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By CERTIFICATE OF NEED PROGRAM at 4:52 pm, Jan 31, 2022

Hospice Agency Certificate of Need Application Packet

Contents:

Application submission must include:

- One electronic copy of your application, including any applicable attachments – no paper copy is required.
- A check or money order for the review fee of $21,968 payable to Department of Health.

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

Mail or deliver the application and review fee to:

Mailing Address:

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

Other Than By Mail:

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

Contact Us:
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

General Instructions:

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable.

Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA isn't required, it's highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

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CN22-35

Certificate of Need Application
Hospice Agency

Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and 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 Sherie Stewart COO Email Address sherie.stewart@envhh.com	Date January 27, 2022 Telephone Number 801-285-7247 ext. 601
Legal Name of Applicant Envision Hospice of Washington LLC Address of Applicant 1345 W. 1600 N., STE 202 Orem, UT 84057	Provide a brief project description ☐ New Agency ☑ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $ 0,000.00
Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately. Pierce County, Washington	

Overview

Envision Hospice of Washington LLC requests approval to expand its existing four-county Puget Sound area hospice to also provide Medicare-certified and Medicaid-approved hospice care to residents of Pierce County, Washington. Envision Hospice of Washington received Certificate of Need approval to establish its Thurston County hospice in September 2018; to expand its service area to Snohomish and King Counties in 2019 and to expand into Kitsap County in 2020.

The Washington Department of Health determined in November of 2021 that there is a need for an additional three hospice agencies in Pierce County. The Department's Hospice Need Model forecasts this need when a county's hospice agencies collectively fall below the state average of hospice utilization considering the projected population of the county. Envision Hospice's application provides documentation that many terminally-ill residents of Pierce County could receive care with better accessibility and availability.

Envision Hospice of Washington is uniquely suited to expand its current hospice services to serve the residents of Pierce County. Its founders are a group of nursing and rehabilitation professionals – nursing, physical therapy, occupational therapy, social work – that established home health and hospice agencies in the Salt Lake City Utah region over fifteen years ago. Envision Home Health of Washington received Medicare certification for its King County home health agency in 2015 and added Pierce County in 2017. In only four years, the diverse and energetic staff of the new agency has successfully navigated the Covid-19 pandemic.

The 2018 CON approval of its Thurston County hospice; the 2020 approval of service area expansions to King and Snohomish Counties and the 2021 approval of hospice expansion to Kitsap County facilitates Envision's ability to efficiently and effectively serve hospice patients across a broad geographic area of five Puget Sound area counties. Envision's experience in serving 20 Pierce County patients in 2020 and 121 patients in 2021 under Proclamation 20-36: Temporary Suspension of Certificate of Need Regulations & Facility Licensing Requirements demonstrates the further "proof of concept" that Envision service delivery model effectively serves Pierce County residents and should be approved to continue to serve hospice patients within Pierce County.

In light of the Department's current determination of substantial Pierce County hospice need, this application emphasizes the manner in which Envision intends to immediately meet that need. Envision wishes to bring new ideas and energy to the existing network of care. Beyond its excellent provision of basic hospice services, Envision has adopted four additional goals that support great depth and breadth of services to terminally-ill residents of the county and also to special groups that Envision Hospice intends to serve with compassionate and relevant end-of-life care.

Goal 1: Provide clinical focus and excellence in palliative care and, especially, in the care of patients with Alzheimer's disease and other dementias.

Goal 2: Make hospice care as accessible as possible in the broadest array of settings.

Goal 3: Respond with cultural competence to the needs of special groups among Pierce County residents.

Goal 4: Work to reduce suffering.

The program details, resources and financial support for these goals are described below in response to the application outline and in accompanying materials. These details describe the great breadth and depth of Envision's proposal and respond to many of the "tiebreakers" the Department's applies when selecting the superior alternative from among multiple applications.

Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

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 246-310-010(6).

   The legal name of the applicant is Envision Hospice of Washington, LLC. Envision Hospice of Washington, LLC, is a wholly-owned subsidiary of Envision Home Health of Washington, LLC.

   Envision Home Health of Washington, LLC
   Washington headquarters
   1818 S. Union Ave, Suite 1A
   Tacoma, WA 98405

   There is no "person or individual" of Envision Home Health of Washington, LLC or of Envision Holdco, LLC that has a 10% or greater financial interest.

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

   The legal structure of the applicant is as an LLC. The UBI is 604174080.

   Please see Appendix B for the Envision chart of organizations

   As the December 2021 Letter of Intent states, Envision Home Health of Washington, LLC is the sole member of Envision Hospice of Washington, LLC. Envision Home Health of Washington, LLC owns 100% of Envision Hospice of Washington, LLC. The UBI for Envision Hospice of Washington, LLC is 604174080

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

   Sherie Stewart, MSW
   Chief Operating Officer
   1345 W. 1600 N., Suite 202
   Orem, UT 84057
   801.285.7247 ext. 601 |
   sherie.stewart@envhh.com

4. **Provide the name, title, address, telephone number, and email address of the**

consultant authorized to speak on your behalf related to the screening of this application (if any).

Robert McGuirk
RMC Consulting
1606 NE 60th Ave.
Portland, OR 97213
503-287-4045
Rmconsulting1@qwestoffice.net

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

As the organization chart at Appendix B illustrates, Envision Hospice of Washington currently serves hospice patients in Thurston County, Kitsap County and King County, Washington and is preparing to serve patients in the fully implemented Snohomish County. It is affiliated through common ownership with Envision Home Health of Washington, LLC which operates home health agencies in King, Pierce, Snohomish and Thurston Counties, Washington. It also shares ownership with Envision Home Health, LLC (Utah) a home health and hospice agency serving five counties in the metropolitan area of Salt Lake City Utah and the greater region.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. 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**

Appendix V provides the identifying information requested in this question.

1) Envision Hospice of Washington, LLC

Envision Hospice of Washington received Certificates of Need to serve Thurston County in September 2018 and to serve Snohomish and King Counties in November 2019 and Kitsap County in October 2020.

Envision Home Health of Washington, LLC is the sole member of Envision Hospice of Washington, LLC. The mailing address of Envision Hospice of Washington's parent office in Washington State is:

Envision Hospice of Washington, LLC
402 Black Hills Lane SW

Suite 402-B
Olympia WA 98502

2) Envision Home Health of Washington LLC

Envision Home Health of Washington, LLC is a Medicare-certified and Medicaid-approved home health agency serving King and Pierce Counties. Envision Home Health provides a broad range of skilled services that includes nursing, physical therapy, occupational therapy, speech therapy, medical social services, and certified nurses' aides. These services are provided in the client's place of residence for the treatment of an illness or injury.

Envision Home Health also operates licensed-only home health in Snohomish and Thurston Counties, Washington.

Envision Home Health of Washington, LLC
1818 S. Union Ave, Suite 1A
Tacoma, WA 98405

3) Envision Home Health & Hospice – Utah

Envision's Utah operations are organized as Envision Home Health LLC, dba Envision Home Health & Hospice, dba Envision Hospice and dba Preferred Medical Group.

a) Envision Home Health is a Medicare/Medicaid-certified home health agency serving a multi-county region in Utah. It provides a broad range of skilled services that includes nursing, physical therapy, occupational therapy, speech therapy, medical social services, and certified nurses' aides. These services are provided in the client's place of residence for the treatment of an illness or injury.

b) Envision Hospice is a Medicare/Medicaid-certified hospice agency that serves the residents of five counties in the Salt Lake City region and surrounding area.

Envision Hospice of Utah provides in-home nursing; medical social services; physician services; counseling services, including spiritual counseling, dietary counseling, and bereavement counseling; hospice aide; volunteer; and homemaker services; physical therapy, occupational therapy, and speech-language pathology services; short-term inpatient care; medical supplies (including drugs and biologicals) and medical appliances.

Envision Parent Office
1345 W 1600 N
STE 202
Orem, UT 84057

Envision Home Health – Salt Lake Branch
990 West Atherton Drive, STE 100
Taylorsville, UT 84123

Envision Home Health – Northern Utah Branch
4155 Harrison Blvd., Ste 102
Ogden, Utah 84403

Envision Hospice – Parent Office
990 West Atherton Drive, STE 100
Taylorsville, UT 84123

Envision Hospice – Northern UT Branch
4155 Harrison Blvd., Ste 102
Ogden, Utah 84403

c) Preferred Medical Group

Envision Home Health LLC operates a physician outreach clinic that provides regular medical care to Utah and Washington patients unable to make the trip to a doctor's office. Staffed by physicians and ARNP's, Preferred Medical Group services are offered in Salt Lake region and Puget Sound Region assisted living facilities and individual patient homes. Preferred Medical Group NPI number (National Provider Identifier Preferred Medical Group NPI Number: 1003282567) and is able to bill Medicare and other payers for its services as a "physician visit."

Project Description

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

The mailing address for the Envision Hospice of Washington, LLC parent office is:

Envision Hospice of Washington, LLC
402 Black Hills Lane SW
Suite 402-B
Olympia WA 98502

Clinical leadership and case conference space for the Pierce expansion will be located in a portion of the existing Tacoma offices of the Washington state headquarters of Envision Home Health of Washington LLC. The address is:

1818 South Union Avenue, Suite 1A, Tacoma 98405.

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.**

The Envision Hospice of Washington, LLC will expand its services into Pierce County. Envision intends to contract with local Pierce County hospitals and skilled nursing homes for hospital and respite services. Clinical leadership for the Pierce County service area expansion will be located in a portion of the Tacoma offices of the Washington state headquarters of Envision Home Health of Washington LLC. The address is:

1818 South Union Avenue, Suite 1A, Tacoma 98405.

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.

Not applicable, this is not a new agency.

4. Provide a detailed description of the proposed project.

Approval is sought to expand the service area of an existing four-county Certificate of Need-approved hospice to also serve the residents of Pierce County, Washington. The Department of Health has determined there is unmet need for an additional 3 Medicare-certified hospices to serve residents of Pierce County. This project is proposed to address that unmet need.

The parent offices of Envision's Thurston County hospice, which received a Certificate of Need in September 2018, are located in Olympia, Washington. With recent CON approvals to add Snohomish County, King County and Kitsap County to its hospice service area, Envision's hospice services in those counties are fully implemented.

In addition to the provision of Medicare and Medicaid hospice services typically provided, Envision has established four goals for serving Pierce County residents with terminal illness:

Goal 1: Respond with focused capabilities to specific clinical groups with special needs.

Goal 2: Make hospice care as accessible as possible in the broadest array of settings.

Goal 3: Respond with cultural competence to the needs of special groups among Pierce County residents.

Goal 4: Work to reduce suffering.

The table below lists the scope of services comprising Medicare hospice and indicates which will be provided directly or will be contracted in Pierce County.

New Services	Medicare Hospice	Provided directly	Contracted

Nursing care	Required	x	
Medical social worker	Required	x	
Speech-language pathology services	Required		x
Physical and occupational therapies	Required		x
Dietary	Required		x
Pastoral care	Required	x	
Home care aide	Required	x	
Interdisciplinary team	Required	x	x
Case management	Required	x	
Medical Director	Required	x	
Medical appliances and supplies, including drugs and biologicals	Required		x
Inpatient hospital care for procedures necessary for pain control and acute and chronic system management	Required		x
Inpatient (nursing home) respite care to relieve home caregiver as necessary	Required		x
24-hour continuous care in the home at critical periods	Required	x	
Bereavement service for the family for 13 months	Required	x	
Available to nursing home residents	Yes	x	

The hospice interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

- A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).
- A registered nurse.
- A social worker.
- A pastoral or other counselor.

- Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.
- Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

- Nursing services.
- Medical social services.
- Physician services.
- Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling
- Hospice aide, volunteer, and homemaker services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Short-term inpatient care.
- Medical supplies (including drugs and biologicals) and medical appliances.

Envision goals for additional depth and breadth of services

In addition to the standard scope of services required under the Medicare hospice benefit Conditions of Participation, Envision Hospice of Washington LLC will provide additional services and/or benefits to Pierce County residents facing life-ending illness.

Additional depth and breadth of hospice services reflect four Envision service goals beyond the core capabilities of a Medicare-certified hospice. For detail regarding each of the four goals and Envision's planned activities supporting each, please see Envision Hospice's "Pierce County Program Detail."

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

a. Patients with Alzheimer's or other dementias and their caregivers

b. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible in the broadest array of settings including:

a. Telemedicine at home

b. Assisted living facilities
c. Adult family homes
d. Nursing homes
e. Homeless outreach
f. Mobile outreach clinics

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

a. Veterans
b. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

a. Excellence in palliative care
b. "Your Hand in Mine"
c. Death with Dignity

For detail regarding each of the four goals and Envision's planned activities supporting each, please see Envision Hospice's "Pierce County Program Detail."

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

The applicant (The legal name of the applicant is Envision Hospice of Washington, LLC. Envision Hospice of Washington, LLC, is a wholly-owned subsidiary of Envision Home Health of Washington, LLC and its members with a 10% interest or greater confirm that this agency will be available and accessible to the entire geography of Pierce County.

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:

Event	Anticipated Month/Year
CN Approval	September 2022
Design Complete (if applicable) – N.A.	September 2022
Construction Commenced (if applicable)	Not applicable
Construction Completed (if applicable)	Not applicable
Agency Survey/License Update Complete	December 2022
Provision of Medicare and Medicaid Services	January 2023

As previously noted, Envision is operating hospice services in Pierce County under the waiver program

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 Durable Medical Equipment
X Home Health Aide	X IV Services
X Physical Therapy	X Nutritional Counseling
X Occupational Therapy	X Bereavement Counseling
X Speech Therapy	X Symptom and Pain Management
X Respiratory Therapy	X Pharmacy Services
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe)	
Services primarily for Alzheimer's disease and other dementias Aroma therapy Music therapy Therapeutic touch Advanced feeding techniques	

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).**

   Thurston County, Snohomish County King County and Kitsap County make up Envision Hospice of Washington, LLC. This application proposes adding the Pierce County service area.

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.**

   The services proposed in Question 7 are consistent with the existing services provided in the other planning areas.

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).**

    Hospice services will be provided to patients requiring end-of-life care; Medicare hospice patients are those terminally ill patients with a life expectancy of 6 months or less.

    Many of these patients will be end-stage cancer patients. The remainder of the patients will have terminal conditions related to a variety of diagnoses. Please see the table at Question 5 in the Need Section below for a percentage breakdown of estimated diagnostic mix for Pierce County. The majority of patients will be over age 75. However, Envision will adhere to its Patient Admission Criteria, including Procedure 5, which states that care will be provided to all patients who can benefit, regardless of age.

Patients receiving in-home care will include not only those still living in their own private homes but also those who are residents of nursing homes, adult family homes and assisted living facilities.

Hospice services will be provided to patients requiring end-of-life care; Medicare hospice patients are those terminally ill patients with a life expectancy of 6 months or less.

The proposed hospice will provide care to patients regardless of the source or availability of payment for care.

Care will be provided to all patients regardless of culture, language, or sensory disability. Where needed, interpretive services and assistive communication methods and technologies will be used.

As discussed above, the depth and breadth of hospice services reflect four Envision service goals beyond the core capabilities of a Medicare-certified hospice. A number of these goals emphasize special or tailored outreach and services to special populations in Pierce County: The underlined items below indicate those special populations that Envision's program detail addresses specifically:

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

a. Patients with Alzheimer's or other dementias and their caregivers
b. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible to groups living in the broadest array of settings including:

a. Telemedicine at home
b. Residents of assisted living facilities
c. Residents of adult family homes
d. Residents of nursing homes
e. Homeless outreach
f. Mobile outreach clinics

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

a. Veterans
b. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

a. Excellence in palliative care
b. "Your Hand in Mine" for persons dying alone

c. Death with Dignity for persons requesting it

For cultural and ethnic minorities, language is a key barrier to optimum hospice care but not the only one. Cultural norms and traditions surrounding illness, death, and dying are major factors in outreach and care. In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Pierce County will be the most effective use of resources. It examined Pierce County demographics, census information and hospice utilization. Envision Hospice concluded that the large size, cultural differences, and increasing diversity of the Pierce County Latino population merits a program of special emphasis and resources in Envision hospice outreach and care.

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. More detailed description of Envision's approach is provided in Envision Hospice's "Pierce County Program Detail."

The table below shows the national average case mix for 2019 published by the National Hospice and Palliative Care Organization. A later report, prepared in October 2021, also focused on the 2019 diagnostic mix but at a higher detail level. Given that Covid-19 has had such a material effect on overall death rates that may persist into the future, Envision has elected to update the presentation methodology when 2021 data becomes available.

Diagnosis	Percent
Cancer	30
Heart/Cardiac/Circulatory	18
Dementia	16
Lung/Respiratory	11
Stroke/Coma	9
Other	14
Chronic Kidney Disease	2
Total	**100%**

This forecast was based on the 2019 national average diagnostic mix published by the National Hospice and Palliative Care Organization. Envision based its forecast on this national average breakdown of patient diagnoses because it is premature to forecast a different mix until Envision becomes more familiar with the unmet needs in this specific service area.

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).

Appendix A provides a copy of the letter of intent submitted for this project.

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.

Envision's proposed Pierce County hospice will be licensed and accredited as an addition to Envision's existing four-county hospice agency. Need the existing agency's license number(s) and Medicare and Medicaid numbers.

IHS.FS. 604174080

Medicare #: 50-1544

Medicaid #: 2157808

13. **Identify whether this agency will seek accreditation. If yes, identify the accrediting body.**

The agency is accredited by the Accreditation Commission for Health Care (ACHC).

Certificate of Need Review Criteria

A. Need (WAC 246-310-210)

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

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.**

The Table below provides utilization information based on the years that the agency was operational within the designated county.

Thurston County	**2019**	**2020**	**2021**
Total number of admissions	24.	24	23
Average Length of Stay	32.95	34.13	61.74
Total patient days	791	1,104	1,420
Average Daily Census	2.2	3.0	3.9
Snohomish County	**2019**	**2020**	**2021**
Total number of admissions	N.A.	N.A.	N.A.
King County	2019	2020	2021
Total number of admissions	N.A.	76	75
Average Length of Stay		46.01	61.17
Total patient days		3,497	7,573
Average Daily Census		9.6	20.8

Kitsap County	**2019**	**2020**	**2021**
Total number of admissions	N.A.	N.A.	63
Average Length of Stay			33.95
Total patient days			2,139
Average Daily Census			5.9
Pierce County	**2019**	**2020**	**2021**
Total number of admissions	N.A.	20	121
Average Length of Stay		46.01	25.80
Total patient days		524	3,838
Average Daily Census		1.4	10.5

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.**

	2022	**2023**	**2024**	**2025**
Total Hospice Agency				
Number of Admissions	276	507	648	815
Average Length of Stay	60	60	60	60
Patient Days	16,535	30,441	38,909	48,910
Average Daily Census	45.3	83.4	106.6	134

Number of Admissions: Envision existing utilization in opened hospice agencies including the impact of Covid-19 on the business plan included in the response to Question 4 in this section and Appendix N for Pierce County. Note that the table in response to Question 1 shows the unusually high impact of Covid-19 on the Envision ability to meet need on a county-by-county basis as well as the impact of delay in additional hospices that are required to meet Pierce County need. Envision employed a similar assessment in each county service area. While the central premise of the State methodology is that the Program's regulation of capacity through certificate of need rules would result in each hospice agency achieving full utilization, the actual results show that variance in hospice utilization rates on a county-by-county basis is large. It is large primarily due to the Covid-19 impact on all health services but it is also related to the specific business plans of each hospice in each county that are quite variable. Taking all of these factors into account, Envision decided to be very conservative in the pro formas associated with determining financial feasibility – particularly in Pierce County, e.g., need jumping from 1 agency to 3 agencies in a single year – in determining the volume of admissions and in Length of Stay which leads to average daily census.

Average Length of Stay: While average length of stay is longer nationally and statewide, Envision for conservative financial feasibility reasons is maintaining average length of stay during the start-up and early expansion phases for each hospice service area at 60 days, which is currently 2.12 days

length of stay shorter than the statewide average used by the Program. The Envision experience has been that as hospices open and carry out outreach activities, the average length of stay increases as shown in the Table response in Question 1.

Patient Days and Average Daily Census are both products of simple algebraic equations, e.g., Patient days divided by 365 days equals Average Daily Census.

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

The Department of Health's 2020 calculation of forecasted Pierce County utilization is provided at Appendix F.

1. Step 5 of the methodology documents substantially more forecasted utilization than the "capacity" of the existing hospices. For 2023, for example, the forecasted Pierce County hospice need at Step 5 totals 4,246 admissions annually at Washington's statewide average use rates.

2. This need of 4,246 admits in 2023 contrasts with the Department's November 2021 "current capacity" of 3,596 admits in Pierce County, also shown in Appendix F as part of the Department of Health's Survey Results, Hospice Numeric Need Methodology - Released November 2021.

3. This leaves 649 persons with an unmet need according to the DOH November 2021 calculation of 2023 need. This translates into a 2023 projected 17.9% shortfall in hospice availability in Pierce county. (645 ÷ 3,596 = 17.9%)

Of the three Pierce County hospices, none were recently established. Taken together, they are not achieving the expected average hospice penetration rate of the hospices across the state of Washington. Calculation of the Department of Health's Hospice Need Methodology indicates that the reach of their services to county residents has not kept pace with the population growth, aging, and end-of-life needs of area residents. Clearly this is related, as previously noted to many factors with the Covid-19 impact on staffing and the ability to conduct outreach services probably being a major contributor since existing capacity declined from the previous year by 13%.

The number of Pierce County residents using hospice dropped each year from 2016 - 2018, while the number of deaths among them increased. However, in 2019 the number using hospice stabilized at the low 2018 level. As noted above Covid-19 had a dramatic impact on hospice use with use declining by 13% from the previous year. In light of below-average hospice utilization in Washington, it is safe to say that the unmet average daily census of 111

patients projected for 2023 understates real need in Pierce County, particularly given that statewide length of stay has also declined from the prior year from 62.66 days (ALOS) to 62.12 days. Whereas the statewide average length of stay (ALOS) used in the Hospice Methodology calculations is 62.12 days, MedPac previously reported the national hospice ALOS at 88.6 days prior to the onset of the Covid-19 pandemic.

- As discussed above and documented in the Department of Health's own 2021 calculation of 2023 Pierce County hospice need, existing services are not sufficiently available. This question is therefore not applicable.

- Definitions of "capacity" and "hospice agency" at WAC 246-310-290, "Hospice services—Standards and need forecasting method" make clear that the capacity of existing hospice providers in Pierce County is not sufficient to address the unmet need calculated by the Department of Health.

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.

As documented in the Department of Health's own 2021 calculation of 2023 Pierce County hospice need, the proposed project is not an unnecessary duplication of services because it will respond to an unmet need of 111 average daily patients per day in 2023.

In recent applications, the Department expressed interested in how applicants will address barriers to care beyond simple availability of service. Barriers to hospice access in Pierce County are not significantly different from the barriers encountered nationally. These include:

- Terminally-ill patients hesitate to enroll in hospice because they are not ready to give up all curative care as Medicare currently requires. Many die before they are fully prepared to accept palliative care only. Add to this the access barrier of obtaining any healthcare service during this Covid-19 pandemic.
- Many patients and/or their families and caregivers do not know about the hospice benefit or how to access it. Some believe it is only for persons dying of cancer. Some believe "hospice" is a place, not a service. Some are completely unaware of it and the ability to "message" to the public is hindered by the intense focus on Covid-19 and its day-to-day impact on every Washington resident and on current providers with limited staff trying to conduct outreach.
- Many persons are referred to hospice by providers or others too late to get substantial benefit from longer-term hospice care that is available. Though this is changing gradually, the culture of medical

care has been more oriented to curing disease and less toward palliation of symptoms and pain.

- Religious and cultural minorities have concerns about hospice care that make them reluctant to sign on.
- Providers differ in their understanding and interpretation of complex Medicare hospice rules. This can dampen referrals by those who see the regulations and paperwork as too burdensome.

The American culture is only gradually accepting discussion of death and dying. For many, this conversation takes place too late to help.

Envision's plans include a number of approaches to increasing access, that is, improving the hospice use rate and length of stay for Pierce County. These fall into three categories, or phases, of a patient and family's relationship to the hospice care decision. The table below shows the objectives under each of Envisions Four Goals support the following:

- Increasing the number of persons deciding to use hospice (use rate)
- Encouraging earlier sign up for hospice among potential patients so that length of stay will be long enough to provide more benefit to those enrolled. (ALOS and median length of stay)
- Improving accessibility of care to patients while they are enrolled in hospice.

In terms of Pierce County, working with existing hospice and other care providers to let them know about the Envision resource capacity has helped get individuals into hospice care even though their length of stay is reduced due to the Covid-19 barriers to care. Envision is now a known quantity among many referral sources and Envision has gained "on-the-ground" experience on patient hospice need in Pierce County and how to address that need.

Envision's Approach to Reducing Barriers to Hospice Access in Pierce County

Envision Access Goals & Program Initiatives	More patients using hospice	Persons enrolling in hospice earlier	Improved accessibility within hospice
Goal 1: Groups with specific clinical needs			
• Patients with Alzheimer's or other dementias	√	√	
• "Pre-hospice" patients & Advanced Care Planning	√	√	
Goal 2: Broadest array of settings			
• Telemedicine at home			√
• Assisted living facilities	√	√	
• Adult family homes	√	√	
• Nursing homes	√	√	√
• Homeless outreach	√		
• Mobile outreach clinics	√	√	
Goal 3: Cultural competency			
• "We Honor Veterans"	√	√	√
• Latino outreach	√	√	√
Goal 4: Reducing suffering			
• Excellence in palliative care			√
• "Your Hand in Mine"			√
• Death with Dignity			√

The table above lists each of those program initiatives as described in the Program Detail section of this application and indicates which phase of improved access it addresses. Specific to Envision's methods for actively increasing hospice utilization, the following information provides highlights of those programs and their potential for reducing Pierce County barriers:

Under Goal 1: Addressing Advanced Care Planning needs of "pre-hospice" patients and early-stage dementia patients is part of Envision's plan to address the needs of specific clinical groups.

In programs specific to "pre-hospice" patients and in support of Advanced Care Planning, Envision will help patients to articulate their end of life wishes through Advanced Care Planning (ACP). They will learn more about their choices and be asked to think directly and communicate about a very difficult topic. This does not change the culture but does give an individual more control if he or she wishes to exercise it. In many cases, persons who participate in Advanced Care Planning before onset of a terminal illness are better prepared and have a clearer idea about whether hospice may or may not be right for them.

One study showed that those who engaged in ACP were less likely to die in a

hospital, more likely to be enrolled in hospice at death, and less likely to receive hospice for 3 days or less before death.

Under Goal 2: Envision's plan to serve patients in as many settings as possible is not a passive matter of accepting patients when called or just being available. Rather, Envision Hospice staff will reach out directly to leadership and care providers in each setting such as retirement centers, assisted living, adult family homes and nursing homes, homeless shelters and harm reduction centers. Envision can help the staff at each type of facility understand the benefits, not only to patient, but to the facility and staff of having Envision's hospice professionals and volunteers become part of the care teams for terminally-ill residents.

It is important to note that Envision has not assertively conducted outreach since it does not have long-term approval to operate hospice services. Still, in 2021 Envision served 121 hospice patients.

In addition, where Envision's Preferred Medical Group provides primary care to patients in such a facility, the combination of those providers and Envision Hospice providers can help a hospice patient maintain his or her home in the facility without emergency room visits and hospital stays that might otherwise occur.

Under Goal 3: A number of the barriers mentioned above have to do with culture and trust. In its program planning, Envision has prioritized two very large groups in Pierce County for which cultural sensitivity and recognition of differences is necessary.

