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CN22-24

AccentCare

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: 12/18/2021

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

Email Address:
rhilliard@seasons.org

Telephone Number:
(954) 952-6194

Legal Name of Applicant:
AccentCare Hospice & Palliative Care of Spokane County, 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:
Spokane County, Washington

Estimated Capital Expenditure:
$96,828

Project Summary:
The applicant proposes to establish a Medicare and Medicaid-Certified Hospice Agency to serve residents of Spokane 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.

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

December 30, 2021

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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 **AccentCare Hospice & Palliative Care of Spokane County, LLC.** Throughout the application, reference to the "*Hospice"*, the *"Applicant"* or "*AccentCare Spokane"* refers to AccentCare Hospice & Palliative Care of Spokane County, LLC.

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

The applicant, AccentCare Hospice & Palliative Care of Spokane County, LLC, is a for-profit, limited liability company, created on November 10, 2021. 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 604-830-166.

AccentCare Hospice & Palliative Care of Spokane County, LLC is the Applicant and intended licensee of the proposed hospice program. This entity is 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. As the merger is ongoing, this application includes resources that are branded Seasons Hospice & Palliative Care. Please note that branding is currently in the process of being finalized and all Seasons materials will be re-branded AccentCare in January 2022. AccentCare, Inc. owns and operates a number of healthcare providers throughout the country. An organizational chart showing the business structure of AccentCare Hospice & Palliative Care of Spokane County, 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 companies and the recent merger is found at www.accentcare.com and www.seasons.org.

AccentCare Spokane will enter into a services agreement with **Seasons Healthcare Management, LLC** ("SHCM"), an entity that provides back-office functions to support billing and reimbursement, payroll and human resource functions, information technology services, and other general administrative services. SHCM provides such administrative services to 31 Seasons Hospice & Palliative Care hospice programs across the country (the "Services Agreement"), a copy of which 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 from SHCM. 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 entity 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
   rhilliard@seasons.org

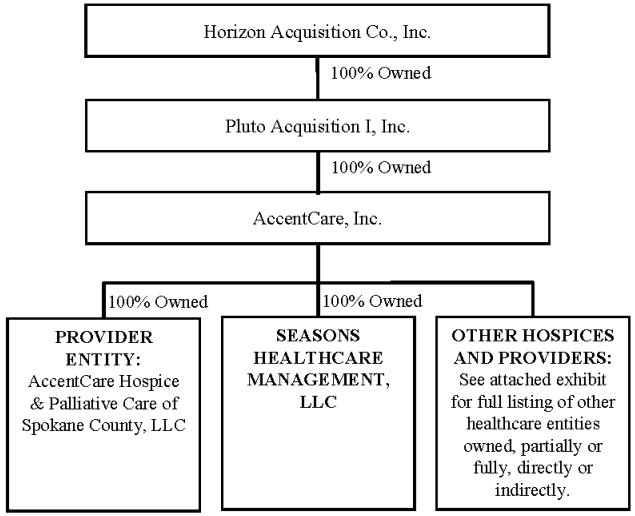
4. ***Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).***

   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).***

AccentCare Hospice & Palliative Care of Spokane County, LLC is 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 AccentCare Hospice & Palliative Care of Spokane County Washington, LLC appears in the following figure:

AccentCare Hospice & Palliative Care of Spokane County, LLC
Organizational Chart



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)***

AccentCare Hospice & Palliative Care of Spokane County Washington, LLC, the applicant entity, is a developmental stage company with 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 applicant is wholly owned by AccentCare, Inc. AccentCare, Inc. owns over 160 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.**

II. PROJECT DESCRIPTION

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

This criterion is not applicable. The applicant entity 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 entity 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:

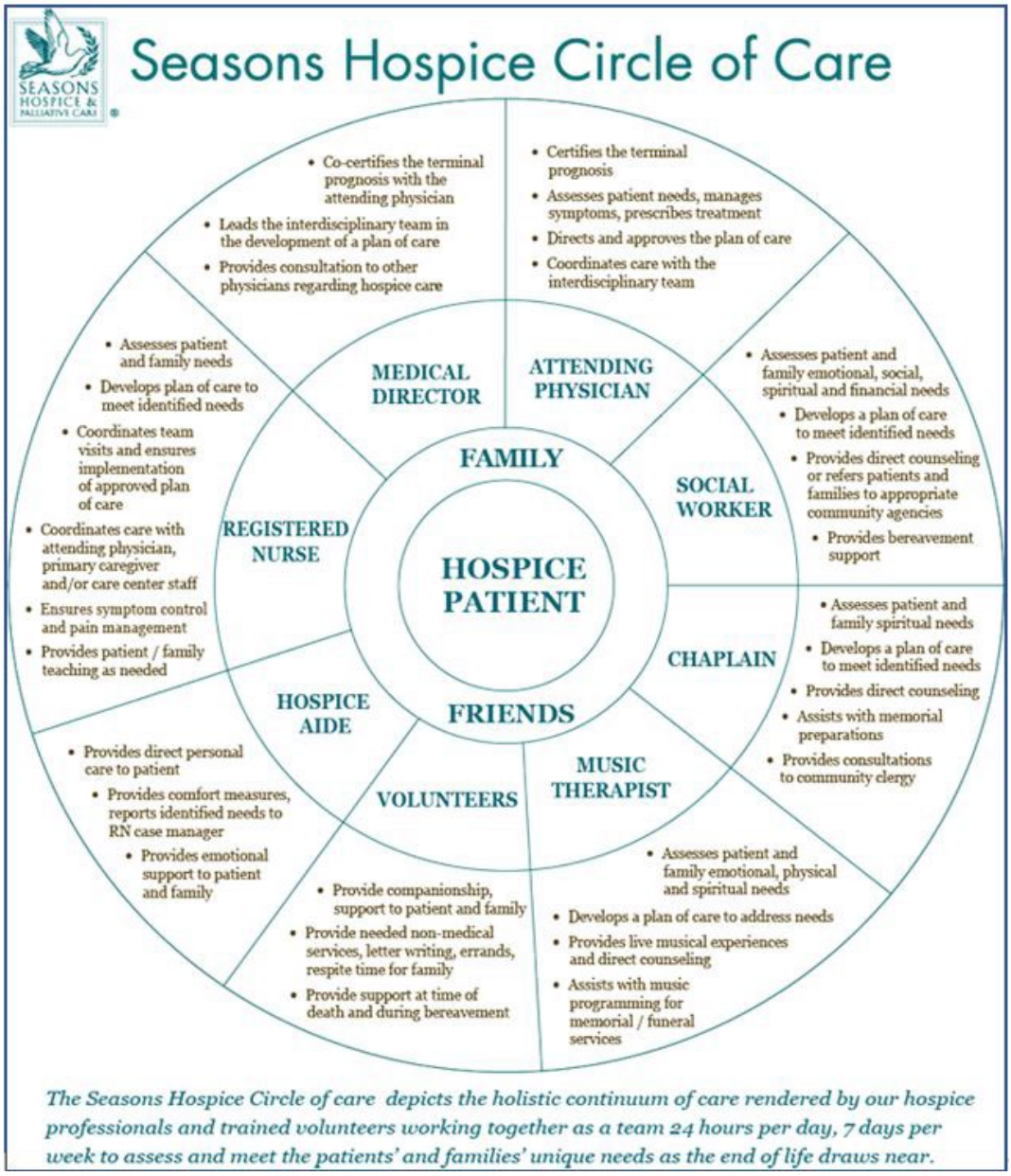
AccentCare Hospice & Palliative Care of Spokane County, LLC
16201 E Indiana Ave
Spokane, WA 99216

A copy of the lease between BH Properties I LLC, Bloch Boyer LLC and Zia Spokane LLC (Landlord) and AccentCare Hospice & Palliative Care of Spokane County Washington, LLC (tenant) is attached as **Exhibit 4.**

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.***

AccentCare Hospice & Palliative Care of Spokane County, LLC is applying for a certificate of need (CN) to establish a Medicare and Medicaid certified hospice agency to serve residents of Spokane 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. AccentCare Spokane 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 Spokane County. The ***Circle of Care*** describes the approach to service delivery that places the patient at its center.



The hospice staff retain responsibility and accountability for the care of patients in the program. Each patient belongs to a care team and remains with that care team. 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. The services also include notes about the patient's preferences, preferred times and days of the week of service delivery, special conditions or wishes, and problems reported and solutions provided.

AccentCare Spokane adopts the values of care, compassion and service, reflected in the vision statements that appear in the box to the right. With these mandates, AccentCare Spokane becomes the ***"can do"*** hospice.

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

A range of services allow for a variety of patients' needs to be met responsively. Integral to keeping patients at the center of all activities, the topical areas that follow showcase the services available to all patients.

A range of services allow for a variety of patients' needs to be met responsively. Integral to keeping patients at the center of all activities, the topical areas that follow showcase the services available to all patients.

A feature that AccentCare Spokane provides establishes it apart from other hospice providers. Specifically, real time communication and ability to contact care teams assures timely responsiveness to patients and their families. A hallmark program is the Call Center.

Call Center. AccentCare Spokane has the advantage of full integration with the Seasons Hospice & Palliative Care 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. Specifically, the tie in with ***Homecare/Homebase*** as described briefly with a brochure in **Exhibit 5,** allows care teams in the field to get access to the medical record and get in touch with all resources in real time.

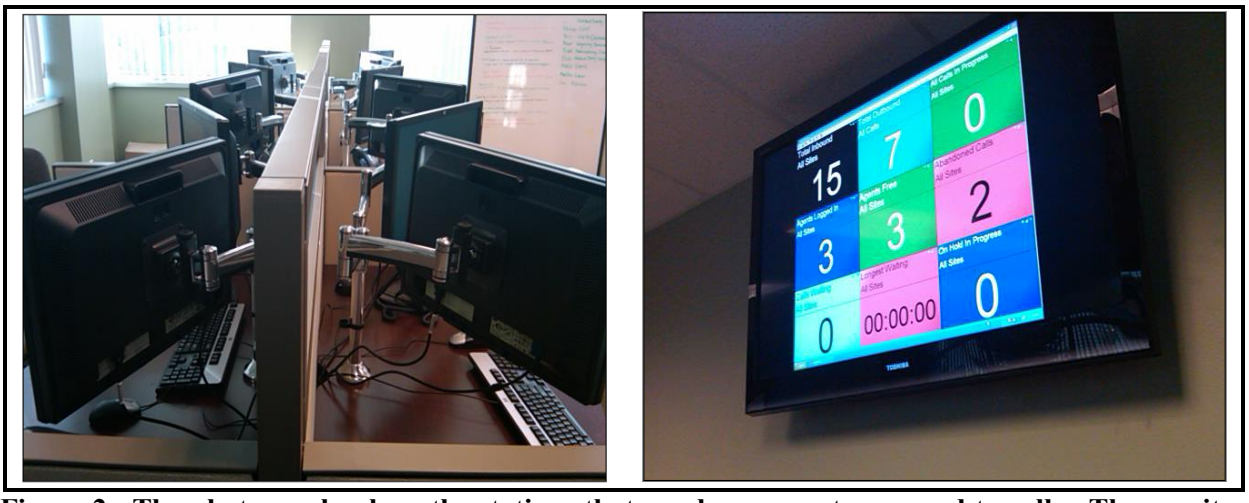


Figure 2. The photographs show the stations that employees use to respond to calls. The monitor displays which of the stations are engaged and the response type in which the employee is engaged.

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. Seasons staff are multilingual and represent the communities Seasons serves. If staff who speak the patient's language are unavailable, Language Line services are used to translate, although Seasons' 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. AccentCare Spokane 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.

AccentCare Spokane 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. AccentCare Spokane 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.

AccentCare Spokane retains responsibility for the care of the patient. In addition, AccentCare Spokane 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 AccentCare Spokane 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 AccentCare Spokane. This allows the care team to resume services in the home.

Continuous Care. AccentCare Spokane 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, AccentCare Spokane 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, Seasons 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.

AccentCare Spokane 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 Seasons serves, and to address the disparities in access to hospice and palliative care. The purpose is to consider the cultural values of all Seasons' 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 AccentCare Spokane 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. AccentCare Spokane 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.

The proposed agency will establish its office proximate to the most populous areas of Spokane 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.

The figure that follows shows the location of the home office on a map with a 45 minute drive time contour 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 45-minute drive-time contour captures 94.5%, documenting accessibility of the proposed program.

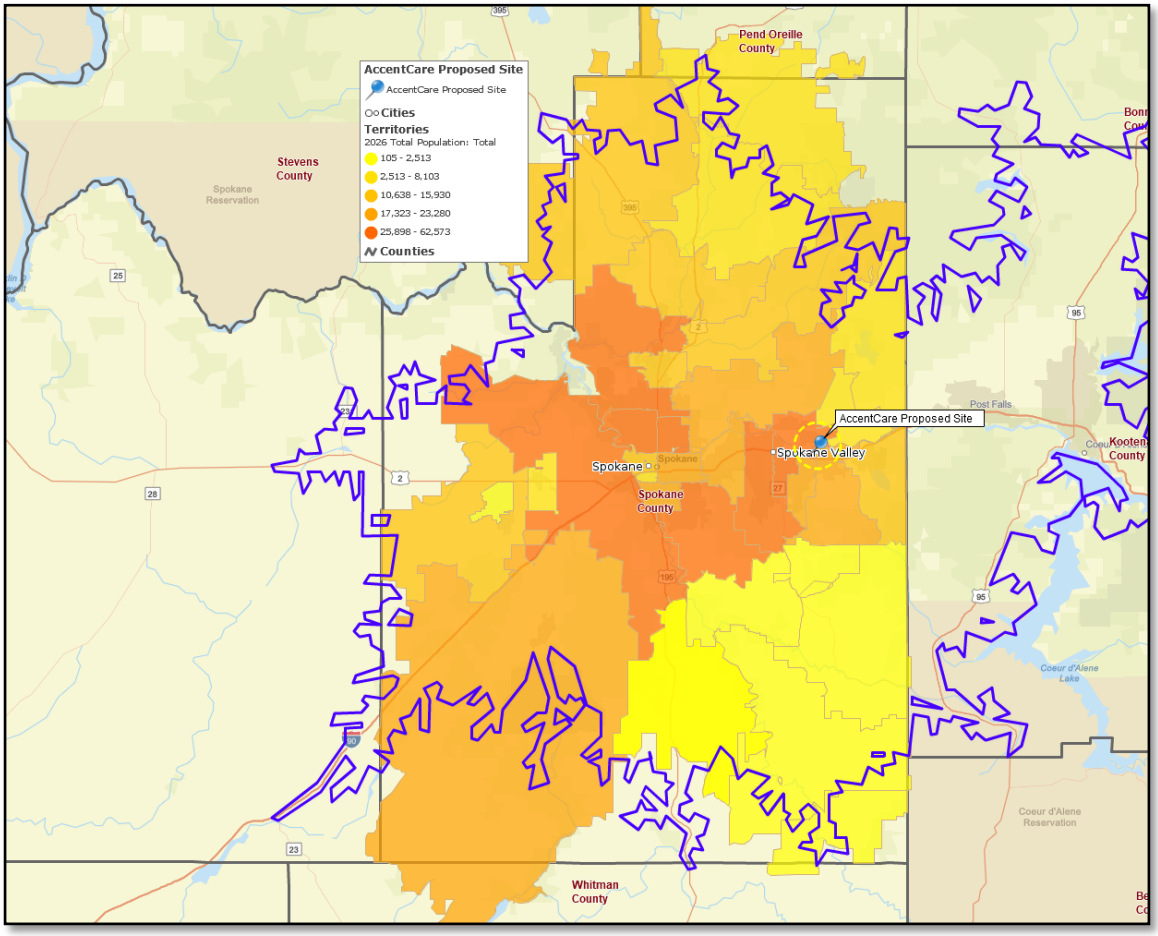


Figure 3. The above map of Spokane County shows the AccentCare Spokane office location as a blue pushpin at 16201 E Indiana Ave, Spokane, WA 99216. The blue line shows a 45 minute drive time from the office. This shows accessibility and availability of the location for employees most of whom are expected to reside in Spokane County. The projected 2026 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 Spokane 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 2022
Design Complete (if applicable)	N/A
Construction Commenced (if applicable)	N/A
Construction Completed (if applicable)	N/A
Agency Prepared for Survey	May 2023
Agency Providing Medicare and Medicaid hospice services in the proposed county.	July 2023

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

AccentCare Spokane proposes to bring an array of programs to all patients served by its hospice in Spokane 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. A brochure for this program appears in **Exhibit 5** that includes information on the ***Homecare Homebase*** software that integrates the electronic medical records with the call center. AccentCare Spokane will offer its AICD Deactivation as part of its Cardiac Care Program in

Spokane 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

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

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

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. AccentCare Spokane will offer this service through these protocols.

AccentCare Spokane 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. AccentCare Spokane 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, with dignity. The CIC acts as a resource to help AccentCare Spokane 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

[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.

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 AccentCare Spokane'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.

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

Death with Dignity – Physician Aid in Dying. AccentCare Spokane 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.

[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.

As part of the "Unchurched Belt," an area with a low religious participation rate, there are a number of Spokane County residents that may have interest in this provision when faced with a terminal illness.

Unchurched Belt

The Unchurched Belt is a region which derives its name from the concept of the Bible Belt. It is located in northwestern and northeastern cities and states of the United States. The area is known for minimum religious participation. About 63% of the people who live in this area do not subscribe to any religious community. The areas include Oregon, Washington, British Columbia, Alaska, Nevada, New Hampshire, Maine, Connecticut, and California who have the lowest church membership rates. Most of the residents of these states do not have a religion, are atheists, or agnostic.

Source: www.worldatlas.com

As indicated in **policy number 2113**, found in **Exhibit 7**, 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 AccentCare Spokane 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 7**. *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

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, AccentCare Spokane 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, AccentCare Spokane 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. AccentCare Spokane will offer its Open Access program in Spokane 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.

AccentCare Spokane 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 Spokane 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 pulmonologiests to help identify patients in the disease process who are eligible for hospice care. These patietns are closely monitored to prevent respiratory distress by specially-trained staff and volunteers, and pharmacological and non-pharmacological interventions will maximize such prevention.
- **Sroke/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. AccentCare Spokane 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 AccentCare Spokane 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 AccentCare Spokane. 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. Two examples of the newsletters 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]

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.

[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

We Honor Veterans. AccentCare Spokane 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.

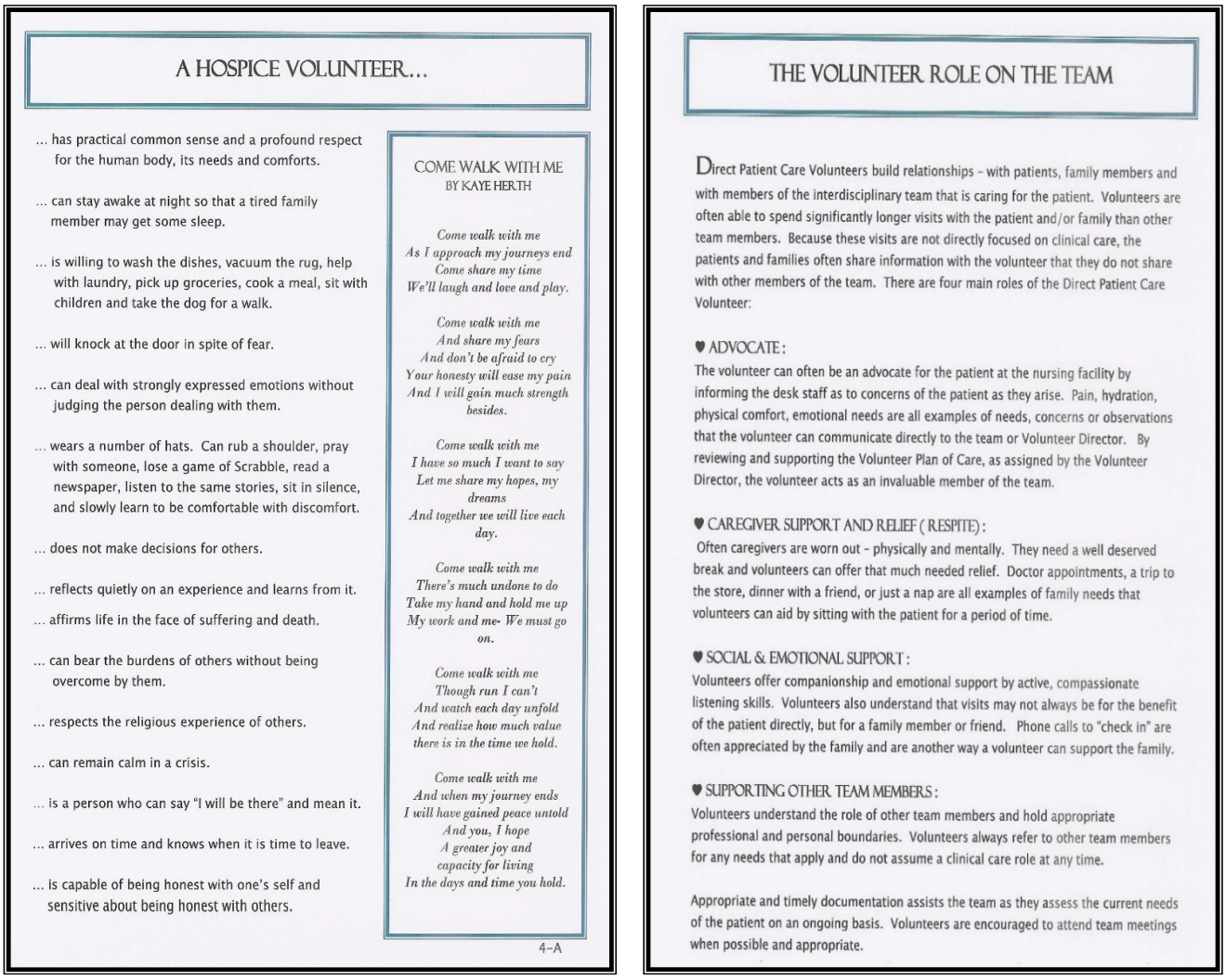
To honor the veterans, a pinning ceremony occurs, that includes invited veterans to participate in acknowledging the honoree. One or more music therapists sing a hymn from the veteran's branch of military service. The photograph below shows a pinning ceremony.

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

AccentCare Spokane 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 8** for an example of bereavement materials distributed.

AccentCare Spokane 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, AccentCare Spokane 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. AccentCare Spokane also contracts for a medical director and physician services. The executed Medical Director Agreement and sample Physician Independent Contractor Agreement are provided in **Exhibit 17.**

The hospice is professionally, financially, and administratively responsible for contracted services. AccentCare Spokane 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.
- AccentCare Spokane will not charge fees for services normally provided directly by the hospice care team but currently being provided by contractual services.
- AccentCare Spokane 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 entity does not own, operate or manage and 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 entity does not own, operate or manage and 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.)

AccentCare Spokane 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 AccentCare Spokane 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 Spokane County and their corresponding rates appear in the table below. Of the top 15 causes of death, the table excludes Accidents (rank 3), Suicide (rank 8), and homicide (rank 15), as they are not appropriate for hospice care. The detailed information from WHO appears in **Exhibit 9.** 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 first leading cause of death in Spokane County and Washington.

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

Cause of Death	Spokane County	Washington	United States
Cancer	176.80	143.41	146.15
Heart Disease	160.99	134.84	161.52
Lung Disease	53.74	33.95	38.18
Stroke	47.73	35.00	36.96
Alzheimer's Disease	42.21	42.24	29.85
Diabetes	25.40	20.54	21.59
Influenza-Pneumonia	13.96	9.97	12.32
Liver Disease	12.35	12.26	11.34
Parkinson's Disease	8.57	9.42	8.83
Hypertension/Renal	7.54	8.68	8.91
Nephritis/Kidney	6.33	4.47	12.71
Blood Poisoning	6.30	6.24	9.51

https://www.worldlifeexpectancy.com

As the information in the table above shows for Spokane 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, cancer, occurs at a rate of 176.80 per 100,000 persons, compared to Washington State at 143.41 per 100,000 and the nation at 146.15 per 100,000. Likewise, heart disease, the second leading cause of death for Spokane County, occurs at a rate of 160.99 per 100,000, but represents 134.84 per 100,000 persons for Washington. Lung disease and stroke, the third and fourth ranked causes of death, respectively, show similar disparity in occurrence for Spokane County when compared to Washington and the nation. The death rates shown above inform the types of patients that AccentCare Spokane can expect to enroll in hospice care. Thus, AccentCare Spokane'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 Spokane 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 **Washington State HIV Surveillance Report, 2020 Edition,** the HIV cases per 100,000 has dropped over the past decade, from 7.2 per 100,000 in 2010 to 5.4 per 100,000 in 2019. In Spokane County, there were 26 new HIV cases reported in 2019, with a rate of 5.0 new cases per 100,000. In total, there were 668 residents of Spokane County living with HIV/AIDS, representing 5% of the state's 13,710 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 100% have initial linkage to HIV care in Spokane County, 23% (6 persons in 2019) are diagnosed late in the progression of the disease. A copy of the report appears in **Exhibit 10.**

AccentCare Spokane has a variety of programs and services and training necessary to deliver care to a wide range of patients with competence and sensitivity.

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

- **The Homeless**
- **Minority populations, including Asians, African-Americans, Hispanics, the LGBT community, the Russian community, and the American Indian population.**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Residents with Alzheimer's Disease**
- **Residents in Spokane County's rural communities (discussed later in the *Need* section of this application).**

❖ 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 (below) 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.**

[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

According to the January 2020 Washington State Point-in-Time (PIT) Count of Persons Experiencing Homelessness, 22,923 are homeless, of which 1,559 or 6.8% are in Spokane County. In fact, Spokane County has the third largest number of homeless persons in the state. The trend data of PIT counts appears below. Although Spokane County experienced a total increase in homelessness of 6.8% over the 5-year period, compared to the state at 10%, homelessness jumped 19% in 2020 over the previous year in Spokane, compared to only 6% for the state. According to the *2018 Annual Report – Homelessness in WA State,* Washington has the fifth highest prevalence of homelessness in the nation, with the count of unsheltered people increasing each year. In the wake of the COVID-19 pandemic and increasing unemployment, homelessness is expected to rise. Research articles on homelessness are found in **Exhibit 11.**

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.

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

	2016	2017	2018	2019	2020
Spokane County Total Homeless	981	1,090	1,245	1,309	1,559
Spokane County Population	494,009	499,709	505,900	511,108	516,808
Spokane Homeless per 100,000	199	218	246	256	302
Washington County Total Homeless	20,844	21,112	22,304	21,621	22,923
Washington County Population	7,183,700	7,310,300	7,427,570	7,546,410	7,656,200
Washington Homeless per 100,000	290	289	300	287	299

Source: www.commerce.wa.gov/serving-communities/homelessness/annual-point-time-count/
Population estimates are from OFM April 1, 2021 estimates of Cities, Towns and Counties
(See **Exhibit 11** for the most recent 2020 PIT Count data.)

With the third largest number of homeless persons in the state, Spokane County needs assistance in caring for those without shelter. If approved, AccentCare Spokane 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.

AccentCare Hospice & Palliative Care of Spokane County, LLC will donate funds each year, beginning with $12,500 the first year of operation, to Seasons Hospice Foundation restricted to Spokane County programs that directly serve homeless persons. AccentCare Spokane 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 Spokane County, including those suffering from a terminal illness.

❖ Commitment to Serving Minority Populations

To promote diversity with its *Inclusion Initiative*, AccentCare Hospice & Palliative Care of Spokane County, LLC commits creating a seven member diversity council (Refer to Exhibit 12). The composition of the council includes an African American board member, an Asian board member, a Hispanic board member, a Russian or Ukrainian board member, and an advocate from the LGBT community, with the remaining two members selected by the initial five members.

As an advisory body, the diversity council provides AccentCare Spokane 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. AccentCare Spokane will also reach out to the Spokane Chapter of the Health Equity Circle to ensure access to end of life care to all individuals.

As shown in the table below, the total population of Spokane County grows at an annual rate of 1.1%, adding 31,213 persons over the next five years. The white race represents 86.8% of the population with 461,761 persons, with the proportion of whites decreasing to 85.6% of the total population by 2026. In contrast, the minority populations have higher compound annual growth rates and proportionately increase by 2026. Hispanics reflect the largest single minority group, with 34,862 persons representing 6.6% of the population, followed by Asians with 12,976 (2.4% of total), and African Americans with 10,706 (2.0% 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. Persons identifying with more than one race account for over 9,000 persons and will increase by 2.9% per year. The table that follows shows the composition of the county.

Table 3
Racial and Ethnic Composition of Spokane County Residents for Years 2021 and 2026

Race Category	Total 2021 Population	Percent	Total 2026 Population	Percent	Compound Annual Growth Rate	Increase
White	461,761	86.8%	482,482	85.6%	0.9%	20,721
Black/African American	10,706	2.0%	12,126	2.2%	2.5%	1,420
American Indian/Alaskan Native	8,918	1.7%	9,773	1.7%	1.8%	855
Asian	12,976	2.4%	14,589	2.6%	2.4%	1,613
Native Hawaiian/Pacific Islander	3,435	0.6%	4,272	0.8%	4.5%	837
Some Other Race	9,317	1.8%	11,179	2.0%	3.7%	1,862
Two or More Races	25,106	4.7%	29,011	5.1%	2.9%	3,905
Total	**532,219**	**100.0%**	**563,432**	**100.0%**	**1.1%**	**31,213**
Ethnic Category						
Hispanic	34,862	6.6%	42,248	7.5%	3.9%	7,386

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.

In addition to the above demographics, conversations with locals identify a large Russian population, many of who have limited English. The information below from the World Population Review confirms this finding, estimating approximately 2% of the Spokane population as Ukrainian or Russian. Additional articles on the Russian population in Spokane is provided in **Exhibit 12.**

Spokane Diversity and Religion

While Spokane has long been criticized for its lack of diversity, the city is becoming more diverse now that people from former Soviet Union countries are forming a more significant part of the city's demographics. Following the collapse of the Soviet Union in 1991, many immigrants -- mainly Ukrainians and Russians -- made their way to Spokane. In 2000, people of Ukrainian or Russian ancestry accounted for 2% of Spokane County's population.

Pacific Islanders are the fastest-growing demographic in the city, and they are believed to be the 3rd largest minority group in Spokane County after Ukrainians, Russians, and Latinos. Spokane formerly had a large Asian community in Chinatown, which was demolished in the 1970s due to urban blight.

Spokane, and the Pacific Northwest area as a whole is part of what is termed the "Unchurched Belt," which refers to the region's low church membership and religious affiliation rates. Out of the population of 212,000 people, there are about 64,000 Evangelical Protestants, 66,000 Catholics, and 25,000 Mainline Protestants. The Spokane Islamic Center became the first mosque in the city in 2009. The city also has at least 3 Jewish congregations, including the Emanu-El congregation, which opened the first synagogue in the state in 1892. Spokane is also home to the Mormon Spokane Washington Temple District, and it's the seat of the Roman Catholic Diocese of Spokane.

Source: www.WorldPopulationReview.com.

Although predominantly white, the demographic profile of Spokane County is becoming more diverse and this diversity adds incentives to meet their needs, particularly with end of life care. AccentCare Spokane's diversity council taps into the growth trend and prepares to engage minorities to know how to best address concerns and meet their needs.

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 populations. Because ***Seasons is an industry leader in serving Asian populations***, they are well positioned to meet the needs of the Asia-Pacific Community residing in Spokane 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 Spokane.

With respect to the LGBT (Lesbian, Gay, Bisexual and Transgender) community, all AccentCare hospice programs seek platinum level of distinction in serving LGBT seniors, with ***SAGE Care certification***. SAGE, Services and Advocacy for LGBT 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 AccentCare Spokane acts on the mandate, ***No one dies alone***, the result assures access and availability of hospice care to LGBT community's members. **AccentCare Spokane intends to apply for SAGE Care certification to further expand the numbers of AccentCare hospices having that certification.**

❖ Commitment to Serving Children

Regarding pediatric hospice care, Spokane County residents are primarily served by Sacred Heart Children's Hospital within the Providence Health System and Hospice of Spokane. However, in conversations with health care providers throughout Spokane County, unless the family resides near the City of Spokane, access to pediatric hospice care is limited. AccentCare Spokane will provide pediatrict hospice care throughout the service area, providing much needed outreach to rural communities.

Table 4, below, shows that approximately 17% of pediatric deaths in Washington State in 2019 occur in Spokane County, up from 8.5% 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 2019 deaths, resulting in an estimate of 27 pediatric deaths in Spokane County that may benefit from hospice and palliative care.

Table 4
Child Deaths and Estimate of Expected Deaths, 2015 Baseline and 2019

	2015 Deaths by Age					
2015 Baseline	**<1**	**1-4**	**5-14**	**15-19**	**Total**	
Spokane Deaths	36	6	10	17	69	
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%**

2019 Deaths by Age and Expected Child Deaths

	0-1	**1-4**	**5-9**	**10-14**	**15-17**	**18-19**	**Total**	***Estimated Expected Deaths***
SpokaneDeaths	26	20	25	24	16	11	**122**	***27***
WA Deaths	368	64	38	68	82	112	**732**	***162***

*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 9** 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 AccentCare Spokane'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.

AccentCare Spokane, through the Seasons Hospice Foundation, 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

AccentCare Spokane 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.

Looking at the most recent available twelve months (from October 2019 to September 2020) in **Table 5** (right), overall experience of all AccentCare hospice programs indicate approximately 12% of admissions arise from persons whose home is an assisted living facility and another 15% arise from persons in a nursing home. Overall, 27% of total admissions are elders in supportive long term care residences.

Table 5
National Seasons Admissions by Location

Location	2019-2020 Admissions	Percent
ALF	3,361	11.7%
Home	10,428	36.4%
Hospital	3,800	13.2%
Inpt. Hospice Facility	6,676	23.3%
SNF	4,399	15.3%
Other	20	0.1%
Total	**28,684**	**100.0%**

Source: Seasons Hospice & Palliative Care Enterprise data by year and location, 10/2019-09/2020

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. AccentCare Spokane'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 Spokane County, with an age adjusted death rate of 41.84 per 100,000 persons, than the national average of 30.52 deaths per 100,000 persons.[10]

[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 9.**

AccentCare Spokane'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 AccentCare Spokane, access improves for residents with Alzheimer's disease and dementia.

As a hospice provider, AccentCare Spokane 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 Spokane County appearing in **Table 1,** Page 34, 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 appear in an 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 13.**

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.

AccentCare Hospice Spokane County Washington intends to enroll as a provider in both Titles XVIII and XIX of the Social Security Act to attain Medicare and Medicaid certification.

[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.

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 AccentCare Spokane is consistent with most recent need methodology produced by the Department of Health. 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 multiple hospice providers and similar population size and demographics as Spokane County. Demographic data comparing Spokane County with Multnomah County, Oregon and the Oregon Service Area is provided in **Exhibit 14**.

Table 6
AccentCare Spokane Forecast, First Three Years

Spokane County	Partial Year 7/23-12/23	Year 1 CY 2024	Year 2 CY 2025	Year 3 CY 2026
Total number of admissions	53	123	175	255
Patient Days	2,107	6,749	10,881	15,830
Average Length of Stay	40.00	55.00	62.12	62.12
Average Daily Census	6	18	30	43

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 November 10, 2021 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	2018	2019	2020	Average	WA Use Rates
0-64	4,114	3,699	3,679	3,831	25.67%
65+	26,207	26,017	27,956	26,727	60.15%
Total	30,321	29,716	31,635	30,557	51.48%
WA Deaths	**2018**	**2019**	**2020**	**Average**	
0-64	14,055	14,047	16,663	14,922	
65+	42,773	44,159	46,367	44,433	
Total	56,828	58,206	63,030	59,355	

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021.

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

In accordance with WAC 246-310-290(8)(b) and consistent with the November 10, 2021 published need methodology, the 3-year average number of deaths for Spokane 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
Spokane County 3-Year Average Deaths by Age Cohort

Spokane Deaths	2018	2019	2020	Average
0-64	1,177	1,143	1,634	1,937
65+	3,556	3,545	4,322	4,982
Total	4,733	4,688	5,956	6,919

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021.

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

In accordance with WAC 246-310-290(8)(e) and consistent with the November 10, 2021 published need methodology, the 3-year average number of deaths for Spokane 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
Spokane County 3-Year Average Deaths and Projected Hospice Patients by Age Cohort

Age	Average Deaths	WA Use Rate	Projected Patients
0-64	1,318	25.67%	338
65+	3,808	60.15%	2,290
Total	5,126	51.48%	2,629

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021.

Step 4: Calculate Spokane County Use Rate by Age Cohort and Projected Hospice Volume Through 2025

In accordance with WAC 246-310-290(8)(d) and consistent with the November 10, 2021 published need methodology, the 3-year average number of deaths for Spokane 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. Since 2026 population projections by age group were not included as part of the Hospice Numerical Need Methodology publication, these values were calculated using 2017 GMA Projections – Medium Series from the Washington State Office of Financial Management (OFM), which is provided in **Exhibit 14**. The data is shown below.

Table 10
Calculation of Spokane County Use Rate (Hospice Patients to 3-Year Average Population) by Age Cohort and Resulting Hospice Volume for Projected years 2020 through 2025

Resident/ Patient Age	Projected Patients	2018 Population	2019 Population	2020 Population	3-Year Ave. Population	Spokane Use Rate
0-64	338	421,066	423,256	425,447	423,256	**0.00080**
65+	2,290	84,343	87,852	91,361	87,852	**0.02607**
Total	2,629	505,409	511,108	516,808	511,108	**0.00514**

Resident/	PROJECTED POPULATION, SPOKANE COUNTY					
Patient Age	2021	2022	2023	2024	2025	2026
0-64	426,740	428,033	429,326	430,619	431,912	434,619
65+	94,670	97,979	101,288	104,597	107,906	110,575
Total	521,410	526,012	530,614	535,216	539,818	545,194

Resident/	PROJECTED HOSPICE VOLUME					
Patient Age	2021	2022	2023	2024	2025	2026
0-64	341	342	343	344	345	347
65+	2,468	2,554	2,641	2,727	2,813	2,883
Total	2,809	2,897	2,984	3,071	3,158	3,230

Sources: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021; 2026 Population Estimates by age group calculated using Office of Financial Management (OFM) Projections, provided in **Exhibit 14**.

Step 5: Calculate the 3-Year Average Hospice Capacity for Spokane County, Then Subtract the Current Capacity From the Total Projected Volume in Step 4 to Determine Need Through 2025.

In accordance with WAC 246-310-290(8)(e), the current supply is calculated as the 3-year average hospice admissions for Spokane County. That number is then subtracted from the projected volume in Step 4 to determine the unmet need for hospice admissions.

Hospice admissions by provider are shown in the following table. With the above adjustments, the 3-year average total hospice admissions for Spokane County is 2,721 as published.

	2018	2019	2020	**3-Year Ave.**
Current Volume	2,648	2,504	3,010	**2,721**

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

	2018 Admissions			**2019 Admissions**			**2020 Admissions**		
Hospice Agency	**0-64**	**65+**	**Total**	**0-64**	**65+**	**Total**	**0-64**	**65+**	**Total**
Horizon Hospice	31	389	420	30	393	423	28	456	484
Hospice of Spokane	346	1,593	1,939	289	1,692	1,981	302	1,895	2,197
Kindred Hospice (Gentiva Hospice)	23	266	289	10	90	100	32	297	329
Total	**400**	**2,248**	**2,648**	**329**	**2,175**	**2,504**	**362**	**2,648**	**3,010**

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021.

The 3-year average of 2,721 is then subtracted from the total projected hospice volume for Spokane in Step 4 (Table 10) to project unmet need (admissions). The forecast is expanded beyond the published 2023 need to 2026, the projected third full calendar year of the project.

Table 12
Spokane County Projected Unmet Need Admissions, Years 2021 Through 2026

	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Projected Hospice Volume	2,809	2,897	2,984	3,071	3,158	3,230
Current Volume	2,721	2,721	2,721	2,721	2,721	2,721
Unmet Need Admissions	89	176	263	351	438	510

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021

Step 6: Multiply the Unmet Need in Step 5 by the Statewide ALOS to Determine Unmet Need Patient Days Through 2025.

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 Spokane County through year 2026, the projected third calendar year of the project.

Table 13
Spokane County Projected Unmet Need Patient Days, Years 2021 Through 2026

	2021	2022	2023	2024	2025	2026	ALOS
Unmet Patient Days	5,511	10,934	16,357	21,780	27,204	31,660	**62.12**

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021

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 2026, the projected third calendar year of the project.

Table 14
Spokane County Projected Unmet Need of Average Daily Census, Years 2021 Through 2026

	2021	2022	2023	2024	2025	2026
Unmet Need ADC	15	30	45	60	75	87

Source: Washington Department of Health 2021-2022 Hospice Numerical Need Methodology, posted November 10, 2021

Step 8: Determine the number of agencies needed by 2023 with an ADC of 45.

In accordance with WAC 246-310-290(8)(h), the 2022 census of 67 from Step 7 is divided by an ADC of 35 which results in need for one new hospice agency for Spokane County.

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

Although AccentCare Spokane is a new entity without experience, it looks to other AccentCare Hospice programs and their start-up experience nationwide. (See **Exhibit 14** for the start-up utilization of new hospice programs over the past 10 years which have Administrative Services Agreements with Seasons Healthcare Management, LLC.) That, and the default calculations for Washington Hospice Agencies, are taken into consideration. Implementation date is July 1, 2023.

Table 15
AccentCare Spokane Projected Patients and Share of Unmet Admissions, 2023 – 2026

	2023	2024	2025	2026
Spokane Unmet Admissions	**263**	351	438	510
AccentCare's Share of Unmet Patients	20.0%	35.0%	40.0%	50.0%
AccentCare's Hospice Patients	**53**	**123**	**175**	**255**

The data above shows AccentCare Spokane's share of unmet patients increasing from 20% in 2023 to 50% in 2026. Therefore, the AccentCare Spokane 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. The resulting market share for AccentCare Spokane by its third full year of operations in 2026 is 7.9% of the total volume for the county.

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

Again, AccenCare Spokane County looks to the start-up experience of other AccentCare Hospice programs nationwide to determine a length of stay that increases during its first year while becoming established in the Medicare and Medicaid programs. The program is assumed to reach the Washington statewide ALOS of 62.66 days by its second calendar year, 2024. Implementation date is July 1, 2022. This conservative approach yields the following patient days and census for the forecast period.

Table 16
AccentCare Spokane Projected Patients and Share of Unmet Admissions, 2023 – 2026

	2023	2024	2025	2026
ALOS	**40**	**55**	**62.12**	**62.12**
AccentCare's Patient Days	**2,107**	**6,749**	**10,881**	**15,830**
AccentCare's Share of Unmet Days	12.9%	31.0%	40.0%	50.0%
AccentCare's ADC	**6**	**18**	**30**	**43**
AccentCare's Share of Unmet Census	12.9%	31.0%	40.0%	50.0%

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

Spokane County has a large, diverse population with several rural communities surrounding an urban center, including a large number within tribal communities. 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 AccentCare's Spokane 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.

In the wake of the COVID-19 pandemic, residents are often fearful to reach out for medical care or other services. Increased efforts to safely connect throughout the population is critical to identifying potential hospice patients to break down these barriers and improve service to the community. Across the nation, AccentCare 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.

AccentCare Spokane 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, African-Americans, Hispanics, the LGBT community, the Russian community, and the American Indian population.**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Residents with Alzheimer's Disease**
- **Residents in Spokane County's rural communities**

❖ The Homeless

Information presented previously addressed the large and persistent homeless population of Spokane County. Spokane 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 appearing on page 36, ***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."[12]

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

AccentCare Spokane 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 Hospice: Moving From Analysis to Intervention*, suggests that diversity among hospice staff influences diversity among hospice patients.[13] 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.*[14] In addition to lack of trust and language barriers, many Latino and Asian cultures do not discuss death openly. Lack of awareness and understanding also creates barriers for Russian immigrants as discussed in *End of Life Care for Older Russian Immigrants – Perspectives of Russian Immegrants and Hospice Staff*.[15] Other reasons for disparity include failure to plan, poverty and tendency to delay treatment, and threat of depotation. Yet these populations can be educated through outreach efforts within their communities. Copies of the above referenced articles are found in **Exhibit 12.**

Evidence of racial and ethnic disparities in hospice care in Spokane County is shown in the data below. Recall from **Table 3** the Spokane County population by race and ethnicity. The numbers are increasing, warranting attention and outreach efforts to assure equality in access. With Hispanics representing 6.6% of the population, African Americans representing 2.0% of the population, and Asians representing 2.4%, the expectation is for hospice admissions to reflect a similar proportion of service. However, that is not the case in Spokane 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 (CY 2020) admissions data from the Centers for Medicare and Medicaid Services (CMS). Rather than showing a 6.6% representation of Hispanics, 2.0% representation of Blacks/African Americans and 2.4% representation of Asians, 96% of all hospice admissions are White/Caucasian, with 0.81% Black/African American, and 1.05% Asian. 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

[13] *Virtual Mentor,* September 2006, Vol. 8, American Medical Association Journal of Ethics
[14] University of Southern California, Annenberg Center for Health Journalism's 2018 California Fellowship, JoAnn Mar.
[15] *Journal of Cross-Cultural Gerontology 33(3), 229-245*, https://doi.org/10.1007/s10823-018-9353-9

White population to other races provides an estimate of expected hospice admissions. The difference, shown in the table below represents the unmet need.

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

Race/Ethnicity	Admissions	Percent	2021 Population	Admits per 100,000	Expected Admissions	Difference
White	2,475	96.0%	461,761	536	2,475	0
Hispanic*	-	-	34,862	-	187	-
Black	21	0.81%	10,706	196	57	-36
Asian	27	1.05%	12,976	208	70	-43
North Amer. Native	18	0.70%	8,918	202	48	-30
Other	17	0.66%	2,996	567	16	1
Unknown	20	0.78%	-	-	-	-
Total	**2,578**	**100.0%**	**532,219**	**484**	**2,853**	**-108**

Source: CMS Hospice Standard Analytic File, 2020
**Value hidden due to CMS cell size suppression policy.*

The above data confirms that minorities, including Hispanics, African Americans, and Asians are not being served in numbers proportionate to their Caucasian counterparts. For instance, if Black residents in Spokane were enrolling in hospice in proportionate numbers, an additional 187 admissions would result. Furthermore, the large number of North American Natives are not represented above, nor are the Russians/Ukrainians, as the North American Native, other & unknown hospice admissions each represent less than one percent of the total.

To initiate outreach efforts, identify unmet communities, and develop cultural competencies specific to the service area, AccentCare Spokane will establish a **Minority Advisory Board.** Board members, representing Asians, Hispanics, African Americans, Native Americans, and Russians 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 community in Southern California or the Hispanic 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 are Hispanic. Furthermore, AccentCare Spokane, 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, AccentCare Spokane provides the level of innovation and commitment necessary to bring hospice care to the next level in Spokane County.

AccentCare Spokane 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. AccentCare Spokane'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 Spokane County by 2026, 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 (2021) and five year projected 2026 pediatric population by age cohort appears in **Table 18** (below) for Spokane County and the state. The data shows that Spokane County's population below the age of 18 is expected to increase by 5,565 or 4.75%, compared to 4.82% for the state, over the next five years.

Table 18
2021 and 2026 Pediatric Population Estimates
Spokane County and Washington

	Spokane County Population Estimates			Children Percent
	Age 0-17	Age 18+	Total	of Total
2021 Population	117,257	414,962	532,219	22.03%
2026 Population	122,822	440,610	563,432	21.80%
5-Year Pop. Increase	5,565	25,648	31,213	
5-Year Growth Rate	4.75%	6.18%	5.86%	
	Washington Population Estimates			Children Percent
	Age 0-17	Age 18+	Total	of Total
2021 Population	1,704,679	6,060,467	7,765,146	21.95%
2026 Population	1,786,903	6,466,293	8,253,196	21.65%
5-Year Pop. Increase	82,224	405,826	488,050	
5-Year Growth Rate	4.82%	6.70%	6.29%	

Source: Claritas Population Estimates, 2021-2026

AccentCare Spokane'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 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.

AccentCare Spokane 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. AccentCare Spokane will work closely with facilities and physicians to ensure they have an understanding of the benefits of hospice care so residents and patients can be referred timely and benefit.

❖ Use of Telemedicine

In the wake of the COVID-19 pandemic, use of technology and telemedicine is more important than ever. Pandemic related restrictions can create barriers to care. Keeping patients and their families connected and in touch is essential to quality of life; keeping Healthcare workers in touch with their patients and families is equally important to delivering quality care; and keeping all providers and practitioners connected allow for seamless health care delivery.

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 afffiliate 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, AccentCare Spokane 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 gate-keepers, 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, Seasons Healthcare Management 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 Spokane 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 **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.

AccentCare Spokane 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 Spokane County where the established hospice provider base falls short of meeting demand. New hospice agencies such as AccentCare Spokane 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 tables that follow. For gauging impact, the admissions during the baseline (based on the average admissions from 2018-2020) for the existing hospice programs remain unchanged, with the forecasted caseload increasing from a baseline of 2,721 to 3,230 in year 3. As demonstrated, the impact of introducing AccentCare Spokane produces no negative consequences because the availability of additional hospice admissions appears.

The table below shows the projected hospice admissions and growth over the baseline, given the addition of AccentCare Spokane through the third full year of operations, 2026.

Table 19
Spokane Projected Growth in Hospice Admissions, CY 2023 – CY 2026

Year	Spokane Admissions	AccentCare Admissions	Remaining Cases for Others	Growth from Baseline
Baseline Cases (Average, 2018-2020)	**2,721**			
CY 2023	2,984	53	2,931	210
CY 2024	3,071	123	2,948	227
CY 2025	3,158	175	2,983	262
CY 2026	3,230	255	2,975	254

The calculation above, showing the increase in admissions over the baseline period after entry of AccentCare Spokane yields an increase of 210 to 262 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 20
Projected Growth in Hospice Admissions by Provider, CY 2023 – CY 2026

Hospice Name	Baseline, 3-Yr Average		Increase from Baseline (Admissions)			
	Admissions	Market Shares	Year 2023	Year 1 2024	Year 2 2025	Year 3 2026
Horizon Hospice	443	16.3%	34	37	43	41
Hospice of Spokane	2,039	74.9%	157	170	197	191
Kindred Hospice (Gentiva Hospice)	239	8.8%	18	20	23	22
TOTAL	**2,721**	**100.0%**	**210**	**227**	**262**	**254**

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." Spokane County is no exception, as growth is expected to continue, increasing need for hospice services in future years.

Furthermore, as a for-profit company, AccentCare Spokane does not actively compete with the non-profit providers competing for fundraising dollars. AccentCare Spokane 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 Spokane County have failed to keep up with demand, resulting in need for an additional hospice agency to serve residents of Spokane County. As a new market entrant, AccentCare Spokane 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, AccentCare Spokane 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 AccentCare Spokane County Agency will be available and accessible to the entire planning area of Spokane County, with sufficient staff and resources allocated for project success.

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

AccentCare Spokane'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 12**. These councils act as key informants that identify impediments that may exist that limit hospice enrollment. The councils also participate with AccentCare Spokane's 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. AccentCare Spokane'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, AccentCare Spokane commits to serving the following under-served populations, as described previously.

- **The Homeless**
- **Minority populations, including Asians, African-Americans, Hispanics, the LGBT community, the Russian community, and the American Indian population.**
- **Children**
- **The elderly, including those residing in Nursing Homes and Assisted Living Facilities**
- **Residents with Alzheimer's Disease**
- **Residents in Spokane County's rural communities**

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 AccentCare Spokane 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 15 contains the policies identified below. *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

- Admission Criteria (policy #208)
- Admission Process (policy#209), including referrals
- Charity care policy and the Application for Financial Assistance
- Patient Rights and Responsibilities (policy #101)
- Notice of Privacy Practices (policy #908)
- Non-Discrimination & Grievance Procedure (policy #105)
- Availability of Services (policy #204)
- Standards of Practice (policy #206)
- Informed Consent (policy #210)
- Patient Discharge (policy #218)
- Communication with Sensory Impaired or Limited English Proficient Persons (policy #227)
- Hospice Care to Residents in a Facility (policy #233)
- Emergency Management Program (policy #703)

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, 2020, identifying need for an additional hospice agency in Spokane 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 16.***

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) beginning on page 43. The forecast is repeated below for consistency.

Table 21
Utilization Projections, AccentCare Spokane, First Three Years

Spokane County	Partial Year 7/23-12/23	Year 1 CY 2024	Year 2 CY 2025	Year 3 CY 2026
Total number of admissions	53	123	175	255
Patient Days	2,107	6,749	10,881	15,830
Average Length of Stay	40.00	55.00	62.12	62.12
Average Daily Census	6	18	30	43

AccentCare Spokane's admissions and patient days are similar to other Seasons Hospice programs and their start-up experience nationwide. (See **Exhibit 14** for the start-up utilization of new hospice programs over the past 10 years which have Administrative Services Agreements with Seasons Healthcare Management, LLC.) 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 Spokane County. Demographic data comparing Spokane County with Multnomah County and the Oregon Service Area is provided in **Exhibit 14.**

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

Table 22
Revenue and Expenses for AccentCare Spokane
Initial Partial Year and First Three Calendar Years

REVENUES	7/1/23-12/31/23	CY 2024	CY 2025	CY 2026
Patient Service Charges				
Medicare & Medicare Managed Care	475,939	1,524,496	2,457,852	3,575,756
Medicaid & Medicaid Managed Care	5,230	16,753	27,009	39,294
Health Options (BHP)	10,460	33,505	54,019	78,588
Charity Care	0	0	0	0
Private Pay	13,075	41,882	67,523	98,235
Third Party Insurance	15,690	50,258	81,028	117,882
Other (Champus, VA)	2,615	8,376	13,505	19,647
Total Patient Service Charges	**523,009**	**1,675,271**	**2,700,936**	**3,929,402**
Revenue Deductions				
Medicare & Medicare Managed Care	81,924	262,412	423,071	615,496
Medicaid & Medicaid Managed Care	1,192	3,818	6,155	8,955
Health Options (BHP)	2,092	6,701	10,804	15,718
Charity Care	5,230	16,753	27,009	39,294
Bad Debt	6,276	20,103	32,411	47,153
Third Party Insurance	785	2,513	4,051	5,894
Other (Champus, VA)	654	2,094	3,376	4,912
Total Revenue Deductions	**98,153**	**314,394**	**506,877**	**737,422**
Net Patient Service Revenues				
Medicare & Medicare Managed Care	394,006	1,262,084	2,034,781	2,960,259
Medicaid & Medicaid Managed Care	4,038	12,935	20,854	30,339
Health Options (BHP)	8,368	26,804	43,215	62,870
Charity Care	0	0	0	0
Private Pay	1,569	5,026	8,103	11,788
Third Party Insurance	14,906	47,745	76,977	111,988
Other (Champus, VA)	1,961	6,282	10,129	14,735
Total Net Patient Service Revenues	**424,848**	**1,360,876**	**2,194,059**	**3,191,979**
Non-Operating Revenues	9,150	29,308	47,251	68,742
TOTAL REVENUES	**433,998**	**1,390,184**	**2,241,310**	**3,260,721**

Table Continued on next page.

Table 22
Revenue and Expenses for AccentCare Spokane
Initial Partial Year and First Three Calendar Years, *continued*:

EXPENSES	7/1/22-12/31/22	CY 2023	CY 2024	CY 2025
Advertising	7,899	15,669	15,669	15,669
Allocated Costs	0	0	0	0
Depreciation and Amortization	5,526	10,962	10,962	10,962
Dues and Subscriptions	1,260	2,500	2,500	2,500
Education and Training	1,037	2,371	2,878	3,485
Employee Benefits	70,429	144,584	194,384	219,284
Equipment Rental	0	0	0	0
Information Technology/Computers	30,100	15,250	20,350	17,800
Insurance	6,301	12,500	12,500	12,500
Interest	0	0	0	0
Legal and Professional	7,370	14,864	15,256	15,727
Licenses and Fees	15,681	19,040	21,540	24,040
Medical Supplies	27,732	88,830	143,214	208,353
Payroll Taxes	30,519	62,653	84,233	95,023
Postage	211	674.9	1,088	1,583
Purchased Services (Utilities, other)	32,237	103,260	166,479	242,199
Rental/Lease	48,175	99,240	102,218	105,284
Repairs and Maintenance	1,764	3,500	3,500	3,500
Salaries and Wages (DNS, RN, OT, clerical, etc.)	469,523	963,892	1,295,892	1,461,892
Supplies	2,107	6,749	10,881	15,830
Telephone/Pagers	39,549	78,453	78,453	78,453
Service Fees	30,000	60,000	60,000	60,000
Washington State B & O Taxes	6,510	20,853	33,620	48,911
Travel (patient care, other)	40,815	121,556	186,835	265,021
TOTAL EXPENSES	**874,745**	**1,847,400**	**2,462,451**	**2,908,014**
Contributions to Seasons Hospice Foundation		12,500	25,000	50,000
NET INCOME	**-440,737**	**-469,716**	**-246,141**	**302,707**

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 23
AccentCare Spokane Balance Sheet and Statement of Cash Flows

BALANCE SHEET						
Current Assets	**31-Dec-21**	**1/01/23-6/30/23**	**7/01/23-12/31/23**	**CY 2024**	**CY 2025**	**CY 2026**
Cash	2,000,000	1,680,111	1,219,557	671,189	340,764	516,904
Accounts Receivable	0	0	70,810	226,813	365,676	531,997
Total Current Assets	**2,000,000**	**1,680,111**	**1,290,367**	**898,002**	**706,440**	**1,048,901**
Long Term Assets						
Land						
Buildings						
Equipment		96,842	96,842	96,842	96,842	96,842
Security Deposit		3,000	3,000	3,000	3,000	3,000
Total Long Term Assets	**0**	**99,842**	**99,842**	**99,842**	**99,842**	**99,842**
Less Accumulated Depreciation		0	5,526	16,488	27,449	38,411
Net Long Term Assets	**0**	**99,842**	**94,316**	**83,354**	**72,393**	**61,431**
Total Assets	**2,000,000**	**1,779,953**	**1,384,683**	**981,356**	**778,833**	**1,110,332**
Liabilities and Equity						
Current Liabilities						
Accounts Payable	0	167	10,280	26,614	36,619	48,602
Salaries Payable	0	12,185	47,539	97,594	131,209	148,017
Current Portion of Long-Term Debt	0					
Total Current Liabilities	**0**	**12,352**	**57,820**	**124,208**	**167,828**	**196,618**
Long Term Debt	0	0	0	0	0	0
Total Liabilities	**0**	**12,352**	**57,820**	**124,208**	**167,828**	**196,618**
Equity	**2,000,000**	**1,767,601**	**1,326,863**	**857,148**	**611,005**	**913,714**
Liabilities Plus Equity	**2,000,000**	**1,779,953**	**1,384,683**	**981,356**	**778,833**	**1,110,332**
STATEMENT OF CASH FLOWS						
	31-Dec-21	**1/01/23-6/30/23**	**7/01/23-12/31/23**	**CY 2024**	**CY 2025**	**CY 2026**
Net Income	0	-232,399	-440,737	-469,716	-246,143	302,709
Less Depreciation	0	0	5,526	10,962	10,962	10,962
Decrease (Increase) in Current Assets	0	0	-70,810	-156,003	-138,864	-166,320
Increase (Decrease) in Current Liabilities	0	12,352	45,468	66,389	43,620	28,790
Net Cash Flows from Operations	0	-220,047	-460,553	-548,368	-330,425	176,140
Purchase of Property, Plant and Equipment		-96,842				
Security Deposit		-3,000				
Payment of Long-Term Debt						
Net Cash Flows from Investing	0	-99,842	0	0	0	0
Contribution of Capital	2,000,000					
Beginning Cash	0	2,000,000	1,680,111	1,219,557	671,189	340,764
Ending Cash	**2,000,000**	**1,680,111**	**1,219,557**	**671,189**	**340,764**	**516,904**

Assumptions appear in the work papers in Exhibit 16.

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.

- ***Administrative Services Agreement***

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

Through the Services Agreement, AccentCare Spokane's 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 SHCM does provide certain back-office support services to individual hospice programs, SHCM does not direct or exercise operational control. AccentCare Spokane 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 SHCM is not authorized or qualified to engage in any activity which constitutes professional medical or hospice services, and none of the Services provided by SHCM shall be construed as the practice of medicine or other professional health care services by SHCM (Section 3).
- [AccentCare Spokane] shall have complete and absolute control over its operations and the methods by which [AccentCare Spokane] and its personnel render the professional hospice services (Section 4(b)).
- [AccentCare Spokane] shall establish and maintain one or more bank accounts (Section 4(c)).
- [AccentCare Spokane] will have no obligation to enter into any contract arranged for by SHCM; all such contracts will be subject to the approval of [AccentCare Spokane] in its sole and absolute discretion (Exhibit A, Section 9).
- [AccentCare Spokane] will have no obligation to purchase any goods or services arranged for by SHCM; all such purchases will be subject to the approval of [AccentCare Spokane] in its sole and absolute discretion (Exhibit A, Section 10).

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

- ***Medical Director***

AccentCare Spokane 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 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 AccentCare Spokane. The terms and conditions for the medical director appear in the contract in **Exhibit 17.** Prior to licensure, Dr. Natarajan provides consultation to the planned hospice.

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 existing 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 review 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 Spokane County and therefore does not have a current location. The proposed office site for AccentCare Spokane is identified as follows:

AccentCare Hospice & Palliative Care of Spokane County
16201 E Indiana Ave
Spokane, WA 99216

The rental area contains 3,730 square feet. 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 24
Summary of Capital Costs for AccentCare Spokane

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	$ 96,842
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	**$ 96,842**

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 16**.)

Unlike a patient treatment facility, AccentCare Spokane'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 AccentCare Spokane 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.

AccentCare Spokane 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 $4,400 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 entity has $2 million in assets provided by the owners of AccentCare Hospice & Palliative Care of Spokane County, LLC. A letter from the Chief Financial Officer for AccentCare, Inc. (the parent organization of AccentCare Hospice & Palliative Care of Spokane County, LLC) and Horizon Acquisition Co., Inc. (found in **Exhibit 18**) 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 Seasons Healthcare Management, LLC, for purchasing equipment and furnishing the office in Spokane 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 Seasons Healthcare Management, LLC'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 16.** 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, 2022 – December 31, 2022) and first full year of operation (CY 2023). The hospice breaks even in calendar year 2024, showing a profit of $185,529.

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 AccentCare Hospice & Palliative Care of Spokane County, 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 18**.

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 inpatient care through

[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

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 AccentCare Spokane, 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 19** 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 2022 at $31,297.61 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.

A second cost cap applies to the hospices that limits the use of inpatient care, the most costly 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 20.)***

[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.

For AccentCare Spokane, **Exhibit 16, 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 25 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.

Table 25
AccentCare Spokane'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	0.0%	1.0%
Private Pay	2.5%	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 Spokane 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 26
Detail of Capital Expenditures for AccentCare Spokane

Item	Item Cost	Qty	Total
Conference Table	$4,235	1	$4,235
Conference Chairs	$424	12	$5,088
Employee Desk	$1,452	9	$13,068
Employee Desk Chair	$484	9	$4,356
Guest Chair	$363	9	$3,267
Filing Cabinet	$1,089	5	$5,445
Reception Area Guest Chair	$787	6	$4,722
Reception Area End Table	$242	3	$726
Reception Area Coffee Table	$484	1	$484
Kitchen Table	$605	2	$1,210
Kitchen Chairs	$242	8	$1,936
Patient Care Kit	$807	6	$4,842
Employee Work Stations	$807	9	$7,263
Subtotal Furnishings			**$56,642**
Electronics and Telecom			
Server, HPE ProLiant ML 150, G9	$9,000	1	$9,000
Firewall, Fortinet Fort iGate 100D	$3,000	1	$3,000
Network Switch 2xAdtran Netvana 1638p	$3,200	1	$3,200
One-time Low Voltage Wiring Installation	$15,000	1	$15,000
Xerox Work Center	$10,000	1	$10,000
Subtotal Electronics and Telecom			**$40,200**
TOTAL			**$96,842**

The estimates in the table above reflect modest costs for equipping a business office in the Renton area of Spokane County. The annual depreciation expense of $10,559 accounts for $4,019 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 $6,540. 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 AccentCare Hospice & Palliative Care of Spokane County Washington, LLC. The CFO's letter found in **Exhibit 18** further provides the 2019 and 2020 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 18 contains a letter from the Chief Financial Officer for AccentCare, Inc. (the parent organization of AccentCare Hospice & Palliative Care of Spokane County, LLC) and Horizon Acquisition Co., Inc. explaining that AccentCare Hospice & Palliative Care of Spokane County, 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, 2020 and 2019 are provided within **Exhibit 18** 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.***

AccentCare Spokane initiates the hospice program with a core staffing that grows over time as the admissions increase. Staffing increases appear in the table below in concert with the growth in average daily census. The proposed hospice staffing will meet or exceed all licensure, Medicare, Medicaid and accreditation standards.

Table 27
FTEs for Season Spokane 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	2.0	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	2.0	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	0.0	1.0	1.0
Subtotal Employees	**12.1**	**13.1**	**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**	**13.4**	**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.

2. ***If this application proposes the expansion of an <u>existing</u> 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 16,** 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.***

AccentCare Spokane 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 16.** AccentCare Spokane'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.

AccentCare adds staff as admissions increase, as shown in Table 27 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.***

AccentCare Spokane 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 17** behind the Medical Director Contract.

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

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 17**.

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

AccentCare Hospice & Palliative Care of Spokane County, 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 Spokane County. New employees provide knowledge of area needs and insight locally, while management personnel can support, enhance, and equip them for success.

Todd Stern, BBA, MBA, CHA, Chief Executive Officer

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. 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, Seasons 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 has grown to become one of the leading hospice and end of life care providers in the nation.

Annemarie Switchulis, RN, MSN, OCN, CHA, Chief Operating Officer

Ms. Switchulis joined Seasons Hospice & Palliative Care in 2005 as the first Executive Director of the Michigan program. She currently serves as the nationwide Chief Operating Officer for Seasons Hospice & Palliative Care. Her range of experience includes serving as Corporate Director of Clinical Operations for Hospice of Michigan, Clinical Case Manager for St. Joseph's Mercy of Macomb and as a registered nurse for 25 years in Eastern Michigan.

Ms. Switchulis has been a member of the Jewish Hospice and Palliative Care Association, Cape Wayne Palliative Research Team and Palliative Care Teams of various Michigan hospitals. She is a graduate of Oakland University in Rochester Hills, Michigan and the University of Phoenix.

David Donenberg, Chief Financial Officer

Mr. Donenberg has been the Chief Financial Officer for Seasons Hospice & Palliative Care since January 2009. Mr. Donenberg is a CPA and holds a joint MBA from Kellogg Graduate School of Management and the McCormick School of Engineering Northwestern. Raised in South Africa, Mr. Donenberg has experience in startup, turnaround and growth companies and currently serves as a board member of the LEED Council of Chicago where he serves as Treasurer. Mr. Donenberg also serves as Chairman of the Seasons Hospice Foundation for the support of end of life care.

Carl J. Brodarick, Chief Marketing Officer

Mr. Brodarick joined Seasons Hospice & Palliative Care in 2006 and is currently the Chief Marketing Officer. He earned his undergraduate degree from Western Illinois University and a Master of Business Administration in Marketing Management from DePaul University. He has over thirty years of census development experience working within various levels of the healthcare continuum. In addition, Mr. Brodarick serves on the Seasons Hospice Foundation Board. Mr. Brodarick most recently served as the Senior Vice President of Business Development at Boulevard Healthcare LLC.

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

Russell Hilliard is the Senior Vice President of Market Expansion Initiatives at Seasons Hospice and Palliative Care 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 Seasons, 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.

Resulting from a merger on December 22, 2020, the Seasons Hospice & Palliative Care team joins AccentCare, Inc. Key individuals within the parent organization, AccentCare, include the following leaders.

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 a number of 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.

As an overview of the key positions involved in hospice care, the policy on the **interdisciplinary group, policy number 205,** appears in **Exhibit 15**. *(Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.)* 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.

Medical supervision, policy number 219, **Exhibit 15**, 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 number 214, **Exhibit 15**, also provides additional information as to how the interdisciplinary team functions to address the patient's needs and scope of care.

Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.

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.

Spokane County was designated as a Medically Underserved Area for Primary Care in 1994 with a Medical Underservice Index Score of 51.84, which falls below the threshold of 62.0. It has three designated geographic primary care Health Professional Shortage Areas (HPSAs): North Spokane, Southeast Spokane, and Southwest Spokane. HPSAs are also recognized in two correctional facilities, two Federally Qualified Health Centers, and two Indian Health Service/Tribal Health/Urban Indian Health Organizations. (Reports generated from the Health Resources & Services Administration at www.data.hrsa.gov documenting the Spokane County MUA and HPSA are provided in **Exhibit 21**.) **AccentCare Spokane will provide outreach and education to the community based organizations throughout the entire county, including rural 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 21.** 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 21**.)

> "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."

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 as the pandemic continues its spread. An article in Frontiers in Psychology, *Mental Health Challenges of United States Healthcare Professionals During COVID-19* **(Exhibit 22),** documents the impact of additional stress.

> *"Psychiatric morbidity in the forms of depression and/or anxiety not only is troubling in its own right, but is also highly correlated with burnout, higher rates of chronic diseases, reduced quality of life, and suicide."*

The article further identifies control beliefs as coping mechanisms (in the figure, right). Having adequate supplies of personal protective equipment and training on how to limit exposure and deliver care safely to those in need can help lessen fears among nursing staff and others involved in care by giving them more control.

> Identifying opportunities for resilience will be especially critical to combat the negative consequences. Control beliefs represent the subjective perceptions that one can influence what happens in one's life and include beliefs or expectations about the extent to which one's actions can bring about desired outcomes (Agrigoroaei and Lachman, 2010). Lachman and Firth (2004) distinguished two main sources of control: one's own efficacy (internal control, competence, or personal mastery), and the responsiveness of the environment or other people (external control, contingency, or perceived constraints) (Bandura, 1977). The two control beliefs included in the present study are mastery and constraint. Mastery is often described in terms of one's judgments about his or her ability to achieve a goal, while perceived constraints refers to the extent to which people believe factors exist which interfere with goal attainment (Lachman and Weaver, 1998b). Pearlin and Schooler (1978) suggested that personal mastery is an important psychological resource that mitigates the effects of stress and strain, and it is also associated with reduced reactivity to work-related stressors (Neupert et al., 2007). When faced with stressful situations, a strong sense of control has also been linked to low levels of self-reported perceived stress (Cameron et al., 1991) and lower risk of depression (Yates et al., 1999).

A study in Nursing Outlook, *Nurses Confronting the Coronavirus: Challenges Met and Lessons Learned to Date* **(Exhibit 22),** having adequate resources to limit risk

and provide additional support to frontline clinicians is necessary to build trust, transparency, and provide compassionate responses to health care delivery challenges.

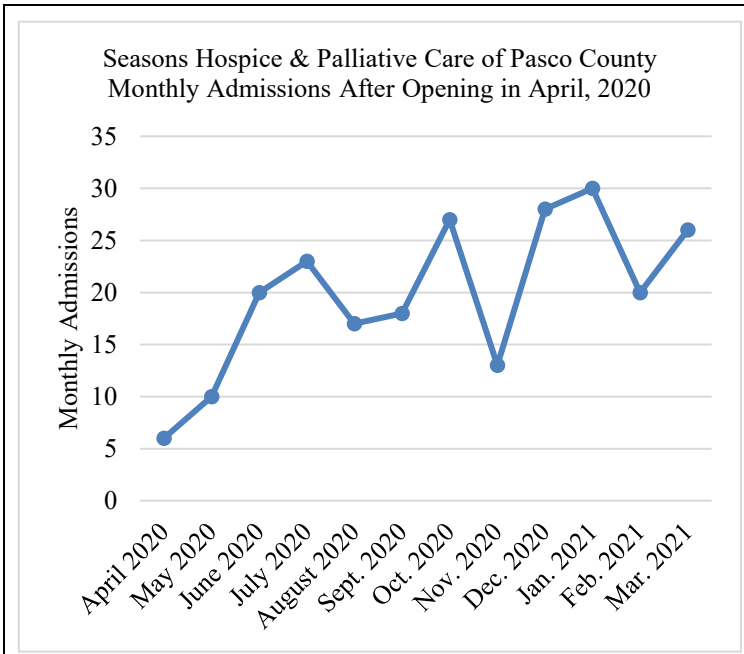
> *"…An early American Nurses Survey of more than 30,000 nurses across the country in April reported that 87% of nurses are very or somewhat afraid to go to work, 58% are extremely concerned about their personal safety and 55% about caring for a COVID-19 patient or person suspected of having the virus.*
> *Ethical practice environments where nurses voices are heard and respected, where teams work well together, where institutional leaders support their staff, do everything they can to garner appropriate resources, and adapt policies to protect staff should be the standard."*

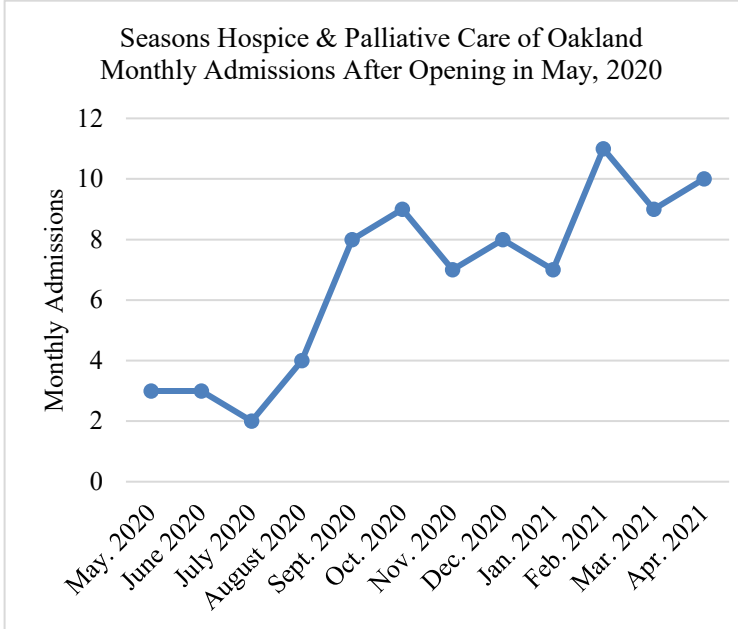
In the wake of the COVID-19 pandemic, health care providers need to be responsive to the changing needs, advisories, and requirements moving forward. AccentCare Spokane has the resources to meet these challenging times. Empowering staff with training, equipment, and having open channels of communication with management, ensures they have the resources needed to focus on their job without fear.

Continuing education, provided through Seasons Healthcare Management, includes recent courses on topics relevant to dealing with COVID-19. **Exhibit 23** 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 AccentCare Spokane 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, two AccentCare Hospice affiliates were able to start new hospice agencies during the COVID-19 pandemic in 2020 – in Pasco County, Florida and in Oakland, California. The initial admissions by month are provided in the graphs below demonstrating the ability to meet or exceed projections.





❖ 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:

- Seasons website, www.seasons.org, select "Careers" from the menus
- 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

AccentCare Spokane 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 AccentCare Spokane.

AccentCare Spokane 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 AccentCare Spokane 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, Seasons Hospice Programs can develop workplaces that support the employees and give them reasons to stay with the company.

AccentCare Spokane 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. **AccentCare Spokane's draft policy on Equal Opportunity Employment, policy number 802, appears in Exhibit 15.** *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

Once a person is hired, Seasons focuses on employee retention. Retaining a trained workforce is a top priority, because 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. Seasons' 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

Seasons officers 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

AccentCare Spokane 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 (seen in the box to the left) driving end of life experiences for each patient and family.

Exhibit 15 includes policies that explain the content of the **orientation period (policy number 804**), **in-service education/staff development, (policy number 814),** and **privacy and security training (policy number 926).** In addition to these policies, additional ones show the extent of training available to employees. **Continuing education (policy number 815**) and **tuition assistance (policy number 816**) show how employees' skill sets advance. With Washington State's Death with Dignity Act, AccentCare Spokane will also provide in-service training on the responsibilities of hospice workers under the law and per Seasons policy pertaining to **aide plan of care (policy number 2112)** and **physician aid in dying (policy number 2113)**, as shown in **Exhibit 7.** The policy outlines the roles and responsibilities of hospice staff when a patient requests aid in dying. **Exhibit 15** also includes the **Patient & Family Education policy (number 224**) that explains 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. *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

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 15.** *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

AccentCare Spokane 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, AccentCare Spokane is able to build a strong workforce.**

AccentCare Spokane 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. Seasons 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 15. A sample Continuing Education Announcement is provided in Exhibit 23.** *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

❖ Research and Advancements in Hospice Care

AccentCare Spokane 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 a Seasons 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. **AccentCare Spokane intends to interact with and develop local agreements with area universities and schools and leverage existing national contracts to provide internships in Spokane 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.

AccentCare Spokane'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 15 includes **policy number 209, Admission Process,** that specifically states, *all inquiries to Seasons Hospice [AccentCare] will have immediate follow-up and admission to hospice within 24 hours of the inquiry unless the patient, family, referral source or physician requests a later admission date. (Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.)*

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 AccentCare Spokane 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. AccentCare Spokane also plans to use the **CHECKSTER** Pulse survey for employee satisfaction. A copy of the CHECKSTER survey appears in **Exhibit 24. Exhibit 15** contains applicable policies that AccentCare Spokane will implement to assure quality assessment and program improvement:

- **Quality Assessment & Performance Improvement, policy #501**
- **Sentinel Events, policy #502**
- **Program Evaluation, policy #612**

AccentCare Spokane will review all policies on an annual basis and conforms the policies to location-specific requirements. *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

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 15 includes three policies that describe how ancillary and support services function with the care team. *Please note that draft policies are provided from Seasons Hospice & Palliative Care who is in the process of rebranding to AccentCare.*

- **Standards of Practice, policy #206**
- **Contracted Services, policy #202**
- **Financial Management, policy #606**

AccentCare Spokane 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 15.**

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 Spokane 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, AccentCare Spokane'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 Spokane County. 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.

AccentCare Hospice & Palliative Care of Spokane County, 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 Spokane 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.

AccentCare Spokane'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**.

AccentCare Spokane 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. AccentCare Spokane'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 are the homeless.** AccentCare Spokane'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.

AccentCare Spokane'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 AccentCare Spokane'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.

AccentCare Spokane 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. AccentCare Spokane'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.

Seasons Healthcare Management 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. AccentCare Spokane will offer more outreach and education, more hope for well-directed care, within the service area, to timely hospice care.

AccentCare Spokane 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.

AccentCare Spokane'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, AccentCare Hospice & Palliative Care of Spokane County, 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 2019-2021 reveal adherence to quality standards and timely implementation of corrective action plans followed by satisfactory compliance survey when necessary. A total of 5 Seasons hospice agencies received condition-level findings during this timeframe. 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 25.**

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. A root cause analysis reveals documentation inconsistencies as a primary basis for citations in routine surveys. As a result, SHCM invested in changing the electronic medical record (EMR) platform to a system that prevents such inconsistencies. The new EMR is in the process of being deployed and will be completed in early 2021, allowing any Washington programs to start with the new system. The new EMR will prevent these 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.***

AccentCare Spokane, is responding to the Department of Health's November 2021 methodology documenting a need for an additional hospice agency to serve residents of Spokane County. Any alternative that does not include adding a program in Spokane 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. However, no opportunities to purchase an existing agency have been identified.

Establishing new hospice agencies in areas where they are needed most, such as Spokane 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 Spokane 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 alternatives exist for establishing a new hospice program within Spokane County, given the announcement of need. There is no hospice currently serving Spokane that is available for purchase and not applying for a CN to establish a new hospice limits patient access to hospice in an area with documented need. Capital costs are addressed in **Section III.B.,** ***Financial Feasibility,*** on pages 59-71, and in the Pro Forma provided in **Exhibit 16.** 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,*** pages 77-85. 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.

Government limitations on the establishment of new hospice agencies through the CN program determines the number needed to serve the planning area. In Spokane County need was announced for an additional hospice agency to meet future need. Regardless of the inability to identify an existing hospice agency willing to sell its operations, not establishing additional capacity limits service, and therefore limits access and quality of health care to the community.

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.

As discussed previously, racial and ethnic disparities in accessing hospice care are seen in Spokane County. AccentCare Spokane 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 12.**

As the methodology in use by the Department of Health demonstrates, the current capacity of hospices serving the market is 2,721, lower than the forecast of 2,984 by CY 2023. 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.

Capital cost outlays are small relative to establishment of a new healthcare facility, as the service for hospice care is delivered in home. AccentCare Spokane'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 third 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.

Furthermore, AccentCare Spokane addresses staffing issues in ***Section C, Structure and Process (Quality) of Care, Question #9,*** pages 77-85, and is not repeated here. Recruitment and retention efforts, along with education and outreach efforts ensure a strong workforce results with establishment of AccentCare Spokane. Therefore, the impact on staffing is positive as development opportunities increase for the healthcare workforce.

Overall, approval of AccentCare Spokane's hospice program for Spokane County is consistent with the Department's need methodology, assures residents of Spokane County with ongoing access to quality hospice services, and improves job opportunities for nursing and social services. The only alternative to establish a new hospice agency is to purchase an existing hospice, but limited availability excludes this alternative.

[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

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***, pages 67-68, 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 19** in the Appendix.

The numerous programs and services of AccentCare Spokane described in detail in ***Section II, Project Description,*** pages 9-14 and in response to ***Question #7,*** pages 16-32, 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 AccentCare Spokane. 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 Spokane 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;

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, two AccentCare Hospice affiliates were able to start new hospice agencies during the COVID-19 pandemic, with the Pasco County, Florida agency exceeding its projections despite limitations.

As a new provider in Spokane 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 Spokane County results in understanding preferences and needs as expressed by residents and professionals within the county.

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 Spokane 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**
- **Expertise in employing technologies that enhance patient care and delivery of services**

- **Expertise that reaches into communities to diversify the workforce and in so doing, reach under-served persons**

- **Expertise in analyzing unmet need within communities and tailoring hospice services to reach and meet such need**

- **Expertise in empowering the workforce through comprehensive training and education**

- **Expertise in networking and creating linkages to schools and universities for internships and other experiences to encourage hospice care as a career choice**

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

AccentCare Spokane'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. 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,*** pages 33-42, AccentCare Spokane's diversity programs and dedication to under-served populations like the homeless; minorities; 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. AccentCare Spokane 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 Spokane 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. AccentCare Spokane will work closely with facilities and physicians to ensure they have an understanding of the benefits of hospice care so residents and patients can be referred timely and benefit.

What AccentCare Spokane 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. AccentCare Spokane'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.

AccentCare Spokane's diversity programs and dedication to under-served populations like the homeless 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, AccentCare Spokane fills the gaps in service.

AccentCare Spokane's ability to attract and recruit staff from across the United States, 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,*** pages 9-14 and in response to ***Question #7,*** pages 16-32, AccentCare Spokane 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 showcase the advantages that AccentCare Spokane brings to residents. AccentCare Spokane leverages the experience and expertise from the entire network of AccentCare Hospice Programs, raising the bar for hospice care in Spokane County. AccentCare Spokane'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 mission 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 AccentCare Spokane, 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. **AccentCare Spokane'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.

AccentCare Hospice & Palliative Care of Spokane County, LLC is the Applicant and intended licensee of the proposed hospice program. This entity is wholly owned by **AccentCare, Inc.** AccentCare, Inc. is also the owner of Seasons Hospice & Palliative Care of Pierce County Washington, LLC, an entity that has filed a Letter of Intent for a CN during this year's concurrent review cycle.

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.***

Each of the proposed hospice programs under AccentCare, Inc. is its own operating entity that is legally, operationally, and financially separate and distinct from the others. Each hospice program will have its own license 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. There is no common financial reporting or operations between the various agencies. Each agency is financially and operationally independent, and its success or failure, both financially and operationally, is dependent on its own performance.

As described previously in the ***Applicant Description Section*** in the front of the application, AccentCare, Inc. owns and operates a number of healthcare providers throughout the country. An organizational chart showing the business structure of AccentCare Hospice & Palliative Care of Spokane County, 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 AccentCare Hospice & Palliative Care providers, is provided in response to Question 6.

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.***

The applicant, AccentCare Hospice & Palliative Care of Spokane County, LLC provided its pro forma balance sheet in **Exhibit 16** for its first full three years of operations. This applicant is not impacted by the proposed operations of the Seasons Hospice & Palliative Care of Pierce County Washington, LLC. However, a combined pro forma balance sheet for both proposed projects in this year's review cycles demonstrating the impact on the parent, AccentCare, Inc., will be provided during the screening period, once the pro forma for the Pierce County applicant is complete.

4. ***In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements may 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.***

All projects for new hospice agencies by applicants for which AccentCare, Inc. is the owner will operate under separate licenses.

APPENDIX

EXHIBIT 1

Applicant Entity Certificate of Formation and Washington Application of Foreign Registration

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 FORMATION

to

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC

A **WA LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 11/10/2021
UBI Number: 604 830 166

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

Kim Wyman, Secretary of State

Date Issued: 11/10/2021

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 11/10/2021
Effective Date: 11/10/2021
UBI #: 604 830 166

CERTIFICATE OF FORMATION

UBI NUMBER

UBI Number:
604 830 166

BUSINESS NAME

Business Name
ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501-1267, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501-1267, UNITED STATES

REGISTERED AGENT CONSENT

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

DURATION

Duration:
PERPETUAL

EFFECTIVE DATE

Effective Date:
11/10/2021

OTHER PROVISIONS

Other Provisions:

PRINCIPAL OFFICE

Phone:
972-201-9168

Email:
SHELLEYMOLGE@ACCENTCARE.COM

Street Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

Mailing Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

EXECUTOR

Title	Executor Type	Entity Name	First Name	Last Name	Address
EXECUTOR	INDIVIDUAL		SHELLEY	MOLGE	17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

RETURN ADDRESS FOR THIS FILING

Attention:
SHELLEY MOLGE

Email:
SHELLEYMOLGE@ACCENTCARE.COM

Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
No Value Found.			

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:
INDIVIDUAL

First Name:
SHELLEY

Last Name:
MOLGE

Title:
PARALEGAL

Office of the Secretary of State
Corporations & Charities Division

Filed
Secretary of State
State of Washington
Date Filed: 11/10/2021
Effective Date: 11/10/2021
UBI #: 604 830 166

INITIAL REPORT

UBI NUMBER

UBI Number:
604 830 166

BUSINESS NAME

Business Name
ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC

REGISTERED AGENT

Registered Agent Name	Street Address	Mailing Address
C T CORPORATION SYSTEM	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501-1267, UNITED STATES	711 CAPITOL WAY S STE 204, OLYMPIA, WA, 98501-1267, UNITED STATES

REGISTERED AGENT CONSENT

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

EFFECTIVE DATE

Effective Date:
11/10/2021

OTHER PROVISIONS

Other Provisions:

PRINCIPAL OFFICE

Phone:
972-201-9168

Email:
SHELLEYMOLGE@ACCENTCARE.COM

Street Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

Mailing Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

GOVERNORS

Title	Governor Type	Entity Name	First Name	Last Name
GOVERNOR	INDIVIDUAL		CHARLES	PIERCE
GOVERNOR	ENTITY	ACCENTCARE, INC.		

NATURE OF BUSINESS

Nature of Business:
ANY LAWFUL PURPOSE

RETURN ADDRESS FOR THIS FILING

Attention:
SHELLEY MOLGE

Email:
SHELLEYMOLGE@ACCENTCARE.COM

Address:
17855 DALLAS PKWY STE 200, DALLAS, TX, 75287-6857, UNITED STATES

UPLOAD ADDITIONAL DOCUMENTS

Name	Document Type
No Value Found.	

UPLOADED DOCUMENTS

Document Type	Source	Created By	Created Date
No Value Found.			

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:
INDIVIDUAL

First Name:
SHELLEY

Last Name:
MOLGE

Title:
PARALEGAL

EXHIBIT 2

Services Agreement

SERVICES AGREEMENT

THIS SERVICES AGREEMENT (this "Agreement") is effective as of the 1st day of December, 2021, between ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC (the "Hospice"), and SEASONS HEALTHCARE MANAGEMENT ("SHCM").

RECITALS

A. SHCM provides hospice consulting and financial services for various hospice programs.

B. Hospice owns and operates or will own and operate a hospice program located in Spokane County, Washington (the "Program").

C. Hospice desires to engage SHCM to provide hospice consulting and services to Hospice for the Program, and SHCM desires to accept such engagement, on the terms and subject to the conditions of this Agreement.

AGREEMENTS

In consideration of the recitals and the mutual agreements below, the parties agree as follows:

1. Term. Unless earlier terminated pursuant to the terms of this Agreement, the terms of this Agreement shall continue until either party sends written notice to the other party setting a termination date which is no less than sixty (60) days following the date of said notice.

2. SHCM Services. During the Term, SHCM shall provide Hospice with the hospice consulting and financial services for the Program as described on Exhibit A (the "Services").

3. No Professional Medical or Hospice Services. The parties acknowledge and agree that SHCM is not authorized or qualified to engage in any activity which constitutes professional medical or hospice services, and none of the Services provided by SHCM as required herein shall be construed as the practice of medicine or other professional health care services by SHCM. To the extent any act or service required to be performed or provided by SHCM is construed or deemed by any legal authority to constitute the practice of medicine or another professional health care service, SHCM shall be released from any obligation to provide such act or service and the provision for such required act or service shall be deemed waived and forever unenforceable without otherwise affecting the terms of this Agreement; provided, however, that the parties shall diligently endeavor in good faith to make other mutually satisfactory agreements relating to any problematic or prohibited provisions or actions which will not constitute the practice of medicine or another professional health care service by SHCM.

Notwithstanding anything to the contrary contained herein, nothing shall impair the independent professional judgment of Hospice and its health care professional employees and agents.

4. Hospice's Obligations.

(a) Exclusivity. Hospice shall, during the Term, not retain, engage or employ, directly or indirectly, any other entity or individual to provide the Services.

(b) Management and Control. Hospice services shall be performed solely by, or under the direct supervision of Hospice and at the sole cost and expense of Hospice. Hospice shall have complete and absolute control over its operations and the methods by which Hospice and its personnel render the professional hospice services. Hospice shall operate in accordance with, and shall require that each of its personnel comply with, all applicable regulations, including, without limitation, applicable state laws and regulations and the Medicare Conditions of Participation for Hospice Care.

(c) Bank Accounts. Hospice shall establish and maintain one or more bank accounts (collectively, the "Operating Account"). Upon receipt by SHCM of any funds from patients or payors or from Hospice for hospice services, SHCM shall immediately deposit such funds into the Operating Account.

(d) Payor Relationships. Hospice shall participate as a provider in Medicare, Medicaid and managed care arrangements. Hospice and its personnel shall comply with all policies, programs and requirements, including, without limitation, the quality assurance and utilization review programs of Medicare, Medicaid and managed care arrangements.

(e) Good Standing. Hospice shall, and shall cause its professional personnel to, take all actions necessary to ensure that Hospice may legally provide hospice services under applicable law and regulations. Hospice shall ensure that each of the hospice's professional personnel participates in appropriate continuing education activities.

(f) Powers of Attorney and Billing.

(i) General. Hospice appoints SHCM to act as its agent in the billing and collection for reimbursement of all of Hospice's services to patients. Hospice shall cooperate with SHCM in all reasonable matters relating to the billing and collection for reimbursement of all Hospice services, including, without limitation, compliance with SHCM's billing and collection policies and procedures and corporate compliance policies. Hospice shall review and approve the reports and other information required to support complete and accurate bills. Hospice will provide such necessary support to appeal or contest any denials of claims or other regulatory issues.

(ii) Attorney-In-Fact. In connection with the billing and collection services to be provided hereunder and throughout the Term, Hospice hereby grants to SHCM a special power of attorney and appoints SHCM as Hospice's true and lawful agent and attorney-in-fact, and SHCM hereby accepts such special power of attorney and appointment, for

the following purposes:

(A) To provide for the billing of Hospice's patients, in the name of Hospice and on behalf of Hospice, as applicable, for all billable services provided by Hospice to patients;

(B) To provide for the billing in Hospice's name and on Hospice's behalf all claims for reimbursement or indemnification from insurance companies, Medicare, Medicaid and all other third-party payors or fiscal intermediaries;

(C) To collect and receive in Hospice's name and on Hospice's behalf, for deposit into the Operating Account, all accounts receivable generated by such billings and claims for reimbursement; and

(D) To endorse in the name of Hospice, for deposit into the Operating Account, any notes, checks, money orders, insurance payments and any other instruments received in payment for services.

(iii) Power. The special and limited power of attorney granted herein shall be coupled with an interest. The power of attorney shall expire on the date this Agreement has been terminated.

(iv) Assignment. If SHCM assigns this Agreement in accordance with its terms, Hospice shall execute a power of attorney in favor of the assignee.

(g) Records.

(i) Maintenance of Records. Hospice shall be responsible for the preparation of, and direct the contents of, patient health care records and shall be responsible for proper documentation of services provided by Hospice. All patient health care records shall remain the property of Hospice.

(ii) Access to Records. Upon termination of this Agreement, Hospice shall retain all patient health care records maintained by Hospice or SHCM in the name of Hospice. SHCM shall, at its option and to the extent permitted under applicable law, have reasonable access during normal business hours to Hospice's patient health care records applicable to the period of SHCM's performance under this Agreement. Hospice shall, at its option, be entitled to retain copies of financial and accounting records relating to all services performed by Hospice or SHCM under this Agreement. The parties agree to maintain the confidentiality of patient identifying information and not to disclose such information except as may be required or permitted by applicable laws.

(h) Insurance. Hospice shall provide, or arrange for the provision of, and maintain throughout the Term, for Hospice and for all Hospice professional personnel, malpractice insurance coverage of no less than $1,000,000 per occurrence and $3,000,000 in the aggregate. Hospice shall maintain workers' compensation insurance coverage at no less than the minimum amounts required by applicable law. Hospice shall, at its sole cost and expense, pay the premium

costs of all insurance coverage during the Term, name SHCM as an additional insured under such policies and, upon request by SHCM, provide SHCM with evidence of such coverage.

5. Compensation. During the Term, Hospice shall pay to SHCM fees for the Services provided by SHCM (the "Service Fees") in an amount equal to $5,000.00 per month. SHCM shall bill Hospice each month for the Service Fees and Hospice shall remit payment to SHCM for the Service Fees no later than thirty (30) days after receipt of the monthly bill from SHCM.

6. Termination.

(a) Termination Without Cause. Either party shall have the right to terminate this Agreement, with or without cause and without penalty or liability to the other party, upon 60 days' prior written notice to the other party.

(b) Termination Upon Default. If either party is in default of any material obligation under this Agreement and tails to cure such default within 30 days of receipt of written notice of such default from the nondefaulting party, the nondefaulting party shall be entitled to terminate this Agreement immediately and seek all rights and remedies available to such nondefaulting party under this Agreement.

(c) Termination by Mutual Consent. The parties may terminate this Agreement at any time by mutual written agreement.

(d) Immediate Termination.

(i) Exclusion from Medicare or Medicaid. SHCM may immediately terminate this Agreement if Hospice, or any of its personnel, is excluded or suspended from participating in the Medicare or Medicaid programs;

(ii) Liquidation. Either party may immediately terminate this Agreement upon:

(A) The filing by the other party of a voluntary petition in bankruptcy;

(B) An involuntary petition in bankruptcy is filed against the other party which is not dismissed within 30 days of its filing; or

(C) An assignment by the other party of its rights and assets for the benefit of its creditors.

(iii) Failure to Have Insurance. SHCM may immediately terminate this Agreement if Hospice ceases to have any of the insurance required under this Agreement; or

(iv) Commission of Misconduct. Either party may immediately

terminate this Agreement if the other party commits an act of misconduct, fraud, dishonesty, or misrepresentation which could reasonably be expected to have a material adverse effect on the other party.

(e) Effects of Termination. Upon the termination or expiration of this Agreement: (i) neither party shall be discharged from any previously accrued obligation which remains outstanding; (ii) any sums of money owing by one party to the other party shall be paid immediately, prorated through the effective date of termination or expiration; (iii) Hospice shall return to SHCM all originals and copies of any SHCM confidential or proprietary information; (iv) the trademark license provided for in Section 9 shall terminate, (v) Hospice and SHCM shall perform matters as are necessary to wind up their activities under this Agreement in an orderly manner; and (vi) each party shall have the right to pursue other legal or equitable relief as may be available depending upon the circumstances of the termination.

7. Independent Contractor Status. Hospice and SHCM are to perform and exercise their rights and obligations under this Agreement as independent contractors and in no event shall the parties be deemed to constitute a partnership or other joint venture of any nature. SHCM shall not become liable for any of the obligations, liabilities, debts or losses of Hospice. Each party shall be solely responsible for compliance with all applicable laws and regulations pertaining to employment taxes, income withholding, unemployment compensation contributions and other employment-related statutes regarding their respective employees, agents and servants.

8. Indemnity.

(a) By Hospice. Hospice releases, and agrees to promptly defend, indemnity and hold harmless SHCM, and SHCM's shareholders, directors, officers, employees and agents from and against all obligations, liabilities, losses, claims, actions, causes of action, damages, costs and expenses (including, without limitation, attorneys' fees) in any way relating to, resulting from or arising out of: (i) any material breach of this Agreement by Hospice; and (ii) the business or operations of Hospice, except to the extent relating to, resulting from or arising out of any material breach of this Agreement by SHCM or any act or omission constituting gross negligence or willful misconduct of SHCM. SHCM shall have the right to participate in any such matter if it so desires.

(b) By SHCM. SHCM releases, and agrees to promptly defend, indemnity and hold harmless Hospice, and Hospice's shareholders, directors, officers, employees and agents from and against all obligations, liabilities, losses, claims, actions, causes of action, damages, costs and expenses (including, without limitation, attorneys' fees) in any way relating to, resulting from or arising out of any material breach of this Agreement by SHCM or any act or omission constituting gross negligence or willful misconduct of SHCM in connection with its provision of the Services. Hospice shall have the right to participate in any such matter if it so desires.

9. Intentionally Omitted.

10. Confidentiality.

(a) Patient Information. Pursuant to the Health Insurance Portability and Accountability Act of 1996 and the corresponding regulations, Hospice and SHCM agree to the business associate terms set forth in Exhibit B.

(b) Nondisclosure of Confidential Information. The parties hereto al:,rree that each party's business connections, customers, customer lists, payors, managed care strategies, contracting terms and strategies, providers, reimbursement methodologies, financing conditions, past performance, future prospects, procedures, operations, techniques and other aspects of their businesses (the "Confidential Information") are established at great expense and protected as confidential information. The parties further agree that, by virtue of the terms of this Agreement, each party will have access to, and be entrusted with, Confidential Information of the other party, and that a party disclosing Confidential Information (the "Disclosing Party") would suffer great loss and injury if the party receiving such information (the "Receiving Party") would disclose this information or use it to compete with the Disclosing Party. Therefore, during the Term and for a period of three years thereafter, the parties covenant and agree that they shall not, in any capacity, use any Confidential Information, except as necessary under this Agreement, or disclose any Confidential Information to third parties within the geographic area in which the parties conducted their business during the Term.

(c) Non-Confidential Information. The requirements of confidentiality and the limitations on use and disclosure set forth in section 10(b) of this Agreement shall not apply to Confidential Information that the Receiving Party can demonstrate by clear and convincing evidence:

(i) at the time of disclosure by the Disclosing Party to the Receiving Party, was known to the Receiving Party as evidenced by the Receiving Party's contemporaneous written records;

(ii) at the time of disclosure by the Disclosing Party, was published or known publicly or otherwise was in the public domain;

(iii) after disclosure by the Disclosing Party and other than as a result of a breach of the Receiving Party's obligations under this Agreement, becomes published or publicly known or otherwise becomes part of the public domain; or

(iv) is disclosed to the Receiving Party in good faith by a third party who is not under obligation of confidence or secrecy to the Disclosing Party at the time such third party discloses the information to the Receiving Party.

11. Warranties. SHCM warrants to Hospice that the Services shall be performed in a professional a n d workmanlike manner. Any claim for breach of the foregoing warranty with respect to any of the Services must be made by written notice to SHCM within thirty (30)

days of performance of such Services. For any breach of such warranty, Hospice's exclusive remedy, and SHCM's entire liability, shall be the reperformance of such Services. If SHCM does not reperform such Services as warranted, then Hospice shall be entitled to recover the fees paid to SHCM under this Agreement for such deficient Services. The foregoing warranty shall only apply provided that all fees due to SHCM hereunder have been paid in full. EXCEPT AS OTHERWISE STATED IN THIS SECTION II, SHCM MAKES NO WARRANTIES OF ANY KIND OR NATURE, WHETHER EXPRESS OR IMPLIED, INCLUDING, BUT NOT LIMITED TO, WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE, WARRANTIES OF ANY PRODUCTS OR SERVICES, OR THE APPROPRIATENESS OF HOSPICE OR THIRD-PARTY SPECIFICATIONS. IN ADDITION, SHCM EXPRESSLY DISCLAIMS ANY WARRANTY OR LIABILITY WITH RESPECT TO DESIGN OR LATENT DEFECTS OR COMPLIANCE WITH LAWS APPLICABLE TO HOSPICE, WHICH SHALL BE THE SOLE RESPONSIBILITY OF HOSPICE.

12. LIMITATION OF LIABILITY. THE MAXIMUM LIABILITY OF SHCM, ITS DIRECTORS AND OFFICERS TO HOSPICE FOR DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER, AND HOSPICE'S MAXIMUM REMEDY, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT OR OTHERWISE, SHALL BE LIMITED TO AN AMOUNT EQUAL TO THE TOTAL FEES PAID BY HOSPICE TO SHCM HEREUNDER FOR THE PORTION OF THE SERVICES GIVING RISE TO ANY SUCH CLAIM. IN NO EVENT SHALL SHCM OR ITS DIRECTORS OR OFFICERS BE LIABLE FOR ANY LOST DATA OR CONTENT, LOST PROFITS, BUSINESS INTERRUPTION OR FOR ANY INDIRECT, INCIDENTAL, SPECIAL, CONSEQUENTIAL, EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATING TO THE SERVICES PROVIDED UNDER THIS AGREEMENT, EVEN IF SHCM HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES, AND NOTWITHSTANDING THE FAILURE OF ESSENTIAL PURPOSE OF ANY LIMITED REMEDY. IN NO EVENT SHALL SHCM OR ITS DIRECTORS OR OFFICERS BE LIABLE FOR DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER, REGARDLESS OF THE FORM OF ACTION, WHETHER IN CONTRACT, TORT OR OTHERWISE, RELATING TO ANY THIRD PARTY CARRIER SERVICES, WHETHER OR NOT DESIGNED BY SHCM OR SOLD TO HOSPICE BY SHCM OR OTHERWISE UTILIZED BY HOSPICE, EACH OF WHICH WILL BE THE SUBJECT OF SEPARATE AGREEMENTS WITH SUCH THIRD PARTY.

13. Miscellaneous Provisions.

(a) Notices. The parties to this Agreement shall give notice under this Agreement by certified or registered U.S. mail, postage prepaid, by hand delivery or by overnight express, charges prepaid. Notices shall be addressed as follows:

If to Hospice:
AccentCare Hospice & Palliative Care of Spokane County, LLC
6400 Shafer Court
Suite 700
Rosemont, IL 60018
Attn: Todd Stern

If to SHCM:
Seasons Healthcare Management
6400 Shafer Court
Suite 700
Rosemont, IL 60018
Attention: David Donenberg, CFO

or other addresses as furnished in writing by a party to the other party. All notices shall be considered received when received by the addressee if by mail, when hand delivered or one business day after delivery to the overnight courier.

(b) Waiver. The failure of either party to insist, in any one or more instances, upon performance of the terms, covenants or conditions of this Agreement shall not be construed as a waiver or a relinquishment of any right granted hereunder or of the future performance of any such term, covenant or condition.

(c) Severability. If any provision shall be held to be invalid or unenforceable for any reason, the parties agree that such invalidity or unenforceability shall not affect any other provision of this Agreement, the remaining covenants, restrictions and provisions hereof shall remain in full force and effect and any court of competent jurisdiction may so modify the objectionable provision as to make it valid and enforceable.

(d) Amendment. This Agreement may be amended only by an agreement in writing signed by the parties hereto.

(e) Applicable Law and Forum. The parties agree and acknowledge that this Agreement is made and will be wholly performed within the State of Illinois. Without limiting the foregoing, the parties agree that SHCM's Services will be deemed rendered wholly within the State of Illinois, notwithstanding that personnel of SHCM may, from time to time, travel to the Program for meetings, to gather information or for other purposes. The laws of the State of Illinois (other than those pertaining to conflicts of law) shall govern all aspects of this Agreement, irrespective of the fact that one of the parties now is or may become a resident of a different state or country. Each party irrevocably agrees that any legal action or proceeding arising out of or relating to this Agreement may be brought only in the courts of the State of Illinois or of the Northern District of Illinois and hereby expressly submits to the personal jurisdiction and venue of such courts for the purposes thereof and expressly waives any claim of improper venue and any claim that any such courts is an inconvenient forum.

(f) Benefit. This Agreement shall be binding upon, inure to the benefit of and be enforceable by and against the parties hereto and their respective permitted successors and assigns.

(g) Counterparts. The parties may execute this Agreement in several counterparts, each of which shall be deemed to be an original, and all of which together shall constitute one and the same instrument.

(h) Assignment. SHCM may assign this Agreement to any individual or entity. Hospice may not assign this Agreement or any rights or obligations hereunder without the prior written consent of SHCM. Subject to the foregoing sentences, no person or entity not a party to this Agreement shall have any right under or by virtue of this Agreement.

(i) Captions. The captions or headings in this Agreement are made for convenience and general reference only and shall not be construed to describe, define or limit the scope or intent of the provisions of this Agreement.

(j) Entire Agreement. This Agreement 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.

(k) Force Majeure. Except with respect to any payment obligations, neither party will be liable for any failure or delay in its performance under this Agreement caused, directly or indirectly, by flood, communications failure, extreme weather, fire, mud slide, earthquake, or other natural calamity or act of God, interruption in water, electricity, heating or air conditioning (depending on the season), acts of terrorism, riots, civil disorders, rebellions or revolutions, acts of governmental agencies, quarantines. embargoes, malicious acts of third parties, labor disputes affecting vendors or subcontractors and for which the party claiming force majeure is not responsible, or any other similar cause beyond the reasonable control of that party and for which such party is not able to prevent or remove the force majeure at reasonable cost. Either party shall give prompt written notice of any condition or event likely to cause any such failure or delay.

IN WITNESS WHEREOF, the parties have executed or caused this Agreement to be executed as of the date first set forth above.

SEASONS HEALTHCARE MANAGEMENT

By: _____
Name: Todd A. Stern
Title: Chief Executive Officer

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC

By: _____
Name: Todd A. Stern
Title: Chief Executive Officer

EXHIBIT A

SERVICES

1. Billing. SHCM shalt provide or arrange for the prov1s1on of billing and collection services necessary for Hospice with respect to the Program. On behalf of Hospice, SHCM shall bill patient, insurance companies, managed care payors, governmental entities and third-party payors and collect the fees from such payors for hospice services rendered by Hospice. SHCM shall prepare, in the name of Hospice and for Hospice's signature, all cost reports and other reports and data necessary for obtaining reimbursement for the items and services provided by Hospice under the Medicare and Medicaid program and any other third party payor in which Hospice participates.

2. Payroll. SHCM shall provide or arrange for the provision of payroll services necessary for Hospice with respect to the Program.

3. Bookkeeping, Accounts Payable and Accounts Receivable. SHCM shall provide or arrange for the provision of bookkeeping, accounts receivable and accounts payable services necessary for Hospice with respect to the Program.

4. Financial Statements; No Tax Planning. SHCM shall prepare or arrange for the preparation of periodic income statements and balance sheets reflecting the results of operations and the financial condition of Hospice with respect to the Program (the "Financial Statements"). The Financial Statements shall reflect revenues generated by or on behalf of Hospice and shall contain a comparison of actual and budgeted Hospice revenues and Hospice expenses. Notwithstanding anything else herein to the contrary, SHCM shall not be responsible for providing Hospice with any tax planning advice.

5. Information Technology Systems. SHCM shall assist with the selection of software and hardware and software SHCMs for operations of Hospice with respect to the Provider. With the approval of Hospice, SHCM shall include Hospice in group hardware and software service contracts.

6. Equipment. SHCM shall analyze and recommend the purchases and leases of equipment SHCM determines advisable in the operation of the Program, subject to the approval of Hospice. SHCM shall monitor and, at Hospice's request, use reasonable efforts to obtain maintenance and repair of such equipment. In arranging for the purchase and lease of such equipment, SHCM MAKES NO WARRANTIES, EXPRESS OR IMPLIED, WITH REGARD TO SUCH EQUIPMENT, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE.

7. Software Training and Support. SHCM shall provide or arrange for the provision of software training and support for Hospice's personnel with respect to the Program.

8. Support. To the extent required by Hospice, SHCM shall provide assistance and technical support for providing hospice and palliative care services. Such services may include assisting Hospice in drafting manuals, policies and procedures, providing staff education and handling identified compliance issues. At Hospice's request, SHCM will assist with engaging legal counsel, consultants and other parties necessary to assist in these activities.

9. Contract Review. SHCM shall advise and assist Hospice in negotiating and maintaining contracts and arrangements with such individuals and entities appropriate for the operation of Hospice with respect to the Program, including, without limitation, third-party payor contracts, facility service agreements, pharmacy agreements, durable medical equipment agreements, laboratory services agreements, radiology services agreements, therapy services agreements and ambulance services agreements. Hospice will have no obligation to enter into any contract arranged for by SHCM; all such contracts will be subject to the approval of Hospice in its sole and absolute discretion.

10. Group Purchasing. SHCM shall arrange for opportunities for Hospice to purchase patient care supplies and office supplies required in the day-to-day operation of Hospice with respect to the Program provided, however, that Hospice shall order, purchase, stock and monitor the inventory of patient care supplies, substances or items whose purchase, maintenance or security require licensure as a health care provider or require a permit, registration, certification or identification number that requires licensure or certification as a health care provider. Hospice shall arrange for waste disposal and other related operational services in accordance with applicable regulations. Hospice will have no obligation to purchase any goods or services arranged for by SHCM; all such purchases will be subject to the approval of Hospice in its sole and absolute discretion.

11. Marketing. To the extent requested by Hospice, SHCM shall consult with Hospice with respect to marketing, strategic planning, corporate communications and community outreach.

12. Website. SHCM shall provide for the development and maintenance of a webpage for the Program, which will provide marketing and other information with respect to the Program.

13. Human Resources.

(a) Policy Manual and Benefit Programs. SHCM shall develop a human resource policy manual for Hospice and provide consulting and assistance with compliance issues, and to the extent requested by Hospice, will coordinate benefit programs of Hospice.

(b) Nonprofessional Personnel. SHCM will provide all employees required to perform its Services hereunder. SHCM shall additionally provide consulting services with respect to the hiring of Hospice administrative, clerical and other personnel necessary for Hospice's effective operation with respect to the Program. Hospice shall determine the salaries and fringe benefits of all Hospice personnel and shall retain decision-making authority regarding hiring, tiring and other employment

decisions with respect to all such Hospice personnel.

14. Legal Services.

(a) At Hospice's request and expense, SHCM shall coordinate legal representation for Hospice for the purpose of obtaining advice, representation and other services.

(b) At Hospice's request and expense, SHCM shall retain attorneys on behalf of Hospice.

15. Compliance.

(a) Compliance Plan. SHC'M shall develop a Compliance Plan for Hospice and provide consulting and assistance with the effective implementation and operation of the Compliance Plan.

(b) Personnel. At Hospice's request and expense, SHCM's chief compliance officer shall either serve directly as the compliance officer for Hospice or work with a compliance officer separately designated by Hospice. SHCM shall additionally provide consulting services with respect to the hiring and oversight of compliance personnel.

EXHIBIT B

To comply with the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the "CFR"), Hospice, as a "Covered Entity", and SHCM, as the "Business Associate", agree to the following:

1. Definitions. Capitalized terms not otherwise defined in the Agreement shall have the meanings given to them in Title 45, Parts 160 and 164 of the CFR and are incorporated herein by reference.

2. Use and Disclosure of Protected Health Information. SHCM shall use or disclose Protected Health Information ("PHI") only to the extent necessary to satisfy SHCM's obligations under the Agreement.

3. Prohibition on Unauthorized Use of Disclosure of PHI. SHCM shall not use or disclose any PHI received from or on behalf of Hospice, except as permitted or required by the Agreement, as required by law or as otherwise authorized in writing by Hospice. SHCM shall comply with: (a) Title 45, Part 164 of the CFR; (b) state laws, rules and regulations applicable to PHI not preempted pursuant to Title 45, Part 160, Subpart B of the CFR; and (c) Hospice's health information privacy and security policies and procedures.

4. SHCM's Operations. SHCM may use or disclose PHI it creates or receives for or from Hospice only to the extent necessary for SHCM's proper performance of Services hereunder and administration or to carry out Hospice's legal responsibilities only if:

(a) The use or disclosure is required by law; or

(b) SHCM obtains reasonable assurance, evidenced by written contract, from any person or organization to which SHCM shall disclose such PHI that such person or organization shall:

(i) Hold such PHI in confidence and use or further disclose it only for the purpose for which SHCM disclosed it to the person or organization or as required by law; and

(ii) Notify SHCM (who shall in tum promptly notify Hospice) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached or of any security incident (including any attempted or actual unauthorized access or breach of PHI).

5. PHI Safeguards. SHCM agrees to implement reasonable systems for the discovery and prompt reporting of any "Breach" of "Unsecured PH1," as those terms are defined in 45 C.F.R. § 164.402. Unless otherwise prevented from disclosing such Breach pursuant to 45 C.F.R. § 164.412, SHCM shall report to Hospice within five (5) days any Breach of Unsecured PHI. Notice of Breach shall include, at minimum: (i) the identification of each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the

Breach; (ii) the date of the Breach, if known or the date of the discovery of the Breach; (iii) the scope of the Breach and who made the Breach; and (iv) a description of SHCM's response to the Breach and actions taken to mitigate the harm to individuals resulting from the Breach. SHCM shall provide Hospice with information related to the Breach and will cooperate with Hospice in any notifications Hospice may be required to make by law. In the event of a Breach, SHCM shall (i) assist Hospice with any Hospice investigation conducted regarding the Breach; (ii) cooperate with and assist Hospice in any investigation being conducted by a governmental agency in connection with the Breach; (iii) assist Hospice in the mitigation of the Breach; and (iv) assist with the implementation of any decision by a governmental agency in connection with the Breach.

6. Electronic Health Information Security and Integrity. SHCM shall develop, implement, maintain and use appropriate administrative, technical and physical security measures in compliance with Section 1173(d) of the Social Security Act, Title 42, Section 1320d-2(d) of the United States Code and Title 45, Part 142 of the CFR to preserve the inteb1fity and confidentiality of all electronically maintained or transmitted Health Information received from or on behalf of Hospice pertaining to an individual. SHCM shall document and keep these security measures current.

7. Protection of Exchanged Information in Electronic Transactions. If SHCM conducts any Standard Transaction for or on behalf of Hospice, SHCM shall comply, and shall require any subcontractor or agent conducting such Standard Transaction to comply, with each applicable requirement of Title 45, Part 162 of the CFR. SHCM shall not enter into or permit its subcontractors or agents to enter into any Trading Partner Agreement in connection with the conduct of Standard Transactions for or on behalf of Hospice that: (a) changes the definition, Health Information condition or use of a Health Information element or segment in a Standard; (b) adds any Health Information elements or segments to the maximum defined Health Information set; (c) uses any code or Health Information elements that are either marked "not used" in the Standard's Implementation Specification or are not in the Standard's Implementation Specification(s); or (d) changes the meaning or intent of the Standard's Implementation Specification(s).

8. SHCM Subcontractors and Agents. SHCM shall require each of its subcontractors or agents to whom SHCM may provide PHI received from, or created or received by SHCM on behalf of Hospice to agree to written contractual provisions that impose at least the same obligations to protect such PHI as are imposed on SHCM by the Agreement.

9. Access to PHI. SHCM shall provide access, at the request of Hospice, to PHI in a Designated Record Set to Hospice or, as directed by Hospice, to an Individual in order to meet the requirements under Title 45, Part 164, Subpart E, Section 164.524 of the CFR and applicable state law. SHCM shall provide access in the time and manner set forth in Hospice's health information privacy and security policies and procedures.

10. Amending PHI. SHCM shall make any amendment(s) to PHI in a Designated Record Set that Hospice directs or agrees to pursuant to Title 45, Part 164, Subpart E, Section 164.526 of the CFR at the request of Hospice or an Individual, and in the time and manner set forth in Hospice's health information privacy and security policies and procedures.

11. Accounting of Disclosures of PHI.

(a) SHCM shall document such disclosures of PHI and information related to such disclosures as would be required for Hospice to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

(b) SHCM agrees to provide Hospice or an Individual, in the time and manner set forth in Hospice's health information privacy and security policies and procedures, information collected in accordance with this subsection, to permit Hospice to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with Title 45, Part 164, Subpart E, Section 164.528 of the CFR.

12. Access to Books and Records. SHCM shall make its internal practices, books and records relating to the use and disclosure of PHI received from or on behalf of Hospice available to Hospice and to HHS or its designee for the purpose of determining Hospice's compliance with the Privacy Rule.

13. Reporting. SHCM shall report to Hospice any privacy or security breach or any Security Incident, use or disclosure of PHI not authorized by this Agreement or in writing by Hospice of which it becomes aware.

14. Mitigation. SHCM agrees to mitigate, to the extent practicable, any harmful effect that is known to SHCM of a use or disclosure of PHI by SHCM in violation of the requirements of the Agreement.

15. Termination for Cause. Upon Hospice's knowledge of a material breach of this Agreement, Hospice shall:

(a) Provide an opportunity for SHCM to cure the breach or end the violation and terminate this Agreement if SHCM does not cure the breach or end the violation within the time specified by Hospice.

(b) Immediately terminate this Agreement if SHCM has breached a material term of the Agreement and cure is not possible.

(c) If neither termination nor cure is feasible, Hospice shall report the violation to the Secretary.

16. Return or Destruction of Health Information.

(a) Except as provided in subsection (b) below, upon termination, cancellation, expiration or other conclusion of the Agreement, SHCM shall return to Hospice or destroy all PHI received from Hospice, or created or received by SHCM acting on behalf of Hospice. SHCM shall not retain copies of the PHI.

(b) In the event that SHCM determines that returning or destroying the PHI is infeasible. SHCM shall provide to Hospice notification of the conditions that male return or destruction infeasible. Upon verification by Hospice that the return or destruction of PHI is infeasible. SHCM shall extend the protections of the Agreement to such PHI and limit further uses and disclosure of PHI to those purposes that make the return or destruction infeasible, for so long as SHCM maintains such PHI.

17. Automatic Amendment. Upon the effective date of any amendment to the regulations promulgated by HHS with respect to PHI, the Agreement shall automatically amend such that the obligations imposed on SHCM as a Business Associate remain in compliance with such regulations.

18. Conflict. In the event of any conflict between the terms of this Exhibit and any other agreements between the parties, the terms of this Exhibit shall govern the use and disclosure of PHI.

