IDG, after training is complete, utilizing the supervisory visit audit tool with a goal of achieving 80% compliance within the first 30 days and 100% compliance	8/31/21

	within the next 60 days. Once a 100% compliance has been achieved for 3 consecutive weeks, the audit will cease.	

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L 762	Continued From page 2 calorie malnutrition and prostate cancer. The patient passed away on 05/21/2021. Review of the hospice plan of care showed that the hospice nurse was to - Visit and evaluate the patient once weekly from 02/11/2021 and then twice weekly starting on 03/07/2021. - The nurse was assigned to "provide wound care per orders", starting 02/12/2021. - Apply calcium alginate dressing to sacral wound, starting 02/12/2021. The dressing change was daily, hospice nurse was to to coordinate care with facility staff. Review of all available nurse visit notes showed that the hospice nurses visited/evaluated the patient 21 times over the the 14 week hospice admission that started on 02/11/2021 and ended at the patient's death on 05/21/2021. According to the hospice policy and administration expectation, the patient's open wound(s) should have been assessed 14 times, or weekly. Review of the skilled nurse visit notes and clinical software review with the hospice team leader showed that the patient's stage IV wound (Stage IV Pressure Sore - a full thickness skin loss with extensive destruction, tissue death or damage to muscle tissue) was assessed only four times by the hospice, on 02/11/2021, 03/26/2021, 04/13/2021, and 04/26/2021. No wounds, other than the stage IV pressure ulcer on the sacral area was documented or assessed by the hospice. Review of the hospice nurse visit on the 03/30/2021 visit showed that the nurse assessed the patient with a stage II pressure ulcer (Stage II Pressure Sore-a partial thickness loss of skin layers that presents clinically as an abrasion,	L 762	The Team Director will review 100% of wound measurements during the IDG meeting to provide real time education for ongoing compliance. **Reporting** Leadership meetings are held every week and results/trends of supervisory visits and chart reviews. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained. **Responsible Person** Executive Director	

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L 762	Continued From page 3 blister, or shallow crater). The nurse failed to identify the location of the ulcer, or assess/describe the ulcer. The nurse documented that the patient had a Stage IV pressure ulcer on the sacral area with no description or measurements. Review of the hospice nurse visit on the 04/30/2021 visit showed that the nurse assessed the patient with a stage III pressure ulcer (Stage III Pressure sore-a full thickness of skin loss, exposing the subcutaneous tissues, presents as a deep crater with or without undermining adjacent tissue). The nurse failed to identify the location of the ulcer, or assess/describe the ulcer. The nurse documented that the patient had a Stage IV pressure ulcer on the sacral area with no description or measurements. Review of the wound care assessments and treatment administration records from the long-term care facility (SNF) where the patient resided showed: - Daily dressings to a stage IV pressure ulcer to the sacral area. - That the patient had an unstaged open wound ulcer on his/her right lower leg that required a dressing change every three days. The dressing change order showed the wound developed and had a dressing order on 05/10/2021. It should be noted that the hospice was unaware of this wound, and the hospice had no care plan or intervention for this wound. - The patient had a "open shear ulcer" on his/her left buttock dated 04/28/2021 that required dressings every seven days. It should be noted that the hospice was unaware of this wound, and the hospice had no care plan or intervention for this wound.	L 762	

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L 762	Continued From page 4 During an interview with the administrator on 06/25/2021 at 10:00 AM, he/she stated that wounds should be assessed weekly. An interview with the patient's primary hospice nurse case manager on 06/29/2021 at 12:15 PM showed that he/she stated the following: - When asked if the patient had any wounds, he/she stated that the patient had one wound, a stage II or stage III pressure ulcer; - When asked to describe the patient's dressing, the nurse stated the he/she could not recall the type of dressing changes used for the patient without looking at the medical record, "The facility was doing it"; - When asked how wound care was coordinated, the nurse stated "They (the SNF) have their own wound team with orders and treatments, they managed the wound"; and - When asked where wound assessments would be documented in the hospice medical record, he/she stated that wounds should be measured and evaluated weekly and documented in the integumentary section of the medical record.	L 762		

Date/Time IJ Template provided to entity: Season's Hospice and Palliative Care of WI 521571 Inpatient Unit located at Lutheran Home

IJ Component	Yes/No	Preliminary fact analysis which demonstrates when key component exists.
Noncompliance: Has the entity failed to meet one or more federal health, safety, and/or quality regulations? If yes, in the blank space, identify the tag and briefly summarize the issues that lead to the determination that the entity is in noncompliance with the identified requirement. This includes the action(s), error(s), or lack of action, and the extent of the noncompliance (for example, number of cases). Use one IJ template for each tag being considered at IJ level.	Yes/No YES L581	Yes – The agency failed to follow infection control guidelines that state in part "people who have been in close contact with someone who has COVID-19. Steps to take stay home 14 days after last contact, after day 10 without testing, after day 7 after receiving a negative test result (test must occur on day 5 or later). RN C worked providing patient care to 3-4 Patients after a Covid 19 Exposure. RN C had close contact with RN C's roommate on 12/20/2020. Using the 7 day quarantine option from the CDC, the last day of quarantine to include RN C's negative test result collected 12/22/20 would be 12/27/2020. RN C reported on RN C's daily self-screen on 12/22/20 indicated very mild chills and body aches starting that afternoon but was still cleared to work on 12/23/20 7 am – 7 pm. On 12/23/20 RN Cs symptom tracker indicated she had chills, body aches, runny nose and fever of 97.7 AM, 100.9 & 101.1 PM. This agency has no documentation to show who is responsible to check the employee's daily tracking results. Interview with Director of Clinical Operations B on 1/22/2020 at 4:57 PM stated that RN C was exposed to RN C's roommate on 12/16/2020, 12/19/2020, and 12/20/2020 when C spent time in the same room as the roommate. C's roommate tested Covid-19 Positive on 12/21/2020. RN C reported to B on 12/21/2020 and RN C was sent home. RN C tested negative for Covid-19 rapid test on 12/22/2020, and was allowed to return to work at the Seasons Hospice Inpatient Unit on 12/23/2020. 7AM – 7 PM according to this agency's National partners follow the CDC guidelines. The agency did not provide which CDC guidelines they follow. The CDC guidelines as stated above call for a longer quarantine period than 48 hours after a known exposure.

Serious injury, serious harm, serious impairment or death: Is there evidence that a serious adverse outcome occurred, or a serious adverse outcome is likely as a result of the identified noncompliance? If Yes, in the blank space, briefly summarize the serious adverse outcome, or likely serious adverse outcome to the recipient.	Yes/No YES	Yes Patient #1 is a 99 year old female with a hospice diagnosis of Protein Calorie Malnutrition. Inpatient 12/9/2020-12/30/2020. Patient #1 discharged to Aurora St Luke's Emergency Room for treatment. Upon admission to the Emergency Room on 12/30/2020 was tested for Covid. Results – Positive. RN C documented on 12/29/2020 at 11:17 AM to having worked with 3-4 patients 12/21/2020 & 12/23/2020 and came into contact with some family members, but was almost always 6 feet apart and or did not spend more than 15 minutes with them. RN C states RN C always wearing N-95 mask (no documentation of fit testing or if it was an N-95 or KN-95). This had the potential to affect all staff and 5 inpatients during 12/21/2020 and 12/23/2020 when RN C was working after a known Covid-19 exposure on 12/20/2020.
A		
Need for Immediate Action: Does the entity need to take immediate action to correct noncompliance that has caused or is likely to cause serious injury, serious harm, serious impairment, or death? If yes, in the blank space, briefly explain why.	Yes/No YES	Yes This facility knowing allowed staff to work after a Covid-19 exposure to a positive Covid roommate on 12/20/2020. RNC was allowed to return to work on 12/23/2020 after testing negative for Covid, but on RN C's daily symptom tracker indicated symptoms of very mild chills body-aches, starting afternoon of 12/22/2020 (cleared for work) and on 12/23/2020 recorded symptoms of chills, body aches, runny nose, fatigue, fever (AM 97.7, PM 100.9/101.1 no time) worked 7 AM – 7 PM . Email documentation on 12/23/2020 at 12:54 PM revealed Director B updated National Specialist L of the RN C's roommate was febrile and improving in symptoms, RN C had a Covid negative test on 12/22/2020 and returned to work 12/23/2020 will wear a N95 mask No indication of when or who from this agency checks the staffs daily symptom checks. This agency did not follow the above CDC guidelines or this agency's Employee Exposure & Symptom Management Reporting Process putting all 5 inpatients at risk due to patient's age and vulnerable related to a hospice diagnosis. This agency will continue to put patients at risk until they put in place and follow policy and procedures for staff working in the hospice inpatient unit.

Disclaimer: The findings on this IJ Template are preliminary and do not represent an official finding against a Medicare provider or supplier. Form CMS-2567 is the only form that contains official survey finding.

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	521571	A. BUILDING _____ B. WING _____	C 02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE AND PALLIATIVE CARE OF WISCONSIN	6737 W WASHINGTON ST SUITE 2150 WEST ALLIS, WI 53214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIC ENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS An unannounced, federally authorized onsite complaint survey was conducted from 1/19/2021 - 2/2/2021 at Seasons Hospice and Palliative Care's Inpatient Unit located at Lutheran Home 4th Floor in Wauwatosa, WI. Seasons Hospice was found to be out of compliance with the Medicare Conditions of Participation 42 CFR 418 for Hospice. Complaint WI00039569 was Substantiated. Complaint #WI00039700 was not substantiated. 42 CFR 418.60 Condition of Participation: Infection Control NOT MET The CMS COVID-19 Focused Infection Control Survey for Acute and Continuing Care tool was completed during this survey and concerns were identified. Immediate Jeopardy was determined on 2/1/2021 at 1:55 PM under L581 regarding the failure to follow infection control guidelines for staff who are symptomatic or who have been in close contact with someone who has Covid-19. Quarantine period per CDC guidelines was not followed. The facility was notified of the Immediate Jeopardy on 2/2/2021 at 11:06 AM. The Immediate Jeopardy was removed on 2/2/2021 at 3:00 PM after providing a plan of correction that included the immediate education of all inpatient unit staff on new protocol for Covid-19 symptom screening questionnaire and temperature check prior to shift, reporting symptoms of Covid-19 directly to Director of Clinical Operations B, following CDC guidelines for symptoms of Covid-19, and exposure to Covid-19. Deficient practice remains	L 000	This Plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPL ER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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L 000	Continued From page 1 at the condition-level as all staff were not immediately available to be trained/educated on the new processes.	L 000		
L 577	INFECTION CONTROL CFR(s): 418.60 This CONDITION is not met as evidenced by: Based on record review, observation and interview, agency staff failed to develop, maintain, and document an effective infection control program and did not follow infection control guidelines when staff presented to work and provided direct care on the inpatient hospice unit after COVID exposure and while symptomatic. This has the potential to affect 9 of 9 inpatients receiving services including 3 of 3 patients (Patient #1, Patient #11, and Patient #12) out of a sample of 12 who were exposed to RN C while she was symptomatic. Patient #1 was later hospitalized with a positive COVID-19 diagnosis. Findings Include: 1. Agency staff failed to ensure a method is in place for identifying infections and a plan for actions that will result in improvement and disease prevention. See L 581 The systematic failure of lack of an infection control program puts all patients, families, visitors, and agency staff at risk for development and spread of communicable and infectious disease.	L 577	**Action steps** The Executive director will develop a new protocol to include all in-patient unit staff complete the Covid screening questionnaire and temperature check prior to shift. All staff who have answered to the affirmative of having covid symptoms or exposure to Covid or present with a temperature greater than 100.0 Degrees Fahrenheit, will call the Director of Clinical Operations for guidance. The Director of Clinical Operations will follow CDC guidelines to determine when the employee will return to work. All questionnaires with temperature screenings will be maintained on site in a folder. The Regional Director of Learning and Development will add new protocol to orientation as of 2/2/2021.	2/2/2021 2/2/21
L 581	CONTROL CFR(s): 418.60(b)(2) [The hospice must maintain a coordinated	L 581		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE AND PALLIATIVE CARE OF WISCONSIN	6737 W WASHINGTON ST SUITE 2150 WEST ALLIS, WI 53214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFIC ENCY)	(X5) COMPLETION DATE
L 581	Continued From page 2 agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that-] (2) Includes the following: (i) A method of identifying infectious and communicable disease problems; and (ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the agency staff failed to have a method with which to identify infectious and communicable disease exposure by staff and did not follow policy when Registered Nurse C worked providing direct care while symptomatic after COVID-19 exposure. This has the potential to affect all 9 of 9 inpatients patients receiving services including 3 of 3 patients (Patient #1, Patient #11, and Patient #12) out of a sample of 12 who were exposed to RN C while she was symptomatic. Patient #1 was later hospitalized with a positive COVID-19 diagnosis. Findings Include: Center for Disease Control and Prevention (CDC) COVID-19 Guidelines, last updated December 10, 2020, reviewed 1/25/2021 at 3:30 PM. It states in part "Who needs to quarantine? People who have been in close contact with someone who has COVID-19. Steps to take. Stay home for 14 days after your last contact with a person who has COVID-19. Options to reduce quarantine, after day 10 without testing, after day 7 after receiving a negative test result (test must	L 581	Due to national depletion of N95 masks and testing solution, Seasons Has not been able to fit test. However, the Vice President of Logistics and Resource Utilization will continue to search for resources to achieve 100% fit testing for IPC staff when obtainable. The Director of Clinical Operations will E-mail new employee screen and reporting practices to all in-patient unit staff with a read receipt. The Director of Clinical Operations will follow up e-mail with virtual training to all Inpatient unit staff. Training is scheduled for 02/12/202. **Monitoring** The Director of Clinical Operations will review all submitted screening tools weekly and compare to worker schedule to ensure 90% compliance with process for 3 consecutive months. **Reporting** Leadership meetings are held every 2 weeks and trends will be discussed and action steps determined based on the data. Quarterly QAPI meetings will also review the trends and any follow up action steps implemented to ensure that compliance is maintained.	2/2/2021 2/12/2021 2/2/2021

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	521571	A. BUILDING _____ B. WING _____	C 02/02/2021

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L 581	Continued From page 3 occur on day 5 or later)." Review of CDC Guideline "Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing" revealed: "Local public health authorities determine and establish the quarantine options for their jurisdictions. CDC currently recommends a quarantine period of 14 days. However, based on local circumstances and resources, the following options to shorten quarantine are acceptable alternatives.Quarantine can end after Day 10 without testing and if no symptoms have been reported during daily monitoring. When diagnostic testing resources are sufficient and available...then quarantine can end after Day 7 if a diagnostic specimen tests negative and if no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation (e.g., in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7." There are no CDC guidelines that allow for return to work within 3 days of COVID-19 exposure. Facility policy entitled, "Employee Exposure & Symptom Reporting Process for All 5 Risk Levels", last updated 11/17/2020, reviewed 1/21/2021 at 4:00 PM. It states in part under "Risk level 3 Known Exposure to COVID-19 + person is a Household Member to Refer to Risk Level 4." Level 4 guidance states, "Known Exposure to COVID-19 + Person who is a household member - Scenario - A Symptomatic, submit symptom tracking form, Work - May not come to work but may work from home if	L 581	**Responsible Person** Executive Director	

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L 581	Continued From page 4	L 581		

approved by supervisor and employee remains asymptomatic. For infection control monitoring, all employees who report any symptom (COVID-19 or non COVID-19) must submit a temperature & symptom report before and after work every day using the Symptom Tracking Form instead of daily screening app until they are A-Symptomatic."

In interview with Director of Clinical Operations B on 1/22/2021 at 4:57 PM, Director of Clinical Operations B was asked to provide any employees of Seasons Hospice Inpatient Unit at the Luther Home that may have been exposed to or tested positive to COVID-19. B provided documentation related to employee Registered Nurse C.

In interview with Director of Clinical Operations B on 1/22/2021 at 4:57 PM stated that Registered Nurse C was exposed to Registered Nurse C's roommate on 12/16/2020, 12/19/2020 and 12/20/2020 when C spent time in the same room as the roommate. C's roommate tested COVID-19 + on 12/21/2020. Registered Nurse C reported the COVID-19 + roommates test results to Director of Clinical Operations B on 12/21/2020 and Registered Nurse C was sent home from work from Seasons Hospice Inpatient Unit. Registered Nurse C tested negative for COVID-19 on 12/22/2020 and was allowed to return to work at the Seasons Hospice Inpatient Unit on 12/23/2020 7 AM - & 7 PM according to this agency's National Documentation Specialist, Seasons Healthcare Management located in Rosemont, IL B stated that the National partners follow the CDC guidelines. The facility did not provide documentation of which CDC guideline the National partner used in making the

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L 581	Continued From page 5	L 581		

determination and CDC guidelines as noted above call for a longer quarantine period.

Employee Exposure e-mail from 12/21/2020 at 2:31 PM from National Documentation Specialist L to Director of Clinical Operations B stated "Based on the information provided, the employee may not come to work".

In interview with Director of Clinical Operations B on 1/22/2021 at 4:57 PM regarding the decision that Registered Nurse C could return to work on 12/23/2020. B stated they were provided the guidance that as long as Registered Nurse C remained asymptomatic and her roommates symptoms had improved and been afebrile for more than 24 hours, that Registered Nurse C could return to work 12/23/2020. Registered Nurse C relayed information via phone call that her roommate was last febrile on 12/21/20, and that symptoms were still present, but improving on 12/22/20, so according to the Exposure Template Registered Nurse C met the criteria to return to work on 12/23/20. B stated, "Our National partners follow a decision tree based on CDC guidelines that is monitored daily." Note: There are no CDC guidelines that were provided by the facility to support the decision to allow Nurse C to return to work with a quarantine period of less than 7 days.

The Employee Exposure Template/Symptom Tracker (this agency's method of daily symptom checks post exposure)also documented Registered Nurse C had the following reported symptoms: 12/21/20 no symptoms, temp PM (no time) 97.6: 12/22/20 very mild chills, body aches starting in afternoon (cleared for work) temp AM (no time) 98.6, PM (no time) 97.8: and 12/23/20;

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L 581	Continued From page 6	L 581		

chills body aches, runny nose, fatigue, fever (went to work 7 AM-7 PM) temp AM (no time 97.7, PM 100.9, 101.1).

In interview with RN C on 2/2/2021 at 1:00 PM, C stated C had education upon hire and orientation on 9/26/2020 with other RN staff related to donning and doffing and appropriate PPE. COVID-19 specific formal training was provided.. The employee file confirmed this training was complete. When asked how symptoms of COVID-19 are monitored daily RN C stated each day upon arrival we log into a symptom checker in the lobby prior to punching in and get cleared to enter the building. Then upon arrival to the unit we have a symptom checking app we are to enter our daily symptoms into. C was unaware symptoms reported on 12/22/2020 an 12/23/2020 were not linked to be sent to Director B.

C was notified C's roommate tested positive on 12/21/2020 at 3:30 PM, C notified Director B and was sent home. C then felt symptoms of mild chills, body aches, 12/22/2020 was cleared to return to work on 12/23/2020, C stated 12/23/2020 had mild chills, body aches, runny nose prior to work, but no fever until returning home after the 7 AM - 7 PM shift.

C stated a COVID rapid test was done on 12/22/2020 that came back negative, C also had a second test completed 12/22/2020, the test results had not returned until 12/25/2020, that test was positive for COVID-19. C stated Director B did not know the second test was pending when allowed to return to work on 12/23/2020. RN C stated a KN95 mask was worn all day 12/23/2020 with the exception of eating (which was alone) and drinking. C could not verify if other staff were

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L 581	Continued From page 7	L 581		

present while taking a drink when the mask was off. While charting C was 6 feet distance from other staff, but was present with staff longer than 15 minutes.

In interview with Director B on 2/2/2021 at 1:40 PM follow up on the symptom tracking app with Director B, B stated that B was not aware of RN C's symptoms on 12/22/2020 or 12/23/2020. Staff are to report symptoms on the symptom tracking app, if any symptoms are present staff are directed to a link that would have notified Director B of symptoms present for RN C and RN C would not have worked 12/23/2020. The link that RN C used is sent to the COVID Infection Team who sends a monthly report. Director B was not aware of the exposure until the time of this original complaint survey 1/19/2021.

RN C provided direct care to three patients on 12/23/2020, Patient #1, Patient #11, and Patient #12.

Patient #1 is a 99 year old female with a hospice diagnosis of Protein Calorie Malnutrition. Patient #1 was Admitted to Seasons Hospice Inpatient unit on 12/9/2020 and transferred from Season's Hospice Inpatient Unit on 12/30/2020 to Aurora St Luke's Emergency Room. Patient #1 was tested for COVID-19 upon admission to the Emergency Room on 12/30/2020 at 1800 with a COVID-19 result of Positive. Patient #1 as of 1/13/2021 resides at an assisted living facility.

Patient #11 and Patient #12's records were reviewed on 2/2/2020. Review revealed Patient #11 was admitted to this unit on 12/23/2020 with a diagnosis of COVID-19 and Patient #12 was admitted to this unit on 12/18/2020 with

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L 581	Continued From page 8	L 581		

diagnosis of brain cancer. Patient #11 had no documentation of further COVID-19 symptoms, and died on the unit 12/27/2020. Patient #12 had no documentation of COVID-19 symptoms, and died on this unit 12/28/2020 related to the hospice diagnosis.

In interview with Director of Clinical Operations B on 2/2/2021 at 11:25 AM were staff/patient who had been exposed to RN C on 12/21/2020 and 12/23/2020 tested for COVID-19. C stated no routine COVID-19 testing was done on staff/patients who were in contact with RN C. B stated RN C had not followed the correct symptom tracking link to report RN C's symptoms of COVID-19 on 12/22/2020 and 12/23/2020. If the symptom tracking app would have been followed correctly, the process then would have contacted B to notify of symptoms of COVID-19 and RN C would have been asked to Quarantine. Director B was not aware of the infection control breach until the time of this survey.

The COVID positive employee was not reported to the state public health agency, Director B stated "We were not the testing location so we don't report the findings." Note: Wisconsin law requires health care providers including hospices to report Category 1 diseases including COVID-19 immediately to the local health officer.

In interview with Director of Clinically Operations B on 2/2/2021 at 12:17 PM what type of masks are worn by staff. The staff who care for COVID-19 patients were an N95 mask. That mask is kept in a bag on the PPE cart for the staff assigned to that patient to use during their shift. No fit testing was provided. The other areas of the inpatient unit staff wear a KN95 mask.

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L 581	Continued From page 9 Observation of inpatient floor plan/COVID-19 positive patient placement, RN C donning and doffing personal protective equipment (PPE) on 2/2/2021 at 1:00 PM. It was observed that RN C followed this agency's posted signs, for isolation of a COVID + patient room was appropriately marked with contact, droplet, airborne precaution signs, and PPE sequence for donning and doffing PPE. The rooms used for COVID + patients are at the end of Inpatient hall B, the rooms are 100 % outside air filtered from outside to the unit MRV12 filters, air pumped into hallways then into rooms, air exhausted out through bathroom in each room. Air is not exchanged between rooms. Observation of RN C included PPE of N95 Mask "titled 3M #1860 tabled, caution M revealed all approved respirators shall be selected, fitted, used and maintained in accordance with MSHA, OSHA, and other applicable regulations. In interview with Executive Director M on 2/2/2021 at 1:42 PM. Director M provided background on why staff have not been fit tested. stated we have been unable to provide fit testing for the following reasons: 1. There is not enough testing solution or kits to source for all of our staff nationwide and we have been trying to address that since last 2/1/2020. 2. We are unable to source smaller N95/KN95 masks which have also attempted to do continuously since 2/1/2020. We have multiple sources including international ones and are still unable to get stock of various sizes of the appropriate masks. We are aware that the OSHA regulations have not changed and we are also aware of the CDC guidelines related to limited PPE resources.	L 581		

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L 581	Continued From page 10 COVID-19 Exposure Form for Registered Nurse C dated 12/29/2020 revealed Registered Nurse C had contact on 12/21/2020 and 12/23/2020 with staff D, E, F, G, H, I, J, and K. Per Registered Nurse C's report Employee Exposure Template/Symptom Tracker dated 12/29/12:08 PM. Register Nurse C had contact with Staff D, on 12/23. Staff D had contact with Patient #1 on 12/26/20, 12/28/20, and 12/29/20. RN C had contact with Staff E on 12/21/20 & 12/23/20. Staff E had contact with Patient #1 on 12/28/20. Register Nurse C had contact with Staff G on 12/21/20. Staff G had contact with Patient #1 on 12/28/20. Registered Nurse C had contact with Staff J on 12/23/2020. Staff J had contact with Patient #1 on 12/29/2020. Immediate Jeopardy was determined on 2/1/2021 at 1:55 PM under L581 regarding the failure to follow infection control guidelines for people who are symptomatic or have been in close contact with someone who has COVID-19. Quarantine period per CDC guidelines was not followed. The facility was notified of the Immediate Jeopardy on 2/2/2021 at 11:06 AM. The Immediate Jeopardy was removed on 2/2/2021 at 3:00 PM after providing a plan of correction that included the immediate education of all inpatient unit staff on new protocol for COVID-19 symptom screening questionnaire and temperature check prior to shift, reporting symptoms of COVID-19 directly to Director of Clinical Operations B, following CDC guidelines for symptoms of COVID-19, and exposure to COVID-19. Deficient practice remains at the condition-level as all staff were not immediately available to be trained/educated on the new processes.	L 581		

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L 581	Continued From page 11 This agency was not able to provide a method of identifying infectious and communicable disease problems for patients, families, caregivers or hospice staff at Seasons Hospice Inpatient Unit who were potentially exposed to COVID 19 via staff infection. The facility had lapses in COVID screening and used incorrect guidelines for quarantine that allowed a symptomatic staff person to work after COVID exposure and without adequate quarantine.	L 581		

Final Accreditation Report

Seasons Hospice & Palliative Care of Massachusetts, LLC
1 Edgewater Drive, Suite 103
Norwood, MA 02062

Organization Identification Number: 590938
Unannounced Full Event: 7/25/2022 - 7/29/2022

Program Surveyed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	07/25/2022 - 07/29/2022	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Home Care

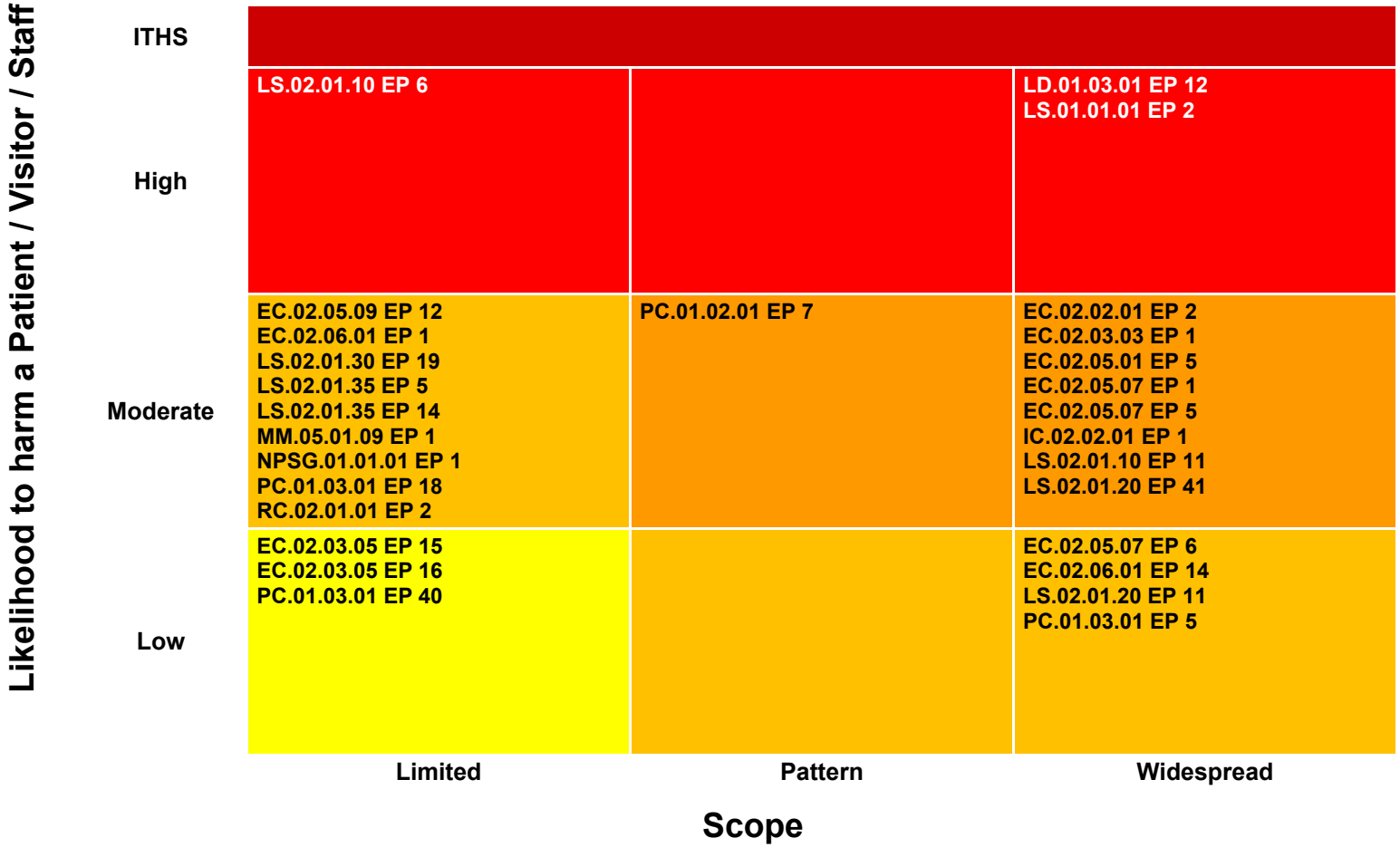
Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.02.01	2	Moderate / Widespread				✓
EC.02.03.03	1	Moderate / Widespread				✓
EC.02.03.05	15	Low / Limited				✓
	16	Low / Limited				✓
EC.02.05.01	5	Moderate / Widespread				✓
EC.02.05.07	1	Moderate / Widespread				✓
	5	Moderate / Widespread				✓
	6	Low / Widespread				✓
EC.02.05.09	12	Moderate / Limited	§418.110 (e)	L-------	✓	✓
EC.02.06.01	1	Moderate / Limited				✓
	14	Low / Widespread	§418.110 (i)(2)	L732	✓	✓
IC.02.02.01	1	Moderate / Widespread	§418.60 (a)	L579		✓
LD.01.03.01	12	High / Widespread	§418.100 (b)	L651	✓	✓
LS.01.01.01	2	High / Widespread	§418.110 (d)(1)(i)	L728	✓	✓