- Latino
- It is humbling for non-Spanish speakers to learn "in Castilian Spanish hospice or "hospicio" means an orphanage or mental institution. . . . In Spain they do not use the word "hospicio." They have palliative medicine centers that provide end-of-life care.
- It is not surprising that language, religious values and other aspects of Latino culture can work against acceptance of hospice care by a person facing terminal illness and in need of palliative care. By engaging with community leaders, recruiting Latino volunteers, hiring bi-cultural staff, Envision expects to tailor its outreach and care to the increasingly diverse Spanish-speaking residents of Pierce County. With appropriate staffing, communication and education - plus diplomacy - Envision will a make a culturally-appropriate case for hospice care to families who otherwise will not consider it. (For more program information, see Envision Program Detail: Cultural Relevance to Latino Community Members.")
- Veterans
- Studies and clinical experiences documented by palliative care providers have shown that many veterans have unspoken health needs at the end of life. These may include a history of substance abuse, history of post-traumatic stress disorder, depression, and chronic health problems associated with their

service. Veterans may also have needs for forgiveness at the end of life for actions during war that were never discussed. By embracing the "We Honor Veterans" program, committing education and training resources, hiring veterans, recruiting veteran volunteers, Envision believes it will help veterans be comfortable choosing hospice earlier and gain more of its benefits. For more program information, see the "Program Detail" section of Envision's CON application.

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

   Envision commits to serving the entire planning area.

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

   The response to Question 4 provided a comprehensive approach to the strategy and actions that Envision will initiate to reduce disparity in availability and accessibility to under-served groups.

7. **Provide a copy of the following policies:**
   - Admissions policy
   - Charity care or financial assistance policy
   - Patient Rights and Responsibilities policy
   - Non-discrimination policy
   - Any other policies directly related with patient access

   - The Admissions and Patient Referral policies are included in Appendix G.
   - The Charity Care policy is included in Appendix H.
   - The Non-discrimination policy is part of the Admissions policy.
   - The Discharge policy is included in Appendix I.
   - The Patient Rights and Responsibilities policy is included in Appendix M**.**

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.**

     Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

   NOT APPLICABLE

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

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

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.**

   Appendix J, Appendix K and Appendix L use the same core assumptions for revenue by payer as well as the costs for each FTE category. Responses to questions 1 - 3 and the outreach plan contained in Appendix N provide documentary support for the utilization assumptions used in the application and in Appendix J, Appendix K and Appendix L assumptions during the Covid-19 time period. Home health assumptions for established county-based operations of Envision Home Health of Washington, LLC are based on historical performance during the pre-Covid-19 and during the Covid-19 time period. All other line items were reviewed in light of the impact of the Covid-19 pandemic disruption on normal operations.

   Appendix Q provides the overall financial performance of Envision in Washington through 2021. There is no doubt that Covid-19 stress-tested each healthcare provider in Washington State. The Envision financial performance is stunning on its own terms but it truly understates the commitment that Envision employees have taken to continue to serve hospice services at this time of the highest healthcare needs that our State has ever faced.

   Appendix J provides the requested pro forma – income statement, balance sheet, cash flow and assumptions for hospice services provided **solely in Pierce County.** Responses to questions 1 - 3 and the outreach plan contained in Appendix N provides documentary support for the utilization assumptions for Pierce County hospice services provided by Envision.

   Existing utilization for Pierce County is provided in the response to Question 1 shows that the 2021 volume for Pierce County was 121 hospice patients with an ALOS of 25.8 days (Envision deliberately did not carry out normal outreach activities described in Appendix N), which resulted in an average daily census of 10.5 patients. Under normal (second or third year of operation maturity) operating conditions, 121 hospice admissions would generate an average daily census at 60 days ALOS of

approximately 20 patients. With 2023 being the first full year of CoN approved utilization, it is easy to see that the expected 30-patient average daily census will be achieved resulting in earnings before taxes of approximately $288,000.

Appendix K provides the pro forma – income statement, balance sheet and cash flow statement for **existing hospice and home health services** of Envision Home Health of Washington, LLC and its wholly owned subsidiary Envision Hospice of Washington, LLC.

Appendix L provides the **combined** pro forma income statement, balance sheet and cash flow statement of the existing hospice and home health services of Envision (Appendix K) with the proposed Pierce County hospice services (Appendix J).

The pro forma for the incremental addition of Envision hospice services in Pierce County is added to the Envision Home Health of Washington, LLC to provide the financial impact of the addition of Envision hospice services in Pierce County to the overall operation of Envision Home Health Services, of Washington, LLC.

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

    Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. <u>Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.</u>

    The Operating Agreement of Envision Hospice of Washington LLC between Envision Hospice of Washington, LLC and Envision Home Health of Washington, LLC and entered into by Envision Home Health of Washington, LLC is included in Appendix B.

    Matthew Schellenberg DO Medical is an employee and the Medical Director. The Medical Director Job Description is included in Appendix C. , The Medical Director carries out all responsibilities described in the position description. In summary, that is being responsible for the medical component of the Envision Hospice patient care program. When the medical director is not available, Envision Hospice designates another physician (a physician employee or a physician contractor) to carry out the responsibilities of the Medical Director position description.

    There is no joint venture agreement between Envision Home Health of Washington LLC and its wholly-owned subsidiary, Envision Hospice of Washington, LLC.

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 renew for not less than a total of two years.**
   d. **A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, 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.**

   Appendix E provides the Tacoma office lease and line drawings that conform the requirements of this section. In addition, Appendix E provides an executed Memorandum of Understanding that memorializes the cost sharing among hospices and home health agencies falling under Envision Home Health of Washington, LLC that flow through the financial pro forma presented in Appendix J and Appendix L.

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.**

Item	Cost
a. Land Purchase	$ N.A.
b. Utilities to Lot Line	$ N.A.
c. Land Improvements	$ N.A.
d. Building Purchase	$ N.A.
e. Residual Value of Replaced Facility	$ N.A.
f. Building Construction	$ N.A.
g. Fixed Equipment (not already included in the construction contract)	$ N.A.
h. Movable Equipment	$ N.A.
i. Architect and Engineering Fees	$ N.A.
j. Consulting Fees	$ N.A.
k. Site Preparation	$ N.A.
l. Supervision and Inspection of Site	$ N.A.
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	$ N.A.
1. Land	$ N.A.
2. Building	$ N.A.
3. Equipment	$ 0
4. Other	$ 0
n. Washington Sales Tax	Included above
Total Estimated Capital Expenditure	**$** 0

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

Envision Hospice of Washington, LLC is responsible for 100% of the capital costs.

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.**

There are no start-up costs as the addition of the Pierce service area will not require any additional management staff, office space or other expense as Envision Hospice of Washington, LLC is currently licensed and operating in the adjacent King and Thurston areas. In fact, Envision Hospice of Washington, LLC is currently serving some patients in Pierce County under the Governor's temporary waiver of certificate of need for hospice services without incurring additional cost or issue. Generally, these services are provided by Envision staff who reside in Pierce County.

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

Not applicable. There are no start-up costs.

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

First, the Hospice Need methodology calculates a need for an additional hospice in Pierce County, so the costs of hospice services are based on growth in the target population needing hospice services and receiving hospice services. The 2020 - 2021 hospice need methodology showed that hospice admissions as a percent of overall deaths, declined from 2016 through 2018. The 2020-2021 methodology shows that this percentage had stabilized at approximately the 2018 admissions percentage level. Due to Covid-19, hospice use in Pierce County dramatically declined in Pierce County in 2020. Hospice use in Washington State is significantly lower than national average rates for hospice patients.

Various studies on the cost-effectiveness of hospice, both federally and privately sponsored, provide convincing evidence that hospice is a cost-efficient approach to care for the terminally ill.

An early study for CMS concluded that during the first three years of the hospice benefit, Medicare saved $1.26 for every $1.00 spent on hospice care. The study found that much of these savings accrue over the last month of life, which is due in large part to the substitution of home care days for inpatient days during this period.[1]

Additional research on hospice supports the premise that cost savings associated with hospice care are frequently unrealized because terminally ill Medicare patients often delay entering hospice care until they are within just a few weeks or days of dying, suggesting that more savings and more appropriate treatment could be achieved through earlier enrollment.

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.**

Envision Hospice of Washington is uniquely suited to expand its current hospice services to serve the residents of Pierce County. Envision Home Health of Washington received Medicare certification for its King County home health agency in 2015 and added Pierce County in 2017. Historically, in the first four years, the diverse and energetic staff of the new agency have grown that start-up to 17,767 visits annually in King and Pierce Counties in 2019. Envision then successfully

[1] Kidder, D. "The effects of hospice coverage on Medicare expenditures"; Health Serv Res. 1992 Jun; 27(2): pp. 195–217

navigated the challenges created by the Covid-19 pandemic in 2020 providing 15,516 visits.

Hospice services throughout the county service areas will increase in 2022 and later years as Covid-19 either subsides or long-term adjustments to all aspects of the economy and healthcare system gradually emerge from the Covid-19 pandemic. With the 2018 CON approval of its Thurston County hospice. The 2019 hospice CON approvals for King and Snohomish Counties allow coordination with home health services as well as economies of scale for hospice services in Pierce County. Co-locating with the home health agency will reduce lease costs for both hospice and home health services. This memorandum is included in Appendix E.

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."

Envision hospice services in Thurston County began operating in late 2019 while hospice services in King and Snohomish counties became operational or fully implemented in 2020. Kitsap started seeing patients in 2021. It is still too early to evaluate differences in payer mix in each of the counties based on the initial year's operating data, so the assumed payer mx in each certificate of need application by county is provided.

Thurston, King, Snohomish, Kitsap Counties Payer Mix

Payer Mix: Thurston	**Percentage of Gross Revenue**	**Percentage by Patient**
Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%
Payer Mix: King	**Percentage of Gross Revenue**	**Percentage by Patient**
Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%
Payer Mix: Snohomish	**Percentage of Gross Revenue**	**Percentage by Patient**
Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%
Payer Mix: Kitsap	**Percentage of Gross Revenue**	**Percentage by Patient**

Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%
Payer Mix: Total Agency	**Percentage of Gross Revenue**	**Percentage by Patient**
Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%

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.

Pierce County Hospice Service Expected Payer Mix

Payer Mix: Total	Percentage of Gross Revenue	Percentage by Patient
Medicare	85%	85%
Medicaid	10%	10%
Commercial	5%	5%
Total	100%	100%

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 capital expense estimate (sales tax included for the proposed hospice is:

Furnishings	$ 0
Phones	$ 0
Computer Equipment	$ 0
Copier/other	$ 0
Total	$ 0

The equipment needed to support Pierce County hospice services was secured in 2020 and 2021 by Envision Home Health and Hospice of Washington as Envision initiated services to support hospice services in Pierce County under Resolution 20-36. No additional equipment is required.

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.

As previously noted, there are no start-up costs for the Pierce County 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.

Not Applicable.

15. Provide the most recent audited financial statements for:

- **The applicant, and**
- **Any parent entity responsible for financing the project.**

Appendix Q provides 3 years of financial information for Envision Home Health of Washington, LLC, dba Envision Home Health and Hospice. Audited financial statements are not available.

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

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

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.

FTEs by Category for Pierce County Hospice Services

STAFFING INPUT - BY FTE'S	2023	2024	2025
CLINICAL OPERATIONS			
Medical Director/Physician(s)	0.83	1.25	1.67
Bereavement	-	0.30	1.00
Spiritual Counselor	0.81	1.22	1.62
Volunteer coordinator	0.40	0.56	0.75
Manager of Patient Services	0.50	0.75	1.00
RN's	3.00	4.50	6.00
Medical Social Worker	1.00	1.29	1.71
HHA's	3.00	4.50	6.00
TOTAL	**9.54**	**14.36**	**19.75**
ADMINISTRATIVE			
Administrator/Director	0.75	1.25	1.75
Admin Asst./Medical Records	1.00	1.25	1.75
Facility Liaison/Community Outreach	2.00	2.50	3.00
QAPI Coordinator	0.50	1.00	1.00
TOTAL	4.25	6.00	7.50
TOTAL FTE'S	13.79	20.36	27.25

Please see Appendix J for additional information on staffing assumptions.

2. If this application proposes the expansion of an existing agency into another

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

Envision Hospice of Washington, LLC Historical, Current and Projected FTE Schedule

STAFFING SUMMARY - PIERCE								
STAFFING INPUT - BY FTE'S	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	
AVERAGE DAILY CENSUS	**2.2**	**12.9**	**41.1**	**45.2**	**83.4**	**106.64**	**133.97**	
CLINICAL OPERATIONS								
Medical Director/Physician(s)	0.06	0.36	*	1.26	2.32	2.96	3.72	Physician FTE for every 36 ADC
Bereavement	0.00	0.00	*	0.50	1.00	1.30	2.50	Done by spiritual counselor until ADC reaches 40
Spiritual Counselor	0.12	0.75	*	1.21	2.29	2.93	3.68	1 per 37 ADC; does bereavement until ADC reaches 40
Volunteer coordinator	0.00	0.00	*	0.50	1.07	1.33	1.67	1 per 80 ADC; starts at minimum of .4 when MSW gets to .75
Manager of Patient Services	0.00	0.00	*	0.75	1.50	2.25	3.00	Done by admin until 20 ADC; starts at .5 ; .75 at 40 ADC; 1.0 at 50 ADC
RN's	1.00	3.00	*	4.52	8.34	10.66	13.40	1 per 10 ADC
Medical Social Worker	0.50	0.75	*	1.00	2.53	3.05	3.83	1 per 35 ADC, minimum of 1; does vol coord until reaching .75
HHA's	0.22	1.00	*	4.52	8.34	10.66	13.40	1 HHA per 10 ADC
TOTAL	**1.90**	**5.86**	*	**14.26**	**27.39**	**35.15**	**45.19**	
ADMINISTRATIVE								
Administrator/Director	1.00	1.00	*	2.00	3.25	3.75	4.75	Combines regional and county level admin: Regional is .25/County is .50 2021, 1 2022, 1.50 2023
Admin Asst./Medical Records	1.00	1.00	*	1.50	2.50	2.75	3.75	
Facility Liaison/Community Outrea	-	-	*	2.00	4.50	5.00	5.50	
QAPI Coordinator	-	-	*	0.50	1.50	2.00	2.00	Administrator does until ADC of 30
TOTAL	**2.00**	**2.00**	*	**6.00**	**11.75**	**13.50**	**16.00**	
TOTAL FTE'S	**3.90**	**7.86**	*	**20.26**	**39.14**	**48.65**	**61.19**	
*** Volume and Staffing for Year-End 2021 still being reviewed and reconciled before report closing**								

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

The assumptions and calculation process are as follows:

- Overall actual and projected agency volume of multiple hospice sites are included in the ADC volume projection in Appendix L.
- Most direct staffing is based on a staff to average daily census ratio, which is included in the assumptions for the Pierce Pro Forma in Appendix J.
- Administrative staffing is based on experience of the Envision corporate officers who have Utah and Washington based experience in the new start-ups in both states and in direct management of the Envision Washington hospices and home health agency sites. This includes new start ups during the Covid-19 pandemic.
- Direct staffing assumptions are further informed by a review of expected performance by Washington State hospice applicants and national standards.

Please see Appendix J for the assumptions on the Pierce County FTE table.

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

The Table below presents the staffing ratios utilized by Envision. These ratios correspond to national averages as published by the National Hospice and Palliative Care Organization. These ratios apply to Envision's employed clinical staffing from the outset, with the exception that, in year one, 2022 Volunteer Coordinator services will be provided in a different way.

- Volunteer Coordinator will be performed by the MSW until the MSW reaches .75 FTE at 1:35.

More generally, members of the Envision administrative and patient care teams work flexibly with each other to meet patient care needs. Envision's Patient Care Manager and the RN's who fill administrative positions such as QAPI and Administrator are all qualified and prepared to provide direct patient care. Thus, the team is readily able to respond to patient needs when the growing agency experiences peaks in census.

Type of Staff	Staff / Patient Ratio
Skilled Nursing (RN & LPN)	1:10
Physical Therapist	Contracted per visit
Occupational Therapist	Contracted per visit
Medical Social Worker	Initially combined with Volunteer Coord. Then 1:35
Speech Therapist	Contracted per visit
Home Health / Hospice Aide	1:10
Other (list)	No other positions are based on ratio to patients
Total	

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.**

Matthew Schellenberg, DO, OP61124925 is the Medical Director.

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

The Medical Director is an employee. The job description is included in Appendix C.

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

Name & Title	WA License Number
Wendy Maita, Area Director, RN	# RN60041114
Matthew Schellenberg DO. Medical Director	OP61124925

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

The staff serving Pierce County will be selected upon approval of the project.

Name	Specialty	Number	State

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.**

Envision currently provides hospice services in Pierce County under the Governor's waiver program using staff who reside in Pierce County and adjoining counties. Between the unique experience wherein a number of registered nurses employed by Envision reside in Pierce County, the co-location of home health and hospice within Pierce County has provided additional flexibility in employing our nursing resources to both home health and hospice services within Pierce County. In addition, our successful staffing of Envision's Thurston Hospice and our home health agency serving the multicounty area - Envision Hospice of Washington, LLC expects no insurmountable barriers to the availability of qualified direct healthcare and management personnel.

Please see Appendix R for Envision's more detailed responses to the overall long-term strategy of addressing labor resources including:

- discussion on the process Envision has used in the past to recruit and retain necessary staff for its home health and hospice agencies
- discussion on the process Envision intends to use to recruit and retain necessary staff for this Pierce County project
- discussion on the process Envision intends to use to recruit and retain necessary staff for the Pierce and Kitsap County projects if both are approved.

Recognizing that volunteers are an integral part of hospice, Envision also provides Appendix S, its plan for volunteer recruitment for the Pierce County hospice. This

plan has been very successful in recruiting a substantial number of volunteers for Envision's Thurston County hospice.

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

The office hours will be 8 a.m. to 5 p.m. Monday through Fridays.

At all other times, Envision will have paid staff on call and accessible by telephone via a phone call to a main number.

Envision Hospice patients who elect to participate in its tele-medicine option will have 24/7 access through their own dedicated electronic tele-medicine device.

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

Envision Hospice of Washington, LLC's methods for assessing customer satisfaction and quality improvement being put in place for its existing four-county hospice agency will be applicable to the Pierce County hospice as well:

- To assess customer satisfaction for the Pierce County hospice, Envision Hospice of Washington, LLC will extend its current Thurston County hospice contract with the CMS-approved vendor of customer satisfaction surveys which is CMS-certified and works collaboratively with the National Hospice and Palliative Care Organization to establish national norms. This approach allows a hospice to compare itself to others and identify and prioritize benchmark approaches for areas needing improvement.

- Starting with FY 2016-2017, CMS required all Medicare hospices to submit required data needed for a new nation-wide program of hospice quality improvement. Envision Hospice of Washington, LLC will comply with all CMS requirements including training staff in the required submitting all required data.

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

Appendix U provides a list of vendors.

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

Please see Appendix U for a list of proposed vendors. This list is based heavily on vendor relationships already in place for Envision Home Health of Washington

and Envision Hospice of Washington in King, Snohomish and Thurston Counties and is not expected to change as a result of this project.

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

Not Applicable.

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

Relationships with healthcare facilities are service area and this case county-specific for the most part, so relationships will be established with Pierce County facilities.

Inpatient contractors
For General Inpatient Care and for Respite Care, the proposed hospice will develop contracts with one or more local facilities.

General Inpatient Care
For Pierce County, Envision will initiate relationships on approval of its Pierce County CON and anticipates developing "general inpatient care" contracts with local hospitals that serve the area. In particular, Envision expects to develop GIP contracts with

- any Pierce County hospitals whose physicians and discharge planners refer patients to Envision Hospice and with
- the regional hospital systems that serve the Pierce County inpatient market, to include CHI-Franciscan/VM, MultiCare, Providence St. Joseph including Swedish and UW/Harborview.

Respite Care

Respite care is typically provided in skilled nursing facility or nursing home beds. In Pierce County, Envision does has not yet initiated contracts with Pierce County nursing facilities for respite care. On receipt of a Pierce County Certificate of Need, Envision will reach out to local nursing facilities to determine the best option for contracting for respite care for Pierce County hospice patients.

In-home care for nursing home residents

In addition to arranging for General Inpatient Care and Respite Care, Envision will also make arrangements with area nursing homes so that long term residents, for whom the facility is home, are able to receive routine in-home hospice services there.

Criteria for selection

In selecting inpatient providers with which to contract, Envision will apply the following criteria:

Of the potential hospital contracts available, Envision believes each provides high quality care. Envision plans to contract with each facility willing to do so. Criteria for contracting and referral of specific patients will include:

a) availability of inpatient hospice beds appropriate to GIP admissions (i.e., least restrictive environment and/or availability of a home-like setting
b) availability of appropriate clinical resources and beds for Envision's patients
c) relative geographic access of the facility for the patient's primary care team and/or potential visitors.
d) availability of a palliative care in-patient team or a hospitalist team that includes individuals with palliative care expertise.
e) compatibility with Envision's adopted policies honoring a patient's End of Life choices
f) cost containment

Respite Care

a) availability of inpatient hospice beds appropriate to "respite care"
b) availability of clinical resources needed for Envision's patients
c) relative geographic access for the patient's primary care team and/or potential visitors.
d) compatibility with Envision's adopted policies honoring a patient's End of Life choices
e) cost containment
f) availability of a home-like setting
g) nursing facilities already contracting with Envision for it to provide in-home hospice visits to its long-term care residents

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

Not Applicable. These relationships would generally be new relationships.

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

See the response to Question 16 in this section.

18. **Identify whether any facility or practitioner associated with this 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 health care 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.**

There is no such history.

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**

It is in the very nature of the Medicare-certified hospice benefit to assure continuity and to avoid unwarranted fragmentation. The core purpose of the inter disciplinary hospice team is to develop the patient's plan of care and to manage the care on a daily basis to support the individual patient's needs. In particular, the per diem payment to the hospice for all services puts the control of the full range of care in the hands of that core team.

One key to effective continuity is to admit patients to hospice as early as appropriate during the course of illness. Waiting until the last week or two of life substantially reduces the ability of the team to plan ahead, to address bereavement issues early, to manage pain effectively, etc. Envision Hospice is committed to community education in support of earlier admission to hospice when needed. Its relationship to Envision's Preferred Medical Group, which can provide regular medical care to residents of assisted living facilities and adult family homes, will increase the potential of earlier identification of persons eligible for hospice.

As part of its Latino outreach program, Envision plans to develop working relationship with organizations such as Centro Latino of Pierce County, Sea Mar, Community Health Care Clinics (FQHC's) and others that frequently address the needs of minority communities.

Envision Hospice of Washington, LLC is committed to Pierce County residents' having desired control over their own health care choices. The majority vote by Washington residents for the "death with dignity" statewide ballot measure indicates this is an important value to the community. Envision Hospice of Washington, LLC intends to include in its network providers who will actively support patients pursuing their "death with dignity" options as available under Washington law (See Appendix O). As part of this effort, Envision Hospice will continue to reach out to End of Life for their advice and support in locating needed resources.

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.

A portion of the Envision response to Question 18 is restated here. Envision established a set of criteria to assure that it would have appropriate relationships with existing healthcare facilities. In regard to physicians and community agencies, a portion of the Envision response to Question 19 includes the Envision Preferred Medical Group. Envision intends to reach out to organizations like Centro Latino of Pierce County, Sea Mar, Community Health Care Clinics (FQHC's) and others that frequently address the needs of minority communities. As noted in the response to Question 19, Envision will work with community agencies involved to assure to support patients pursuing "death with dignity."

In selecting inpatient providers with which to contract, Envision will apply the following criteria:

Of the potential hospital contracts available, Envision believes each provides high quality care. Envision plans to contract with each facility willing to do so.

Criteria for contracting and referral of specific patients will include:

a) availability of inpatient hospice beds appropriate to GIP admissions (i.e., least restrictive environment and/or availability of a home-like setting

b) availability of appropriate clinical resources and beds for Envision's patients

c) relative geographic access of the facility for the patient's primary care team and/or potential visitors.

d) availability of a palliative care in-patient team or a hospitalist team that includes individuals with palliative care expertise.

e) compatibility with Envision's adopted policies honoring a patient's End of Life choices

f) cost containment

Respite Care

g) availability of inpatient hospice beds appropriate to "respite care"

h) availability of clinical resources needed for Envision's patients

i) relative geographic access for the patient's primary care team and/or potential visitors.

j) compatibility with Envision's adopted policies honoring a patient's End of Life choices

k) cost containment

l) availability of a home-like setting

m) nursing facilities already contracting with Envision for it to provide in-home hospice visits to its long-term care residents

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.

Not Applicable.

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.**

Not applicable. There is no such history.

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

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

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

   The certificate of need rules suggest criteria to be considered including:

   Decision making criteria (*cost limits, availability, quality of care, legal restriction, etc.):*

   - **Advantages and disadvantages, and whether the sum of either the advantages or the disadvantages outweigh each other by application of the decision-making criteria;**

   - **Capital costs;**

   - **Staffing impact**

The 2021-2022 State Methodology concluded that there is a need for three additional hospices in Pierce County by 2023 even with admissions and lengths of stay for hospice patients at levels substantially lower than the national average, so need for action to add capacity has been established. Generally, capital costs are not applicable to hospice patients because services are delivered in the patient's in the community and not in a facility and required office space is generally for the administrative staff and does not require special facilities. In terms of selecting how to add capacity; an important factor is staffing, particularly nurse staffing during this staff shortage period. Any strategy that improves staffing efficiency would be advantageous.

The alternatives Envision Hospice of Washington, LLC considered in developing this proposed project included:

- Postponing action
- Acquisition vs. start-up
- Implementing the Project through a new start-up
- Adding Pierce County to the existing hospice agency

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**.

Postponing Action

Need:
Postponing action has already been determined to be an inferior alternative. There is current need for three additional hospices in Pierce County based on the 2021-22 Hospice Need Methodology. The 2020-2021 methodology projected a 2021 Need for a 40-patient average daily census. The 2021-22 methodology projected a 2021 Need for a 111-patient average daily census. In short holding population constant, actual utilization of hospice services decreased 13% due to postponement in adding services as well as Covid-19 effects resulting in a reduction of a 19% difference between existing capacity as of year-end 2020 and need for services in 2023.

Financial feasibility:
Postponing action when there is need and when the capital and operating costs of other alternatives is minimal is unwarranted. The lack of choice and availability has depressed utilization of services.

Structure and Process of Care:
Since there is need for new agencies and postponing action has been demonstrated to reduce utilization; postponing action cannot be justified particularly when several alternatives only require variable hospice staffing and Envision has demonstrated expertise in recruiting staff.

Cost Effectiveness:
Washington State is committed to the Triple Aim and even adding the fourth leg of the stool -- reducing disparity. Not providing additional resources results in hospice services in Washington State making no progress in Pierce County in terms of the Triple Aim of improving health, health care and managing costs.

Acquisition versus Start-Up of New Hospice Agency

Need:
There is need for three additional hospices in Pierce County based on the 2021-22 Hospice Need Methodology. The 2020-2021 methodology projected a 2021 Need for a 40-patient average daily census. The 2021-22 methodology projected a 2021 Need for a 111-patient average daily census. In short holding population constant, actual utilization of hospice services decreased 13% due to postponement in adding services as well as Covid-19 effects resulting in a reduction of a 19% difference

between existing capacity as of year-end 2020 and need for services in 2023.

Financial feasibility:
Since Envision found that no acquisition was available at this time, a financial feasibility analysis could not be undertaken. Even if an acquisition opportunity were available, the capital costs of acquisition would exceed the proposed alternative since there is no working capital required, and there is no capital expenditure for the project. As previously noted, Envision has already demonstrated the feasibility of its Pierce County hospice service under the Governor's waiver in Resolution 20-36.