EXHIBIT 3

Accentcare, Inc. Facility List

ACCENTCARE, INC. PROVIDER ENTITIES						
Provider	**Service**	**Address**	**License #**	**Medicare #**	**Accreditation**	**Date affiliated with AccentCare, Inc., if within the last 3 years**
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	3050 Navajo Dr, STE 110 Prescott Valley, AZ 86314	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 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	500 E Fry Blvd, STE L-7 Sierra Vista, AZ 85635	N/A	N/A	N/A	
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	2340 W 24th St., STE B Yuma, AZ 85367	N/A	N/A	N/A	
AccentCare Fairview Home Health-East, LLC	Home Health	1655 Beam Ave. #100, Maplewood, MN 55109	397305	24-7166	N/A	11/2/2020
AccentCare Fairview Home Health-West, LLC	Home Health	767 Eustis St, #150, Saint Paul, MN 55114-0018	397303	24-7078	N/A	11/2/2020
AccentCare Fairview Hospice-West, LLC	Hospice	767 Eustis St, #150, Saint Paul, MN 55114-0018	397304	24-1514	N/A	11/2/2020
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	119 S Court St, STE A Circleville, OH 43113	N/A	36-7270	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	2590 Goodwater Ave., STE 100 Redding, CA 96002-1550	230000205	55-7273	CHAP	
AccentCare Home Health of California, Inc.	Home Health	2880 Sunrise Blvd Ste 218 Rancho Cordova. CA 95742-6501	100000471	55-7253	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	5050 Murphy Canyon Rd, STE 200 San Diego, CA 92123-4441	080000226	05-7564	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	3170 Crow Canyon Place, STE 270 San Ramon, CA 94583-1160	020000285	05-7517	CHAP	
AccentCare Home Health of California, Inc.	Hospice	2344 S 2nd, Suite B El Centro, CA 92243-5606	550003173	92-1522	CHAP	
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	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.	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	Home Health	2460 W 26th Ave, STE C-185 Denver, CO 80211-5331	04K558	06-7445	CHAP	
AccentCare Home Health of Mountain Valley, LLC	Hospice	4065 St. Cloud, STE 200 Loveland, CO 80538	17B924	06-1560	CHAP	
AccentCare Home Health of Rogue Valley, LLC	Home Health	691 Murphy Road, STE 236 Medford, OR 97504	13-505	38-7098	CHAP	
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	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	23725 Birtcher Dr, STE 150 Lake Forest, CA 92630	304700040	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	2500 E Colorado Blvd, STE 301 Pasadena, CA 91107-6616	194700054	N/A	N/A	
AccentCare of California, Inc.	Personal Care Services	1470 Civic Court, STE 300 Concord, CA 94520-5290	074700019	N/A	N/A	
AccentCare of Massachusetts, Inc.	Home Health	30 Perwal Street, Westwood, MA 02090	N/A	22-7203	CHAP	12/31/2018
AccentCare of Massachusetts, Inc.	Home Health	30 Perwal Street, Westwood, MA 02090	04307	22-7203	CHAP	12/31/2018
AccentCare of Massachusetts, Inc.	Hospice	30 Perwal Street, Westwood, MA 02090	7218	22-1518	CHAP	12/31/2018
AccentCare of Massachusetts, Inc.	Hospice	30 Perwal Street, Westwood, MA 02090	04306	22-1518	CHAP	12/31/2018
AccentCare of New York, Inc.	Personal Care Services	27 Main Street Yonkers, NY 10701	N/A	N/A	N/A	
AccentCare of Washington, Inc.	Personal Care Services	7100 Fort Dent Way, STE 275 Tukwila, WA 98188-7501	000111	N/A	N/A	
AccentCare UCLA Health, LLC	Home Health	9221 Corbin Ave, STE160 Northridge, CA 91324-1659	980000746	05-7761	CHAP	
Alliance for Health, Inc.	Personal Care Services	105 Court Street, 2nd Floor Brooklyn, NY 11201	1170L001	N/A	N/A	
Aloha Home Care LLC	Home Health	548 NW University Blvd Suite 101, Port St Lucie, FL 34986	299992038	10-8134	CHAP	4/15/2019
Doctors Choice Jacksonville LLC	Home Health	1542 Kingsley Ave. Ste 131/132 Orange Park, FL 32073	299991611	10-7725	CHAP	
Gareda, LLC	Personal Care Services	1431 Huntington Dr., Calumet City, IL 60409	3002048	N/A	N/A	12/21/2020
Guardian Home Care of Central Georgia, LLC	Home Health	1551 Jennings Mill Road, Bulding 2500 Watkinsville, GA 30677-7274	029-279-H	11-7145	CHAP	
Guardian Home Care of Nashville, LLC	Home Health	741 Cool Springs Blvd., Suite 110 Franklin, TN 37067-2697	0000000607	44-7566	CHAP	
Guardian Home Care of Northeast Georgia, LLC	Home Health	5089 Bristol Industrial Way, Suite B Buford, GA 30518-1780	069-274-H	11-7139	CHAP	
Guardian Home Care, LLC	Home Health	11660 Alphareta Hwy, Suite 440 Roswell, GA 30076-3880	060-264	11-7131	CHAP	
Guardian Home Care, LLC	Home Health	6116 Shallowford Road, Suite 114 Chattanooga, TN 37421-7202	0000000115	44-7559	CHAP	
Guardian Hospice of Nashville, LLC	Hospice	741 Cool Springs Blvd., Suite 102 Franklin, TN 37067-2697	0000000603	44-1591	CHAP	
Guardian Personal Care Services, LLC	Personal Care Services	441 Donelson Pike, Suite 430, Nashville, TN 37214	Pending	N/A	N/A	
Halifax Health Services, LLC	Home Health	1200 West Granada Blvd, Ste 4 Ormond Beach, FL 32174	299992196	10-8284	CHAP	
Health Resource Solutions, Inc.	Home Health	1806 S. Highland Avenue, Suite 225, Lombard, IL 60148-3948	1010385	14-7811	CHAP	12/21/2020
HRS Home Health of Indiana, LLC	Home Health	11037 Broadway, Suite C, Crown Point, IN 46307	IN008882	15-7436	CHAP	12/21/2020
HRS Home Health of Michigan, LLC	Home Health	515 E. 11 Mile Rd, Madison Heights, MI 48071	N/A	Pending	Pending	12/21/2020
HRS of Nebraska, Inc.	Home Health	900 S. 74th Plaza, Suite 111, Omaha, NE 68114	HHA201607	28-7151	CHAP	12/21/2020
KindStar, Inc.	Home Health	1801 W. 21st St, Clovis, NM 88101	003331	32-7210	Pending	
KindStar, Inc.	Home Health	2728 Williams Ave. Bld K101 #U/V, Woodward, OK 73801	007836	37-7711	CHAP	
KindStar, Inc.	Home Health	3800 E. 42nd ST. #203 (PMB), Odessa, TX 79762	012084	45-9246	N/A	
KindStar, Inc.	Home Health	5201 Indiana Ave 200 Central, Lubbock, TX 79413	009402	67-9485	CHAP	
KindStar, Inc.	Home Health	1111 N. Interstate 35, #204, Round Rock, TX 78664	009343	45-7821	CHAP	
KindStar, Inc.	Home Health	1934 Medi Park Dr., Amarillo, TX 79106	008662	45-7754	CHAP	
KindStar, Inc.	Hospice	5201 Indiana Ave 101 South, Lubbock, TX 79413	012120	45-1774	CHAP	
KindStar, Inc.	Hospice	225 W. Mulberry #102 Rm HOS, Denton, TX 76201	011196	67-1528	CHAP	
KindStar, Inc.	Hospice	101 W. Goodwin Ace #925, Victoria, TX 77901	009272	45-1779	CHAP	
KindStar, Inc.	Pediatric Therapy	5201 Indiana Ave 200 Central, APT, Lubbock, TX 79413	N/A	N/A	N/A	

New Directions Primary Care, LLC	Clinic Practice	1501 GRUNDY LN, STE 100, BRISTOL, PA 19007-1506	N/A	63-1475	N/A	6/15/2021
Nurses Unlimited, Inc.	Home Health	3800 E. 42nd, Suite 203 Odessa, TX 79762	001383	45-7528	CHAP	
Nurses Unlimited, Inc.	Personal Assistance Services	1020 Suite B Andrews Hwy Midland, TX 79701	016556	N/A	N/A	
Nurses Unlimited, Inc.	Personal Assistance Services	8140 N. Mopac Expwy., Suite 150 Bldg. 1 Austin, TX 78759-8837	016942	N/A	N/A	
Nurses Unlimited, Inc.	Personal Assistance Services	1205 N. State Highway 123, Suite 302 San Marcos, TX 78666	016504	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	2625 NE Loop 286 Paris, TX 75460	020688	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	1200 Golden Key Circle, Suite 435, El Paso, TX 79925	020509	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	3002 50th Street Lubbock, TX 79413	020365	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	3303 N. 3rd St., Suite A Abilene, TX 79603	020358	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	600 S. Tyler Street, Suite 804 Amarillo, TX 79109	020357	N/A	N/A	
Nurses Unlimited, Inc.	Personal Care Services	3800 E. 42nd, Suite 228 Odessa, TX 79762	003467	N/A	N/A	
Oahu, Home Care LLC	Home Health	2401 W. Eau Galle Blvd #6, Melbourne, FL 32935	299991835	10-8218	CHAP	4/15/2019
SE Health Care at Home, LLC	Home Health	4641 POTTSVILLE PIKE, STE 106, READING, PA 19605-9707	N/A	398114	N/A	
Seasons Hospice & Palliative Care of Arizona, LLC	Hospice	1144 E Jefferson Street, Phoenix, AZ 85034	HSPC10582	03-1603	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Broward Florida, LLC	Hospice	1815 Griffin Rd, Ste 204, Dania Beach, FL 33004	50370977	10-1555	N/A	12/21/2020
Seasons Hospice & Palliative Care of California -Oakland, LLC	Hospice	7677 Oakport Street, Suite 500, Oakland, CA 94621-1931	550004462	A0-1539	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of California -Orange, LLC	Hospice	750 The City Dr South, Ste 120, Orange, CA 92868	80001673	05-1603	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of California -Sacramento, LLC	Hospice	2295 Gateway Oaks Dr, Ste 165, Sacramento, CA 95833	# 550003943	92-1743	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of California -San Bernardino, LLC	Hospice	8686 Haven Ave, Ste 300, Rancho Cucamonga, CA 91730	# 550001512	55-1621	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of California -San Diego, LLC	Hospice	16745 West Bernardo Dr, Ste 240, San Diego, CA 92127	# 550000796	55-1550	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of California, LLC	Hospice	320 W Arden Ave, Ste 100, Glendale, CA 91203	980001546	05-1790	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Colorado, LLC	Hospice	9191 Sheridan Blvd, Ste 103, Westminster, CO 80031	17R289	06-1593	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Connecticut, LLC	Hospice	1579 Straits Turnpike, Ste 1E, Middlebury, CT 06762	# 9915725	07-1539	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Delaware, LLC	Hospice	220 Continental Dr, Ste 407, Newark, DE 19713	HSPC-010C	08-1508	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Georgia, LLC	Hospice	5775 Peachtree Dunwoody Rd NE, Ste C120, Atlanta, GA 30342	060-0244-H	11-1640	N/A	12/21/2020
Seasons Hospice & Palliative Care of Indiana, LLC	Hospice	2629 Waterfront Pkwy East Dr, Ste 375, Indianapolis, IN 46214	20-011779-1	15-1603	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Maryland, LLC	Hospice	5457 Twin Knolls Rd, Ste 100, Columbia, MD 21045	H1507	21-1507A	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Massachusetts, LLC	Hospice	1 Edgewater Dr., Suite 103 Norwood, MA 02062	7T5G	22-1578	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Michigan, LLC	Hospice	27355 John R Rd, Suite 100, Madison Heights, MI 48071	1041000088	23-1601	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Missouri, LLC	Hospice	3660 South Geyer Rd, Ste 120, St. Louis, MO 63127	200-8HO	26-1641	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Nevada, LLC	Hospice	9205 W Russell Rd, Ste 305, Las Vegas, NV 89148	7521-HPC-9	29-1539	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of New Jersey, LLC	Hospice	Edison, NJ 08817	24819	31-1577	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Northern California, LLC	Hospice	400 Race St, Ste 101, San Jose, CA 95126	# 550002261	55-1750	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Oregon, LLC	Hospice	6500 S Macadam Ave, Ste 160, Portland, OR 97239	16-1063	38-1561	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Pasco County, LLC	Hospice	2644 Cypress Ridge Blvd., Suite 104, Wesley Chapel, FL 33544	50370984	10-1561	N/A	12/21/2020
Seasons Hospice & Palliative Care of Pennsylvania, LLC	Hospice	2200 Renaissance Blvd, Ste 110, King of Prussia, PA 19406	17091601	39-1709	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Pinellas County, LLC	Hospice	17757 US HWY 19 North, Ste 175, Clearwater, FL 33764	50370982	10-1559	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Southern Florida, LLC	Hospice	5200 Northeast Second Ave, 3rd Flr Stein Bldg, Miami, FL 33137	50370965	10-1543	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Tampa, LLC	Hospice	1408 N Westshore Blvd, Ste 260, Tampa, FL 33607	# 50370980	10-1557	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Texas -Houston, LLC	Hospice	10318 Lake Rd, Bldg C Ste 102, Houston, TX 77070	14939	67-1741	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Texas -San Antonio, LLC	Hospice	300 E Sonterra Blvd, Bldg 1 Ste 1260, San Antonio, TX 78258	14478	67-1721	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Texas, LLC	Hospice	6341 Campus Circle Dr E, Ste 150, Irving, TX 75063	11037	67-1578	The Joint Commission	12/21/2020
Seasons Hospice & Palliative Care of Wisconsin, LLC	Hospice	6737 W Washington St, Ste 2150, West Allis, WI 53214	2008	52-1571	The Joint Commission	12/21/2020
Seasons Hospice, LLC	Hospice	606 Potter Road, 6th Floor, Des Plaines, IL 60016	2002012	14-1582	The Joint Commission	12/21/2020
Southeastern Health Services of Pennsylvania, LLC	Home Health	1501 GRUNDY LN, STE 100, BRISTOL, PA 19007-1506	747205	397472; HIT 1K9912, 1K9935, 1K9937, 1K9942, 1K9945, 1K9950, 1K9953	N/A	6/15/2021
Southeastern Home Health Care, LLC	Home Health	7502 Lee Davis Road, Mechanicsville, VA 23111	N/A	49-7508A	N/A	6/15/2021
Southeastern Home Health Services	Home Health	282 MAYTOWN RD, STE 200, ELIZABETHTOWN, PA 17022-9302	02960501	398062; HIT 1O1718	The Joint Commission	6/15/2021
Southeastern Hospice Services, LLC	Hospice	1501 GRUNDY LN, STE 100, BRISTOL, PA 19007-1506	17851601	391785	The Joint Commission	6/15/2021
Sta-Home Health Agency of Carthage, Inc.	Home Health	616 Hwy 35 S Carthage, MS 39051-5802	10985	25-7129	CHAP	
Sta-Home Health Agency of Greenwood, Inc.	Home Health	205 Walthall St. Greenwood, MS 38930	11095	25-7131	CHAP	
Sta-Home Health Agency of Jackson, Inc.	Home Health	130 Fairmont St., STE A Clinton, MS 39056-4714	11195	25-7102	CHAP	
Sta-Home Hospice of Mississippi, Inc.	Hospice	3500 Lakeland Dr, STE 515 Flowood, MS 39232-3017	023	25-1511	CHAP	
Texas Home Health Group of College Station, LLC	Home Health	1605 Rock Prairie Road, Suite 206 College Station, TX 77845-8358	018330	67-9189	CHAP	
Texas Home Health Group of Denton, LLC	Home Health	225 W. Mulberry #101, Denton, TX 76201	19300	67-9325	CHAP	12/31/2018
Texas Home Health Group of DeSoto, LLC	Home Health	911 York Dr. #203 DeSoto, TX 75115-2064	019958	Pending	CHAP	8/31/2019
Texas Home Health Group of Fort Worth, LLC	Home Health	3880 Hulen Street, Suite 200A, Fort Worth, TX 76107	018324	74-7526	CHAP	
Texas Home Health Group of Marble Falls, LLC	Home Health	1100 Mission Hills Drive, Suite 100 Marble Falls, TX 78654	018353	67-9520	CHAP	
Texas Home Health Group of McKinney, LLC	Home Health	6800 Weiskopf Ave., Suite 110 McKinney, TX 75070-5241	018485	67-9236	CHAP	
Texas Home Health Group of Taylor, LLC	Home Health	567 Chris Kelley Blvd. Suite 201 Hutto, TX 78634-2086	018337	67-7035	CHAP	
Texas Home Health Group of Temple, LLC	Home Health	3809 South General Bruce Drive, Suite 105B Temple, TX 76502	018252	45-7443	CHAP	
Texas Home Health Group of Waco, LLC	Home Health	8300 Central Park Dr. Suite A Waco, TX 76712-6667	018352	67-9200	CHAP	
Texas Home Health Hospice - Austin, LLC	Hospice	3520 Executive Center Drive, Suite 320 Austin, TX 78731-1625	017838	67-1554	CHAP	
Texas Home Health Hospice, LP	Hospice	6800 Weiskopf Ave, Suite 105 McKinney, TX 75070-1639	018363	74-1652	CHAP	
Texas Home Health Hospice, LP	Hospice	1605 Rock Prairie Road, Suite 206 College Station, TX 77845	016579	74-1588	CHAP	
Texas Home Health Hospice, LP	Hospice	5685 Eastex Freeway Beaumont, TX 77706-6923	010904	67-1560	CHAP	
Texas Home Health Hospice, LP	Hospice	8876 Gulf Freeway, Suite 350 Houston, TX 77017-6513	010899	67-1559	CHAP	
Texas Home Health Hospice, LP	Hospice	2904 N. Fourth Street, Suite 102 Longview, TX 75605-5124	010521	67-1545	CHAP	
Texas Home Health Hospice, LP	Hospice	8300 Central Park Dr. Suite A Waco, TX 76712-6667	010507	67-1552	CHAP	
Texas Home Health of America, LP	Personal Assistance Services	3303 N. 3rd Street, Suite A, Abilene, TX 79603	Pending	N/A	N/A	
Texas Home Health of America, LP	Personal Assistance Services	3880 Hulen Street, Suite 200C, Fort Worth, TX 76107	020687	N/A	N/A	
Texas Home Health of America, LP	Personal Assistance Services	1200 Golden Key Circle, Suite 435, El Paso, TX 79925	020361	N/A	N/A	

Texas Home Health of America, LP	Personal Assistance Services	12808 W. Airport Blvd. Suite 335 Sugar Land, TX 77478-6197	020221	N/A	N/A	
Texas Home Health of America, LP	Personal Assistance Services	3939 Beltline Road, Suite 120 Addison, TX 75001-4323	020160	N/A	N/A	
Texas Home Health of America, LP	Personal Assistance Services	4202 Sherwood Way, Suite A San Angelo, TX 76904	019893	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	1615 Osprey Drive, Suite 101 DeSoto, TX 75115-2427	018685	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	101 W. Goodwin Ave. Suite 360 Victoria, TX 77901	016780	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	3880 Hulen Street, Suite 200B, Fort Worth, TX 76107	014325	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	5695 Eastex Freeway Beaumont, TX 77706-6923	007608	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	8876 Gulf Freeway, Suite 410 Houston, TX 77017	007607	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	4242 Woodcock Drive, Suite 220 San Antonio, TX 78228-1325	007592	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	5151 Flynn Parkway, Suite 510 Corpus Christi, TX 78411-4372	007591	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	8300 Central Park Drive, Suite A Waco, TX 76712-6667	007587	N/A	N/A	
Texas Home Health of America, LP	Personal Care Services	2221 H.G. Mosley Pkwy, Suite 101 Longview, TX 75604	007586	N/A	N/A	
Texas Home Health Skilled Services, LP	Home Health	2512 S. IH-35, Suite 320 Austin, TX 78704-5758	018406	74-7786	CHAP	
Texas Home Health Skilled Services, LP	Home Health	1809 Judson Road Longview, TX 75605-4710	018168	45-7173	N/A	
Texas Home Health Skilled Services, LP	Home Health	101 W. Goodwin Ave, Suite 370 Victoria, TX 77901-6502	008990	67-3133	CHAP	
Texas Home Health Skilled Services, LP	Home Health	5687 Eastex Freeway Beaumont, TX 77706-6923	008922	67-3115	CHAP	
Texas Home Health Skilled Services, LP	Home Health	400 Belcher, Suite 6 Cleveland, TX 77327-3654	008904	67-3151	CHAP	
Texas Home Health Skilled Services, LP	Home Health	10358 US 59 Hwy, Suite B Wharton, TX 77488-0709	008158	67-9233	CHAP	
Texas Home Health Skilled Services, LP	Home Health	4801 NW Loop 410, Suite 115 San Antonio, TX 78229-5342	007949	67-9174	CHAP	
Texas Home Health Skilled Services, LP	Home Health	12808 W. Airport Blvd. Suite 350 Sugar Land, TX 77478-6187	007751	67-9102	CHAP	
Texas Home Health Skilled Services, LP	Home Health	4920-F Seawall Blvd. Galveston, TX 77551-6011	007750	67-9104	CHAP	
Texas Home Health Skilled Services, LP	Home Health	4619 North Street Nacogdoches, TX 75965-1816	007744	67-9108	CHAP	
Texas Home Health Skilled Services, LP	Home Health	3520 Executive Center Drive, Suite G100 Austin, TX 78731-1625	007742	67-9120	CHAP	
Texas Home Health Skilled Services, LP	Home Health	1809 Judson Road Longview, TX 75605-4710	007741	67-9090	CHAP	

EXHIBIT 4

Lease Documents

River View Corporate Center
Spokane Valley, Washington

OFFICE LEASE

Landlord:

BH PROPERTIES I LLC, BLOCH BOYER LLC and ZIA SPOKANE LLC

Tenant:

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC

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OFFICE LEASE

THIS OFFICE LEASE (the "**Lease**") is made and entered into as December 30, 2021, by and between **BLOCH RIVER VIEW LLC**, a Washington limited liability company, as Asset Manager on behalf of **BH PROPERTIES I LLC**, a Washington limited liability company, **BLOCH BOYER LLC**, a Washington limited liability company, and **ZIA SPOKANE LLC**, a Washington limited liability company (collectively, "**Landlord**"), and **ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC**, a Washington limited liability company ("**Tenant**").

1. Basic Lease Information.

1.01 "**Building**" shall mean the building located at 16201 E. Indiana Avenue, Spokane Valley, Washington 99216, commonly known as River View Corporate Center.

1.02 "**Premises**" shall mean the area shown on **Exhibit A** to this Lease. The Premises is located on the third floor of the Building and known as Suite 3200 ("**Suite 3200**") and Suite 3180 ("**Suite 3180**"). The "Premises" shall initially only contain Suite 3200 and Suite 3180 shall be added to the "Premises" upon the earlier of (i) the date Landlord delivers possession of Suite 3180 to Tenant, and (ii) January 1, 2023 ("**Suite 3180 Commencement Date**"). The "**Rentable Square Footage of the Premises**" is deemed to initially be 866 square feet (which is solely attributable to Suite 3200), and shall be deemed to contain 3,854 square feet effective as of the Suite 3180 Commencement Date (with the additional 2,988 square feet being attributable to Suite 3180). Landlord and Tenant stipulate and agree that the Rentable Square Footage of the Premises is correct. Tenant shall have a single suite address of Suite 3200 during the Term.

1.03 "**Monthly Rent**":

Period	Monthly Rent	Annual Rate/RSF
1/1/2022 – 12/31/2022	$3,000.00	
1/1/2023 – 12/31/2023	$8,029.16	$25.00
1/1/2024 – 12/31/2024	$8,270.03	$25.75
1/1/2025 – 12/31/2025	$8,518.13	$26.52
1/1/2026 – 12/31/2026	$8,773.67	$27.32
1/1/2027 – 12/31/2027	$9,036.88	$28.14

Upon execution and delivery of this Lease, Tenant shall pay to Landlord, as prepaid Monthly Rent, the amount of $3,000.00, which shall be applied against Monthly Rent for January 2022.

1.04 "**Term**": The Term shall commence on January 1, 2022 ("**Commencement Date**") and, unless terminated early in accordance with this Lease, end on the last day of the seventy-second (72nd) full calendar month following the Commencement Date (the "**Termination Date**"); provided, however Tenant shall have the option to extend the Term for one (1) additional 5-year period pursuant to the terms and conditions set forth in **Exhibit F**.

1.05 "**Security Deposit**": $3,000.00, as more fully described in Section 6.

1.06 "**Guarantor(s)**": None.

1.07 "**Broker(s)**": Ira Perlman of Ira Perlman and Associates, LLC ("**Tenant's Broker**") and Jack Marr of Jack Marr Properties ("**Landlord's Broker**").

1.08 "**Permitted Use**": General office purposes.

1.09 "**Notice Address(es)**":

Landlord:	Tenant:
c/o Bloch River View LLC 1200 112th Avenue NE, Suite A-101 Bellevue, WA 98004 Attention: Darren Bloch	Prior to the Commencement Date: Legal Department AccentCare, Inc. 17855 North Dallas Parkway Dallas, TX 75287
with a copy to:	From and after the Commencement Date:
Fikso Kretschmer Smith Dixon Ormseth PS 901 Fifth Avenue, Suite 4000 Seattle, WA 98164 Attention: Leif Ormseth	Legal Department AccentCare, Inc. 17855 North Dallas Parkway Dallas, TX 75287

1.10 "**Business Day(s)**" are Monday through Friday of each week, exclusive of New Year's Day, Martin Luther King, Jr. Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the Friday following Thanksgiving Day and Christmas Day ("**Holidays**"). Landlord may designate additional Holidays that are commonly recognized by other office buildings in the area where the Building is located. "**Building Service Hours**" are 6:00 A.M. to 6:00 P.M. on Business Days.

1.11 "**Property**" means the Building and the parcel(s) of land on which it is located and, at Landlord's discretion, the parking facilities and other improvements, if any, serving the Building and the parcel(s) of land on which they are located.

1.12 Riders/Exhibits:

Exhibit A – Outline and Location of Premises
Exhibit B – Legal Description of Property
Exhibit C – Work Letter
Exhibit D – Suite 3180 Commencement Letter
Exhibit E – Building Rules and Regulations
Exhibit F – Extension Term

2. Lease Grant.

The Premises are hereby leased to Tenant from Landlord, together with the right to use any portions of the Property that are designated by Landlord for the common use of tenants and others (the "**Common Areas**"), which Commons Areas may include without limitation the Building's common entrances, lobbies, restrooms, elevators, stairway and accessways, loading docks, ramps, drives and platforms and any passageways and serviceways thereto, and mechanical and electrical systems for the Building, including without limitation, plumbing, sewage, electrical systems, pipes conduits, and wires, and appurtenant equipment of the Building, all to the extent serving the Premises.

3. Possession; Early Termination.

3.01 Possession. Notwithstanding the date Landlord completes the Landlord Work (defined on **Exhibit C**), the Term will commence on the Commencement Date. Notwithstanding that the Term has commenced and Tenant is paying Monthly Rent, Tenant shall not be tendered possession of Suite 3200 until Landlord completes the Landlord Work. Landlord shall endeavor to deliver possession of Suite 3200 to Tenant with the Landlord Work Substantially Complete by April 1, 2022 ("**Target Landlord Work Completion Date**") and shall endeavor to deliver possession of Suite 3180 to Tenant by January 1, 2023 ("**Suite 3180 Target Commencement Date**"). Landlord's failure to deliver possession of Suite 3200 to Tenant by the Target Landlord Work Completion Date or failure to deliver Suite 3180 by the Suite 3180 Target Commencement Date shall not be a default by Landlord or otherwise render Landlord liable for

damages. Subject to Landlord's completion of the Landlord Work in Suite 3200, the entire Premises are accepted by Tenant in there "as is" condition and configuration without any representations or warranties by Landlord. By taking possession of the Premises, Tenant agrees that the Premises are in good order and satisfactory condition and delivered in accordance with the obligations of this Lease. Promptly after the determination of the Suite 3180 Commencement Date, Landlord and Tenant shall enter into a commencement letter agreement in the form attached as **Exhibit D** at the request of either party. Tenant's failure to execute and return such commencement letter, or to provide written objection to the statements contained in such letter, within 30 days after the date of such letter shall be deemed an approval by Tenant of the statements contained therein.

3.02 Tenant's Early Termination Right (Entire Lease). Tenant shall have the one-time right to terminate and cancel this Lease in its entirety (i.e., with respect to both Suite 3200 and 3180) effective as of December 31, 2022 ("**Early Termination Date**"), provided that (i) Landlord receives written notice ("**Early Termination Notice**") from Tenant on or before October 1, 2022 stating that Tenant is electing to terminate this Lease pursuant to the terms and conditions of this Section 3.02, and (ii) concurrently with Tenant's delivery of the Early Termination Notice, Tenant pays to Landlord $18,041.65 ("**Early Termination Fee**"), as consideration for and as a condition precedent to such early termination. It is hereby acknowledged and agreed that the Early Termination Fee required to be paid by Tenant in connection with such early termination is not a penalty but a reasonable pre-estimate of the damages which would be incurred by Landlord as a result of such early termination of this Lease (which damages are impossible to calculate more precisely) and, in that regard, constitutes liquidated damages with respect to such loss. Provided that Tenant terminates this Lease in accordance with the terms and conditions of this Section 3.02, then the Lease shall automatically terminate and be of no further force or effect as of the Early Termination Date, and Landlord and Tenant shall be relieved of their respective obligations under this Lease as of the Early Termination Date, except for those obligations set forth in this Lease which accrued prior to the Early Termination Date, including, without limitation, the payment by Tenant of all amounts owed to Landlord under this Lease up to and including the Early Termination Date. For the avoidance of doubt, if Tenant does not timely deliver an Early Termination Notice in accordance with this Section 3.02, Tenant's termination right under this Section 3.02 shall be deemed null and void and this Lease shall continue in full force and effect. The right to terminate the Lease as provided above is personal to Original Tenant (defined on **Exhibit F**), and no assignee, sublessee or successor of Original Tenant, other than an assignee of Tenant's entire leasehold estate pursuant to a Permitted Transfer, shall be entitled to exercise such right.

3.03 Tenant's Early Termination Right (Suite 3180 Only). Tenant shall have the right to terminate and cancel this Lease with respect to Suite 3180 only effective at any time between January 1, 2023 through December 31, 2024 ("**Early Termination Date**"), provided that (i) Landlord receives written notice ("**Early Termination Notice**") from Tenant on or before the date that is thirty (30) days' prior to the Early Termination Date identified in Tenant's Early Termination Notice stating that Tenant is electing to terminate this Lease with respect to Suite 3180 only pursuant to the terms and conditions of this Section 3.03, and (ii) within five (5) business days after Tenant's receipt of the Early Termination Payment Notice (defined below) from Landlord, Tenant pays to Landlord an amount equal to the sum of (a) three (3) months' worth of Monthly Rent attributable to Suite 3180 for the three (3) month period following the Early Termination Date, and (b) the unamortized portions of (1) the Suite 3180 Cost Cap (defined on **Exhibit C**), and (2) all leasing commissions paid by Landlord in connection with Suite 3180 (with items (1) and (2) being amortized in each case with substantially equal payments over the period commencing on the Suite 3180 Commencement Date and continuing through the end of the initial Term (collectively, the "**Early Termination Fee**"), as consideration for and as a condition precedent to such early termination. Landlord shall deliver to Tenant written notice ("**Early Termination Payment Notice**") of the amount of the Early Termination Fee promptly after Landlord's receipt of the Early Termination Notice from Tenant. Any delay in sending the Early Termination Payment Notice will not affect Landlord's right to receive the Early Termination Fee. It is hereby acknowledged and agreed that the Early Termination Fee required to be paid by Tenant in connection with such early termination is not a penalty but a reasonable pre-estimate of the damages which would be incurred by Landlord as a result of such early termination of this Lease with respect to Suite 3180 (which damages are impossible to calculate more precisely) and, in that regard, constitutes liquidated damages with respect to such loss. Provided that Tenant terminates this Lease with respect to Suite 3180 only in accordance with the terms and conditions of this Section 3.03, then the Lease with respect to Suite 3180 only shall automatically

terminate and be of no further force or effect as of the Early Termination Date, and Landlord and Tenant shall be relieved of their respective obligations under this Lease with respect to Suite 3180 only as of the Early Termination Date, except for those obligations set forth in this Lease which accrued prior to the Early Termination Date, including, without limitation, the payment by Tenant of all amounts owed to Landlord under this Lease with respect to Suite 3180 up to and including the Early Termination Date. For the avoidance of doubt, if Tenant does not timely deliver an Early Termination Notice in accordance with this Section 3.03, Tenant's termination right under this Section 3.03 shall be deemed null and void and this Lease shall continue in full force and effect. The right to terminate the Lease as provided above is personal to Original Tenant, and no assignee, sublessee or successor of Original Tenant, other than an assignee of Tenant's entire leasehold estate pursuant to a Permitted Transfer, shall be entitled to exercise such right. For the sake of clarity, if Tenant exercises its rights under this Section 3.03, effective as of the date immediately following the Early Termination Date, the "Premises" shall deemed to only contain Suite 3200, and Monthly Rent shall be adjusted by Landlord for the remainder of the Term with reference to the 866 rentable square feet of Suite 3200 and the Annual Rate/RSF reflected in Section 1.03.

4. Rent.

4.01 Rent. Beginning on the Commencement Date and throughout the Term, Tenant shall pay to Landlord the Monthly Rent specified in Section 1.03 and any Additional Rent (defined hereinafter) as set forth elsewhere in this Lease (the Monthly Rent and the Additional Rent are collectively referred to as "**Rent**"). "**Additional Rent**" means all sums (exclusive of Monthly Rent) that Tenant is or becomes obligated to pay Landlord under this Lease or other agreement entered in connection herewith. Monthly Rent shall be paid in advance, on or before the first day of each calendar month of the Term. All other items of Rent shall be due and payable by Tenant on or before 30 days after billing by Landlord. Rent for any period during the Term that is for less than one month shall be prorated for the actual number of days in such period. Tenant's covenant to pay Rent is independent of every other covenant in this Lease.

4.02 Manner of Payment. Rent shall be paid without prior notice, demand, set off, counterclaim, deduction or defense and, except as otherwise expressly provided in this Lease, without abatement or suspension. All Rent shall be paid to Landlord at the address for notices set forth in Section 1.9, in lawful money of the United States of America, or to such other person or at such other place as Landlord may from time to time designate in writing.

4.03 General Payment Matters. All remedies applicable to the non payment of Rent shall be applicable thereto. In addition to all other Landlord remedies, (i) any Rent not paid by Tenant when due shall accrue interest from the due date at 12% per annum until payment is received by Landlord, and (ii) in addition to such interest, Tenant shall pay Landlord an administration fee equal to $250.00 or 5% of all past due Rent, whichever is greater, if any portion of Rent is not received within 5 Business Days after the due date; provided that Tenant shall be entitled to a grace period of 5 days for the first 2 late payments of Rent in a calendar year. Landlord's acceptance of less than the correct amount of Rent shall be considered a payment on account of the earliest Rent due. No delay by Landlord in providing any Rent statement to Tenant shall be deemed a default by Landlord or a waiver of Landlord's right to require payment of Tenant's obligations hereunder.

4.04 No Abatement of Rent. Except as specifically provided herein, there shall be no abatement of Rent in any circumstance under this Lease.

4.05 Personal Property Taxes. Tenant shall pay prior to delinquency all personal property taxes payable with respect to all personal property of Tenant located on the Premises or the Building and promptly upon request of Landlord shall provide satisfactory evidence of such payment. "**Personal property taxes**" under this Section 4.05 shall include all property taxes assessed against the property of Tenant, whether assessed as real or personal property.

4.06 Additional Taxes. All Rent due Landlord under this Lease is exclusive of any sales, business and occupational gross receipts or tax based on rents or tax upon this Lease or tax measured by the number of employees of Tenant or the area of the Premises or any similar tax or charge. If any such

tax or charge be hereafter enacted, Tenant shall, as Additional Rent, reimburse Landlord the amount thereof. If it is not lawful for Tenant to reimburse Landlord for the same, the Monthly Rent payable to Landlord under this Lease shall be increased to net Landlord the same net rental after imposition of any such tax or charge upon Landlord as would have been payable to Landlord prior to the imposition of such tax or charge. Tenant shall not be liable to reimburse Landlord any federal income tax or other income tax of a general nature applicable to Landlord's income.

5. Use; Compliance with Laws and Rules and Regulations; Governing Property Documents.

5.01 Use. The Premises shall be used for the Permitted Use and for no other use whatsoever without the prior written consent of Landlord.

5.02 Compliance with Laws and Rules and Regulations. During the Term, Tenant shall at all times:

a. Comply with all statutes, codes, ordinances, orders, rules and regulations of any municipal or governmental entity whether in effect now or later, including the Americans with Disabilities Act ("**Laws**"), regarding the operation of Tenant's business and the use, condition, configuration and occupancy of the Premises. Tenant shall promptly provide Landlord with copies of any notices it receives regarding an alleged violation of Law.

b. At its sole cost and expense, promptly comply with any Laws that relate to the "Base Building" (defined below), but only to the extent such obligations are triggered by Tenant's use of the Premises, other than for general office use, or Alterations or improvements in the Premises performed or requested by Tenant. "**Base Building**" shall include the structural portions of the Building, the public restrooms and the Building mechanical, electrical and plumbing systems and equipment located in the internal core of the Building on the floor or floors on which the Premises are located.

c. Faithfully observe and comply with such other reasonable rules and regulations that Landlord shall from time to time promulgate, including without limitation rules and regulations for the performance of Alterations (defined in Section 9) and the rules and regulations of the Building attached as **Exhibit E**.

5.03 Governing Property Documents. The Property is subject to and governed by that certain Declaration of Covenants, Conditions, Restrictions and Reservations of Easements for Hanson Center East, as amended, recorded under Spokane County Recording Nos. 4582480, 5949961 and 5963318 (collectively, "**Governing Property Documents**"). Tenant's use of the Premises, Property and common areas, and rights and interest in this Lease, all are subject to the Governing Property Documents, and Tenant shall be responsible for complying with those requirements in the Governing Property Documents applicable to Tenant's use of the Premises. Additions and modifications to Governing Property Documents shall be binding on Tenant upon delivery of a copy of them to Tenant.

6. Security Deposit.

The Security Deposit shall be delivered to Landlord upon the execution of this Lease by Tenant and held by Landlord as security for the performance of Tenant's obligations. No interest accrued on the Security Deposit shall be credited to Tenant. The Security Deposit is not an advance payment of Rent or a measure of damages. Landlord may use all or a portion of the Security Deposit to satisfy past due Rent, to cure any Default (defined in Section 18) by Tenant, or to satisfy any other loss or damage resulting from Tenant's Default as provided in Section 19. If Landlord uses any portion of the Security Deposit, Tenant shall, within 5 days after demand, restore the Security Deposit to its original amount. Landlord shall return any unapplied portion of the Security Deposit to Tenant within 45 days after the later to occur of the Termination Date or the date Tenant surrenders the Premises to Landlord in compliance with Section 25. Landlord may assign the Security Deposit to a successor or transferee and, following the assignment, Landlord shall have no further liability for the return of the Security Deposit. Landlord shall not be required to keep the Security Deposit separate from its other accounts.

7. Utilities and Services.

7.01 Standard Landlord Utilities and Services. Provided Tenant is not in default of this Lease, Landlord shall provide Tenant the following utilities and services:

a. Elevator service during Building Service Hours and the service of at least one elevator during all other hours.

b. Heating and cooling to maintain a temperature condition which in Landlord's judgment provides for comfortable occupancy of the Premises under Building Service Hours, provided Tenant complies with Landlord's instructions regarding use of window coverings and thermostats and Tenant does not utilize heat generating machines or equipment which affect the temperature otherwise maintained by the air cooling system. Upon request Landlord shall make available at Tenant's expense after-hours heat or air cooling. The minimum use of after-hours heat or air cooling and the cost thereof shall be determined by Landlord and confirmed in writing to Tenant, as the same may change from time to time.

c. Water for drinking, lavatory, and toilet purposes.

d. Toilet room supplies.

e. Electricity for Building-standard overhead office lighting fixtures, and equipment and accessories customary for offices (up to 280 hours per month), where: (a) the connected electrical load of all of the same does not exceed an average of 4 watts per usable square foot of the Premises (or such lesser amount as may be available, based on the safe and lawful capacity of the electrical circuit(s) and facilities serving the Premises), (b) the electricity is at nominal 120 volts, single phase (or 110 volts, depending on available service in the Building), and (c) the systems and equipment are suitable, the safe and lawful capacity thereof is not exceeded, and sufficient capacity remains at all times for other existing and future tenants, as determined in Landlord's reasonable discretion.

f. Janitorial service for the Premises 5 times per week, except on Holidays, and for the Building as customary for comparable buildings within the market, which includes vacuum cleaning of carpets and cleaning of Building standard vinyl composition tile, but no other services with respect to carpets or non-standard floor coverings.

g. Maintenance of windows, doors, floors and walls (exclusive of coverings), ceilings, plumbing and plumbing fixtures, and electrical distribution system and lighting fixtures in good condition and repair, except for damage caused by Tenant, its employees, agents, invitees or visitors, except that such service will not be provided as to any of the foregoing items that are not standard for the Building.

h. Lighting replacement (bulbs, tubes and ballasts) for Landlord furnished lighting fixtures which are standard for the Building. Burned out lamps or other light sources in fixtures which are not standard for the Building will be replaced by Landlord at Tenant's expense.

i. Such other services as Landlord reasonably determines are necessary or appropriate for the Property.

7.02 Non-Standard Usage. Landlord may impose a reasonable charge for utilities and services, including without limitation, air cooling, electric current and water, required to be provided to the Premises by reason of (a) any substantial recurrent use of the Premises at any time other than Building Service Hours, (b) any use beyond what Landlord agrees to furnish as described above, (c) electricity used by equipment designated by Landlord as high power usage equipment or (d) the installation, maintenance, repair, replacement or operation of supplementary air cooling equipment, additional electrical systems or other equipment required by reason of special electrical, heating, cooling or ventilating requirements of equipment used by Tenant at the Premises. At Landlord's option, separate meters for such utilities and

services may be installed for the Premises and Tenant upon demand therefor, shall immediately pay Landlord for the installation, maintenance, repair and replacement of such meters.

7.03 Interruptions. Landlord shall use reasonable diligence to remedy an interruption in the furnishing of such services and utilities. If, however, any governmental authority imposes regulations, controls or other restrictions upon Landlord or the Building which would require a change in the services provided by Landlord under this Lease, Landlord may comply with such regulations, controls or other restrictions, including without limitation, curtailment, rationing or restrictions on the use of electricity or any other form of energy serving the Premises. Tenant will cooperate and do such things as are reasonably necessary to enable Landlord to comply with such regulations, controls or other restrictions. Except when caused by Landlord's negligence or misconduct, Landlord's failure to furnish, or any interruption, diminishment or termination of services due to the application of Laws, the failure of any equipment, the performance of repairs, improvements or alterations, utility interruptions or the occurrence of an event of Force Majeure (defined in Section 29.03) (collectively a "**Service Failure**") shall not render Landlord liable to Tenant, constitute a constructive eviction of Tenant, give rise to an abatement of Rent, nor relieve Tenant from the obligation to fulfill any covenant or agreement.

8. Leasehold Improvements.

All improvements in and to the Premises, including without limitation any Alterations (defined in Section 9.03) and Tenant Improvements (defined in **Exhibit C**) (collectively, "**Leasehold Improvements**") shall remain upon the Premises at the end of the Term without compensation to Tenant, provided that Tenant, at its expense, in compliance with the National Electric Code or other applicable Law, shall remove any Cable (defined in Section 9.01 below). In addition, Landlord, by written notice to Tenant at least 30 days prior to the Termination Date, may require Tenant, at its expense, to remove any Landlord Work or Alterations that, in Landlord's reasonable judgment, are of a nature that would require removal and repair costs that are materially in excess of the removal and repair costs associated with standard office improvements (the Cable and such other items collectively are referred to as "**Required Removables**"). The Required Removables shall be removed by Tenant before the Termination Date. Tenant shall repair damage caused by the installation or removal of Required Removables. If Tenant fails to perform its obligations in a timely manner, Landlord may perform such work at Tenant's expense. Tenant, at the time it requests approval for a proposed Alteration, including any Tenant Improvements or Landlord Work, as such terms are defined in **Exhibit C**, may request in writing that Landlord advise Tenant whether the Alteration, including any Tenant Improvements or Landlord Work, or any portion thereof, is a Required Removable. Within 10 days after receipt of Tenant's request, Landlord shall advise Tenant in writing as to which portions of the Alteration or other improvements are Required Removables.

9. Maintenance, Repairs and Alterations.

9.01 Tenant shall periodically inspect the Premises to identify any conditions that are dangerous or in need of maintenance or repair. Tenant shall promptly provide Landlord with notice of any such conditions. Tenant shall, at its sole cost and expense, perform all maintenance and repairs to the Premises that are not Landlord's express responsibility under this Lease, and keep the Premises in good condition and repair, reasonable wear and tear excepted. Tenant's repair and maintenance obligations include without limitation repairs to: (a) floor covering; (b) interior partitions; (c) interior and doors; (d) the interior side of demising walls; (e) electronic, fiber, phone and data cabling and related equipment that is installed by or for the exclusive benefit of Tenant (collectively, "**Cable**"); (f) supplemental air conditioning units, kitchens, including hot water heaters, plumbing, and similar facilities exclusively serving Tenant; and (g) Alterations. Subject to the terms of Section 15 below, to the extent Landlord is not reimbursed by insurance proceeds, Tenant shall reimburse Landlord for the cost of repairing damage to the Building caused by the acts of Tenant, Tenant Related Parties and their respective contractors and vendors. If Tenant fails to make any repairs to the Premises for more than 15 days after notice from Landlord (although notice shall not be required in an emergency), Landlord may make the repairs, and Tenant shall pay the reasonable cost of the repairs, together with an administrative charge in an amount equal to 5% of the cost of the repairs.

9.02 Landlord shall keep and maintain in good repair and working order and perform maintenance upon the: (a) structural elements of the Building; (b) mechanical (including HVAC), electrical, plumbing and fire/life safety systems serving the Building in general; (c) Common Areas; (d) roof of the Building; (e) exterior windows of the Building; and (f) elevators serving the Building. Landlord shall promptly make repairs for which Landlord is responsible.

9.03 Tenant shall not make alterations, repairs, additions or improvements or install any Cable (collectively referred to as "**Alterations**") without first obtaining the written consent of Landlord in each instance, which consent shall not be unreasonably withheld or delayed. However, Landlord's consent shall not be required for any Alteration that satisfies all of the following criteria (a "**Cosmetic Alteration**"): (a) is of a cosmetic nature such as painting, wallpapering, hanging pictures and installing carpeting; (b) is not visible from the exterior of the Premises or Building; (c) will not affect the Base Building; (d) does not require work to be performed inside the walls or above the ceiling of the Premises; and (e) does not cost more than $10,000. Cosmetic Alterations shall be subject to all the other provisions of this Section 9.03. Prior to starting work, Tenant shall furnish Landlord with plans and specifications; names of contractors reasonably acceptable to Landlord (provided that Landlord may designate specific contractors with respect to work affecting the Base Building); required permits and approvals; evidence of contractor's and subcontractor's insurance in amounts reasonably required by Landlord and naming Landlord as an additional insured; and any security for performance in amounts reasonably required by Landlord. Changes to the plans and specifications must also be submitted to Landlord for its approval. Alterations shall be constructed in a good and workmanlike manner using materials of a quality reasonably approved by Landlord. Tenant shall reimburse Landlord for any sums paid by Landlord for third party examination of Tenant's plans for non-Cosmetic Alterations. In addition, Tenant shall pay Landlord a fee for Landlord's oversight and coordination of any non-Cosmetic Alterations equal to 5% of the cost of the non-Cosmetic Alterations. Upon completion, Tenant shall furnish "as-built" plans for non-Cosmetic Alterations, completion affidavits and full and final lien waivers. Landlord's approval of an Alteration shall not be deemed a representation by Landlord that the Alteration complies with Law.

10. Entry by Landlord.

Landlord may enter the Premises to inspect, show or clean the Premises or to perform or facilitate the performance of repairs, alterations or additions to the Premises or any portion of the Building. Except in emergencies or to provide Building services, Landlord shall provide Tenant with reasonable prior oral notice of entry and shall use reasonable efforts to minimize any interference with Tenant's use of the Premises. If reasonably necessary, Landlord may temporarily close all or a portion of the Premises to perform repairs, alterations and additions. However, except in emergencies, Landlord will not close the Premises if the work can reasonably be completed on weekends and after Building Service Hours. Entry by Landlord shall not constitute a constructive eviction or entitle Tenant to an abatement or reduction of Rent provided Tenant is able to use the Premises during normal business hours.

11. Assignment and Subletting.

11.01 Except in connection with a Permitted Transfer (defined in Section 11.04), Tenant shall not assign, sublease, transfer or encumber any interest in this Lease or allow any third party to use any portion of the Premises (collectively or individually, a "**Transfer**") without the prior written consent of Landlord, which consent shall not be unreasonably withheld, conditioned or delayed if Landlord does not exercise its recapture rights under Section 11.02. If the entity(ies) which directly or indirectly controls the voting shares/rights of Tenant changes at any time, such change of ownership or control shall constitute a Transfer unless Tenant is an entity whose outstanding stock is listed on a recognized securities exchange or if at least 80% of its voting stock is owned by another entity, the voting stock of which is so listed. Any Transfer in violation of this Section shall, at Landlord's option, be deemed a Default by Tenant as described in Section 18, and shall be voidable by Landlord. In no event shall any Transfer, including a Permitted Transfer, release or relieve Tenant from any obligation under this Lease.

11.02 Tenant shall provide Landlord with financial statements for the proposed transferee, a fully executed copy of the proposed assignment, sublease or other Transfer documentation and such other

information as Landlord may reasonably request. Within 20 Business Days after receipt of the required information and documentation, Landlord shall either: (a) consent to the Transfer by execution of a consent agreement in a form reasonably designated by Landlord; (b) reasonably refuse to consent to the Transfer in writing; or (c) in the event of an assignment of this Lease or subletting of more than 20% of the Rentable Square Footage of the Premises for more than 50% of the remaining Term (excluding unexercised options), recapture the portion of the Premises that Tenant is proposing to Transfer. If Landlord exercises its right to recapture, this Lease shall automatically be amended (or terminated if the entire Premises is being assigned or sublet) to delete the applicable portion of the Premises effective on the proposed effective date of the Transfer, although Landlord may require Tenant to execute a reasonable amendment or other document reflecting such reduction or termination. Tenant shall pay Landlord a review fee equal to Landlord's actual third party legal costs, provided that such fee shall not exceed $2,000.00 for Landlord's review of any requested Transfer (including a Permitted Transfer) where no material modifications to the Lease are requested.

11.03 Tenant shall pay Landlord 50% of all rent and other consideration which Tenant receives as a result of a Transfer that is in excess of the Rent payable to Landlord for the portion of the Premises and Term covered by the Transfer. Tenant shall pay Landlord for Landlord's share of the excess within 30 days after Tenant's receipt of the excess. Tenant may deduct from the excess, on a straight-line basis, all reasonable and customary expenses directly incurred by Tenant attributable to the Transfer.

11.04 If Tenant is in Default, Landlord may require that all sublease payments be made directly to Landlord, in which case Tenant shall receive a credit against Rent in the amount of Tenant's share of payments received by Landlord.

11.05 Tenant may assign this Lease to a successor to Tenant by purchase, merger, consolidation or reorganization (an "**Ownership Change**") or assign this Lease or sublet all or a portion of the Premises to an Affiliate without the consent of Landlord, provided that all of the following conditions are satisfied (each, a "**Permitted Transfer**"): (a) Tenant is not in Default; (b) (1) in the event of an Ownership Change, Tenant's successor shall own substantially all of the assets of Tenant and have a net worth which is at least equal to Tenant's net worth as of the day prior to the proposed Ownership Change, or (2) in the event of a Transfer to an Affiliate (defined below), Tenant continues to have a net worth equal to or greater than Tenant's net worth at the date of this Lease or the Affiliate has a net worth equal to Tenant's net worth at the date of this Lease; (c) Tenant and Guarantor (if any) remain liable for Tenant's obligations under this Lease; and (d) Tenant shall give Landlord written notice at least 15 days prior to the effective date of the Permitted Transfer. Tenant's notice to Landlord shall include information and documentation evidencing the Permitted Transfer and showing that each of the above conditions has been satisfied. If requested by Landlord, Tenant's successor shall sign a commercially reasonable form of assumption agreement. "**Affiliate**" shall mean an entity controlled by, controlling or under common control with Tenant ("control" being defined as ownership of at least fifty percent (50%) of the equity interests in and voting rights with respect to an entity).

12. Liens.

Tenant shall not permit mechanics' or other liens to be placed upon the Property, Premises or Tenant's leasehold interest in connection with any work or service done or purportedly done by or for the benefit of Tenant or its transferees. Tenant shall give Landlord notice at least 15 days prior to the commencement of any work in the Premises to afford Landlord the opportunity, where applicable, to post and record notices of non-responsibility. Tenant, within 10 days of notice from Landlord, shall fully discharge any lien by settlement, by bonding or by insuring over the lien in the manner prescribed by the applicable Law and, if Tenant fails to do so, Tenant shall be deemed in Default under this Lease and, in addition to any other remedies available to Landlord as a result of such Default by Tenant, Landlord, at its option, may bond, insure over or otherwise discharge the lien. Tenant shall reimburse Landlord for any amount paid by Landlord, including without limitation, reasonable attorneys' fees.

13. Indemnity and Waiver of Claims.

Except to the extent caused by the negligence or willful misconduct of Landlord or any Landlord Related Parties (defined below), Tenant shall indemnify, defend and hold Landlord and Landlord Related Parties harmless against and from all liabilities, obligations, damages, penalties, claims, actions, costs, charges and expenses, including without limitation, reasonable attorneys' fees and other professional fees (if and to the extent permitted by Law) (collectively referred to as "**Losses**"), which may be imposed upon, incurred by or asserted against Landlord or any of the Landlord Related Parties by any third party and arising out of or in connection with any damage or injury occurring in the Premises or any acts or omissions (including violations of Law) of Tenant, the Tenant Related Parties (defined below) or any of Tenant's transferees, contractors or licensees. "**Tenant Related Parties**" means Tenant, its trustees, members, principals, beneficiaries, partners, officers, directors, employees and agents. Except for claims related to Landlord's negligence or misconduct, Tenant hereby waives all claims against and releases Landlord and its trustees, members, principals, beneficiaries, partners, officers, directors, employees, Mortgagees (defined in Section 23) and agents (the "**Landlord Related Parties**") from all claims for any injury to or death of persons, damage to property or business loss in any manner related to (a) Force Majeure, (b) acts of third parties, (c) the bursting or leaking of any tank, water closet, drain or other pipe, (d) the inadequacy or failure of any security or protective services, personnel or equipment, or (e) any matter not within the reasonable control of Landlord.

14. Insurance.

Tenant shall maintain the following insurance ("**Tenant's Insurance**"): (a) Commercial General Liability Insurance applicable to the Premises and its appurtenances providing, on an occurrence basis, a minimum combined single limit of $2,000,000.00; (b) Property/Business Interruption Insurance written on an All Risk or Special Cause of Loss Form, including earthquake sprinkler leakage, at replacement cost value and with a replacement cost endorsement covering all of Tenant's business and trade fixtures, equipment, movable partitions, furniture, merchandise and other personal property within the Premises ("**Tenant's Property**") and any Leasehold Improvements performed by or for the benefit of Tenant; (c) Workers' Compensation Insurance in amounts required by Law; and (d) Employers Liability Coverage of at least $1,000,000.00 per occurrence (provided that if this coverage is unavailable from the Worker's Compensation carrier or applicable State Fund, a "Stop Gap Liability" endorsement to the Commercial General Liability Policy is acceptable). Any company writing Tenant's Insurance shall have an A.M. Best rating of not less than A-VIII. All Commercial General Liability Insurance policies shall name as additional insureds Landlord (or its successors and assigns), the property manager for the Building (Bloch River View LLC or its successor and assigns) and their respective members, principals, beneficiaries, partners, officers, directors, employees, and agents, and other designees of Landlord and its successors as the interest of such designees shall appear. In addition, Landlord shall be named as a loss payee with respect to Property/Business Interruption Insurance on the Leasehold Improvements. All policies of Tenant's Insurance shall contain endorsements that the insurer(s) shall give Landlord and its designees at least 30 days' advance written notice of any cancellation, termination, material change or lapse of insurance. Tenant shall provide Landlord with a certificate of insurance evidencing Tenant's Insurance prior to the earlier to occur of the Commencement Date or the date Tenant is provided with possession of the Premises, and thereafter as necessary to assure that Landlord always has current certificates evidencing Tenant's Insurance. So long as the same is available at commercially reasonable rates, Landlord shall maintain so called All Risk property insurance on the Building at replacement cost value as reasonably estimated by Landlord, together with such other insurance coverage as Landlord, in its reasonable judgment, may elect to maintain.

15. Subrogation.

Landlord and Tenant hereby waive and shall cause their respective insurance carriers to waive any and all rights of recovery, claims, actions or causes of action against the other for any loss or damage with respect to Tenant's Property, Leasehold Improvements, the Building, the Premises, or any contents thereof, including rights, claims, actions and causes of action based on negligence, which loss or damage is (or would have been, had the insurance required by this Lease been carried) covered by insurance. For the

purposes of this waiver, any deductible with respect to a party's insurance shall be deemed covered by and recoverable by such party under valid and collectable policies of insurance.

16. Casualty Damage.

16.01 If all or any portion of the Premises becomes untenantable by fire or other casualty to the Premises (collectively a "**Casualty**"), Landlord, with reasonable promptness, shall cause a general contractor selected by Landlord to provide Landlord and Tenant with a written estimate of the amount of time required using standard working methods to Substantially Complete the repair and restoration of the Premises and any Common Areas necessary to provide access to the Premises ("**Completion Estimate**"). If the Completion Estimate indicates that the Premises or any Common Areas necessary to provide access to the Premises cannot be made tenantable within 270 days from the date the repair is started, then either party shall have the right to terminate this Lease upon written notice to the other within 10 days after receipt of the Completion Estimate. Tenant, however, shall not have the right to terminate this Lease if the Casualty was caused by the negligence or intentional misconduct of Tenant or any Tenant Related Parties. In addition, Landlord, by notice to Tenant within 90 days after the date of the Casualty, shall have the right to terminate this Lease if: (1) the Premises have been materially damaged and there is less than 2 years of the Term remaining on the date of the Casualty; (2) any Mortgagee requires that the insurance proceeds be applied to the payment of the mortgage debt; or (3) a material uninsured loss to the Building or Premises occurs.

16.02 If this Lease is not terminated, Landlord shall promptly and diligently, subject to reasonable delays for insurance adjustment or other matters beyond Landlord's reasonable control, restore the Premises and Common Areas. Such restoration shall be to substantially the same condition that existed prior to the Casualty, except for modifications required by Law or any other modifications to the Common Areas deemed desirable by Landlord. Upon notice from Landlord, Tenant shall assign or endorse over to Landlord (or to any party designated by Landlord) all property insurance proceeds payable to Tenant under Tenant's Insurance with respect to any Leasehold Improvements performed by or for the benefit of Tenant; provided if the estimated cost to repair such Leasehold Improvements exceeds the amount of insurance proceeds received by Landlord from Tenant's insurance carrier, the excess cost of such repairs shall be paid by Tenant to Landlord prior to Landlord's commencement of repairs. Within 15 days of demand, Tenant shall also pay Landlord for any additional excess costs that are determined during the performance of the repairs. In no event shall Landlord be required to spend more for the restoration than the proceeds received by Landlord, whether insurance proceeds or proceeds from Tenant. Landlord shall not be liable for any inconvenience to Tenant, or injury to Tenant's business resulting in any way from the Casualty or the repair thereof. Provided that Tenant is not in Default, during any period of time that all or a material portion of the Premises is rendered untenantable as a result of a Casualty, the Rent shall abate for the portion of the Premises that is untenantable and not used by Tenant.

17. Condemnation.

Either party may terminate this Lease if any material part of the Premises is taken or condemned for any public or quasi-public use under Law, by eminent domain or private purchase in lieu thereof (a "**Taking**"). Landlord shall also have the right to terminate this Lease if there is a Taking of any portion of the Building or Property which would have a material adverse effect on Landlord's ability to profitably operate the remainder of the Building. The terminating party shall provide written notice of termination to the other party within 45 days after it first receives notice of the Taking. The termination shall be effective as of the effective date of any order granting possession to, or vesting legal title in, the condemning authority. If this Lease is not terminated, Monthly Rent shall be appropriately adjusted to account for any reduction in the square footage of the Building or Premises. All compensation awarded for a Taking shall be the property of Landlord. The right to receive compensation or proceeds are expressly waived by Tenant, however, Tenant may file a separate claim for Tenant's Property and Tenant's reasonable relocation expenses, provided the filing of the claim does not diminish the amount of Landlord's award. If only a part of the Premises is subject to a Taking and this Lease is not terminated, Landlord, with reasonable diligence, will restore the remaining portion of the Premises as nearly as practicable to the condition immediately prior to the Taking.

18. Events of Default.

In addition to any other default specifically described in this Lease, each of the following occurrences shall be a "**Default**": (a) Tenant's failure to pay any portion of Rent when due; provided, however, for the first two (2) occurrences in any twelve (12) month calendar period, no Default shall occur if Tenant cures such failure within five (5) days after written notice thereof from Landlord ("**Monetary Default**"); (b) Tenant's failure (other than a Monetary Default) to comply with any term, provision, condition or covenant of this Lease, if the failure is not cured within 10 days after written notice to Tenant provided, however, if Tenant's failure to comply cannot reasonably be cured within 10 days, Tenant shall be allowed additional time (not to exceed 30 days) as is reasonably necessary to cure the failure so long as Tenant begins the cure within 10 days and diligently pursues the cure to completion; (c) Tenant permits a Transfer without Landlord's required approval or otherwise in violation of Section 11 of this Lease; (d) Tenant or any Guarantor becomes insolvent, makes a transfer in fraud of creditors, makes an assignment for the benefit of creditors, admits in writing its inability to pay its debts when due or forfeits or loses its right to conduct business; (e) the leasehold estate is taken by process or operation of Law; or (f) Tenant is in default beyond any notice and cure period under any other lease or agreement with Landlord at the Building or Property. If Landlord provides Tenant with notice of Tenant's failure to comply with any specific provision of this Lease on 3 separate occasions during any 12-month period, Tenant's subsequent violation of such provision shall, at Landlord's option, be an incurable Default by Tenant. All notices sent under this Section shall be in satisfaction of, and not in addition to, notice required by Law.

19. Remedies.

19.01 Upon Default, Landlord shall have the right to pursue any one or more of the following remedies:

(a) Terminate this Lease, in which case Tenant shall immediately surrender the Premises to Landlord. If Tenant fails to surrender the Premises, Landlord, in compliance with Law, may enter upon and take possession of the Premises and remove Tenant, Tenant's Property and any party occupying the Premises. Tenant shall pay Landlord, on demand, losses and damages Landlord suffers as a result of Tenant's Default, including without limitation, all Costs of Reletting (defined below) to the extent allocable to the remaining Term (e.g., if this Lease is terminated with 2 years then remaining on the Term, and Landlord enters into a new 10 year lease for the Premises, Tenant shall pay one-fifth of the Costs of Reletting), any deficiency that may arise from reletting or the failure to relet the Premises, and (i) the Worth at the time of award of the unpaid Rent that had been earned by Landlord at the time of termination of Tenant's right to possession; (ii) the Worth at the time of award of the amount by which the unpaid Rent which would have been earned after termination of Tenant's right of possession (excluding any unexercised extension option) until the time of award exceeds the amount of such rental loss that Tenant proves could have been reasonably avoided; (iii) the Worth at the time of award of the amount by which the unpaid rent for the balance of the Term (excluding any unexercised extension option) after the time of award exceeds the amount of such rental loss that Tenant proves could be reasonably avoided. The "Worth" as used for items (i) and (ii) above shall be computed by allowing interest at the Prime Rate to accrue on all such unpaid Rent (or such lesser rate required by Law, if any). The Worth as used for item (iii) above shall be computed by discounting the amount of Rent at the discount rate of the Federal Reserve Bank of San Francisco at the time of termination of Tenant's right of possession. "**Prime Rate**" shall be the per annum interest rate publicly announced as its prime or base rate by a federally insured bank selected by Landlord in the state in which the Building is located. "**Costs of Reletting**" shall include all reasonable costs and expenses incurred by Landlord in reletting or attempting to relet the Premises, including without limitation, legal fees, brokerage commissions, the cost of alterations and the value of other concessions or allowances granted to a new tenant. Landlord shall attempt to mitigate damages and attempt to relet the Premises.

(b) Terminate Tenant's right to possession of the Premises and, in compliance with Law, remove Tenant, Tenant's Property and any parties occupying the Premises. Landlord may (but shall not be obligated to) relet all or any part of the Premises, without notice to Tenant, for such period of time and on such terms and conditions (which may include concessions, free rent and work allowances) as Landlord in its absolute discretion shall determine. Landlord may collect and receive all rents and other

income from the reletting. Tenant shall pay Landlord on demand all past due Rent, all Costs of Reletting and any deficiency arising from the reletting or failure to relet the Premises. The re-entry or taking of possession of the Premises shall not be construed as an election by Landlord to terminate this Lease. Landlord shall attempt to mitigate damages and attempt to relet the Premises.

19.03 If Tenant is in Default of any of its non-monetary obligations under the Lease, Landlord shall have the right to perform such obligations. Tenant shall reimburse Landlord for the cost of such performance upon demand together with an administrative charge equal to 5% of the cost of the work performed by Landlord. The repossession or re-entering of all or any part of the Premises shall not relieve Tenant of its liabilities and obligations under this Lease. No right or remedy of Landlord shall be exclusive of any other right or remedy. Each right and remedy shall be cumulative and in addition to any other right and remedy now or subsequently available to Landlord at Law or in equity.

20. Limitation of Liability.

NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED IN THIS LEASE, THE LIABILITY OF LANDLORD (AND OF ANY SUCCESSOR LANDLORD) SHALL BE LIMITED TO THE LESSER OF (A) THE INTEREST OF LANDLORD IN THE PROPERTY, OR (B) THE EQUITY INTEREST LANDLORD WOULD HAVE IN THE PROPERTY IF THE PROPERTY WERE ENCUMBERED BY THIRD PARTY DEBT IN AN AMOUNT EQUAL TO 70% OF THE VALUE OF THE PROPERTY. TENANT SHALL LOOK SOLELY TO LANDLORD'S INTEREST IN THE PROPERTY FOR THE RECOVERY OF ANY JUDGMENT OR AWARD AGAINST LANDLORD OR ANY LANDLORD RELATED PARTY. NEITHER LANDLORD NOR ANY LANDLORD RELATED PARTY SHALL BE PERSONALLY LIABLE FOR ANY JUDGMENT OR DEFICIENCY, AND IN NO EVENT SHALL LANDLORD OR ANY LANDLORD RELATED PARTY BE LIABLE TO TENANT FOR ANY LOST PROFIT, DAMAGE TO OR LOSS OF BUSINESS OR ANY FORM OF SPECIAL, INDIRECT OR CONSEQUENTIAL DAMAGE. BEFORE FILING SUIT FOR AN ALLEGED DEFAULT BY LANDLORD, TENANT SHALL GIVE LANDLORD AND THE MORTGAGEE(S) WHOM TENANT HAS BEEN NOTIFIED HOLD MORTGAGES (DEFINED IN SECTION 23 BELOW), NOTICE AND REASONABLE TIME TO CURE THE ALLEGED DEFAULT.

21. Relocation.

Landlord, at its expense, at any time before or during the Term, may relocate Tenant from the Premises to space of reasonably comparable size and utility ("**Relocation Space**") within the Building or other buildings within the same project upon 60 days' prior written notice to Tenant. From and after the date of the relocation, the Monthly Rent shall be adjusted based on the rentable square footage of the Relocation Space, provided the Monthly Rent shall not increase beyond what Tenant paid in the original Premises. Landlord shall pay Tenant's reasonable costs of relocation, including all costs for moving Tenant's furniture, equipment, supplies and other personal property, as well as the cost of printing and distributing change of address notices to Tenant's customers and one month's supply of stationery showing the new address.

22. Holding Over.

If Tenant fails to surrender all or any part of the Premises at the termination of this Lease, occupancy of the Premises after termination shall be that of a tenancy at sufferance. Tenant's occupancy shall be subject to all the terms and provisions of this Lease, and Tenant shall pay an amount (on a per month basis without reduction for partial months during the holdover) equal to 150% of the greater of (i) the sum of the Monthly Rent immediately preceding the holdover; (ii) the then fair market rental value of the Premises at the time of the holdover. No holdover by Tenant or payment by Tenant after the termination of this Lease shall be construed to extend the Term or prevent Landlord from immediate recovery of possession of the Premises by summary proceedings or otherwise. If Landlord is unable to deliver possession of the Premises to a new tenant or to perform improvements for a new tenant as a result of Tenant's holdover and Tenant fails to timely vacate the Premises upon the expiration or earlier termination of this Lease, Tenant shall be liable for all damages that Landlord suffers from the holdover, which may include without limitation (i) any rent payable by, or any damages claimed by, any prospective tenant of any part or all of the Premises, and (ii) Landlord's damages resulting from such prospective tenant rescinding or refusing to enter into the

prospective lease of part or all of the Premises by reason of Tenant's failure to timely surrender the Premises.

23. Subordination to Mortgages; Estoppel Certificate.

Tenant accepts this Lease subject and subordinate to any mortgage(s), deed(s) of trust, ground lease(s) or other lien(s) now or subsequently arising upon the Premises, the Building or the Property, and to renewals, modifications, refinancings and extensions thereof (collectively referred to as a "**Mortgage**"). The party having the benefit of a Mortgage shall be referred to as a "**Mortgagee**". This clause shall be self-operative, but upon request from a Mortgagee, Tenant shall execute a commercially reasonable subordination agreement in favor of the Mortgagee. As an alternative, a Mortgagee shall have the right at any time to subordinate its Mortgage to this Lease. Upon request, Tenant, without charge, shall attorn to any successor to Landlord's interest in this Lease. Landlord and Tenant shall each, within 10 days after receipt of a written request from the other, execute and deliver a commercially reasonable estoppel certificate to those parties as are reasonably requested by the other (including a Mortgagee or prospective purchaser). Without limitation, such estoppel certificate may include a certification as to the status of this Lease, the existence of any defaults and the amount of Rent that is due and payable.

24. Notices.

Except as expressly provided to the contrary in this Lease, every notice or other communication to be given by either party to the other with respect hereto or to the Premises, Building or Property, shall be in writing and shall not be effective for any purpose unless the same shall be served personally, by email, or by nationally recognized overnight courier service, or United States certified mail, return receipt requested, postage prepaid, to the party's respective Notice Address(es) set forth in Section 1.9. Every notice or other communication hereunder shall be deemed to have been properly given (i) upon delivery, if delivered in person or if delivered by email during Building Service Hours, (ii) 1 Business Day after having been deposited for overnight delivery with any reputable overnight courier service, or (iii) 3 Business Days after having been deposited in any post office or mail depository regularly maintained by the U.S. Postal Service and sent by registered or certified mail, postage prepaid, return receipt requested, addressed as required above. If notice is sent by email, a copy shall also be sent by mail as set forth herein. Notices not sent in accordance with the foregoing shall be of no force or effect until received by the foregoing parties at such addresses required herein. Either party may, at any time, change its Notice Address(es) (other than to a post office box address) by giving the other party written notice of the new address.

25. Surrender of Premises.

At the termination of this Lease or Tenant's right of possession, Tenant shall comply with the obligations of Section 8 above and also remove Tenant's Property from the Premises, and quit and surrender the Premises to Landlord, broom clean, and in good order, condition and repair, ordinary wear and tear and damage which Landlord is obligated to repair hereunder excepted. If Tenant fails to remove any of Tenant's Property within 2 days after termination of this Lease or Tenant's right to possession, Landlord, at Tenant's sole cost and expense, shall be entitled (but not obligated) to remove and store Tenant's Property. Landlord shall not be responsible for the value, preservation or safekeeping of Tenant's Property. Tenant shall pay Landlord, upon demand, the expenses and storage charges incurred. If Tenant fails to remove Tenant's Property from the Premises or storage, within 30 days after notice, Landlord may deem all or any part of Tenant's Property to be abandoned and title to Tenant's Property shall vest in Landlord.

26. Parking.

During the Term, Tenant and its employees, agents and independent contractors ("**Tenant Authorized Parkers**") shall have the right to park in unreserved parking spaces in the parking facilities serving the Building on a first come first served basis, subject to (a) all applicable laws and municipal and other governmental regulations relating to parking, (b) any rules, regulations, restrictions and rates Landlord may reasonably establish, impose or alter at any time or from time to time, including without limitation the rules and regulations in **Exhibit E** attached hereto, and (c) any exclusive or reserved parking rights that Landlord

may have granted or in the future may grant in favor of other tenants of the Building. Parking spaces marked as 'Visitor Parking' shall only be used by invitees or visitors who remain in the Building for one hour or less, and in no event shall Tenant, its employees, invitees or guests use such parking spaces. When parking spaces marked for visitors are full, visitors may park in unreserved parking spaces on a first come first served basis. Parking spaces marked as handicapped persons or reserved shall only be used by such persons for whom the spaces are reserved.

27. Signs.

Tenant shall not place on the exterior walls of the Premises or upon the roof or any exterior door or wall or on the exterior or interior of any window thereof any sign, awning, canopy, marquee, advertising matter, decoration, letter, or other similar thing (each, a "**Sign**") (not including signs provided for in the original construction or improvement plans and specifications approved by Landlord) without the prior written approval of Landlord, at Landlord's sole discretion. Any Signs installed by Tenant with Landlord's prior written approval shall comply with all applicable Laws and regulations. Tenant shall at its sole cost and expense, repair, paint, and/or replace the Building surface where any signs are attached following removal. In the event Tenant installs any Sign not in compliance with this Section 27, Landlord shall have the right without liability to Tenant to enter upon the Premises, remove, and store the subject Sign and repair all damage caused by the removal of the Sign. All costs and expenses incurred by Landlord shall be immediately paid by Tenant as Additional Rent. Landlord reserves the right to remove Tenant's Sign during any period when Landlord repairs, restores, constructs, or renovates the Premises or the Building. Tenant shall remove all signs installed by Tenant at the expiration or soon after termination of this Lease. Tenant's obligations under this Section shall survive the expiration or sooner termination of this Lease.

28. Hazardous Materials.

28.01 Presence of Hazardous Materials. Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about the Premises or Landlord's Property by Tenant or its agents, employees, contractors, or invitees. Tenant shall be liable to Landlord for, and shall defend and indemnify Landlord and Landlord's lender and hold them all harmless with respect to, any and all cleanup costs and any and all other charges, fees (including Landlord's and Landlord's lender's attorneys' fees), fines, expenses, costs and penalties relating to or growing out of Tenant's or its contractors', agents', employees', assignees' or subtenants' use, storage, disposal, transportation, generation, release or sale of Hazardous Materials on, under, or from the Premises, Building or Property. Tenant shall immediately notify Landlord of any spills or releases of any Hazardous Materials and of any inquiry, investigation, or notice that Tenant receives regarding the actual or suspected presence of Hazardous Material on the Premises. This paragraph shall survive the expiration or earlier termination of this Lease.

28.02 Definition of Hazardous Materials. "**Hazardous Materials**" means any hazardous, dangerous, toxic, or harmful substance; material or waste, including biomedical waste, which is or becomes regulated by any local governmental authority, the State of Washington or the United States government, and specifically includes mold.

29. Miscellaneous.

29.01 This Lease shall be interpreted and enforced in accordance with the Laws of the state or commonwealth in which the Building is located and Landlord and Tenant hereby irrevocably consent to the jurisdiction and proper venue of such state or commonwealth. If any term or provision of this Lease shall to any extent be void or unenforceable, the remainder of this Lease shall not be affected. If there is more than one Tenant or if Tenant is comprised of more than one party or entity, the obligations imposed upon Tenant shall be joint and several obligations of all the parties and entities, and requests or demands from any one person or entity comprising Tenant shall be deemed to have been made by all such persons or entities. Notices to any one person or entity shall be deemed to have been given to all persons and entities. Tenant represents and warrants to Landlord that each individual executing this Lease on behalf of Tenant is authorized to do so on behalf of Tenant and that Tenant is not, and the entities or individuals constituting Tenant or which may own or control Tenant or which may be owned or controlled by Tenant are not, (i) in

violation of any laws relating to terrorism or money laundering, or (ii) among the individuals or entities identified on any list compiled pursuant to Executive Order 13224 for the purpose of identifying suspected terrorists or on the most current list published by the U.S. Treasury Department Office of Foreign Assets Control at its official website, http://www.treas.gov/ofac/tllsdn.pdf or any replacement website or other replacement official publication of such list.

29.02 If either party institutes a suit against the other for violation of or to enforce any covenant, term or condition of this Lease, the prevailing party shall be entitled to reimbursement of all of its costs and expenses, including without limitation reasonable attorneys' fees. Landlord and Tenant hereby waive any right to trial by jury in any proceeding based upon a breach of this Lease. Either party's failure to declare a default immediately upon its occurrence, or delay in taking action for a default, shall not constitute a waiver of the default, nor shall it constitute an estoppel.

29.03 Whenever a period of time is prescribed for the taking of an action by Landlord or Tenant (other than the payment of the Security Deposit or Rent), the period of time for the performance of such action shall be extended by the number of days that the performance is actually delayed due to strikes, acts of God, shortages of labor or materials, war, terrorist acts, civil disturbances and other causes beyond the reasonable control of the performing party ("**Force Majeure**").

29.04 Landlord shall have the right to transfer and assign, in whole or in part, all of its rights and obligations under this Lease and in the Building and Property. Upon transfer Landlord shall be released from any further obligations hereunder and Tenant agrees to look solely to the successor in interest of Landlord for the performance of such obligations, provided that, any successor pursuant to a voluntary, third party transfer (but not as part of an involuntary transfer resulting from a foreclosure or deed in lieu thereof) shall have assumed Landlord's obligations under this Lease.

29.05 Each party represents and warrants to the other that, except for the Brokers identified in Section 1.07, it has not had dealings with any real estate broker other, agent or salesperson with respect to this Lease that would cause the other party to have any liability for any commissions or other compensation to such broker, agent or salesperson, and that no such broker, agent or salesperson has asserted any claim or right to any such commission or other compensation. Such representing party shall defend and indemnify the other party and hold the other party harmless from and against any and all loss, cost, liability, damage and expense (including reasonable attorneys' fees) whatsoever that may arise out of the breach of such representation and warranty. Landlord shall pay the Brokers identified in Section 1.07 a commission in connection with this Lease in accordance with the terms and conditions of a separate written agreement.

29.06 Time is of the essence with respect to Tenant's exercise of any expansion, renewal or extension rights granted to Tenant. The expiration of the Term, whether by lapse of time, termination or otherwise, shall not relieve either party of any obligations which accrued prior to or which may continue to accrue after the expiration or termination of this Lease.

29.07 Tenant may peacefully have, hold and enjoy the Premises, subject to the terms of this Lease, provided Tenant pays the Rent and fully performs all of its covenants and agreements. This covenant shall be binding upon Landlord and its successors only during its or their respective periods of ownership of the Building.

29.08 This Lease does not grant any rights to light or air over or about the Building. Landlord excepts and reserves exclusively to itself any and all rights not specifically granted to Tenant under this Lease. This Lease constitutes the entire agreement between the parties and supersedes all prior agreements and understandings related to the Premises, including all lease proposals, letters of intent and other documents. Neither party is relying upon any warranty, statement or representation not contained in this Lease. This Lease may be modified only by a written agreement signed by an authorized representative of Landlord and Tenant.

29.09 This Lease may be executed in counterparts, each of which shall be deemed an original, and all of which together shall constitute one and the same instrument. Signatures transmitted by email will have the same effect as personal delivery of original ink signatures.

29.10 Subject to the provisions of this Lease pertaining to assignment and subletting, this Lease shall be binding on the heirs, legal representatives, successors and assigns of the parties.

29.11 The invalidity of any provision of this Lease as determined by a court of competent jurisdiction shall not affect the validity of any other provision of this Lease.

29.12 This Lease including the Exhibits, which are made a party to this Lease, constitutes the entire agreement between Landlord and Tenant regarding the subject matter hereof and supersedes all oral statements and prior writings relating to the subject matter including without limitation any prior letters of intent, term sheets, or confidentiality and nondisclosure agreements. There are no promises, agreements, conditions, understandings, inducements, warranties or representations, oral or written, expressed or implied, regarding the subject matter of this Lease other than as expressly set forth in this Lease. This Lease shall not be modified in any manner except by an instrument, in writing, executed by the parties.

29.13 Tenant shall keep the content and all copies of this Lease, related documents, or amendments now or hereafter entered, and all proposals, materials, information, and matters relating to this Lease strictly confidential, and shall not disclose, disseminate, or distribute any of the same, except to the extent reasonably required for proper business purposes by Tenant's employees, attorneys, insurers, auditors, lenders and Transferees (and Tenant shall obligate any such parties to whom disclosure is permitted to honor the confidentiality provisions of this Lease), and except as may be required by applicable law or court proceedings.

[*Signature Page Follows*]

EXECUTED, the day and year first above written.

ASSET MANAGER AS AGENT OF LANDLORD:

BLOCH RIVER VIEW LLC,
a Washington limited liability company

By: _____
Darren Bloch, Manager

TENANT:

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC,
a Washington limited liability company

By: _____
Name: _____
Title: _____

EXECUTED, the day and year first above written.

ASSET MANAGER AS AGENT OF LANDLORD:

BLOCH RIVER VIEW LLC,
a Washington limited liability company

By: _____
Darren Bloch, Manager

TENANT:

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC,
a Washington limited liability company

By: _____
Name: Todd Stern
Title: CEO - Hospice

ASSET MANAGER ACKNOWLEDGMENT

STATE OF WASHINGTON)
) ss.
COUNTY OF KING)

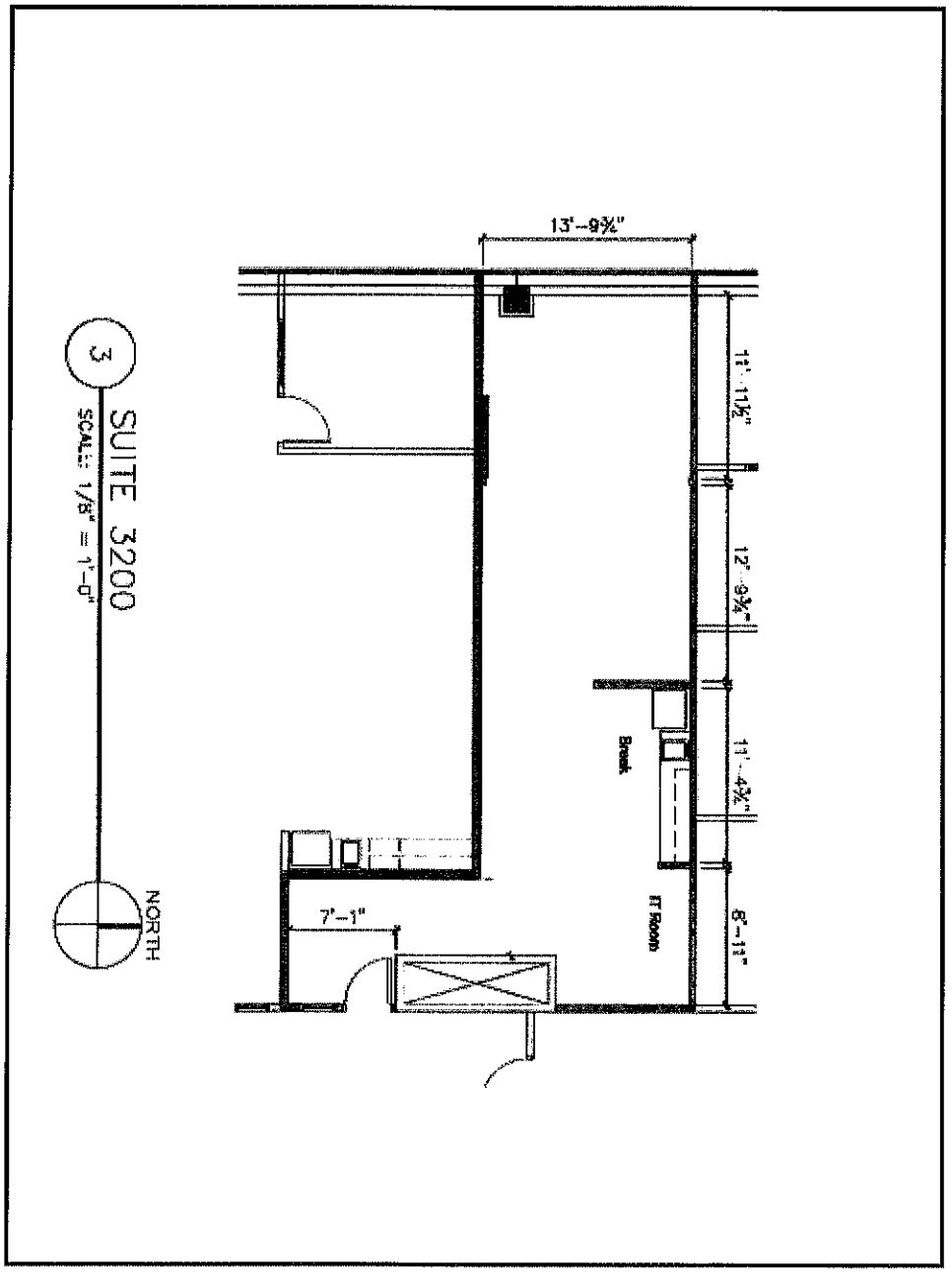
I certify that I know or have satisfactory evidence that Darren Bloch is the person who appeared before me, and said person acknowledged that said person signed this instrument, on oath stated that said person was authorized to execute the instrument and acknowledged it as the Manager of BLOCH RIVER VIEW LLC, a Washington limited liability company, to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

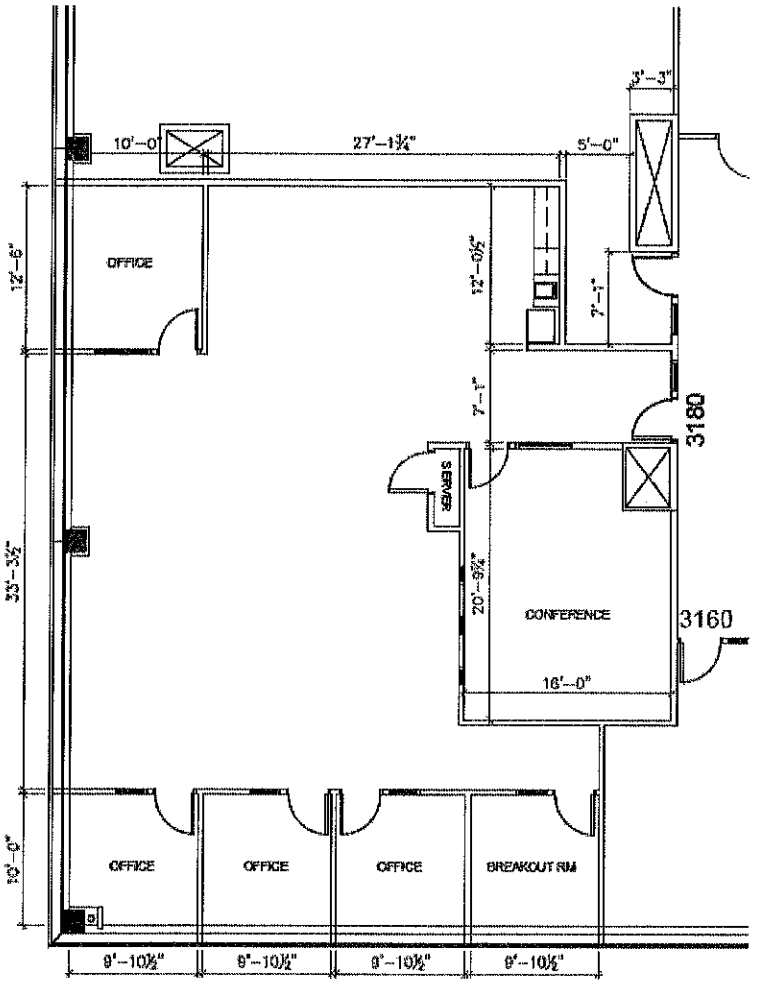
Dated this 29th day of December, 2021.

Laurie D Eide
LAURIE D EIDE
(print or type name)
NOTARY PUBLIC in and for the State of Washington,
residing at Clyde Hill
My Commission expires: 2/24/22

EXHIBIT A

OUTLINE AND LOCATION OF PREMISES





3 SUITE 3180

SCALE: 3/32" = 1'-0"

EXHIBIT B

LEGAL DESCRIPTION OF PROPERTY

ALL OF LOTS 6, 7, 8, AND 9, BLOCK 1, FINAL PLAT OF HANSON CENTER EAST, AS PER PLAT RECORDED IN VOLUME 27 OF PLATS, PAGES 10 THROUGH 12, RECORDS OF SPOKANE COUNTY;

EXCEPT THAT PORTION OF SAID LOT 6, BLOCK 1 DESCRIBED AS FOLLOWS;
BEGINNING AT THE NORTHWEST CORNER OF SAID LOT 6;
THENCE SOUTH 78°37'56" EAST, ALONG THE NORTH BOUNDARY OF SAID PLAT A DISTANCE OF 60.00 FEET; THENCE SOUTH 11°22'04" WEST, A DISTANCE OF 40.00 FEET;
THENCE NORTH 78°37'56" WEST, A DISTANCE OF 60.00 FEET;
THENCE NORTH 11°22'04" EAST, A DISTANCE OF 40.00 FEET TO THE POINT OF BEGINNING;

TOGETHER WITH A PORTION OF BURLINGTON NORTHERN RAILROAD COMPANY'S (FORMERLY GREAT NORTHERN RAILWAY COMPANY'S) SPOKANE TO GREENACRES, WASHINGTON BRANCH LINE RIGHT OF WAY, BEING A PORTION OF THE PROPERTY AS DESCRIBED IN QUIT CLAIM DEED RECORDED IN VOLUME 1178 OF DEEDS, PAGES 1634 THROUGH 1640 UNDER AUDITOR'S FILE NUMBER 9103270283 RECORDS OF SPOKANE COUNTY, NOW DISCONTINUED, BEING OF VARIABLE WIDTHS ON EACH SIDE OF SAID RAILROAD COMPANY'S MAIN TRACK CENTERLINE AS ORIGINALLY LOCATED AND CONSTRUCTED UPON, OVER AND ACROSS GOVERNMENT LOTS 1, 2, 3, AND 4 IN SECTION 13, TOWNSHIP 25 NORTH, RANGE 44 EAST, WILLAMETTE MERIDIAN, SPOKANE COUNTY, WASHINGTON, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS;

BEGINNING AT THE NORTHEAST CORNER OF SAID LOT 7;
THENCE N78°37'56"W ALONG THE SOUTHERLY RIGHT OF WAY LINE OF SAID BURLINGTON NORTHERN RAILROAD COMPANY'S (FORMERLY GREAT NORTHERN RAILWAY COMPANY'S) SPOKANE TO GREENACRES, WASHINGTON BRANCH LINE A DISTANCE OF 903.11 FEET;
THENCE N11°22'04"E A DISTANCE OF 50.00 FEET TO THE CENTERLINE OF SAID RAILROAD COMPANY'S 100.00 FOOT WIDE BRANCH LINE RIGHT OF WAY, BEING 50.00 FEET WIDE ON EACH SIDE OF SAID RAILROAD COMPANY'S MAIN TRACK;
THENCE S78°37'56"E ALONG SAID CENTERLINE A DISTANCE OF 909.44 FEET TO A POINT ON THE NORTH/SOUTH CENTER OF SECTION LINE FOR SAID SECTION 13;
THENCE S00°33'21"E ALONG SAID NORTH/SOUTH CENTER OF SECTION LINE A DISTANCE OF 51.10 FEET; THENCE N78°37'56"W A DISTANCE OF 16.89 FEET TO THE POINT OF BEGINNING;

ALSO TOGETHER WITH A PORTION OF BURLINGTON NORTHERN RAILROAD COMPANY'S (FORMERLY GREAT NORTHERN RAILWAY COMPANY'S) SPOKANE TO GREENACRES, WASHINGTON BRANCH LINE RIGHT OF WAY, BEING A PORTION OF THE PROPERTY AS DESCRIBED IN QUIT CLAIM DEED RECORDED IN VOLUME 1178 OF DEEDS, PAGES 1634 THROUGH 1640 UNDER AUDITOR'S FILE NUMBER 9103270283 RECORDS OF SPOKANE COUNTY, NOW DISCONTINUED, BEING OF VARIABLE WIDTHS ON EACH SIDE OF SAID RAILROAD COMPANY'S MAIN TRACK CENTERLINE AS ORIGINALLY LOCATED AND CONSTRUCTED UPON, OVER AND ACROSS GOVERNMENT LOTS 1, 2, 3, AND 4 IN SECTION 13, TOWNSHIP 25 NORTH, RANGE 44 EAST, WILLAMETTE MERIDIAN, SPOKANE COUNTY, WASHINGTON, BEING MORE PARTICULARLY DESCRIBED AS FOLLOWS;

BEGINNING AT THE NORTHERLY MOST CORNER OF SAID LOT 8;
THENCE N00°33'21"W A DISTANCE OF 30.66 FEET TO THE CENTERLINE OF SAID RAILROAD COMPANY'S 60.00 FOOT WIDE BRANCH LINE RIGHT OF WAY, BEING 30.00 FEET WIDE ON EACH SIDE OF SAID RAILROAD COMPANY'S MAIN TRACK;
THENCE S78°37'56"E ALONG THE SAID CENTERLINE A DISTANCE OF 566.67 FEET TO A POINT ON THE NORTHERLY EXTENSION OF THE EASTERLY LINE OF SAID LOT 9;
THENCE S15°32'31"E ALONG THE SAID EXTENSION LINE A DISTANCE OF 33.64 FEET TO THE NORTHEAST CORNER OF SAID LOT 9;

THENCE N78°37'56"W ALONG THE SOUTHERLY RIGHT OF WAY LINE OF SAID BURLINGTON NORTHERN RAILROAD COMPANY'S (FORMERLY GREAT NORTHERN RAILWAY COMPANY'S) SPOKANE TO GREENACRES, WASHINGTON BRANCH LINE A DISTANCE OF 575.56 FEET TO THE POINT OF BEGINNING;

SITUATE IN THE CITY OF SPOKANE VALLEY, COUNTY OF SPOKANE, STATE OF WASHINGTON.

EXHIBIT C

WORK LETTER

This Work Letter ("**Work Letter**") sets forth the terms and conditions relating to the construction of all leasehold improvements in Suite 3200. Subject to the other terms hereof, Landlord will construct the Tenant Improvements (defined below) in accordance with the Final Plans (defined below) ("**Landlord Work**").

1. Conflicts; Terms. This Work Letter supplements the Lease and, if there is any conflict or inconsistency between the provisions of the Lease and this Work Letter, the provisions of this Work Letter will control. Except as expressly defined in this Work Letter, all initially capitalized terms will have the meanings stated for such terms in the Lease. The following terms have the meanings indicated:

(a) **"Cost of Construction"** means the total of all Landlord's direct and indirect costs of designing and reviewing designs for the Tenant Improvements, constructing the Tenant Improvements, fees and other charges payable to any third parties with respect to the Tenant Improvements, a project management and supervisor fee to Landlord in an amount equal to the actual number of hours Landlord's project manager spends in connection with the Tenant Improvements, at a rate equal to $60.00 per hour, and all sales and excise taxes. Such costs include without limitation the total cost of: preparing and revising the Approved Plans, obtaining all permits (including the cost of any changes to the Approved Plans or Tenant Improvements required by applicable building codes), all of Landlord's space planning and engineering costs, all insurance directly related to the Tenant Improvements (including builders risk, worker's compensation, stop gap and liability insurance), the cost of any changes in the base Building when such changes are required by the Approved Plans (including without limitation if such changes are due to the fact that such work is prepared on an unoccupied basis), such cost to include all direct architectural and/or engineering fees and expenses incurred in connection therewith, and providing Building services required during construction (such as electricity and other utilities, refuse removal and janitorial services).

(b) **"Tenant Improvements"** means the leasehold improvements to be constructed as a permanent part of Suite 3200 pursuant to the Space Plan (as defined below) and the Approved Plans in accordance with this Work Letter. All Tenant Improvements shall be constructed using Building standard materials, equipment and finishes. Upon request, Landlord shall provide Tenant with a list of Building standard materials, equipment and finishes. "Tenant Improvements" shall exclude cabling, furniture, trade fixtures and equipment (such as moveable furniture partitions, appliances, telephones and computers) and fine finish items such as artwork and specialty wall coverings.

2. Preparation of Construction Documents.

2.1. Space Plan. Promptly following the Effective Date of this Lease, Landlord and Tenant shall work collaboratively to prepare a final space plan showing the layout and designation of all rooms and other partitioning in Suite 3200. Tenant and Landlord will work together to approve or disapprove the proposed space plan, within ten (10) business days after receipt. The space plan as finally approved by Landlord and Tenant is the "**Space Plan**".

2.2. Approved Plans. As soon as reasonably possible following the parties' approval of the Space Plan, Landlord will prepare plans which (a) specify building standard equipment, materials and finishes and be compatible with the base building and the mechanical and electrical components of the base building, all as reasonably determined by Landlord; (b) show, in reasonable detail, the design and appearance of the Building standard finishing material Landlord will use in connection with installing the Tenant Improvements; (c) be prepared in accordance with the approved Space Plan; and (d) contain such other detail or description as may be necessary for Landlord to construct the Tenant Improvements. Tenant and Landlord will work together to approve or disapprove the proposed plans within ten (10) business days after receipt. The plans as finally approved by Landlord and Tenant are the "**Approved Plans**".

2.3. Final Plans. Landlord will submit the Approved Plans for permits (if required). Landlord will promptly notify Tenant of any changes to the Approved Plans that are required by the City of Spokane. The Approved Plans, revised and approved by the City of Tacoma, will be the "**Final Plans**".

3. Changes. Tenant will notify Landlord in writing of any changes it wishes to have made to the Approved Plans. Landlord shall have 5 Business Days to approve or reject such changes. If Landlord approves the changes, Landlord will notify Tenant of the additional Cost of Construction and the anticipated delay in completing the Tenant Improvements caused by such changes. Tenant will approve or disapprove the increased Cost of Construction and delay in writing within 5 Business Days after receipt of Landlord's notice. If Tenant fails to notify Landlord of its approval or disapproval of the additional Cost of Construction and delay within the 5 Business Day period, Tenant is deemed to have disapproved the additional Cost of Construction or delay. If Tenant disapproves the additional Cost of Construction or delay, Tenant is deemed to have withdrawn its proposed changes. If Tenant approves the additional Cost of Construction and delay within the 5 Business Day period, Landlord will change the Approved Plans accordingly. If, incident to a requested change to the Approved Plans, Landlord stops work pending resolution of whether Tenant finally approves or disapproves the additional Cost of Construction or delay of a proposed change, then whether or not Tenant ultimately approves or disapproves the proposed change and its attendant additional Cost of Construction or delay, any delay resulting from the work stoppage will constitute a Tenant Delay. All additional Costs of Construction resulting from Tenant Delay or Tenant requested changes to the Approved Plans shall be the responsibility of Tenant and shall be deposited with or reimbursed to Landlord upon demand.

4. Completion.

4.1 Substantial Completion. Landlord intends to cause Substantial Completion of the Tenant Improvements on or before the Target Landlord Work Completion Date (defined in the Lease). Subject to Section 4.2 below, the Tenant Improvements shall be deemed "Substantially Complete" upon the later of (a) the date of completion of the Tenant Improvements pursuant to the Approved Plans, with the exception of any details of construction, mechanical adjustment or any other similar matter the non-completion of which does not materially interfere with Tenant's use of Suite 3200 ("**Punch List Items**"), or (b) the date Landlord receives from the appropriate governmental authorities, with respect to the Tenant Improvements, all approvals necessary for the occupancy of Suite 3200. Landlord will complete the Punch List items within the timeframe specified in Section 7 of this Work Letter.

4.2 Tenant Delay. Each of the following shall constitute a "**Tenant Delay**": (a) Tenant's failure to comply with the deadlines which are Tenant's responsibility to meet as specified in this Work Letter; (b) Tenant's requirement for long lead time items; (c) any changes Tenant proposes to the Approved Plans; (d) Tenant's request that Landlord suspend any portion of the construction for reasons unrelated to construction of the Tenant Improvements in an unsatisfactory manner or breach of Landlord's obligations under this Work Letter or the Lease; (e) Tenant's requirement for materials, components, finishes or improvements which are not available in a commercially reasonable time given the anticipated Target Landlord Work Completion Date; or (f) any other acts or omissions of Tenant, its agents, contractors or employees. Notwithstanding any contrary provision of this Lease, and regardless of when the Tenant Improvements are actually Substantially Completed, the Tenant Improvements shall be deemed to be Substantially Completed on the date on which the Tenant Improvements would have been Substantially Completed if no such Tenant Delay had occurred.

5. Cost Cap. Landlord's agreement to construct the Tenant Improvements is contingent on the total Cost of Construction for the Tenant Improvements not exceeding $21,650 ("**Cost Cap**"). If the Cost of Construction of the Tenant Improvements exceeds the Cost Cap, then Tenant shall be responsible for payment of 100% of such excess cost. Landlord in consultation with its contractor will provide Tenant with an estimate of the total Cost of Construction (as such estimate may be adjusted from time to time, the "**Budget**"). If the Budget identifies a total Cost of Construction in excess of the Cost Cap, then Tenant, prior to commencement of construction, will deposit with Landlord in cash the entire amount by which the total Cost of Construction as estimated in the Budget exceeds the Cost Cap, to be held by Landlord and disbursed from time-to-time to pay Costs of Construction. If from time-to-time Landlord determines that the

Cost of Construction will exceed any prior Budget estimate, then upon demand Tenant will deposit the excess amount (meaning the amount of any increase in estimated Cost of Construction) with Landlord in cash, to be held by Landlord and disbursed in payment of Costs of Construction. Notwithstanding any provision to the contrary contained herein, any portion of the Cost Cap that is not spent on Costs of Construction as of the date which is the first anniversary of the Commencement Date shall revert to Landlord, and Tenant shall have no right to use such amount for any improvements or furniture, trade fixtures, equipment or data cabling, nor as a Rent credit or otherwise (and, for the avoidance of doubt, in no event shall any unspent and unapplied amounts be available to Tenant as a cash payment). In no event shall any portion of the Cost Cap be used to pay Cost of Construction caused by Tenant Delay, Tenant-requested changes to the Space Plan, the Approved Plans or the Final Plans, and/or any Tenant-requested upgrades to materials or finishes, the costs of which shall be paid by Tenant and deposited with or reimbursed to Landlord upon demand.

6. Representatives. **"Landlord's Representative"** means Jack Marr and **"Tenant's Representative"** means Josiah Lisman. Landlord appoints Landlord's Representative to act for Landlord in all matters covered by this Work Letter. Tenant appoints Tenant's Representatives to act for Tenant in all matters covered by this Work Letter. The designated Landlord's Representative and Tenant's Representatives are authorized to speak and act on behalf of Landlord or Tenant respectively and the other will fully and unconditionally be entitled to rely for any and all purposes of this Work Letter, until such designation will be revoked or altered. Either Landlord or Tenant may change its designated representatives by written notice to the other, but no such change or revocation of the power of such representative will affect any approval or consent given by the representative prior to the receipt of such notice. The signature or initials of the designated Representative of a party will be deemed conclusive evidence of the approval of such party to any matter arising under this Work Letter.

7. Tenant's Acceptance of Suite 3200. If on the date the Tenant Improvements are Substantially Complete there remain Punch List Items to complete, Landlord and Tenant will, within 5 Business Days from the date the Tenant Improvements are Substantially Complete (the **"Inspection Period"**), inspect Suite 3200 and prepare a written list (the **"Punch List"**) of such uncompleted items. Landlord agrees to complete (or repair) the Punch List item(s) with commercially reasonable diligence and speed, and within 10 Business Days after the Punch List is delivered to Landlord, provided that if the nature of any items on the list is such that they cannot be completed within 10 Business Days, then within such longer period of time as is reasonably necessary to complete the same and provided further that Landlord commences the completion within the 10 Business Day period and thereafter diligently pursues completion; subject to delays caused by Tenant Delays. If Tenant refuses to inspect Suite 3200 with Landlord within the 5 Business Day period, Tenant is deemed to have accepted Suite 3200 is as delivered. If there is any dispute as to work performed or required to be performed by Landlord, the existence of any Punch List Items or the completion thereof in accordance with the terms of the Lease, or Substantial Completion of the Tenant Improvements, such dispute will be decided jointly by Landlord and Tenant. Tenant's acceptance of possession will conclusively be deemed to establish that Suite 3200 has been completed.

8. Suite 3180 Tenant Improvements. So long as Tenant's termination right under Section 3.02 of the Lease was not exercised and is null and void, Tenant may elect at any time after the Suite 3180 Commencement Date and before January 1, 2024 to have Landlord construct Tenant Improvements in Suite 3180 ("**Suite 3180 Tenant Improvement Work**"). In such event, the terms and conditions of this **Exhibit C** shall apply to the Suite 3180 Tenant Improvement Work, except that the Cost Cap for the Suite 3180 Tenant Improvement Work shall equal $44,820 ("**Suite 3180 Cost Cap**"). For the avoidance of doubt, if the Cost of Construction of the Suite 3180 Tenant Improvement Work exceeds the Suite 3180 Cost Cap, then Tenant shall be responsible for payment of 100% of such excess cost. Landlord in consultation with its contractor will provide Tenant with an estimate of the total Cost of Construction for the Suite 3180 Tenant Improvement Work (as such estimate may be adjusted from time to time, the "**Suite 3180 Budget**"). If the Suite 3180 Budget identifies a total Cost of Construction for the Suite 3180 Tenant Improvement Work in excess of the Suite 3180 Cost Cap, then Tenant, prior to commencement of construction, will deposit with Landlord in cash the entire amount by which the total Cost of Construction as estimated in the Suite 3180 Budget exceeds the Suite 3180 Cost Cap, to be held by Landlord and disbursed from time-to-time to pay Costs of Construction. If from time-to-time Landlord determines that the Cost of Construction will exceed

any prior Suite 3180 Budget estimate, then upon demand Tenant will deposit the excess amount (meaning the amount of any increase in estimated Cost of Construction) with Landlord in cash, to be held by Landlord and disbursed in payment of Costs of Construction. Notwithstanding any provision to the contrary contained herein, any portion of the Suite 3180 Cost Cap that is not spent on Costs of Construction for the Suite 3180 Tenant Improvement work as of January 1, 2024 shall revert to Landlord, and Tenant shall have no right to use such amount for any improvements or furniture, trade fixtures, equipment or data cabling, nor as a Rent credit or otherwise (and, for the avoidance of doubt, in no event shall any unspent and unapplied amounts be available to Tenant as a cash payment). In no event shall any portion of the Suite 3180 Cost Cap be used to pay Cost of Construction for Suite 3180 Tenant Improvement Work caused by Tenant Delay, Tenant-requested changes to the Space Plan, the Approved Plans or the Final Plans, and/or any Tenant-requested upgrades to materials or finishes, the costs of which shall be paid by Tenant and deposited with or reimbursed to Landlord upon demand.

Tenant acknowledges and agrees that if Tenant elects to have Landlord perform the Suite 3180 Tenant Improvement Work, such Suite 3180 Tenant Improvement Work might occur after the Suite 3180 Commencement Date, and in such event, Landlord shall have access to Suite 3180 for purposes of performing the Suite 3180 Tenant Improvement Work. Landlord shall have no responsibility and shall not be liable to Tenant for any injury to or interference with Tenant's business arising from the Suite 3180 Tenant Improvement Work, nor shall Tenant be entitled to any compensation or damages from Landlord for loss of the use of the whole or any part of Suite 3180, or for any inconvenience or annoyance occasioned by the Suite 3180 Tenant Improvement Work. Notwithstanding the foregoing, Landlord shall use commercially reasonable efforts to perform all Suite 3180 Tenant Improvement Work in a manner, whenever reasonably possible, to minimize any material, adverse or unreasonable interference with Tenant's use of or access to Suite 3180.

EXHIBIT D

SUITE 3180 COMMENCEMENT LETTER

Date _____

Tenant _____
Address _____
_____
_____

Re: Commencement Letter with respect to that certain Office Lease dated as of the _____ day of _____, 202_, by and between **BLOCH RIVER VIEW LLC**, a Washington limited liability company, as Asset Manager for **BH PROPERTIES I LLC**, a Washington limited liability company, **BLOCH BOYER LLC**, a Washington limited liability company, and **ZIA SPOKANE LLC**, a Washington limited liability company ("**Landlord**"), and **ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC**, a Washington limited liability company ("**Tenant**"), for _____ rentable square feet on the third floor of the Building located at 16201 E. Indiana Avenue, Spokane Valley, Washington 99216.

Dear _____:

In accordance with the terms and conditions of the above referenced Lease, Tenant accepts possession of the Premises and agrees:

1. The Suite 3180 Commencement Date of the Lease is _____.

2. The Termination Date of the Lease is _____.

Please acknowledge your acceptance of possession and agreement to the terms set forth above by signing this Commencement Letter in the space provided below and returning one fully executed counterpart to my attention. Tenant's failure to execute and return this Commencement Letter, or to provide written objection to the statements contained in this Commencement Letter, within 30 days after the date of this letter shall be deemed an approval by Tenant of the statements contained herein.

Sincerely,

BLOCH RIVER VIEW LLC, a
Washington limited liability company,
Asset Manager

By: [EXHIBIT ONLY—DO NOT SIGN]
Darren Bloch, Manager

Agreed and Accepted:

ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC,
a Washington limited liability company

By: [EXHIBIT ONLY—DO NOT SIGN]
Name: _____
Title: _____

EXHIBIT E

BUILDING RULES AND REGULATIONS

This Exhibit is attached to and made a part of the Lease by and between **BLOCH RIVER VIEW LLC**, a Washington limited liability company, as Asset Manager for **BH PROPERTIES I LLC**, a Washington limited liability company, **BLOCH BOYER LLC**, a Washington limited liability company, and **ZIA SPOKANE LLC**, a Washington limited liability company ("**Landlord**"), and **ACCENTCARE HOSPICE & PALLIATIVE CARE OF SPOKANE COUNTY, LLC**, a Washington limited liability company ("**Tenant**") for space in the Building located at 16201 E. Indiana Avenue, Spokane Valley, Washington 99216.

The following rules and regulations shall apply, where applicable, to the Premises, the Building, the parking facilities, the Property and the appurtenances. In the event of a conflict between the following rules and regulations and the remainder of the terms of the Lease, the remainder of the terms of the Lease shall control. Capitalized terms have the same meaning as defined in the Lease.

1. Sidewalks, doorways, vestibules, halls, stairways and other similar areas shall not be obstructed by Tenant or used by Tenant for any purpose other than ingress and egress to and from the Premises. No rubbish, litter, trash, or material shall be placed, emptied, or thrown in those areas. At no time shall Tenant permit Tenant's employees to loiter in common areas or elsewhere about the Building or Property.

2. Plumbing fixtures and appliances shall be used only for the purposes for which designed and no sweepings, rubbish, rags or other unsuitable material shall be thrown or placed in the fixtures or appliances. Damage resulting to fixtures or appliances due to the gross negligence or willful misconduct of Tenant, its agents, employees or invitees shall be paid for by Tenant and Landlord shall not be responsible for the damage.

3. No signs, advertisements or notices shall be painted or affixed to windows, doors or other parts of the Building, except those of such color, size, style and in such places as are first approved in writing by Landlord. All tenant identification and suite numbers at the entrance to the Premises shall be installed by Landlord, at Tenant's cost and expense, using the standard graphics for the Building. Except in connection with the hanging of lightweight pictures and wall decorations, no nails, hooks or screws shall be inserted into any part of the Premises or Building except by the Building maintenance personnel without Landlord's prior approval, which approval shall not be unreasonably withheld.

4. Landlord may provide and maintain in the first floor (main lobby) of the Building an alphabetical directory board or other directory device listing tenants and no other directory shall be permitted unless previously consented to by Landlord in writing.

5. Tenant shall not place any lock(s) on any door in the Premises or Building without Landlord's prior written consent, which consent shall not be unreasonably withheld, and Landlord shall have the right at all times to retain and use keys or other access codes or devices to all locks within and into the Premises. A reasonable number of keys to the locks on the entry doors in the Premises shall be furnished by Landlord to Tenant at Tenant's cost and Tenant shall not make any duplicate keys. All keys shall be returned to Landlord at the expiration or early termination of the Lease.

6. All contractors, contractor's representatives and installation technicians performing work in the Building shall be subject to Landlord's prior approval, which approval shall not be unreasonably withheld, and shall be required to comply with Landlord's standard rules, regulations, policies and procedures, which may be revised from time to time.

7. Movement in or out of the Building of furniture or office equipment, or dispatch or receipt by Tenant of merchandise or materials requiring the use of elevators, stairways, lobby areas or loading dock areas, shall be restricted to hours reasonably designated by Landlord. Tenant shall obtain

Landlord's prior approval by providing a detailed listing of the activity, which approval shall not be unreasonably withheld. If approved by Landlord, the activity shall be under the supervision of Landlord and performed in the manner required by Landlord. Tenant shall assume all risk for damage to articles moved and injury to any persons resulting from the activity. If equipment, property, or personnel of Landlord or of any other party is damaged or injured as a result of or in connection with the activity, Tenant shall be solely liable for any resulting damage, loss or injury.

8. Landlord shall have the right to approve the weight, size, or location of heavy equipment or articles in and about the Premises, which approval shall not be unreasonably withheld. Damage to the Building by the installation, maintenance, operation, existence or removal of Tenant's Property shall be repaired at Tenant's sole expense.

9. Corridor doors, when not in use, shall be kept closed.

10. Tenant shall not: (1) make or permit any improper, objectionable or unpleasant noises or odors in the Building, or otherwise interfere in any way with other tenants or persons having business with them; (2) solicit business or distribute or cause to be distributed, in any portion of the Building, handbills, promotional materials or other advertising; or (3) conduct or permit other activities in the Building that might, in Landlord's sole opinion, constitute a nuisance.

11. No animals, except those assisting handicapped persons, shall be brought into the Building or kept in or about the Premises.

12. No inflammable, explosive or dangerous fluids or substances shall be used or kept by Tenant in the Premises, Building or about the Property, except for those substances as are typically found in similar premises used for general office purposes and are being used by Tenant in a safe manner and in accordance with all applicable Laws. Tenant shall not, without Landlord's prior written consent, use, store, install, spill, remove, release or dispose of, within or about the Premises or any other portion of the Property, any asbestos-containing materials or any solid, liquid or gaseous material now or subsequently considered toxic or hazardous under the provisions of 42 U.S.C. Section 9601 et seq. or any other applicable environmental Law which may now or later be in effect. Tenant shall comply with all Laws pertaining to and governing the use of these materials by Tenant and shall remain solely liable for the costs of abatement and removal.

13. Tenant shall not use or occupy the Premises in any manner or for any purpose which might injure the reputation or impair the present or future value of the Premises or the Building. Tenant shall not use, or permit any part of the Premises to be used for lodging, sleeping or for any illegal purpose. Tenant shall not allow the Premises to be occupied by more than one person per 200 rentable square feet without the prior written consent of Landlord.

14. Tenant shall not take any action which would violate Landlord's labor contracts or which would cause a work stoppage, picketing, labor disruption or dispute or interfere with Landlord's or any other tenant's or occupant's business or with the rights and privileges of any person lawfully in the Building (**"Labor Disruption"**). Tenant shall take the actions necessary to resolve the Labor Disruption, and shall have pickets removed and, at the request of Landlord, immediately terminate any work in the Premises that gave rise to the Labor Disruption, until Landlord gives its written consent for the work to resume. Tenant shall have no claim for damages against Landlord or any of the Landlord Related Parties nor shall the Commencement Date of the Term be extended as a result of the above actions.

15. Tenant shall not install, operate or maintain in the Premises or in any other area of the Building, electrical equipment that would overload the electrical system beyond its capacity for proper, efficient and safe operation as determined solely by Landlord. Tenant shall not furnish cooling or heating to the Premises, including without limitation, the use of electric or gas heating devices, without Landlord's prior written consent. Tenant shall not use more than its proportionate share of telephone lines and other telecommunication facilities available to service the Building.

16. Tenant shall not operate or permit to be operated a coin or token operated vending machine or similar device (including without limitation, telephones, lockers, toilets, scales, amusement devices and machines for sale of beverages, foods, candy, cigarettes and other goods), except for machines for the exclusive use of Tenant's employees and invitees.

17. Bicycles and other vehicles are not permitted inside the Building or on the walkways outside the Building, except in areas designated by Landlord.

18. Landlord may from time to time adopt systems and procedures for the security and safety of the Building and Property, its occupants, entry, use and contents. Tenant, its agents, employees, contractors, guests and invitees shall comply with Landlord's systems and procedures.

19. Landlord shall have the right to prohibit the use of the name of the Building or any other publicity by Tenant that in Landlord's sole opinion may impair the reputation of the Building or its desirability. Upon written notice from Landlord, Tenant shall refrain from and discontinue such publicity immediately.

20. The Building (including the Premises) is designated as a non-smoking building. Neither Tenant nor its agents, employees, contractors, guests or invitees shall smoke or permit smoking in the Premises or the Building. Neither Tenant nor its agents, employees, contractors, guests or invitees shall smoke or permit smoking in the Common Areas, unless a portion of the common areas have been declared a designated smoking area by Landlord.

21. Landlord shall have the right to designate and approve standard window coverings for the Premises and to establish rules to assure that the Building presents a uniform exterior appearance. Tenant shall ensure, to the extent reasonably practicable, that window coverings are closed on windows in the Premises while they are exposed to the direct rays of the sun.

22. Deliveries to and from the Premises shall be made only at the times in the areas and through the entrances and exits reasonably designated by Landlord. Tenant shall not make deliveries to or from the Premises in a manner that might interfere with the use by any other tenant of its premises or of the Common Areas, any pedestrian use, or any use which is inconsistent with good business practice.

23. The work of cleaning personnel shall not be hindered by Tenant after 6:00 P.M., and cleaning work may be done at any time when the offices are vacant. Windows, doors and fixtures may be cleaned at any time. Tenant shall provide adequate waste and rubbish receptacles to prevent unreasonable hardship to the cleaning service.

24. Parking Rules and Regulations. The following rules and regulations shall apply with respect to all parking on the Property:

    a. Landlord reserves the right to designate the use of parking spaces at the Property, and parking shall be prohibited except in areas specifically marked for parking. All parked vehicles shall be parked within (and never across) the striped lanes designated for such purpose, and no portion of any parked vehicle may block any driveway.

    b. Parking between the hours of 7:00 P.M. and 6:00 A.M. is not permitted without the prior consent of Landlord or its property manager.

    c. Areas marked as "loading" zones shall be used solely for purposes of loading and unloading of equipment, personal property, or materials used at the Property. Any vehicles being loaded or unloaded shall be properly parked in a parking space or stopped in such a marked "loading" zone. No vehicle stopped in a "loading" zone may be left unattended.

d. Only passenger vehicles may be parked at the Property. The parking of trucks, trailers, recreational vehicles, boats, and campers is specifically prohibited. Landlord may, in its sole discretion, designate separate areas for bicycles and motorcycles.

e. No "For Sale" or other advertising signs or signs referring to the Property may be placed on or about any vehicle parked at the Property.

f. No vehicles may be parked overnight at the Property without Landlord's prior written consent.

g. No vehicle that exceeds 30 feet in length may enter the Property for any purpose.

h. While driving in the driveways and parking lots, drivers shall comply with all directional signs and arrows and shall not exceed the speed limit of 5 miles per hour.

i. Washing, waxing, cleaning and servicing of vehicles in the Property are prohibited.

j. Tenant shall provide Landlord with a list of license plate numbers of Tenant's employees using the parking facilities to enable Landlord to monitor the use of the parking facilities. Tenant shall be responsible for notifying Landlord as to any modifications to such list.

k. Landlord reserves the right to have any vehicle that violates any provision of these Parking Rules and Regulations towed at the vehicle owner's or user's expense.

l. Parking stickers or any other device or form of identification supplied by Landlord shall remain the property of Landlord. Such parking identification device shall be displayed as requested and may not be mutilated in any manner. Such devices shall not be transferable, and any device in the possession of an unauthorized holder shall be void. There shall be a replacement charge to the Tenant, at Landlord's then standard rates, for loss of any such device. Loss or theft of any such device shall be reported to Landlord immediately. Any parking identification devices found on or used for an unauthorized car may be confiscated and the illegal holder shall be subject to prosecution. Lost or stolen devices previously reported and then found shall be reported found to Landlord immediately.

EXHIBIT F

EXTENSION TERM

1. **Option to Extend Term and Method of Exercise.** Tenant shall have the right ("**Extension Option**"), subject to all of the terms and conditions stated in this Exhibit, to extend the Term for one additional period of 5 years ("**Option Term**"), with the Option Term to commence immediately following the then effective Termination Date of the initial Term. Tenant shall exercise the Extension Option by delivery of written notice to Landlord at least 180 days and no more than 360 days prior to the then effective Termination Date of the initial Term. The Extension Option is not assignable separate and apart from this Lease. Moreover, the Extension Option is personal to the original Tenant (meaning Accentcare Hospice & Palliative Care of Spokane County, LLC) and may not be exercised by or assigned to any other person or entity, voluntarily or involuntarily, other than an assignee of Tenant's entire leasehold estate pursuant to a Permitted Transfer. Otherwise, no assignee or sublessee shall be entitled to or have the right to exercise the Extension Option.

2. **Incorporation of Lease by Reference.** All of the terms, covenants and conditions contained in this Lease shall be applicable to the Option Term in the event of exercise by Tenant; provided, however, that the Term and the Monthly Rent shall be modified as provided herein and Tenant shall not be entitled to any additional or further Extension Option or Option Terms.

3. **Rent.** The Monthly Rent for the Option Term shall be adjusted to equal the Prevailing Market Rent, described below.

4. **Prevailing Market Rent.** The "**Prevailing Market Rent**" shall be equal to the rental per square foot of rentable area per year (divided by 12) as of the date which is 6 months prior to the expiration of the initial Term, prevailing for comparable office/medical space in the Building or in similar buildings in the area of the Building, as reasonably determined by Landlord (or by appraisal, as provided below), including any market annual escalations after the first year of the Option Term. In determining the Prevailing Market Rent, whether considering comparable space within the Building or in the area of the Building, the following shall apply:

a. The rentable area, particular configuration, frontage along a public thoroughfare, signage visible to the public, parking facilities, and general level of quality of improvements and location of each comparison building shall be taken into account.

b. Charges for parking, if any, and charges for operating expenses, taxes and insurance, shall be taken into account.

c. No rent which has not been set or adjusted during the twelve-month period immediately preceding the then effective Termination Date shall be considered prevailing or current.

d. Periods of free rent or other rent concessions shall not be taken in account.

e. No deduction or offset shall be made for any tenant improvement or refurbishment allowance paid with respect to the comparable spaces.

The Prevailing Market Rent determined in accordance with this Section 4 shall be increased to reflect any commissions paid by Landlord in connection with the Option Term.

5. **Notice; Appraisal.** If Tenant has timely exercised the Extension Option, Landlord shall notify Tenant in writing of the Prevailing Market Rent and the new Monthly Rent as determined by Landlord for the Option Term at least 90 days prior to the Commencement Date of the Option Term. Tenant shall have the right to notify Landlord within 10 days after receipt of such notice from Landlord that Tenant does not agree with the new Monthly Rent as established by Landlord and that Tenant elects to have the Prevailing Market Rent determined by appraisal of comparable space in the Building or in similar buildings in the area of the Building. In such event, Landlord will within an additional 10 days thereafter choose an appraiser of its choice ("**First Appraiser**") whose name will be submitted to Tenant who shall then have 10 days ("**Approval Period**") within

which to approve or disapprove of the First Appraiser. Any appraiser appointed pursuant to this section shall be an MAI with at least 10 years' experience appraising rental rates for commercial space similar to the Premises in buildings similar to the Building. All appraisals conducted for the purpose of determining Prevailing Market Rent shall be based on the factors listed above under the heading "**Prevailing Market Rent.**" Whether or not approval is given, Landlord will commission an appraisal of the Prevailing Market Rent by the First Appraiser and if Tenant has approved the First Appraiser, the Prevailing Market Rent will be the amount calculated by the First Appraiser based upon such appraisal. If approval is not given, then Tenant shall have 10 days after the expiration of the Approval Period within which to designate in writing to Landlord a second appraiser ("**Second Appraiser**"), whose services shall be utilized by Tenant. Both the First and Second Appraisers shall submit their appraisals of the Prevailing Market Rent as soon as commercially reasonable, but in no event later than 30 days subsequent to the designation of the Second Appraiser. If the Prevailing Market Rents determined by the First Appraiser and Second Appraiser differ by less than 10%, the average of the two values shall be the Prevailing Market Rent. If they differ by 10% or more, the two appraisers shall immediately appoint a third appraiser, who shall determine the Prevailing Market Rent by what is commonly referred to as the "baseball arbitration" approach, that is, the third appraiser shall select the appraisal of either the First Appraiser or the Second Appraiser as determinative of Prevailing Market Rent, and may not make a decision other than in favor of one of the two appraisals presented. If the First and Second Appraisers fail to agree upon a third appraiser as provided for herein, then the appointment of such required third appraiser shall be made, at the request of any party, by the American Arbitration Association, in its sole and absolute discretion, subject to the provisions hereof. Landlord and Tenant shall each bear one-half of all fees and expenses of the appraisal process and the appraiser(s) selected pursuant to this paragraph. If the appraisal process described herein is not concluded by the commencement of the Option Term, then the Monthly Rent at the commencement of the Option Term shall be the Monthly Rent in effect during the last month of the initial Term, with any increase that is due upon conclusion of the appraisal process and determination of the Prevailing Market Rent to accrue from and be owed retroactively to the commencement date of the Option Term.

6. Effect of Default. If Tenant has been in material default beyond any applicable cure period during the initial Term of the Lease, or if at the time of Tenant's exercise of the Extension Option any event or condition has occurred which but for the lack of notice or passage of time would constitute a material default under the Lease, then Tenant shall have no Extension Option and no right to exercise the Extension Option, and any purported exercise of the Extension Option by Tenant shall be null, void and of no force or effect. In addition, if Tenant has been in default in payment of any sum required by this Lease where a late charge has become due under this Lease for more than 3 times during the initial Term, then the provisions of this Extension Option to extend the Term shall be canceled and shall be of no force or effect. No condition of the Premises, including without limitation any alteration or improvement made by Tenant, oral intention expressed by Tenant or detrimental reliance by Tenant on any statement, act or omission by Landlord shall vest any rights in Tenant for exercise of this Extension Option or to possess the Premises during any period set for extension of the Term or estop Landlord from eviction of Tenant after the end of the initial Term or give rise to any equitable defense to such eviction. Tenant hereby waives any and all equitable remedies with respect to the Extension Option unless Tenant has complied in all respects with the written notice requirements set forth herein. The sole and exclusive method for exercise of the Extension Option contained herein shall be delivery of the written notice called for herein by Tenant to Landlord on a timely basis. Landlord and Tenant hereby agree that time is of the essence with respect to delivery of any notice of exercise by Tenant to Landlord. The date for delivery of any notice required or permitted in this Extension Option shall be determined by the provisions for delivery of notice contained in this Lease.

EXHIBIT 5

Homecare Homebase Brochure
Cardiac Care Program Brochure
Sample *PharmSmart* Newsletter

Your Single Software for Complete Hospice Care

homecare homebase™
Empowering Exceptional Care™

HOSPICE

A history of hospice innovation

Since 2005, Homecare Homebase℠ (HCHB) has been helping solve the unique challenges of hospice care. Our software is now the most robust solution in the industry – used by 8 of the 10 top hospice agencies serving over one third of the country's hospice patients and their families.

No matter what your size, we can help you create powerful, positive changes in everything from recruitment and staffing to patient care, billing and compliance. And with streamlined scheduling, workflow, documentation and improved cash flow, you can spend more quality time with patients.