The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
LS.02.01.10	11	Moderate / Widespread	§418.110 (d)(1)(i)	L728	✓	✓
	6	High / Limited				✓
LS.02.01.20	11	Low / Widespread	§418.110 (d)(1)(i)	L728	✓	✓
	41	Moderate / Widespread	§418.110 (d)(1)(i)	L728	✓	✓
LS.02.01.30	19	Moderate / Limited	§418.110 (d)(1)(i)	L728	✓	✓
LS.02.01.35	14	Moderate / Limited				✓
	5	Moderate / Limited	§418.110 (d)(1)(i)	L728	✓	✓
MM.05.01.09	1	Moderate / Limited	§418.106 (e)(1)	L693		✓
NPSG.01.01.01	1	Moderate / Limited				✓
PC.01.02.01	7	Moderate / Pattern	§418.54 (c)(5)	L529		✓
PC.01.03.01	18	Moderate / Limited	§418.56 (c)(4)	L549		✓
	40	Low / Limited	§418.112 (d)(1)	L774		✓
	5	Low / Widespread	§418.56 (c)	L545		✓
RC.02.01.01	2	Moderate / Limited	§418.104 (a)(3)	L674		✓

The Joint Commission
SAFER™ Matrix

Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.100	L649	Condition	OME
Hospice	§418.100(b)	L651	Condition	OME/LD.01.03.01/EP12
Hospice	§418.104	L670	Standard	OME
Hospice	§418.104(a)(3)	L674	Standard	OME/RC.02.01.01/EP2
Hospice	§418.106	L687	Standard	OME
Hospice	§418.106(e)(1)	L693	Standard	OME/MM.05.01.09/EP1
Hospice	§418.110	L719	Condition	OME
Hospice	§418.110(d)(1)(i)	L728	Standard	OME/LS.01.01.01/EP2 OME/LS.02.01.10/EP11 OME/LS.02.01.20/EP11 OME/LS.02.01.20/EP41 OME/LS.02.01.30/EP19 OME/LS.02.01.35/EP5
Hospice	§418.110(e)	L-------	Standard	OME/EC.02.05.09/EP12
Hospice	§418.110(i)(2)	L732	Standard	OME/EC.02.06.01/EP14
Hospice	§418.112	L759	Standard	OME
Hospice	§418.112(d)(1)	L774	Standard	OME/PC.01.03.01/EP40
Hospice	§418.54	L520	Standard	OME
Hospice	§418.54(c)(5)	L529	Standard	OME/PC.01.02.01/EP7
Hospice	§418.56	L538	Standard	OME
Hospice	§418.56(c)	L545	Standard	OME/PC.01.03.01/EP5
Hospice	§418.56(c)(4)	L549	Standard	OME/PC.01.03.01/EP18
Hospice	§418.60	L577	Standard	OME
Hospice	§418.60(a)	L579	Standard	OME/IC.02.02.01/EP1

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.02.01	2	Moderate Widespread	The organization manages hazardous materials and waste from receipt or generation through final use or disposal. (See also IC.02.01.01, EP 6; MM.01.01.03, EP 2)	1) Observed in EOC Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the organization failed to conduct an evaluation of the use and disposal requirements of a product used to disinfect the floors in the inpatient unit. The surveyor noted that the MSDS indicated that personal protective equipment was required for preparing solutions of "Lemon Air Plus"; however the surveyor observed and confirmed that staff were not wearing googles and a face shield or protective clothing when mixing and using the product. Also, there was no evidence that the chemical was being disposed of correctly or that an evaluation of the local requirements was evaluated. This was confirmed with the director.		
EC.02.03.03	1	Moderate Widespread	The organization conducts quarterly fire drills. Note 1: Evacuation of patients during drills is not required. Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use a coded announcement to notify staff instead of activating audible alarms. For full text, refer to NFPA 101-2012: 18/19: 7.1.7. Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies. (See also LS.01.02.01, EP 11)	1) Observed in Environment of Care Session at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 3 of 3 years, The hospice nurse surveyor noted that the only fire drill available for review in 2022 was announced and the time was not specified. In 2021, there were only two drills documented on the night sift, none for the day shift and there was no description of the event or indication that it was evaluated. There was no documentation available for 2020 or 2019. This was confirmed with the director.		

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.03.05	15	Low Limited	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check for the correct type of and clear and unobstructed access to fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional information on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the tag on the fire extinguisher in the gas pump room was last dated 8/2018. There was no documented evidence that the fire extinguisher was inspected monthly. This was confirmed with the director.		
EC.02.03.05	16	Low Limited	Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented. Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the tag on the fire extinguisher in the gas pump room was last dated 8/2018 and there was no evidence that maintenance had been performed annually for the last three years. This was confirmed with the director.		
EC.02.05.01	5	Moderate Widespread	The organization identifies, in writing, the intervals for inspecting, testing, and maintaining all components of the utility systems, based on criteria such as manufacturers' recommendations, risk levels, or organization experience.	1) Observed in Document Review at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the inpatient unit (IPU) did not have a written policy on testing water in tanks and showers for biologicals such as Legionella. This was confirmed with the director.		
EC.02.05.07	1	Moderate Widespread	At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)	1) Observed in Document Review at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 36 of 36 months, The hospice nurse surveyor noted that there was no documentation available to confirm that he organization performed a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.05.07	5	Moderate Widespread	At least monthly, the organization tests each emergency generator under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)	1) Observed in Document Review at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 36 of 36 months, The hospice nurse surveyor noted that the organization tested each emergency generator under load for at least 30 continuous minutes, monthly. No documentation was available.		
EC.02.05.07	6	Low Widespread	The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load.	1) Observed in Document Review at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 36 of 36 months, The hospice nurse surveyor noted that there was no documentation available to confirm that the transfer switch was tested, as the monthly load tests documentation was not available. The surveyor noted that the annual test documentation indicated that the transfer switch was not tested. This was confirmed with the director.		
EC.02.05.09	12	Moderate Limited	The hospice implements a policy on all cylinders within the hospice that includes the following: - Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care (For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that both full and empty oxygen tanks were stored together without a delineation or separation of space for the tanks. This was corrected on site and the empty tanks relegated to another room.	§418.110(e)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.06.01	1	Moderate Limited	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, or services provided.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 3 of 10 areas observed, The hospice nurse surveyor noted that there were stained ceiling tiles in the main corridor, the small storage room and two tiles in the soiled utility room. Also, the surveyor noted that the shower rod in patient room 14 was rusted. This was confirmed with the director.		
EC.02.06.01	14	Low Widespread	For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice supplies an adequate amount of hot water at all times for patient use and has plumbing fixtures with control valves that automatically regulate the temperature of the hot water.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 3 of 3 years, The hospice nurse surveyor noted that there was no available documentation of water temperature testing in the patient rooms for the last three years. This was confirmed with the director.	§418.110(i)(2)	Standard
IC.02.02.01	1	Moderate Widespread	The organization implements infection prevention and control activities when doing the following: Cleaning and performing disinfection of medical supplies and devices. * Note: Disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions. Footnote *: For further information regarding cleaning and performing disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3. (See also EQ.01.05.01, EPs 3, 4)	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 4 of 5 home visits conducted, The hospice nurse surveyor noted (HV#2) that the nurse did not follow organizational policy #4004 and manufacturer's guidelines when using Sani-wipes to disinfect equipment before returning it to the bag. The manufacturer's guidelines require a two (2) minute wet time; however the equipment was cleansed and left to dry and did not stay wet, as required. Also, in (HV#3) and (HV#4), the nurses did not maintain the wet-time and in (HV#5) the nurse disinfected the equipment and immediately returned the equipment to the bag, while still wet. This was confirmed with the director.	§418.60(a)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LD.01.03.01	12	High Widespread	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . The hospice nurse surveyor noted through discussion s with staff, tracer activities and documentation review that leadership and the governing body should have reasonably known about requirement for COP 418.100 and 418.110. This was confirmed with the executive director.	§418.100(b)	Condition

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LS.01.01.01	2	High Widespread	In time frames defined by the organization, the organization performs a building assessment to determine compliance with the “Life Safety” (LS) chapter. Note: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the organization had no evidence that there was a person responsible for the evaluation and maintenance for the environmental and Life safety needs of the facility. The surveyor noted that there was no evidence that environmental inspections were performed on a routine base or that environmental tours were conducted. Also, the Life Safety drawings provided, did not accurately describe the building. For example, the firewall ended in an egress and there was no indication on the drawing of a corridor B smoke barrier door. A fire watch process was implement on site for all Life safety deficiencies. The surveyor did not receive documentation of the generator maintenance and testing, fire extinguisher annual maintenance, or any utility maintenance reports while on site. This was confirmed with the director.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization’s ILSM policy: Fire watch or evacuation(EP-2)	§418.110(d)(1)(i)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LS.02.01.10	6	High Limited	Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that there was a break in the continuity through all concealed spaces, such as those found above a ceiling, including the interstitial spaces. The surveyor noted that the IT closet had a misplaced tile in the drop ceiling. The surveyor noted that there was no solid ceiling above and the space opened to the attic space and that the firewall only extended approximately three feet above the dropped ceiling. This space was opened to the patient rooms. A fire watch as per policy was instituted until corrected.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)		
LS.02.01.10	11	Moderate Widespread	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 2 of 2 fire barrier door checks, The hospice nurse surveyor noted that there was >1/8 inch gap between the fire doors in both the A and B corridor doors and the base of both doors had a gap >3/4 inches. The surveyor noted that the corridor B door had a gap greater than one inch both between the doors and at the floor. This was confirmed with the director and a fire watch was instituted on site. The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)	§418.110(d)(1)(i)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LS.02.01.20	11	Low Widespread	The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 2 of 2 corridor egresses, The hospice nurse surveyor noted that both the A and B patient care corridor egresses were blocked with computer terminals, laundry carts and bedside table. The corridors were cleared and corrected on site.This finding was observed during survey activity, but corrected onsite prior to the surveyor's departure. The corrective action taken needs to be included in the organization's Evidence of Standards Compliance submission	§418.110(d)(1)(i)	Standard
LS.02.01.20	41	Moderate Widespread	Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . In 16 of 16 patient patio exits, The hospice nurse surveyor noted that sixteen (16) patient rooms with exit doors to closed patios, were not labelled as "NO EXIT". The surveyor noted that each patio had a fixed railing blocking the egress to a clear area. This has not been corrected and a fire watch was instituted.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation (EP-2)	§418.110(d)(1)(i)	Standard
LS.02.01.30	19	Moderate Limited	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted a penetration of a pipe into the ceiling of the large storage room that was not caulked and penetrated the ceiling smoke barrier. A fire watch was instituted on site until resolved.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation (EP-2)	§418.110(d)(1)(i)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LS.02.01.35	5	Moderate Limited	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that there was a missing escutcheon plate on the sprinkler head in the large storage room in a smoke barrier ceiling. A fire watch was instituted until corrected.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)	§418.110(d)(1)(i)	Standard
LS.02.01.35	14	Moderate Limited	The organization meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.	1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted a missing ceiling tile/panel in the large storage room, with an 18 inch square opening to the attic space and above the fire wall. This was confirmed with the director.The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)		
MM.05.01.09	1	Moderate Limited	Medication containers are labeled whenever medications are prepared but not immediately administered. Note 1: This element of performance does not apply to segregated pill boxes that store medications by day and time of day. Note 2: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Note 3: This element of performance is also applicable to sample medications. (See also MC.03.08.05, EP 1; MC.05.01.01, EPs 4, 6)	1) Observed in Medication Management Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor noted that the nurse failed to label the medication and there was a break in the break in process. The nurse prepared a medication at the nurses' station and extracted liquid haloperidol from its original container into a syringe. The nurse did not label the syringe and carried it down the hall and into the patient's room. The nurse handed the syringe to another person in the room while she attended to settling the patient, and then administered the medication. This was confirmed with the director.	§418.106(e)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
NPSG.01.01.01	1	Moderate Limited	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. (See also MM.05.01.09, EPs 7, 10)	1) Observed in Medication Management Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site . The hospice nurse surveyor observed the nurse perform the two patient identifier before administering a medication; however, there was no reference on the medication or readily available to verify the right patient and right medication. This was confirmed with the director.		
PC.01.02.01	7	Moderate Pattern	The hospice conducts and documents a patient-specific comprehensive assessment and reassessment that identifies the patient's need for hospice care and services. The assessment includes the patient's need for physical, psychosocial, emotional, and spiritual care, including the following: - Support with activities of daily living - All areas of hospice care related to the palliation and management of the terminal illness and related conditions - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms - The comfort level of a patient who chooses not to take nutrition therapy - Patient and family spiritual orientation, including their desire for the involvement of a religious group - Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness - Patient and family involvement in a support group, if any - Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness - The need for volunteer services to offer support or respite to the patient, family, or other caregivers - The need for an alternative setting or level of care	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 4 of 20 patient records reviewed, The hospice nurse surveyor noted (ARR#1) that the comprehensive assessment was incomplete and did not include an assessment of the severity of the patient's symptom of seizures, currently being treated with intravenous Keppra. Also, there was no evidence that a nutritional assessment was completed or indication as to whether or not the patient was taking oral nutrition. In (HV#1), the surveyor noted that the assessment indicated that the patient had orthostatic hypotension and hallucinations; however, there was no documentation of the severity. In (HV#2), there was no assessment of the severity of seizures and agitation. In (HV#4), there was no assessment of the severity of spasms, agitation or hallucinations. This was confirmed with the director.	§418.54(c)(5)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- Anticipated discharge needs, including bereavement and funeral needs - Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions - For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient's and family's ability to cope with the patient's death - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals			
PC.01.03.01	5	Low Widespread	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 20 of 20 patient records reviewed, The hospice nurse surveyor noted in (HV#1) that the patient plan of care goals did not include any measurable outcomes or time frames for achieving outcomes, since admission. The surveyor noted that in (HV#2), (HV#3), (HV#4) and (HV#5) the plan of care did not include any outcome measures or time frames. There were no outcome measures in 19 of 20 records reveiw and there were no time frames noted in 20 of 20 records reviewed. This was confirmed with the director.	§418.56(c)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	18	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 3 of 20 patient records reviewed, The hospice nurse surveyor noted (HV#4) that there were no orders for the Baclofen pump, oxygen or amount and frequency for prn catheter irrigation. Also, in (ARR#5) and (ARR#6), the assessment and visit notes indicated that the patient was on oxygen however, there were no oxygen orders on the plan of care or in the order documentation. This was confirmed with the director.	§418.56(c)(4)	Standard
PC.01.03.01	40	Low Limited	For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 1 of 20 patient records reviewed, The hospice nurse surveyor noted (HV#3) that the plan of care for this patient residing in a skilled nursing facility did not indicate who was responsible for the provision of care and treatments. The surveyor noted that the form in the hospice binder to identify the task responsibilities was also blank. This was confirmed with the team manager.	§418.112(d)(1)	Standard
RC.02.01.01	2	Moderate Limited	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results	1) Observed in Individual Tracer at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site . In 1 of 20 patient records reviewed, The hospice nurse surveyor noted (HV#4) that the medication profile was incomplete and did not include medication delivered through the Baclofen pump; however it was not included on the medication list and had not been listed since the patient was admitted with it in 2021. This was confirmed with the director.	§418.104(a)(3)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)			

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Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§418.54 Initial and Comprehensive Assessment of the Patient	L520	§418.54 Condition of participation: Initial and comprehensive assessment of the patient.
§418.54(c)(5) Content of the comprehensive assessment	L529	(5) Severity of symptoms.
§418.60 Infection control	L577	§418.60 Condition of participation: Infection control.
§418.60(a) Prevention	L579	§418.60(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
§418.100 Organization and administration of services	L649	The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.
§418.100(b) Governing body and administrator	L651	§418.100(b) Standard: Governing body and administrator. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.
§418.106 Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment	L687	Medical supplies and appliances, as described in §410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.
§418.106(e)(1) Labeling, disposing, and storing of drugs and biologicals	L693	(1) Labeling. Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate usage and cautionary instructions, as well as an expiration date (if applicable).
§418.110 Hospices that Provide Inpatient Care Directly	L719	§418.110 Condition of Participation: Hospices that provide inpatient care directly.
§418.110(d)(1)(i) Fire protection	L728	(i) The hospice must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.)

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CoP	Tag	CoP Standard text
§418.110(e) Physical environment	L-------	§418.110(e) Standard: Building Safety. Except as otherwise provided in this section, the hospice must meet the applicable provisions and must proceed in accordance with the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12–2, TIA 12– 3, TIA 12–4, TIA 12–5 and TIA 12–6).
§418.110(i)(2) Plumbing facilities	L732	(2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.
§418.56 Interdisciplinary group, care planning, and coordination of services	L538	The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
§418.56(c) Content of the plan of care	L545	The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
§418.56(c)(4) Content of the plan of care	L549	(4) Drugs and treatment necessary to meet the needs of the patient.
§418.104 Clinical Records	L670	§418.104 Condition of participation: Clinical records.
§418.104(a)(3) Content	L674	(3) Responses to medications, symptom management, treatments, and services.
§418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.	L759	§418.112 Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID. In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards.
§418.112(d)(1) Hospice plan of care	L774	(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
EC.02.02.01	2	The organization manages risks related to hazardous materials and waste.	The organization manages hazardous materials and waste from receipt or generation through final use or disposal. (See also IC.02.01.01, EP 6; MM.01.01.03, EP 2)
EC.02.03.03	1	The organization conducts fire drills.	The organization conducts quarterly fire drills. Note 1: Evacuation of patients during drills is not required. Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use a coded announcement to notify staff instead of activating audible alarms. For full text, refer to NFPA 101-2012: 18/19: 7.1.7. Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies. (See also LS.01.02.01, EP 11)
EC.02.03.05	15	The organization maintains fire safety equipment and fire safety building features. Note 1: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply. Note 2: The references to the National Fire Protection Association (NFPA) guidelines noted at the elements of performance are for information only.	At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented. Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: Inspections involve a visual check for the correct type of and clear and unobstructed access to fire extinguisher, in addition to a check for broken parts and full charge. Note 3: For additional information on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.
EC.02.03.05	16	The organization maintains fire safety equipment and fire safety building features. Note 1: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply. Note 2: The references to the National Fire Protection Association (NFPA) guidelines noted at the elements of performance are for information only.	Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented. Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory. Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.
EC.02.05.01	5	The organization manages risks associated with its utility systems.	The organization identifies, in writing, the intervals for inspecting, testing, and maintaining all components of the utility systems, based on criteria such as manufacturers' recommendations, risk levels, or organization

Standard	EP	Standard Text	EP & Addendum Text
			experience.
EC.02.05.07	1	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)
EC.02.05.07	5	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	At least monthly, the organization tests each emergency generator under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)
EC.02.05.07	6	The organization inspects, tests, and maintains emergency power systems. Note: This standard does not require organizations to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.	The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer's recommended prime movers' exhaust gas temperature. If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1) Note: Tests for non-diesel-powered generators need only be conducted with available load.
EC.02.05.09	12	The hospice inspects, tests, and maintains medical gas and vacuum systems. Note: This standard does not require hospices to have the medical gas and vacuum systems discussed below. However, if a hospice has these types of systems, then the following inspection, testing, and maintenance requirements apply.	The hospice implements a policy on all cylinders within the hospice that includes the following: - Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2 - Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder - Labeling empty cylinders - Prohibiting transfilling in any compartment with patient care (For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)
EC.02.06.01	1	The organization establishes and maintains a safe, functional environment.	Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, or services provided.
EC.02.06.01	14	The organization establishes and maintains a safe, functional environment.	For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice supplies an adequate amount of hot water at all times for patient use and has plumbing fixtures with control valves that automatically regulate the temperature of the hot water.

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Standard	EP	Standard Text	EP & Addendum Text
IC.02.02.01	1	The organization reduces the risk of infections associated with medical equipment, devices, and supplies.	The organization implements infection prevention and control activities when doing the following: Cleaning and performing disinfection of medical supplies and devices. * Note: Disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions. Footnote *: For further information regarding cleaning and performing disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3. (See also EQ.01.05.01, EPs 3, 4)
LD.01.03.01	12	Governance is ultimately accountable for the safety and quality of care, treatment, or services.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.
LS.01.01.01	2	The organization designs and manages the physical environment to comply with the Life Safety Code. Note: This standard applies only to facilities with hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.	In time frames defined by the organization, the organization performs a building assessment to determine compliance with the "Life Safety" (LS) chapter. Note: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.
LS.02.01.10	6	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)
LS.02.01.10	11	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs

Standard	EP	Standard Text	EP & Addendum Text
		outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)
LS.02.01.20	11	The organization maintains the integrity of the means of egress. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1)
LS.02.01.20	41	The organization maintains the integrity of the means of egress. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3)
LS.02.01.30	19	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.
LS.02.01.35	5	The organization provides and maintains systems for extinguishing fires. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)
LS.02.01.35	14	The organization provides and maintains systems for extinguishing fires. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	The organization meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5.
MM.05.01.09	1	Medications are labeled. Note: This standard is applicable to all organizations that prepare and administer medications.	Medication containers are labeled whenever medications are prepared but not immediately administered. Note 1: This element of performance does not apply to segregated pill

Standard	EP	Standard Text	EP & Addendum Text
			boxes that store medications by day and time of day. Note 2: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Note 3: This element of performance is also applicable to sample medications. (See also MC.03.08.05, EP 1; MC.05.01.01, EPs 4, 6)
NPSG.01.01.01	1	Use at least two patient identifiers when providing care, treatment, or services. Note: In the home care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician "knows" the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient's confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.	Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. (See also MM.05.01.09, EPs 7, 10)
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice conducts and documents a patient-specific comprehensive assessment and reassessment that identifies the patient's need for hospice care and services. The assessment includes the patient's need for physical, psychosocial, emotional, and spiritual care, including the following: - Support with activities of daily living - All areas of hospice care related to the palliation and management of the terminal illness and related conditions - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms - The comfort level of a patient who chooses not to take nutrition therapy - Patient and family spiritual orientation, including their desire for the involvement of a religious group - Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness - Patient and family involvement in a support group, if any - Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness - The need for volunteer services to offer support or respite to the patient, family, or other caregivers - The need for an alternative setting or level of care - Anticipated discharge needs, including bereavement and funeral needs - Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological

Standard	EP	Standard Text	EP & Addendum Text
			grief reactions - For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient's and family's ability to cope with the patient's death - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	18	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs
PC.01.03.01	40	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services

Standard	EP	Standard Text	EP & Addendum Text
			- The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

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Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

Joint Commission Health Care Organization

Organization ID: 590938-Seasons Hospice & Palliative Care of Massachusetts, LLC
1 Edgewater Drive, Suite 103 Norwood, MA 02062

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 12/21/2022

Home Care Accreditation Program LD.01.03.01 EP 12
Likelihood: High Scope: WideSpread

Standard Text: Governance is ultimately accountable for the safety and quality of care, treatment, or services.

EP Text: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization.For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program.For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (1 Edgewater Dr., Suite 103, Norwood, MA) site .
In 6 of 8 CLDs, In 6 of 8 CLDs, The hospice nurse surveyor noted through discussions with staff, tracer activities and documentation review that leadership and the governing body should have reasonably known about requirement for COP 418.100 and 418.110. This was confirmed with the executive director.;

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Director of Real Estate Operations, VP Finance, VP Operations, Senior VP Operations, VP Quality, VP Inpatient Services, Chief Clinical Operations Officer

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. Training on life safety requirements was provided to them and weekly meetings were established to review environment of care/life safety standards/EPs, current status,

scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

VP of Finance approved the cost of $1400 per day for a member of the fire department to be on site continuously from 7/27/22 through 12/21/22 to provide every 15 minute fire checks to ensure the safety of our staff and patients.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. They agreed that the Executive Director can not be responsible for on-going facility issues, identifying all potential maintenance needs, and managing the grounds. The ED role should be focused on patient care and staff support. The corporate team discussed the best way to ensure that all of the facility items can be addressed and then monitoring/escalation plans established that leverage non-patient-care staff and limit the burden on clinicians. It was clear that not all of the corporate team understood the Life Safety regulations and the importance of these facility reviews. The decision was made to hire a Life Safety Consultant to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety,

patients, and staff.

Q. All corrective actions identified below must be completed prior to submission

A Life Safety Consultant was hired to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. The Life Safety Consultant vendor on 11/29/22 submitted a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Since 7/27/22, a fire department employee has been on site continuously providing every 15 minutes fire checks. Fire suppression systems have been active and operational throughout this process.

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task, when it is due, and when it is completed/documented is reviewed weekly by Executive Director and monthly by leadership team. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What is the frequency of the monitoring activities?

Spreadsheet that tracks daily, weekly, monthly, quarterly, and annual tasks related to Life Safety is reviewed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Maintenance ticketing system, used by IPC staff to alert corporate to any needs identified during normal business or life safety walk-throughs, is reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items that were due this month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Home Care Accreditation Program LS.01.01.01 EP 2
Likelihood: High Scope: WideSpread

Standard Text: The organization designs and manages the physical environment to comply with the Life Safety Code. Note: This standard applies only to facilities with hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.

EP Text: In time frames defined by the organization, the organization performs a building assessment to determine compliance with the "Life Safety" (LS) chapter.Note: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site .
In 6 of 8 CLD, In 6 of 8 CLD, The hospice nurse surveyor noted that the organization had no evidence that there was a person responsible for the evaluation and maintenance for the environmental and Life safety needs of the facility. The surveyor noted that there was no evidence that environmental inspections were performed on a routine base or that environmental tours were conducted. Also, the Life Safety drawings provided, did not accurately describe the building. For example, the firewall ended

in an egress and there was no indication on the drawing of a corridor B smoke barrier door. A fire watch process was implement on site for all Life safety deficiencies. The surveyor did not receive documentation of the generator load testing time and percentage of load run, verification of the fire wall rating and expanse. This was confirmed with the executive director.

The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Director of Real Estate Operations, VP Finance, VP Quality, Senior VP Operations

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Above list of corporate leaders met with site leadership and established weekly meetings to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

VP of Finance authorized the payment of $1400 a day for the fire department to have someone on site at the IPC continuously fro 7/27/22 through 12/21/22 conducting every 15 minute fire checks around the clock to ensure the safety of our staff and our patients.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. They agreed that the Executive Director can not be responsible for on-going facility issues, identifying all potential maintenance needs, and managing the grounds. The ED role should be focused on patient care and staff support. The corporate team discussed the best way to ensure that all of the facility items can be addressed and then monitoring/escalation plans established that leverage non-patient-care staff and limit the burden on clinicians. It was clear that not all of the corporate team understood the Life Safety regulations and the importance of these facility reviews. The decision was made to hire a Life Safety Consultant to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. All corrective actions identified below must be completed prior to submission

Since 7/27/22, a member of the fire department remains on site to conduct a fire watch at least every 15 minutes around the clock. Fire suppression systems are intact and operable.