Structure and Process of Care:
Since Envision has approved and operating hospices throughout the Puget Sound area, there would be no advantages in terms of developing ancillary support agreements The same relationships could be maintained for a separate Pierce County agency. Direct staffing would probably be neutral between either a new hospice agency or an extension of an existing hospice agency to a new county; particularly since the hospice service location for serving Pierce County under either models would remain unchanged – offices are maintained in Pierce County.

Cost Effectiveness:
This approach could increase overall Envision administrative costs when compared with just adding a county to the existing Envision Hospice of Washington, LLC agency. Envision has already determined that its most effective model is to operate one hospice agency in the Puget Sound area with individual county-based certificate of need approved counties.

Establishing a new Hospice Agency to Serve Pierce County

Need:
There is need for three additional hospices in Pierce County based on the 2021-22 Hospice Need Methodology. The 2020-2021 methodology projected a 2021 Need for a 40-patient average daily census. The 2021-22 methodology projected a 2021 Need for a 111-patient average daily census. In short holding population constant, actual utilization of hospice services decreased 13% due to postponement in adding services as well as Covid-19 effects resulting in a reduction of a 19% difference between existing capacity as of year-end 2020 and need for services in 2023.

Financial feasibility:
This alternative is feasible. Working capital start-up costs would be minimized for this alternative of adding Pierce County to the existing Envision Hospice of Washington, LLC agency because certification approval time and efforts would delay the agency anticipated start up time by an estimated 3 months. There are no capital costs.

Administrative staff costs could be higher under this alternative either at the Envision Home Health of Washington or the Envision Hospice of Washington level for maintaining two separately licensed and certified hospice agencies operated by Envision in the Puget Sound area.

Structure and Process of Care:
Since Envision has approved and operating hospice services throughout the Puget Sound area, there would be no advantages in terms of developing ancillary support agreements. Staffing efficiencies would be lower since Envision has another Pierce County alternative that would reduce administrative overhead of an independent agency. There would be little difference in direct care staffing since that is variable based on volume.

Cost Effectiveness:
This approach does not reduce overall Envision administrative costs when compared with adding a service area to an existing agency in Pierce County. This option would take longer to implement than adding a county to the existing Envision agency since certification time would be added to the development schedule. Either operating a new Envision hospice agency or providing hospice services to Pierce County residents with the existing Envision Hospice of Washington agency adds equal choice for residents at no loss in cost effectiveness given that the Program has determined a Need for an additional agency; Envision already has office space available in Pierce County and the central administrative staff is housed in Thurston County.

Adding Pierce County to Envision Hospice of Washington, LLC

Need:
There is need for three additional hospices in Pierce County based on the 2021-22 Hospice Need Methodology. The 2020-2021 methodology projected a 2021 Need for a 40-patient average daily census. The 2021-22 methodology projected a 2021 Need for a 111-patient average daily census. In short holding population constant, actual utilization of hospice services decreased 13% due to postponement in adding services as well as Covid-19 effects resulting in a reduction of a 19% difference between existing capacity as of year-end 2020 and need for services in 2023.

Capital costs:
There are no capital costs and there are no working capital requirements.

Structure and Process of Care
Adding Pierce County to the existing agency minimizes staffing costs since most costs are related to the volume of services provided. Since Envision has approved and operating hospices throughout the Puget Sound area, there would be no advantages in terms of developing ancillary support agreements since the same relationships could be maintained for a separate Pierce County agency or this option. Direct staffing would probably be neutral between either a new hospice agency or an extension of an existing hospice agency to a new county. This is particularly the case since the hospice service location for serving Pierce County under either model would remain unchanged – offices are maintained in Pierce County.

Cost Effectiveness:
Adding a service area to an existing agency in Pierce County will reduce overall Envision administrative costs when compared to operating a new Envision hospice

agency. Adding a county to the existing Envision Hospice of Washington agency adds choice for residents and does so more expeditiously by reducing start up times necessary for certification; and at no loss in cost effectiveness given that the Program has determined a Need for an additional agency; Envision already has office space available in Pierce County and the central administrative staff is housed in Thurston County.

When viewing cost effectiveness it affects each component of an alternatives evaluation – Need, Capital Costs and Operating Costs (rent and staffing) which are expanded on below.

Need: Envision Hospice of Washington is already providing hospice services within Pierce County under the Governor's waiver program. Approval of the Pierce application will allow a nearly seamless transition to Envision hospice services which will likely simultaneously coincide with the lifting of the waiver and providing continued access and availability of hospice services for Pierce County residents. As noted in the application, the early provision of hospice services reduces overall healthcare costs and is a primary tool of cost containment.

Capital Costs: The model of housing Envision hospice services for Pierce County within the existing Envision Hospice of Washington agency and located within the existing Envision Home Health of Washington leased Pierce County location reduces future capital costs avoiding the costs of establishing both a new agency and a new location.

Operating Costs – Rent: The model of housing Envision hospice services for Pierce County within the existing Envision Hospice of Washington agency and located within the existing Envision Home Health of Washington leased Pierce County location reduces rent and related operating expenses by 80% per the Memorandum of Understanding in Appendix E by avoiding the costs of establishing both a new agency and a new location in an identical office space.

Operating Costs – Staffing: The model of adding Pierce County to the existing Envision Hospice of Washington as well as housing the hospice service in existing Pierce County space converts all administrative staff positions to variable staffing as well as Medical Director related services to variable staffing which would represent a substantial cost containment achievement when combined with administrative overhead reductions in developing and maintaining vendor contracts for a broad variety of support services (see Appendix U as an example).

Alternatives Summary

Considering the alternatives available in light of the criteria above, the advantages and disadvantages taken together make it clear that adding the Pierce County service area to the Envision Hospice of Washington, LLC agency is the best alternative.

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.**

Not Applicable.

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.**

The Envision response to Question 10 in the **Project Description** section provides an overview of improvements and innovations in service delivery that foster cost containment, quality assurance and cost effectiveness.

Hospice Agency Superiority

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

Envision may respond to Hospice Agency Superiority Criteria after reviewing any competing applications.

Multiple Applications in One Year

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. **Related to this, answer the following questions:**

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.

Envision did not submit any project in Cycle 1 of the Hospice concurrent review and this is the only project being submitted in the second 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.**

    Not Applicable.

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.**

    Not Applicable.

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 propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.**

List of Appendices: Envision Hospice of Washington, LLC - Pierce County

Appendix A	Letter of Intent
Appendix B	Envision Organization Chart of Entities and the Operating Agreement
Appendix C	Medical Director Job Description
Appendix D	Depreciation
Appendix E	• Tacoma Office Lease, addendum, line drawings • Memorandum of Understanding on Lease Expense Allocations
Appendix F	• DOH 2021-22 Hospice Need Method, November 2021 • DOH 2021-22 Hospice Need Extended through 2025
Appendix G	Patient Admission Criteria
Appendix H	Charity Care Policy
Appendix I	Discharge Policy and Patient Referral Policy
Appendix J	Pro Forma Financials, Pierce Hospice Only • Assumptions & Methods Including Staffing Summary • Operating Statement • Pro Forma Cash Flow and Balance Sheet
Appendix K	Existing Pro Forma Financials of Envision Home Health and Hospice Agencies
Appendix L	Pro Forma Financials, Envision Home Health of Washington, LLC, Existing Operations combined with Envision Hospice of Washington - Operating Statement • Pro Forma Cash Flow and Balance Sheet
Appendix M	Patient Rights and Responsibilities
Appendix N	Envision Business Plan Goals and Strategies
Appendix O	Envision Policy on Death with Dignity
Appendix P	Commitment letter from Chief Financial Officer
Appendix Q	Envision Home Health of Washington LLC Historical financials, 2018 – 2021 • Operating Statement • Pro Forma Cash Flow and Balance Sheet
Appendix R	Staff recruitment

Appendix S	Envision Hospice Volunteer Recruitment Plan
Appendix T	Envision Hospice Training Policies
Appendix U	List of proposed vendors
Appendix V	List of Envision Agencies
Appendix W	Accreditation standards for ACHC Palliative Care Distinction

ENVISION

Envision Hospice of Washington, LLC
1345 W 1600 N, STE 202
Orem, UT 84057

December 28, 2021

Eric Hernandez, Program Manager
Certificate of Need Program
WA Department of Health
111 Israel Road
Tumwater, WA 98501

Dear Mr. Hernandez,

This letter is written to notify the Department of Health that Envision Hospice of Washington, of which Envision Home Health of Washington, LLC is the sole member, intends to seek Certificate of Need approval to extend its Medicare-certified hospice agency to serve residents of Pierce County, Washington.

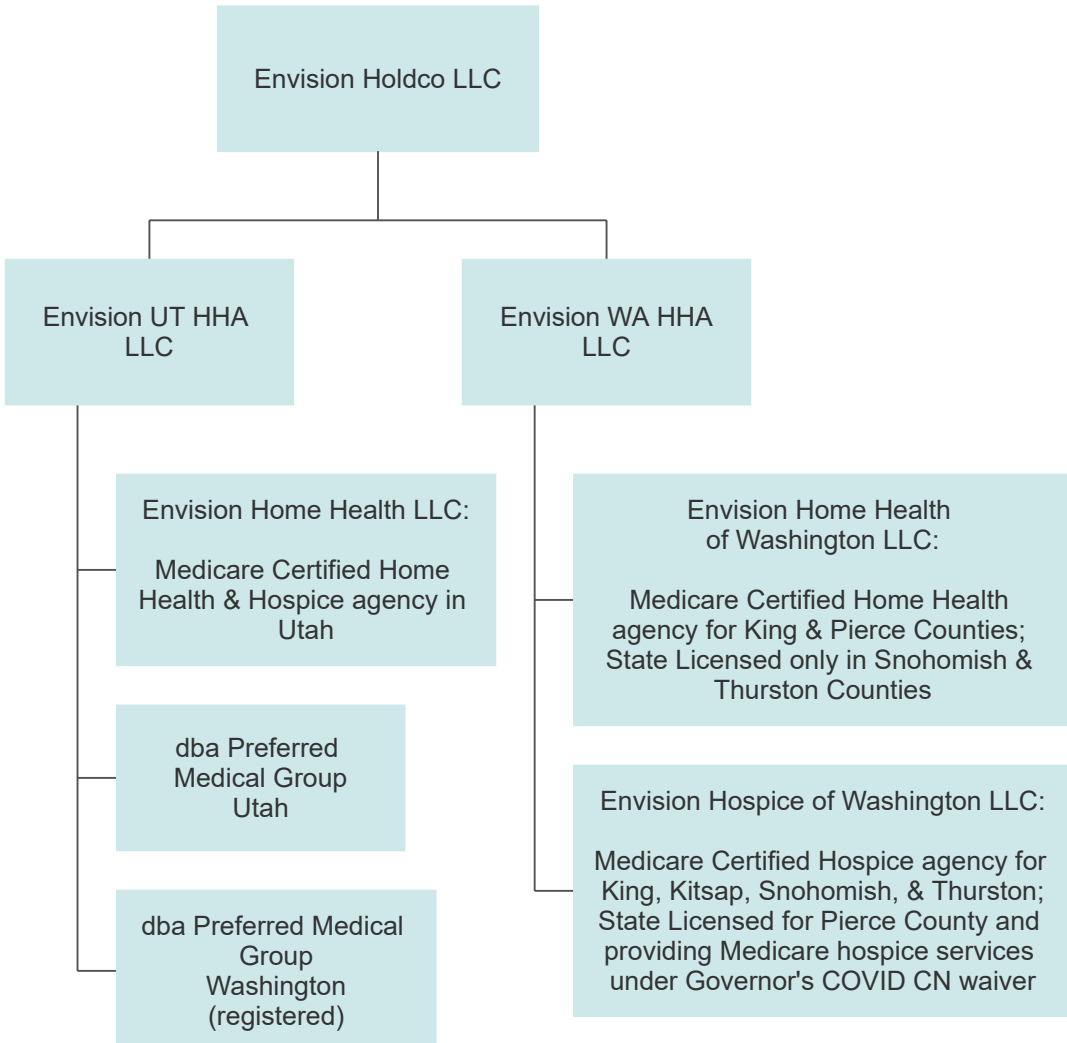
Upon receipt of a Certificate of Need, Envision Hospice of Washington, LLC will provide Medicare and Medicaid hospice services to terminally-ill residents of Pierce County, Washington.

Our current estimate of capital costs is $0.00.

Thank you very much,

Sherie Stewart
Chief Operating Officer

Envision Hospice of Washington LLC - Chart of Related Organizations



ENVISION HOSPICE OF WASHINGTON, LLC

AMENDED AND RESTATED OPERATING AGREEMENT

This AMENDED AND RESTATED OPERATING AGREEMENT (this "Agreement") of Envision Hospice of Washington, LLC, a Washington limited liability company (the "Company"), effective as of March 1, 2021, has been entered into by Envision Home Health of Washington, LLC, a Washington limited liability company (the "Member"). The Member's address and limited liability company interest are as set forth on Schedule A hereto.

WHEREAS, the Company was formed in accordance with Chapter 25.15 of the Revised Code of Washington (the "Act"), upon the execution and filing of the Certificate of Formation of the Company (the "Certificate") with the State of Washington Secretary of State, on September 28, 2017; and

WHEREAS, the Member now desires to enter into this Agreement, which shall amend and restate all previous limited liability company agreements of the Company.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained herein and for other good and valuable consideration, it is agreed as follows:

1. Business, Address and Registered Agent.

(a) The Member hereby acknowledges that the Company has been formed under the Act for the purpose of engaging in any business of any kind necessary to, in connection with, related to or incidental to such purposes as the Member shall from time to time deem desirable.

(b) The principal place of business of the Company shall be at the offices of the Member. The Company may locate its places of business and registered office at any other place or places as the Member may from time to time deem advisable.

(c) The name and address of the registered agent of the Company for service of process on the Company in the State of Washington are as set forth in the Certificate, as updated from time to time in accordance with the Act.

2. Management. Except as otherwise provided herein or in the Act, the sole responsibility for managing the business and affairs of the Company shall be vested in the Member.

3. Officers.

(a) Appointment of Officers; Term. Officers, including assistant and subordinate officers ("Officers"), may from time to time be appointed by the Member.

(b) Removal of Officers; Vacancies. Any Officer may be removed summarily with or without cause, at any time, by the Member. Vacancies may be filled by the Member.

(c) Duties. To the extent the Member has appointed any Officers, the Member hereby delegates authority to manage the day-to-day affairs of the Company to the Officers. The Member hereby authorized the Officers to take, or cause to be taken, such actions and to execute and deliver, or cause to be executed and delivered, for and in the name and on behalf of the Company, all documents and instruments as the Officers may deem necessary to advisable and in the best interests of the Company. In the event no Officer has been appointed by the Member, then such matters shall be managed directly by the Member.

4. Term. The term of the Company shall be perpetual, except that the Company shall be dissolved upon the first to occur of any of the following events:

(a) The election of the Member to dissolve and terminate the Company;

(b) At any time there are no remaining members, except as may be avoided under the Act;

(c) The entry of a decree of judicial dissolution under the Act; or

(d) Automatic cancellation of the Certificate under the Act.

5. Capital. The Member may contribute such capital, in cash or other property, as it so chooses in its sole discretion. No capital contributions shall be required unless the Member consents thereto in writing in its sole and absolute discretion.

6. Bank Accounts. The Member or, to the extent that there are any officers, any officer, including any assistant or subordinate officer, as may be authorized to do so in writing by the Member, is authorized to open commercial banking accounts for and in the name of the Company throughout the United States, at any time and from time to time, and to deposit to the credit of the Company in such banking accounts any monies, checks, drafts, orders or other commercial paper payable to the Company, and from time to time to withdraw all or any part of the funds on deposit in the name of the Company by check drawn in the name of the Company and signed by such officer.

7. Voting of Shares. The Member or any officer may from time to time appoint an attorney or attorneys or agent or agents of the Company, in the name and on behalf of the Company, to cast the vote which the Company may be entitled to cast as a stockholder or otherwise in any corporation, partnership, limited liability company, joint venture or any other entity, any of whose securities may be held by the Company, at meetings of the holders of the shares or other securities of such entity or to consent in writing to any action by any such entity. Such officer shall instruct the person or persons so appointed as to the manner of casting such votes or giving such consent and may execute or cause to be executed on behalf of the Company such written proxies, consents, waivers or other instruments as may be necessary or proper in the premises.

8. Distributions. Any cash or other property of the Company not required for the operation of the Company shall be distributable to the Member at such times and in such amounts as determined by the Member.

9. Liquidation. Any net proceeds from the sale, exchange or other disposition (including a disposition pursuant to foreclosure or deed in lieu of foreclosure) of the assets of the Company following the dissolution of the Company shall be distributed to the Member.

10. Other Activities. The Member may engage in or possess any interest in another venture or business of any nature or description, independently or with others.

11. Tax Matters. The Member may make on behalf of the Company any such filings as it deems necessary or appropriate to permit the Company to elect its classification for U.S. federal tax purposes.

12. Tax Classification. The Member intends that the Company be disregarded for U.S. federal income tax purposes as long as there is only one Member, and that if there is ever more than one Member or more than one owner of the Company as determined for U.S. federal income tax purposes, that the Company be classified as a partnership for U.S. federal income tax purposes and this Agreement shall be interpreted accordingly.

13. Limited Liability. The Member shall not have any personal obligation for any debts, obligations or liabilities of the Company, whether arising in contract, tort or otherwise, except as provided under the Act.

14. Exculpation; Indemnification.

(a) Except as otherwise provided by any written employment, consulting or similar agreement, if applicable, or unless otherwise expressly required by law, neither the Member nor any officer of the Company (including any former officer or member) (each such person referred to herein as a "Covered Person") shall have any liability to the Company or to any Member for any loss suffered by the Company or any member that arises out of any act or omission or alleged act or omission of the Covered Person in the Covered Person's capacity as a Covered Person to the extent the Covered Person acted in good faith and to the extent such course of conduct did not constitute bad faith, willful misconduct or gross negligence of the Covered Person. Each Covered Person shall be indemnified by the Company against any losses, judgments, liabilities, claims, damages, costs, expenses (including reasonable legal fees and other expenses actually incurred in investigating or defending against any such losses, judgments, liabilities or claims and expenses actually incurred enforcing this Agreement) and amounts paid in settlement of any claim (approved in advance and in good faith by the Member) sustained by any of them by reason of any act or omission or alleged act or omission in connection with the activities of the Company (including any subsidiaries thereof) unless there is a final judicial determination by a court of competent jurisdiction to which all rights of appeal have been exhausted or expired that the same were the result of bad faith, willful misconduct or gross negligence of the Covered Person. The Covered Person may rely in good faith upon the advice of legal counsel.

(b) To the extent available on commercially reasonable terms, the Company may purchase, at the Company's expense, insurance (including without limitation, liability insurance policies and errors and omissions policies) to cover any liabilities covered by this Section 14 in such amount and with such deductibles as the Company may determine; provided, however, that the failure to obtain such insurance shall not affect the right to indemnification of

any Covered Person. Any such insurance may extend beyond the termination of the Company for a commercially reasonable period. The Company shall be subrogated to the Covered Person's rights under such indemnification or insurance. If any Covered Person recovers any amounts in respect of any such liabilities from insurance coverage or any third party source, then such Covered Person shall, to the extent that such recovery is duplicative, reimburse the Company for any amounts previously paid to it by the Company in respect of such liabilities. The Company shall not incur the cost of that portion of any insurance, other than public liability insurance, which insures any party against any liability the indemnification of which is herein prohibited.

(c) The Company may, as determined in good faith by the Member, pay the legal fees and other expenses reasonably incurred by any Covered Person hereunder in connection with any proceeding in advance of the final disposition of such proceeding, so long as the Company receives a written undertaking, in form and content approved by the Company's counsel, by such Covered Person to repay the full amount advanced if there is a final judicial determination by a court of competent jurisdiction, as to which all rights of appeal have been exhausted or expired, that such Covered Person did not satisfy the standards which entitle it to indemnification pursuant to the terms of this Section 14.

(d) The right of indemnification hereby provided shall not be exclusive of, and shall not affect, any other rights to which any Covered Person may be entitled. Nothing contained in this Section 14 shall limit any lawful rights to indemnification existing independently of this Section 14.

(e) The indemnification rights provided by this Section 14 shall not be construed to increase the liability of the Member.

(f) The indemnification rights provided by this Section 14 shall inure to the benefit of the heirs, executors, administrators, successors and assigns of each Covered Person.

(g) The provisions of this Section 14 shall continue to afford protection to each Covered Person regardless of whether such Covered Person remains in the position or capacity pursuant to which such Covered Person became entitled to indemnification under this Section 14 and regardless of any subsequent amendment to this Agreement; provided, however, that no such amendment shall reduce or restrict the extent to which the indemnification provisions of this Section 14 apply to actions taken or omissions made or alleged actions taken or omissions made prior to the date of such amendment.

(h) If deemed appropriate or necessary by the Member, the Company may establish reserves, escrow accounts or similar accounts to fund its obligations under this Section 14.

(i) The provisions of this Section 14 shall survive the termination or dissolution of the Company.

15. Article 8 of the Uniform Commercial Code. Each Member hereby agrees that the membership interests shall not be securities governed by Article 8 of the Uniform Commercial Code of the State of Washington (and the Uniform Commercial Code of any other applicable jurisdiction).

16. No Third Party Beneficiary. No creditor or other third party having dealings with the Company shall have the right to enforce the right or obligation of the Member to make capital contributions or loans or to pursue any other right or remedy hereunder or at law or in equity, it being understood and agreed that the provisions of this Agreement shall be solely for the benefit of, and may be enforced solely by, the Member, the Covered Persons (to the extent granted herein) and the Company and their respective successors and permitted assigns.

[Signature page follows.]

IN WITNESS WHEREOF, the undersigned Member has executed this Agreement effective as of the date first set forth above.

MEMBER:

Envision Home Health of Washington, LLC, a Washington limited liability company

DocuSigned by:

By: _____
81F56809C9A149B...
Name: Rhett Andersen
Title: Manager

DocuSigned by:

By: _____
DFB4B17CC6AB4DE...
Name: Sherie Stewart
Title: Manager

SCHEDULE A

MEMBER

Member	LLC Interest
Envision Home Health of Washington, LLC 1818 S Union Avenue, Ste 1A Tacoma, WA 98405	100%

JOB DESCRIPTION
Medical Director

REPORTING RELATIONSHIP:

Supervised by: Administrator and Director
Positions Supervised: Hospice IDG
Interrelationships: Patients, family, IDG and other health care team members

JOB SUMMARY:
Directs the medical aspects of the Hospice's patient care program. Serves as consultant and advisor to the Director, offering his/her expertise to assess and interpret medical problems. The Hospice physician serves as consultant to the primary physician of Hospice patients but does not take over the medical direction of the patient's care. Serves as consultant to the Interdisciplinary Group.

QUALIFICATIONS:

Educational/Degree:	Graduate from an accredited school of medicine and is a doctor of medicine or osteopathy.
Training/Licensure:	Practicing physician currently licensed under the provisions of the State Board of Medicine.
Knowledge/Skills/Ability:	Approved for admitting privileges and treatment of patients in the hospital of their locality of practice. Understanding of the principles of Hospice care. Willingness to work as a Hospice team member.
Experience:	Demonstrated knowledge and well developed skills in: medicine, oncology, pharmacology; pain and symptom control; psychology of loss; and acceptance of Hospice principles of care.

JOB FACTORS:

Physical Requirements:
Must possess sight/hearing senses or use appropriate adaptive devices that will enable senses to function at a level required to meet the essential duties of the position.

Mental Requirements:
Must be able to work independently, make judgments based on assessments and data available and act accordingly. Must be flexible, innovative and possess good interpersonal skills. Must be able to cope with mental and emotional stress and demonstrate emotional stability.

Working Conditions:
Be able to tolerate exposure to elements including, but not limited to, odors, blood, body fluids and excrements, adverse environmental conditions and hazardous materials.

Transportation:
Must have a current valid driver's license, auto liability insurance and reliable transportation.

Essential Functions:

1. Oversees the implementation of the entire physician, nursing, social work, therapy and counseling areas within Hospice to ensure that these areas consistently meet patient and family needs.

2. The Hospice Medical Director, physician employees and contracted physicians, in conjunction with the patient's attending physician, are responsible for the palliation and management of terminal illness and conditions related to the terminal illness.

3. The Medical Director assumes overall responsibility for the medical component of the Hospice patient care program, functions as part of the Hospice IDG, and acts as consultant for medical care.

4. The duties and responsibilities of the Medical Director include, but are not limited to:

   - Oversees the implementation of the entire physician, nursing, social work, therapy and counseling areas within Hospice to ensure that these areas consistently meet patient and family needs.
   - Responsibility for medical component of the Hospice's patient care program.
   - Participates in and acts as a medical resource to the IDG and Hospice leadership.
   - The Medical Director or physician designee reviews the clinical information for each Hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following when making this determination:
     - The primary terminal condition.
     - Related diagnosis(es), if any.
     - Current subjective and objective medical findings.
     - Current medication and treatment orders.
     - Information about the medical management of any of the patient's conditions unrelated to the terminal illness.
   - Before the recertification period for each patient the Medical Director or physician designee must review the patient's clinical information.
   - Participates in the establishment and implementation of the plan of care, which is coordinated with the attending physician and IDG prior to providing care.
   - Participates in conjunction with the attending physician and IDG to review, update and sign the plan of care when changes are made and at least every fifteen days.
   - Consults with attending physicians, if requested.
   - Is available to patients on a 24-hour basis to manage their terminal illness and medical needs to the extent that the attending physician is absent or not able to meet these needs.

- Acts as a liaison with other physicians in the community serviced by Hospice and facilitates communication.
- Participates in educational programs for staff, when requested.
- Is a member of and participates in designated interdisciplinary group activities.
- Provides advice, guidance and assistance to Hospice staff until a satisfactory resolution is reached when a medical order:
  - Is of a questionable nature.
  - Contains a discrepancy.
  - Lacks clarity.
  - Continues to be a concern for the staff after consultation with the primary physician.
- Provides medical consultation and direction when the attending physician or their designee cannot be reached and there is a change in the patient's condition requiring medical attention.

5. When the Medical Director is not available, a physician designated by Hospice assumes the same responsibilities and obligations as the Medical Director.

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

Olympia, Washington 98504

1/25/2022

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Osteopathic Physician and Surgeon License Interstate Medical Licensure Compact for Schellenberg, Matthew Michael.

This site is a Primary Source for Verification of Credentials.

Credential Number:	OP61124925
Credential Type:	Osteopathic Physician and Surgeon License Interstate Medical Licensure Compact
First Credential Date:	11/23/2020
Last Renewal Date:	08/23/2021
Credential Status:	ACTIVE
Current Expiration Date:	10/08/2022
Enforcement Action:	No

The Washington Department of Health presents this information as a service to the public.

The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, the mere presence of such information does not imply a practitioner is not competent or qualified.

This site provides disciplinary actions taken and credentials denied for failure to meet qualifications. If the Enforcement Action is listed as a No, there has been no disciplinary action. It allows viewing and downloading of related legal documents since July 1998. Contact our Public Records Office for information on actions before July 1998. This information comes directly from our database. It is updated daily.