No matter where you are, we're there for you

HCHB serves 1/3 of all hospice patients in the United States

The software you need for a whole new era

The future of hospice care involves constant change and unknown challenges. Homecare Homebase is dedicated to tackling these with innovative software and interoperability with all those in your patients' circle of care. In close community with top hospices, we're always looking for new ways to streamline processes, maximize resources and capitalize on emerging trends to enhance the patient experience and keep you at the top of your game.

The heart of our hospice solution

Our Person-Centered Care Plan lets you document specific Problems, Goals & Interventions for each patient, then easily update or modify them as needed. These updates are readily available to nurses, physicians, social workers, chaplains and others, giving the team the most accurate, helpful data to provide the best care possible.

Hospice Inpatient Unit (HIU)

For 'round the clock care in a Hospice Inpatient Unit, our new HIU solution offers everything you need in one live interface. The "always on" functionality in this laptop-based platform tracks multiple assessments by various clinicians throughout the day, then keeps everyone informed and updated, enabling seamless shift changes and a helping ensure consistent, quality care.

No back and forth between apps – It's all right here:

- *Real-time assessments across all disciplines*
- *Medication alerts, reminders and documentation*
- *Fully-integrated clinical and back office connectivity*
- *Robust analytics and reporting*

HCHB Hospice software makes it easy to:

- Stay in compliance with visit frequencies and other regulations
- Easily track and manage IDG collaboration
- Complete documentation onsite, then quickly upload in under 2 minutes
- Manage bereavement support services
- View schedules and optimize routes for better staffing utilization
- Track and coordinate volunteer staff

Connect, Share and Care

Advanced interoperability across the healthcare community

homecare homebase™
Empowering Exceptional Care™

INTEROPERABILITY

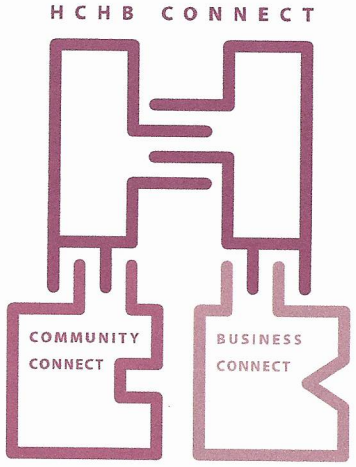
Connecting communities for the future of home-based care

Today's ever-evolving care requires trusted connections and seamless sharing of complex data across multiple platforms and locations. At Homecare Homebase℠ (HCHB) we've made interoperability a key part of everything we do. The result is informed, expert patient care at every touch point across the entire health care ecosystem.

As America's #1 home health and hospice software, we're leading the way with cutting-edge technologies to strengthen communications, streamline processes and build solid partnerships to better serve all those who depend on you.

It all comes together with HCHB Connect

The future of home health and hospice requires extreme interoperability with fast, accurate, two-way data sharing on every level — with virtually every health care partner and provider. That's why we've created **HCHB Connect**, a suite of cross-platform, EMR-agnostic solutions to reach everyone in a patient's circle of care.



HCHB Community Connect and **HCHB Business Connect** offer two distinct pathways to help ensure constant communication and streamlined exchanges that empower exceptional care and keep your agency running at peak performance. Turn the page to see how they can benefit you.

Strengthen relationships and attract more referrals

HCHB Community Connect allows you to easily share patient data with health systems, ACOs, HIEs and the larger healthcare continuum. It also helps you attract more referrals and streamline the most critical and time-consuming tasks.

Referral
Receive referrals and data directly to your HCHB software

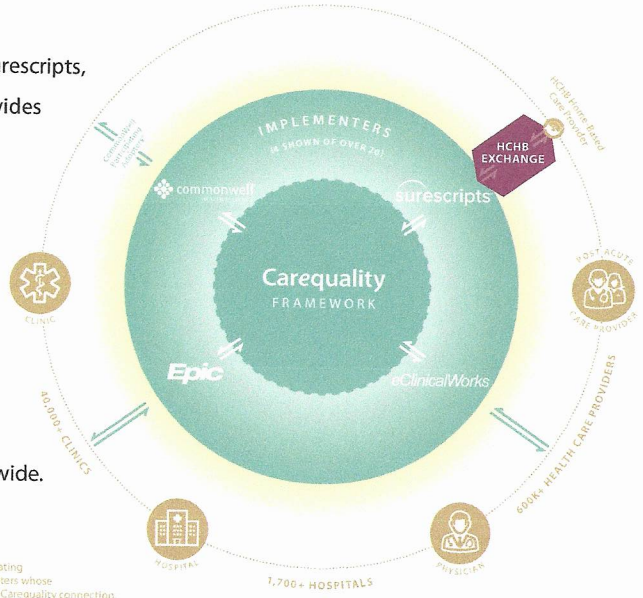
Signature
Electronically present documents for physician review and signature

Clinical Information Exchange (CIE)
Send/request patient data to update caregivers across the clinical network

Population Health
Monitor and take action on patients at risk for readmission

Extend your reach with HCHB Exchange

In partnership with Surescripts, **HCHB Exchange** provides a safe, secure onramp to the Carequality framework, enabling Clinical Information Exchange (CIE) with over 600,000 health care providers, 40,000 clinics and 1,700 hospitals nationwide.



*Carequality Implementers include participating CommonWell Health Alliance Service Adopters whose provider sites are live on the CommonWell-Carequality connection.

Quickly and easily transact with key business partners

HCHB Business Connect enables communication with partners, vendors, facilities, payroll and others across multiple platforms and locations. It gives you everything you need to provide expert patient care while you streamline processes and boost staff satisfaction, productivity and profits.

Benchmarking Provides detailed metrics for informed business decisions

Careplan Optimization Enhances patient care and profits

Document Management Eliminates manual processes and boosts cash flow

EVV Transmits visit data to state aggregators

General Ledger	Customized HCHB exports to load into agency's general ledger
Market Targeting	Identifies lucrative new territories and referral sources
Medication Management	Oversees meds throughout the patient's care journey
Payroll	Custom HCHB payroll export to be uploaded to agency's payroll system
Pharmacy	Transmits patient information to pharmacy partner
Revenue Cycle	Simplifies claims processing and shortens AR time frame
Supplies & DME	Streamlines orders and lowers overall cost
Surveys	Automates transmission of data to survey partner
Telehealth/Monitoring	Enables constant visibility into patient's health status
Visit Documentation	Transmits specialty visit types directly into HCHB
Wound Care	Seamlessly manage HCHB patients in your wound care platform

Seasons Hospice & Palliative Care
Hope for Advanced Cardiac Disease

The Seasons Cardiac Care Program manages the unique end-of-life symptoms of your cardiac patients. Our team of hospice physicians and cardiac-trained nurses focuses on providing the latest guideline-based therapies for end-of-life management of advanced cardiac disease, and education to provide support for patients and families in the home environment. Our team helps prevent unnecessary emergency department and hospital admissions by focusing on symptom control, functional status, and quality of life.*

Reduced emergency room visits and hospital readmissions

Cardiac Care Program Goals:

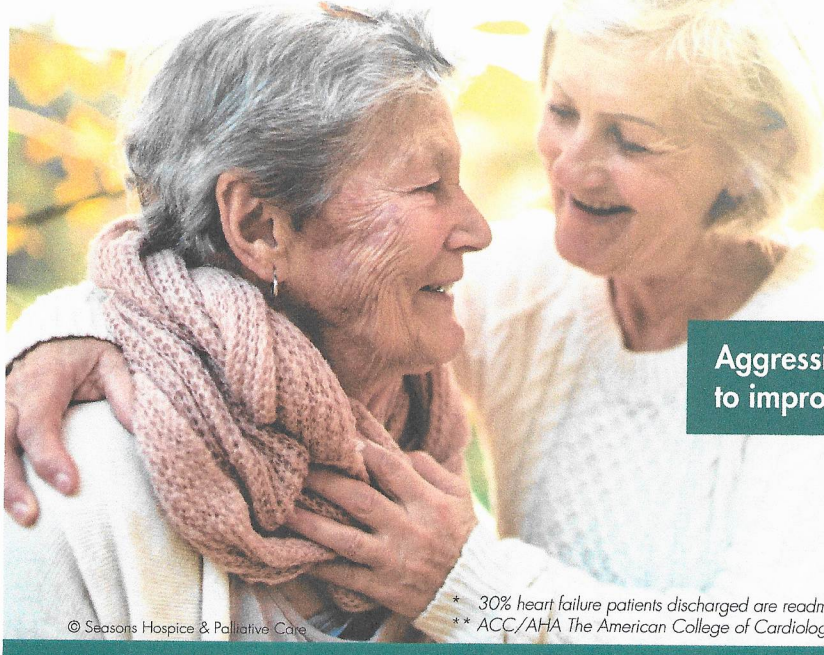
1. **Deliver ACCF/AHA** guideline-based hospice care** to the Class IV Stage D heart failure (HF) patients
2. **Provide symptom relief** with HF guideline medications, including IV inotropes and IV diuretics
3. **Provide emergency support** and management tools to prevent calls to 911
4. **Provide hospice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

Clinical Care for Class IV Stage D patients with end-stage heart failure includes:

- 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

Your patient is ready for the Seasons Hospice & Palliative Cardiac Care Program when he/she:

- Has Class IV Stage D HF with significant symptoms despite optimal treatment with HF guideline medications
- Has been admitted to the hospital for HF decompensation > 3 times in the last 6 months
- Is not a candidate for high risk revascularization, LVAD, transplant or have inoperable aortic stenosis
- Is end-stage LVAD or heart transplant
- Is unable to tolerate indicated guideline medications



Aggressive symptom management to improve quality of life

For more information about our Hospice Cardiac Care program, please call **855-893-0530**

* 30% heart failure patients discharged are readmitted within 48 hours
** ACC/AHA The American College of Cardiology Foundation/American Heart Association/HFSA Heart Failure Society of America guidelines

CCP_5/2018

Seasons Hospice & Palliative Care Services

SEASONS HOSPICE & PALLIATIVE CARE 20 YEARS OF HONORING LIFE OFFERING HOPE ANNIVERSARY EST. 1997

Palliative Care

Qualified specialists led by certified hospice and palliative care physicians and advanced practice nurses provide pain and symptom management to enhance the quality of life for patients who do not meet the hospice eligibility criteria or are not ready to access hospice care.

Open Access

Allows patients with terminal illnesses who are currently receiving medical treatments and/or experiencing intense psychosocial issues to access hospice services sooner. Treatments include, but are not limited to, ventilator support, IV antibiotics/hydration, TPN, cardiac drips, chest tubes, palliative radiation and oral chemotherapy.

Cardiac Care Program

A team of hospice phsysicians and cardiac-trained nurses use the latest guideline-based therapies to provide education and support for patients and families managing advanced cardiac disease at the end of life.

Continuous Care

Promotes timely intervention to ensure comfort and quality of life by allowing patients to remain home and avoid hospitalization during periods of acute medical crisis. Seasons Continuous Care staff also provide support and education to caregivers for safe, skilled care at home.

Namaste Care

Highly specialized program that improves quality of life through meaningful person-centered sensory activities stimulating the senses to evoke memory, decrease pain and agitation, promote relaxation, and offer comfort and serenity to those living with dementia and diseases. Namaste Care also provides moments of peace and tranquility to family caregivers.

Music Therapy

Seasons Hospice recognizes the power of music as an integral component of our holistic approach to the treatment of our patients and their families. Even when people have difficulty communicating, they can be consoled and comforted with music.

Cardiac Care Program

Hospice physicians and cardiac trained hospice nurses focus on providing the latest Heart Failure guideline-based therapies, along with education to provide support for patients and families in their home environment. Our team helps prevent unnecessary emergency department and hospital admissions by focusing on symptom control, functional status, and quality of life.

855-893-0530

December 7, 2017

PharmSmart Newsletter

Corticosteroids: Essential Medications in Advanced Illness

Hi Team Seasons,

This email is being sent to all clinical staff and all Hospice Care Consultants.

PharmSmart

Volume 10, Number 8

A newsletter dedicated to the safe and effective use of medications in caring for patients with advanced illnesses. PharmSmart is produced and edited by Seasons National Consultant Pharmacist, Mary Lynn McPherson, PharmD, MA, BCPE.

Corticosteroids: Essential Medications in Advanced Illness

Let's meet **Mr. Johnson**, a 59-year-old African American man diagnosed with prostate cancer about 9 months ago. He was treated with surgery, chemotherapy and radiation; despite these interventions, his disease progressed, and he has been admitted to hospice care. On admission his main complaint is pain – a severe, achy pain in his right ribs and vertebral column. He rates the pain as between an 8 and 10, and states that the pain keeps him from getting a decent night's sleep. He gets tired very quickly, and just feels so rotten in general that he's lost his appetite as well. He is taking MS Contin 30 mg po q12h, with oral morphine solution 10 mg po q2h prn additional pain. He uses the oral morphine solution, but it only partially relieves the pain. When he takes repeated doses it doesn't seem to be MORE effective for his pain, but it gives him "medicine head" and makes him more constipated. He tells you he's not sure how much longer he can keep going on like this.

Patients with advanced illness, cancer and non-cancer, suffer from a variety of pain and non-pain symptoms (e.g., fatigue, anorexia, cachexia, nausea, depression). The pathogenesis of these symptoms is thought to be due to inflammatory cytokines and proteins that stem from arachidonic acid conversion to prostaglandins and leukotrienes by phospholipase A. Metastatic bone pain, in particular, is caused by prostaglandin activity; this type of pain is only partially response to opioid therapy. The enzyme that generates these prostaglandins and leukotrienes can be inhibited by corticosteroids, explaining why corticosteroids (or, "steroids") are incredibly valuable tools in treating pain and other symptoms in advanced illness. Nonsteroidal anti-inflammatory drugs (NSAIDs) can also inhibit prostaglandin activity, and are useful in treating metastatic bone pain.

What else can steroids be used for? Other uses in advanced illness include the reduction of inflammation such as that associated with metastatic disease to the brain, or a partial bowel obstruction. Steroids help with obstructive airway disease (e.g., asthma, COPD), some forms of nausea, neuropathic pain, spinal cord compression, liver capsular pain, anorexia/cachexia, depression and general well-being/weakness. Sounds like a wonder drug, doesn't it?

Let's not get ahead of ourselves – we left poor Mr. Johnson hanging! How do we decide whether to recommend an NSAID for his metastatic bone pain, or a steroid? Several considerations go into this decision. First, a steroid will provide multiple pharmacologic effects for Mr. Johnson – not only will a steroid help with his pain, it will also help perk him up and hopefully give him a little more energy. A NSAID will only help the metastatic bone pain. Another big consideration is what side effects will the NSAID vs. steroid cause?

NSAIDs are known to cause a variety of short-term and long-term adverse effects. The most likely side effect is gastrointestinal upset, which could cause or reactivate an ulcer. NSAIDs can also cause sodium and fluid retention, causing and worsening hypertension and heart disease. NSAIDs may also compromise renal function by reducing renal blood flow. More serious, but less common, adverse effects (and more likely associated with long-term therapy) include an increased risk of heart attack and stroke.

Steroids also cause short-term and long-term toxicities. Adverse effects seen more quickly include immunosuppression (increasing the risk of thrush), hyperglycemia, and psychiatric disorders. If the patient is having cognitive changes due to primary or metastatic disease to the brain, often a steroid will remediate these symptoms. On the other hand, steroids can also CAUSE psychiatric disorders! Longer-term adverse effects include proximal myopathy, peptic ulceration, osteoporosis, thinning of the skin and Cushing's syndrome.

Since we are MORE concerned about short-term or immediate onset side effects, it is worth considering if Mr. Johnson has a history of peptic ulcer disease, GI upset from medications, or glucose intolerance (such as diabetes). If he DOES have a history of GI upset or peptic ulceration, both NSAIDs and steroids can be problematic. If it's not too severe, it may be sufficient to add a proton pump inhibitor to his regimen (e.g., omeprazole). If Mr. Johnson has hyperglycemia (e.g., pre-diabetes or diabetes mellitus) we would have to carefully consider whether or not to use a steroid. Diabetes is not an absolute contraindication to steroid therapy; in fact the benefit of a steroid may be so significant that it is still worthwhile even if we have to pharmacologically manage the resultant hyperglycemia.

Luckily, Mr. Johnson doesn't have any significant comorbid issues that would preclude the use of a NSAID or steroid, so let's go big and decide to use a steroid. We are hopeful that a steroid will provide multiple pharmacologic benefits for Mr. Johnson. So, which steroid should we pick? There really isn't sufficient literature to support the selection of one steroid over another, but we can consider the half-life, anti-inflammatory potency (glucocorticoid effect) and effect on sodium and fluid retention (mineralocorticoid effect). Let's consider this comparative chart:

Steroid	Equivalent Dose (mg)	Glucocorticoid Potency (anti-inflammatory)	Mineralocorticoid Potency (sodium and water retention)
Hydrocortisone	20	1	2
Prednisone	5	4	1
Methylprednisolone	4	5	0
Dexamethasone	0.75	25	0

As you can see from the chart, dexamethasone is a much more potent steroid in terms of anti-inflammatory action – it's over five times more potent than prednisone. But it has far LESS mineralocorticoid activity, so it's less likely to cause sodium and fluid retention.

Consider this conversation – a nurse in the field calls the consultant pharmacist to discuss a patient's pain problem. The pharmacist suggests adding a corticosteroid, to which the nurses responds, "Oh he's already on one – he's getting prednisone 10 mg once a day." Ten milligrams sounds like a hefty dose, but when you look at the equivalency data in the chart above, 10 mg of prednisone is only about 1.5 mg of dexamethasone. Is 1.5 mg dexamethasone enough to get the job done when used to treat pain? Let's take a look at dosing recommendations for the most common uses of steroids in end of life care.

Indication	Recommended dose/day (mg) dexamethasone
Bone and neuropathic pain	4-8 mg
Anorexia/general well-being	2-4 mg
Nausea and vomiting	4-8 mg
Dyspnea	4-8 mg
Raised intracranial pressure	8-16 mg
Spinal cord compression	16-32 mg
Superior vena cava obstruction	16-24 mg
Bowel obstruction	8-16 mg

The lowest dose recommended is 2-4 mg a day (anorexia/general well-being); the dose for **pain** is generally 4-8 mg a day. We COULD stay with prednisone and just increase the dose to 25 mg (prednisone 25 mg ~ dexamethasone 4 mg), or we could switch to dexamethasone 2 mg twice a day (with breakfast and lunch), capitalizing on the greater glucocorticoid potency and less mineralocorticoid activity. Because we're switching steroids (not simply discontinuing the prednisone), AND going to a higher dose, it's ok to stop the prednisone, and pick up the next day with the dexamethasone.

Back at the ranch with Mr. Johnson, since we're treating his metastatic bone pain primarily, we can start at either 4 or 8 mg a day of dexamethasone. Generally speaking, because dexamethasone has a long half-life, we could dose this medication once daily. To make things a little easier on the stomach, it's probably better to split the dose and offer it with breakfast and lunch. For example, we could start Mr. Johnson on dexamethasone 2 mg by mouth with breakfast and again with lunch. Because steroids can cause insomnia, we

don't want to give the medication after early afternoon. If Mr. Johnson has a partial response, but is tolerating the dexamethasone, we can increase the dose to 4 mg with breakfast and 4 mg with lunch as needed.

Some additional guidance regarding the use of steroids is as follows:

- If the patient has not responded after dosage titration, and a 5-7 day trial, discontinue the steroid.
- Steroids may be stopped without tapering if the course of therapy is 2 weeks or less. If a taper is necessary, reduce the totally daily dose by 10-20% every 1-2 weeks until the steroid is stopped. If a patient is tolerating the steroid with good effect, and not experiencing adverse effects, there is NOT an obligation to taper down or discontinue the steroid.
- Dexamethasone is available as a 0.5, 0.75, 1, 1.5, 2, 4 and 6 mg tablet; an oral solution as 0.5 mg/5 ml and an oral intensol solution as 1 mg/ml. The intensol solution may be administered in the buccal cavity (prop the upper body up 30 degrees to prevent aspiration).

Mr. Johnson was started on dexamethasone 2 mg po twice daily. His pain improved, as did his mood. But there was still room for improvement, so after one week his dexamethasone dose was titrated to 4 mg po twice daily. He remained on this dose, with good effect until his death. His hospice nurse switched to the oral intensol solution a week before he died, to facilitate administration.

Resources:

- Guidelines for the use of corticosteroids in palliative care. The Princess Alice Hospice. Available at: https://www.palliativedrugs.com/download/090423_Steroid_Guidelines_Summary_2008.pdf
- Leppert W, Buss T. The role of corticosteroids in the treatment of pain in cancer patients. Curr Pain Headache Rep 2012;16:307-313.
- Liu D, Ahmet A, Ward L, et al. A practical guide to the monitoring and management of the complications of systemic corticosteroid therapy. Allergy, Asthma & Clinical Immunology 2013;9:30.
- Mercadante S, Fulfaro F, Casuccio A. The use of corticosteroids in home palliative care. Support Care Cancer 2001;9:386-389.
- Shih A, Jackson KC. Role of corticosteroids in palliative care. Journal of Pain & Palliative Care Pharmacotherapy 2007;21(4):69-76.
- Use of corticosteroids in palliative medicine. 3 counties hospice. Available at: http://www.gloshospitals.nhs.uk/SharePoint75/Palliative%20Care%20Web%20Documents/3CCN%20steroids2010%20updated.pdf
- Yennurajalingam S, Bruera E. Role of corticosteroids for fatigue in advanced incurable cancer: is it a "wonder drug" or "deal with the devil." *Curr Opin Support Palliat Care* 2014;8(4):346-351.

Contact us

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February 5, 2018

PharmSmart Newsletter

Effective Medication Management in Hospice Care: It All Starts with ASSESSMENT!

Hi Team Seasons,

This email is being sent to all clinical staff and all Hospice Care Consultants.

PharmSmart

Volume 11, Number 2

A newsletter dedicated to the safe and effective use of medications in caring for patients with advanced illnesses. PharmSmart is produced and edited by Seasons National Consultant Pharmacist, Mary Lynn McPherson, PharmD, MA, BCPE.

Effective Medication Management in Hospice Care: It All Starts With Assessment!

Patients with advanced, serious illness routinely take multiple medications. This may include medications used to manage their chronic medical conditions, as well as medications used for pain and non-pain symptom control. The greater the number of medications a patient is taking, the greater the risk of causing an adverse drug reaction, or drug interaction. Before we can review the medication regimen to assure the patient is receiving only medically appropriate medications, we must first begin with a comprehensive medication reconciliation.

The Joint Commission defines **medication reconciliation** as "the process of comparing a patient's medication orders to all of the medications that the patient has been taking."[1] Medication reconciliation is performed at every transition in care (including changes in setting, service, practitioner, or level of care) to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.[1]

All hospice programs have their own policy and procedure for medication reconciliation, but some best practice elements are likely common themes. Examples include:[2]

1. The hospice has a standardized medication reconciliation process in place that is completed and reviewed by the interdisciplinary team (IDT) within five days of the initiation of care.
2. Any discrepancies that are identified are clarified with the physician and/or pharmacy consultant within 24 hours.
3. There is a process in place to review the medication regimen to determine if it has been optimized and which medications are the financial responsibility of the hospice program.

One medication management model proposed by this author is the **"1-2-3-A-B-C"** model. Let's investigate, one step at a time:

1. The very first step in medication management is to collect an accurate list of ALL the medications the patient is taking. This includes:

- Prescription medications
- Non-prescription medications
- Herbal products/supplements
- Vaccinations
- Sample medications from prescriber

A savvy provider may call the patient, or family, prior to arrival and request they gather together all the medications the patient is taking or may take as needed. Admittedly this may require dusting off the little red Radio Flyer wagon and dragging it throughout the house on a treasure hunt!

In addition to all the medications the patient or family present you with, ask probing questions about other medications they may have forgotten. For both prescription and non-prescription medications, do a review of systems, head to toe. Any medications to eyes, ears, nose, throat? Respiratory medications? Anything topical applied to the skin? If the patient has a history of hypertension or diabetes mellitus, ask about medications used for those conditions.

2. The second step is to figure out exactly **HOW** the patient is taking each medication, AND the **purpose** for each medication. For example, if the nurse case manager holds up a bottle of gabapentin 300 mg, reads the label and says to the patient, "So, you're taking one of these tablets three times a day, right?" the patient is going to look the nurse right in the eye and say "Yes!" If the nurse had instead, opened the vial, shaken out a tablet or two and asked "Can you tell me what you take this medication for and how you take it?" the RN could have determined if the patient knew the name of the medication, the purpose, and provided an honest report of how they used it. This is especially important with an "as needed" opioid. For example, instead of saying "So, this says you can take one oxycodone/acetaminophen tablet every 4 hours as needed, so you don't take more than six a day, right?" it might give greater insight to how the patient is using the medication by asking "How many of these oxycodone/acetaminophen tablets do you need to take each day to stay comfortable?" Even if it's different than labeled, it's more important for the nurse to get the scoop.

It's also really important for the nurse to have a good understanding of the purpose for each medication the patient is taking. It's not enough to acknowledge that lisinopril is "a heart pill" – that heart pill can be used for multiple indications. How will you know if the drug is getting the job done, if you're not quite sure what the job is??! Sometimes the patient doesn't know why they are on a particular medication, the family doesn't know, and even the prescriber doesn't know – this is not a good situation! One case report in the literature described the case of a patient who had been accidently receiving amiodarone for TEN YEARS due to a transcription error! And amiodarone is not a user-friendly drug![3]

3. Step 3 has us channeling Dr. Phil – so, how's that workin' for ya? In other words, assessing the therapeutic success of a medication. If the medication in question is being used to treat pain or some other symptom, and the patient still has the pain or symptom, apparently, it's not working very well! We can look at subjective and objective monitoring parameters for therapeutic success. For example, if a patient were receiving MS Contin 30 mg by mouth twice daily, and oral morphine solution as needed for additional pain, what monitoring parameters for therapeutic

success would we ask about? Assume the patient has shared with you that the pain negatively impacts his ability to sleep and ambulate, and has made him unhappy.

We can break our monitoring parameters down into subjective parameters of therapeutic success as follows:

- Subjective parameters for therapeutic success to monitor include:
  - Pain rating (best, worst, average, now)
  - Subjective assessment of sleep
  - Subjective assessment of ambulation
  - Subjective assessment of mood
- Objective parameters for therapeutic success to monitor include:
  - Respiratory rate
  - Observed grimacing, guarding
  - Number of hours sleeping/night
  - Assessment of affect
  - Use of PRN oral morphine solution

Or, perhaps the symptom resolved on its own and the medication is no longer needed. Or, maybe a medication was continued through clinical inertia. Medications such as acetylcholinesterase inhibitors (e.g., donepezil) and memantine (Namenda), indicated for Alzheimer's disease, may no longer be providing any benefit once the patient's disease has progressed to a FAST 7A or higher level of severity.

So that covers the 1-2-3 – let's see what the A-B-C brings!

A. Step 4 has us assessing whether the patient is experiencing any adverse effects from their medications. Again, we can evaluate both subjective and objective monitoring parameters for potential for each medication. Let's go back to our example of the patient receiving MS Contin 30 mg by mouth twice daily, and oral morphine solution as needed for additional pain: what side effects can we anticipate and ask about? How about these parameters?

- Subjective parameters for toxicity to monitor include:
  - Complaints of constipation
  - Complaints of nausea, vomiting
  - Complaints of itching
  - Complaints of sleepiness
  - Complaints of confusion
- Objective parameters for toxicity to monitor include:
  - BM frequency
  - # episodes of vomiting
  - Excoriation
  - # hours sleeping
  - MMSE score/delirium scoring

B. The next step is interpreting the data from the previous two steps – the therapeutic success (or lack thereof) and toxicity. B represents evaluating the **benefits** and **burdens** of the drug regimen. The first step is to consider the overall risk of drug-induced harm in individual patients in determining the required intensity of deprescribing intervention. One consideration is the number of drugs a patient is taking – this is one of the biggest predictors of adverse outcomes from drug therapy, especially as the number of routinely taken medications exceed 5 per day. Also, the use of "high risk" drugs (which we use QUITE often in hospice care: opioid,

benzodiazepines, psychotropic drugs, NSAIDs, anticoagulants, digoxin, cardiovascular drugs, hypoglycemic agents, anticholinergic drugs, etc.). Last, patient-specific variables such as their age (> 80 increases risk), cognitive impairment, multiple comorbidities, substance abuse, multiple prescribers, and past or current nonadherence

Then consider each medication one at a time. Some examples of where the burden may exceed the benefit include the following examples:

- Medication has no valid indication (drug use without indication)
- Medication is part of a prescribing cascade (drug-induced adverse effects)
- Medication is causing actual or potential harm of a drug to a greater degree than benefit (inappropriate drug therapy)
- Disease and/or symptom control is ineffective, or symptoms have completed resolved
- Drug is for prevention, and is unlikely to confer any patient-important benefit over the patient's remaining lifespan
- Drug is imposing unacceptable treatment burden (drug-induced adverse effects)
- Drug is imposing unacceptable treatment burden (drug-induced adverse effects)

C. The last step in our journey is "Conversation" – these conversations could be with the prescriber, patient or family about stopping an inappropriate medication, or conversations educating the patient and family about medications that will be continued.

Using the "1-2-3-A-B-C" method we can assure patients are receiving the best medication regimen to treat their symptoms, maximizing therapeutic success and minimizing toxicity. In summary, the six steps are:

1. Comprehensive medication reconciliation
2. Determine purpose of each medication and how patient is taking it
3. Determine if the medication is achieving the therapeutic goal

A. Evaluate for medication-induced adverse effects
B. Carefully weigh the benefits and burdens of each medication
C. Conversations about stopping, or appropriate continuation of a medication

But the whole thing….starts with assessment!

Resources:

- The Joint Commission. Sentinel Event Alert – Using Medication Reconciliation to Prevent Errors. 2006;35. Available at: https://www.jointcommission.org/assets/1/18/SEA_35.PDF
- VNAA Best Practice for Hospice and Palliative Care. Patient Safety: Medication Reconciliation and Management. Available at: http://ahhqi.org/images/uploads/VNAA_Webinar_Slides_+_Intro_140813.pdf
- Comer R, Lizer M. Medication review and transitions of care: A case report of a decade-old medication error. The Consultant Pharmacist 2017;32(Supp D):7-11.

Contact us

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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 AccentCare Hospice & Palliative Care of Spokane County, 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
AccentCare Hospice & Palliative Care of Spokane County, 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 AccentCare Hospice & Palliative Care of Spokane County, 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 AccentCare Hospice & Palliative Care of Spokane County, 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

Physician Aid-In-Dying Policies

Aide Plan of Care: Coordination, Documentation & Supervision 2112

Purpose:
Assure accurate and timely documentation and coordination of care communications for the Hospice Aide (HA) and Seasons Nurse. Assure HA services are provided under the direction and supervision of a registered professional nurse when personal care services are indicated and ordered by the physician.

To ensure TRUE HOPE values:

- **T**rust – the patient and family will trust all of us to meet their needs,
- **R**esponsiveness – respond to changing patient needs,
- **U**nderstanding – respect each patient's values, beliefs, and culture
- **E**mpowerment – empowered to speak up for our patients and families

- **H**umility **–** recognize that the patient and family are the experts in their care
- **O**wnership – complete your work and together ensure that patient needs are met
- **P**assion – commit to never leaving a patient need unmet, and
- **E**xcellence –create the perfect end of life experience every time.

NURSE / AIDE DOCUMENTATION & COORDINATION OF CARE PROTOCOL:

1. Registered Nurse:
   a) Assesses patient's personal care and sensory needs (for example, Namaste Care) to determine HA plan of care according to the patient/family goals of care.
   b) Documents the HA Plan of Care (POC) including goals, interventions, and adds HA discipline into the EMR
      i. Refer to 2076 Long Term Care and 2076a Home Chart Hard Copy Requirements
   c) Documents visit frequency
   d) Communicates with site scheduler if need for same day HA services is needed

2. Site Scheduler (Aide Coordinator, TA, or ED designee):
   a) Puts appointments in the Scheduling module of the EMR
   b) May notify HA of same day need via phone call communication

3. Hospice Aide:
   a) Reviews POC before visit. If any concerns, contacts RN Case Manager, TD or RN Supervisor for clarification
   b) Delivers care according to the POC

c) If POC *can* be completed as ordered:
    i. HA completes documentation at the point of care, and completes and locks the Mobile Care Note (see Mobile Care Quick Guide)
d) If the POC *cannot* be completed as ordered, or there is a concern re the patient condition, the HA will:
    i. Contact RN Case Manager, TD, or RN Supervisor during visit to report concern via phone or need for special program (for example, Namaste Care)
    ii. Do NOT check interventions that are not able to be performed
    iii. Check the box indicating "Unable to complete POC as ordered, RN Notified" in the Mobile Care Note
    iv. Document who was notified in the Mobile Care Note (see Mobile Care Quick Guide)
e) If unable to complete a visit – document reason and who was notified in Mobile Care Note

4. RN Case Manager, TD, or RN Supervisor:
a) Assess Aide's concerns and related patient needs, and directs the HA accordingly to allow completion of the visit.
b) Make changes to the Aide POC in the EMR within 24 hours (notify CM via email as necessary)
c) If no change in POC necessary, Case Manager documents review/no changes needed in the Care Coordination Memo/Phone Call profile

AIDE SUPERVISION

1. Written patient care instructions via the plan of care for a hospice aide will be prepared and approved by a registered nurse who is responsible for the supervision of the hospice aide.

   NJ: If the RN delegates selected tasks to the hospice aide, the nurse shall determine the degree of supervision to provide, based upon an evaluation of the patient's condition, the education,
   skill and training of the hospice aide, and the nature of the tasks and activities to be delegated.
   The RN shall delegate a task only to a hospice aide who meets the requirements specified and
   who has demonstrated the knowledge, skill and competency to perform the delegated tasks.

2. The Registered Nurse:
    a. If determines that the patient's care is complicated, the nurse will make the initial visit with the hospice aide and instruct him/her on the care.
    b. Makes a supervisory visit at least every 14 days to assess the quality of care and services provided. The hospice aide does not need to be present during the supervisory visit, but is preferred.
        - CT: A registered nurse must also visit and complete an assessment of patients receiving hospice aide services as often as necessary based on

the patient's condition but no less frequently than every 60 days while the hospice aide is providing services in the patient's home.

- GA Medicaid: A Registered Nurse must visit the home every (2) weeks when aide services are provided. The visit must include an assessment of the aide services (this shall mean observation of the aide).

c. During the HA Supervisory visit the RN will:
   i. Ask pt/CG
      1. Are your needs being met by HA?
      2. How are you getting along with the aide?
      3. Does the HA wash his/her hands before care?
      4. Does HA ask you to rank our care from 1-10?
      5. Does HA ask you if you need additional training?
   ii. Review the POC with the patient/CG and evaluate if personal care and sensory needs are being met
   iii. Review the HA documentation in the EMR and determine if the aide is following HA POC and reporting changes in the patient's condition
   iv. If HA POC meets patient needs, document supervision visit in EMR
   v. If HA POC does NOT meet patient needs:
      1. Nurse revises HA POC in EMR
      2. Communicates changes to HA via phone
      3. Documents this communication in EMR
      4. Document supervision in EMR

3. If an area of concern is noted by the supervising nurse, then the Case Manager/ Supervisor will:
   a. Make an on-site visit to observe and assess the aide while he or she is performing care.
   b. If an area of concern is verified by the nurse during the on-site visit, a competency evaluation will be completed and documented.

4. A registered nurse will make an on-site visit annually and as needed to observe and assess each aide while performing care. The supervising nurse will assess an aide's ability to demonstrate satisfactory performance including:

   a. Following the patient's plan of care;
   b. Creating successful interpersonal relationships with the patient and family;
   c. Demonstrating competency with assigned tasks;
   d. Complying with infection control policies and procedures; and,
   e. Reporting changes in the patient's condition.

5. If hospice aide services are provided by an individual who is not directly employed by Seasons Hospice, but under arrangement, Seasons Hospice will take the responsibility to ensure overall quality of care, provide supervision according to regulations, and ensure that training and competency requirements are met.

   CT: Seasons Hospice shall designate a full-time registered nurse, who may have other responsibilities, to be responsible for supervision of the homemaker-hospice aide program and staff. When the number of

homemaker-hospice aides employed is twenty-five (25) or more persons, Seasons Hospice will employ a full-time supervisor whose primary responsibility shall be the management of the homemaker-hospice aide program. If the supervisor is not a registered nurse, Seasons Hospice shall designate one full-time registered nurse, who may have other responsibilities, to assist with the homemaker-hospice aide program and staff supervision.

Effective: 3/22/2016

Revised:	8/26/16	11/30/16							
Reviewed:									
Reviewed:									

PHYSICIAN AID-IN-DYING 2113

PURPOSE:

To define state laws regarding physician aid-in-dying and provide direction to our staff on our role in supporting patients and families who are considering participating in the activities under one of these laws

BACKGROUND:

Various states have passed laws involving physician aid-in-dying, which give qualified terminally ill persons the right to request life-ending medication from their doctor and to administer this medication to their own self. Each law generally outlines a process a person must legally follow, and includes significant safeguards intended to protect persons from coercion. Information related to specific states can be found on SharePoint on the Physician Aid-in Dying (P.A.D.) Hub: https://seasonshm.sharepoint.com/sites/PatientExperience/SitePages/P.A.D-Hub.aspx.

A foundational tenet of hospice care is that hospice providers do not intentionally hasten the death of a patient; however, Seasons team members are welcome to talk to patients and others about their state-approved physician aid-in-dying law and are encouraged to provide educational, emotional, and spiritual support to those considering this option. Discussion of laws regarding physician aid-in-dying, or even implementing it, would not be a reason to discharge a patient from our services.

Seasons team members are not required to participate in any aspect of an individual's decision to exercise his/her rights under state laws regarding physician aid-in-dying, and may request to be withdrawn from the care of a person considering following such a law.

PROTOCOL:

1. If a patient or family member wishes to discuss their state-approved physician aid-in-dying law, Seasons team members may provide education about the provisions of that law and direct them to Compassion and Choices Advocacy Group (www.compassionandchoices.org) or a recognized group for more information. Any Seasons team member who wishes to be withdrawn from the care of the patient may request this from their team director at any time.

2. The Seasons team members will communicate to the patient our Seasons Hospice's limitations in participating in the activities under this type of law.

PHYSICIAN AID-IN-DYING 2113

3. The Seasons team members will advise the patient to discuss wishes with their attending physician. The assigned Seasons team members will be informed that the patient is considering obtaining physician aid-in-dying pursuant to state law.

4. The Seasons team members will maintain confidentiality of patient request, including next of kin pursuant to state law, if patient identifies their wish for such.

5. The Seasons team members will inform the patient/patient representative of their right to continue hospice care and receive all services throughout the process.

6. When applicable, the Seasons team members will inform the facility staff of any communications related to physician aid-in-dying.

7. If a Seasons team member is aware that a formal request has been made to the physician, or the patient has initiated dialogue related to physician aid-in-dying, the Team Director, National Hospice Medical Director, and National Director-Patient Experience (and facility, if appropriate) will be immediately notified.

8. The assigned Seasons team members will meet to discuss care plan needs with the Director-Clinical Operations.

9. Seasons team members will explain to the patient that Seasons Hospice is required to follow state law with regard to life sustaining treatment if a Do Not Resuscitate order is not obtained.

10. Seasons clinical team members *will not participate* in requesting, ordering or filling the order for the aid-in-dying drug. If the attending physician is a Seasons employee, it will be at his/her discretion whether to participate in prescribing the aid-in-dying medications or not.

11. If a patient/patient's representative requests that Seasons team members be present when aid-in-dying medication is self-administered, at least two Seasons team members must attend.

12. Seasons 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 must indicate:

    a. Confirmation that patient presented with decisional capacity prior to self-administering physician aid-in-dying medications;

    b. Medication and dose taken by the patient;

    c. Location/setting;

PHYSICIAN AID-IN-DYING 2113

d. Who was present with patient; and

e. Approximate time of death.

13. Seasons team members will be available to the patient and family during and following the medication administration to offer support, as requested.

14. After a death:

    a. Follow Seasons Hospice procedures as customary at the time of death, noting the particular circumstances of the death and potential needs of the family.

    b. Notify the attending physician, if not present, of the death.

    c. A meeting may be held, consisting of the involved Seasons team members and other interested parties, to debrief and review the case.

Effective: 4/29/16

Revised:	9/21/17	2/27/19	4/22/19	5/18/20					
Reviewed:									
Reviewed:									

EXHIBIT 8

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.
www.SeasonsFoundation.org

Honoring Life ~ Offering Hope

1144 E. Jefferson Street
Phoenix, AZ 85034

BNC_MASTER_3-19

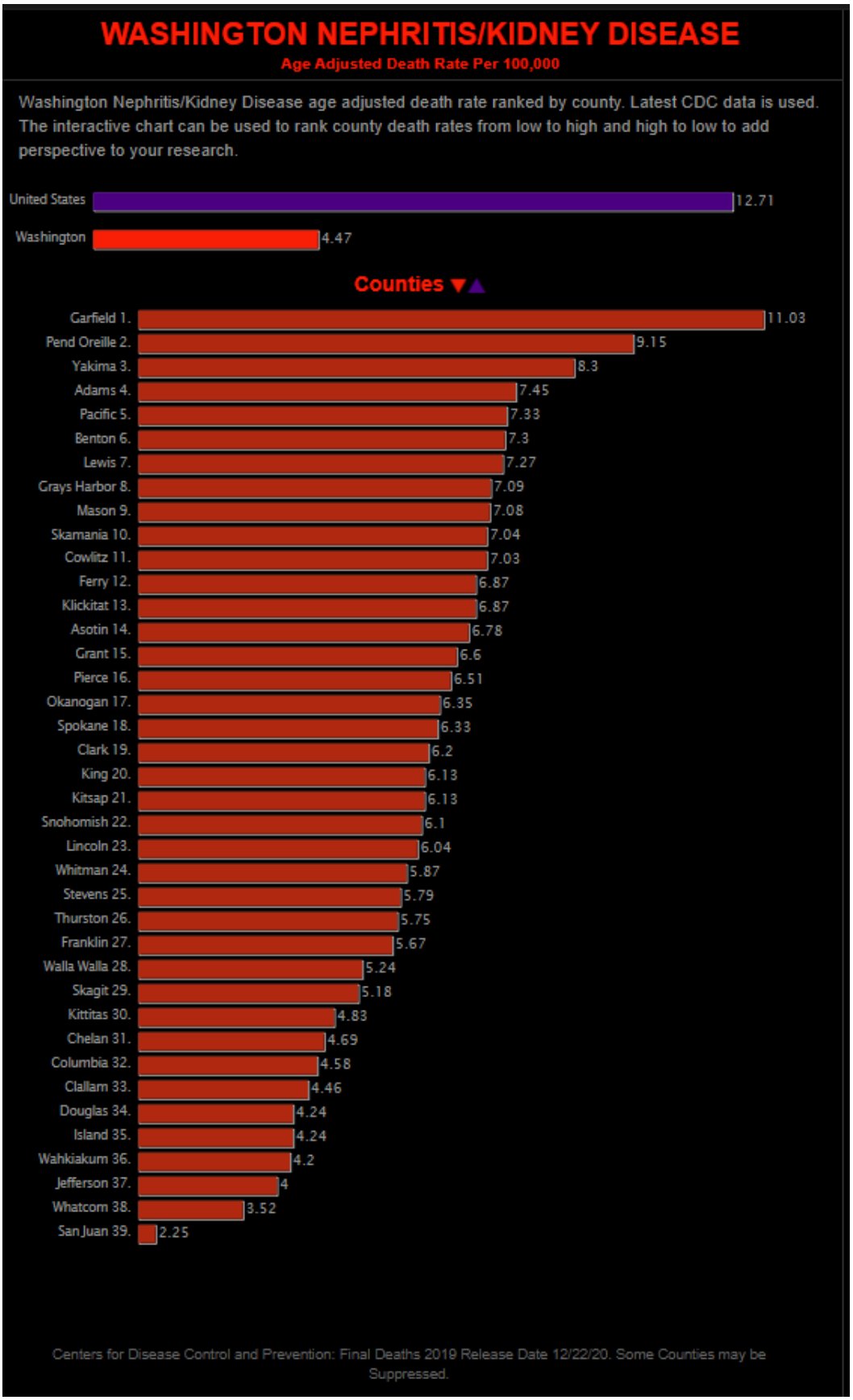
with thoughts of peace and courage for you

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.

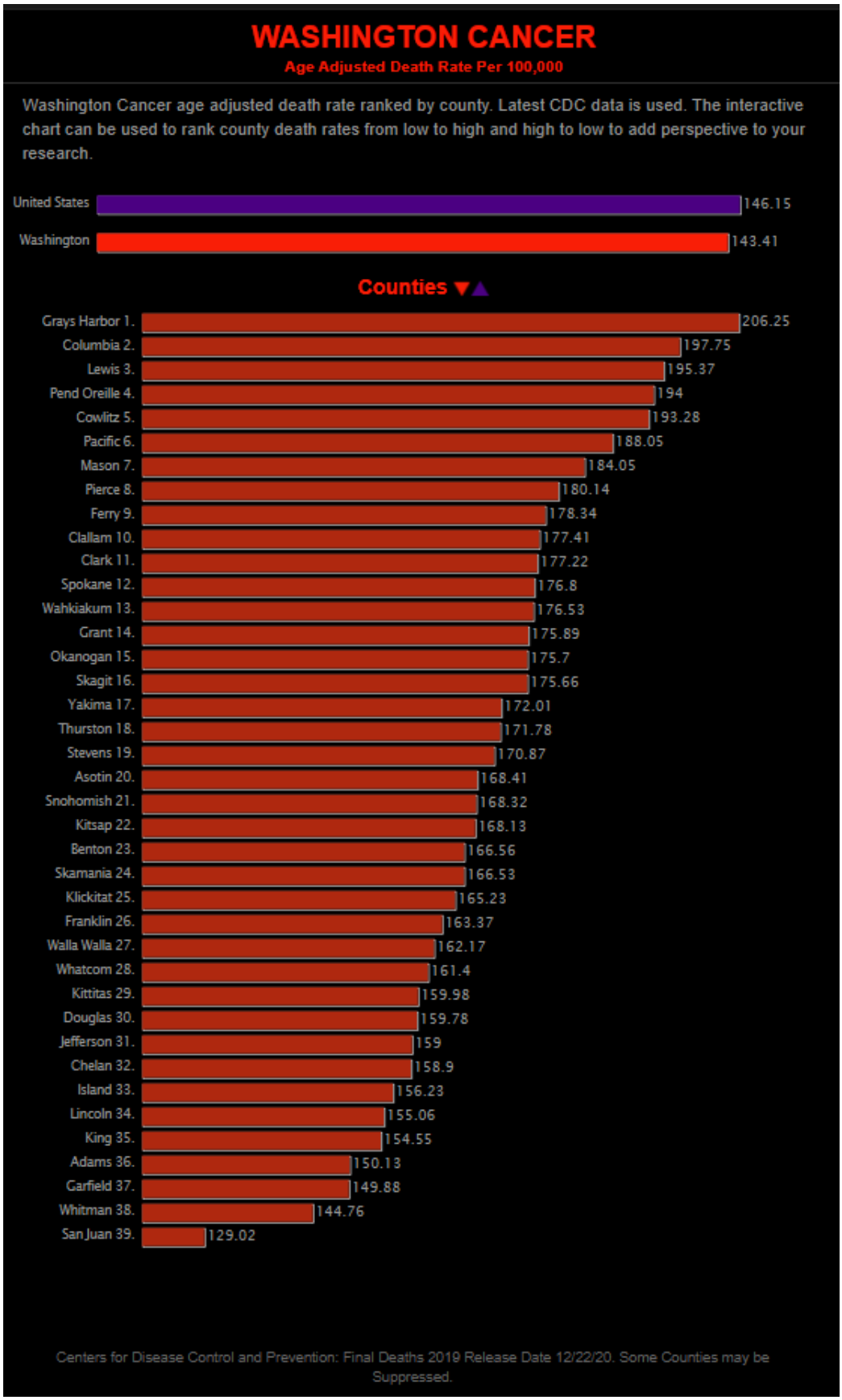
Your friends at Seasons Hospice are thinking of you.

EXHIBIT 9

Mortality Data
(WHO Death Rates and DOH Statistics)



Taken from www.worldlifeexpectancy.com , accessed 12/08/2021
Source: Centers for Disease Control and Prevention: Final Deaths 2019 Release Date 12/22/20



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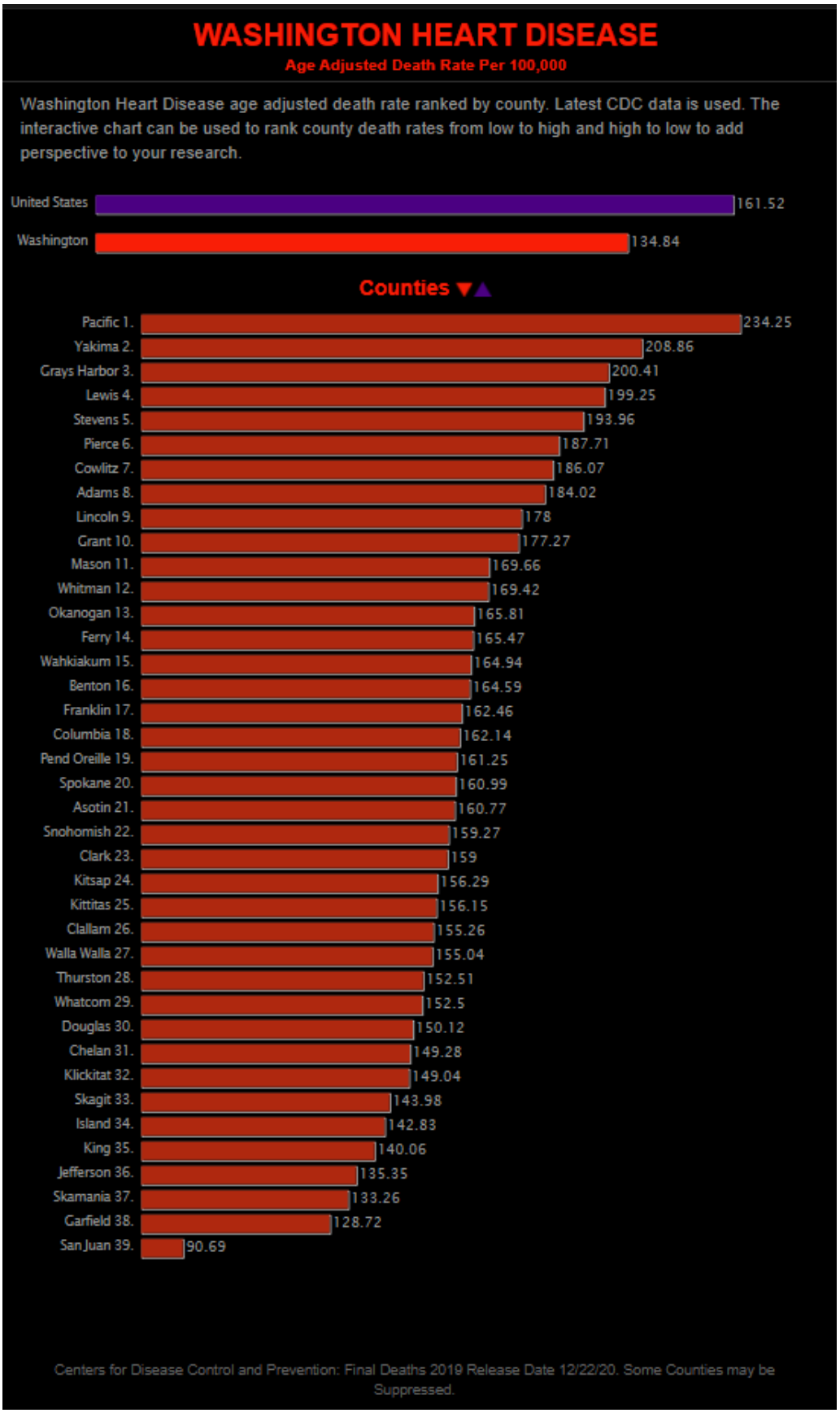

Taken from www.worldlifeexpectancy.com , accessed 12/08/2021
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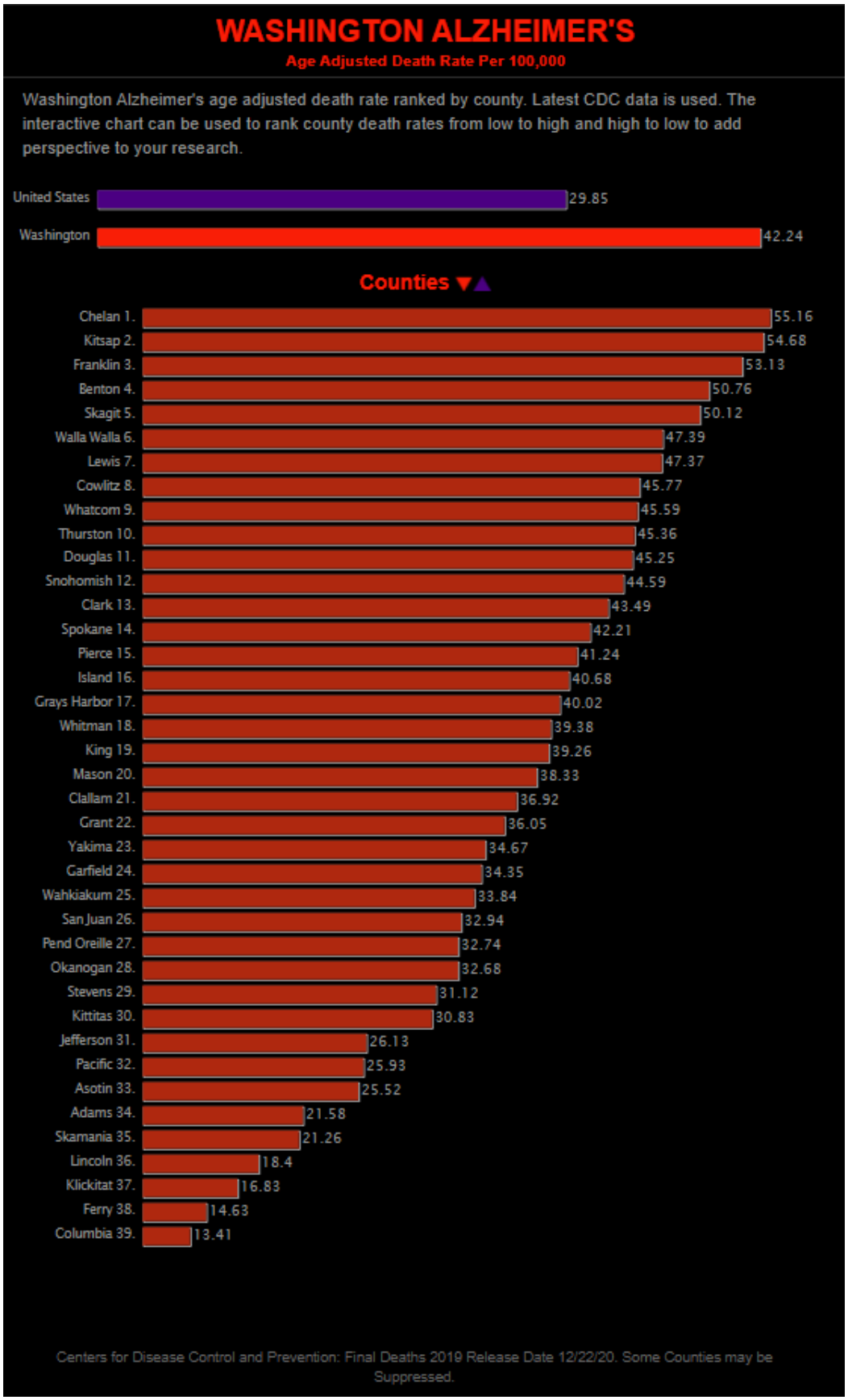

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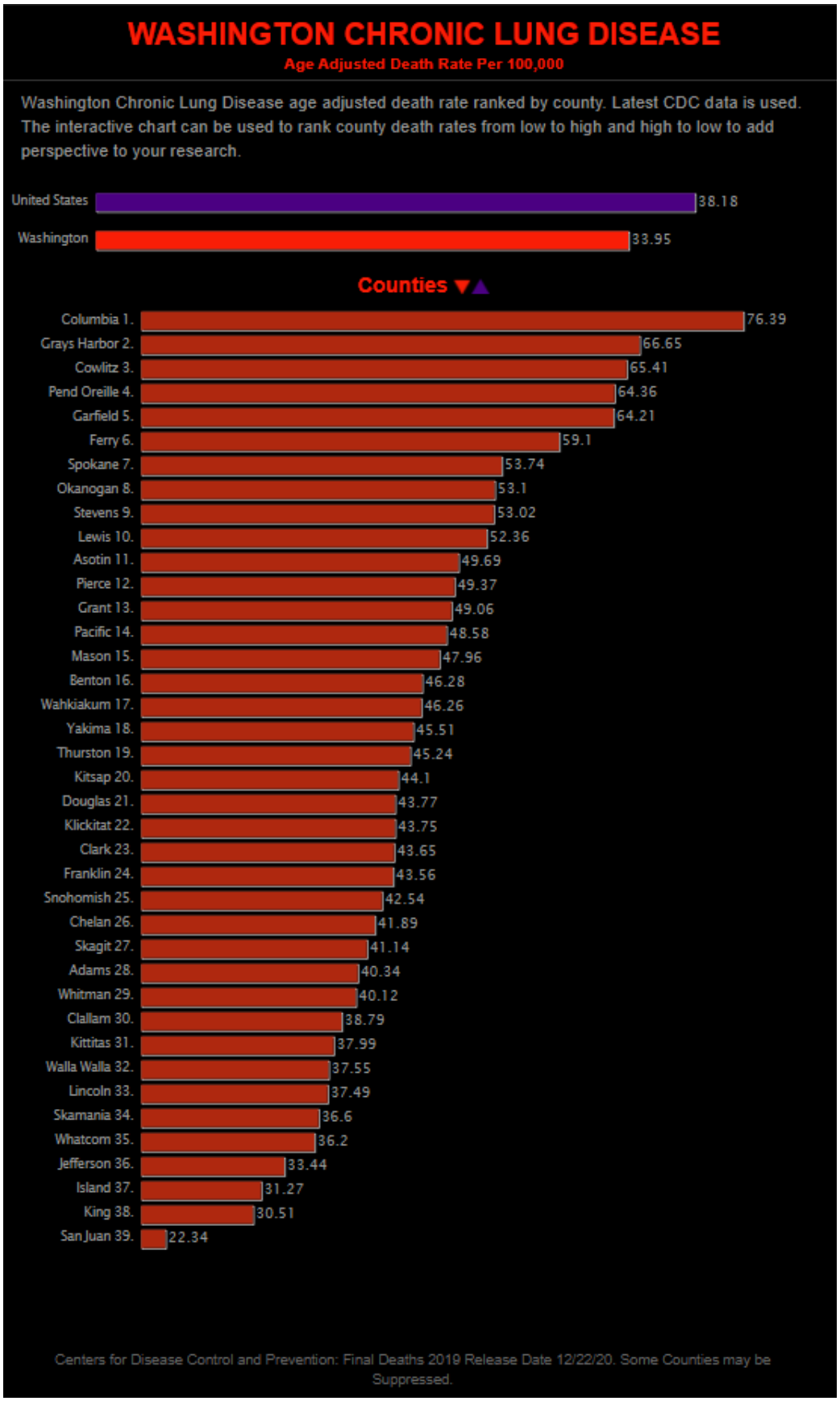

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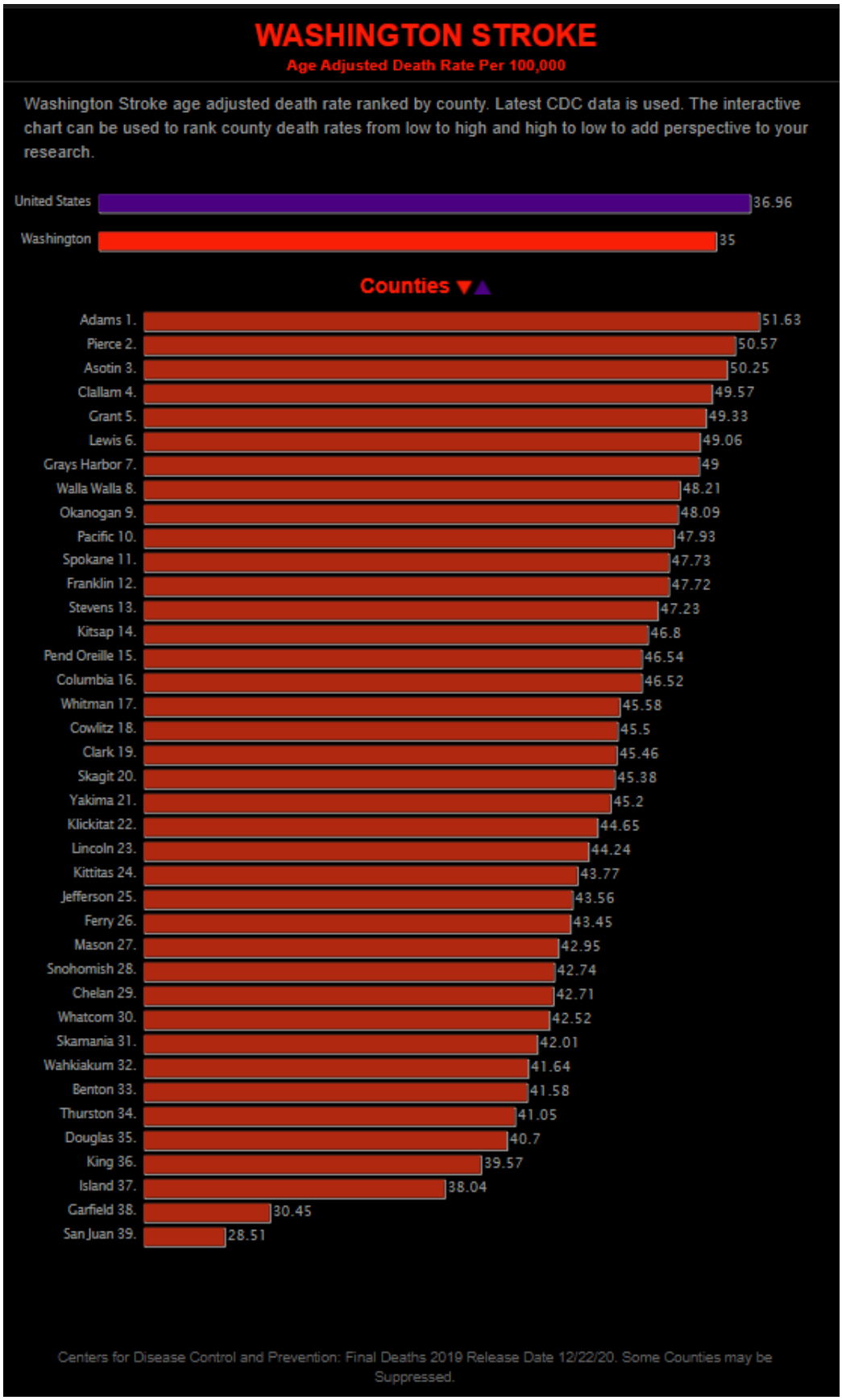

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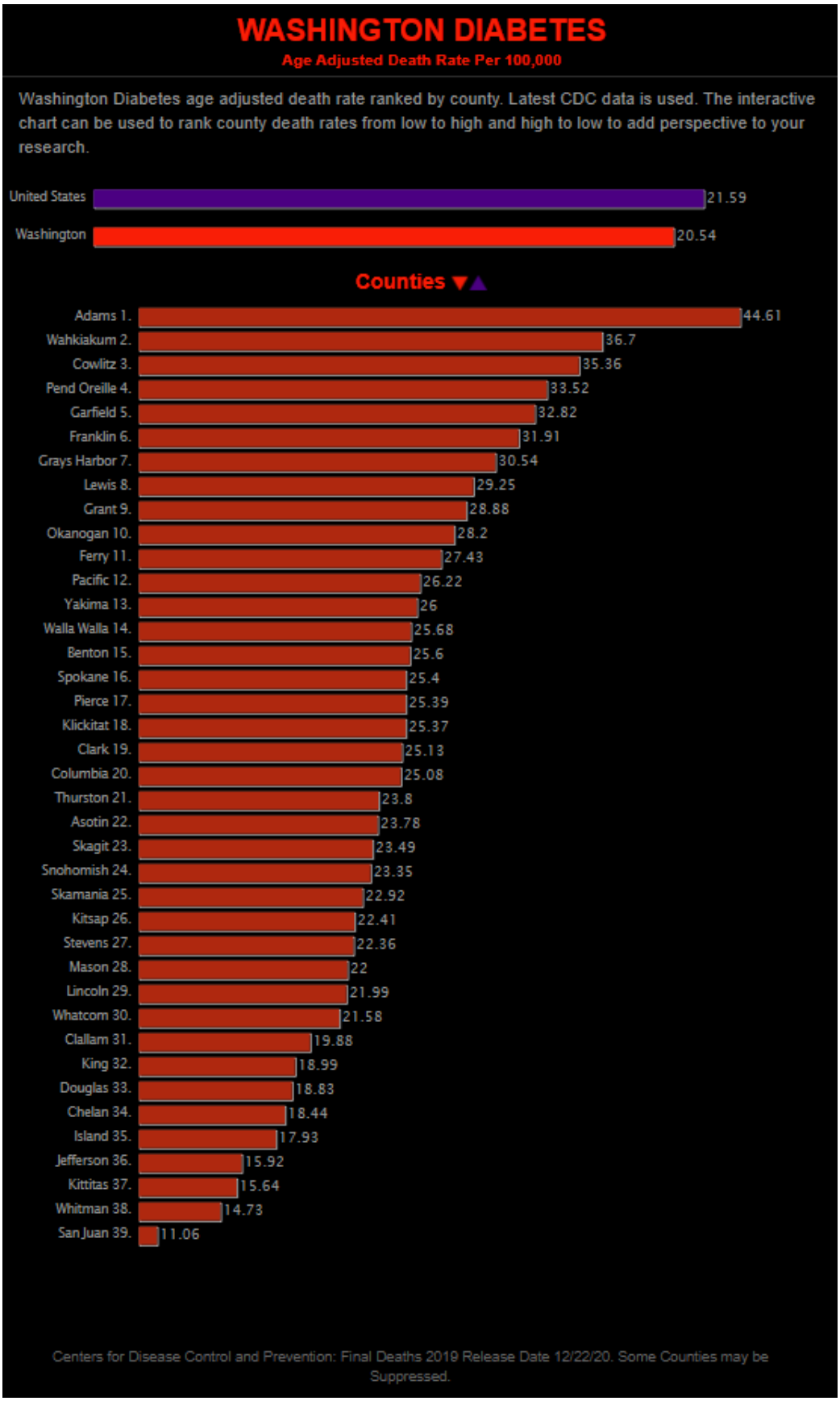

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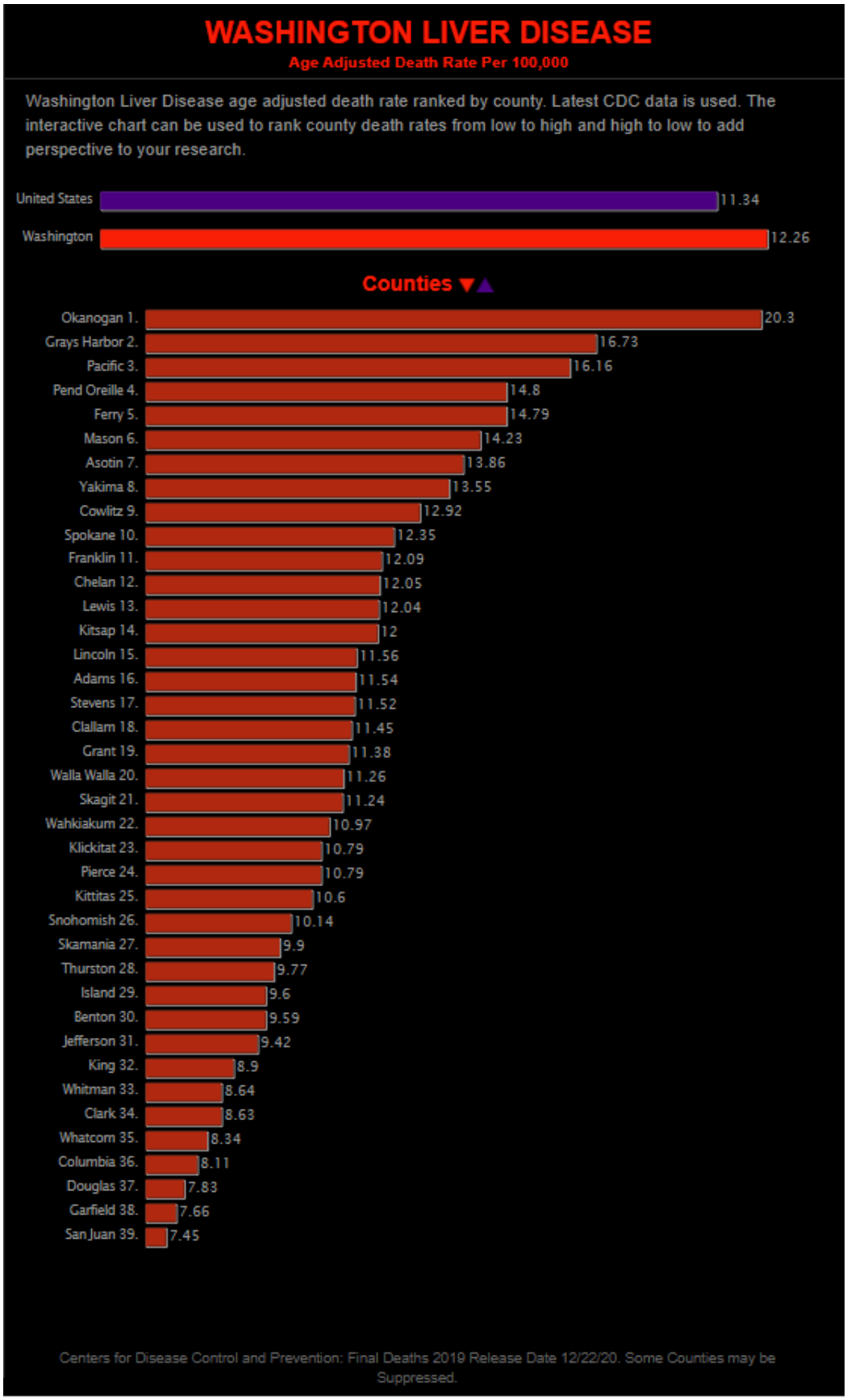

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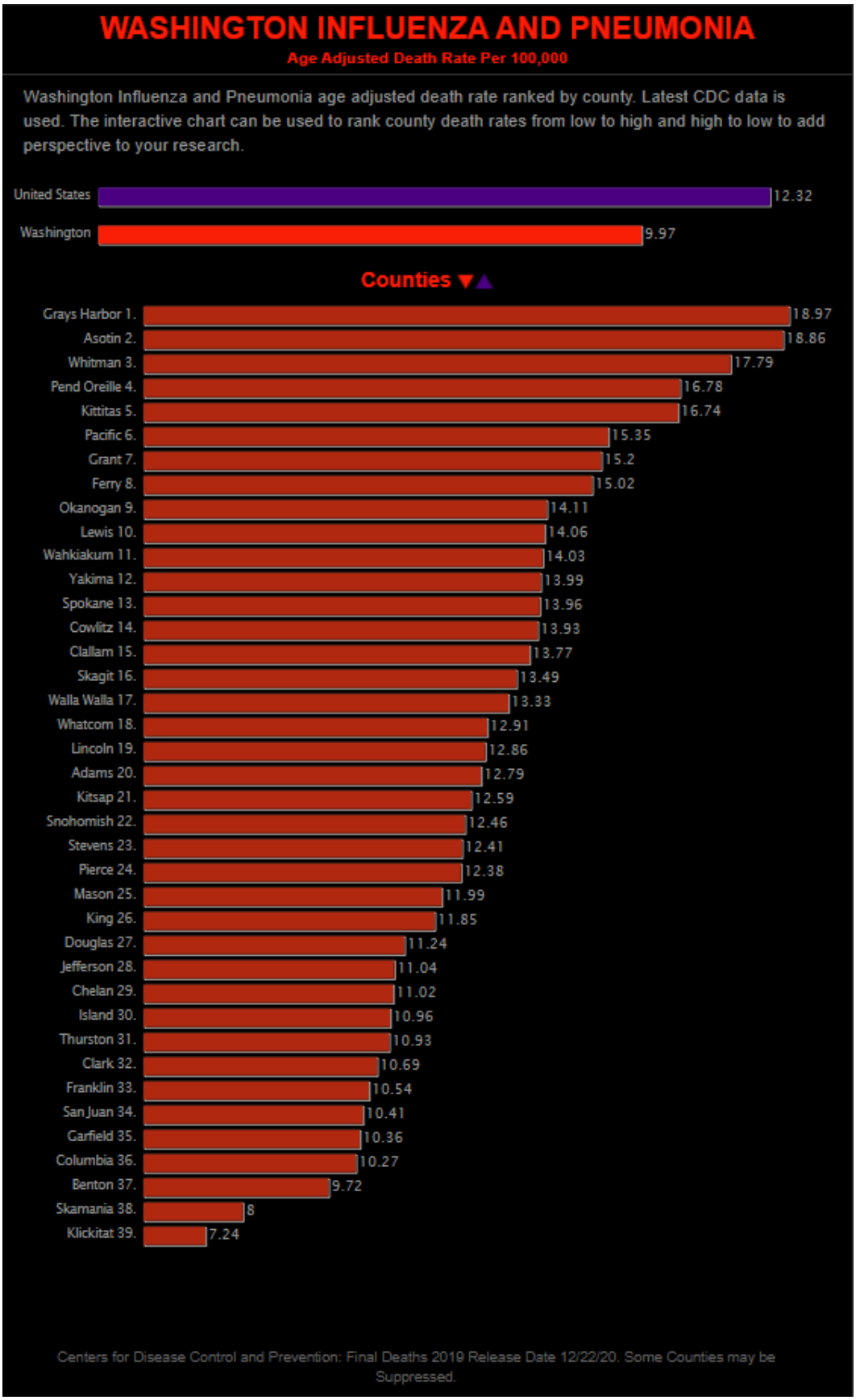

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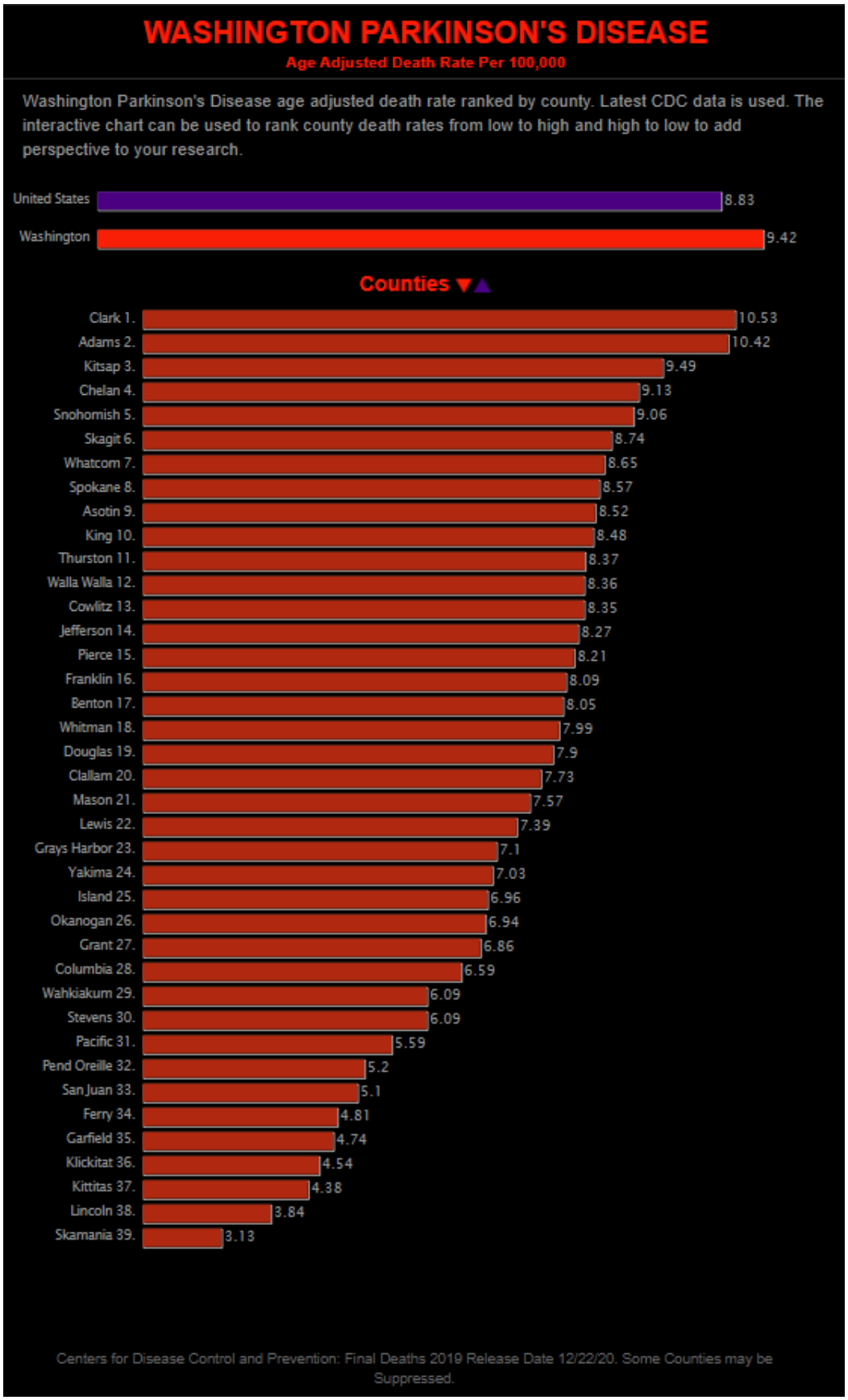

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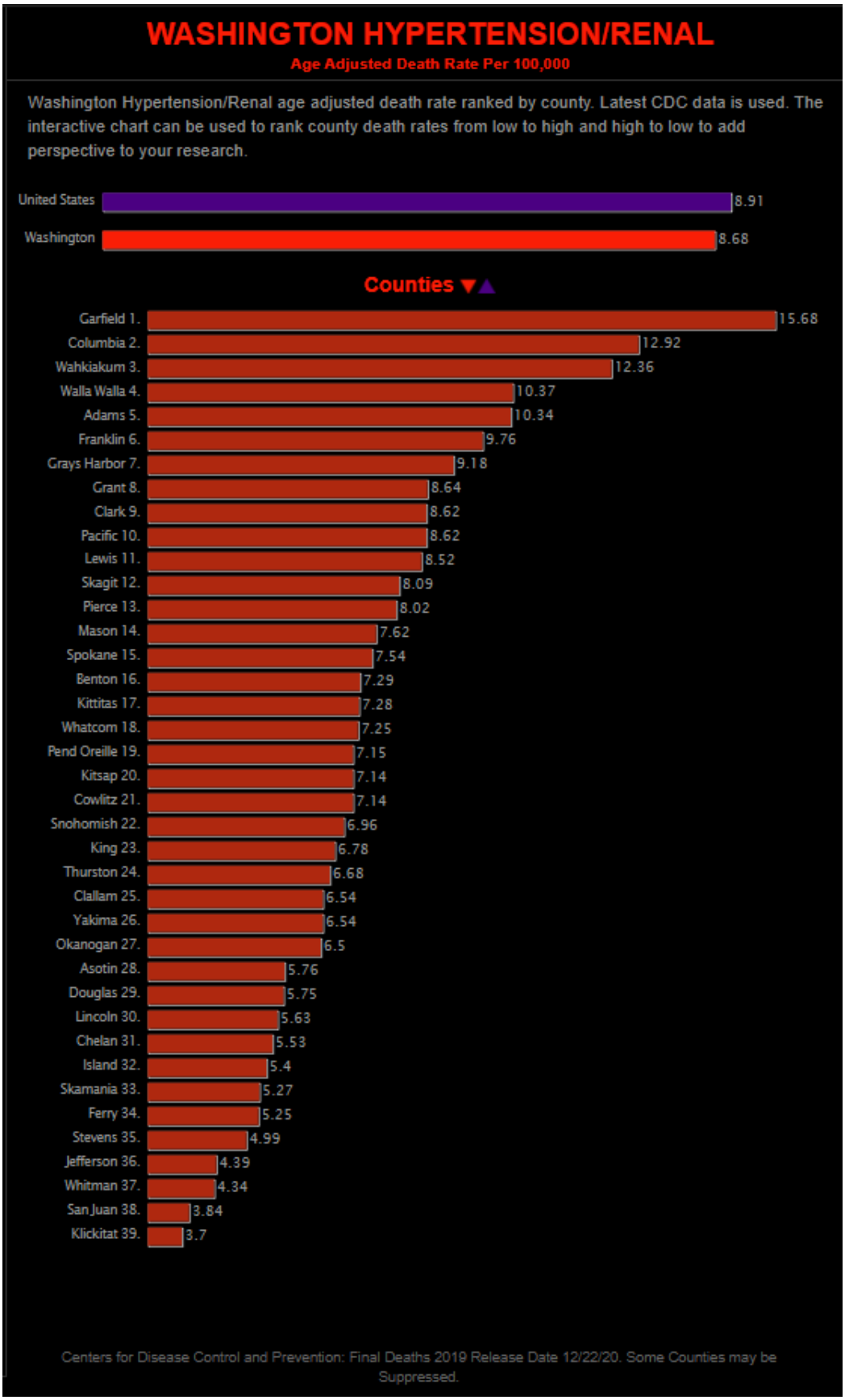

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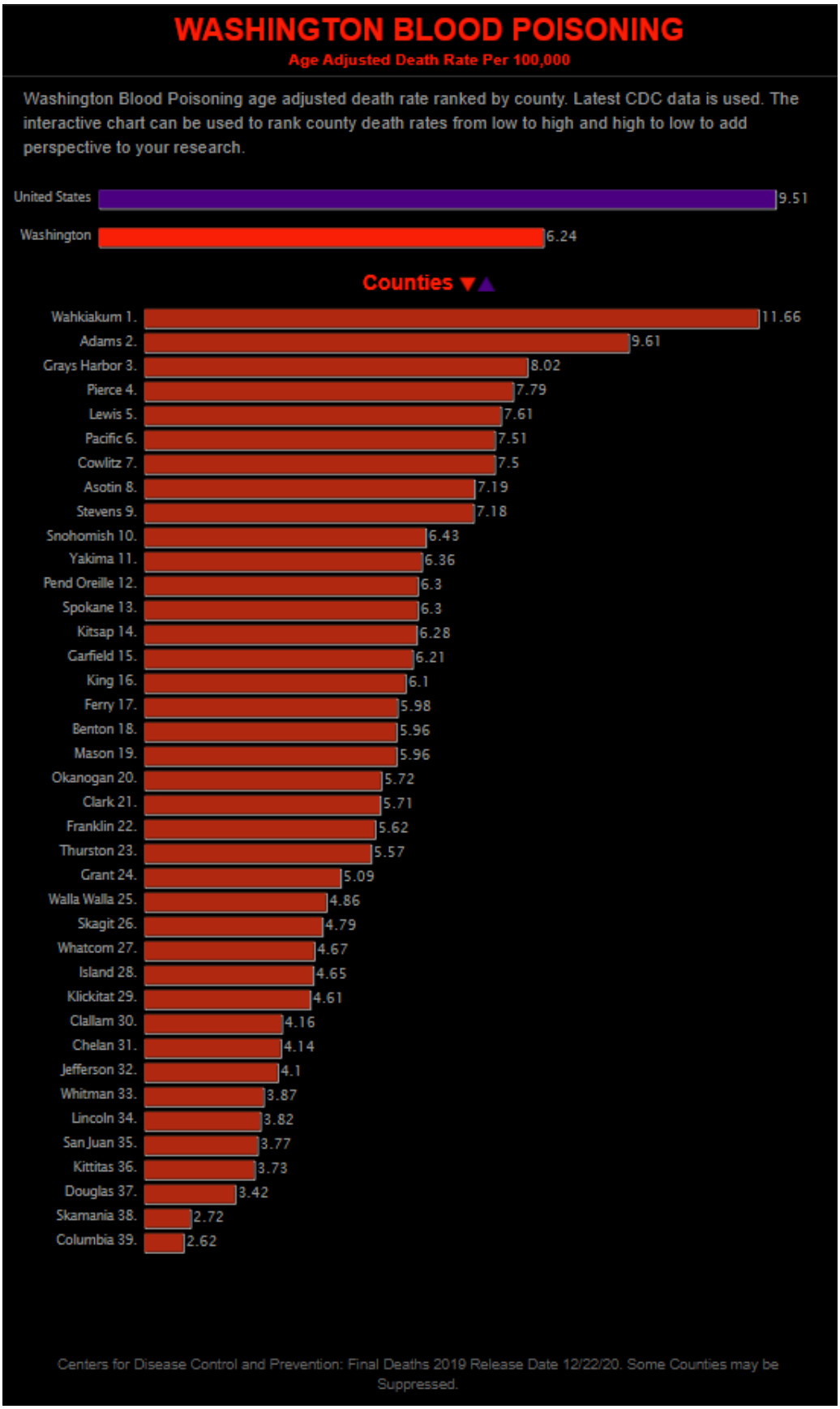

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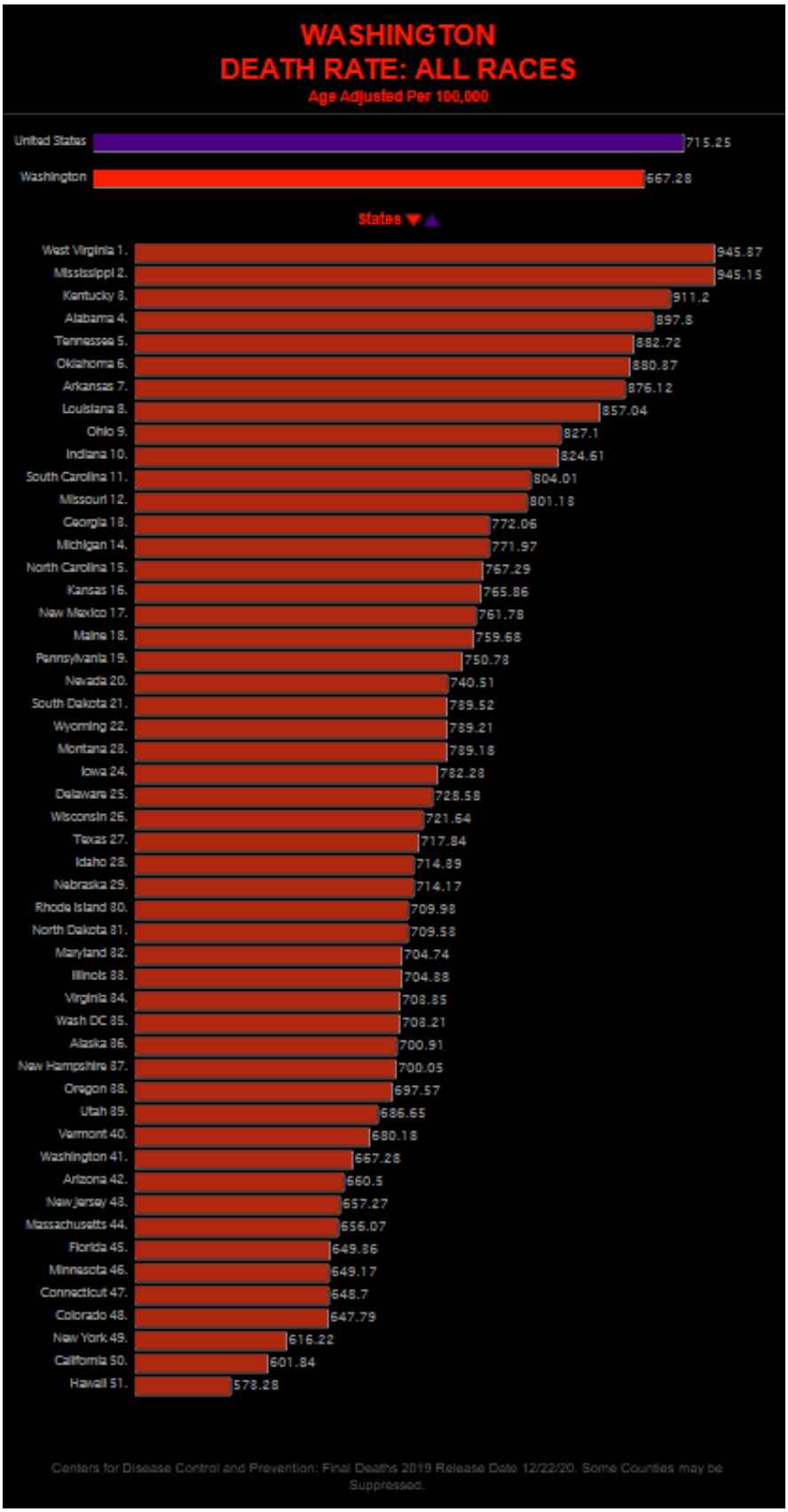

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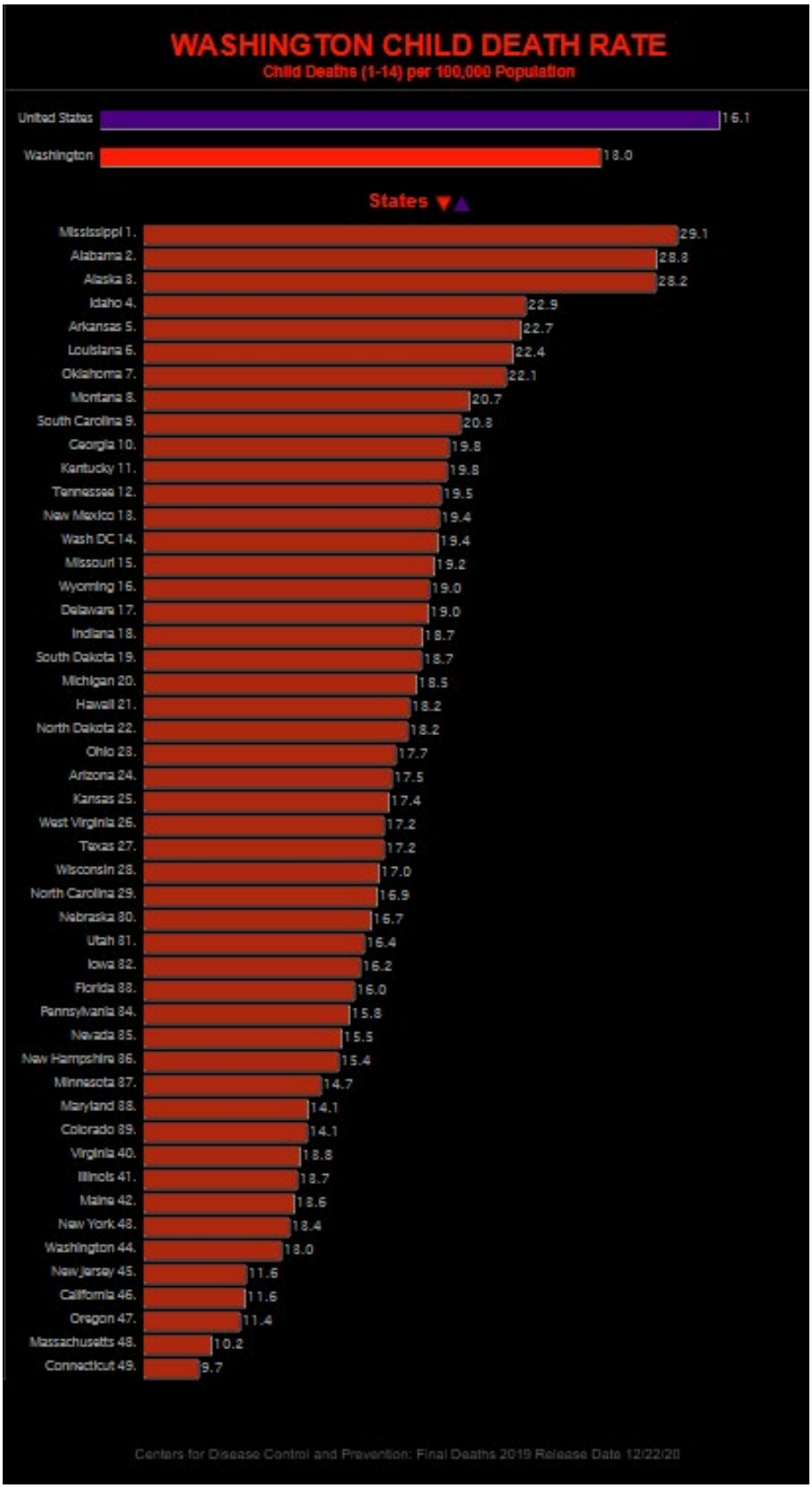

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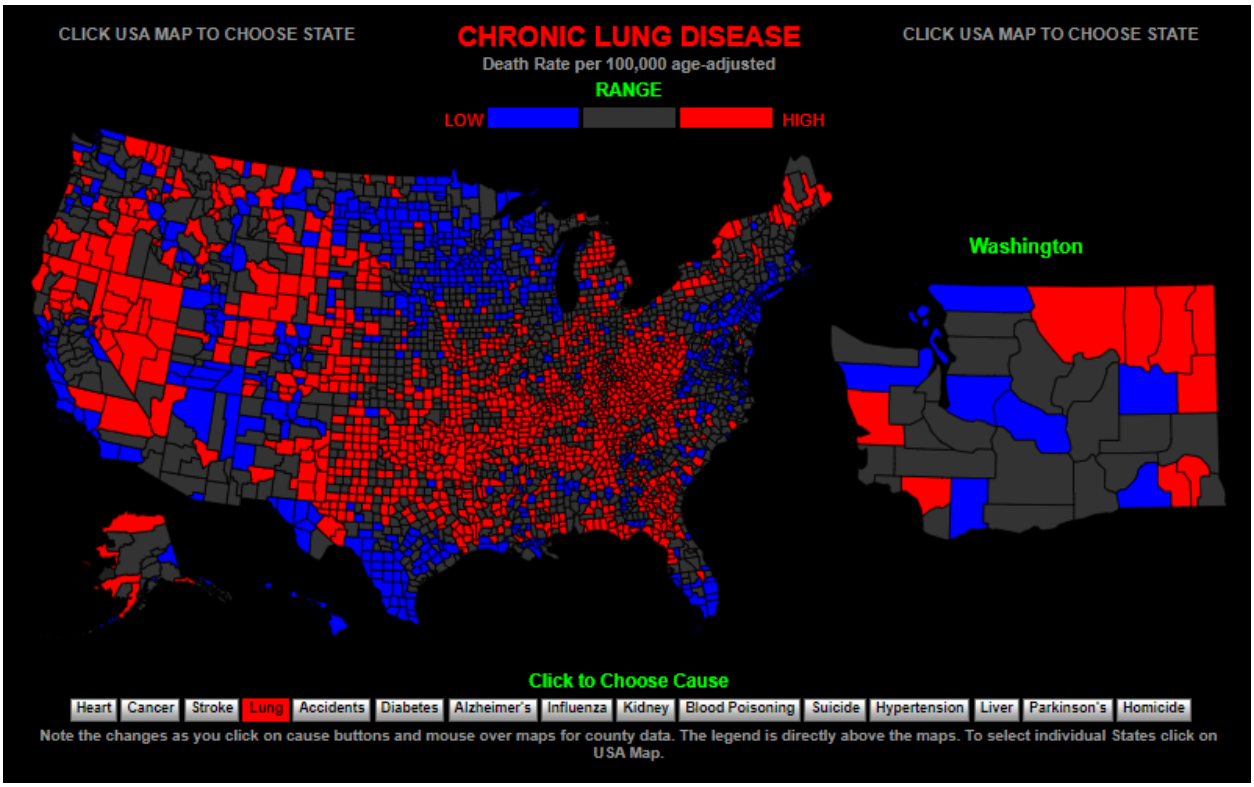

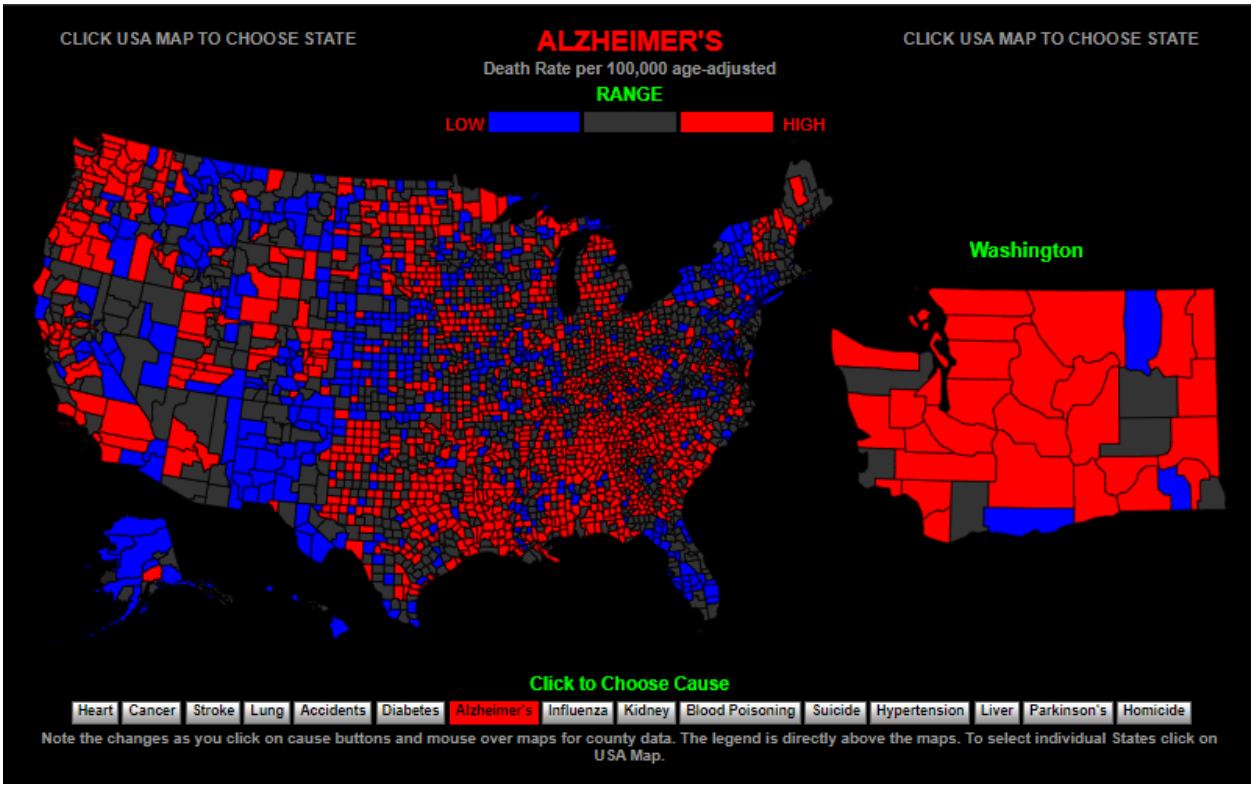

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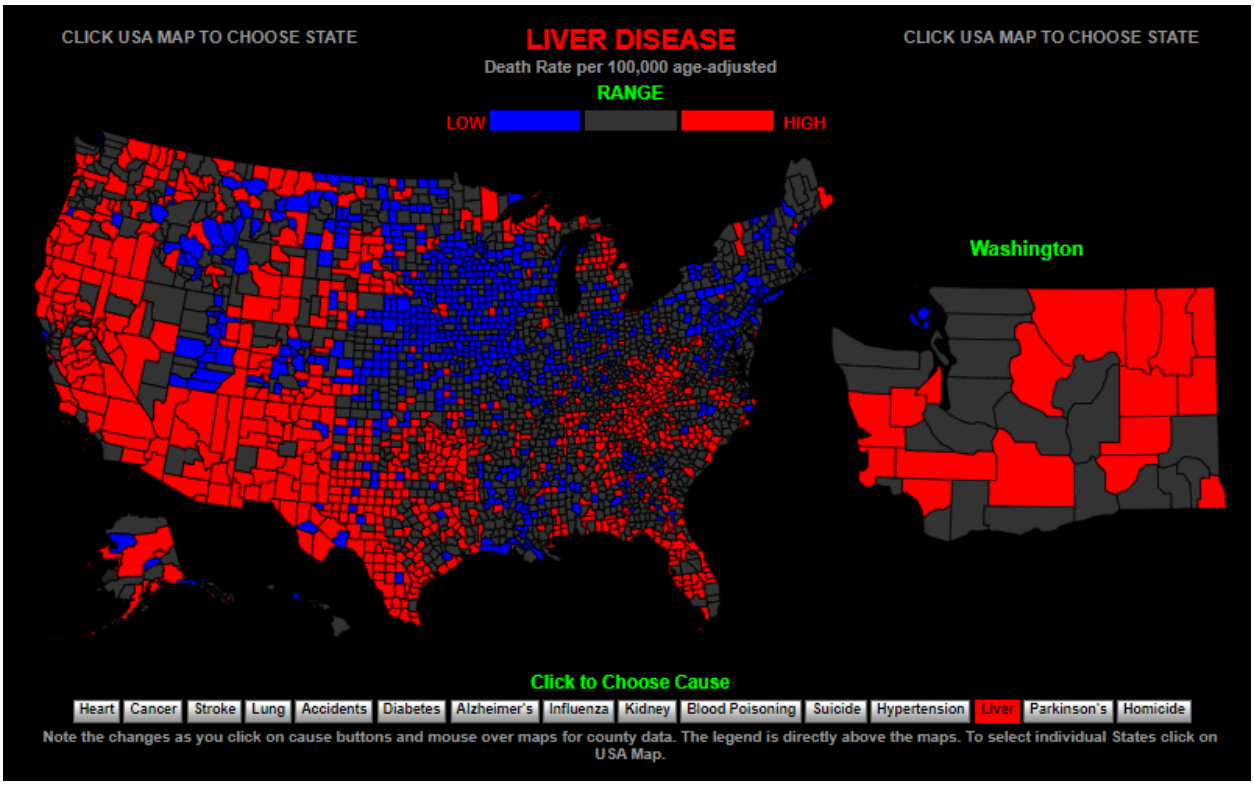
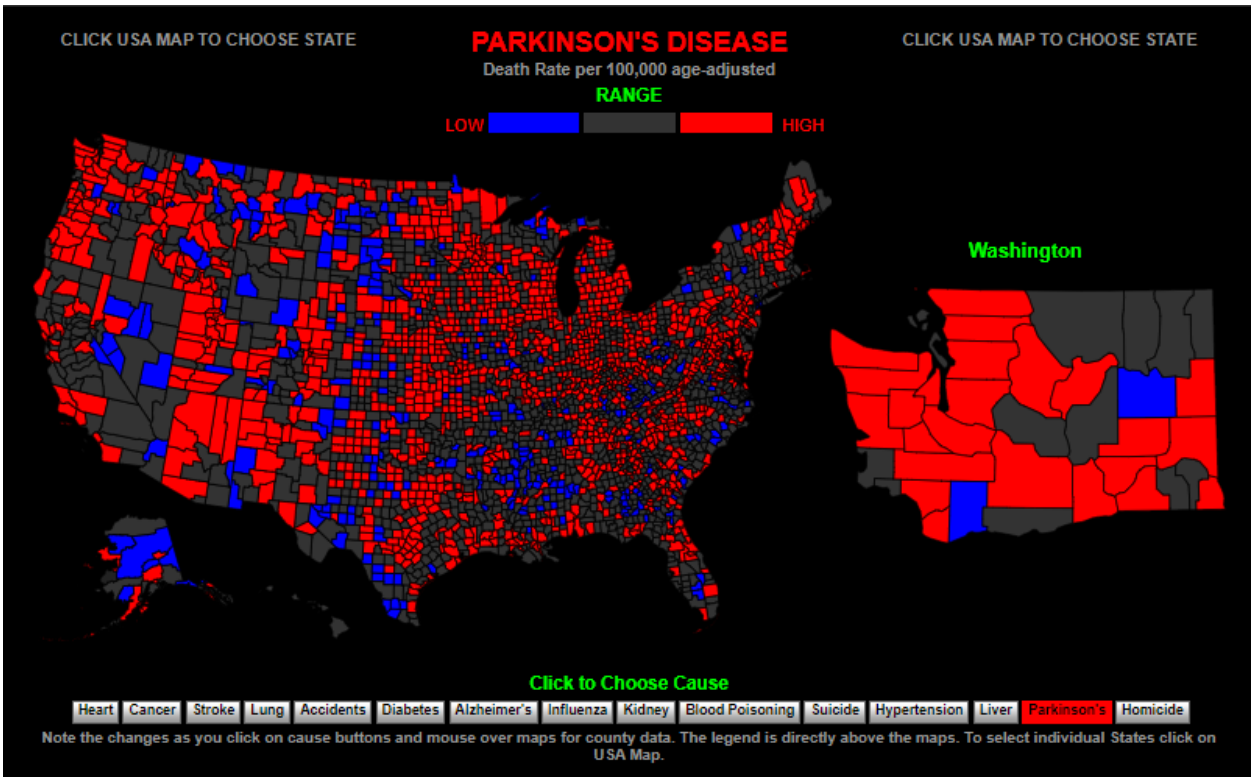




Taken from www.worldlifeexpectancy.com , accessed 12/17/2021
Source: Centers for Disease Control and Prevention: Final Deaths 2019 Release Date 12/22/20

Mortality Table A9. Age Group by County of Residence, 2015

County	Total	< 1	1-4	5-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85 and Over	Age Unk
State Total	**54,514**	**431**	**79**	**107**	**194**	**352**	**967**	**1,310**	**3,241**	**7,065**	**10,026**	**12,384**	**18,357**	**1**
Adams	137	0	2	1	3	2	3	5	6	13	28	28	46	0
Asotin	274	3	0	0	0	1	5	3	17	30	53	68	94	0
Benton	1,475	15	3	6	6	10	21	28	93	171	266	339	517	0
Chelan	695	3	0	2	2	6	9	10	37	75	108	164	279	0
Clallam	957	9	1	2	4	3	15	17	41	105	173	245	342	0
Clark	3,434	24	3	6	13	18	62	77	193	447	689	786	1,116	0
Columbia	62	0	0	0	0	0	0	1	6	6	20	12	17	0
Cowlitz	1,144	8	1	1	3	2	14	21	76	141	252	254	371	0
Douglas	312	1	1	1	1	3	8	6	22	36	62	78	93	0
Ferry	77	0	0	0	1	2	2	1	3	14	15	18	21	0
Franklin	368	5	3	2	4	5	6	12	19	49	58	86	119	0
Garfield	32	0	0	0	0	0	0	0	0	3	12	7	10	0
Grant	685	5	2	4	4	6	7	23	41	95	146	161	191	0
Grays Harbor	793	5	0	2	2	3	20	14	54	133	180	182	198	0
Island	762	7	0	0	2	4	10	13	30	94	141	196	265	0
Jefferson	380	1	0	0	2	2	3	5	13	38	84	101	131	0
King	12,705	93	17	24	37	86	226	345	774	1,615	2,064	2,634	4,790	0
Kitsap	2,147	18	3	4	7	10	37	52	98	290	398	505	725	0
Kittitas	305	2	0	1	1	4	3	8	20	42	60	69	95	0
Klickitat	152	0	0	0	0	0	2	2	10	15	37	44	42	0
Lewis	903	14	2	2	2	4	10	20	40	134	157	234	284	0
Lincoln	98	1	0	0	0	0	1	1	1	16	25	25	28	0
Mason	683	4	3	2	0	5	11	13	41	102	151	185	166	0
Okanogan	468	1	0	0	0	2	9	10	36	64	89	126	130	1
Pacific	329	3	1	0	0	0	3	2	17	42	75	92	94	0
Pend Oreille	142	0	0	0	0	0	1	8	5	27	39	33	29	0
Pierce	6,442	62	5	18	29	41	143	188	410	936	1,262	1,484	1,864	0
San Juan	150	1	0	0	0	0	2	2	7	17	22	37	62	0
Skagit	1,188	8	1	0	3	8	19	17	69	138	205	279	441	0
Skamania	87	0	0	0	1	2	0	2	7	21	23	14	17	0
Snohomish	5,311	40	7	7	25	39	101	147	382	675	977	1,222	1,689	0
Spokane	4,591	36	6	10	17	31	88	117	276	607	815	1,047	1,541	0
Stevens	486	2	1	1	1	5	10	3	22	77	112	123	129	0
Thurston	2,232	19	1	2	7	10	32	53	127	294	416	500	771	0
Wahkiakum	44	0	0	1	0	0	1	1	1	0	16	11	13	0
Walla Walla	590	6	2	1	0	3	8	6	35	52	96	118	263	0
Whatcom	1,633	14	5	1	7	9	22	28	88	183	294	380	602	0
Whitman	297	5	3	0	1	3	8	3	11	34	49	57	123	0
Yakima	1,944	16	6	6	9	23	45	46	113	234	357	440	649	0

Source: Center for Health Statistics, Washington State Department of Health, 07/2016.

Mortality Table C3. Leading Causes by Age Group and Sex for Residents, 2015

Age Group with Causes and ICD-10 Codes	Total			Male			Female		
	No.	Rate[1]	Pct[2]	No.	Rate[1]	Pct[2]	No.	Rate[1]	Pct[2]
All Ages									
All Causes	54,514	772.0	100.0	27,749	787.9	100.0	26,752	755.8	100.0
Malignant Neoplasms (C00-C97)	12,658	179.3	23.2	6,652	188.9	24.0	6,006	169.7	22.5
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	10,987	155.6	20.2	5,988	170.0	21.6	4,999	141.2	18.7
Alzheimer's Disease (G30)	3,489	49.4	6.4	1,120	31.8	4.0	2,369	66.9	8.9
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	3,188	45.1	5.8	1,905	54.1	6.9	1,283	36.2	4.8
Chronic Lower Respiratory Diseases (J40-J47)	3,151	44.6	5.8	1,511	42.9	5.4	1,640	46.3	6.1
Cerebrovascular Diseases (I60-I69)	2,693	38.1	4.9	1,125	31.9	4.1	1,568	44.3	5.9
Diabetes Mellitus (E10-E14)	1,805	25.6	3.3	1,005	28.5	3.6	800	22.6	3.0
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	1,136	16.1	2.1	824	23.4	3.0	312	8.8	1.2
Chronic Liver Disease & Cirrhosis (K70,K73-K74)	1,021	14.5	1.9	646	18.3	2.3	375	10.6	1.4
Influenza and Pneumonia (J10-J18)	851	12.1	1.6	380	10.8	1.4	471	13.3	1.8
All Other Causes	13,535	191.7	24.8	6,593	187.2	23.8	6,929	195.8	25.9
Under 1									
All Causes	431	484.3	100.0	222	484.2	100.0	209	484.4	100.0
Congenital Malformations (Q00-Q99)	109	122.5	25.3	53	115.6	23.9	56	129.8	26.8
Sudden Infant Death Syndrome (R95)	55	61.8	12.8	33	72.0	14.9	22	51.0	10.5
Short Gestation & Low Birth Weight (P07)	54	60.7	12.5	30	65.4	13.5	24	55.6	11.5
Complic. of Placenta, Cord & Membranes (P02)	33	37.1	7.7	12	26.2	5.4	21	48.7	10.0
Maternal Complications of Pregnancy (P01)	29	32.6	6.7	13	28.4	5.9	16	37.1	7.7
All Other Causes	151	169.7	35.0	81	176.7	36.5	70	162.2	33.5
1-4									
All Causes	79	22.5	100.0	45	25.1	100.0	34	19.8	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	23	6.5	29.1	11	6.1	24.4	12	7.0	35.3
Malignant Neoplasms (C00-C97)	14	4.0	17.7	8	4.5	17.8	6	3.5	17.6
Assault (Homicide) (X85-Y09,Y87.1)	9	2.6	11.4	6	3.3	13.3	3	.	8.8
Congenital Anomalies (Q00-Q99)	4	.	5.1	1	.	2.2	3	.	8.8
Cerebrovascular Diseases (I60-I69)	2	.	2.5	2	.	4.4	.	.	.
All Other Causes	27	7.7	34.2	17	9.5	37.8	.	.	.
5-14									
All Causes	107	12.0	100.0	57	12.5	100.0	50	11.5	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	25	2.8	23.4	14	3.1	24.6	11	2.5	22.0
Malignant Neoplasms (C00-C97)	21	2.3	19.6	9	2.0	15.8	12	2.7	24.0
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	17	1.9	15.9	8	1.7	14.0	9	2.1	18.0
Congenital Anomalies (Q00-Q99)	5	0.6	4.7	3	.	5.3	2	.	4.0
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	5	0.6	4.7	3	.	5.3	2	.	4.0
All Other Causes	34	3.8	31.8	20	4.4	35.1	14	3.2	28.0
15 - 19									
All Causes	194	43.3	100.0	142	61.8	100.0	52	23.8	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	67	14.9	34.5	52	22.6	36.6	15	6.9	28.8
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	64	14.3	33.0	52	22.6	36.6	12	5.5	23.1
Assault (Homicide) (X85-Y09,Y87.1)	27	6.0	13.9	21	9.1	14.8	6	2.7	11.5
Malignant Neoplasms (C00-C97)	13	2.9	6.7	7	3.0	4.9	6	2.7	11.5
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	6	1.3	3.1	3	.	2.1	3	.	5.8
All Other Causes	17	3.8	8.8	7	3.0	4.9	10	4.6	19.2
20 - 24									
All Causes	352	73.2	100.0	264	107.0	100.0	88	37.6	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	152	31.6	43.2	113	45.8	42.8	39	16.6	44.3
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	80	16.6	22.7	67	27.1	25.4	13	5.5	14.8
Assault (Homicide) (X85-Y09,Y87.1)	34	7.1	9.7	28	11.3	10.6	6	2.6	6.8
Malignant Neoplasms (C00-C97)	19	3.9	5.4	13	5.3	4.9	6	2.6	6.8
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	11	2.3	3.1	8	3.2	3.0	3	.	3.4
All Other Causes	56	11.6	15.9	35	14.2	13.3	21	9.0	23.9
25 - 34									
All Causes	967	98.9	100.0	662	132.3	100.0	305	63.9	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	360	36.8	37.2	261	52.2	39.4	99	20.7	32.5
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	178	18.2	18.4	135	27.0	20.4	43	9.0	14.1
Malignant Neoplasms (C00-C97)	76	7.8	7.9	37	7.4	5.6	39	8.2	12.8
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	60	6.1	6.2	44	8.8	6.6	16	3.4	5.2
Assault (Homicide) (X85-Y09,Y87.1)	47	4.8	4.9	34	6.8	5.1	13	2.7	4.3
All Other Causes	246	25.2	25.4	151	30.2	22.8	95	19.9	31.1

Mortality Table C3. Leading Causes by Age Group and Sex for Residents, 2015

Age Group with Causes and ICD-10 Codes	Total			Male			Female		
	No.	Rate[1]	Pct[2]	No.	Rate[1]	Pct[2]	No.	Rate[1]	Pct[2]
35 - 44									
All Causes	1,310	143.4	100.0	835	180.7	100.0	474	105.0	100.0
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	323	35.4	24.7	226	48.9	27.1	97	21.5	20.5
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	180	19.7	13.7	132	28.6	15.8	48	10.6	10.1
Malignant Neoplasms (C00-C97)	180	19.7	13.7	80	17.3	9.6	100	22.1	21.1
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	136	14.9	10.4	99	21.4	11.9	37	8.2	7.8
Chronic Liver Disease & Cirrhosis (K70,K73-K74)	78	8.5	6.0	48	10.4	5.7	30	6.6	6.3
All Other Causes	413	45.2	31.5	250	54.1	29.9	162	35.9	34.2
45 - 54									
All Causes	3,241	341.1	100.0	1,953	409.9	100.0	1,288	271.9	100.0
Malignant Neoplasms (C00-C97)	828	87.1	25.5	370	77.7	18.9	458	96.7	35.6
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	498	52.4	15.4	377	79.1	19.3	121	25.5	9.4
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	451	47.5	13.9	294	61.7	15.1	157	33.1	12.2
Chronic Liver Disease & Cirrhosis (K70,K73-K74)	260	27.4	8.0	155	32.5	7.9	105	22.2	8.2
Intentional Self-Harm (Suicide)(X60-X84,Y87.0)	223	23.5	6.9	148	31.1	7.6	75	15.8	5.8
All Other Causes	981	103.2	30.3	609	127.8	31.2	372	78.5	28.9
55 - 64									
All Causes	7,065	760.6	100.0	4,244	934.8	100.0	2,818	593.4	100.0
Malignant Neoplasms (C00-C97)	2,438	262.5	34.5	1,355	298.5	31.9	1,083	228.0	38.4
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	1,256	135.2	17.8	905	199.3	21.3	351	73.9	12.5
Unintentional Injury (Accident) (V01-X59,Y85-Y86)	437	47.0	6.2	287	63.2	6.8	150	31.6	5.3
Chronic Lower Respiratory Diseases (J40-J47)	353	38.0	5.0	174	38.3	4.1	179	37.7	6.4
Chronic Liver Disease & Cirrhosis (K70,K73-K74)	345	37.1	4.9	223	49.1	5.3	122	25.7	4.3
All Other Causes	2,236	240.7	31.6	1,300	286.3	30.6	933	196.5	33.1
65 - 74									
All Causes	10,026	1,623.0	100.0	5,765	1,944.2	100.0	4,252	1,323.7	100.0
Malignant Neoplasms (C00-C97)	3,549	574.5	35.4	1,967	663.4	34.1	1,582	492.5	37.2
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	1,799	291.2	17.9	1,155	389.5	20.0	644	200.5	15.1
Chronic Lower Respiratory Diseases (J40-J47)	826	133.7	8.2	432	145.7	7.5	394	122.7	9.3
Diabetes Mellitus (E10-E14)	472	76.4	4.7	285	96.1	4.9	187	58.2	4.4
Cerebrovascular Diseases (I60-I69)	394	63.8	3.9	214	72.2	3.7	180	56.0	4.2
All Other Causes	2,986	483.4	29.8	1,712	577.4	29.7	1,265	393.8	29.8
75-84									
All Causes	12,384	4,413.3	100.0	6,451	5,075.7	100.0	5,933	3,864.8	100.0
Malignant Neoplasms (C00-C97)	3,238	1,153.9	26.1	1,744	1,372.2	27.0	1,494	973.2	25.2
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	2,519	897.7	20.3	1,426	1,122.0	22.1	1,093	712.0	18.4
Chronic Lower Respiratory Diseases (J40-J47)	981	349.6	7.9	467	367.4	7.2	514	334.8	8.7
Alzheimer's Disease (G30)	826	294.4	6.7	343	269.9	5.3	483	314.6	8.1
Cerebrovascular Diseases (I60-I69)	692	246.6	5.6	322	253.4	5.0	370	241.0	6.2
All Other Causes	4,128	1,471.1	33.3	2,149	1,690.9	33.3	1,979	1,289.2	33.4
85 and Over									
All Causes	18,357	14,195.0	100.0	7,108	15,288.0	100.0	11,249	13,582.0	100.0
Diseases of the Heart (I00-I09,I11,I13,I20-I51)	4,690	3,626.8	25.5	1,963	4,222.1	27.6	2,727	3,292.6	24.2
Alzheimer's Disease (G30)	2,467	1,907.7	13.4	687	1,477.6	9.7	1,780	2,149.2	15.8
Malignant Neoplasms (C00-C97)	2,281	1,763.9	12.4	1,061	2,282.1	14.9	1,220	1,473.0	10.8
Cerebrovascular Diseases (I60-I69)	1,275	986.0	6.9	399	858.2	5.6	876	1,057.7	7.8
Chronic Lower Respiratory Diseases (J40-J47)	907	701.4	4.9	395	849.6	5.6	512	618.2	4.6
All Other Causes	6,737	5,209.7	36.7	2,603	5,598.7	36.6	4,134	4,991.4	36.7

[1] Rate per 100,000 population in each age-sex group.

[2] Percent of total deaths in each age-sex group. Percents may not add to 100% due to rounding.

[*] Rate not calculated because number of deaths was less than 5.

[T]otal includes 1 death for which sex is unknown.

Source: Center for Health Statistics, Washington State Department of Health, 10/2016.

EXHIBIT 10

Washington State HIV Surveillance Report 2020 Edition

WASHINGTON STATE HIV SURVEILLANCE REPORT 2020 EDITION

Washington State Department of Health

DOH 150-030

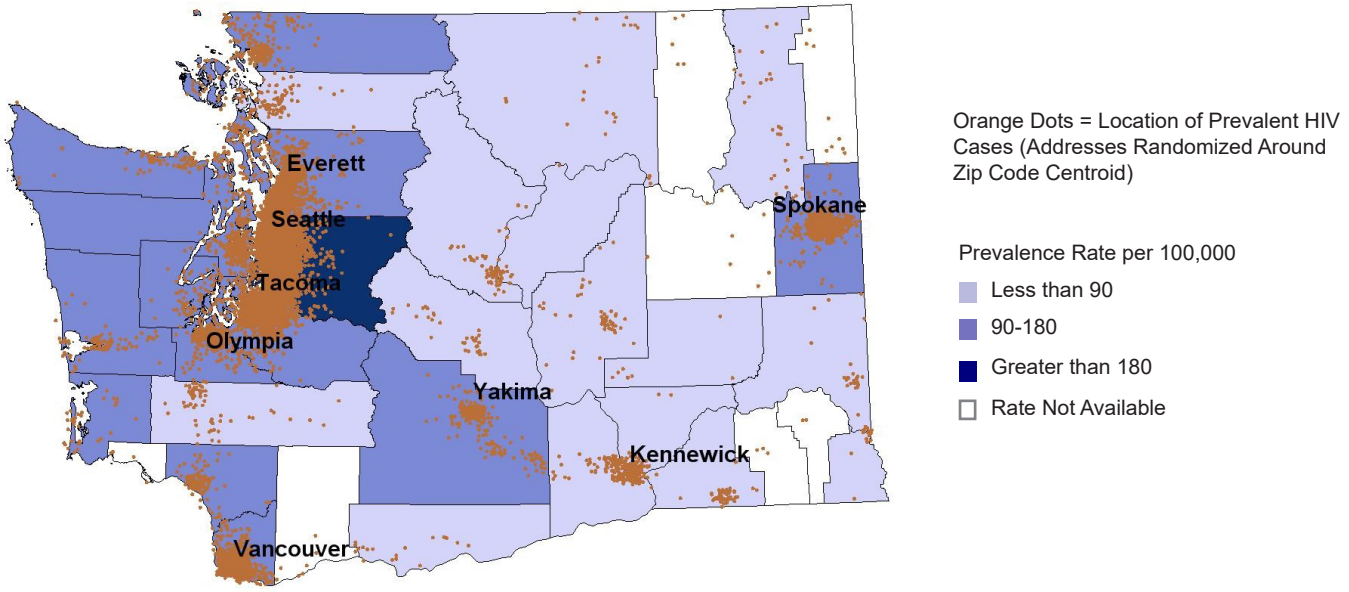
Office of Infectious Disease Assessment Unit (360) 236-3455 www.doh.wa.gov/HIVAIDSData

What's in this report?

HIV IN WASHINGTON: AN OVERVIEW

- In Washington, the first case of HIV was diagnosed in 1981.
- The number of new HIV cases in Washington (n=410 in 2019) has remained stable in recent years.
- By the end of 2019, over 14,000 people were estimated to be living with HIV across Washington State, of who approximately 91% have been diagnosed.
- Roughly three out of four living cases of HIV in Washington appear to be receiving optimal HIV medical care.