Training on life safety requirements was provided to them and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance.

Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

The contract with the Generator company was reviewed/ammended to include the testing required/described in the standard and their cadence of on-site checks of the emergency systems was changed to monthly with the larger load test being conducted quarterly.

The architect met with the Life Safety Consultant to review the available facility drawings and update/revise them for accuracy.

The Life Safety Consultant confirmed the newly installed fire doors, caulking, etc. met the requirements.

Interim Life Safety Plan updated to reflect vendors on site, reports received, work completed and next steps to maintain Life Safety compliance in the facility.

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

An environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented was created. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO.

Q. What is the frequency of the monitoring activities?

Life Safety spreadsheet with daily, weekly, monthly, quarterly and annual tasks identified, assigned, and tracked is reviewed monthly during leadership meetings. Outstanding items are reviewed during weekly calls between Exec Dir and VPOperations. Maintenance needs are reviewed in ticketing system at least weekly to prioritize completion.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items from the spreadsheet that were due this

month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Home Care Accreditation Program LS.02.01.10 EP 6
Likelihood: High Scope: WideSpread

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

EP Text: Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site .
The hospice nurse surveyor noted that a ceiling tile was out of place, in a patient room. The surveyor observed above the tile and noted that a corrugated metal panel located approximately four feet and expanding three feet across, obscured the view of the fire wall and the surveyor was unable to determine that the fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. This was confirmed with the executive director.

The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)

Assigning Accountability

The Ececutive Director is ultimately responsible for all corrective actions and ongoing compliance

associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Director of Real Estate Operations, VP Finance, SVP Operations, VP Operations, VP Quality

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. Training on life safety requirements was provided to them and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet to use during EOC rounds with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

VP of Finance authorized the payment of $1400 a day from 7/27/22 through 12/21/22 for a member of the fire department to be on site continuously conducting every 15 minute fire checks around the clock for the safety of our patients and staff.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. They agreed that the Executive Director can not be responsible for on-going facility issues, identifying all potential maintenance needs, and managing the grounds. The ED role should be focused on patient care and staff support. The corporate team discussed the best way to ensure that all of the facility items can be addressed and then monitoring/escalation plans established that leverage non-patient-care staff and limit the burden on clinicians. It was clear that not all of the corporate team understood the Life Safety regulations and the importance of these facility

reviews. The decision was made to hire a Life Safety Consultant to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. All corrective actions identified below must be completed prior to submission

Since 7/27/22, a member of the fire department has been on fire watch every 15 minutes around the clock. The fire suppression system is active and operational.

A Life Safety Consultant was hired to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet to use during EOC rounds with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Maintenance tickets entered for work on misplaced/missing ceiling tiles. Vendor notified of IT closet dangling wires and misplaced ceiling tile. Work completed to ensure ceiling integrity and proper function of fire retardation system and received confirmation from vendor on 10/24/22 that fire barriers are intact and that the caulking used to seal the IT room is fire rated.

TJC surveyor confirmed compliance on 12/20/22 by reviewing vendor documentation of work completed and the updated architectural drawings.

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task, when it is due, and when it is completed/documented is reviewed weekly by Executive Director and monthly by leadership team. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What is the frequency of the monitoring activities?

Spreadsheet that tracks daily, weekly, monthly, quarterly, and annual tasks related to Life Safety is reviewed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Maintenance ticketing system, used by IPC staff to alert corporate to any needs identified during normal business or life safety walk-throughs, is reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items from the spreadsheet that were due this month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Home Care Accreditation Program LS.02.01.10 EP 11
Likelihood: Moderate Scope: WideSpread

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

EP Text: Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site .
In 1 of 1 cld, In 1 of 1 cld, The hospice nurse surveyor noted that there was greater than 1/8 inch gap between the fire doors in both the A and B corridor doors and the base of both doors had a gap greater than 3/4 inches. The surveyor noted that the corridor B door had a gap greater than one inch both between the doors and at the floor. This was confirmed with the director and a fire watch was instituted on site.

The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Dir of Real Estate Operations, SVP Operations, VP Finance, VP Quality, VP Inpatient Services

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. Training on life safety requirements was provided to them and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

VP Inpatient Services and her team make on-site visits to the IPC at least quarterly and will participate in EOC rounds to confirm that the above process is taking place and all action items are tracked for completion and properly documented in the Life Safety binder.

VP of Finance authorized the payment of $1400 per day from 7/27/22 through 12/21/22 for a member of the fire department to be on site continuously conducting every 15 minute fire checks for the safety of our patients and staff.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. They agreed that the Executive Director can not be responsible for on-going facility issues, identifying all potential maintenance needs, and managing the grounds. The ED role should be focused on patient care and staff support. The corporate team discussed the best way to ensure that all of the facility items can be addressed and then monitoring/escalation plans established that leverage non-patient-care staff and limit the burden on clinicians. It was clear that not all of the corporate team understood the Life Safety regulations and the importance of these facility reviews. The decision was made to hire a Life Safety Consultant to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site.

This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. All corrective actions identified below must be completed prior to submission

A Life Safety Consultant was hired to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. The Life Safety Consultant vendor on 11/29/22 submitted a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Life Safety consultant confirmed that the new fire doors that were installed along with the sweep meet the fire safety standards and are compliance with TJC standards/EPs.

TJC surveyor confirmed compliance during site visit on 12/20/22.

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task, when it is due, and when it is completed/documented is reviewed weekly by Executive Director and monthly by leadership team.

Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What is the frequency of the monitoring activities?

Spreadsheet that tracks daily, weekly, monthly, quarterly, and annual tasks related to Life Safety is reviewed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Maintenance ticketing system, used by IPC staff to alert corporate to any needs identified during normal business or life safety walk-throughs, is reviewed a minimum of weekly and priorityzed for completion based on impact to environment/safety, patients, and staff.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items that were due this month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Home Care Accreditation Program LS.02.01.20 EP 41
Likelihood: High Scope: WideSpread

Standard Text: The organization maintains the integrity of the means of egress. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

EP Text: Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012;

18/19.2.10.1; 7.10.8.3)

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site .
In 15 of 15 patient rooms, In 15 of 15 patient rooms, The hospice nurse surveyor noted that fifteen (15) patient rooms with exit doors to closed patios, were not labelled as "NO EXIT". The surveyor noted that one patio had no signage and the remaining rooms that had some signage on the door were not visible as the doors had a shade pulled down and blocking the sign. Aa fixed railing blocking the egress to a clear area. This has not been corrected and a fire watch remains in place.

The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Dir of Real Estate Operations, SVP Operations, VP Quality, VP Finance

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. Training on life safety requirements was provided to them and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

VP Finance approved cost of $1400 per day for around the clock fire department details providing fire watch at the unit continuously from 7/27/22 through 12/21/22

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

Entire team of corporate leaders met with site leadership to review Joint Commission findings and discuss root cause and solutions. They agreed that the Executive Director can not be responsible for on-going facility issues, identifying all potential maintenance needs, and managing the grounds. The ED role should be focused on patient care and staff support. The corporate team discussed the best way to ensure that all of the facility items can be addressed and then monitoring/escalation plans established that leverage non-patient-care staff and limit the burden on clinicians. It was clear that not all of the corporate team understood the Life Safety regulations and the importance of these facility reviews. The decision was made to hire a Life Safety Consultant to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. VP Finance contracted with a Life Safety Consultant vendor on 11/29/22 to submit a report with everything required to get the facility into compliance and to provide recommendations for how to accomplish ongoing monitoring/compliance. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. All corrective actions identified below must be completed prior to submission

Since 7/27/22, a fire department employee has been on site in the unit around the clock conducting every 15 minute checks. The fire suppression system is active and operational.

A Life Safety Consultant was hired to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to

SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

8/1/22 NO EXIT signs per specifications provided by surveyor were placed on patio doors in rooms 1-10. on 10/21/22 TJC surveyor on site did not find placement effective due to the way the blinds on the patio doors hang which partially blocks visibility of the NO EXIT signs. 12/20 - signs were moved to glass panel on the door near the door handle to improve visibility.

12/20 TJC surveyor on site and confirmed compliance in rooms 1-10.

12/21 Remaining rooms 11-16 (no room 13) had NO EXIT signs placed on the glass panel to match rooms 1-10.

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task, when it is due, and when it is completed/documented is reviewed weekly by Executive Director and monthly by leadership team. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What is the frequency of the monitoring activities?

Spreadsheet that tracks daily, weekly, monthly, quarterly, and annual tasks related to Life Safety is reviewed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Maintenance ticketing system, used by IPC staff to alert corporate to any needs identified during normal business or life safety walk-throughs, is reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items from EOC spreadsheet that were due this month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Home Care Accreditation Program LS.02.01.30 EP 19
Likelihood: Moderate Scope: Limited

Standard Text: The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

EP Text: Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7)Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.

Finding(s): 1) Observed in Building Tour at Seasons Hospice & Palliative Care of Massachusetts, LLC (597 Randolph Ave., Milton, MA) site .
The hospice nurse surveyor noted a penetration of a pipe and cabling, into the ceiling of the IT room ceiling that were caulked; however there was no evidence or available documentation to confirm that it was fire rated caulking. A fire watch was instituted on site until resolved.

The surveyor discussed the Life Safety deficiency with the organization, and it was determined that the following ILSMs will be implemented until the deficiency has been resolved and according to the organization's ILSM policy: Fire watch or evacuation(EP-2)

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

Since 7/27/22, a fire department employee has been on site in the unit around the clock conducting every 15 minute checks. The fire suppression system is active and operational.

A Life Safety Consultant was hired to assist us in establishing a list of the right activities and the cadence in which they should be completed. Training on life safety requirements was provided to the corporate team and weekly meetings were established to review environment of care/life safety standards/EPs, current status, scope of work needed to bring facility up to compliance, and contracts needed to do that work. VP Quality and Executive Director created an environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and annual deadlines identified and columns to track who was assigned the task and when it was completed/documented. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. These items are also scanned into an electronic binder so that monitoring can occur without having to be present on-site. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

10/25 – DREO connects with Architect on remediation discussion. 3rd party life safety evaluation company identified to perform site visit.

11/29 – Architect, Life Safety Consultant, and Accentcare senior leadership on site to review site

11/30 – Industrial-grade caulking/fireproofing company contacted to seal off remaining IT closet issues. Architect begins drafting plans and estimating process for remediation of patient rooms.

12/13 – National Firestopping Solutions registers as official vendor with Accentcare to conduct the work

12/20 - TJC surveyor on site to review architectural drawing and facility - compliance of all smoke and fire barriers was confirmed

Q. All corrective actions described above were completed by

Dec 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The environment of care/life safety spreadsheet with all the daily, weekly, monthly, quarterly and

annual deadlines identified and columns to track who was assigned the task, when it is due, and when it is completed/documented is reviewed weekly by Executive Director and monthly by leadership team. Executive Director created physical binders to keep all vendor information, inspections, reports, Safety Spreadsheet, and Interim Life Safety documentation in one place on the unit. This binder is reviewed during monthly leadership meetings and open action items are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Dir of Real Estate Operations established a maintenance ticketing system so that the IPC staff could alert corporate to any needs identified during normal business or life safety walk-throughs. These electronic tickets are reviewed a minimum of weekly and prioritized for completion based on impact to environment/safety, patients, and staff.

Q. What is the frequency of the monitoring activities?

Spreadsheet that tracks daily, weekly, monthly, quarterly, and annual tasks related to Life Safety is reviewed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPO. Escalation to SVPO and above is executed for any item that is not addressed within the established time frame. Maintenance ticketing system, used by IPC staff to alert corporate to any needs identified during normal business or life safety walk-throughs, is reviewed a minimum of weekly and priorityzed for completion based on impact to environment/safety, patients, and staff.

Q. What data will be collected from these activities?

1. a list of the Life Safety/Environment of Care items that were due this month
2. which ones were completed by the due date
3. a list of anything that is overdue
4. what is due in the next 30 days.
5. a list of any actions needed to confirm or maintain compliance with these tasks
6. a list of all maintenance tickets submitted in the prior month, what was completed, and what, if anything is overdue.

Q. To who, and how often, will this data be reported?

Leadership team (Executive Director, Clinical Director, Medical Director, Director of Business Operations) will review Life Safety Spreadsheet and maintenance tickets/work completed a minimum of monthly during leadership meetings. Actions needed are reviewed during weekly call with VPOperations.

Final Accreditation Report

Seasons Hospice & Palliative Care of Massachusetts, LLC
1 Edgewater Drive, Suite 103
Norwood, MA 02062

Organization Identification Number: 590938
60-day Evidence of Standards Compliance Submitted: 12/21/2022

ESC Programs Reviewed
Home Care

The Joint Commission
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The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	12/21/2022	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score
Hospice	§418.100	L649	Compliant
Hospice	§418.100(b)	L651	Compliant
Hospice	§418.110	L719	Compliant
Hospice	§418.110(d)(1)(i)	L728	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
LD.01.03.01	Compliant
LS.01.01.01	Compliant
LS.02.01.10	Compliant
LS.02.01.20	Compliant
LS.02.01.30	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
LD.01.03.01	12	Governance is ultimately accountable for the safety and quality of care, treatment, or services.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.
LS.01.01.01	2	The organization designs and manages the physical environment to comply with the Life Safety Code. Note: This standard applies only to facilities with hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.	In time frames defined by the organization, the organization performs a building assessment to determine compliance with the "Life Safety" (LS) chapter. Note: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.
LS.02.01.10	6	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)
LS.02.01.10	11	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than 1/8 of an inch wide, and undercuts are no larger than 3/4 of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; 7.2.1.8.2; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7;

Standard	EP	Standard Text	EP & Addendum Text
			6.4.5)
LS.02.01.20	41	The organization maintains the integrity of the means of egress. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Signs reading "NO EXIT" are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3)
LS.02.01.30	19	The organization provides and maintains building features to protect individuals from the hazards of fire and smoke. Note: The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).	Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7) Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Final Accreditation Report

Seasons Hospice & Palliative Care of Michigan, LLC
27355 John R Road
Madison Heights, MI 48071-3300

Organization Identification Number: 524828
Unannounced Full Event: 2/8/2022 - 2/11/2022

Program Surveyed
Home Care

The Joint Commission
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The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	02/08/2022 - 02/11/2022	Preliminary Denial of Accreditation	Plan of Correction	Submit within 10 business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 45 Calendar Days from the last day of survey
			Unannounced PDA Review	Survey approximately 60 calendar days from the final posted report date

The Joint Commission
What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Plan of Correction (within 10 Business Days)	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Unnanounced PDA Review (within 60 Calendar Days)
EC.02.01.01	2	Moderate / Limited			✓		✓
EC.02.02.01	12	Low / Limited			✓		✓
EC.02.06.01	20	Low / Limited			✓		✓
HR.01.01.01	2	Low / Limited	§418.114 (a)	L784	✓		✓
HR.01.03.01	1	Low / Limited			✓		✓
IC.01.04.01	1	Low / Pattern	§418.60 (b)(2)(ii)	L581	✓	✓	✓
IC.02.01.01	1	High / Widespread	§418.60 (b)	L580	✓	✓	✓
	2	Moderate / Limited	§418.60 (a)	L579	✓	✓	✓
IC.02.02.01	4	Low / Limited			✓		✓
IC.02.04.01	7	Low / Pattern			✓		✓
	8	Moderate / Pattern			✓		✓
LD.01.03.01	12	High / Widespread	§418.100 (b)	L651	✓	✓	✓
LD.03.07.01	6	Moderate / Widespread	§418.58	L560	✓	✓	✓
	7	Moderate / Pattern	§418.58	L560	✓	✓	✓
LD.03.09.01	12	High / Widespread	§418.58 (c)(2)	L569	✓	✓	✓

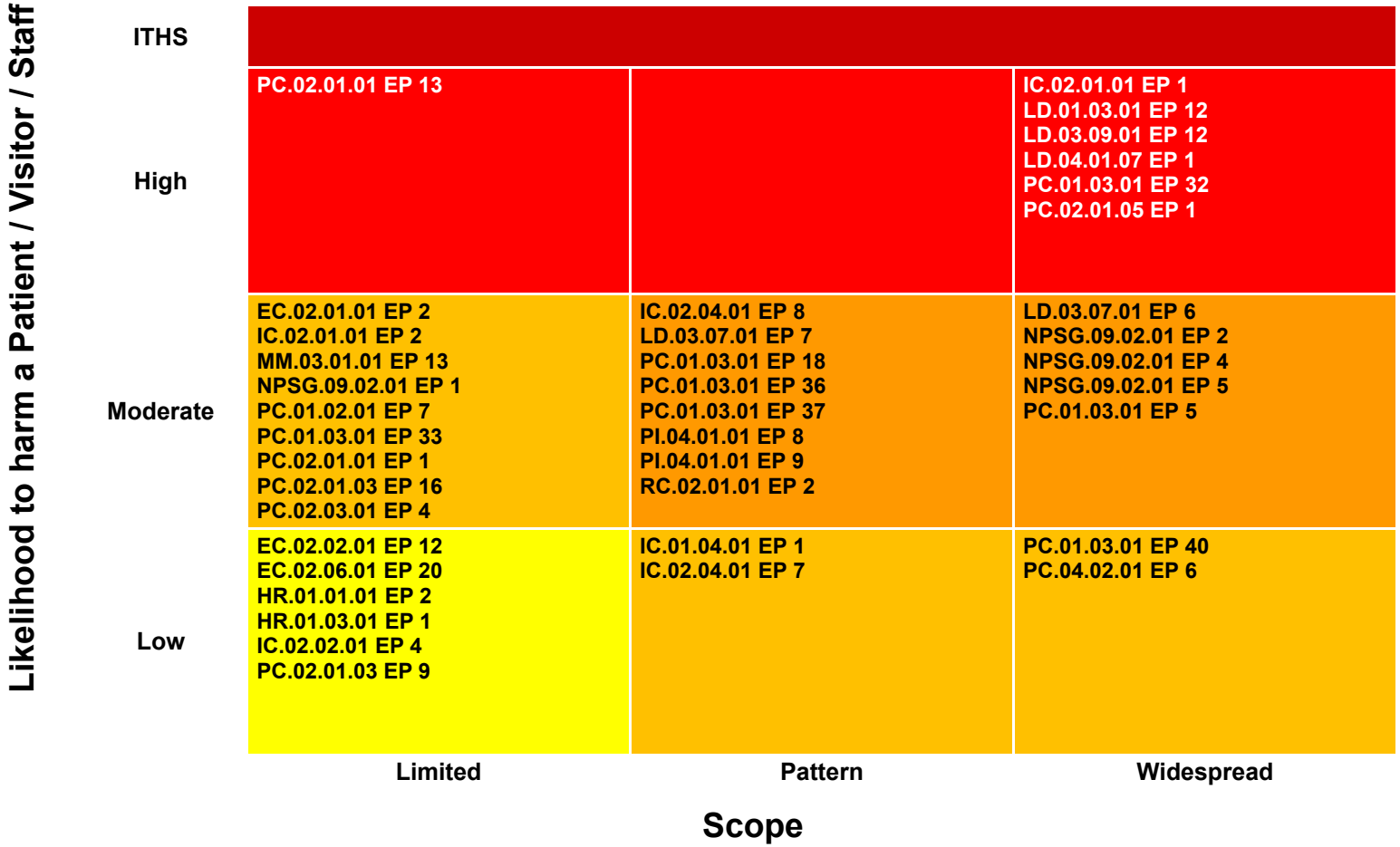
The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Plan of Correction (within 10 Business Days)	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Unnanounced PDA Review (within 60 Calendar Days)
LD.04.01.07	1	High / Widespread			✓		✓
MM.03.01.01	13	Moderate / Limited	§418.106 (e)(3)(ii)	L700	✓		✓
NPSG.09.02.01	1	Moderate / Limited			✓		✓
	2	Moderate / Widespread			✓		✓
	4	Moderate / Widespread			✓		✓
	5	Moderate / Widespread			✓		✓
PC.01.02.01	7	Moderate / Limited	§418.54 (c)(7)	L531	✓	✓	✓
			§418.54	L521	✓	✓	✓
PC.01.03.01	18	Moderate / Pattern	§418.56 (c)(4)	L549	✓	✓	✓
	32	High / Widespread	§418.56 (d)	L553	✓	✓	✓
	33	Moderate / Limited	§418.76 (g)(1)	L625	✓		✓
	36	Moderate / Pattern	§418.64 (d)(1)(iii)	L596	✓	✓	✓
	37	Moderate / Pattern	§418.64 (d)(1)(iv)	L596	✓	✓	✓
	40	Low / Widespread	§418.112 (d)(1)	L774	✓		✓
	5	Moderate / Widespread	§418.56 (c)	L545	✓	✓	✓
PC.02.01.01	1	Moderate / Limited	§418.56 (e)(2)	L555	✓	✓	✓

The Joint Commission

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Plan of Correction (within 10 Business Days)	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Unnanounced PDA Review (within 60 Calendar Days)
	13	High / Limited	§418.56 (e)(3)	L556	✓	✓	✓
PC.02.01.03	16	Moderate / Limited	§418.76 (g)(4)	L628	✓		✓
	9	Low / Limited	§418.76 (g)(2)(ii)	L626	✓		✓
PC.02.01.05	1	High / Widespread	§418.56 (e)(4)	L557	✓	✓	✓
PC.02.03.01	4	Moderate / Limited	§418.56 (b)	L544	✓	✓	✓
PC.04.02.01	6	Low / Widespread	§418.104 (e)(3)(i)	L684	✓		✓
PI.04.01.01	8	Moderate / Pattern	§418.58 (d)(1)	L572	✓	✓	✓
	9	Moderate / Pattern	§418.58 (d)(2)	L573	✓	✓	✓
RC.02.01.01	2	Moderate / Pattern	§418.104 (a)(3)	L674	✓		✓

The Joint Commission
SAFER™ Matrix
Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.100	L649	Condition	OME
Hospice	§418.100(b)	L651	Condition	OME/LD.01.03.01/EP12
Hospice	§418.104	L670	Standard	OME
Hospice	§418.104(a)(3)	L674	Standard	OME/RC.02.01.01/EP2
Hospice	§418.104(e)(3)(i)	L684	Standard	OME/PC.04.02.01/EP6
Hospice	§418.106	L687	Standard	OME
Hospice	§418.106(e)(3)(ii)	L700	Standard	OME/MM.03.01.01/EP13
Hospice	§418.112	L759	Standard	OME
Hospice	§418.112(d)(1)	L774	Standard	OME/PC.01.03.01/EP40
Hospice	§418.114	L783	Standard	OME
Hospice	§418.114(a)	L784	Standard	OME/HR.01.01.01/EP2
Hospice	§418.54	L520	Condition	OME
Hospice	§418.54	L521	Condition	OME/PC.01.02.01/EP7
Hospice	§418.54(c)(7)	L531	Standard	OME/PC.01.02.01/EP7
Hospice	§418.56	L538	Condition	OME
Hospice	§418.56(b)	L544	Standard	OME/PC.02.03.01/EP4
Hospice	§418.56(c)	L545	Standard	OME/PC.01.03.01/EP5
Hospice	§418.56(c)(4)	L549	Standard	OME/PC.01.03.01/EP18
Hospice	§418.56(d)	L553	Condition	OME/PC.01.03.01/EP32
Hospice	§418.56(e)(2)	L555	Standard	OME/PC.02.01.01/EP1
Hospice	§418.56(e)(3)	L556	Condition	OME/PC.02.01.01/EP13
Hospice	§418.56(e)(4)	L557	Condition	OME/PC.02.01.05/EP1

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Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.58	L560	Condition	OME/LD.03.07.01/EP6 OME/LD.03.07.01/EP7
Hospice	§418.58	L559	Condition	OME
Hospice	§418.58(c)(2)	L569	Condition	OME/LD.03.09.01/EP12
Hospice	§418.58(d)(1)	L572	Standard	OME/PI.04.01.01/EP8
Hospice	§418.58(d)(2)	L573	Standard	OME/PI.04.01.01/EP9
Hospice	§418.60	L577	Condition	OME
Hospice	§418.60(a)	L579	Standard	OME/IC.02.01.01/EP2
Hospice	§418.60(b)	L580	Standard	OME/IC.02.01.01/EP1
Hospice	§418.60(b)(2)(ii)	L581	Standard	OME/IC.01.04.01/EP1
Hospice	§418.64	L587	Condition	OME
Hospice	§418.64(d)(1)(iii)	L596	Standard	OME/PC.01.03.01/EP36
Hospice	§418.64(d)(1)(iv)	L596	Standard	OME/PC.01.03.01/EP37
Hospice	§418.76	L607	Standard	OME
Hospice	§418.76(g)(1)	L625	Standard	OME/PC.01.03.01/EP33
Hospice	§418.76(g)(2)(ii)	L626	Standard	OME/PC.02.01.03/EP9
Hospice	§418.76(g)(4)	L628	Standard	OME/PC.02.01.03/EP16

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Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.01.01	2	Moderate Limited	The organization identifies potential safety and security risks in the patient's home.	1) Observed in Tracer Visit at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. RoadMadison Heights, MI) site . In 1 of 5 home visits conducted, it was noted in home visit #4 that there were three small oxygen tanks and two E oxygen tanks that were unsecured, standing upright or leaning against a wall. This was observed by the team lead who was present on the visit.		
EC.02.02.01	12	Low Limited	The organization labels hazardous materials and waste. * Labels identify the contents and hazard warnings. Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. (See also IC.02.01.01, EP 6)	1) Observed in Patient Home at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 5 home visits conducted, the organization had not managed risks related to hazardous materials. During HV#1, the RN cleansed her equipment using wipes that came out of an unlabeled container. The RN confirmed that they were PDI wipes that she had removed from the large container. Organizational policy "Bag Technique" required that if individual wipes were removed from a canister as long as the bag was labeled with the type of germicidal disposable cloth, expiration date found on canister and manufacturer's recommended dry time as well as a biohazard sticker was placed on the bag. This was confirmed with the Director of Clinical Services.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.06.01	20	Low Limited	Areas used by patients are clean and free of offensive odors.	1) Observed in Tracer Visit at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. RoadDetroit, MI) site . In 1 of 5 home visits conducted, it was noted in home visit #5 in the General Inpatient Unit in the Detroit Medical Center that the patient care area was not maintained. For example, the wall suction in the room was full with approximately 1000 cc of sputum and fluids and had not been used for the past several days per the significant other in the room. Additionally, the significant other in the room stated that the "housekeeping" could be better and referenced dried stains on the floor which she stated were dried phlegm. Lastly, the surveyor observed that the bed frame was not clean and had flecks of dried skin present. These were observed by the Senior Leader of Clinical Operations present on the visit.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
HR.01.01.01	2	Low Limited	The organization verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. For home health agencies that elect to use The Joint Commission deemed status option: The organization maintains current licensure and qualifications in personnel records. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.	1) Observed in HR File Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 5 HR files reviewed, in which licensure was required, the organization had not verified and documented credentials of care when credentials were renewed. In the file for RN1, the primary source verification of current license renewal was completed more than 3 months past the expiration date.	§418.114(a)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
HR.01.03.01	1	Low Limited	Supervisors understand the care, treatment, or services provided by staff under their supervision.	1) Observed in Tracer Visit at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 5 home visits conducted, it was noted that during home visit #4 the aide was performing wound care to the patient's right lower leg following her shower, applying Neosporin ointment, a telfa pad and kling dressing. The aide stated that the supervising RN and the ALF facility staff instructed her to perform this task. It was not on the plan of care for the aide. The RN was unaware if this task was within the skill set or if the Aide was competent to perform. In another example, in record review #9 it was noted that the RN documented supervision of the hospice aide on every visit note even after the aide had been discontinued. The aide had not seen this patient yet during this benefit period due to COVID diagnosis and restrictions from the SNF as confirmed with the Clinical Director.		
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 1 of 20 patient records reviewed, the supervising RN did not understand the care, treatment, services provided by staff under their supervision. In the chart for RR#7, the RN documented supervision of the hospice aide at the second scheduled supervisory visit in the current benefit period and documented that the aide was following the plan of care. The aide had not seen this patient yet during this benefit period due to COVID diagnosis and restrictions from the SNF as confirmed with the Clinical Director.		
IC.01.04.01	1	Low Pattern	The organization's written infection prevention and control goals include the following: Addressing its prioritized risks.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During review of data, documents and discussion in data session it was noted that there were no goals for the prioritized risks of UTI with foley and Wound infections. Additionally, the goals for Covid and flu were not specific or measurable.	§418.60(b)(2)(ii)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.02.01.01	1	High Widespread	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 1 of 20 patient records reviewed, the organization had not implemented its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. In the chart for RR#7, the patient developed COVID19 approximately 1 week prior to the current benefit period. There was no infection control report created when this infection was diagnosed. This was confirmed with the QA Documentation Manager who was assisting with chart review.	§418.60(b)	Standard
				2) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During discussion in data session and review of data it was noted that for 2020 and 2021 the only infections which were reported were Covid 19 infections. There was no other data collection or surveillance activities for any other infections. Additionally, the Covid 19 data for 2020 and 2021 was raw data which had not been aggregated, analyzed or trended to identify any issues of transmission between patients and staff.	§418.60(b)	Standard
IC.02.01.01	2	Moderate Limited	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)	1) Observed in Tracer Visit at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . In 1 of 5 home visits conducted, it was noted that standard precautions were not followed per accepted practices. For example, in the IPU HV#5 the nurse was observed performing wound care to a sacral wound. She removed the old dressing, cleaned the buttocks with stool present, washed the wound and applied the clean dressing without changing gloves. This was observed by the Senior Director of Clinical Operations who was present at the visit.	§418.60(a)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.02.02.01	4	Low Limited	The organization implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies. (See also EQ.01.05.01, EPs 1, 2, 3, 4, 5)	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . During unit tour of the IPU the surveyor observed that 3 of 5 lab tubes were expired. This was confirmed by the Senior Director of Clinical Operations present on the unit.		
IC.02.04.01	7	Low Pattern	The organization evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During data session and review of data it was noted that there had been no aggregation of data collected for reasons for not obtaining the seasonal flu vaccine in 2019, 2020 or 2021. The reasons may have been collected on individual forms but no aggregate data had been compiled or evaluated.		
IC.02.04.01	8	Moderate Pattern	The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.) Note: Organizations with a small number of staff and licensed independent practitioners (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During review of data for seasonal influenza vaccination rates it was noted that the vaccination rates did not improve. For example, there was no data available for 2019, the rate for 2020 was 43% and the rate for 2021 was 40%. This was confirmed by the Senior Director of Clinical Operations.		