Yrs	WA HH	Expense	Current 2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	Ending Balance
7	**Furnishings**	9,751.99	(6,128.43)	(1,393.14)	(1,393.14)	(837.28)									(0.00)
5	**Phones/ System**														-
5	**Computer Equipment**	1,712.53	(1,076.20)	(342.51)	(293.83)										(0.00)
5	**Copier/Other**														-
	Total	11,464.52	(7,204.63)	(1,735.65)	(1,686.97)	(837.28)	-	-	-	-	-	-	-	-	(0.01)
															-
	WA HOSPICE 3 Counties														-
7	**Furnishings**	20,000.00		(2,857.14)	(2,857.14)	(2,857.14)	(2,857.14)	(2,857.14)	(2,857.14)	(2,857.14)					-
5	**Phones/ System**	6,000.00		(1,200.00)	(1,200.00)	(1,200.00)	(1,200.00)	(1,200.00)							-
5	**Computer Equipment**	3,500.00		(700.00)	(700.00)	(700.00)	(700.00)	(700.00)							-
5	**Copier/Other**	10,000.00		(2,000.00)	(2,000.00)	(2,000.00)	(2,000.00)	(2,000.00)							-
	Total	39,500.00	-	(6,757.14)	(6,757.14)	(6,757.14)	(6,757.14)	(6,757.14)	(2,857.14)	(2,857.14)	-	-	-	-	0.00
															-
															-
	Pierce Hosp Assumption														-
7	**Furnishings**	3,000.00	-			(428.57)	(428.57)	(428.57)	(428.57)	(428.57)	(428.57)	(428.57)			0.00
5	**Phones/ System**	1,000.00	-			(200.00)	(200.00)	(200.00)	(200.00)	(200.00)					-
5	**Computer Equipment**	2,250.00	-			(450.00)	(450.00)	(450.00)	(450.00)	(450.00)					-
5	**Copier/Other**	750.00	-			(150.00)	(150.00)	(150.00)	(150.00)	(150.00)					-
	Total	7,000.00	-	-		(1,228.57)	(1,228.57)	(1,228.57)	(1,228.57)	(1,228.57)	(428.57)	(428.57)	-		0.00
															-
	Kitsap Hosp Assumption														-
7	**Furnishings**	3,000.00	-		(428.57)	(428.57)	(428.57)	(428.57)	(428.57)	(428.57)	(428.57)				0.00
5	**Phones/ System**	1,000.00	-		(200.00)	(200.00)	(200.00)	(200.00)	(200.00)						-
5	**Computer Equipment**	2,250.00	-		(450.00)	(450.00)	(450.00)	(450.00)	(450.00)						-
5	**Copier/Other**	750.00	-		(150.00)	(150.00)	(150.00)	(150.00)	(150.00)						-
	Total	7,000.00	-	-	(1,228.57)	(1,228.57)	(1,228.57)	(1,228.57)	(1,228.57)	(428.57)	(428.57)	-	-		0.00

LEASE AMENDMENT AGREEMENT

This extension of Lease Term is made this 09th day of January between VNJ Enterprises, LLC, a Washington limited liability company ("Landlord"), Envision Home Health of Washington LLC, ("Tenant") is an amendment to that certain Lease Agreement dated March 16th 2018, by and between VNJ Enterprises, LLC, as Landlord and Envision Home Health of Washington LLC, as Tenant.

As parties hereto, Landlord and Tenant agree:

1. The Commencement Date and the expiration date of the Lease Term is as follows:

   (a) The date of February 1st 2020 is the Commencement Date of the Lease Term.

   (b) The Date of January 31st, 2025 is the expiration date of the Lease Term.

2. The monthly Rent is as follows:
   - $7,317.00 per month for February 1st 2018 – January 31st 2025
   - $ 7,536.51 per month for Option Year 1
   - $ 7,762.61 per month for Option Year 2
   - $ 7,795.49 per month for Option Year 3
   - $ 8,235.35 per month for Option Year 4
   - $ 8,482.41 per month for Option Year 5

3. All terms and conditions agreed to in the Lease dated March 16th 2018 still hold for the duration of this lease term.

TENANT

Michelle Gill

BY: Michelle Gill

For: Envision Home Health of Washington LLC

DATE: 9 January 2020

LANDLORD

Vidya Iyengar

BY: Vidya Iyengar

For: VNJ Enterprises LLC

DATE: 01/09/2020

State of Washington)
County of Pierce)

This certificate is attached to a document described by:

Dated: 01/09/2020, with 1 pages.

On this day personally appeared before me Michele D Gill,
to me known to be the individual, or individuals, described in and who executed the within and foregoing instrument and acknowledged that he/she/they signed the same as his/her/their free and voluntary and deed, for the uses and purposes therein mentioned.

Given under my hand and official seal this
09 day of January (month), 2020 (year).

x..

Jocelyn Barber
Notary Public – State of Washington
My appointment Expires: February 8, 2023

JOCELYN BARBER
NOTARY PUBLIC #206404
STATE OF WASHINGTON
MY COMMISSION EXPIRES
03-08-23

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

LEASE AGREEMENT
(Multi Tenant Gross Lease)

THIS LEASE AGREEMENT (the "Lease") is entered into and effective as of this 16 day of March, 2018, between VNJ Enterprises, LLC. ("Landlord"), and Envision Home Health of Washington, LLC. (Tenant"). Landlord and Tenant agree as follows:

1. LEASE SUMMARY.

a. Leased Premises. The leased commercial real estate i) consists of an agreed area of 3,750 rentable square feet and is outlined on the floor plan attached as Exhibit A (the "Premises"); ii) is located on the land legally described on attached Exhibit B; and iii) is commonly known as 1818 S Union Ave (Suite 1A), Tacoma WA 98405 (suite number and address). The Premises do not include, and Landlord reserves, the exterior walls and roof of the Premises; the land beneath the Premises; the pipes and ducts, conduits, wires, fixtures, and equipment above the suspended ceiling; and the structural elements of the building in which the Premises are located (the "Building"). The Building, the land upon which it is situated, all other improvements located on such land, and all common areas appurtenant to the Building are referred to as the "Property." The Building and all other buildings on the Property as of the date of this Lease consist of an agreed area of 10,170 rentable square feet.

b. Lease Commencement Date. The term of this Lease shall be for a period of sixty-four (64) months and shall commence on June 1, 2018 or such earlier or later date as provided in Section 3 (the "Commencement Date"). Tenant shall have no right or option to extend this Lease, unless otherwise set forth in a rider attached to this Lease (e.g., Option to Extend Rider, CBA Form OR).

c. Lease Termination Date. The term of this Lease shall expire at midnight on September 30, 2023 or such earlier or later date as provided in Section 3 (the "Termination Date").

d. Base Rent. The base monthly rent shall be (check one): ☐ $_____, or ☒ according to the Rent Rider attached hereto ("Base Rent"). Rent shall be payable at Landlord's address shown in Section 1(h) below, or such other place designated in writing by Landlord.

e. Prepaid Rent. Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $7,317.00 as prepaid rent, to be applied to the Rent due for months five (5) ~~through _____~~ of the Lease. *FREE RENT PERIOD IS MONTHS ONE (1) THROUGH FOUR (4) OF THE LEASE.*

f. Security Deposit. Upon execution of this Lease, Tenant shall deliver to Landlord the sum of $7,317.00 to be held as a security deposit pursuant to Section 5 below. The security deposit shall be in the form of (check one): ☐ cash, ☐ letter of credit according to the Letter of Credit Rider (CBA Form LCR) attached hereto, or ☒ check.

g. Permitted Use. The Premises shall be used only for medical home health office and for no other purpose without the prior written consent of Landlord (the "Permitted Use").

h. Notice and Payment Addresses.

Landlord: VNJ Enterprises, LLC.
PO Box 731689
Puyallup, WA 98373-0017
Fax No.: _____

LEASE AGREEMENT
(Multi Tenant Gross Lease)

Email: _____

Tenant: Envision Home Health of Washington, LLC.
1818 S Union Ave (Suite 1A)
Tacoma, WA 98405
Fax No.: _____
Email: _____

2. PREMISES.

a. Lease of Premises. Landlord leases to Tenant, and Tenant leases from Landlord the Premises upon the terms specified in this Lease.

b. Acceptance of Premises. Except as specified elsewhere in this Lease, Landlord makes no representations or warranties to Tenant regarding the Premises, including the structural condition of the Premises or the condition of all mechanical, electrical, and other systems on the Premises. Except for any tenant improvements to be completed by Landlord as described on attached Exhibit C (the "Landlord's Work"), Tenant shall be responsible for performing any work necessary to bring the Premises into a condition satisfactory to Tenant. By signing this Lease, Tenant acknowledges that it has had adequate opportunity to investigate the Premises; acknowledges responsibility for making any corrections, alterations and repairs to the Premises (other than the Landlord's Work); and acknowledges that the time needed to complete any such items shall not delay the Commencement Date.

c. Tenant Improvements. Attached Exhibit C sets forth all of Landlord's Work, if any, and all tenant improvements to be completed by Tenant (the "Tenant's Work"), if any, that will be performed on the Premises. Responsibility for design, payment and performance of all such work shall be as set forth on attached Exhibit C. If Tenant fails to notify Landlord of any defects in the Landlord's Work within thirty (30) days of delivery of possession to Tenant, Tenant shall be deemed to have accepted the Premises in their then condition. If Tenant discovers any major defects in the Landlord's Work during this 30-day period that would prevent Tenant from using the Premises for the Permitted Use, Tenant shall notify Landlord and the Commencement Date shall be delayed until Landlord has notified Tenant that Landlord has corrected the major defects and Tenant has had five (5) days to inspect and approve the Premises. The Commencement Date shall not be delayed if Tenant's inspection reveals minor defects in the Landlord's Work that will not prevent Tenant from using the Premises for the Permitted Use. Tenant shall prepare a punch list of all minor defects in Landlord's Work and provide the punch list to Landlord, which Landlord shall promptly correct.

3. TERM. The term of this Lease shall commence on the Commencement Date specified in Section 1, or on such earlier or later date as may be specified by notice delivered by Landlord to Tenant advising Tenant that the Premises are ready for possession and specifying the Commencement Date, which shall not be less than 30 days (thirty (30) days if not filled in) following the date of such notice.

a. Early Possession. If Landlord permits Tenant to possess and occupy the Premises prior to the Commencement Date specified in Section 1, then such early occupancy shall not advance the Commencement Date or the Termination Date set forth in Section 1, but otherwise all terms and conditions of this Lease shall nevertheless apply during the period of early occupancy before the Commencement Date.

LEASE AGREEMENT
(Multi Tenant Gross Lease)

b. Delayed Possession. Landlord shall act diligently to make the Premises available to Tenant; provided, however, neither Landlord nor any agent or employee of Landlord shall be liable for any damage or loss due to Landlord's inability or failure to deliver possession of the Premises to Tenant as provided in this Lease. If possession is delayed, the Commencement Date set forth in Section 1 shall also be delayed. In addition, the Termination Date set forth in Section 1 shall be modified so that the length of the Lease term remains the same. If Landlord does not deliver possession of the Premises to Tenant within 60 days (sixty (60) days if not filled in) after the Commencement Date specified in Section 1, Tenant may elect to cancel this Lease by giving notice to Landlord within ten (10) days after such time period ends. If Tenant gives notice of cancellation, the Lease shall be cancelled, all prepaid rent and security deposits shall be refunded to Tenant, and neither Landlord nor Tenant shall have any further obligations to the other. The first "Lease Year" shall commence on the Commencement Date and shall end on the date which is twelve (12) months from the end of the month in which the Commencement Date occurs. Each successive Lease Year during the initial term and any extension terms shall be twelve (12) months, commencing on the first day following the end of the preceding Lease Year. To the extent that the tenant improvements are not completed in time for the Tenant to occupy or take possession of the Premises on the Commencement Date due to the failure of Tenant to fulfill any of its obligations under this Lease, the Lease shall nevertheless commence on the Commencement Date set forth in Section 1.

4. RENT.

a. Payment of Rent. Tenant shall pay Landlord without notice, demand, deduction or offset, in lawful money of the United States, the monthly Base Rent stated in Section 1 in advance on or before the first day of each month during the Lease term beginning on (check one): ☒ the Commencement Date, or ☐ _____ (if no date specified, then on the Commencement Date), and shall also pay any other additional payments due to Landlord ("Additional Rent") (collectively, "rent" or "Rent") when required under this Lease. Payments for any partial month at the beginning or end of the Lease shall be prorated. All payments due to Landlord under this Lease, including late fees and interest, shall also constitute Additional Rent, and upon failure of Tenant to pay any such costs, charges or expenses, Landlord shall have the same rights and remedies as otherwise provided in this Lease for the failure of Tenant to pay rent.

b. Late Charges; Default Interest. If any sums payable by Tenant to Landlord under this Lease are not received within five (5) business days after their due date, Tenant shall pay Landlord an amount equal to the greater of $100 or five percent (5%) of the delinquent amount for the cost of collecting and handling such late payment in addition to the amount due and as Additional Rent. All delinquent sums payable by Tenant to Landlord and not paid within five (5) business days after their due date shall, at Landlord's option, bear interest at the rate of fifteen percent (15%) per annum, or the highest rate of interest allowable by law, whichever is less (the "Default Rate"). Interest on all delinquent amounts shall be calculated from the original due date to the date of payment.

c. Less Than Full Payment. Landlord's acceptance of less than the full amount of any payment due from Tenant shall not be deemed an accord and satisfaction or compromise of such payment unless Landlord specifically consents in writing to payment of such lesser sum as an accord and satisfaction or compromise of the amount which Landlord claims. Any portion that

LEASE AGREEMENT
(Multi Tenant Gross Lease)

remains to be paid by Tenant shall be subject to the late charges and default interest provisions of this Section.

5. SECURITY DEPOSIT. Upon execution of this Lease, Tenant shall deliver to Landlord the security deposit specified in Section 1 above. Landlord's obligations with respect to the security deposit are those of a debtor and not of a trustee, and Landlord may commingle the security deposit with its other funds. If Tenant breaches any covenant or condition of this Lease, including but not limited to the payment of Rent, Landlord may apply all or any part of the security deposit to the payment of any sum in default and any damage suffered by Landlord as a result of Tenant's breach. Tenant acknowledges, however, that the security deposit shall not be considered as a measure of Tenant's damages in case of default by Tenant, and any payment to Landlord from the security deposit shall not be construed as a payment of liquidated damages for Tenant's default. If Landlord applies the security deposit as contemplated by this Section, Tenant shall, within five (5) days after written demand therefor by Landlord, deposit with Landlord the amount so applied. If Tenant complies with all of the covenants and conditions of this Lease throughout the Lease term, the security deposit shall be repaid to Tenant without interest within thirty (30) days after the surrender of the Premises by Tenant in the condition required by Section 12 of this Lease.

6. USES. The Premises shall be used only for the Permitted Use specified in Section 1 above, and for no other business or purpose without the prior written consent of Landlord. No act shall be done on or around the Premises that is unlawful or that will increase the existing rate of insurance on the Premises, the Building, or the Property, or cause the cancellation of any insurance on the Premises, the Building, or the Property. Tenant shall not commit or allow to be committed any waste upon the Premises, or any public or private nuisance. Tenant shall not do or permit anything to be done on the Premises, the Building, or the Property which will obstruct or interfere with the rights of other tenants or occupants of the Property, or their employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, or to injure or annoy such persons.

7. COMPLIANCE WITH LAWS. Tenant shall not cause or permit the Premises to be used in any way which violates any law, ordinance, or governmental regulation or order. Landlord represents to Tenant that as of the Commencement Date, to Landlord's knowledge but without duty of investigation, and with the exception of any Tenant's Work, the Premises comply with all applicable laws, rules, regulations, or orders, including without limitation, the Americans With Disabilities Act, if applicable, and Landlord shall be responsible to promptly cure at its sole cost any noncompliance which existed on the Commencement Date. Tenant shall be responsible for complying with all laws applicable to the Premises as a result of the Permitted Use, and Tenant shall be responsible for making any changes or alterations as may be required by law, rule, regulation, or order for Tenant's Permitted Use at its sole cost and expense. Otherwise, if changes or alterations are required by law, rule, regulation, or order unrelated to the Permitted Use, Landlord shall make changes and alterations at its expense.

8. UTILITIES AND SERVICES. Landlord shall provide the Premises the following services: water, *HEATING, VENTILATION, AIR CONDITIONING,* and electricity for the Premises seven (7) days per week, twenty-four (24) hours per day~~, and heating, ventilation and air conditioning from _____ a.m. to _____ p.m. Monday through Friday; _____ a.m. to _____ p.m. on Saturday; and _____ a.m. to _____ p.m. on Sunday~~, and Landlord shall also provide janitorial service to the ~~Premises and~~ Building five (5) nights each week, exclusive of holidays. ~~Heating, ventilation and air conditioning services will also be provided by Landlord to the Premises during additional hours on reasonable notice to Landlord, at Tenant's sole cost and expense, at an hourly rate reasonably established by Landlord from time to time and payable by Tenant, as and when billed, as Additional Rent. If water and electricity services are not separately~~

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~~metered to the Premises, Tenant shall pay its proportionate share of all charges for any utilities that are jointly metered based on the ratio which the rentable square feet of the Premises bears to the total rentable square feet served by the joint meters. Notwithstanding the foregoing, if Tenant's use of the Premises incurs utility charges which are above those usual and customary for the Permitted Use, Landlord reserves the right to require Tenant to pay a reasonable additional charge for such usage.~~

Tenant shall furnish all other utilities (including, but not limited to, telephone, Internet, and cable service if available) and other services which Tenant requires with respect to the Premises, and shall pay, at Tenant's sole expense, the cost of all utilities separately metered to the Premises, and of all other utilities and other services which Tenant requires with respect to the Premises, except those to be provided by Landlord as described above. Landlord shall not be liable for any loss, injury or damage to person or property caused by or resulting from any variation, interruption, or failure of utilities due to any cause whatsoever, and Rent shall not abate as a result thereof. *ELECTRICITY IS SEPARATELY METERED AND TENANT SHALL BE RESPONSIBLE FOR PAYMENT OF SEPARATELY METERED ELECTRICITY.*

9. TAXES. Tenant shall pay all taxes, assessments, liens and license fees ("Taxes") levied, assessed or imposed by any authority having the direct or indirect power to tax or assess any such liens, related to or required by Tenant's use of the Premises as well as all Taxes on Tenant's personal property located on the Premises. Landlord shall pay all Taxes with respect to the Building and the Property, including any Taxes resulting from a reassessment of the Building or the Property due to a change of ownership or otherwise.

10. COMMON AREAS.

a. Definition. The term "Common Areas" means all areas, facilities and building systems that are provided and designated from time to time by Landlord for the general, non-exclusive use and convenience of Tenant with other tenants and which are not leased or held for the exclusive use of a particular tenant. To the extent that such areas and facilities exist within the Property, Common Areas include hallways, entryways, stairs, elevators, driveways, walkways, terraces, docks, loading areas, restrooms, trash facilities, parking areas and garages, roadways, pedestrian sidewalks, landscaped areas, security areas, lobby or mall areas, common heating, ventilating and air conditioning systems, common electrical service, equipment and facilities, and common mechanical systems, equipment and facilities. Tenant shall comply with reasonable rules and regulations concerning the use of the Common Areas adopted by Landlord from time to time. Without advance notice to Tenant and without any liability to Tenant, Landlord may change the size, use, or nature of any Common Areas, erect improvements on the Common Areas or convert any portion of the Common Areas to the exclusive use of Landlord or selected tenants, so long as Tenant is not thereby deprived of the substantial benefit of the Premises. Landlord reserves the use of exterior walls and the roof, and the right to install, maintain, use, repair and replace pipes, ducts, conduits, and wires leading through the Premises in areas which will not materially interfere with Tenant's use thereof.

b. Use of the Common Areas. Tenant shall have the non-exclusive right, in common with such other tenants to whom Landlord has granted or may grant such rights, to use the Common Areas. Tenant shall abide by rules and regulations adopted by Landlord from time to time and shall use its best efforts to cause its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, to comply with those rules and regulations, and not interfere with the use of Common Areas by others.

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c. Maintenance of Common Areas. Landlord shall maintain the Common Areas in good order, condition and repair. In performing such maintenance, Landlord shall use reasonable efforts to minimize interference with Tenant's use and enjoyment of the Premises.

11. ALTERATIONS. Tenant may make alterations, additions or improvements to the Premises, including any Tenant Work identified on attached Exhibit C (the "Alterations"), only with the prior written consent of Landlord, which, with respect to Alterations not affecting the structural components of the Premises or utility systems therein, shall not be unreasonably withheld, conditioned, or delayed. Landlord shall have thirty (30) days in which to respond to Tenant's request for any Alterations so long as such request includes the names of Tenant's contractors and reasonably detailed plans and specifications therefor. The term "Alterations" shall not include the installation of shelves, movable partitions, Tenant's equipment, and trade fixtures that may be performed without damaging existing improvements or the structural integrity of the Premises, the Building, or the Property, and Landlord's consent shall not be required for Tenant's installation or removal of those items. Tenant shall perform all work at Tenant's expense and in compliance with all applicable laws and shall complete all Alterations in accordance with plans and specifications approved by Landlord, using contractors approved by Landlord, and in a manner so as to not unreasonably interfere with other tenants. Tenant shall pay, when due, or furnish a bond for payment (as set forth in Section 19) all claims for labor or materials furnished to or for Tenant at or for use in the Premises, which claims are or may be secured by any mechanics' or materialmens' liens against the Premises or the Property or any interest therein. Tenant shall remove all Alterations at the end of the Lease term unless Landlord conditioned its consent upon Tenant leaving a specified Alteration at the Premises, in which case Tenant shall not remove such Alteration, and it shall become Landlord's property. Tenant shall immediately repair any damage to the Premises caused by removal of Alterations.

12. REPAIRS AND MAINTENANCE; SURRENDER. Tenant shall, at its sole expense, maintain the Premises in good condition and promptly make all non-structural repairs and replacements necessary to keep the Premises safe and in good condition~~, including all HVAC components and other utilities and systems to the extent exclusively serving the Premises~~. Landlord shall maintain and repair the Building structure, foundation, subfloor, exterior walls, roof structure and surface, and HVAC components and other utilities and systems serving more than just the Premises, and the Common Areas. Tenant shall not damage any demising wall or disturb the structural integrity of the Premises, the Building, or the Property and shall promptly repair any damage or injury done to any such demising walls or structural elements caused by Tenant or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. Notwithstanding anything in this Section to the contrary, Tenant shall not be responsible for any repairs to the Premises made necessary by the negligence or willful misconduct of Landlord or its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees therein. If Tenant fails to perform Tenant's obligations under this Section, Landlord may at Landlord's option enter upon the Premises after ten (10) days' prior notice to Tenant and put the same in good order, condition and repair and the cost thereof together with interest thereon at the default rate set forth in Section 4 shall be due and payable as Additional Rent to Landlord together with Tenant's next installment of Base Rent. Upon expiration of the Lease term, whether by lapse of time or otherwise, Tenant shall promptly and peacefully surrender the Premises, together with all keys, to Landlord in as good condition as when received by Tenant from Landlord or as thereafter improved, reasonable wear and tear and insured casualty excepted.

13. ACCESS AND RIGHT OF ENTRY. After twenty-four (24) hours' notice from Landlord (except in cases of emergency, when no notice shall be required), Tenant shall permit Landlord and its agents, employees and contractors to enter the Premises at all reasonable times to make repairs, inspections, alterations or improvements, provided that Landlord shall use reasonable efforts to minimize interference

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with Tenant's use and enjoyment of the Premises. This Section shall not impose any repair or other obligation upon Landlord not expressly stated elsewhere in this Lease. After reasonable notice to Tenant, Landlord shall have the right to enter the Premises for the purpose of (a) showing the Premises to prospective purchasers or lenders at any time, and to prospective tenants within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term, and (b) posting "for lease" signs within one hundred eighty (180) days prior to the expiration or sooner termination of the Lease term. *LANDLORD AND TENANT WILL DILIGENTLY WORK TOGETHER TO ALLOW TENANT TO ACCEPT DELIVERIES TO THE PREMISES DURING NON-BUSINESS HOURS.*

14. SIGNAGE. Tenant shall obtain Landlord's written consent as to size, location, materials, method of attachment, and appearance, before installing any signs upon the Premises. Tenant shall install any approved signage at Tenant's sole expense and in compliance with all applicable laws. Tenant shall not damage or deface the Premises in installing or removing signage and shall repair any injury or damage to the Premises caused by such installation or removal.

15. DESTRUCTION OR CONDEMNATION.

a. Damage and Repair. If the Premises or the portion of the Building or the Property necessary for Tenant's occupancy are partially damaged but not rendered untenantable, by fire or other insured casualty, then Landlord shall diligently restore the Premises and the portion of the Property necessary for Tenant's occupancy to the extent required below and this Lease shall not terminate. Tenant may, however, terminate the Lease if Landlord is unable to restore the Premises within six (6) months of the casualty event by giving twenty (20) days notice of termination.

The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are damaged. If insurance proceeds are not available or are not sufficient to pay the entire cost of restoring the Premises, or if Landlord's lender does not permit all or any part of the insurance proceeds to be applied toward restoration, then Landlord may elect to terminate this Lease and keep the insurance proceeds, by notifying Tenant within sixty (60) days of the date of such casualty.

If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or fifty percent (50%) or more of the rentable area of the Property are entirely destroyed, or partially damaged and rendered untenantable, by fire or other casualty, Landlord may, at its option: (a) terminate this Lease as provided herein, or (b) restore the Premises and the portion of the Property necessary for Tenant's occupancy to their previous condition to the extent required below; provided, however, if such casualty event occurs during the last six (6) months of the Lease term (after considering any option to extend the term timely exercised by Tenant) then either Tenant or Landlord may elect to terminate the Lease. If, within sixty (60) days after receipt by Landlord from Tenant of notice that Tenant deems the Premises or the portion of the Property necessary for Tenant's occupancy untenantable, Landlord fails to notify Tenant of its election to restore those areas, or if Landlord is unable to restore those areas within six (6) months of the date of the casualty event, then Tenant may elect to terminate the Lease upon twenty (20) days' notice to Landlord unless Landlord, within such twenty (20) day period, notifies Tenant that it will in fact restore the Premises or actually completes such restoration work to the extent required below, as applicable.

If Landlord restores the Premises or the Property under this Section, Landlord shall proceed with reasonable diligence to complete the work, and the base monthly rent shall be abated in the

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same proportion as the untenantable portion of the Premises bears to the whole Premises, provided that there shall be a Rent abatement only if the damage or destruction of the Premises or the Property did not result from, or was not contributed to directly or indirectly by the act, fault or neglect of Tenant, or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees. No damages, compensation or claim shall be payable by Landlord for inconvenience, loss of business or annoyance directly, incidentally or consequentially arising from any repair or restoration of any portion of the Premises or the Property. Landlord shall have no obligation to carry insurance of any kind for the protection of Tenant; any alterations or improvements paid for by Tenant; any Tenant Work identified in Exhibit C (regardless of who may have completed them); Tenant's furniture; or on any fixtures, equipment, improvements or appurtenances of Tenant under this Lease, and Landlord's restoration obligations hereunder shall not include any obligation to repair any damage thereto or replace the same.

b. Condemnation. If the Premises, the portion of the Building or the Property necessary for Tenant's occupancy, or 50% or more of the rentable area of the Property are made untenantable by eminent domain, or conveyed under a threat of condemnation, this Lease shall terminate at the option of either Landlord or Tenant as of the earlier of the date title vests in the condemning authority or the condemning authority first has possession of the Premises or the portion of the Property taken by the condemning authority. All Rents and other payments shall be paid to that date.