Figure 1.Prevalent HIV Cases and Prevalence Rates by County, 2019



STATISTICS: NEW HIV CASES

Table 1. New HIV and AIDS Cases, Including Late HIV Diagnoses and Linkage to Care, by Demographic and Risk Characteristics, WA State, 2019

	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	184	100%	2.4	410	100%	5.4	100	24%	338	82%
Gender										
Female	152	83%	4.0	63	15%	1.7	16	25%	54	86%
Male	32	17%	0.8	339	83%	9.0	83	24%	279	82%
Transgender female	0	0%	n/a	7	2%	n/a	--	--	--	--
Transgender male	0	0%	n/a	1	0%	n/a	--	--	--	--
Age at HIV Diagnosis										
< 13	0	0%	0.0	0	0%	0.0	--	--	--	--
13-24	7	4%	0.6[NR]	62	15%	5.4	7	11%	43	69%
25-34	51	28%	4.8	167	41%	15.7	33	20%	143	86%
35-44	44	24%	4.5	75	18%	7.6	20	27%	61	81%
45-54	41	22%	4.4	64	16%	6.9	19	30%	54	84%
55-64	31	17%	3.2	31	8%	3.2	16	52%	27	87%
65+	10	5%	0.8[NR]	11	3%	0.9[NR]	5	45%	10	91%
Race/ethnicity										
AI/AN[c]	1	0%	1.1[NR]	3	1%	3.2[NR]	--	--	--	--
Asian	10	4%	1.5[NR]	19	5%	2.8	9	47%	17	89%
Black	42	28%	14.4	71	17%	24.4	20	28%	59	83%
Foreign-born[d,e]	22	16%	31.8	30	7%	43.4	11	37%	25	83%
U.S.-born[d,e]	19	12%	8.4	33	8%	14.6	8	24%	27	82%
Hispanic	36	18%	3.6	97	24%	9.8	22	23%	72	74%
Foreign-born[d,e]	22	10%	7.1	50	12%	16.1	17	34%	39	78%
U.S.-born[d,e]	9	4%	1.3[NR]	28	7%	4.1	2	7%	22	79%
NHOPI	3	2%	5.6[NR]	3	1%	5.6[NR]	--	--	--	--
White	81	42%	1.6	201	49%	3.9	45	22%	171	85%
Multiple	11	6%	3.3[NR]	16	4%	4.9[NR]	3	19%	15	94%
Mode of Exposure										
MSM[f]	88	48%	n/a	242	59%	n/a	50	21%	200	83%
IDU	19	10%	n/a	42	10%	n/a	11	26%	33	79%
MSM/IDU	15	8%	n/a	22	5%	n/a	3	14%	17	77%
Heterosexual	27	15%	n/a	38	9%	n/a	12	32%	35	92%
Blood/pediatric	3	2%	n/a	2	0%	n/a	--	--	--	--
NIR	33	18%	n/a	64	16%	n/a	22	34%	51	80%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

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 diagnoses

[b] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnoses

[c] AI/AN = American Indian or Alaska Native, NHOPI = Native Hawaiian or Other Pacific Islander

[d] Country of origin data are missing for approximately 11% and 20% of newly diagnosed cases among Black and Hispanics, respectively

[e] Population estimate for 2019 was extrapolated using previous estimates from years 2010-2018

[f] MSM = men having sex with men, IDU = injection drug use, NIR = no identified risk

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, 2019

County or Health District of Residence	New HIV Cases			Late HIV Diagnoses[a]		Initial Linkage to HIV Care[b]	
	no.	column %	rate	no.	row %	no.	row %
Adams Co.	2	0%	9.9[NR]	--	--	--	--
Asotin Co.	0	0%	0.0	--	--	--	--
Benton Co.	13	3%	6.4[NR]	--	--	10	77%
Benton-Franklin HD	18	4%	6.1	2	11%	12	77%
Chelan Co.	2	0%	2.6[NR]	--	--	--	--
Chelan-Douglas HD	4	1%	3.3[NR]	--	--	--	--
Clallam Co.	2	0%	2.6[NR]	--	--	--	--
Clark Co.	29	7%	5.9	7	24%	21	72%
Columbia Co.	0	0%	0.0	--	--	--	--
Cowlitz Co.	2	0%	1.8[NR]	--	--	--	--
Douglas Co.	2	0%	4.7[NR]	--	--	--	--
Ferry Co.	0	0%	0.0	--	--	--	--
Franklin Co.	5	1%	5.3[NR]	--	--	--	--
Garfield Co.	0	0%	0.0	--	--	--	--
Grant Co.	2	0%	2.0[NR]	--	--	--	--
Grays Harbor Co.	2	0%	2.7[NR]	--	--	--	--
Island Co.	5	1%	5.9[NR]	--	--	--	--
Jefferson Co.	0	0%	0.0	--	--	--	--
King Co.	195	48%	8.8	41	21%	166	85%
Kitsap Co.	9	2%	3.3[NR]	--	--	--	--
Kittitas Co.	3	1%	6.4[NR]	--	--	--	--
Klickitat Co.	0	0%	0.0	--	--	--	--
Lewis Co.	2	0%	2.5[NR]	--	--	--	--
Lincoln Co.	0	0%	0.0	--	--	--	--
Mason Co.	6	1%	9.2[NR]	--	--	--	--
Ne Tri-County HD	1	0%	1.5[NR]	--	--	--	--
Okanogan Co.	0	0%	0.0	--	--	--	--
Pacific Co.	0	0%	0.0	--	--	--	--
Pend Oreille Co.	1	0%	7.3[NR]	--	--	--	--
Pierce Co.	52	13%	5.9	14	27%	39	75%
San Juan Co.	0	0%	0.0	--	--	--	--
Skagit Co.	4	1%	3.1[NR]	--	--	--	--
Skamania Co.	0	0%	0.0	--	--	--	--
Snohomish Co.	29	7%	3.5	9	31%	24	83%
Spokane Co.	26	6%	5.0	6	23%	26	100%
Stevens Co.	0	0%	0.0	--	--	--	--
Thurston Co.	6	1%	2.1[NR]	--	--	--	--
Wahkiakum Co.	0	0%	0.0	--	--	--	--
Walla Walla Co.	0	0%	0.0	--	--	--	--
Whatcom Co.	4	1%	1.8[NR]	--	--	--	--
Whitman Co.	0	0%	0.0	--	--	--	--
Yakima Co.	7	2%	2.7[NR]	--	--	--	--
Total	410	100%	5.4	100	24%	335	82%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

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 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, 2015-2019

	2015	2016	2017	2018	2019	2015-2019			
	no.	no.	no.	no.	no.	total no.	avg. no.	%	rate
Total									
	403	370	374	405	410	1962	392	100%	5.4
Gender									
Female	60	75	67	89	63	354	71	18%	1.9
Male	339	290	301	313	339	1582	316	81%	8.7
Transgender female	4	5	5	3	7	24	5	1%	n/a
Transgender male	0	0	1	0	1	2	0	0%	n/a
Age at HIV Diagnosis									
< 13	4	2	3	0	0	9	2	0%	0.2[NR]
13-24	64	63	59	54	62	302	60	15%	5.4
25-34	150	116	144	141	167	718	144	37%	14.1
35-44	84	78	62	94	75	393	79	20%	8.3
45-54	67	63	63	67	64	324	65	17%	6.9
55-64	28	36	34	41	31	170	34	9%	3.6
65+	6	12	9	8	11	46	9	2%	0.8[NR]
Race/ethnicity									
AI/AN[a]	4	9	5	3	3	24	5	1%	5.2[NR]
Asian	25	27	24	16	19	111	22	6%	3.7
Black	71	65	72	85	71	364	73	19%	26.9
Foreign-born[b,c]	25	28	36	44	30	163	33	8%	52.6
U.S.-born[b,c]	40	32	31	34	33	170	34	9%	6.0
Hispanic	81	62	79	72	97	391	78	20%	8.4
Foreign-born[b,c]	44	31	38	30	50	193	39	10%	12.9
U.S.-born[b,c]	23	26	34	29	28	140	28	7%	4.4
NHOPI	3	4	3	5	3	18	4	1%	7.2[NR]
White	207	184	178	203	201	973	195	50%	3.9
Multiple	12	19	13	21	16	81	16	4%	5.2[NR]
Mode of Exposure									
MSM[d]	249	193	209	200	242	1093	219	56%	n/a
IDU[d]	31	28	19	44	42	164	33	8%	n/a
MSM/IDU[d]	27	27	27	39	22	142	28	7%	n/a
Heterosexual	29	53	37	51	38	218	44	11%	n/a
Blood/pediatric	4	1	5	0	2	12	2	1%	n/a
NIR[d]	53	68	77	71	64	333	67	17%	n/a

Table based on HIV surveillance data reported to the WA State Department of Health as of June, 30 2020

n/a Rate cannot be calculated due to no available population estimate

[NR] Not reliable, RSE ≥25

[a] AI/AN = American Indian or Alaska Native, NHOPI = Native Hawaiian or Other Pacific Islander

[b] Country of origin data are missing for approximately 11% and 20% of newly diagnosed cases among Black and Hispanics, respectively

[c] Population estimate for 2019 was extrapolated using previous estimates from years 2010-2018

[d] MSM = men having sex with men, IDU = injection drug use, NIR = no identified risk

STATISTICS: NEW HIV CASES (continued)

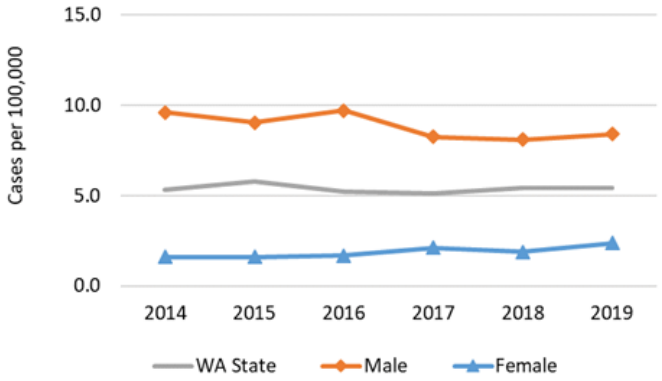
Table 4. New HIV Case Counts over Time, by County and Health District (HD) of Residence at HIV Diagnosis, WA State, 2015-2019

County and Health District of Residence	2015	2016	2017	2018	2019	2015-2019			
	no.	no.	no.	no.	no.	total no.	avg. no.	%	rate
Adams Co.	1	0	0	0	2	3	1	0%	3.0[NR]
Asotin Co.	1	0	0	0	0	1	0	0%	0.9[NR]
Benton Co.	0	7	2	0	13	22	4	1%	2.3
Benton-Franklin Hd	5	10	3	5	18	41	8	2%	2.9
Chelan Co.	5	6	1	3	2	17	3	1%	4.4
Chelan-Douglas Hd	8	6	2	4	4	24	5	1%	4.1
Clallam Co.	4	2	2	5	2	15	3	1%	4.0[NR]
Clark Co.	17	18	24	21	29	109	22	6%	4.6
Columbia Co.	0	0	1	0	0	1	0	0%	4.9[NR]
Cowlitz Co.	2	2	4	1	2	11	2	1%	2.1[NR]
Douglas Co.	3	0	1	1	2	7	1	0%	3.4[NR]
Ferry Co.	0	0	0	0	0	0	0	0%	0.0
Franklin Co.	5	3	1	5	5	19	4	1%	4.2
Garfield Co.	0	0	0	0	0	0	0	0%	0.0
Grant Co.	0	0	0	4	2	6	1	0%	1.2[NR]
Grays Harbor Co.	4	1	4	0	2	11	2	1%	3.0[NR]
Island Co.	1	2	3	2	5	13	3	1%	3.1[NR]
Jefferson Co.	1	2	0	1	0	4	1	0%	2.6[NR]
King Co.	203	181	177	230	195	986	197	50%	9.2
Kitsap Co.	10	7	9	9	9	44	9	2%	3.3
Kittitas Co.	1	1	0	3	3	8	2	0%	3.6[NR]
Klickitat Co.	0	0	1	0	0	1	0	0%	0.9[NR]
Lewis Co.	1	0	0	1	2	4	1	0%	1.0[NR]
Lincoln Co.	0	1	1	0	0	2	0	0%	3.7[NR]
Mason Co.	5	3	4	5	6	23	5	1%	7.3
Ne Tri-County Hd	1	1	0	0	1	3	1	0%	0.9[NR]
Okanogan Co.	0	1	0	0	0	1	0	0%	0.5[NR]
Pacific Co.	0	0	0	1	0	1	0	0%	0.9[NR]
Pend Oreille Co.	1	0	0	0	1	2	0	0%	3.0[NR]
Pierce Co.	64	42	41	50	52	249	50	13%	5.8
San Juan Co.	0	0	0	0	0	0	0	0%	0.0
Skagit Co.	1	7	4	3	4	19	4	1%	3.1
Skamania Co.	1	0	0	0	0	1	0	0%	1.7[NR]
Snohomish Co.	34	36	27	20	29	146	29	7%	3.7
Spokane Co.	19	26	21	17	26	109	22	6%	4.4
Stevens Co.	0	1	0	0	0	1	0	0%	0.4[NR]
Thurston Co.	7	8	10	8	6	39	8	2%	2.8
Wahkiakum Co.	0	0	0	0	0	0	0	0%	0.0
Walla Walla Co.	0	1	2	1	0	4	1	0%	1.3[NR]
Whatcom Co.	5	2	8	3	4	22	4	1%	2.0
Whitman Co.	1	0	0	3	0	4	1	0%	1.6[NR]
Yakima Co.	6	10	26	10	7	59	12	3%	4.7
Total	403	370	374	407	410	1964	393	100%	5.4

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020
NR = Not reliable, RSE ≥25

STATISTICS: NEW HIV CASES (continued)

Figure 2. New HIV Case Rates by Gender,* WA State, 2014-2019



*Transgender rates not available due to small case counts

Figure 3. New HIV Case Rates by Age at Diagnosis, WA State, 2014-2019

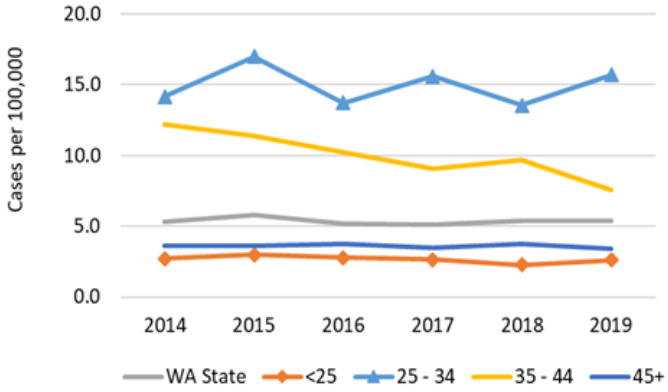


Figure 4. New HIV Case Rates among Black Persons by Nativity, WA State, 2014-2019

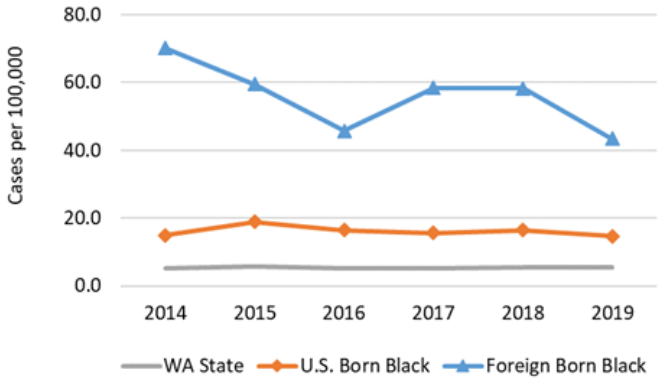


Figure 5. New HIV Case Rates among Hispanic Persons by Nativity, WA State, 2014-2019

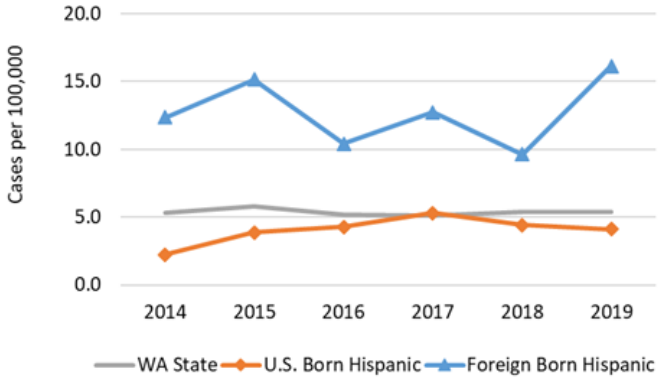
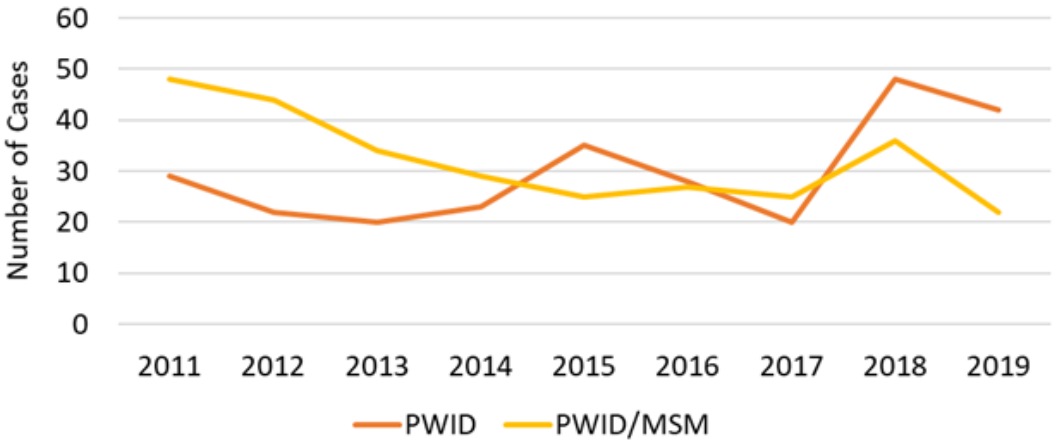


Figure 6. New HIV Case Counts among Persons who Inject Drugs (PWID) and PWID/MSM, WA State, 2011-2019



STATISTICS: NEW HIV CASES (continued)

Table 5. New Cases of HIV Infection, by Current Gender*, Race/Ethnicity, and HIV Exposure Category, WA State, 2015-2019

		White		Black		Hispanic		Asian		Other	
Gender	Exposure Category	No.	%	No.	%	No.	%	No.	%	No.	%
Male	Male / Male Sex (MSM)	547	66%	127	57%	264	76%	73	82%	65	69%
	Injecting Drug Use (IDU)	67	8%	8	4%	8	2%	1	1%	5	5%
	MSM and IDU	101	12%	10	4%	16	5%	0	0%	9	10%
	Heterosexual Contact	17	2%	12	5%	14	4%	1	1%	1	1%
	Blood/Pediatric	3	0%	4	2%	0	0%	0	0%	0	0%
	No Identified Risk	94	11%	63	28%	44	13%	14	16%	14	15%
	Total Male	829	100%	224	100%	346	100%	89	100%	94	100%

		White		Black		Hispanic		Asian		Other	
		No.	%	No.	%	No.	%	No.	%	No.	%
Female	Injecting Drug Use (IDU)	58	43%	3	2%	5	13%	1	5%	8	32%
	Heterosexual Contact	22	16%	20	15%	10	26%	5	25%	5	20%
	Blood/Pediatric	0	0%	7	5%	0	0%	1	5%	0	0%
	No Identified Risk	55	41%	106	78%	23	61%	13	65%	12	48%
	Total Female	135	100%	136	100%	38	100%	20	100%	25	100%

		Total									
		No.	%	No.	%	No.	%	No.	%	No.	%
Transgender Female	Male sex partner	17	71%	-	-	-	-	-	-	-	-
	Male sex partner and IDU	6	25%	-	-	-	-	-	-	-	-
	Other	0	0%	-	-	-	-	-	-	-	-
	No Identified Risk	1	4%	-	-	-	-	-	-	-	-
	Total Transgender Female	24	100%	-	-	-	-	-	-	-	-

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30,2020
*Due to the small number of HIV Cases reported as transgender, further stratification among transgender females and data for transgender males are not displayed

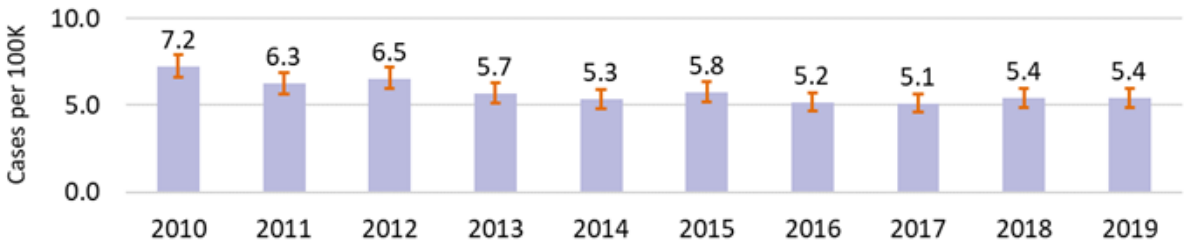
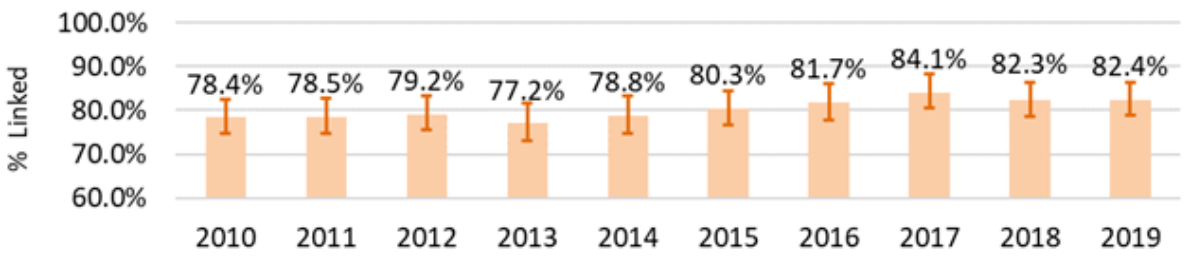


Figure 8. Linkage to Care among New HIV Cases, WA State, 2010-2019



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, 2019

	Prevalent Cases of HIV			Engaged in Care[a]		Suppressed Viral Load[b]	
	no.	column %	rate	no.	row %	no.	row %
Total	13710	100%	181.7	12199	89%	11274	82%
Gender							
Female	2130	16%	56.3	1894	89%	1708	80%
Male	11454	84%	304.1	10195	89%	9466	83%
Transgender female	113	1%	n/a	100	88%	92	81%
Transgender male	13	0%	n/a	10	77%	8	62%
Current Age							
< 13	30	0%	2.5	29	97%	29	97%
13-24	302	2%	26.3	266	88%	222	74%
25-34	1806	13%	170.0	1538	85%	1344	74%
35-44	2708	20%	274.5	2334	86%	2114	78%
45-54	3863	28%	414.6	3421	89%	3144	81%
55-64	3644	27%	373.8	3348	92%	3196	88%
65+	1357	10%	110.6	1263	93%	1225	90%
Race/ethnicity							
AI/AN[c]	135	1%	143.6	117	87%	105	78%
Asian	485	4%	71.5	434	89%	417	86%
Black	2359	17%	810.8	2049	87%	1849	78%
Foreign-born[d,e]	1008	7%	1457.2	899	89%	846	84%
U.S.-born[d,e]	1255	9%	556.4	1070	85%	931	74%
Hispanic	2030	15%	204.1	1758	87%	1624	80%
Foreign-born[d,e]	1013	7%	326.8	878	87%	825	81%
U.S.-born[d,e]	850	6%	125.2	747	88%	681	80%
NHOPI[c]	62	0%	115.6	52	84%	44	71%
White	7766	57%	152.1	6995	90%	6518	84%
Multiple	867	6%	263.3	788	91%	711	82%
Mode of Exposure							
MSM[f]	8425	61%	n/a	7556	90%	7100	84%
IDU[f]	796	6%	n/a	689	87%	597	75%
MSM/IDU[f]	1235	9%	n/a	1123	91%	982	80%
Heterosexual	1718	13%	n/a	1514	88%	1391	81%
Blood/pediatric	189	1%	n/a	175	93%	159	84%
NIR[f]	1347	10%	n/a	1142	85%	1045	78%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

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] AI/AN = American Indian or Alaska Native, NHOPI = Native Hawaiian or Other Pacific Islander

[d] Country of origin data are missing for approximately 8% and 4% of living cases among Blacks and Hispanics, respectively

[e] Population estimate for 2019 was extrapolated using previous estimates from years 2010-2018

[f] MSM = men having sex with men, IDU=injection drug use, NIR = no identified risk

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, 2019

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%	64.5[NR]	13	100%	10	77%
Asotin Co.	18	0%	79.9	15	83%	14	78%
Benton Co.	175	1%	86.7	154	88%	134	77%
Benton-Franklin Hd	254	2%	85.7	169	67%	147	58%
Chelan Co.	61	0%	77.8	49	80%	47	77%
Chelan-Douglas Hd	80	1%	66.0	64	80%	60	75%
Clallam Co.	80	1%	105.2	71	89%	63	79%
Clark Co.	752	5%	153.9	625	83%	575	76%
Columbia Co.	3	0%	72.1[NR]	--	--	--	--
Cowlitz Co.	140	1%	128.5	122	87%	105	75%
Douglas Co.	19	0%	44.4	15	79%	13	68%
Ferry Co.	5	0%	63.9[NR]	--	--	--	--
Franklin Co.	79	1%	83.4	68	86%	61	77%
Garfield Co.	2	0%	90.1[NR]	--	--	--	--
Grant Co.	48	0%	48.6	43	90%	40	83%
Grays Harbor Co.	90	1%	121.4	74	82%	68	76%
Island Co.	95	1%	112.0	77	81%	73	77%
Jefferson Co.	45	0%	141.1	42	93%	38	84%
King Co.	7056	51%	316.9	6390	91%	5952	84%
Kitsap Co.	335	2%	124.0	294	88%	279	83%
Kittitas Co.	30	0%	64.4	29	97%	26	87%
Klickitat Co.	17	0%	75.8	17	100%	15	88%
Lewis Co.	65	0%	81.8	56	86%	51	78%
Lincoln Co.	7	0%	63.9[NR]	--	--	--	--
Mason Co.	66	0%	101.6	59	89%	55	83%
Ne Tri-County Hd	41	0%	61.1	36	88%	36	88%
Okanogan Co.	22	0%	51.5	16	73%	16	73%
Pacific Co.	32	0%	147.9	25	78%	24	75%
Pend Oreille Co.	11	0%	80.1[NR]	10	91%	10	91%
Pierce Co.	1534	11%	172.7	1308	85%	1182	77%
San Juan Co.	21	0%	122.4	19	90%	18	86%
Skagit Co.	94	1%	72.8	84	89%	80	85%
Skamania Co.	6	0%	49.8[NR]	--	--	--	--
Snohomish Co.	1196	9%	146.1	1079	90%	1017	85%
Spokane Co.	668	5%	129.6	597	89%	528	79%
Stevens Co.	25	0%	54.9	22	88%	22	88%
Thurston Co.	322	2%	112.7	282	88%	256	80%
Wahkiakum Co.	3	0%	71.6[NR]	--	--	--	--
Walla Walla Co.	53	0%	85.2	44	83%	41	77%
Whatcom Co.	246	2%	109.2	224	91%	207	84%
Whitman Co.	27	0%	53.9	25	93%	24	89%
Yakima Co.	247	2%	96.5	230	93%	211	85%
Uknown	2	0%	n/a	--	--	--	--
Total	13710	100%	1817.7	12199	89%	11274	82%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

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 viral load result within calendar year

[b] Suppressed viral load = last reported viral load result in calendar year <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, 2019

		Asian		Black		Hispanic		Other		White	
Gender	Exposure Category	No.	%	No.	%	No.	%	No.	%	No.	%
Female	Injecting Drug Use (IDU)	2	2%	39	4%	28	11%	44	27%	212	28%
	Heterosexual Contact	59	71%	542	61%	172	70%	99	60%	434	58%
	Blood/Pediatric	3	4%	55	6%	7	3%	4	2%	22	3%
	No Identified Risk	19	23%	249	28%	40	16%	19	11%	80	11%
	Total Female	83	100%	885	100%	247	100%	166	100%	748	100%
Male	Male / Male Sex (MSM)	292	74%	776	53%	1319	75%	604	69%	5345	77%
	Injecting Drug Use (IDU)	6	2%	75	5%	45	3%	44	5%	298	4%
	MSM and IDU	9	2%	94	6%	142	8%	131	15%	834	12%
	Heterosexual Contact	13	3%	172	12%	70	4%	37	4%	116	2%
	Blood/Pediatric	3	1%	40	3%	9	1%	5	1%	40	1%
	No Identified Risk	74	19%	298	20%	164	9%	57	6%	337	5%
	Total Male	397	100%	1455	100%	1749	100%	878	100%	6970	100%
Transgender Female	Male sex partner	25	64%	16	94%	24	71%	5	100%	13	72%
	Male sex partner and IDU	11	28%	1	6%	8	24%	0	0%	5	28%
	Other	0	0%	0	0%	1	3%	0	0%	0	0%
	No Identified Risk	3	8%	0	0%	1	3%	0	0%	0	0%
	Total Transgender Female	39	100%	17	100%	34	100%	5	100%	18	100%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

* Due to the small number of HIV Cases reported as transgender male data are not displayed

Figure 9. Living HIV Case Rates, WA State, 2010-2019

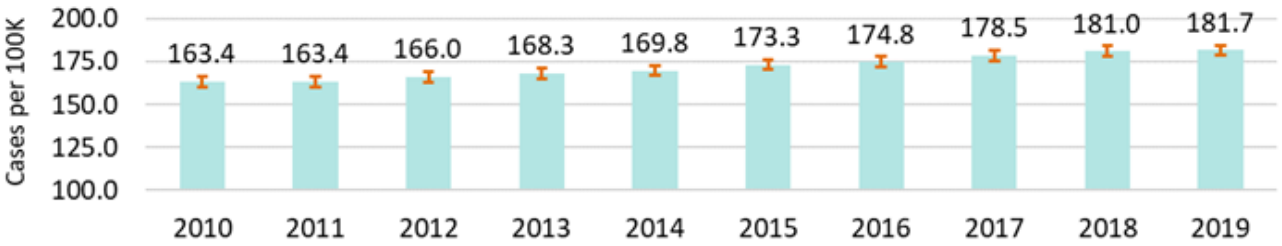
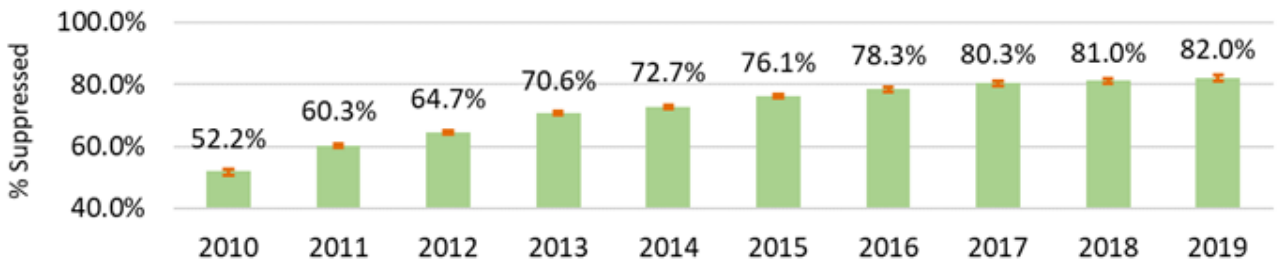


Figure 10. Virologic Suppression among Living HIV Cases, WA State, 2010-2019



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 9. Characteristics and Care Outcomes of People Living with HIV Reporting Any American Indian or Alaska Native Race, 2015-2019

	New HIV Cases		Prevalent HIV Cases	
	no.	column %	no.	column %
Total	63	2%[a]	551	4%[a]
Gender				
Female	19	30%	106	19%
Male	43	68%	434	79%
Transgender female	1	2%	9	2%
Transgender male	0	0%	2	0%
Mode of Exposure				
MSM[b]	27	43%	288	52%
IDU[b]	12	19%	69	13%
MSM/IDU[b]	7	11%	82	15%
Heterosexual	7	11%	78	14%
NIR[b]/Other	10	16%	34	6%
Geography				
King County	30	48%	263	48%
Other Western Washington	18	29%	214	39%
Eastern Washington	15	24%	74	13%
Care Metrics				
Initial Linkage to HIV Care[c]	48	76%	N/A	N/A
Engaged in Care[d]	N/A	N/A	501	91%
Viral Suppression[e]	N/A	N/A	444	81%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

[a] Percentage of total Washington Cases

[b] MSM = men having sex with men, IDU= injection drug use, NIR= no identified risk

[c] Initial linkage to care = at least one CD4 or viral load result within 30 days of HIV diagnoses

[d] Engaged in care = at least one reported CD4 or VL result within calendar year

[e] Suppressed viral load = last reported viral load result in calendar year was < 200 copies/mL

STATISTICS: MORTALITY

Table 10. Deaths among Cases of HIV, by Demographic and Risk Characteristics, WA State, 1982-2018

	2018					1982-2018	
	no.	column %	Mortality rate (per 100,000)	case fatality rate (per 1,000)	standardized mortality ratio	no.	column %
Total							
	205	100%	2.6*	15.0	2.1	8414	100%
Gender							
Female	33	16%	0.9	15.5	3.2	737	9%
Male	169	82%	4.6	14.8	1.9	7657	91%
Transgender female	3	1%	n/a	26.5[NR]	n/a	20	0%
Transgender male	0	0%	n/a	0.0	n/a	0	0%
Current Age							
< 13	0	0%	0.0	0.0	0.0	19	0%
13-24	0	0%	0.0	0.0	0.0	100	1%
25-34	10	5%	1.0[NR]	5.5[NR]	4.5	1741	21%
35-44	20	10%	2.1	7.4	3.6	3039	36%
45-54	54	26%	5.7	14.0	3.8	2038	24%
55-64	66	32%	6.8	18.1	2.1	1018	12%
65+	55	27%	4.7	40.5	1.2	459	5%
Race/ethnicity							
AI/AN[a]	6	3%	6.4[NR]	44.4[NR]	n/a	133	2%
Asian	1	0%	0.2[NR]	2.1[NR]	n/a	96	1%
Black	29	14%	10.5	12.3	n/a	808	10%
Foreign-born[b]	8	4%	10.6[NR]	7.9[NR]	n/a	77	1%
U.S.-born[b]	21	10%	10.2	16.7	n/a	717	9%
Hispanic	24	12%	2.5	11.8	n/a	553	7%
Foreign-born[b]	6	3%	1.9[NR]	5.9[NR]	n/a	193	2%
U.S.-born[b]	18	9%	2.7	21.2	n/a	330	4%
NHOPI[a]	1	0%	1.9[NR]	16.1[NR]	n/a	18	0%
White	124	60%	2.4	16.0	n/a	6509	77%
Multiple	20	10%	6.2	23.1	n/a	296	4%
Mode of Exposure							
MSM[c]	105	51%	n/a	12.5	n/a	5378	64%
IDU[c]	24	12%	n/a	30.2	n/a	943	11%
MSM/IDU[c]	26	13%	n/a	21.1	n/a	926	11%
Heterosexual	25	12%	n/a	14.6	n/a	496	6%
Blood/pediatric	1	0%	n/a	5.3NR	n/a	185	2%
NIR[c]	24	12%	n/a	17.8	n/a	486	6%

Table based on HIV surveillance data reported to the WA State Department of Health as of June 30, 2020

* Age-adjusted death rate

n/a Rate cannot be calculated due to no available population estimate

[NR] Not reliable, RSE ≥25

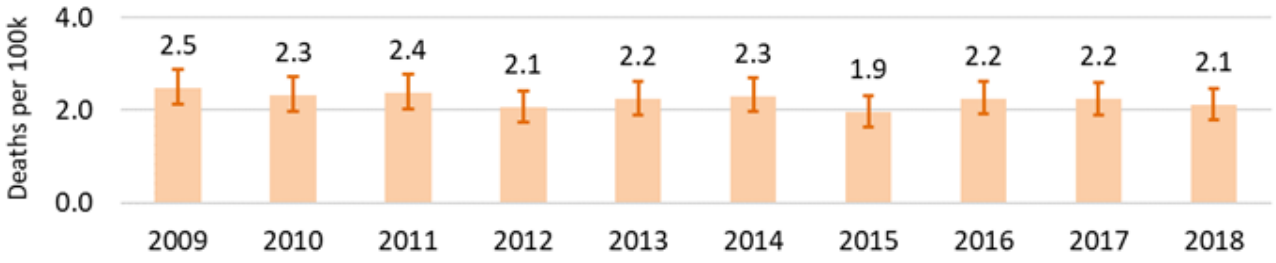
a AI/AN = American Indian or Alaska Native, NHOPI = Native Hawaiian or Other Pacific Islander

b Country of origin data are missing for approximately 4% and 8% of living cases among Black and Hispanics, respectively

c MSM = men having sex with men, IDU = injection dru guse, NIR = no identified risk

STATISTICS: MORTALITY (continued)

Figure 11. Age-Adjusted HIV Death Rates, WA State, 2009-2018



STATISTICS: HIV CARE CONTINUA

Figure 12. HIV Care Continuum, WA State, 2019

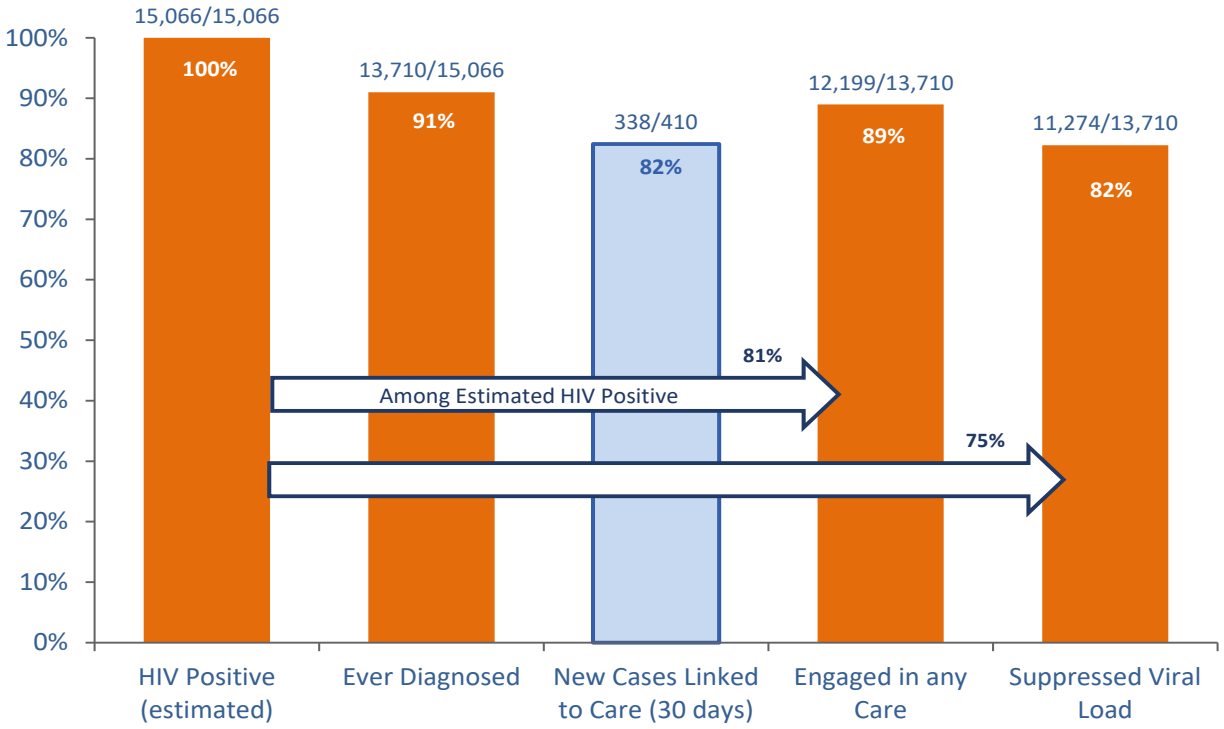
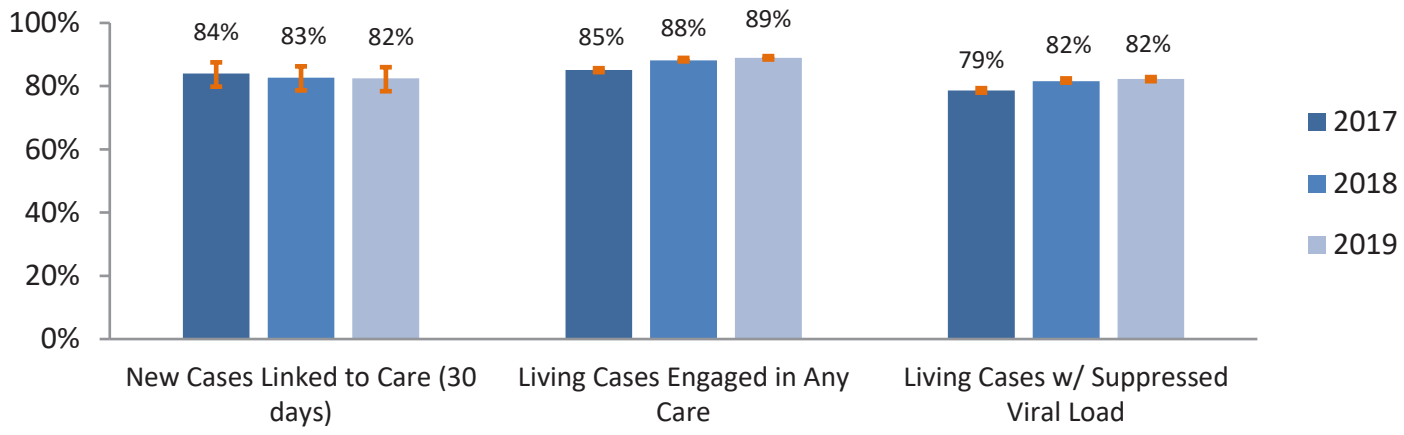
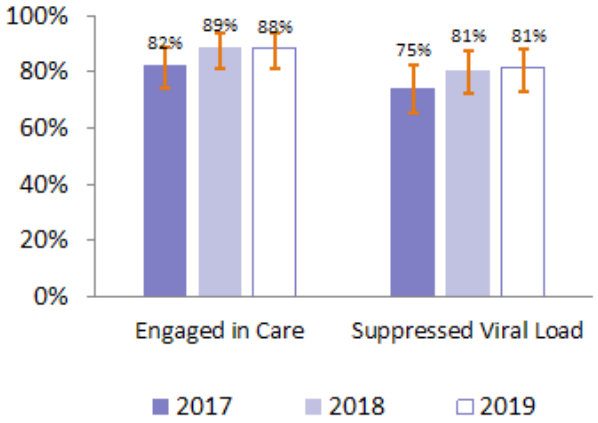


Figure 13. HIV Care Outcomes over Time, WA State, 2017-2019



STATISTICS: HIV CARE CONTINUA FOR END AIDS WASHINGTON PRIORITY POPULATIONS, WA state, 2017-2019

Figure 14. Transgender Women



*Linkage to care not shown due to small case counts

Figure 15. Young Adults (Ages 18-29)

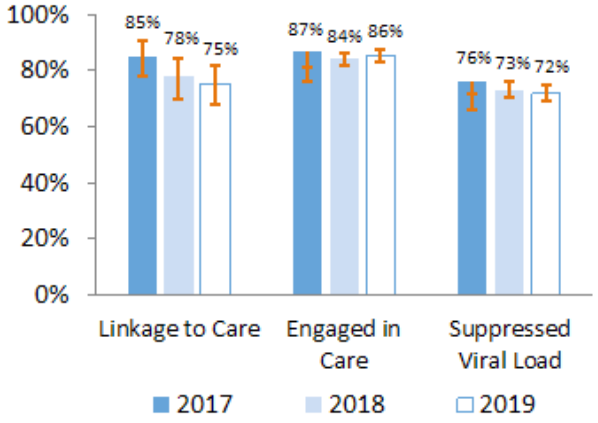


Figure 16. U.S.-Born Black Persons

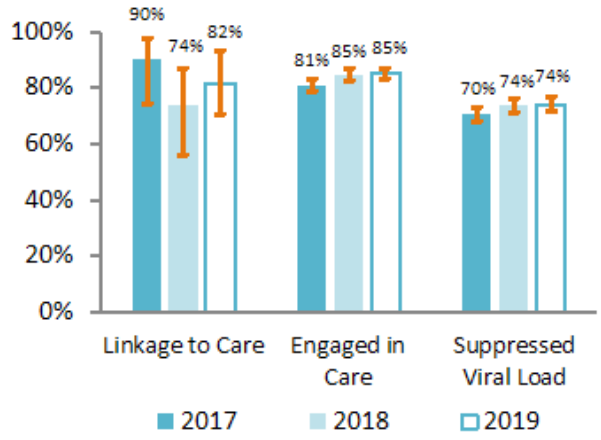


Figure 17. Foreign-Born Black Persons

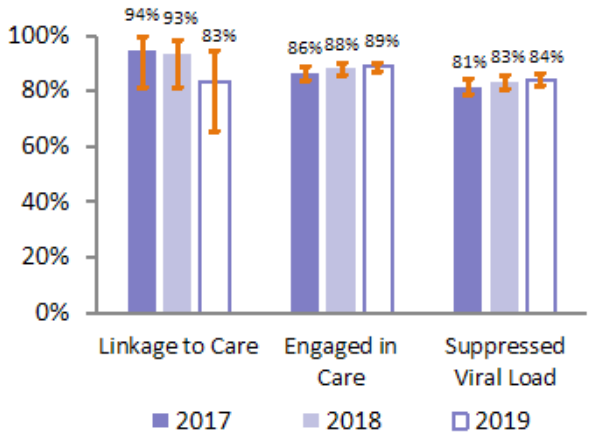


Figure 18. Foreign-Born Hispanic Persons

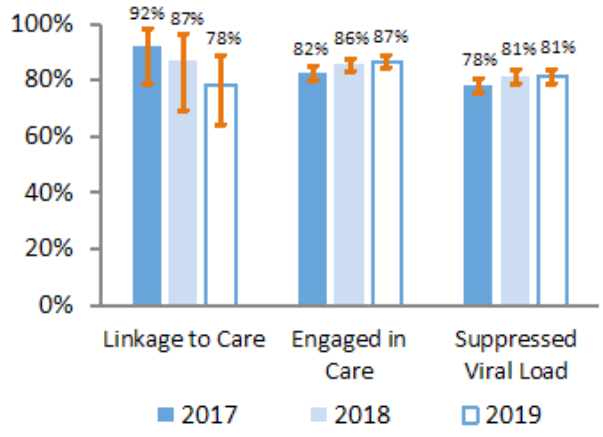
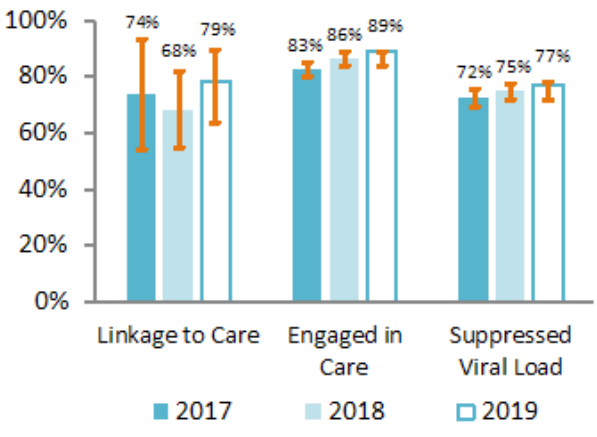


Figure 19. Persons who Inject Drugs



STATISTICS: CORONAVIRUS DISEASE 2019 AND HIV COINFECTION

From January 1, 2020 to July 31,2020 there were 57,552 cases of COVID-19 reported in Washington State, representing of 77.5 cases per 10,000 population. Among people living with HIV (PLWH), there were 140 cases, representing of 102.1 cases per 10,000 population. Adjusted for county of residence, the risk ratio of COVID-19 infection among PLWH relative to the general population was 1.4 (1.2-1.7). The risk of COVID-19 was highest among female, Black and Hispanic PLWH and among PLWH between the ages of 20 and 40. Case mortality among PLWH was higher than the general population but not significantly so.

During the first 6 months of the COVID-19 pandemic PLWH were 60% more likely to be tested for SARS-Cov-2 and 30% more likely to be diagnosed with COVID-19 than those who do not have HIV. We interpret this data to suggest that PLWH are not higher risk of COVID-19 infection than the general population. While PLWH are more likely to be diagnosed with COVID-19, antibody surveys of the general population suggest that a large proportion of COVID-19 cases are undiagnosed and unreported. In this context, a larger proportion of individuals being tested, as seen in the population of PLWH, may lead to a larger number of diagnoses independently of the underlying incidence.

Table 11. Cases of COVID-19 and HIV Coinfection in Washington State, 1/21/2020 - 7/31/2020

Attribute	Value	COVID-19 Cases	Prevalent HIV Cases	Cases Per 10,000	95% Confidence Interval	P - value[a]
Total	-	140	13,708	102.1	86.5 - 120.5	
Sex at Birth	Female	36	2142	168.1	121.2 - 233.0	
	Male	104	11568	89.9	74.2 - 109.0	0.01
Race	Black	35	2359	148.4	106.5 - 206.6	
	Hispanic	38	2030	187.2	136.2 - 257.3	<0.01
	White	45	7766	57.9	43.3 - 77.6	
	Other	32	2065	141.5	93.2 - 214.9	
Age	0 - 20	0	11	0	N/A	0.02
	20 - 40	13	879	150.5	87.4 - 259.1	
	40 - 60	70	5531	128.9	102.0 - 163.0	
	60 - 80	50	6816	74	56.1 - 97.7	
	>80	7	644	107.2	51.1 - 224.9	
Transmission Category	MSM[b]	75	8425	89	71.0 - 111.6	0.19
	IDU[b]	7	796	87.9	41.9 - 184.5	
	MSM/IDU[b]	12	1235	97.2	55.2 - 171.1	
	Heterosexual	17	1253	144.5	100.7 - 208.6	
	Other	29	2001	135.7	84.3 - 218.2	
Geography	King County	90	6966	127.6	103.7 - 156.8	<0.01
	Other	50	6604	75.1	57.0 - 99.1	
Viral Suppression	Suppressed	123	11274	109.1	91.4 - 130.2	0.08
	Not Suppressed	17	2436	69.7	43.3 - 112.3	

[a] P - values and confidence intervals from Poisson distribution

[b] MSM = men having sex with men, IDU= injection drug use

DEFINITIONS

AIDS: Acquired Immune Deficiency Syndrome. An advanced stage of HIV disease which is defined by the existence of certain opportunistic illnesses or other clincial 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 populations 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 describe the results of anonymous HIV testing.

Case Fatality Rate: The rate of all-cause deaths per 1,000 people living with HIV within a calendar year. We report on all-cause deaths in this report due to the challenging nature of determining the primary cause of death among people living with HIV.

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 case rates. Error bars on figures display the confidence interval.

Coronvairus Disease 2019 (COVID-19): An acute respiratory illness in humans caused by the SARS-CoV-2 virus. COVID-19 can cause severe symptoms and death, especially in older people and those with underlying health conditions.

Engaged in Care: The proportion of living cases who have a CD4 test or viral load test within the calendar year of interest. This is a key performance measure within the HIV care continuum.

HIV: Human Immunodeficiency Virus is a virus that weakens a person's immune system by destroying T cells that fight disease and prevent infection. If left untreated HIV can progress to AIDS.

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 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.

DEFINITIONS (continued)

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 appear to have completed an HIV medical care visit within 30 days following their HIV diagnosis date, based on the report of HIV-related laboratory results. This is a key performance measure within the HIV care continuum.

Men Having Sex with Men (MSM): In this report, refers to men who report any history of male-male 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 per 100,00 residents of Washington State, 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' or living HIV case'.

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. In this report, all RSEs ≥ 25 are flagged

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 (TSM) 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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Infectious Disease Assessment Unit
PO Box 47838, Olympia, WA 98504-7838
Phone: 360-236-3455 Email: HIV_Surv@doh.wa.gov

ABOUT THIS PUBLICATION

This surveillance report reflects events occurring through December 31, 2019 and reported by June 30 2020, 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, 2020 Edition.

ALTERNATIVE FORMATS

Electronic copies of this report are available at: https://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/HIVAIDSData/SurveillanceReports

EDITORIAL NOTES

Annual 2019 population estimates for foreign-born and U. S.-bornpopulations were not available at the time this report was created. To account for this, the population estimates were extrapolated using data from 2010-2018.

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).

EXHIBIT 11

Point-In-Time Homeless Counts
Articles on Homelessness

Column1	Population	Emergency Shelter	Transitional	Safe Haven	Total Sheltered	Un-sheltered	TOTAL
Households with adults and children	HH	659	1222	0	1881	308	**2189**
	persons	2093	3888	0	5981	963	**6944**
Households with only children	HH	53	29	0	82	15	**97**
	persons	54	35	0	89	15	**104**
Households without children	HH	4565	1616	42	6223	7145	**13368**
	persons	4605	1653	42	6300	7496	**13796**
TOTAL	HH	5277	2867	42	8186	7468	**15654**
	persons	6752	5576	42	12370	8474	**20844**
Subpopulations	CH Individuals	810	0	24	834	1563	**2397**
	CH Families	57	0	0	57	50	**107**
	Persons in CH Families	156	0	0	156	134	**290**
	CH Veteran Individuals	126	0	0	126	178	**304**
	CH Veteran Families	4	0	0	4	8	**12**
	Persons in CH Veteran Families	9	0	0	9	22	**31**
	Adults with a Serious Mental Illness	1511	293	0	1804	1457	**3261**
	Adults with a Substance Use Disorder	889	187	0	1076	996	**2072**
	Adults with HIV/AIDS	45	1	0	46	27	**73**
	Adult Victims of Domestic Violence	916	323	0	1239	672	**1911**
VETERANS ONLY							
HH with adults and children	HH	12	18	0	30	4	**34**
	persons	54	80	0	134	42	**176**
	veterans	18	27	0	45	16	**61**
HH without children	HH	532	422	2	956	492	**1448**
	persons	454	302	2	758	287	**1045**
	veterans	530	422	2	954	469	**1423**
YOUTH HOUSEHOLDS (UNDER 25)							
Households	Total number of households	344	521	0	845	464	**1309**
	Number of parenting youth households	77	220	0	284	32	**316**
	Number of unaccompanied youth households	267	301	0	561	432	**993**
Persons	Total number of persons	532	1033	0	1523	705	**2228**
Parenting Youth Households	Persons in parenting youth households	246	685	0	896	259	**1155**
	Number of parenting youth	164	358	0	509	217	**726**
Unaccompanied Youth Households	Persons in unaccompanied youth households	286	348	0	627	446	**1073**

Washington State Point in Time Count of Homeless Persons --January 2016															
	Sheltered				Unsheltered				TOTAL Homeless (sheltered and				Chronically Homeless (CH) Individuals		
County	**HH w/out minors**	**HH w/ adults & minor**	**HH w/ only minors**	**TOTAL**	**HH w/out minors - Un**	**HH w/ minors - Un**	**HH w/ only minors - Un**	**TOTAL - Un**	**HH w/ out minors-Total**	**HH w/ minors-Total**	**HH w/ only minors-Total**	**TOTAL**	**Emergency Shelter + Safe Haven**	**Unsheltered**	**TOTAL CH Individuals**
Adams	0	0	0	0	2	0	0	2	2	0	0	2	0	0	0
Asotin	0	0	0	0	13	11	0	24	13	11	0	24	0	1	1
Benton-Franklin	153	65	0	218	57	2	0	59	210	67	0	277	6	0	6
Chelan-Douglas	144	141	0	285	74	31	0	105	218	172	0	390	7	14	21
Clallam	60	128	0	188	81	24	0	105	141	152	0	293	3	24	27
Clark	200	255	8	463	110	114	1	225	310	369	9	688	28	27	55
Columbia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cowlitz	109	113	0	222	110	24	0	134	219	137	0	356	13	57	70
Ferry	0	0	0	0	1	0	0	1	1	0	0	1	0	0	0
Garfield	4	4	0	8	0	0	0	0	4	4	0	8	0	0	0
Grant	6	30	0	36	76	61	0	137	82	91	0	173	0	16	16
Grays Harbor	77	24	0	101	99	3	0	102	176	27	0	203	14	48	62
Island	17	34	0	51	103	46	0	149	120	80	0	200	1	35	36
Jefferson	29	30	0	59	85	37	0	122	114	67	0	181	0	31	31
King	3270	2926	29	6225	4448	56	1	4505	7718	2982	30	10730	427	358	785
Kitsap	120	154	0	274	174	7	0	181	294	161	0	455	7	76	83
Kittitas	9	11	0	20	4	0	0	4	13	11	0	24	2	3	5
Klickitat	2	32	0	34	11	0	0	11	13	32	0	45	0	0	0
Lewis	21	24	0	45	92	13	0	105	113	37	0	150	1	17	18
Lincoln	8	3	0	11	0	0	0	0	8	3	0	11	0	0	0
Mason	19	108	0	127	106	183	0	289	125	291	0	416	10	43	53
Okanogan	18	0	0	18	27	5	0	32	45	5	0	50	0	7	7
Pacific	7	0	0	7	61	8	0	69	68	8	0	76	1	15	16
Pend Oreille	1	15	0	16	0	0	0	0	1	15	0	16	0	0	0
Pierce	628	631	9	1268	425	69	0	494	1053	700	9	1762	127	180	307
San Juan	0	0	0	0	45	10	3	58	45	10	3	58	0	5	5
Skagit	41	97	2	140	149	78	0	227	190	175	2	367	3	61	64
Skamania	3	4	0	7	7	4	0	11	10	8	0	18	0	1	1
Snohomish	248	223	18	489	429	35	7	471	677	258	25	960	28	211	239
Spokane	503	296	10	809	164	8	0	172	667	304	10	981	67	91	158
Stevens	3	7	0	10	20	2	0	22	23	9	0	32	0	4	4
Thurston	188	201	8	397	189	0	0	189	377	201	8	586	14	85	99
Wahk-iakum	3	2	0	5	2	0	0	2	5	2	0	7	0	1	1
Walla Walla	76	28	0	104	62	0	0	62	138	28	0	166	5	35	40
Whatcom	177	198	5	380	211	126	3	340	388	324	8	720	24	93	117
Whitman	3	2	0	5	1	0	0	1	4	2	0	6	0	0	0
Yakima	153	195	0	348	58	6	0	64	211	201	0	412	46	24	70
TOTAL	6300	5981	89	12370	7496	963	15	8474	13796	6944	104	20844	834	1563	2397

2017 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**	750	1,073		**1,823**	**170**	**1,993**
	Persons	2,492	3,296		**5,788**	**543**	**6,331**
Households with only children	**Households**	64	35		**99**	**184**	**283**
	Persons	66	41		**107**	**214**	**321**
Households without children	**Households**	4,836	1,661	43	**6,540**	**5,070**	**11,610**
	Persons	4,890	1,693	43	**6,626**	**7,834**	**14,460**
TOTAL	**Households**	5,650	2,769	43	**8,462**	**11,274**	**13,886**
	Persons	7,448	5,030	43	**12,521**	**8,591**	**21,112**
Subpopulations	**Chronically Homeless Individuals**	836			**836**	**1,557**	**2,393**
	Chronically Homeless Families	90			**90**	**11**	**101**
	Persons in Chronically Homeless Families	300			**300**	**<10**	**300**
	Adults with a Serious Mental Illness	1,182	675	<10	**1,857**	**3,004**	**4,861**
	Adults with a Substance Use Disorder	685	451	-	**1,136**	**2,153**	**3,289**
	Adults with HIV/AIDS	48	22	-	**70**	**176**	**246**
	Adult Victims of Domestic Violence	1,072	989	10	**2,071**	**2,366**	**4,437**
Veterans	**Veteran Households**	542	545	-	1,087	**989**	**2,076**
	Veterans	548	546	-	1,094	**999**	**2,093**
Youth Households (under 25)							
Households	**Total numbers of households**	461	454	-	915	**1,230**	**2,145**
	Unaccompanied Youth households	381	328	-	709	**1,204**	**1,913**
	Parenting Youth Households	80	126	-	206	**26**	**232**
Persons	**Total number of persons**	**617**	**656**	**-**	**1,273**	**1,529**	**2,802**
	Persons in parenting youth household	234	325	-	559	**127**	**686**
	Persons in unaccompanied youth household	383	331	-	714	**1,402**	**2,116**

2017 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	< 10	< 10	0	0	< 10	< 10
Asotin	12	11	< 10	< 10	0	0	18	14
Benton-Franklin	143	141	70	18	10	10	223	169
Chelan-Douglas	181	176	189	55	0	0	370	231
Clallam	157	152	124	34	0	0	281	186
Clark	347	319	395	122	< 10	< 10	749	447
Columbia	< 10	< 10	0	0	0	0	< 10	< 10
Cowlitz	194	171	137	44	0	0	331	215
Ferry	0	0	0	0	0	0	0	0
Garfield	0	0	0	0	0	0	0	0
Grant	35	32	41	13	0	0	76	45
Grays Harbor	170	163	29	< 10	< 10	< 10	201	174
Island	91	83	33	11	< 10	< 10	127	97
Jefferson	144	137	43	12	0	0	187	149
King	8,585	6,029	2,833	905	225	195	11,643	7,129
Kitsap	354	336	162	47	< 10	< 10	517	384
Kittitas	28	27	10	< 10	0	0	38	30
Klickitat	< 10	< 10	12	< 10	0	0	17	< 10
Lewis	112	104	32	11	0	0	144	115
Lincoln	< 10	< 10	< 10	< 10	0	0	< 10	< 10
Mason	85	79	131	41	0	0	216	120
Okanogan	13	13	< 10	< 10	0	0	15	14
Pacific	10	< 10	< 10	< 10	0	0	12	< 10
Pend Oreille	< 10	< 10	12	< 10	0	0	16	< 10
Pierce	879	827	442	132	0	0	1,321	959
San Juan	23	22	10	< 10	< 10	< 10	36	25
Skagit	184	172	136	40	< 10	< 10	321	213
Skamania	< 10	< 10	0	0	0	0	< 10	< 10
Snohomish	754	715	281	90	31	28	1,066	833
Spokane	770	757	299	103	21	19	1,090	879
Stevens	29	29	18	< 10	0	0	47	35
Thurston	270	258	256	79	< 10	< 10	534	345
Wahkiakum	< 10	< 10	0	0	0	0	< 10	< 10
Walla Walla	141	140	26	< 10	< 10	< 10	168	149
Whatcom	434	406	272	90	< 10	< 10	713	503
Whitman	< 10	< 10	36	10	0	0	41	15
Yakima	286	275	285	94	< 10	< 10	572	370
TOTAL	**14,460**	**11,610**	**6,331**	**1,993**	**321**	**283**	**21,112**	**13,886**

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**

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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.

REFERENCES AND ADDITIONAL RESOURCES

DeNavas-Walt, C., Proctor, B.D., and Smith, J. United States Census Bureau. "Income, Poverty, and Health Insurance Coverage in the United States: 2007." Issued Aug. 2008. p. 60-233. Available at http://www.census.gov.

National Health Care for the Homeless Council. "The Basics of Homelessness." Feb. 2008. Available at http://www.nhchc.org.

National Health Care for the Homeless Council. "Federal Programs to Address Homelessness in the U.S." 2003. Available at www.nhchc.org.

National Health Care for the Homeless Council. "Health Care for the Homeless: Comprehensive Services to Meet Complex Needs." Dec. 2008. Available from http://www.nhchc.org.

National Health Care for the Homeless Council. "Mainstreaming Health Care for Homeless People." Apr. 2005. Available at http://www.nhchc.org.

O'Connell, J., Lozier, J., and Gingles, K. Increased Demand and Decreased Capacity: Challenges to the McKinney Act's Health Care for the Homeless Program, 1997. Available from the National Health Care for the Homeless Council, P.O. Box 68019, Nashville, TN 37206 8019; 615/226-2292.

O'Connell, J.J. "Premature Mortality in Homeless Populations: A Review of the Literature." 19 pages. Nashville: National Health Care for the Homeless Council, Inc., 2005.

Whitbeck, Les B. Mental health and Emerging Adulthood among Homeless Young People. 2009. Psychology Press, Taylor & Francis Group, 270 Madison Avenue, New York, NY 10016.

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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.

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References

1. US Department of Housing and Urban Development. *The 2015 Annual Homeless Assessment Report (AHAR) to Congress: Part 1. Point-in-Time Estimates of Homelessness*. Washington, DC: US Department of Housing and Urban Development; 2015.
2. Gelberg L, Siecke N. Accuracy of homeless adults' self-reports. *Med Care*. 1997;35(3):287-290.
3. Nyamathi AM, Leake B, Gelberg L. Sheltered versus nonsheltered homeless women: differences in health, behavior, victimization, and utilization of care. *J Gen Intern Med*. 2000;15(8):565-572.
4. Levitt AJ, Culhane DP, DeGenova J, O'Quinn P, Bainbridge J. Health and social characteristics of homeless adults in Manhattan who were chronically or not chronically unsheltered. *Psych Serv*. 2009;60(7):978-981.
5. Shern DL, Tsemberis S, Anthony W, et al. Serving street-dwelling individuals with psychiatric disabilities: outcomes of a psychiatric rehabilitation clinical trial. *Am J Public Health*. 2000;90(12):1873-1878.
6. Levitt AJ, Jost JJ, Mergl KA, Hannigan A, DeGenova J, Chung SY. Impact of chronically street homeless tenants in congregate supportive housing. *Am J Orthopsychiatry*. 2012;82(3):413-20.
7. Byrne T, Montgomery AE, Fargo JD. Unsheltered homelessness among veterans: correlates and profiles. *Community Ment Health J*. 2016;52(2):148-157.
8. Stergiopoulos V, Dewa CS, Tanner G, Chau N, Pett M, Connelly JL. Addressing the needs of the street homeless. *Int J Ment Health*. 2010;39(1):3-15.
9. Macnee CL, Forrest LJ. Factors associated with return visits to a homeless clinic. *J Health Care Poor Underserved*. 1997;8(4):437-445.
10. O'Toole TP, Gibbon JL, Hanusa BH, Fine MJ. Utilization of health care services among subgroups of urban homeless and housed poor. *J Health Polit Policy Law*. 1999;24(1):91-114.
11. O'Connell JJ. *Premature Mortality in Homeless Populations: A Review of the Literature*. Nashville, TN: National Health Care for the Homeless Council; 2005.
12. O'Connell JJ, Roncarati JS, Reilly EC, et al. Old and sleeping rough: elderly homeless persons on the streets of Boston. *Care Manag J*. 2004;5(2):101-106.
13. O'Connell JJ, Mattison S, Judge CM, Allen HJ, Koh HK. A public health approach to reducing morbidity and mortality among homeless people in Boston. *J Public Health Manag Pract*. 2005;11(4):311-316.
14. Hwang SW, Lebow JM, Bierer MF, O'Connell JJ, Orav EJ, Brennan TA. Risk factors for death in homeless adults in Boston. *Arch Intern Med*. 1998;158(13):1454-1460.
15. Hwang SW, O'Connell JJ, Lebow JM, Bierer MF, Orav EJ, Brennan TA. Health care utilization among homeless adults prior to death. *J Health Care Poor Underserved*. 2001;12(1):50-58.
16. Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of death in homeless adults in Boston. *Ann Intern Med*. 1997;126(8):625-628.
17. Montgomery AE, Byrne TH, Treglia D, Culhane DP. Characteristics and likelihood of ongoing homelessness among unsheltered veterans. *J Health Care Poor Underserved*. 2016;27(2):911-922.
18. Leopold J, Ho H. *Evaluation of the 100 000 Homes Campaign*. Washington, DC: Urban Institute; 2015.
19. Community Solutions. The 100 000 Homes vulnerability index: prioritizing homeless people for housing by mortality risk. http://100khomes.org/sites/default/files/About%20the%20Vulnerability%20Index.pdf. Accessed May 23, 2016.
20. Community Solutions. Making PIT counts work in your community: integrating the registry week methodology into your point-in-time count. http://100khomes.org/sites/default/files/Registry%20Week%20PIT%20Integration%20Toolkit_FINAL.pdf. Accessed July 7, 2016.
21. SAS Institute Inc. *SAS/STAT Version 9.4*. Cary, NC: SAS Institute Inc; 2012.
22. Gelberg L, Linn LS. Assessing the physical health of homeless adults [published erratum appears in *JAMA*. 1989;262(22):3132]. *JAMA*. 1989;262(14):1973-1979.
23. Cousineau MR. Health status of and access to health services by residents of urban encampments in Los Angeles. *J Health Care Poor Underserved*. 1997;8(1):70-82.
24. Tsai J, Kasprow WJ, Kane V, Rosenheck RA. Street outreach and other forms of engagement with literally homeless veterans. *J Health Care Poor Underserved*. 2014;25(2):694-704.
25. Hudson AL, Nandy K. Comparisons of substance abuse, high-risk sexual behavior and depressive symptoms among homeless youth with and without a history of foster care placement. *Contemp Nurse*. 2012;42(2):178-186.
26. Dworsky A, Napolitano L, Courtney M. Homelessness during the transition from foster care to adulthood. *Am J Public Health*. 2013;103(suppl 2):S318-S323.
27. Patterson ML, Moniruzzaman A, Somers JM. History of foster care among homeless adults with mental illness in Vancouver, British Columbia: a precursor to trajectories of risk. *BMC Psychiatry*. 2015;15:32.
28. Zlotnick C, Tam TW, Soman LA. Life course outcomes on mental and physical health: the impact of foster care on adulthood. *Am J Public Health*. 2012;102(3):534-540.
29. Brisson D, Covert J. Housing instability risk among subsidized housing recipients: characteristics associated with late or nonpayment of rent. *Soc Work Res*. 2015;39(2):119-128.
30. Cheung AM, Hwang SW. Risk of death among homeless women: a cohort study and review of the literature. *CMAJ*. 2004;170(8):1243-1247.

Department of Commerce

Homelessness in Washington State

2018 Annual Report

December 2018
Report to the Legislature
Brian Bonlender, Director

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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.

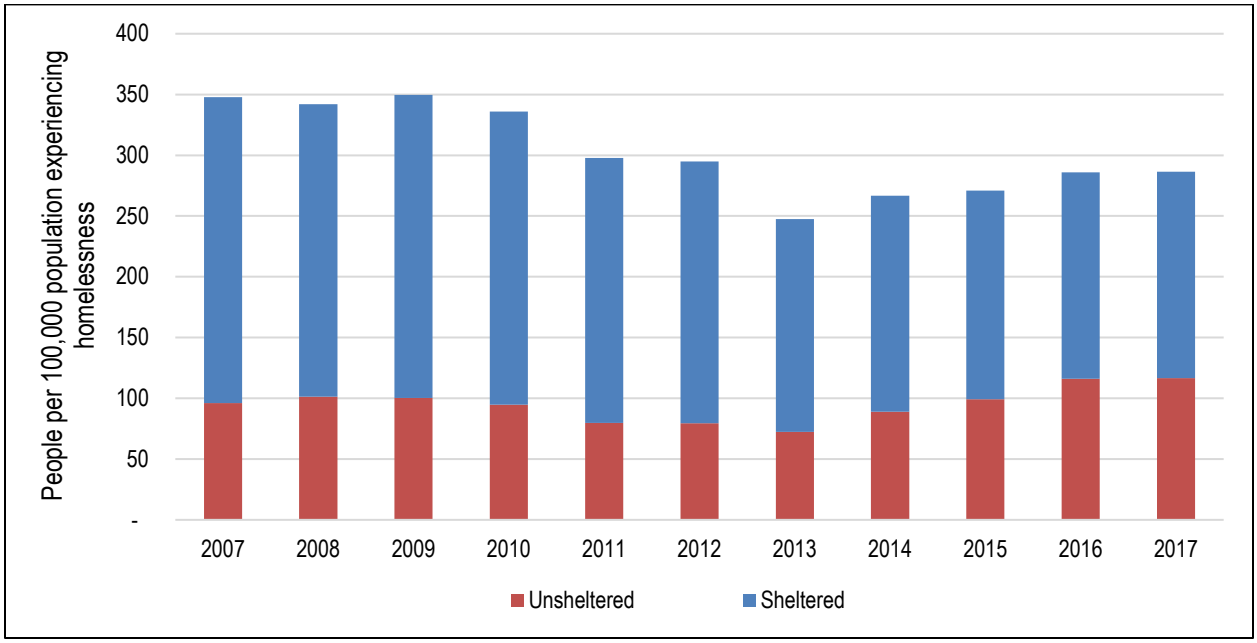
Complementing the department's broad effort to address homelessness, the Office of Homeless Youth, created through the Homeless Youth Prevention and Protection Act of 2015, continues its cross-systems partnership to work toward all young people having a safe and stable home and the support they need 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

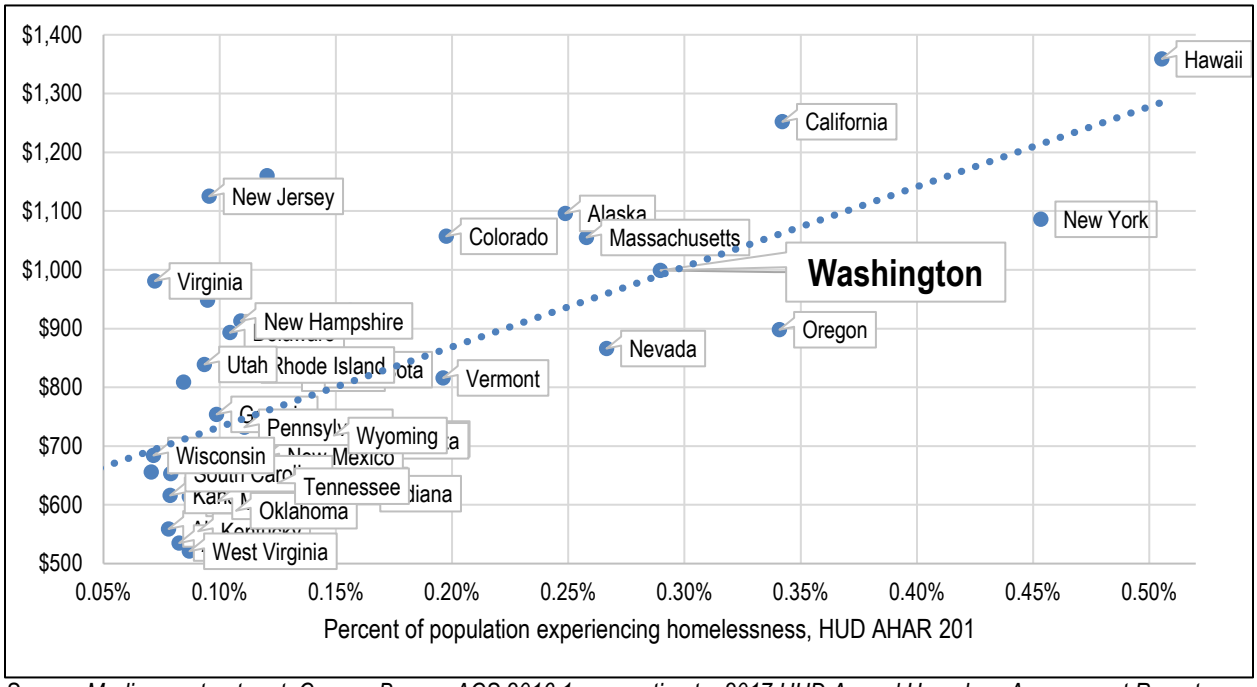


Source: Washington Annual Point in Time Count

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.

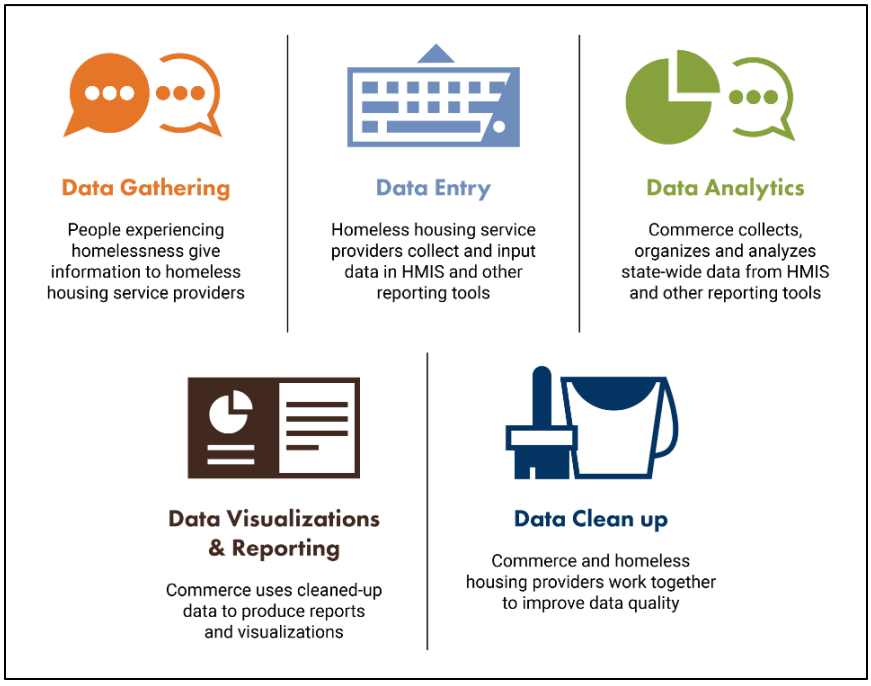
The reports:

- 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.

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[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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BMC Public Health

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

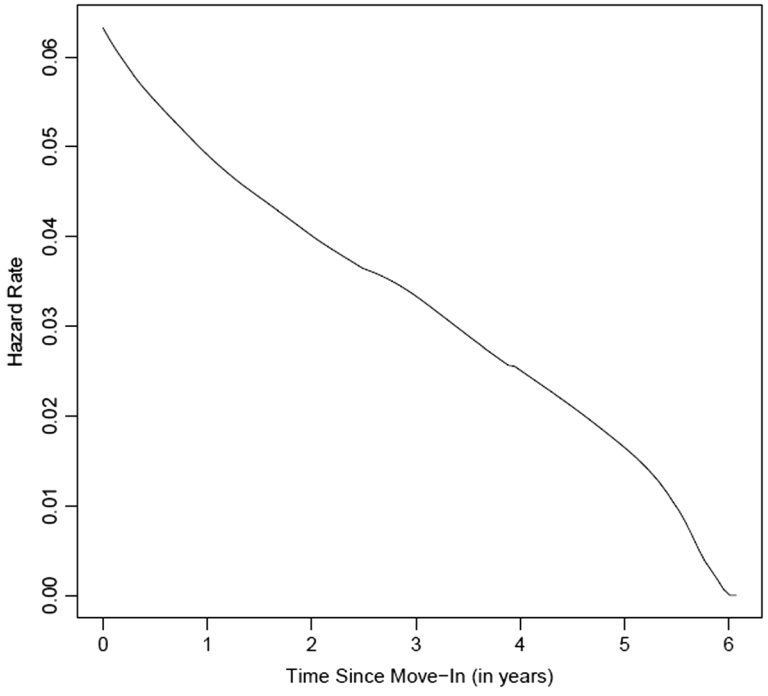

Fig. 1 Hazard function for death following move to housing among Housing First participants

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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References

1. O'Connell J. Premature mortality in homeless populations: a review of the literature. Nashville: National Health Care for the Homeless Council; 2005.
2. Morrison DS. Homelessness as an independent risk factor for mortality: Results from a retrospective cohort study. Int J Epidemiol. 2009;38:877–83. doi:10.1093/ije/dyp160.
3. Hibbs JR, Benner L, Klugman L, Spencer R, Macchia I, Mellinger A, et al. Mortality in a cohort of homeless adults in Philadelphia. N Engl J Med. 1994; 331:304–9. doi:10.1056/NEJM199408043310506.
4. Gambatese M, Marder D, Begier E, Gutkovich A, Mos R, Griffin A, et al. Programmatic impact of 5 years of mortality surveillance of New York City homeless populations. Am J Public Health. 2013;103(suppl):S193–8. doi:10.2105/AJPH.2012.301196.
5. Hoffman R, Maguire M, Cancellier R, Cherington M. City of Philadelphia Homeless Death Review, 2009–2010. Philadelphia: City of Philadelphia; 2012.
6. Metraux S, Eng N, Bainbridge J, Culhane DP. The impact of shelter use and housing placement on mortality hazard for unaccompanied adults and adults in family households entering New York City shelters: 1990–2002. J Urban Health. 2011;88:1091–104. doi:10.1007/s11524-011-9602-5.
7. Henwood BF, Cabassa LJ, Craig CM, Padgett DK. Permanent supportive housing: Addressing homelessness and health disparities? Am J Public Health. 2013;103 suppl 2:S188–92. doi:10.2105/AJPH.2013.301490.
8. Tsemberis S, Gulcur L, Nakae M. Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. Am J Public Health. 2004;4:651–6.
9. U.S. Interagency Council on Homelessness. Opening doors: the federal strategic plan to prevent and end homelessness. Washington: Author; 2010.
10. Aubry T, Tsemberis S, Adair CE, Goering P. One-year outcomes of a randomized controlled trial of Housing First with ACT in five Canadian cities. Psychiatr Serv. 2015;66:463–9. doi:10.1176/appi.ps.201400167.
11. Busch-Geertsema V. Housing First Europe: A "social experimentation project". Eur J Homelessness. 2011;5:209–11.
12. Johnson G, Parkinson S, Parsell C. Policy shift or program drift? implementing Housing First in Australia. AHURI Final Report No. 184. Melbourne: Australian Housing and Urban Research Institute; 2012.
13. Padgett DK, Smith BT, Henwood BF, Tiderington E. Life course adversity in the lives of formerly homeless persons with serious mental illness: Context and meaning. Am J Orthopsychiatry. 2012;82:421–30. doi:10.1111/j.1939-0025.2012.01159.x.
14. Hwang S. Homelessness and health. Can Med Assoc J. 2001;164:229–33.
15. Culhane DP, Metraux S, Byrne T, Stino M, Bainbridge J. The age structure of contemporary homelessness: Evidence and implications for public policy. Anal Soc Issues Public Policy. 2013;13:228–44. doi:10.1111/asap.12004.
16. Rosner B. Fundamentals of biostatistics. 5th ed. Boston: Cengage; 2000.
17. Centers for Disease Control and Prevention. Compressed mortality file 1999–2013 on CDC WONDER online database. Data from Compressed Mortality File 1999–2013 Series 20 No. 2S, 2014.
18. Hwang SW, Wilkins R, Tjepkema M, O'Campo PJ, Dunn JR. Mortality among residents of shelters, rooming houses, and hotels in Canada: 11 year follow-up study. BMJ. 2009;339:b4036.
19. Hwang SW. Causes of death in homeless adults in Boston. Ann Intern Med. 1997;126:625–8. doi:10.7326/0003-4819-126-8-199704150-00007.

20. Hwang SW. Mortality among men using homeless shelters in Toronto, Ontario. JAMA. 2000;283:2152–7. doi:10.1001/jama.283.16.2152.
21. Baggett TP, Hwang SW, O'Connell JJ, Porneala BC, Stringfellow EJ, Orav EJ, et al. Mortality among homeless adults in Boston. JAMA Intern Med. 2013; 173:189–95. doi:10.1001/jamainternmed.2013.1604.
22. Barrow SM, Herman DB, Córdova P, Struening EL. Mortality among homeless shelter residents in New York City. Am J Public Health. 1999;89: 529–34. doi:10.2105/AJPH.89.4.529.
23. Cheung AM. Risk of death among homeless women: A cohort study and review of the literature. Can Med Assoc J. 2004;170:1243–7. doi:10.1503/cmaj.1031167.
24. Roy É. Mortality in a cohort of street youth in Montreal. JAMA. 2004;292: 569–74. doi:10.1001/jama.292.5.569.
25. Kerker BD, Bainbridge J, Kennedy J, Bennani Y, Agerton T, Marder D, et al. A population-based assessment of the health of homeless families in New York City, 2001–2003. Am J Public Health. 2011;101:546–53. doi:10.2105/AJPH.2010.193102.
26. Kuhn R, Culhane DP. Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. Am J Community Psychol. 1998;26:207–32. doi:10.1023/A:1022176402357.
27. Kanis R, McCannon J, Craig C, Mergl KA. An end to chronic homelessness: An introduction to the 100,000 homes campaign. J Health Care Poor Underserved. 2012;23:321–6. doi:10.1353/hpu.2012.0019.
28. Henwood BF, Katz ML, Gilmer TP. Aging in place within permanent supportive housing. Int J Geriatr Psychiatry. 2015;30:80–7. doi:10.1002/gps.4120.
29. Henwood BF, Stanhope V, Brawer R, Weinstein LC, Lawson J, Stwords E, et al. Addressing chronic disease within supportive housing programs. Prog Community Health Partnersh. 2013;7:67–75. doi:10.1353/cpr.2013.0005.
30. Heath B, Wise Romero P, Reynolds K. A standard framework for levels of integrated health care. Washington: SAMSHSA-HRSA Center for Integrated Health Solutions; 2013.
31. Pickett SA, Luther S, Stellon E, Batia K. Making integrated care a reality: Lessons learned from Heartland Health Outreach's integration implementation. Am J Psychiatr Rehabil. 2015;18:87–104. doi:10.1080/15487768.2015.1001698.
32. Burt MR, Wilkins C, Locke G. Medicaid and permanent supportive housing for chronically homeless individuals: emerging practices from the field. Washington: U.S. Department of Health and Human Services; 2014.
33. Keene EA, Hutton N, Hall B, Rushton C. Bereavement debriefing sessions: An intervention to support health care professionals in managing their grief after the death of a patient. Pediatr Nurs. 2010;36:185–9.

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

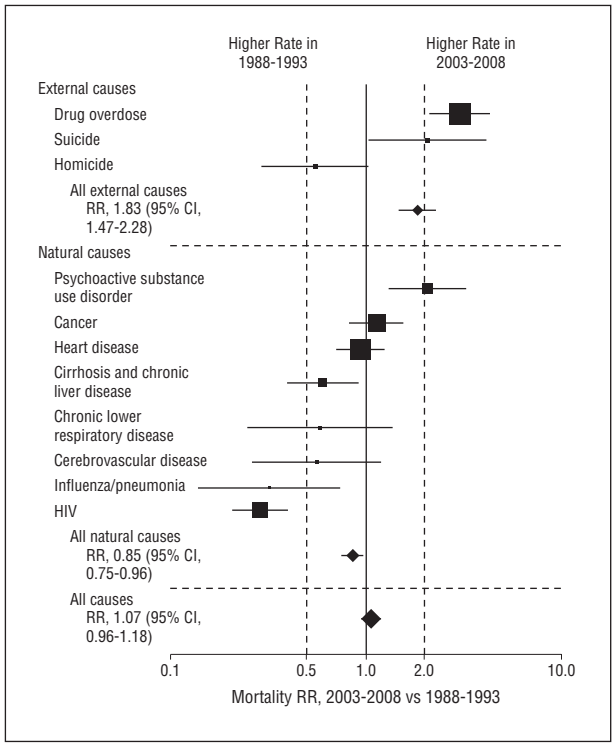

Figure 1. Mortality rate ratios (RRs) comparing cause-specific and overall mortality rates for the 2003-2008 and 1988-1993 homeless cohorts. Boxes are weighted in proportion to the total number of deaths owing to the specified cause. Prior to computing RRs, mortality rates from the 2003-2008 cohort were 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%).

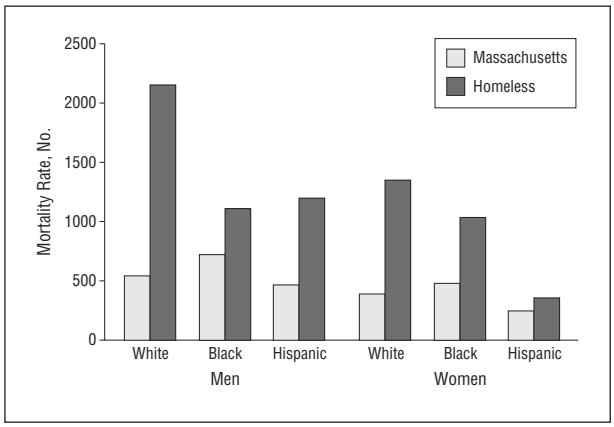

Figure 2. Race-specific age-standardized mortality rates for homeless adults and adults in the general population of Massachusetts (2003-2008), stratified by sex. Mortality rate is expressed as the number of deaths per 100 000 person-years of observation for the homeless cohort, and deaths per 100 000 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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Author Contributions: Travis Baggett had full access to all 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:* Baggett, Hwang, and O'Connell. *Acquisition of data:* Baggett, Hwang, and Stringfellow. *Analysis and interpretation of data:* Baggett, Hwang, O'Connell, Porneala, Orav, Singer, and Rigotti. *Drafting of the manuscript:* Baggett. *Critical revision of the manuscript for important intellectual content:* Baggett, Hwang, O'Connell, Porneala, Stringfellow, Orav, Singer, and Rigotti. *Statistical analysis:* Baggett, Hwang, Porneala, and Orav. *Obtained funding:* Baggett and O'Connell. *Administrative, technical, and material support:* Baggett, Hwang, O'Connell, Stringfellow, and Singer. *Study supervision:* Baggett, O'Connell, and Rigotti.
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Online-Only Material: The eTable is available at http://www.jamainternalmed.com.
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REFERENCES

1. Burt MR, Aron LY, Lee E, Valente J. *How Many Homeless People Are There? Helping America's Homeless: Emergency Shelter or Affordable Housing?* Washington, DC: Urban Institute; 2001:23-54.
2. US Department of Housing and Urban Development, Office of Community Planning and Development. 2010 Annual Homeless Assessment Report to Congress. http://www.hudhre.info/documents/2010HomelessAssessmentReport.pdf. Accessed February 29, 2012.
3. Burt MR. *Urban Institute. Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients: Technical Report.* Washington, DC: US Dept of Housing and Urban Development, Office of Policy Development and Research; 1999.
4. Breakey WR, Fischer PJ, Kramer M, et al. Health and mental health problems of homeless men and women in Baltimore. *JAMA.* 1989;262(10):1352-1357.
5. Wright JD. The health of homeless people: evidence from the national health care for the homeless program. In: Brickner PW, Scharer LK, Conanan B, Savarese M, Scanlan BC, eds. *Under the Safety Net: The Health and Social Welfare of the Homeless in the United States.* New York, NY: Norton; 1990:15-31.
6. Hibbs JR, Benner L, Klugman L, et al. Mortality in a cohort of homeless adults in Philadelphia. *N Engl J Med.* 1994;331(5):304-309.
7. Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of death in homeless adults in Boston. *Ann Intern Med.* 1997;126(8):625-628.
8. Barrow SM, Herman DB, Córdova P, Struening EL. Mortality among homeless shelter residents in New York City. *Am J Public Health.* 1999;89(4):529-534.
9. Hwang SW. Mortality among men using homeless shelters in Toronto, Ontario. *JAMA.* 2000;283(16):2152-2157.
10. Cheung AM, Hwang SW. Risk of death among homeless women: a cohort study and review of the literature. *CMAJ.* 2004;170(8):1243-1247.
11. Hwang SW, Wilkins R, Tjepkema M, O'Campo PJ, Dunn JR. Mortality among residents of shelters, rooming houses, and hotels in Canada: 11-year follow-up study. *BMJ.* 2009;339:b4036.
12. Kasprow WJ, Rosenheck R. Mortality among homeless and nonhomeless mentally ill veterans. *J Nerv Ment Dis.* 2000;188(3):141-147.
13. Nordentoft M, Wandall-Holm N. Ten-year follow-up study of mortality among users of hostels for homeless people in Copenhagen. *BMJ.* 2003;327(7406):81.
14. Nielsen SF, Hjorthøj CR, Erlangsen A, Nordentoft M. Psychiatric disorders and mortality among people in homeless shelters in Denmark: a nationwide register-based cohort study. *Lancet.* 2011;377(9784):2205-2214.
15. Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *Int J Epidemiol.* 2009;38(3):877-883.
16. Roy E, Haley N, Leclerc P, Sochanski B, Boudreau JF, Boivin JF. Mortality in a cohort of street youth in Montreal. *JAMA.* 2004;292(5):569-574.
17. Beijer U, Andreasson S, Agren G, Fugelstad A. Mortality and causes of death among homeless women and men in Stockholm. *Scand J Public Health.* 2011;39(2):121-127.
18. Metraux S, Eng N, Bainbridge J, Culhane DP. The impact of shelter use and housing placement on mortality hazard for unaccompanied adults and adults in family households entering New York City shelters: 1990-2002. *J Urban Health.* 2011;88(6):1091-1104.
19. Boston Health Care for the Homeless Program. www.bhchp.org. Accessed February 29, 2012.
20. O'Connell JJ, Oppenheimer SC, Judge CM, et al. The Boston Health Care for the Homeless Program: a public health framework. *Am J Public Health.* 2010;100(8):1400-1408.
21. Centers for Disease Control and Prevention. *Registry Plus: Link Plus Users Guide, Version 2.0.* Atlanta, GA: US Centers for Disease Control and Prevention, Cancer Division; 2007.
22. National Center for Health Statistics. National Death Index Matching Criteria. http://www.cdc.gov/nchs/ndi.htm. Accessed February 29, 2012.
23. West J, Hood M, Caceres I, Cohen B. *Massachusetts Deaths, 2008.* Boston, MA: Massachusetts Dept of Public Health, Division of Research and Epidemiology, Bureau of Health Information, Statistics, Research, and Evaluation; 2010.
24. Paulozzi LJ, Kilbourne EM, Desai HA. Prescription drug monitoring programs and death rates from drug overdose. *Pain Med.* 2011;12(5):747-754.
25. Breiding MJ, Wiersema B. Variability of undetermined manner of death classification in the US. *Inj Prev.* 2006;12(suppl 2):ii49-ii54.
26. Donaldson AE, Larsen GY, Fullerton-Gleason L, Olson LM. Classifying undetermined poisoning deaths. *Inj Prev.* 2006;12(5):338-343.
27. Anderson RN, Miniño AM, Fingerhut LA, Warner M, Heinen MA. Deaths: injuries, 2001. *Natl Vital Stat Rep.* 2004;52(21):1-86.
28. Rothman KJ, Greenland S. *Modern Epidemiology.* 2nd ed. Philadelphia, PA: Lippincott; 1998.
29. Newman SC. *Biostatistical Methods in Epidemiology.* New York, NY: Wiley; 2001.
30. Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File, 1999-2008. CDC WONDER Online Database, compiled from Compressed Mortality File 1999-2008. Series 20, No. 2N, 2011. http://wonder.cdc.gov/cmf-icd10.html. Accessed April 19, 2012.
31. Kochanek K, Smith B, Anderson RN. *Deaths: Preliminary Data for 1999: National Vital Statistics Reports.* Vol. 49, No. 3. Hyattsville, MD: National Center for Health Statistics; 2001.
32. Anderson RN, Miniño AM, Hoyert DL, Rosenberg HM. Comparability of cause of death between *ICD-9* and *ICD-10*: preliminary estimates. *Natl Vital Stat Rep.* 2001;49(2):1-32.
33. Minino AM, Parsons VL, Maurer JD, et al. *A Guide to State Implementation of ICD-10 for Mortality, Part II: Applying Comparability Ratios.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Health Statistics; 2000.
34. Ahmed SR, Toro PA. African-Americans. In: Levinson D, ed. *Encyclopedia of Homelessness.* Vol 1. Thousand Oaks, CA: Sage; 2004:3-7.
35. North CS, Smith EM. Comparison of white and nonwhite homeless men and women. *Soc Work.* 1994;39(6):639-647.
36. Rosenheck R, Bassuk EL, Salomon A. Special Populations of Homeless Americans. Paper presented at: National Symposium on Homelessness Research: What Works? October 29-30, 1998; Arlington, VA.
37. Warner M, Chen L, Makuc D, Anderson RN, Minino AM. *Drug Poisoning Deaths in the United States, 1980-2008. NCHS Data Brief, No. 81.* Hyattsville, MD: National Center for Health Statistics; 2011.
38. Paulozzi LJ, Budnitz DS, Xi Y. Increasing deaths from opioid analgesics in the United States. *Pharmacoepidemiol Drug Saf.* 2006;15(9):618-627.
39. Paulozzi LJ, Xi Y. Recent changes in drug poisoning mortality in the United States by urban-rural status and by drug type. *Pharmacoepidemiol Drug Saf.* 2008;17(10):997-1005.
40. Hwang SW, Wilkins E, Chambers C, Estrabillo E, Berends J, MacDonald A. Chronic pain among homeless persons: characteristics, treatment, and barriers to management. *BMC Fam Pract.* 2011;12:73.
41. Centers for Disease Control and Prevention (CDC). Community-based opioid overdose prevention programs providing naloxone, United States, 2010. *MMWR Morb Mortal Wkly Rep.* 2012;61(6):101-105.
42. Patrick-Murray Administration Announces New Milestone in Fight Against Opiate Overdose Deaths in Massachusetts. 1000th opiate overdose reversal due to innovative Narcan pilot program. http://www.mass.gov/governor/administration/ltgov/lgcommittee/subabuseprevent/new-milestone-in-fighting-opiate-overdose-deaths.html. Accessed March 5, 2012.
43. Alford DP, LaBelle CT, Richardson JM, et al. Treating homeless opioid dependent patients with buprenorphine in an office-based setting. *J Gen Intern Med.* 2007;22(2):171-176.
44. Baggett TP, Rigotti NA. Cigarette smoking and advice to quit in a national sample of homeless adults. *Am J Prev Med.* 2010;39(2):164-172. doi:10.1016/j.amepre.2010.1003.1024.
45. Hahn JA, Kushel MB, Bangsberg DR, Riley E, Moss AR. Brief report: the aging of the homeless population: fourteen-year trends in San Francisco. *J Gen Intern Med.* 2006;21(7):775-778.
46. Marmot M. Social determinants of health inequalities. *Lancet.* 2005;365(9464):1099-1104.
47. Ravakhah K. Death certificates are not reliable: revivification of the autopsy. *South Med J.* 2006;99(7):728-733.
48. Moyer LA, Boyle CA, Pollock DA. Validity of death certificates for injury-related causes of death. *Am J Epidemiol.* 1989;130(5):1024-1032.
49. Kircher T, Nelson J, Burdo H. The autopsy as a measure of accuracy of the death certificate. *N Engl J Med.* 1985;313(20):1263-1269.
50. German RR, Fink AK, Heron M, et al; Accuracy of Cancer Mortality Study Group. The accuracy of cancer mortality statistics based on death certificates in the United States. *Cancer Epidemiol.* 2011;35(2):126-131.

EXHIBIT 12

African American Council
Articles on Racial Disparity in Hospice

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

- BD^2 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.

References

1. Kane RL, Wales J, Bernstein L, Leibowitz A, Kaplan S. A randomized

controlled trial of hospice care. *Lancet*. 1984;2:890-892.
2. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004;291:88-93.
3. Miller SC, Mor V, Teno J. Hospice enrollment and pain assessment and management in nursing homes. *J Pain Symptom Manage*. 2003;26:791-799.
4. Greiner KA, Perera S, Ahluwalia JS. Hospice usage by minorities in the last year of life: results from the National Mortality Followback Survey. *J Am Geriatr Soc*. 2003;51:970-978.
5. Virnig BA, Kind S, McBean M, Fisher E. Geographic variation in hospice use prior to death. *J Am Geriatr Soc*. 2000;48:1117-1125.
6. National Hospice and Palliative Care Organization. *NHPCO's 2004 Facts and Figures*. Available at: www.nhpco.org/files/public/Facts_Figures_for2004data.pdf. Accessed July 31, 2006.
7. Rhodes RL, Teno JM, Welch LC. Access to hospice for African Americans: are they informed about the option of hospice? *J Palliat Med*. 2006;9:268-272.
8. Born W, Greiner KA, Sylvia E, Butler J, Ahluwalia JS. Knowledge, attitudes, and beliefs about end-of-life care among inner-city African Americans and Latinos. *J Palliat Med*. 2004;7:247-256.
9. Jackson F, Schim SM, Seeley S, Grunow K, Baker J. Barriers to hospice care for African Americans: problems and solutions. *J Hosp Palliat Nursing*. 2000;2:65-72.
10. Reese DJ, Ahern RE, Nair S, O'Faire JD, Warren C. Hospice access and use by African Americans: addressing cultural and institutional barriers through participatory action research. *Soc Work*. 1999;44:549-559.
11. Reese DJ, Melton E, Ciaravino K. Programmatic barriers to providing culturally competent end-of-life care. *Am J Hosp Palliat Care*. 2004;21:357-364.
12. McKinley ED, Garrett JM, Evans AT, Danis M. Differences in end-of-life decision making among black and white ambulatory cancer patients. *J Gen Intern Med*. 1996;11:651-656.
13. Strothers HS III, Rust G, Minor P, Fresh E, Druss B, Satcher D. Disparities in antidepressant treatment in Medicaid elderly diagnosed with depression. *J Am Geriatr Soc*. 2005;53:456-461.
14. Welch LC, Teno JM, Mor V. End-of-life care in black and white: race matters for medical care of dying patients and their families. *J Am Geriatr Soc*. 2005;53:1145-1153.
15. Rhodes RL, Teno JM, Connor SR. Bereaved family members' perceptions of satisfaction with hospice services: do racial differences exist? *J Am Geriatr Soc*. 2006;54:S5.

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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.

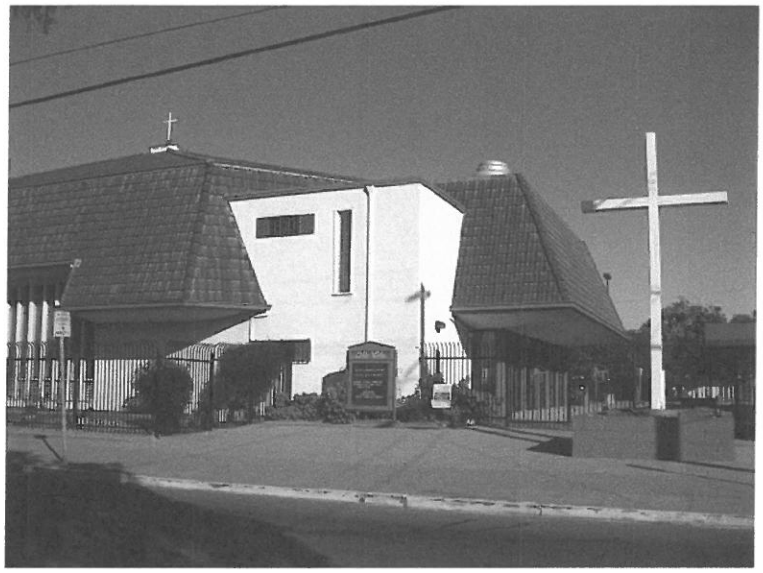
The Faith Community and Its Potential Role in Reducing Racial Disparities in End-of-Life Care

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

M. Courtney Hughes, PhD, MS[1,2] and Erin Vernon, PhD, MA[3]

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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References

Adams, C. E., Horn, K., & Bader, J. (2007). Hispanics' experiences in the health system prior to hospice admission. *Journal of Cultural Diversity*, *14*(4), 155-163.

Aldridge, M. D., Canavan, M., Cherlin, E., & Bradley, E. H. (2015). Has hospice use changed? 2000-2010 utilization patterns. *Medical Care*, *53*, 95-101. doi:10.1097/mlr.0000000000000256

Aldridge, M. D., Schlesinger, M., Barry, C. L., Morrison, R. S., McCorkle, R., Hurzeler, R., & Bradley, E. H. (2014). National hospice survey results: For-profit status, community engagement, and service. *JAMA Internal Medicine*, *174*, 500-506. doi:10.1001/jamainternmed.2014.3

Alegria, M., Alvarez, K., Ishikawa, R. Z., DiMarzio, K., & McPeck, S. (2016). Removing obstacles to eliminating racial and ethnic disparities in behavioral health care. *Health Affairs*, *35*, 991-999. doi:10.1377/hlthaff.2016.0029

American Hospice Foundation. (n.d.). *FAQ: Why do people choose to receive hospice care?* Retrieved from https://americanhospice.org/learning-about-hospice/why-do-people-choose-to-receive-hospice-care/

Baicker, K., Chandra, A., Skinner, J. S., & Wennberg, J. E. (2004). Who you are and where you live: How race and geography affect the treatment of Medicare beneficiaries: There is no simple story that explains the regional patterns of racial disparities in health care. *Health Affairs*, *23*(Suppl. 2), VAR33. doi:10.1377/hlthaff.var.33

Barclay, J. S., Kuchibhatla, M., Tulsky, J. A., & Johnson, K. S. (2013). Association of hospice patients' income and care level with place of death. *JAMA Internal Medicine*, *173*, 450-456. doi:10.1001/jamainternmed.2013.2773

Bischoff, K. E., Sudore, R., Miao, Y., Boscardin, W. J., & Smith, A. K. (2013). Advance care planning and the quality of end-of-life care in older adults. *Journal of the American Geriatrics Society*, *61*, 209-214. doi:10.1111/jgs.12105

Brown, C. E., Engelberg, R. A., Sharma, R., Downey, L., Fausto, J. A., Sibley, J., . . . Curtis, J. R. (2018). Race/ethnicity, socioeconomic status, and healthcare intensity at the end of life. *Journal of Palliative Medicine*, *21*, 1308-1316. doi:10.1089/jpm.2018.0011

Bureau of Economic Analysis. (2018). *Personal income by state*. Retrieved from https://www.bea.gov/data/income-saving/personal-income-by-state

Byhoff, E., Harris, J. A., Langa, K. M., & Iwashyna, T. J. (2016). Racial and ethnic differences in end-of-life Medicare expenditures. *Journal of the American Geriatrics Society*, *64*, 1789-1797. doi:10.1111/jgs.14263

Chronic Conditions Data Warehouse. (2018). *Medicare data*. Retrieved from http://ccwdata.org

Dolin, R., Holmes, G. M., Stearns, S. C., Kirk, D. A., Hanson, L. C., Taylor, D. H., Jr., & Silberman, P. (2017). A positive association between hospice profit margin and the rate at which patients are discharged before death. *Health Affairs*, *36*, 1291-1298.

Elliott, A. M., Alexander, S. C., Mescher, C. A., Mohan, D., & Barnato, A. E. (2016). Differences in physicians' verbal and nonverbal communication with black and white patients at the end of life. *Journal of Pain Symptom Management*, *51*(1), 1-8. doi:10.1016/j.jpainsymman.2015.07.008

French, E. B., McCauley, J., Aragon, M., Bakx, P., Chalkley, M., Chen, S. H., . . . Kelly, E. (2017). End-of-life medical spending in last twelve months of life is lower than previously reported. *Health Affairs*, *36*, 1211-1217. doi:10.1377/hlthaff.2017.0174

Haines, K. L., Jung, H. S., Zens, T., Turner, S., Warner-Hillard, C., & Agarwal, S. (2018). Barriers to hospice care in trauma patients: The disparities in end-of-life care. *American Journal of Hospice & Palliative Care*, *35*, 1081-1084. doi:10.1177/1049909117753377

Hanchate, A., Kronman, A. C., Young-Xu, Y., Ash, A. S., & Emanuel, E. (2009). Racial and ethnic differences in end-of-life costs: Why do minorities cost more than whites? *Archives of Internal Medicine*, *169*, 493-501. doi:10.1001/archinternmed.2008.616

Hardy, D., Chan, W., Liu, C. C., Cormier, J. N., Xia, R., Bruera, E., & Du, X. L. (2011). Racial disparities in the use of hospice services according to geographic residence and socioeconomic status in an elderly cohort with nonsmall cell lung cancer. *Cancer*, *117*, 1506-1515. doi:10.1002/cncr.25669

Harris, J. A., Byhoff, E., Perumalswami, C. R., Langa, K. M., Wright, A. A., & Griggs, J. J. (2017). The relationship of obesity to hospice use and expenditures: A cohort study. *Annals of Internal Medicine*, *166*, 381-389. doi:10.7326/m16-0749

Hayes, S. L., Riley, P., Radley, D. C., & McCarthy, D. (2017). *Reducing racial and ethnic disparities in access to care: Has the Affordable Care Act made a difference?* The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/publications/issue-briefs/2017/aug/reducing-racial-and-ethnic-disparities-access-care-has

Hospice Analytics. (2018). *National Hospice Locator*. Retrieved from http://www.nationalhospiceanalytics.com/

Institute of Medicine. (1997). *Approaching death: Improving care at the end of life*. Retrieved from https://www.nap.edu/catalog/5801/approaching-death-improving-care-at-the-end-of-life

Jackson, C. S., & Gracia, J. N. (2014). Addressing health and health-care disparities: The role of a diverse workforce and the social determinants of health. *Public Health Reports*, *129*(Suppl. 2), 57-61. doi:10.1177/00333549141291s211

Jenkins, T. M., Chapman, K. L., Ritchie, C. S., Arnett, D. K., McGwin, G., Cofield, S. S., & Maetz, H. M. (2011). Hospice use in Alabama, 2002-2005. *Journal of Pain and Symptom Management*, *41*, 374-382. doi:10.1016/j.jpainsymman.2010.04.027

Johnson, K. S., Kuchibhatla, M., & Tulsky, J. A. (2008). What explains racial differences in the use of advance directives and attitudes toward hospice care? *Journal of the American Geriatrics Society*, *56*, 1953-1958. doi:10.1111/j.1532-5415.2008.01919.x

Kaiser Family Foundation. (2017). *Distribution of Medicare beneficiaries by Race/Ethnicity*. Retrieved from https://www.kff.org/medicare/state-indicator/medicare-beneficiaries-by-raceethnicity/?dataView=1&currentTimeframe=2&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Kaiser Family Foundation. (n.d.). *State health facts*. Retrieved from https://www.kff.org/statedata/

Kehl, K. A., & McCarty, K. N. (2012). Readability of hospice materials to prepare families for caregiving at the time of death. *Research in Nursing & Health*, *35*, 242-249. doi:10.1002/nur.21477

Kelley, A. S., Deb, P., Du, Q., Aldridge Carlson, M. D., & Morrison, R. S. (2013). Hospice enrollment saves money for Medicare and improves care quality across a number of different lengths-of-stay. *Health Affairs*, *32*, 552-561. doi:10.1377/hlthaff.2012.0851

Kelley, A. S., Ettner, S. L., Morrison, R. S., Du, Q., Wenger, N. S., & Sarkisian, C. A. (2011). Determinants of medical expenditures in the last 6 months of life. *Annals of Internal Medicine*, *154*, 235-242. doi:10.7326/0003-4819-154-4-201102150-00004

Koroukian, S. M., Schiltz, N. K., Warner, D. F., Given, C. W., Schluchter, M., Owusu, C., & Berger, N. A. (2017). Social determinants, multimorbidity, and patterns of end-of-life care in older adults dying from cancer. *Journal of Geriatric Oncology*, *8*, 117-124. doi:10.1016/j.jgo.2016.10.001

Koss, C. S., & Baker, T. A. (2017). A question of trust: Does mistrust or perceived discrimination account for race disparities in advance directive completion? *Innovation in Aging*, *1*(1), igx017. doi:10.1093/geroni/igx017

Livne, R. (2014). Economies of dying: The moralization of economic scarcity in U.S. hospice care. *American Sociological Review*, *79*, 888-911. doi:10.1177/0003122414547756

Martin, M. Y., Pisu, M., Oster, R. A., Urmie, J. M., Schrag, D., Huskamp, H. A., . . . Fouad, M. N. (2011). Racial variation in willingness to trade financial resources for life-prolonging cancer treatment. *Cancer*, *117*, 3476-3484. doi:10.1002/cncr.25839

Meier, D. E. (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *Milbank Quarterly*, *89*, 343-380. doi:10.1111/j.1468-0009.2011.00632.x

National Hospice and Palliative Care Organization. (2018). *NHPCO facts and figures: Hospice care in America*. Alexandria, VA: Author.

National Institutes of Health. (n.d.). *Clear communication*. Retrieved from https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clear-communication

Ornstein, K. A., Aldridge, M. D., Mair, C. A., Gorges, R., Siu, A. L., & Kelley, A. S. (2016). Spousal characteristics and older adults' hospice use: Understanding disparities in end-of-life care. *Journal of Palliative Medicine*, *19*, 509-515. doi:10.1089/jpm.2015.0399

Pan, C. X., Abraham, O., Giron, F., LeMarie, P., & Pollack, S. (2015). Just ask: Hospice familiarity in Asian and Hispanic adults. *Journal of Pain and Symptom Management*, *49*, 928-933. doi:10.1016/j.jpainsymman.2014.09.016

Price, R. A., Parast, L., Haas, A., Teno, J. M., & Elliott, M. N. (2017). Black and Hispanic patients receive hospice care similar to that of white patients when in the same hospices. *Health Affairs*, *36*, 1283-1290. doi:10.1377/hlthaff.2017.0151

Ramey, S. J., & Chin, S. H. (2012). Disparity in hospice utilization by African American patients with cancer. *American Journal of Hospice & Palliative Care*, *29*, 346-354. doi:10.1177/1049909111423804

Riley, G. F., & Lubitz, J. D. (2010). Long-term trends in Medicare payments in the last year of life. *Health Services Research*, *45*, 565-576. doi:10.1111/j.1475-6773.2010.01082.x

Rizzuto, J., & Aldridge, M. D. (2018). Racial disparities in hospice outcomes: A race or hospice-level effect? *Journal of the American Geriatrics Society*, *66*, 407-413. doi:10.1111/jgs.15228

Silveira, M. J., Connor, S. R., Goold, S. D., McMahon, L. F., & Feudtner, C. (2011). Community supply of hospice: Does wealth play a role? *Journal of Pain and Symptom Management*, *42*, 76-82. doi:10.1016/j.jpainsymman.2010.09.016

Smith, G., Cooperman, A., Mohamed, B., Martinez, J., Alper, B., Sciupac, E., & Gecewicz, C. (2015). *America's changing religious landscape: Christians decline sharply as share of population; unaffiliated and other faiths continue to grow*. Washington, DC: Pew Research Center.

Steinhauser, K. E., Clipp, E. C., McNeilly, M., Christakis, N. A., McIntyre, L. M., & Tulsky, J. A. (2000). In search of a good death: Observations of patients, families, and providers. *Annals of Internal Medicine*, *132*, 825-832.

Stevenson, D. G., Grabowski, D. C., Keating, N. L., & Huskamp, H. A. (2016). Effect of ownership on

hospice service use: 2005–2011. *Journal of the American Geriatrics Society*, *64*, 1024-1031.

Substance Abuse and Mental Health Services Administration. (2016). *Improving cultural competence*. Retrieved from https://store.samhsa.gov/system/files/sma16-4932.pdf

Taylor, D. H., Jr., Bhavsar, N. A., Bull, J. H., Kassner, C. T., Olson, A., & Boucher, N. A. (2018). Will changes to Medicare payment rates alter hospice's cost-saving ability? *Journal of Palliative Medicine*, *21*, 645-651. doi:10.1089/jpm.2017.0485

Taylor, D. H., Jr., Ostermann, J., Van Houtven, C. H., Tulsky, J. A., & Steinhauser, K. (2007). What length of hospice use maximizes reduction in medical expenditures near death in the US Medicare program? *Social Science & Medicine*, *65*, 1466-1478. doi:10.1016/j.socscimed.2007.05.028

Teno, J. M., Clarridge, B. R., Casey, V., Welch, L. C., Wetle, T., Shield, R., & Mor, V. (2004). Family perspectives on end-of-life care at the last place of care. *The Journal of the American Medical Association*, *291*, 88-93. doi:10.1001/jama.291.1.88

Teno, J. M., Gruneir, A., Schwartz, Z., Nanda, A., & Wetle, T. (2007). Association between advance directives and quality of end-of-life care: A national study. *Journal of the American Geriatrics Society*, *55*, 189-194. doi:10.1111/j.1532-5415.2007.01045.x

U.S. Census Bureau. (2015). *Current Population Survey Annual Social and Economic Supplement (CPS-ASEC)*. Retrieved from https://www.census.gov/topics/health/health-insurance/guidance/cps-asec.html

U.S. Census Bureau. (n.d.). *American Community Survey*. Retrieved from https://www.census.gov/programs-surveys/acs

Wachterman, M. W., Marcantonio, E. R., Davis, R. B., & McCarthy, E. P. (2011). Association of hospice agency profit status with patient diagnosis, location of care, and length of stay. *The Journal of the American Medical Association*, *305*, 472-479. doi:10.1001/jama.2011.70

Washington, K. T., Bickel-Swenson, D., & Stephens, N. (2008). Barriers to hospice use among African Americans: A systematic review. *Health & Social Work*, *33*, 267-274.

Wright, A. A., Keating, N. L., Balboni, T. A., Matulonis, U. A., Block, S. D., & Prigerson, H. G. (2010). Place of death: Correlations with quality of life of patients with cancer and predictors of bereaved caregivers' mental health. *Journal of Clinical Oncology*, *28*, 4457-4464. doi:10.1200/jco.2009.26.3863

Young, J. S. (2014). Online resources for culturally and linguistically appropriate services in home healthcare and hospice: Resources for Spanish-speaking patients. *Home Healthcare Nurse*, *32*(5, Suppl.), S12-S18. doi:10.1097/nhh.0000000000000081

Zuckerman, R. B., Stearns, S. C., & Sheingold, S. H. (2016). Hospice use, hospitalization, and Medicare spending at the end of life. *Journal of Gerontology, Series B: Psychological Sciences & Social Sciences*, *71*, 569-580. doi:10.1093/geronb/gbv109

City in eastern Washington state has become home to many Russians and Ukrainians

By Interns.
Published May 23, 2002 at 6:00 pm

SPOKANE (Washington), May 23 – Eric Miller bakes 90 loaves of bread each day in a bakery named Mariupol after his hometown, and many who buy his bread are among 200 residents in and around Spokane who also are from the city in Ukraine on the coast of the Sea of Azov.
From 1990 to 2000, the number of people of Russian or Ukrainian ancestry more than quadrupled in Spokane, a city on the high desert plain in eastern Washington close to the border with Idaho. In Spokane County, the number of Russians and Ukrainians more than doubled, U.S. Census data showed. "We live here, we are part of the community," said Alexandr Kaprian, Miller's brother-in-law and one of the first Mariupol residents to settle in Spokane. "In order for our children to have a better future, we need to educate others about who we are and why we came."
The 2000 Census found more than 4,900 people of Russian or Ukrainian ancestry in Spokane, compared with some 1,000 in 1990. In Spokane County – which includes the city of Spokane – they numbered more than 7,700 in the latest census. People of Russian and Ukrainian ancestry now make up 2.5 percent of Spokane's population and nearly 2 percent of the county's.
Members of the Slavic community contend the number of people from former Soviet republics is much higher. They say the census asked for only Russian or Ukrainian ancestry, and many people who speak Russian but came from former socialist republics such as Kyrgyzstan, Moldova and Uzbekistan may have been misidentified or lumped as "other" in the count. It's also likely that thousands more didn't respond because they don't speak English, said Gregori Senchenko, who immigrated from Ukraine as a teen-ager in 1989.
A history of Soviet oppression also could have intimidated some families from replying to the census, said Miller, who also left Mariupol in 1989. "It's that KGB heritage," he said. "They're scared. If they can hide, they will." Many of the new residents came to escape religious persecution and poverty, choosing Spokane for its relatively mild climate, affordable cost of living and the strength of its Russian-speaking churches. "It's better here because I have enough food for my kids," said Nadia Chekulayev, a mother of seven and former Mariupol resident. "We are happy in Spokane."
The growing immigrant population inevitably takes a toll on charities, schools and social services. About 15 percent to 18 percent of low-income families who come to Mission Community Outreach Center in northeast Spokane are of Russian or Ukrainian descent, said Walter Shields, the executive director. Elena Solodyankin, who moved to Spokane 11 years ago from Kyrgyzstan, said coming to a new country presents a variety of challenges. "We need more time to adjust, to learn another culture and language. ... It's not easy to start a new life," said Solodyankin, who will earn a master's degree this spring.
Svitlana Sharkevych, a native of Ukraine and a mother of three, said she quickly found she needed to study English to survive. She is among more than 700 adults from the former Soviet republics who enroll in free English courses each year at the Institute for Extended Learning.
The influx of Slavic peoples is having its effect on Spokane. Public agencies now publish some pamphlets in Russian, and community newspapers printed in the Cyrillic alphabet have become widespread. Teachers, police, social workers and many others are required to study Slavic culture, and eight Spokane-area churches serve people who worship in Russian.
At the city's East Valley High School, last year's beauty queen for the annual lilac festival was Natalya Litoshyk, who was born in Kyrgyzstan.

Pilgrim Slavic Baptist Church in Spokane/SpokaneFāVS File Photo

Patrick Jones May 26, 2020 Commentary 1,912 Views

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Guest column by Patrick Jones

Throughout American history, the United States has supported ethnic diaspora and immigration to support millions of people who are facing persecution or discrimination in their home countries. This has allowed the U.S. to diversify culturally, ethnically and religiously. It gives the inhabitants of the country many different perspectives of the different worldly cultures and those who practice those different cultural ideologies. Washington state is no different; we have two large metropolitan areas that house different people of many cultural and ethnic backgrounds and heritage.

Here in Spokane, we have a large population of Slavic-speaking people. In 2000, 2 percent of Spokane's population was of Eastern European heritage; that is about 4,900 people. That is unfortunately the most recent data point I can find about the presence of Eastern Europeans in Spokane. That number however is most likely less than what was accurate in 2000. According to a 2002 article in the Kiev Post, Ukraine's Global Voice, there are many other Eastern Europeans living in Spokane that have not been reported.

This column, which was originally a study I did at Gonzaga, aims to capture how the third wave Slavs of the Pilgrim Slavic Baptist Church create cultural meaning through their speech community, how they use their language to maintain and strengthen their ancestral culture in church context.

Site of Study

The Pilgrim Slavic Baptist Church is a Slavic speaking church in Spokane. The church is located in the downtown area of Spokane right next to the I-90 Highway. It has been around since 1994 and has served the Baptist community of Slavic speaking members in Spokane since then. Ever since the third wave of Slavic migration in the early 90s, the Spokane area has been a hotbed for immigrants from the previous sovereign state of the USSR. The third wave immigrants were Slavs that were primarily leaving the USSR due to religious persecution. This led to the rise of Baptist and Pentecostal churches in and around Spokane that only preached and worshiped in Russian. There are dozens of different churches to this day that operate with plenty of Slavic patrons to stay afloat and worship.

Upon entering the church, a security guard greeted me at the door and asked me if I had needed an English translation. I said yes and he led me upstairs to get a receiver with headphones to hear the live English translation from a church member. I sat down and listened to the English translations while also observing the surroundings of the church.

The church also boasts multiple choirs, a brass band and a symphony orchestra therefore showing the importance of music to the congregation. The church also has ample classes throughout the week. One of note is the Russian language classes for the younger Slavic Baptists to learn their cultural language. Most of these children's first language was English, since that is the language that they learn to speak in school. Therefore, going to a church that primarily uses Russian is difficult, which explains the need for the classes. The church is constantly busy with numerous events, camps and rehearsals. The grounds are almost always in use throughout the week.

Pilgrim Slavic Baptist Church in Spokane/SpokaneFāVS File Photo

Most of the information that I have received about the church was found on their extensive site. Their website has all the information about the church that one would need with many different tabs to engage with the church from your computer or tablet. The site is home to a detailed history of Russians in the

United States and in Spokane. The site also has descriptions of all of their camps, bands, events and ministries in great detail. Lastly, there are many local news articles about how Spokane and United States politics will affect the U.S Russian community, and their church in particular, in order to help the many church patrons that may not speak English.

The church has a social media presence with profiles on Facebook and Instagram. Most of the posts were of different church events, new lectures and thematic series of church sermons. After the live services, the church would advertise fun events and ways to continue to connect with them. Most of these advertisements were in English and occasionally, they would put up the same advertisement in Russian as well.