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LD.01.03.01	12	High Widespread	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . The governing body/leadership did not ensure that the following Conditions of Participation were met as determined through observations, documentation, and staff interviews: - §418.100, §418.60, §418.116, §418.56, §418.58, §418.76, §418.104, §418.54, §418.64.	§418.100(b)	Condition
LD.03.07.01	6	Moderate Widespread	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization's governing body is responsible for making sure the quality assessment and performance improvement program (QAPI) meets the following criteria: - Reflects the complexity of the organization and its services - Involves all services provided by the organization, including those provided under contract or arrangement - Takes actions to demonstrate improvement in the organization's performance For home health agencies that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators related to improved outcomes, including the prevention and reduction of medical errors, hospital admissions, hospital readmissions, and the use of emergent care services. For hospices that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators that are related to improved palliative outcomes.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During data session, review of documentation and discussion with leadership it was noted that the governing body had not been responsible for making sure that the QAPI program met the criteria for complexity, all services, demonstration of improvement. There had been only one PIP for 2020 on bereavement services and one in 2021 related to volunteer hours being increased. There were no quality initiatives for contract services, pharmacy or HME.	§418.58	Condition

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LD.03.07.01	7	Moderate Pattern	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During data session, review of documentation and discussion with leadership it was noted that there was no documentation to demonstrate the operation of the QAPI program for 2020 and 2021. While areas for improvement were identified there was no follow up or initiation of group activities to implement change or documented improvement.	§418.58	Condition
LD.03.09.01	12	High Widespread	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 1 of 20 patient records reviewed, the organization had not tracked adverse patient events. In the chart for HV#3, the patient had multiple falls during his admission with the organization. There was no documentation that these events had been reported as is required by organizational policy for aggregation, analysis and performance improvement as confirmed with the Clinical Director.	§418.58(c)(2)	Condition
				2) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. RoadMadison Heights, MI) site . The organization had not implemented preventative actions and mechanisms that included feedback and learning throughout the organization from the action plan related to the suicide incident of June 2021.	§418.58(c)(2)	Condition

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
LD.04.01.07	1	High Widespread	Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, or services. Note: For hospices that elect to use The Joint Commission deemed status option: Establishment of policies governing the provision of hospice care is the responsibility of the hospice's interdisciplinary group.	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. RoadMadison Heights, MI) site . During review of records for high risk patients with depression it was noted that the organization had not followed their own policies related to Suicide Risk Assessment, Prevention and Follow up, #2111. For example, in record reviews #8 a confirmed suicide and #6 a suspected suicide which occurred during the hospice benefit period it was noted in record review that protocol was not followed when patients indicated potential for self harm as no one was deployed to stay with the patient and no documentation of notification of leadership was found. Care plans were not updated to include risk of harm. In record #8 the patient home was not reassessed for firearms after level of care change. The Suicide prevention plan was not completed for either patient and visit frequencies were not adjusted to the needs of the patient. This was confirmed by the Director of Patient Experience who was an MSW and who participated in the development of the policy.		
MM.03.01.01	13	Moderate Limited	For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice follows procedures for the control and accountability of all medications within the hospice facility.	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . During the tour of the IPU it was noted that there were unlabeled atropine drops at the patient bedside in visit #5. Additionally during a tour of the medication room an unopened vial of Haldol was loose in a bin on the counter. It was not labeled for a particular patient or if it was to be a stock medication. This was confirmed by the Senior Director of Clinical Operations.	§418.106(e)(3)(ii)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
NPSG.09.02.01	1	Moderate Limited	Assess the patient’s risk for falls.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 20 patient records reviewed, the organization had not assessed the patient's risk for falls. In the chart for RR#6, the patient transferred from the inpatient unit to the home. A fall risk assessment had not been performed at any visit with the change in location as confirmed with the Director of Patient Experience assisting with chart review.		
NPSG.09.02.01	2	Moderate Widespread	Implement interventions to reduce falls based on the patient’s assessed risk.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 20 of 20 patient records reviewed, the organization had not implemented interventions to reduce falls based on the patient's assessed risk. While this education was observed during HV#1, there was no documentation in any patient record that the specific fall reduction interventions had been implemented. In the chart for HV#3, the patient with multiple falls during the episode, the POC had no fall reduction interventions. There were no fall reduction interventions included on any plan of care as confirmed with the Clinical Director.		
NPSG.09.02.01	4	Moderate Widespread	Educate the patient and, as needed, the family on any individualized fall reduction strategies.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 20 of 20 patient records reviewed, the organization had not educated the patient and/or caregivers on any fall reduction strategies. There was no documentation of any fall reduction education in any chart for any patient assessed to be at risk for falls as confirmed with the Clinical Director.		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
NPSG.09.02.01	5	Moderate Widespread	Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education. Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number of falls with injuries.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During discussion in the data session as well as record reviews and document reviews it was noted that no evaluation of fall reduction effectiveness had taken place. For example, in record review #12 there was no documentation in the Quality data of a fall that the patient had, in record review #5 and #6 and #8, all of the patients had falls documented however there was no documentation in the Quality data of these falls. Lastly, the Senior Director of Clinical Operations stated during the data session that the only falls data collected are falls that involve an injury.		
PC.01.02.01	7	Moderate Limited	The hospice conducts and documents a patient-specific comprehensive assessment and reassessment that identifies the patient's need for hospice care and services. The assessment includes the patient's need for physical, psychosocial, emotional, and spiritual care, including the following: - Support with activities of daily living - All areas of hospice care related to the palliation and management of the terminal illness and related conditions - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms - The comfort level of a patient who chooses not to take nutrition therapy - Patient and family spiritual orientation, including their desire for the involvement of a religious group - Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness - Patient and family involvement in a support group, if any - Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . In 1 of 20 patient records reviewed, it was noted that in review of record for visit #5, a patient in the IPU the bereavement risk assessment did not include his significant other with whom the patient had lived prior to hospitalization. Additionally for this same patient it was noted that in three of three nursing assessments review at the beginning of each 12 hour shift there was no documentation of lung sounds or respiratory status for this patient with ES CHF who had recently been extubated. Lastly there was no documentation in six days of the patient's wound or wound measurements. This was observed by the Senior Director of Clinical Services.	§418.54(c)(7)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness - The need for volunteer services to offer support or respite to the patient, family, or other caregivers - The need for an alternative setting or level of care - Anticipated discharge needs, including bereavement and funeral needs - Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions - For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient's and family's ability to cope with the patient's death - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals			
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . In 1 of 20 patient records reviewed, the organization had not assessed its patient. In the chart for RR#3, the patient was identified as having an implanted port in his chest upon admission to the inpatient unit from the home program. The initial comprehensive assessment to the hospice (home program) did not identify that the patient had a port. This was confirmed with the Clinical Director.	§418.54	Condition

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	5	Moderate Widespread	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 20 of 20 patient records reviewed, the written plan of care (POC) was not based on the patient's goals and the time frames, settings, and services required to meet those goals. In no charts were there time frames for anticipated goal achievement included as confirmed with the Clinical Director, as this was not the agency practice. Additional examples included, in the chart for HV#3, the patients stated goal for depression scale was 0 on a 1-10 scale in the SN assessment. This goal was not on the patient's POC. In the chart for RR#5, the Social Worker wrote a goal that the patients suicidal thoughts/isolation would reduced or eliminated, however there was no timeframe associated with the anticipated achievement of the goal. In the chart for RR#2, the RN documented in the assessment that the patient had a self-identified target for pain management goal, however this goal was included in the POC.These were confirmed with the Clinical Director.	§418.56(c)	Standard
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 7 of 20 patient records reviewed, it was noted that there were no measurable goals stated on the plan of care. For example, the following goals were documented in multiple charts; "caregiver will demonstrate proper wound care", "pt/cg will have understanding of skin care", "pt/cg will have understanding of pain scale", "pt/cg will verbalize effect of pain meds on bowel function". Other examples include "pain will be maintained at an acceptable level" and "relief of cardiopulmonary symptoms". The goals were without any measures or time frames. This was observed in record reviews #11-15 and home visits #4 and 5 and confirmed by nursing staff assisting with record review.	§418.56(c)	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	18	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. RoadDetroit, MI) site . In 1 of 20 patient records reviewed, it was noted that in review of record for IPU patient, visit #5 there were no orders in the plan of care for care of the jugular central line. This was observed by the Senior Director of Clinical Operations.	§418.56(c)(4)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 9 of 20 patient records reviewed, the plan of care (POC) did not include all services needed for the palliation and management of the terminal illness and related conditions, including the following: Medications and treatment necessary to meet the patient's needs. In the chart for RR#7, the patient was at risk for falls, had oxygen ordered, was using Ensure as confirmed in the assessment and with facility staff. There were no interventions related to these treatments on the POC. The order for foley catheter was incomplete and read "May irrigate with 10c" without indication of irrigant, clarity of volume measurement, nor frequency. In the charts for HV#1, HV#2, HV#3, RR#1, RR#2 (upon admission to the inpatient unit) and RR#3, these patients were all at fall risk. The POCs did not include any interventions related to this risk. In the chart for RR#5, the patient resided in a nursing facility with primary diagnosis of dementia and schizo-affective disorder. The POC orders included the RN to instruct on the medication schedule, however did not indicate who was to be instructed; the patient or the nursing facility staff. Additionally, the RN documented the patients blood sugar ranges were 100-200. there were no orders for blood sugar monitoring on the POC. This was confirmed with the Clinical Director. In the chart for RR#3, the patient in the Inpatient hospice unit, there were no physician orders documented to access the patient's implanted port upon admission as confirmed with the Clinical Director and Inpatient Unit Manager.	§418.56(c)(4)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				3) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 3 of 20 patient records reviewed, it was noted in record review for home visit #4 that the aide visits were increased in December to twice per week however there was no order to increase the visits. In record review #12 the aide visits were started, discontinued, restarted and discontinued during a period of three months and there were no orders to discontinue the services and the most recent order to restart did not contain the duration for the current week. In review of record #8 it was noted that only one aide visit was made however the order was stated as 1 x 11 wks, however there was no order to discontinue the service. This was confirmed by nursing staff assisting with record review.	§418.56(c)(4)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	32	High Widespread	For hospices that elect to use The Joint Commission deemed status option: The plan of care revisions are based on information from updates to the patient's comprehensive assessment and address the patient's progress toward goals and outcomes.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 2 of 20 patient records reviewed, the plan of care (POC) revisions were not based on information from updates to the patient's comprehensive assessment and did not address the patient's progress toward goals and outcomes. In the chart for RR#7, the patient developed COVID19 at the end of the previous benefit period, yet the plan of care was not updated with any new interventions/goals. The facility was refusing aide visits due to COVID visitation policies, yet the aide visits remained on the POC. There was no documentation of progress toward goals in any patient chart. This was confirmed with the Clinical Director. In the chart for RR#6, the MSW assessed the patient's pain to be "uncontrolled" at 10/10 with patient's behavior changed to aggressive, described as throwing furniture, expressing feelings of fear and grief. The plan of care was not updated with any interventions related to this change in status. This was confirmed with the Director of Patient Experience assisting with chart review. There was no documentation of progress toward goals in any patient record reviewed.	§418.56(d)	Condition

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 7 of 20 patient records reviewed, it was noted that the plan of care had not been revised or updated. For example, in review of record #14 the plan of care was not updated to show decrease in LOC and safety issues in December, also in February new issues with skin integrity, pain and dyspnea were documented but the plan of care was not updated. In another example, in record review #11 there is documentation of goals being met however the plan of care still lists them as "Not Met". In record review #10 the plan of care was not updated related to new issue of edema and profuse itching. In record review #12 the recert plan of care stated "no unmet goals". In record review for home visit #5 the plan of care listed "goals not met" but also stated that there were no goals "not met". In review of record for home visit #4 it was noted that the plan of care had not been updated and oxygen was ordered as "continuous" however both the nurse and the aide stated that the patient rarely uses oxygen. This was all confirmed by the nursing staff assisting with record review. In review of record #8 the patient depression and suicidal ideation was increasing as evidenced by depression screening, had multiple falls, was having pain management issues, losing weight and becoming weaker however the plan of care was not revised to increase nursing visits or implement any other interventions to address the changes.	§418.56(d)	Condition

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	33	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.	1) Observed in Tracer Visit at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 5 home visits conducted, it was noted that during home visit #4 the aide care plan did not include whether or not the patient was to use her oxygen during the shower although the oxygen order was stated as "continuous". Additionally the aide care plan did not indicate any reasons for which the nurse should be contacted and lastly it did not contain any instructions related to the management of a wound on the patient's right lower leg. This was confirmed by the aide and the team lead who were present on the visit.	§418.76(g)(1)	Standard
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 1 of 20 patient records reviewed, the written aide care plan was not appropriately individualized to the patient. In the chart for RR#7, the aide care plan ncluded instruction to care for both a foley catheter, drainage bag and urinal. The patient did not have a foley catheter. The Aide care plan had not been updated with the actual frequency of visits and still stated 1w1 which was the effective frequency at the admission which was more than 14 months prior to this survey. This was discussed with the Clinical Director.	§418.76(g)(1)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	36	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: Bereavement services reflect the needs of the bereaved.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 2 of 3 patient records reviewed, it was noted that bereavement services were not performed per policy and plans of care were not updated to reflect the needs of the bereaved. For example, in bereavement record review #2 and #3 the risk level was determined to be of moderate risk however the plan of care did not reflect any additional needed services and in fact the proposed interventions of phone calls did not either take place at all or voice messages were left with no follow up. In review of record #2 the bereaved daughter was at moderate risk, no initial bereavement call was made, a one month call with voice message was made, one month later another voice message was left, the next month the planned call was not made, and finally at the 6 month mark a call was made where the daughter stated she was "struggling", "having a hard time" she was encouraged to attend support group and call if needed. Another call was made one month later and documentation indicated that she "thought about hurting herself daily". She indicated that she would not carry out a suicide attempt but was provided with the suicide hotline # and it was noted that she was receiving care from a private therapist and attempting to get medications. Another call was not placed until one month later with only a voice message left, three weeks later another call with voice message left and one month later she was determined to be "low" risk because she was receiving outside resources for her depression. In review of bereavement record #2 the bereaved husband was identified as moderate risk but the proposed calls at six month and 12 month were only voice mail message left. This was confirmed by the bereavement coordinator.	§418.64(d)(1)(iii)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.03.01	37	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery. Note: Bereavement counseling is a required hospice service but is not reimbursable.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 3 of 3 patient records reviewed, for bereavement services, it was noted that the bereavement plan of care did not include specific, individualized interventions, the goals were generic and did not include any time frames and the same interventions were listed for all levels of bereavement risk. The care plan was essentially a list of what month calls would be made and what month mailings would be done. This was reviewed with the bereavement coordinator.	§418.64(d)(1)(iv)	Standard
PC.01.03.01	40	Low Widespread	For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 7 of 7 patient records reviewed, for those patients that resided in a SNF it was noted that there was no plan of care which identified the care and services that are needed and identified which provider is responsible for performing the functions that have been agreed upon and included in the plan of care. This was noted in record reviews #5, 7, 11, 12 and 13 and in record review for home visits #2 and #3. This was confirmed by nursing staff assisting with record review.	§418.112(d)(1)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.01.01	1	Moderate Limited	The organization provides the patient with care, treatment, or services according to the patient's individualized plan of care.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. RoadDetroit, MI) site . In 2 of 20 patient records reviewed, it was noted that care was not provided according to the individualized plan of care. For example, in review of record for a General Inpatient and visit, it was noted that the orders for wound care were to be completed every 72 hours however there was no documentation that wound care had been done in the past six days. Additionally, there were orders for central line flushes, 3 ml of NS after all medications administered. There was no documentation that this was done. In another example, record review #13 it was noted that home health aide services were ordered however they were never made and there was no order to discontinue the service and no missed visit notes. This was observed by the Senior Director of Clinical Operations.	§418.56(e)(2)	Standard
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 20 patient records reviewed, the organization had not provided care according to the patient's individualized plan of care. In the chart for RR#6, the patient was admitted to service into the Inpatient unit. The patient had Hydromorphone ordered 4mg IVP every 3 hours prn pain. In the majority of the documented administrations on the MAR available in the hospice chart, the nurses were administering 2-3mg of Hydromorphone. This was observed by and discussed with the Director of Patient Experience assisting with chart review.	§418.56(e)(2)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.01.01	13	High Limited	For hospices that elect to use The Joint Commission deemed status option: The hospice provides care and services that are based on the initial assessment, comprehensive assessment, and updated assessments of the patient's and family's needs.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . This finding contributed to the immediate threat to health and safety decision and cannot be clarified. in 1 of 20 patient records reviewed, the hospice had not provided care and services that were based on updated assessments of the patient's needs. In the chart for RR#6, the RN made a home visit and determined the patient had no pain, no depression. The next day, the MSW made a visit and assessed the patient to have anger, pain not managed at 10/10, grief and fear. The PHQ2 was performed which triggered the PHQ9 which should have demonstrated a score of 5, which would have triggered a further assessment of depression/suicide risk - the Columbia assessment which is the organizational protocol. During the chart review, attended by the Director of Patient Experience (a MSW on the suicide prevention work team) and the Administrator, it was observed that the EMR did not auto-calculate this risk accurately and the total was documented as 0 on the PHQ9, so the Columbia assessment did not automatically trigger the MSW to perform it. This assessment tool is available in a manual process within the EMR so the clinician could have accessed the tool without the automated trigger. Immediate Mitigation Activities Implemented: Scheduled a mandatory town hall to discuss training; All staff enrolled in mandatory training course; Suicide screening was forced as required function 1/26/22.	§418.56(e)(3)	Condition

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.01.03	9	Low Limited	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health aide or hospice aide provides services that are ordered by the physician or allowed practitioner in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.	1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 5 home visits conducted, it was noted that in home visit #4 the aide was performing wound care to the patient's right lower leg. She was observed removing the dressing prior to the shower and stated that after the shower she would apply neosporin ointment and a telfa pad and kling. This was observed by the Team Nurse present on the visit.	§418.76(g)(2)(ii)	Standard
PC.02.01.03	16	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: Hospice aides report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and performance and improvement activities.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 1 of 20 patient records reviewed, it was noted that the nurse was not notified of changes in the patient's needs by the aide. For example, in review of hospice record #12 the aide documented on 12/9/21 that the pt refused all care and was not feeling well and then documented on 12/15/21 that a bed bath was given instead of shower as stated in the aide plan of care. There was no documentation of nurse being notified and no changes made to the aide plan of care. This was confirmed by the nursing staff assisting with record review.	§418.76(g)(4)	Standard

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.01.05	1	High Widespread	All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. RoadMadison Heights, MI) site . In 1 of 20 visits, the organization had not provided interdisciplinary care and had not informed the hospice physician with an unanticipated change in condition. During an SN visit, the RN arrived at the facility where the patient was temporarily residing for respite care to make a routine assessment. She was rounding in collaboration with the facility physician. She, and the physician were informed by the facility nurse that sometime prior to the hospice nurse arrival, the facility nurse had observed the patient with a handful of unknown pills in the bed and when she asked about them, the patient took them all and swallowed them. There was no further detail about the amount of time that lapsed between this observation by the facility nurse and the arrival of the hospice RN. There was no documentation in the record that the RN inquired of the patient about what he took, the reasoning why he took them and no indication that the RN notified the Hospice physician or Medical Director as confirmed with the Clinical Director. The patient died later that day. Prior to the respite stay for this patient, the RN saw the patient at home and assessed no pain, no depression. The next day, the MSW saw the patient who complained of uncontrolled pain at 10/10 (resolved to 7 at end of visit), aggressive behavior he and the PCG related to fear and grief. There was no indication that the MSW contacted the RN to discuss the drastic change in assessment from one day to the next, except for a general care collaboration note, with no detail, that was seen in every patient chart on every visit.	§418.56(e)(4)	Condition

The Joint Commission

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.02.03.01	4	Moderate Limited	The organization provides education and training to the patient based on the patient's assessed needs. For hospices that elect to use The Joint Commission deemed status option: The hospice also provides education and training to the primary caregiver as appropriate to the responsibilities assigned to the caregiver in the plan of care. For home health agencies that elect to use The Joint Commission deemed status option: Each patient, and their caregiver(s) where applicable, receive ongoing education and training regarding the care and services identified in the plan of care. The organization must provide training, as necessary, to ensure a timely discharge.	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 1 of 20 patient records reviewed, the organization had not provided education and training to the primary caregiver. In the chart for RR#6, the patient had a stage 4 decub with daily dressing changes required. When the patient transferred out of the Inpatient unit to home, there was no documentation found in the chart that the caregiver had been instructed to provide care for the patients wound. The hospice RN was visiting the patient weekly.	§418.56(b)	Standard
PC.04.02.01	6	Low Widespread	For hospices that elect to use The Joint Commission deemed status option: The hospice discharge summary includes the following: - A summary of the patient's stay, including treatments, symptoms, and pain management - The patient's current plan of care - The patient's latest physician orders - Any other documentation that will assist in postdischarge continuity of care or that is requested by the attending physician or receiving physician	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (1 Heritage Place Suite 105, Southgate, MI) site . In 2 of 2 patient records reviewed, in which a live discharge occurred, the discharge summary did not include the patients current plan of care, a summary of the patient's stay including treatments, symptoms and pain management, latest physician orders. These items were not included in the discharge summaries for RR#1 and RR#3 as confirmed with the Clinical Director.	§418.104(e)(3)(i)	Standard
PI.04.01.01	8	Moderate Pattern	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The number and scope of annual performance improvement projects is based on the patients' needs and internal organization needs. The projects reflect the scope, complexity, and past performance of the organization's services and operations.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. RoadMadison Heights, MI) site . During discussion with leadership in the data session it was noted that for 2020 and 2021 the number of performance improvement projects did not reflect the scope or complexity of the organization. For example, for 2021 the only project that was implemented related to increasing volunteer hours. A project on facility integration of plan of care and another on medication reconciliation were identified in the first quarter of 2021 but no progress had been documented for the remainder of the year. In 2020 there was only one project on bereavement services.	§418.58(d)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PI.04.01.01	9	Moderate Pattern	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization documents what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on them.	1) Observed in Data Session at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . During the data session it was noted that for 2021 the only project that was implemented related to increasing volunteer hours. A project on facility integration of plan of care and another on medication reconciliation were identified in the first quarter of 2021 but no progress had been documented for the remainder of the year which demonstrated documentation of why the project was chosen, what activities were conducted or any data to demonstrate improvement.	§418.58(d)(2)	Standard
RC.02.01.01	2	Moderate Pattern	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services	1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (3990 John R. Road, Detroit, MI) site . In 2 of 20 patient records reviewed, the patient record did not include all pertinent information. In the chart for RR#2, the patient was admitted to the inpatient unit and the RN documented "insertion Huber needle". There was no documentation about the size needle, securement device, etc. as confirmed with the Clinical Director. In the chart for RR#5, the RN documented in the EMR under how often are blood sugars checked "Gabapentin BID". Additionally, she indicated the patient was on Lexapro for his depression as of the admission; the patient was not on Lexapro. This was also confirmed with the Clinical Director.	§418.104(a)(3)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)			

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				2) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site . In 6 of 20 patient records reviewed, it was noted that the clinical records did not contain accurate or complete information. For example, in record review #15 a patient in the IPU the following was noted; pt was on a ventilator however the admission documentation stated that the patient was dyspneic at rest and had a shortness of breath score of 10. The patient had a sacral wound however this was not identified on the body figure document, there was documentation that the pt/cg had been instructed on when to call the hospice nurse for urinary issues, the use of an interpreter, and the availability of 24 hour on-call. The patient was in the IPU and spoke English as a primary language. In another example, record review #14 the nurse documented in the most recent IDT meeting that the patient had Alzheimer's however this was not a current diagnosis for this patient. In record review #13 the nurse documented on admission that the patient was "obtunded, stuporous or in a coma" however she fed her graham crackers during the visit. In review of record for visit #5 it was noted that the MSW documented that the patient was non-verbal but also that he self identified, additionally there were inconsistencies related to names of siblings documented. In another example, in record review #13 there was conflicting documentation related to the patient's advance directive. For example, DNR was listed on hospice documents but there was order for DNR, in the SNF facility EMR it was stated as Partial DNR, no resuscitation, but ok to hospitalize, give fluids, xrays, labs and antibiotics. It also stated a copy was obtained but was not present in the hospice record. In another example in record review #8 the following was documented "Pain has been well controlled with MASCOT twice a day Pt is not required in a 200 for breakthrough pain". This was confirmed by nursing staff assisting with record reviews.	§418.104(a)(3)	Standard

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Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§418.54 Initial and Comprehensive Assessment of the Patient	L520	§418.54 Condition of participation: Initial and comprehensive assessment of the patient.
§418.54(c)(7) Content of the comprehensive assessment	L531	(7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
§418.60 Infection control	L577	§418.60 Condition of participation: Infection control.
§418.60(a) Prevention	L579	§418.60(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
§418.60(b) Control	L580	§418.60(b) Standard: Control. The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—
§418.60(b)(2)(ii) Control	L581	(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
§418.64 Core Services	L587	§418.64 Condition of participation: Core services.
§418.64(d)(1)(iii) Counseling services	L596	(iii) Ensure that bereavement services reflect the needs of the bereaved.
§418.64(d)(1)(iv) Counseling services	L596	(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in §418.204 (c).
§418.100 Organization and administration of services	L649	The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of the terminal illness and related conditions.

CoP	Tag	CoP Standard text
§418.100(b) Governing body and administrator	L651	§418.100(b) Standard: Governing body and administrator. A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.
§418.106 Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment	L687	Medical supplies and appliances, as described in §410.36 of this chapter; durable medical equipment, as described in §410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.
§418.106(e)(3)(ii) Labeling, disposing, and storing of drugs and biologicals	L700	(ii) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate State authority. A written account of the investigation must be made available to State and Federal officials if required by law or regulation.
§418.54 Initial and Comprehensive Assessment of the Patient	L521	The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient’s need for hospice care and services, and the patient’s need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.
§418.56 Interdisciplinary group, care planning, and coordination of services	L538	The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.
§418.56(b) Plan of care	L544	The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.
§418.56(c) Content of the plan of care	L545	The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
§418.56(c)(4) Content of the plan of care	L549	(4) Drugs and treatment necessary to meet the needs of the patient.
§418.56(d) Review of the plan of care	L553	A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient’s progress toward outcomes and goals specified in the plan of care.
§418.56(e)(2) Coordination of services	L555	(2) Ensure that the care and services are provided in accordance with the plan of care.
§418.56(e)(3) Coordination of services	L556	(3) Ensure that the care and services provided are based on all assessments of the patient and family needs.
§418.56(e)(4) Coordination of services	L557	(4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in all settings, whether the care and services are provided directly or under arrangement.