If the condemning authority takes a portion of the Premises or of the Building or the Property necessary for Tenant's occupancy that does not render them untenantable, then this Lease shall continue in full force and effect and the base monthly rent shall be equitably reduced based on the proportion by which the floor area of any structures is reduced. The reduction in Rent shall be effective on the earlier of the date the condemning authority first has possession of such portion or title vests in the condemning authority. The Premises or the portion of the Building or the Property necessary for Tenant's occupancy shall not be deemed untenantable if twenty-five percent (25%) or less of each of those areas are condemned. Landlord shall be entitled to the entire award from the condemning authority attributable to the value of the Premises or the Building or the Property and Tenant shall make no claim for the value of its leasehold. Tenant shall be permitted to make a separate claim against the condemning authority for moving expenses if Tenant may terminate the Lease under this Section, provided that in no event shall Tenant's claim reduce Landlord's award.

16. INSURANCE.

a. Tenant's Liability Insurance. During the Lease term, Tenant shall pay for and maintain commercial general liability insurance with broad form property damage and contractual liability endorsements. This policy shall name Landlord, its property manager (if any), and other parties designated by Landlord as additional insureds using an endorsement form acceptable to Landlord, and shall insure Tenant's activities and those of Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees with respect to the Premises against loss, damage or liability for personal injury or bodily injury (including death) or loss or damage to property with a combined single limit of not less than $2,000,000, and a deductible of not more than $10,000. Tenant's insurance will be primary and noncontributory with any liability insurance carried by Landlord. Landlord may also require Tenant to obtain and maintain business income coverage for at least six (6) months, business

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auto liability coverage, and, if applicable to Tenant's Permitted Use, liquor liability insurance and/or warehouseman's coverage.

b. Tenant's Property Insurance. During the Lease term, Tenant shall pay for and maintain special form clauses of loss coverage property insurance (with coverage for earthquake if required by Landlord's lender and, if the Premises are situated in a flood plain, flood damage) for all of Tenant's personal property, fixtures and equipment in the amount of their full replacement value, with a deductible of not more than $10,000.

c. Miscellaneous. Tenant's insurance required under this Section shall be with companies rated A-/VII or better in Best's Insurance Guide, and which are admitted in the state in which the Premises are located. No insurance policy shall be cancelled or reduced in coverage and each such policy shall provide that it is not subject to cancellation or a reduction in coverage except after thirty (30) days prior notice to Landlord. Tenant shall deliver to Landlord upon commencement of the Lease and from time to time thereafter, copies of the insurance policies or evidence of insurance and copies of endorsements required by this Section. In no event shall the limits of such policies be considered as limiting the liability of Tenant under this Lease. If Tenant fails to acquire or maintain any insurance or provide any policy or evidence of insurance required by this Section, and such failure continues for three (3) days after notice from Landlord, Landlord may, but shall not be required to, obtain such insurance for Landlord's benefit and Tenant shall reimburse Landlord for the costs of such insurance upon demand. Such amounts shall be Additional Rent payable by Tenant hereunder and in the event of non-payment thereof, Landlord shall have the same rights and remedies with respect to such non-payment as it has with respect to any other non-payment of Rent hereunder.

d. Landlord's Insurance. Landlord shall carry special form clauses of loss coverage property insurance of the Building shell and core in the amount of their full replacement value, and such other insurance of such types and amounts as Landlord, in its discretion, shall deem reasonably appropriate.

e. Waiver of Subrogation. Landlord and Tenant hereby release each other and any other tenant, their agents or employees, from responsibility for, and waive their entire claim of recovery for any loss or damage arising from any cause covered by property insurance required to be carried or otherwise carried by each of them. Each party shall provide notice to the property insurance carrier or carriers of this mutual waiver of subrogation, and shall cause its respective property insurance carriers to waive all rights of subrogation against the other. This waiver shall not apply to the extent of the deductible amounts to any such property policies or to the extent of liabilities exceeding the limits of such policies.

17. INDEMNIFICATION.

a. Indemnification by Tenant. Tenant shall defend, indemnify, and hold Landlord harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Tenant or Tenant's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises or the Property, or arising from any breach of this Lease by Tenant. Tenant shall use legal counsel reasonably acceptable to Landlord in defense of any action within Tenant's defense obligation.

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b. Indemnification by Landlord. Landlord shall defend, indemnify and hold Tenant harmless against all liabilities, damages, costs, and expenses, including attorneys' fees, for personal injury, bodily injury (including death) or property damage arising from any negligent or wrongful act or omission of Landlord or Landlord's employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees on or around the Premises or the Property, or arising from any breach of this Lease by Landlord. Landlord shall use legal counsel reasonably acceptable to Tenant in defense of any action within Landlord's defense obligation.

c. Waiver of Immunity. Landlord and Tenant each specifically and expressly waive any immunity that each may be granted under the Washington State Industrial Insurance Act, Title 51 RCW. Neither party's indemnity obligations under this Lease shall be limited by any limitation on the amount or type of damages, compensation, or benefits payable to or for any third party under the Worker Compensation Acts, Disability Benefit Acts or other employee benefit acts.

d. Exemption of Landlord from Liability. Except to the extent of claims arising out of Landlord's gross negligence or intentional misconduct, Landlord shall not be liable for injury to Tenant's business or assets or any loss of income therefrom or for damage to any property of Tenant or of its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, other licensees or invitees, or any other person in or about the Premises or the Property.

e. Survival. The provisions of this Section shall survive expiration or termination of this Lease.

18. ASSIGNMENT AND SUBLETTING. Tenant shall not assign, sublet, mortgage, encumber or otherwise transfer any interest in this Lease (collectively referred to as a "Transfer") or any part of the Premises, without first obtaining Landlord's written consent, which shall not be unreasonably withheld, conditioned, or delayed. No Transfer shall relieve Tenant of any liability under this Lease notwithstanding Landlord's consent to such Transfer. Consent to any Transfer shall not operate as a waiver of the necessity for Landlord's consent to any subsequent Transfer. In connection with each request for consent to a Transfer, Tenant shall pay the reasonable cost of processing same, including attorneys' fees, upon demand of Landlord, up to a maximum of $1,250.

If Tenant is a partnership, limited liability company, corporation, or other entity, any transfer of this Lease by merger, consolidation, redemption or liquidation, or any change in the ownership of, or power to vote, which singularly or collectively represents a majority of the beneficial interest in Tenant, shall constitute a Transfer under this Section.

As a condition to Landlord's approval, if given, any potential assignee or sublessee otherwise approved by Landlord shall assume all obligations of Tenant under this Lease and shall be jointly and severally liable with Tenant and any guarantor, if required, for the payment of Rent and performance of all terms of this Lease. In connection with any Transfer, Tenant shall provide Landlord with copies of all assignments, subleases and assumption agreement and documents.

19. LIENS. Tenant shall not subject the Landlord's estate to any liens or claims of lien. Tenant shall keep the Premises free from any liens created by or through Tenant. Tenant shall indemnify and hold Landlord harmless from liability for any such liens including, without limitation, liens arising from any Alterations. If a lien is filed against the Premises by any person claiming by, through or under Tenant, Tenant shall, within ten (10) days after Landlord's demand, at Tenant's expense, either remove the lien or

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furnish to Landlord a bond in form and amount and issued by a surety satisfactory to Landlord, indemnifying Landlord and the Premises against all liabilities, costs and expenses, including attorneys' fees, which Landlord could reasonably incur as a result of such lien.

20. DEFAULT. The following occurrences shall each constitute a default by Tenant (an "Event of Default"):

a. Failure To Pay. Failure by Tenant to pay any sum, including Rent, due under this Lease following five (5) days' notice from Landlord of the failure to pay.

b. Vacation/Abandonment. Vacation by Tenant of the Premises (defined as an absence for at least fifteen (15) consecutive days without prior notice to Landlord), or abandonment by Tenant of the Premises (defined as an absence of five (5) days or more while Tenant is in breach of some other term of this Lease). Tenant's vacation or abandonment of the Premises shall not be subject to any notice or right to cure.

c. Insolvency. Tenant's insolvency or bankruptcy (whether voluntary or involuntary); or appointment of a receiver, assignee or other liquidating officer for Tenant's business; provided, however, that in the event of any involuntary bankruptcy or other insolvency proceeding, the existence of such proceeding shall constitute an Event of Default only if such proceeding is not dismissed or vacated within sixty (60) days after its institution or commencement.

d. Levy or Execution. The taking of Tenant's interest in this Lease or the Premises, or any part thereof, by execution or other process of law directed against Tenant, or attachment of Tenant's interest in this Lease by any creditor of Tenant, if such attachment is not discharged within fifteen (15) days after being levied.

e. **Other Non-Monetary Defaults.** The breach by Tenant of any agreement, term or covenant of this Lease other than one requiring the payment of money and not otherwise enumerated in this Section or elsewhere in this Lease, which breach continues for a period of thirty (30) days after notice by Landlord to Tenant of the breach.

f. **Failure to Take Possession.** Failure by Tenant to take possession of the Premises on the Commencement Date or failure by Tenant to commence any Tenant Improvement in a timely fashion.

Landlord shall not be in default unless Landlord fails to perform obligations required of Landlord within a reasonable time, but in no event less than thirty (30) days after notice by Tenant to Landlord. If Landlord fails to cure any such default within the allotted time, Tenant's sole remedy shall be to seek actual money damages (but not consequential or punitive damages) for loss arising from Landlord's failure to discharge its obligations under this Lease. Nothing herein contained shall relieve Landlord from its duty to perform of any of its obligations to the standard prescribed in this Lease.

Any notice periods granted herein shall be deemed to run concurrently with and not in addition to any default notice periods required by law.

21. REMEDIES. Landlord shall have the following remedies upon an Event of Default. Landlord's rights and remedies under this Lease shall be cumulative, and none shall exclude any other right or remedy allowed by law.

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a. **Termination of Lease.** Landlord may terminate Tenant's interest under the Lease, but no act by Landlord other than notice of termination from Landlord to Tenant shall terminate this Lease. The Lease shall terminate on the date specified in the notice of termination. Upon termination of this Lease, Tenant will remain liable to Landlord for damages in an amount equal to the rent and other sums that would have been owing by Tenant under this Lease for the balance of the Lease term, less the net proceeds, if any, of any re-letting of the Premises by Landlord subsequent to the termination, after deducting all of Landlord's Reletting Expenses (as defined below). Landlord shall be entitled to either collect damages from Tenant monthly on the days on which rent or other amounts would have been payable under the Lease, or alternatively, Landlord may accelerate Tenant's obligations under the Lease and recover from Tenant: (i) unpaid rent which had been earned at the time of termination; (ii) the amount by which the unpaid rent which would have been earned after termination until the time of award exceeds the amount of rent loss that Tenant proves could reasonably have been avoided; (iii) the amount by which the unpaid rent for the balance of the term of the Lease after the time of award exceeds the amount of rent loss that Tenant proves could reasonably be avoided (discounting such amount by the discount rate of the Federal Reserve Bank of San Francisco at the time of the award, plus 1%); and (iv) any other amount necessary to compensate Landlord for all the detriment proximately caused by Tenant's failure to perform its obligations under the Lease, or which in the ordinary course would be likely to result from the Event of Default, including without limitation Reletting Expenses described below.

b. **Re-Entry and Reletting**. Landlord may continue this Lease in full force and effect, and without demand or notice, re-enter and take possession of the Premises or any part thereof, expel the Tenant from the Premises and anyone claiming through or under the Tenant, and remove the personal property of either. Landlord may relet the Premises, or any part of them, in Landlord's or Tenant's name for the account of Tenant, for such period of time and at such other terms and conditions as Landlord, in its discretion, may determine. Landlord may collect and receive the rents for the Premises. To the fullest extent permitted by law, the proceeds of any reletting shall be applied: first, to pay Landlord all Reletting Expenses (defined below); second, to pay any indebtedness of Tenant to Landlord other than rent; third, to the rent due and unpaid hereunder; and fourth, the residue, if any, shall be held by Landlord and applied in payment of other or future obligations of Tenant to Landlord as the same may become due and payable, and Tenant shall not be entitled to receive any portion of such revenue. Re-entry or taking possession of the Premises by Landlord under this Section shall not be construed as an election on Landlord's part to terminate this Lease, unless a notice of termination is given to Tenant. Landlord reserves the right following any re-entry or reletting, or both, under this Section to exercise its right to terminate the Lease. Tenant will pay Landlord the rent and other sums which would be payable under this Lease if repossession had not occurred, less the net proceeds, if any, after reletting the Premises and after deducting Landlord's Reletting Expenses. "Reletting Expenses" are defined to include all expenses incurred by Landlord in connection with reletting the Premises, including without limitation, all repossession costs, brokerage commissions and costs of securing new tenants, attorneys' fees, remodeling and repair costs, costs for removing persons or property, costs for storing Tenant's property and equipment, and costs of tenant improvements and rent concessions granted by Landlord to any new Tenant, prorated over the life of the new lease

c. **Waiver of Redemption Rights.** Tenant, for itself, and on behalf of any and all persons claiming through or under Tenant, including creditors of all kinds, hereby waives and surrenders all rights and privileges which they may have under any present or future law, to redeem the Premises or to have a continuance of this Lease for the Lease term or any extension thereof.

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d. **Nonpayment of Additional Rent.** All costs which Tenant is obligated to pay to Landlord pursuant to this Lease shall in the event of nonpayment be treated as if they were payments of Rent, and Landlord shall have the same rights it has with respect to nonpayment of Rent.

e. **Failure to Remove Property**. If Tenant fails to remove any of its property from the Premises at Landlord's request following an uncured Event of Default, Landlord may, at its option, remove and store the property at Tenant's expense and risk. If Tenant does not pay the storage cost within five (5) days of Landlord's request, Landlord may, at its option, have any or all of such property sold at public or private sale (and Landlord may become a purchaser at such sale), in such manner as Landlord deems proper, without notice to Tenant. Landlord shall apply the proceeds of such sale: (i) to the expense of such sale, including reasonable attorneys' fees actually incurred; (ii) to the payment of the costs or charges for storing such property; (iii) to the payment of any other sums of money which may then be or thereafter become due Landlord from Tenant under any of the terms hereof; and (iv) the balance, if any, to Tenant. Nothing in this Section shall limit Landlord's right to sell Tenant's personal property as permitted by law or to foreclose Landlord's lien for unpaid rent.

22. MORTGAGE SUBORDINATION AND ATTORNMENT. This Lease shall automatically be subordinate to any mortgage or deed of trust created by Landlord which is now existing or hereafter placed upon the Premises including any advances, interest, modifications, renewals, replacements or extensions ("Landlord's Mortgage"). Tenant shall attorn to the holder of any Landlord's Mortgage or any party acquiring the Premises at any sale or other proceeding under any Landlord's Mortgage provided the acquiring party assumes the obligations of Landlord under this Lease. Tenant shall promptly and in no event later than fifteen (15) days after request, execute, acknowledge and deliver documents which the holder of any Landlord's Mortgage may reasonably require as further evidence of this subordination and attornment. Notwithstanding the foregoing, Tenant's obligations under this Section to subordinate in the future are conditioned on the holder of each Landlord's Mortgage and each party acquiring the Premises at any sale or other proceeding under any such Landlord's Mortgage not disturbing Tenant's occupancy and other rights under this Lease, so long as no uncured Event of Default by Tenant exists.

23. NON-WAIVER. Landlord's waiver of any breach of any provision contained in this Lease shall not be deemed to be a waiver of the same provision for subsequent acts of Tenant. The acceptance by Landlord of Rent or other amounts due by Tenant hereunder shall not be deemed to be a waiver of any previous breach by Tenant.

24. HOLDOVER. If Tenant shall, without the written consent of Landlord, remain in possession of the Premises and fail to return the Premises to Landlord after the expiration or termination of this Lease, the tenancy shall be a holdover tenancy and shall be on a month-to-month basis, which may be terminated according to Washington law. During such tenancy, Tenant agrees to pay to Landlord 150% of the rate of rental last payable under this Lease, unless a different rate is agreed upon by Landlord. All other terms of the Lease shall remain in effect. Tenant acknowledges and agrees that this Section does not grant any right to Tenant to holdover, and that Tenant may also be liable to Landlord for any and all damages or expenses which Landlord may have to incur as a result of Tenant's holdover.

25. NOTICES. All notices under this Lease shall be in writing and effective (i) when delivered in person or via overnight courier to the other party, (ii) three (3) days after being sent by registered or certified mail to the other party at the address set forth in Section 1; or (iii) upon confirmed transmission by facsimile to the other party at the facsimile numbers set forth in Section 1. The addresses for notices

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and payment of rent set forth in Section 1 may be modified by either party only by notice delivered in conformance with this Section.

26. COSTS AND ATTORNEYS' FEES. If Tenant or Landlord engage the services of an attorney to collect monies due or to bring any action for any relief against the other, declaratory or otherwise, arising out of this Lease, including any suit by Landlord for the recovery of Rent or other payments or possession of the Premises, the losing party shall pay the prevailing party a reasonable sum for attorneys' fees in such action, whether in mediation or arbitration, at trial, on appeal, or in any bankruptcy proceeding.

27. ESTOPPEL CERTIFICATES. Tenant shall, from time to time, upon written request of Landlord, execute, acknowledge and deliver to Landlord or its designee a written statement specifying the following, subject to any modifications necessary to make such statements true and complete: (i) the total rentable square footage of the Premises; (ii) the date the Lease term commenced and the date it expires; (iii) the amount of minimum monthly Rent and the date to which such Rent has been paid; (iv) that this Lease is in full force and effect and has not been assigned, modified, supplemented or amended in any way; (v) that this Lease represents the entire agreement between the parties; (vi) that all obligations under this Lease to be performed by either party have been satisfied; (vii) that there are no existing claims, defenses or offsets which the Tenant has against the enforcement of this Lease by Landlord; (viii) the amount of Rent, if any, that Tenant paid in advance; (ix) the amount of security that Tenant deposited with Landlord; (x) if Tenant has sublet all or a portion of the Premises or assigned its interest in the Lease and to whom; (xi) if Tenant has any option to extend the Lease or option to purchase the Premises; and (xii) such other factual matters concerning the Lease or the Premises as Landlord may reasonably request. Tenant acknowledges and agrees that any statement delivered pursuant to this Section may be relied upon by a prospective purchaser of Landlord's interest or assignee of any mortgage or new mortgagee of Landlord's interest in the Premises. If Tenant shall fail to respond within ten (10) days to Landlord's request for the statement required by this Section, Landlord may provide the statement and Tenant shall be deemed to have admitted the accuracy of the information provided by Landlord.

28. TRANSFER OF LANDLORD'S INTEREST. This Lease shall be assignable by Landlord without the consent of Tenant. In the event of any transfer or transfers of Landlord's interest in the Premises, other than a transfer for security purposes only, upon the assumption of this Lease by the transferee, Landlord shall be automatically relieved of obligations and liabilities accruing from and after the date of such transfer, including any liability for any retained security deposit or prepaid rent, for which the transferee shall be liable, and Tenant shall attorn to the transferee.

29. LANDLORD'S LIABILITY. Anything in this Lease to the contrary notwithstanding, covenants, undertakings and agreements herein made on the part of Landlord are made and intended not as personal covenants, undertakings and agreements for the purpose of binding Landlord personally or the assets of Landlord but are made and intended for the purpose of binding only the Landlord's interest in the Premises, as the same may from time to time be encumbered. In no event shall Landlord or its partners, shareholders, or members, as the case may be, ever be personally liable hereunder.

30. RIGHT TO PERFORM. If Tenant shall fail to timely pay any sum or perform any other act on its part to be performed hereunder, Landlord may make any such payment or perform any act on Tenant's behalf. Tenant shall, within ten (10) days of demand, reimburse Landlord for its expenses incurred in making such payment or performance. Landlord shall (in addition to any other right or remedy of Landlord provided by law) have the same rights and remedies in the event of the nonpayment of sums due under this Section as in the case of default by Tenant in the payment of Rent.

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31. HAZARDOUS MATERIAL. As used herein, the term "Hazardous Material" 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, due to its potential harm to the health, safety or welfare of humans or the environment. Landlord represents and warrants to Tenant that, to Landlord's knowledge without duty of investigation, there is no Hazardous Material on, in, or under the Premises as of the Commencement Date except as may otherwise have been disclosed to Tenant in writing before the execution of this Lease. If there is any Hazardous Material on, in, or under the Premises as of the Commencement Date which has been or thereafter becomes unlawfully released through no fault of Tenant, then Landlord shall indemnify, defend and hold Tenant harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including without limitation sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees, incurred or suffered by Tenant either during or after the Lease term as the result of such contamination.

Tenant shall not cause or permit any Hazardous Material to be brought upon, kept, or used in or about, or disposed of on the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, except with Landlord's prior consent and then only upon strict compliance with all applicable federal, state and local laws, regulations, codes and ordinances. If Tenant breaches the obligations stated in the preceding sentence, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses including, without limitation, diminution in the value of the Premises or the Property; damages for the loss or restriction on use of rentable or usable space or of any amenity of the Premises or the Property, or elsewhere; damages arising from any adverse impact on marketing of space at the Premises or the Property; and sums paid in settlement of claims, attorneys' fees, consultant fees and expert fees incurred or suffered by Landlord either during or after the Lease term. These indemnifications by Landlord and Tenant include, without limitation, costs incurred in connection with any investigation of site conditions or any clean-up, remedial, removal or restoration work, whether or not required by any federal, state or local governmental agency or political subdivision, because of Hazardous Material present in the Premises, or in soil or ground water on or under the Premises. Tenant shall immediately notify Landlord of any inquiry, investigation or notice that Tenant may receive from any third party regarding the actual or suspected presence of Hazardous Material on the Premises.

Without limiting the foregoing, if the presence of any Hazardous Material brought upon, kept or used in or about the Premises or the Property by Tenant, its employees, officers, agents, servants, contractors, customers, clients, visitors, guests, or other licensees or invitees, results in any unlawful release of any Hazardous Material on the Premises or the Property, Tenant shall promptly take all actions, at its sole expense, as are necessary to return the Premises and the Property to the condition existing prior to the release of any such Hazardous Material; provided that Landlord's approval of such actions shall first be obtained, which approval may be withheld at Landlord's sole discretion. The provisions of this Section shall survive expiration or termination of this Lease.

32. QUIET ENJOYMENT. So long as Tenant pays the Rent and performs all of its obligations in this Lease, Tenant's possession of the Premises will not be disturbed by Landlord or anyone claiming by, through or under Landlord.

33. MERGER. The voluntary or other surrender of this Lease by Tenant, or a mutual cancellation thereof, shall not work a merger and shall, at the option of Landlord, terminate all or any existing

subtenancies or may, at the option of Landlord, operate as an assignment to Landlord of any or all of such subtenancies.

34. GENERAL.

a. **Heirs and Assigns.** This Lease shall apply to and be binding upon Landlord and Tenant and their respective heirs, executors, administrators, successors and assigns.

b. Brokers' Fees. Tenant represents and warrants to Landlord that except for Tenant's Broker, if any, described and disclosed in Section 36 of this Lease), it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Landlord against any loss, cost, liability or expense incurred by Landlord as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Tenant. Landlord represents and warrants to Tenant that except for Landlord's Broker, if any, described and disclosed in Section 36, it has not engaged any broker, finder or other person who would be entitled to any commission or fees for the negotiation, execution or delivery of this Lease and shall indemnify and hold harmless Tenant against any loss, cost, liability or expense incurred by Tenant as a result of any claim asserted by any such broker, finder or other person on the basis of any arrangements or agreements made or alleged to have been made by or on behalf of Landlord.

c. Entire Agreement. This Lease contains all of the covenants and agreements between Landlord and Tenant relating to the Premises. No prior or contemporaneous agreements or understandings pertaining to the Lease shall be valid or of any force or effect and the covenants and agreements of this Lease shall not be altered, modified or amended except in writing, signed by Landlord and Tenant.

d. Severability. Any provision of this Lease which shall prove to be invalid, void or illegal shall in no way affect, impair or invalidate any other provision of this Lease.

e. Force Majeure. Time periods for either party's performance under any provisions of this Lease (excluding payment of Rent) shall be extended for periods of time during which the party's performance is prevented due to circumstances beyond such party's control, including without limitation, fires, floods, earthquakes, lockouts, strikes, embargoes, governmental regulations, acts of God, public enemy, war or other strife.

f. **Governing Law.** This Lease shall be governed by and construed in accordance with the laws of the State of Washington.

g. Memorandum of Lease. Neither this Lease nor any memorandum or "short form" thereof shall be recorded without Landlord's prior consent.

h. Submission of Lease Form Not an Offer. One party's submission of this Lease to the other for review shall not constitute an offer to lease the Premises. This Lease shall not become effective and binding upon Landlord and Tenant until it has been fully signed by both of them.

i. No Light, Air or View Easement. Tenant has not been granted an easement or other right for light, air or view to or from the Premises. Any diminution or shutting off of light, air or

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view by any structure which may be erected on or adjacent to the Building shall in no way effect this Lease or the obligations of Tenant hereunder or impose any liability on Landlord.

j. **Authority of Parties.** Each party signing this Lease represents and warrants to the other that it has the authority to enter into this Lease, that the execution and delivery of this Lease has been duly authorized, and that upon such execution and delivery, this Lease shall be binding upon and enforceable against the party on signing.

k. **Time**. "Day" as used herein means a calendar day and "business day" means any day on which commercial banks are generally open for business in the state where the Premises are situated. Any period of time which would otherwise end on a non-business day shall be extended to the next following business day. Time is of the essence of this Lease.

35. EXHIBITS AND RIDERS. The following exhibits and riders are made a part of this Lease, and the terms thereof shall control over any inconsistent provision in the sections of this Lease:

Exhibit A: Floor Plan/Outline of the Premises
Exhibit B: Legal Description of the Property
Exhibit C: Tenant Improvement Schedule
CHECK THE BOX FOR ANY OF THE FOLLOWING THAT WILL APPLY. CAPITALIZED TERMS USED IN THE RIDERS SHALL HAVE THE MEANING GIVEN TO THEM IN THE LEASE.

- ☒ Rent Rider
- ☐ Arbitration Rider
- ☐ Letter of Credit Rider
- ☐ Guaranty of Tenant's Lease Obligations Rider
- ☐ Parking Rider
- ☒ Option to Extend Rider
- ☐ Rules and Regulations

36. AGENCY DISCLOSURE. At the signing of this Lease, Landlord is represented by First Western Properties - Tacoma, Inc. (insert both the name of the Broker and the Firm as licensed) (the "Landlord's Broker"); and Tenant is represented by Jameson Sullivan of First Western Properties - Tacoma, Inc. (insert both the name of the Broker and the Firm as licensed) (the "Tenant's Broker").

This Agency Disclosure creates an agency relationship between Landlord, Landlord's Broker (if any such person is disclosed), and any managing brokers who supervise Landlord Broker's performance (collectively the "Supervising Brokers"). In addition, this Agency Disclosure creates an agency relationship between Tenant, Tenant's Broker (if any such person is disclosed), and any managing brokers who supervise Tenant's Broker's performance (also collectively the "Supervising Brokers"). If Tenant's Broker and Landlord's Broker are different real estate licensees affiliated with the same Firm, then both Tenant and Landlord confirm their consent to that Firm and both Tenant's and Landlord's Supervising Brokers acting as dual agents. If Tenant's Broker and Landlord's Broker are the same real estate licensee who represents both parties, then both Landlord and Tenant acknowledge that the Broker, his or her Supervising Brokers, and his or her Firm are acting as dual agents and hereby consent to such dual agency. If Tenant's Broker, Landlord's Broker, their Supervising Brokers, or their Firm are dual agents, Landlord and Tenant consent to Tenant's Broker, Landlord's Broker and their Firm being

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compensated based on a percentage of the rent or as otherwise disclosed on an attached addendum. Neither Tenant's Broker, Landlord's Broker nor either of their Firms are receiving compensation from more than one party to this transaction unless otherwise disclosed on an attached addendum, in which case Landlord and Tenant consent to such compensation. Landlord and Tenant confirm receipt of the pamphlet entitled "The Law of Real Estate Agency."