This church has multiple generations of people that are different and grew up in different ways. The older generation spent most of their days in the USSR and moved over to the U.S as adults who already have their cultural identity. But many in the younger generation were born in the U.S, specifically in Spokane. This generation is farther removed from their heritage and cultural background, and they align more with the cultural identity of those from the U.S. This divide is also seen in the languages that the two generations tend to speak. The older generation tends to speak in solely Russian while the younger generation tends to speak in mainly English; for both groups, that was their first language. This divide fragments their speech community and fragments their common culture.

Other than the difference of language, the services were typical for a modern day Christian church service. The service held songs which the whole congregation sang, the sermon was given by one of the many pastors of the church, children were hard to control and teenagers often talked silently in the background. Every member that I interacted with was nice and welcoming of my presence. The church community made me feel extremely welcome and did not mind that I was not a typical member of their community. They embraced my curiosity and tried to help me the best that they could.

Findings

The Russian language is central to the Pilgrim Slavic Baptist Church's cultural identity and the continuation of their heritage in Spokane. To many Slavs in Spokane, the preservation of their culture in the next generation of Slavs and in the Spokane area is extremely important. Others Slavs do not care if their children pass on the Slavic languages or cultural practices. This threatens the existence of Russian language, Slav culture and the church itself. There is a definite divide in the generations of church goers when it comes to the language they speak and practices they follow in relation to their cultural background. The church knows the existence of this divide and is doing everything they can do close it and retain their culture.

One of the most important things that the church does is Russian language courses for young people. This shows how important language is to this community and how influential language is to the understanding and practicing of culture. The abnormality of hosting a class for a language not often spoken in the

country of origin shows its great importance and necessity. The difficult nature of learning a new language is seen in the children's time during the service. They have great trouble speaking Russian due to their typical use of English in school and their struggle learning a language they are being forced to study and learn outside of school is apparent. Language is an inherent aspect of culture as it creates separate meanings than other cultures and speech communities. Different language perceive certain objects and phenomena in unique ways. This is proven through untranslatable words between popular languages. When a language does not have a word associated to something that another language does, that shows a complete difference in understanding and perceiving. Therefore, these classes were teaching Russian and preserving the cultural perception and ideology of the Slavic region where most of the third wave immigrants, the younger generations parents, were born and raised. The more of the younger generation that speaking Russian, the more likely the next generation will attend this church and use Russian in church, which will lead to a continuation of the Slavic tradition.

The necessity of the English translation and the demographic that uses the translation shows the resistance that exists within the younger generations of Slavs. The younger generations grow up speaking English since that is what they hear every day in school, and they do not seem to feel that the culture of their ancestors is important enough at that age to take the time and effort to master another language. Mastering a second language is difficult and if there is no perceivable point, a young kid is not going to want to take more time to study. But, their parents still speak Russian and choose to keep the language as part of their worship, and this is what brings the English translations to the ears of mainly young children.

The churches online presence tells a lot about how they are trying to bring people into their church by what languages they use. By this point, I have noticed that the younger generation and the older generation have a language gap between Russian and English, where the younger generation is speaking English and the older generation is speaking Russian. This method of thinking translates perfectly into how the church uses their social media platforms in relation to language. As mentioned above, Facebook is largely used by older generations, and Instagram's demographics are mainly those who are a part of the younger generation. The church uses mostly Russian for Facebook and mostly English for Instagram. This is playing directly into the demographics of the two platforms. In reaching their older audiences, Russian is used due to the older populations' mainly Russian-speaking tradition. And in reaching younger audiences, English is used due to the younger populations' English-speaking tradition. This demonstrates the marketing tools that the church uses not only to keep the church afloat, but to keep the tradition alive. Their Instagram, which is geared toward the younger people, mainly advertises fun events, new interactive and enjoyable lecture series' and other things that younger populations would enjoy. When I first saw this divide, I noticed the generational divide due to the drastic difference between the two platforms in what they advertise. The drastic difference proves that a generational divide exists, and show how most of it is defined by language.

Their easy to use website shows that the church is attempting to put themselves out into this technological age and keep people coming back. This website will make it easier for younger generations to start an engagement with them and to engage with them on a consistent matter. Technology and the internet run the modern world and the church understands that it is necessary to be relevant with the younger crowd. Bringing the young crowd in leads to the continuation of the Russian language which perpetuates the Slavic culture in Spokane.

Their language perpetuates the method of praise and worship that accompanies the Slavic languages, and creates a whole different atmosphere. After my first time visiting, I went home and felt strange, like I had just left a whole other country and came back home. I felt as if I had entered a completely different world that was not Spokane. In this regard, the Russian language creates a whole new atmosphere that is unique to other American and English speaking churches. Russian brings the culture together, making it stronger and uninhibited by location or borders. Language is keeping the church and the way it worships afloat. Language to the Pilgrim Slavic Baptist Church is their staple method of praise and membership.

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About Patrick Jones

Patrick Jones is a Gonzaga University graduate of the class of 2020. He has a degree in Communication Studies and minored in Journalism and Psychology. Currently, he is looking for work as a journalist or writer full-time. He has plans to attend a graduate program for journalism after a few years of work experience.

Patrick is interested in ethnography and linguistics which led to his senior capstone study on the Pilgrim Slavic Baptist Church in Spokane, WA. His capstone was his final project for the Gonzaga Communication Studies Department. He is also interested in writing about the arts, especially music. One day, he could see himself working as a reporter covering music or a reporter for a local or national newspaper.

End of life care for older Russian immigrants - perspectives of Russian immigrants and Hospice staff

By: Emily H. Eckemoff, S. Sudha, and Dan Wang

Eckemoff, E.H., Sudha, S. & Wang, D. (2018). End of Life Care for Older Russian Immigrants - Perspectives of Russian Immigrants and Hospice Staff. *Journal of Cross-Cultural Gerontology 33*(3), 229–245. https://doi.org/10.1007/s10823-018-9353-9

Abstract:

This pilot study examined immigrant Russian seniors and adult children's views on end-of-life care, and hospice staff members' experiences providing care to diverse immigrant clients, in areas of North Carolina with a high proportion of immigrants. Data were collected through individual in-depth interviews with informants, including Russian immigrant seniors, Russian adult children, and hospice staff, and analyzed by qualitative techniques. Findings indicate that there is little awareness of end-of-life care options among the Russian immigrant community in North Carolina. End-of-life care is rarely discussed within the family of first generation Russian immigrants but second-generation families are more open to doing so. First generation immigrant Russian seniors in our study do not seem to want any specialized end-of-life care often due to lack of awareness, and prefer family care. Second generation seniors' attitudes are more accepting of this type of care. Hospice staff serve all those who seek care, receive training to serve diverse clients, and prioritize professional policies. There is sometimes potential for a gap between hospice policies regarding care and immigrant families' expectations for care. Results suggest a great need for community outreach to immigrant groups to raise awareness of end-of-life care, including advance directives and hospice care and the role of interpreters in health care settings.

Keywords: Russian immigrants | end-of-life care attitudes in diverse populations | Hospice staff care for diverse patients

Article:

Introduction

Recent trends in immigration to the United States and decreased birth rates among native-born groups have led to an older American population that is increasingly diverse and foreign-born (Ortman et al. 2014). In 2010, almost 12% of seniors were foreign born, a proportion that is

projected to increase (Scommegna 2013). Immigrant seniors will likely experience challenges because of unfamiliarity with the language, social norms, and health care system of the United States. These challenges may be especially likely when facing end-of-life care choices.

End-of-life care choices in the United States (US) include hospice care. Hospice care provides comfort care designed to alleviate pain and uncomfortable symptoms while acknowledging psychosocial and spiritual needs, in accordance with the patient's wishes (Bushfield 2010). Though hospice care use is increasing in the US, it is still not the predominant mode of care at the end of life. In 2016, fewer than half (about 48%) of deaths took place under hospice care (NHPCO 2018). Moreover, disparities persist in the use of hospice care, as race/ethnic minority groups are less likely to use hospice care or end-of-life care planning. Difficulties in cross-cultural communication play a role in this disparity (Carr 2012; Colón and Lyke 2015; Kwak and Haley 2005; NHPCO 2018). Fewer studies examine immigrants' use of end-of-life care in the US, and tend to focus on Hispanic or Asian immigrants (e.g. Pan et al. 2015; Rising et al. 2017), but those from other regions such as the Former Soviet Union (FSU) have been less examined. Hospice care does appear to benefit immigrants as enrolling in palliative care decreased immigrant patients' chances of hospitalization and increased their likelihood of discussing and documenting end-of-life care wishes (Carrion et al. 2012; Fernandes et al. 2010; Selsky et al. 2012). However, questions remain whether diverse immigrant groups are aware of such care, and whether they find it acceptable. To address this gap, this pilot study examines views on end-of-life care and hospice care among Russian immigrants in North Carolina, and hospice workers' training and policies regarding diverse immigrant patients.

Russian Immigrants' Use of Health Care

Since information on older Russian immigrants' use of hospice care is limited, insight can be gained by considering their use of health care overall. Immigrants and refugees from the FSU are one of the largest groups of 'émigrés' to enter the US in recent decades, due to the dissolution of the FSU and the outmigration of persecuted religious minorities (e.g. Jews and Protestant Christians) (Van Son and Gileff 2013). According to the American Community Survey 2009–2013, there are approximately 890,120 Russian speakers in the US who originating from the FSU (Schoua-Glusberg et al. 2016). Most research refers to them as 'Russians' (Newhouse 2013). They are mostly urban and middle class and 40% of them have college education. They are significantly older than the US population: 44% are aged 55 years and over (Ameredia 2012; Belusova 2011). Russian immigrants report higher levels of disability despite higher education and lower rates of smoking and alcohol consumption, than the general US population (Hofmann 2012; Mehta and Elo 2012). They are also higher consumers of health services, for reasons including loneliness and somaticized stress (Aroian et al. 2001).

Unfamiliarity with the language and medical systems in the US, and lack of money and health insurance, affect use of health services among older Russian immigrants (Ivanov et al. 2010). Understanding the role of insurance, fee-for-service, and other aspects of the US healthcare system is difficult for immigrants accustomed to universal socialized health care. This results in feelings of ambivalence and lack of trust for Russian immigrants utilizing health services in the US (Aroian et al. 2001; Iowa Center on Health Disparities 2010; Yarova et al. 2013). Moreover, palliative or hospice care was not available under the Soviet health system and was introduced in

1990 in Russia. Though hospice coverage has grown in the FSU since then, Russia has no overall policy for palliative care, training for palliative care is limited among medical professionals, and strict controls on pain medications create a barrier to terminally ill patients accessing appropriate care (Goss et al. 2014). Lynch et al. (2013) describe Russia as being in the group of countries that provide 'isolated instances' of palliative care provision, which is patchy in scope, not well supported, restricted in provision of pain medication, and limited given the population to be covered. Thus, immigrants from the FSU are less likely to be familiar with hospice care or to seek it out when terminally ill.

Language differences and acculturation are also challenging. Jackson et al. (2011) found that in 31% of all medical encounters involving a patient with limited English the information communicated had been altered, significantly so in 5% of the cases. Phrases get lost in translation or appropriate terms may not exist in the patient's language, leading to substantial communication challenges for health providers discussing care with immigrant seniors. Older Russian-speaking immigrants who live alone are more likely to be depressed and to experience difficulties using the health care system (Tran et al. 2000, 2008). Immigrants more familiar with the new culture, who know the language, and make friends, suffer less from depression and culture shock (Tsytsarev and Krichmar 2000).

Hospice care in the US is paid for mainly through Medicare, Medicaid, private insurance, private pay, or charitable contributions. Medicare is the primary source of hospice payments. Patients receive hospice care regardless of ability to pay, but several factors may create perceived barriers to access for older immigrants. Older immigrants often lack a US work history that creates eligibility for Social Security or Medicare benefits (O'Neil and Tienda 2014). Low income naturalized citizens can receive Supplemental Security Income but may not apply for Medicaid during their first five years as citizens. Eligibility guidelines vary by state, are strict, confusing, and often the primary focus is on pregnant women and children, excluding many vulnerable seniors (Fortuny and Chaudry 2012). Some insurance options for immigrant seniors may be available under the Affordable Care Act (MedicareResources.Org 2015). The application process for US citizenship requires English capability, which may be challenging for older immigrants (Van Son and Gileff 2013). While no national level data appear to exist for older Russian immigrants' health insurance access, Current Population Survey data show that 23.2% of Russian immigrants overall are without health insurance (Camarota 2012). These factors may create a perception of barriers to accessing hospice care for Russian immigrants.

Therefore, families and health care providers will face challenges providing adequate end-of-life care to Russian immigrant seniors, aspects less studied for this population. The present pilot study aims to take a first step toward addressing these gaps. We examine the following research questions:

1. What are Russian immigrant older adults' awareness and views regarding end-of-life care?
2. What are the awareness and views of the adult children of older Russian immigrants on end-of-life care for their seniors?
3. What are the policies of hospice facility staff to care for older immigrants?

Materials

Participants

The pilot study was conducted in 2012–2013 in central North Carolina counties with a high concentration of immigrant populations. The research team comprised an undergraduate student having basic familiarity with spoken and written Russian and a personal connection with the Russian immigrant community, a faculty member with expertise in gerontology and immigrant health, and a graduate student, neither of whom know Russian. In addition, a Russian language native speaker was available for additional translation/interpretation support during interviews if needed. All team members have an academic focus on family studies. We used a qualitative approach to explore the research questions, with individual in-depth interviews as the method of data collection, to elicit greater detail on immigrants' and providers' perspectives (Strauss and Corbin 1998). This study was reviewed and approved by the Institutional Review Board of the University of North Carolina Greensboro.

We interviewed three groups of participants: a) Russian seniors aged 60 years and above, b) Russian adult children with an older parent, and c) local area hospice staff. The first author reached out to local employers and service and religious organizations with substantial numbers of Russian clients, and sought introductions to potential participants. We solicited additional introductions from the first set of interviewees. For hospice staff, the first author contacted the Directors of area hospice and palliative care organizations to solicit participants among the staff.

This selection strategy made purposeful contact with persons whose qualities and experiences highlighted end-of-life care for immigrants, allowing our pilot study to achieve meaningful information with fewer participants (Polit and Beck 2006). These participant subgroups shared aspects of homogeneity, such as demographic homogeneity and life history homogeneity, based on their ethnic background, life experiences, and work experiences. Moreover, the aim of our pilot study is idiographic in nature, to bring forth attitudes and experiences toward end of life care among this immigrant community and relevant professionals, so that a smaller number of participants gives the chance for each individual to have a voice within the study, in contrast to studies that aim to develop or test a general theory that need more participants (Robinson 2014).

The first author interviewed four Russian seniors and five Russian adult children (including one community leader). All these participants self-identified as members of the Russian immigrant community. The seniors' ages ranged from 60 to 70 years, and all were female. One had immigrated from the FSU as a young adult, and three were born in the US. The adult children's ages ranged from mid-thirties till 60 years. Four were female, and two were male. Only one (a man) was the child of one of the seniors. The others were unrelated. All were college educated with professional occupations. Three had immigrated from the FSU as young adults, and two were born in the US. Participants who were born in the FSU and had moved to the US are referred in our analyses to as 'first generation immigrants'. Those born in the US are referred to as 'second generation immigrants'. The first author also interviewed four hospice staff who were all US born and trained, all female, with work experience ranging from two to 30 years. One was a facility director, one was a nurse, and two were social workers. They worked at a free-standing

hospice facility. The facility served all who sought care, irrespective of immigration status. They did not have information on whether Russian clients had been served.

Methods

Data Collection

The first author sought informed consent and interviewed participants at locations of their choice. The Russian immigrant participants were all fluent in Russian and had good conversational capacity in English. Due to participant preference, individual in-depth interviews were conducted in English, with occasional interspersed Russian words with some older adults. These words were within the linguistic capability of the first author. The additional Russian language interpreter support was not needed. Each initial interview, shaped by an interview guide, lasted about 45 min and was audiotaped, supplemented by handwritten notes, and briefer follow up interviews when needed. Interview recordings were transcribed mostly by the first author who translated where necessary, and some transcribed by the other two authors when no Russian words were used.

The individual in-depth interview guides included questions, follow up questions, and probes as needed (Strauss and Corbin 1998). Questions for Russian seniors and adult children included, for example, “What kind of care do you think older adults will need toward the end of life?” A follow up question was “What does your culture view as good care for older persons nearing the end of life?”, and a probe was “have you discussed this with your children/parent?” Additional questions investigated whether they had heard of hospice care or advance directives, whether the senior had health insurance, and how they accessed health care. We also solicited recommendations on what could be done to improve end-of-life care for Russian immigrants.

Hospice staff were also interviewed individually, in depth. Questions for hospice staff workers included, for example, “What are the hospice policies and procedures with regard to patients from diverse cultures, or unfamiliar with English, or with the U.S. healthcare system?” and follow up questions including “Have you received special training to care for older immigrant patients?” Probes included “What do you recommend to improve care for terminally ill seniors who are immigrants?” Questions for hospice staff focused on immigrants in general, and asked if they had experience with Russian immigrants in particular, which none reported.

Data Analyses

We followed a content analysis approach to analyze the interview data, using inductive approaches to identify emerging themes and patterns (Cho and Lee 2014). Data analyses were continuously carried out while data collection was ongoing, as emerging themes from transcripts were discussed during weekly research team meetings. First, each researcher individually read one or two transcripts and identified emerging themes, which were discussed during the meetings. Notes were kept of the meeting discussions and decisions. Follow-up interviews were conducted if questions arose that were not answered in the existing data. After all transcripts were analyzed, identified themes were discussed and organized. Questions and concerns were addressed and any disagreements resolved to consensus via discussion. These procedures

facilitated close, ongoing engagement with the data; maintained an audit trail; and supported credibility, dependability, and confirmability of the data and analytic process; thus promoting rigor in this pilot qualitative study (Barusch et al. 2011; Knapik et al. 2010).

Results

Russian Immigrants

Themes emerging from data analyses are presented in Table 1.

Table 1. Themes emerging from individual in-depth interviews

	Participants		
	Russian elders	**Russian adult children**	**Hospice staff**
Themes	Preference for family care for seniors	Preference for family care for seniors	Preference for family care among immigrants
	Negative perceptions of institutional care, lack of knowledge	Negative perceptions of institutional care, slightly more knowledge	Lack of knowledge of care institutions among immigrants
	Different views from younger generation	Different views from older generation	
	Lack of advance planning for end of life care	Lack of advance planning for end of life care, more open to it	Less knowledge of advance planning for end of life care among immigrants
	Societal responsibility for care	Societal responsibility for care	
			Receive training to work with diverse communities, challenges
			Patient self-determination can counter families' preferences

We first present results from the interviews with Russian seniors and adult children. Five major themes emerged. The first was the preference for family care for aging parents. Second was the perceptions of care provided in institutions. One interesting sub-theme was that of assisted suicide as a preferred alternative to care. Third was differences in views based on acculturation of participants. Fourth was the lack of advance care planning by families, and fifth, the view that society had a responsibility to contribute to care of seniors.

Family Involvement in Care

There was a widespread preference for family care for elders. Some of the adult children had a parent living with them, or were in the process of having their parents immigrate to live with them. Seniors and adult children born in the FSU expected the family to act as primary caregivers. One participant said: *"as for our family traditions, we rely more on ourselves."* This participant went on to explain her life in Russia and her feelings toward end-of-life care.

> *We were living together … in Russia … me and my brother, my mom, my dad, my grandmom … and great-grandmom with her husband, … in one small apartment. And … I could not imagine that I will send my old grandparents somewhere to hospice.*

An older adult immigrant said: *"<sighs> I think it should be primarily the family, not the hospitals at all. I think a doctor who knows the family well and knows the older person well should be involved and be advising the family."*

Perceptions of Institutional Care

Many participants did not distinguish between long term care facilities and end-of-life care, and expressed negative perceptions of facilities. An adult child first generation immigrant said:

> *In those senior places where people live doing nothing. They have no future … They don't know what to do … they're lost people there … how those other Russians live here in this Golden Gate … They have small rooms, they have everything there but they cannot go outside. They have no cars. They are locked there in this Golden Gate, even a cage or whatever.*

Thinking about himself, an adult child first generation immigrant spontaneously mentioned that he would prefer assisted suicide to hospice care or losing independence:

> *I would not want to end up in a hospice. I would rather have, what's the medical term for it, I don't know, to ending life before, like they have it in Oregon for example, so you … don't have to wait till you are completely powerless about yourself.*

He indicated that his father also shared this attitude:

> *Well, my dad is pretty explicit about that, he said when he can't do stuff himself he'll just go 'off' himself, <chuckles> he was joking … but that gives you the idea that he would not want … just to extend another few months of his life -when it's time to go, it's time to go, that's his position.*

Another first-generation adult child explained how she took care of her mother who had suffered a stroke. Language unfamiliarity was a deciding factor in not utilizing a care facility: *"My mom lived with me after having one stroke and then a second one and she was in total care and that was fine. She didn't speak English well so she couldn't really go to a nursing home."*

However, second generation adult children showed different attitudes toward care institutions including hospice, as exemplified by one woman:

> *I believe that older adults require careful attention. … in order to relieve the children of primary responsibilities older adults should prepare themselves to go into … graduated care, so their children don't have the primary responsibility for overseeing their care.*

A first-generation adult child acknowledged that family care could sometimes be difficult:

> *there could be different family situations, like you need to go to work … and at the same time this older person will open the door and go somewhere on the street and be lost there forever … so I am not sure what the approach is for each particular case could be.*

Acculturation

Differences appeared in expectations of end-of-life care between first- and second-generation immigrants, likely attributable to acculturation. Regarding preference for care, one first generation immigrant adult child said: *"we more rely on ourselves because … I could not trust the first person from the street … I could trust my own kids"*. By contrast, one second-generation immigrant older adult expressed a preference not to be cared for by her children.

> *Interviewer- "So, you have no expectation whatsoever of your children being your primary caregiver?"*
> *Participant: "Not at all. I would not want it that way."*

She clarified that she was close to her children, but did not want them to be her primary caregivers, and was already on a waiting list for a retirement community. Regarding hospice care, she said:

> *When my dad became very sick … for his last six months he was visited by a hospice nurse every day, toward the end more than once a day, and it was a wonderful help both to him and my mother. I think it's an amazing institution.*

Another second-generation immigrant adult child said:

> *I don't want to be a burden to anybody. My mother and father both had chronic illnesses and that just drags it out ... for myself, I would just like to live close to one of my daughters, so they could stop in and … check in on me, not necessarily for me to live in their home.*

Such wishes reflected the preference found in US society for 'intimacy at a distance', where older adults prefer to live close to their family to facilitate contact and support, but not to live with them.

Advance Care Planning

Participants raised in the US appeared more familiar with American health and legal systems including advance care planning, advance directives, end-of-life care preferences, health care power of attorneys, etc. This information was lacking among the first-generation adult children, even in this more educated, professional group. One first generation participant said that he knew nothing about hospice care and living wills. He said: *"I hear about hospice care but I actually never have much closer [sic] experience."* He also expressed concern about the cost of professional end-of-life care. Other participants also had not heard of the term 'advance directive', and confused 'living will' that documents preferences for life sustaining treatment and end-of-life care with the last will and testament that disposes of property.

In contrast, second generation immigrant adult children knew more about these systems, including potential difficulties. For example, regarding health care power of attorney, a second-generation woman, a nurse, said

> *I think it's a good thing. … The problem is that you need to carry it with you all the time. My mom would have these episodes where she would need to go to the ER, and I wouldn't have it with me (laughs).*

Regarding advance directives, she also said:

> *I think it's a good thing but with the same problem … my mom was hospitalized and they said 'remember to bring it in' and I kept forgetting … I think they are good things but not implementable and the whole idea is implementing them.*

There seemed to exist a 'culture of silence' surrounding discussion of end-of-life care among first generation immigrants. Some mentioned that in Russian culture, death is a taboo topic which people do not usually discuss until the very end. One adult child said:

> *I don't think Russians really discuss those matters, it's like … something in the future and you don't really talk about this ... I don't see an easy way to start talking about that because if I say, 'So, Mom what do you want to do when you have six months left?' … then she will be, 'Are you already ready to bury me?'*

Another first-generation adult child also had no plan or legal paperwork for his parents. He said *"You know, I think they are living from another society. It may be … [they think] we are kids and we will take care of them without signing any papers."*

By contrast, second-generation adult children believed in the need for families to plan ahead of time. One second-generation daughter shared:

> *I think that within families it's essential to discuss these things realistically … we all die and that is an essential part of life and that is how I raised my children … as difficult as it is … it must be discussed. … when people get older things do happen, like … a person can fall down and then they have some injury … then they need help, so … they need to know what sort of things they want and discuss that with their family.*

Though first-generation adult children felt it would be almost impossible to discuss these issues with their parents, they did indicate a willingness to plan ahead for themselves. One first-generation adult child said: *"we do have a will right now (my wife and I), so even though we're both mid-thirties, I think it's good to have ... very few Russians have wills at all"*. This participant did not distinguish between a property will and a living will/advance directive, and had not heard of the latter.

Societal Responsibility for Care

Another theme evident among immigrant participants was that society should share the responsibility for end-of-life care. One participant said:

> *I strongly believe in socialized medicine … a comprehensive coverage for everybody that is tax based, not insurance based … the plan should include caring for people who are older … but … if the family wants to take care of this person, then they have absolutely the priority, … only certain families can afford that and the predominant majority wouldn't be able to.*

Another participant, referring to terminally ill seniors, said: *"there should be family … plus medical professional care. So, if this medical care could be … paid for from government funds or some kind of health insurance funds … then maybe family will be a little bit relieved".* She felt that lack of health insurance prevented her elderly mother in Eastern Europe from joining her in the US:

> *my mom is getting sick right now and I'm here and … I am trying to bring her here but … because she will not have benefits for medical treatments, so she knows if something were to happen to her I would pay all the big amount of money for that, and maybe she don't want to involve me with this trouble.*

Hospice Staff

We next present findings from interviews with hospice staff which also revealed five broad themes. First, though staff are trained to serve diverse populations, it is challenging to serve immigrant seniors. Second, immigrant seniors prefer family care. Third, the hospice philosophy that patients have the right to determine their own care can run counter to immigrant patients' and families' preference for families to have priority in determining care. A related theme was that non-family interpreters are sometimes not welcomed by immigrant families, because of the reluctance to involve outside persons in family matters; this runs counter to hospice guidelines about using non-family interpreters. Finally, hospice staff also noted that immigrant families were usually less familiar with health care systems in the US, especially end-of-life care. All staff had worked with diverse clients including immigrants, but none had worked with Russian immigrants.

Care for Diverse Immigrants at the End-of-Life

Hospice staff described receiving training on working with a diverse clientele. One staff worker said: *"We have policies and procedures that dictate every year that every clinical staff, that means anybody who walks into a home, takes a class on cultural competence … that discusses diversity and respect, so we are extraordinarily mindful of that."* However, staff also acknowledged that accommodating immigrant patients is more challenging, partly because some immigrants are not fluent in English, and partly due to the requirement to be culturally competent and to honor patients' preferences. A hospice staffer said:

> *It's definitely more difficult to have an interpreter … at three o'clock in the morning to use the AT&T language line and have a relay conversation, rather than a direct*

> *conversation … It takes another level of coordination … It can also be difficult for staff to interact with people, families, patients who have customs and practices that are not familiar to them and it takes more time to learn … so that you're respectful and mindful.*

Patients' immigration or insurance status was not considered by staff. A staff member stated:

> *Their status does not matter … if they are uninsured with legal status or not, we will provide care … we try to create a safe place that people can receive care … at end of life, and are extraordinarily mindful of that responsibility because people are so vulnerable at that time.*

Preference to Stay at Home

Another theme mentioned by hospice workers paralleled Russian immigrants' reports that immigrant seniors strongly prefer to be cared for at home. A hospice worker with thirty years' experience said, *"The one thing that I have seen almost across the board in people from other countries who I've cared for at the end of life, is the desire to be in their own home, as opposed to being in a 'facility'."* This participant expectation of family care contrasted to the time available to the younger generation to provide care:

> *I think that there is an expectation of older adults, especially those from other countries, that the family will provide … care at the end of their life. … I think some of the older adults may not be able to quite grasp that the younger people and their family maybe have to go to work every day, and that those care-giving responsibilities are more than what they are able to manage. And so a facility is something that is necessary.*

When families are unable to provide adequate care at home, hospice staff assist families to form a feasible plan. A hospice staffer said: *"It also often depends on the patient's physical needs, the reality of their situation. Many people hate the thought of being in a nursing home, but reality tells us if care needs are great that is sometimes the only option and sometimes we have to look at the best worst option."*

Gap between Hospice Staff and Family's Views on Care

Hospice staff's philosophy on appropriate end-of-life care contrasted to immigrant seniors' and families' views. According to hospice policies, older persons have the right to determine their own care, even if the family disagrees. A hospice worker said:

> *Well I don't think that families … have the right to make any decisions if the patient is able to make decisions for themselves … as a professional, we need to advocate for that … even if takes longer to explain it to them … we … need to take the lead in seeing that that happens … in all cases we look to the patient first.*

Hospice staff felt that family members should consult patients' preferences and not make decisions without honoring the patients' opinion. Another hospice worker said: *"It's not really*

up to the daughters, and grandchildren, and the nephews. It's truly up to what that person wants and if they're capable of making decisions."

To address situations when a patient can no longer communicate, individuals are encouraged to document their wishes in an advance directive. A hospice staffer said: *"I think the idea of advance directives and helping people to define decision makers … is very important.*" Another said: *"If someone has an advance directive … if they're not able to answer a question at the moment but they identified somebody they wanted to speak on their behalf, we need to honor that."*

However, this can be challenging. Different cultures may not share the idea that the patient should be told they are terminally ill, or that the patient should make the decisions, as one hospice staff member noted.

> *Sometimes the dynamics might seem different because we don't understand the cultural norms within a particular culture or family or religion. We might think it's inappropriate for the oldest man to be making the decisions when in fact that's really what happens.*

Another hospice worker said

> *But yeah, family dynamics, you have cultures where you don't tell people about their diagnosis … about the prognosis. You have to respect that, you know, maybe … let's just say, the mother, who is going through all of this … has cancer. But their culture dictates that you do not talk to the mother about that, you talk to the children. Children make the decisions for the mother.*

If the patient and the family don't agree on a care option, or if the patient can no longer communicate and family members disagree, an interdisciplinary team is brought in. Using open communication to express fears, concerns, and hopes, the team aims to bring everyone to an understanding of the situation and move at a pace which all are able to accept.

Use of Non-Family Interpreters

Another potential divergence between hospice policies vs. immigrant patients and families' views, is the use of non-family translation and interpretation services for patients with limited English. A hospice staff member said: *"Well, most agencies, government agencies especially, have to have an interpreter available, that's just a requirement."* Another said:

> *Not only our licensure responsibility but our ethical responsibility is to provide care for a patient and their family in the language that they are most comfortable with. We also put a priority on family members not being the interpreters because that's just not ethically appropriate.*

This can create unintended friction when patients may prefer family members to interpret, and families might expect that they will interpret for their relative due to privacy concerns and being familiar with their language, needs, etc. Another hospice worker said,

> *With some populations … they don't want a translator. They don't want to share their private information through anybody else. We recently had a patient that refused translation, and we had a signed consent that they did not want translation, to actually in some ways protect us. And that also was very, very hard because we knew they were not understanding what we were saying. And I think the translator also helps us identify what the patient's family really wants and needs. But if someone refused a translator, we had a translator come so that we could really determine that they didn't want a translator (laugh).*

Immigrants' Information on End-of-Life Care

Hospice staff also pointed out immigrants' information sources and gaps regarding end-of-life care. One hospice staffer said, *"we had a number of people who have experienced the health care system but maybe not understand exactly how it works."* Another pointed out the importance of agencies and community organizations in connecting immigrant and refugee families with health care providers, and bridging the information gap. She said: *"A lot of needs are met when they initially get over … they have the government actually moving them in, and getting them hooked up with whatever resources are here, and so that's usually how it all starts."* Another staffer said:

> *Whatever agency might call us in … we're working with that agency to help the family … it's the people from their community that have been here longer and that know the resources that really … provide the most help to them.*

Discussion

Russian Immigrants and Staff Views

This study examined Russian immigrants' views on end-of-life care and hospice care in the US, and hospice workers' training and policies regarding working with immigrant clients. Many prior studies showing that immigrants have less awareness and use of hospice care examined ethnic minority groups (Kwak and Haley 2005). However, immigrants from the FSU have been less studied. Our findings indicated similarities between the attitudes of immigrants from the FSU and other immigrant groups in the US. There was less awareness of end-of-life care among first generation immigrants, though adult children appeared more open to these options compared to seniors. Discussing end-of-life care with children seemed almost taboo among older Russians, as also noted by Newhouse (2013) who attributed this to factors such as poor health care in the FSU, beliefs about bad luck, and reluctance to talk about pain or to tell a family member about a terminal diagnosis. Such reticence is also noted among other immigrant communities such as Latinos (Kreling et al. 2010). Advance care planning and taking individual initiative on health care decision-making may be alien to seniors raised in the FSU, because individual planning was not a feature of a centrally planned Socialist society, and doctors were more authoritarian and complied less with patients' wishes (Kwak et al. 2014; Richter et al. 2001). We found a strong preference for families to care for aging parents. However, second generation participants were

more likely to be aware of end-of-life care options, prefer non-family care, and discuss hospice care in families.

Practice Recommendations

Our findings suggest strategies for raising awareness and use of hospice care among Russian immigrant seniors, which parallel recommendations for other diverse groups. As also stated by Carrion et al. (2012), hospice staff should work more closely with immigrants' families to raise awareness of and allay concerns about hospice care. They should let families know hospice policies on interpreters, including that offering interpretation services is mandatory though the family can refuse them, and that family members cannot be interpreters due to ethical concerns. These policies are less known to immigrants. The policy of non-family interpreter / translator services can pose an unintended barrier for clients with limited English who do not want their private information to be shared with others. Hospice staff could consider honoring patients' preference for a trusted family interpreter when there are no circumstances that make this inappropriate. Patients could be offered a choice of interpreters (Van Son and Gileff 2013). However, professional recommendations endorse using a non-family interpreter trained in palliative care (Crawley and Koffman 2015; Newhouse 2013). Another challenge arises between families who want to direct seniors' care vs. hospice staff who focus on carrying out patients' wishes. Families and patients should be made aware early in the process that patients' wishes are paramount, and facilitated to discuss and document the patient's wishes, so that family members' 'subsidiary plans' (which might mask the patient's interests) are deflected (Michael et al. 2014). Having the physician initiate the dialogue, involving adult children, approaching the topic slowly, providing adequate information about choices, and showing personal warmth are also strategies recommended in the literature (Newhouse 2013). Patients who received end-of-life care consultation had lower scores of pain and post-traumatic stress disorder; earlier transition to care provided more benefits (Casarett et al. 2008). Therefore, it is important to have immigrant families and communities educated about the U.S. health system, including options for end-of-life care.

There should be improved co-ordination between hospice staff, immigrant service agencies, and senior service organizations to develop and disseminate information to diverse immigrant communities on end-of-life care (Kwak et al. 2014). Fostering trust and open communication among the FSU immigrant community and those who can be seen as authority figures, is a delicate task which can be accomplished by sustained engagement between service providers and community leaders (Van Son and Gileff 2013). A variety of communication techniques and technologies should be used to overcome gaps in language, culture, education, reluctance to talk about death, etc. Agencies should fine-tune continuing education to their staff on end-of-life care to diverse cultures. To promote these goals, hospices and other agencies should actively recruit staff and volunteers with multi-cultural skills and multiple language competencies.

Current trends in demographic profiles of immigrant populations, coupled with trends in cause of death patterns, underscore pressing policy and outreach needs in end-of-life care including hospice care in the US. Increased variation in diagnoses, greater multimorbidity and disease complexity among people with terminal illnesses, accompanied by changing patterns and locations of end-of-life care, create greater 'care intensity' and associated need for high quality

care at the end of life (Aldridge and Bradley 2017; Meier 2011). This creates growing need for hospice care and concomitant need for increased outreach to diverse populations including immigrants.

Study Limitations

This pilot study had some limitations. First, the research team could only interview a limited cross section of Russian participants, all whom were educated and middle class. Thus, the broader spectrum of Russian immigrants are less represented. Nonetheless, even among this segment of society, knowledge gaps regarding end-of-life care were revealed. A related major limitation is that all the participants of this study had sufficient English fluency to prefer to be interviewed in that language. This contrasts with a large proportion of immigrants from the FSU, about 42% of whom have limited English proficiency (Zong and Batalova 2015). Among older immigrants, the percent with limited English is likely greater. Thus, these results need additional verification from studies with a wider range of participants who were interviewed in the Russian language. However, since knowledge about end-of-life care was limited even in this group, it is likely that average Russian immigrants who are not fluent in English would know even less about these aspects of the US healthcare system. Therefore, our results represent a conservative estimate of the situation. Participant recruitment for this study was challenging, since the topic was viewed as sensitive. A community-engaged approach including ongoing partnership with community organizations and individuals is needed to reach more participants. It may also be that Russian immigrants raised under the Communist regime may feel apprehensive about being involved in a study of a sensitive topic, and wary of seemingly official inquiries. Notwithstanding these limitations, our pilot study adds to the evidence on views toward end-of-life care among immigrants from the FSU, and on potential gaps created by hospice policies versus immigrant patients' preferences, and paves the way for further studies addressing end of life care needs among immigrants from the FSU.

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References

Aldridge, M. D., & Bradley, E. H. (2017). Epidemiology and patterns of care at the end of life: Rising complexity, shifts in care patterns and sites of death. *Health Affairs, 36*(7), 1175–1183.

Ameredia (2012). Russian American demographics. *Integrated multicultural marketing*. Retrieved on May 13, 2014, from http://www.ameredia.com/resources/demographics/russian.html

Aroian, K. J., Khatutsky, G., Tran, T. V., & Balsam, A. L. (2001). Health and social service utilization among elderly immigrants from the former Soviet Union. *Journal of Nursing Scholarship, 33*(3), 265–271.

Barusch, A., Gringeri, C., & George, M. (2011). Rigor in qualitative social work research: A review of strategies used in published articles. *Social Work Research, 35*(1), 11–19.

Belusova M. (2011). The Russian diaspora in the US *Russian Analytical Digest No.* 107*,* 27 January 2011.

Bushfield, S. (2010). Use of spiritual life maps in a hospice setting. *Journal of Religion, Spirituality And Aging, 22*, 254–270.

Camarota, S. A. (2012). *Immigrants in the United States: A profile of America's foreign-born population*. Center for Immigration Studies. Retrieved from https://cis.org/Immigrants-United-States-2010. Accessed 2 Nov 2016.

Carr, D. (2012). Racial and ethnic differences in advance care planning: Identifying subgroup patterns and obstacles. *Journal of Aging Health, 24*, 923–947. https://doi.org/10.1177/0898264312449185.

Carrion, I. V., Park, N. S., & Lee, B. S. (2012). Hospice use among African Americans, Asians, Hispanics, and whites implications for practice. *Hospice and Palliative Care, 29*(2), 116–121. https://doi.org/10.1177/1049909111410559.

Casarett, D., Pickard, A., Bailey, F., Ritchie, C., Furman, C., Rosenfeld, K., & Shea, J. A. (2008). Do palliative consultations improve patient outcomes? *Journal of the American Geriatrics Society, 56*, 593–599. https://doi.org/10.1111/j.1532-5415.2007.01610.x.

Cho, J. Y., & Lee, E. (2014). Reducing confusion about grounded theory and qualitative content analysis: Similarities and differences. *The Qualitative Report, 19*(32), 1–20 Retrieved November 12, 2015 from http://nsuworks.nova.edu/tqr/vol19/iss32/2.

Colón, M., & Lyke, J. (2015). Comparison of hospice use by European Americans, African Americans, and Latinos: A follow-up study. *American Journal of Hospice and Palliative Medicine®, 32*(2), 205–209.

Crawley, L., & Koffman, J. (2015). Ethnic and cultural aspects of palliative care. In N. Cherny, M. Fallon, S. Kaasa, R. Portenoy, & D. C. Currow (Eds.), *Oxford textbook of palliative medicine* (5th ed.). Oxford: Oxford University Press.

Fernandes, R., Braun, K. L., Ozawa, J., Compton, M., Guzman, C., & Somogyi-Zalud, E. (2010). Home-based palliative care services for underserved populations. *Journal of Palliative Medicine, 13*, 413–419. https://doi.org/10.1089/jpm.2009.0216.

Fortuny K. & Chaudry A. (2012). Overview of immigrants' eligibility for SNAP, TANF, MEDICAID, and CHIP *ASPE Issue Brief March 2012*, Office of the Assistant Secretary for planning and evaluation, US Dept. of Health and Human Services. Retrieved May 26, 2015 from http://aspe.hhs.gov/hsp/11/ImmigrantAccess/#Publications

Goss, P. E., Strasser-Weippl, K., Lee-Bichkovsky, B., Fan, L., Li, J., Chavarri-Guerra, J., et al. (2014). Challenges to effective cancer control in China, India, and Russia. *The Lancet Oncology, 15*(5), 489–538, April 2014. https://doi.org/10.1016/S1470-2045(14)70029-4.

Hofmann, E. T. (2012). The burden of culture? Health outcomes among immigrants from the former Soviet Union in the United States. *Journal of Immigrant & Minority Health, 14*(2), 315–322. https://doi.org/10.1007/s10903-010-9436-3.

Iowa Center on Health Disparities. (2010). *Russians and Other Immigrants from the Former Soviet Union* retrieved on 8/5/15 from http://www.iowahealthdisparities.org/documents/russian.pdf

Ivanov, L. L., Hu, J., & Leak, A. (2010). Immigrant women's cancer screening behaviors. *Journal of Community Health Nursing, 27*, 32–45.

Jackson, J., Nguyen, D., Hu, N., Harris, R., & Terasaki, G. S. (2011). Alterations in medical interpretation during routine primary care. *Journal of General Internal Medicine, 26*(3), 259–264. https://doi.org/10.1007/s11606-010-1519.

Knapik, G. P., Martsolf, D. S., Draucker, C. B., & Strickland, K. D. (2010). Attributes of spirituality described by survivors of sexual violence. *Qualitative Report, 15*(3), 644–657.

Kreling, B., Selsky, C., Perret-Gentil, M., Huerta, E. E., & Mandelblatt, J. S. (2010). 'The worst thing about hospice is that they talk about death': Contrasting hospice decisions and experience among immigrant central and south American Latinos with US-born white, non-Latino cancer caregivers. *Palliative Medicine, 24*(4), 427–434. https://doi.org/10.1177/0269216310366605.

Kwak, J., & Haley, W. E. (2005). Current research findings on end-of-life decision making among racially or ethnically diverse groups. *The Gerontologist, 45*(5), 634–641.

Kwak, J., Ko, E., & Kramer, B. J. (2014). Facilitating advance care planning with ethnically diverse groups of frail, low-income elders in the USA: Perspectives of care managers on challenges and recommendations. *Health and Social Care in the Community, 22*(2), 169–177. https://doi.org/10.1111/hsc.12073.

Lynch, T., Connor, S., & Clark, D. (2013). Mapping levels of palliative care development: A global update. *Journal of Pain and Symptom Management, 45*(6), 1094–1106. https://doi.org/10.1016/j.jpainsymman.2012.05.011.

MedicareResources.org (2015). Retrieved May 26, 2015 from http://www.medicareresources.org/faqs/can-recent-immigrants-to-the-united-states-get-health-coverage-if-theyre-over-65/

Mehta, N. K., & Elo, I. T. (2012). Migrant selection and the health of U.S. immigrants from the former Soviet Union. *Demography, 49*, 425–447. https://doi.org/10.1007/s13524-012-0099-7.

Meier, D. E. (2011). Increased access to palliative care and hospice services: Opportunities to improve value in health care. *Milbank Quarterly, 89*, 343–380. https://doi.org/10.1111/j.1468-0009.2011.00632.x.

Michael, N., O'Callaghan, C., Baird, A., Hiscock, N., & Clayton, J. (2014). Cancer caregivers advocate a patient- and family-centered approach to advance care planning. *Journal of Pain and Symptom Management, 47*(6), 1064–1077.

National Hospice and Palliative Care Organization. (2018). *NHPCO facts and figures: Hospice Care in America Rev Ed April 2018*. Alexandria: National Hospice and Palliative Care Organization.

Newhouse, L. (2013). Working with Russian-Jewish immigrants in end-of-life care settings. *Journal of Social Work in End-of-Life & Palliative Care, 9*(4), 331–342. https://doi.org/10.1080/15524256.2013.846884.

O'Neil, K., & Tienda, M. (2014). Age at immigration and the incomes of older immigrants, 1994–2010. *Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 70*(2), 291–302.

Ortman J. M., Velkoff V. A., & Hogan H. (2014). An aging nation: The older population in the United States. *Population Estimates and Projections Current Population Reports* Issued May 2014 P25-1140 U.S. Dept. of Commerce Economics and Statistics Administration U.S. Census Bureau.

Pan, C. X., Abraham, O., Giron, F., LeMarie, P., & Pollack, S. (2015). Just ask: Hospice familiarity in Asian and Hispanic adults. *Journal of Pain and Symptom Management, 49*(5), 928–933. https://doi.org/10.1016/j.jpainsymman.2014.09.016.

Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal, and utilization* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.

Richter, J., Eisemann, M., & Zgonnikova, E. (2001). Doctors' authoritarianism in end-of-life treatment decisions. A comparison between Russia, Sweden and Germany. *Journal of Medical Ethics, 27*(3), 186–191.

Rising, M. L., Hassouneh, D. S., Lutz, K. F., Lee, C. S., & Berry, P. (2017). Integrative review of the literature on Hispanics and hospice. *American Journal of Hospice and Palliative Medicine, 35*(3), 542–554. https://doi.org/10.1177/1049909117730555.

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A theoretical and practical guide. *Qualitative Research in Psychology, 11*, 25–41. https://doi.org/10.1080/14780887.2013.801543.

Schoua-Glusberg A., Kenward K., & Morales G. (2016). Qualitative research with demographically diverse Russian speakers. - U.S. Census Bureau research support services −*2016 AAPOR Annual Conference–Austin, Texas–May 14, 2016*. Retrieved November 12, 2016 from https://www.census.gov/content/dam/Census/newsroom/press-kits/2016/Qualitative%20Research%20with%20Demographically%20Diverse%20Russian%20Speakers.pdf.

Scommegna, P. (2013). "Elderly immigrants in the United States," *Today's Research on Aging*, no. 29, Population Reference Bureau, October 2013.

Selsky, C., Kreling, B., Lhuta, G., Makgoeng, S. B., Gomez-Duarte, J., Barbo, A. G. A., Mandelblatt, J. S., & Latin American Cancer Research Coalition. (2012). Hospice

knowledge and intentions among Latinos using safety-net clinics. *Journal of Palliative Medicine, September 15*(9), 984–990. https://doi.org/10.1089/jpm.2011.0517.

Strauss, A. C., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks: Sage.

Tran, T. V., Khatutsky, G. G., Aroian, K. K., Balsam, A. A., & Conway, K. K. (2000). Living arrangements, depression, and health status among elderly Russian-speaking immigrants. *Journal of Gerontological Social Work, 33*, 63–77.

Tran, T. V., Sung, T., & Huynh-Hohnbaum, A. T. (2008). Measure of English acculturation stress and its relationships with psychological and physical health status in a sample of elderly Russian immigrants. *Journal of Gerontological Social Work, 50*, 37–50.

Tsytsarev, S., & Krichmar, L. (2000). Relationship of perceived culture shock, length of stay in the U.S., depression, and self-esteem in elderly Russian-speaking immigrants. *Journal of Social Distress and the Homeless, 9*, 35–49.

Van Son, C. R., & Gileff, T. Y. (2013). Relying on what they know: Older Slavic Émigrés managing chronic health conditions. *Qualitative Health Research, 23*(12), 1660–1671. https://doi.org/10.1177/1049732313508842.

Yarova, L. A., Covan, E. K., & Fugate-Whitlock, E. (2013). Effect of acculturation and health beliefs on utilization of health care services by elderly women who immigrated to the USA from the former Soviet Union. *Health Care for Women International, 34*, 1097–1115. https://doi.org/10.1080/07399332.2013.807259.

Zong, J., & Batalova, J. (2015). European immigrants in the United States. *Migration Policy Institute Migration Information Source*, Dec 1 2015. Retrieved from: https://www.migrationpolicy.org/article/european-immigrants-united-states-2. Accessed 3 Oct 2016.

EXHIBIT 13

Letter of Intent for Seasons Hospice & Palliative Care of Spokane County Washington, LLC

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 9:38 am, Nov 15, 2021

November 15, 2021

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 – AccentCare Hospice & Palliative Care of Spokane County, LLC

Dear Mr. Hernandez,

AccentCare Hospice & Palliative Care of Spokane County, LLC ("AccentCare") hereby submits this letter of intent to apply for a certificate of need to establish a hospice agency. In accordance with WAC 246-310-080, please find the following information:

1. Description of Services Provided. AccentCare 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 Spokane County, Washington.

Thank you for your support. We look forward to one day serving hospice patients in 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 Key Initiatives
RHILLIARD@SEASONS.ORG

EXHIBIT 14

Proxy Data Used in Projections

Seasons Hospice Palliative Care Agencies
Most Recent 10 Years Start-Up Experience, Initial 3 Years Utilization

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
Arizona	Oct-11	218	9,117	42	25	68%	367	24,608	67	67	-17%	305	34,347	113	94
Georgia	Sep-10	57	4,685	82	13	161%	149	10,410	70	29	23%	183	14,492	79	40
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					
FL-Pasco	Apr-20	238	13,277	56	36										
CA-Oakland	May-20	81	4,054	50	11										
Average		**167**	**8,806**	**53**	**24**	**106%**	**344**	**23,432**	**68**	**64**	**27%**	**438**	**32,138**	**73**	**88**
Median		**165**	**8,976**	**51**	**25**	**77%**	**251**	**19,967**	**72**	**55**	**32%**	**321**	**28,406**	**83**	**78**

Comparison of Seasons Hospice Oregon Service Area with Spokane County, Washington

Fact	Fact Note	Multnomah County, OR	Clackamas County, OR	Washington County, OR	Oregon	Value Note for Oregon	Spokane County, Washington
Population Estimates, July 1 2021, (V2021)		NA	NA	NA	4,246,155		NA
Population estimates base, April 1, 2020, (V2021)		NA	NA	NA	4,237,256		NA
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)		NA	NA	NA	0.20%		NA
Population, Census, April 1, 2020		815,428	421,401	600,372	4,237,256		539,339
Population, Census, April 1, 2010		735,334	375,992	529,710	3,831,074		471,221
Persons under 5 years, percent		5.10%	5.20%	5.80%	5.40%		6.00%
Persons under 18 years, percent		18.40%	21.20%	22.50%	20.50%		22.00%
Persons 65 years and over, percent		13.90%	18.80%	13.90%	18.20%		16.60%
Female persons, percent		50.50%	50.70%	50.50%	50.40%		50.40%
White alone, percent		79.00%	88.90%	79.60%	86.70%		88.90%
Black or African American alone, percent	(a)	6.00%	1.20%	2.50%	2.20%		2.00%
American Indian and Alaska Native alone, percent	(a)	1.40%	1.10%	1.10%	1.80%		1.80%
Asian alone, percent	(a)	8.10%	4.90%	11.70%	4.90%		2.40%
Native Hawaiian and Other Pacific Islander alone, percent	(a)	0.70%	0.30%	0.50%	0.50%		0.60%
Two or More Races, percent		4.70%	3.70%	4.50%	4.00%		4.20%
Hispanic or Latino, percent	(b)	12.00%	9.00%	17.10%	13.40%		6.10%
White alone, not Hispanic or Latino, percent		69.10%	81.10%	64.60%	75.10%		84.00%
Veterans, 2015-2019		37,495	26,384	31,391	283,045		43,294
Foreign born persons, percent, 2015-2019		13.80%	8.20%	17.70%	9.90%		5.40%
Housing units, July 1, 2019, (V2019)		359,778	170,724	234,162	1,808,465		223,079
Owner-occupied housing unit rate, 2015-2019		54.50%	71.10%	61.60%	62.40%		62.40%
Median value of owner-occupied housing units, 2015-2019		$386,200	$395,100	$386,600	$312,200		$224,800
Median selected monthly owner costs -with a mortgage, 2015-2019		$1,924	$2,003	$1,972	$1,699		$1,433
Median selected monthly owner costs -without a mortgage, 2015-2019		$672	$655	$660	$538		$489
Median gross rent, 2015-2019		$1,237	$1,295	$1,359	$1,110		$913
Building permits, 2020		2,709	2,011	3,062	18,665	1	3,170
Households, 2015-2019		326,229	157,408	219,053	1,611,982		202,811
Persons per household, 2015-2019		2.41	2.59	2.66	2.51		2.41
Living in same house 1 year ago, percent of persons age 1 year+, 2015-2019		81.90%	85.60%	83.80%	82.90%		80.60%
Language other than English spoken at home, percent of persons age 5 years+, 2015-2019		20.00%	12.10%	24.80%	15.40%		7.40%
Households with a computer, percent, 2015-2019		94.10%	94.20%	96.10%	93.00%		92.60%
Households with a broadband Internet subscription, percent, 2015-2019		87.90%	87.80%	90.70%	85.90%		87.00%
High school graduate or higher, percent of persons age 25 years+, 2015-2019		91.50%	93.40%	92.20%	90.70%		93.80%
Bachelor's degree or higher, percent of persons age 25 years+, 2015-2019		45.90%	37.40%	44.40%	33.70%		30.80%
With a disability, under age 65 years, percent, 2015-2019		9.10%	7.50%	6.60%	9.90%		10.50%
Persons without health insurance, under age 65 years, percent		8.30%	7.40%	6.90%	8.60%		7.00%
In civilian labor force, total, percent of population age 16 years+, 2015-2019		69.40%	64.60%	69.00%	62.30%		60.80%
In civilian labor force, female, percent of population age 16 years+, 2015-2019		65.90%	58.80%	61.90%	57.90%		57.60%
Total accommodation and food services sales, 2012 ($1,000)	(c)	2,506,213	637,512	970,572	8,466,788		1,062,633
Total health care and social assistance receipts/revenue, 2012 ($1,000)	(c)	7,703,673	2,424,207	3,238,074	24,956,816		3,968,007
Total manufacturers shipments, 2012 ($1,000)	(c)	10,278,074	5,371,545	13,525,848	51,349,948		3,943,094

Source: www.census.gov "Quick Facts Reports"
Accessed 12/27/2021

Total retail sales, 2012 ($1,000)	(c)	9,982,933	5,125,309	8,389,744	49,481,054		6,560,827
Total retail sales per capita, 2012	(c)	$13,148	$13,352	$15,319	$12,690		$13,791
Mean travel time to work (minutes), workers age 16 years+, 2015-2019		27	29.2	25.2	23.9		22
Median household income (in 2019 dollars), 2015-2019		$69,176	$80,484	$82,215	$62,818		$56,904
Per capita income in past 12 months (in 2019 dollars), 2015-2019		$39,245	$41,492	$39,679	$33,763		$31,146
Persons in poverty, percent		11.20%	6.80%	7.50%	11.00%		13.40%
Total employer establishments, 2019		27,789	12,265	15,945	119,074		13,458
Total employment, 2019		453,756	147,709	290,205	1,643,425		197,989
Total annual payroll, 2019 ($1,000)		26,235,886	7,773,205	21,320,118	87,517,282		9,584,508
Total employment, percent change, 2018-2019		1.30%	-0.90%	1.40%	0.90%		1.00%
Total nonemployer establishments, 2018		75,048	32,935	40,983	302,653		32,197
All firms, 2012		85,366	35,537	43,536	339,305		36,392
Men-owned firms, 2012		42,283	17,619	21,357	165,691		17,704
Women-owned firms, 2012		33,046	12,643	16,207	123,015		11,526
Minority-owned firms, 2012		13,825	3,367	7,571	41,456		2,726
Nonminority-owned firms, 2012		67,269	30,740	33,958	285,028		32,022
Veteran-owned firms, 2012		6,676	3,250	4,102	30,918		3,801
Nonveteran-owned firms, 2012		74,013	30,021	36,745	288,790		29,695
Population per square mile, 2010		1,704.90	201	731.4	39.9		267.2
Land area in square miles, 2010		431.3	1,870.32	724.23	95,988.01		1,763.79
FIPS Code		"41051"	"41005"	"41067"	"41"		"53063"
NOTE: FIPS Code values are enclosed in quotes to ensure leading zeros remain intact.							
Value Notes							
1	Includes data not distributed by county.						
Fact Notes							
(a)	Includes persons reporting only one race						
(c)	Economic Census - Puerto Rico data are not comparable to U.S. Economic Census data						
(b)	Hispanics may be of any race, so also are included in applicable race categories						
Value Flags							
-	Either no or too few sample observations were available to compute an estimate, or a ratio of medians cannot be calculated because one or both of the median estimates falls in the lowest or upper interval of an open ended distribution.						
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 of sample cases is too sma						
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 12/27/2021

Seasons Hospice & Palliative Care of Oregon

Income Statement

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	CY20
Revenues													
Routine Revenue	328,127	300,295	317,291	294,298	287,505	308,324	358,710	341,294	333,196	362,855	377,015	405,163	4,014,075
Respite Revenue	49	1,971	(6)	470	-	(1)	-	-	-	-	-	(2)	2,482
General Inpatient Revenue	48,899	67,466	44,666	32,318	42,209	38,894	63,972	68,671	51,632	61,592	58,389	119,245	697,953
Inpatient Unit Revenues	-	-	-	-	-	-	-	-	-	-	-	-	-
Continuous Care Revenue	(0)	-	-	-	-	0	-	-	-	-	-	-	-
Physician Revenue	9,159	5,990	12,067	4,681	5,348	9,241	7,610	10,665	10,678	19,277	10,741	2,299	107,755
Nursing Home R&B, Net of Expenses	-	-	-	165	-	572	327	277	(165)	15,753	-	82	17,010
Grant Revenue	-	-	190	7,797	502	9,393	1,890	26,030	2,435	179	2,112	272,649	323,176
Other Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-
Net Revenue	**386,234**	**375,722**	**374,209**	**339,728**	**335,565**	**366,424**	**432,509**	**446,936**	**397,776**	**459,656**	**448,257**	**799,435**	**5,162,451**
Direct Expenses													
Clinical	2,768	2,205	4,328	2,435	2,374	2,442	2,379	3,284	2,670	3,484	2,794	3,501	34,663
DME	9,287	8,909	9,907	9,390	7,071	10,314	13,892	10,472	9,751	9,984	10,789	12,123	121,889
Pharmacy	15,068	11,629	12,986	12,272	13,561	22,289	11,506	12,641	12,788	16,611	12,744	14,939	169,033
Open Access	-	17	-	-	-	-	-	86	677	233	-	-	1,014
Inpatient/Respite Boarding Costs	672	1,400	(10,709)	2,100	15,984	-	-	-	9,100	2,800	3,000	(1,600)	22,747
Labor - Direct	119,865	107,106	111,227	111,452	115,063	111,991	110,228	114,185	118,643	117,604	112,062	118,548	1,367,975
Labor - Indirect	15,154	14,228	15,042	14,655	15,039	14,651	15,214	15,250	14,870	16,140	14,780	15,355	180,378
Other Direct	23,556	42,066	24,810	28,166	16,306	35,424	46,692	31,980	19,331	22,975	24,123	53,578	369,007
Direct Expenses	**186,371**	**187,560**	**167,590**	**180,471**	**185,397**	**197,111**	**199,911**	**187,897**	**187,831**	**189,831**	**180,292**	**216,444**	**2,266,706**
Gross Margin	**199,863**	**188,162**	**206,619**	**159,257**	**150,167**	**169,313**	**232,599**	**259,039**	**209,945**	**269,824**	**267,965**	**582,992**	**2,895,746**
Operating Expenses													
Labor - Operating	69,016	53,030	52,483	70,318	73,712	65,723	52,899	79,162	61,431	71,409	63,662	70,158	783,003
Benefits	37,523	34,240	33,557	39,162	40,311	35,795	35,613	34,404	38,304	39,368	37,571	85,695	491,544
Employee Relations	378	154	277	151	336	169	173	333	333	195	305	238	3,042
Recruitment	-	-	-	-	-	-	-	500	-	-	-	859	1,359
Printing	1,995	1,454	496	1,396	984	982	816	778	1,004	778	-	1,104	11,786
Marketing	1,330	1,302	2,117	2,117	1,112	864	431	402	1,310	1,418	1,155	2,112	15,669
Outside Services	892	856	873	847	827	847	920	892	874	1,002	928	(4,960)	4,794
Facilities	9,600	10,549	9,927	9,888	9,379	10,197	10,356	9,379	9,898	11,416	9,658	9,660	119,907
IS & Telecommunications	4,629	5,705	4,789	4,798	3,405	4,084	4,037	4,627	4,509	3,938	4,882	4,117	53,519
Conferences/Training	-	-	-	-	-	-	-	-	185	-	-	-	185
Travel	211	91	15	4	-	5	90	163	81	98	-	128	886
cALL Center	2,337	2,534	2,196	1,762	2,035	2,101	2,341	2,045	2,055	1,764	1,889	1,875	24,934
Other Operating Expense	668	1,316	1,496	1,148	1,077	1,037	1,109	1,371	1,230	1,638	994	1,229	14,313
Management Shared Costs	48,326	48,402	47,387	40,945	39,569	45,251	55,809	53,406	53,691	63,695	58,232	353,421	908,134
Depreciation Expense	1,133	1,148	1,148	1,148	1,148	1,155	1,155	1,417	3,260	1,402	1,395	1,395	16,907
Operating Expenses	**178,038**	**160,781**	**156,760**	**173,683**	**173,896**	**168,209**	**165,749**	**188,877**	**178,164**	**198,122**	**180,670**	**527,031**	**2,449,982**
Operating Income (Loss)	**21,825**	**27,381**	**49,859**	**(14,427)**	**(23,729)**	**1,105**	**66,849**	**70,162**	**31,781**	**71,702**	**87,295**	**55,961**	**445,764**
Other Income (Expense)													

Interest/Other Income	(0)	22	15	-	-	-	-	-	-	-	0	-	38
Interest Expense	-	-	-	-	-	-	-	-	-	-	-	-	-
State Taxes	-	-	(32,150)	27,738	-	-	-	-	-	-	-	-	(4,412)
Other Expenses	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Income (Expense)	**(0)**	**22**	**(32,135)**	**27,738**	**-**	**-**	**-**	**-**	**-**	**-**	**0**	**-**	**(4,374)**
Net Income (Loss)	**21,825**	**27,403**	**17,724**	**13,311**	**(23,729)**	**1,105**	**66,849**	**70,162**	**31,781**	**71,702**	**87,295**	**55,961**	**441,389**

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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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

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.
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	Census	Estimate								
	2010	2015	2017	2018	2019	2020	2021	2022	2023	2024
State	6,724,540	7,061,410	7,310,300	7,426,346	7,535,510	7,638,415	7,736,240	7,827,874	7,916,032	8,001,476
Adams	18,728	19,410	19,870	20,143	20,397	20,633	20,874	21,078	21,276	21,472
Asotin	21,623	22,010	22,290	22,432	22,554	22,657	22,830	22,941	23,042	23,137
Benton	175,177	188,590	193,500	196,364	199,045	201,563	204,954	207,695	210,391	213,065
Chelan	72,453	75,030	76,830	77,579	78,256	78,868	79,742	80,424	81,078	81,712
Clallam	71,404	72,650	74,240	74,463	74,616	74,707	75,344	75,744	76,122	76,486
Clark	425,363	451,820	471,000	480,899	490,353	499,400	508,136	516,454	524,563	532,508
Columbia	4,078	4,090	4,100	4,088	4,072	4,052	4,040	4,022	4,003	3,982
Cowlitz	102,410	104,280	105,900	106,991	107,982	108,885	109,780	110,470	111,107	111,702
Douglas	38,431	39,990	41,420	42,279	43,100	43,883	44,500	45,109	45,693	46,258
Ferry	7,551	7,710	7,740	7,774	7,801	7,821	7,851	7,862	7,869	7,877
Franklin	78,163	87,150	90,330	93,541	96,667	99,712	102,684	105,422	108,176	110,959
Garfield	2,266	2,260	2,200	2,208	2,213	2,217	2,214	2,204	2,195	2,184
Grant	89,120	93,930	95,630	98,052	100,385	102,634	104,498	106,160	107,794	109,408
Grays Harbor	72,797	73,110	72,970	73,250	73,462	73,613	74,043	74,195	74,337	74,475
Island	78,506	80,600	82,790	83,283	83,698	84,044	84,910	85,544	86,147	86,728
Jefferson	29,872	30,880	31,360	31,818	32,246	32,646	33,015	33,318	33,616	33,912
King	1,931,249	2,052,800	2,153,700	2,181,564	2,207,401	2,231,408	2,257,650	2,283,693	2,308,542	2,332,421
Kitsap	251,133	258,200	264,300	268,411	272,274	275,910	279,250	282,166	284,969	287,685
Kittitas	40,915	42,670	44,730	45,514	46,255	46,958	47,568	48,198	48,798	49,372
Klickitat	20,318	21,000	21,660	21,682	21,684	21,667	21,737	21,785	21,824	21,855
Lewis	75,455	76,660	77,440	78,436	79,360	80,220	81,065	81,702	82,302	82,874
Lincoln	10,570	10,720	10,700	10,731	10,752	10,765	10,829	10,849	10,867	10,882
Mason	60,699	62,200	63,190	64,725	66,199	67,621	68,668	69,620	70,544	71,448
Okanogan	41,120	41,860	42,110	42,473	42,797	43,084	43,409	43,615	43,804	43,981
Pacific	20,920	21,210	21,250	21,289	21,308	21,311	21,423	21,456	21,483	21,508
Pend Oreille	13,001	13,240	13,370	13,565	13,746	13,919	14,035	14,133	14,219	14,298
Pierce	795,225	830,120	859,400	874,137	888,066	901,251	913,426	924,876	935,842	946,412
San Juan	15,769	16,180	16,510	16,602	16,680	16,743	16,965	17,113	17,257	17,401
Skagit	116,901	120,620	124,100	126,415	128,612	130,705	132,296	133,823	135,305	136,753
Skamania	11,066	11,430	11,690	11,815	11,928	12,034	12,169	12,276	12,377	12,476
Snohomish	713,335	757,600	789,400	807,659	825,176	841,998	853,365	865,573	877,286	888,574
Spokane	471,221	488,310	499,800	505,924	511,578	516,807	522,275	526,857	531,271	535,569
Stevens	43,531	44,030	44,510	44,990	45,429	45,830	46,238	46,537	46,816	47,082
Thurston	252,264	267,410	276,900	282,965	288,768	294,333	299,069	303,611	308,012	312,300
Wahkiakum	3,978	3,980	4,030	4,025	4,016	4,006	3,987	3,968	3,948	3,926
Walla Walla	58,781	60,650	61,400	61,673	61,888	62,049	62,567	62,866	63,149	63,422

	Census	Estimate								
	2010	**2015**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**
Whatcom	201,140	209,790	216,300	221,214	225,925	230,450	233,566	236,702	239,738	242,700
Whitman	44,776	47,250	48,640	48,846	49,005	49,124	49,394	49,604	49,792	49,964
Yakima	243,231	249,970	253,000	256,527	259,816	262,887	265,874	268,209	270,478	272,708

	Projection										
	2025	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**
State	8,085,043	8,169,048	8,252,948	8,336,721	8,420,220	8,503,178	8,584,146	8,664,048	8,742,996	8,819,675	8,894,306
Adams	21,666	21,909	22,132	22,360	22,594	22,832	23,151	23,431	23,707	23,977	24,241
Asotin	23,227	23,298	23,373	23,446	23,515	23,579	23,641	23,696	23,747	23,790	23,826
Benton	215,740	218,148	220,674	223,190	225,688	228,162	230,604	233,011	235,393	237,718	239,987
Chelan	82,335	82,950	83,563	84,170	84,770	85,359	85,920	86,467	87,004	87,519	88,014
Clallam	76,847	77,241	77,613	77,977	78,335	78,683	79,012	79,322	79,616	79,882	80,123
Clark	540,344	547,367	554,786	562,186	569,557	576,879	584,026	591,154	598,230	605,164	611,968
Columbia	3,962	3,956	3,946	3,933	3,924	3,913	3,910	3,902	3,894	3,885	3,875
Cowlitz	112,267	112,733	113,227	113,706	114,169	114,611	115,048	115,449	115,829	116,174	116,485
Douglas	46,807	47,305	47,825	48,341	48,854	49,362	49,853	50,339	50,826	51,305	51,779
Ferry	7,882	7,903	7,914	7,928	7,940	7,951	7,958	7,967	7,971	7,972	7,972
Franklin	113,781	116,309	119,029	121,792	124,599	127,443	130,586	133,654	136,772	139,914	143,087
Garfield	2,175	2,174	2,170	2,166	2,161	2,157	2,150	2,142	2,134	2,126	2,116
Grant	111,014	112,489	114,031	115,574	117,112	118,645	120,156	121,658	123,153	124,624	126,072
Grays Harbor	74,617	74,934	75,166	75,387	75,597	75,794	75,718	75,823	75,886	75,899	75,865
Island	87,297	87,805	88,330	88,848	89,355	89,848	90,344	90,812	91,271	91,710	92,133
Jefferson	34,211	34,652	35,036	35,432	35,837	36,253	36,779	37,252	37,718	38,169	38,609
King	2,355,571	2,379,739	2,403,467	2,427,224	2,450,969	2,474,625	2,498,788	2,522,135	2,545,225	2,567,674	2,589,545
Kitsap	290,344	293,057	295,737	298,380	300,981	303,528	305,470	307,573	309,620	311,567	313,420
Kittitas	49,927	50,427	50,949	51,469	51,985	52,493	52,999	53,493	53,982	54,456	54,918
Klickitat	21,882	21,972	22,031	22,087	22,140	22,189	22,182	22,183	22,179	22,166	22,145
Lewis	83,425	83,788	84,220	84,639	85,046	85,438	85,903	86,310	86,709	87,087	87,449
Lincoln	10,897	10,902	10,912	10,918	10,923	10,926	10,930	10,929	10,925	10,921	10,912
Mason	72,339	73,147	73,991	74,838	75,684	76,530	77,475	78,363	79,250	80,123	80,985
Okanogan	44,149	44,285	44,428	44,567	44,699	44,824	44,952	45,063	45,167	45,257	45,335
Pacific	21,532	21,568	21,595	21,621	21,647	21,670	21,700	21,719	21,737	21,749	21,758
Pend Oreille	14,369	14,379	14,412	14,443	14,469	14,493	14,544	14,577	14,608	14,634	14,656
Pierce	956,682	965,451	974,827	984,127	993,332	1,002,412	1,011,832	1,020,854	1,029,783	1,038,461	1,046,915
San Juan	17,545	17,672	17,806	17,938	18,067	18,193	18,324	18,449	18,568	18,682	18,789
Skagit	138,184	140,030	141,711	143,417	145,140	146,880	148,575	150,264	151,960	153,640	155,309
Skamania	12,573	12,659	12,749	12,837	12,923	13,007	13,091	13,171	13,249	13,323	13,393
Snohomish	899,527	910,862	922,096	933,363	944,644	955,910	966,947	977,898	988,759	999,377	1,009,774
Spokane	539,816	545,194	550,074	554,933	559,760	564,538	568,211	572,179	576,021	579,649	583,078
Stevens	47,337	47,558	47,788	48,012	48,230	48,441	48,640	48,828	49,018	49,204	49,388
Thurston	316,508	320,259	324,221	328,164	332,083	335,965	339,750	343,509	347,232	350,864	354,414
Wahkiakum	3,902	3,886	3,867	3,847	3,829	3,811	3,802	3,787	3,773	3,759	3,745
Walla Walla	63,695	63,978	64,249	64,517	64,787	65,052	65,416	65,716	66,008	66,282	66,541

	Projection										
	2025	**2026**	**2027**	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**
Whatcom	245,610	249,048	252,284	255,525	258,764	261,996	264,601	267,413	270,171	272,833	275,405
Whitman	50,125	50,380	50,592	50,802	51,011	51,219	51,428	51,617	51,799	51,966	52,118
Yakima	274,932	277,634	280,127	282,617	285,100	287,567	289,730	291,939	294,102	296,173	298,162

	2036	2037	2038	2039	2040
State	8,966,953	9,037,784	9,106,882	9,174,747	9,242,022
Adams	24,415	24,583	24,746	24,906	25,062
Asotin	23,857	23,883	23,902	23,917	23,928
Benton	242,174	244,315	246,410	248,474	250,524
Chelan	88,550	89,065	89,560	90,038	90,509
Clallam	80,322	80,499	80,656	80,797	80,928
Clark	618,455	624,839	631,126	637,349	643,552
Columbia	3,864	3,851	3,837	3,823	3,809
Cowlitz	116,779	117,042	117,276	117,487	117,682
Douglas	52,327	52,867	53,399	53,925	54,449
Ferry	7,966	7,959	7,948	7,937	7,925
Franklin	146,128	149,194	152,285	155,407	158,574
Garfield	2,105	2,094	2,083	2,071	2,059
Grant	127,488	128,886	130,264	131,631	132,995
Grays Harbor	75,846	75,806	75,747	75,673	75,589
Island	92,639	93,121	93,582	94,027	94,461
Jefferson	38,881	39,143	39,397	39,645	39,889
King	2,610,572	2,631,048	2,650,998	2,670,566	2,689,938
Kitsap	315,437	317,380	319,251	321,071	322,859
Kittitas	55,363	55,795	56,218	56,631	57,040
Klickitat	22,113	22,074	22,030	21,981	21,930
Lewis	87,834	88,198	88,538	88,863	89,178
Lincoln	10,904	10,893	10,881	10,865	10,848
Mason	81,807	82,615	83,410	84,194	84,976
Okanogan	45,414	45,480	45,535	45,581	45,621
Pacific	21,788	21,813	21,831	21,845	21,857
Pend Oreille	14,658	14,656	14,649	14,641	14,630
Pierce	1,055,163	1,063,185	1,070,990	1,078,637	1,086,201
San Juan	18,872	18,950	19,022	19,092	19,160
Skagit	157,231	159,132	161,013	162,886	164,760
Skamania	13,461	13,526	13,588	13,646	13,704
Snohomish	1,019,751	1,029,545	1,039,163	1,048,661	1,058,113
Spokane	586,444	589,667	592,754	595,738	598,663
Stevens	49,740	50,080	50,411	50,732	51,050
Thurston	357,785	361,088	364,327	367,522	370,699
Wahkiakum	3,740	3,734	3,725	3,717	3,709
Walla Walla	66,755	66,952	67,132	67,299	67,457

	2036	2037	2038	2039	2040
Whatcom	277,891	280,321	282,701	285,044	287,369
Whitman	52,266	52,400	52,520	52,630	52,734
Yakima	300,168	302,105	303,977	305,798	307,591

EXHIBIT 15

Policies Referenced in Application

PATIENT RIGHTS AND RESPONSIBILITIES 101

POLICY:

The patient has the right to be informed of his or her rights. Seasons Hospice is committed to protecting and promoting the exercise of these rights.

PROCEDURES:

1. Before services are provided, patients or their representative will be informed, both orally and in writing of the patient's rights and responsibilities related to the care or services provided. This information will be provided in a language and manner that the patient or their representative understands and will be repeated, as needed, during care by Seasons Hospice.

   NJ: A copy of the patient rights will be made available in any language which is spoken as the primary language by more than 10% of the population in Seasons Hospice's service area.

2. A signature of the patient or representative will be obtained to verify that they have received and understand this information. The patient has the right to have assistance in understanding and exercising his/her rights.

3. Seasons Hospice will educate all employees and volunteers during orientation and annually about patient rights and will ensure that all employees and volunteers respect these rights.

4. If the patient has been adjudged either incompetent or lacking decisional capacity under state law, the rights of the patient are exercised by a legal representative or the person appointed by the court to act on the patient's behalf.

5. Seasons Hospice will not request nor obtain from the patient any waiver of any of the patient's rights.

6. A list of the patients' rights and responsibilities can be found in the "Patient/Family Consent and Education for Hospice Care" Booklet. The list of rights and responsibilities will be redistributed to patients or their representative following any revisions or modifications.

   AZ: A complete statement of the patient's rights and responsibilities will be conspicuously posted in the hospice's office.

   NJ: A complete statement of the patients' rights, including the right to file a complaint with the NJ State Department of Health and Senior Services, shall be conspicuously posted in the hospice office and shall be distributed to all staff and contracted personnel.

PATIENT RIGHTS AND RESPONSIBILITIES 101

7. NJ: Seasons Hospice will ensure that all verified violations of patients' rights involving anyone furnishing services on behalf of Seasons Hospice are reported to the State and local authorities having jurisdiction within (5) working days of becoming aware of the violation.

Effective: 2/18/1997

Revised:	1/10/99	3/23/00	11/27/01	9/14/07	12/2/08	2/20/10	8/5/11	11/17/12	4/7/14
Revised:	9/20/17								
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	10/17/06
Reviewed:	10/26/07	12/19/08	7/9/09	12/13/10	8/26/11	9/28/12	2/1/13	1/24/14	1/23/15
Reviewed:	1/29/16	1/27/17	1/26/18	1/25/19	1/24/20				

SECTION III. Patient/Family Rights and Responsibilities

As a hospice provider, we have an obligation to protect your rights and to provide these rights to you or your representative verbally and in writing in a language and manner you can understand, during the initial assessment visit before care is provided and on an ongoing basis, as needed.

YOUR RIGHTS

RESPECT AND CONSIDERATION - YOU HAVE THE RIGHT TO:

- Exercise your rights as a hospice patient without discrimination or reprisal for doing so. Your court-appointed representative or the legal representative you have selected in accordance with state law, may exercise these rights for you in the event that you are not competent or able to exercise them for yourself.
- Have a relationship with our staff that is based on honesty and ethical standards of conduct. To have ethical issues addressed, and inform you of any financial benefit we receive if we refer you to another organization, service, individual or other reciprocal relationship.
- Be free from mistreatment, neglect, verbal, mental, sexual and physical abuse, injuries of unknown source and misappropriation of your property. All mistreatment, abuse, neglect, injury and exploitation complaints by anyone furnishing service on behalf of hospice are reported immediately by our staff to the hospice administrator. All reports will be promptly investigated and immediate action taken to prevent potential violations during our investigation. Hospice will take appropriate corrective action in accordance with state law. All verified violations will be reported to the appropriate state and local authorities, including to the state survey and certification agency, within five (5) working days of becoming aware of the violation.
- Be free from physical and mental abuse, corporal punishment, restraint or seclusion of any form imposed as a means of coercion, discipline, convenience or retaliation by staff while receiving hospice care.
- Be treated with respect and personal dignity and to have individual cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. You will not be discriminated against based on social status, marital status, political belief, sexual preference, race, color, religion, national origin, diagnosis, disease, age, sex, physical/mental disabilities, ability to pay or source of payment. If you feel that you have been the victim of discrimination, you have the right to file a grievance without retaliation for doing so. Our staff is prohibited from accepting gifts or borrowing from you.

- Have an environment that preserves dignity and contributes to a positive self-image.
- Receive information in plain language to ensure accurate communication, in a manner that is accessible, timely and free of charge to:
  - Persons with disabilities. This includes access to websites, auxiliary aids and services in accordance with state and federal law and regulations.
  - Persons with limited English proficiency. This includes access to interpreters and written translation.

FILING A GRIEVANCE - YOU HAVE THE RIGHT TO:

- Receive information on our complaint resolution process, and know about the results of complaint investigations. We must document both the existence and the resolution of the complaint.
- Voice grievances/complaints or recommend changes in policy, staff or service/care regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice without fear of coercion, discrimination, restraint, interference, reprisal or an unreasonable interruption in care, treatment or services for doing so.
- Be advised when you are accepted for treatment or care, of the availability of the state's toll-free home care/hospice hotline number, its purpose and hours of operation. The hotline receives complaints or questions about local home care/hospice agencies and is also used to lodge complaints concerning the implementation of the advance directives requirements. You also have the right to be advised of the address to submit written complaints or questions.
- Be informed how to contact The Joint Commission to ask questions, report grievances or voice complaints.

Our complaint resolution process, the state hotline number and contact information for The Joint Commission are provided in "How to Comment on Your Care."

DECISION MAKING - YOU HAVE THE RIGHT TO:

- Choose your attending physician and other health care providers and communicate with those providers.
- Be informed in advance about the services covered under the hospice benefit, the scope of services hospice will provide, service limitations, care alternatives available from the hospice, name(s) and responsibilities of staff members who are providing and responsible for your care, treatment or services, the planned frequency of visits proposed to be furnished, expected and unexpected outcomes, potential risks or problems, barriers to treatment and payment resources.
- Be advised of any change in your plan of care before the change is made.
- Be involved in developing your hospice plan of care; and to participate in changing the plan whenever possible and to the extent that you are competent to do so.

- Have family involved in decision making as appropriate, concerning your care, treatment and services, when approved by you or your representative, if any, and when allowed by law.
- Participate or refuse to participate in research, investigational or experimental studies or clinical trials. Your access to care, treatment and services will not be affected if you refuse or discontinue participation in research.
- Formulate advance directives; to receive written information about the agency's policies and procedures on advance directives, including a description of applicable state law. You will be informed if we cannot implement an advance directive on the basis of conscience.
- Address your wishes concerning end of life decisions and to have health care providers comply with your advance directives in accordance with state laws; and to receive care without condition or discrimination based on the execution of advance directives.
- Accept, refuse or discontinue care, treatment and services without fear of reprisal or discrimination. You may refuse part or all of care/services to the extent permitted by law; however, should you refuse to comply with the plan of care and your refusal threatens to compromise our commitment to quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care.

PRIVACY AND SECURITY - YOU HAVE THE RIGHT TO:

- Personal privacy and security during home care visits and to have your property and person treated with respect.
- Restrict visitors or have unlimited contact with visitors and others and to communicate privately with these persons if you are residing in an inpatient hospice facility.
- Confidentiality of written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home.
- Refuse filming or recording or revoke consent for filming or recording of care, treatment and services for purposes other than identification, diagnosis or treatment.
- Access, request changes to and receive an accounting of disclosures regarding your own health information as permitted by law.
- Request us to release information written about you only as required by law or with your written authorization and to be advised of our policies and procedures regarding accessing and/or disclosure of clinical records. Our Notice of Privacy Practices describes your rights in detail.

FINANCIAL INFORMATION - YOU HAVE THE RIGHT TO:

- Before care is initiated, to be advised orally and in writing of the extent to which payment may be expected from Medicare, Medicaid, any other federally funded or aided program, or any other sources known to us; charges for services that will not be covered by Medicare; and the charges that you may have to pay.
- Be advised of any changes in payment, charges and patient payment liability when they occur. We will advise you of these changes orally and in writing as soon as possible, but no later than 30 calendar days from the date that we become aware of a change.
- Have access to all bills upon request for services you have received regardless of whether the bills are paid by you or another party.

QUALITY OF CARE - YOU HAVE THE RIGHT TO:

- Receive care of the highest quality.
- Receive effective pain management and symptom control from the hospice for conditions related to your terminal illness. You also have the right to receive education about your role and your family's role in managing pain when appropriate, as well as potential limitations and side effects of pain treatments.
- Receive pastoral and other spiritual services for you and your family.
- Be admitted only if we can provide the care you need. A qualified staff member will assess your needs. If you require care or services that we do not have the resources to provide, we will inform you, and refer you to alternative services, if available; or admit you, but only after explaining our limitations and the lack of a suitable alternative.
- Be informed of the hospice agency's discharge policy and to be involved in discharge planning, if appropriate.
- Be informed of short term inpatient care options available for pain control, management and respite.
- Receive emergency instructions and be told what to do in case of an emergency.

Will add the following rights:

Be cared for by appropriately trained or credentialed personnel, contractors and volunteers with coordination of services.

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.

Be informed of the hospice's policies and procedures for providing back-up care when services cannot be provided as scheduled.

YOUR RESPONSIBILITIES

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information to the best of your knowledge about your present complaints and past illness(es), hospitalizations, pain, medications, allergies and other matters relating to your health;
- Remain under a doctor's care while receiving hospice services.
- Notify us of perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status or change of physician).
- Follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment or service plan.
- Ask questions when you do not understand about your care, treatment and service or other instruction about what you are expected to do. If you have concerns about your care or cannot comply with the plan, let us know.
- Report and discuss pain, pain relief options and your questions, worries and concerns about pain medication with staff or appropriate medical personnel.
- Notify us if your visit schedule needs to be changed due to medical appointment, family emergencies, etc.
- Notify us if your Medicare or other insurance coverage changes or if you decide to enroll in a Medicare or private HMO (Health Maintenance Organization).
- Promptly meet your financial obligations and responsibilities agreed upon with the agency.
- Follow the organization's rules and regulations.
- Inform us of the existence of, and any changes made to advance directives.
- Advise us of any problems or dissatisfaction with the services provided;
- Provide a safe and cooperative environment for care to be provided (such as keeping pets confined, putting away weapons or not smoking during your care).
- Show respect and consideration for agency staff and equipment.
- Carry out your mutually agreed responsibilities.

NON-DISCRIMINATION & GRIEVANCE PROCEDURE 105

POLICY:

Seasons Hospice & Palliative Care complies with applicable federal civil rights laws and does not discriminate, exclude, or treat people differently on the basis of social status, marital status, political belief, sexual orientation, gender identity, gender expression, race, color, religion, national origin, diagnosis, disease, age, sex, physical/mental disabilities, citizenship, veteran status, ability to pay or source of payment with regard to admission or access to treatment whether carried out by Seasons Hospice directly or through a contractor or any other entity with which Seasons Hospice arranges to carry out its program and activities.*

PROCEDURES:

1. This policy is disseminated to staff, volunteers, patients, families, referral sources and other interested parties via the following methods:

    a. A copy of the policy is available to employees and volunteers in each office and on the Seasons Hospice intranet. It is also available to all others that request it.

    b. All employees and volunteers will be instructed about Seasons Hospice's non-discrimination policy during orientation and throughout employment as needed.

    c. Information provided to the public will reflect Seasons Hospice's policy on non-discrimination and will include the phone number and website for Seasons Hospice.

    d. Published advertisements will reflect Seasons Hospice's policy on non-discrimination and will include informing the public of Seasons Hospice's phone number and website.

    AZ: A complete statement of the non-discrimination policy shall be conspicuously posted in the hospice office.

2. All persons and organizations contracted to provide services on behalf of Seasons Hospice shall do so without regard to social status, marital status, political belief, sexual preference, race, color, religion, national origin, diagnosis, disease, age, sex, physical/mental disabilities, ability to pay or source of payment regarding admission, access to treatment or employment.

3. All persons and organizations having occasion either to refer persons for services or to recommend Seasons Hospice will be advised to do so without regard to the person's social status, marital status, political belief, sexual preference, race, color, religion, national origin, diagnosis, disease, age, sex, physical/mental disabilities, ability to pay or source of payment regarding admission, access to treatment or employment.

NON-DISCRIMINATION & GRIEVANCE PROCEDURE 105

4. Any person who believes that Seasons Hospice has failed to provide these services or discriminated in any other way may file a grievance in person or by mail, fax or email to the Civil Rights/Section 1557 Coordinator listed below.

    a. Grievances must be submitted to Seasons Hospice & Palliative Care within (60) days of the date the person became aware of the possible discriminatory action and must state the problem and relief sought.

    b. A complaint must be in writing and contain 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.

    c. The Seasons Hospice's Civil Rights/Section 1557 Coordinator (or his/her designee) shall conduct a thorough investigation of the complaint, affording all interested persons an opportunity to submit evidence relevant to the complaint.

    d. The Civil Rights/Section 1557 Coordinator will maintain the files and records for Seasons Hospice relating to such grievance and will, to the extent possible and according to applicable law, take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

    e. The Civil Rights/Section 1557 Coordinator will issue a written decision on the grievance based on a preponderance of evidence no later than (30) days after its filing, including a notice of the right to pursue further administrative or legal action.

    f. An appeal of the decision may be filed in writing to the Executive Director within (15) days of the decision. The Executive Director will issue a written response within (30) days after the appeal is filed.

5. The availability and use of this grievance procedure does not prevent anyone from pursuing other legal or administrative remedies.

6. Civil rights complaints may also be filed with the U.S. Department of Health and Human Services, Office for Civil Rights within (180) days of the date of the alleged discrimination by any of the following methods:

    a. Submit electronically through the Office for Civil Rights Complaint Portal.

    b. Write to the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington D.C. 20201. Click here for a complaint form.

    c. Call 1-800-368-1019 (toll free) or 1-800-537-7697 (TDD).

NON-DISCRIMINATION & GRIEVANCE PROCEDURE 105

7. Seasons Hospice will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services if need to participate in this grievance process. The Civil Rights/Section 1557 Coordinator will be responsible for such arrangements.

8. Seasons Hospice will not retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

9. Seasons Hospice does not discriminate in matters of employment. For more information, see Policy 821 Anti-Harassment/Anti-Discrimination.

Civil Rights/Section 1557 Coordinator for Seasons Hospice & Palliative Care:

Donna Hyatt, RN
6400 Shafer Court, Suite 700
Rosemont, Illinois 60018
Phone: (847) 692-1000
Fax: (847) 692-1001
DHyatt@seasons.org

*This policy is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to theses statutes at Title 45 Code of Federal Regulations Parts 80, 84, 91 and 92.

Effective: 2/18/1997

Revised:	8/26/11	11/17/12	6/4/15	2/8/16	10/17/16	9/20/17	4/18/18		
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	10/17/06
Reviewed:	10/26/07	12/19/08	7/9/09	12/13/10	8/26/11	9/28/12	2/1/13	1/24/14	1/23/15
Reviewed:	1/29/16	1/27/17	1/26/18	1/25/19	1/24/20				

CONTRACTED SERVICES 202

POLICY:

Seasons Hospice will retain professional, financial and administrative responsibility for contracted services and will require that they be provided in a safe and effective manner by qualified personnel and in accordance with the written plan of care in order to ensure excellence in care for all Seasons Hospice's patients.

PROCEDURES:

1. Seasons Hospice will ensure that substantially all core services are routinely provided directly by Seasons Hospice employees. Contracted staff may be used if necessary to supplement its employees to meet the needs of patients during periods of peak patient loads or under extraordinary circumstance (e.g., a rapid increase in census, staffing shortages due to illness, an acute local nursing shortage or the temporary travel of a patient outside of the service area). All efforts to avoid such contingencies will be documented.

   CO: When hospice services are provided in a Long-Term Care Facility, Assisted Living Residence, or Intermediate Care Facility for Persons with Developmental Disabilities, there shall be a written agreement that specifies the provision of hospice services in that facility.

   MA: For any services provided under contract agreement, each patient/family shall be provided, upon request, with written information that clearly defines the services provided under contract and identifies the contracted individual(s) or organizations(s).

   NJ: Nursing services provided under contract shall be rendered only if 1) all available full and part-time employees have achieved maximum caseloads, or specialized care which is unavailable through existing staff is needed; 2) contracted nursing personnel are oriented to the policies and procedures of the hospice and receive supervision from supervisory staff employed by the hospice; and, 3) provisions are made for continuity of patient care by the same contracted nursing personnel whenever possible.

2. If contracted services are utilized, the contractor shall meet all applicable provisions of hospice regulations.

3. Seasons Hospice will provide orientation to hospice care for employees of contracting agencies.

4. Backup services will be provided by regular employees or resource employees when an agency employee or contractor is not able to provide the services.

5. Seasons Hospice will ensure the continuity of patient/family care between the home, outpatient and inpatient settings from admission to discharge.

CONTRACTED SERVICES 202

6. Seasons Hospice will enter into legally binding written agreements with the providers of contracted services which may include, as appropriate, the following:
   - Identification and availability of the services to be provided;
   - An expectation for documentation regarding the services that are provided;
     - NJ: the documentation must be provided within (7) working days
   - A stipulation that services may be provided only with the authorization of Seasons Hospice, in accordance with the physicians' orders and as directed by the hospice plan of care;
   - Specification that Seasons Hospice retains administrative responsibility for the services rendered, including subcontracted services;
   - The way the contracted services are coordinated, supervised and evaluated by Seasons Hospice;
   - A stipulation that the outside agency will complete criminal background checks on contracted employees who provide direct patient care or who have access to patient records;
   - The delineation of the role(s) of Seasons 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;
   - Requirements for documenting that services are furnished in accordance with the agreement;
   - The qualifications of the personnel providing the services including verification of licensure, certification or registration when applicable;
   - The financial arrangements and charges, including donated services;
   - The period of time the contract is to be in effect;
   - The party responsible for implementation of the provisions 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.

AZ: The Chief Administrative Officer (Executive Director) will approve each contract with an agency or individual to provide a hospice service.

CO: Contracted services shall be supported by written agreements that require all services be:
- Authorized by Seasons Hospice;
- Furnished in a safe and effective manner by qualified personnel;
- Delivered in accordance with the patient's plan of care; and,
- Evaluated as part of the quality management program.

CT: A written contract with a contractor agency or individuals shall clearly specify the following:
- That the patient's contract for care is with Seasons Hospice;
- The services to be provided by the contractor;
- The necessity to conform to all applicable primary hospice policies, including personnel qualifications, supervisory ratios and staffing patterns;
- The responsibility for participating in developing the patient care plans;
- The procedures for submitting clinical and progress notes, scheduling visits, periodic patient evaluation, and determining charges and reimbursement;
- The procedure for annual assurance of clinical competence of all personnel utilized under contract; and,
- The contract will be renewable on an annual basis.

CONTRACTED SERVICES 202

FL: A contract for hospice services, including inpatient services, will also include:

- A requirement that the direct patient care shall be maintained, supervised and coordinated by the hospice core team;
- Identification of methods for ensuring continuity of hospice care; and
- A plan for joint quality assurance.

MA: Seasons Hospice will offer contracted providers/vendors the opportunity to participate in the Quality Assessment/Performance Improvement program.

MI: All contracts will be signed and dated by the Administrator (Executive Director) and the duly authorized official of the agency providing the contracted services.

7. Seasons Hospice will maintain financial responsibility for payment of all services related to the terminal illness.

8. Employees of an agency providing a contractual service shall not seek or accept reimbursement in addition to that due the agency for the actual service delivered.

9. All contracts shall prohibit the sharing of fees between a referring agency or an individual and the hospice.

10. Seasons Hospice shall not charge fees for services normally provided directly by the hospice care team but currently being provided by contractual services.

11. Seasons Hospice will review and/or revise all standing 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 Seasons Hospice expects.

12. For Joint Commission accredited sites, services provided by consultation, contractual arrangements, or other agreements will meet applicable Joint Commission standards.

Effective: 2/18/1997

Revised:	4/6/99	11/19/01	12/14/04	6/21/05	12/27/06	9/14/07	9/15/08	11/13/08	3/12/11
Revised:	8/5/11	11/18/12	6/1/13	4/8/14	10/27/14	8/24/15	7/5/16	9/4/19	
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06
Reviewed:	4/18/07	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15
Reviewed:	2/19/16	2/24/17	2/23/18	2/22/19	2/21/20				

AVAILABILITY OF SERVICES 204

POLICY:

All covered services are available 24-hours a day, seven days a week including during the bereavement period to the extent necessary for the palliation and management of the terminal illness and related conditions.

PROCEDURES:

1. Staffing schedules will be implemented to facilitate continuity of care to patients, whenever possible.

2. The Seasons Hospice cALL Center will answer phone calls during non-business hours and during times of emergency (e.g. power outages, severe weather conditions, etc.).

   GA: Seasons Hospice shall maintain an on-call log for all calls received after normal business hours, the records of which shall be kept for a period of two years.

3. A registered nurse will be available twenty-four (24) hours per day, seven (7) days per week to meet the needs of our patients and families.

   MO: When clinically indicated, emergent visits will be made within one (1) hour from the time the need is identified. Unscheduled non-emergent nursing visits, when indicated, will normally occur within three (3) hours from the time the need is identified or as agreed upon by the hospice and the patient.

   GA: On-site nursing services shall be made available within one hour of notification when the patient experiences a symptom management crisis situation.

4. A physician will be available twenty-four (24) hours per day, seven (7) days per week to meet the needs of our patients and families.

5. Seasons will utilize supplemental employees or resource employees to provide backup services when an agency employee or contractor is not available to provide services.

6. Seasons Hospice will make provisions for staff with equivalent qualifications to provide services in place of absent staff members.

7. Seasons Hospice will enter into contracts with at least one durable medical equipment company and at least one pharmacy that will assure the twenty-four (24) hour a day, seven (7) days a week availability of equipment and medications necessary to meet the needs of our patients and families.

AVAILABILITY OF SERVICES 204

8. All other services, including social services, counseling, volunteer care, bereavement support, pharmacy consultation and coordination of short-term inpatient care, will be available on a 24-hour basis to the extent necessary to meet the needs of the patients and/or families for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions.

9. At the time of admission, and thereafter as needed, the patient, family and/or caregiver will be informed about how to notify Seasons Hospice twenty-four (24) hours a day, seven (7) days a week if there is a need.

10. Seasons Hospice staff are kept updated on the status of their patients during non-business hours via voicemail, e-mail, and/or phone contact.

11. TX: Seasons Hospice's operating hours are from 8:30 a.m. to 5 p.m. Monday through Friday except on holidays. When the hospice is closed between the hours of 8:30 a.m. and 5 p.m., Monday through Friday, the administrator, the director of clinical operations, or their designee will:

    a) Post a notice in a visible location outside of the hospice that will provide information regarding how to contact the person in charge; and,
    b) Transfer the phones to the triage service so that the caller will be able to obtain information regarding how to contact the person in charge.

Effective: 2/18/1997

Revised:	12/18/01	12/14/04	12/27/06	9/14/07	3/12/11	5/11/11	9/17/11	11/18/12	4/8/14	7/5/16
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18	2/22/19	2/21/20							

INTERDISCIPLINARY GROUP* 205

POLICY:

Seasons Hospice will designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the hospice patients and families facing terminal illness and bereavement.

*IDG (Interdisciplinary Group) and IDT (Interdisciplinary Team) are used interchangeably at Seasons Hospice and have the same meaning.

PROCEDURES:

1. In addition to the patient and family, the IDG 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; and,
   - A pastoral and/or other counselor, for example, a nationally board-certified music therapist;
   - 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. The IDG shall make use of consultants and community resources as necessary and appropriate.

CA: The interdisciplinary care team includes, but is not limited to, the patient and patient's family, a physician, a registered nurse, a social worker, a volunteer (which may be represented by the volunteer coordinator/director) and a spiritual caregiver.

CT: The hospice interdisciplinary team shall be composed of individuals who have clinical experience and education appropriate to the needs of the terminally ill and their families. The team shall include the medical director or physician designee, a registered nurse, a consulting pharmacist, and one or more of the following based on the needs of the patient: a social worker, a spiritual, bereavement or other counselor, the volunteer coordinator, and a volunteer with a role in the patient's plan of care, who work together to meet the physiological, psychological, social and spiritual needs of patients and their families.

GA: Hospice care team means an interdisciplinary working unit including, but not limited to, a physician, a registered professional nurse, a social worker, a member of the clergy or other counselors and volunteers who provide hospice care.

IL: Seasons Hospice will have an interdisciplinary working unit called the hospice care team which will be made up of, at a minimum, a physician, a nurse, a social worker, a counselor and trained volunteers (which may be represented by the volunteer manager). The patient, patient's physician and patient's family are considered members of the hospice care team when development or revision of the patient's plan of care takes place.

INTERDISCIPLINARY GROUP 205

IN: The physician (the patient's attending physician and the hospice physician), a registered nurse, a social worker, a clergy member, the coordinator of volunteers and appropriate volunteers make up the interdisciplinary care team. Dietary counseling, hospice aide services and other services may be included in the team when appropriate.

MA: A bereavement coordinator and a volunteer (who may be represented by the coordinator / manager of volunteer services) is also considered part of the interdisciplinary team.

MD: Each interdisciplinary care team consists of at least the patient' attending physician, a physician with training in palliative care, a registered nurse with demonstrated experience in pain and symptom management and the performance of physical assessments, a master's degree-prepared social worker with clinical experience in counseling and casework for the terminally ill, a volunteer(s) supervised by an individual with management experience in a hospice care program (which may be represented by the volunteer director) and a spiritual care counselor with education and experience in pastoral counseling.

MO: The IDG will include at least the following who are employees of the hospice: a doctor of medicine or osteopathy (may be contracted), a registered nurse, a social worker, and a spiritual counselor. The IDG will meet no less often than every two (2) weeks.

NV: The IDG means a group of persons who work collectively to meet the special needs of terminally ill patients and their families and include such persons as the physician, a registered nurse, a social worker, a member of the clergy, and trained volunteers.

OR: The Interdisciplinary team consists of individuals working together in a coordinated manner to provide hospice care and includes, but is not limited to, the patient-family unit, the patient's attending physician and the four core team members required by Medicare: hospice physician, registered nurse, social worker and a pastoral or other counselor.

2. The interdisciplinary group(s) are responsible for:

- Participating in the establishment of the plan of care for each patient and family in consultation with the attending physician (if any);
- Providing or supervising the hospice care and services in accordance with accepted standards of care and the plan of care;
- Reviewing and updating the plan of care for each patient receiving hospice care;
- Encouraging active involvement of the patient/family in the development and implementation of the plan of care;
- Monitoring continuity of care across all settings;

INTERDISCIPLINARY GROUP 205

- Establishing, reviewing and implementing the policies governing the day-to-day provision and evaluation of hospice care and services (for sites with more than one team, the site must designate in advance the group it chooses to fulfill this responsibility); and,
- Actively participating in the Quality Assessment Performance Improvement Program.

3. Seasons Hospice will designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.

Effective: 10/2004

Revised:	3/9/06	6/2/06	12/27/06	9/14/07	9/15/08	11/13/08	12/2/08	5/11/11	11/18/12	6/1/13
Revised:	10/27/14	8/24/15	12/14/17							
Reviewed:	6/3/05	11/8/06	4/18/07	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14
Reviewed:	2/20/15	2/19/16	2/24/17	2/23/18	2/22/19	2/21/20				

STANDARDS OF PRACTICE 206

POLICY:

Seasons Hospice is committed to providing care and services in compliance with acceptable professional standards as well as all state and federal laws and regulations.

PROCEDURES:

1. Seasons Hospice shall employ an adequate amount of staff and volunteers to meet the needs of patients and families accepted for care. Services provided to specialized populations (e.g., pediatric patients) will be provided by staff that have been educated and demonstrate competence in the care of the specialized patients.

2. Seasons Hospice will regard the patient and family together as one unit of care. Family will be defined by the patient and may include the patient's offspring, parents, siblings, spouse, significant other, friends, relatives, and/or others.

   CT: Family means a group of two (2) or more individuals related by blood, legal status or affection who consider themselves a family.

   OR: Patient-family unit includes an individual who has a life-threatening disease with a limited prognosis and all others sharing housing, common ancestry or a common personal commitment with the individual.

3. Seasons Hospice will provide services to the patient, family, and/or caregiver based on identified care, treatment, and service needs of the patients, families and/or caregivers.

   CT: A primary caregiver is a person who provides care for the patient and who, if not residing with the patient, is readily available to assure the patient's safety.

4. Seasons Hospice will provide services that are reasonable and necessary for the palliation or management of the terminal illness as well as related conditions. Services will be consistent with an individualized plan of care that is established for each patient and family.

5. Seasons Hospice will provide continuity of care by the same health care practitioner whenever possible.

6. Services provided to the terminally ill patient will be furnished, to the maximum extent possible, in the patient's place of residence which may include, but is not limited to, a private home, nursing home, assisted living facility, adult family-care home, group home, residential health care facility, comprehensive personal care home, a general or specialized hospital, or a specialized residence that provides supportive services.

STANDARDS OF PRACTICE 206

7. Seasons Hospice will provide routine visits during normal waking hours except when requested by the patient and/or family to come at another specific time.

   TX-Houston: The ALF Administrator, or designee, and /or the responsible person for the patient, will be notified of the visit schedule for routine visits, for changes in the schedule and when an on-call visit is going to be made. The nurse will notify the patient's physician and the supervising nurse of the hospice of any incidents or occurrences during visits.

8. 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 home.

9. Seasons Hospice will foster independence of the patient and family by providing training, encouragement and support to empower self-sufficiency and allow the patient to remain comfortably at home for as long as possible.

10. Seasons Hospice will not discontinue or diminish care, treatment or services because of the patient's inability to pay for that care.

11. Seasons Hospice employees will practice in accordance with applicable professional standards of practice. Seasons Hospice's nurses will refer to "Lippincott Procedures" located on the intranet for guidance on nursing procedures. Physician orders will be obtained for nursing procedures not included in the "Lippincott Procedures".

12. Seasons Hospice will maintain a program of continuing training directed at maintenance of appropriate skill levels for all hospice employees providing services to patients and their families.

13. All employees will receive education regarding laws and regulations governing hospice care.

14. Care will be provided in a coordinated, effective, appropriate, cost-conscious and safe manner in accordance with Seasons Hospice goals, objectives, and philosophy.

15. Seasons Hospice shall not impose or dictate any value or belief system on its patients and /or their families and shall respect the values and belief systems of its patients and families.

16. All Seasons Hospice physicians and nurses will be licensed in the state in which they provide hospice care.

17. Seasons Hospice will coordinate its services with professional and non-professional services already in the community.

Effective: 2/18/1997

Revised:	9/2001	1/8/02	12/27/06	9/14/07	11/13/08	3/12/11	6/1/13	4/8/14	10/27/14	8/24/15
Revised:	10/20/17	11/7/17	12/14/17							
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18	2/22/19	2/21/20							

ADMISSION CRITERIA 208

POLICY:

Patients will be accepted for care and treatment based on reasonable criteria and under the expectation that the physical, emotional, social and spiritual needs of patients and families can be met adequately by Seasons Hospice, primarily in the patient's place of residence.

PROCEDURES:

1. The patient must have a terminal illness which is expected to result in a prognosis of (6) months or less if the disease runs its normal course as certified by the medical director of the hospice or the physician member of the hospice interdisciplinary group and the individual's attending physician if the individual has an attending physician. This decision will be based on prognostic indicators (Local Coverage Determinations) and information from the patient, family, attending physician and any available past medical records.

2. Seasons Hospice admits patients only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any). Patients not accepted under care will be referred to an alternate health care provider.

3. The patient/legal representative must make an informed decision to forego curative treatment for the terminal illness in preference for palliative treatment/services.

4. For Medicare or Medicaid beneficiaries, the patient/legal representative must make an informed decision to forfeit all treatment for the terminal illness under the Medicare Part A or Medicaid plan and to elect the Medicare or Medicaid Hospice Benefit.

5. A Do Not Resuscitate (DNR) order and Advanced Directives are not required for admission to Seasons Hospice.

6. As a recipient of Federal financial assistance, Seasons Hospice does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, creed, religion, gender, national origin, ancestry, disability, handicap, diagnosis, sexual orientation, age, marital status, pregnancy, childbirth, ability to pay, cost of therapy, life circumstances, the presence of a contagious disease or DNR status in admission to, participation in, or receipt of the services and benefits under any of its programs and activities.

7. At the time of admission to Seasons Hospice and thereafter, a patient/family must be under the care of a physician who shall be responsible for medical care.

   CT: Seasons Hospice shall accept a plan of treatment from a chiropractor or podiatrist for services within the scope of their practices.

ADMISSION CRITERIA 208

8. Seasons Hospice does not require that the patient have a primary caregiver. If there is no primary caregiver, the hospice team will start discussions upon admission with the patient to make plans for their care when they are no longer able to make decisions for themselves. Refer to protocol 2077 "Hospice Patients Without a Known Primary Caregiver".

   DE: 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 care giver.

   GA: Seasons Hospice shall only admit patients that have an identified primary caregiver. In the absence of a primary caregiver, Seasons Hospice shall develop a detailed plan for meeting the daily care and safety needs of the patient.

9. Physical facilities must be adequate for proper care and a safe environment for patient and hospice staff.

10. The patient must live in the geographic areas served by Seasons Hospice:

    AZ: Maricopa and Pinal Counties
    CT: All counties in the state of Connecticut
    CA: Per the requirements of the local DHS office
    CO: Boulder, Broomfield and Denver cities; and Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Gilpin, Jefferson, Park, and Weld Counties
    DE: Kent, Newcastle, and Sussex Counties
    FL (Broward): Broward County
    FL (Hillsborough): Hillsborough County
    FL (Miami): Dade and Monroe Counties
    FL (Pinellas): Pinellas County
    GA: Barrow, Carroll, Cherokee, Clayton, Cobb, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Hall, Henry, Gwinnett, Paulding, and Rockdale Counties
    IL: Boone, Cook, De Kalb, Du Page, Grundy, Kane, Kankakee, Kendall, Lake, LaSalle, McHenry, Ogle, and Will Counties
    IN: All Counties in the state of Indiana
    MA: All Counties in the state of Massachusetts
    MI: Genesee, Hillside, Ingham, Jackson, Lapeer, Lenawee, Livingston, Macomb, Mason, Monroe, Oakland, Shiawassee, St. Clair, Wayne, and Washtenaw Counties
    MD: Baltimore City; and Anne Arundel, Baltimore, Carroll, Cecil, Harford, Howard, Montgomery, and Prince George Counties
    MO: St. Louis City, and Franklin, Jefferson, St. Charles, and St. Louis Counties
    NV: Clark County
    NJ: Burlington, Camden, Mercer, Middlesex, Monmouth, and Ocean Counties
    OR: Clackamas, Multnomah, and Washington Counties
    PA: Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, Philadelphia, and York Counties

ADMISSION CRITERIA 208

TX (Dallas/Fort Worth): Collin, Cooke, Dallas, Denton, Ellis, Fannin, Grayson, Hood, Hunt, Jack, Johnson, Kaufman, Montague, Palo Pinto, Parker, Rains, Rockwall, Somervell, Tarrant, Van Zendt, and Wise Counties

TX (Houston): Austin, Brazoria, Brazos, Burleson, Chambers, Fort Bend, Galveston, Grimes, Harris, Liberty, Madison, Montgomery, Polk, San Jacinto, Walker, Waller, and Washington Counties

TX (San Antonio): Atascosa, Bandera, Bexar, Blanco, Caldwell, Comal, Gonzales, Guadalupe, Hays, Kendall, Kerr, Medina, and Wilson Counties

WA: Snohomish, Pierce, King, and Thurston Counties

WI: Dodge, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha Counties

11. Seasons Hospice periodically reviews admission criteria for access to hospice care.

12. FL & GA: Hospice care will be provided regardless of the patient or the family unit's ability to pay.

Effective: 2/18/1997

Revised:	12/15/99	8/8/00	3/7/05	7/5/05	1/23/06	12/27/06	9/14/07	9/15/08	11/13/08	3/12/11
Revised:	8/5/11	9/17/11	7/30/12	11/18/12	6/1/13	9/9/13	4/8/14	10/27/14	8/24/15	311/16
Revised:	12/14/17	2/20/19	12/18/20							
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18									

ADMISSION PROCESS 209

POLICY:

All inquiries to Seasons Hospice will have immediate follow-up and admission to hospice within 24 hours of the inquiry unless the patient, family, referral source or physician requests a later admission date.

PROCEDURES:

1. A referral may be made by the patient themselves or by someone on their behalf, such as a family member, friend, physician, nurse practitioner, nursing home, group home, hospital, nurse, social worker, or clergy, by calling the hospice office. The referral "Intake" may be taken by any one of the trained hospice staff that is available 24-hours a day, 7-days a week.

2. Seasons Hospice will not knowingly offer to pay or agree to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind, to or from, another for securing or soliciting a patient.

3. If the patient/family is interested in the hospice program, an appointment will be set up for a hospice representative to meet with the patient and/or family to explain the hospice program and to evaluate and determine the patient's needs, eligibility and appropriateness for hospice. If Seasons Hospice can meet these needs and the hospice services are desired, the patient/representative will sign informed consents for hospice care. All requests for admission to the Open Access program will have their treatments reviewed and approved by the Clinical Leadership prior to admission. See Protocol 2065 Open Access Admission and Management.

   AZ: At the time of patient admission, a hospice physician or a registered nurse will assess the patient's medical, social, nutritional and psychological needs and obtain informed consent.

   CA: The hospice representative will make an initial contact to determine the immediate care and support needs of the patient. This initial contact will occur as soon as possible after receipt of the referral for care. Following the consent of the patient, Seasons Hospice will conduct a comprehensive assessment.

4. Seasons Hospice may meet with the patient and/or family to provide hospice information without a physician's order. However, a physician's order will be obtained prior to accessing the patient's medical record or performing a physical assessment. A physician's order to evaluate is valid for up to 30 days.

5. The hospice nurse will document prognostic indicators (Local Coverage Determinations) supporting the hospice diagnosis. Seasons Hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any).

ADMISSION PROCESS 209

6. The patient will be considered admitted to Seasons Hospice after:

   a) Admission consent and Election of Benefit forms are completed and signed;
   b) The nursing assessment is completed;
   c) The plan of care is initiated;
   d) The physician's orders are obtained, and;
   e) The hospice physician has approved the admission.

   AZ: Before admitting an individual as a patient, Seasons Hospice will 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.

   CT: 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.

7. Seasons Hospice's Admissions Department will verify the License, DEA and NPI of all attending physicians at the time of referral.

Effective: 2/18/1997

Revised:	8/1998	3/2000	6/13/00	11/26/01	3/7/05	4/15/05	1/23/06	12/27/06	9/14/07	12/2/08
Revised:	3/12/11	8/5/11	12/4/11	11/18/12	9/9/13	4/8/14	7/5/16	9/19/18		
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18	2/22/19	2/21/20							

INFORMED CONSENT 210

POLICY:

Seasons Hospice ensures that an informed consent form that specifies the type of care and services that may be provided as hospice care during the illness has been obtained for every individual, either from the individual or his/her representative. Hospice care and services are never provided without first obtaining a written informed consent.

DEFINITIONS:

Adult: An individual who has reached or surpassed the age of 18 years old.

PROCEDURES:

1. A hospice representative will explain hospice care and services available through Seasons Hospice to the patient and/or representative. They may elect to receive hospice care during one of the following election periods:

   - An initial 90-day period,
   - A subsequent 90-day period, or
   - An unlimited number of subsequent 60 day periods.

   PA Medicaid: The election periods are for (60) days each.

   TX & WI Medicaid: The election periods are for (6) months each.

   MO Medicaid: Anytime a patient leaves hospice, whether it is a revocation, discharge, or decertification, and then re-elects hospice, it is considered a new election, beginning with an initial certification period of 90 days that requires the certifications signed by both the attending physician and the hospice medical director or physician member of the hospice's interdisciplinary group.

2. Before care is provided, the patient shall be advised of:

   - The difference of the palliative rather than curative nature of hospice care;
   - 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;
   - Alternatives to hospice services;
   - The patient/family rights and responsibilities;
   - The right to receive an election statement addendum listing any conditions, items, services, and drugs that Seasons Hospice determines to be unrelated to the terminal illness and related conditions and 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.

INFORMED CONSENT 210

- The impact of the election of the Medicare Hospice Benefit on eligibility for reimbursement by Medicare for other health care services (if the patient is a Medicare Beneficiary);
- The patient's right to revoke the hospice benefit at any time;
- The options of a durable power of attorney for health care, advance directive or "do not resuscitate" orders in accordance with applicable law;
- The levels of care available (routine, continuous care, respite, and inpatient-acute);

- Supervision by Seasons Hospice of all services provided;
- The availability of services 24 hours a day / 7 days a week and how to contact on-call staff;
- The fees for services, the extent to which payment for services may be expected from any third-party payer, and the charges for services the patient may have to pay in the absence of reimbursement by any third-party payer; and
- The hospice's criteria for discharging the individual from the program.

3. The consent forms will include the following:

- A statement that Seasons Hospice will be providing the care and services;
- The patient/representative's identification of the attending physician;
- The patient/representative's acknowledgement 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;
- An acknowledgement that certain Medicare services are waived by the election of the hospice benefit;
- Acknowledgement that the patient or patient's representative has received a written copy of the Patients' Rights and Responsibilities;
- The effective date of the election, which will be the first day of hospice care or a later date (but will not be earlier than the date of the election statement);
- A disclosure of overlapping ownership of Seasons Hospice and the facility in which the patient resides, if applicable;
- A complete statement enumerating all charges for services, materials and equipment which shall, or may be, furnished to the patient during the period of hospice care;
- 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 the implementation of such changes;
- The signature of the patient or representative and the date of the signature; and,
- The reason why the patient did not sign their own consents (if applicable).

AZ: At the time of patient admission, a hospice physician or a Registered Nurse will assess the patient's medical, social, nutritional and psychological needs and obtain informed consent.

IN: Seasons Hospice will update, as necessary, a disclosure document to be presented to each potential patient of the hospice program. The disclosure document will contain the items listed in IC 16-25-7-2.

INFORMED CONSENT 210

MA: A copy of the patient/family rights and a statement of patient/family financial responsibilities shall be provided to the patient/family and shall be signed by the patient/family upon admission. If a patient has no family, the copy of the patient/family rights shall be signed by the patient and the primary caregiver.

4. If a hospice patient does not have the mental capacity to make healthcare decisions, and had not previously appointed a health care power of attorney, a legal surrogate will be identified in accordance with state law (see attached addendum). The hospice team will inform the surrogate of the hospice plan of care and include the surrogate in decision making related to hospice care and treatment. Two (2) physicians will sign a statement of decisional capacity (or the required state form) as required by state law. The reason the patient cannot sign his/her own consents will be documented on the consent form.

5. **In the absence of any state law**, the following shall apply:

   A. 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 representative. The following individuals, in the following order of priority, may consent to an admission for hospice care. If there is more than one individual at the highest available level of priority, any person of that 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 bioethics committee of a facility at which the non-decisional individual resides or is receiving treatment when the bioethics committee agrees that hospice care is appropriate for the incapacitated individual;
      9) Two non-Seasons physicians who agree that hospice care is appropriate for the non-decisional individual;

   B. 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 and may authorize expenditures related to health care to the same extent as a guardian of the estate may, until the earliest 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.

INFORMED CONSENT 210

6. Seasons Hospice shall not admit any persons under the age of eighteen (18) years without a signed parent/guardian consent.

7. The consents and election statement may be signed for up to (14) days before the start of care. Seasons Hospice does not accept verbal consents for hospice care. Faxed, scanned or emailed consents are acceptable (see Protocol 2011B Obtaining Remote Consents for additional information).

8. The patient/family shall be advised of any significant changes in the type or frequency of services, and of changes to the fee schedule.

9. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the patient:

   - Remains in the care of hospice;
   - Does not revoke the election; and
   - Is not discharged from the hospice.

Effective: 2/18/1997

Revised:	11/27/01	1/23/06	7/21/06	12/27/06	9/14/07	9/15/08	12/2/08	5/16/09	3/12/11	8/5/11
Revised:	11/18/12	8/24/15	2/8/16	4/2/16	7/5/16	12/14/17	10/20/20			
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18	2/22/19	2/21/20							

PLAN OF CARE 214

POLICY:

The interdisciplinary group (IDG) will collaborate to develop and maintain a plan of care, treatment and services that is individualized and appropriate to the needs, strengths, limitations and goals for each patient/family admitted to the hospice program as it relates to the terminal illness and related conditions. The care provided to the patient will be in accordance with the physicians' orders and the plan of care (POC). The POC will emphasize prevention and control of pain and other distressing symptoms and optimize comfort and dignity.

PROCEDURES:

1. All hospice care and services furnished to patients and their families will follow an individualized written POC in accordance with the patient's and family's medical, social, nutritional, and psychological needs and goals (the patient's needs and goals are a priority). The POC is established by the IDG in collaboration with the attending physician (if any) and with the patient or representative and the primary caregiver, if any of them so desire.

    a) Upon completion of the nursing assessment, the comprehensive POC will be initiated to address the needs identified in the assessment.

    b) Based on the information gathered in the comprehensive assessment, the POC will be updated to reflect patient and family goals and will include all interventions needed to address the problems identified in the comprehensive assessment.

    AZ: 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.

    NV: The medical director shall cause a written POC to be established for each patient in the program. Any person who furnishes care to the patient shall adhere to the plan.

    NJ Medicaid: The POC will be signed by the attending physician, the medical director or physician designee and the IDG.

2. The comprehensive POC will include the patient's diagnosis and all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

    a) Interventions to manage pain, symptoms, and grief, including the level of care to be provided and any safety measures employed to protect the patient from harm;

    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 POC;

PLAN OF CARE 214

d) Drugs and treatments necessary to meet the needs of the patient;

e) Medical supplies, assistive devices and appliances necessary to meet the needs of the patient;

f) The IDG's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC;

g) Designation of the primary caregiver or alternate plan to provide 24-hour care and support in the patient's home to ensure that the patient's needs will be met;

h) Plans for instructing and educating the patient/family and the designated caregiver as appropriate to their responsibilities for the care and services identified in the POC;

i) Identification of advance directives;

j) Plans and arrangements for after the patient's death, once known; and,

k) Physicians' orders.

CT: All diagnoses or conditions (primary and secondary), prognosis (including rehabilitation potential), functional limitations, activities permitted and therapeutic diet.

FL: A description of how needed care and services will be provided in the event of an emergency.

3. The hospice IDG in collaboration with the individual's attending physician, if any, will review, revise, and document the individualized POC as frequently as the patient's condition requires but no less frequently than every (15) days; the review must be documented in writing. Communication with the attending physician may be through phone calls, orders received and mailing an updated interdisciplinary POC every (15) days.

CT: The POC for all hospice services shall be reviewed and revised by members of the IDG as often as the patient's condition indicates but no less frequently than every 14 days. Case management and monitoring will occur at regular intervals based on the patient's condition, but at least every sixty (60) days. The patient, family, physician or dentist and all Seasons Hospice staff serving the patient shall participate in case management. Summary reports to the patient's physician or dentist of skilled services provided to the patient shall be forwarded within ten (10) days of admission and at least every sixty (60) days thereafter. The original plan and any modification shall be signed by the patient's physician or dentist within twenty-one (21) days.

MD: The interdisciplinary POC will be reviewed, and revised if necessary, at least:

- Every 14 days after admission for home-based hospice services; and
- Every 7 days after admission for inpatient hospice services.

PLAN OF CARE 214

MO: The plan will be reviewed and updated by the IDG at a minimum of every two (2) weeks. These reviews will be documented in the patient's medical record. Written reports on the patient's condition will be provided to the attending physician at least every 15 days.

NJ Medicaid: The POC will be reviewed and updated at least once per month by the attending physician, medical director or physician designee and the IDG. These reviews will be documented in the medical record.

4. A POC must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the POC.

5. Seasons Hospice will designate a registered nurse that is a member of the IDG to provide coordination of care and to ensure continuous assessments of each patient's and family's needs and implementation of the interdisciplinary POC. The designated registered nurse is responsible for ensuring that the updated plans of care are placed in the patient's facility or home chart.

6. The IDG will maintain and document a system of communication to:
   a) Ensure that the IDG maintains responsibility for directing, coordinating and supervising the care and services provided;
   b) Ensure that the care and services are provided in accordance with the POC;
   c) Ensure that the care and services provided are based on all assessments of the patient's and family's needs;
   d) 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 arrangements;
   e) Provide for an ongoing sharing of information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions. All communications will be documented in the patient's medical record; and,
   f) Ensure the referral of the patient to appropriate agencies for needed services not provided by Seasons Hospice.

7. The written POC will be maintained in the patient's medical record and will be available to all personnel providing patient care. The patient and/or family will have access to the written POC upon request.

Effective: 2/18/1997

Revised:	12/17/01	1/6/05	6/27/05	3/9/06	7/21/06	9/16/06	12/27/06	9/14/07	11/13/08	12/2/08
Revised:	12/19/08	8/22/10	3/12/11	5/11/11	8/5/11	6/1/13	9/9/13	4/8/14	8/24/15	12/14/17
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	9/9/11	8/17/12	4/26/13	2/21/14	2/20/15	2/19/16	2/24/17
Reviewed:	2/23/18	2/22/19	2/21/20							

PATIENT DISCHARGE 218

POLICY:

Seasons Hospice will not automatically or routinely discharge a Medicare patient at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements.