The Joint Commission

CoP	Tag	CoP Standard text
§418.58 Quality assessment and performance improvement.	L560	The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
§418.76 Hospice Aide and Homemaker Services	L607	§418.76 Condition of participation: Hospice aide and homemaker services.
§418.76(g)(1) Hospice aide assignments and duties	L625	(1) Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
§418.76(g)(2)(ii) Hospice aide assignments and duties	L626	(ii) Included in the plan of care.
§418.76(g)(4) Hospice aide assignments and duties	L628	(4) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.
§418.104 Clinical Records	L670	§418.104 Condition of participation: Clinical records.
§418.104(a)(3) Content	L674	(3) Responses to medications, symptom management, treatments, and services.
§418.104(e)(3)(i) Discharge or transfer of care	L684	(i) A summary of the patient's stay including treatments, symptoms and pain management.
§418.58 Quality assessment and performance improvement.	L559	§418.58 Condition of participation: Quality assessment and performance improvement.
§418.58(c)(2) Program activities	L569	(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.
§418.58(d)(1) Performance improvement projects	L572	(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.
§418.58(d)(2) Performance improvement projects	L573	(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
§418.114 Personnel Qualifications	L783	§418.114 Condition of Participation: Personnel qualifications.

The Joint Commission

CoP	Tag	CoP Standard text
§418.114(a) Personnel Qualifications	L784	§418.114(a) General qualification requirements. Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.
§418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.	L759	§418.112 Condition of Participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID. In addition to meeting the conditions of participation at §418.10 through §418.116, a hospice that provides hospice care to residents of a SNF/NF or ICF/IID must abide by the following additional standards.
§418.112(d)(1) Hospice plan of care	L774	(1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
EC.02.01.01	2	The organization manages safety and security risks. Note 1: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 99-2012: 1.4.	The organization identifies potential safety and security risks in the patient's home.
EC.02.02.01	12	The organization manages risks related to hazardous materials and waste.	The organization labels hazardous materials and waste. * Labels identify the contents and hazard warnings. Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. (See also IC.02.01.01, EP 6)
EC.02.06.01	20	The organization establishes and maintains a safe, functional environment.	Areas used by patients are clean and free of offensive odors.
HR.01.01.01	2	The organization defines and verifies staff qualifications.	The organization verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. For home health agencies that elect to use The Joint Commission deemed status option: The organization maintains current licensure and qualifications in personnel records. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification

Standard	EP	Standard Text	EP & Addendum Text
			organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.
HR.01.03.01	1	Staff are supervised effectively.	Supervisors understand the care, treatment, or services provided by staff under their supervision.
IC.01.04.01	1	Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.	The organization's written infection prevention and control goals include the following: Addressing its prioritized risks.
IC.02.01.01	1	The organization implements the infection prevention and control activities it has planned.	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.
IC.02.01.01	2	The organization implements the infection prevention and control activities it has planned.	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)
IC.02.02.01	4	The organization reduces the risk of infections associated with medical equipment, devices, and supplies.	The organization implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies. (See also EQ.01.05.01, EPs 1, 2, 3, 4, 5)
IC.02.04.01	7	The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.	The organization evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually.
IC.02.04.01	8	The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.	The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.) Note: Organizations with a small number of staff and licensed independent practitioners (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).
LD.01.03.01	12	Governance is ultimately accountable for the safety and quality of care, treatment, or services.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed

Standard	EP	Standard Text	EP & Addendum Text
			status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.
LD.03.07.01	6	Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization's governing body is responsible for making sure the quality assessment and performance improvement program (QAPI) meets the following criteria: - Reflects the complexity of the organization and its services - Involves all services provided by the organization, including those provided under contract or arrangement - Takes actions to demonstrate improvement in the organization's performance For home health agencies that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators related to improved outcomes, including the prevention and reduction of medical errors, hospital admissions, hospital readmissions, and the use of emergent care services. For hospices that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators that are related to improved palliative outcomes.
LD.03.07.01	7	Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.
LD.03.09.01	12	The organization has an organizationwide, integrated patient safety program.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.
LD.04.01.07	1	The organization has policies and procedures that guide and support patient care, treatment, or services.	Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, or services. Note: For hospices that elect to use The Joint Commission deemed status option: Establishment of policies governing the provision of hospice care is the responsibility of the hospice's interdisciplinary group.
MM.03.01.01	13	The organization safely stores medications.	For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice follows procedures for the control and accountability of all medications within the

Standard	EP	Standard Text	EP & Addendum Text
			hospice facility.
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient's risk for falls.
NPSG.09.02.01	2	Reduce the risk of falls.	Implement interventions to reduce falls based on the patient's assessed risk.
NPSG.09.02.01	4	Reduce the risk of falls.	Educate the patient and, as needed, the family on any individualized fall reduction strategies.
NPSG.09.02.01	5	Reduce the risk of falls.	Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education. Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number of falls with injuries.
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice conducts and documents a patient-specific comprehensive assessment and reassessment that identifies the patient's need for hospice care and services. The assessment includes the patient's need for physical, psychosocial, emotional, and spiritual care, including the following: - Support with activities of daily living - All areas of hospice care related to the palliation and management of the terminal illness and related conditions - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms - The comfort level of a patient who chooses not to take nutrition therapy - Patient and family spiritual orientation, including their desire for the involvement of a religious group - Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness - Patient and family involvement in a support group, if any - Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness - The need for volunteer services to offer support or respite to the patient, family, or other caregivers - The need for an alternative setting or level of care - Anticipated discharge needs, including bereavement and funeral needs - Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions - For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient's and family's ability to cope with the patient's death

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Standard	EP	Standard Text	EP & Addendum Text
			- For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	18	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs
PC.01.03.01	32	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care revisions are based on information from updates to the patient's comprehensive assessment and address the patient's progress toward goals and outcomes.
PC.01.03.01	33	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.
PC.01.03.01	36	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: Bereavement services reflect the needs of the bereaved.
PC.01.03.01	37	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery. Note: Bereavement counseling is a required hospice service but is not reimbursable.
PC.01.03.01	40	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.
PC.02.01.01	1	The organization provides care, treatment, or services for each patient.	The organization provides the patient with care, treatment, or services

Standard	EP	Standard Text	EP & Addendum Text
			according to the patient's individualized plan of care.
PC.02.01.01	13	The organization provides care, treatment, or services for each patient.	For hospices that elect to use The Joint Commission deemed status option: The hospice provides care and services that are based on the initial assessment, comprehensive assessment, and updated assessments of the patient's and family's needs.
PC.02.01.03	9	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health aide or hospice aide provides services that are ordered by the physician or allowed practitioner in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.
PC.02.01.03	16	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	For hospices that elect to use The Joint Commission deemed status option: Hospice aides report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and performance and improvement activities.
PC.02.01.05	1	The organization provides interdisciplinary, collaborative care, treatment, or services.	All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.
PC.02.03.01	4	The organization provides patient education and training based on each patient's needs and abilities.	The organization provides education and training to the patient based on the patient's assessed needs. For hospices that elect to use The Joint Commission deemed status option: The hospice also provides education and training to the primary caregiver as appropriate to the responsibilities assigned to the caregiver in the plan of care. For home health agencies that elect to use The Joint Commission deemed status option: Each patient, and their caregiver(s) where applicable, receive ongoing education and training regarding the care and services identified in the plan of care. The organization must provide training, as necessary, to ensure a timely discharge.
PC.04.02.01	6	When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.	For hospices that elect to use The Joint Commission deemed status option: The hospice discharge summary includes the following: - A summary of the patient's stay, including treatments, symptoms, and pain management - The patient's current plan of care - The patient's latest physician orders - Any other documentation that will assist in postdischarge continuity of care or that is requested by the attending physician or receiving physician
PI.04.01.01	8	The organization improves performance.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The number and scope of annual performance improvement projects is based on the patients' needs and

Standard	EP	Standard Text	EP & Addendum Text
			internal organization needs. The projects reflect the scope, complexity, and past performance of the organization's services and operations.
PI.04.01.01	9	The organization improves performance.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization documents what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on them.
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

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Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

Joint Commission Health Care Organization

Organization ID: 524828-Seasons Hospice & Palliative Care of Michigan, LLC
27355 John R Road Madison Heights, MI 48071-3300

Accreditation Activity- 60-day Evidence of Standards Compliance
Submission Date: 7/22/2022

Home Care Accreditation Program IC.02.01.01 EP 2
Likelihood: Moderate Scope: Limited

Standard Text: The organization implements the infection prevention and control activities it has planned.

EP Text: The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)

Finding(s): 1) Observed in Patient Home at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site .
In 1 of 2 tracers conducted, In 1 of 2 tracers conducted, the surveyor observed that the staff member did not follow organization policy on Bag Technique. For example, during the home visit for HV1, the surveyor observed that the staff member wore gloves to wipe down her reusable medical equipment and then replaced it immediately in her equipment bag wearing the same contaminated gloves. Per policy, used gloves were not to be worn when entering the clean area of the bag. This was observed by the Senior Director Clinical Operations also present on the visit.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

All nurses and leaders will be assigned Bag Technique Video in the learning management system to be completed by 6/17/22

Q. All corrective actions described above were completed by

Jul 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The learning management system will show 100% completion of training. The leadership team will complete a minimum of 6 supervisory visits per week to provide immediate feedback . The audits will show 80% or better compliance with bag technique to meet a threshold of 80% or better for 4 consecutive weeks. After the threshold is met, the clinical leadership will continue to monitor monthly through routine supervisory visits per protocol.

Q. What is the frequency of the monitoring activities?

Monitoring will occur weekly.

Q. What data will be collected from these activities?

Data with compliance with infection control protocols will be collected.

Q. To who, and how often, will this data be reported?

The Senior Clinical Director will report trends with supervisory visits weekly to the leadership team and quaterly to the QAPI committee to create action plans on identified trends for ongoing improvement.

Home Care Accreditation Program PC.01.03.01 EP 40
Likelihood: Moderate Scope: Pattern

Standard Text: The organization plans the patient's care.

EP Text: For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site .
In 2 of 2 patient records reviewed, In 2 of 2 patient records reviewed, where they patient had been in a SNF, the surveyor did not find where the organization had identified the care and services that were needed and identified which provider was responsible for performing the functions that had been agreed upon and included in the plan of care. For example. in HV1, the patient was transferred to a SNF for a respite stay. The plan of care did not identify what care and services were needed for the respite stay and did not identify which provider was responsible for the services. The Facility Integration form was not found in the record. In review of the medical record for RR4, the Facility Integration form that would indicate the provider responsible for the services in the plan of care was not found. The Facility Integration form was required documentation per organization process. This was verified by the

Regional Director of Quality assisting with review of the record.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Senior Director of Clinical operations and Director of Business Operations

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

The Senior Director of Clinical Operations will maintain oversight of the clinical process for creating a collaborative plan of care using the Facility Integration Form with the facility staff and scanning a copy to the office. The Director of Business Operations will maintain oversight of the business operations process of attaching a copy of the Facility Integration Form to the medical record.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high level resolution), but also any underlying reasons for the failure were addressed as well?

After discussion with the leadership team, the following reasons were found to hinder the process: 1) a miss understanding of the protocol by staff, 2) the paper process is difficult to track, 3) there was not a well-defined process on how to get the copy of the form to attach it to the medical record.

Q. All corrective actions identified below must be completed prior to submission

Immediate action items; Retrain staff on the protocol and the process. Long Term action items: submit request to the national EMR committee for an electronic process development. All nurses and leaders will recieve training on a proposed updated Protocol Long Term Care Facility Charts in the learning management system. All Leaders will recieve education on how to pull the report to review patients in a facility from HomeCare HomeBase in the learning management system.

Q. All corrective actions described above were completed by

Jul 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The learning management system will show 100% completion of training. The leadership team will complete a minimum of 6 supervisory visits per week to provide immediate feedback and will complete a chart audit of the previous 2 weeks with each visit. The audits will show 80% or better compliance to meet a threshold of 80% or better for 4 consecutive weeks. After the threshold is met, the clinical leadership will continue to monitor monthly through routine supervisory visits per protocol.

Q. What is the frequency of the monitoring activities?

Monitoring will occur weekly

Q. What data will be collected from these activities?

Data on compliance with policies and protocols.

Q. To who, and how often, will this data be reported?

The Senior Clinical Director will report trends with supervisory visits weekly to the leadership team and quaterly to the QAPI committee to create action plans on identified trends for ongoing improvement.

Home Care Accreditation Program PC.02.01.03 EP 9
Likelihood: Moderate Scope: Limited

Standard Text: The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.

EP Text: For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health aide or hospice aide provides services that are ordered by the physician or allowed practitioner in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.

Finding(s): 1) Observed in Tracer Activities at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site .
In 1 of 6 patient records reviewed, In 1 of 6 patient records reviewed, with hospice aide services ordered, the surveyor noted that the aide had not followed the aide plan of care. For instance, during the home visit for HV1, the patient caregiver stated that the aide had been assisting the patient with a bed bath. The nurse, during the visit, stated she would need to update the aide plan of care for the bath change because at the time of the visit, the aide plan of care listed a shower with chair bath. This was discussed with the Senior Director Clinical Operations at the time of the visit and validated through subsequent

record review

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

All nurses, hospice aides, and leaders will receive training on new Hospice Aide Documentation course and updated protocol 2112 Aide Plan of Care in the learning management system. The Leaders will receive training on how to pull the Aide Care Plan history Report for review in the learning management system.

Q. All corrective actions described above were completed by

Jul 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The learning management system will show 100% completion of training. The leadership team will complete a minimum of 6 supervisory visits per week to provide immediate feedback and will complete a chart audit of the previous 2 weeks with each visit. The audits will show 80% or better compliance to meet a threshold of 80% or better for 4 consecutive weeks. After the threshold is met, the clinical leadership will continue to monitor monthly through routine supervisory visits per protocol.

Q. What is the frequency of the monitoring activities?

Monitoring will occur weekly

Q. What data will be collected from these activities?

Data toward compliance with protocol 2112 Aide Plan of Care.

Q. To who, and how often, will this data be reported?

The Senior Clinical Director will report trends with supervisory visits weekly to the leadership team and quaterly to the QAPI committee to create action plans on identified trends for ongoing improvement.

Home Care Accreditation Program RC.01.01.01 EP 11
Likelihood: Low Scope: Limited

Standard Text: The organization maintains complete and accurate patient records.

EP Text: For hospices that elect to use The Joint Commission deemed status option: The patient record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site .
In 1 of 8 patient records reviewed, In 1 of 8 patient records reviewed, the surveyor noted that information was not accurate for the patient. For example. in review of the medical record for RR5, the patient was assessed to have a 16FR suprapubic catheter and there was also an order for a 16FR 10cc suprapubic catheter. Multiple subsequent notes documented an 18FR suprapubic catheter. In discussion with the staff member, it was found that the patient had a 16FR catheter and not the 18FR documented. This was confirmed by the Senior Director Clinical Services.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Correcting Non - Compliance

Q. All corrective actions identified below must be completed prior to submission

All nurses will receive the following training in the learning management system by 6/17/22:

Listen: Raising the Bar - The ACES Cycle and Having Consistency in Documentation (7:37)

Read: Field Nurse Manual page 87-100 'Communicate' about the importance of cross discipline collaboration

Watch: Archived CMRV - Quality Series 4 "Tying It All Together" 1/2021 in the learning management system.

Q. All corrective actions described above were completed by

Jul 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The learning management system will show 100% completion of training. The leadership team will complete a minimum of 6 supervisory visits per week to provide immediate feedback and will complete a chart audit of the previous 2 weeks with each visit. The audits will show 80% or better compliance to meet a threshold of 80% or better for 4 consecutive weeks. After the threshold is met, the clinical leadership will continue to monitor monthly through routine supervisory visits per protocol.

Q. What is the frequency of the monitoring activities?

Monitoring will occur weekly.

Q. What data will be collected from these activities?

Data will be collected to show compliance with policies and protocols.

Q. To who, and how often, will this data be reported?

The Senior Clinical Director will report trends with supervisory visits weekly to the leadership team and quaterly to the QAPI committee to create action plans on identified trends for ongoing improvement.

Home Care Accreditation Program RC.02.01.01 EP 2
Likelihood: Moderate Scope: Pattern

Standard Text: The patient record contains information that reflects the patient's care, treatment, or services.

EP Text: The patient record contains the following clinical information:- Any medications administered, including dose- Any activity restrictions- Any changes in the patient's condition- Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner- The patient's medical history- Any allergies to medications- Any adverse drug reactions- The patient's functional status- Any diet information or any dietary restrictions- Diagnostic and therapeutic tests, procedures, and treatments, and their results- Any specific notes on care, treatment, or services- The patient's response to care, treatment, or services- Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders- Any information required by organization policy, in accordance with law and regulation- A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services- The plan(s) of care- For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner.Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the

personal care or support service staff, or another separate document.Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

Finding(s): 1) Observed in Record Review at Seasons Hospice & Palliative Care of Michigan, LLC (27355 John R. Road, Madison Heights, MI) site .
In 2 of 8 patient records reviewed, In 2 of 8 patient records reviewed, the surveyor found that all information related care and services provided had not been documented. For example, in review of RR2 the record reflected a BP of 192/122 and pulse of 106. There was no documentation to indicate the physician had been notified. In discussion with the staff member related to this, she stated that discussion with the physician had taken place and that it was thought the elevated BP and pulse were due to the patient's elevated pain levels and no antihypertensives had been ordered for that reason. In review of DC2, the patient was discharged for an extended prognosis. In review of the medical record, documentation was found in IDG notes that the patient was to be assessed by the physician to determine potential discharge. The physician encounter note stated that the patient met criteria to be recertified. Further review of the record found that the patient had been discharged and there was no discharge order. In discussion with the nurse it was learned that the nurse and physician had discussed the patient's status after both had seen the patient and agreed the patient could be discharged for an extended prognosis and received an order to discharge. This discussion and the order to discharge were not found in the medical record. These observations were verified by the Senior Director Clinical Services and the Regional Director of Quality assisting with record review.

Assigning Accountability

The Executive Director is ultimately responsible for all corrective actions and ongoing compliance associated with this element of performance.

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change? (select one or more)

Other

Q. Which member(s) of leadership have been involved in the corrective action and are maintaining ongoing involvement with this change?

Senior Director of Clinical Operations

Q. Please describe how the above leadership involvement is helping to support compliance with this element of performance in the future?

The Senior Director of Clinical Operations is responsible for the management of all clinical processes including documentation. The Senior Director of Clinical Operations will make complete documentation a priority for all bedside trainings.

Correcting Non - Compliance

Q. What analysis was completed to ensure not only the noncompliant issue was corrected (surface/high

level resolution), but also any underlying reasons for the failure were addressed as well?

The leadership team met to discuss the underlying reasons for the failure. The team feels that staffing challenges and staff burnout are contributing factors for missing documentation. The team has re-evaluated the case loads to ensure that there is a fair distribution of patients. The team also felt that there was a misunderstanding of everything that needs to be documented in the medical record. The team will be re-trained on communication and medical record documentation expectations.

Q. All corrective actions identified below must be completed prior to submission

All nurses will receive the following training in the learning management system by 6/17/22:

Listen: Raising the Bar - The ACES Cycle and Having Consistency in Documentation (7:37)

Read: Field Nurse Manual page 87-100 'Communicate' about the importance of cross discipline collaboration

Watch: Archived CMRV - Quality Series 4 "Tying It All Together" 1/2021 in the learning management system.

Q. All corrective actions described above were completed by

Jul 21, 2022

Ensuring Sustained Compliance

Q. What procedures or activities have been identified to monitor your compliance with this element of performance?

The learning management system will show 100% completion of training. The leadership team will complete a minimum of 6 supervisory visits per week to provide immediate feedback and will complete a chart audit of the previous 2 weeks with each visit. The audits will show 80% or better compliance to meet a threshold of 80% or better for 4 consecutive weeks. After the threshold is met, the clinical leadership will continue to monitor monthly through routine supervisory visits per protocol.

Q. What is the frequency of the monitoring activities?

Monitoring will occur weekly

Q. What data will be collected from these activities?

Data will be collected to show compliance with policies and protocols

Q. To who, and how often, will this data be reported?

The Senior Clinical Director will report trends with supervisory visits weekly to the leadership team and quaterly to the QAPI committee to create action plans on identified trends for ongoing improvement.

Final Accreditation Report

Seasons Hospice & Palliative Care of Michigan, LLC
27355 John R Road
Madison Heights, MI 48071-3300

Organization Identification Number: 524828
Plan of Correction Submitted: 3/23/2022

POC Programs Reviewed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Submit Date	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	3/23/2022	Reviewed	None	None

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The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	Corresponds to:
Hospice	§418.100	L649	OME
Hospice	§418.100(b)	L651	OME/LD.01.03.01/EP12
Hospice	§418.104	L670	OME
Hospice	§418.104(a)(3)	L674	OME/RC.02.01.01/EP2
Hospice	§418.104(e)(3)(i)	L684	OME/PC.04.02.01/EP6
Hospice	§418.106	L687	OME
Hospice	§418.106(e)(3)(ii)	L700	OME/MM.03.01.01/EP13
Hospice	§418.112	L759	OME
Hospice	§418.112(d)(1)	L774	OME/PC.01.03.01/EP40
Hospice	§418.114	L783	OME
Hospice	§418.114(a)	L784	OME/HR.01.01.01/EP2
Hospice	§418.54	L520	OME
Hospice	§418.54	L521	OME/PC.01.02.01/EP7
Hospice	§418.54(c)(7)	L531	OME/PC.01.02.01/EP7
Hospice	§418.56	L538	OME
Hospice	§418.56(b)	L544	OME/PC.02.03.01/EP4
Hospice	§418.56(c)	L545	OME/PC.01.03.01/EP5
Hospice	§418.56(c)(4)	L549	OME/PC.01.03.01/EP18
Hospice	§418.56(d)	L553	OME/PC.01.03.01/EP32
Hospice	§418.56(e)(2)	L555	OME/PC.02.01.01/EP1
Hospice	§418.56(e)(3)	L556	OME/PC.02.01.01/EP13
Hospice	§418.56(e)(4)	L557	OME/PC.02.01.05/EP1

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Deemed Service	CoP(s)	Tag	Corresponds to:
Hospice	§418.58	L560	OME/LD.03.07.01/EP6 OME/LD.03.07.01/EP7
Hospice	§418.58	L559	OME
Hospice	§418.58(c)(2)	L569	OME/LD.03.09.01/EP12
Hospice	§418.58(d)(1)	L572	OME/PI.04.01.01/EP8
Hospice	§418.58(d)(2)	L573	OME/PI.04.01.01/EP9
Hospice	§418.60	L577	OME
Hospice	§418.60(a)	L579	OME/IC.02.01.01/EP2
Hospice	§418.60(b)	L580	OME/IC.02.01.01/EP1
Hospice	§418.60(b)(2)(ii)	L581	OME/IC.01.04.01/EP1
Hospice	§418.64	L587	OME
Hospice	§418.64(d)(1)(iii)	L596	OME/PC.01.03.01/EP36
Hospice	§418.64(d)(1)(iv)	L596	OME/PC.01.03.01/EP37
Hospice	§418.76	L607	OME
Hospice	§418.76(g)(1)	L625	OME/PC.01.03.01/EP33
Hospice	§418.76(g)(2)(ii)	L626	OME/PC.02.01.03/EP9
Hospice	§418.76(g)(4)	L628	OME/PC.02.01.03/EP16

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Requirements for Improvement Summary

Program: Home Care

Standard
EC.02.01.01
EC.02.02.01
EC.02.06.01
HR.01.01.01
HR.01.03.01
IC.01.04.01
IC.02.01.01
IC.02.02.01
IC.02.04.01
LD.01.03.01
LD.03.07.01
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PC.02.01.01
PC.02.01.03
PC.02.01.05
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PC.04.02.01
PI.04.01.01

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Standard
RC.02.01.01

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
EC.02.01.01	2	The organization manages safety and security risks. Note 1: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 99-2012: 1.4.	The organization identifies potential safety and security risks in the patient's home.
EC.02.02.01	12	The organization manages risks related to hazardous materials and waste.	The organization labels hazardous materials and waste. * Labels identify the contents and hazard warnings. Footnote *: The Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements. (See also IC.02.01.01, EP 6)
EC.02.06.01	20	The organization establishes and maintains a safe, functional environment.	Areas used by patients are clean and free of offensive odors.
HR.01.01.01	2	The organization defines and verifies staff qualifications.	The organization verifies and documents the following: - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. - Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed. For home health agencies that elect to use The Joint Commission deemed status option: The organization maintains current licensure and qualifications in personnel records. Note 1: It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented. Note 2: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source. Note 3: An external organization (for example, a credentials verification

Standard	EP	Standard Text	EP & Addendum Text
			organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.
HR.01.03.01	1	Staff are supervised effectively.	Supervisors understand the care, treatment, or services provided by staff under their supervision.
IC.01.04.01	1	Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections. Note: See NPSG.07.01.01 for hand hygiene guidelines.	The organization's written infection prevention and control goals include the following: Addressing its prioritized risks.
IC.02.01.01	1	The organization implements the infection prevention and control activities it has planned.	The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. Note: Surveillance activities address processes and/or outcomes.
IC.02.01.01	2	The organization implements the infection prevention and control activities it has planned.	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)
IC.02.02.01	4	The organization reduces the risk of infections associated with medical equipment, devices, and supplies.	The organization implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies. (See also EQ.01.05.01, EPs 1, 2, 3, 4, 5)
IC.02.04.01	7	The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.	The organization evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually.
IC.02.04.01	8	The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.	The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.) Note: Organizations with a small number of staff and licensed independent practitioners (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).
LD.01.03.01	12	Governance is ultimately accountable for the safety and quality of care, treatment, or services.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. For home health agencies that elect to use The Joint Commission deemed

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Standard	EP	Standard Text	EP & Addendum Text
			status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program. For hospices that elect to use The Joint Commission deemed status option: A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operations of the hospice.
LD.03.07.01	6	Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization's governing body is responsible for making sure the quality assessment and performance improvement program (QAPI) meets the following criteria: - Reflects the complexity of the organization and its services - Involves all services provided by the organization, including those provided under contract or arrangement - Takes actions to demonstrate improvement in the organization's performance For home health agencies that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators related to improved outcomes, including the prevention and reduction of medical errors, hospital admissions, hospital readmissions, and the use of emergent care services. For hospices that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators that are related to improved palliative outcomes.
LD.03.07.01	7	Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.
LD.03.09.01	12	The organization has an organizationwide, integrated patient safety program.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.
LD.04.01.07	1	The organization has policies and procedures that guide and support patient care, treatment, or services.	Leaders review, approve, and manage the implementation of policies and procedures that guide and support patient care, treatment, or services. Note: For hospices that elect to use The Joint Commission deemed status option: Establishment of policies governing the provision of hospice care is the responsibility of the hospice's interdisciplinary group.
MM.03.01.01	13	The organization safely stores medications.	For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice follows procedures for the control and accountability of all medications within the

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Standard	EP	Standard Text	EP & Addendum Text
			hospice facility.
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient's risk for falls.
NPSG.09.02.01	2	Reduce the risk of falls.	Implement interventions to reduce falls based on the patient's assessed risk.
NPSG.09.02.01	4	Reduce the risk of falls.	Educate the patient and, as needed, the family on any individualized fall reduction strategies.
NPSG.09.02.01	5	Reduce the risk of falls.	Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education. Note: Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number of falls with injuries.
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice conducts and documents a patient-specific comprehensive assessment and reassessment that identifies the patient's need for hospice care and services. The assessment includes the patient's need for physical, psychosocial, emotional, and spiritual care, including the following: - Support with activities of daily living - All areas of hospice care related to the palliation and management of the terminal illness and related conditions - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms - The comfort level of a patient who chooses not to take nutrition therapy - Patient and family spiritual orientation, including their desire for the involvement of a religious group - Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness - Patient and family involvement in a support group, if any - Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness - The need for volunteer services to offer support or respite to the patient, family, or other caregivers - The need for an alternative setting or level of care - Anticipated discharge needs, including bereavement and funeral needs - Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions - For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient's and family's ability to cope with the patient's death

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Standard	EP	Standard Text	EP & Addendum Text
			- For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.03.01	5	The organization plans the patient's care.	The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.
PC.01.03.01	18	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: - Interventions to manage pain and symptoms - A statement of the scope and frequency of the services necessary to meet the patient's and family's needs - Measurable outcomes anticipated from implementing and coordinating the plan of care - Medications and treatment necessary to meet the patient's needs - Medical supplies and appliances necessary to meet the patient's needs
PC.01.03.01	32	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care revisions are based on information from updates to the patient's comprehensive assessment and address the patient's progress toward goals and outcomes.
PC.01.03.01	33	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.
PC.01.03.01	36	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: Bereavement services reflect the needs of the bereaved.
PC.01.03.01	37	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery. Note: Bereavement counseling is a required hospice service but is not reimbursable.
PC.01.03.01	40	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.
PC.02.01.01	1	The organization provides care, treatment, or services for each patient.	The organization provides the patient with care, treatment, or services