37. COMMISSION AGREEMENT. If Landlord has not entered into a listing agreement (or other compensation agreement with Landlord's Broker), Landlord agrees to pay a commission to Landlord's Broker (as identified in the Agency Disclosure paragraph above) as follows:

☐ $_____
☐ _____% of the gross rent payable pursuant to the Lease
☐ $_____ per square foot of the Premises
☒ Other Per separate agreement.

Landlord's Broker ☐ shall ☒ shall not (shall not if not filled in) be entitled to a commission upon the extension by Tenant of the Lease term pursuant to any right reserved to Tenant under the Lease calculated ☒ as provided above or ☐ as follows _____ (if no box is checked, as provided above). Landlord's Broker ☐ shall ☒ shall not (shall not if not filled in) be entitled to a commission upon any expansion of the Premises pursuant to any right reserved to Tenant under the Lease, calculated ☒ as provided above or ☐ as follows _____ (if no box is checked, as provided above).

Any commission shall be earned upon execution of this Lease, and paid one-half upon execution of the Lease and one-half upon occupancy of the Premises by Tenant. Landlord's Broker shall pay to Tenant's Broker (as identified in the Agency Disclosure paragraph above) the amount stated in a separate agreement between them or, if there is no agreement, $_____ or _____% (complete only one) of any commission paid to Landlord's Broker, within five (5) days after receipt by Landlord's Broker.

If any other lease or sale is entered into between Landlord and Tenant pursuant to a right reserved to Tenant under the Lease, Landlord ☐ shall ☒ shall not (shall not if not filled in) pay an additional commission according to any commission agreement or, in the absence of one, according to the commission schedule of Landlord's Broker in effect as of the execution of this Lease. Landlord's successor shall be obligated to pay any unpaid commissions upon any transfer of this Lease and any such transfer shall not release the transferor from liability to pay such commissions.

38. BROKER PROVISIONS.

LANDLORD'S BROKER, TENANT'S BROKER AND THEIR FIRMS HAVE MADE NO REPRESENTATIONS OR WARRANTIES CONCERNING THE PREMISES, THE MEANING OF THE TERMS AND CONDITIONS OF THIS LEASE, LANDLORD'S OR TENANT'S FINANCIAL STANDING, ZONING, COMPLIANCE OF THE PREMISES WITH APPLICABLE LAWS, SERVICE OR CAPACITY OF UTILITIES, OPERATING COSTS, OR HAZARDOUS MATERIALS. LANDLORD AND TENANT ARE EACH ADVISED TO SEEK INDEPENDENT LEGAL ADVICE ON THESE AND OTHER MATTERS ARISING UNDER THIS LEASE.

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

LEASE AGREEMENT
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IN WITNESS WHEREOF this Lease has been executed the date and year first above written.

Vidya Iyengar **LANDLORD:**	Michele Gill **TENANT:**
LANDLORD:	**TENANT:**
Vidya Iyengar **BY:**	Michele Gill **BY:**
Member **ITS:**	Authorized Signature **ITS:**

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STATE OF WASHINGTON
COUNTY OF Pierce | ss.

I certify that I know or have satisfactory evidence that Vidya Iyengar is the person who appeared before me and said person acknowledged that She signed this instrument, on oath stated that She was authorized to execute the instrument and acknowledged it as the Member of VNJ Enterprises, LLC to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 2nd day of April, 2018

HEATHER MAE RAMIREZ Commission Expires NOTARY PUBLIC 04-24-2021 STATE OF WASHINGTON

(Signature of Notary)

Heather Mae Ramirez
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington,
residing at Spanaway
My appointment expires 4/24/21

STATE OF WASHINGTON
COUNTY OF Pierce | ss.

I certify that I know or have satisfactory evidence that Michele Gill is the person who appeared before me and said person acknowledged that She signed this instrument, on oath stated that She was authorized to execute the instrument and acknowledged it as the Individual of Michele Gill to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this 2nd day of April, 2018

HEATHER MAE RAMIREZ Commission Expires NOTARY PUBLIC 04-24-2021 STATE OF WASHINGTON

(Signature of Notary)

Heather Mae Ramirez
(Legibly Print or Stamp Name of Notary)

Notary public in and for the state of Washington,
residing at Spanaway
My appointment expires 4/24/21

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

LEASE AGREEMENT
(Multi Tenant Gross Lease)

STATE OF WASHINGTON
ss.
COUNTY OF _____

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me and said person acknowledged that _____ signed this instrument, on oath stated that _____ was authorized to execute the instrument and acknowledged it as the _____ of _____ to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this _____ day of _____, 20___.

_____
(Signature of Notary)

_____
(Legibly Print or Stamp Name of Notary)
Notary public in and for the state of Washington,
residing at _____
My appointment expires _____

STATE OF WASHINGTON
ss.
COUNTY OF _____

I certify that I know or have satisfactory evidence that _____ is the person who appeared before me and said person acknowledged that _____ signed this instrument, on oath stated that _____ was authorized to execute the instrument and acknowledged it as the _____ of _____ to be the free and voluntary act of such party for the uses and purposes mentioned in the instrument.

Dated this _____ day of _____, 20___.

_____
(Signature of Notary)

_____
(Legibly Print or Stamp Name of Notary)
Notary public in and for the state of Washington,
residing at _____
My appointment expires _____

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
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LEASE AGREEMENT
(Multi Tenant Gross Lease)

EXHIBIT A

[Floor Plan/Outline of the Premises]

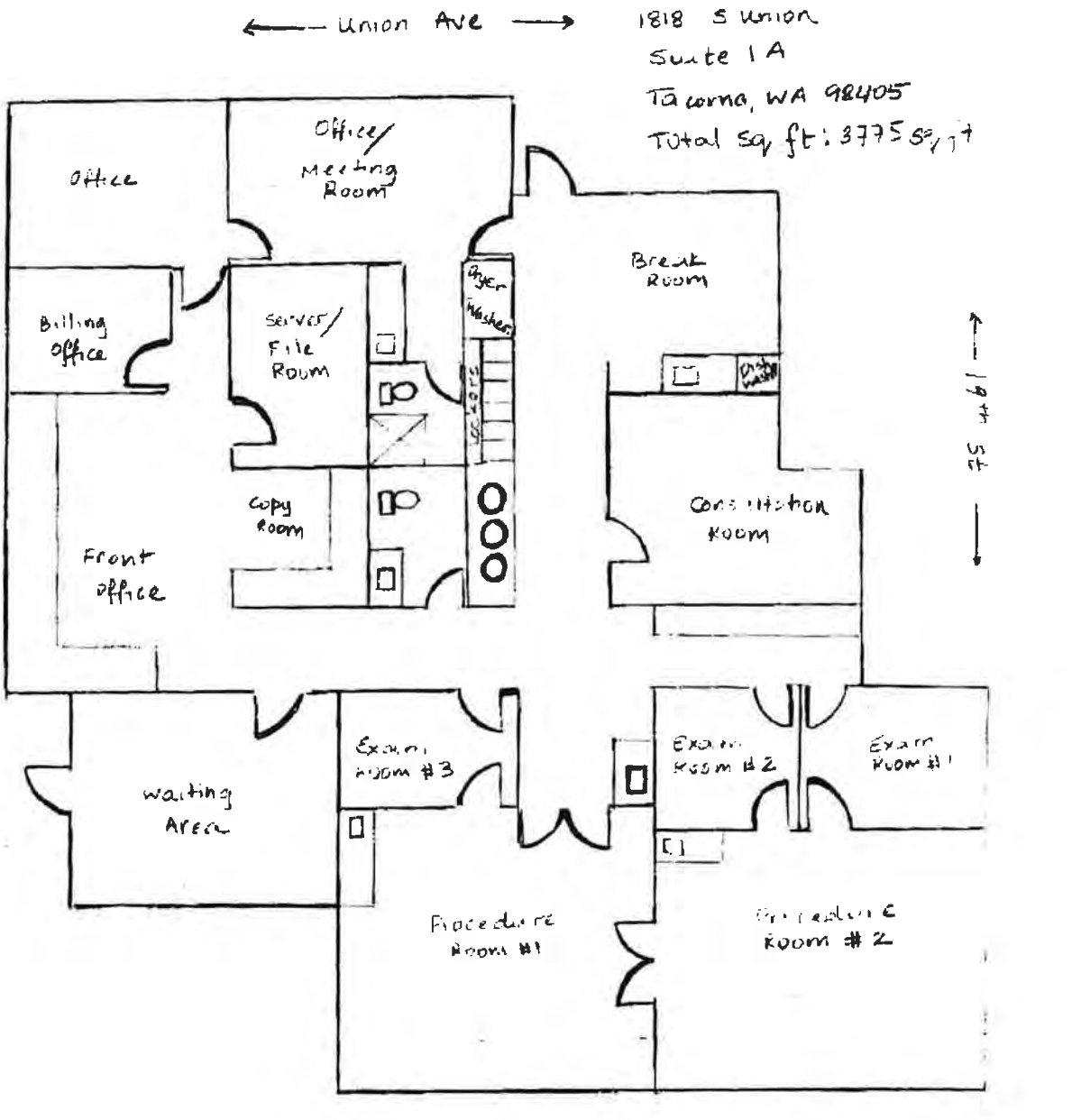

Exhibit A

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

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EXHIBIT B

[Legal Description of the Property]

Property Details		Taxpayer Details	
Parcel Number:	3175001171	**Taxpayer Name:**	VNJ ENTERPRISES LLC
Site Address:	1818 S UNION AV	**Mailing Address:**	PO BOX 111750 TACOMA WA 98411-1750
Account Type:	Real Property		
Category:	Land and Improvements		
Use Code:	6511-MEDICAL OFFICES SERVICES		
Appraisal Details		**Assessment Details**	
Value Area:	PI6	**2015 Values for 2016 Tax**	
Appr Acct Type:	Commercial	**Taxable Value:**	1,131,000
Business Name:	1818 PROFESSIONAL BLDG	**Assessed Value:**	1,131,000
Last Inspection:	07/17/2012 - Physical Inspection		

Related Parcels

Group Account Number: 812

Mobile/MFG Home and Personal Property parcel(s) located on this parcel: 1200112714 2000200582 2000202301

Real parcel on which this parcel is located: n/a

Tax Description

Section 06 Township 20 Range 03 Quarter 33 CONGDONS: CONGDONS L 1 THRU 5, PART OF L 6 B 53 LESS ST AS WIDENED BY WD # 2193476 TOG/W PART ALLEY VAC TOG/W POR OF VAC W UNION AVE UNDER FEE #2342015 EASE OF RECORD SEG F 0260

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

LEASE AGREEMENT
(Multi Tenant Gross Lease)

EXHIBIT C

[Tenant Improvement Schedule]

1. Tenant Improvements to be Completed by Landlord

Tenant shall take delivery of the Premises in its AS IS condition with all systems in "Good Working" condition.

2. Tenant Improvements to be Completed by Tenant

Tenant shall be permitted to make all alterations and improvements necessary for Tenant's use of the Premises. All Tenant Improvments to be Completed by Tenant shall be subject to Landlord written approval, which shall not be unreasonably withheld or denied.

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

ADDENDUM/AMENDMENT TO
CBA LEASES

CBA Text Disclaimer: Text deleted by licensee indicated by strike.

The following is part of the Commercial Lease Agreement dated March 16,2018,

Between VNJ Enterprises, LLC. ("Landlord")

And Envision Home Health of Washington, LLC ("Tenant")

regarding the lease of the Property known as: 1818 S Union Ave, Tacoma WA 98405

IT IS AGREED BETWEEN THE LANDLORD AND TENANT AS FOLLOWS: _____

TENANT IMPROVEMENT ALLOWANCE: Landlord shall reimburse Tenant with up to twenty-two thousand five hundred dollars ($22,500.00) for Tenant's interior improvements. Landlord shall reimburse Tenant within thirty (30) days of: i) Tenant providing lien waivers, ii) receipts, iii) as-built drawings, and iv) Tenant opening.

SIGNAGE: Tenant may install a sign on the building façade, subject to Landlord Sign Criteria. Tenant shall submit all sign proposals to Landlord in writing for approval prior to submitting sign to governing authority for approval, fabrication, or installation.

ACCESS: Tenant shall have access to the Premises 24 hours per day, 365 days per year.

AGENT (COMPANY): _____ By: _____

ALL OTHER TERMS AND CONDITIONS of said Agreement remain unchanged.

INITIALS:
Landlord/Lessor: _____ Date 4/2/18 Tenant/Lessee: _____ Date 4/2/2018

Landlord/Lessor: _____ Date _____ Tenant/Lessee: _____ Date _____

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

OPTION TO EXTEND RIDER

CBA Text Disclaimer: Text deleted by licensee indicated by strike. New text inserted by licensee indicated by small capital letters.

This Option to Extend Rider ("Rider") is made part of the lease agreement dated March 16, 2018 (the "Lease") between VNJ Enterprises, LLC. ("Landlord") and Envision Home Health of Washington, LLC. ("Tenant") concerning the leased space commonly known as 1818 S Union Ave (Suite 1A), Tacoma WA 98405 (the "Premises"), located at the property commonly known as 1818 S Union Ave, Tacoma WA 98405 (the "Property").

1. **Extension of Lease.** Provided Tenant is not in default of any provision of the Lease at the time that Tenant exercises the right to extend the Lease or at the time the new term begins, Tenant shall have one (1) (zero if not completed) ~~successive~~ option~~s~~ to extend the term of the Lease for no less than one (1) year and no more than five (5) years ~~each~~. The term of the Lease shall be extended on the same terms, conditions and covenants set forth in the Lease, except that (i) the amount of the Base Rent stated in the Lease shall be adjusted as set forth below (provided, however, that Base Rent shall not be decreased); (ii) there shall be no free or abated rent periods, tenant improvement allowances or other concessions that may have been granted to Tenant at the beginning of the initial term hereof; and (iii) after exercise of Tenant's final extension term option, there shall be no further extension or renewal term options.

2. **Notice.** To extend the Lease, Tenant must deliver written notice to Landlord not less than one hundred eighty (180) days prior to the expiration of the then-current Lease term. Time is of the essence of this Rider.

3. **Monthly Rent.** *PER RENT RIDER.* ~~Landlord and Tenant shall make a good faith effort to determine and agree on the fair market value of rent for the Premises for the next term of the Lease.~~

   a. ~~**Failure to Agree on Rent.** If Landlord and Tenant are unable to agree on the fair market rental value for the Premises within thirty (30) days after Tenant gives notice to extend, they shall then have ten (10) days to select or, appoint one real estate appraiser to determine the fair market value of rent for the Premises. All appraisers selected or appointed pursuant to this Rider shall be a Member of the American Institute of Real Estate Appraisers ("M.A.I.") with at least ten (10) years experience appraising commercial properties in the commercial leasing market in which the Premises are located, or equivalent. The appraiser appointed shall determine the fair market rental value for the Premises within twenty (20) days of appointment, which determination shall be final, conclusive, and binding upon both Landlord and Tenant, and Base Rent shall be adjusted accordingly for the new term. The appraiser's fees and expenses shall be shared equally between the parties.~~

   b. ~~**Failure to Appoint One Appraiser.** If Landlord and Tenant cannot mutually agree upon an appraiser, then either party may give the other party written notice that it has selected and appointed an M.A.I. appraiser, complete with the name, address, and other identifying information about the appraiser. The party receiving such notice shall then have ten (10) days to select and appoint its own M.A.I. appraiser and respond by giving written notice to the other party, complete with the name, address, and other identifying information about the appraiser. If, however, the responding party fails to select and appoint an appraiser and give notice to the other party within ten (10) days, the determination of the appraiser first appointed shall be final, conclusive and binding upon both parties, and the Base Rent shall be adjusted accordingly for the new term. The appraiser's fees and expenses shall be shared equally between the parties.~~

   c. ~~**Method of Determining Rent.** The appraisers appointed shall proceed to determine fair market rental value within twenty (20) days following their appointment. The conclusion shall be final, conclusive and binding upon both Landlord and Tenant. If the appraisers should fail to agree, but the difference in their conclusions as to fair market rental value is ten percent (10%) or less of the lower of the two appraisals, then the fair market rental value shall be deemed to be the average of the two, and Base Rent shall be adjusted~~

FIRST WESTERN PROPERTIES

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

OPTION TO EXTEND RIDER

~~accordingly for the new term. If the two appraisers should fail to agree on the fair market rental value, and the difference between the two appraisals exceeds ten percent (10%) of the lower of the two appraisals, then the two appraisers shall appoint a third M.A.I. qualified appraiser. If they fail to agree on a third appraiser within ten (10) days after their individual determination of the fair market rental value, either party may apply to the courts for the county in which the Premises are located, requesting the appointment of a the third M.A.I. qualified appraiser. The third appraiser shall promptly determine the fair market rental value of the Premises. The parties shall then take the average of the two appraisals that are closest in value, which shall then constitute the fair market value; shall be final, conclusive and binding upon both parties; and Base Rent shall be adjusted accordingly for the new term. Each party shall pay the fees and expenses for its own appraiser. In the event a third appraiser must be appointed, his or her fees and expenses shall be borne equally by the parties.~~

INITIALS: LANDLORD Mdy DATE 4/2/18 TENANT MG DATE 4/2/2018
LANDLORD _____ DATE _____ TENANT _____ DATE _____

First Western Properties - Tacoma Inc.
6402 Tacoma Mall Blvd
Tacoma, WA 98409
Phone: (253) 472-0404
Fax: (253) 472-0541

RENT RIDER

CBA Text Disclaimer: Text deleted by licensee indicated by strike.
New text inserted by licensee indicated by small capital letters.

This Rent Rider ("Rider") is a part of the lease agreement dated March 16, 2018 (the "Lease") between VNJ Enterprises, LLC. ("Landlord") and Envision Home Health of Washington, LLC. ("Tenant") concerning the space commonly known as 1818 S Union Ave (Suite 1A), Tacoma WA 98405 (the "Premises"), located at the property commonly known as 1818 S Union Ave, Tacoma WA 98405 (the "Property").

☒ **1. BASE MONTHLY RENT SCHEDULE.** Tenant shall pay Landlord base monthly rent during the Lease Term according to the following schedule:

Lease Year (Stated in Years or Months)	Base Monthly Rent Amount
Months 1-4	$0.00
Months 5-64	$7,317.00 (plus electricity)
Option Year 1	$7,536.51
Option Year 2	$7,762.61
Option Year 3	$7,995.49
Option Year 4	$8,235.35
OPTION YEAR 5	$8,482.41

☐ **2. CONSUMER PRICE INDEX ADJUSTMENT ON BASE MONTHLY RENT.** ~~The base monthly rent shall be increased on the first day of the second year of the Lease and on the first day of each year of the Lease thereafter (each, an "Adjustment Date") during the term of this Lease (but not during any extension term(s) unless specifically set forth elsewhere in the Lease or another Rider attached thereto). The increase shall be determined in accordance with the increase in the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers (all items for the geographical statistical area in which the Premises is located on the basis of 1982-1984 equals 100) (the "Index"). The base monthly rent payable immediately prior to the applicable adjustment date shall be increased by the percentage that the Index published for the date nearest preceding the applicable Adjustment Date has increased over the Index published for the date nearest preceding the first day of the Lease Year from which the adjustment is being measured. Upon the calculation of each increase, Landlord shall notify Tenant of the new base monthly rent payable hereunder. Within twenty (20) days of the date of Landlord's notice, Tenant shall pay to Landlord the amount of any deficiency in Rent paid by Tenant for the period following the subject Adjustment Date, and shall thereafter pay the increased Rent until receiving the next notice of increase from Landlord. If the components of the Index are materially changed after the Commencement Date, or if the Index is discontinued during the Lease term, Landlord shall notify Tenant of a substitute published index which, in Landlord's reasonable discretion, approximates the Index, and shall use the substitute index to make subsequent adjustments in base monthly rent. In no event shall base monthly rent be decreased pursuant to this Rider.~~

INITIALS: LANDLORD VNJ DATE 4/2/18 TENANT MA DATE 4/2/2018
LANDLORD _____ DATE _____ TENANT _____ DATE _____

RESOLUTION OF MANAGER
of
ENVISION HOME HEALTH OF WASHINGTON, LLC

The undersigned, acting as Manager of ENVISION HOME HEALTH OF WASHINGTON, LLC, a Washington limited liability company (the "Company"), hereby adopts the following resolution:

RESOLVED, that Michele Gill is hereby authorized to execute and deliver on behalf of the Company any and all documents, and agreements, deemed necessary or appropriate to effectuate a lease on the following property in Pierce County in the State of Washington: 1818 S Union Ave (Suite 1A), Tacoma WA 98405. A person who in good faith enters into a transaction in reliance upon this Resolution may enforce the transaction against the Company as if the representations contained herein are correct.

Rhett Andersen acting as Manager of the Company, has executed this resolution this 30th day of March 2018.

Rhett Andersen, Manager
Envision Home Health of Washington, LLC

Initial **Initial**

4/2/18 4/2/18

Memorandum of Understanding

Between

Envision Home Health of Washington, LLC and Envision Hospice of Washington, LLC

Whereas Envision Home Health of Washington, LLC (Home Health) currently leases office space in the City of Tacoma, Pierce County in the state of Washington with an address of 1818 S Union Ave Ste 1A, Tacoma, WA 98405 and

Whereas Envision Hospice of Washington, LLC (Hospice) is currently applying for a Certificate of Need for Pierce County and will be in need of office space upon approval and

Whereas Hospice is a wholly owned subsidiary of Home Health, Home Health and Hospice hereby agree that:

1. Upon the approval of Pierce County, 20 % of the current physical space within the existing office on 1818 S. Union Ave in Tacoma will be allocated for use of Hospice as per the application with the Washington Department of Health.
2. For purposes of accounting, the lease expenses will be allocated to Hospice's operating expenses as described in the applications with the Washington Department of Health.
3. Such cost allocation will be done monthly in the internal accounting for Hospice and Home Health.

This Memorandum will become effective as of the date of approval of the Pierce County Certificate of need herein referenced.

Date: January 26, 2021

Sherie Stewart
Manager of Envision Home Health of Washington, LLC and Envision Hospice of Washington, LLC

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(a) Step 1:

Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.

WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

Hospice admissions ages 0-64	
Year	Admissions
2018	4,114
2019	3,699
2020	3,679
	average: 3,831

Deaths ages 0-64	
Year	Deaths
2018	14,055
2019	14,047
2020	16,663
	average: 14,922

Use Rates	
0-64	25.67%
65+	60.15%

Hospice admissions ages 65+	
Year	Admissions
2018	26,207
2019	26,017
2020	27,956
	average: 26,727

Deaths ages 65+	
Year	Deaths
2018	42,773
2019	44,159
2020	46,367
	average: 44,433

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(b) Step 2:
Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

0-64				
County	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**
Adams	28	35	20	**28**
Asotin	52	54	56	**54**
Benton	331	346	555	**411**
Chelan	130	137	224	**164**
Clallam	191	186	195	**191**
Clark	874	887	1,043	**935**
Columbia	6	7	7	**7**
Cowlitz	300	294	314	**303**
Douglas	51	63	42	**52**
Ferry	28	20	19	**22**
Franklin	145	123	100	**123**
Garfield	5	5	5	**5**
Grant	195	197	186	**193**
Grays Harbor	227	251	209	**229**
Island	135	167	110	**137**
Jefferson	64	72	68	**68**
King	3,264	3,275	4,456	**3,665**
Kitsap	515	557	454	**509**
Kittitas	68	90	78	**79**
Klickitat	58	46	42	**49**
Lewis	227	210	205	**214**
Lincoln	25	25	15	**22**
Mason	158	167	143	**156**
Okanogan	103	119	88	**103**
Pacific	64	66	55	**62**
Pend Oreille	43	31	41	**38**
Pierce	1,964	1,911	2,364	**2,080**
San Juan	19	20	18	**19**
Skagit	231	229	269	**243**
Skamania	27	19	26	**24**
Snohomish	1,533	1,533	1,587	**1,551**
Spokane	1,177	1,143	1,634	**1,318**
Stevens	113	112	86	**104**
Thurston	554	525	628	**569**
Wahkiakum	13	11	10	**11**
Walla Walla	110	118	150	**126**
Whatcom	360	394	457	**404**
Whitman	66	47	51	**55**
Yakima	601	555	653	**603**

65+				
County	**2018**	**2019**	**2020**	**2018-2020 Average Deaths**
Adams	72	93	59	**75**
Asotin	214	222	186	**207**
Benton	1,125	1,154	1,522	**1,267**
Chelan	573	626	785	**661**
Clallam	871	955	777	**868**
Clark	2,767	2,987	3,205	**2,986**
Columbia	43	52	43	**46**
Cowlitz	840	951	968	**920**
Douglas	255	270	160	**228**
Ferry	55	64	58	**59**
Franklin	278	313	263	**285**
Garfield	30	21	11	**21**
Grant	524	508	455	**496**
Grays Harbor	647	659	558	**621**
Island	675	642	505	**607**
Jefferson	336	338	273	**316**
King	9,917	10,213	11,186	**10,439**
Kitsap	1,713	1,811	1,714	**1,746**
Kittitas	239	266	241	**249**
Klickitat	158	160	113	**144**
Lewis	730	722	653	**702**
Lincoln	94	89	75	**86**
Mason	526	548	408	**494**
Okanogan	332	358	277	**322**
Pacific	279	265	177	**240**
Pend Oreille	130	125	101	**119**
Pierce	4,926	5,002	5,608	**5,179**
San Juan	114	127	94	**112**
Skagit	1,001	1,018	1,068	**1,029**
Skamania	56	87	47	**63**
Snohomish	4,055	4,081	4,278	**4,138**
Spokane	3,556	3,545	4,322	**3,808**
Stevens	373	345	248	**322**
Thurston	1,823	1,908	2,007	**1,913**
Wahkiakum	33	53	18	**35**
Walla Walla	445	450	522	**472**
Whatcom	1,252	1,461	1,481	**1,398**
Whitman	199	219	226	**215**
Yakima	1,517	1,451	1,675	**1,548**

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(c) Step 3.
Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.