PROCEDURES:

1. No patient will be discharged due to an inability to pay for hospice services or for punitive reasons.

2. Seasons Hospice may discharge a live patient for the following reasons:

   a) The patient moves out of the hospice's service area (including when a patient is admitted to a non-contracted facility) or transfers to another hospice;

   b) The hospice determines that the patient is no longer terminally ill; or

   c) The hospice determines that the patient's (or other persons in the patient's home) 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. Seasons Hospice will do the following before it seeks to discharge a patient for cause:

      1) Advise the patient that a discharge for cause is being considered - a Notice of Medicare Non-Coverage form is not required;
      2) Make a serious effort to resolve the problem(s) 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 problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records; and,
      5) Notify the state licensing agency of the discharge for cause and document this notification.

CT: Patients will not be discharged from the hospice program solely because of an admission to an inpatient setting with which Seasons Hospice has a coordination of inpatient care agreement.

CT Medicaid: No patient shall be discharged for just cause or if he or she is considered no longer terminally ill without a review by the Department of Social Services. When the hospice advises the patient that discharge is being considered either for good cause or because the physician believes the client is no longer terminally ill, a copy of that written communication shall be sent to the Department and the attending physician.

GA: Seasons Hospice will not discontinue hospice care, nor shall a patient be discharged or transferred 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.

PATIENT DISCHARGE 218

WA: When Seasons Hospice is concerned about a patient's ongoing care and safety when the patient is discharged, it may submit a self-report to appropriate state agencies identifying the reasons for the discharge and the steps taken to mitigate safety concerns.

3. When a Medicare patient is being discharged for extended prognosis, Seasons Hospice will notify the patient/responsible person at least two calendar days before the discharge date.

   Seasons Hospice will explain to the patient/responsible person that they have the right to appeal the discharge decision and will provide them with the generic form of the Notice of Medicare Provider Non-Coverage which can be found on MNP\Common\Common Forms\Notice of Medicare Provider Non-Coverage\Forms. The patient or legal representative will sign the appropriate form confirming that they have received the written information.

   If SHPC is unable to notify the patient/responsible person directly and obtain the signature, an attestation that the patient/responsible person was notified verbally must be completed (the attestation has been incorporated into the Notice of Medicare Provider Non-Coverage generic form).

   Regardless of the QIO's decision, the hospice physician should NOT recertify the patient if they do not believe that the patient's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course. In this situation, the patient should still be discharged. Contact the Chief Compliance Officer with any questions.

See Protocol 2047 Medicare Notice of Non-Coverage & QIO and Protocol 2049 Live Discharges for further information and instructions.

Effective: 2/18/1997

Revised:	8/1998	11/10/01	3/2000	6/13/00	2/2002	3/7/05	7/1/05	1/23/06	12/27/06	9/14/07
Revised:	9/15/08	12/2/08	12/19/08	3/12/11	11/18/12	6/1/13	6/9/14	8/24/15	1/22/16	5/12/16
Revised:	7/5/16	12/14/17	9/19/18	2/20/19						
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	11/10/11	8/31/12	5/31/13	4/4/14	3/20/15	3/18/16	3/24/17
Reviewed:	3/12/18									

MEDICAL SUPERVISION 219

POLICY:

All patients shall be under the care of an attending physician, if any, and the hospice medical director or a physician member of the interdisciplinary group (IDG) while receiving hospice services.

DEFINITIONS:

Attending Physician: A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs that function or action; or, a nurse practitioner (NP) who meets the federal and state requirements for training, education and experience. Effective January 1, 2019, a physician assistant (PA) may serve as the attending physician for a hospice patient, if allowed by state regulations.

PROCEDURES:

1. Each patient's medical record shall clearly indicate the name of the attending physician who is identified by the patient or family at the time he or she elects to receive hospice care as having the most significant role in the determination and delivery of the individual's medical care.

   CT: An attending physician is a doctor of medicine or osteopathy, licensed in CT or in a state that borders CT, who is identified at the time of selection of hospice care as having the most significant role in the determination and delivery of the patient's medical care.

   MO: An attending physician is a person who is licensed as a doctor of medicine or osteopathy in MO or in a bordering state.

2. The attending physician and hospice physician shall be responsible for the initial certification of terminal illness, verbally within (2) days of admission and in writing before billing. Seasons Hospice expects that two physicians confirm each patient is eligible to receive hospice services. If the hospice physician is also the attending physician, the second evaluation of hospice eligibility should be obtained from another hospice physician, the medical director, or the national medical director.

   MI: The attending physician and/or hospice physician shall review the patient's medical history and physical assessment within (48) hours before or after the patient's admission to hospice.

3. An NP or PA cannot certify or recertify a terminal diagnosis or prognosis of (6) months or less.

4. The attending physician and medical director shall be responsible for collaborating with the IDG in developing, evaluating and revising the plan of care.

MEDICAL SUPERVISION 219

5. Physician orders will be obtained before the start of care. The physician orders shall outline the disciplines providing care, and the type and frequency of services to be provided.

6. Care, treatment, and services emphasizing the prevention and control of pain and other distressing symptoms, will be provided using the most recent orders.

7. The attending physician will make available to Seasons Hospice all necessary information, including medical history, physical findings, treatments, laboratory and other diagnostic findings, to facilitate continuity of care.

8. Tracking will be conducted by each team assistant to facilitate return of signed physician orders.

9. Physicians will be contacted when any of the following occurs:

   - Unanticipated changes in the patient's condition;
   - Unexpected response to treatment or medication changes;
   - Laboratory results are received;
   - The patient dies;
   - The patient transfers or is discharged;
   - The patient needs a change in level of care;
   - When orders have not been returned;
   - When the patient/family is not following the physician's orders; and,
   - When allegations of abuse, neglect, or exploitation are made.

10. The IDG will coordinate with the patient's attending physician, if any, in reviewing and updating the patient's plan of care at least every 15 days.

11. In the event an attending physician is not going to be available, they will notify Seasons Hospice of the name and method to contact the physician providing coverage. If Seasons Hospice is unable to contact the attending physician/designee within a reasonable amount of time, Seasons Hospice physicians will be utilized.

12. If the patient changes attending physicians:

    a. Physician orders will be obtained from the hospice physician until valid orders are obtained from the new attending physician.
    b. A "Change in Attending Physician" form must be signed by the patient/legal representative.

13. If the patient meets admission criteria and requests service but does not have an attending physician, Seasons Hospice will offer the patient the names of physicians who are available to become their attending physician.

MEDICAL SUPERVISION 219

14. Additional attending physician responsibilities will include:
    - Remaining in regular communication with the patient and see them as often as necessary to adequately plan for care;
    - Providing complete and accurate patient information about the medical condition and inform Seasons Hospice of changes in the plan of care;
    - Certifying that the eligible patient meets the criteria for services as required for hospice;
    - Being available for consultation when there are changes in the patient's condition or having alternate medical coverage when not available;
    - Signing and returning written orders to the agency as soon as possible;
    - Notifying Seasons Hospice when a referral to another physician or provider is made, if Seasons Hospice services would be affected; and
    - Notifying Seasons Hospice prior to ordering hospitalization and/or diagnostic studies.

15. Seasons Hospice's responsibilities include:

    - Providing the physician with complete and accurate information when there are unanticipated changes in the patient's medical condition and any changes that would impact the plan of care;
    - Being available to the physician for consultation about the patient's medical condition;
    - Providing the physician with written updates on the patient's progress;
    - Maintaining confidentiality of the patient, physician, and the contents of the plan of care; and,
    - Providing the physician with a discharge summary for patients who revoke or are discharged alive.

Effective: 2/18/1997

Revised:	12/18/01	3/7/05	6/27/05	12/27/06	9/14/07	11/13/08	3/12/11	5/11/11	12/4/11	11/18/12
Revised:	6/1/13	7/5/16	12/14/17	9/19/18	9/4/19	10/20/20				
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07
Reviewed:	12/19/08	10/16/09	11/22/10	11/10/11	8/31/12	5/31/13	4/4/14	3/20/15	3/18/16	3/24/17
Reviewed:	3/23/18	3/22/19	3/20/20							

PATIENT & FAMILY EDUCATION 224

POLICY:
Seasons Hospice will provide patients and caregivers with education and training appropriate to the services provided and needs assessed by the interdisciplinary group or patient/caregiver requests.

PROCEDURES:

1. Educational needs or knowledge deficits related to the disease process, medications, patient care and/or hospice services will be assessed during the admission process, and regularly during the provision of hospice care.

2. The education provided to the patient and/or caregiver will be based on an assessment of learning style, the patient's condition, identified needs and the services that will be provided.

   GA: During home care visits, employees will provide continuing education for the patient and primary caregiver regarding the progression of the patient's illness and the patient's care needs.

3. The education provided will be appropriate to the patient and/or caregiver's abilities and will take in to consideration:
   - Physical limitations
   - Cognitive limitations
   - Language barriers
   - Religious or cultural practices
   - Emotional barriers
   - Desire and motivation to learn

4. Patients or caregivers who have special educational needs or language barriers will be provided interpreters or assistive devices to facilitate communication as needed.

5. Teaching materials will accommodate various learning styles and will be presented in an understandable manner. Teaching materials may include:
   - Oral instructions with repetition as needed
   - Written materials
   - Audio-visual materials
   - Return demonstration
   - Formal or informal classes
   - Support groups, for example, related to disease process or coping skills
   - One-to-one counseling sessions
   - Community resources

6. Patient and/or caregiver comprehension of the education will be evaluated with a return demonstration and/or verbal or other acknowledgment of understanding.

PATIENT & FAMILY EDUCATION 224

7. All patient and/or caregiver education and instruction, as well as their ability to understand and respond to instructions, will be documented in the patient's record.

8. The patient/family teaching issues will be documented in the ongoing interdisciplinary plan of care.

9. All members of the interdisciplinary group may participate in patient and/or caregiver education if they have had the necessary training and education to provide these services.

Effective: 3/2000

Revised:	12/04/01	1/6/05	12/27/06	9/14/07	11/18/12	4/8/14				
Reviewed:	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	11/8/06	4/18/07	12/19/08	11/6/09
Reviewed:	11/22/10	11/10/11	8/31/12	5/31/13	4/4/14	3/20/15	3/18/16	3/24/17	3/23/18	3/22/19
Reviewed:	3/20/20									

HOSPICE CARE TO RESIDENTS IN A FACILITY 233

POLICY:

Hospice patients that live in a skilled nursing facility (SNF), nursing facility (NF), or an intermediate care facility for individuals with intellectual disabilities (ICF/IID) deserve to receive the same high level of quality hospice care as patients who live in their own homes.

PROCEDURES:

1. Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the same hospice eligibility criteria as patients who reside in their own home.

2. Seasons Hospice will 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 will make any arrangements necessary for hospice related inpatient care in a participating Medicare/Medicaid facility.

3. Seasons Hospice will have a written agreement with the facility that will be signed by authorized representatives of the hospice and the facility before the provision of hospice services and will include, at a minimum, the following:

    a. The way the facility and Seasons Hospice are to communicate with each other and document such communications to ensure that the needs of the patients are addressed and met 24 hours a day;

        GA: The written communication shall specify an individual from the hospice and an individual from the facility who shall be responsible for communication between service providers regarding each patient's treatment and condition and for addressing any care issues. Such communication shall be ongoing throughout the period of hospice service provision and shall be documented in the patient's medical record.

    b. A provision that the facility immediately notifies Seasons Hospice if:

        i. A significant change in a patient's physical, mental, social, or emotional status occurs;
        ii. Clinical complications appear that suggest a need to alter the plan of care;
        iii. A need to transfer a patient from the facility; Seasons Hospice will make the arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary and related to the terminal illness and related conditions; or
        iv. A 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;

HOSPICE CARE TO RESIDENTS IN A FACILITY 233

d. An agreement that it is the facility's responsibility to continue to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected;

e. An agreement that it is the hospices 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 Season Hospice's responsibilities which include, but are not limited to, providing the following:

i. Medical direction and management of the patient;
ii. Nursing services;
iii. Counseling (including spiritual, dietary and bereavement) services;
iv. Social work services;
v. Medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and,
vi. All other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

GA: The hospice shall provide a copy of any self-determination documentation and shall communicate with the facility as to the procedure for implementation of any advance directive.

g. A provision that the hospice may use the facility nursing personnel where permitted by State law and as specified by the facility 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 hospice patient's family in implementing the plan of care.

h. A provision stating 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 facility administrator within 24 hours of the hospice becoming aware of the alleged violation.

i. A requirement that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records

j. A delineation of the responsibilities of the hospice and the facility to provide bereavement services to facility staff.

HOSPICE CARE TO RESIDENTS IN A FACILITY 233

CO: When hospice services are provided in a long-term care facility, assisted living residence or intermediate care facility for persons with developmental disabilities, there shall be a written agreement that specifies the provision of hospice services in the facility. The written agreement shall be signed by authorized representatives of the hospice and the non-hospice licensed facility prior to the provision of hospice services.

CT: Seasons Hospice will establish a "Shared Services Agreement" with those providers who may be providing concurrent services to a Seasons Hospice patient (see protocol 2101 Shared Services – Coordination of Care).

4. A written hospice plan of care must be established and maintained in consultation with the facility representatives. All hospice care provided will be in accordance with the hospice plan of care.

    a. 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;

    b. The hospice plan of care reflects the participation of the hospice, the facility, and the patient and family to the extent possible; and,

    c. Any changes in the hospice plan of care must be discussed with the patient or representative, and the facility representatives, and must be approved by the hospice before implementation.

5. Seasons Hospice will coordinate services by:

    a. Designating a member of each interdisciplinary group (IDG) that is responsible for a patient who is a resident of the facility. The designated IDG member is responsible for:

        i. Providing overall coordination of the hospice care of the facility resident with facility representatives; and,
        ii. Communicating with 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.

    b. Ensuring that the hospice IDG communicates with the facility medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the patient with the medical care provided by other physicians;

HOSPICE CARE TO RESIDENTS IN A FACILITY 233

c. Providing the facility with the following information:

i. The most recent hospice plan of care specific to each patient;
ii. Hospice election form and any advance directives specific to each patient;
iii. Physician certification and recertification of the terminal illness specific to each patient;
iv. Names and contact information for hospice personnel involved in hospice care of each patient;
v. Instructions on how to access the hospice's 24-hour-on-call system;
vi. Hospice medication information specific to each patient; and hospice physician and attending physician (if any) orders specific to each patient.

6. Seasons Hospice staff will ensure orientation of facility staff furnishing care to hospice patients regarding the following information, at a minimum:

a. Hospice philosophy;

b. Hospice policies and procedures regarding methods of comfort, pain control, and symptom management;

c. Principles about death and dying, including individual responses to death;

d. Patient rights;

e. Appropriate forms; and,

f. Record keeping requirements.

Effective: 12/2/08

Revised:	11/18/12	2/8/16	12/14/17	9/19/18						
Reviewed:	12/19/08	11/6/09	11/22/10	11/10/11	8/31/12	5/31/13	4/4/14	3/20/15	3/18/16	3/24/17
Reviewed:	3/23/18	3/22/19	3/20/20							

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT 501

POLICY:

Seasons Hospice has implemented and will maintain an effective, ongoing, hospice-wide and data-driven quality assessment and performance improvement (QAPI) program that reflects the complexity of the organization and services and includes services provided under contract.

DEFINITIONS:

Adverse Event: Any undesired event which negatively affects the patient, family, or employee, or that impacts the patient or family's satisfaction with hospice care.

PROCEDURES:

1. The QAPI program includes processes for collecting, measuring, analyzing, and tracking relevant data, including data related to patient care, adverse patient events, and other aspects of performance.

2. The Leadership will set priorities for data collection (to be collected monthly, quarterly or annually) that is used to monitor the effectiveness and safety of services and quality of care and to identify opportunities and priorities for improvement. Leaders may reprioritize performance improvement activities in response to changes in the internal or external environment.

3. Performance improvement activities focus on high risk, high volume or problem-prone areas that affect palliative care outcomes, patient safety and quality of care with a consideration of incidence, prevalence and severity of problems in those areas.

4. Performance improvement activities track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

5. As a result of quality assessment activities, Seasons Hospice takes actions aimed at performance improvement and measures and monitors improved performance to ensure that improvements are sustained.

6. The number and scope of annual performance improvement projects (aka QIAPs) is based on the patients' needs and internal organization needs. The projects reflect the scope, complexity, and past performance of the hospice's services and operations.

7. Documentation of the QAPI program includes:

    a) Evidence that demonstrates the operation of the hospice's QAPI program;
    b) All performance improvement projects being conducted;
        i. The reasons for conducting each project; and,
        ii. Measurable progress of each performance improvement project.

QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT 501

8. The governing body ensures that the QAPI program is developed, implemented, maintained and evaluated annually and delegates leadership and management of the program to the executive director.

9. The QAPI Committee, which includes representatives of the scope of the program (e.g. may include social work, spiritual care, music therapy, volunteers, etc), directs and assists in the management of on-going quality assessment and performance improvement activities through regularly scheduled meetings.

   MA: Seasons Hospice will offer contracted hospice providers the opportunity to participate in the QAPI program.

10. The executive director, or designee, ensures the overall implementation of the program and regularly reports activities and findings to the governing body.

11. All hospice employees are accountable and responsible for the quality of care and services within their respective departments and are expected to participate in the QAPI program.

12. Improvements in processes or outcomes as a result of the QAPI program are communicated throughout the hospice and documented in the meeting minutes of the QAPI Committee.

13. Documentary evidence of the functioning and effectiveness of the hospice's QAPI program is maintained by the executive director, or designee.

14. FL: Seasons Hospice must submit the State of Florida Department of Elder Affairs Hospice Demographic & Outcome Measures report by March 31st of each year which covers January 1 through December 31 of the previous year. The form can be obtained here.

Effective: 2/18/1997

Revised:	8/1998	11/2/98	3/30/05	6/21/05	9/14/07	10/23/08	12/2/08	12/19/08	2/20/10
Revised:	12/16/10	9/17/11	9/21/12	4/15/13	12/9/14	9/19/15			
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	9/26/06
Reviewed:	11/27/07	12/19/08	5/5/09	11/22/10	9/9/11	9/21/12	3/29/13	5/23/14	5/22/15
Reviewed:	5/20/16	5/26/17	5/25/18	5/24/19	5/22/20				

SENTINEL EVENTS 502

POLICY:

Seasons Hospice will participate in identifying, reporting, analyzing, and managing sentinel events in order to help prevent the occurrence (or recurrence) of such incidents and to improve patient care.

DEFINITIONS:

Sentinel Event: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm or severe temporary harm.

Severe temporary harm: Critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, or additional major surgery, procedure or treatment to resolve the condition.

PROCEDURES:

1. Seasons Hospice takes actions to prevent sentinel events by having a vigorous quality assessment and performance improvement (QAPI) program, by addressing adverse events and by asking patients, families, and employees to report any concerns about the quality or safety of the care provided.

2. Sentinel events that are reviewable under The Joint Commission's Sentinel Event policy include the following:

    a) Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from an emergency department;

    b) Abduction of any patient receiving care, treatment or services;

    c) Any elopement (unauthorized departure) of a patient from a staffed around-the-clock care setting leading to the death, permanent harm, or severe temporary harm of the patient;

    d) The rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, or services while on site at the organization;

    e) The rape, assault (leading to death, permanent harm or severe temporary harm) or homicide of a staff member, licensed independent practitioner, visitor or vendor while on site at the organization;

    f) An invasive procedure on the wrong patient, at the wrong site, or is the wrong (unintended) procedure;

SENTINEL EVENTS 502

g) Fire, flame, or unanticipated smoke, heat, or flashes leading to death, permanent harm or severe temporary harm;

h) A patient fall leading to death, permanent harm or severe temporary harm as a direct result of the injuries sustained in the fall; or,

i) Any patient death, permanent harm or severe temporary harm associated with a medication error.

5. Examples of sentinel events that are <u>not</u> reviewable under The Joint Commission's Sentinel Event Policy include the following:

   a) Any close call ("near miss");

   b) Medication errors that do not result in death or major permanent loss of function;

   c) Any sentinel event that has not affected a recipient of care;

   d) A death or loss of function following a discharge against medical advice (AMA);

   e) Full or expected return of limb or bodily function to the same level as prior to the adverse event within two weeks of the initial loss of said function;

   f) Unsuccessful suicide attempts unless resulting in major permanent loss of function;

   g) Suicide other than in an around-the-clock care setting or following elopement from such a setting; and,

   h) Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae.

6. Any employee that becomes aware of a potential sentinel event must report this immediately to their supervisor. The supervisor will immediately notify the National Director of Quality & Field Compliance (NDQFC) and the Executive Director. The NDQFC will provide support and guidance through the root cause analysis and will notify the Chief Compliance Officer or Chief Counsel, if applicable.

7. Seasons Hospice recognizes that a sentinel event (whether it is reviewable or not) requires an immediate investigation and response. This response will include, at a minimum, the following:

   - Conducting a timely, thorough, and credible root cause analysis;
   - Developing an action plan designed to implement improvements to reduce risk;

SENTINEL EVENTS 502

- Implementing the improvements;
- Monitoring the effectiveness of those improvements; and
- Reporting the sentinel event to the Joint Commission (for JC accredited sites only)

CA: Occurrences that threaten the welfare, safety or health of patients or hospice personnel shall be reported to the California Department of Health Services.

8. The root cause analysis will be initiated by the appropriate manager within five (5) days of the event (or learning of the event) and the analysis will be completed within forty-five (45) days. The root cause analysis will:

   - Focus primarily on systems and processes, not on individual performance;
   - Progress from special causes in clinical processes to common causes in organizational processes;
   - Repeatedly research by asking "Why?", then when answered, "Why?" again, and so on;
   - Identify changes that could be made in systems and processes which would reduce the risk of such events occurring in the future; and,
   - Be thorough and credible.

9. The executive director or his/her designee will inform the patient (or family, as appropriate) about unanticipated outcomes of care, treatment and services relating to that patient.

10. Seasons Hospice employees will be educated about sentinel events during their orientation, annually and on an as needed basis.

11. All reports related to sentinel events will be retained in a secure location by the executive director. Sentinel events will be reported to the QAPI Committee and the governing body.

12. Sample forms for the Root Cause Analysis can be found on the Joint Commission website.

Effective: 2/18/1997

Revised:	2/2002	12/11/01	2/11/05	6/2/06	10/23/06	11/27/07	12/19/08	2/20/10	12/16/10	4/15/13
Revised:	10/13/14	9/19/15	10/6/16	10/31/18						
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/2/05	9/26/06	11/27/07
Reviewed:	12/19/08	5/5/09	11/22/10	9/9/11	9/21/12	3/29/13	5/23/14	5/22/15	5/20/16	5/26/17
Reviewed:	5/25/18	5/24/19	5/22/20							

FINANCIAL MANAGEMENT 606

POLICY:

All aspects of business conducted by Seasons Hospice shall be conducted in compliance with local, state and federal regulations, accepted business practice and generally accepted accounting principles.

PROCEDURES:

1. A claim will only be submitted when appropriate documentation supports the claim and only when such documentation is maintained, appropriately organized, in a legible format, and available for audit and review.

2. All claims will indicate that the diagnosis and codes for hospice care reported on the claim are based on the patient's medical record and other documentation, as well as comply with all applicable official coding rules and guidelines. All codes used by billing staff will accurately describe the service that was ordered by the physician and performed by the interdisciplinary group.

3. Compensation for billing personnel shall offer no financial incentive to submit claims regardless of whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered.

4. A process for pre-billing review shall be conducted on a regular basis by the Health Information Department to ensure that all claims submitted for reimbursement accurately represent medically necessary services provided.

5. Seasons Hospice's policies and procedures shall prevent services being provided by unqualified or unlicensed persons or by sanctioned individuals, and therefore, preventing the submission of claims for such services.

6. Seasons Hospice shall employ/contract with individuals fully knowledgeable in properly completing cost reports.

7. Costs shall not be claimed unless they are reimbursable, reasonable, and are based on appropriate and accurate documentation. Unallowable costs shall not be claimed for reimbursement.

8. Allocation of costs to various cost centers shall be made accurately and be supported by verifiable and auditable data.

9. Medicare fiscal intermediary prior year audit adjustments shall be implemented and either claimed for reimbursement or clearly identified as protested amounts on cost reports.

10. Any return of overpayments shall be appropriately reflected in cost reports.

FINANCIAL MANAGEMENT 606

Effective: 3/12/02

Revised:	7/9/09	12/2/14	9/20/15							
Reviewed:	5/15/02	3/11/03	5/18/04	6/3/05	5/10/06	4/24/07	12/19/08	7/9/09	11/22/10	11/10/11
Reviewed:	8/10/12	6/28/13	6/20/14	6/19/15	6/17/16	6/23/17	6/22/18	6/21/19	6/19/20	

PROGRAM EVALUATION 612

POLICY:

The executive director and leadership team will conduct an overall evaluation of their program at least annually.

PROCEDURES:

1. The evaluation shall consist of the following areas:

   - Organization review;
   - Policy and administrative review; and,
   - Clinical record review.

2. The evaluation shall assess the extent to which Seasons Hospice's program(s) are appropriate, adequate, effective and efficient.

3. As part of the evaluation process, the policies and administrative practices shall be reviewed to determine the extent to which they promote patient/family care that is appropriate, adequate, effective and efficient.

4. Seasons Hospice will collect data on an ongoing basis, including demographic and patient related data. The data to be considered may include, but not be limited to:

   - Financial report;
   - Operating budget;
   - Patient statistics including census, length of stay, patient demographics, referral sources, major diagnostic categories, and the number of and reasons for non-admits;
   - Quality Assessment & Performance Improvement activities, including current monitors, data collection, analysis and implementation strategies;
   - Human resources report, including staffing and volunteer levels, competency assessment data, competency maintenance and enhancement activities, volunteer hours and cost savings report;
   - Program specific reports as appropriate, such as new program development, bereavement, community outreach;
   - Continuum of care: joint ventures with hospitals, home care, nursing homes and other partnership organizations and sites of care, status of new contracts, or joint performance improvement projects; and,
   - Requests for governing body support, especially regarding marketing and technical support.

5. The executive director will report the results of the evaluations to the governing body at least annually with recommendations as appropriate.

PROGRAM EVALUATION 612

6. The governing body will authorize actions to be taken in response to the reported evaluations.

7. Results of the annual evaluation shall be maintained separately as administrative records.

   IN: Documentation of the evaluation must include:
   - Criteria and methods used to accomplish it;
   - Names and credentials of individuals who did the evaluation; and,
   - Action taken because of findings, including any subsequent policy change

8. CT: There shall be a professional advisory committee appointed by the governing authority. 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 and at least annually review agency policies.

   NJ: The governing body shall appoint an advisory group which ensures participation by at least one physician, the executive director, the director of clinical operations and/or the nursing supervisor, a consumer and at least one representative of the interdisciplinary group. At least one member of the advisory group shall be neither an owner nor an employee of Seasons Hospice. This full advisory group will meet at least annually. Responsibilities will include, but are not limited to, the annual review of policies.

Effective: 2/18/1997

Revised:	9/2001	9/12/07	9/15/08	11/13/08	11/17/12	9/9/13	4/7/14	9/20/15		
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	5/10/06	4/24/07
Reviewed:	12/19/08	7/9/09	11/22/10	11/10/11	8/10/12	6/28/13	6/20/14	6/19/15	6/17/16	6/23/17
Reviewed:	6/22/18	6/21/19	6/19/20							

EMERGENCY MANAGEMENT PROGRAM 703

POLICY:

Seasons Hospice will maintain an Emergency Operations Plan that is designed to coordinate its communications, resources and assets, staff responsibilities, utilities, and patient clinical and support activities during an emergency.

PROCEDURES:

1. The leadership at each site will develop and maintain an emergency operations plan based on a hazardous vulnerability analysis that is specific to its site.

2. All employees, volunteers and contracted staff will be educated on the emergency operations plan during orientation and at least every two (2) years thereafter, including the staff's assigned emergency response roles. The education will be documented and updated annually and when the roles change. Staff knowledge of emergency procedures will be demonstrated.

3. The Emergency Operations Plan (EOP) will be available to all staff and volunteers, including those on the inpatient centers, to review procedures that are necessary to protect patients and others.

4. The EOP will be based on, and include, a documented, facility-based and community-based risk assessment, utilizing an all-hazard approach. Emergency situations that may affect the ability for Seasons Hospice to provide care include:

    a) Natural events, for example, extremes in cold or heat, hurricanes, floods, or snowstorms

    b) Human related events, for example, epidemics, a shooter on the premises, or terrorist activities

    c) Technological events, for example, phone or computer failure

5. The EOP will include, at a minimum, the following information:

    a) Key Definitions so that a common language is used during any event that threatens to disrupt normal hospice operations.

    b) A description of the patient population served by the hospice (see Patient Triage Categories) and the extent to which Seasons Hospice will provide care to additional patients during an emergency;

    c) Identification of potential risks in the community that could impact Seasons Hospice's ability to provide care for our patients (see Emergency situations);

    d) Mitigation and preparedness steps including patient education, based on the patient's condition and assessed needs (clinical, functional, and communication needs; reliance upon equipment or assistive devices; and available caregiver support) and regarding procedures to follow if care, treatment or services are disrupted by a natural disaster or emergency.

EMERGENCY MANAGEMENT PROGRAM 703

e) Response to emergencies, including at a minimum, the following:

1) The process for informing state and local emergency preparedness officials before, during, and after emergencies of the following:

   i. Patients for whom the organization is unable to contact to determine service needs;
   ii. Patients in need of evacuation due to their medical or behavioral health condition or home environment; and,
   iii. Any on-duty staff that Seasons Hospice is unable to contact.

2) A communications plan that includes, at a minimum, the following:

   i. The names and contact information for hospice employees; patients' physicians; volunteers; contracted entities; relevant federal, state, tribal, regional and local emergency preparedness staff; and, any other potential response partners (e.g. home health agencies, other hospices, etc.);
   ii. The hospice's primary and alternate means of communicating with hospice employees and federal, state, tribal, and local emergency management agencies;
   iii. The hospice's arrangements for communicating information and medical documentation on patients under the hospice's care, as necessary, with other health care providers to maintain continuity of care as permitted under 45 CFR 164.510(b)(1)(ii);
   iv. The process for communicating information about the general condition and location of patients under the hospice's care to public and private entities assisting with disaster relief (e.g. The Red Cross) as permitted under 45 CFR 164.510(b)(4); and,
   v. The process for communicating information about the hospice's needs and the ability to provide assistance to the authority having jurisdiction, the incident command center, or designee.

3) Maintaining documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in the service area (including in-person meetings; conference calls; emails; participation in health care coalitions, committee, boards, working groups; and attendance at educational events presented by the emergency preparedness officials).

4) A plan for how the hospice will obtain and replenish nonmedical supplies (including food, bedding, and other provisions consistent with the hospice's plan for sheltering on site) that will be required in response to an emergency.

5) A description of how state and federally designated health care professionals will be incorporated into the staffing strategy for addressing a surge in needs during an emergency.

EMERGENCY MANAGEMENT PROGRAM 703

6) Arrangements with other hospices and/or other providers to receive patients in the event of limitations or cessations of operations to maintain continuity of services to Seasons Hospice's patients.

7) Inpatient Centers will also include the following in their EOP:

   i. The identification of alternative sites for care, treatment, and services that meet the needs of the hospice patients during emergencies;
   ii. A procedure for requesting a 1135 waiver for care and treatment at an alternative care site identified by emergency management officials;
   iii. The plan to shelter inpatient patients and hospice staff on site who remain in the inpatient center during an emergency, including food, water, medications, personal hygiene, essential space, utilities, and supplies;
   iv. Arrangements for transporting some or all patients and their requisite medications, supplies, and equipment, and staff to alternative care site(s) when the inpatient center cannot support care, treatment, and services;
   v. A system for tracking the location of patients and employees sheltered on site during an emergency, including the name and location of the receiving facility or alternate site in the event a patient and/or employee(s) are relocated during the emergency.
   vi. An alternative means of providing the following:
      a. Electricity;
      b. Water needed for consumption and essential care activities;
      c. Water needed for equipment and sanitary purposes;
      d. Essential utility systems (e.g. heating and cooling systems);
      e. Emergency lighting;
      f. Fire detection, extinguishing and alarm systems;
      g. Sewage and waste disposal and,
      h. Management of hazardous materials.
   vii. A plan for evacuating patients from one section or floor to another within the building, or, completely outside the building when the building cannot support care, treatment, or services which includes, at a minimum, the following:
      a. Care and treatment needs of patients when deciding where they will be evacuated to (e.g. transport to an alternative site in the community or discharge to home);
      b. Primary and alternate means of communication with external sources of assistance regarding patient care; and,
      c. Transportation for the evacuated patient to an alternative site.

8) Inpatient Centers (IPC) that will be following the host facility's EOP must demonstrate its participation in the integrate emergency preparedness program through the following:

   i. Designation of a staff member(s) who will collaborate with the host facility in developing the program;

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ii. Documentation that the IPC has reviewed the community-based risk assessment developed by the host facility's integrated all-hazards emergency management program;
iii. Documentation that the IPC's individual risk assessment utilized an all-hazard approach and is incorporated into the host facility's integrated program;
iv. Documentation that the IPC's patient population, services offered, and any unique circumstances of the Inpatient Center are reflected in the host facility's integrated program.
v. Documentation of an integrated communication plan, including information on key contacts in the host facility's integrated program;
vi. Documentation that the IPC participates in the review of the host facilities integrated program at least ever;
vii. Documentation of the integration of communication procedures for emergency planning and response activities in coordination with the host facility's integrated emergency preparedness program;
viii. Documentation of the identification of the IPC's emergency preparedness, response, and recovery activities that are coordinated with the host facility's integrated program (e.g. acquiring or storing clinical supplies, assigning staff to the local health care coalition to create joint training protocols, etc.);
ix. Documentation of the IPC's communication and/or collaboration with local, tribal, regional, state, or federal emergency preparedness officials through the host facility's integrated program;
x. Documentation of coordination of operations planning with the host facility; and,
xi. Plans for integrated training and exercise activities with the host facility's integrated program.

9) Seasons Hospice will implement the "EMR Down" process whenever the electronic medical record is not usable during an emergency to preserve patient information, protect confidentiality of patient information, and secure and maintain the availability of records.

f) Recovery – depending on the scope and severity of the emergency, the activated Command Center may continue for hours, or even days post-emergency, to ensure staff and patient safety.

g) A Continuity of Operations Plan that includes, at a minimum, the following:

1) Continuity of facilities and communications to support hospice functions at the original site or alternate site(s), in case the original site is incapacitated;

2) A succession plan that lists who replaces the key leader(s) during an emergency if the leader is not available to carry out his or her duties; and,

EMERGENCY MANAGEMENT PROGRAM 703

3) A delegation of authority plan that describes the decisions and policies that can be implemented by authorized successors during an emergency and criteria or triggers that initiate this delegation.

5. Seasons Hospice will conduct at least two EOP exercises each year:

a) One of the annual exercises will be an operations-based exercise that is conducted either as part of a full-scale community exercise, or if a community exercise is not available, it will be a facility based, functional exercise.

b) The other annual exercise may be a mock disaster drill or a tabletop exercise which will include a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statement, directed messages, or prepared questions designed to challenge the emergency plan.

c) If Seasons Hospice activates the EOP in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises;

d) The scope of the exercise reflects the response procedures described in the Emergency Operations Plan and, at a minimum, the exercise reviews and confirms the following:

i. Staff communication procedures and content as well as assigned roles and responsibilities related to essential response functions;
ii. How the hospice will communicate with patients during an emergency;
iii. Communications with any response partners as described in the EOP (for example, vendors, contracted providers, drug suppliers, the national team, local hospital, or county emergency operation centers); and,
iv. Business continuity and recovery strategies for restoring the hospice's capabilities to provide care, treatment, or services after an emergency.

e) The exercises sufficiently stress the EOP to identify weaknesses in key areas of safety by doing the following:

i. Activating and testing patient acuity assignment and tracking procedures to validate the ability to identify and locate high risk patients; and,
ii. Activating and testing key care, treatment, or service processes consistent with planned response activities (e.g. medication management, DME and supplies, instructions for self-evacuation, medical record documentation, coordination of information with alternative care sites, etc.).

6. An evaluation of the EOP must be completed after each event, whether it was an actual emergency or a planned exercise. The evaluation must include an identification of deficiencies and opportunities for improvement based upon monitoring activities and observations during the event and will be completed by representatives of administration, clinical and support staff. Seasons

EMERGENCY MANAGEMENT PROGRAM 703

Hospice will modify the EOP in response to the evaluation; future exercises or real emergencies will evaluate the effectiveness of the modifications.

7. The EOP, including the communication plan, will be reviewed and updated at least every two (2) years. The review and updates will be presented at the Quality Assessment Performance Improvement Committee meeting.

EQUAL EMPLOYMENT OPPORTUNITY 802

POLICY:

Seasons Hospice provides equal employment opportunities to all people without regard to race, color, religion, national origin, ancestry, sex, pregnancy, sexual orientation, gender identity, gender expression, parental status, marital status, order of protection status, age, disability, citizenship, veteran status, military status, unfavorable discharge from military service, genetic information or testing, and any other characteristics protected by federal, state, or local law, and promotes the full realization of an inclusive employment policy.

PROCEDURES:

1. Seasons Hospice is fully committed to equal opportunity and equal consideration to all applicants and employees in employment matters and practices including recruitment, hiring, placement, promotion, demotion, compensation, discipline and collective actions, transfer, training, leaves of absence, lay-off, or termination.

2. Any employee who has questions regarding this policy or feels that Seasons Hospice is failing in its dedication to equal employment opportunity should contact their supervisor, any member of management, or Human Resources. Please follow the complaint procedure set forth in Seasons Hospice's Anti-Harassment/Anti-Discrimination policy and, if necessary, the reconsideration process. Seasons Hospice will likewise be guided by that policy's procedures and prohibition against retaliation should any complaints or concerns be raised.

3. Seasons Hospice's Equal Employment Opportunity Policy is communicated to all relevant audiences within and outside Seasons Hospice.

   - The policy is included on the Seasons' intranet.
   - A copy of this document will be given to every employee.
   - This policy will be thoroughly discussed in New Hire Orientation.
   - Legal employee notices required by the Equal Employment Opportunity Commission will be posted in each Company location.

3. Any report of a discrimination complaint will not cause retaliation.

Effective: 2/18/1997

Revised:	9/4/98	7/21/06	11/13/08	6/19/10	12/7/15	1/16/18				
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	7/18/06	7/10/07
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Reviewed:	8/25/17	8/24/18	8/23/19	8/21/20						

ORIENTATION PERIOD 804

POLICY:

All newly hired employees and existing employees who have a change in position will participate in an orientation period for up to (90) days from date of hire or effective date of change.

PROCEDURES:

1. The orientation period for full-time employees starts on the first day of employment and continues for (90) consecutive calendar days. Orientation period for a part-time/resource employee will vary based on schedule.

2. The general classroom orientation for new hires will include a review of Seasons Hospice's mission, vision and values; employment policies/procedures, and protocols; a review of hospice philosophy, objectives, and goals; a review of the organizational structure; and a description of the client population and geographic area served. The discipline specific orientation will include a review of safety measures, appropriate interactions with patients and families, and applicable state and federal regulations and policies/procedures and protocols governing the delivery of the care provided by the discipline.

   CT: The Homemaker or Hospice Aide shall be provided with ten (10) hours of orientation prior to the individual providing homemaker or hospice aide services. Seasons Hospice will provide training and education on Alzheimer's Disease/Dementia symptoms and care to all staff providing direct care, upon employment and annually thereafter.

   FL: Upon beginning employment with Seasons Hospice, each employee will receive basic written information about interacting with persons who have Alzheimer's disease or dementia-related disorders. Additional education will be provided to 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.

   MO: Seasons Hospice will provide dementia-specific training about Alzheimer's disease and related dementias to their employees and those persons working as independent contractors who provide direct care to or may have daily contact with residents, patients, clients or consumers with Alzheimer's disease or related dementia. The training will be provided annually and updated as needed.

   NJ: Seasons Hospice will 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. In addition, Seasons Hospice shall provide access to approved programs in Human Trafficking Handling and Response Training for employees who have direct contact and / or interaction with facility patients and / or visitors of facility patients.

ORIENTATION PERIOD 804

TX: All personnel who are direct care staff and who have direct contact with patients (employed or under contract) will sign a statement that they have read, understand and will comply with all applicable company policies.

3. All newly hired employees and existing employees who have a change in position will be evaluated upon completion utilizing both the (90) day performance appraisal and the discipline specific competency.

4. Discipline specific competencies must be completed prior to an employee providing independent hands-on patient care. The supervisor, or a qualified designee, must complete the initial competency assigned for their job description(s) during a supervisory visit.

5. Employment may be terminated if the employee's performance or conduct during the orientation period does not meet Seasons Hospice standards.

6. Under appropriate circumstances, the employee's supervisor may decide to extend the orientation period for an additional period of time. Reasons for extending the orientation period include but are not limited to:
   - additional time needed for training;
   - more time to evaluate the employee's performance; or,
   - an extended absence of (5) or more individual or consecutive days.

7. When an employee completes the orientation period, the relationship with Seasons Hospice is still one of employment-at-will.

Effective: 2/18/1997

Revised:	9/7/01	8/14/02	7/21/06	9/13/07	11/13/08	3/13/11	5/11/11	9/9/13	12/6/13	4/7/14
Revised:	12/7/15	1/16/18	12/4/18							
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	7/18/06	7/10/07
Reviewed:	12/19/08	12/15/09	12/17/10	12/16/11	10/26/12	8/30/13	8/22/14	5/5/2015	8/21/15	8/19/16
Reviewed:	8/25/17	8/24/18	8/23/19	8/21/20						

IN-SERVICE EDUCATION / STAFF DEVELOPMENT 814

POLICY:

In-service education and staff development programs are provided for employees and will be appropriate to their responsibilities and to the maintenance of skills necessary to care for patients and families.

PROCEDURES:

1. An annual educational needs assessment will be conducted for all employees.

2. All direct patient care employees will attend in-service education programs at least once annually. These programs will be based on identified needs.

   AZ: Seasons Hospice will provide each staff member with a minimum of two (2) clock hours of annual in-service education in palliative care.

   CA: Seasons Hospice shall provide or make provisions for at least quarterly in-service education programs to its employees and volunteers who have direct patient contact. In addition, Seasons Hospice shall provide employees annual training on the Seasons Hospice workplace violence prevention plan.

   CO: Seasons 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. Seasons Hospice will maintain documentation of the annual education and training offered.

   CT: Each employee serving patients will receive an average of at least one (1) hour of in-service education per month. The in-service education shall include current information regarding drugs and treatment, specific service procedures and techniques, recognized professional standards, and criteria and classification of patients serviced. Six (6) hours of the annual in-service education requirement shall address topics related to hospice care. In addition, Seasons Hospice will provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter.

   FL: Seasons Hospice shall provide 24 hours of in-service training each biennium for certified nursing assistants during monthly HHA education and/or Annual Review materials that 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, and medical error prevention and safety.

   GA: Seasons Hospice will have an effective annual training and education program for all staff and volunteers who provide direct care to patients that addresses, at a minimum, emerging trends in infections control, recognizing abuse and neglect and reporting requirements, patient rights, and palliative care.

IN-SERVICE EDUCATION / STAFF DEVELOPMENT 814

IL: All employees shall attend in-service education programs pertaining to their assigned duties at least annually. Written records of program content and personnel attending each session shall be maintained.

MO: 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.

NJ: Seasons Hospice shall develop and implement a staff education plan, including plans for each service and designation of the person(s) responsible for training.

TX: The administrator and alternate administrator are required to complete continuing education hours per 97.259 of the Texas Licensing Standards (see protocol 6016 Administrator and Alternate Administrator Training – Texas Only).

3. Seasons Hospice will provide job-specific training to all employees and will:

- Ensure that personnel are properly oriented to assigned tasks;
- Ensure demonstration of competency for tasks when competency cannot be determined through education, license, certification or experience; and,
- Ensure personnel are informed of changes in techniques, philosophies, goals, patient's rights, policies, procedures, protocols, equipment, products and new populations served.

4. Educational programs may be held in conjunction with vendors or other health care organizations.

5. In-service and staff development includes programs relevant to all of the services offered by Seasons Hospice.

6. Attendance is documented using a sign-in sheet at the in-service and/or programs. Employees who attend staff development programs outside the agency should submit documentation of attendance to be included in the employee's personnel record.

7. An educational/in-service attendance record will track all offsite and onsite educational in-services that employees attend and is available to all appropriate state, federal and accrediting agencies.

8. Seasons Hospice will maintain the following documentation of in-service/staff development programs:

a) Program subject, date, and content or summary;
b) Copies of handouts; and,
c) Program attendee names and titles.

IN-SERVICE EDUCATION / STAFF DEVELOPMENT 814

9. Hospice Aides will receive at least twelve (12) hours of in-service training during each 12-month period (on an employment anniversary basis). This training will be provided by or under the supervision of a Registered Nurse and documentation demonstrating that this requirement has been met will be maintained.

10. At the discretion of the Executive Director or Clinical Director, employees may attend in-service programs during the course of their workday and may be given time off with pay to attend such programs. Employees will not be paid for attending education programs that occur outside of their regularly scheduled hours.

11. Approval for an absence from required in-service education sessions must be obtained prior to the session from the employee's supervisor.

12. If an employee's license or certification depends upon attending a required number of hours of in-service education sessions, it is the employee's responsibility to meet that requirement to continue their employment.

Effective: 5/2000

Revised:	2/22/02	3/9/06	7/21/06	9/13/07	11/13/08	12/2/08	6/19/10	9/20/11	10/7/11	12/16/11
Revised:	11/18/12	6/4/13	4/7/14	12/7/15						
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	7/18/06	7/10/07
Reviewed:	12/19/08	12/15/09	12/17/10	12/16/11	10/26/12	8/30/13	8/22/14	8/21/15	8/19/16	8/25/17
Reviewed:	8/24/18	8/23/19	8/21/20							

CONTINUING EDUCATION 815

POLICY:

Seasons Hospice supports the continuing education of its employees.

PROCEDURES:

1. Full time regular employees of Seasons Hospice who have successfully completed their (90) day orientation period are eligible for participation.

2. All courses and programs must be directly related to increasing the employee's professional knowledge/skills with hospice, improving the day-to-day business operations of the hospice or improving patient/family care.

3. Expenses which may be reimbursed include:
   - Travel, lodging and meals, if necessary,
   - Cost of registration and tuition, and/or
   - Training materials and books necessary for course work.

4. Continuing education requests will be approved by the Executive Director or designee based on budgetary considerations.

Effective: 2/18/1997

Revised:	3/9/06									
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	7/18/06	7/10/07
Reviewed:	12/19/08	12/15/09	12/17/10	12/16/11	10/26/12	8/30/13	8/22/14	8/21/15	8/19/16	8/25/17
Reviewed:	8/24/18	8/23/19	8/21/20							

TUITION ASSISTANCE LOANS 816

POLICY:

Seasons Hospice provides tuition loans to eligible employees who enroll in and successfully complete approved courses of study in accredited education institutions in order to assist employees in maintaining a high level of effectiveness in their present positions and in preparing themselves for future development.

PROCEDURES:

1. Eligibility requirements include:

   - The employee must be a regular, full-time employee in good standing and employed at Seasons Hospice for at least one (1) year.
   - Employees on a leave of absence are not eligible.

2. Seasons Hospice defines approved courses or programs as:

   - Courses leading to a degree which has bearing on the employee's present work assignment or a position to which they are likely to be assigned in the future;
   - A general course approved by the employee's immediate supervisor, the Executive Director, and the National Manager-Employee Benefits which does not lead to a degree, but which has bearing on the employee's present work assignment or a position to which they are likely to be assigned in the future; and,
   - Workshops, conferences, and seminars are not included, but may be covered under continuing education or as additional job training.

3. Seasons Hospice defines approved institutions as:

   - An accredited junior college, a college or a university, which offers courses leading to an undergraduate and/or graduate degree; or,
   - An accredited, approved or reputable business, secretarial, vocational, or technical school.

4. All loans shall be based on actual tuition charge per one-hour credit and shall not exceed the amount of tuition except for allowable costs (registration fees, laboratory fees and any other instruction fees). Up to 100% of the tuition may be available, except:

   - If the approved course is for a degree and the employee fails to receive a grade of C or better or a passing grade for a Pass/Fail class, there will be no loan available to pay for repeating the course or for enrolling in another course until the above course has been successfully completed with a grade of C or better.
   - If the approved course is a general, non-credit course and the employee fails to receive a grade of C or better, there will be no loan available to pay for repeating the class.

TUITION ASSISTANCE 816

5. The maximum allowable reimbursement for any calendar year is two thousand and five hundred dollars ($2,500.00) per employee. However, this amount is not guaranteed.

6. Advance approval is required for educational loan assistance. Each case will be judged on its own merits using these criteria:

   a) There is a demonstrable need within the hospice for the skills, knowledge, and/or attitudes that are expected to result from the employee's participation in the course of study.

   b) The course of study undertaken by the employee is the most economical and feasible method of acquiring such skills, knowledge or attitudes.

   c) A direct relationship exists between the recommended training and the employee's current job description or another position within the organization for which the employee may be eligible.

   d) Budgetary considerations and the number of staff requesting assistance.

7. This loan may be forgiven by Seasons Hospice if the employee successfully completes the course of study by receiving a grade of "C" or higher and continues in Seasons Hospice's employ.

   - 50% of the loan will be forgiven after one year of continuous employment following the successful completion of the approved course of study.
   - The balance of the loan may be forgiven after two years of continuous employment following the successful completion of the approved course of study.

8. The employee receiving a tuition loan will sign a loan agreement and shall be responsible for repayment of 100% of the tuition loan if he/she leaves Seasons Hospice for any reason before completing the course of study.

9. The employee will be responsible for repayment of the tuition loan, or a portion of the loan, if they leave Seasons Hospice for any reason before completing two years of employment following completion of the course of study.

10. Seasons Hospice may, at its option, withhold these funds from the employee's final paycheck, to the extent permitted by state or local law, or, if necessary, institute collection procedures against the employee.

Effective: 2001

Revised:	3/14/02	7/21/06	9/13/07	1/16/18						
Reviewed:	2/17/98	3/24/99	4/11/00	2/27/01	5/15/02	3/11/03	5/18/04	6/3/05	7/18/06	7/10/07
Reviewed:	12/19/08	12/15/09	12/17/10	12/16/11	10/26/12	8/30/13	8/22/14	8/21/15	8/19/16	8/25/17
Reviewed:	8/24/18	8/23/19	8/21/20							

NOTICE OF PRIVACY PRACTICES 908

POLICY:

Patients have a right to adequate notice of the uses and disclosures of protected health information (PHI) that may be made by Seasons Hospice and of the patient's rights, and Seasons Hospice's legal duties, with respect to protected health information.

PROCEDURES:

1. The privacy practices of Seasons Hospice are described in the Notice of Privacy Practices which is included in the Patient/Family Consent and Education for Hospice Care booklet. The privacy practices are further explained in Seasons Hospice's policies and procedures.

2. The Notice of Privacy Practices is given to all patients or their representative no later than the date of the first service delivery and is available to anyone upon request. Seasons Hospice may provide the notice to an individual by email if the individual agrees to electronic notice and such agreement has not been withdrawn. If it is known that the email transmission failed, a paper copy of the notice will be provided to the individual.

3. The Notice of Privacy Practices is given to bereaved family members and community members if treatment is provided (i.e. a care plan is developed beyond the mailings, memorial services, bereavement support groups, etc.).

4. A good faith effort is made to obtain written acknowledgement of the patient or their representative's receipt of the Notice of Privacy Practices. When written acknowledgement cannot be obtained, there will be documentation in the medical record to explain efforts made to obtain it and the reason(s) why it was not obtained.

5. The Notice of Privacy Practices will be prominently displayed in our hospice unit(s) and available on the Seasons Hospice website at http://www.seasons.org.

6. The Notice of Privacy Practices will be revised as needed to reflect any changes in Seasons Hospice's privacy practices. Revisions to the Notice of Privacy Practices will not be implemented prior to the effective date of the revised Notice.

7. When revisions to the Notices of Privacy Practices are necessary, all current patients (or their representative), employees, and business associates will receive a revised copy upon request.

8. The Privacy Officer retains copies of the original Notice of Privacy Practices and any subsequent revisions for a period of six (6) years from the date of its creation or when it was last in effect, whichever is later.

NOTICE OF PRIVACY PRACTICES 908

9. Written acknowledgement of receipt of the hospice's Notice of Privacy Practices by adult patients will be retained for seven (7) years. If written acknowledgement of the patient's receipt of the Notice of Privacy Practices cannot be obtained, the detailed explanation documented in the medical record will be retained for seven (7) years.

10. Written acknowledgment on behalf of minors (under the age of 18) of receipt of the Notice of Privacy Practices will be retained until the patient reaches (or would have reached) 18 years plus (5) years, or for a minimum of seven (7) years. If written acknowledgement on behalf of minors (under the age of 18) of the receipt of the Notice of Privacy Practices cannot be obtained, the detailed explanation documented in the medical record will be retained until the patient reaches (or would have reached) 18 years plus 5 years, or for a minimum of seven (7) years.

    IN: Written acknowledgment for minors will be retained for 7 years after the age of majority.

11. All employees and business associates of Seasons Hospice are required to adhere to the privacy practices as detailed in the Notice of Privacy Practices, privacy policies and procedures and business associate contracts.

12. Violations of Seasons Hospice's privacy practices will result in disciplinary action up to and including termination of employment or contracts.

Effective: 4/17/2003

Revised:	4/18/05	10/23/06	11/15/07	12/19/08	2/20/10	3/12/11	11/17/12	9/20/13	
Reviewed:	5/18/04	6/3/05	10/17/06	10/26/07	12/19/08	7/9/09	12/13/10	8/26/11	9/28/12
Reviewed:	2/1/13	1/24/14	9/26/14	9/25/15	9/23/16	9/22/17	9/21/18	9/20/19	9/18/20

PRIVACY AND SECURITY TRAINING 926

POLICY:

Seasons Hospice will ensure that all workforce members have been trained in, and fully understand, the privacy and security policies and procedures of the organization. In addition, all workforce members will be trained on how to identify, report, and prevent potential privacy and security incidents.

PROCEDURES:

1. A formal privacy and security training program is provided during the orientation program for all new employees before access to protected health information is authorized.

2. Privacy and security training will be an ongoing activity at Seasons Hospice. Periodic privacy and security reminders will keep workforce members up-to-date with new threats, such as computer viruses or scams. The frequency and form of these reminders will be determined by the Privacy and Security Officer and may include flyers or posters in break rooms, reminder emails and verbal updates at meetings.

3. Seasons Hospice employees, including management, receive training on the hospice's policies and procedures related to protection from malicious software, log-in monitoring, password management and reporting privacy and security incidents.

4. Emphasis is placed, throughout the trainings, on procedures for reporting potential or actual privacy or security incidents, including those that involve a breach of protected health information.

5. All employees and volunteers who have access to PHI will complete the HIPAA privacy and security training and sign a statement indicating their understanding and commitment to follow the HIPAA requirements to maintain confidentiality of the protected health information.

6. All privacy and security training provided to employees and volunteers will be documented and maintained in personnel records. Documentation of the privacy and security training program is maintained for seven (7) years from the date the training was provided.

7. Evidence that students (including interns, residents and nursing) have received HIPAA training will be included in any contract between a school and Seasons Hospice. If a relationship exists that does not require a contract but the student will have access to patient protected health information, Seasons Hospice will request verification of HIPAA training from the student.

Effective: 4/17/03

Revised:	12/20/07	2/21/10	11/18/12	6/1/14						
Reviewed:	5/18/04	6/3/05	11/13/06	10/26/07	12/19/08	12/16/09	10/18/10	12/16/11	11/7/12	10/25/13
Reviewed:	9/26/14	9/25/15	9/23/16	9/22/17	9/21/18	9/20/19	9/18/20			

Charity Care Policy

PURPOSE:
To help patient's get access to hospice care regardless of payor source. Seasons does not discriminate based on a patient's ability to pay.

POLICY:
Seasons Hospice Charity Care committee in collaboration with the local program's Executive Director shall approve acceptable Charity care awards. No further collection activity will be made on the amounts approved for write-off.

Eligibility;

- All patients are eligible to apply.
- A Confidential Application for Financial Assistance must be completed, signed and dated, by the patient/guarantor. Application details include, but are not limited to;
    - Citizenship status
    - Assets
    - Household income
    - Patient/Spouse income considered
- Patient's are not eligible for Financial Assistance when:
    - They did not complete the application process
    - Falsified information on the application
- Any Medicaid eligible individual that is determined to be over (income) resources for his/her respective State, but under 200% of the Federal Poverty Guideline is eligible for Charity Care.
- Any Non-US citizen who otherwise lack any insurance coverage for hospice is eligible for Charity Care.

Alternate funding options;

- If eligible, it will be requested that the patient apply for state and/or federal assistance (including coverage available through the Healthcare Exchange) to be considered for financial assistance.
    - If the patient's prognosis does not support pursing alternate funding options he/she will be eligible for Charity care consideration.
    - Premium Assistance for coverage pursued via the Healthcare Exchange may be available through Seasons Hospice Foundation for any Hospice eligible individual who demonstrates a need for assistance.
        - Premium Assistance grants are awarded by Seasons Hospice Foundation.

Assets;

- The liquid assets of the applicant may not exceed $2,000. The exceptions will be reviewed on a case-by-case basis. Approval can still be made depending on the case circumstances.
    - Individuals with more than $2,000 in liquid assets would be encouraged to spend those funds down to pursue State Medical Assistance.
- These resources include cash, monies in checking and savings or credit union accounts and savings bonds. These may include trust funds, company stocks and bonds, Life Insurance Policy cash value and property other than the home place.

Sliding scale;

- Seasons Hospice utilizes the annual Federal Poverty Guidelines issued by the Department of Health and Human Services (HHS) when granting Charity Care for a Patient balance discount.

Percentage of the Federal Poverty line (based on family size)	**Percentage of award (write off)**	**Percentage patient/guarantor is responsible for**
201 – 250	75	20
251 - 300	70	30
301 – 350	65	35
351 – 400	60	40
401 – 450	55	45
451 – 500	50	50
501 – 550	45	54
551 – 600	40	60
601 - 650	35	65
651 – 700	30	70
701+	25	75

Approval;

- Charity Care for a Patient balance discount;
    - Approved at the National level by the National Manager of Patient Funding, VP Finance, or National Controller.
    - The award granted will be applied to all open patient balances
- Charity write off for the Indigent;
    - Approved locally by the Site's Executive Director or Vice President of Operations in his/her absence. Approved Nationally by a member of the National Financial Assistance Committee. Committee members include;
        - Chief Financial Officer, Vice President of Finance, Vice President of Patient Experience, National Director(s) of Patient Experience, National Manager of Patient Funding, National Controller.

- A determination of Financial Assistance submitted during normal business hours will be made within 2 hours of receipt of the application.
    - Monday – Friday 8am - 4:30pm central standard time
- Award approvals will be communicated to the patient/guarantor by a member of his/her local team unless otherwise requested by the patient/guarantor.

Certification periods

- At each Hospice recertification period, the patient must re-apply for Financial Assistance (addendum - 2096d).
    - Seasons Hospice will follow the Medicare Certification period irrespective of payor for the pursues of re-certifying Financial Assistance.

Deceased Patients

- Seasons Hospice will notify the Estate of the patient *Care Of* the patient's designated Next of Kin. Seasons Hospice will attempt to pursue payment directly from the patient's Estate for any balance over $400.
- Any patient balance that is not collected will be applied to Bad Debt.

Confidential Application For Financial Assistance

SEASONS HOSPICE & PALLIATIVE CARE®

Honoring Life
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Seasons Hospice & Palliative Care ("Seasons Hospice") encourages you to apply for financial assistance if you require help paying for your hospice care. Under this program, Seasons Hospice will review your application and determine whether you qualify for free or reduced cost care based on your eligibility and income. If you have questions or need help completing this application, please contact your Seasons Hospice team, or the National Patient Funding Advocate at 224-458-7405.

Submit completed form to NATFinanceFinancialAssistance@Seasons.org

Patient Name:	Date of Birth:
Street Address:	Telephone:
City/State/Zip	Social Security Number:
Mailing Address (if different):	

Citizenship status. Select one

☐ US Citizen ☐ Non US Citizen ☐ Working Visa ☐ Permanent Resident ☐ Visitor Visa:

If Permanent Resident; number of years in the US?

Please provide the following for all household members

Name	Age	Relationship to Patient

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Application

Do you have insurance?	Yes ☐	No ☐	If Yes, list all active policies	
If No, did you apply for insurance through the Health Insurance Marketplace?	Yes ☐	No ☐	If No, please provide a brief explanation as to why you did not enroll	
Do you have Medicaid?	Yes ☐	No ☐	If Yes, list ID and case worker information	
Have you ever applied for Medicaid?	Yes ☐	No ☐	If No, why? If Yes, why was your case denied?	
Do you receive any other assistance with your Medical bills?	Yes ☐	No ☐	If Yes, list organization name and contact information	
Have you applied for disability?	Yes ☐	No ☐	If Yes, When?	
Is there a member of the household who has become unemployed within the past 60 days?	Yes ☐	No ☐	If Yes, Name?	
Have you ever been covered under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA insurance)?	Yes ☐	No ☐	If yes, when did that coverage end?	

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Assets

Report any income for the patient and any individual that may be claiming or may have been claimed by the patient as a dependent for tax purposes.

Assets		Value
Cash on Hand		$
Checking Account Balance	Bank:	$
Savings Account	Bank:	$
Retirement Savings	Bank:	$
Investments or Other Securities		$
Life Insurance Policy Cash Value		$
Real Estate, Primary Residence	Location:	$
Real Estate other than Primary Residence	Location:	$
Vehicle 1	Year:	$
Vehicle 2	Year:	$
Total Assets: $		

Employment

Person Employed	Employer	Monthly Gross
		$
		$
		$

Monthly Household Income from other sources

Source	Monthly
Child Support/ Alimony	$
Federal Assistance Program Type_____ (ie. Cash, Food Stamps)	$
Pension/ IRA/ Annuity Cash out	$

Social Security/Social Security Disability	$
Unemployment or Worker's Comp Start Date:_____ End Date:_____	$
Other income (Stocks/Bonds/Annuities/Interest/Rental Property)	$
Total month income (Gross and Other sources combined): $	

If the patient does not have any income, provide a short narrative as to who is financially supporting the patient:

_____

_____

_____

_____

Monthly Household Expenses

Type of Expense	**Total Monthly**
Mortgage	$
Rent	$
Child care	$
Child support/ Alimony	$
Utilities (combined) gas, electric, water, sewer	$
Telephone	$
Insurance: Home_____ Auto_____	$
Car loan:	$
Transportation:	$
Credit card payments:	$
Total monthly expenses: $	

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Applicant Certification:

I certify that the above information is true and complete to the best of my/our knowledge. I understand that as part of the financial screening process, Seasons Hospice may require that I provide supporting documentation regarding my finances.

I also understand that Seasons Hospice may require that I seek to obtain health insurance coverage through State Medical Assistance or a federal or state health insurance exchange prior to approving my request for financial assistance.

I am aware that any misstated, missing, or false information can retroactively revoke any financial assistance allowance made by Seasons Hospice. I authorize Seasons Hospice to obtain copies of my tax returns from the Internal Revenue Service.

I understand that filling out this Financial Assistance Application does not guarantee that I will receive any financial assistance. If I am not eligible for financial assistance, I will be responsible for my full bill for hospice services provided by Seasons Hospice.

Signature: _____ Date: _____

Spouse signature (if applicable): _____ Date: _____

Surrogate/DPOA signature (if applicable): _____ Date: _____

EXHIBIT 16

Pro Forma Financial Statements and Assumptions

WASHINGTON STATE
CON FINANCIAL FORM TEMPLATE

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

WAC 246-310-990(2) defines "total capital expenditure" to mean the total project cots to be capitalized according to generally acccepted accounting principles. These costs include, but are not limited to, the following; legal fees; feasibility studies; site development; soil survey and investigation; consulting fees; interest expenses during construction; temporary relocation; architect and engineering fees; construction, renovation, or alteration; total costs of leases of capital assets; labor; materials; fixed or mavable equipment; sales taxes; equipment delivery; and equipment installation.

1. Provide the proposed capital expenditures for the project. These expenditures should be broken out in detail and account for at least the following.

Item	Cost
Land Acquisition	
Site Survey, Tests, Inspections:	
Construction Contract:	
Financial Feasibility Studies:	
Architectural Fees	
Engineering Fees	
Consulting Fees	
Fixed Equipment	
Movable Equipment	$ 96,842
Freight and Delivery Charges	
Sales Tax	
Cost of Tuning Up and Trial Runs	
Reconditioning Costs	
Costs of Title Investigations	
Legasl Fees	
Brokerage Commissions	
Other Activities	
Financing Costs	
Total	$ 96,842

2. Explain in detail the methods and sources used for estimated capital expenditures

The Table below itemizes the capital expenditures estimated in connection with this project. The cost estimates were developed by the Applicant's purchasing department and reflect the types of expenditures made in connection with its start-up programs in other service areas. The item costs reflect corporate pricing agreements with the Applicant's vendors, and are inclusive of applicable state and local sales taxes.

Item	Item Cost	Qty	Total	Depreciable Life	Annual Depreciation Expense
Conference Table	$ 4,235	1	$ 4,235	15	$ 282
Conference Chairs	$ 424	12	$ 5,088	15	$ 339
Employee Desk	$ 1,452	9	$ 13,068	15	$ 871
Employee Desk Chair	$ 484	9	$ 4,356	15	$ 290
Guest Chair	$ 363	9	$ 3,267	15	$ 218
Filing Cabinet	$ 1,089	5	$ 5,445	15	$ 363
Reception Area Guest Chair	$ 787	6	$ 4,722	15	$ 315
Reception Area End Table	$ 242	3	$ 726	15	$ 48
Reception Area Coffee Table	$ 484	1	$ 484	15	$ 32
Kitchen Table	$ 605	2	$ 1,210	15	$ 81
Kitchen Chairs	$ 242	8	$ 1,936	15	$ 129
Patient Care Kit	$ 807	6	$ 4,842	5	$ 968
Employee Work Stations	$ 807	9	$ 7,263	15	$ 484
Subtotal Furnishings			$ 56,642		$ 4,422
Electronics and Telecom					
Server, HPE ProLiant ML 150, G9	$ 9,000	1	$ 9,000	5	$ 1,800
Firewall, Fortinet Fort iGate 100D	$ 3,000	1	$ 3,000	5	$ 600
Network Switch 2xAdtran Netvana 1638p	$ 3,200	1	$ 3,200	5	$ 640
On-time Low Voltage Wiring Installation	$ 15,000	1	$ 15,000	10	$ 1,500
Xerox Work Center	$ 10,000	1	$ 10,000	5	$ 2,000
Subtotal Electronics and Telecom			$ 40,200		$ 6,540
TOTAL			$ 96,842		$ 10,962

www.northwestern.edu/controller/accounting-services/equipment-inventory/docs/useful-lives-table.xls

3. Document the project impact on (a) capital costs; and (b) operating costs and charges for health services.

As shown in the estimates provided above, the capital costs associated with the implementation of this project are quite modes and will not affect charges for health care services in the proposed service area. It is projected that the annual depreciation expense for the project will be : $ 10,962 annually.

Based on the Applicant's utilization projections, this cost will not materially impact the cost of providing health care services in its service area.

4. Provide the total estimated operating revenue and expenses for the first three years of operation (please show each year separately) for the following as applicable. Include all formulas and calculations used to arrive at totals on a separate page.

	Last Audit	Last Audit through Construction	6 Months Ended	12 Month Period Ending:		
REVENUES	**31-Dec-21**	**30-Jun-23**	**31-Dec-23**	**31-Dec-24**	**31-Dec-25**	**31-Dec-26**
Patient Service Charges						
Medicare	$ -	$ -	$ 142,782	$ 457,349	$ 737,356	$ 1,072,727
Medicare Managed Care			333,157	1,067,147	1,720,496	2,503,029
Medicaid			5,230	16,753	27,009	39,294
Health Options (BHP)			10,460	33,505	54,019	78,588
Charity Care			-	-	-	-
Private Pay			13,075	41,882	67,523	98,235
Third Party Insurance			15,690	50,258	81,028	117,882
Other (Champus, VA)			2,615	8,376	13,505	19,647
Total Patient Service Charges	$ -	$ -	$ 523,010	$ 1,675,271	$ 2,700,936	$ 3,929,402
Revenue Deductions						
Medicare	$ -	$ -	$ 20,290	$ 64,991	$ 104,781	$ 152,439
Medicare Managed Care			61,634	197,421	318,290	463,057
Medicaid			1,192	3,818	6,155	8,955
Health Options (BHP)			2,092	6,701	10,804	15,718
Charity Care			5,230	16,753	27,009	39,294
Bad Debt			6,276	20,103	32,411	47,153
Third Party Insurance			785	2,513	4,051	5,894
Other (Champus, VA)			654	2,094	3,376	4,912
Total Revenue Deductions	$ -	$ -	$ 98,152	$ 314,394	$ 506,878	$ 737,421
Net Patient Service Revenues						
Medicare	$ -	$ -	$ 122,492	$ 392,358	$ 632,574	$ 920,288
Medicare Managed Care			271,524	869,726	1,402,207	2,039,971
Medicaid			4,038	12,935	20,854	30,339
Health Options (BHP)			8,368	26,804	43,215	62,870
Charity Care						
Private Pay			1,569	5,026	8,103	11,788
Third Party Insurance			14,906	47,745	76,977	111,988
Other (Champus, VA)			1,961	6,282	10,129	14,735
Total Net Patient Service Revenues	$ -	$ -	$ 424,858	$ 1,360,877	$ 2,194,058	$ 3,191,980
Non-Operating Revenues	$ -	$ -	9,150	29,308	47,251	68,742
TOTAL REVENUES	$ -	$ -	$ 434,008	$ 1,390,184	$ 2,241,309	$ 3,260,722
EXPENSES						
Advertising	$ -	$ 2,000	$ 7,899	$ 15,669	$ 15,669	$ 15,669
Allocated Costs			-	-	-	-
Depreciation and Amortization			5,526	10,962	10,962	10,962
Dues and Subscriptions			1,260	2,500	2,500	2,500
Education and Training			1,037	2,371	2,878	3,485
Employee Benefits			70,429	144,584	194,384	219,284
Equipment Rental			-	-	-	-
Information Technology/Computers			30,100	15,250	20,350	17,800
Insurance			6,301	12,500	12,500	12,500
Interest			-	-	-	-
Legal and Professional			7,370	14,864	15,256	15,727
Licenses and Fees			15,681	19,040	21,540	24,040
Medical Supplies			27,732	88,830	143,214	208,353
Payroll Taxes			30,519	62,653	84,233	95,023
Postage			211	675	1,088	1,583
Purchased Services (Utilities,other)			32,237	103,260	166,479	242,199
Rental/Lease		84,175	48,175	99,240	102,218	105,284
Repairs and Maintenance			1,764	3,500	3,500	3,500
Salaries and Wages (DNS, RN, OT, clerical, etc.)		146,224	469,523	963,892	1,295,892	1,461,892
Supplies			2,107	6,749	10,881	15,830
Telephone/Pagers			39,549	78,453	78,453	78,453
Service Fees			30,000	60,000	60,000	60,000
Washington State B & O Taxes			6,510	20,853	33,620	48,911
Travel (patient care, other)			40,815	121,556	186,835	265,021
TOTAL EXPENSES	$ -	$ 232,399	$ 874,745	$ 1,847,400	$ 2,462,451	$ 2,908,014
Contributons to Seasons Hospice Foundation	$ -	$ -	$ -	$ 12,500	$ 25,000	$ 50,000
NET INCOME	$ -	$ (232,399)	$ (440,737)	$ (469,716)	$ (246,143)	$ 302,709

Workpaper 1: Global Assumptions

Consistent with the instructions provided by the Department of Health, none of the revenues or expenses in these projections have been inflation-adjusted. The values of 1.000 shown for the inflation rates below indicate zero inflation.

Inflation Rates:				
Patient Charges		1.000		
Government Payors		1.000		
Salaries and Wages		1.000		
Medical Supplies		1.000		
Project Year 1 Ending Date	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Fringe Benefit Percentage (Excluding Government)	15.0%	15.0%	15.0%	15.0%
Payroll Taxes	6.5%	6.5%	6.5%	6.5%

Workpaper 2 : Patient Days by Setting

Projected Patient Days	2,107	6,749	10,881	15,830
ADC	11.5	18.5	29.8	43.4
Percentage by Setting				
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%

Workpaper 3: Payor Mix by Patient Day

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 Payor

Medicare				
Routine	564	1,806	2,911	4,235
Continuous Care	1	4	6	9
Respite	2	6	9	13
GIP	9	28	45	65
Total	575	1,842	2,971	4,322
	575	1,842	2,971	4,322
Medicare Managed Care				
Routine	1,315	4,213	6,793	9,882
Continuous Care	3	9	14	20
Respite	4	13	21	30
GIP	20	64	104	151
Total	1,342	4,299	6,931	10,084
	1,342	4,299	6,931	10,084
Medicaid				
Routine	21	66	107	155
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	2	2
Total	21	67	109	158
	21	67	109	158
Health Options (BHP)				
Routine	41	132	213	310
Continuous Care	0	0	0	1
Respite	0	0	1	1
GIP	1	2	3	5
Total	42	135	218	317
	42	135	218	317
Charity Care				
Routine	21	66	107	155
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	2	2
Total	21	67	109	158
	21	67	109	158
Private Pay				
Routine	31	99	160	233
Continuous Care	0	0	0	0
Respite	0	0	0	1
GIP	0	2	2	4
Total	32	101	163	237
	32	101	163	237
Third Party Insurance				
Routine	62	198	320	465
Continuous Care	0	0	1	1
Respite	0	1	1	1
GIP	1	3	5	7
Total	63	202	326	475
	63	202	326	475
Other (Champus, VA)				
Routine	10	33	53	78
Continuous Care	0	0	0	0
Respite	0	0	0	0
GIP	0	1	1	1
Total	11	34	54	79
	11	34	54	79
ALL PAYORS				
Routine	2,065	6,614	10,663	15,513
Continuous Care	4	13	22	32
Respite	6	20	33	47
GIP	32	101	163	237
Total	2,107	6,749	10,881	15,830
	2,107	6,749	10,881	15,830

Workpaper 5: Patient Charges

Patient charges are based on Medicare per diem rates for Spokane County hospice services, with a slight increase to accommodate other payors.

Base Time Period

Routine	$ 230.00
Continuous Care	$ 1,625.00
Respite	$ 525.00
GIP	$ 1,200.00

Effective Dates		30-Sep-22		
	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Inflation Factors	1.000	1.000	1.000	1.000
Inflation-Adjusted Charges				
Routine	$ 230.00	$ 230.00	$ 230.00	$ 230.00
Continuous Care	$ 1,625.00	$ 1,625.00	$ 1,625.00	$ 1,625.00
Respite	$ 525.00	$ 525.00	$ 525.00	$ 525.00
GIP	$ 1,200.00	$ 1,200.00	$ 1,200.00	$ 1,200.00
Projected Patient Charges				
Medicare				
Routine	$ 129,653	$ 415,294	$ 669,554	$ 974,086
Continuous Care	$ 1,869	$ 5,988	$ 9,654	$ 14,045
Respite	$ 906	$ 2,902	$ 4,679	$ 6,807
GIP	$ 10,354	$ 33,165	$ 53,469	$ 77,789
Total	$ 142,782	$ 457,349	$ 737,356	$ 1,072,727
Medicare Managed Care				
Routine	$ 302,523	$ 969,020	$ 1,562,292	$ 2,272,868
Continuous Care	4,362	13,972	22,526	32,772
Respite	2,114	6,771	10,917	15,882
GIP	24,159	77,384	124,762	181,507
Total	$ 333,157	$ 1,067,147	$ 1,720,496	$ 2,503,029
Medicaid				
Routine	$ 4,749	$ 15,212	$ 24,526	$ 35,681
Continuous Care	68	219	354	514
Respite	33	106	171	249
GIP	379	1,215	1,959	2,849
Total	$ 5,230	$ 16,753	$ 27,009	$ 39,294

Workpaper 5: Patient Charges (Cont'd)

	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Health Options (BHP)				
Routine	$ 9,498	$ 30,424	$ 49,052	$ 71,362
Continuous Care	137	439	707	1,029
Respite	66	213	343	499
GIP	759	2,430	3,917	5,699
Total	$ 10,460	$ 33,505	$ 54,019	$ 78,588
Charity Care				
Routine	$ -	$ -	$ -	$ -
Continuous Care	-	-	-	-
Respite	-	-	-	-
GIP	-	-	-	-
Total	$ -	$ -	$ -	$ -
Private Pay				
Routine	$ 11,873	$ 38,031	$ 61,314	$ 89,202
Continuous Care	171	548	884	1,286
Respite	83	266	428	623
GIP	948	3,037	4,896	7,124
Total	$ 13,075	$ 41,882	$ 67,523	$ 98,235
Third Party Insurance				
Routine	$ 14,248	$ 45,637	$ 73,577	$ 107,042
Continuous Care	205	658	1,061	1,543
Respite	100	319	514	748
GIP	1,138	3,644	5,876	8,548
Total	$ 15,690	$ 50,258	$ 81,028	$ 117,882
Other (Champus, VA)				
Routine	$ 2,375	$ 7,606	$ 12,263	$ 17,840
Continuous Care	34	110	177	257
Respite	17	53	86	125
GIP	190	607	979	1,425
Total	$ 2,615	$ 8,376	$ 13,505	$ 19,647
ALL PAYORS	$ 523,010	$ 1,675,271	$ 2,700,936	$ 3,929,402

Workpaper 6: Net Revenues by Payor and Patient Setting

Part 1: Net Per Diem Revenues

Medicare			Percent 1-60	Percent 60 Plus	Blended Rate
Routine	$ 217.00	$ 171.44	52%	48%	$ 195.13
Continuous Care	$ 1,575.14				$ 1,575.14
Respite	$ 502.94				$ 502.94
GIP	$ 1,137.57				$ 1,137.57

Source: Final FY 2022 Hospice Rates CMS

Inflation-Adjusted Rates

Inflation Amount	1.000	
Effective Date	30-Sep-20	

Inflation Factor	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Compound Inflation	1.000	1.000	1.000	1.000

Inflation-Adjusted Medicare Rates

Routine	$ 195.13	$ 195.13	$ 195.13	$ 195.13
Continuous Care	$ 1,575.14	$ 1,575.14	$ 1,575.14	$ 1,575.14
Respite	$ 502.94	$ 502.94	$ 502.94	$ 502.94
GIP	$ 1,137.57	$ 1,137.57	$ 1,137.57	$ 1,137.57

It is assumed that remibursement rates for Medicare Managed Care and Medicaid will follow the Medicare methodology with discounts from the Medicare rates.

Medicare Managed Care Discount	5%	5%	5%	5%
Medicaid Discount	10%	10%	10%	10%

Medicare Managed Care Rates

Routine	$ 185.37	$ 185.37	$ 185.37	$ 185.37
Continuous Care	$ 1,496.38	$ 1,496.38	$ 1,496.38	$ 1,496.38
Respite	$ 477.79	$ 477.79	$ 477.79	$ 477.79
GIP	$ 1,080.69	$ 1,080.69	$ 1,080.69	$ 1,080.69

Medicaid Rates

Routine	$ 175.62	$ 175.62	$ 175.62	$ 175.62
Continuous Care	$ 1,417.63	$ 1,417.63	$ 1,417.63	$ 1,417.63
Respite	$ 452.65	$ 452.65	$ 452.65	$ 452.65
GIP	$ 1,023.81	$ 1,023.81	$ 1,023.81	$ 1,023.81

Other Payors Percentage of Charges Collected

Healthy Options (BHP)	80.0%	80.0%	80.0%	80.0%
Charity Care	0.0%	0.0%	0.0%	0.0%
Private Pay	20.0%	20.0%	20.0%	20.0%
Third Party Insurance	95.0%	95.0%	95.0%	95.0%
Other	75.0%	75.0%	75.0%	75.0%

Workpaper 6: Net Revenues by Payor and Patient Setting (Cont'd)

Part 1: Net Per Diem Revenues (Cont'd)

For payors other than Medicare, Medicare Managed Care and Mediciad, net revenues are computed as a percentage of charges.

Per Diem Collections	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Healthy Options (BHP)				
Routine	$ 184.00	$ 184.00	$ 184.00	$ 184.00
Continuous Care	$ 1,300.00	$ 1,300.00	$ 1,300.00	$ 1,300.00
Respite	$ 420.00	$ 420.00	$ 420.00	$ 420.00
GIP	$ 960.00	$ 960.00	$ 960.00	$ 960.00
Charity Care				
Routine	$ -	$ -	$ -	$ -
Continuous Care	$ -	$ -	$ -	$ -
Respite	$ -	$ -	$ -	$ -
GIP	$ -	$ -	$ -	$ -
Private Pay				
Routine	$ 46.00	$ 46.00	$ 46.00	$ 46.00
Continuous Care	$ 325.00	$ 325.00	$ 325.00	$ 325.00
Respite	$ 105.00	$ 105.00	$ 105.00	$ 105.00
GIP	$ 240.00	$ 240.00	$ 240.00	$ 240.00
Third Party Insurance				
Routine	$ 218.50	$ 218.50	$ 218.50	$ 218.50
Continuous Care	$ 1,543.75	$ 1,543.75	$ 1,543.75	$ 1,543.75
Respite	$ 498.75	$ 498.75	$ 498.75	$ 498.75
GIP	$ 1,140.00	$ 1,140.00	$ 1,140.00	$ 1,140.00
Other				
Routine	$ 172.50	$ 172.50	$ 172.50	$ 172.50
Continuous Care	$ 1,218.75	$ 1,218.75	$ 1,218.75	$ 1,218.75
Respite	$ 393.75	$ 393.75	$ 393.75	$ 393.75
GIP	$ 900.00	$ 900.00	$ 900.00	$ 900.00
Percentage of GIP Revenues to be paid to outside providers:				
GIP Charges	$ 1,200.00	$ 1,200.00	$ 1,200.00	$ 1,200.00
Contract Percentage	85%	85%	85%	85%
Contract Payments	$ 1,020.00	$ 1,020.00	$ 1,020.00	$ 1,020.00
GIP Days	32	101	163	237
GIP Contract Payments	32,237	103,260	166,479	242,199

Workpaper 6: Net Revenues by Payor and Patient Setting (Cont'd)

Part 2: Aggregated Net Revenues

Medicare	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Routine	$ 109,997	$ 352,334	$ 568,047	$ 826,412
Continuous Care	1,812	5,804	9,358	13,614
Respite	868	2,780	4,482	6,521
GIP	9,815	31,439	50,687	73,742
Total	$ 122,492	$ 392,358	$ 632,574	$ 920,288
Medicare Managed Care				
Routine	$ 243,826	$ 781,008	$ 1,259,171	$ 1,831,879
Continuous Care	4,017	12,866	20,743	30,178
Respite	1,924	6,162	9,935	14,454
GIP	21,757	69,690	112,357	163,461
Total	$ 271,524	$ 869,726	$ 1,402,207	$ 2,039,971
Medicaid				
Routine	$ 3,626	$ 11,615	$ 18,727	$ 27,244
Continuous Care	60	191	309	449
Respite	29	92	148	215
GIP	324	1,036	1,671	2,431
Total	$ 4,038	$ 12,935	$ 20,854	$ 30,339
Health Options (BHP)				
Routine	$ 7,599	$ 24,340	$ 39,241	$ 57,089
Continuous Care	110	351	566	823
Respite	53	170	274	399
GIP	607	1,944	3,134	4,559
Total	$ 8,368	$ 26,804	$ 43,215	$ 62,870
Charity Care				
Routine	$ -	$ -	$ -	$ -
Continuous Care	-	-	-	-
Respite	-	-	-	-
GIP	-	-	-	-
Total	$ -	$ -	$ -	$ -
Private Pay				
Routine	$ 1,425	$ 4,564	$ 7,358	$ 10,704
Continuous Care	21	66	106	154
Respite	10	32	51	75
GIP	114	364	588	855
Total	$ 1,569	$ 5,026	$ 8,103	$ 11,788
Third Party Insurance				
Routine	$ 13,535	$ 43,355	$ 69,898	$ 101,690
Continuous Care	195	625	1,008	1,466
Respite	95	303	488	711
GIP	1,081	3,462	5,582	8,121
Total	$ 14,906	$ 47,745	$ 76,977	$ 111,988
Other (Champus, VA)				
Routine	$ 1,781	$ 5,705	$ 9,197	$ 13,380
Continuous Care	26	82	133	193
Respite	12	40	64	93
GIP	142	456	734	1,069
Total	$ 1,961	$ 6,282	$ 10,129	$ 14,735
ALL PAYORS				
Routine	$ 381,789	$ 1,222,920	$ 1,971,639	$ 2,868,399
Continuous Care	6,240	19,986	32,222	46,878
Respite	2,990	9,579	15,443	22,467
GIP	33,839	108,392	174,754	254,237
ALL PAYORS	$ 424,858	$ 1,360,877	$ 2,194,058	$ 3,191,980
Charity Care Discount	$ 5,230	$ 16,753	$ 27,009	$ 39,294

Balance Sheet

	31-Dec-21	30-Jun-23	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Current Assets						
Cash	2,000,000	1,680,111	1,219,557	671,189	340,764	516,904
Accounts Reveivable	-	-	70,810	226,813	365,676	531,997
Total Current Assets	2,000,000	1,680,111	1,290,367	898,002	706,440	1,048,901
Long Term Assets						
Land						
Buidlings						
Equipment		96,842	96,842	96,842	96,842	96,842
Security Deposit		3,000	3,000	3,000	3,000	3,000
Total	-	99,842	99,842	99,842	99,842	99,842
Less Accumulated Depreciation		-	5,526	16,488	27,449	38,411
Net Long Term Assets	-	99,842	94,316	83,354	72,393	61,431
Total Assets	2,000,000	1,779,953	1,384,683	981,356	778,833	1,110,332
Liabilities and Equity						
Current Liabilities						
Accounts Payable	-	167	10,280	26,614	36,619	48,602
Salaries Payable	-	12,185	47,539	97,594	131,209	148,017
Current Portion of Long-Term Debt	-					
Total Current Liabilities	-	12,352	57,820	124,208	167,828	196,618
Long Term Debt	-	-	-	-	-	-
Total Liabilities	-	12,352	57,820	124,208	167,828	196,618
Equity	2,000,000	1,767,601	1,326,863	857,148	611,005	913,714
Liabilities Plus Equity	2,000,000	1,779,953	1,384,683	981,356	778,833	1,110,332

STATEMENT OF CASH FLOWS

		12 Month Period ending:				
	31-Dec-21	**30-Jun-23**	**31-Dec-23**	**31-Dec-24**	**31-Dec-25**	**31-Dec-26**
Net Income	-	(232,399)	(440,737)	(469,716)	(246,143)	302,709
Less Depreciation	-	-	5,526	10,962	10,962	10,962
Decrease (Increase) in Current Assets	-	-	(70,810)	(156,003)	(138,864)	(166,320)
Increase (Decrease) in Current Liabilities	-	12,352	45,468	66,389	43,620	28,790
Net Cash Flows from Operations	-	(220,047)	(460,553)	(548,368)	(330,425)	176,140
Purchase of Property, Plant and Equipment	-	(96,842)	-	-	-	-
Security Deposit	-	(3,000)	-	-	-	-
Payment of Long-Term Debt						
Net Cash Flows from Investing	-	(99,842)	-	-	-	-
Contribution of Capital	2,000,000					
Beginning Cash	0	2,000,000	1,680,111	1,219,557	671,189	340,764
Ending Cash	2,000,000	1,680,111	1,219,557	671,189	340,764	516,904

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	$	36,000
First Six Months of 2023		48,175
Projected Pre-Opening Rental Expense	$	84,175

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	$	467,250
Annual Salary for Other Positions	$	485,000
Two Months Salary Supervisor	$	77,875
One Month Salary Other	$	40,417
Pre-Opening Medical Director Fee	$	2,500
Total Pre-Opening Salary	$	120,792
Benefit Percentage (Does not Apply to Med Director Stipend)		21.5%
Total Pre-Opening Salary Plus Benefits Plus Stipend	$	146,224

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	$	232,399
Rental Security Deposit	$	3,000

Worksheet 7:
Non-Salary Costs are based on the experience of Seasons Hospice and Palliative Care of Oregon. The grid below summarizes patient days for this facility for Calendar Year 2020. 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
Routine	21,194
Respite	5
GIP	644
Continuous Care	-
Total	24,814
ADC	68

Physician Fees	$ 107,755			
Patient Days	24,814			
Per Diem Physician Fees	$ 4.34			
Other Revenue Inflation Factors	1.00	1.00	1.00	1.00
Other Revenue Per Diem	$ 4.34	$ 4.34	$ 4.34	$ 4.34
Projected Patient Days	2,107	6,749	10,881	15,830
Projected Non-Operating Revenues	$ 9,150	$ 29,308	$ 47,251	$ 68,742

Worksheet 8: Estimation of Fixed and Variable Non-Salary Costs

The figures below are from the 2017 Income Statement for Seasons Hospice and Palliative Care of Oregon.

The numbers below that are not highlighted in yellow are not used because they are computed separately.

If the number is used, it is divided into its fixed and variable components based on the scheme shown below.

In these columns, the fixed and variable amounts of each line item are calculated

The variable amount is divided by the patient days delivered at Season of Oregon in 2017 to compute the variable per diem.

$ 326,599 13.16

Item	Amount	Use ?	Percent Fixed	Percent Variable		Amount Fixed	Amount Variable	Patient Days	Variable Per Diem
Clinical	34,663	1	0%	100%		-	34,663	24,814	$ 1.40
DME	121,889	1	0%	100%		-	121,889		$ 4.91
Pharmacy	169,033	1	0%	100%		-	169,033		$ 6.81
Open Access	1,014	1	0%	100%		-	1,014		$ 0.04
Room and Board	22,747	1	0%	100%		-	22,747		$ 0.92
Labor Direct	1,367,975	0	0%	100%		-	-		$ -
Labor Indirect	180,378	0	0%	100%		-	-		$ -
Other Direct	369,007	1	0%	100%	15.80	-	369,007		$ 14.87
Labor Operating	783,003	0	20%	80%		-	-		$ -
Benefits	491,544	0	20%	80%		-	-		$ -
Employee Relations	3,042	1	0%	100%		-	3,042		$ 0.12
Recruitment	1,359	1	100%	0%		1,359	-		$ -
Printing	11,786	1	80%	20%		9,429	2,357		$ 0.095
Marketing	15,669	1	100%	0%		15,669	-		$ -
Outside Services	4,794	1	100%	0%		4,794	-		$ -
Facilities	119,907	0	100%	0%		-	-		$ -
IS & Telecommunications	53,519	1	100%	0%		53,519	-		$ -
Conferences and Training	185	1	100%	0%		185	-		$ -
Travel	886	1	70%	30%		620	266		$ 0.01
Call Center	24,934	1	100%	0%		24,934	-		$ -
Other Operating Expenses	14,313	1	100%	0%		14,313	-		$ -
Allocated Expenses	908,134	0	0%	100%		-	-		$ -
Depreciation Expense	16,907	0	100%	0%		-	-		$ -
Total	4,716,688						391,855		
Check	4,716,688	3,227							
		0.13							

The expense accounts from Seasons Hospice of Oregon Have been assigned to the expense accounts set forth in the Department's Income Statement template

In some cases, additional expense allowances are added to the historical amounts.

The Values shown below are the sum of the historical fixed amount and any additional expense allowance added in

As with the fixed costs, it is possible to increase the historical per diem for individual expense accounts.

The values shown below represent the the historical variable per diem expense.

The Values shown below are the sum of the historical per deim amount plus any add-on.

	Fixed Amount							Variable Per Diem					
	31-Dec-19 Base	Add-On	31-Dec-23 1.00	31-Dec-24 1.00	31-Dec-25 1.00	31-Dec-26 1.00	Add-On	31-Dec-17 Base		31-Dec-23 1.00	31-Dec-24 1.00	31-Dec-25 1.00	31-Dec-26 1.00
Advertising	15,669		15,669	15,669	15,669	15,669		$	-	$ -	$ -	$ -	$ -
Allocated Costs	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Depreciation and Amortization	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Dues and Subscriptions	2,500	2,500	2,500	2,500	2,500	2,500		$	-	$ -	$ -	$ -	$ -
Education and Training	1,544		1,544	1,544	1,544	1,544		$	0.123	$ 0.12	$ 0.12	$ 0.12	$ 0.12
Employee Benefits	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Equipment Rental	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Information Technology/Computers	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Insurance	12,500	12,500	12,500	12,500	12,500	12,500		$	-	$ -	$ -	$ -	$ -
Interest	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Legal and Professional	14,223		14,223	14,223	14,223	14,223		$	0.0950	$ 0.09	$ 0.09	$ 0.09	$ 0.09
Licenses and Fees	5,000	5,000	5,000	5,000	5,000	5,000		$	-	$ -	$ -	$ -	$ -
Medical Supplies	-		-	-	-	-		$	13.16	$ 13.16	$ 13.16	$ 13.16	$ 13.16
Payroll Taxes	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Postage	-		-	-	-	-	$ 0.10	$	0.10	$ 0.10	$ 0.10	$ 0.10	$ 0.10
Purchased Services (Utilities,other)	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Rental/Lease	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Repairs and Maintenance	3,500	3,500	3,500	3,500	3,500	3,500		$	-	$ -	$ -	$ -	$ -
Salaries and Wages (DNS, RN, OT, clerical, etc	-		-	-	-	-		$	-	$ -	$ -	$ -	$ -
Supplies	-		-	-	-	-	$ 1.00	$	1.00	$ 1.00	$ 1.00	$ 1.00	$ 1.00
Telephone/Pagers	78,453		78,453	78,453	78,453	78,453		$	-	$ -	$ -	$ -	$ -
Travel (patient care, other)	14,933		14,933	14,933	14,933	14,933		$	15.80	$ 15.80	$ 15.80	$ 15.80	$ 15.80

-

	Variable Per Diem x Patient Days				Total Non-Salary is the Sum of the Fixed and Variable Costs Computed for Each Expense Account			
	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
	2,107	6,749	10,881	15,830				
Advertising	$ -	$ -	$ -	$ -	7,899	15,669	15,669	15,669
Allocated Costs	$ -	$ -	$ -	$ -	-	-	-	-
Depreciation and Amortization	$ -	$ -	$ -	$ -	-	-	-	-
Dues and Subscriptions	$ -	$ -	$ -	$ -	1,260	2,500	2,500	2,500
Education and Training	$ 258	$ 827	$ 1,334	$ 1,941	1,037	2,371	2,878	3,485
Employee Benefits	$ -	$ -	$ -	$ -	-	-	-	-
Equipment Rental	$ -	$ -	$ -	$ -	-	-	-	-
Information Technology/Computers	$ -	$ -	$ -	$ -	30,100	15,250	20,350	17,800
Insurance	$ -	$ -	$ -	$ -	6,301	12,500	12,500	12,500
Interest	$ -	$ -	$ -	$ -	-	-	-	-
Legal and Professional	$ 200	$ 641	$ 1,034	$ 1,504	7,370	14,864	15,256	15,727
Licenses and Fees	$ -	$ -	$ -	$ -	15,681	19,040	21,540	24,040
Medical Supplies	$ 27,732	$ 88,830	$ 143,214	$ 208,353	27,732	88,830	143,214	208,353
Payroll Taxes	$ -	$ -	$ -	$ -	-	-	-	-
Postage	$ 211	$ 675	$ 1,088	$ 1,583	211	675	1,088	1,583
Purchased Services (Utilities,other)	$ -	$ -	$ -	$ -	-	-	-	-
Rental/Lease	$ -	$ -	$ -	$ -	-	-	-	-
Repairs and Maintenance	$ -	$ -	$ -	$ -	1,764	3,500	3,500	3,500
Salaries and Wages (DNS, RN, OT, clerical, etc.)	$ -	$ -	$ -	$ -	-	-	-	-
Supplies	$ 2,107	$ 6,749	$ 10,881	$ 15,830	2,107	6,749	10,881	15,830
Telephone/Pagers	$ -	$ -	$ -	$ -	39,549	78,453	78,453	78,453
Travel (patient care, other)	$ 33,287	$ 106,623	$ 171,902	$ 250,088	40,815	121,556	186,835	265,021

9429	4764
4753.2493	2401.578082

The Expenses Shown below are additional projections of costs for telecommunications, EMR, and Software Licenses. The telecommunications and EMR Expenses are recorded in the Line for Information Technology and Computers. The amount for Licenses in included in the expense projection for Licenses and Fees.

Telecommunications and EMR

	Unit Cost	Six Months Ending 31-Dec-23	Calendar Year 31-Dec-24	31-Dec-25	31-Dec-26	Six Months Ending 31-Dec-23	Calendar Year 31-Dec-24	31-Dec-25	31-Dec-26
Toshiba Protégé x20W-D, Lap Top	$ 1,400	6	1	3	2	$ 8,400	$ 1,400	$ 4,200	$ 2,800
Samsung S8 Cell Phone	$ 700	6	1	3	2	$ 4,200	$ 700	$ 2,100	$ 1,400
Lenovo Think Center M7 10Q Computer	$ 700	4	1	1	1	$ 2,800	$ 700	$ 700	$ 700
Monitor	$ 150	6	1	3	2	$ 900	$ 150	$ 450	$ 300
Desk Phone	$ 300	6	1	3	2	$ 1,800	$ 300	$ 900	$ 600
Internet Charges	$ 8,400	1	1	1	1	$ 8,400	$ 8,400	$ 8,400	$ 8,400
Telecom Charges	$ 3,600	1	1	1	1	$ 3,600	$ 3,600	$ 3,600	$ 3,600
Total						$ 30,100	$ 15,250	$ 20,350	$ 17,800

Licenses	Unit Cost	Six Months Ending 31-Dec-23	Calendar Year 31-Dec-24	31-Dec-25	31-Dec-26	Six Months Ending 31-Dec-23	Calendar Year 31-Dec-24	31-Dec-25	31-Dec-26
Windows 365 & Related	$ 540	4	1	1	1	$ 2,160	$ 540	$ 540	$ 540
EMR Costs Operating	3,500	1	1	1	1	$ 3,500	$ 3,500	$ 3,500	$ 3,500
EMR Costs Incremental	$ 2,500	3	4	5	6	$ 7,500	$ 10,000	$ 12,500	$ 15,000
Total						$ 13,160	$ 14,040	$ 16,540	$ 19,040
						$ 43,260	$ 29,290	$ 36,890	$ 36,840
Management Fees	30,000	60,000	60,000	60,000					

Workpaper 9: Projected Staffing

	Current FTE		First Six Months		Year 1		Year 2		Year 3	
Staff	**FTE**	**Contracted**	**FTE**	**Contracted**	**FTE**	**Contracted**	**FTE**	**Contracted**	**FTE**	**Contracted**
RN			2.000		2.000		4.000		5.000	
LPN										
Hospice Aide			1.000		2.000		3.000		4.000	
NURSING TOTAL			**3.000**	**-**	**4.000**	**-**	**7.000**	**-**	**9.000**	**-**
Admin			3.000		3.000		4.000		4.000	
Medical Director				0.030		0.030		0.030		0.030
Medical Director Contracted				0.200		0.200		0.200		0.200
DNS										
Business\Clerical			3.000		3.000		4.000		5.000	
ADMIN. TOTAL			**6.000**	**0.230**	**6.000**	**0.230**	**8.000**	**0.230**	**9.000**	**0.230**
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	
Med Social Worker			1.000		1.000		1.000		1.000	
Pastoral/Other Counselor			1.000		1.000		1.000		1.000	
Volunteers										
Other (specify): Music Therapy			1.000		1.000		1.000		1.000	
ALL OTHERS TOTAL			**3.100**	**0.051**	**3.100**	**0.051**	**3.100**	**0.051**	**3.100**	**0.051**
TOTAL STAFFING			**12.100**	**0.281**	**13.100**	**0.281**	**18.100**	**0.281**	**21.100**	**0.281**

Workpaper 10: Staffing and Salary Levels

Seasons follows a corporate staffing model in it member hospices. The staffing levels shown below are the levels indicated for the census levels projected for the project in its first three years of operations.

	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
	184	366	365	365
Patient Days	2,107	6,749	10,881	15,830
ADC	11.5	18.4	29.8	43.4
Department	FTEs	FTEs	FTEs	FTEs
Admissions Department	-	-	-	1.000
Business Development-Department	2.000	2.000	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	2.000	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	-	-	1.000	1.000
Total	12.4	13.4	18.4	21.4

6.00	7.00	10.00	12.00
6.00	1.00	3.00	2.00

Workpaper 10: Staffing and Salary Levels (Cont'd)

Annual Salary Per FTE

Department	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Admissions Department	-	-	-	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	38,000
Team Assistant	35,750	35,750	35,750	35,750
Team Director	87,500	87,500	87,500	87,500
Volunteer-Department	-	-	52,000	52,000

Effective Date	31-Dec-21			
Inflation Rate		1		
Inflation Factor	1.00	1.00	1.00	1.00
No Inlfation Adjustement is Made				

469,523	963,892	1,295,892	1,461,892
469,523	963,892	1,295,892	1,461,892
1.0000			

<<<<These Values Must be edited

Annual Salary Per FTE

Department	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Admissions Department	-	-	-	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	-	-	52,000	52,000

Workpaper 10: Staffing and Salary Levels (Cont'd)

Portion of Year	50%	100%	100%	100%
		Annual Salary		
Department	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Admissions Department	-	-	-	48,500
Business Development-Department	78,137	155,000	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	170,000	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	-	-	52,000	52,000
Total	469,523	963,892	1,295,892	1,461,892

2. Please Provide your staff to patient ratio.

Type of Staff	Stub Year	Year 1	Year 2	Year 3
Skilled Nursing (RN & LPN)	0.1747	0.1085	0.1342	0.1153
Physical Therapist	0.0013	0.0008	0.0005	0.0003
Occupational Therapist	0.0010	0.0006	0.0004	0.0003
Medical Social Worker	0.0873	0.0542	0.0335	0.0231
Speech Therapist	0.0022	0.0014	0.0008	0.0006
Clinical Nutritionist	0.0087	0.0054	0.0034	0.0023
Home Health/Hospice Aide	0.0873	0.1085	0.1006	0.0922
Other (List)				
Chaplain	0.0873	0.0542	0.0335	0.0231
Medical Director	0.0201	0.0125	0.0077	0.0053
Administration	0.2620	0.1627	0.1342	0.0922
Business Office \ Admissions	0.2620	0.1627	0.1342	0.1153
Music Therapy	0.0873	0.0542	0.0335	0.0231
Total	1.0812	0.7257	0.6166	0.4930

0.025

Assumptions

REVENUES

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 revenues are billings for physician services outside of the Medicare hospice benefit. The amount shown is based on the experience of the Seasons-Affiliated program Seasons Hospice and Palliative Care of Oregon.

Net Patient Service Revenues:

Net Patient service revenues by payor are computed as follow:

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.

Other Payors:

Net reimbursement for other payors is projected on the basis of percentages of charges:

Payor		Percentage of Charges Collected
Healthy Options		80
Private Pay *		12
Third Party Insurance		95
Other **		75

* A portion of the write-off from Private Pay Charges is attributable to Charity Care.

** Other payors include relatively small payors such as VA, Worker's Comp and Tri-Care

EXPENSES

Advertising:

Advertising costs are bases on the 2020 experience of Seasons Hospice and Palliative Care of Oregon, which was $15,669. No inflation adjustment has been made to this amount. Advertising costs are treated as fixed and do not respond to changes in clinical volume. An advertising budget of $2,000 is also included in the pre-opening expenditures of the Applicant.

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 with useful lives provided by the Northwestern University Kellogg Business School.

Item		Item Cost	Qty	Total		Depreciable Life	Annual Depreciation Expense
Conference Table		$ 4,235	1	$ 4,235		15	$ 282
Conference Chairs		$ 424	12	$ 5,088		15	$ 339
Employee Desk		$ 1,452	9	$ 13,068		15	$ 871
Employee Desk Chair		$ 484	9	$ 4,356		15	$ 290
Guest Chair		$ 363	9	$ 3,267		15	$ 218
Filing Cabinet		$ 1,089	5	$ 5,445		15	$ 363
Reception Area Guest Chair		$ 787	6	$ 4,722		15	$ 315
Reception Area End Table		$ 242	3	$ 726		15	$ 48
Reception Area Coffee Table		$ 484	1	$ 484		15	$ 32
Kitchen Table		$ 605	2	$ 1,210		15	$ 81
Kitchen Chairs		$ 242	8	$ 1,936		15	$ 129
Patient Care Kit		$ 807	6	$ 4,842		5	$ 968
Employee Work Stations		$ 807	9	$ 7,263		15	$ 484
Subtotal Furnishings				$ 56,642			$ 4,422
Electronics and Telecom							
Server, HPE ProLiant ML 150, G9		$ 9,000	1	$ 9,000		5	$ 1,800
Firewall, Fortinet Fort iGate 100D		$ 3,000	1	$ 3,000		5	$ 600
Network Switch 2xAdtran Netvana 1638p		$ 3,200	1	$ 3,200		5	$ 640
On-time Low Voltage Wiring Installation		$ 15,000	1	$ 15,000		10	$ 1,500
Xerox Work Center		$ 10,000	1	$ 10,000		5	$ 2,000
Subtotal Electronics and Telecom				$ 40,200			$ 6,540
TOTAL				$ 96,842			$ 10,962
www.northwestern.edu/controller/accounting-services/equipment-inventory/docs/useful-lives-table.xls							

Dues and Subscriptions

The Applicant has 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

The budget for this line item is based upon the 2020 expenses at of Seasons Hospice and Palliative Care of Oregon for Conferences and Training, which was $1,544 and its expense for Employee Relations which was $3,042. Conferences and Training Costs are treated as fixed costs and do not respond to changes in clinical volume. Employee Relations Costs are treated as variable.

Based on the 24,814 patient days delivered at Seasons Hospice and Palliative Care of Oregon in 2020, the $3,042 expense for Employee Relations coverts to a per diem cost of Approximately $0.123 per diem. ($3,042 / 24,814 = $0.123)

Total Education and Training costs are computed as follows:

Projection of Education and Training Expense	**Initial Six Months**	**Year 1**	**Year 2**	**Year 3**
Fixed Costs				
Conferences and Training	$ 778	$1,544	$1,544	$ 1,544
Variable Costs				
Patient Days	2,107	6,749	10,881	15,830
Per Diem Employee Relations Expense	$0.123	$0.123	$0.123	$0.123
Projected Employee Relations Expense	$ 258	$ 827	$1,334	$ 1,941
Total Education and Training Expense	$ 1,037	$ 2,371	$ 2,878	$ 3,485

No inflation adjustment has been made to this amount. This budget does not reflect salary costs of professional clinical mangers who will be employed by the Applicant in connection with this project. Those costs are captioned under Salaries and Wages, Payroll Taxes and Employee benefits.

Employee Benefits

Employee benefits are projected to equal 15 percent of salaries and wages. This percentage does not include provision for Employer FICA contributions, which are forecast under the caption of Payroll Taxes.

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.

Telecommunications and EMR									
		Six Months Ending	Calendar Year			Six Months Ending	Calendar Year		
		31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Toshiba Protégé x20W-D, Lap Top	$ 1,400	6	1	3	2	$ 8,400	$ 1,400	$ 4,200	$ 2,800
Samsung S8 Cell Phone	$ 700	6	1	3	2	$ 4,200	$ 700	$ 2,100	$ 1,400
Lenovo Think Center M7 10Q Computer	$ 700	4	1	1	1	$ 2,800	$ 700	$ 700	$ 700
Monitor	$ 150	6	1	3	2	$ 900	$ 150	$ 450	$ 300
Desk Phone	$ 300	6	1	3	2	$ 1,800	$ 300	$ 900	$ 600
Internet Charges	$ 8,400	1	1	1	1	$ 8,400	$ 8,400	$ 8,400	$ 8,400
Telecom Charges	$ 3,600	1	1	1	1	$ 3,600	$ 3,600	$ 3,600	$ 3,600
Total						$ 30,100	$ 15,250	$ 20,350	$ 17,800

Insurance

The insurance expense of $12,500 is based on the experience of other Seasons-affiliated organizations. This expense is not forecast to be sensitive to increases in clinical volume.

Interest

There is no long or short-term debt forecast in connection with this projector its operations.

Legal and Professional

Legal and Professional fees are based upon the $11,786 in printing costs and $4,794 in Outside services expensed at of Seasons Hospice and Palliative Care of Oregon in 2020. Outside services are treated as 100 percent fixed. 80 percent of the printing expense of $11,786 is treated as fixed – or $9,429. The balance of $2,357 is considered to be variable and computes to a per diem amount of $0.095 per diem ($2,357 / 24,814 = $0.095).

The Table below shows the computations that result in the expense projection for Legal and Professional Fees shown in the pro forma Income and Expense projections:

Projection of Legal and Professional Expense	**Initial Six Months**	**Year 1**	**Year 2**	**Year 3**
Fixed Costs				
Printing	$ 4,753	$ 9,429	$ 9,429	$ 9,429
Outside Services	$ 2,417	$ 4,794	$ 4,794	$ 4,794
Variable Costs				
Patient Days	2,107	6,749	10,881	15,830
Printing Cost Per Diem Expense	$ 0.095	$ 0.095	$ 0.095	$ 0.095
Variable Printing Cost Expense	$ 200	$ 641	$ 1,034	$ 1,504
Total Education and Training Expense	$ 7,370	$ 14,864	$ 15,526	$ 15,727

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	Calendar Year			Six Months Ending	Calendar Year		
Licenses		31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26	31-Dec-23	31-Dec-24	31-Dec-25	31-Dec-26
Windows 365 & Related	$ 540	4	1	1	1	$ 2,160	$ 540	$ 540	$ 540
EMR Costs Operating	3,500	1	1	1	1	$ 3,500	$ 3,500	$ 3,500	$ 3,500
EMR Costs Incremental	$ 2,500	3	4	5	6	$ 7,500	$ 10,000	$ 12,500	$ 15,000
Total						$ 13,160	$ 14,040	$ 16,540	$ 19,040

These costs added to the $5,000 annual license allowance referenced above result in the projections that appear in the pro forma income and expense statement.

Medical Supplies

Medical Supplies are forecast on the basis of the experience of Seasons Hospice and Palliative Care of Oregon in 2020. These expenses include Clinical Supplies of $34,663, DME Expense of $121,889, Pharmacy Costs of $169,033, and Open Access of $1,014. These amounts sum to $326,599. Application

of the 24,814 patient days delivered at of Seasons Hospice and Palliative Care of Oregon in 2020 results in a per diem expense of $13.16.

The table below shows the computations used to develop the Supply Expense projection for the Por Forma Statement of Income and Expense:

Projection of Supply Expenses	**Initial Six Months**	**Year 1**	**Year 2**	**Year 3**
Variable Costs				
Patient Days	2,107	6,749	10,881	15,830
Supply Cost Per Diem	$ 13.16	$ 13.16	$ 13.16	$ 13.16
Projected Supply Cost	$ 27,732	$ 88,830	$ 143,214	$ 208,353

Payroll Taxes

Payroll Taxes are projected to equal 6.5 percent of Salaries and Wages.

Postage

Postage is based on an estimated per-diem expense of $0.10 per patient day of care.

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.

Projection of Purchased Services Expense		**Initial Six Months**	**Year 1**	**Year 2**	**Year 3**
GIP Days		31.60	101.23	163.21	237.45
Projected GIP Per Diem Charge		$ 1,200	$ 1,200	$ 1,200	$ 1,200
Projected GIP Per Diem Contract Payment	85%	$ 1,020	$ 1,020	$ 1,020	$ 1,020
Total Purchased Services		$ 32,237	$ 103,260	$ 166,479	$ 242,199

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 of $3,500 per year to cover unexpected costs of this type.

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 Seasons staffing model.

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

The Supply line item refers to general office supplies. This line item is assumed to be variable with respect to clinical volume. A provision of $1.00 per diem is forecast for this line item.

Telephones\Pagers

The expenses included in this line item include the Information Systems and Call Center expenses at of Seasons Hospice and Palliative Care of Oregon in 2020. These expenses totaled $78,453 and are assumed to be fixed with respect to the clinical volume changes forecast in this application.

Service Fees

Service Fees consist of the management fee paid by the Applicant to Seasons. 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 (Patient Care and Other)

The expenses included in this line item include the following line items form the 2020 Income and expenses statement of Seasons Hospice and Palliative Care of Oregon.

Room and Board:	$ 22,747
Other Direct Expense:	$ 369,007
Travel:	$ 886
Other Operating Expenses:	$ 14,313
Total:	**$ 406,953**

These costs include not only travel, but payments to Nursing Homes for resident patients as well as other operating costs. For budgeting purposes, the following assumptions were made concerning the sensitivity of these expenses to clinical volume:

Line Item	Amount	Percent Fixed	Percent Variable	Amount Fixed	Amount Variable
Room and Board	$ 22,747	0 %	100 %	$0	$ 22,747
Other Direct Expenses	$ 369,007	0 %	100 %	$0	$ 369,007
Travel	$ 886	70 %	30 %	$ 620	$ 266
Other Operating Expenses	$ 14,313	100%	0 %	$ 14,313	$ 0
Total	$ 406,953			$ 14,933	$ 392,020
Seasons Oregon Patient Days 2020					24,814
Variable Per Diem Expense Travel and Other					$ 15.80

The detail of the forecast for this line item is presented below:

Projection of Legal and Professional Expense	**Initial Six Months**	**Year 1**	**Year 2**	**Year 3**
Fixed Costs				
Travel	$ 310	$ 620	$ 620	$ 620
Other Operating Costs	$ 7,215	$ 14,313	$ 14,313	$ 14,313
Variable Costs				
Patient Days	2,107	6,749	10,881	15,830
Variable Per Diem Costs Travel and Other	$ 15.80	$ 15.80	$ 15.80	$ 15.80
Variable Travel and Other Cost Projection	$ 33,287	$ 106,623	$ 171,902	$ 250,088
Total Education and Training Expense	$ 40,815	$ 121,556	$ 186,835	$ 265,021

Contributions to Foundation These amounts reflect the commitment of the Applicant to provide funding for identified special programs as discussed in the application.

EXHIBIT 17

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 December, 2021 (the "Effective Date") by and between AccentCare Hospice & Palliative Care of Spokane County, LLC ("AccentCare") and Balakrishnan Natarajan, M.D. ("Physician").

RECITALS

A. WHEREAS, AccentCare operates a licensed hospice program, or is seeking suchlicensure, 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, AccentCare desires to employ Physician, and Physician desires to be soemployed, to provide Services for AccentCare 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 AccentCare, 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 AccentCare 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 AccentCare's group of qualifiedindividuals, 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 AccentCare who isdesignated as AccentCare's Medical Director, and who has overall responsibility for AccentCare's 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 AccentCare or Patients.

2. Employment. AccentCare hereby employs Physician to provide Services for AccentCare 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 AccentCare.

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 AccentCare and Physician.

(c) Supervision. As an employee of AccentCare, for services Physician provides on behalf of AccentCare, Physician shall at all times be subject to the general administrative control and supervision of AccentCare, and for administrative purposes shall report directly to the ExecutiveDirector of AccentCare, or such other individual appointed by AccentCare.

(d) AccentCare Policies and Procedures. Physician shall follow and at all times comply with AccentCare's policies and procedures, which will remain available for review at AccentCare 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, AccentCare policies and procedures, and other reasonable requirements of AccentCare. 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 AccentCare and Physician shall not have any ownership interest in Documentation of AccentCare 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 shallnot 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 AccentCare, Physician shallprovide supervision of AccentCare 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 AccentCare, upon execution of Agreement and continuously throughoutthe 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 AccentCare 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) AccentCare policies and procedures; and (iii) generally recognized standards of care and the codesof 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 AccentCare in writing, and shall promptly furnish AccentCare 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 AccentCare policies and procedures.

5. AccentCare's Responsibilities. AccentCare retains full professional management responsibility and authority over, and control of, all aspect of AccentCare business and operationsthat may not legally be carried on by persons or entities other than AccentCare 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 AccentCare 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. AccentCare reserves the right to withhold payment if a Physician fails to provide Documentation of such Services and/or any Services cannot be billed by AccentCare due to failure of Physician to complete Documentation, where permitted by state law. AccentCare 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 AccentCare of such overpayment. The amounts to be paid by AccentCare to Physician pursuant to this Agreement havebeen 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 receivebenefits in accordance with, and subject to, the terms and conditions of AccentCare 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 AccentCare. 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 AccentCare; 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 AccentCare of such required disclosure in writing. Such Confidential Information shall not otherwise be used to the detriment of AccentCare in any manner and all Confidential Information provided by AccentCare to Physician, including all copies and extracts thereof, will be returned to AccentCare 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 AccentCare, including but not limited to, information with respect to AccentCare's existing and contemplated services, products, trade secrets, know how, research and development, formulas, models, compilations, processes, inventions, computer code generated ordeveloped, 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 AccentCare policies and procedures, operating strategies, expansion strategies or business strategies or other confidential or proprietary information of AccentCare.

(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 AccentCare for any business or other purpose competitive with the business of AccentCare (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 AccentCare for any business or purpose competitive with the business of AccentCare (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 AccentCare.

(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 AccentCare to leave AccentCare for any reason whatsoever, or hire (in any capacity) any person who was an employee of AccentCare 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 withinsuch 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, AccentCare would suffersubstantial and irrevocable damage and would encounter extreme difficulty in attempting to prove the actual amount of damages suffered by AccentCare as a result of such breach, and AccentCarewould not have an adequate remedy at law in such event and, therefore, in addition to any otherremedy AccentCare may have at law or in equity in the event of any such breach, AccentCare 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 fromany 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. AccentCare shall at all times during the Term of this Agreement maintainprofessional 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 AccentCare on a claims-made basis with AccentCare's purchase of tail end coverage to insure claims occurring during the Term of this Agreement, or may be maintained by AccentCare's on an occurrence basis. This section shall survive termination of this Agreement. PHYSICIAN ACKNOWLEDGES AND AGREES THAT THE PROFESSIONAL LIABILITY AND OTHERINSURANCE PROVIDED HEREUNDER DOES NOT COVER PHYSICIAN'S ACTIVITIES WHICH ARE OUTSIDE THE SCOPE OF THIS AGREEMENT AND NOT PERFORMED FOR THE BENEFIT OF ACCENTCARE, 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 AccentCare may, after the expiration of such 30 day period, terminate this Agreement upon written notice to Physician.

(ii) AccentCare 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 AccentCare'sinsurance policy. Such termination shall be effective immediately upon written notice of termination to Physician. Physician shall immediately notify AccentCare in writing of the occurrence or threat of occurrence of any of the events specified in this section.

(iii) AccentCare may terminate this Agreement if it determines in its solediscretion that continuation of this Agreement may be detrimental to the operations of AccentCare,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, AccentCare may suspend the operation of this Agreement at any time upon the occurrence of any of the events giving rise to AccentCare's right to terminate this Agreement pursuant to the sections above or upon AccentCare's 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 AccentCare in its solediscretion 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 AccentCarenotifies Physician that he or she shall continue to provide Services in accordance with this Agreement until a successor is named, in which event AccentCare 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 AccentCare 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 AccentCare shall not control theprofessional 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 AccentCare:

AccentCare Hospice & Palliative Care of Spokane County, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: President

With a copy to:

AccentCare Hospice & Palliative Care of Spokane County, 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; (i) 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 AccentCare 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 AccentCare is located without giving effect to any choice or conflict of law provision or rule (whether of the State where AccentCare is located or anyother jurisdiction) that would cause the application of the laws of any jurisdiction other than theState where AccentCare 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 AccentCare and Physician. No such amendment, postponement, or waiver shall be deemedto 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 AccentCare or Physician inexercising 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 AccentCare and Physician and their respective heirs, executors, successors andpermitted assigns. No party may assign this Agreement or any of such party's rights, interests, orobligations hereunder without the prior approval of the other party hereto, except that AccentCare

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 AccentCare 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 availabilityof reimbursement to AccentCare 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. AccentCare 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 AccentCare and Physician and no presumption or burden of proof shall arise favoring or disfavoring AccentCare 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 AccentCare 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 relatingto 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.

ACCENTCARE:	PHYSICIAN:
By: 	By: 
Name: Todd Stern	Name: Balakrishnan Natarajan, M.D.
Title: CEO	Title: N/A

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 AccentCare'scredentialing process. Physician shall serve on AccentCare's 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 AccentCare and community physicians including making regular contacts with practicing physiciansto 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 AccentCare 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 AccentCare to medical and nursing colleges in the community. Physician shall assistin 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 AccentCare's employees and volunteers aspart 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 AccentCare becoming licensed as a hospice provider, AccentCare will pay Physician a one-time payment of $2,500.00. Physician shall providesuch Medical Director Services upon AccentCare's request.

(b) Compensation After Licensure. In consideration for the Medical Director Services provided by Physician hereunder once AccentCare is licensed as a hospice provider, AccentCare will pay Physician $7,500.00 annually, paid in biweekly installments. Physician shallprovide 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 AccentCare for Medical Director Services under this exhibit will not be contingent on AccentCare's ability to collect the amounts billed to Patients, Medicare, Medicaid, or third-party payors, unless any inability to collect isthrough fault of Physician.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

2/3/2021

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 Disclosure Office at pdrc@doh.wa.gov 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 AccentCare Hospice & Palliative Care of Spokane County, LLC ("AccentCare") and _____("Group").

RECITALS

A. WHEREAS, AccentCare operates a licensed hospice program, or is seeking suchlicensure, 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, AccentCare desires to engage Group, and Group desires to be so engaged, to provide Services for AccentCare in accordance with the terms and conditions of thisAgreement.

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 AccentCare, Group, Group Physicians, or the Services to be performed byGroup 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 AccentCare 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 AccentCare's group of qualifiedindividuals, 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 AccentCare who isdesignated as AccentCare's Medical Director, and who has overall responsibility for AccentCare's medical component in accordance with Applicable Laws.

(h) "Non-Hospice Palliative Care Services" means palliative care services provided to Patients by AccentCare.

(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. AccentCare hereby engages Group, through its physicians, to provide Services for AccentCare 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 AccentCare pursuant to this Agreement. A Physician may be added to Appendix 1 upon written notification by AccentCare to Group, and Group's written approval of such addition. AccentCare may remove a Physician from Appendix 1 atany 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 AccentCare and Group.

(c) Supervision. Group shall at all times be subject to the general administrative control and supervision of AccentCare, and for administrative purposes Physiciansshall report directly to AccentCare's Executive Director or such other individual appointed by AccentCare.

(d) Hospice Policies and Procedures. Group shall follow and at all times comply with AccentCare's policies and procedures, which have been made available to Group andwill remain available for review at AccentCare 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, AccentCare's policies and procedures, andother reasonable requirements of AccentCare. 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 AccentCare and Group shall not have any ownership interest in Documentation of AccentCare or AccentCare's 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 shallnot 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 AccentCare, Physician shallprovide supervision of AccentCare 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 AccentCare, upon execution of Agreement and continuously throughoutthe 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 AccentCare 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) AccentCare's 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 orPhysicians are a member.

(d) Board Certification. Physician shall be board certified as agreed to by Group and AccentCare in writing, and Group shall promptly furnish AccentCare with evidence of suchboard 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 AccentCare's policies and procedures.