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Standard	EP	Standard Text	EP & Addendum Text
			according to the patient's individualized plan of care.
PC.02.01.01	13	The organization provides care, treatment, or services for each patient.	For hospices that elect to use The Joint Commission deemed status option: The hospice provides care and services that are based on the initial assessment, comprehensive assessment, and updated assessments of the patient's and family's needs.
PC.02.01.03	9	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health aide or hospice aide provides services that are ordered by the physician or allowed practitioner in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.
PC.02.01.03	16	The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	For hospices that elect to use The Joint Commission deemed status option: Hospice aides report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and performance and improvement activities.
PC.02.01.05	1	The organization provides interdisciplinary, collaborative care, treatment, or services.	All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.
PC.02.03.01	4	The organization provides patient education and training based on each patient's needs and abilities.	The organization provides education and training to the patient based on the patient's assessed needs. For hospices that elect to use The Joint Commission deemed status option: The hospice also provides education and training to the primary caregiver as appropriate to the responsibilities assigned to the caregiver in the plan of care. For home health agencies that elect to use The Joint Commission deemed status option: Each patient, and their caregiver(s) where applicable, receive ongoing education and training regarding the care and services identified in the plan of care. The organization must provide training, as necessary, to ensure a timely discharge.
PC.04.02.01	6	When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.	For hospices that elect to use The Joint Commission deemed status option: The hospice discharge summary includes the following: - A summary of the patient's stay, including treatments, symptoms, and pain management - The patient's current plan of care - The patient's latest physician orders - Any other documentation that will assist in postdischarge continuity of care or that is requested by the attending physician or receiving physician
PI.04.01.01	8	The organization improves performance.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The number and scope of annual performance improvement projects is based on the patients' needs and

Standard	EP	Standard Text	EP & Addendum Text
			internal organization needs. The projects reflect the scope, complexity, and past performance of the organization's services and operations.
PI.04.01.01	9	The organization improves performance.	For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization documents what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on them.
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care

Standard	EP	Standard Text	EP & Addendum Text
			and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

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Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Final Accreditation Report

Seasons Hospice & Palliative Care of Connecticut, LLC
1579 Straits Turnpike, Unit 1E
Middlebury, CT 06762-1835

Organization Identification Number: 546050
Unannounced Full Event: 12/13/2022 - 12/16/2022

Program Surveyed
Home Care

The Joint Commission
Table of Contents

The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	12/13/2022 - 12/16/2022	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Evidence of Standards Compliance (ESC)	Submit within 60 Calendar Days from the final posted report date

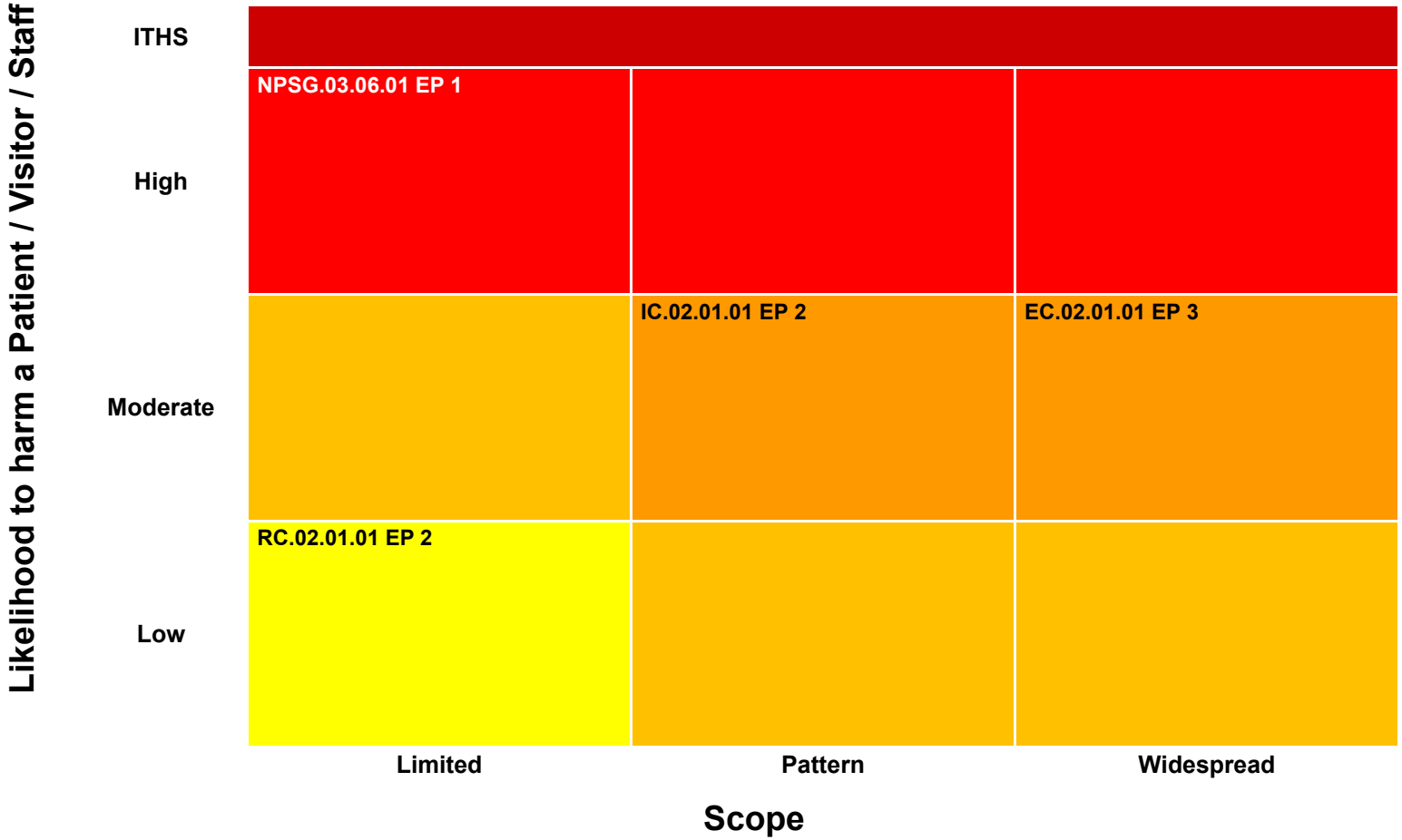
The Joint Commission
What's Next - Follow-up Activity

Program: Home Care

Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Evidence of Standard Compliance (within 60 calendar days)
EC.02.01.01	3	Moderate / Widespread	§418.110 (c)(1)	L725	✓
IC.02.01.01	2	Moderate / Pattern	§418.60 (a)	L579	✓
NPSG.03.06.01	1	High / Limited			✓
RC.02.01.01	2	Low / Limited	§418.104 (a)(3)	L674	✓

The Joint Commission
SAFER™ Matrix

Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

Deemed Service	CoP(s)	Tag	CoP Score	Corresponds to:
Hospice	§418.104	L670	Standard	OME
Hospice	§418.104(a)(3)	L674	Standard	OME/RC.02.01.01/EP2
Hospice	§418.110	L719	Standard	OME
Hospice	§418.110(c)(1)	L725	Standard	OME/EC.02.01.01/EP3
Hospice	§418.60	L577	Standard	OME
Hospice	§418.60(a)	L579	Standard	OME/IC.02.01.01/EP2

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EC.02.01.01	3	Moderate Widespread	The organization takes action to minimize identified safety and security risks. Note: In the patient's home, actions may be limited to education.	1) Observed in Patient Home at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site . In 2 of 2 home visits conducted, The HCO did not take actions to ensure safe storage of the patient's oxygen cylinders. For example, on HV #2/RR #2, the surveyor observed the patient's oxygen cylinder shut up in the room closet, not secured in a holder and on HV #4/RR #4, three cylinders were observed, two sitting on the floor and one leaning against the wall in front of a fireplace. None were secured in racks. The patient caregiver stated the fireplace is "never used anymore". Standards require the organization take actions to identify and minimize risks to patient safety, including providing education as necessary. This finding was reviewed, discussed and validated by the Clinical Manager.	§418.110(c)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.02.01.01	2	Moderate Pattern	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)	1) Observed in Patient Home at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site . In 2 of 4 home visits conducted, The HCO staff failed to use standard infection prevention and control precautions at times required by the organization's policy. For example, on HV #1/RR #1, the surveyor observed the chaplain making direct patient contact without conducting hand hygiene prior to and after. And on HV #3/RR #3, the Registered Nurse was observed completing the patient's physical assessment, examining the patient's feet, moving to the upper body, assessing the buttocks and then repositioning without changing gloves in between and conducting hand hygiene. The organization's hand washing policy, number 4003, requires hand hygiene be performed prior to direct patient contact, when moving from contaminated to clean body areas, and for personnel who do not provide hands-on patient care to have a waterless antiseptic agent in their possession for times of direct patient contact. These findings were reviewed, discussed, and confirmed with the Clinical Manager.	§418.60(a)	Standard
NPSG.03.06.01	1	High Limited	Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the patient's medication information during the first contact. The information is updated when the patient's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.	1) Observed in Patient Home at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site . The HCO failed to ensure the patient had a useful medication list in the home. For example, the surveyor noted on HV #2/RR #2, the patient's home folder contained blank medication list forms. The organization's policy, Medication Reconciliation 3019, General Nursing Principle and Process, item number five, requires medications list to be left in the patient's home. These findings were reviewed, discussed, and confirmed with the Clinical Manager.		
RC.02.01.01	2	Low	The patient record contains the following clinical	1) Observed in Patient Home at Seasons Hospice &	§418.104(a)(3)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Limited	information: - Any medications administered, including dose - Any activity restrictions - Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided	Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site . The HCO did not ensure the patient's facility record contain documentation pertinent to hospice care, for example, the surveyor noted in HV #1/RR #1 the facility's hospice record for the patient did not contain up-to-date care plan documents. The last form was dated for July 2022. The organization's policy, IDG Meeting Process 2063, requires the RN Case Manager to place updated copies of the Interdisciplinary Group documents in the patient's facility chart following each meeting update. These findings were reviewed, discussed and confirmed with the Clinical Manager.		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)			

The Joint Commission

Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§418.60 Infection control	L577	§418.60 Condition of participation: Infection control.
§418.60(a) Prevention	L579	§418.60(a) Standard: Prevention. The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
§418.110 Hospices that Provide Inpatient Care Directly	L719	§418.110 Condition of Participation: Hospices that provide inpatient care directly.
§418.110(c)(1) Physical environment	L725	(1) Safety management. The hospice must address real or potential threats to the health and safety of the patients, others, and property.
§418.104 Clinical Records	L670	§418.104 Condition of participation: Clinical records.
§418.104(a)(3) Content	L674	(3) Responses to medications, symptom management, treatments, and services.

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP & Addendum Text
EC.02.01.01	3	The organization manages safety and security risks. Note 1: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply. Note 2: For further information on waiver and equivalency requests, see https://www.jointcommission.org/resources/patient-safety-topics/the-physical-environment/life-safety-code-information-and-resources/ and NFPA 99-2012: 1.4.	The organization takes action to minimize identified safety and security risks. Note: In the patient's home, actions may be limited to education.
IC.02.01.01	2	The organization implements the infection prevention and control activities it has planned.	The organization uses standard precautions, * including the use of personal protective equipment, to reduce the risk of infection. Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients. Footnote *: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/hicpac/recommendations/core-practices.html (Infection Control in Healthcare Settings). (See also EC.02.02.01, EP 3)
NPSG.03.06.01	1	Maintain and communicate accurate patient medication information.	Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications. Note 1: The organization obtains the patient's medication information during the first contact. The information is updated when the patient's medications change. Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications. Note 3: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.
RC.02.01.01	2	The patient record contains information that reflects the patient's care, treatment, or services.	The patient record contains the following clinical information: - Any medications administered, including dose - Any activity restrictions

Standard	EP	Standard Text	EP & Addendum Text
			- Any changes in the patient's condition - Any summaries of the patient's care, treatment, or services furnished to the patient’s physician or allowed practitioner - The patient's medical history - Any allergies to medications - Any adverse drug reactions - The patient's functional status - Any diet information or any dietary restrictions - Diagnostic and therapeutic tests, procedures, and treatments, and their results - Any specific notes on care, treatment, or services - The patient's response to care, treatment, or services - Any assessments relevant to care, treatment, or services - Physician or allowed practitioner orders - Any information required by organization policy, in accordance with law and regulation - A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services - The plan(s) of care - For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner. Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document. Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)

The Joint Commission

Appendix

Report Section Information

SAFER™ Matrix Description

All Requirements for Improvement (RFIs) are plotted on the SAFER matrix according to the likelihood the issue could cause harm to patient(s), staff, and/or visitor(s), and the scope at which the RFI is observed. Combined, these characteristics identify a risk level for each RFI, which in turn will determine the level of required post-survey follow up. As the risk level of an RFI increases, the placement of the standard and Element of Performance moves from the bottom left corner to the upper right. The definitions for the Likelihood to Harm a Patient/Staff/Visitor and Scope are as follows:

Likelihood to Harm a Patient/Staff/Visitor:
- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:
- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

The Evidence of Standards Compliance (ESC) or Plan of Correction (POC) forms with findings of a higher risk will require two additional fields within the ESC or POC. The organization will provide a more detailed description of Leadership Involvement and Preventive Analysis to assist in sustainment of the compliance plan. Additionally, these higher risk findings will be provided to surveyors for possible review or onsite validation during any subsequent onsite surveys, up until the next full triennial survey occurs. The below legend illustrates the follow-up activity associated with each level of risk.

SAFER™ Matrix Placement	Required Follow-Up Activity
HIGH/LIMITED HIGH/PATTERN HIGH/WIDESPREAD	• Two additional areas surrounding Leadership Involvement and Preventive Analysis will be included in the ESC or POC • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full survey or review
MODERATE/PATTERN MODERATE/WIDESPREAD	
MODERATE/LIMITED LOW/PATTERN LOW/WIDESPREAD	• ESC or POC will not include Leadership Involvement and Preventive Analysis
LOW/LIMITED	

The Joint Commission

Appendix

Report Section Information

CMS Summary Description

For organizations that utilize The Joint Commission for deeming purposes, observations noted within the Requirements for Improvement (RFI) section that are crosswalked to a CMS Condition of Participation (CoP)/Condition for Coverage (CfC) are highlighted in this section. The table included within this section incorporates, from a Centers for Medicare and Medicaid Services (CMS) perspective, the CoPs/CfCs that were noted as noncompliant during the survey, the Joint Commission standard and element of performance the CoP/CfC is associated with, the CMS score (either Standard or Condition Level), and if the standard and EP will be included in an upcoming Medicare Deficiency Survey (MEDDEF) if applicable.

Requirements for Improvement Description

Observations noted within the Requirements for Improvement (RFI) section require follow-up through the Evidence of Standards Compliance (ESC) process. The identified timeframes for submission for each observation are found in the Executive Summary section of the Final Report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame to perform the unannouced follow-up visit is dependent on the scope and severity of the issue identified within Requirements for Improvement.

The Joint Commission

Appendix

Report Section Information

Clarification Instructions

Documents not available at the time of survey
Any required documents that are not available at the time of survey will no longer be eligible for the clarification process. These RFIs will become action items in the post-survey ESC process.

Clerical Errors
Clerical errors in the report will no longer be eligible for the clarification process. The Joint Commission will work with the organization to correct the clerical error, so that the report is accurate. The corrected RFIs will become action items in the post-survey process.

Audit Option
There will no longer be an audit option as part of the clarification process. With the implementation of the SAFER™ matrix, the "C" Element of Performance (EP) category is eliminated. The "C" EPs were the subject of Clarification Audits.

The clarification process provides an organization the opportunity to demonstrate compliance with standards that were scored "not compliant" at the time of the survey. The organization has 10 business days from the date the report is published on the extranet site to submit the clarification. *The Evidence of Standards Compliance (ESC) due dates will remain the same whether or not the organization submits a clarification and/or is successful in the clarification process.*

Clarifications may take either of the following forms:

- An organization believes it had adequate evidence available to the surveyor(s) and was in compliance **at the time of the survey.** (Please note that actions taken during or immediately after the survey will not be considered.) The organization must use the clarification form to support their contention.

- The organization has detailed evidence that was not immediately available **at the time of the survey.** The clarification must include an explanation as to why the surveyor(s) did not have access to the information or why it was not provided to the surveyor(s) at the time of the survey. However, any required documents that are not available at the time of survey are not eligible for the Clarification Process. These RFIs will become action items in the post-survey ESC process.

- Please do not submit supplemental documentation unless requested by The Joint Commission. If additional information is requested, the organization will be required to highlight the relevance to the standards in the documentation.

EXHIBIT 28

State of Washington Office of the Governor
COVID-19 State of Emergency Proclamation
& Rescission
Presentation on COVID-19 Waiver Offboarding

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

PROCLAMATION BY THE GOVERNOR

20-05

WHEREAS, On January 21, 2020, the Washington State Department of Health confirmed the first case of the novel coronavirus (COVID-19) in the United States in Snohomish County, Washington, and local health departments and the Washington State Department of Health have since that time worked to identify, contact, and test others in Washington State potentially exposed to COVID-19 in coordination with the United States Centers for Disease Control and Prevention (CDC); and

WHEREAS, COVID-19, a respiratory disease that can result in serious illness or death, is caused by the SARS-CoV-2 virus, which is a new strain of coronavirus that had not been previously identified in humans and can easily spread from person to person; and

WHEREAS, The CDC identifies the potential public health threat posed by COVID-19 both globally and in the United States as "high", and has advised that person-to-person spread of COVID-19 will continue to occur globally, including within the United States; and

WHEREAS, On January 31, 2020, the United States Department of Health and Human Services Secretary Alex Azar declared a public health emergency for COVID-19, beginning on January 27, 2020; and

WHEREAS, The CDC currently indicates there are 85,688 confirmed cases of COVID-19 worldwide with 66 of those cases in the United States, and the Washington State Department of Health has now confirmed localized person-to-person spread of COVID-19 in Washington State, significantly increasing the risk of exposure and infection to Washington State's general public and creating an extreme public health risk that may spread quickly; and

WHEREAS, The Washington State Department of Health has instituted a Public Health Incident Management Team to manage the public health aspects of the incident; and

WHEREAS, The Washington State Military Department, State Emergency Operations Center, is coordinating resources across state government to support the Department of Health and local officials in alleviating the impacts to people, property, and infrastructure, and is assessing the magnitude and long-term effects of the incident with the Washington State Department of Health; and

WHEREAS, The worldwide outbreak of COVID-19 and the effects of its extreme risk of person-to-person transmission throughout the United States and Washington State significantly impacts the life and health of our people, as well as the economy of Washington State, and is a public disaster that affects life, health, property or the public peace.

NOW, THEREFORE, I, Jay Inslee, Governor of the state of Washington, as a result of the above-noted situation, and under Chapters 38.08, 38.52 and 43.06 RCW, do hereby proclaim that a State of Emergency exists in all counties in the state of Washington, and direct the plans and procedures of the Washington State Comprehensive Emergency Management Plan be implemented. State agencies and departments are directed to utilize state resources and to do everything reasonably possible to assist affected political subdivisions in an effort to respond to and recover from the outbreak.

As a result of this event, I also hereby order into active state service the organized militia of Washington State to include the National Guard and the State Guard, or such part thereof as may be necessary in the opinion of The Adjutant General to address the circumstances described above, to perform such duties as directed by competent authority of the Washington State Military Department in addressing the outbreak. Additionally, I direct the Washington State Department of Health, the Washington State Military Department Emergency Management Division, and other agencies to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

Signed and sealed with the official seal of the state of Washington this 29th day of February, A.D., Two Thousand and Twenty at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

JAY INSLEE
Governor

STATE OF WASHINGTON
OFFICE OF THE GOVERNOR
P.O. Box 40002 • Olympia, Washington 98504-0002 • (360) 902-4111 • www.governor.wa.gov

PROCLAMATION BY THE GOVERNOR

20-05.1
Terminating the COVID-19 State of Emergency

WHEREAS, On January 21, 2020, the Washington State Department of Health confirmed the first case of the novel coronavirus (COVID-19) in the United States in Snohomish County, Washington, and local health departments and the Washington State Department of Health worked to identify, contact, and test others in Washington State potentially exposed to COVID-19 in coordination with the United States Centers for Disease Control and Prevention (CDC); and

WHEREAS, COVID-19, a respiratory disease that can result in serious illness or death, is caused by the SARS-CoV-2 virus, which is a new strain of coronavirus that had not been previously identified in humans and can easily spread from person to person; and

WHEREAS, On January 31, 2020, the United States Department of Health and Human Services Secretary Alex Azar declared a public health emergency for COVID-19, beginning on January 27, 2020; and

WHEREAS, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout the state of Washington as a result of the COVID-19 outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State; and

WHEREAS, as a result of the continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations, I have subsequently issued several amendatory proclamations, exercising my emergency powers under RCW 43.06.220 by prohibiting certain activities and waiving and suspending specified statutory and regulatory obligations and limitations; and

WHEREAS, although COVID-19 continues as an ongoing and present threat in Washington State, the measures we have taken together as Washingtonians over the past 31 months, including the willingness of most Washingtonians to take advantage of the remarkable, life-saving vaccines being administered throughout the state, have made a difference and have altered the course of the pandemic in fundamental ways; and

WHEREAS, while COVID-19 appears to be here to stay, recent advances in medicine, including the availability of bivalent COVID-19 boosters for people 5 years and older and vaccines for children 6 months and older, as well as treatments like antivirals, are reasons to be hopeful that we will have the tools to protect ourselves and communities from severe disease and death to the greatest extent possible; and

WHEREAS, although Department of Health statistics reflect the continued persistence of COVID-19 in the state, including continued hospitalizations and deaths due to COVID-19, health experts and epidemiological modeling experts believe that as a state we have made adequate progress against COVID-19 to end the state of emergency; and

WHEREAS, the Secretary of Health's face covering order, issued under public health authorities provided by RCW 43.70.130, RCW 70.05.070, and WAC 246-100-036, will remain in effect until public health authorities determine it is no longer necessary for control of transmission of SARS-CoV-2; and

WHEREAS, the Washington State Department of Health will continue to monitor COVID-19 disease activity in the state and carry out public health activities that help prevent severe disease and death from COVID-19.

NOW, THEREFORE, I, Jay Inslee, Governor of the state of Washington, as a result of the above-noted situation, and under Chapter 43.06 RCW, do hereby proclaim that, although the threat of COVID-19 remains in all counties in the state of Washington, a State of Emergency Proclamation is no longer necessary to continue to respond to this disease.

As a result, I hereby declare the termination of the state of emergency proclaimed in Proclamation 20-05 and rescind and terminate Proclamation 20-05, and I also hereby rescind all COVID-19 emergency proclamations issued pursuant to Proclamation 20-05, effective October 31, 2022, at 11:59 PM.

Signed and sealed with the official seal of the state of Washington this 28th day of October, A.D., Two Thousand and Twenty-Two at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

Washington State Department of Health

COVID-19 WAIVER OFFBOARDING

August 9, 2022

Presenters

Eric Hernandez
Certificate of Need Program Manager
State Department of Health
Julie Tomaro
Facilities Program Manager-Hospitals and Behavioral Health
State Department of Health
John Williams
Executive Director, Construction Review, Certificate of Need & Facilities
State Department of Health
Ian Corbridge
Office Director, Office of Community Health Systems
State Department of Health

Land Acknowledgement

We start today with a land acknowledgement. I acknowledge that I am on the traditional homelands of the coastal Salish people. Their people have lived on and stewarded these lands since the beginning of time, and continue to do so today.

We recognize that this land acknowledgement is one small step toward true allyship and we commit to uplifting the voices, experiences, and histories of the Indigenous people of this land and beyond.

Agenda

- Acknowledgement and thank you!
- Reflection on waiver background and current use
- Overview of the department's waiver offboarding process (glidepath)
  - Construction Review Services (CRS)
  - Certificate of Need (CN)
  - Licensing
- Next steps and key dates
- Q&A

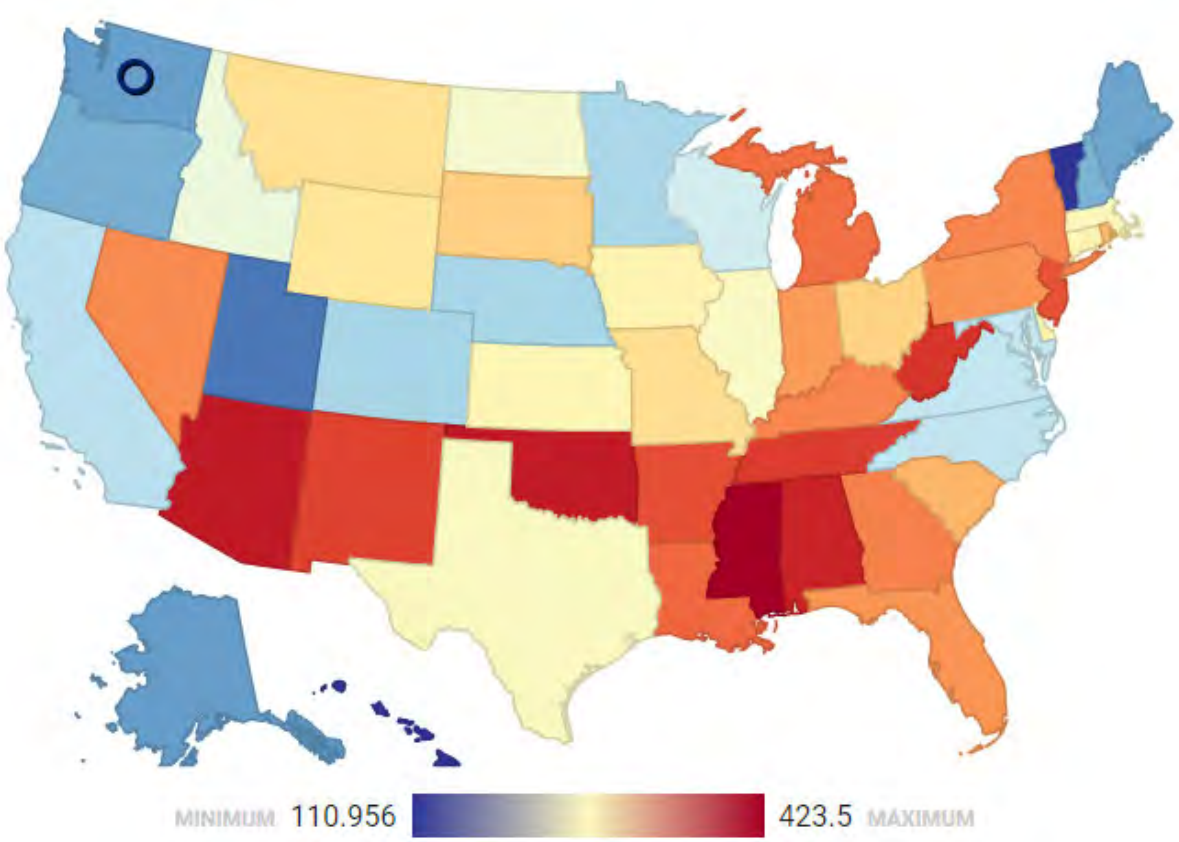
Housekeeping

- Please use the chat function in Zoom to submit questions during the presentation
- Slides will be shared via Gov Delivery next week
- **Questions and all required documentation** as part of the offboarding process should be submitted to **COVIDwaiver@doh.wa.gov**
- There will be time for chat at the end of the presentation

Thank You!