0-64		
County	2018-2020 Average Deaths	Projected Patients: 25.67% of Deaths
Adams	28	7
Asotin	54	14
Benton	411	105
Chelan	164	42
Clallam	191	49
Clark	935	240
Columbia	7	2
Cowlitz	303	78
Douglas	52	13
Ferry	22	6
Franklin	123	31
Garfield	5	1
Grant	193	49
Grays Harbor	229	59
Island	137	35
Jefferson	68	17
King	3,665	941
Kitsap	509	131
Kittitas	79	20
Klickitat	49	12
Lewis	214	55
Lincoln	22	6
Mason	156	40
Okanogan	103	27
Pacific	62	16
Pend Oreille	38	10
Pierce	2,080	534
San Juan	19	5
Skagit	243	62
Skamania	24	6
Snohomish	1,551	398
Spokane	1,318	338
Stevens	104	27
Thurston	569	146
Wahkiakum	11	3
Walla Walla	126	32
Whatcom	404	104
Whitman	55	14
Yakima	603	155

65+		
County	2018-2020 Average Deaths	Projected Patients: 60.15% of Deaths
Adams	75	45
Asotin	207	125
Benton	1,267	762
Chelan	661	398
Clallam	868	522
Clark	2,986	1,796
Columbia	46	28
Cowlitz	920	553
Douglas	228	137
Ferry	59	35
Franklin	285	171
Garfield	21	12
Grant	496	298
Grays Harbor	621	374
Island	607	365
Jefferson	316	190
King	10,439	6,279
Kitsap	1,746	1,050
Kittitas	249	150
Klickitat	144	86
Lewis	702	422
Lincoln	86	52
Mason	494	297
Okanogan	322	194
Pacific	240	145
Pend Oreille	119	71
Pierce	5,179	3,115
San Juan	112	67
Skagit	1,029	619
Skamania	63	38
Snohomish	4,138	2,489
Spokane	3,808	2,290
Stevens	322	194
Thurston	1,913	1,150
Wahkiakum	35	21
Walla Walla	472	284
Whatcom	1,398	841
Whitman	215	129
Yakima	1,548	931

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(d) Step 4:

Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate

0-64								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	7	18,160	18,456	18,622	18,787	7	7	7
Asotin	14	16,715	16,596	16,540	16,485	14	14	14
Benton	105	167,984	171,026	172,638	174,249	107	108	109
Chelan	42	62,227	62,512	62,562	62,611	42	42	42
Clallam	49	52,494	52,233	52,027	51,821	49	49	48
Clark	240	411,278	421,901	426,529	431,158	246	249	252
Columbia	2	2,822	2,745	2,710	2,675	2	2	2
Cowlitz	78	85,817	85,843	85,769	85,695	78	78	78
Douglas	13	35,130	35,803	36,080	36,356	14	14	14
Ferry	6	5,628	5,541	5,506	5,470	6	6	6
Franklin	31	88,012	92,443	94,784	97,124	33	34	35
Garfield	1	1,581	1,541	1,522	1,502	1	1	1
Grant	49	86,033	88,240	89,322	90,403	51	51	52
Grays Harbor	59	57,387	56,679	56,401	56,122	58	58	57
Island	35	63,114	63,280	63,296	63,312	35	35	35
Jefferson	17	20,705	20,636	20,550	20,463	17	17	17
King	941	1,885,115	1,918,470	1,930,192	1,941,913	958	963	969
Kitsap	131	218,538	220,614	221,192	221,771	132	132	133
Kittitas	20	38,453	39,286	39,556	39,827	21	21	21
Klickitat	12	15,702	15,439	15,304	15,168	12	12	12
Lewis	55	62,700	63,164	63,327	63,491	55	55	56
Lincoln	6	7,864	7,751	7,698	7,644	5	5	5
Mason	40	50,632	51,397	51,672	51,946	41	41	41
Okanogan	27	32,364	32,087	31,991	31,896	26	26	26
Pacific	16	14,545	14,322	14,242	14,161	16	16	15
Pend Oreille	10	9,859	9,769	9,727	9,684	10	10	10
Pierce	534	756,339	769,918	774,696	779,475	543	547	550
San Juan	5	10,863	10,730	10,707	10,684	5	5	5
Skagit	62	100,807	101,887	102,236	102,586	63	63	63
Skamania	6	9,248	9,223	9,205	9,186	6	6	6
Snohomish	398	705,787	721,527	726,273	731,019	407	410	412
Spokane	338	423,256	426,740	428,033	429,326	341	342	343
Stevens	27	34,109	33,917	33,841	33,766	26	26	26
Thurston	146	238,190	243,867	246,235	248,602	150	151	152
Wahkiakum	3	2,498	2,405	2,368	2,332	3	3	3
Walla Walla	32	50,763	51,028	51,075	51,121	33	33	33
Whatcom	104	185,418	189,267	190,722	192,178	106	107	107
Whitman	14	43,222	43,315	43,322	43,330	14	14	14
Yakima	155	222,774	225,822	227,147	228,473	157	158	159

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(d) Step 4:
Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.

65+								
County	Projected Patients	2018-2020 Average Population	2021 projected population	2022 projected population	2023 projected population	2021 potential volume	2022 potential volume	2023 potential volume
Adams	45	2,227	2,383	2,424	2,466	48	49	50
Asotin	125	5,812	6,175	6,344	6,514	132	136	140
Benton	762	30,986	33,373	34,597	35,820	821	851	881
Chelan	398	15,876	17,052	17,695	18,339	427	443	460
Clallam	522	21,800	22,901	23,535	24,168	548	563	579
Clark	1,796	78,605	85,686	89,247	92,807	1,958	2,039	2,121
Columbia	28	1,236	1,287	1,304	1,322	29	29	30
Cowlitz	553	22,148	23,719	24,470	25,220	592	611	630
Douglas	137	7,976	8,666	8,974	9,283	149	155	160
Ferry	35	2,168	2,289	2,337	2,386	37	38	39
Franklin	171	9,188	10,083	10,557	11,030	188	197	206
Garfield	12	645	669	680	692	13	13	13
Grant	298	14,861	16,071	16,665	17,258	322	334	346
Grays Harbor	374	16,123	17,133	17,612	18,092	397	408	419
Island	365	20,239	21,412	22,047	22,682	386	398	409
Jefferson	190	11,588	12,323	12,722	13,121	202	208	215
King	6,279	310,572	337,771	350,881	363,992	6,829	7,094	7,359
Kitsap	1,050	53,833	58,185	60,492	62,800	1,135	1,180	1,225
Kittitas	150	7,647	8,266	8,589	8,911	162	168	174
Klickitat	86	5,829	6,268	6,448	6,627	93	96	98
Lewis	422	16,808	17,697	18,175	18,652	444	456	468
Lincoln	52	2,891	3,039	3,119	3,200	54	56	57
Mason	297	15,905	17,167	17,836	18,504	321	333	346
Okanogan	194	10,475	11,210	11,519	11,827	207	213	219
Pacific	145	6,747	7,035	7,159	7,284	151	153	156
Pend Oreille	71	3,925	4,239	4,371	4,504	77	80	82
Pierce	3,115	130,688	142,422	148,729	155,037	3,395	3,545	3,695
San Juan	67	5,768	6,174	6,357	6,541	72	74	76
Skagit	619	27,881	30,314	31,460	32,607	673	698	724
Skamania	38	2,670	2,923	3,048	3,172	42	43	45
Snohomish	2,489	119,333	131,978	138,737	145,495	2,753	2,894	3,035
Spokane	2,290	87,852	94,670	97,979	101,288	2,468	2,554	2,641
Stevens	194	11,360	12,214	12,591	12,969	208	215	221
Thurston	1,150	50,757	54,900	56,967	59,035	1,244	1,291	1,338
Wahkiakum	21	1,503	1,580	1,595	1,611	22	22	22
Walla Walla	284	11,006	11,350	11,632	11,915	293	300	308
Whatcom	841	40,902	44,217	45,794	47,372	909	941	974
Whitman	129	5,526	6,008	6,201	6,395	140	145	149
Yakima	931	37,530	39,475	40,559	41,643	979	1,006	1,033

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Posted November 10, 2021

WAC246-310-290(8)(e) Step 5:
Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.

County	2021 potential volume	2022 potential volume	2023 potential volume	Current Supply of Hospice Providers	2021 Unmet Need Admissions*	2022 Unmet Need Admissions*	2023 Unmet Need Admissions*
Adams	55	56	57	**51.33**	4	5	6
Asotin	146	150	153	**105.00**	41	45	48
Benton	928	959	990	**1,016.67**	(88)	(57)	(26)
Chelan	469	486	502	**428.67**	41	57	73
Clallam	597	612	627	**392.80**	204	219	234
Clark	2,204	2,288	2,372	**2,584.47**	(380)	(296)	(212)
Columbia	30	31	31	**35.00**	(5)	(4)	(4)
Cowlitz	670	689	708	**788.00**	(118)	(99)	(80)
Douglas	163	168	174	**160.67**	2	8	13
Ferry	43	44	45	**32.00**	11	12	13
Franklin	221	231	240	**201.67**	19	29	39
Garfield	14	14	15	**6.00**	8	8	9
Grant	373	386	398	**292.33**	81	93	106
Grays Harbor	455	466	477	**295.57**	160	170	181
Island	422	433	445	**399.67**	22	34	45
Jefferson	219	226	232	**198.00**	21	28	34
King	7,786	8,057	8,328	**7,830.73**	(44)	226	497
Kitsap	1,267	1,312	1,358	**1,223.57**	43	89	134
Kittitas	182	189	195	**168.00**	14	21	27
Klickitat	105	108	110	**217.80**	(113)	(110)	(107)
Lewis	500	512	524	**445.33**	54	67	79
Lincoln	60	61	63	**29.00**	31	32	34
Mason	361	374	387	**304.57**	57	70	82
Okanogan	234	239	245	**188.33**	45	51	57
Pacific	166	169	171	**93.00**	73	76	78
Pend Oreille	87	89	92	**65.33**	22	24	26
Pierce	3,938	4,092	4,246	**3,596.23**	342	496	649
San Juan	77	79	81	**87.00**	(10)	(8)	(6)
Skagit	736	762	787	**729.00**	7	33	58
Skamania	48	50	51	**32.00**	16	18	19
Snohomish	3,160	3,303	3,447	**3,508.33**	(349)	(205)	(61)
Spokane	2,809	2,897	2,984	**2,720.50**	89	176	263
Stevens	235	241	247	**148.67**	86	92	99
Thurston	1,394	1,442	1,491	**1,565.30**	(171)	(123)	(75)
Wahkiakum	25	25	25	**9.33**	15	16	16
Walla Walla	326	333	340	**272.33**	53	60	68
Whatcom	1,015	1,048	1,081	**1,094.57**	(80)	(46)	(13)
Whitman	154	159	163	**158.17**	(4)	1	5
Yakima	1,136	1,164	1,192	**1,261.00**	(125)	(97)	(69)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(f) Step 6:
Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	**2021 Unmet Need Admissions***	**2022 Unmet Need Admissions***	**2023 Unmet Need Admissions***	**Statewide ALOS**	**2021 Unmet Need Patient Days***	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***
Adams	4	5	6	**62.12**	244	300	356
Asotin	41	45	48	**62.12**	2,563	2,786	3,009
Benton	(88)	(57)	(26)	**62.12**	(5,497)	(3,565)	(1,633)
Chelan	41	57	73	**62.12**	2,535	3,539	4,542
Clallam	204	219	234	**62.12**	12,682	13,613	14,543
Clark	(380)	(296)	(212)	**62.12**	(23,619)	(18,396)	(13,174)
Columbia	(5)	(4)	(4)	**62.12**	(281)	(258)	(235)
Cowlitz	(118)	(99)	(80)	**62.12**	(7,320)	(6,160)	(5,000)
Douglas	2	8	13	**62.12**	134	470	807
Ferry	11	12	13	**62.12**	691	737	784
Franklin	19	29	39	**62.12**	1,201	1,801	2,401
Garfield	8	8	9	**62.12**	506	518	531
Grant	81	93	106	**62.12**	5,021	5,799	6,578
Grays Harbor	160	170	181	**62.12**	9,916	10,589	11,261
Island	22	34	45	**62.12**	1,377	2,090	2,802
Jefferson	21	28	34	**62.12**	1,324	1,726	2,127
King	(44)	226	497	**62.12**	(2,759)	14,070	30,899
Kitsap	43	89	134	**62.12**	2,696	5,513	8,331
Kittitas	14	21	27	**62.12**	889	1,290	1,691
Klickitat	(113)	(110)	(107)	**62.12**	(6,994)	(6,835)	(6,676)
Lewis	54	67	79	**62.12**	3,378	4,132	4,886
Lincoln	31	32	34	**62.12**	1,917	2,004	2,091
Mason	57	70	82	**62.12**	3,529	4,319	5,108
Okanogan	45	51	57	**62.12**	2,823	3,173	3,523
Pacific	73	76	78	**62.12**	4,554	4,714	4,875
Pend Oreille	22	24	26	**62.12**	1,337	1,483	1,630
Pierce	342	496	649	**62.12**	21,240	30,788	40,337
San Juan	(10)	(8)	(6)	**62.12**	(639)	(507)	(375)
Skagit	7	33	58	**62.12**	435	2,029	3,623
Skamania	16	18	19	**62.12**	984	1,094	1,204
Snohomish	(349)	(205)	(61)	**62.12**	(21,649)	(12,726)	(3,802)
Spokane	89	176	263	**62.12**	5,511	10,934	16,357
Stevens	86	92	99	**62.12**	5,345	5,741	6,136
Thurston	(171)	(123)	(75)	**62.12**	(10,646)	(7,645)	(4,643)
Wahkiakum	15	16	16	**62.12**	956	967	977
Walla Walla	53	60	68	**62.12**	3,304	3,758	4,213
Whatcom	(80)	(46)	(13)	**62.12**	(4,953)	(2,888)	(823)
Whitman	(4)	1	5	**62.12**	(231)	50	330
Yakima	(125)	(97)	(69)	**62.12**	(7,760)	(6,032)	(4,305)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources: CPS MDCR Hospice 3 Report
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(g) Step 7:
Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2021 Unmet Need Patient Days***	**2022 Unmet Need Patient Days***	**2023 Unmet Need Patient Days***	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***
Adams	244	300	356	1	1	1
Asotin	2,563	2,786	3,009	7	8	8
Benton	(5,497)	(3,565)	(1,633)	(15)	(10)	(4)
Chelan	2,535	3,539	4,542	7	10	12
Clallam	12,682	13,613	14,543	35	37	40
Clark	(23,619)	(18,396)	(13,174)	(65)	(50)	(36)
Columbia	(281)	(258)	(235)	(1)	(1)	(1)
Cowlitz	(7,320)	(6,160)	(5,000)	(20)	(17)	(14)
Douglas	134	470	807	0	1	2
Ferry	691	737	784	2	2	2
Franklin	1,201	1,801	2,401	3	5	7
Garfield	506	518	531	1	1	1
Grant	5,021	5,799	6,578	14	16	18
Grays Harbor	9,916	10,589	11,261	27	29	31
Island	1,377	2,090	2,802	4	6	8
Jefferson	1,324	1,726	2,127	4	5	6
King	(2,759)	14,070	30,899	(8)	39	85
Kitsap	2,696	5,513	8,331	7	15	23
Kittitas	889	1,290	1,691	2	4	5
Klickitat	(6,994)	(6,835)	(6,676)	(19)	(19)	(18)
Lewis	3,378	4,132	4,886	9	11	13
Lincoln	1,917	2,004	2,091	5	5	6
Mason	3,529	4,319	5,108	10	12	14
Okanogan	2,823	3,173	3,523	8	9	10
Pacific	4,554	4,714	4,875	12	13	13
Pend Oreille	1,337	1,483	1,630	4	4	4
Pierce	21,240	30,788	40,337	58	84	111
San Juan	(639)	(507)	(375)	(2)	(1)	(1)
Skagit	435	2,029	3,623	1	6	10
Skamania	984	1,094	1,204	3	3	3
Snohomish	(21,649)	(12,726)	(3,802)	(59)	(35)	(10)
Spokane	5,511	10,934	16,357	15	30	45
Stevens	5,345	5,741	6,136	15	16	17
Thurston	(10,646)	(7,645)	(4,643)	(29)	(21)	(13)
Wahkiakum	956	967	977	3	3	3
Walla Walla	3,304	3,758	4,213	9	10	12
Whatcom	(4,953)	(2,888)	(823)	(14)	(8)	(2)
Whitman	(231)	50	330	(1)	0	1
Yakima	(7,760)	(6,032)	(4,305)	(21)	(17)	(12)

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

WAC246-310-290(8)(h) Step 8:
Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.

Application Year

Step 7 (Patient Days / 365) = Unmet ADC				Step 8 - Numeric Need	
County	**2021 Unmet Need ADC***	**2022 Unmet Need ADC***	**2023 Unmet Need ADC***	**Numeric Need?**	**Number of New Agencies Needed?****
Adams	1	1	1	FALSE	FALSE
Asotin	7	8	8	FALSE	FALSE
Benton	(15)	(10)	(4)	FALSE	FALSE
Chelan	7	10	12	FALSE	FALSE
Clallam	35	37	40	*TRUE*	*1*
Clark	(65)	(50)	(36)	FALSE	FALSE
Columbia	(1)	(1)	(1)	FALSE	FALSE
Cowlitz	(20)	(17)	(14)	FALSE	FALSE
Douglas	0	1	2	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	3	5	7	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	27	29	31	FALSE	FALSE
Island	4	6	8	FALSE	FALSE
Jefferson	4	5	6	FALSE	FALSE
King	(8)	39	85	*TRUE*	*2*
Kitsap	7	15	23	FALSE	FALSE
Kittitas	2	4	5	FALSE	FALSE
Klickitat	(19)	(19)	(18)	FALSE	FALSE
Lewis	9	11	13	FALSE	FALSE
Lincoln	5	5	6	FALSE	FALSE
Mason	10	12	14	FALSE	FALSE
Okanogan	8	9	10	FALSE	FALSE
Pacific	12	13	13	FALSE	FALSE
Pend Oreille	4	4	4	FALSE	FALSE
Pierce	58	84	111	*TRUE*	*3*
San Juan	(2)	(1)	(1)	FALSE	FALSE
Skagit	1	6	10	FALSE	FALSE
Skamania	3	3	3	FALSE	FALSE
Snohomish	(59)	(35)	(10)	FALSE	FALSE
Spokane	15	30	45	*TRUE*	*1*
Stevens	15	16	17	FALSE	FALSE
Thurston	(29)	(21)	(13)	FALSE	FALSE
Wahkiakum	3	3	3	FALSE	FALSE
Walla Walla	9	10	12	FALSE	FALSE
Whatcom	(14)	(8)	(2)	FALSE	FALSE
Whitman	(1)	0	1	FALSE	FALSE
Yakima	(21)	(17)	(12)	FALSE	FALSE

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Vital Statistics Death Data for Years 2018-2020
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
Admissions - Summarized

0-64 Total Admissions by County

Sum of 0-64	Column Labels		
Row Labels	2018	2019	2020
Adams	6	8	4
Asotin	6	9	24
Benton	118	103	132
Chelan	34	28	32
Clallam	16	23	24
Clark	336	287	297
Columbia	1	3	3
Cowlitz	107	121	94
Douglas	10	19	17
Ferry	6	5	3
Franklin	30	26	34
Garfield	1	1	3
Grant	41	45	40
Grays Harbor	35	41	27
Island	38	43	54
Jefferson	21	26	17
King	1009	765	889
Kitsap	180	173	96
Kittitas	15	16	12
Klickitat	10	12	12
Lewis	56	50	47
Lincoln	7	3	5
Mason	14	34	43
Okanogan	21	27	31
Pacific	13	15	12
Pend Oreille	8	4	17
Pierce	543	556	425
San Juan	6	6	8
Skagit	48	77	70
Skamania	2	1	3
Snohomish	422	342	361
Spokane	400	329	362
Stevens	30	20	21
Thurston	114	115	129
Wahkiakum	2	0	3
Walla Walla	24	41	41
Whatcom	117	138	80
Whitman	19	12	12
Yakima	248	175	195

65+ Total Admissions by County

Sum of 65+	Column Labels		
Row Labels	2018	2019	2020
Adams	34	54	48
Asotin	121	71	84
Benton	887	837	973
Chelan	386	385	421
Clallam	187	234	283
Clark	2124	2060	2238
Columbia	23	25	50
Cowlitz	600	735	707
Douglas	136	130	170
Ferry	29	25	28
Franklin	155	166	194
Garfield	2	4	7
Grant	261	236	254
Grays Harbor	180	212	186
Island	348	341	375
Jefferson	155	181	194
King	6359	6315	7131
Kitsap	1021	1074	921
Kittitas	135	169	157
Klickitat	81	90	87
Lewis	420	362	401
Lincoln	29	22	21
Mason	161	193	263
Okanogan	148	171	167
Pacific	72	98	69
Pend Oreille	53	65	49
Pierce	3175	3170	2714
San Juan	79	73	89
Skagit	680	705	607
Skamania	20	33	37
Snohomish	2636	2214	2636
Spokane	2247.5	2175	2648
Stevens	121	126	128
Thurston	936	947	1070
Wahkiakum	5	7	11
Walla Walla	227	242	242
Whatcom	770	995	978
Whitman	226.5	77	128
Yakima	977	998	1190

Total Admissions by County - Not Adjusted for New

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	257	307	**255.67**
Clark	2460	2347	2535	**2447.33**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	213	**227.00**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7080	8020	**7489.33**
Kitsap	1201	1247	1017	**1155.00**
Kittitas	150	185	169	**168.00**
Klickitat	91	102	99	**97.33**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	306	**236.00**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3139	**3527.67**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	2556	2997	**2870.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1050	1062	1199	**1103.67**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1058	**1026.00**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

Total Admissions by County - Adjusted for New

Adjusted Cells Highlighted in YELLOW

County	2018	2019	2020	Average
Adams	40	62	52	**51.33**
Asotin	127	80	108	**105.00**
Benton	1005	940	1105	**1016.67**
Chelan	420	413	453	**428.67**
Clallam	203	462.7	512.7	**392.80**
Clark	2460	2552.7	2740.7	**2584.47**
Columbia	24	28	53	**35.00**
Cowlitz	707	856	801	**788.00**
Douglas	146	149	187	**160.67**
Ferry	35	30	31	**32.00**
Franklin	185	192	228	**201.67**
Garfield	3	5	10	**6.00**
Grant	302	281	294	**292.33**
Grays Harb	215	253	418.7	**295.57**
Island	386	384	429	**399.67**
Jefferson	176	207	211	**198.00**
King	7368	7400.4	8723.8	**7830.73**
Kitsap	1201	1247	1222.7	**1223.57**
Kittitas	150	185	169	**168.00**
Klickitat	272.7	281.7	99	**217.80**
Lewis	476	412	448	**445.33**
Lincoln	36	25	26	**29.00**
Mason	175	227	511.7	**304.57**
Okanogan	169	198	198	**188.33**
Pacific	85	113	81	**93.00**
Pend Oreill	61	69	66	**65.33**
Pierce	3718	3726	3344.7	**3596.23**
San Juan	85	79	97	**87.00**
Skagit	728	782	677	**729.00**
Skamania	22	34	40	**32.00**
Snohomish	3058	3378.8	4088.2	**3508.33**
Spokane	2647.5	2504	3010	**2720.50**
Stevens	151	146	149	**148.67**
Thurston	1255.7	1449.4	1990.8	**1565.30**
Wahkiakun	7	7	14	**9.33**
Walla Wall	251	283	283	**272.33**
Whatcom	887	1133	1263.7	**1094.57**
Whitman	245.5	89	140	**158.17**
Yakima	1225	1173	1385	**1261.00**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.12 ALOS = 205.7 default admissions
205.7 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

Sources:
Self-Report Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

Recent approvals showing default volumes:

Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019-2020
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019-2020
The Pennant Group - Grays Harbor County. Approved August 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019-2020
Continuum Care of King - King County. CN issued March 2020. Default volumes for 2020
EmpRes Healthcare Group - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - King County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Kitsap County. Approved in 2020. Default volumes for 2020
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2018-2019.
The Pennant Group - Mason County. Approved September 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Providence Health & Services - Pierce County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019-2020
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019-2020
EmpRes Healthcare Group - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Seasons Hospice - Snohomish County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2020.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019-2020
Bristol Hospice - Thurston County. Approved March 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
MultiCare Health - Thurston County. Approved in 2021. No adjustment possible for 2021, adjustment in 2020 as proxy.
EmpRes Healthcare Group - Whatcom County. Approved in 2020. Default volumes for 2020

Department of Health
2021-2022 Hospice Numeric Need Methodology
Survey Responses

Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the average of 2016 and 2017 data was used as a proxy for 2018.

Agency Name	License Number	County	Year	0-64	65+
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Grant	2018	40	254
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Lincoln	2018	6	28
Assured Home Health and Hospice (Central Basin/Assured Hospice)	IHS.FS.60092413	Adams	2018	6	34
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Jefferson	2018	1	11
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Mason	2018	4	44
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Clallam	2018	16	186
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Thurston	2018	24	273
Assured Home Health, Hospice & Home Care	IHS.FS.00000229	Lewis	2018	35	280
Astria Home Health and Hospice (Yakima Regional Home Health and Hospice)	IHS.FS.60097245	Yakima	2018	41	8
Central Washington Hospital Home Care Services	IHS.FS.00000250	Douglas	2018	10	133
Central Washington Hospital Home Care Services	IHS.FS.00000250	Chelan	2018	34	386
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Wahkiakum	2018	2	5
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Clark	2018	54	383
Community Home Health and Hospice CHHH Community Home Care Hospice	IHS.FS.00000262	Cowlitz	2018	87	524
Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2018	1	2
Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2018	6	121
Evergreen Health Home Care Services	IHS.FS.00000278	Island	2018	1	9
Evergreen Health Home Care Services	IHS.FS.00000278	Snohomish	2018	79	690
Evergreen Health Home Care Services	IHS.FS.00000278	King	2018	348	1989
Franciscan Hospice	IHS.FS.00000287	Kitsap	2018	141	693
Franciscan Hospice	IHS.FS.00000287	King	2018	102	921
Franciscan Hospice	IHS.FS.00000287	Pierce	2018	331	2110
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Douglas	2018	0	3
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Grant	2018	1	7
Frontier Home Health and Hospice (Okanogan Regional)	IHS.FS.60379608	Okanogan	2018	21	148
Gentiva Hospice (Odyssey Hospice)	IHS.FS.60330209	King	2018	37	180
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2018	13	71
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2018	35	180
Heart of Hospice	IHS.FS.00000185	Skamania	2018	none repo	10
Heart of Hospice	IHS.FS.00000185	Klickitat	2018	1	23
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Benton	2018	6	137
Heartlinks Hospice and Palliative Care (Lower Valley Hospice)	IHS.FS.00000369	Yakima	2018	24	219
Home Health Care of Whidbey General Hospital (Whidbey General)	IHS.FS.00000323	Island	2018	20	235
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Skamania	2018	1	1
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Cowlitz	2018	20	76
Homecare and Hospice Southwest (Hospice SW)	IHS.FS.60331226	Clark	2018	243	1305
Horizon Hospice	IHS.FS.00000332	Spokane	2018	31	389
Hospice of Kitsap County	IHS.FS.00000335	Kitsap	2018	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2018	1	1
Hospice of Spokane	IHS.FS.00000337	Ferry	2018	6	29
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2018	8	53
Hospice of Spokane	IHS.FS.00000337	Stevens	2018	30	121
Hospice of Spokane	IHS.FS.00000337	Spokane	2018	346	1593
Hospice of Spokane	IHS.FS.00000337	Whitman	2018	none repo	none repor
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Island	2018	6	60
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Snohomish	2018	2	67
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	San Juan	2018	6	79
Hospice of the Northwest (Skagit Hospice Service)	IHS.FS.00000437	Skagit	2018	48	680
IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE	IHS.FS.00000262	Pacific	2018	0	1
IRREGULAR-MULTICARE	IHS.FS.60639376	Clallam	2018	0	1
Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County)	IHS.FS.00000349	Jefferson	2018	20	144
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2018	39	436
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2018	none repo	none repor
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Skamania	2018	none repo	none repor
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Snohomish	2018	14	94
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Kitsap	2018	14	96
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	Pierce	2018	35	198
Kaiser Permanente Home Health and Hospice (Group Health)	IHS.FS.00000305	King	2018	25	416
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Whitman	2018	19	226.5
Kindred Hospice (Gentiva Hospice	IHS.FS.60308060	Spokane	2018	23	265.5
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2018	15	135
Klickitat Valley Home Health & Hospice (Klickitat Valley Health)	IHS.FS.00000361	Klickitat	2018	5	40
Kline Galland Community Based Services	IHS.FS.60103742	King	2018	29	368
Memorial Home Care Services	IHS.FS.00000376	Yakima	2018	183	750
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639376	King	2018	32	158