5. AccentCare's Responsibilities. AccentCare retains full professional management responsibility and authority over, and control of, all aspects of AccentCare's business. AccentCare retains full professional management responsibility and authority over, and control of, all aspectof AccentCare's business and operations that may not legally be carried on by persons or entities other than AccentCare including, but not limited to, the responsibility for planning, coordinating, and providing Hospice Services for Patients and their families. Nothing in this Agreement shallbe construed to delegate to Group any professional management or other responsibility or authority that may only be exercised by AccentCare 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. AccentCare reserves the right to withhold payment if a Physician fails to provide Documentation of such Services and/or any Services cannot be billed by AccentCare due to failure of Physician to complete Documentation. AccentCare 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 AccentCare of such overpayment. The amounts to be paid by AccentCare 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 AccentCare any vacation pay, sick leave, retirement benefits, social security, workers' compensation, disability or unemployment insurance benefits, or employee benefits of any kind, and AccentCare will not withhold for taxes from Group's fees paid pursuant hereto. Group shall be fully responsible for all vacation pay, sick leave, retirementbenefits, 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 AccentCare. 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 AccentCare; 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 AccentCare of such required disclosure in writing. Such Confidential Information shall not otherwise be used to the detriment of AccentCare in any manner and all Confidential Information provided by AccentCare to Group or Physicians, including all copies and extracts thereof, will be returned to AccentCare 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 AccentCare, including but not limited to, information with respect to AccentCare's 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 AccentCare policies and procedures, operating strategies, expansion strategies or business strategies or other confidential or proprietary information of AccentCare.

(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 AccentCare for any business or other purpose competitive with the business of AccentCare. 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 AccentCare for any business or purpose competitive with the business of

AccentCare; 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 AccentCare.

(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 AccentCare to leave AccentCare for any reason whatsoever, or hire (in any capacity) any person who was an employee of AccentCare at any time during the 6 month period immediatelyprior 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, AccentCare would suffer substantialand irrevocable damage and would encounter extreme difficulty in attempting to prove the actualamount of damages suffered by AccentCare as a result of such breach, and AccentCare would not have an adequate remedy at law in such event and, therefore, in addition to any other remedy AccentCare may have at law or in equity in the event of any such breach, AccentCare 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. AccentCare shall at all times during the Term of this Agreement maintainprofessional 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 Termof 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 OUTSIDETHE SCOPE OF THIS AGREEMENT AND NOT PERFORMED FOR THE BENEFIT OF ACCENTCARE, AND THAT PHYSICIAN OR GROUP MUST OBTAIN SEPARATE PROFESSIONAL LIABILITY AND OTHER INSURANCE FOR SUCH OUTSIDE ACTIVITIES.

9. Indemnification. Group agrees to indemnify AccentCare, 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 AccentCare may, after the expiration of such 30 day period, terminate this Agreement upon written notice to Group.

(ii) AccentCare 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 AccentCare's insurance policy. Such termination shall be effective immediately upon written notice of termination to Group. Group shall immediately notify AccentCare in writing of the occurrence orthreat of occurrence of any of the events specified in this section.

(iii) AccentCare may terminate this Agreement if it determines in its solediscretion that continuation of this Agreement may be detrimental to the operations of AccentCare, 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, AccentCare may suspend the operation of this Agreement at any time upon the occurrence of any of the events giving rise to AccentCare's right to terminate this Agreement pursuant to the sections above or upon AccentCare's 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 AccentCare notifies Group that it shall continue to provide Services in accordance with this Agreement untila successor is named, in which event AccentCare 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 AccentCare 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 AccentCare for theprovision of physician services hereunder and are, therefore, considered part of AccentCare'sworkforce, as defined in by the Standards for Privacy of Individually Identifiable HealthInformation (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 AccentCare shall not control theprofessional 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 AccentCare:

AccentCare Hospice & Palliative Care of Spokane County, LLC
6400 Shafer Ct., Suite 700
Rosemont, IL 60018
Attention: President

With a copy to:

AccentCare Hospice & Palliative Care of Spokane County, 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 AccentCare 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 AccentCare is located without giving effect to any choice or conflict of law provision or rule (whether of the State where AccentCare is located or anyother jurisdiction) that would cause the application of the laws of any jurisdiction other than theState where AccentCare 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 AccentCare and Group. No such amendment, postponement, or waiver shall be deemed toextend 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 AccentCare or Group in exercising any right, power, or privilege under this Agreement shall operate as a waiver thereofnor 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 AccentCare 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, orobligations hereunder without the prior approval of the other party hereto, except that AccentCare 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 AccentCare 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 AccentCare 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. AccentCare 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 AccentCare and Group and no presumption or burden of proof shall arise favoring or disfavoring AccentCare 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 AccentCare 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.

ACCENTCARE:

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 AccentCare pursuant to this Agreement. A Physician may be added tothis appendix upon written notification by AccentCare to Group, and Group's written approval of such addition. AccentCare 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 AccentCare, 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 AccentCare in accordance with AccentCare's 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 AccentCare's 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, AccentCare will pay Group $50,000.00 annually, paid in biweekly installments. Physician shall provide approximately 8hours 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 AccentCare, in its name, utilizing its provider number and for its benefit, and all funds received shall be deposited in the accounts of AccentCare. Physician will cooperate with AccentCare to facilitate such billing submissions. Physician and Group shall not separately bill for any professional or other services renderedpursuant to this Agreement, and hereby assign to AccentCare all such rights. Physician and AccentCare shall execute and deliver such reassignment of benefits forms and such managed care credentialing and provider participation applications as AccentCare shall reasonably request. AccentCare shall be entitled to collect all accounts receivable generated by Physician.

6. Right to Payment. Group's right to payment from AccentCare for Services under this exhibit will notbe contingent on AccentCare's 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 18

Commitment of Funding

December 17, 2021

Mr. Eric Hernandez
Manager - Certificate of Need
Department of Health - Community Health Systems
111 Israel Road, S.E.
Tumwater, WA 98501-5447

RE: AccentCare Hospice & Palliative Care of Spokane County, LLC
Certificate of Need Application to Establish a Hospice Agency in Spokane County

Dear Mr. Hernandez:

As Chief Financial Officer of AccentCare, Inc. (the parent organization of AccentCare Hospice & Palliative Care of Spokane County, LLC) and Horizon Acquisition Co., Inc., my letter expresses commitment to the funds for the development of operation of the applicant's proposed hospice program.

In regard to the audit requirement, AccentCare Hospice & Palliative Care of Spokane County, LLC is a new entity, created on November 10, 2021, and therefore, has no operations or audited financial statements. Attached is the Consolidated Financial Statements for Horizon Acquisition Co., Inc. and Subsidiaries for the years ended December 31, 2020 and 2019.

AccentCare, Inc. is pleased to commit funding of $2,000,000 for the proposed hospice agency to serve residents of Spokane County. The attached audit demonstrates $315 million in cash and current assets and $950 million in total revenues for the year ended December 31, 2020. Therefore, sufficient reserves are available to fund the proposed project.

Sincerely,

Ryan Solomon

Ryan Solomon
Chief Financial Officer

Attachment

CONSOLIDATED FINANCIAL STATEMENTS

Horizon Acquisition Co., Inc. and Subsidiaries
Years Ended December 31, 2020 and 2019
With Report of Independent Auditors

Horizon Acquisition Co., Inc. and Subsidiaries

Consolidated Financial Statements

Years Ended December 31, 2020 and 2019

Contents

Ernst & Young LLP
One Victory Park
2323 Victory Avenue
Suite 2000
Dallas, TX 75219

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ey.com

Report of Independent Auditors

The Board of Directors
Horizon Acquisition Co., Inc.

We have audited the accompanying consolidated financial statements of Horizon Acquisition Co., Inc. and subsidiaries, which comprise the consolidated balance sheets as of December 31, 2020 and 2019, and the related consolidated statements of comprehensive income (loss), stockholders' equity, and cash flows for the year ended December 31, 2020 (Successor), the period from June 20, 2019 through December 31, 2019 (Successor), and for the period from January 1, 2019 through June 19, 2019 (Predecessor), and the related notes to the consolidated financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of 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 audits. We conducted our audits 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.

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.

Building a better working world

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Horizon Acquisition Co., Inc. and subsidiaries at December 31, 2020 and 2019, and the consolidated results of their operations and their cash flows for the year ended December 31, 2020 (Successor), the period from June 20, 2019 through December 31, 2019 (Successor), and for the period from January 1, 2019 through June 19, 2019 (Predecessor), in conformity with U.S. generally accepted accounting principles.

Ernst & Young LLP

April 22, 2021

Horizon Acquisition Co., Inc. and Subsidiaries

Consolidated Balance Sheets

(amounts in thousands, except share and par value data)

	As of December 31,	
	2020	2019
ASSETS		
CURRENT ASSETS		
Cash and cash equivalents	$ 56,331	$ 9,740
Restricted cash	244	425
Patient accounts receivable, net	238,111	103,500
Prepaid expenses	14,171	10,281
Other current assets	6,544	7,580
Total current assets	315,401	131,526
Property and equipment, net	52,860	24,897
Goodwill	1,554,652	705,549
Intangible assets	376,105	265,980
Other assets	5,825	4,138
Total assets	$ 2,304,843	$ 1,132,090
LIABILITIES AND STOCKHOLDERS' EQUITY		
CURRENT LIABILITIES		
Accounts payable	$ 17,412	$ 3,627
Accrued payroll and related benefits	71,993	40,928
Accrued expenses	80,084	46,997
Current portion of long-term obligations	8,800	3,550
Income taxes payable	393	-
Other current liabilities	27,362	6,092
Total current liabilities	206,044	101,194
Long-term obligations, less current portion	1,113,869	462,771
Deferred tax liability, net	72,845	62,391
Other long-term liabilities	44,221	20,746
Total liabilities	1,436,979	647,102
Commitments and Contingencies - Note 9		
STOCKHOLDERS' EQUITY		
Horizon Acquisition Co., Inc. stockholders' equity:		
Common stock, $.01 par value - 1,000 shares authorized; 1,000 shares issued and outstanding as of December 31, 2020 and December 31, 2019	-	-
Additional paid-in capital	784,697	424,922
Accumulated deficit	(16,928)	(17,655)
Accumulated other comprehensive loss	(887)	-
Total Horizon Acquisition Co., Inc. stockholders' equity	766,882	407,267
Noncontrolling interests	100,982	77,721
Total stockholders' equity	867,864	484,988
Total liabilities and stockholders' equity	$ 2,304,843	$ 1,132,090

See accompanying notes to consolidated financial statements

Horizon Acquisition Co., Inc. and Subsidiaries
Consolidated Statements of Comprehensive Income (Loss)
(amounts in thousands)

	Successor		Predecessor
	Year Ended December 31, 2020	Period From June 20, 2019 to December 31, 2019	Period From January 1, 2019 to June 19, 2019
Net service revenue	$ 932,802	$ 475,532	$ 409,992
Other operating income	16,908	-	-
Total revenues	949,710	475,532	409,992
Cost of services	520,776	290,625	253,852
Gross profit	428,934	184,907	156,140
General and administrative expenses:			
Salary and benefits	256,220	116,757	100,581
Stock-based compensation	1,347	1,562	11,172
Other	109,925	53,099	53,879
Depreciation and amortization	14,113	6,381	19,821
Asset impairment	637	-	-
Loss on fixed asset disposal	-	-	16
Total operating expenses	382,242	177,799	185,469
Income (loss) from operations	46,692	7,108	(29,329)
Other income (expense):			
Interest income	233	22	52
Interest expense	(38,694)	(23,405)	(13,429)
Other income, net	410	-	-
Total other expense, net	(38,051)	(23,383)	(13,377)
Income (loss) before income tax provision and noncontrolling interests	8,641	(16,275)	(42,706)
Income tax expense	5,789	1,559	1,009
Net income (loss)	2,852	(17,834)	(43,715)
Less net income (loss) attributable to noncontrolling interests	2,125	(179)	694
Net income (loss) attributable to Horizon Acquisition Co., Inc.	727	(17,655)	(44,409)
Net income (loss)	2,852	(17,834)	(43,715)
Unrealized comprehensive loss on cash flow hedges, net of tax expense	(887)	-	-
Comprehensive income (loss)	1,965	(17,834)	(43,715)
Less comprehensive income (loss) attributable to noncontrolling interests	2,125	(179)	694
Comprehensive loss attributable to Horizon Acquisition Co., Inc.	$ (160)	$ (17,655)	$ (44,409)

See accompanying notes to consolidated financial statements

Horizon Acquisition Co., Inc. and Subsidiaries

Consolidated Statements of Stockholders' Equity

(amounts in thousands, except share data)

	Horizon Acquisition Co., Inc.								
	Common Stock		Preferred Stock Series A, B, C		Additional Paid-In Capital	Accumulated Deficit	Accumulated Comprehensive Loss	Non-Controlling Interest	Total Equity
	Shares	Amount	Shares	Amount					
Predecessor									
Balance, December 31, 2018	11,059	$ -	1,121,104	$ 164,788	$ 71,903	$ (242,327)	$ -	$ 10,572	$ 4,936
Stock-based compensation	-	-	-	-	11,172	-	-	-	11,172
Non-controlling interest distribution	-	-	-	-	-	-	-	(410)	(410)
Non-controlling interest contribution	-	-	-	-	-	-	-	1,300	1,300
Conversion upon change in control	1,372,349	14	(1,121,104)	(164,788)	164,774	-	-	-	-
Net (loss) income	-	-	-	-	-	(44,409)	-	694	(43,715)
Balance, June 19, 2019	1,383,408	$ 14	-	$ -	$ 247,849	$ (286,736)	$ -	$ 12,156	$ (26,717)
Successor									
Balance, June 20, 2019	-	$ -	-	$ -	$ -	$ -	$ -	$ -	$ -
Proceeds from issuance of common stock units	1,000	-	-	-	423,360	-	-	-	423,360
Fair value step-up of noncontrolling interest	-	-	-	-	-	-	-	77,900	77,900
Stock-based compensation	-	-	-	-	1,562	-	-	-	1,562
Net loss	-	-	-	-	-	(17,655)	-	(179)	(17,834)
Balance, December 31, 2019	1,000	$ -	-	$ -	$ 424,922	$ (17,655)	$ -	$ 77,721	$ 484,988
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)
Non-controlling interest distribution	-	-	-	-	-	-	-	(1,504)	(1,504)
Non-controlling interest acquired	-	-	-	-	-	-	-	22,640	22,640
Net income	-	-	-	-	-	727	-	2,125	2,852
Balance, December 31, 2020	1,000	$ -	-	$ -	$ 784,697	$ (16,928)	$ (887)	$ 100,982	$ 867,864

See accompanying notes to consolidated financial statements

Horizon Acquisition Co., Inc. and Subsidiaries
Consolidated Statements of Cash Flows
(amounts in thousands)

	Successor		Predecessor
	Year Ended December 31, 2020	Period Form June 20, 2019 to December 31, 2019	Period From January 1, 2019 to June 19, 2019
CASH FLOWS FROM OPERATING ACTIVITIES:			
Net income (loss)	$ 2,852	$ (17,834)	$ (43,715)
Adjustments to reconcile net loss to net cash provided used in operating activities:			
Depreciation and amortization	14,113	6,381	19,827
Stock-based compensation	1,347	1,562	11,172
Deferred income taxes	4,102	1,957	579
Loss on fixed asset disposal	-	-	(16)
Amortization of deferred financing charges	2,753	1,337	342
Changes in assets and liablities, net of acquisitions:			
Accounts receivable	(14,031)	4,790	2,762
Prepaid expenses	(1,099)	4,730	(2,972)
Other current assets	5,223	(6,688)	(1,665)
Other long-term assets	(2,190)	(134)	(1,100)
Accounts payable	(3,137)	(27,777)	18,049
Accrued expenses	(15,153)	(7,851)	(64)
Other current liabilities	17,097	985	(776)
Other long-term liabilities	14,551	22,531	36
Accrued payroll and related expenses	(10,874)	(7,332)	3,768
Net cash provided by (used in) operating activities	15,554	(23,343)	6,227
CASH FLOWS FROM INVESTING ACTIVITIES:			
Purchase of property and equipment, net of acquisitions	(9,307)	(8,730)	(8,497)
Acquisitions of businesses, net of cash acquired	(787,740)	(874,372)	(7,806)
Proceeds from the sale of property and equipment	-	415	-
Net cash used by investing activities	(797,047)	(882,687)	(16,303)
CASH FLOWS FROM FINANCING ACTIVITIES:			
Repayment of long-term debt	(3,550)	(1,775)	(898)
Proceeds from debt issuance	677,000	485,000	
Proceeds from revolver	103,500	-	8,500
Repayment of revolver	(103,500)	-	-
Costs associated with debt issuance	(20,811)	(18,241)	-
(Distributions to) contributions from and acquisitions of noncontrolling interest, net	(1,504)	-	890
Proceeds from acquisition related capital contributions	176,768	-	-
Proceeds from issuance of common stock	-	423,360	-
Net cash provided by financing activities	827,903	888,344	8,492
Net increase (decrease) in cash, cash equivalents and restricted cash	46,410	(17,686)	(1,584)
Cash, cash equivalents and restricted cash at beginning of period	10,165	27,851	29,435
Cash, cash equivalents and restricted cash at end of period	$ 56,575	$ 10,165	$ 27,851
Supplemental cash flow information:			
Cash paid for income taxes	$ 2,339	$ 356	$ 301
Cash paid for interest	$ 42,165	$ 12,701	$ 7,029
Noncash activity:			
Fixed assets acquired included in accounts payable	$ 263	$ 412	$ 349
Equity units in the parent for acquisition of business	$ 181,658	$ -	$ -

See accompanying notes to consolidated financial statements

1. Nature of Operations and Organization

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, 2020, we operated 109 home health, 36 hospice, and 53 personal-care care centers in 28 states.

The financial statements for the period from January 1, 2019 to June 19, 2019 have been presented to reflect the results of the Pluto Acquisition I, Inc. (the "Predecessor"). The financial statements for the period from June 20, 2019 to December 31, 2019 and the year ended December 31, 2020 have been presented to reflect the financial results of the Company post-Merger (the "Successor"). Refer to Note 4, *Business Combinations,* for additional information on the Merger transaction.

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

Certain prior period amounts have been reclassified to conform to the current year presentation. Such reclassifications had no impact on our reported net income or stockholders' equity.

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 for 2020 and 2019 (in thousands):

	As of December 31,	
	2020	2019
Cash and cash equivalents	$ 56,331	$ 9,740
Restricted cash	244	425
Cash, cash equivalents, and restricted cash	$ 56,575	$ 10,165

Patient Accounts Receivable

Accounts receivable are stated at estimated net realizable value from services rendered at their estimated transaction price, which includes contractual and non-contractual 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 net patient accounts receivable balance as of December 31, 2020 and 2019, related to these state programs was approximately $10.8 million and $13.1 million, respectively, and related to Medicare was approximately $61.9 million and $51.8 million, respectively.

The Company also has contractual arrangements with third-party payors and individual patients. 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.

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 for 2020 and 2019 (in thousands):

	As of December 31,	
	2020	2019
Furniture and equipment [(1)]	$ 18,598	$ 7,829
Computer equipment and software	37,595	17,004
Building and leasehold improvements	11,370	3,278
Land	4,184	-
Construction-in-progress	2,507	2,403
Property and equipment	74,254	30,514
Less: accumulated depreciation	(21,394)	(5,617)
Property and equipment, net	$ 52,860	$ 24,897

(1) Furniture and equipment includes capitalized leases which consist of $2.3 million of office equipment and $2.8 million of service vehicles.

Depreciation, inclusive of capital lease depreciation, for the Successor periods ending December 31, 2020 and December 31, 2019 was $13.6 million and $6.0 million, respectively. Depreciation expense for the Predecessor period ending June 19, 2019 was $4.4 million. At December 31, 2020, total capital leases, net of accumulated amortization, of $2.8 million bear interest rates ranging from 6.5% to 8.2%.

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, 2020 and 2019, the Company had unamortized deferred debt issuance costs and debt discounts of approximately $33.9 million and $16.9 million, respectively, reflected within long-term debt on the consolidated balance sheets. See Note 6, *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 Accounting Standards Codification ("ASC") Topic 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 the reporting unit below its carrying amount. These events or circumstances include, but are not limited to, a significant adverse change in the business environment, regulatory environment, or legal factors

During 2020, we performed a quantitative assessment to determine if the fair value of the reporting unit is less than its carrying values by using the income and market valuation approaches. Based on this valuation, the carrying value of the reporting unit was less than fair value. As such, we did not record any goodwill impairment charges and the goodwill associated with our reporting unit was not considered at risk of impairment as of October 1, 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 unit would be less than its carrying amount. For 2019, the Company performed a qualitative assessment of goodwill and determined that it is not more likely than not that the fair values of its reporting units are less than the carrying amounts. The Company has not recognized any goodwill impairment charges in 2020 or 2019 related to the annual impairment testing. See Note 5, *Goodwill and Intangible Assets*, for further discussion.

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 for non-compete agreements. 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. During 2020, we performed a quantitative assessment of our indefinite-lived intangible assets; as a result of this analysis, we noted there was no impairment. During 2019, we performed a qualitative assessment of our indefinite-lived intangible assets; as a result of this analysis, we noted no impairment. 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.

Previously, the Predecessor applied the provisions of Accounting Standards Update ("ASU") 2014-02, *Intangibles – Goodwill and Other (Topic 350): Accounting for Goodwill (a consensus of the Private Company Council)*, for private companies allowing for an optional accounting alternative for goodwill. As a result, the Company amortized goodwill on a straight-line basis over ten years and recorded $15.1 million of amortization expense for the Predecessor period ended June 19, 2019.

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.

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, and 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.

Revenue Recognition

The Company accounts for revenue from contracts with customers in accordance with 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, personal care services, hospice care, 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 contractual and non-contractual 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 (Non-contractual price concessions). Non-contractual 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. Non-contractual 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, Personal Care Services ("PCS"), and Hospice.

Revenue by payor class as a percentage of total net service revenue for the years ending December 31, 2020 and December 31, 2019 was as follows:

	For the year ended December 31,	
	2020	**2019**
Home Health		
Medicare	49%	47%
Private Pay	5%	7%
Other	2%	2%
Total Home Health	56%	56%
Personal Care		
Medicaid	17%	17%
Private Pay	7%	8%
Other	10%	12%
Total Personal Care	34%	37%
Hospice		
Medicare	9%	6%
Other	1%	1%
Total Hospice	10%	7%
	100%	100%

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. Effective January 1, 2020, the Centers for Medicare and Medicaid Services ("CMS") implemented a revised case-mix adjustment methodology, the Patient-Driven Groupings Model ("PDGM"), to better align payment with patient care needs and ensure that clinically complex and ill beneficiaries have adequate access to home health care. PDGM uses 30-day periods of care rather than 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.

Net service revenue is recorded based on the established Federal Medicare home health payment rate for a 30-day period of care. ASC 606 notes that if an entity has a right to consideration from a customer in an amount that corresponds directly with the value of the entity's performance completed to date, the entity may recognize revenue in the amount to which the entity has a right to invoice. We have elected to apply the "right to invoice" practical expedient and therefore, our revenue recognition is based on the reimbursement we are entitled to for each 30-day payment period. We utilize our historical average length of stay for each 30-day period of care as the measure of progress towards the satisfaction of our performance obligation.

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.

As of December 31, 2020 and 2019, the difference between the cash received from Medicare for a request for anticipated payments ("RAP") on episodes in progress and the associated estimated revenue is recorded to deferred revenue within the Company's consolidated balance sheets in accrued expenses. As of December 31, 2020 and 2019, the balances were approximately $0.6 million and $9.2 million, respectively, and subsequently amortized into revenue. Revenue earned in excess of revenue invoiced is recorded as unbilled revenue, which is reflected within patient accounts receivable on the Company's consolidated balance sheets. CMS reduced the upfront payment for RAPs to 20% for 2020 and has fully eliminated payments associated with RAPs in 2021.

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. Contractual 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. Non-contractual 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 97% of our total Medicare hospice service revenue for both of 2020 and 2019. There are two separate payment rates for routine care: payments for the first 60 days of care and 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 non-contractual 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 non-contractual revenue adjustments based on our historical experience, which primarily includes a historical collection rate of over 93% 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, 2020, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2018. As of December 31, 2020, we have recorded $5.5 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2019 through September 30, 2020. As of December 31, 2019, we had recorded $0.1 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2018 through September 30, 2019.

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. Contractual 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 non-contractual adjustments to non-Medicare revenue based on our historical experience to reflect the estimated transaction price.

Personal Care Services 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 contractual and non-contractual 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").

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 effect of forfeitures is recognized as incurred.

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 Successor periods ending December 31, 2020 and December 31, 2019 was $0.7 million and $0.5 million, respectively. Advertising expense for the Predecessor period ending June 19, 2019 was $0.3 million.

Recent Accounting Pronouncements

Recently Adopted

Stock Compensation

On January 1, 2020, the Company adopted ASU 2018-07, *Compensation - Stock Compensation (Topic 718): Improvements to Nonemployees Share-Based Payment Accounting,* which expands the scope of Topic 718 to include share-based payments issued to nonemployees for goods or services. Our adoption of this standard did not have an effect on our consolidated financial statements.

Reference Rate Reform

On March 12, 2020, the Financial Accounting Standards Board ("FASB") issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*, which provides optional expedients and exceptions for applying U.S. GAAP to contract modifications and hedging relationships

that reference LIBOR or another reference rate expected to be discontinued, subject to meeting certain criteria. The amendments in this ASU were effective beginning on March 12, 2020 and may generally be applied as of any date from the beginning of an interim period that includes or is subsequent to March 12, 2020, or prospectively from a date within an interim period that includes or is subsequent to March 12, 2020, up to the date that the financial statements are available to be issued. Our adoption of this standard did not have an effect on our consolidated financial statements.

Pending Accounting Pronouncements

Leases

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842).* The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short-term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in just the lease expense being recognized on a straight-line basis over the lease term. The guidance is effective for annual and interim periods beginning after December 15, 2021 and allows modified retrospective application of the new guidance at the beginning of the earliest comparable period presented. Early adoption is permitted. The new guidance must be adopted using a modified retrospective transition. The Company is evaluating the impact of adopting the new lease standard on the consolidated financial statements.

Credit Losses

In June 2016, the FASB issued ASU 2016-13, *Financial Instruments - Credit Losses (Topic 326)*. ASU 2016-13 affects loans, debt securities, trade receivables, and any other financial assets that have the contractual right to receive cash. The ASU requires an entity to recognize expected credit losses rather than incurred losses for financial assets. ASU 2016-13 is effective for fiscal years beginning after December 15, 2022, including interim periods within those fiscal years. The Company is evaluating the impact of adopting the new standard on the consolidated financial statements.

Goodwill Impairment

In January 2017, the FASB issued ASU 2017-04, *Intangibles - Goodwill and Other: Simplifying the Test for Goodwill Impairment*, which requires an entity to no longer perform a hypothetical purchase price allocation to measure goodwill impairment. Instead, impairment will be measured using the difference between the carrying amount and the fair value of the reporting unit. This ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2021. The Company is evaluating the impact of adopting the new standard on the consolidated financial statements.

Income Taxes

In December 2019, the FASB issued ASU 2019-12, *Simplifications to accounting for income taxes,* which removes certain exceptions to the general principles of ASC Topic 740, “Income Taxes,” and adds guidance to reduce complexity in accounting for income taxes. The ASU is effective for annual and interim periods in fiscal years beginning after December 15, 2020. Early adoption is permitted. The Company is currently evaluating the impact of the adoption of this standard on the Company's 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 billion to healthcare providers, including hospitals on the front lines of the COVID-19 pandemic. Of this total allocated amount, $30 billion was distributed immediately to providers based on their proportionate share of Medicare fee-for-service reimbursements in 2019. 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 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. 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").

For our wholly owned subsidiaries, we have first reimbursed qualifying COVID-19 expenses of $5.0 million. The remaining $11.4 million was utilized to cover lost revenues resulting from COVID-19. Expenses incurred to date are reflected in other operating income within our consolidated statement of operations. The grant income associated with the COVID-19 expenses incurred to date is reflected in other operating income within our consolidated statement of operations.

HHS issued new guidance in September 2020 noting that PRF funds can be used towards lost revenues or expenses attributable to COVID-19 through June 30, 2021. Funds that we intend to use in the future to cover COVID-19 expenses, which we have estimated to be approximately $2.1 million, have been recorded to a deferred liability account within accrued expenses in our consolidated balance sheet. These estimates may change as our ability to utilize and retain the funds will depend on the magnitude, timing and nature of the impact of the pandemic. In summary, the total funds that we have received from the CARES Act PRF as of December 31, 2020 consist of the following (amounts in thousands):

	Amount
Funds utilized during the year ended December 31, 2020	$ 16,908
Estimated funds to be utilized January 2021 through June 2021	2,148
Estimated funds to be repaid to the government	-
	$ 19,056

The CARES Act also provides for the temporary suspension of the automatic 2% reduction of Medicare claim reimbursements (sequestration) for the period May 1 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. Fifty percent of the deferred payroll taxes are due on December 31, 2021 with the remaining amounts due on December 31, 2022. As of December 31, 2020, we have deferred $36.7 million of social security taxes; approximately half is reflected in each of other current liabilities and other long-term liabilities within our consolidated balance sheet.

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.

4. Business Combinations

2020 Transactions

Spring 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 controlled groups of companies: Seasons, Health Resource Solutions, and Gareda (collectively referred to as the "Spring Companies"). Prior to the transaction, these 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, and $181.7 million of equity units in the parent for total consideration of $954.0 million. The transaction closed on December 21, 2020. The Company incurred $8.3 million of transaction fees in association with the Spring Companies acquisition. These expenses are reflected in other general and administrative expenses in the accompanying consolidated statements of comprehensive income (loss).

The Company's acquisition of the Spring Companies was accounted for in accordance with ASC 805, and the resulting goodwill and intangibles were accounted for under ASC Topic 350, Accounting for Goodwill. 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 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, $905.3 million of goodwill and intangible assets were acquired in the Spring Acquisition. Of that total, $694.7 million 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	$	772,389
Equity units in the parent		181,658
Fair value of total consideration exchanged		954,047
Recognized amount of identified assets acquired and liabilities assumed:		
Cash and cash equivalents		39,536
Patients accounts receivable		104,793
Prepaid expenses		2,746
Other current assets		1,688
Property and equipment		30,556
Intangible assets		104,788
Other assets		391
Accounts payable		(17,287)
Accrued payroll and related benefits		(41,939)
Accrued expenses		(47,654)
Income taxes payable		(28)
Other current liability		(4,173)
Deferred tax liability, net		(6,164)
Other long-term liabilities		(4,180)
Total identifiable assets, net		163,073
Noncontrolling interest in subsidiaries		(9,510)
Goodwill		800,484
Total Purchase Price	$	954,047

The estimates of fair value are preliminary, and are therefore subject to further refinement. The results of operations of Spring Companies are included in the consolidated statements of comprehensive income (loss) since the date of the acquisition. 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.

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 $68.8 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 was paid at closing on November 2, 2020. 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 comprehensive income (loss).

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 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, $53.3 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 preliminary allocation of the purchase price to estimated fair values of assets acquired and liabilities assumed as a result of the Fairview acquisition (in thousands):

Fair value of consideration exchanged	$	54,887
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 in subsidiaries		(13,130)
Goodwill		48,619
Total Purchase Price	$	54,887

The estimates of fair value are preliminary, and are therefore subject to further refinement. The results of operations of Fairview is included in the consolidated statements of comprehensive income (loss) since the date of the acquisition. 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 represent a Level 3 fair value measurement, as defined under ASC 820. The valuation was assessed with the assistance of a valuation specialist.

2019 Transactions

Horizon Merger

On June 19, 2019, the Company completed the acquisition of all of the outstanding stock of Pluto Acquisition I, Inc. (the "Merger"). The final purchase price was $875 million plus closing cash of $27.8 million, a working capital adjustment and $5.3 million of management rollover shares for total consideration of $902.2 million. The Company incurred $8.9 million of transaction fees in association with the Merger. These expenses are reflected in other general and administrative expenses in the accompanying consolidated statements of comprehensive income (loss) for the Successor period ended December 31, 2019.

The following table summarizes the final allocation of the purchase price to the estimated fair values of assets acquired and liabilities assumed as a result of the Merger (in thousands):

Fair value of consideration exchanged	$	902,223
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Cash and cash equivalents		27,622
Restricted cash		229
Patient accounts receivable		108,644
Prepaid expenses and other current assets		15,549
Other assets		4,003
Property and equipment		23,030
Intangible assets		266,324
Accounts payable and accrued expenses		(37,200)
Accrued payroll and related benefits		(48,260)
Claims reserve - workers' compensation		(22,926)
Deferred tax liability		(60,435)
Other long-term liabilities		(2,006)
Total identifiable assets, net		274,574
Noncontrolling interest in subsidiaries		(77,900)
Goodwill		705,549
Total purchase price	$	902,223

Aloha Home Care

On April 15, 2019, the Company acquired all the issued and outstanding shares of Aloha Home Care, Inc., Oahu, Inc. and Mobile Physicians Group, Inc. ("Aloha"). Aloha is headquartered in Port St. Lucie, Florida, with an average census of 275 patients. The company provides Medicare-certified skilled home health care in Eastern Florida. Aloha provides services in two locations covering two districts. The company employs more than 115 employees.

The Company acquired the three entities for an aggregate purchase price of $8.3 million. The purchase price consisted of an $8.0 million cash payment at closing, net of cash acquired of $10,000 and a subsequent $0.3 million working capital adjustment. The Company incurred $0.1 million of transaction fees in association with the Aloha acquisition. These expenses are reflected in other general and administrative expenses in the accompanying consolidated statements of comprehensive income (loss) for the Predecessor period ended June 19, 2019. The acquisition was financed using funds available under the 2018 Credit Agreement.

The following table summarizes the final allocation of the purchase price to the estimated fair values of assets acquired and liabilities assumed as a result of the Aloha Home Care acquisition (in thousands):

Fair value of consideration exchanged	$	8,253
Recognized amounts of identifiable assets acquired and liabilities assumed:		
Patient accounts receivable		1,052
Property and equipment		7
Accounts payable and accrued expenses		(99)
Accrued payroll and related benefits		(8)
Total identifiable assets, net		952
Goodwill		7,301
Total purchase price	$	8,253

The purchase price allocations for the Merger and the Aloha acquisition were finalized in 2020. The associated results of operations for the Merger are included in the consolidated statements of comprehensive income (loss) as of January 1, 2019. The associated results of operations for the Aloha acquisition are included in the consolidated statements of comprehensive income (loss) since the date of the acquisition. The acquisitions were accounted for as business combinations in accordance with ASC 805, and the resulting goodwill was accounted for under ASC 350. The purchase prices were allocated to the net tangible and identifiable intangible assets based on their estimated fair values, which were based on significant inputs not observed in the market and thus represent Level 3 fair value measurements, as defined under ASC 820. The valuations were assessed with the assistance of a valuation specialist.

The excess of the purchase price over the aggregate fair value of the assets acquired was allocated to goodwill and is primarily attributable to the Company operating model and capabilities that are expected to facilitate continued revenue growth by the Company in association with the Merger, and to the expansion of the Company's service geography to Florida in association with the Aloha acquisition. The goodwill and intangible assets acquired in association with the Merger and Aloha acquisition were not deductible for tax purposes.

5. Goodwill and Intangible Assets

The following is a summary of goodwill balances and activity (in thousands):

	Successor		Predecessor
	Year-Ended December 31, 2020	**Period From June 20, 2019 to December 31, 2019**	**Period From January 1, 2019 to June 19, 2019**
Balance, beginning of period	$ 705,549	$ -	$ 255,341
Merger	-	705,549	-
Acquisitions and joint ventures	849,103	-	6,837
Amortization	-	-	(15,100)
Balance, end of period	$ 1,554,652	$ 705,549	$ 247,078

As of June 20, 2019 (the Successor period), goodwill is no longer amortized. 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	Certificates of Need	Medicare Licenses	Non-Compete Covenant[2]	Favorable Leases[3]	Total	Unfavorable Leases[4]
Predecessor							
Balance as of December 31, 2018	$ 45,318	$ 5,190	$ 15,117	$ 2,239	$ -	$ 67,864	$ -
Additions	-	-	250	-	-	250	-
Amortization	-	-	-	(330)	-	(330)	-
Balance as of June 19, 2019	45,318	5,190	15,367	1,909	-	67,784	-
Successor							
Acquisition adjustments[1]	125,582	77,675	(4,867)	-	150	198,540	-
Balance as of June 20, 2019	170,900	82,865	10,500	1,909	150	266,324	-
Amortization	-	-	-	(344)	-	(344)	-
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[5]	-	-	(300)	-	-	(300)	-
Balance as of December 31, 2020	$ 237,094	$ 121,358	$ 15,900	$ 1,029	$ 724	$ 376,105	$ (1,519)

(1) On June 20, 2019, the Company adjusted the respective intangible balances as a result of the completion of purchase price accounting for the Merger (see Note 4).

(2) The weighted average remaining amortization period of our non-compete covenants was 4.8 years. Accumulated amortization associated with our non-compete covenants totaled $0.9 million and $0.3 million as of December 31, 2020 and December 31, 2019, respectively.

(3) The weighted average remaining amortization period of our favorable leases was 1.7 years. Accumulated amortization associated with our favorable totaled $0.4 million as of December 31, 2020. There were no favorable prior to the Merger (see Note 4).

(4) The weighted average remaining amortization period of our unfavorable leases was 3.7 years. Accumulated amortization associated with our unfavorable leases totaled $0.4 million as of December 31, 2020. There were no unfavorable leases prior to the Merger (see Note 4). Unfavorable leases are included in other long-term liabilities on the accompanying consolidated balance sheets.

(5) During 2020, the Company recognized a disposal of $0.3 million related to Medicare licenses that were returned due to closed locations and is included in impairment loss on the Company's consolidated statements of comprehensive income (loss).

The estimated aggregate amortization expense related to intangible assets for each of the three succeeding years is as follows (in thousands):

	Intangible Asset Amortization
2021	$ 449
2022	348
2023	232
	$ 1,029

6. Long-Term Obligations

The Company's long-term debt consisted of the following (in thousands):

	As of December 31,	
	2020	2019
Term loans	$ 1,156,675	$ 483,225
Debt issuance cost and debt discount, net of amortization	(34,006)	(16,904)
Total long-term debt, net	1,122,669	466,321
Less current portion:		
Term loans	(8,800)	(3,550)
Long-term debt, excluding current portion	$ 1,113,869	$ 462,771

At December 31, 2020 and 2019, long-term debt is reflected net of unamortized debt issuance costs and debt discounts of $33.9 million and $16.9 million, respectively. Amortization of debt issuance costs and debt discounts for the Successor periods ending December 31, 2020 and December 31, 2019 was $2.9 million and $1.4 million, respectively. Amortization of debt issuance costs and debt discounts for the Predecessor period ending June 19, 2019 was $0.4 million.

Annual future principal payment obligations for long-term debt were as follows as of December 31, 2020 (in thousands):

	Long-term obligations
2021	$ 8,800
2022	8,800
2023	8,800
2024	8,800
2025	8,800
Thereafter	1,112,675
Total	$ 1,156,675

2020 Credit Agreement

On December 21, 2020, the Company amended the 2019 Credit Agreement (as defined below) to provide financing for the Spring Acquisition. The Company entered into two new term loans, a $525 million incremental first lien term loan (the "Incremental First Lien Term Loan") and a $152 million incremental second lien term loan (the "Incremental Second Lien Term Loan"), collectively the "2020 Incremental Term Loans." The existing ABL and Revolver were also amended. The availability under the ABL credit agreement was increased to $150 million and there were no changes in availability to the $40 million revolver. The 2020 Incremental Term Loans are collateralized by substantially all of the Company's assets.

The Company incurred fees and discounts of $20.8 million associated with the 2020 Credit Agreement, which were capitalized as deferred financing costs and debt discounts and are amortized proportionality over the terms of the respective loans on an effective interest rate basis.

Incremental First Lien Term Loan

The $525 million Incremental First Lien Term Loan provides for quarterly principal and interest payments, with the remaining principal balance due at maturity on June 20, 2026. The interest rate of the Incremental First 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 *London Interbank Offered Rate* ("LIBOR") plus 1.0%, and (c) the *Wall Street Journal Prime Rate*. The applicable percentage per annum is 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. There is a LIBOR floor of 0.50%. As of December 31, 2020, the interest rate calculated on the Incremental First Lien Term Loan was 5.50% and the outstanding balance was $525.0 million.

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 and are being amortized to interest expense proportionally over the terms of the respective loans using the effective interest rate method.

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 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. 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, 2020, the interest rate on the 2020 Second Lien Term Loan was 9.50% 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 amendments, the availability under the ABL credit facility increased to $150.0 million in the form of an asset-based revolving facility. 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 loans using the effective interest rate method.

The Company did not have an outstanding balance under the ABL credit facility at December 31, 2020.

The 2020 Credit Agreement has a restrictive covenant for leverage ratios. The Company was in compliance with the covenants under the 2020 Credit Agreement through the year ending December 31, 2020.

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 million (the "First Lien Term Loan") and a second lien term loan for $130 million (the "Second Lien Term Loan") over a respective seven-year and eight-year initial terms. The 2019 Credit Agreement also includes a $40 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 million. The 2019 Credit Agreement is collateralized by substantially all of the Company's assets.

The Company incurred fees and discounts of $18.2 million associated with the 2019 Credit Agreement, which were capitalized as deferred financing costs and debt discounts and are amortized proportionality over the terms of the respective loans on an effective interest rate basis.

First Lien Term Loan

The $355 million First Lien Term Loan provides 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 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, plus an 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, 2020, the interest rate on the 2019 First Lien Term Loan was 5.15% with an outstanding balance of $350.6 million. As of December 31, 2019, the interest rate calculated on the First Lien Term Loan was 6.95% with an outstanding balance of $353.2 million.

Second Lien Term Loan

The $130 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 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, plus an 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, 2020, the interest rate on the 2019 Second Lien Term Loan was 9.50% with an outstanding balance of $130 million. As of December 31, 2019, the interest rate of the Second Lien Term Loan was 10.70% with an outstanding balance of $130 million.

Revolving Credit Facility

As part of the 2019 Credit Agreement, the lender made available a $40 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. 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, 2020 or December 31, 2019. The Company had utilized $23.2 million and $19.3 million of the availability related to Letters of Credit issued to the Company's workers' compensation programs as of December 31, 2020 and December 31, 2019, respectively. These standby letters of credit benefit our third-party insurer for our 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, 2020 or December 31, 2019.

ABL Credit Facility

As part of the 2019 Credit Agreement, $75 million was made available to the Company in the form of an asset-based revolving facility. 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% (c) the *Wall Street Journal* Prime Rate. The Applicable Rate is equal to the rate per annum 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.

The Company did not have an outstanding balance under the 2019 ABL at December 31, 2019.

The 2019 Credit Agreement has a restrictive covenant for leverage ratios. The Company was in compliance with the covenants under the 2019 Credit Agreement through the year ending December 31, 2020 and 2019.

2018 Credit Agreement

During 2018, the Predecessor entered into a credit agreement (the "2018 Credit Agreement") which included a $250 million, six-year initial term loan, a $50 million delayed draw term loan, and a $75 million revolving credit facility, including a letter of credit facility. The 2018 Credit Agreement was collateralized by substantially all of the Predecessor's assets. Fees of $5.1 million were incurred associated with the 2018 Credit Agreement.

Pursuant to the terms of the Merger, the existing principal balance of $374.3 million as of the Predecessor period ended June 19, 2019 was not assumed in the Successor period. Unamortized deferred financing fees related to the 2018 Credit Agreement totaling $4.1 million are reflected in the line as a result of the Merger.

7. 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):

	Successor		Predecessor
	Year-Ended December 31, 2020	Period From June 20, 2019 to December 31, 2019	Period From January 1, 2019 to June 19, 2019
Current income taxes:			
Federal	$ (269)	$ (230)	$ (125)
State	1,956	(168)	555
	1,687	(398)	430
Deferred income taxes:			
Federal	3,297	1,576	524
State	805	381	55
	4,102	1,957	579
Provision for income taxes	$ 5,789	$ 1,559	$ 1,009

The components of deferred income taxes, net were as follows (in thousands):

	As of December 31,	
	2020	2019
Deferred income tax assets	$ 68,774	$ 56,174
Deferred income tax liabilities	(72,988)	(62,625)
Less: Valuation allowance	(68,631)	(55,940)
Deferred income taxes, net	$ (72,845)	$ (62,391)

The Company's effective income tax rate is 66.99% for the Successor year ended December 31, 2020, (9.58)% for the Successor period from June 20, 2019 to December 31, 2019; and (2.36)% for the Predecessor period from January 1, 2019 to June 19, 2019. The significant reconciling items between the reported amount of income tax expense that would result from applying domestic statutory tax rates are state taxes, valuation allowance, transaction costs, intangibles, stock compensation, and variable and minority interest amounts.

The Company had federal net operating loss carryforwards of approximately $84.1 million and $109.9 million at December 31, 2020 and December 31, 2019, respectively. The Company had state net operating loss carryforwards of approximately $74.2 million and $70.6 million at December 31, 2020 and December 31, 2019, respectively. The state net operating loss carryforwards are reflected on a post-apportionment basis. Federal net operating loss carryforwards will begin to expire in 2032. State net operating losses will begin expiring in 2027. The Company also had federal tax credits of approximately $2.1 million and $2.5 million as of December 31, 2020 and December 31, 2019, respectively.

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 show that projected net operating loss and credit carryforward utilization at December 31, 2020 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 $68.6 million and $55.9 million as of December 31, 2020 and December 31, 2019, respectively. The valuation allowance increased $12.7 million during the year ended December 31, 2020. The valuation allowance increased $3.3 million for the Successor period from June 20, 2019 to December 31, 2019 and increased $15.1 million for the Predecessor period from January 1, 2019 to June 19, 2019, resulting in a total increase of $18.4 million during 2019. 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 Successor period and both Predecessor periods includes purchase price adjustments both related to acquisitions and to the Merger.

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 Successor year ended December 31, 2020; the Successor period from June 20, 2019 to December 31, 2019; or the Predecessor period from January 1, 2019 to June 19, 2019.

The CARES Act (Note 3) also contained major tax reform legislation including, among other provisions, an acceleration of the refund of alternative minimum tax credits, the modification of net operating loss carrybacks provisions, and the modification of net interest deduction limitations. The Company filed for and received a refund of their alternative minimum credit in the amount of $0.5 million during the period ended December 31, 2020. Otherwise, as of December 31, 2020 and 2019, management considers that the CARES Act will have an immaterial impact to income taxes. However, going forward, the Company will analyze the impact based on revised circumstances.

The Company's open years for Internal Revenue Service (IRS) examination purposes due to normal statute of limitation are 2017, 2018, and 2019. 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.

8. Stock and Share-Based Compensation

Successor

At December 31, 2020 and 2019, 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 Spring 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 Company's 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. No expense was recognized during the Successor periods ended December 31, 2020 and 2019 for the performance awards, as the probability of meeting these targets was zero. The Company recognized $1.3 million and $1.6 million of compensation expense related to the Horizon Incentive Plan, for the Successor periods ended December 31, 2020 and 2019, respectively.

The following table provides a summary of the Parent's incentive units activity:

	Time Based Incentive Units	Performance Based Incentive Units	Total Incentive Units		Weighted Average Grant Date Fair Value Per Unit
Incentive units outstanding - December 31, 2019	15,109	21,152	36,261	$	1,000
Granted	7,585	10,620	18,205	$	918
Forfeited	(3,240)	(4,537)	(7,777)	$	581
Incentive units outstanding - December 31, 2020	19,454	27,235	46,689	$	932
Incentive units vested and unvested - December 31, 2020					
Unvested units	16,933	27,235	44,168	$	953
Vested units	2,521	-	2,521	$	564
Incentive units outstanding - December 31, 2020	19,454	27,235	46,689	$	932

The fair value of the time-cased units that vested during 2020 totaled $1.4 million. The total unrecognized compensation cost related to the incentive units was $41.0 million. Of this amount, $10.6 million and $30.4 million are related to time-based and performance-based incentive units, respectively. The balance related to time-based incentive units is expected to be recognized over a weighted average remaining period of 4.4 years. Total awards available to be granted under the Horizon Incentive Plan are 50,805 units, of which 46,689 units are outstanding as of December 31, 2020 and 36,261 were outstanding as of December 31, 2019.

In connection with the Spring 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-based units, with a weighted average grant date fair value of $1,279, 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 $21 thousand of compensation expense related to the Seasons Incentive Plan for the Successor period ended December 31, 2020.

The total unrecognized compensation cost related to the Seasons Incentive Plan incentive units was $3.6 million. The balance related to the incentive units is expected to be recognized over a weighted average remaining period of 5 years. 2,827 units were available to be granted and are outstanding under the Seasons Incentive Plan as of December 31, 2020.

Predecessor

Prior to the Merger, the Predecessor had three classes of Preferred Stock with authorized 800,000, 250,000, and 250,000 shares of Series A Preferred Stock, Series B Preferred Stock, and Series C Preferred Stock, respectively. The Series A and Series B shares had a stated value of $155 per share, and the Series C shares had a stated value of $88.72 per share. In anticipation of the Merger, the Company authorized an additional 250,000 shares of Common Stock to bring the total quantity of Common Stock authorized to 1,550,000. Immediately preceding the Merger, all of the Series A, Series B and Series C Preferred Stock were converted into Common Stock.

In November 2012, the Company's Board approved a stock option plan, whereby the Company may grant non-qualified stock options ("Options") for the purchase of common shares, with exercise prices not less than fair market value. The vesting period has two separate components: (i) service-based (70% of option award) and (ii) performance-based (30% of option award). The service-based portion will vest 20% on the first anniversary date of grant, with the remainder vesting over the following four years in equal, semiannual installments. The performance-based vesting is dependent on a change in control of the Company, coupled with a graduated scale of vesting percentages dependent on the return on invested equity earned by the Company's primary investor.

On April 18, 2017, option agreements were modified to make the unvested portion of the performance-based award immediately vested and exercisable upon a change in control.

Option activity under the 2012 Stock Option Plan is as follows:

	Options	Weighted Average Exercise Price	Weighted Average Grant Date Fair Value Per Share
Predecessor			
Options outstanding - December 31, 2018	122,764		
Granted	81,120	$ 272.96	$ 92.93
Exercised	(203,884)	134.98	71.38
Forfeited	-	-	-
Options outstanding - June 19, 2019	-		

Total unrecognized compensation cost related to stock options was $0 as of Predecessor period end June 19, 2019.

In 2018, the Company awarded 31,279 Preferred Share Bonus units ("Preferred Bonus") and 9,671 Common Share Warrant Bonus Units ("Warrants") to employees. The Company did not grant Warrants or Preferred Bonuses in the year ended December 31, 2019 and Predecessor period ended June 19, 2019. The Preferred Bonus and Warrants are equity classified and vested upon change of control on June 19, 2019 with a weighted average grant date fair value per unit of $42.54 and $61.04 respectively.

All Warrants and Preferred Bonus units were fully vested on June 19, 2019 upon consummation of the Merger (Note 4). For the Predecessor period ended June 19, 2019 the Company recorded compensation expense related to the Options, Warrants and Preferred Bonus units of $11.1 million.

9. Commitments and Contingencies

Lease Commitments

The Company has operating leases in place with respect to facilities (property and equipment) and fleet vehicles with termination option dates in various years through 2030. The Company's lease portfolio primarily consists of administrative office space with initial terms of one to ten years, most with one or two renewal options of one to five years.

Future minimum lease obligations required under the leases as of December 31, 2020 were 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 Successor periods ending December 31, 2020 and December 31, 2019 was $13.2 million and $7.2 million, respectively. Rent expense for the Predecessor period ending June 19, 2019 was $6.7 million.

Guarantees and Indemnities

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. For December 31, 2020 and 2019, the claims reserve balance associated with workers' compensation was being discounted using a rate of 0.50% and 1.75%, respectively.

The following table presents details of our insurance programs, including amounts accrued for the periods indicated (amounts in thousands) in accrued expenses in our consolidated balance sheets:

	As of December 31,	
Type of Insurance	**2020**	**2019**
Health insurance	$ 6,978	$ 3,206
Workers' compensation	26,954	23,680
	33,932	26,886
Less: long-term portion	19,809	18,116
	$ 14,123	$ 8,770

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 $50,000 per incident for claims against AccentCare, Inc. and $0.3 million for claims against Seasons Hospice and Palliative Care.

10. Benefit Plans

The Company has continued the defined contribution plan and deferred compensation plan existing prior to the Merger with Horizon to be consistent in the Successor period.

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 Successor periods ending December 31, 2020 and 2019, 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 $1.8 million and $1.6 million in contributions associated with those employees for the Successor periods ended December 31, 2020 and December 31, 2019, respectively. The Company matched $1.1 million for the Predecessor period ended June 19, 2019.

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. During the year-ended December 31, 2020, the Company changed providers for its deferred compensation plan and obtained new insurance contracts. The Company paid a $0.9 million premium using plan assets, which is the main driver in the balance change from prior year. For the years ended December 31, 2020 and 2019, plan assets totaled $1.8 million (inclusive of $1.5M in cash surrender value of an insurance contract) and $2.4 million, respectively, and plan liabilities totaled $3.4 million and $2.4 million, respectively.

11. Fair Value Measurements

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.

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 Income (Loss), net of related income taxes, and reclassified into interest expense in the consolidated statements of comprehensive income (loss) in the same periods during which the hedge transactions affect earnings.

During 2020, $0.2 million was reclassified from Accumulated Other Comprehensive Income (Loss) into interest expense on the consolidated statements of comprehensive income (loss). As of December 31, 2020, amounts expected to be reclassified from Accumulated Other Comprehensive Income (Loss) into interest expense during the next twelve months are approximately $0.5 million. No significant amounts were excluded from the assessment of cash flow hedge effectiveness as of December 31, 2020. For the year ended December 31, 2019, the Company had no such agreements.

The assets and liabilities measured at fair value related to the Company's interest rate swaps, excluding accrued interest, were as follows (in thousands):

		December 31, 2020			
			Fair Value Measurements Using:		
	Balance Sheet Classification	Fair Value	Quoted Prices in Active Markets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Interest rate swap, current portion	Other current liability	$ 575	$ -	$ 575	$ -
Interest rate swap, non-current portion	Other long-term liability	312	-	312	-
		$ 887	$ -	$ 887	$ -

Deferred Compensation Plan Assets

As discussed in Note 10, 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, which results are summarized as follows (in thousands):

			December 31, 2020	December 31, 2019
	Balance Sheet Classification	Fair Value Heirarchy	Fair Value	Fair Value
Deferred compensation plan assets	Other assets	Level 2	$ 1,785	$ 2,394

Financial Instruments

The Company's financial instruments include cash and cash equivalents, accounts receivable, accounts payable, accrued expenses, and long-term debt. 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 debt approximates fair value based on the variable interest rate of the long-term debt.

12. 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.

13. Related-Party Transactions

For the periods ended December 31, 2020 and 2019, the Company had $0.5 million and $1.8 million, respectively, of expenses on the consolidated statements of comprehensive income (loss) related to Advent International, an investor of Horizon Group Holdings, L.P., for accounting, consulting, travel, and board fees incurred on behalf of the Company. As of December 31, 2020, $0.1 million of such expense was included in accrued expenses on the consolidated balance sheets. There were no accrued liabilities for such transactions on the consolidated balance sheets as of December 31, 2019.

At December 31, 2018, the Company had $2.2 million liability recorded, respectively, in other long-term liabilities on the consolidated balance sheets for amounts owed to Oak Hill Capital Management, Inc., an investor of Pluto Acquisition I Inc., for accounting, consulting, travel, and board fees incurred on behalf of the Company. This liability was settled during the Predecessor period ended June 19, 2019.

14. Subsequent Events

In accordance with ASC 855, Company's management reviewed all material events through April 22, 2021 and determined that there were the following material subsequent events to report:

On January 7, 2021, the Company amended one of its interest rate swap to reduce the notional value from $192.6 million to $157.2 million. The Company paid $0.1 million for this amendment.

On February 4, 2021, the Company amended its First Lien Term Loan to reduce the base rate on LIBOR loans from 5% to 4.5%. No other terms of the First Lien Term Loan were changed as a result of this amendment.

EXHIBIT 19

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.

References

1. Obermeyer Z, Makar M, Abujaber S, et al.: Association between the Medicare hospice benefit and health care utilization and costs for patients with poor-prognosis cancer. JAMA 2014;312:1888–1896.
2. Steinhauser KE, Christakis NA, Clipp EC, et al.: Factors considered important at the end of life by patients, family, physicians, and other care providers. JAMA 2000;284:2476–2482.
3. Glare P, Christakis NA: *Prognosis in Advanced Cancer.* Oxford: Oxford University Press, 2008.
4. Gill TM, Gahbauer EA, Han L, Allore HG: Trajectories of disability in the last year of life. N Engl J Med 2010;362:1173–1180.

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Hospice Leads To Better Care, Lower Costs At End Of Life: JAMA

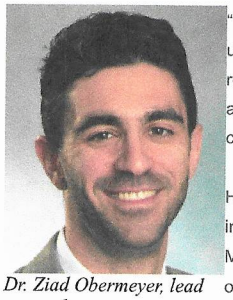
December 7, 2014 Hospice and Palliative Care, Politics and Law No Comments

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
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Reuters Health: LMM Reports
Society and Culture
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Voices in Bioethics: LMM Commentary
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Hospice and Palliative Care

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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

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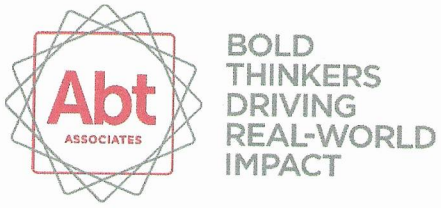
About this Report

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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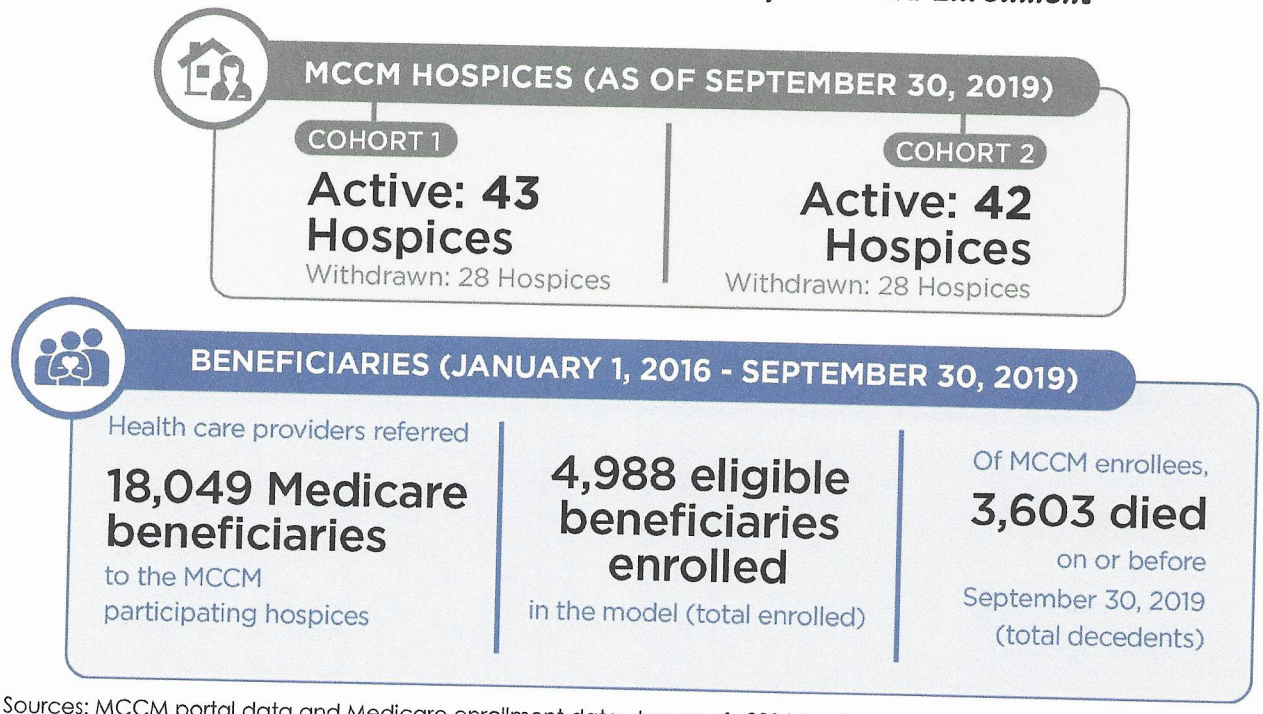
Beneficiaries also must be enrolled in Medicare Parts A and B and must have had at least 3 Medicare-covered office visits and 1 hospital encounter during the 12 months before enrollment. A hospital encounter can be an emergency department visit, observational stay, or inpatient admission. Beneficiaries 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 3,603 MCCM enrollees who died on or before September 30, 2019. Percent savings 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 20

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 10929	**Date: August 4, 2021**
	Change Request 12354

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10876, dated July 15, 2021, is being rescinded and replaced by Transmittal 10929, dated, August 4, 2021 to update the attached payment tables. All other information remains the same.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2022

I. SUMMARY OF CHANGES: This Change Request (CR) updates the hospice payment rates, hospice wage index, and Pricer for FY 2022. The CR also updates the FY 2022 hospice aggregate cap amount. These updates apply to Pub 100-04, Chapter 11, section 30.2.

EFFECTIVE DATE: October 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 4, 2021

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: 10929	Date: August 4, 2021	Change Request: 12354

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 10876, dated July 15, 2021, is being rescinded and replaced by Transmittal 10929, dated, August 4, 2021 to update the attached payment tables. All other information remains the same.

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2022

EFFECTIVE DATE: October 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 4, 2021

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 revert to the original methodology that updates the cap amount by the Consumer Price Index (CPI). This rule will extend 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 the Consolidated Appropriations Act of 2021. Therefore, for accounting years that end after September 30, 2016 and before October 1, 2030, the hospice cap will be updated by the hospice payment update percentage.

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: <u>FY 2022 Hospice Payment Rates</u>

The hospice payment update percentage for Fiscal Year (FY) 2022 is based on the inpatient hospital market basket update of 2.7 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 2022 of 2.7 percent must be reduced by an MFP

adjustment as mandated by Affordable Care Act (currently estimated to be 0.7 percentage point for FY 2022). In effect, the hospice payment update percentage for FY 2022 is 2.0 percent.

The FY 2022 hospice payment rates are effective for care and services furnished on or after October 1, 2021, through September 30, 2022. 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 2022 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 2022 cap year will start on October 1, 2021 and end on September 30, 2022.

For the inpatient cap for the 2022 cap year, we will calculate the percentage of all hospice days that were provided as inpatient days (GIP care and Respite care) from October 1, 2021 through September 30, 2022.

The hospice cap amount for the 2022 cap year is equal to the FY 2021 cap amount ($30,683.93) updated by the FY 2022 hospice payment update percentage of 2.0 percent. As such, the FY 2022 cap amount is $31,297.61.

Hospice Wage Index

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 General Inpatient 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12354.1	Medicare systems shall apply the FY 2022 rates for claims with dates of service on or after October 1,					X				Hospice Pricer

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	2021 through September 30, 2022.									
12354.2	Medicare systems shall install the new Hospice Pricer software.					X				Hospice Pricer
12354.3	Medicare systems shall use a table of wage index values associated with Core Based Statistical Area (CBSA) codes for FY 2022 hospice payment calculation.					X				Hospice Pricer
12354.4	Contractors shall calculate hospices' aggregate cap amounts for the FY 2022 cap year, starting on October 1, 2021 and ending on September 30, 2022, based on the cap amount of $31,297.61.			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12354.5	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.			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 2022 Hospice Payment Rates for Hospices that Submit the Required Quality Data

Code	Description	FY 2022 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$203.40	$134.24	$69.16
651	Routine Home Care (days 61+)	$160.74	$106.09	$54.65
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate=$60.94	$1,462.52	$1099.82	$362.70
655	Inpatient Respite Care	$473.75	$288.99	$184.76
656	General Inpatient Care	$1,068.28	$678.36	$389.92

Table 2: FY 2022 Hospice Payment Rates for Hospices that DO NOT Submit the Required Quality Data

Code	Description	FY 2022 Payment Rate	Labor Share	Non-Labor Share
651	Routine Home Care (days 1-60)	$199.41	$131.61	$67.80
651	Routine Home Care (days 61+)	$157.58	$104.00	$53.58
652	Continuous Home Care Full Rate = 24 hours of care Hourly rate=$59.74	$1,433.84	$1078.25	$355.59
655	Inpatient Respite Care	$464.46	$283.32	$181.14
656	General Inpatient Care	$1,047.33	$665.05	$382.28

EXHIBIT 21

Health Resources and Services Administration Workforce Statistics

Service Area	MUA/P Source ID	Designation Type	Index of Medical Underservice Score	State	Status	MUA/P Designation Date	MUA/P Update Date	HHS Region	Rural Status	County
Spokane Service Area	03697	Medically Underserved Area	51.84	WA	Designated	05/11/1994	05/11/1994	Region 10	Non-Rural	Spokane County, WA
Low Inc - Southwest Spokane Service Area	05019	Medically Underserved Population	61.8	WA	Designated	03/31/1999	03/31/1999	Region 10	Non-Rural	Spokane County, WA

Health Profession Shortage Areas (HPSAs) - Spokane County, WA

HPSA Name	Designation Type	HPSA Discipline Class	HPSA Score	HPSA Status	HPSA Designation Date	HPSA Designation Last Update	# of FTE Short	Address	City	ZIP	Rural Status	County
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Mental Health	20	Designated	05/14/2003	09/11/2021		611 N Iron Bridge Way	Spokane	99202-4932	Non-Rural	Spokane County, WA
North Spokane Service Area	Geographic HPSA	Mental Health	19	Designated	12/04/2006	09/08/2021	1.93				Non-Rural	Spokane County, WA
Southeast Spokane Service Area	Geographic HPSA	Mental Health	19	Designated	12/15/2006	09/09/2021	5.09				Non-Rural	Spokane County, WA
LI/H - City of Spokane Service Area	HPSA Population	Mental Health	19	Designated	09/15/2017	09/09/2021	7.305				Non-Rural	Spokane County, WA
Southwest Spokane Service Area	Geographic HPSA	Mental Health	18	Designated	12/22/2006	09/09/2021	2.33				Non-Rural	Spokane County, WA
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Dental Health	24	Designated	12/03/2003	09/11/2021		611 N Iron Bridge Way	Spokane	99202-4932	Non-Rural	Spokane County, WA
LI/H - Spokane County	HPSA Population	Dental Health	16	Designated	05/17/1982	09/09/2021	32.7075				Non-Rural	Spokane County, WA
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Primary Care	19	Designated	05/08/2003	09/11/2021		611 N Iron Bridge Way	Spokane	99202-4932	Non-Rural	Spokane County, WA
North Spokane County	Geographic HPSA	Primary Care	16	Designated	09/15/2017	09/08/2021	24.51				Non-Rural	Spokane County, WA
Southeast Spokane County	Geographic HPSA	Primary Care	16	Designated	09/15/2017	09/08/2021	22.38				Non-Rural	Spokane County, WA
Southwest Spokane County	Geographic HPSA	Primary Care	17	Designated	09/15/2017	09/08/2021	7.8				Non-Rural	Spokane County, WA
LI/H - City of Spokane Service Area	HPSA Population	Primary Care	17	Designated	10/21/2021	10/21/2021	36.0271				Non-Rural	Spokane County, WA
LI/H/MFW-Downtown Spokane	HPSA Population	Primary Care	16	Proposed For Withdrawal	04/03/2014	10/21/2021	39.4				Non-Rural	Spokane County, WA
Low Income/Homeless - City of Spokane	HPSA Population	Mental Health	18	Withdrawn	04/26/2007	07/02/2018	4.87					Spokane County, WA
Low Income - Southwest Spokane	HPSA Population	Primary Care	0	Withdrawn	09/20/1999	11/03/2011	0					Spokane County, WA
Low Income - Eastern Spokane	HPSA Population	Primary Care	0	Withdrawn	09/20/1999	11/03/2011	1.5					Spokane County, WA
Homeless - City of Spokane (Simplified)	HPSA Population	Primary Care	0	Withdrawn	02/01/2001	11/03/2011	0					Grant County, WA | King County, WA | Spokane County, WA

Source: https://data.hrsa.gov/tools/data-explorer ; Accessed 12/29/2021

HPSA Name	Designation Type	HPSA Discipline Class	HPSA Score	HPSA Status	HPSA Designation Date	HPSA Designation Last Update	Withdrawn Date	# of FTE Short	Address	City	ZIP	County
Airway Heights Corrections Center	Correctional Facility	Mental Health	12	Designated	02/05/2019	12/10/2021		0.44	11919 W Sprague Ave	Airway Heights	99001	Spokane County, WA
CF-Airway Heights Corrections Center	Correctional Facility	Dental Health	3	Designated	08/20/2007	11/24/2017		0.52	11919 W Sprague Ave	Airway Heights	99001	Spokane County, WA
Airway Heights Corrections Center	Correctional Facility	Primary Care	12	Designated	07/09/2003	12/10/2021		0.36	11919 W Sprague Ave	Airway Heights	99001	Spokane County, WA
N. A. T. I. V. E. Project, The	Federally Qualified Health Center	Mental Health	21	Designated	08/05/2010	09/10/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Mental Health	20	Designated	05/14/2003	09/11/2021			611 N Iron Bridge Way	Spokane	99202-4932	Spokane County, WA
N. A. T. I. V. E. Project, The	Federally Qualified Health Center	Dental Health	25	Designated	08/05/2010	09/10/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Dental Health	24	Designated	12/03/2003	09/11/2021			611 N Iron Bridge Way	Spokane	99202-4932	Spokane County, WA
N. A. T. I. V. E. Project, The	Federally Qualified Health Center	Primary Care	21	Designated	08/05/2010	09/10/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
COMMUNITY HEALTH ASSOCIATION OF SPOKANE	Federally Qualified Health Center	Primary Care	19	Designated	05/08/2003	09/11/2021			611 N Iron Bridge Way	Spokane	99202-4932	Spokane County, WA
North Spokane Service Area	Geographic HPSA	Mental Health	19	Designated	12/04/2006	09/08/2021		1.93				Spokane County, WA
Southeast Spokane Service Area	Geographic HPSA	Mental Health	19	Designated	12/15/2006	09/09/2021		5.09				Spokane County, WA
Southwest Spokane Service Area	Geographic HPSA	Mental Health	18	Designated	12/22/2006	09/09/2021		2.33				Spokane County, WA
North Spokane County	Geographic HPSA	Primary Care	16	Designated	09/15/2017	09/08/2021		24.51				Spokane County, WA
Southeast Spokane County	Geographic HPSA	Primary Care	16	Designated	09/15/2017	09/08/2021		22.38				Spokane County, WA
Southwest Spokane County	Geographic HPSA	Primary Care	17	Designated	09/15/2017	09/08/2021		7.8				Spokane County, WA
LI/H - City of Spokane Service Area	HPSA Population	Mental Health	19	Designated	09/15/2017	09/09/2021		7.305				Spokane County, WA
LI/H - Spokane County	HPSA Population	Dental Health	16	Designated	05/17/1982	09/09/2021		32.7075				Spokane County, WA
LI/H - City of Spokane Service Area	HPSA Population	Primary Care	17	Designated	10/21/2021	10/21/2021		36.0271				Spokane County, WA
The Native Project	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Mental Health	20	Designated	08/18/2019	09/11/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
Camas Path Behavioral Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Mental Health	19	Designated	08/18/2019	09/12/2021			934 S Garfield Rd	Airway Heights	99001-9030	Spokane County, WA
Camas Path Behavioral Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Dental Health	20	Designated	08/18/2019	09/12/2021			934 S Garfield Rd	Airway Heights	99001-9030	Spokane County, WA
The Native Project	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Dental Health	22	Designated	08/18/2019	09/11/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
The Native Project	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Primary Care	19	Designated	08/18/2019	09/11/2021			1803 W Maxwell Ave	Spokane	99201-2831	Spokane County, WA
Camas Path Behavioral Health	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Primary Care	18	Designated	08/18/2019	09/12/2021			934 S Garfield Rd	Airway Heights	99001-9030	Spokane County, WA
LI/H/MFW-Downtown Spokane	HPSA Population	Primary Care	16	Proposed For Withdrawal	04/03/2014	10/21/2021		39.4				Spokane County, WA
Rockford Service Area	Geographic HPSA	Primary Care	13	Withdrawn	05/04/1990	07/02/2018	07/02/2018	0.85				Spokane County, WA
Deer Park Service Area	Geographic HPSA	Primary Care	0	Withdrawn	01/10/1983	06/30/2005	06/30/2005					Spokane County, WA | Stevens County, WA
Deer Park/Colbert	Geographic HPSA	Primary Care	4	Withdrawn	06/30/2005	07/02/2018	07/02/2018	0.48				Spokane County, WA
Medical Lake	Geographic HPSA	Primary Care	0	Withdrawn	08/18/1980	03/16/1984	03/16/1984					Spokane County, WA
Low Income/Homeless - City of Spokane	HPSA Population	Mental Health	18	Withdrawn	04/26/2007	07/02/2018	07/02/2018	4.87				Spokane County, WA
Low Income - Southwest Spokane	HPSA Population	Primary Care	0	Withdrawn	09/20/1999	11/03/2011	11/03/2011	0				Spokane County, WA
Low Income - Eastern Spokane	HPSA Population	Primary Care	0	Withdrawn	09/20/1999	11/03/2011	11/03/2011	1.5				Spokane County, WA
Homeless - City of Spokane (Simplified)	HPSA Population	Primary Care	0	Withdrawn	02/01/2001	11/03/2011	11/03/2011	0				Grant County, WA | King County, WA | Spokane County, WA
Healing Lodge of the Seven Nations	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Mental Health	18	Withdrawn	10/26/2002	09/18/2020	09/18/2020		5600 E 8th Ave	Spokane Valley	99212-0220	Spokane County, WA
Healing Lodge of the Seven Nations	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Dental Health	20	Withdrawn	10/26/2002	09/18/2020	09/18/2020		5600 E 8th Ave	Spokane Valley	99212-0220	Spokane County, WA
Healing Lodge of the Seven Nations	Indian Health Service, Tribal Health, and Urban Indian Health Organizations	Primary Care	18	Withdrawn	10/26/2002	09/18/2020	09/18/2020		5600 E 8th Ave	Spokane Valley	99212-0220	Spokane County, WA

Source: https://data.hrsa.gov/tools/data-explorer
Accessed: 12/29/2021

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.

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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.

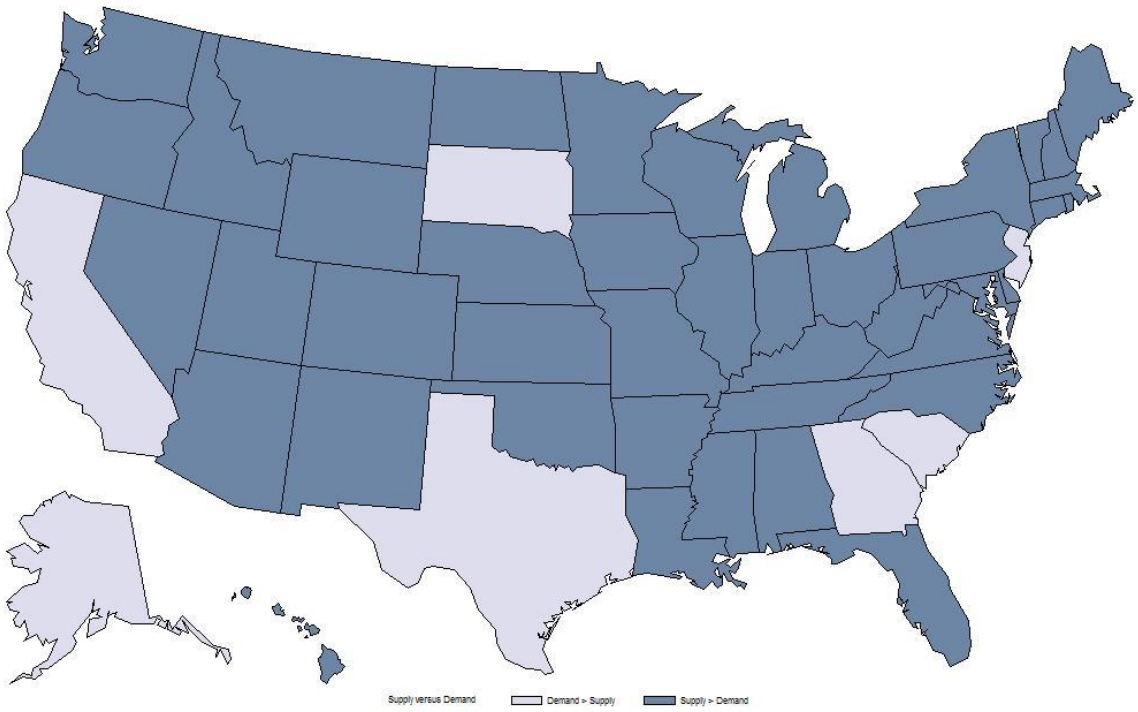
Expressing each 2030 state-level shortage or surplus as a percentage of the state's 2030 demand helps to inform comparisons of differences between supply and demand across states by considering how the size of each state's surplus or shortage relates to that state's underlying provider demand.

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 Supply/ Demand [a]	2030 Supply	2030 Demand	2030 Difference [b]	2030 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 Supply/ Demand [a]	2030 Supply	2030 Demand	2030 Difference [b]	2030 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%

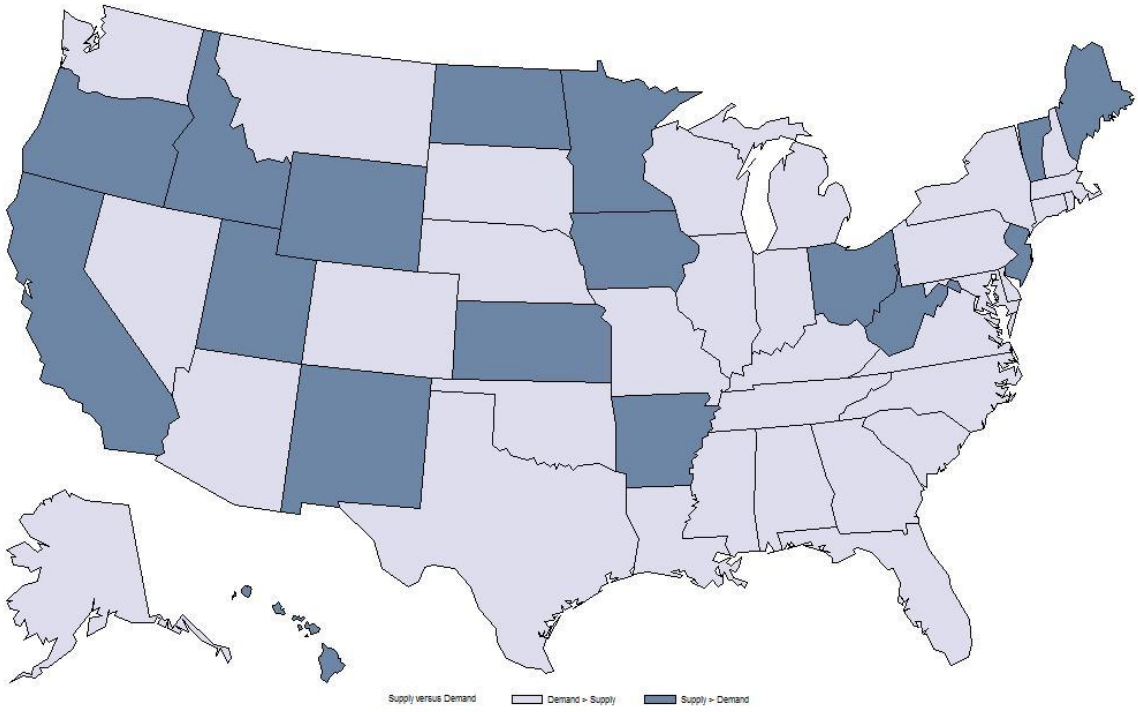
Notes: The model assumes increased insurance coverage associated with Medicaid expansion and insurance marketplaces, together with year 2014 health care use and delivery patterns. Numbers may not sum to totals due to rounding.
[a] The projections assume that each state's supply and demand are equal in 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.

[25] Staiger, D. O., Auerbach, D. I., & Buerhaus, P. I. (2012). Registered nurse labor supply and the recession—are we in a bubble? *New England Journal of Medicine*, *366*(16), 1463-1465.

[26] Institute of Medicine (US). Committee on the Future Health Care Workforce for Older Americans. (2008). *Retooling for an aging America: Building the health care workforce*. National Academies Press.

[27] Rother, J., & Lavizzo-Mourey, R. (2009). Addressing the nursing workforce: A critical element for health reform. *Health Affairs*, *28*(4), w620-w624..

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.

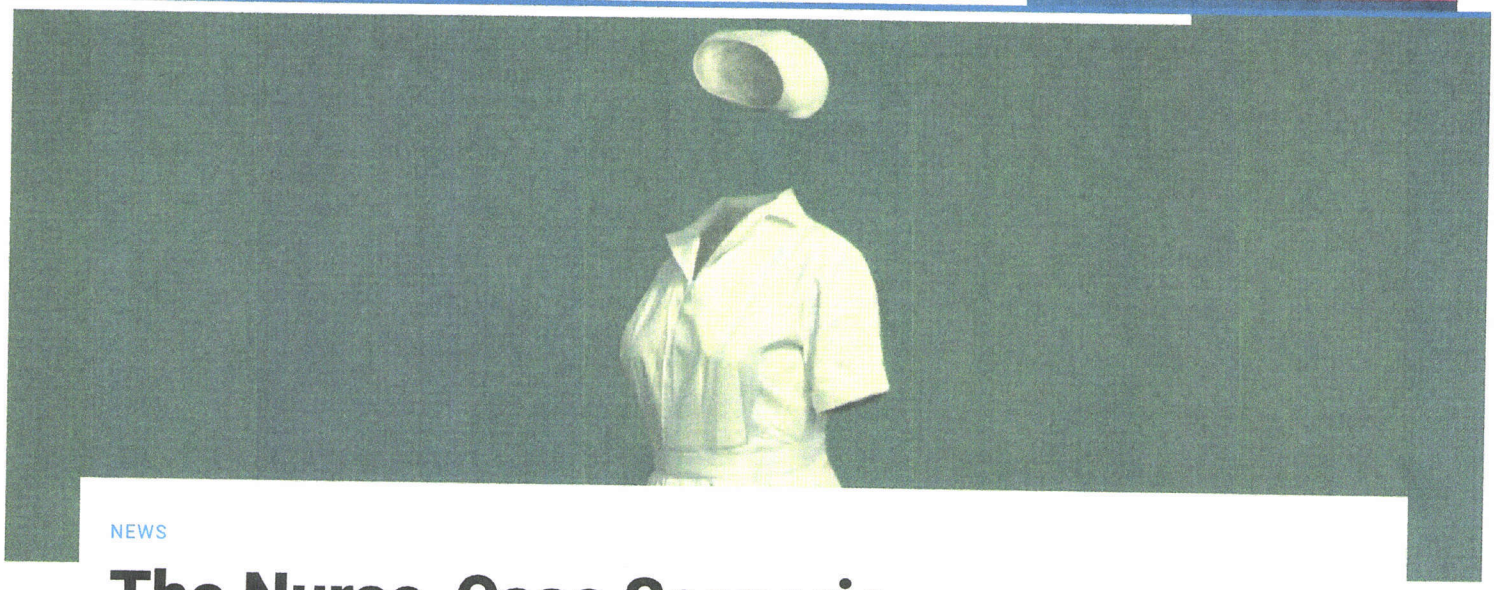
The supply component of the Model simulates workforce decisions for each provider based on his or her demographics and profession, along with the characteristics of the local or national economy and the labor market. The starting supply, plus new additions to the workforce, minus attrition provides an 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.

[1] Holahan, J. & Blumberg, L. (2010 January). *How would states be affected by health reform? Timely analysis of immediate health policy issues.* Retrieved August 2013 from http://www.urban.org/UploadedPDF/412015_affected_by_health_reform.pdf.

[2] Holahan, J. (2014 March) *The launch of the Affordable Care Act in selected states: coverage expansion and uninsurance* Retrieved August 2013 from http://www.urban.org/uploadedPDF/413036-the-launch-of-the-Affordable-Care-Act-in-selected-states-coverage-expansion-and-uninsurance.pdf. Washington D.C., The Urban Institute.



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.

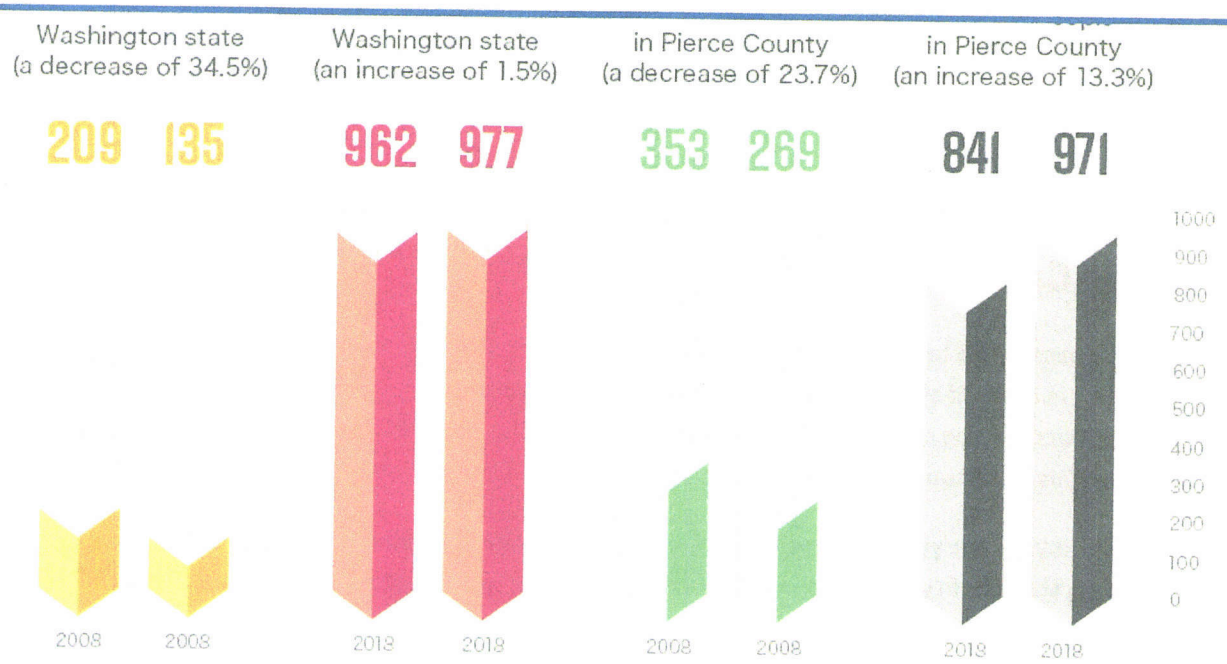
Now I work two jobs: one as a nurse at a hospital ICU in Olympia, and one as a nurse at a virtual acute care unit in Tacoma. Nurses from multiple hospitals contact us with questions or problems that need to be solved. Experienced nurses help new nurses figure out what to do with their patients.

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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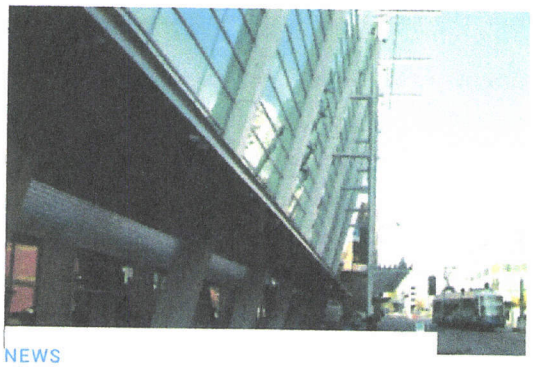
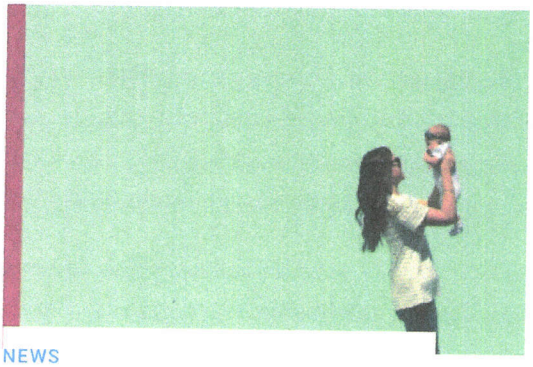


NEWS

South Sound Summit Aims to Advance Local Businesses



NEWS

Thurston County 'Leads by Example' with Infant at Work Pilot Program

EXHIBIT 22

Articles Regarding Impact of COVID-19

frontiers in Psychology

BRIEF RESEARCH REPORT
published: 13 August 2020
doi: 10.3389/fpsyg.2020.02065

Mental Health Challenges of United States Healthcare Professionals During COVID-19

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As COVID-19 continues to impact global society, healthcare professionals (HCPs) are at risk for a number of negative well-being outcomes due to their role as care providers. The objective of this study was to better understand the current psychological impact of COVID-19 on HCPs in the United States This study used an online survey tool to collect demographic data and measures of well-being of adults age 18 and older living in the United States between March 20, 2020 and May 14, 2020. Measures included anxiety and stress related to COVID-19, depressive symptoms, current general anxiety, health questions, tiredness, control beliefs, proactive coping, and past and future appraisals of COVID-related stress. The sample included 90 HCPs and 90 age-matched controls (M_{age} = 34.72 years, *SD* = 9.84, range = 23 – 67) from 35 states of the United States. A multivariate analysis of variance was performed, using education as a covariate, to identify group differences in the mental and physical health measures. HCPs reported higher levels of depressive symptoms, past and future appraisal of COVID-related stress, concern about their health, tiredness, current general anxiety, and constraint, in addition to lower levels of proactive coping compared to those who were not HCPs ($p < 0.001$, $\eta^2 = 0.28$). Within the context of this pandemic, HCPs were at increased risk for a number of negative well-being outcomes. Potential targets, such as adaptive coping training, for intervention are discussed.

Keywords: health care professionals, pandemic (COVID-19), stress and coping, depression, anxiety

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INTRODUCTION

On May 14, 2020, the United States had 1,340,098 confirmed COVID-19 cases with 80,695 deaths (World Health Organization, 2020) and was considered the epicenter of the pandemic. Although social distancing and quarantine guidelines have slowed the pandemic's spread, the recent relaxing of guidelines suggests continued challenges to the healthcare systems and healthcare professionals (HCPs). Indeed, there are calls for COVID-19 to be considered as a new occupational hazard for H around the globe (Godderis et al., 2020). Not only are many HCPs more likely to be exposed to and, therefore, contract COVID-19, but providing care during a pandemic can place tremendous pressure on HCPs caring for very sick and dying patients, helping the families of the sick, and dealing with the frustrations of healthcare systems, all while trying to take care of their own families and loved ones (Maunder et al., 2003; Bai et al., 2004).

Studies out of China have examined the experiences of HCPs during the height of their COVID-19 outbreak. In a sample of 1,563 medical staff workers in China working during the COVID-19 pandemic, 73.4% reported stress-related symptoms, 50.7% reported symptoms of depression, 44.7% reported anxiety, and 36.1% reported experiencing insomnia (Liu et al., 2020). Lai et al. (2020) found evidence for higher rates of anxiety, depression, and distress among HCPs in Wuhan compared to HCPs in other regions in China. Other studies examined the need for and impact of services offered to healthcare workers, such as adjusting shifts to allow time for rest (Chen et al., 2020; Kang et al., 2020).

While there have been several well-written opinion pieces and commentaries regarding the well-being of healthcare workers in the United States during this pandemic (Godderis et al., 2020; Gold, 2020; Greenberg et al., 2020), we are aware of only one descriptive study with data from New York City (Shechter et al., 2020) that did not include a control group. There have been several meta-analyses and reviews of the impact of this pandemic on HCPs internationally (Chew et al., 2020; Pappa et al., 2020; Rajkumar, 2020), but no studies from the United States were available to be included in these studies. Previous studies have shown that the mental health challenges HCPs face during pandemics often impact their ability to continue to be part of the frontlines working to help treat and care for patients and their own families (Maunder et al., 2006; Shechter et al., 2020). Further, enduring psychological effects could negatively impact their ability to provide patient care in the future as well as impacting their quality of life (Goulia et al., 2010). A crucial mission for researchers during this time is enhancing our understanding of the experiences of HCPs in order to plan for interventions and care both in the short-term (now) and in the long-term (over the next couple of years). The current study is designed to examine several critical outcomes such as depressive symptoms, anxiety (current general anxiety as well as anxiety about developing COVID-19), COVID-related stress, and health in HCPs during the early months of the COVID-19 pandemic across the entire United States. In addition, we also examine potentially beneficial indicators of resilience such as control beliefs and proactive coping.

Psychiatric morbidity in the forms of depression and/or anxiety not only is troubling in its own right, but is also highly correlated with burnout, higher rates of chronic diseases, reduced quality of life, and suicide (Kumar, 2016). During the severe acute respiratory syndrome (SARS) pandemic in Goulia et al. (2010) found that the pressure of the work environment combined with fears about the disease itself created negative outcomes in the form of anxiety and depression that had profound impacts on the well-being of healthcare workers during that time. Additionally, follow-up studies revealed that the emotional distress from the pandemic was often long-lasting (Maunder et al., 2006). For instance, one to 2 years after the SARS outbreak, Maunder et al. (2006) found that SARS healthcare workers reported higher levels of burnout and distress, had increased smoking and alcohol consumption, were more likely to have reduced patient contact, and worked fewer hours compared to healthcare workers who did not treat SARS. The SARS outbreak was much more contained than the current worldwide pandemic which has even greater potential to have both ongoing and lasting consequences on society as a whole and HCPs in particular.

Identifying opportunities for resilience will be especially critical to combat the negative consequences. Control beliefs represent the subjective perceptions that one can influence what happens in one's life and include beliefs or expectations about the extent to which one's actions can bring about desired outcomes (Agrigoroaei and Lachman, 2010). Lachman and Firth (2004) distinguished two main sources of control: one's own efficacy (internal control, competence, or personal mastery), and the responsiveness of the environment or other people (external control, contingency, or perceived constraints) (Bandura, 1977). The two control beliefs included in the present study are mastery and constraint. Mastery is often described in terms of one's judgments about his or her ability to achieve a goal, while perceived constraints refers to the extent to which people believe factors exist which interfere with goal attainment (Lachman and Weaver, 1998b). Pearlin and Schooler (1978) suggested that personal mastery is an important psychological resource that mitigates the effects of stress and strain, and it is also associated with reduced reactivity to work-related stressors (Neupert et al., 2007). When faced with stressful situations, a strong sense of control has also been linked to low levels of self-reported perceived stress (Cameron et al., 1991) and lower risk of depression (Yates et al., 1999).

Aspinwall and Taylor (1997) characterized proactive coping as a series of steps one takes to preemptively modify or avoid stressful events. Those who have higher levels of proactive coping compared to those with lower levels of proactive coping have more meaning in life (Miao et al., 2017), fewer symptoms of PTSD (Vernon et al., 2009), and higher levels of quality of life (Cruz et al., 2018). Proactive coping is also associated with lower levels of depression, fewer declines in functional disability in aging, and larger systems of social support (Greenglass et al., 2006; Bokszczanin, 2012). When stressors do occur, those with higher levels of proactive coping are able to maintain their emotional functioning better than those with lower levels of proactive coping (Polk et al., 2020). Within the context of the COVID-19 pandemic, individuals who are at high risk of exposure to the virus, HCPs, could particularly benefit from engaging in proactive coping strategies in an effort to prevent exposure to future stressors. Indeed, we know from our past work that older adults, who are vulnerable to the effects of the virus, had lower levels of stress when they were high in proactive coping (Pearman et al., 2020).

This study is designed to examine the experiences of HCPs in the United States during this pandemic. Data collection took place between March 20 and May 14, 2020, a timeframe when the United States experienced a spike in new coronavirus cases, which limited the availability of important medical resources including appropriate personal protective equipment, and put tremendous strain on the nation's HCPs. The sample is derived from a larger online study focused on individuals' psychological and behavioral responses to COVID-19 (Pearman et al., 2020). In the current study, we specifically examine the following variables: stress related to COVID-19, anxiety about developing COVID-19, depressive symptoms, current

general anxiety, past and future appraisals of stress related to COVID-19, perceived health and health-related concern, tiredness, control beliefs (mastery and constraint), and proactive coping in a sample of HCPs and age-matched controls. We hypothesized that HCPs would show significantly more challenges on our measures of stress, mental and physical health issues, control, and coping.

METHODS

Participants

Amazon Mechanical Turk (mturk.com) was used to recruit participants for a larger study on the impact of COVID-19. MTurk is an international online crowdsourcing panel administered by Amazon and used here for collecting data. Potential participants responded to the description: *The purpose of this study is to examine how people living across the United States are reacting to the current COVID-19 pandemic. Select the link below to complete the 30-min survey*. Participant requirements for the current study were as follows: 18 years of age or older, living in the United States, native English-speakers and free from a dementia diagnosis. Once recruited and consented (see section "Procedure"), the participants completed the survey through the Qualtrics platform which is an online survey tool. The sample for the larger study consisted of 1,000 participants. Participants answered "Yes" or "No" to the question, "Are you a HCP?" Participants for the current study included all participants who answered "Yes" to this question as well as age-matched controls drawn from the same dataset. Because of concerns regarding age differences in our health indicators, we age-matched the controls. The final sample included 90 HCPs and 90 age-matched controls (M_{age} = 34.72 years, SD = 9.84, range = 23–67) from 35 states across the United States. Sample characteristics, including type of HCP, are reported in **Table 1**.

Procedure

Informed consent was obtained online; participants who wished to participate in the study indicated electronically that they read and understood the study procedures. After indicating interest, participants were provided a Qualtrics survey link on MTurk between March 20, 2020 and May 14, 2020, which was the time period that encompassed the majority of stay-at-home orders as well as many peaks in hospitalizations and death from COVID-19 in the United States. Human intelligence tasks (HITS) were released approximately every 3 days on MTurk to promote continued enrollment and survey completion throughout the 6 weeks of data collection. Participants were compensated $3.00 for completing the 30-min survey. The study was approved by the Georgia Institute of Technology Institutional Review Board.

Measures

Demographics

Participants indicated their year of birth, gender, their education from a checklist (e.g., GED, Associates), and their race. HCPs were also asked to report the specific profession within the healthcare field from a checklist (see **Table 1**).

COVID-19 Anxiety

Participants indicated their level of anxiety related to contracting coronavirus by answering the question, "How anxious are you about developing (COVID-19)?" on a 1 (*not at all anxious*) to 5 (*very anxious*) scale.

COVID-19 Stress

On a 1 (*not at all*) to 5 (*extremely*) scale, participants indicated their level of stress by answering the question, "How stressed are you about the COVID-19 outbreak?"

Depressive Symptoms

Participants completed the 15-item Geriatric Depression Scale Short Form (GDS) (Yesavage, 1988). The GDS is a self-report screening tool that examines depressive symptoms. Reflecting over the past week, participants respond "Yes" or "No" to

TABLE 1 | Sample characteristics by group (in valid percentages).

Variables	Healthcare professionals (n = 90) (%)	Matched sample (n = 90) (%)
Gender:		
Men	54.4	54.4
Women	45.6	45.6
Degree:		
GED	0	1.1
High school graduate	0	4.4
Elementary/middle school	1.1	0
Two year college, vocational school, associate's degree	1.1	6.7
Some college but no degree	6.7	12.2
Bachelor's degree (e.g., BA, BS, BFA)	56.7	57.8
Some graduate school but no degree	1.1	1.1
Master's degree (e.g., MA, MS, MPH)	27.8	12.2
Ph.D., EdD, MD, DDS, JD, other professional degree	5.6	4.4
Race:		
Asian	5.6	4.4
Black or African American	15.6	12.2
Native Hawaiian	2.2	0
White	75.6	81.1
More than one race	0	2.2
I do not wish to answer	1.1	0
Healthcare occupation:		
Nurse	13.3	
Physician	36.7	
Occupational therapy	2.2	
Physical therapy	4.4	
Technician	24.4	
Nursing assistant	4.4	
Other	11.1	
Not specified	3.3	

Other Healthcare Occupations include n = 1 Administration, n = 1 Facility Manager, n = 1 Legal Operations, n = 1 Counselor, n = 1 Exercise Physiologist, n = 1 Health Insurance, n = 1 Medical Student, n = 2 Optometry, n = 1 Registered Dental Hygienist.

each item. An example item includes, "Do you feel that your situation is helpless?" The scale has been shown to have good diagnostic sensitivity and specificity for adults across the adult lifespan (Guerin et al., 2018). The scale was not used for diagnostic purposes in this study, but higher scores indicate greater depressive symptoms ($\alpha = 0.81$).

Current Anxiety

Ten state anxiety items from the State-Trait Anxiety Inventory (Spielberger et al., 1983) were rated on a four-point scale ranging from 1 (*not at all*) to 4 (*very much so*). Participants indicated how they were feeling in the current moment. Example items include "I am tense" and "I feel frightened." Five items were reverse coded. A mean was calculated across the 10 items with higher scores indicating more state anxiety ($\alpha = 0.88$).

Health

Participants self-rated their health on a five-point scale ranging from 1 (*poor*) to 5 (*excellent*) by answering the question, "How would you rate your overall health?" In addition, participants rated their health concern on a 1 (*no concern*) to 5 (*very serious concern*) scale, responding to the question, "How much concern/distress do you feel about your health at this time?" Both items were included in analyses as one focuses on current health status while the other focuses more specifically on how concerned the individual is about their health.

Tiredness

On a five-point scale ranging from 1 (*not at all tired*) to 5 (*very tired*), participants were asked "In general, how tired are you right now?"

Control Beliefs

Control beliefs were measured using the mastery (four items, $\alpha = 0.84$) and constraint (eight items, $\alpha = 0.95$) scales from the Sense of Control Scales from the Midlife Development Inventory (Lachman and Weaver, 1998a). On a 1 (*strongly disagree*) to 7 (*strongly agree*) scale, participants rated their agreement with statements such as "What happens in my life is often beyond my control" (constraint) and "I can do just about anything I really set my mind to" (mastery).

Proactive Coping

The Proactive Coping Scale (Aspinwall et al., 2005) includes six items rated on a five-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). An example item includes, "I prepare for adverse events." One item was reverse coded. Higher scores indicate more proactive coping ($\alpha = 0.71$).

Stress Appraisals

On a four-point scale ranging from 1 (*not at all*) to 4 (*a lot*), participants rated the extent to which COVID-19 affected different areas of their lives in the past 24 h (past appraisal, $\alpha = 0.84$) as well as the extent to which they expected COVID-19 to affect their lives in the next 24 h (future appraisal, $\alpha = 0.87$). Example items include, "Your physical health or safety?" and "Your plans for the future?" (Lazarus, 2006). Items were scored so that higher scores indicate COVID-19 having a greater impact on one's life.

Statistical Analysis

All data analyses were performed using SPSS version 26 (IBM Corp.). The significance level was set at $\alpha = 0.05$ and all tests were two-tailed. A MANOVA was conducted with education (degree) as a covariate and HCP (0 = *no*, 1 = *yes*) as the independent variable and COVID-19 stress and anxiety, depressive symptoms, current anxiety, self-reported health, health concern, tiredness, mastery, constraint, proactive coping and appraisal (past and future) as continuous dependent variables. Because healthcare positions commonly require postsecondary education, education was included as a covariate to account for group differences. Significant multivariate tests were followed up with tests of between-subjects effects for each dependent variable individually.

RESULTS

There were no significant differences between HCPs and the control group on gender [χ^2 (1, $N = 180$) = 0.00, $p = 1.00$] or race [χ^2 (5, $N = 180$) = 5.65, $p = 0.34$]. As expected, there were significant differences on education [χ^2 (8, $N = 180$) = 16.61, $p = 0.03$] such that HCPs had more education than non-HCPs. Results from the MANOVA (**Table 2**) controlling for education show that HCPs reported significantly higher levels of depressive symptoms, current anxiety, concern about their health, tiredness, constraint, and past and future appraisal of COVID-related stress, but lower levels of proactive coping compared to non-HCPs (Pillai's Trace = 0.28, $F(12,160) = 5.29$, $p < 0.001$, $\eta^2 = 0.28$). Of note, there were also no significant group differences on COVID-related stress or on the specific anxiety of developing COVID-19.

TABLE 2 | MANOVA results with means and standard deviations by group.

	Healthcare Professional (*n* = 85)		Matched Sample (*n* = 89)			
Variables	**Mean**	***SD***	**Mean**	***SD***	***P***	η^2
COVID-19 anxiety	3.25	1.46	3.20	1.48	0.74	0.001
COVID-19 stress	3.52	1.12	3.22	1.24	0.22	0.01
Depressive symptoms	6.49	3.23	4.58	3.75	0.001	0.06
Current anxiety	2.32	0.54	2.01	0.77	0.003	0.05
Self-rated health	3.92	0.93	3.75	1.00	0.38	0.004
Health concern	3.40	1.25	2.53	1.16	<0.001	0.11
Tiredness	2.93	1.29	1.85	0.96	<0.001	0.18
Mastery	5.11	1.01	5.28	1.17	0.27	0.01
Constraint	4.64	1.36	3.28	1.50	<0.001	0.16
Proactive coping	3.62	0.58	4.08	0.63	<0.001	0.12
Appraisal (past 24 h)	2.61	0.63	2.22	0.74	0.002	0.05
Appraisal (next 24 h)	2.60	0.66	2.20	0.81	0.002	0.05

η^2 = partial eta squared. Multivariate Test Results: Pillai's Trace = 0.28, $F(12,160) = 5.29$, $p < 0.001$, $\eta^2 = 0.28$, observed power = 1.00.

DISCUSSION

This study is a timely look into the experiences of HCPs across the United States during the COVID-19 pandemic. Using an age-matched comparison group, the HCPs were significantly more depressed and generally anxious than the non-HCPs during the first months of the pandemic. In line with Shechter et al. (2020) who documented high rates of lack of control and sleep disturbances within HCPs in New York City, our results show that HCPs across the United States had significantly higher rates of lack of control and tiredness compared to controls. Additionally, the HCP group on average fell into the clinically depressed range on the GDS (Guerin et al., 2018). While some of the other findings (e.g., fatigue) may represent the nature of professional differences sometimes seen between HCPs and other professions in non-pandemic times (Dyrbye et al., 2014), meeting the criteria for depressive disorder should not. We believe that the heightened level of depressive symptoms in HCPs may be due to not just occupational differences but occupational differences during a pandemic. Clearly, this is of concern not just for understanding and, perhaps, helping the current situation but also to look ahead to the potential lasting influence of this experience (see Maunder et al., 2006; Lee et al., 2007). It is well-understood that the long-term consequences of depression and anxiety can create enduring negative impacts (Sareen et al., 2005; Musliner et al., 2016). Finding ways to intervene and support HCPs, such as cognitive behavioral therapy or support groups, will be an important goal to healthcare systems and workplaces now and in the future.

In addition to increased general anxiety and depressive symptoms, HCPs were more tired and more concerned about their health than the age-matched controls. There are many possible reasons for the health concerns of HCPs during this pandemic (Centers for Disease Control, 2020). To start, HCPs are more likely to be exposed to COVID-19 which increases HCP's health risk. Other health risks include long work hours and mental and physical exhaustion (Shanafelt et al., 2020; The Lancet, 2020). It is not surprising therefore that the HCPs also have higher perceived constraints and are more tired. The real experiences in healthcare settings during the pandemic may present HCPs with what seem like insurmountable pressure when it comes to finding ways to accomplish their goals both in terms of maintaining their own health and well-being. Helping HCPs find ways to differentiate between immovable constraints, such as personal protective equipment deficits, and possible malleable constraints, such as feeling as though there is no opportunity to engage in self-care, may be a possible avenue for buoying the well-being of HCPs (De Raedt and Hooley, 2016).

Along these same lines, the HCPs showed lower proactive coping and fewer resources to dedicate to adaptive coping behaviors. We know from past work that proactive coping (Polk et al., 2020) and control beliefs (Neupert et al., 2007) are key ingredients for resilient stress responses, representing potential targets for intervention. For instance, Stauder et al. (2017, 2018) found that using coping skills training with employees from work-environments that were stressful, but unchanging, helped reduce stress and improve well-being.

Although statistically equivalent on COVID-19-related stress and anxiety, the HCPs in the current study scored significantly higher on both current and future stress appraisal when compared to controls. In their real-time study of work stress in nurses, Johnston et al. (2016) showed that appraisals of stress were more predictive of psychological and physiological reactivity than the actual tasks being performed. In addition, the perceived reward for the work actually helped reduce stress. Given the high levels of stress appraisal both current and future in our sample, it may be beneficial during this time of crisis to help HCPs recognize and focus on the reward of their work as a means of managing negative stress appraisals.

We acknowledge several limitations in this study. The observational design limits our ability to make causal conclusions. Future longitudinal studies should examine the long-term impact of this pandemic on the mental health of HCPs. We also do not know the extent to which the HCPs in the sample are serving on the frontlines of the pandemic. However, given that the HCPs showed significant differences on most of our measures of interest, it is likely that our effects actually underestimate the experiences of frontline workers. In addition, Smereka and Szarpak (2020) note that COVID-19 is an ongoing challenge for all HCPs, not just the frontline workers. Another potential limitation is that the professions of the control group nor the hours worked by either group were collected so we are unable to make finer distinctions between the experiences of HCP and the others. We do know, however, that the two groups are statistically equivalent in their stress and anxiety related to the pandemic, so we are reasonably confident that the differences that we do see in our study are associated with healthcare profession status. We encourage future work that seeks to further explore potential differences between professions, but note that our results suggest that all HCPs are at risk for decreased well-being, perceived control, and coping resources during the COVID-19 pandemic. Finally, our sample was not random or nationally representative and was restricted to those living in the United States, the current epicenter of the pandemic. HCPs' experiences during the COVID-19 pandemic could differ for those living and working in countries outside of the United States.

In conclusion, our results suggest that COVID-19 may function as an occupational hazard for HCPs (Godderis et al., 2020) because we found evidence of higher levels of anxiety and depressive symptoms, more tiredness and concern for their health, and more severe stress appraisals of COVID-19, along with lower levels of perceived control and coping compared to age-matched controls. Across a wide array of indicators, HCPs appear to be at increased risk for mental health challenges. In addition, given that previous studies during other pandemics have shown lasting impacts of service during this time, including reduced workforce participation and increased traumatic symptomatology, this is a critical issue to address. We encourage efforts to intervene that can provide relief now and in the future.

DATA AVAILABILITY STATEMENT

The dataset presented in this article is not readily available because data sharing options were not included in consent documents. Requests to access the datasets should be directed to AP, ann.pearman@psych.gatech.edu.

ETHICS STATEMENT

This study involved human participants was reviewed and approved by Georgia Institute of Technology Office Research Integrity Assurance – Institutional Review Board (Protocol # H20141). Written informed consent for participation was not required for this study in accordance with the national legislation and the institutional requirements for exempt studies.

AUTHOR CONTRIBUTIONS

AP designed the study and funded it out of her internal funds and a grant both from Georgia Tech, as well as manuscript writing. MH managed the online portion of the project and the data, wrote the methods, helped to prepare the references, and helped with primary prose. ES helped with data analyses, created the tables, helped to prepare the references, and helped with primary prose. SN helped with study design, primary data analyses, as well as manuscript writing. All authors contributed to the article and approved the submitted version.

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REFERENCES

Agrigoroaei, S., and Lachman, M. E. (2010). "Personal control and aging: how beliefs and expectations matter," in *Praeger Perspectives. Aging in America*, Vol. 1, eds J. C. Cavanaugh, and R. West (Santa Barbara, CA: Praeger) 177–201. .

Aspinwall, L. G., Sechrist, G. B., and Jones, P. R. (2005). Expect the best and prepare for the worst: anticipatory coping and preparations for Y2K. *Motiv. Emot.* 29, 353–384. doi: 10.1007/s11031-006-9008-y

Aspinwall, L. G., and Taylor, S. E. (1997). A stitch in time: self-regulation and proactive coping. *Psychol. Bull.* 121, 417–436. doi: 10.1037/0033-2909.121.3.417

Bai, Y., Lin, C. C., Lin, C. Y., Chen, J. Y., Chue, C. M., and Chou, P. (2004). Survey of stress reactions among health care workers involved with the SARS outbreak. *Psychiatr. Serv.* 55, 1055–1057. doi: 10.1176/appi.ps.55.9.1055

Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychol. Rev.* 84, 191–215. doi: 10.1037/0033-295X.84.2.191

Bokszczanin, A. (2012). Social support provided by adolescents following a disaster and perceived social support, sense of community at school, and proactive coping. *Anxiety Stress Coping* 25, 575–592. doi: 10.1080/10615806.2011.622374

Cameron, S. J., Armstrong-Stassen, M., Orr, R. R., and Loukas, A. (1991). Stress, coping, and resources in mothers of adults with developmental disabilities. *Couns. Psychol. Q.* 4, 301–310. doi: 10.1080/09515079108254438

Centers for Disease Control (2020). Characteristics of health care personnel with COVID-19 — United States, February 12–April 9. *MMWR Morb. Mortal. Wkly. Rep.* 69, 477–481. doi: 10.15585/mmwr.mm6915e6

Chen, Q., Liang, M., Li, Y., Guo, J., Fei, D., Wang, L., et al. (2020). Mental health care for medical staff in China during the COVID-19 outbreak. *Lancet Psychiatry* 7, e15–e16. doi: 10.1016/S2215-0366(20)30078-X

Chew, N. W., Lee, G. K., Tan, B. Y., Jing, M., Goh, Y., Ngiam, N. J., et al. (2020). A multinational, multicentre study on the psychological outcomes and associated physical symptoms amongst healthcare workers during COVID-19 outbreak. *Brain Behav. Immun.* 88, 559–565. doi: 10.1016/j.bbi.2020.04.049

Cruz, J. P., Cabrera, D. N., Hufana, O. D., Alquwez, N., and Almazan, J. (2018). Optimism, proactive coping and quality of life among nurses: a cross-sectional study. *J. Clin. Nur.* 27, 2098–2108. doi: 10.1111/jocn.14363

De Raedt, R., and Hooley, J. M. (2016). The role of expectancy and proactive control in stress regulation: a neurocognitive framework for regulation expectation. *Clin. Psychol. Rev.* 45, 45–55. doi: 10.1016/j.cpr.2016.03.005

Dyrbye, L. N., West, C. P., Satele, D., Boone, S., Tan, L., Sloan, J., et al. (2014). Burnout among US medical students, residents, and early career physicians relative to the general US population. *Acad. Med.* 89, 443–451. doi: 10.1097/ACM.0000000000000134

Godderis, L., Boone, A., and Bakusic, J. (2020). COVID-19: a new work-related disease threatening healthcare workers. *Occup. Med.* 70, 315–316. doi: 10.1093/occmed/kqaa056

Gold, J. A. (2020). Covid-19: adverse mental health outcomes for healthcare workers. *BMJ.* 5:m1815. doi: 10.1136/bmj.m1815

Goulia, P., Mantas, C., Dimitroula, D., Mantis, D., and Hyphantis, T. (2010). General hospital staff worries, perceived sufficiency of information and associated psychological distress during the A/H1N1 influenza pandemic. *BMC Infect. Dis.* 10:322. doi: 10.1186/1471-2334-10-322

Greenberg, N., Docherty, M., Gnanapragasam, S., and Wessely, S. (2020). Managing mental health challenges faced by healthcare workers during covid-19 pandemic. *BMJ.* 26:m1211. doi: 10.1136/bmj.m1211

Greenglass, E., Fiksenbaum, L., and Eaton, J. (2006). The relationship between coping, social support, functional disability and depression in the elderly. *Anxiety Stress Coping* 19, 15–31. doi: 10.1080/14659890500436430

Guerin, J. M., Copersino, M. L., and Schretlen, D. J. (2018). Clinical utility of the 15-item geriatric depression scale (GDS-15) for use with young and middle-aged adults. *J. Affect. Disord.* 1, 59–62. doi: 10.1016/j.jad.2018.07.038

Johnston, D., Bell, C., Jones, M., Farquharson, B., Allan, J., Schofield, P., et al. (2016). Stressors, appraisal of stressors, experienced stress and cardiac response: a real-time, real-life investigation of work stress in nurses. *Ann. Behav. Med.* 50, 187–197. doi: 10.1007/s12160-015-9746-8

Kang, L., Li, Y., Hu, S., Chen, M., Yang, C., Yang, B. X., et al. (2020). The mental health of medical workers in Wuhan, China dealing with the 2019 novel coronavirus. *Lancet Psychiatry.* 7:e14. doi: 10.1016/S2215-0366(20)30047-X

Kumar, S. (2016). Burnout and doctors: prevalence, prevention and intervention. *Healthcare* 4:37. doi: 10.3390/healthcare4030037

Lachman, M. E., and Firth, K. M. (2004). *The Adaptive Value of Feeling in Control during Midlife*. Chicago, III: University of Chicago Press.

Lachman, M. E., and Weaver, S. L. (1998a). Sociodemographic variations in the sense of control by domain: findings from the MacArthur studies of midlife. *Psychol. Aging* 13, 553–562. doi: 10.1037/0882-7974.13.4.553

Lachman, M. E., and Weaver, S. L. (1998b). The sense of control as a moderator of social class differences in health and well-being. *J. Pers. Soc. Psychol.* 74, 763–773. doi: 10.1037/0022-3514.74.3.763

Lai, J., Ma, S., Wang, Y., Cai, Z., Hu, J., Wei, N., et al. (2020). Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. *JAMA Netw. Open* 3:e203976. doi: 10.1001/jamanetworkopen.2020.3976

Lazarus, R. S. (2006). *A New Synthesis: Stress and Emotion*. New York, NY: Springer Publishing Company.

Lee, A. M., Wong, J. G., McAlonan, G. M., Cheung, V., Cheung, C., Sham, P. C., et al. (2007). Stress and psychological distress among SARS survivors 1 year after the outbreak. *Canad. J. Psychiatry* 52, 233–240. doi: 10.1177/070674370705200405

Liu, S., Yang, L., Zhang, C., Xiang, Y. T., Liu, Z., Hu, S., et al. (2020). Online mental health services in China during the COVID-19 outbreak. *Lancet Psychiatry* 7, e17–e18. doi: 10.1016/S2215-0366(20)30077-8

Maunder, R., Hunter, J., Vincent, L., Bennett, J., Peladeau, N., Leszcz, M., et al. (2003). The immediate psychological and occupational impact of the 2003 SARS outbreak in a teaching hospital. *CMAJ* 168, 1245–1251.

Maunder, R. G., Lancee, W. J., Balderson, K. E., Bennett, J. P., Borgundvaag, B., Evans, S., et al. (2006). Long-term psychological and occupational effects of providing hospital healthcare during SARS outbreak. *Emerg. Infect. Dis.* 12, 1924–1932. doi: 10.3201/eid1212.060584

Miao, M., Zheng, L., and Gan, Y. (2017). Meaning in life promotes proactive coping via positive affect: a daily diary study. *J. Happiness Stud.* 18, 1683–1696. doi: 10.1007/s10902-016-9791-4

Musliner, K. L., Munk-Olsen, T., Laursen, T. M., Eaton, W. W., Zandi, P. P., and Mortensen, P. B. (2016). Heterogeneity in 10-year course trajectories of moderate to severe major depressive disorder: a danish national register-based study. *JAMA Psychiatry* 1, 346–353.

Neupert, S. D., Almeida, D. M., and Charles, S. T. (2007). Age differences in reactivity to daily stressors: the role of personal control. *J. Gerontol. Ser. B Psychol. Sci. Soc. Sci.* 62, 216–225. doi: 10.1093/geronb/62.4.P216

Pappa, S., Ntella, V., Giannakas, T., Giannakoulis, V. G., Papoutsi, E., and Katsaounou, P. (2020). Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: a systematic review and meta-analysis. *Brain Behav. Immun.* 88, 901–907. doi: 10.1016/j.bbi.2020.05.026

Pearlin, L. I., and Schooler, C. (1978). The structure of coping. *J. Health Soc. Behav.* 19, 2–21. doi: 10.2307/2136319

Pearman, A., Hughes, M. L., Smith, E. L., and Neupert, S. D. (2020). Age differences in risk and resilience factors in COVID-19-related stress. *J. Gerontol. B Psychol. Sci. Soc. Sci.* doi: 10.1093/geronb/gbaa120 [Epub ahead of print].

Polk, M. G., Smith, E. L., Zhang, L. R., and Neupert, S. D. (2020). Thinking ahead and staying in the present: implications for reactivity to daily stressors. *Pers. Individ. Differ.* 15:109971. doi: 10.1016/j.paid.2020.109971

Rajkumar, R. P. (2020). COVID-19 and mental health: a review of the existing literature. *Asian J. Psychiatr.* 10:102066. doi: 10.1016/j.ajp.2020.102066

Sareen, J., Cox, B. J., Afifi, T. O., de Graaf, R., Asmundson, G. J., ten Have, M., et al. (2005). Anxiety disorders and risk for suicidal ideation and suicide attempts: a population-based longitudinal study of adults. *Arch. Gen. Psychiatr.* 62, 1249–1257. doi: 10.1001/archpsyc.62.11.1249

Shanafelt, T., Ripp, J., and Trockel, M. (2020). Understanding and addressing sources of anxiety among health care professionals during the COVID-19 pandemic. *JAMA* 323, 2133–2134. doi: 10.1001/jama.2020.5893

Shechter, A., Diaz, F., Moise, N., Anstey, D. E., Ye, S., Agarwal, S., et al. (2020). Psychological distress, coping behaviors, and preferences for support among New York healthcare workers during the COVID-19 pandemic. *Gen. Hosp. Psychiatry* 66, 1–8. doi: 10.1016/j.genhosppsych.2020.06.007

Smereka, J., and Szarpak, L. (2020). COVID 19 a challenge for emergency medicine and every health care professional. *Am. J. Emerg. Med.* doi: 10.1016/j.ajem.2020.03.038 Online ahead of print

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., and Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory*. Palo Alto, CA: Consulting Psychologists Press.

Stauder, A., Cserháti, Z., and Thege, B. K. (2018). Decreasing the negative effects of work-related stress in unchanged working environments. *Eur. J. Ment. Health.* 13, 163–183. doi: 10.5708/EJMH.13.2018.2.4

Stauder, A., Nistor, K., Zakor, T., Szabó, A., Nistor, A., Ádám, S., et al. (2017). Quantifying multiple work-related psychosocial risk factors: proposal for a composite indicator based on the COPSOQ II. *Int. J. Behav. Med.* 24, 915–926. doi: 10.1007/s12529-017-9651-6

The Lancet (2020). COVID-19: protecting health-care workers. *Lancet* 395:922. doi: 10.1016/S0140-6736(20)30644-9

Vernon, L. L., Dillon, J. M., and Steiner, A. R. (2009). Proactive coping, gratitude, and posttraumatic stress disorder in college women. *Anxiety Stress Coping* 22, 117–127. doi: 10.1080/10615800802203751

World Health Organization (2020). *Coronavirus disease (COVID-19) Situation Report 115*. Available online at: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200514-covid-19-sitrep-115.pdf?sfvrsn=3fce8d3c_6 (accessed June 15, 2020)

Yates, M. E., Tennstedt, S., and Chang, B. H. (1999). Contributors to and mediators of psychological well-being for informal caregivers. *J. Gerontol. Ser. B Psychol. Sci. Soc. Sci.* 54, 12–22. doi: 10.1093/geronb/54B.1.P12

Yesavage, J. A. (1988). Geriatric depression scale. *Psychopharmacol. Bull.* 24, 709–711.

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Nurses confronting the coronavirus: Challenges met and lessons learned to date

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ABSTRACT

Registered nurses are an essential workforce group across the globe. They use their expertise and skill sets every day in clinical practice to protect, promote, and advocate on behalf of patients and families under their care. In this article we discuss the physical, emotional, and moral stresses that nurses are experiencing in their day-to-day practice settings created by the novel coronavirus. We consider the demands placed on nurses by unexpected patient surges within hospital environments and inadequate personal protective equipment and other critical resources, challenging nurses' ability to meet their professional and ethical obligations. We also share our thoughts on supporting nurses and others now, and ideas for needed healing for both individuals and organizations as we move forward. Finally, we argue for the need for substantive reform of institutional processes and systems that can deliver quality care in the future when faced with another devastating humanitarian and public health crises.