- Our state faced unprecedented demands during the COVID-19 pandemic
- Collectively we worked through extreme challenges to ensure patient access to care
- Thank you for your partnership and commitment to the residents of Washington

COVID-19 Deaths per 100K Population



[COVID-19 Death Rate by State | US News Best States]

Background

- Governor Inslee issued Proclamation 20-36 early in the pandemic to allow health care facilities to meet demands for **COVID surge capacity**
- Proclamation 20-36 waived certain CN, CRS, and facility licensing requirements
- Many facilities have used the waivers to meet an increase in demand caused by COVID

Facility	Certificate of Need	Construction Review	Licensing
Ambulatory Surgery	**WAIVED**	required	required
Hospital, acute	**WAIVED**	**WAIVED**	***Partially WAIVED**
Hospital, psychiatric	**WAIVED**	required	required
In-home services			
• Hospice	**WAIVED**	required	required
• Home care (CMS)	**WAIVED**	NA	required
Nursing Home	**WAIVED**	required	required
Kidney Dialysis	**WAIVED**	NA	NA

Proclamation 20-36 Rescinded

- On 7/29/22, Governor Inslee indicated his intent to rescind Proclamation 20-36.
- On 10/27/22, proclamation 20-36 will be formally rescinded
  - 90-days after the announcement
  - facilities must comply with state law applicable for your license type
- Glidepath: If a facility took advantage of the waivers in Proclamation 20-36 and plans to maintain these changes beyond 10/27/22, you must take immediate action to come into compliance

WASHINGTON GOVERNOR
JAY INSLEE
NEWS RELEASE

July 29, 2022
Public and constituent inquiries | 360.902.4111
Press inquiries | 360.902.4136

Inslee announces upcoming rescission of twelve proclamations related to COVID-19

Gov. Jay Inslee today announced the rescission of 12 proclamations under his COVID-19 emergency authority that are no longer needed to respond to the pandemic. All relate to certain health care facilities, including hospitals, long term care facilities, and health care professionals.

These emergency orders waived and suspended various statutes and rules, and prohibited certain activities, in order to provide the flexibility needed to respond to the pandemic and protect those receiving care. Examples of suspended statutory requirements include those related to training, testing and certification of various health care professionals and the certificate of need process for health care facilities.

The rescissions apply to Proclamations 20-52 (which incorporates 20-06, 20-10, 20-16, 20-17, and 20-18), 20-24, 20-32, 20-36, 20-59, 20-65, 20-66 and 20-74.

To ensure providers and facilities have time to achieve a smooth transition to pre-COVID statutory requirements, the rescission of these orders will become effective in 90 days, on October 27. In support of this transition, the Department of Health and the Department of Social and Health Services have worked diligently to create a glidepath for these health care facilities and professionals. The Department of Health will provide technical assistance to all facilities as they return to full regulatory compliance. DSHS will provide additional technical assistance support for long term care facilities.

In addition, to support the health care system as it addresses certain non-COVID challenges, the state is providing approximately $22 million to maintain contracted health care staff statewide and to support patients transitioning to community-based services. Some of those funds will be used to support Harborview Medical Center in its efforts to secure community-based care for patients with complex medical and behavioral needs.

The governor had previously rescinded about 75% of all COVID-19 emergency orders. When these 12 healthcare-related emergency orders are terminated, approximately 87% of all COVID emergency proclamations will have been rescinded. COVID-19 remains a state and federal public health emergency and known workplace hazard.

Glidepath Approach

- Connecting with stakeholders – Staff from the Governor's office and DOH met with stakeholders in early summer to better understand:
  - What waivers were currently being used
  - How facilities had used the waivers to respond to COVID surge
  - What facilities would find valuable as waivers were offboarded
- Glidepath to supporting compliance
  - Reasonable enforcement approach to move toward compliance
  - Focused on processes that may take longer than 90-days

What Does This Mean for Licensed Facilities?

There are two primary pathways facilities can take:

1. **Revert to original operations by 10/27/22**
2. **Compliance Glidepath** – Follow the departments processes and timelines for coming into compliance.
   - Construction Review Services (CRS)
   - Certificate of Need (CN)
   - Licensing

Construction Review Services (CRS)

Construction Review Services – Examples

- If you made...
  - Changes to the physical environment
    - Added beds
    - Changed your ventilation system
    - Added walls, fixed equipment
    - Added tents, trailers
  - Functional changes to spaces beyond there original approved use
    - Repurposed spaces for more intensive use
    - Changed PACUs to 24 hour stay beds
    - Turned waiting rooms into exam rooms

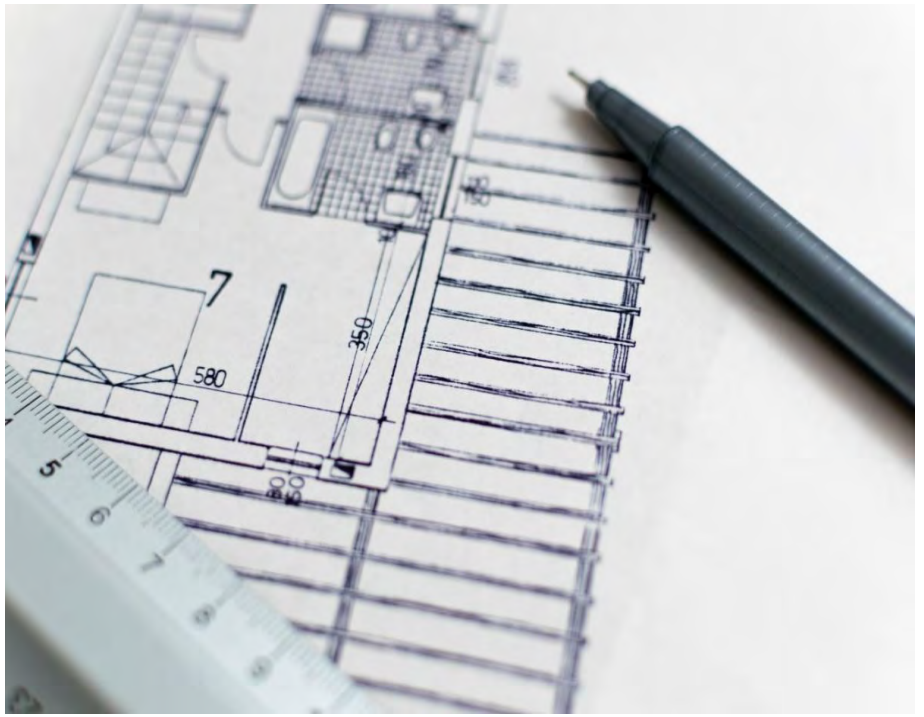
- If yes to any of the above, and you wish to make these changes permanent, you must go through CRS review.

Construction Review Services – Coming into Compliance

- If your license type requires review by CRS, you must:
- **By Aug 28, submit a CRS application.**
- Applications must include:
  - A clear description of the scope of work (physical changes, additions, renovations).
  - Appropriate fee

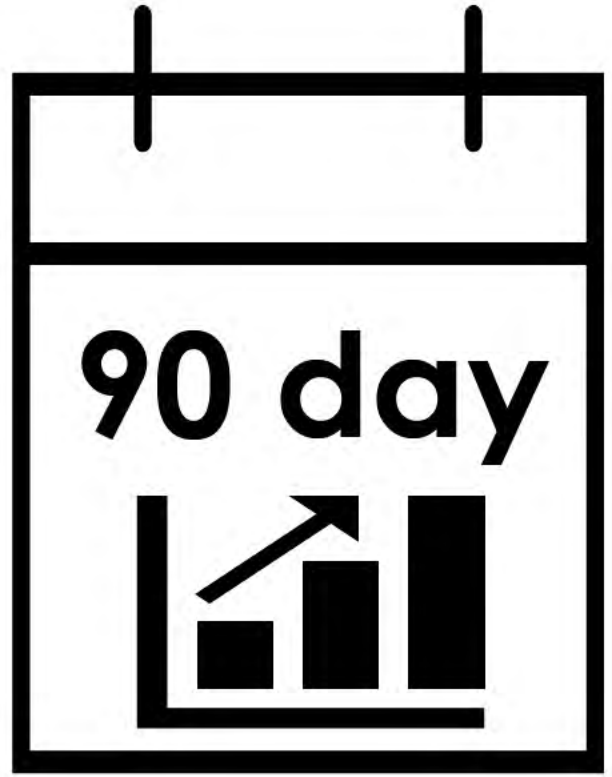
Construction Review Services – Coming into Compliance

- **By Oct 27, submit project documentation**
- Documentation includes:
  - Functional program
  - Architectural and engineering plans
- Alternatively, facilities must request a technical assistance meeting to establish:
  - Scope of review
  - Documentation requirements
  - Schedule

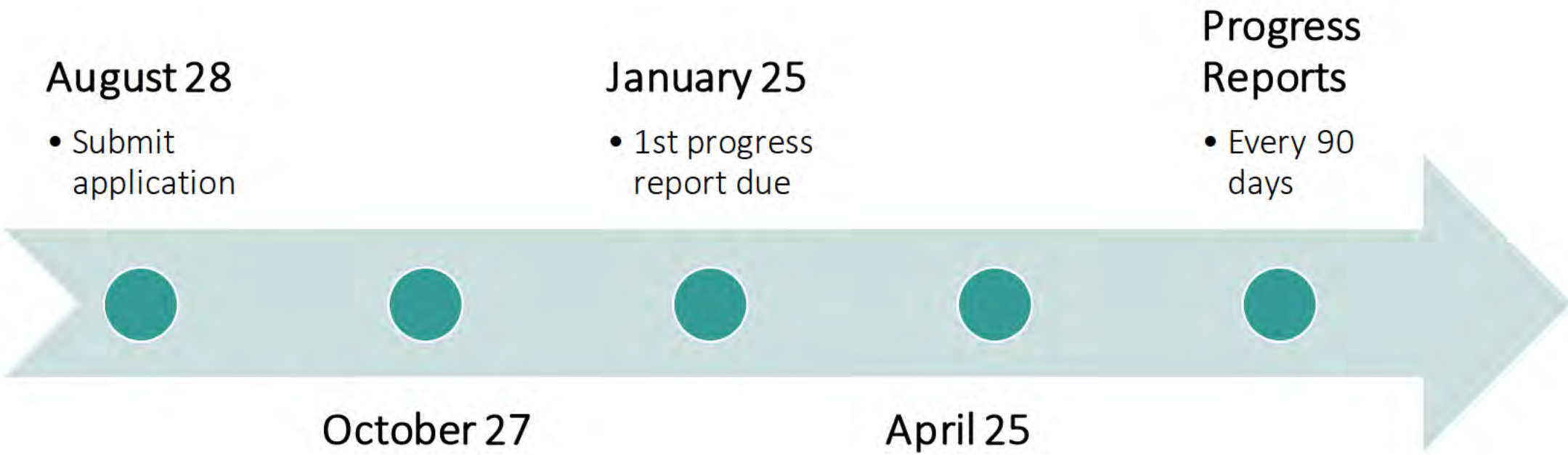


Construction Review Services – Coming into Compliance

- **By Jan 25, begin quarterly Progress reports**
- Until fully approved, facilities must respond quickly and in good faith to correct non-compliant construction, eliminate hazards within the environment and complete the review project.
- Progress Reports must:
  - be submitted every 90 days
  - address project status, updates since last report, and planned completion date



CRS Timeline Recap



Certificate of Need (CN)

Certificate of Need – Examples

- Did you establish/expand a CN reviewable facility, such as:
  - Hospice center/agency
  - Dialysis center
  - Nursing home
  - Hospital beds
  - Elective Percutaneous Coronary Intervention (PCI)
  - Ambulatory Surgery Facility/Center
  - Any tertiary service
- If yes to any of the above, and you wish to continue on a permanent basis, you must submit a CN application

Certificate of Need – Coming into Compliance

- If your license type requires review by CN, you must:
- By Aug 28, submit a Letter of Intent
- Letter of Intent must:
  - Conform to WAC 246-310-080
  - Describe the increase in capacity and/or new location(s)
  - Include a patient transition plan
  - Be submitted through COVIDwaiver@doh.wa.gov

Certificate of Need – Coming into Compliance (Cont'd)

- By Oct 27, facilities must submit a CN application
- Applications must include:
  - Appropriate fee
  - Patient transition plan, if not approved
    - Note: If the CN application is denied, you must execute your patient transition plan and revert operations back to the previously approved CN
- Exception: Facilities with concurrent review cycles.

Certificate of Need – Concurrent Review Exception

- Exception: Facilities with concurrent review cycles.
  - This includes nursing homes, hospice care centers and agencies, and end stage renal disease facilities.
- These facilities must submit a second Letter of Intent, CN application, and appropriate fee.
  - These must be submitted in compliance with the department's published schedule the next time the application cycle opens.
  - Note: Following the process above will not adversely affect a facility's CN application.

CN Timeline Recap

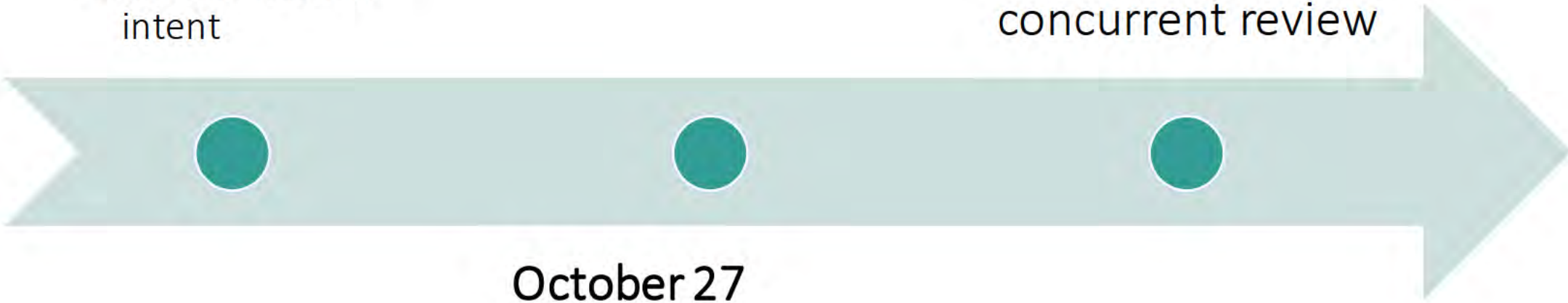
August 28

- Submit letter of intent

October 27

- Submit CN application

*Exception for facilities with concurrent review



Facility Licensing

Licensing – Coming into Compliance

- Hospitals that intend to maintain the following on a permanent basis must submit an updated hospital application and fee (if applicable):
  - added beds
  - additional locations under the hospital license
  - new service lines
- By Oct 27, submit either an updated hospital application -or- a revised licensing renewal application.

Enforcement

Enforcement

- Failure to revert to pre COVID operation or to follow the department's waiver offboarding requirements will be considered non-compliance
  - The department will use existing structures to identify and manage non-compliance
  - The department may take appropriate enforcement action in cases of non-compliance
  - All patient safety related complaints will be addressed through the department's normal complaint process

Questions

Please use the chat function

Next Steps

- Facilitating two webinars next week
- Developing an FAQ
- Pay attention to key dates
- We are here to support COVIDwaiver@doh.wa.gov

STATE OF WASHINGTON
OFFICE OF GOVERNOR JAY INSLEE

PROCLAMATION BY THE GOVERNOR
AMENDING AND EXTENDING
PROCLAMATIONS 20-05 and 20-36, et seq.

20-36.10
Department of Health– Health Care Facilities and Hand Sanitizer

WHEREAS, on February 29, 2020, I issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout the state of Washington as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and confirmed person-to-person spread of COVID-19 in Washington State; and

WHEREAS, as a result of the continued worldwide spread of COVID-19, its significant progression in Washington State, and the high risk it poses to our most vulnerable populations, I have subsequently issued several amendatory proclamations, exercising my emergency powers under RCW 43.06.220 by waiving and suspending specified laws; and

WHEREAS, the COVID-19 disease, caused by a virus that spreads easily from person to person which may result in serious illness or death and has been classified by the World Health Organization as a worldwide pandemic, continues to increase its spread throughout Washington State, seriously increasing the threat of serious associated health risks statewide; and

WHEREAS, several vaccines have now been developed for use against the virus that causes COVID-19, and the need for rapid inoculation of health care workers, particularly vulnerable individuals, and ultimately the general public, requires the waiver and suspension of additional rules that regulate pharmacies, and requires an amendment to the existing prohibition contained in Proclamation 20-36 et seq., to allow pharmacies the flexibility to store the vaccines and other treatments outside of the main pharmacy location and to relax the requirements for supervision of non-pharmacy staff who need to access the storage areas where the vaccines and treatments are stored; and

WHEREAS, on March 30, 2020, I issued Proclamation 20-36 waiving and suspending statutes and rules relating to the administrative requirements to license health care facilities and the production of hand sanitizer to increase the availability of health care facilities and hand sanitizer, and imposing certain prohibitions; and

WHEREAS, under the provisions of RCW 43.06.220(4), the statutory waivers and suspensions of Proclamation 20-36, et seq., have been periodically extended by the leadership of the Washington State Senate and House of Representatives, and which I have acknowledged

and similarly extended the prohibitions and waivers and suspension of rules therein in subsequent sequentially numbered proclamations; and

WHEREAS, on January 15, 2021, under the provisions of RCW 43.06.220(4), the statutory waivers and suspensions of Proclamation 20-36, et seq., were extended by Senate Concurrent Resolution 8402 until the termination of the state of emergency pursuant to RCW 43.06.210, or until rescinded, whichever occurs first; and

WHEREAS, to fully extend Proclamations 20-36, et seq., it is also necessary for me to extend the prohibitions and the waivers and suspensions of rules in Proclamations 20-36, et seq.; and

WHEREAS, the worldwide COVID-19 pandemic and its progression in Washington State continues to threaten the life and health of our people as well as the economy of Washington State, and remains a public disaster affecting life, health, property or the public peace; and

WHEREAS, the Washington State Department of Health continues to maintain a Public Health Incident Management Team in coordination with the State Emergency Operations Center and other supporting state agencies to manage the public health aspects of the incident; and

WHEREAS, the Washington State Military Department Emergency Management Division, through the State Emergency Operations Center, continues coordinating resources across state government to support the Department of Health and local health officials in alleviating the impacts to people, property, and infrastructure, and continues coordinating with the Department of Health in assessing the impacts and long-term effects of the incident on Washington State and its people.

NOW, THEREFORE, I, Jay Inslee, Governor of the state of Washington, as a result of the above-noted situation, and under Chapters 38.08, 38.52, and 43.06 RCW, do hereby proclaim that a State of Emergency continues to exist in all counties of Washington State, that Proclamation 20-05 and all amendments thereto remain in effect as otherwise amended, and that Proclamations 20-36, et seq., are amended to (1) recognize the extension of statutory waivers and suspensions therein by the Washington State Legislature until the termination of the COVID-19 State of Emergency or until rescinded, whichever occurs first; (2) similarly extend the prohibitions and waivers and suspensions of rules therein until the termination of the COVID-19 State of Emergency or until rescinded.

I again direct that the plans and procedures of the *Washington State Comprehensive Emergency Management Plan* be implemented throughout state government. State agencies and departments are directed to continue utilizing state resources and doing everything reasonably possible to support implementation of the *Washington State Comprehensive Emergency Management Plan* and to assist affected political subdivisions in an effort to respond to and recover from the COVID-19 pandemic.

I continue to order into active state service the organized militia of Washington State to include the National Guard and the State Guard, or such part thereof as may be necessary in the opinion of The Adjutant General to address the circumstances described above, to perform

such duties as directed by competent authority of the Washington State Military Department in addressing the outbreak. Additionally, I continue to direct the Department of Health, the Washington State Military Department Emergency Management Division, and other agencies to identify and provide appropriate personnel for conducting necessary and ongoing incident related assessments.

Violators of this order may be subject to criminal penalties pursuant to RCW 43.06.220(5).

Signed and sealed with the official seal of the state of Washington on this 19th day of January, A.D., Two Thousand and Twenty-One at Olympia, Washington.

By:

/s/
Jay Inslee, Governor

BY THE GOVERNOR:

/s/
Secretary of State

EXHIBIT 29

2020 & 2021 Washington State Death with Dignity Act Reports

2020 Death with Dignity Act Report

October 21, 2021

Chapter 70.245 RCW

Disease Control & Health Statistics
Center for Health Statistics

Washington State Department of Health

For persons with disabilities, this document is available in other formats.
Please call 800-525-0127 (TTY 711) or email civil.rights@doh.wa.gov.

Publication Number
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Published by:
Washington Department of Health
Disease Control and Health Statistics
Center for Health Statistics

Umair Shah, MD
Secretary of Health

Contents

Executive Summary

Washington State's Death with Dignity Act allows adult residents in the state with six months or less to live to request lethal doses of medication from a physician. This report provides available information about people who participated in the program between January 1, 2020 and December 31, 2020. This report includes data received by the Washington State Department of Health as of October 21, 2021. In this report, a participant is defined as someone to whom medication was given under the terms of the law.

Beginning in 2019, the number of participants who received medication was calculated using expanded criteria. In addition to individuals with a valid prescription date on the pharmacy dispensing form, individuals with a valid prescription date on either the Attending Physician's Compliance Form or the After Death Reporting Form were also included[1].

A total of 340 individuals received the medication in 2020.

- 169 different physicians prescribed the medication.
- 50 different pharmacists provided the medication.

The department received death certificates for 333 participants and After Death Reporting Forms for 301 participants.

- 334 participants are known to have died.
  - 252 died after taking the medication.
  - 41 died without having taken the medication.
  - Ingestion status is unknown for the remaining participants.

Out of the 252 that died after ingesting the medication:

- 90% were enrolled in hospice care when they ingested the medication.
- 97% had some form of health insurance.
- 91% died at home/in a private residence.

Demographics of participants (as indicated in death certificates, 333 participants):

- The average age of participants was 73 years.
- 93% of participants were white. We are unable to report other races due to the small numbers involved, and the need to protect participant confidentiality.
- 86% of participants lived west of the Cascade mountains[2].

[1] These dates were used in a hierarchical manner in the order stated. Any participants with multiple available dates were only counted once.

[2] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom.

For the purposes of this report, a participant of the Death with Dignity Act in 2020 is defined as someone who received medication in 2020 under the terms of the act. Details of the act are included in Appendix A.

As of October 21, 2021, the department has received documentation indicating that lethal doses of medication were given to 340 participants under the law in 2020. These prescriptions were written by 169 different physicians and provided by 50 different pharmacists. The department has not yet received all required paperwork for all participants. Table 5 in Appendix A shows details of the documentation that has been received by the department. When all the required paperwork is not received, department staff contact health care providers to obtain the documentation.

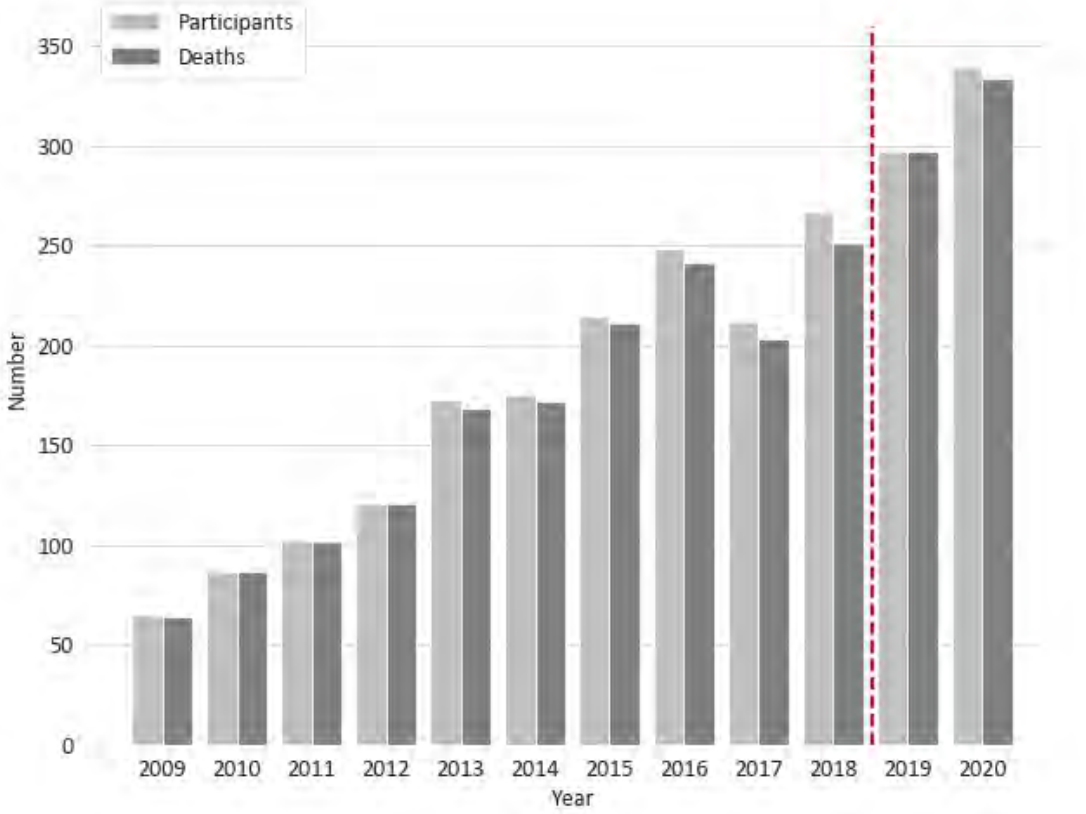
Among the 340 participants who received medication in 2020, the department has confirmed that 334 have died; 252 ingested the medication, 41 did not ingest, and the ingestion status is unknown for the remaining participants (Figure 2). We established through receipt of the After Death Reporting Form and/or a registered death certificate.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have, therefore, been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf.

Death with Dignity Participation Over Time

Since publication of the last Death with Dignity report, the department received additional information on participants from prior years. Figure 1 shows the known number of participants and the number of deaths as of October 21, 2021, for 2009 through 2020. The status of the remaining participants in prior years remains unknown. These participants may have died, but no documentation of the death has been received.

Figure 1. Number of Death with Dignity participants and known deaths, 2009-2020[3]. The dotted line represents a change in inclusion criteria.[4]



[3] Participants prior to 2019 were counted based on receipt of the pharmacy dispensing form. Deaths prior to 2019 were counted based on registered death certificates.

[4] Participants from 2019 onwards were counted using the receipt of the pharmacy dispensing form, or receipt of another form that indicates that medication was dispensed. Deaths were counted based on receipt of a registered death certificate or a valid date of death on an After Death Reporting Form. This was done due to ensure counting all participants; due to COVID-19 the Center for Health Statistics lacked staffing capacity to track down forms that were not submitted.

Table 1. Death with Dignity Act Participation: 2020

Participant Characteristic	Number	Percent
Sex[5]		
Male	183	55.0
Female	150	45.0
Total	333	100.0
Age (years)[5]		
18-54	22	6.6
55-64	41	12.3
65-74	122	36.6
75-84	87	26.1
85+	61	18.3
Total	333	100.0
Marital Status[5]		
Married	160	48.0
Divorced	76	22.8
Widowed	62	18.6
Never married	31	9.3
Other/unknown	4	1.2
Total	333	100.0
Education[5]		
Some College/College Degree	253	76.0
Some High School/High School Degree	78	23.4
Unknown	2	0.6
Total	333	100.0
Residence[6]		
West of Cascades	288	86.5
East of Cascades	45	13.5
Total	333	100.0

[5] Based on death certificate information.
[6] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom. Counties east of the Cascades: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.

Insurance Status[7]		
Insured	**	>95.0[8]
Uninsured	**	<5.0
Total	301	100.0
Patient Race[9]		
White	309	92.8
Asian	14	4.2
Other	**	**
Unknown	**	**
Black	**	**
Hispanic	**	**
Total	333	100.0

Table 2. Death with Dignity Act Participants' Underlying Illness(es)

	2020	
	Number	%
Illness Reported[10]		
Cancer	229	74.8
Respiratory disease	29	9.5
Neurodegenerative	20	6.5
Other illness(es) only	19	6.2
Heart disease	17	5.6

[7] Data are collected from After Death Reporting Forms.
[8] All counts for insured have been suppressed to ensure participant confidentiality.
[9] Based on death certificate information.
[10] Data are collected from the Attending Physician Compliance Form. Please note that a patient may have multiple diagnoses, so illnesses are not mutually exclusive. "Other illness only" indicates that a diagnosis was reported without an obvious diagnosis of a cancer, respiratory disease, cardiac disease, or neurodegenerative condition.

Table 3. End of life concerns of participants who died, 2020

	2020	
	Number	%
End of Life Concerns[11]		
Less able to engage in activities making life enjoyable	269	90.6
Loss of autonomy	267	89.6
Loss of control of bodily functions	143	48.8
Burden on family, friends/caregivers	174	58.6
Loss of dignity	220	74.8
Financial implications of treatment	23	7.8
Inadequate pain control/Concerns about pain control	113	38.4
Total	301	--

[11] Data are collected from the After Death Reporting form. Participants may report more than one concern. Total concerns therefore can exceed the total number of participants.

Table 4. Time Intervals

	2020	
	Number	%
Time Between First Oral Request and Death[12]		
0-14 days	**	**
15-30 days	107	36.3
31-60 days	67	22.7
61-90 days	38	12.9
91-120 days	18	6.1
More than 120 days	49	16.6
Not Known	**	**
Total	295	100.0
Time between Ingestion and Loss of Consciousness[13]		
0 to 5 minutes	87	34.5
10 to 20 minutes	20	7.9
6 to 10 minutes	73	29.0
More than 20 minutes	15	6.0
Not known	57	22.6
Total	252	100.0
Time between Ingestion and Death[13]		
0 to 30 minutes	65	25.8
31 to 60 minutes	51	20.2
61 to 120 minutes	43	17.1
More than 120 minutes	48	19.0
Not known	45	17.9
Total	252	100.0

[12] Based on Pharmacy Dispensing Report. Some counts suppressed to maintain participant confidentiality.
[13] Based on After Death Reporting Form

Appendix A

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

Role of Department of Health in Monitoring Compliance with the Act

To comply with the act, attending physicians and pharmacists must file documentation with the department. Patient eligibility for participation in the act must be confirmed by two independent physicians (an attending physician and a consulting physician). Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with the department:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

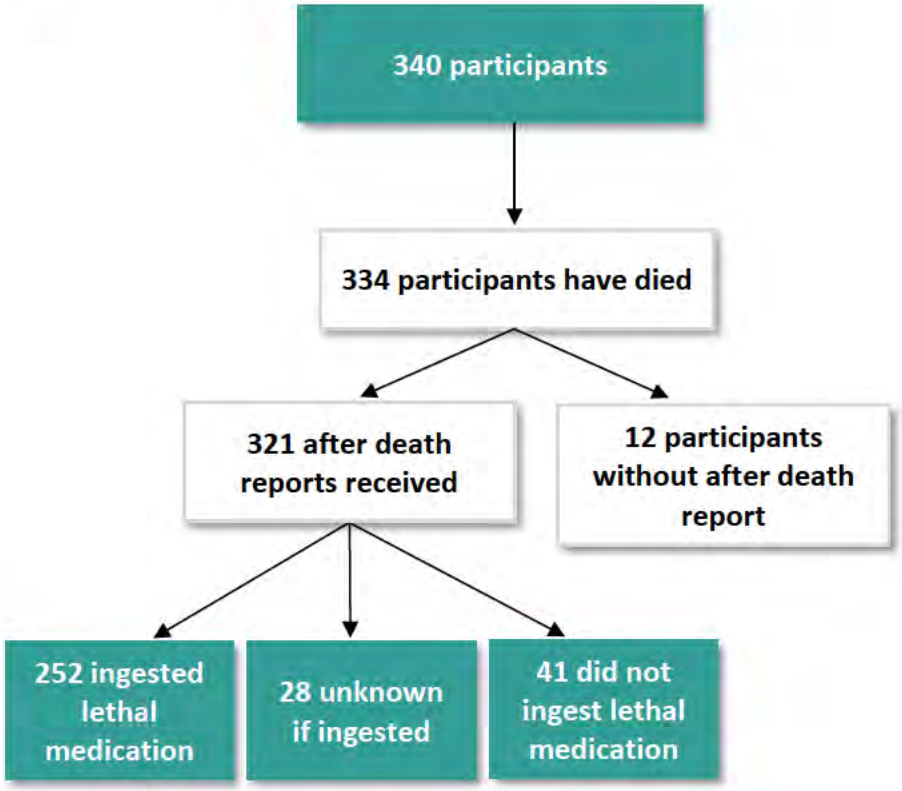
If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms must be submitted to the department.

Within 30 days of providing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from taking a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

Figure 2. Outcome of the Death with Dignity Act Participants, 2020



The department received the following documentation for 2020 Death with Dignity participants (people who received medication) as of October 21, 2021:

Table 5. Documentation Received for 2020 Participants

Form	Number
Written Request to End Life Form	295
Attending Physician Compliance Form	306
Consulting Physician Compliance Form	299
Psychiatric/Psychological Consulting	**[14]
Pharmacy Dispensing Form	318
After Death Reporting Form	301
Death Certificate	333
Total Participants	340

Confidentiality

The Death with Dignity Act requires that the department collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, the department will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers. Some fields have therefore been suppressed due to their small numbers. For more information, the guidelines can be accessed here: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

[14] Redacted due to DOH Small Numbers Guidelines.


Washington State Department of
Health

2021 Death with Dignity Act Report

July 15, 2022

Chapter 70.245 RCW

Disease Control & Health Statistics

Center for Health Statistics

Washington State Department of Health

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In this report, a participant is defined as someone who was dispensed medication under the terms of the law (see Appendix A).

A total of 400 individuals were dispensed the medication in 2021.

- 186 different physicians prescribed the medication.
- 62 different pharmacists dispensed the medication.

DOH received death certificates for 387 participants and After Death Reporting Forms for 348 participants.

- 387 participants are known to have died.
  - 291 died after taking the medication.
  - 44 died without having taken the medication.
  - For the remaining participants, it is unknown if they took the medication before dying.

Out of the 291 that died after taking the medication:

- 91% were enrolled in hospice care when they took the medication.
- 95% had some form of health insurance.
- 88% died at home or in a private residence.

Demographics of participants (as shown in death certificates, 387 participants):

- The average age of participants was 75 years.
- 92% of participants were White, and 5% were Asian.
- 88% of participants lived west of the Cascade Mountains[1].

[1] Based on death certificate information. Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom.

Overview of Death with Dignity Act

The Washington State Death with Dignity Act, chapter 70.245 RCW, was passed by voter initiative on November 4, 2008, and became law on March 5, 2009. The law allows terminally ill adults seeking to end their lives in a humane and dignified manner to request lethal doses of medication from medical and osteopathic physicians. These terminally ill patients must be Washington residents who have an estimated six months (180 days) or less to live. More information on the Death with Dignity Act is available on the Department of Health website (http://www.doh.wa.gov/dwda/).

The Department of Health (DOH) defines a program participant as someone who was dispensed medication under the terms of the law. DOH identified program participants based on one of the following types of documentation:

- A valid prescription date for the lethal medication on the Pharmacy Dispensing Form (used before 2019).
- A valid prescription date on either the Attending Physician's Compliance Form or the After Death Reporting Form.
- An After Death Reporting Form showing they took the lethal medication and a death certificate.

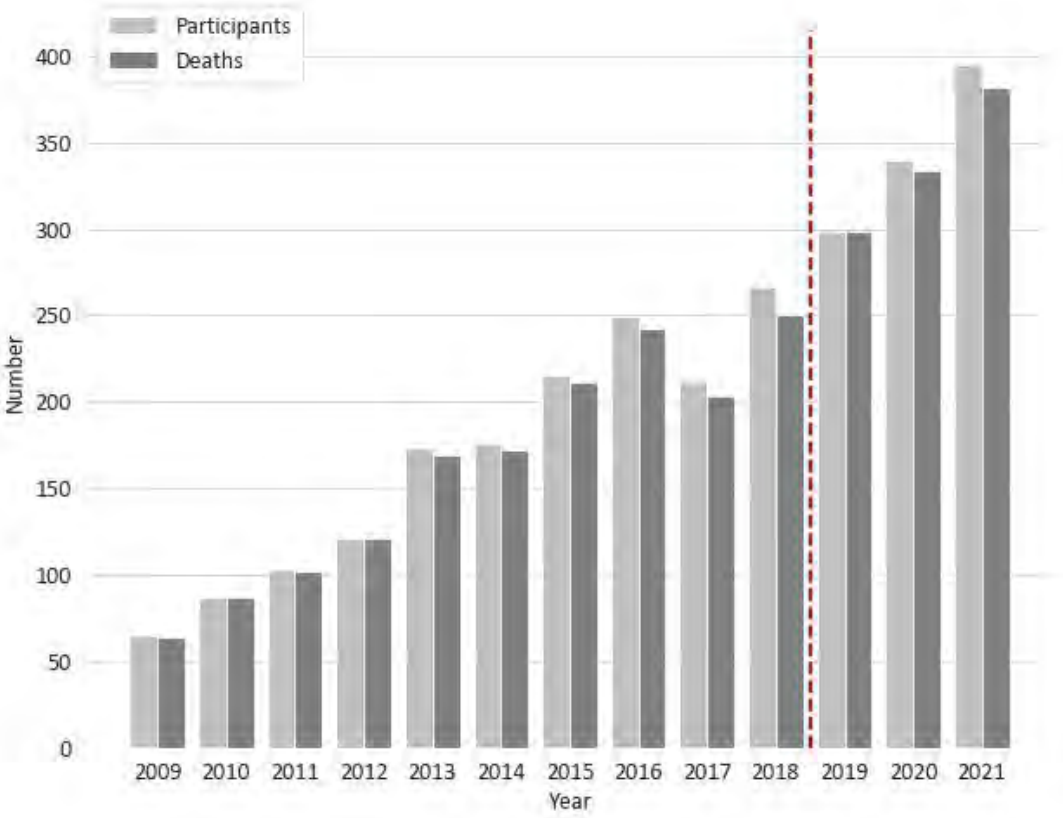
Under the Death with Dignity Act, the Department of Health collects information from healthcare providers, reviews this information for compliance with reporting requirements, contacts the healthcare provider if the information is incomplete or inadequate, and produces this annual statistical report.

Death with Dignity Act Participation Data

Participation Over Time

Figure 1 shows the known number of participants and deaths for 2009 through 2021, as of May 26, 2022. The status of the remaining participants in prior years is still unknown. These participants may have died, but DOH has not received documentation of the deaths.

Figure 1: Number of Death with Dignity participants and known deaths, 2009-2021[2]



[2] Participants prior to 2019 were counted based on receipt of the pharmacy dispensing form. Deaths prior to 2019 were counted based on registered death certificates. The dotted line represents a change in inclusion criteria.

Participation Demographics

Table 1: Death with Dignity Act Participation, 2021

Participant Characteristic	Number	Percent (%)
Sex[3]		
Male	214	55.0
Female	173	45.0
Total	387	100.0
Age (years)[4]		
18-54	23	6.0
55-64	52	13.0
65-74	118	30.0
75-84	106	27.0
85+	88	23.0
Total	387	100.0
Marital Status[5]		
Married	189	49.0
Divorced	85	22.0
Widowed	81	21.0
Never married	<50[6]	<10.0
Other/unknown	<10	<5.0
Total	387	100.0
Education[7]		
Some College/College Degree	300	77.5
Some High School/High School Degree	85	22.0
Other/Unknown	2	0.5
Total	387	100.0

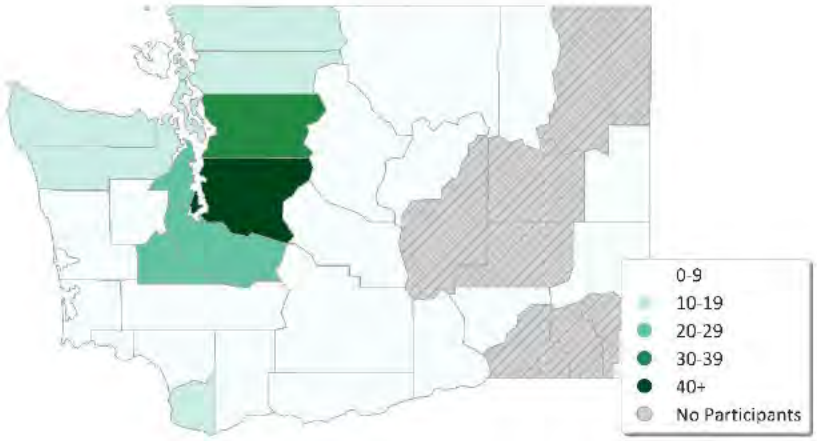
[3] Based on death certificate information.
[4] Based on death certificate information.
[5] Based on death certificate information.
[6] Data represented with a "<" is suppressed to protect participant confidentiality.
[7] Based on death certificate information.

Participant Characteristic	Number	Percent (%)
Residence[8]		
West of Cascades[9]	341	88.0
East of Cascades[10]	46	12.0
Total	387	100.0
Insurance Status[11]		
Insured	330	95.0
Uninsured	18	5.0
Total	348	100.0
Race[12]		
White	358	92.0
Asian	19	5.0
Other	10	3.0
Total	387	100.0

[8] Based on death certificate information.
[9] Counties west of the Cascades: Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, and Whatcom.
[10] Counties east of the Cascades: Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, and Yakima.
[11] Data are collected from After Death Reporting Forms.
[12] Based on death certificate information.

Participation by County

Figure 2: Participation by county, 2021



Underlying Illness

Table 1: Death with Dignity Act participants' underlying illness(es), 2021

Illness Reported[13]	Number	Percent (%)
Cancer	267	73.2
Heart and/or vascular disease	31	8.5
Neurodegenerative	30	8.2
Respiratory disease	29	7.9
Other illness(es) only	8	2.2
Total[14]	365	--

[13] Data are collected from the Attending Physician Compliance Form. Please note that a patient may have multiple diagnoses, so illnesses are not necessarily mutually exclusive. "Other illness only" indicates that a diagnosis was reported without an obvious diagnosis of a cancer, respiratory disease, cardiac disease, or neurodegenerative condition.

[14] More than one illness may be reported. Total illnesses therefore can exceed the total number of participants.

End of Life Concerns

Table 2: End of life concerns of participants who died, 2021

End of Life Concerns[15]	Number	Percent (%)
Less able to engage in activities making life enjoyable	293	85.0
Loss of autonomy	295	85.0
Loss of control of bodily functions	172	50.0
Burden on family, friends, or caregivers	194	56.0
Loss of dignity	251	73.0
Financial implications of treatment	<10[16]	<5.0
Inadequate pain control or concerns about pain control	160	46.0
Total[17]	348	--

[15] Data are collected from the After Death Reporting Form.
[16] Data represented with a "<" is suppressed to protect participant confidentiality.
[17] Participants may report more than one concern. Total concerns therefore can exceed the total number of participants.

Lethal Medication and Timing

Table 3: Lethal Medication and Timing, 2021

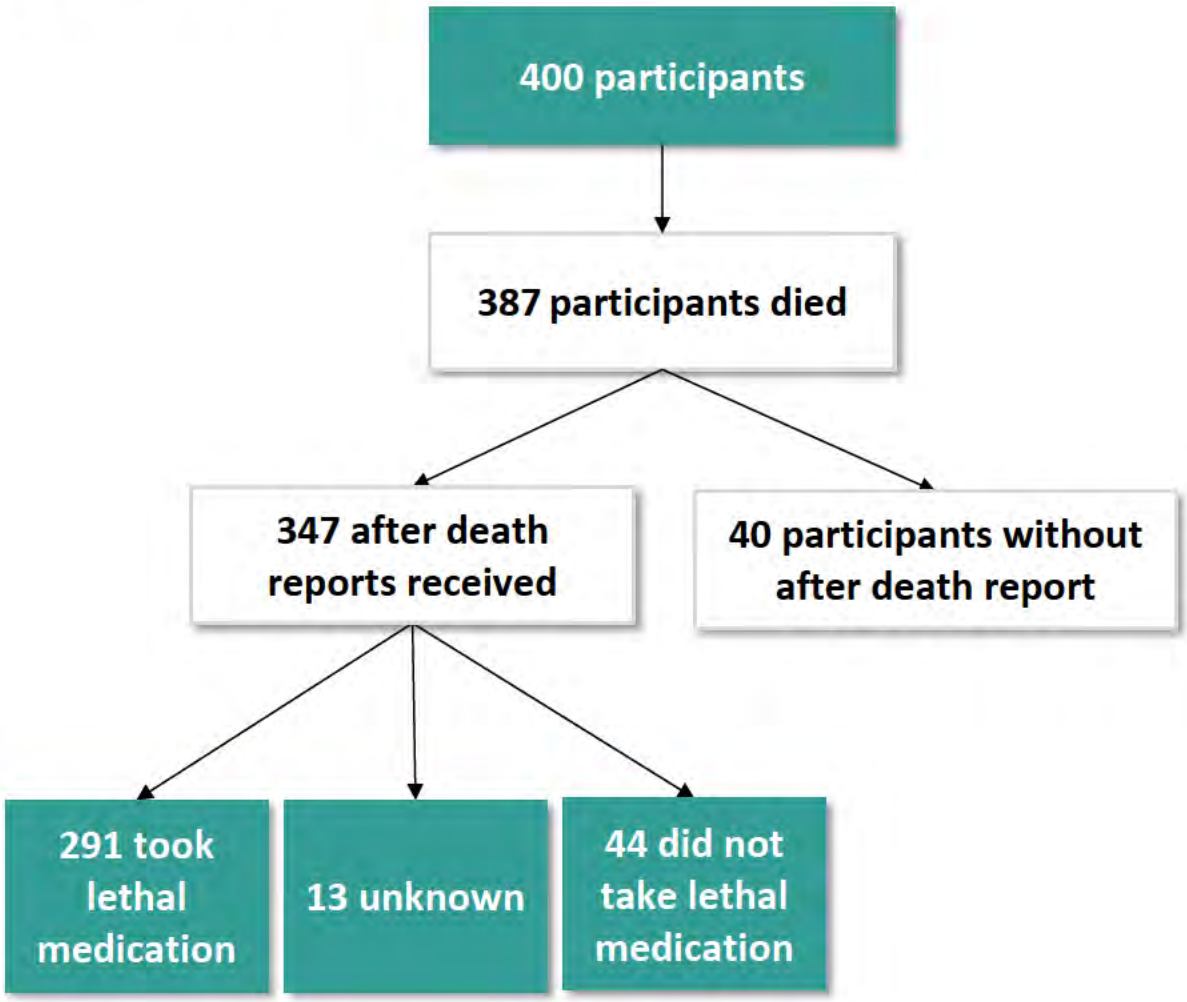
	Number	Percent (%)
Time between first oral request and death[18]		
0-14 days	<10[19]	<5.0
15-30 days	126	36.0
31-60 days	97	28.0
61-90 days	28	8.0
91-120 days	17	5.0
More than 120 days	67	19.0
Not Known	<10	<5.0
Total	346	100.0
Time between ingestion and loss of consciousness[20]		
0 to 5 minutes	139	48.0
6 to 10 minutes	65	22.0
10 to 20 minutes	<50	<10.0
More than 20 minutes	<10	<5.0
Not known	55	19.0
Total	291	100.0

[18] Based on Pharmacy Dispensing Report
[19] Data represented with a "<" is suppressed to protect participant confidentiality.
[20] Based on After Death Reporting Form

	Number	Percent (%)
Time between ingestion and death[20]		
0 to 30 minutes	90	31.0
31 to 60 minutes	67	23.0
61 to 120 minutes	45	16.0
More than 120 minutes	48	16.0
Not known	41	14.0
Total	291	100.0

Participant Outcomes

Figure 3: Outcome of Death with Dignity Act participants, 2021[21]



[21] Death of a participant is established when DOH receives the After Death Reporting Form or a registered death certificate.

Participant Documentation

Table 5 shows the documentation that DOH received for Death with Dignity participants as of May 26, 2022. DOH has not yet received all documentation for 2021 participants.

Table 5: Documentation Received for 2021 Participants

Form	Number
Written Request to End Life Form	354
Attending Physician Compliance Form	365
Consulting Physician Compliance Form	353
Psychiatric Evaluation From	<10
Pharmacy Dispensing Form	380
After Death Reporting Form	348
Death Certificate	387
Total Participants	400

Appendix A

Role of Department of Health (DOH) in monitoring compliance

To comply with the act, attending physicians and pharmacists must file documentation with DOH. Two independent physicians (an attending physician and a consulting physician) must confirm patient eligibility. Within 30 days of writing a prescription for medication under this act, the attending physician must file the following forms with DOH:

- Written Request for Medication to End Life Form (completed by the patient)
- Attending Physician Compliance Form (completed by the attending physician)
- Consulting Physician Compliance Form (completed by the consulting physician)

A psychiatric or psychological evaluation is not required under the terms of the law. However, if the attending or consulting physician requests an evaluation, the psychiatrist or psychologist must complete a Psychiatric/Psychological Consultant Compliance Form and the attending physician must file this form within 30 days of writing the prescription.

If the attending or consulting physician (or the psychiatrist or psychologist, if a referral is made) determines that a patient does not meet the qualifications to receive a prescription for medication under chapter 70.245 RCW, no forms must be submitted to DOH.

Within 30 days of dispensing medication, the dispensing pharmacist must file a Pharmacy Dispensing Record Form.

Within 30 days of a qualified patient's death from taking a lethal dose of medication obtained under the act, or death from any cause, the attending physician must file an Attending Physician After Death Reporting Form.

To receive the immunity protection provided by chapter 70.245 RCW, physicians and pharmacists must make a good faith effort to file required documentation in a complete and timely manner.

DOH staff contact health care providers for documentation when all required paperwork is not submitted.

Confidentiality

The Death with Dignity Act requires that DOH collect information and make an annual statistical report available to the public (RCW 70.245.150). The law also states that, except as otherwise required by law, the information collected is not a public record. That means it is not subject to public disclosure. To comply with that statutory mandate, DOH will not disclose any information that identifies patients, physicians, pharmacists, witnesses, or other participants in activities covered by the Death with Dignity Act.

The information presented in this report is subject to the Department of Health Agency Standards for Reporting Data with Small Numbers.[22] Small numbers can potentially lead to participant identification. DOH suppresses some data fields to protect confidentiality.

[22] https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

EXHIBIT 30

List of Assisted Living Facilities (ALFs), Nursing Homes, and Acute Care Hospitals in Pierce County, WA

FacilityName	LocationAddress	LocationCity
6th Avenue Senior Living LLC	610 N FIFE ST	TACOMA
Alpha Cottage, LLC	10816 18th Ave E	Tacoma
Bonaventure of Puyallup	14503 Meridian Avenue E	Puyallup
Bridgeport Place	5250 Bridgeport Way W	University Place
Brookdale Allenmore AL (WA)	3615 S. 23RD STREET	TACOMA
Brookdale Courtyard Puyallup	4610 6TH STREET PLACE SE	PUYALLUP
Brookdale Harbor Bay	9324 NORTH HARBORVIEW DR	GIG HARBOR
Brookdale Puyallup South	8811 176TH ST EAST	PUYALLUP
Cascade Park Gardens, L.L.C.	4347 S UNION AVE	TACOMA
Cedar Ridge Retirement & Assisted Living Community	9515 198th Avenue East	Bonney Lake
CHARLTON PLACE	9723 South Steele St	Tacoma
Deer Ridge Memory Care Community	3901 5th St SE	Puyallup
eliseo	1301 N HIGHLANDS PARKWAY	TACOMA
Emerald Care Center Inc	23809 46th Ave E	Spanaway
Fieldstone Memory Care of Puyallup	2121 S Meridian	Puyallup
FRANKE TOBEY JONES	5340 N Bristol St	Tacoma
Franklin Place	5713 Parker Rd E	Sumner
GenCare Lifestyle Tacoma at Point Ruston	4970 Main St	Tacoma
Gig Harbor Court, Independent Living & Assisted Living	3213 45th Street Ct NW	Gig Harbor
Gig Harbor Memory Care	3025 14TH AVE NW	GIG HARBOR
Grand Park, LLC	242 St Helens Ave	Tacoma
HARBOR PLACE AT COTTESMORE	1016 29TH STREET NW	GIG HARBOR
Hearthside Manor	3615 Drexler Dr W	University Place
HERITAGE HOUSE BUCKLEY	28833 State Route 410 E	Buckley
Heron's Key	4340 Borgen Blvd NW	Gig Harbor
Hope Guest Home	915 S 7th St	Tacoma
King's Manor Senior Living Community	8609 Portland Ave E	Tacoma
KLEINER GROUP HOME	6415 6th Ave	Tacoma
Living Hope Care Center	402 NORTH J ST	TACOMA
Maple Creek Venture, LLC	10420 Gravelly Lake Dr SW	Lakewood
MCGEE GUEST HOME	21520 82ND AVE E	SPANAWAY
Memory Haven Sumner	5107 Parker Rd E	Sumner
Merrill Gardens At Tacoma	7290 Rosemount Circle	Tacoma
MILL RIDGE VILLAGE	607 28TH AVE	MILTON
Narrows Glen	802 N Laurel Ln	Tacoma
PACIFIC AVENUE RESIDENTIAL CARE	5621 PACIFIC AVE	TACOMA
Passionate Care Center	321 S 116th St	Tacoma
PATRIOTS LANDING OPERATIONS LLC	1600 MARSHALL CIRCLE	DUPONT
PEOPLES RETIREMENT COMMUNITY	1720 E 67TH ST	TACOMA
PIONEER PLACE ALZHEIMER RESIDENCE OF TACOMA	11519 24th Ave E	Tacoma
Puyallup Valley Enhanced Residential Care Inc	723 2nd St NW	Puyallup
SILVER CREEK RETIREMENT & ASSISTED LIVING COMMUNITY	17607 91ST AVENUE E	PUYALLUP
SOUND VISTA VILLAGE	6633 McDonald Ave	Gig Harbor
Spring Ridge Retirement, LLC	6856 E Portland Ave	Tacoma
STAFFORD SUITES	15519 62nd Street Ct E	Sumner
The Cottages at Edgewood	2510 Meridian Ave E	Edgewood
The Cottages at University Place	5417 64th St W	University Place
The Lodge at Mallard's Landing	7083 Wagner Way NW	Gig Harbor
The Rivers at Puyallup, Independent Living & Assisted Living	123 4th Ave NW	Puyallup
The Village Retirement and Assisted Living	4707 S Orchard St	Tacoma
Trouves St Ann's Inc	6602 S Alaska St	Tacoma
Vineyard Park of Puyallup	1813 S Meridian St	Puyallup
WALLER ROAD HOME	4710 WALLER RD E	TACOMA
WEATHERLY INN	6016 N Highlands Parkway	Tacoma
Wesley Homes Bradley Park LLC	707 39th Ave SE	Puyallup
Wesley Homes Pierce County	17702 Cascadia Blvd E	Bonney Lake

Source: https://fortress.wa.gov/dshs/adsaapps/lookup/BHAdvLookup.aspx , Accessed 1/31/2023)

Facility Name	Facility Location	Facility City
Alaska Gardens Health and Rehabilitation Center	6220 South Alaska St	Tacoma
Arcadia Healthcare - University Place	5520 Bridgeport Way W	University Place
Avamere at Pacific Ridge	3625 East B Street	Tacoma
AVAMERE HERITAGE REHABILITATION OF TACOMA	7411 PACIFIC AVENUE	TACOMA
Avamere Transitional Care of Puget Sound	630 S Pearl St	Tacoma
COTTESMORE OF LIFE CARE	2909 14TH AVENUE NW	GIG HARBOR
eliseo	1301 N HIGHLANDS PARKWAY	TACOMA
FRANKE TOBEY JONES	5340 NORTH BRISTOL	TACOMA
Heartwood Extended Healthcare	1649 E 72nd St	Tacoma
Heron's Key	4340 Borgen Blvd	Gig Harbor
LIFE CARE CENTER OF PUYALLUP	511 10TH AVENUE SE	PUYALLUP
Life Care Center of South Hill	2508 7th Street Southeast	Puyallup
Linden Grove Health Care Center	400 29TH ST NE	PUYALLUP
Manor Care Health Services (Gig Harbor)	3309 45th Street Ct	Gig Harbor
Orchard Park Health Care & Rehabilitation Center	4755 South 48th Street	Tacoma
PARK ROSE CARE CENTER	3919 S 19th St	Tacoma
ProMedica Skilled Nursing and Rehabilitation (Tacoma)	5601 SOUTH ORCHARD STREET	TACOMA
PUYALLUP NURSING AND REHABILITATION CENTER	516 23RD AVE SE	PUYALLUP
RAINIER REHABILITATION	920 12TH AVE SE	PUYALLUP
Tacoma Nursing and Rehabilitation Center	2102 S 96th St	Tacoma
The Oaks at Lakewood	11411 Bridgeport Way SW	Lakewood
WASHINGTON SOLDIERS HOME	1301 ORTING KAPOWSIN HWY E	ORTING

Source: https://fortress.wa.gov/dshs/adsaapps/lookup/NHAdvLookup.aspx , Accessed 1/31/2023

Pierce County Acute Care Hospitals

License #	Facility Name	Facility City
HAC.FS.00000032	St Joseph Medical Center	Tacoma
HAC.FS.00000081	Good Samaritan Hospital	Puyallup
HAC.FS.00000132	St Clare Hospital	Lakewood
HAC.FS.00000146	Tacoma General/Allenmore Hospital	Tacoma
HAC.FS.00000175	Mary Bridge Childrens Hospital and Health Center	Tacoma
HAC.FS.00000176	Tacoma General/Allenmore Hospital	Tacoma
HAC.FS.00000182	Puget Sound Hospital	Tacoma
HAC.FS.60075769	St Anthony Hospital	Gig Harbor
HAC.FS.60221541	Multicare Good Samaritan	Puyallup
HAC.FS.60833232	CHI Franciscan Rehabilitation Hospital	Tacoma
HAC.FS.61078517	Meridian Surgery Center	Puyallup

source: https://fortress.wa.gov/doh/facilitysearch/