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"Nursing is not just evaluating patient symptoms, dressing wounds, lab work, and value-based care—nursing impacts the soul in each of us. In our weakest places, in our most vulnerable areas of life, nursing has literally opened the door to the most painful, but most rewarding moments in the lives of others. The dying, the hurt, the raw, emotional places of life: nurses have the privilege to walk in these spaces and provide a comforting hand, a compassionate touch, and a life-changing presence."

— Love et al., 2021, 87

Introduction

Nursing is the nation's largest health care professional group, with nearly 4 million registered nurses licensed to practice in the United States (American Association of Colleges of Nurses, 2019). In fact, nurses are critical to every health care delivery system across the globe. The World Health Organization cites a global deficit of 5.9 million nurses to adequately meet the current and future care needs of the growing population (Lovelace, 2020). Most U.S.-based nurses today work in hospital-centered systems, but they also practice in long-term care facilities, community settings, and primary

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care, among others. Nursing has long been defined from a tripartite perspective: A practice, an art, and a science with ethical foundations that guide the profession. It is also recognized as a caring and trusting vocation by the diversity of publics served by nurses—a profession that is committed to meeting the basic and complex humanistic needs of the healthy and the sick.

Nursing is not an easy career path. Nurses have sometimes been portrayed in subservient roles and in misogynistic ways, given the fact that approximately 90% of nurses are women. Nurses who work at the bedside, however, demonstrate competence as they face unique challenges and see patients at the sickest and most vulnerable moments in their lives. Some of the competencies and skill sets that nurses possess are enacted behind hospital walls and thus not visible to the general public. Nurses' intelligence, expertise, compassion, ingenuity, dedication, and agility to adapt to changing circumstances are markers of excellence. But as Christie Watson notes, "There is a danger of forgetting what nursing is, what it means: the importance of providing care." (2018, 197).

The novel SARS-CoV-2 pandemic has brought nursing to the forefront in unexpected ways and has shown the public in real-time nurses' valor and their core values as well as their vulnerabilities. It has also exposed the fractures and inefficiencies within health care systems that have a responsibility to protect nurses and other clinicians and has highlighted the many ethical issues that these frontline health care workers encounter daily. This essay will focus on three critical ethical issues: (a) the daily demands of nursing care for patients with COVID-19 and the physical, emotional, and moral toll of these demands; (b) the importance of an ethical workplace environment and supportive systems for nurses' physical and psychological safety and effective moral agency; and (c) the need for infrastructure reform and institutional processes that can move us forward in the aftermath of the SARS-CoV-2 pandemic.

The Daily Demands of Nursing Care for Patients with COVID-19

With more than 27 million confirmed cases of COVID-19 and more than 890,000 deaths globally as of the beginning of September (Johns Hopkins University & Medicine Coronavirus Resource Center, 2020), nursing care has been stretched to its limits. The United States is also suffering with a steady increase of fatalities that is beyond 190,000 deaths in September (Johns Hopkins University & Medicine Coronavirus Resource Center, 2020). The demand for nursing care has rarely been as high, and the consequences of providing it never more severe. Nurses go to work every day under conditions of uncertainty. Indeed, regardless of their clinical specialty or practice setting, nurses have always understood that there is an inherent risk that comes with being a nurse. In their day-to-day work settings, they can be exposed to occupational hazards such as needle-stick injuries, back and muscular strains, splashes from contact with blood and body fluids, verbal and physical abuse, and fumes from noxious chemicals and disinfectants. Nurses have also donned personal protective equipment to care for patients with HIV, Ebola, tuberculosis, methicillin-resistant *Staphylococcus aureus* (MRSA), and other infectious diseases. And they have done so by upholding and honoring their professional and ethical commitment to promote and respect the dignity and worth of all patients in their care—and by assessing what they believed to be an "acceptable risk" for the overall benefit of the patient.

The emergence and highly contagious nature of this coronavirus, however, has shattered traditional standards of practice. The lack of adequate personal protective equipment and general lack of institutional preparedness for the volume of COVID-19 patients within hospital systems has left frontline nurses susceptible—physically and emotionally—to a persistent sense of guilt and anxiety. While we often think of patients as being vulnerable because of their illness or other underlying circumstances, nurses, too, are vulnerable to multiple stressors as well as to infection and illness. Stress is exacerbated in clinical practice when health care clinicians' claims or voices are discounted (Hurst, 2008). Danis and Patrick argue that "risk factors that influence health are so encompassing that any member of the population may, at some point in his or her life course or in some special circumstance, be vulnerable" (2002, 311). What nurses assumed would be available to protect them simply is not reliably there. Photographs and videos of nurses in makeshift masks and goggles and protective gear made from garbage bags have stunned and angered viewers across the U.S., as have the tears of sorrow and mental anguish on the faces of many nurses trying to cope with the pressures of an unimaginable situation. Nurses themselves have become, and will likely continue to become, infected, and several hundreds have died from the disease (The Staffs of Kaiser Health News and The Guardian, 2020). The Centers for Disease Control and Prevention (2020) estimates that at least 156,000 U.S. health care workers had become infected with COVID-19 by early September, recognizing that this is an underestimate.

In other countries, the infection rate has been remarkable with more than 37,000 health care workers infected in Spain, accounting for 20% of confirmed cases in that country (McMurtry, 2020).

Nurses are working long hours caring for COVID-19 patients, wearing masks that make their skin bleed and are suffering under the heat of whatever gear they have available to protect themselves and their patients. They are being asked to transfer from one unit to another to cover shortages, sit alone with patients who are dying, and suffering anxieties and fears from walking through hospital doors to begin another shift. Indeed, an early American Nurses Survey of more than 30,000 nurses across the country in

April reported that 87% of nurses are very or somewhat afraid to go to work, 58% are extremely concerned about their personal safety and 55% about caring for a COVID-19 patient or person suspected of having the virus (American Nurses Association, 2020a, 2020b). With this worry and others, some nurses decided to leave their jobs, but many others have carried on. Multitudes of nurses are working hard and meeting these challenges, finding the strength to continue to provide care and relieve the suffering of patients despite constraints, adversity, and unavoidable deaths. Both groups- those who chose to leave and those who chose to carry on- are facing situations that may lead to moral distress— the distress that arises when the ethically appropriate action is not taken because of internal or external constraints (Ulrich & Grady, 2018). In addition, fear of reprisal is ever looming if nurses speak out about their concerns. How do we begin to rebuild trust in a system that has fundamentally challenged our notions of how to do "good," how to safely protect patients, families, nurses and other clinicians on the front lines of a pandemic, and how to provide care to patients in need with limited resources?

Selected Internal and External Approaches to Support Ethical Environments, Nurses' Moral Agency and Well-being

The environment in which nurses deliver care matters greatly.

> "Organizations depend on their members to make difficult ethical choices, to accomplish ambitious tasks, to take initiative and drive performance, to persevere in the face of adversity, to engage in experimental activities related to change, and to guard what is right in the face of threats." (Worline, 2012, 307).

Ethical practice environments where nurses voices are heard and respected, where teams work well together, where institutional leaders support their staff, do everything they can to garner appropriate resources, and adapt policies to protect staff should be the standard. In these environments, nurses and others can say no to unsafe conditions or procedures without fear of repercussions. Nurses can, and should, demand appropriate resources and staffing levels, and work on teams where members support each other in providing care as safely as possible, and institutions should support difficult decisions made because of extreme scarcities (Table 1).

Certain priorities should guide efforts to help nurses, other health care providers, and institutions to get through this time of crisis. It is essential to advocate for and take care of basic needs right now. Nurses need breaks during their work/ shifts, time to eat and access to healthy food, as well as time off and the opportunity to rest and sleep (National Academy of Medicine, 2020). Although it may seem obvious that these basic needs should be attended to, the demands in some areas are so great that some nurses are not getting breaks, access to food, or time off. In addition, institutions should provide nurses and other frontline providers with accurate and consistently updated information and guidance on how to use personal protective equipment (PPE), what to do when it is lacking, and how to proceed when patient care conditions are unsafe (American Nurses Association, 2020b).

It is unreasonable and unfair to expect individual nurses to care for so many critically ill patients at once that no one receives good care, or to expect nurses to provide care that puts them at high risk without adequate information and PPE. To the extent possible, resources should be made available to support the work of bedside nurses and other front-line providers. There are examples of creative and resourceful use of technology to provide resources at the bedside. For example, telemedicine can connect providers in remote locations via computer; FaceTime and other video communication options provide tools for nurses to help patients communicate with their loved ones, especially at the end of life. In addition, using Artificial Intelligence to assist staff in monitoring patients with COVID-19 could reduce workload burden and contact time that potentially affects nurses' exposure to virus. Machine Learning algorithms that determine a risk deterioration index allows for initiation of early treatment intervention (Ross, 2020). Neither is without ethical concerns and need more data on outcomes compared to standard practice.

Resources such as palliative care can help to support patients and families during isolating illness and help them express their preferences and choices. Ethics consultation services can help nurses, other providers, patients and families, and institutions make difficult and sometimes heartbreaking decisions. Some institutions have consult services devoted to addressing moral distress among health care providers and others are providing virtual Moral Resilience Rounds (Herleth & Paiewonsky, 2020). One suggested approach for dealing with stress in real time is to encourage informal, voluntary peer-to- peer relationships (such as buddy systems) between colleagues, friends, and team members to provide ongoing support and encouragement. Programs such as Resilience in Stressful Events (RISE), a peer to peer psychological support model, offers nurses an additional resource to address the stress and trauma they are experiencing (Wu, Connors, Everyly, Jr., 2020). Chaplains in many institutions are providing spiritual support and some institutions are expanding their mental health services using volunteer mental health professionals to respond to requests from frontline clinicians. Creative external strategies for supporting health care workers also have been reported in some regions. Examples include medical and nursing students providing childcare for working health care providers, community volunteers delivering food for ICU or nursing home staff, and hospitals offering temporary housing for frontline

Table 1 – Selected Internal and External Approaches to Support an Ethical Environment, Moral Agency, and Clinician-Staff Well-Being

Internal Approaches	Benefits
1. Explicit policies to protect staff from harm (e.g., breaks and rest periods, staffing, use of personal protective equipment; limits to the number of hours worked per shift)	• Respects staff, protects their well-being, and enhances their contributions to quality patient care
2. Access to palliative care, ethics consultative service, chaplaincy, and other In-house resources	• Promotes organizational transparency and commitment to supporting patients, families, and staff
3. Innovative resources: Virtual moral resilience rounds; Resilience in stressful events (RISE); Moral distress consultative service	• Recognizes unique ethical challenges faced by clinicians and innovative mechanisms to foster well-being
4. Use of Artificial Intelligence: Robotics	• Advances solutions when physical distancing is required and aids nursing staff by transporting supplies, disinfecting rooms, and using telemedicine technology to communicate with patients and families (Murphy, Adams, & Gandudi, 2020)
Selected External Approaches	**Benefits**
1. Medical and nursing students providing childcare	• Provides basic human needs for clinicians to support their well-being, lessen worries and anxieties over children, strengthens, supports, and protects their rights
2. Hospital systems providing temporary housing	
3. Volunteers delivering food	
4. Legislation to protect the rights of essential workers	

providers worried about bringing possible infection home to elderly or ill family members or very young children, among others.

Infrastructure and Institutional Process Reforms

Planning to address the needs of nurses and other frontline providers over the long term is essential. Three priorities include practice-based programs, policy, and research. Institutions, professional organizations, and others will need to establish programs to engage nurses and others to process what they have been through and to identify and describe the challenges they are confronting during this crisis. We will need strategies and programs to help frontline providers cope with what they have experienced, opportunities to debrief about specific cases or issues, and support services to help contextualize tragic decisions that nurses and others will have to live with. Institutions should develop programs to cultivate moral resilience and bolster moral strength. Research will be needed to guide efforts at recovery, resilience, and restoration.

From a programmatic and policy perspective, hospital administrators have an opportunity to rebuild trust with frontline clinicians by taking seriously the burden they have shouldered and the sacrifices they have made and investing in systemic solutions. The novel coronavirus pandemic arose in the context of an already stressed health care system that was contributing to escalating levels of burnout among nurses and other health care professionals. Reports published before the pandemic showed that 35% to 45% of nurses experience at least one symptom of burnout—an occupational syndrome characterized by "exhaustion, cynicism and inefficacy" (National Academies of Sciences, Engineering, and Medicine, & National Academy of Medicine, 2019, 40). Burnout in health care reflects a complex interplay between personal and organizational factors that create the conditions for burnout to thrive. When job demands such as excessive workload, inadequate resources, workflow distractions exceed job resources such as job control, alignment of values and expectations, and organizational culture, burnout is more likely to ensue. This should raise alarm bells about the magnitude of potential burnout resulting from this pandemic. A recent report by the National Academies of Medicine (NAM, 2019) concluded that health care system characteristics significantly contribute to burnout. The intensity of the global pandemic and the lack of preparation contribute to widespread suffering and long-term consequences for both nurses and the health systems where they practice. We are poised to proactively document the wide range of consequences (physical, psychological, moral, spiritual) as we begin to heal from the pandemic and to use this information to inform redesign.

Health care leaders are ideally positioned to demonstrate their investment in the well-being of frontline clinicians by taking proactive steps to assure that the deficiencies in the health care system are substantially addressed. During the pandemic, nurses are expected to provide high level care for their patients often without adequate resources to do so safely and effectively. Actively involving frontline nurses in devising the solutions that are needed to avoid the challenges that the pandemic has revealed is an important step in rebuilding trust and work engagement. Listening to and acting upon their recommendations can be a visible indicator of a shift from business as usual. Creating the infrastructure in health care organizations to

address ethical concerns without fear of retribution is no longer optional. Even in an otherwise healthy ethical workplace climate, where one feels supported and has a positive view of the organization's usual ability to address ethical concerns and problem solve difficult challenges, the demands and expectations of caring for COVID-19 positive patients are shattering perceptions of support and trust.

Empirical bioethics research can be important during a pandemic because it facilitates understanding the day-to-day ethical issues and challenges that nurses and other clinicians are experiencing (Ulrich, Anderson, & Walter, 2020). Previous research found that nurses and others want respect within their workplaces but do not always feel psychologically safe to voice their concerns for fear of retribution (Danis et al., 2008; Ulrich et al., 2007). During this pandemic, there have been examples of retribution for nurses who voiced concerns, including being dismissed from the workplace. Nurses' ability to act as moral agents for their patients and families is sometimes thwarted. A nationwide survey of 1,200 nurses from more than 400 hospitals in early April 2020 reported that 78% were experiencing physical, emotional, and mental stress and 67% were planning to leave their facility (Lunsford, 2020). These data speak to the suffering that is occurring across the country and the need for both individual and organizational healing. How should we proceed in helping nurses and others regain a sense of meaning in their workplace and address their shared experiences? What systemic reforms are needed to create cultures where integrity and well-being can thrive? More qualitative and quantitative data from front-line workers and those most affected by SARS-CoV2 can help researchers identify meaningful improvements for implementation within and across health care systems; and bringing forward nurses' voices for the public and others in key administrative and policy positions demonstrates not only their challenges but also their unparalleled value.

What Lessons Can We Carry Forward?

There are several lessons we should take away from the COVID-19 pandemic, and we are still learning. First, nurses must use their voices for change. Second, organizations have moral responsibilities to their employees; and third, although there continues to be moral failures and disruptions from the SARS-CoV-2 virus within the broader public sphere, we must also look to the moral successes as a roadmap for the future.

It would be easy to remain in a state of moral outrage-a predictable and justified response to threats or violations of ethical values or standards (Rushton, 2013). When activated, moral outrage can instigate a cascade of blame, shame and retribution and deplete vital energy needed to confront the crisis in front of us. Possible targets of our moral outrage include the myriad factors that result in lack of PPE, clear guidelines regarding proper protection during a pandemic, or health care organization culture that silences the voices of concern about the safety of patients or clinicians. This pandemic has forced nurses and others to face many difficult professional, ethical, and philosophical questions, – from those that directly affect the individual nurse to those that affect the profession, the patients and families they serve, the systems in which they work, and the policies that have, and will impact their future practice. Hospitals' and health systems' lack of preparedness for the care of COVID-19 patients has frightened many nurses, and more than 80% have reported fears of going to work with 43% indicating they made their own PPE (American Nurses Association, 2020). An important broader question is how this might change the nursing workforce when this crisis abates.

Given the enormity of the tasks ahead, we must harness moral outrage and instead use its power to fuel constructive progress rather than leaving a destructive swath of suffering, powerlessness, and fear(Rushton, 2013). Yes, the public has applauded and praised the momentous efforts of nurses and other clinicians, recognizing their commitment through enduring struggles. Support for nurses must, however, go beyond this. Substantive discussions about hazard pay, state-mandated staffing ratios, policies that protect those who speak out about unacceptable risks, infrastructure redesign solutions, ethics training for future clinicians, and the characteristics and quality of leadership within organizations and systems that engender trust, transparency, and compassionate responses are worthwhile goals. Our moral outrage and lessons learned can also stimulate constructive action to address the underlying structures, patterns, policies, and norms that have contributed to the conditions that created or exacerbated challenges that nurses are confronting. The U.S. Congress has considered a bill that would support the rights of essential workers and address safety and whistleblower protections, compensation relief, collective bargaining agreements, and corporation's accountability, among other areas. Powley (2012, 864) asks us to consider several important questions related to organizational healing following traumatic events and disruptions that affect groups within those systems. These include: "What is strengthened after crisis?" "What outcomes are important to examine with respect to healing?" "How does one know whether an organization has healed?'' Healing from the difficult emotions surfacing from the coronavirus pandemic will take time.

Organizations should begin to work toward building positive ethical climates by repairing interpersonal connections through compassion and collective support, and by understanding and fortifying the different types of strengths (moral, physical, and emotional) that allow their clinicians to meet shifting priorities with the volume of patients in need of nursing care, and uncertainties about whether resources will be available to meet these care needs on a day-to-day basis. Understanding how our strengths support our

individual and collective ability to confront moral adversities with integrity might allow every person to remain whole and undiminished. Our capacity to be morally resilient in the midst of these challenging times can help restore our integrity and our moral community. This begins with acknowledgment that the inherent worth and the resilient potential that resides in everyone can be strengthened through strategies aimed at healing the wounds that the pandemic has created (Rushton, 2018). Leaders committed to cultivating the conditions that foster moral resilience are uniquely poised to implement the recommendations of the American Nurses Association Call to Action that outlines strategies for individuals, leaders, and organizations (American Nurses Association, 2017).

Leveraging the collaboration and collegial support that has arisen during the pandemic could also promote healing our organizations. The pandemic may help us identify and begin to dissolve structures that do not perform well, create new patterns and the kind of workplaces that better serve not only patients but the people who serve in them. It is an opportunity to reclaim values foundational to our professions, establish new norms of communication and teamwork, intentionally address disparities and power imbalances, and foster professional and relational integrity. The pandemic has brought into sharp focus our interconnectedness and how intertwined our individual integrity is with the integrity of others and the moral ecosystem we reside in. Relational integrity enables us to preserve our personal and professional integrity by considering what we owe each other as part of our moral community and what expectations and commitments we are willing to hold ourselves accountable for (Rushton, 2018).

Finally, we must remember the nurses who go to work every day, endure many hardships, care for their patients, save lives, and touch "*. . . the soul in each of us*". They found the courage to persevere even when facing risk themselves, and even death. We must recognize that although there were moral failures, there were many moral successes that reflect the integrity of individuals, teams and organizations. We now must choose to look forward, advocate for and commit to change, and rebuild a broken health care system after this coronavirus leaves so many vulnerable in its path.

REFERENCES

American Association of Colleges of Nurses. (2019). Nursing fact sheet. https://www.aacnnursing.org/News-Information/Fact-Sheets/Nursing-Fact-Sheet

American Nurses Association. (2020a). COVID-19 survey responses. https://www.nursingworld.org/~4987e5/globalassets/covid19/ana_covid19infographic_dataset1_20200424-final.pdf

American Nurses Association. (2020b). COVID-19 Survey, March 20-April 10. https://app.powerbi.com/view?r=eyJrIjoiNTY0YjRmOGEtMThmZC00NDQwLWFlMWMtMWE5YmJkMmM2ODNiIiwidCI6ImI3MTQ5MGE1LTc1MjUtNDRhOS1iYjIxLTYyZTg5ZjhkYjY1MCIsImMiOjF9

American Nurses Association. (2017). Exploring moral resilience toward a culture of ethical practice. https://www.nursingworld.org/~4907b6/globalassets/docs/ana/ana-call-to-action–exploring-moral-resilience-final.pdf

American Nurses Association. (2020). COVID-19 resource center. https://www.nursingworld.org/practice-policy/work-environment/health-safety/disaster-preparedness/coronavirus

April 27, 2020. https://www.aa.com.tr/en/world/spain-healthcare-workers-protest-deaths-top-23-500-/1819904

Centers for Disease Control and Prevention. (2020). https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#health-care-personnel

Danis, M., & Patrick, D. L. (2002). Health policy, vulnerability, and vulnerable populations. In Marion Danis, Carolyn Clancy, Larry R. Churchill (Eds.), *Ethical dimensions of health policy* (p. 311). New York: Oxford.

Danis, M., Farrar, A., Grady, C., Taylor, C., Soeken, K., & Ulrich, C. (2008). Does fear of retaliation deter requests for ethics consultations? *Journal of Medicine Healthcare and Philosophy, 11*(1), 27–34.

Herleth, A. & Paiewonsky, A. (2020). "Moral Resilience Rounds": Johns Hopkins Secret to Help Staff Navigate Moral Distress. https://www.advisory.com/research/physician-executive-council/prescription-for-change/2020/05/moral-resilience-rounds

Hurst, S. (2008). Vulnerability in research and health care; Describing the elephant in the room? *Bioethics, 22*(4), 191–202.

Johns Hopkins University, & Medicine Coronavirus Resource Center (2020). https://coronavirus.jhu.edu.

Love, R., Hanrahan, N., Ackermann, M. L., Lawlor, F. A., Taylor, A. R., & Toner, R. (2021). *The rebel nurse handbook: Inspiring stories by shift disruptors*. New York: Springer Publishing Company.

Lovelace, B. (2020). *WHO says there's a global shortfall of 5.9 million nurses as world battles coronavirus pandemic*. CNBC. April 62020 https://www.cnbc.com/2020/04/06/who-says-theres-a-global-shortfall-of-5point9-million-nurses-as-world-battles-coronavirus-pandemic.html.

Lunsford, C. (2020). Holliblu and Feedtrail COVID-19/Mental Wellbeing Nurse Survey. https://www.holliblunurses.com/survey

McMurtry, A. (2020). Spain: Healthcare workers protest, Death Tops23,500.

Murphy, R. R., Adams, J., & Gandudi, V. B. N. (2020). Robots have demonstrated their crucial role in pandemics - and how they can help for years to come. *World Economic Forum*. https://www.weforum.org/agenda/2020/05/robots-coronavirus-crisis/.

National Academy of Medicine. (2020). Strategies to support the health and well-being of clinicians during the COVID-19 outbreak. https://nam.edu/initiatives/clinician-resilience-and-well-being/clinician-well-being-strategies-during-covid-19/

National Academies of Sciences, Engineering and Medicine, & National Academy of Medicine. (2019). *Committee on Systems Approaches to Improve Patient Care by Supporting Clinician Well-Being. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being*. Washington DC: National Academies Press (US).

Powley, E. H. (2012). Organizational healing: A relational process to handle major disruption. In Kim S. Cameron, & Gretchen M Spreitzer (Eds.), *The Oxford handbook of positive organizational scholarship* (pp. 855–866). New York: Oxford.

Rushton, C. H. (2013). Principled moral outrage. *AACN Advanced Critical Care, 24*(1), 82–89.

Rushton, C. H. (2018). Integrity: The Anchor for Moral Resilience. *Moral Resilience: Transforming Moral Suffering in Healthcare* (pp. 77–103). New York: Oxford University Press.

Rushton, C. H. (2018). Conceptualizing Moral Resilience. *Moral Resilience: Transforming Moral Suffering in Healthcare* (pp. 125–149). New York: Oxford University Press.

The Staffs of Kaiser Health News and The Guardian. (2020). COVID-19: Lost on the Frontlines. July 29, 2020, https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/

Ulrich, C., O'Donnell, P., Taylor, C., Farrar, A., Danis, M., & Grady, C. (2007). Ethical climate, ethics stress, and the job satisfaction of nurses and social workers in the United States. *Social Science and Medicine, 8*, 1708–1719.

Ulrich, C. M., Anderson, E., & Walter, J. (2020). COVID-19: Advancing Empirical Bioethics Research.. *American Journal of Bioethics: Empirical Bioethics, 11*(3), 145–147.

Ulrich, C. M., & Grady, C. (2018). *Moral Distress in the Health Professions*. Switzerland: Springer Nature.

Watson, C. (2018). *The language of kindness: A nurse's story*. New York: Tim Duggan Books.

Worline, M. C. (2012). Courage in organizations: An integrative review of the "Difficult Virtue". In Kim S. Cameron, & Gretchen M Spreitzer (Eds.), *The Oxford handbook of positive organizational scholarship* (pp. 304–315). New York: Oxford.

Wu, A. W., Connors, C., & Everly, G. S. Jr. (2020). COVID-19: Peer support and crisis communication strategies to promote institutional resilience. *Annals of Internal Medicine*. [Epub ahead of print 6 April 2020] https://doi.org/10.7326/M20-1236.

EXHIBIT 23

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.

Upcoming Live CE/CME events:

STRATEGIES TO FEEL EMPOWERED AMIDST MORAL DISTRESS

January 12th, 2021 at 2:00 pm ET/11:00 am PT

Recorded Webinars Available for Credit

Watch our recorded webinars at your convenience

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.*

- Home
- About
- Hospice Care
- Our Services
- Volunteering & Internships
- Contact Us

1 (855) 812-1136

VISIT THE FOUNDATION

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 while completing her graduate clinical training at Northwestern Memorial Hospital's 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.

EXHIBIT 24

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

23. Please select your Department: *

Business Development	Business Operations
Call Center	Clinical Operations
Communications	Continuous Care
Education & Quality	Executive
Finance	HIIM
HR	IT
Legal	Physician & NP
Supportive Care	

EXHIBIT 25

Surveys of Seasons Hospice Agencies Requiring Corrective Action Plans, 2019-2021

Final Accreditation Report

Seasons Hospice & Palliative Care of Connecticut, LLC
1579 Straits Turnpike, Unit 1E
Middlebury, CT 06762-1835

Organization Identification Number: 546050
60-day Evidence of Standards Compliance Submitted: 10/21/2019

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	10/21/2019	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score
§418.104	L671	Compliant
§418.104(a)(3)	L674	Compliant
§418.54	L520	Compliant
§418.54(b)	L523	Compliant
§418.54(c)(7)	L531	Compliant
§418.56	L538	Compliant
§418.56(c)	L545	Compliant
§418.56(e)(2)	L555	Compliant
§418.76	L607	Compliant
§418.76(g)(1)	L625	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
EC.02.01.01	Compliant
NPSG.15.02.01	Compliant
PC.01.02.01	Compliant
PC.01.02.03	Compliant
PC.01.03.01	Compliant
PC.02.01.01	Compliant
RC.01.01.01	Compliant
RC.02.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP 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/life_safety_code_information_resources/ and NFPA 99-2012: 1.4.	The organization identifies potential safety and security risks in the patient's home.
NPSG.15.02.01	4	Identify risks associated with home oxygen therapy such as home fires.	Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - 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

Standard	EP	Standard Text	EP Text
			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.01.02.03	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 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	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.
RC.01.01.01	11	The organization maintains complete and accurate patient records.	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.
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 - Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law

Standard	EP	Standard Text	EP Text
			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.

Preliminary 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: 8/12/2019 - 8/15/2019

Program Surveyed
Home Care

Preliminary Report: Posted 8/15/2019

The Joint Commission
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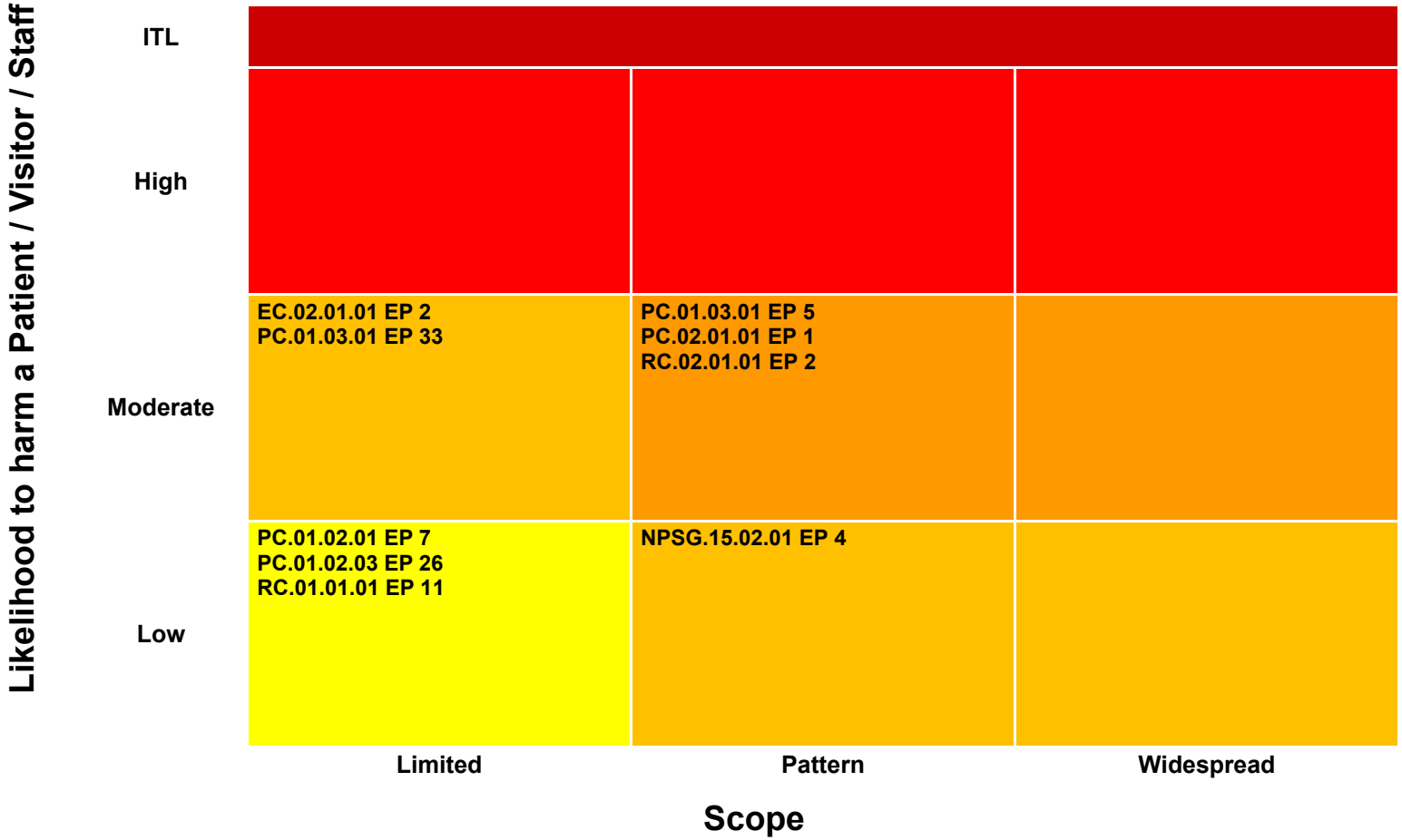
The Joint Commission
Executive Summary

Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	08/12/2019 - 08/15/2019	Requirements for Improvement	Your official report will be posted to your organization's confidential extranet site. It will contain specific follow-up instructions regarding your survey findings.	Your official report will contain specific follow-up instructions regarding your survey findings.

The Joint Commission
SAFER™ Matrix
Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score	Corresponds to:
§418.104	L670	Standard	
§418.104(a)(3)	L674	Standard	OME/RC.02.01.01/EP2
§418.54	L520	Condition	
§418.54(b)	L523	Standard	OME/PC.01.02.03/EP26
§418.54(c)(7)	L531	Standard	OME/PC.01.02.01/EP7
§418.54(e)(2)	L535	Standard	OME/RC.01.01.01/EP11
§418.56	L538	Standard	
§418.56(c)	L545	Standard	OME/PC.01.03.01/EP5
§418.56(e)(2)	L555	Standard	OME/PC.02.01.01/EP1
§418.76	L607	Standard	
§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.02.01.01	2	Moderate Limited	The organization identifies potential safety and security risks in the patient's home.	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 1 out of 3 home visits conducted, Hospice surveyor noted the patients home had two free standing oxygen tanks in the patients bedroom that were not secured in a rack or lying flat. This was confirmed by the patients grand son in law that was at the home at the time of the visit.		
NPSG.15.02.01	4	Low Pattern	Assess the patient's, family's, and/or caregiver's level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 1 out of 4 home visits conducted, Hospice surveyor noted the clinical record for home visit #1 indicated on the oxygen assessment visit that there were smoking materials and open flame. It did not indicate what type of smoking materials or open flame and no documentation was noted as to the education regarding these areas assessed as potential risk factors. This was confirmed by the Clinical Director.		
PC.01.02.01	7	Low Limited	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - 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	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 2 out of 16 patient records reviewed, Hospice surveyor noted for home visit #2 and home visit #3, the clinical records did not contain an initial bereavement assessment. This was confirmed by the Clinical Director.	§418.54(c)(7)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			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 - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals			
PC.01.02.03	26	Low Limited	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 & Palliative Care (35 Jolley Dr., Suite 202, Bloomfield, CT) site. In 1 out of 16 patient records reviewed, Hospice surveyor noted for HV#3, the social worker did not complete an initial assessment within 5 days. The patient was called by a social work intern within the five day window but the initial visit was not made from 3/13/19 start of care until 3/25/19. There was no indication in the clinical record that the family had refused a visit or postponed the visit. This was confirmed by the Clinical Director.	§418.54(b)	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 (35 Jolley Dr., Suite 202, Bloomfield, CT) site. In 5 out of 16 patient records reviewed, Hospice surveyor noted for RR#11, the physician statement and nursing notes indicated the patient had C Difficile. This was not noted as a	§418.56(c)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				problem on the care plan. For RR#12 the patient had dermatitis caused by incontinence. This was noted in the IDG minutes, physician statement of terminal illness and IDG however, no care plan was developed for incontinence or skin impairment. For RR#8, the goal for skin integrity was " caregiver will demonstrate interventions to maintain skin integrity within the limits of the disease within 90 day. For RR#6 the goal was patient will maintain optimal function. These goals were not measurable. This was confirmed by the Clinical Director.		
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 & Palliative Care (35 Jolley Dr., Suite 202, Bloomfield, CT) site. In 1 out of 4 patient records reviewed, Hospice surveyor noted the hospice aide care plan prepared by the RN did not contain precautions related to the patient having C Difficile. This was validated by the Clinical Director.	§418.76(g)(1)	Standard
PC.02.01.01	1	Moderate Pattern	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 & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 5 out of 16 patient records reviewed, Hospice surveyor noted for record review #2, the chaplain visit frequency approved by IDG was 1 to 2 visits every four weeks. The chaplain last visit to the patient was 6/28/19 no other visits were noted in the clinical record. For home visit #3, the chaplain had made a visit on 3/14/19 the plan did not indicate whether the chaplain would continue to follow the patient or not. The IDG note for this patient for 3/20/19 indicated further chaplain visits would be made. The clinical record did not contain any additional visits after 3/14/19 as of todays date 8/13/19. For RR#3, the chaplain did not perform visits in accordance with the plan of care. The plan of care stated the chaplain visits would be 1 to 2 times per month for 13 weeks. The chaplain only made one visit on 6/7/19. For RR#5 and RR#6, the social worker made an initial visit only. The plan for future visits was left	§418.56(e)(2)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				blank. This was confirmed by the Clinical Director.		
RC.01.01.01	11	Low Limited	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.	1). Observed in Record Review at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 2 out of 16 patient records reviewed, Hospice surveyor noted for RR#3, the idg minutes of 7/30/19 were not accurate. The minutes indicated the social worker had not made any home visits in the past two weeks when the clinical notes by the social worker had a visit dated 7/29/19. For RR#1, the social worker documentation did not correlate with the documentation at IDG. The social worker did not have an established plan to continue seeing the patient and had not seen the patient since 6/14/19 however the IDG minutes for this same period indicated the patient would have social worker followup visits.This was confirmed by the Clinical Director.	§418.54(e)(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 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 - Any assessments relevant to care, treatment, or services - Physician orders	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Connecticut, LLC (1579 Straits Turnpike, Unit 1E, Middlebury, CT) site. In 2 out of 3 home visits conducted, Hospice surveyor noted the clinical record did not contain an accurate medication list as compared to the Skilled Nursing Medication list. For example, The hospice list contained: Haloperidol lactate 1mg every 6 hours prn, Hydrochlorothiazide 12.5 mg daily and Ativan 0.5mg prn twice daily. The medication administration record at the Skilled nursing facility did not contain any of these medications. The nursing home medication nurse informed the hospice nurse that the nursing facility doesn't even allow Haloperidol at the facility. The hospice staff nurse stated she may have forgotten to discontinue the hydrochlorothiazide from the hospice medication profile. For home visit #3, the current medication list provided to the surveyor did not match the	§418.104(a)(3)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			- 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.	medications the patient was currently taking in the home. For example, DOK 100 mg was listed twice on the medication profile while Docusate Sodium 100mg was also listed twice on the current medication profile all as active. Prochlorperazine 10mg one every six hours was in the comfort pack in the patients home yet this medication was not in the current medication profile. This was confirmed by the RN doing the medication reconciliation in the home.		

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Appendix

Conditions of Participation Text

Program: Home Care

CoP	Tag	CoP Standard text
§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.
§418.54 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.
§418.54(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.
§418.54(e)(2) Patient outcome measures	L535	(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.
§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(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.

CoP	Tag	CoP Standard text
§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.

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP 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/life_safety_code_information_resources/ and NFPA 99-2012: 1.4.	The organization identifies potential safety and security risks in the patient's home.
NPSG.15.02.01	4	Identify risks associated with home oxygen therapy such as home fires.	Assess the patient’s, family’s, and/or caregiver’s level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - 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

Standard	EP	Standard Text	EP Text
			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.01.02.03	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 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	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.
RC.01.01.01	11	The organization maintains complete and accurate patient records.	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.
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 - Any assessments relevant to care, treatment, or services - Physician orders - Any information required by organization policy, in accordance with law

Standard	EP	Standard Text	EP Text
			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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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.

Final Accreditation Report

Seasons Hospice & Palliative Care of Delaware, LLC
220 Continental Drive, Suite 407
Newark, DE 19713

Organization Identification Number: 448394
60-day Evidence of Standards Compliance Submitted: 8/21/2019

ESC Programs Reviewed
Home Care

Final Report: Posted 8/21/2019

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	8/21/2019	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score
§418.54	L520	Compliant
§418.54(b)	L523	Compliant
§418.54(c)(5)	L529	Compliant
§418.56	L538	Compliant
§418.56(c)	L545	Compliant
§418.56(e)(2)	L555	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
NPSG.09.02.01	Compliant
PC.01.02.01	Compliant
PC.01.02.03	Compliant
PC.01.03.01	Compliant
PC.02.01.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
NPSG.09.02.01	1	Reduce the risk of falls.	Assess the patient's risk for falls.
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - 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 - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.02.03	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 care.

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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.02.01.01	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.

Final Accreditation Report

Seasons Hospice & Palliative Care of Delaware, LLC
220 Continental Drive, Suite 407
Newark, DE 19713

Organization Identification Number: 448394
60-day Evidence of Standards Compliance Submitted: 7/3/2019

ESC Programs Reviewed
Home Care

Final Report: Posted 7/18/2019

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	7/3/2019	No Requirements for Improvement	None	None

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The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score
§418.100	L649	Compliant
§418.100(b)	L651	Compliant
§418.104	L671	Compliant
§418.104(e)(1)(i)	L682	Compliant
§418.54	L520	Compliant
§418.54(b)	L523	Compliant
§418.54(c)(5)	L529	Compliant
§418.56	L538	Compliant
§418.56(c)	L545	Compliant
§418.56(c)(1)	L546	Compliant
§418.56(c)(2)	L547	Compliant
§418.56(c)(4)	L549	Compliant
§418.56(e)(2)	L555	Compliant
§418.60	L577	Compliant
§418.60(a)	L579	Compliant
§418.64	L587	Compliant
§418.64(d)(3)(i)	L598	Compliant
§418.76	L607	Compliant
§418.76(g)(1)	L625	Compliant
§418.76(g)(2)(ii)	L626	Compliant
§418.76(h)(1)(i)	L629	Compliant

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Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
HR.01.03.01	Compliant
IC.02.01.01	Compliant
IM.02.02.01	Compliant
LD.01.03.01	Compliant
MM.04.01.01	Compliant
NPSG.09.02.01	Compliant
PC.01.02.01	Compliant
PC.01.02.03	Compliant
PC.01.03.01	Compliant
PC.02.01.01	Compliant
PC.02.01.03	Compliant
PC.04.01.05	Compliant
PC.04.02.01	Compliant
RC.01.01.01	Compliant

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
HR.01.03.01	14	Staff are supervised effectively.	For hospices that elect to use The Joint Commission deemed status option: In order to assess the quality of care and services provided by the hospice aide and to ensure that services ordered meet the patient's needs, the registered nurse supervises the hospice aide during an on-site visit to the patient's home no less frequently than every 14 days. If nursing services are not provided, a physical or occupational therapist or speech-language pathologist can supervise the hospice aide. Note: The aide does not need to be present during the supervisor's visit.
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 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 http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
IM.02.02.01	3	The organization effectively manages the collection of health information.	The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and

Standard	EP	Standard Text	EP Text
			medication-related documentation. Medication-related documentation can be either handwritten or electronic.
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.04.01.01	2	Medication orders or prescriptions are clear and accurate. Note: For more information on verbal and telephone orders, refer to Standards RC.02.03.07 and PC.02.01.03.	For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization follows a written policy that defines the following: - The required elements of a complete medication order - The precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear
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.
PC.01.02.01	5	The organization assesses and reassesses its patients.	Based on the patient's condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient's assessment and reassessment: - Pertinent diagnoses - Pertinent physical findings - Pertinent medical history - Functional status - Psychosocial status - Cultural or religious practices that may affect care - Care the family or support system is capable of and willing to provide - Educational needs, including the abilities, motivation, and readiness to learn - Barriers and safety hazards in the home environment - Any other relevant information that may affect the patient's goals
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms

Standard	EP	Standard Text	EP Text
			- 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 - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.02.03	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 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

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Standard	EP	Standard Text	EP Text
			- 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.02.01.03	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 in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.
PC.04.01.05	2	Before the organization discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, or services.	Before the patient is discharged, the organization informs the patient of the kinds of continuing care, treatment, or services he or she will need. (See also PC.04.01.01, EP 10)
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.01.01.01	11	The organization maintains complete and accurate patient records.	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.

Final Accreditation Report

Seasons Hospice & Palliative Care of Delaware, LLC
220 Continental Drive, Suite 407
Newark, DE 19713

Organization Identification Number: 448394
Unannounced Full Event: 4/30/2019 - 5/2/2019

Program Surveyed
Home Care

Final Report: Posted 5/8/2019

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	04/30/2019 - 05/03/2019	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)
HR.01.03.01	14	Low / Limited	§418.76 (h)(1)(i)	L629		✓
IC.02.01.01	2	Moderate / Limited	§418.60 (a)	L579		✓
IM.02.02.01	3	Moderate / Limited				✓
LD.01.03.01	12	Moderate / Widespread	§418.100 (b)	L651		✓
MM.04.01.01	2	Moderate / Limited				✓
NPSG.09.02.01	1	Moderate / Limited				✓
	2	Moderate / Limited				✓
PC.01.02.01	5	Moderate / Pattern				✓
	7	Moderate / Pattern	§418.64 (d)(3)(i)	L598		✓
			§418.54 (c)(5)	L529		✓
PC.01.02.03	26	Low / Limited	§418.54 (b)	L523		✓
PC.01.03.01	18	High / Widespread	§418.56 (c)(2)	L547	✓	✓
			§418.56 (c)(4)	L549	✓	✓
			§418.56 (c)(1)	L546	✓	✓

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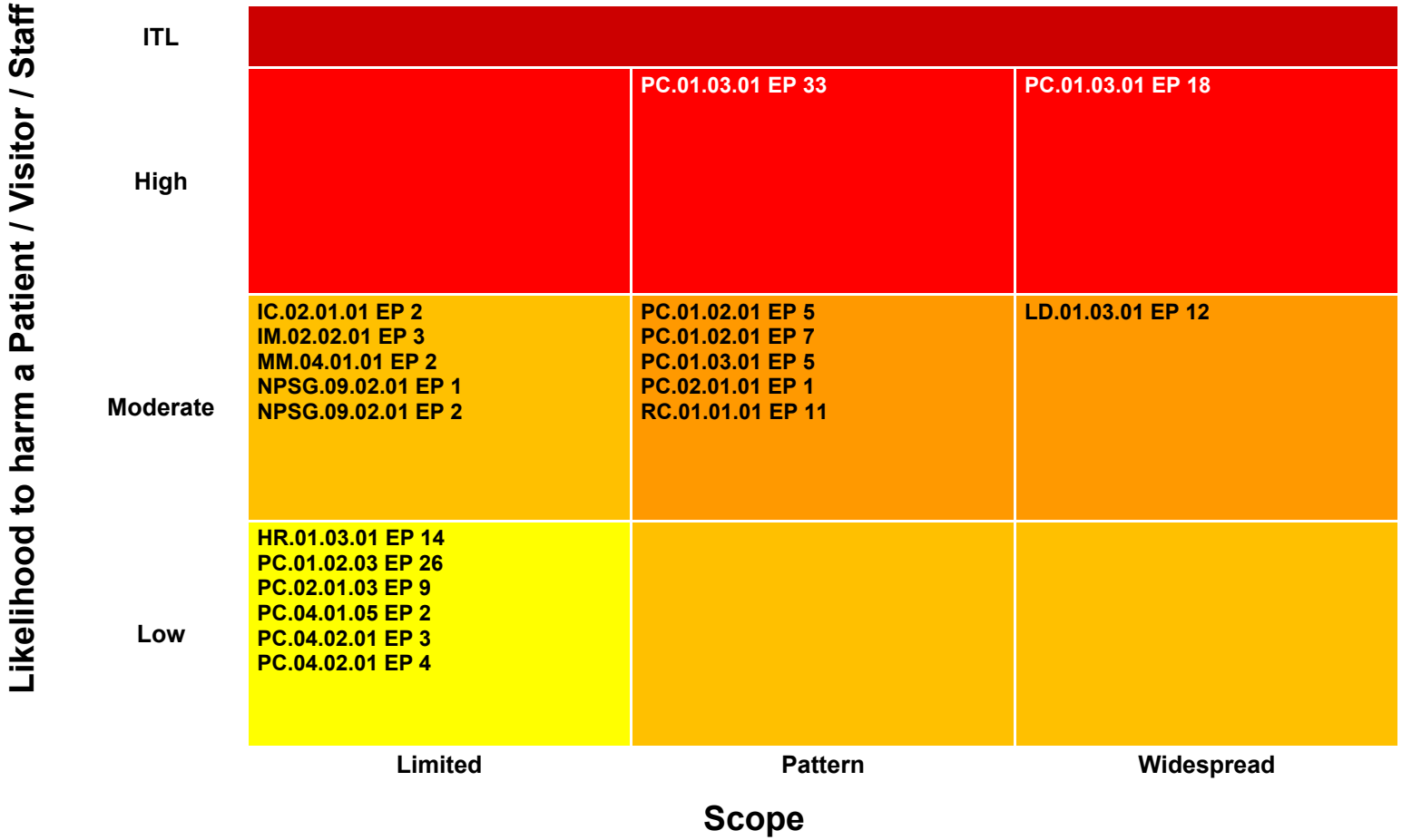
Standard	EP	SAFER™ Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 Calendar Days)	Included in the Evidence of Standard Compliance (within 60 calendar days)
	33	High / Pattern	§418.76 (g)(1)	L625		✓
	5	Moderate / Pattern	§418.56 (c)	L545	✓	✓
PC.02.01.01	1	Moderate / Pattern	§418.56 (e)(2)	L555	✓	✓
PC.02.01.03	9	Low / Limited	§418.76 (g)(2)(ii)	L626		✓
PC.04.01.05	2	Low / Limited				✓
PC.04.02.01	3	Low / Limited	§418.104 (e)(1)(i)	L682		✓
	4	Low / Limited	§418.104 (e)(1)(i)	L682		✓
RC.01.01.01	11	Moderate / Pattern	§418.104	L671		✓

The Joint Commission
SAFER™ Matrix
Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score	Corresponds to:
§418.54	L520	Standard	
§418.54(b)	L523	Standard	OME/PC.01.02.03/EP26
§418.54(c)(5)	L529	Standard	OME/PC.01.02.01/EP7
§418.60	L577	Standard	
§418.60(a)	L579	Standard	OME/IC.02.01.01/EP2
§418.64	L587	Standard	
§418.64(d)(3)(i)	L598	Standard	OME/PC.01.02.01/EP7
§418.100	L649	Standard	
§418.100(b)	L651	Standard	OME/LD.01.03.01/EP12
§418.104	L671	Standard	OME/RC.01.01.01/EP11
§418.56	L538	Condition	
§418.56(c)	L545	Condition	OME/PC.01.03.01/EP5
§418.56(c)(1)	L546	Condition	OME/PC.01.03.01/EP18
§418.56(c)(2)	L547	Standard	OME/PC.01.03.01/EP18
§418.56(c)(4)	L549	Standard	OME/PC.01.03.01/EP18
§418.56(e)(2)	L555	Standard	OME/PC.02.01.01/EP1
§418.76	L607	Standard	
§418.76(g)(1)	L625	Standard	OME/PC.01.03.01/EP33
§418.76(g)(2)(ii)	L626	Standard	OME/PC.02.01.03/EP9
§418.76(h)(1)(i)	L629	Standard	OME/HR.01.03.01/EP14
§418.104(e)(1)(i)	L682	Standard	OME/PC.04.02.01/EP3 OME/PC.04.02.01/EP4

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
HR.01.03.01	14	Low Limited	For hospices that elect to use The Joint Commission deemed status option: In order to assess the quality of care and services provided by the hospice aide and to ensure that services ordered meet the patient's needs, the registered nurse supervises the hospice aide during an on-site visit to the patient's home no less frequently than every 14 days. If nursing services are not provided, a physical or occupational therapist or speech-language pathologist can supervise the hospice aide. Note: The aide does not need to be present during the supervisor's visit.	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 2 of 10 patient records reviewed, the registered nurse did not perform a hospice aide supervisory visit every 14 days. In HOS2 HV #1, the Surveyor noted the hospice aide supervisory visit was made 15 days apart. This was confirmed with the Director of Quality. In HOS2 RR #4, the Surveyor noted the hospice aide supervisory visit was not made until 18 days after the first aide visit. This was confirmed with the Director of Quality.	§418.76(h)(1)(i)	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. (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 http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 3 home visits conducted, the organization did not use standard precautions to reduce the risk of infection. In HOS HV #2, the Surveyor noted the medical social worker did not perform hand hygiene in the home before patient contact. This was discussed with the Director of Quality.	§418.60(a)	Standard
				2). Observed in Tracer Visit at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . During HOS1 HV2 the Hospice surveyor noted that the RN failed to remove gloves after inspecting the Foley catheter and then touching the remote control and other objects on the patients bed. This was validated in a discussion with the clinical director.	§418.60(a)	Standard
IM.02.02.01	3	Moderate	The organization follows its list of prohibited	1). Observed in Record Review at Seasons Hospice		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Limited	abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.	& Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 10 patient records reviewed, the organization did not follow its list of prohibited abbreviations. In HOS2 RR #4, the Surveyor noted the nurse documented omeprazole qd and mometasone qd which were unapproved abbreviations. This was confirmed with the Director of Quality.		
				2). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . During HOS1 HV2 and subsequent RR of the skilled nursing process, the HOS1 surveyor noted that there were 4 instances of the unapproved abbreviation "QD" on the medication profile. This was validated in a discussion with the senior director of clinical operations.		
LD.01.03.01	12	Moderate 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	1). Observed in Tracer Activities at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . The surveyor noted that the organization did not ensure compliance with 418.104 and 418.56. This was validated in a discussion with senior leadership.	§418.100(b)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			assessment and performance improvement (QAPI) program.			
MM.04.01.01	2	Moderate Limited	For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization follows a written policy that defines the following: - The required elements of a complete medication order - The precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of DE, LLC (30265 Commerce Drive, Suite 205, Millsboro, DE) site . In 1 of 3 home visits conducted, In HOS HV #2, the Surveyor noted the medication profile included ibuprofren and tramadol prn for pain; however, there was no indication as to which one to take first. Second example, the medication profile include both lorazepam and alprazolam prn for anxiety; however, no indication as to which medication to take first. In discussion with the nurse, one of the antianxiety medications was from the comfort kit. Third example, the medication profile included compazine and zofran for nausea; medication to take first. In discussion with the nurse, one of the antiemetic medications was from the comfort kit. Fourth example, the medication profile included aspirin 81 mg daily; however, the patient was never on this medication per the assisted living facility. This was discussed with the Director of Quality.		
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 DE, LLC (30265 Commerce Drive, Suite 205, Millsboro, DE) site . In HOS 1 HV 1 the surveyor noted that the patient relocated from an ALF to a SNF and there was no falls risk assessment done on 2/14 as required by agency policy. This was validated in a discussion with and observation by the Sr. Director of Clinical Operations.		
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 & Palliative Care of DE, LLC (30265 Commerce Drive, Suite 205, Millsboro, DE) site . In HOS2 HV #1, the Surveyor noted the patient was identified at risk for falls; however, the plan of care did not include interventions to decrease fall risk. This was confirmed with the Director of Quality.		
PC.01.02.01	5	Moderate	Based on the patient's condition and the care,	1). Observed in Record Review at Seasons Hospice		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
		Pattern	treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient's assessment and reassessment: - Pertinent diagnoses - Pertinent physical findings - Pertinent medical history - Functional status - Psychosocial status - Cultural or religious practices that may affect care - Care the family or support system is capable of and willing to provide - Educational needs, including the abilities, motivation, and readiness to learn - Barriers and safety hazards in the home environment - Any other relevant information that may affect the patient's goals	& Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 4 of 10 patient records reviewed, The organization did not assess and reassess its patients based on the patient's condition and the care, treatment or services it provided. In HOS2 HV #1, the Surveyor noted the nurse documented the patient had an open wound on the buttocks which the patient refused to let the nurse assess on that visit; however, there was no further follow-up assessment or documentation related to the open wound on the buttocks. This was confirmed with the Director of Quality. In HOS2 RR #5, the Surveyor noted the patient was admitted with a dehisced surgical wound to the back; however, the nurse did not assess the wound bed, perimeter or measurements on admission. This was confirmed with the Director of Quality. In HOS2 RR #6, the Surveyor noted the patient was on oxygen; however, the admission assessment did not indicate the flow rate of oxygen the patient was currently receiving. This was confirmed with the Director of Quality. In HOS2 RR #7, the Surveyor noted the nurse did not assess of cardiac status, genitourinary status or gastrointestinal symptoms at the admission assessment. This was confirmed with the Director of Quality.		
PC.01.02.01	7	Moderate Pattern	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - 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	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 5 of 10 patient records reviewed, the hospice did not provide an assessment of the patient's and family's spiritual needs. In HOS2 HV #2, HOS2 RR #1, HOS2 RR #3, HOS2 RR #6 and HOS2 RR #7, the Surveyor noted the	§418.64(d)(3)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			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 - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals	policy indicated the nurse and the medical social worker would complete the spiritual assessment; however, the nurse's assessment only indicated if there were any spiritual needs identified and the medical social worker spiritual assessment section was blank. In review of the patient/family assessment policy and the chaplain services policy, the hospice did not define the information the organization would collect related to spiritual concerns or needs identified by the patient or family such as despair suffering, guilt and forgiveness. This was confirmed with the Director of Quality.		
				2). Observed in Tracer Activities at Seasons Hospice & Palliative Care of Delaware, LLC (4755 Ogletown Stanton Road, 6th Floor, Newark, DE) site . In 2 of 2 patient records reviewed, In IPU 1 the surveyor noted that ativan and roxanol were given on 4/28 with no numerical assessment pre or post intervention that is required by policy. In IPU 2 moarphine was given on 4/27 with no numerical assessment pre or post intervention. This was validated in a discussion with and observation by the Sr. Director of Clincal Operations.	§418.54(c)(5)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
PC.01.02.03	26	Low Limited	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 & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 10 patient records reviewed, the interdisciplinary team did not complete the comprehensive assessment no later than 5 calendar days after the election of hospice. In HOS2 RR #4, the Surveyor noted the spiritual assessment was not completed by the interdisciplinary team until 8 days after the start of care. This was confirmed with the Director of Quality.	§418.54(b)	Standard
				2). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 7 patient records reviewed, In HOS 1 HV 2 the surveyor noted that the chaplain was ordered on the SOC however the visit was not performed until day 8. This was validated in a discussion with and observation by the Sr. Director of Clincal Operations.	§418.54(b)	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 Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 5 of 10 patient records reviewed, the written plan of care was not based on measurable goals. In HOS2 HV #1, HOS2 HV #2, HOS2 RR #1, HOS2 RR #2 and HOS2 RR #7, the Surveyor noted the goals on the plan of care did not include time frames. This was confirmed with the Director of Quality. In HOS2 RR #1, the Surveyor noted the following unmeasurable goal: patient will experience ease in breathing. This was confirmed with the Director of Quality. In HOS2 RR #2, the Surveyor noted the plan of care included the following unmeasurable goals: patient will have a comfortable death and patient anxiety will	§418.56(c)	Condition

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				be reduced. This was confirmed with the Director of Quality. In HOS2 RR #7, the Surveyor noted the plan of care included interventions for the biliary drainage tube; however, there was no goal. This was confirmed with the Director of Quality.		
				2). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 4 of 4 patient records reviewed, In record review HOS1 surveyor noted that the IDT notes did not include a time frame for the various goals listed. In addition the notes only had a description of the clinical picture by the RN with no reference to other services being provided, nor documetation of progress, or lack thereof, to goals. This was validated in a discussion with and observation by the Sr. Director of Clincal Operations.	§418.56(c)	Condition
PC.01.03.01	18	High Widespread	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 Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 2 of 10 patient records reviewed, the plan of care did not include a deteailed statement of the scope and frequency of services necessary to meet the specific patient and family needs. In HOS2 RR #3, the Surveyor noted the nurse documented on admission the patient was to be referred to chaplain services; however, the plan of care did not include an evaluation or visit frequency for chaplain services. The chaplain did not see the patient until four months later. This was confirmed with the Director of Quality. In HOS2 HV #3, the Surveyor noted the medical social worker documented the patient was to be referred to chaplain services; however, the plan of care did not include a visit frequency for chaplain services. This was confirmed with the Director of Quality.	§418.56(c)(2)	Standard
				2). Observed in Record Review at Seasons Hospice	§418.56(c)(4)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				& Palliative Care of DE, LLC (30265 Commerce Drive, Suite 205, Millsboro, DE) site . the patient record did not contain an accurate medication list. In HOS HV #2, the Surveyor noted the medication profile included ibuprofren and tramadol prn for pain; however, there was no indication as to which one to take first. Second example, the medication profile include both lorazepam and alprazolam prn for anxiety; however, no indication as to which medication to take first. In discussion with the nurse, one of the antianxiety medications was from the comfort kit. Third example, the medication profile included compazine and zofran for nausea; however, there was no indication as to which medication to take first. In discussion with the nurse, one of the antiemetic medications was from the comfort kit. This was discussed with the Director of Quality.		
				3). Observed in Record Review at Seasons Hospice & Palliative Care of DE, LLC (30265 Commerce Drive, Suite 205, Millsboro, DE) site . During HOS1 HV2 the Hospice surveyor noted that record did not have a complete medication order as required by policy. Morphine 7 mg bolus was ordered as "PRN as Directed" with no time frame included making the order unclear. This was validated in a discussion with the senior director of clinical operations.	§418.56(c)(4)	Standard
				4). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 9 of 10 patient records reviewed, the plan of care did not include interventions to manage pain and symptoms. In HOS2 RR #1, the Surveyor noted the patient was placed on general inpatient for shortness of breath; however, the nurse documented the patient did not have shortness or breath on admission or any subsequent nursing notes. Also, the plan of care did not include interventions to address this	§418.56(c)(1)	Condition

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				symptom. Second example, the patient had an intravenous catheter; however, there was no goal or interventions for the catheter on the plan of care. Third example, there were conflicting diet orders for inpatient unit of NPO and regular diet. This was confirmed with the Director of Quality. In HOS2 RR #2, the Surveyor noted the plan of care included an order for foley catheter which indicated 16 fr and change every 30 days and prn; however, there was no indication given for the prn order. This was confirmed with the Director of Quality. In HOS2 RR #3, the Surveyor noted the patient developed a urinary tract infection; however, the plan of care was not updated to include interventions to address this issue. This was confirmed with the Director of Quality. In HOS2 HV #3, the Surveyor noted the patient had a foley catheter on admission; however, the plan of care did not specify the patient's urologist was changing the foley catheter. In addition, last month, the nurse documented the Foley catheter now to be inserted by the hospice nurse; however, the plan of care was not updated to reflect this. This was confirmed with the Director of Quality. In HOS2 RR #4, the Surveyor noted the patient complained of shortness of breath on admission; however, the plan of care did not include interventions for shortness of breath. Also, the plan of care did not include wound care orders for the sacral wound present on admission until 12 days after start of care. This was confirmed with the Director of Quality. In HOS2 RR #5, the Surveyor noted the patient was admitted to general inpatient level of care for		

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				shortness of breath and agitation; however, the plan of care did not include interventions for these symptoms. In addition, the patient was on oxygen at 6 liters and BIPAP; however, there were no order for these on the plan of care. Also, the patient had a dehisced surgical wound infected with MRSA to the back; however, the plan of care did not include interventions. In addition, the patient had anxiety/agitation, at risk for falls, diabetic, and dysphagia and these issues were not addressed in the plan of care. Lastly, the patient's level of care was changed from general inpatient to routine; however, there was no order written from three days ago. This was confirmed with the Director of Quality. In HOS2 RR #7, the Surveyor noted the patient was identified as having pain; however, the plan of care did not include pain interventions. In addition, the plan of care did not specify who was flushing the biliary tube daily as well as the specific care to be provided to the biliary tube site. This was confirmed with the Director of Quality.		
PC.01.03.01	33	High Pattern	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 Patient Home at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 3 of 10 patient records reviewed, the registered nurse did not prepare specific written patient care instructions for the hospice aide. In HOS2 RR #1, the Surveyor noted the aide plan of care indicated foley catheter care; however, the patient did not have a foley catheter. This was confirmed with the Director of Quality. In HOS2 RR #2, the Surveyor noted the aide plan of care indicated "diabetic" under safety measures; however, the patient was not diabetic. This was confirmed with the Director of Quality. In HOS2 RR #4, the Surveyor noted there was no aide plan of care in the clinical record; however, the	§418.76(g)(1)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				patient was seen four times by the aide. This was confirmed with the Director of Quality.		
PC.02.01.01	1	Moderate Pattern	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 & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 3 of 10 patient records reviewed, the interdisciplinary team did not ensure that care and services were provided in accordance with the plan of care. In HOS2 HV #1, the Surveyor noted there was a missed visit due to patient declined; however, there was no documentation the interdisciplinary team was notified of the missed visit. In addition, the Surveyor noted the plan of care for the hospice aide visit frequency was five visits in the first two weeks of service; however, the patient was only seen three times by the hospice aide in the first two weeks of service. There was no documentation of a missed visit. This was confirmed with the Director of Quality. In HOS2 HV #3, the Surveyor noted the current plan of care ordered daily aide visits; however, there were four missed aide visits without documentation of the reason for the missed visits. This was confirmed with the Director of Quality. In HOS2 RR #4, the Surveyor noted the skilled nurse visit frequency was 2 - 3 x's per for the first two weeks; however, the patient was only seen one time the second week of services. In addition, the aide visit frequency was 1 week 1, 3 week 12; however, the patient was not seen the third week of service. There was no documentation of missed visits. This was confirmed with the Director of Quality.	§418.56(e)(2)	Standard
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 in the plan of care, consistent with the aide's training, and	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 10 patient records reviewed, the hospice aide did not perform care according to the aide plan of care.	§418.76(g)(2)(ii)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			that the aide is permitted to perform under state law.	In HOS2 HV #2, the Surveyor noted the aide plan of care indicated a shower daily; however, the aide did not perform a shower on 5 of 6 visit notes reviewed. This was confirmed with the Director of Quality.		
PC.04.01.05	2	Low Limited	Before the patient is discharged, the organization informs the patient of the kinds of continuing care, treatment, or services he or she will need. (See also PC.04.01.01, EP 10)	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 1 patient records reviewed where the patient was discharged from hospice services, the organization did not educate the patient about his or her follow-up care, treatment or services. In HOS2 RR #3, the Surveyor noted the hospice did not provide education to the patient, family or assisted living facility regarding the patient's follow-up care, treatment or services. This was confirmed with the Quality Director.		
PC.04.02.01	3	Low 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 & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 1 patient records reviewed where the patient was discharged, the hospice did not notify the attending physician of the availability of the discharge summary. In HOS2 RR #3, the Surveyor noted the organization did not inform the attending physician of the availability of the discharge summary. This was confirmed with the Director of Quality.	§418.104(e)(1)(i)	Standard
PC.04.02.01	4	Low 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	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 1 of 1 patient	§418.104(e)(1)(i)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			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.	records reviewed where the patient was transferred or discharged to another medicare faicility, the hospice did not provide the receiving facility with a copy of the hospice discharge summary. In HOS RR #1, the Surveyor noted the patient was transferred from the hospice inpatient unit to a skilled nursing facility for rehabilitation services; however, the hospice did not provide to the nursing facility a copy of the hospice discharge summary or a copy of the patient's clinical record. This was confirmed with the Director of Quality.		
RC.01.01.01	11	Moderate Pattern	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.	1). Observed in Record Review at Seasons Hospice & Palliative Care of Delaware, LLC (220 Continental Drive, Suite 407, Newark, DE) site . In 4 of 10 patient records reviewed, the patient record was not complete, promptly and accurately documented. In HOS2 HV #1, the Surveyor noted the interdisciplinary meeting notes for the first eight weeks of service were identical. Although the patient had complaints of constipation at the nursing visits during that time frame, there was no documentation of this discussion in the meeting notes. This was confirmed with the Director of Quality. In HOS2 HV #2, the Surveyor noted the nurse did not document the assessment of the rash to the groin area in clinical notes for the past several weeks. This was confirmed with the Director of Quality. In HOS2 RR #4, the Surveyor noted the nurse documented "small pinhole on buttock"; however, there was no documentation of the wound bed or periwound assessment. In addition, the aide completed four visits; however, the documentation was blank. This was confirmed with the Director of Quality.	§418.104	Standard

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Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
				In HOS2 RR #3, the Surveyor noted the discharge summary was not promptly entered into the clinical record. The discharge summary was not entered into the clinical record until the day of survey. The patient was discharged eight weeks ago. This was confirmed with the Director of Quality.		

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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.
§418.54(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.
§418.64 Core Services	L587	§418.64 Condition of participation: Core services.
§418.64(d)(3)(i) Counseling services	L598	(i) Provide an assessment of the patient's and family's spiritual needs.
§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.
§418.104 Clinical Records	L671	A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

CoP	Tag	CoP Standard text
§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)(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.
§418.76(g)(2)(ii) Hospice aide assignments and duties	L626	(ii) Included in the plan of care.
§418.76(h)(1)(i) Supervision of hospice aides	L629	(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.
§418.104(e)(1)(i) Discharge or transfer of care	L682	(i) The hospice discharge summary; and

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Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
HR.01.03.01	14	Staff are supervised effectively.	For hospices that elect to use The Joint Commission deemed status option: In order to assess the quality of care and services provided by the hospice aide and to ensure that services ordered meet the patient's needs, the registered nurse supervises the hospice aide during an on-site visit to the patient's home no less frequently than every 14 days. If nursing services are not provided, a physical or occupational therapist or speech-language pathologist can supervise the hospice aide. Note: The aide does not need to be present during the supervisor's visit.
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 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 http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
IM.02.02.01	3	The organization effectively manages the collection of health information.	The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following: - U,u - IU - Q.D., QD, q.d., qd - Q.O.D., QOD, q.o.d, qod - Trailing zero (X.0 mg) - Lack of leading zero (.X mg) - MS - MSO4 - MgSO4 Note 1: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation. Note 2: The prohibited list applies to all orders, preprinted forms, and

Standard	EP	Standard Text	EP Text
			medication-related documentation. Medication-related documentation can be either handwritten or electronic.
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.04.01.01	2	Medication orders or prescriptions are clear and accurate. Note: For more information on verbal and telephone orders, refer to Standards RC.02.03.07 and PC.02.01.03.	For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization follows a written policy that defines the following: - The required elements of a complete medication order - The precautions for ordering medications with look-alike or sound-alike names - Actions to take when medication orders are incomplete, illegible, or unclear
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.
PC.01.02.01	5	The organization assesses and reassesses its patients.	Based on the patient's condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient's assessment and reassessment: - Pertinent diagnoses - Pertinent physical findings - Pertinent medical history - Functional status - Psychosocial status - Cultural or religious practices that may affect care - Care the family or support system is capable of and willing to provide - Educational needs, including the abilities, motivation, and readiness to learn - Barriers and safety hazards in the home environment - Any other relevant information that may affect the patient's goals
PC.01.02.01	7	The organization assesses and reassesses its patients.	The hospice's written definition of information the organization collects during assessment and reassessment includes the following: - The severity of symptoms - Factors that alleviate or exacerbate physical symptoms

Standard	EP	Standard Text	EP Text
			- 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 - For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals
PC.01.02.03	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 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

Standard	EP	Standard Text	EP Text
			- 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.02.01.03	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 in the plan of care, consistent with the aide's training, and that the aide is permitted to perform under state law.
PC.04.01.05	2	Before the organization discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, or services.	Before the patient is discharged, the organization informs the patient of the kinds of continuing care, treatment, or services he or she will need. (See also PC.04.01.01, EP 10)
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.01.01.01	11	The organization maintains complete and accurate patient records.	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.

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.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Frank W. Berry, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

March 23, 2020

Carla Griffin, Administrator
Seasons Hospice & Palliative Care
5775 Peachtree Dunwoody Road Ne Suite C-120
Atlanta, GA 30342-1556]

Dear Ms. Griffin:

Thank you for submitting your Plan of Correction outlining the measures you will be implementing to ensure that deficiencies noted during the State Licensure inspection are corrected.

The plan is acceptable and will become a part of the record and files of your facility. As the agency with the responsibility for recommending licensure, we insist that this Plan of Correction be carried out. A follow-up inspection to determine compliance may be conducted.

If you have any questions, please contact us at (404) 657-5700 or by email at Canessa.johnson@dch.ga.gov.

Sincerely,

Home Health & Hospice Programs
Healthcare Facility Regulation Division
Department of Community Health

MY

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-0244-H	A. BUILDING: _____ B. WING _____	R-C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

(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) COMPLETE DATE
{Z 000}	INITIAL COMMENTS. As of March 3, 2020, Seasons Hospice and Palliative Care is in compliance with Chapter 111-8-37, Rules and Regulations for Hospices, as a result of a follow-up survey conducted on 3/2/20-3/3/20. The following deficiencies were cited:	{Z 000}	This plan of correction constitutes our written allegation of compliance for 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 regulations.	3/17/2020
{Z1507} SS=D	111-8-37-.15(3) ASSESSMENT AND PLAN OF CARE. 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 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. This RULE is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the hospice failed to ensure the hospice social worker completed the initial comprehensive psychosocial assessment to assess the patient's psychosocial status and needs within five days of admission to hospice services for two of six (#1 and #4) patients who currently receive hospice services. Findings: 1. Review of the clinical record for patient #1 revealed that the patient was admitted on 1/25/20. Documentation revealed the social worker contacted patient on 1/29/20 and left a	{Z1507}	Training to the Standard: Regional Director of Learning & Development (RDLD) will retrain Social Workers (SW) on Comprehensive Assessment guidelines using Policy 212 & difference between "declining visit" and "declining services". RDLD will also retrain to specific documentation of who declined SW services. Monitoring for Compliance: SW comprehensive assessment will be reviewed by NCSS during IPOC locking and during IDG discussion of all new admits. Review of clinical mgt report by NCSS weekly will confirm all initial assessments are complete. Feedback will be provided to staff who are not completing the assessment visits timely or documenting within 24 hours. Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months	3/20/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carla Jeweleze Griffin | Executive Director | 3/19/20

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060-0244-H	A. BUILDING: _____ B. WING _____	R-C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

(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) COMPLETE DATE
{Z1507}	Continued From page 1 voicemail. The record revealed documentation at the 2/5/20 interdisciplinary team meeting that services had been declined. The record had no further documentation of additional attempts to contact patient. The record had no documentation that patient or representative had declined social work services. 2. Review of the clinical record for patient #4 revealed that the patient was admitted on 2/9/20. Documentation reflected that the social worker contacted the caregiver by phone on 2/12/20. The social worker documented the caregiver declined a visit at this time. The records revealed no further contact to arrange a visit. The clinical record lacked specific documentation that the caregiver was declining social work services. During an interview on 3/3/20 at 11:30 a.m. the executive director verified that social worker services had been declined by both patients, but agreed there was no clear documentation of patient refusal.	{Z1507}	see page 1	
Z1834 SS=D	111-8-37-.18(3)(d) NURSING SERVICES. A registered nurse must prepare for each personal care aide written instructions for patient care that are consistent with the interdisciplinary plan of care and must make and document supervisory visits to the terminally ill patient's residence or living facility at least every two weeks to assess the performance of the personal care aide services. This RULE is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the hospice	Z1834	Training to the Standard: NCSS/ED will train Nurses and aides to Protocol 2112, Aide Plan of Care, and associated process flow maps. NCSS to facilitate printing by the Team Assistant of HACP011 for IDG review the first 2 IDG meetings of each month; RNCM to review with aide after IDG and make corrections in the EMR. NCSS to train the leadership team on the proper way to audit the hospice aide note for accuracy and on the use of the Clinical Management Report (CMR) which has a section for hospice aide visit note compliance.	3/31/2020

Carla Jewelene Griffin
Executive Director
3/19/20

State of GA, Healthcare Facility Regulation Division

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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Z1834	Continued From page 2 failed to ensure that the registered nurse's written instructions on the hospice aide care plan reflected the specific tasks to be provided for 2 of 2 (#5 and #6) sampled current patients who received personal care services. Findings were: 1. Review of the clinical records for patient #5 and #6 revealed that the patient received hospice aide services for personal care. The clinical record included a hospice aide care plan that required the aide to perform catheter care twice a shift but lacked the specific instructions for the care such as with soap and water. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the hospice aide care plan was not specific, leaving the decision of how to perform the catheter care up to the hospice aide	Z1834	Monitoring for Compliance: Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months.	

Carla Jewelexe Griffin
Executive Director
3/19/20

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Frank W. Berry, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | www.dch.georgia.gov

March 23, 2020

Carla Griffin, Administrator
Seasons Hospice & Palliative Care
5775 Peachtree Dunwoody Road Ne Suite C-120
Atlanta, GA 30342-1556

Dear Ms. Griffin:

Thank you for submitting your Plan of Correction outlining the measures you will be implementing to ensure that deficiencies noted during the Medicare/Medicaid survey will be corrected.

The plan is acceptable and will become a part of the record and files of your facility. As the agency with the responsibility for recommending certification, we insist that this Plan of Correction is implemented. A follow-up inspection to determine compliance may be conducted. After a review of the status of your facility, we will determine if you continue to meet the requirements for Medicare/Medicaid recertification.

If you have any questions, please contact us at (404) 657-5700 or by email at Canessa.johnson@dch.ga.gov.

Sincerely,

Home Health & Hospice Programs
Healthcare Facility Regulation Division
Department of Community Health

MY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111640	A. BUILDING _____ B. WING _____	R-C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

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{L 000}	INITIAL COMMENTS At the time of the survey, Season's Hospice and Palliative Care was in compliance with 42 CFR Part 418.56; Interdisciplinary Group, Care Planning, and Coordination of Services, was placed back into compliance as a result of a follow up survey conducted on March 2-3, 2020. Standard level deficiencies were cited:	{L 000}	This plan of correction constitutes our written allegation of compliance for 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 regulations.	3/17/2020
{L 523}	TIMEFRAME FOR COMPLETION OF ASSESSMENT CFR(s): 418.54(b) 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. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the hospice failed to ensure the hospice social worker completed the initial comprehensive psychosocial assessment to assess the patient's psychosocial status and needs within five days of admission to hospice services for two of six (#1 and #4) patients who currently receive hospice services. Findings: 1. Review of the clinical record for patient #1 revealed that the patient was admitted on 1/25/20. Documentation revealed the social worker contacted patient on 1/29/20 and left a	{L 523}	Training to the Standard: Regional Director of Learning & Development (RDLD) will retrain Social Workers (SW) on Comprehensive Assessment guidelines using Policy 212 & difference between "declining visit" and "declining services". RDLD will also retrain to specific documentation of who declined SW services. Monitoring for Compliance: SW comprehensive assessment will be reviewed by NCSS during IPOC locking and during IDG discussion of all new admits. Review of clinical mgt report by NCSS weekly will confirm all initial assessments are complete. Feedback will be provided to staff who are not completing the assessment visits timely or documenting within 24 hours. Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months.	3/20/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Carla Jeuvedere Griffin | Executive Director | 3/9/20

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{L 523}	Continued From page 1 voicemail. The record revealed documentation at the 2/5/20 interdisciplinary team meeting that services had been declined. The record had no further documentation of additional attempts to contact patient. The record had no documentation that patient or representative had declined social work services. 2. Review of the clinical record for patient #4 revealed that the patient was admitted on 2/9/20. Documentation reflected that the social worker contacted the caregiver by phone on 2/12/20. The social worker documented the caregiver declined a visit at this time. The records revealed no further contact to arrange a visit. The clinical record lacked specific documentation that the caregiver was declining social work services. During an interview on 3/3/20 at 11:30 a.m. the executive director verified that social worker services had been declined by both patients, but agreed there was no clear documentation of patient refusal.	{L 523}	See Page 1	
{L 543}	PLAN OF CARE CFR(s): 418.56(b) All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. This STANDARD is not met as evidenced by: Based on clinical record review and staff	{L 543}	Training to the Standard: ED / NCSS to retrain nursing staff on Head to Toe Assessment & Reassessment and using those assessment findings to complete a thorough plan of care. ED / NCSS will review Policy 214 "Plan of Care" Protocol 2014 "IV Flushing Guidelines" Protocol 2005 "Wound Care" Addendum 2005a "Wound Care Derma Rite" Policy 301 "Medication Orders" Policy 222 "Orders from Licensed Providers" Policy 212 "Patient & Family Assessment" Policy 213 "Patient & Family Reassessment" Policy 205 "Interdisciplinary Group	3/31/2020

Carla Jeurdene Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

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{L 543}	Continued From page 2 interview, it was determined that the hospice failed to ensure that hospice care and services furnished to patients and their families followed an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire for three of six sampled patients (#3, #5 and #6) who were receiving hospice services. Findings were: 1. Review of the clinical record for patient #3 revealed that patient was admitted to the inpatient unit under general inpatient level of care on 2/29/20 with a terminal diagnosis of COPD. Admission orders were for continuous administration oxygen at 3 liters per minute via a nasal cannula. The patient also had an order for Bilevel positive airway pressure (BiPAP). The order had no specified frequency as in: continuous, as needed, or only at night. The medical record reveals no skilled nurse assessment findings of the patient wearing the BiPAP, only the oxygen, on record reviewed from 2/29/20-3/1/20. The record also did not have any orders to discontinue the BiPAP. The patient also had a peripheral intravenous access device in the right inner arm. The orders were to flush the device with 5 milliliters of normal saline daily and following administration of intravenous medications. The normal saline flush was not listed on the patient's medication list. The medical record nor the medication administration record documented daily flushes or flushes with intravenous medication administration. However, the medication administration record did reveal	{L 543}	Monitoring for Compliance: 7 supervisory joint visits with chart review will be completed each month to confirm that accurate and thorough assessments and follow up activities are occurring by each discipline on each visit. Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months	

Carla Jeweluxe Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{L 543}	Continued From page 3 the patient receiving the morphine sulfate intravenously throughout their stay. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the plan of care lacked identified clinical nursing assessments/needs and the plan of care was not followed. 2. Review of clinical record for patient #5 revealed the patient was admitted to the inpatient unit under general inpatient level of care on 2/27/20 with a terminal diagnosis of malignant neoplasm of the pancreas. The patient had a Foley catheter. The hospice aide care plan required the aide to perform catheter care twice per shift. The care plan did not specify the type of catheter care. There is no documentation that catheter care was performed on either shift on any records reviewed from 2/27/20-3/1/20. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the plan of care lacked identified clinical nursing assessments/needs and the plan of care was not followed. 3. Review of clinical record for patient #6 revealed the patient was admitted to the inpatient unit under general inpatient level of care on 2/25/20 with a terminal diagnosis of Parkinson's Disease. The patient also had a Foley catheter and the hospice aide care plan specified catheter care twice a shift. The care plan did not specify the type of catheter care. There is no documentation that catheter care was performed on either shift on any records reviewed from 2/25/20-3/2/20. Further review revealed on 2/26/20 the register nurse documented the	{L 543}	See page 3	

Carla Jeweleze Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{L 543}	Continued From page 4 patient had "complicated technical delivery of medication requiring registered nurse to do calibration, tubing changes, or site care." Patient does have three medications requiring IV administration which are: Ativan 1 milligram intravenous (IV) every 4 hours as needed for agitation, Morphine Sulfate 10 milligrams IV three times a day at 8 am, 2 pm, and 8 pm, and Robinul 0.2 milligram IV every 4 hours as needed for secretions. Further review of the medical record and medication administration record did not reveal any other specific orders or assessment finding for an intravenous access device, yet the orders were for at least one scheduled IV medication. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the plan of care lacked identified clinical nursing assessments/needs and the hospice aide care plan was not specific and not followed 4. Review of the clinical record for patient #4 revealed that patient was admitted on 2/9/20 with a terminal diagnosis of non traumatic intracerebral hemorrhage. The patient also has a Foley catheter. On the initial plan of care the orders read: maintain Foley catheter, size: 14 French; balloon size: 10cc of saline. Change: prn (as needed). The skilled nurse assessment on 2/17/20 does not reference a catheter. The assessment findings read: incontinent, adult undergarments, number per day 3. The 2/27/20 skilled nurse assessment reads urinary catheter 16 French, balloon volume 5, balloon size During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the plan of care lacked consistent clinical nursing	{L 543}	See page 3	

Carla Jeudere Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111640	A. BUILDING _____ B. WING _____	R-C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

(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 543}	Continued From page 5 assessments/needs and the orders at not specific in keeping with standards of care. 5. Review of patient records revealed initial plan of care not consistently signed by the registered nurse for 6 of 6 patients (#1, #2, #3, #4, #5, and #6) who are receiving hospice services. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the plan of care lacked registered nurse signatures. The director stated this was due to their electronic medical record program(EMR), but the agency is committed to correcting this problem. The director stated they would print plan of cares for signature and are planning on changing EMR programs later this year.	{L 543}	See page 3	
{L 544}	PLAN OF CARE CFR(s): 418.56(b) 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. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined the hospice failed to 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 for 1 of 6 (#4) sampled patients receiving hospice services. Finding were:	{L 544}	Training to the Standard: ED / NCSS will re-train nursing staff to ensure that all relevant patient/caregiver training is provided and documented. This training will correlate to patient assessed needs, interventions, DME, medications, disease progression, and care plans. Documentation of education will include care plan that identifies who is teaching and who is being taught and visit documentation will include their understanding of education and agreement of plan of care. ED / NDCO will review: Policy 214 "Plan of Care" Policy 224 "Patient & Family Education"	3/31/2020

Carla Jeneane Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	111640	A. BUILDING _____ B. WING _____	R-C 03/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HOSPICE & PALLIATIVE CARE	5775 PEACHTREE DUNWOODY ROAD NE SUITE C-120 ATLANTA, GA 30342

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{L 544}	Continued From page 6 1. Review of clinical records for patient #4 lacked documentation of patient specific education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care. Teaching was documented in broad generalities: Medication side effects and monitoring and reporting, as opposed to which medications and side effects were taught. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the patient teaching was generalized and not patient specific.	{L 544}	Monitoring for Compliance: 7 supervisory joint visits with chart r eview will be completed each month to ensure that staff are providing and documenting effective training for patients/caregivers. Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months.	
L 625	HOSPICE AIDE ASSIGNMENTS AND DUTIES CFR(s): 418.76(g)(1) (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. This STANDARD is not met as evidenced by: Based on clinical record review and staff interview, it was determined that the hospice failed to ensure that the registered nurse's written instructions on the hospice aide care plan reflected the specific tasks to be provided for 2 of 2 (#5 and #6) sampled current patients who received personal care services. Findings were: 1. Review of the clinical records for patient #5 and #6 revealed that the patient received hospice	L 625	Training to the Standard: NCSS/ED will train Nurses and aides to Protocol 2112, Aide Plan of Care, and associated process flow maps. NCSS to facilitate printing by the Team Assistant of HACP011 for IDG review the first 2 IDG meetings of each month; RNCM to review with aide after IDG and make corrections in the EMR. NCSS to train the leadership team on the proper way to audit the hospice aide note for accuracy and on the use of the Clinical Management Report (CMR) which has a section for hospice aide visit note compliance. Monitoring for Compliance: Audit that is provided by NMQFC. 6 Inpatient Center charts & 4 home team charts q week. Reporting Trends: NCSS / ED to report results in weekly leadership meetings. Will continue until the compliance percentage goal of 85% of the answers "Yes" occur for 3 consecutive months.	3/31/2020

Carla Jewedexe Griffin
Executive Director
3/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 625	Continued From page 7 aide services for personal care. The clinical record included a hospice aide care plan that required the aide to perform catheter care twice a shift but lacked the specific instructions for the care such as with soap and water. During an interview on 3/3/20 at 11:30 a.m., the executive director confirmed that the hospice aide care plan was not specific, leaving the decision of how to perform the catheter care up to the hospice aide	L 625		

Carla Jeveleze Griffin
Executive Director
3/19/20

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Kansas City Regional Office
601 E12th Street, Suite 355
Kansas City, MO 64106

RE: PLAN OF CORRECTION

October 23, 2020

VIA EMAIL: dmullins@seasons.org

CMS Certification Number (CCN): 261641

Administrator
Seasons Hospice and Palliative Care of Missouri
3660 S Geyer Rd, Suite 120
Saint Louis, MO 63127

Dear Administrator,

This is to inform you that your plan of correction received on October 22, 2020 following our letter dated October 15, 2020 has been accepted.

The State agency will conduct an unannounced revisit survey to verify whether your hospice agency is in substantial compliance with the Medicare Conditions of Participation for hospice agencies.

If you have questions regarding this matter, please contact me at Elizabeth.Henningfeld1@cms.hhs.gov.

Sincerely,

Elizabeth A. Henningfeld -S

Digitally signed by Elizabeth A. Henningfeld -S
Date: 2020.10.23 12:03:03 -05'00'

Elizabeth Henningfeld, JD
Health Insurance Specialist
Division of Survey & Certification
Non-Long Term Branch-Kansas City

cc: MODHSS
MO Medicaid
JC

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Kansas City Regional Office
601 E12th Street, Suite 355
Kansas City, MO 64106

RE: PRELIMINARY NOTICE OF MEDICARE TERMINATION & CONTINUED REMOVAL OF DEEMED STATUS

October 15, 2020

VIA EMAIL: dmullins@seasons.org

CMS Certification Number (CCN): 261641

Administrator
Seasons Hospice and Palliative Care of Missouri
3660 S Geyer Rd, Suite 120
Saint Louis, MO 63127

Dear Administrator,

The Centers for Medicare & Medicaid Services has received and reviewed the report of the October 7, 2020 follow-up survey conducted by the State of Missouri following receipt of your plan of correction based on citations made following a complaint survey that occurred on August 12, 2020. Based on our review of the revisit survey findings, we have determined that your Hospice now complies with the following Medicare Condition of Participation for Hospice Agencies:

- 42 CFR § 418.64 Core Services

However, the Centers for Medicare & Medicaid Services has also received and reviewed the report of an October 7, 2020 survey conducted by the State of Missouri following a second complaint against your hospice agency. Based on our review of these complaint survey findings, we have determined that your Hospice does not comply with the following Medicare Condition of Participation for Hospice Agencies:

- 42 CFR § 418.52 Patient Rights

We have determined that the deficiencies are significant and limit your hospices' capacity to render adequate care and ensure the health and safety of your patients. Enclosed is a complete listing of all deficiencies cited. In accordance with Section 1865 of the Social Security Act and implementing regulations at 42 CFR § 488.5, a provider accredited by the Joint Commission (JC) is deemed to meet Medicare Conditions of Participation. Section 1864(c) of the Act requires the Secretary of Health and Human Services to survey an accredited hospice participating in Medicare if there are substantial allegations, which suggest the existence of a significant deficiency or deficiencies which would adversely affect the health and safety of patients.

If, in the course of such a survey, a hospice is found not to meet one or more Conditions of Participation and a significant deficiency exists, the hospice is no longer deemed to meet the Medicare Conditions of Participation. With notification to the accrediting agency, the hospice is then placed under the survey jurisdiction of the State survey agency. In addition, when a hospice does not meet the requirements established under Title XVIII of the Social Security Act and the additional requirements established by the Secretary of Health and Human Services under the authority contained in Section 1861 of the Social Security Act, Section 1866(b) authorizes the Secretary to terminate the hospice's participation from the Medicare program.

REMOVAL OF DEEMED STATUS

Therefore, based on the determination that your hospice agency still does not comply with the Conditions of Participation and that significant deficiencies exist, your hospice continues to be no longer deemed. Please be advised that removal of deemed status is an administrative action, not an initial determination by the Secretary. Therefore, formal reconsideration and hearing procedures do not apply. See 42 C.F.R. §§ 498.3(b), (d)(9), (d)(12).

TERMINATION OF MEDICARE PROVIDER AGREEMENT

However, in addition to your continued loss of deemed status, and based on the findings of noncompliance cited in the Statement of Deficiencies (Form CMS 2567) and pursuant to the statutory provisions at Section 1866 of the Act and the Federal Regulation at 42 CFR § 489.53, **your provider agreement is subject to termination on January 13, 2021.** The Medicare health insurance program will not make payment for services furnished to patients admitted on or after January 13, 2021. For patients admitted prior to January 13, 2021, payment may continue to be made for up to 30 days of services furnished on or after January 13, 2021.

In accordance with Federal regulations at 42 CFR 489.53(d), we will also publish a notice to the public of the termination. Termination can only be averted by correction of these deficiencies immediately. Should we not hear from you, we will assume that the deficiencies have not been corrected.

If you cannot achieve compliance by the termination date, you may reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act.

PLAN OF CORRECTION/CREDIBLE ALLEGATION OF COMPLIANCE

If you believe you are now in compliance with the Medicare Conditions of Participation, please **notify this office immediately in writing but no later than October 25, 2020.** If we determine that your allegation of compliance is credible, we will authorize a resurvey of your Hospice.

Your plan of correction needs to:

- Clearly state the specific nature of the corrective actions for each deficiency;
- Set reasonable completion dates for all deficiencies prior to the termination date unless an extension is requested and approved;
- Describe how the plan or action will prevent recurrence; and
- Describe who will be the person responsible for implementing and monitoring the plan for future compliance with the federal regulations.

The plan of correction must be signed and dated on the bottom of the first page of the CMS-2567 by the authorized official at your facility. Additional documentation may be attached to the CMS-2567 when necessary. If a deficiency has been corrected since the survey, this should also be indicated along with the date of correction.

You must submit your plan of correction to both the Centers for Medicare & Medicaid Services (CMS) and the Missouri Department of Health and Senior Services. The plan of correction can be sent to CMS to the attention of Elizabeth Henningfeld at Elizabeth.Henningfeld1@cms.hhs.gov **and** to Missouri Division of Health and Senior Services to the attention of Lisa Coots at hospiceproviders@health.mo.gov. Staff will review the hospice's plan. If it is found to be credible, surveyors will conduct an unannounced survey to verify Hospice staff have implemented necessary corrections and the Hospice is once again in compliance with all conditions of participation. Should we not hear from you, we assume that the situation and deficiencies have not been corrected. After the survey, we will communicate to you in writing the findings of that revisit survey and any further actions we will take.

In you have questions regarding this matter, please contact me at elizabeth.henningfeld1@cms.hhs.gov.

Sincerely,

Elizabeth A. Henningfeld -S

Digitally signed by Elizabeth A. Henningfeld -S
Date: 2020.10.15 08:57:42 -05'00'

Elizabeth Henningfeld, JD
Acting Acute & Continuing Care Branch Manager
Survey & Operations Group
CMS Kansas City

Enclosure: Statement of Deficiencies (2567)

cc: Missouri DHSS
Missouri Medicaid
JC

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 _____	R-C 10/07/2020

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 follow-up survey to the complaint survey of 8/12/2020 was completed on 10/07/2020. The agency had 179 current patients. The following condition was corrected: - §418.64 Condition of Participation: Core Services	{L 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 000	INITIAL COMMENTS A complaint investigation MO00176419 was completed on 10/07/2020 at Seasons Hospice and Palliative Care of Missouri. The agency had 179 current patients. The complaint was substantiated. One or more of the allegations reported are verified and deficiencies were cited that are related to the allegations being investigated. One condition-level deficiency is identified at §418.52 Patient's Rights.	L 000		
L 500	PATIENTS' RIGHTS CFR(s): 418.52 This CONDITION is not met as evidenced by: Based on policy review, clinical record review, and interview, the agency failed to ensure: - Alleged violations involving misappropriation of the patient property are reported immediately to hospice administrator (L508); - Violations are immediately investigated (L509); and - Verified violations were reported to State and local bodies having jurisdiction within five working days (L511). The cumulative effect of these deficient practices has the potential to adversely affect the protection of patient rights and the safety of all the agency's patients.	L 500		
L 508	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON CFR(s): 418.52(b)(4)(i) The hospice must:	L 508		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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L 508	Continued From page 1 (i) Ensure that 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 furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator; This STANDARD is not met as evidenced by: Based on policy review, record review, and interview, the agency failed to ensure that alleged violations involving misappropriation of patient property were reported immediately to the agency administrator in one (Record/Patient #3) of three records reviewed. This deficient practice has the potential to adversely affect the patient's right to be free from misappropriation of property for all the agency's patients. Findings included: Review of the agency's policy titled, "Suspected Abuse, Neglect, or Exploitation," dated 03/22/2019 showed, in part, the following: - Any employee, volunteer, or contracted staff who discovers any exploitation will immediately (as soon as possible, but not more than (24) hours after discovery of the incident) report their observations to the team director or administrator-on-call, who will then inform the executive director; - The executive director will immediately (as soon as possible, but not more than (24) hours after being notified of the incident) initiate an investigation of all alleged violations; - The executive director will make sure that	L 508		

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L 508	Continued From page 2	L 508		

verified violations are reported to State and local bodies having jurisdiction (including to the State Survey and Certification agency) within 5 days of becoming aware of the violation;
-Documentation of the investigation should be made in an adverse event report; and
- The definition of exploitation is the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

RECORD/PATIENT #3:
Review of the clinical record showed the patient was admitted to hospice services on 05/29/2020 with a terminal diagnosis of end-stage renal disease (kidney disease that leads to death). The patient lived alone at home but had children that lived close and helped with care.

Review of the record showed a nurse visit note dated 09/19/2020 by registered nurse (RN) A. The narrative note showed an FYI (for your information) The patient does not have a comfort pack.

During an interview on 10/07/2020 at 11:10 AM, the on-call registered nurse, RN A, stated that:
- When he/she made the visit on 09/19/2020, it was on a weekend and he/she noticed the patient did not have a comfort kit (package of medications frequently needed for end-of-life care);
- He/she "checked" and found out it had never been ordered for this patient; and
- Was not concerned that it was not in the home.

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L 508	Continued From page 3	L 508		

Continued review of the clinical record showed a nurse visit note dated 09/24/2020 completed by registered nurse (RN) B. The documentation showed:
- The comfort kit was not in the refrigerator and was apparently missing;
- The patient also stated that her purse was stolen yesterday (09/23/2020) and all of her identification cards and medicines were in the purse;
- The patient also stated he/she had the Percocet (combination drug with narcotic for pain control) in his/her sweater pocket and was not stolen; and
- A new comfort kit order was requested from attending physician.

During an interview on 10/07/2020 at 11:30 AM, the case manager registered nurse (RN) B stated that:
- He/she received a report from the weekend nurse, RN A, that on 09/19/2020, the comfort kit was not found in the patient's home;
- The comfort kit was delivered to the patient's home, RN B checked on it, and knew it was in the refrigerator prior to 09/19/2020;
- On the 09/24/2020 skilled nurse visit, the comfort kit was not found in the refrigerator;
- The patient reported that his/her purse containing medications was also stolen;
- The patient also reported that other items were missing from the home;
- The patient had two children that had opioid addiction;
- The daughter was at the home during the visit and was aware of the missing items and was sure the purse was misplaced and they would find it;
- He/she was unsure if the team leader was informed of the missing items;

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L 508	Continued From page 4	L 508		

- As of 10/01/2020, the items had not been found; and
- The patient requested to not have a comfort kit in the home "since it would just come up missing, too."

During an interview on 10/07/2020 at 2:30 PM, the team leader registered nurse (RN) C stated that:
- The patient missing a comfort kit and purse, sounded familiar and he/she may have heard about it on the end-of-day report or someone may have called and reported it;
- He/she checked the end-of-day reports and did not find it mentioned on 09/24/2020;
- He/she did not remember RN B calling and reporting missing items;
- If this had been reported, he/she would have responded by initiating an adverse event report which would go to the clinical director and then to the executive director; and
- RN B should have reported this to the team leader.

An interview was conducted with the executive director on 10/07/2020 at 2:54 PM. He/she stated that:
- Misappropriation of property was exploitation of the patient; and
- "You would think the employee would have reported this to a supervisor"; and
- The staff were trained at orientation and yearly on abuse and neglect, mandatory reporting, and agency procedures.

The agency's employee failed to report misappropriation of the patient's property to the agency executive director.

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L 509	Continued From page 5	L 509		
L 509	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON CFR(s): 418.52(b)(4)(ii) [The hospice must:] (ii) 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. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures; This STANDARD is not met as evidenced by: Based on policy review, record review, and interview, the agency failed to: - Immediately investigate the alleged violations and immediately take action to prevent further potential violation while the alleged violation was being verified; and - Conduct the investigation and the documentation of the violations in accordance with established procedures. These failures occurred in one (Record/Patient #3) of three records reviewed. This deficient practice has the potential to adversely affect the patient's right to be free from misappropriation of property for all the agency's patients. Findings included: Review of the agency's policy titled, "Suspected Abuse, Neglect, or Exploitation," dated 03/22/2019 showed, in part, the following: - Any employee, volunteer, or contracted staff who discovers any exploitation will immediately	L 509		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 509	Continued From page 6	L 509		

(as soon as possible, but not more than (24) hours after discovery of the incident) report their observations to the team director or administrator-on-call, who will then inform the executive director;
- The executive director will immediately (as soon as possible, but not more than (24) hours after being notified of the incident) initiate an investigation of all alleged violations;
- The executive director will make sure that verified violations are reported to State and local bodies having jurisdiction (including to the State Survey and Certification agency) within 5 days of becoming aware of the violation;
-Documentation of the investigation should be made in an adverse event report; and
- The definition of exploitation is the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

RECORD/PATIENT #3:
Review of the clinical record showed the patient was admitted to hospice services on 05/29/2020 with a terminal diagnosis of end-stage renal disease (kidney disease that leads to death). The patient lived alone at home but had children that lived close and helped with care.

Review of the record showed a nurse visit note dated 09/19/2020 by registered nurse (RN) A. The narrative note showed an FYI (for your information) The patient does not have a comfort pack.

During an interview on 10/07/2020 at 11:10 AM,

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 10/07/2020

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 509	Continued From page 7	L 509		

the on-call registered nurse, RN A, stated that:
- When he/she made the visit on 09/19/2020, it was on a weekend and he/she noticed the patient did not have a comfort kit (package of medications frequently needed for end-of-life care);
- He/she "checked" and found out it had never been ordered for this patient; and
- Was not concerned that it was not in the home.

Continued review of the clinical record showed a nurse visit note dated 09/24/2020 completed by registered nurse (RN) B. The documentation showed:
- The comfort kit was not in the refrigerator and was apparently missing;
- The patient also stated that her purse was stolen yesterday (09/23/2020) and all of her identification cards and medicines were in the purse;
- The patient also stated he/she had the Percocet (combination drug with narcotic for pain control) in his/her sweater pocket and was not stolen; and
- A new comfort kit order was requested from attending physician.

During an interview on 10/07/2020 at 11:30 AM, the case manager registered nurse (RN) B stated that:
- He/she received a report from the weekend nurse, RN A, that on 09/19/2020, the comfort kit was not found in the patient's home;
- The comfort kit was delivered to the patient's home, RN B checked on it, and knew it was in the refrigerator prior to 09/19/2020;
- On the 09/24/2020 skilled nurse visit, the comfort kit was not found in the refrigerator;
- The patient reported that his/her purse containing medications was also stolen;

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 10/07/2020

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 509	Continued From page 8	L 509		

- The patient also reported that other items were missing from the home;
- The patient had two children that have opioid addiction;
- The daughter was at the home during the visit and was aware of the missing items and was sure the purse was misplaced and they would find it;
- He/she was unsure if the team leader was informed of the missing items;
- As of 10/01/2020, the items had not been found; and
- The patient requested to not have a comfort kit in the home "since it would just come up missing, too."

During an interview on 10/07/2020 at 2:30 PM, the team leader registered nurse (RN) C stated that:
- The patient missing a comfort kit and purse, sounded familiar and he/she may have heard about it on the end-of-day report or someone may have called and reported it;
- He/she checked the end-of-day reports and did not find it mentioned on 09/24/2020;
- He/she did not remember RN B calling and reporting missing items;
- If this had been reported, he/she would have responded by initiating an adverse event report which would go to the clinical director and then to the executive director; and
- RN B should have reported this to the team leader.

An interview was conducted with the executive director on 10/07/2020 at 2:54 PM. He/she stated that:
- Misappropriation of property was exploitation of the patient;

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 10/07/2020

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 509	Continued From page 9 - "You would think the employee would have reported this to a supervisor;" and - There have been no complaints or grievances since the prior survey in August. The agency failed to investigate misappropriation of the patients property and medications and failed to immediately take action to prevent further potential violations from occurring.	L 509		
L 511	EXERCISE OF RIGHTS/RESPECT FOR PROPRTY/PERSON CFR(s): 418.52(b)(4)(iv) [The hospice must:] (iv) Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation. This STANDARD is not met as evidenced by: Based on policy review, record review, and interview, the agency failed to ensure that the verified violations were reported to the State body having jurisdiction (including the State Survey and Certification Agency) within five working days of becoming aware of the violation in one (Record/Patient #3) of three records reviewed. This deficient practice has the potential to adversely affect the patient's right to be free from misappropriation of property for all the agency's patients. Findings included: Review of the agency's policy titled, "Suspected Abuse, Neglect, or Exploitation," dated	L 511		

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 10/07/2020

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 511	Continued From page 10 03/22/2019 showed, in part, the following: - Any employee, volunteer, or contracted staff who discovers any exploitation will immediately (as soon as possible, but not more than (24) hours after discovery of the incident) report their observations to the team director or administrator-on-call, who will then inform the executive director; - The executive director will immediately (as soon as possible, but not more than (24) hours after being notified of the incident) initiate an investigation of all alleged violations; - The executive director will make sure that verified violations are reported to State and local bodies having jurisdiction (including to the State Survey and Certification agency) within 5 days of becoming aware of the violation; -Documentation of the investigation should be made in an adverse event report; and - The definition of exploitation is the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets. RECORD/PATIENT #3: Review of the clinical record showed the patient was admitted to hospice services on 05/29/2020 with a terminal diagnosis of end-stage renal disease (kidney disease that leads to death). The patient lived alone at home but had children that lived close and helped with care. Review of the record showed a nurse visit note dated 09/19/2020 by registered nurse (RN) A. The narrative note showed an FYI (for your information) The patient does not have a comfort	L 511		

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 10/07/2020

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 511	Continued From page 11	L 511		

pack.

During an interview on 10/07/2020 at 11:10 AM, the on-call registered nurse, RN A, stated that:
- When he/she made the visit on 09/19/2020, it was on a weekend and he/she noticed the patient did not have a comfort kit (package of medications frequently needed for end-of-life care);
- He/she "checked" and found out it had never been ordered for this patient; and
- Was not concerned that it was not in the home.

Continued review of the clinical record showed a nurse visit note dated 09/24/2020 completed by registered nurse (RN) B. The documentation showed:
- The comfort kit was not in the refrigerator and was apparently missing;
- The patient also stated that her purse was stolen yesterday (09/23/2020) and all of her identification cards and medicines were in the purse;
- The patient also stated he/she had the Percocet (combination drug with narcotic for pain control) in his/her sweater pocket and was not stolen; and
- A new comfort kit order was requested from attending physician.

During an interview on 10/07/2020 at 11:30 AM, the case manager registered nurse (RN) B stated that:
- He/she received a report from the weekend nurse, RN A, that on 09/19/2020, the comfort kit was not found in the patient's home;
- The comfort kit was delivered to the patient's home, RN B checked on it, and knew it was in the refrigerator prior to 09/19/2020;
- On the 09/24/2020 skilled nurse visit, the

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 10/07/2020

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 511	Continued From page 12	L 511		

comfort kit was not found in the refrigerator;
- The patient reported that his/her purse containing medications was also stolen;
- The patient also reported that other items were missing from the home;
- The patient had two children that have opioid addiction;
- The daughter was at the home during the visit and was aware of the missing items and was sure the purse was misplaced and they would find it;
- He/she was unsure if the team leader was informed of the missing items;
- As of 10/01/2020, the items had not been found; and
- The patient requested to not have a comfort kit in the home "since it would just come up missing, too."

During an interview on 10/07/2020 at 2:30 PM, the team leader registered nurse (RN) C stated that:
- The patient missing a comfort kit and purse, sounded familiar and he/she may have heard about it on the end-of-day report or someone may have called and reported it;
- He/she checked the end-of-day reports and did not find it mentioned on 09/24/2020;
- He/she did not remember RN B calling and reporting missing items;
- If this had been reported, he/she would have responded by initiating an adverse event report which would go to the clinical director and then to the executive director; and
- RN B should have reported this to the team leader.

An interview was conducted with the executive director on 10/07/2020 at 2:54 PM. He/she stated

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 10/07/2020

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 511	Continued From page 13 that: - Misappropriation of property was exploitation of the patient; - The employee should have reported this to a supervisor; and - There have been no complaints or grievances since the prior survey in August. The agency failed to investigate misappropriation of the patients property and medications and failed to inform the State of Missouri Survey and Certification Agency.	L 511		

Final Accreditation Report

Seasons Hospice & Palliative Care of Texas, Inc.
6341 Campus Circle Dr. East, Suite 150
Irving, TX 75063

Organization Identification Number: 448165
60-day Evidence of Standards Compliance Submitted: 6/20/2019

ESC Programs Reviewed
Home Care

Final Report: Posted 6/28/2019

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	6/20/2019	No Requirements for Improvement	None	None

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score
§418.54	L520	Compliant
§418.54(c)(6)(i)	L530	Compliant
§418.56	L538	Compliant
§418.56(c)	L545	Compliant
§418.56(c)(2)	L547	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
PC.01.02.01	Compliant
PC.01.03.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
PC.01.02.01	11	The organization assesses and reassesses its patients.	For hospices that elect to use The Joint Commission deemed status option: The organization assesses potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy.
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	15	The organization plans the patient's care.	For hospices that elect to use The Joint Commission deemed status option: The plan of care includes an assessment of the patient's needs and an identification of the provided services, including the management of discomfort and symptom relief.
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

Final Accreditation Report

Seasons Hospice & Palliative Care of Texas, Inc.
6341 Campus Circle Dr. East, Suite 150
Irving, TX 75063

Organization Identification Number: 448165
Evidence of Standards Compliance Submitted: 6/5/2019

ESC Programs Reviewed
Home Care

Final Report: Posted 6/12/2019

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	6/5/2019	No Requirements for Improvement	None	None

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
IC.01.03.01	Compliant

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
IC.01.03.01	3	The organization identifies risks for acquiring and spreading infections.	The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.

Final Accreditation Report

Seasons Hospice & Palliative Care of Texas, Inc.
6341 Campus Circle Dr. East, Suite 150
Irving, TX 75063

Organization Identification Number: 448165
60-day Evidence of Standards Compliance Submitted: 5/29/2019

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	5/29/2019	Requirements for Improvement	Evidence of Standards Compliance	Submit within 30 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 Standards Compliance (within 30 Calendar Days)
IC.01.03.01	3	Low / Widespread			✓

The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score
§418.113	E-0001	Compliant
§418.113(d)(2)	E-0039	Compliant
§418.113(d)(2)(iii)	E-0039	Compliant
§418.54	L520	Compliant
§418.54(b)	L523	Compliant
§418.54(c)(6)(iv)	L530	Compliant
§418.54(d)	L533	Compliant
§418.56	L538	Compliant
§418.56(c)	L545	Compliant
§418.58	L559	Compliant
§418.58(b)(2)(ii)	L564	Compliant

The Joint Commission
Requirements for Improvement Summary

Program: Home Care

Standard	Level of Compliance
EM.03.01.03	Compliant
IC.01.03.01	Non Compliant
NPSG.09.02.01	Compliant
PC.01.02.01	Compliant
PC.01.02.03	Compliant
PC.01.03.01	Compliant
PI.02.01.01	Compliant

The Joint Commission
Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
IC.01.03.01	3	Low Widespread	The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.	1). Observed in Infection Control System Tracer at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site. Organization failed to prioritize the identified risks for acquiring and spreading infections. Organization completed a risk analysis but did not identify or document any priorities based on the results of the analysis. Discussed with Director of Clinical Operations and Executive Director.		

The Joint Commission

Appendix

Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
EM.03.01.03	5	The organization evaluates the effectiveness of its Emergency Operations Plan.	Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of communications, resources and assets, staff, utilities (for facility-based care only), and patients. (See also EM.02.01.01, EP 2)
EM.03.01.03	13	The organization evaluates the effectiveness of its Emergency Operations Plan.	Management and staff evaluate all emergency response exercises and all responses to actual emergencies.
IC.01.03.01	3	The organization identifies risks for acquiring and spreading infections.	The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.
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 and severity of fall-related injuries.
PC.01.02.01	11	The organization assesses and reassesses its patients.	For hospices that elect to use The Joint Commission deemed status option: The organization assesses potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy.
PC.01.02.01	37	The organization assesses and reassesses its patients.	For hospices that elect to use The Joint Commission deemed status option: The update of the comprehensive assessment is based on changes that have taken place since the initial assessment and includes information about the patient's progress toward desired outcomes and a reassessment of the patient's response to care.
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 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.
PI.02.01.01	4	The organization compiles and analyzes data.	The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. (See also

The Joint Commission

Standard	EP	Standard Text	EP Text
			MC.01.01.01, EP 7)

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

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.

Final Accreditation Report

Seasons Hospice & Palliative Care of Texas, Inc.
6341 Campus Circle Dr. East, Suite 150
Irving, TX 75063

Organization Identification Number: 448165
Unannounced Full Event: 3/12/2019 - 3/15/2019

Program Surveyed
Home Care

Final Report: Posted 3/20/2019

The Joint Commission
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The Joint Commission
Executive Summary

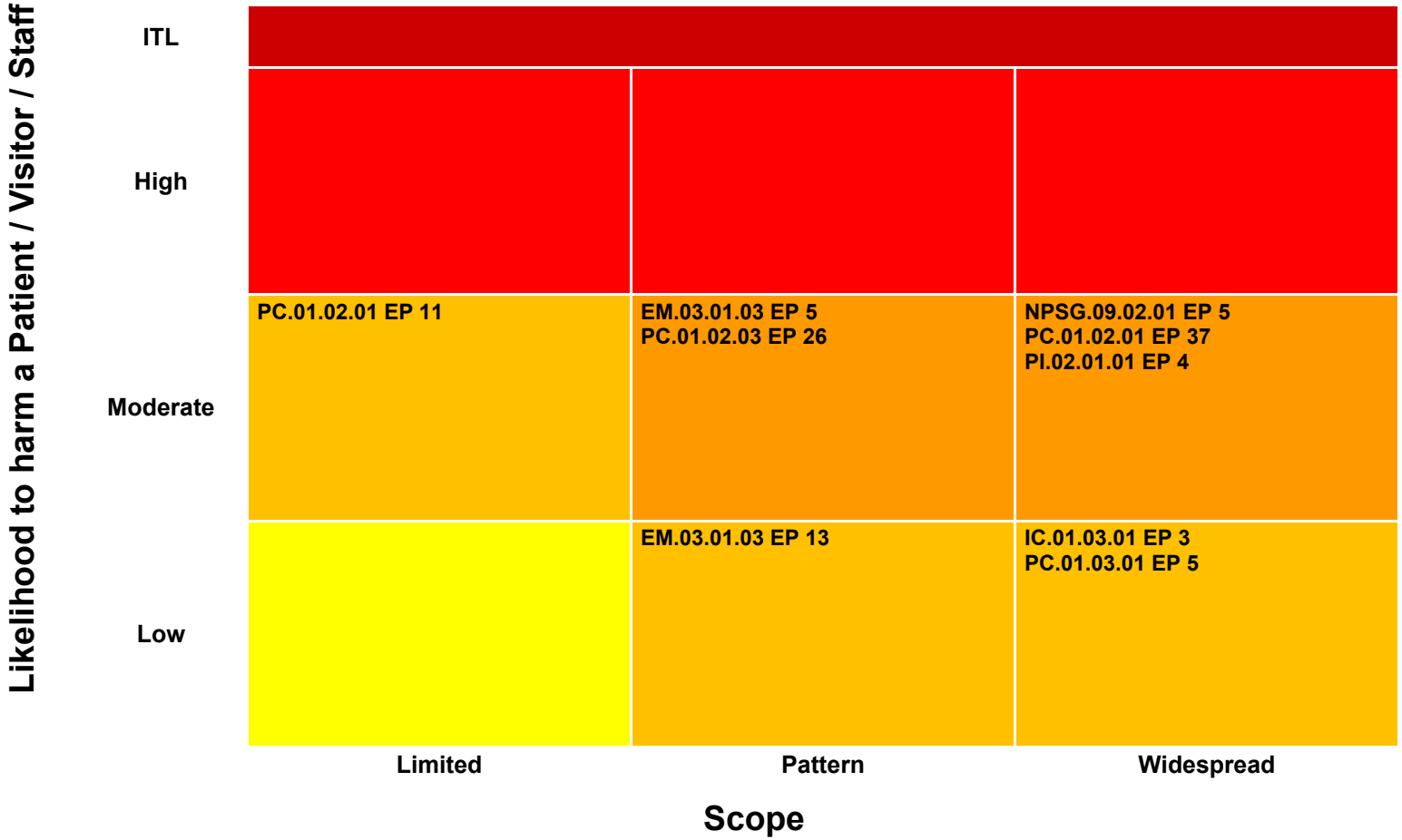
Program	Survey Dates	Event Outcome	Follow-up Activity	Follow-up Time Frame or Submission Due Date
Home Care	03/12/2019 - 03/15/2019	Requirements for Improvement	Clarification (Optional)	Submit within 10 Business Days from the final posted report date
			Unannounced Medicare Deficiency Survey	Survey within 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)
EM.03.01.03	13	Low / Pattern	§418.113 (d)(2)(iii)	E-0039		✓
	5	Moderate / Pattern	§418.113 (d)(2)	E-0039		✓
IC.01.03.01	3	Low / Widespread				✓
NPSG.09.02.01	5	Moderate / Widespread				✓
PC.01.02.01	11	Moderate / Limited	§418.54 (c)(6)(iv)	L530	✓	✓
	37	Moderate / Widespread	§418.54 (d)	L533	✓	✓
PC.01.02.03	26	Moderate / Pattern	§418.54 (b)	L523	✓	✓
PC.01.03.01	5	Low / Widespread	§418.56 (c)	L545	✓	✓
PI.02.01.01	4	Moderate / Widespread	§418.58 (b)(2)(ii)	L564		✓

The Joint Commission
SAFER™ Matrix
Program: Home Care



The Joint Commission
The Centers for Medicaid and Medicare Services (CMS) Summary

Program: Home Care

CoP(s)	Tag	CoP Score	Corresponds to:
§418.54	L520	Condition	
§418.54(b)	L523	Standard	OME/PC.01.02.03/EP26
§418.54(c)(6)(iv)	L530	Standard	OME/PC.01.02.01/EP11
§418.54(d)	L533	Standard	OME/PC.01.02.01/EP37
§418.56	L538	Condition	
§418.56(c)	L545	Condition	OME/PC.01.03.01/EP5
§418.58	L559	Standard	
§418.58(b)(2)(ii)	L564	Standard	OME/PI.02.01.01/EP4
§418.113	E-0001	Standard	
§418.113(d)(2)	E-0039	Standard	OME/EM.03.01.03/EP5
§418.113(d)(2)(iii)	E-0039	Standard	OME/EM.03.01.03/EP13

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Requirements for Improvement

Program: Home Care

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
EM.03.01.03	5	Moderate Pattern	Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of communications, resources and assets, staff, utilities (for facility-based care only), and patients. (See also EM.02.01.01, EP 2)	1). Observed in Emergency Management Session at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . Organization failed to conduct likely disaster scenarios that tested and evaluated all capabilities of the Emergency Operations Plan. Organization conducted internal fire drills annually (which they assigned a risk score of 0), which did not test the handling of all required elements of the EOP. Therefore, were unable to evaluate the full effectiveness of their EOP. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.113(d)(2)	Standard
EM.03.01.03	13	Low Pattern	Management and staff evaluate all emergency response exercises and all responses to actual emergencies.	1). Observed in Emergency Management Session at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . Organization failed to have management and staff evaluate the effectiveness of the Emergency Operations Plan. Since the last survey, only two drills/events were evaluated. Of the two evaluations that were completed, staff was not involved in the evaluation process per the documentation of the written evaluation reports provided by the organization. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.113(d)(2)(iii)	Standard
IC.01.03.01	3	Low Widespread	The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.	1). Observed in Infection Control System Tracer at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . Organization failed to prioritize the identified risks for acquiring and spreading infections. Organization completed a risk analysis but did not identify or document any priorities based on the results of the analysis. Discussed with Director of Clinical Operations and Executive 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 and severity of fall-related injuries.	1). Observed in Data Session at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . Organization failed to evaluate the effectiveness of the falls reduction activities for 2017 and 2018. Raw data was collected, however, outcome indicators were not calculated or evaluated for 2017 and 2018. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.		
PC.01.02.01	11	Moderate Limited	For hospices that elect to use The Joint Commission deemed status option: The organization assesses potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy.	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . In 1 of 2 home visits conducted, organization failed to assess potential medication related problems, including noncompliance with drug therapy, as evidenced by the absence of any discussion, assessment, or reconciliation of the medications during HV#1. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.54(c)(6)(iv)	Standard
PC.01.02.01	37	Moderate Widespread	For hospices that elect to use The Joint Commission deemed status option: The update of the comprehensive assessment is based on changes that have taken place since the initial assessment and includes information about the patient's progress toward desired outcomes and a reassessment of the patient's response to care.	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . In 3 of 3 patient records reviewed, organization failed to update the patient's care plan reflective of the most recent comprehensive assessment. Patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care was not updated on the care plan following IDG for RR#8, RR#9, and RR#10. All three of these patients had specific issues and changes in condition discussed at the IDG that was not reflected on the updated care plan. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.54(d)	Standard
PC.01.02.03	26	Moderate Pattern	For hospices that elect to use The Joint Commission deemed status option: The hospice's	1). Observed in Individual Tracer at Seasons Hospice & Palliative Care of Texas, Inc. (6341	§418.54(b)	Standard

Standard	EP	SAFER™ Placement	EP Text	Observation	CoP	CoP Score
			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.	Campus Circle Dr. East, Suite 150, Irving, TX) site . In 8 of 13 patient records reviewed, organization failed to complete the comprehensive assessment within five days of the election of hospice. The bereavement assessment was not completed by the required time frame for HV#2, HV#3, RR#1, RR#3, RR#8, and RR#9. The social worker assessment was not completed by the required time frame for HV#3, RR#1, RR#2, RR#7, RR#8, and RR#9. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.		
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 Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . In 13 of 13 patient records reviewed, organization failed to reflect time frames for the patient's goals on the written plan of care. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.56(c)	Condition
PI.02.01.01	4	Moderate Widespread	The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. (See also MC.01.01.01, EP 7)	1). Observed in Data Session at Seasons Hospice & Palliative Care of Texas, Inc. (6341 Campus Circle Dr. East, Suite 150, Irving, TX) site . Organization failed to analyze and compare internal data over time. Raw data was collected in the areas of patient satisfaction, complaints/grievances, medication errors, and adverse events. However, outcome indicators were not calculated or evaluated to identify levels of performance, patterns, trends, or variations. Discussed with Clinical Operations Director, Executive Director, National Director of Quality and Compliance, and National Director of Clinical Operations.	§418.58(b)(2)(ii)	Standard

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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.
§418.54(c)(6)(iv) Content of the comprehensive assessment	L530	(iv) Duplicate drug therapy.
§418.54(d) Update of the comprehensive assessment	L533	§418.54(d) Standard: Update of the comprehensive assessment. The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.
§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:
§418.58 Quality assessment and performance improvement.	L559	§418.58 Condition of participation: Quality assessment and performance improvement.
§418.58(b)(2)(ii) Program data	L564	(ii) Identify opportunities and priorities for improvement.
§418.113 Establishment of the Emergency Program (EP)	E-0001	418.113 Condition of participation: Emergency preparedness. The hospice must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospice must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

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CoP	Tag	CoP Standard text
§418.113(d)(2) Emergency Prep Testing Requirements	E-0039	(2) Testing. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
§418.113(d)(2)(iii) Emergency Prep Testing Requirements	E-0039	(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the hospice's emergency plan, as needed.

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Standard and EP Text

Program: Home Care

Standard	EP	Standard Text	EP Text
EM.03.01.03	5	The organization evaluates the effectiveness of its Emergency Operations Plan.	Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of communications, resources and assets, staff, utilities (for facility-based care only), and patients. (See also EM.02.01.01, EP 2)
EM.03.01.03	13	The organization evaluates the effectiveness of its Emergency Operations Plan.	Management and staff evaluate all emergency response exercises and all responses to actual emergencies.
IC.01.03.01	3	The organization identifies risks for acquiring and spreading infections.	The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.
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 and severity of fall-related injuries.
PC.01.02.01	11	The organization assesses and reassesses its patients.	For hospices that elect to use The Joint Commission deemed status option: The organization assesses potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy.
PC.01.02.01	37	The organization assesses and reassesses its patients.	For hospices that elect to use The Joint Commission deemed status option: The update of the comprehensive assessment is based on changes that have taken place since the initial assessment and includes information about the patient's progress toward desired outcomes and a reassessment of the patient's response to care.
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 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.
PI.02.01.01	4	The organization compiles and analyzes data.	The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. (See also

Standard	EP	Standard Text	EP Text
			MC.01.01.01, EP 7)

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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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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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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.