Sources:
Self-Report Service Utilization Surveys for 2018-2020
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Agency Name	License Number	County	Year	0-64	65+
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639377	Kitsap	2018	25	232
MultiCare Home Health, Hospice and Palliative Care	IHS.FS.60639378	Pierce	2018	177	867
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Skamania	2018	1	9
Providence Hospice (Hospice of the Gorge)	IHS.FS.60201476	Klickitat	2018	4	18
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2018	11	44
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2018	316	1772
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	King	2018	none repo	none repor
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2018	11	13
Providence Hospice of Seattle	IHS.FS.00000336	King	2018	407	1959
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Mason	2018	10	117
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Lewis	2018	21	140
Providence SoundHomeCare and Hospice	IHS.FS.00000420	Thurston	2018	90	663
Tri-Cities Chaplaincy	IHS.FS.00000456	Franklin	2018	30	155
Tri-Cities Chaplaincy	IHS.FS.00000456	Benton	2018	112	750
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2018	1	23
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2018	24	227
Wesley Homes	IHS.FS.60276500	King	2018	29	368
Whatcom Hospice (Peacehealth)	IHS.FS.00000471	Whatcom	2018	117	770
Alpha Home Health	IHS.FS.61032013	Snohomish	2019	0	0
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2019	9	71
Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2019	1	4
Central Washington Homecare Services	IHS.FS.00000250	Chelan	2019	28	385
Central Washington Homecare Services	IHS.FS.00000250	Douglas	2019	19	125
Chaplaincy Health Care 2018	IHS.FS.00000456	Benton	2019	96	700
Chaplaincy Health Care 2018	IHS.FS.00000456	Franklin	2019	26	164
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2019	98	636
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2019	0	7
Community Home Health/Hospice	IHS.FS.00000262	Clark	2019	60	453
Continuum Care of King LLC	IHS.FS.61058934	King	2019	0	0
Continuum Care of Snohomish LLC	IHS.FS.61010090	Snohomish	2019	0	0
Envision Hospice of Washington	IHS.FS.60952486	Thurston	2019	2	22
EvergreenHealth	IHS.FS.00000278	King	2019	225	2025
EvergreenHealth	IHS.FS.00000278	Snohomish	2019	53	471
EvergreenHealth	IHS.FS.00000278	Island	2019	1	11
Franciscan Hospice	IHS.FS.00000287	King	2019	92	921
Franciscan Hospice	IHS.FS.00000287	Kitsap	2019	118	757
Franciscan Hospice	IHS.FS.00000287	Pierce	2019	364	2236
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2019	27	171
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2019	0	5
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2019	4	8
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2019	41	212
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2019	15	98
Heartlinks	IHS.FS.00000369	Benton	2019	7	137
Heartlinks	IHS.FS.00000369	Yakima	2019	21	180
Heartlinks	IHS.FS.00000369	Franklin	2019	0	2
Horizon Hospice	IHS.FS.00000332	Spokane	2019	30	393
Hospice of Jefferson County, Jefferson Healthcare	IHI.FS.00000349	Jefferson	2019	26	172
Hospice of Spokane	IHS.FS.00000337	Spokane	2019	289	1692
Hospice of Spokane	IHS.FS.00000337	Stevens	2019	20	126
Hospice of Spokane	IHS.FS.00000337	Ferry	2019	5	25
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2019	4	65
Hospice of the Northwest	IHS.FS.00000437	Island	2019	14	56
Hospice of the Northwest	IHS.FS.00000437	San Juan	2019	6	73
Hospice of the Northwest	IHS.FS.00000437	Skagit	2019	77	705
Hospice of the Northwest	IHS.FS.00000437	Snohomish	2019	5	58
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Skamania	2019	0	17
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Klickitat	2019	2	24
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Clark	2019	0	3
Inspiring Hospice Partners of Oregon dba Heart of Hospice	IHS.FS.60741443	Snohomish	2019	0	0
Kaiser Continuing Care Services Hospice	IHS.FS.00000353	Clark	2019	43	387
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	King	2019	37	489
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Kitsap	2019	18	123
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Pierce	2019	25	176
Kaiser Permanente Home Health and Hospice	IHS.FS.00000305	Snohomish	2019	7	62
Kindred Hospice	IHS.FS.60308060	Spokane	2019	10	90
Kindred Hospice	IHS.FS.60308060	Whitman	2019	12	77
Kindred Hospice	IHS.FS.60330209	King	2019	6	217
Kittitas Valley Healthcare Home Health and Hospice	IHS.FS.00000320	Kittitas	2019	16	169

Sources:
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Agency Name	License Number	County	Year	0-64	65+
Klickitat Valley Hospice	IHS.FS.00000361	Klickitat	2019	1	44
Kline Galland Community Based Services	IHS.FS.60103742	King	2019	35	345
Memorial Home Care Services	IHS.FS.00000376	Yakima	2019	148	730
MultiCare Hospice	IHS.FS.60639376	King	2019	27	149
MultiCare Hospice	IHS.FS.60639376	Pierce	2019	167	758
MultiCare Hospice	IHS.FS.60639376	Kitsap	2019	37	194
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2019	23	234
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2019	0	9
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2019	17	244
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2019	6	45
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2019	22	240
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2019	0	0
PeaceHealth Hospice	IHS.FS.60331226	Clark	2019	184	1217
PeaceHealth Hospice	IHS.FS.60331226	Cowlitz	2019	23	99
PeaceHealth Hospice	IHS.FS.60331226	Skamania	2019	0	1
PeaceHealth Whatcom	IHS.FS.00000471	Whatcom	2019	138	995
Providence Hospice	IHS.FS.60201476	Klickitat	2019	9	22
Providence Hospice	IHS.FS.60201476	Skamania	2019	1	15
Providence Hospice	IHS.FS.60201476	Clark	2019	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2019	272	1613
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2019	1	29
Providence Hospice of Seattle	IHS.FS.00000336	King	2019	338	2083
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2019	5	10
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2019	91	685
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2019	28	148
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2019	33	118
Puget Sound Hopsice	IHS.FS.61032138	Thurston	2019	0	0
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2019	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2019	3	25
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2019	8	54
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2019	41	228
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2019	3	22
Wesley Homes	IHS.FS.60276500	King	2019	5	86
WhidbeyHealth Home Health, Hospice	IHS.FS.00000323	Island	2019	27	245
Yakima HMA Home Health, LLC	IHS.FS.60097245	Yakima	2019	6	88
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0

Sources:
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Agency Name	License Number	County	Year	0-64	65+
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	0	0
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16

Sources:
Self-Report Provider Utilization Surveys for years 2018-2020
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Department of Health
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Preliminary Death Data Updated October 12, 2021

County	0-64			65+		
	2018	2019	2020	2018	2019	2020
ADAMS	28	35	20	72	93	59
ASOTIN	52	54	56	214	222	186
BENTON	331	346	555	1,125	1154	1522
CHELAN	130	137	224	573	626	785
CLALLAM	191	186	195	871	955	777
CLARK	874	887	1043	2,767	2987	3205
COLUMBIA	6	7	7	43	52	43
COWLITZ	300	294	314	840	951	968
DOUGLAS	51	63	42	255	270	160
FERRY	28	20	19	55	64	58
FRANKLIN	145	123	100	278	313	263
GARFIELD	5	5	5	30	21	11
GRANT	195	197	186	524	508	455
GRAYS HARBOR	227	251	209	647	659	558
ISLAND	135	167	110	675	642	505
JEFFERSON	64	72	68	336	338	273
KING	3,264	3,275	4456	9,917	10213	11186
KITSAP	515	557	454	1,713	1811	1714
KITTITAS	68	90	78	239	266	241
KLICKITAT	58	46	42	158	160	113
LEWIS	227	210	205	730	722	653
LINCOLN	25	25	15	94	89	75
MASON	158	167	143	526	548	408
OKANOGAN	103	119	88	332	358	277
PACIFIC	64	66	55	279	265	177
PEND OREILLE	43	31	41	130	125	101
PIERCE	1,964	1,911	2364	4,926	5002	5608
SAN JUAN	19	20	18	114	127	94
SKAGIT	231	229	269	1,001	1018	1068
SKAMANIA	27	19	26	56	87	47
SNOHOMISH	1,533	1,533	1587	4,055	4081	4278
SPOKANE	1,177	1,143	1634	3,556	3545	4322
STEVENS	113	112	86	373	345	248
THURSTON	554	525	628	1,823	1908	2007
WAHKIAKUM	13	11	10	33	53	18
WALLA WALLA	110	118	150	445	450	522
WHATCOM	360	394	457	1,252	1461	1481
WHITMAN	66	47	51	199	219	226
YAKIMA	601	555	653	1,517	1451	1675

Sources:
Vital Statistics Death Data for Years 2018-2020
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2021-2022 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,291	18,456	18,622	18,787	18,953	19,118	18,160
Asotin	16,969	16,906	16,842	16,779	16,715	16,652	16,596	16,540	16,485	16,429	16,373	16,715
Benton	162,262	163,693	165,123	166,554	167,984	169,415	171,026	172,638	174,249	175,861	177,472	167,984
Chelan	61,284	61,520	61,755	61,991	62,227	62,463	62,512	62,562	62,611	62,661	62,710	62,227
Clallam	52,716	52,661	52,605	52,550	52,494	52,439	52,233	52,027	51,821	51,615	51,409	52,494
Clark	387,296	393,291	399,287	405,282	411,278	417,273	421,901	426,529	431,158	435,786	440,414	411,278
Columbia	2,988	2,947	2,905	2,863	2,822	2,780	2,745	2,710	2,675	2,640	2,605	2,822
Cowlitz	85,417	85,517	85,617	85,717	85,817	85,917	85,843	85,769	85,695	85,621	85,547	85,817
Douglas	33,540	33,938	34,335	34,732	35,130	35,527	35,803	36,080	36,356	36,633	36,909	35,130
Ferry	5,834	5,782	5,731	5,680	5,628	5,577	5,541	5,506	5,470	5,435	5,399	5,628
Franklin	79,651	81,742	83,832	85,922	88,012	90,102	92,443	94,784	97,124	99,465	101,806	88,012
Garfield	1,665	1,644	1,623	1,602	1,581	1,560	1,541	1,522	1,502	1,483	1,464	1,581
Grant	81,535	82,660	83,784	84,909	86,033	87,158	88,240	89,322	90,403	91,485	92,567	86,033
Grays Harb	59,105	58,675	58,246	57,817	57,387	56,958	56,679	56,401	56,122	55,844	55,565	57,387
Island	62,514	62,664	62,814	62,964	63,114	63,264	63,280	63,296	63,312	63,328	63,344	63,114
Jefferson	20,636	20,653	20,670	20,688	20,705	20,722	20,636	20,550	20,463	20,377	20,291	20,705
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,906,749	1,918,470	1,930,192	1,941,913	1,953,635	1,965,356	1,885,115
Kitsap	212,548	214,045	215,543	217,040	218,538	220,035	220,614	221,192	221,771	222,349	222,928	218,538
Kittitas	36,206	36,768	37,330	37,892	38,453	39,015	39,286	39,556	39,827	40,097	40,368	38,453
Klickitat	16,208	16,082	15,955	15,828	15,702	15,575	15,439	15,304	15,168	15,033	14,897	15,702
Lewis	61,494	61,796	62,097	62,398	62,700	63,001	63,164	63,327	63,491	63,654	63,817	62,700
Lincoln	8,101	8,042	7,982	7,923	7,864	7,805	7,751	7,698	7,644	7,591	7,537	7,864
Mason	48,672	49,162	49,652	50,142	50,632	51,122	51,397	51,672	51,946	52,221	52,496	50,632
Okanogan	33,087	32,906	32,726	32,545	32,364	32,183	32,087	31,991	31,896	31,800	31,704	32,364
Pacific	15,115	14,972	14,830	14,688	14,545	14,403	14,322	14,242	14,161	14,081	14,000	14,545
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,812	9,769	9,727	9,684	9,642	9,599	9,859
Pierce	721,137	729,937	738,738	747,538	756,339	765,139	769,918	774,696	779,475	784,253	789,032	756,339
San Juan	11,305	11,194	11,084	10,974	10,863	10,753	10,730	10,707	10,684	10,661	10,638	10,863
Skagit	97,885	98,616	99,346	100,076	100,807	101,537	101,887	102,236	102,586	102,935	103,285	100,807
Skamania	9,272	9,266	9,260	9,254	9,248	9,242	9,223	9,205	9,186	9,168	9,149	9,248
Snohomish	661,812	672,806	683,800	694,793	705,787	716,781	721,527	726,273	731,019	735,765	740,511	705,787
Spokane	414,493	416,684	418,875	421,066	423,256	425,447	426,740	428,033	429,326	430,619	431,912	423,256
Stevens	34,576	34,459	34,343	34,226	34,109	33,992	33,917	33,841	33,766	33,690	33,615	34,109
Thurston	224,951	228,261	231,571	234,880	238,190	241,500	243,867	246,235	248,602	250,970	253,337	238,190
Wahkiakun	2,726	2,669	2,612	2,555	2,498	2,441	2,405	2,368	2,332	2,295	2,259	2,498
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,981	51,028	51,075	51,121	51,168	51,215	50,763
Whatcom	175,840	178,234	180,629	183,023	185,418	187,812	189,267	190,722	192,178	193,633	195,088	185,418
Whitman	42,880	42,965	43,051	43,137	43,222	43,308	43,315	43,322	43,330	43,337	43,344	43,222
Yakima	215,882	217,605	219,328	221,051	222,774	224,497	225,822	227,147	228,473	229,798	231,123	222,774

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Department of Health
2020-2021 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2018-2020 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,341	2,383	2,424	2,466	2,507	2,549	2,227
Asotin	5,041	5,233	5,426	5,619	5,812	6,005	6,175	6,344	6,514	6,683	6,853	5,812
Benton	26,328	27,492	28,657	29,821	30,986	32,150	33,373	34,597	35,820	37,044	38,267	30,986
Chelan	13,746	14,279	14,811	15,343	15,876	16,408	17,052	17,695	18,339	18,982	19,626	15,876
Clallam	19,934	20,401	20,867	21,334	21,800	22,267	22,901	23,535	24,168	24,802	25,436	21,800
Clark	64,524	68,044	71,564	75,085	78,605	82,125	85,686	89,247	92,807	96,368	99,929	78,605
Columbia	1,102	1,135	1,169	1,202	1,236	1,269	1,287	1,304	1,322	1,339	1,357	1,236
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,969	23,719	24,470	25,220	25,971	26,721	22,148
Douglas	6,450	6,831	7,213	7,595	7,976	8,358	8,666	8,974	9,283	9,591	9,899	7,976
Ferry	1,876	1,949	2,022	2,095	2,168	2,241	2,289	2,337	2,386	2,434	2,482	2,168
Franklin	7,499	7,921	8,343	8,765	9,188	9,610	10,083	10,557	11,030	11,504	11,977	9,188
Garfield	595	607	620	633	645	658	669	680	692	703	714	645
Grant	12,395	13,011	13,628	14,244	14,861	15,477	16,071	16,665	17,258	17,852	18,446	14,861
Grays Harb	14,005	14,535	15,064	15,594	16,123	16,653	17,133	17,612	18,092	18,571	19,051	16,123
Island	18,086	18,625	19,163	19,701	20,239	20,777	21,412	22,047	22,682	23,317	23,952	20,239
Jefferson	10,244	10,580	10,916	11,252	11,588	11,924	12,323	12,722	13,121	13,520	13,919	11,588
King	254,219	268,307	282,395	296,484	310,572	324,660	337,771	350,881	363,992	377,102	390,213	310,572
Kitsap	45,652	47,697	49,743	51,788	53,833	55,878	58,185	60,492	62,800	65,107	67,414	53,833
Kittitas	6,464	6,760	7,055	7,351	7,647	7,943	8,266	8,589	8,911	9,234	9,557	7,647
Klickitat	4,792	5,051	5,310	5,570	5,829	6,088	6,268	6,448	6,627	6,807	6,987	5,829
Lewis	15,166	15,576	15,987	16,398	16,808	17,219	17,697	18,175	18,652	19,130	19,608	16,808
Lincoln	2,619	2,687	2,755	2,823	2,891	2,959	3,039	3,119	3,200	3,280	3,360	2,891
Mason	13,528	14,123	14,717	15,311	15,905	16,499	17,167	17,836	18,504	19,173	19,841	15,905
Okanogan	8,773	9,198	9,624	10,050	10,475	10,901	11,210	11,519	11,827	12,136	12,445	10,475
Pacific	6,095	6,258	6,421	6,584	6,747	6,910	7,035	7,159	7,284	7,408	7,533	6,747
Pend Oreill	3,195	3,378	3,560	3,742	3,925	4,107	4,239	4,371	4,504	4,636	4,768	3,925
Pierce	108,983	114,409	119,836	125,262	130,688	136,114	142,422	148,729	155,037	161,344	167,652	130,688
San Juan	4,876	5,099	5,322	5,545	5,768	5,991	6,174	6,357	6,541	6,724	6,907	5,768
Skagit	22,735	24,021	25,308	26,595	27,881	29,168	30,314	31,460	32,607	33,753	34,899	27,881
Skamania	2,158	2,286	2,414	2,542	2,670	2,798	2,923	3,048	3,172	3,297	3,422	2,670
Snohomish	95,788	101,674	107,560	113,447	119,333	125,219	131,978	138,737	145,495	152,254	159,013	119,333
Spokane	73,817	77,325	80,834	84,343	87,852	91,361	94,670	97,979	101,288	104,597	107,906	87,852
Stevens	9,454	9,930	10,407	10,884	11,360	11,837	12,214	12,591	12,969	13,346	13,723	11,360
Thurston	42,459	44,534	46,608	48,683	50,757	52,832	54,900	56,967	59,035	61,102	63,170	50,757
Wahkiakun	1,254	1,316	1,379	1,441	1,503	1,565	1,580	1,595	1,611	1,626	1,641	1,503
Walla Wall	10,757	10,819	10,881	10,944	11,006	11,068	11,350	11,632	11,915	12,197	12,479	11,006
Whatcom	33,950	35,688	37,426	39,164	40,902	42,640	44,217	45,794	47,372	48,949	50,526	40,902
Whitman	4,370	4,659	4,948	5,237	5,526	5,815	6,008	6,201	6,395	6,588	6,781	5,526
Yakima	34,088	34,949	35,809	36,670	37,530	38,391	39,475	40,559	41,643	42,727	43,811	37,530

Sources:
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

Patient Admission Criteria

See items #6 - #8 below for Referral Policies

POLICY

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's needs can be met adequately by Hospice in the patient's place of residence. Patients will be accepted for care only if Hospice can meet a patient's identified needs.

PURPOSE

To establish criteria for the admission of patients to Hospice.

REFERENCE

The Joint Commission CAMHC Standard: PC.01.01.01; Medicare CoP #s: 418.20, 418.25; CHAP Standard: CI.5c; ACHC Standards: HSP2-1A, HSP5-2A.01, HSP5-2B.01, HSP5-2B.02, HSP5-9A.01

PROCEDURE

1. Criteria for admission are:
   - The patient must reside within Hospice's service area.
   - The patient must be entitled to receive covered Hospice services under the Social Security Act (Medicare and Medicaid) or have other funding source.
   - Medicare patients must be certified as being terminally ill with a prognosis of six (6) months or less, if the terminal illness runs its normal course.
   - Targeted patients are primarily adults.

2. Hospice admits a patient only on the recommendation of the Medical Director in consultation with, or input from the patient's attending physician (if any). In reaching a decision to certify that the patient is terminally ill, the Medical Director must consider at least the following information:
   - Diagnosis of the terminal condition of the patient.
   - Other health conditions, whether related or unrelated to the terminal condition.
   - Current clinically relevant information supporting all diagnoses.

3. Hospice will not deny admission to patients with communicable disease, including, but not limited to, HIV, MRSA, TB and Hepatitis B.

4. Care follows a written plan of care established by the IDG and reviewed at least every 15 days and IDG. Care will continue under the general supervision of the Medical Director.

5. Care will be available to all patients who can benefit regardless of race, color, religion, national origin, sex, sexual preference, disability, age, socioeconomic level, marital status, source of payment or diagnostic status. Information to be gathered to determine eligibility includes:
   - Hospice has resources to provide the services required by the patient.
   - Attitudes of the patient and family toward care are appropriate.
   - Qualified personnel to provide needed services are available.
   - Reasonable expectations that the patient's needs can be met adequately.
   - Care can be provided safely and effectively in the patient's home.
   - Adequate physical facilities in the patient's residence for proper care exist.
   - Family or caregiver is available, able and willing to participate in the patient's care when conditions warrant.

6. Patient referrals may be made by anyone including the family, physician, discharge planners, healthcare workers, friends, relatives or the patient.

7. When a telephone or verbal referral is received by Hospice, a referral form is completed by a RN. Referrals may also be received by fax, in person or in the mail. The referral form includes at least the following information from the attending physician:
   - Patient identification information, e.g., name, address, telephone number, date of birth, sex, Medicare or social security number, insurance information, emergency contact and telephone number.
   - Physician's name, address and telephone number and alternative physician to contact is attending is not available.
   - Referral source.
   - Primary admitting terminal diagnosis and other diagnosis(es).
   - Medications and treatments required, including orders for treatments and symptom management.
   - Date of hospital discharge, if applicable.
   - Care or treatments to be provided, including frequency and duration.
   - Dietary restrictions.
   - Any other information reported, e.g., medical management of conditions unrelated to the terminal illness.
   - Current medical findings.

8. Each referral is evaluated by the Manager of Patient Services and/or Director to determine the appropriateness of Hospice care.

9. One home evaluation visit may be made before deciding to accept the patient for Hospice care.

10. During the initial assessment, the RN will:
    - Perform initial assessment.
    - Provide information relevant to physician's orders and services to be provided so that patient/caregiver can give consent.

- Obtain the patient's signature on the consent and other required forms.
- Verify the information on the referral form.
- Explain and provide a copy of the *Patient's Bill of Rights/Responsibilities* and advance directives. If patient has an advance directive, a copy will be obtained or the patient's wishes will be documented.
- Provide a copy of the HIPAA Privacy Notice.
- Explain the visit procedures to the patient and the patient's family.
- Provide a copy of Hospice's scope of services, mission statement, office hours and how to access the on-call system.
- Perform a safety and environmental assessment.
- Develop a medication profile.
- Discuss emergency operations plan with the patient/caregiver.
- Explain the patient's liability for payment of services. Give the patient in writing his/her expected payment responsibility.
- Refer patient to other disciplines, as appropriate.
- Obtain past medical information, as appropriate.
- Obtain and implement the physician's orders.
- Submit the completed admission paperwork to the Manager of Patient Services or the Director for review.

11. A log of all referrals received is maintained by Hospice.

12. If Hospice is not able to provide the needed care, the referral source will be notified. Hospice will assist the referral source in alternative care.

Envision Hospice of Washington
Charity Care Policy

POLICY

To provide medically necessary hospice care at a reduced rate or without charge to patients or their legal financial sponsors, when adequate income or assets are not available to pay for hospice services. Envision Hospice of Washington LLC ("Envision Hospice") will provide charity care as dictated by its available resources and consistent with the following procedure. Envision Hospice will not deny palliative or hospice care to any individual based on that individual's ability to pay, national origin, age physical disabilities, race, color, sex, or religion.

PURPOSE

Envision Hospice is committed to its local communities and recognizes our communities' need to provide necessary hospice care at a reduced rate or without charge to patients or their legal financial sponsors, when there is inadequate income or assets to cover such services. Additionally, Envision Hospice is committed to provide quality care to our patients and such commitment dictates that clinical needs override economic factors in individual care decisions.

PROCEDURE

General Description:

1. Charity care is generally secondary to all other financial resources available to the patient including: group or individual medical plans, workers' compensation, Medicare, Medicaid or medical assistance programs, other state, federal or military programs, third party liability situations, or any other situation in which another person or entity may have a legal responsibility to pay for the cost of medical services.

2. In those situations where appropriate payment sources for necessary care are not available, patients shall be considered for charity care under this policy based on the following criteria as calculated for the 12 months prior to the date of charity application.

- Determination of eligibility of a patient for charity care shall be applied regardless of the source of referral and without discrimination as to race, color, creed, or national origin.
- Full charity care will be provided to patients with gross family income below 200% of the Federal Poverty Guidelines as adjusted for family size.
- Partial charity care may be provided to patients with gross family income above 200% of the Federal Poverty Guidelines as adjusted for family size when circumstances determined by Envision Hospice indicate that full payment may cause social and financial hardship so as to significantly harm the patient or family unit.

Process for Eligibility Determination:

1. Cases for consideration may be proposed by the patient or family, by the patient's physician, by Envision Hospice personnel, or by recognized social agencies. Application forms and instructions to complete them will be furnished to patients when charity care is requested or when need is indicated. It is preferred that the application form be completed prior to admission or upon admission. However, when circumstances prevent early completion, the application form may be completed after admission. These application forms are available upon request to all patients.

2. Confidential financial information will be requested, including:
   - Gross income – current and prospective
   - Net worth – emphasis on liquidity
   - Employment status
   - Family size and ages of dependents
   - Other financial obligations
   - Amounts of other health care bills
   - All other support sources

3. All applications shall be accompanied by documentation to verify family income. When returned, the application shall be accompanied by one or more of the following types of documentation for purposes of verifying income. This documentation may be verified through a credit-reporting agency.
   - W2 Withholding statements for all employment during the relevant time period
   - Payroll check stubs from all employment during the relevant time period
   - IRS tax returns from the most recently filed calendar year
   - Forms approving or denying eligibility for Medicaid and or state-funded Medical assistance
   - Forms approving or denying unemployment; compensation
   - Written statements from employers or welfare agencies

4. All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

5. Hospice will make final eligibility determination and will notify the patient within 14 days of receipt of the completed application and related documentation and material (proof of income, etc.).

6. Designation of charity care, while generally determined at time of admission may occur at any time upon Hospice's learning of facts that would indicate medical indigence. Should charity care be provided after the patient has made full or partial payment, said payment shall be refunded to the patient within 30 days of the charity care designation.

Process for Notification:

1. Whether or not the patient received verbal notification, a notification letter is mailed not later than 14 days following application submission date. Financial agreement forms will state that financial responsibility is waived or reduced if the patient is determined eligible for charity care. Denials will be written and include instructions for appeal or reconsideration.

2. Hospice's decision to provide partial or full charity care in no way affects the patient's financial obligations to his or her other health care providers.

Appeals Procedure:

1. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size within 30 calendar days of receipt of notification. The Administrator of Envision Hospice will review all appeals for final determination.

2. Catastrophic medical costs, sizable other medical bills, or other patient specific circumstances (based on fairness and ability to pay) may justify granting charity care, even when a patient exceeds the indigence standards.

Policy Administration:

1. The Hospice Administrator shall oversee this policy.

2. Hospice Administer shall responsible for:
   - assuring that current Federal poverty guidelines are available to applicants and to staff assisting with administering this policy;
   - assuring that initial determinations for charity care meet the requirements of the policy;
   - for reviewing applications for charity care;

- for assuring that a timely determination of eligibility is made; • for notifying the applicant of the results of determination;
- and for considering any appeals.

Discharge Criteria

• POLICY

Patients are discharged by Hospice based on specifically defined criteria.

• PURPOSE

To establish guidelines for discharge of patients from Hospice.

• REFERENCE

The Joint Commission CAMHC Standards: PC.04.01.01, PC.04.01.03, PC.04.01.05, PC.04.02.01, RI.01.02.03; NPSG: .08.03.01; Medicare CoP #s: 418.26a, 418.26b, 418.26c, 418.100D; CHAP Standards: HCDT 37.D, HCDT 38.1; ACHC Standard: HSP5-8B

• RELATED DOCUMENTS

"*Discharge Instructions*" form

• PROCEDURE

1. Patient will be discharged from services as follows:
   - Patient expired.
   - Patient revoked.
   - Patient moves out of Hospice's service area.
   - Patient transfer to another hospice.
   - Hospice determines that the patient is no longer terminally ill.
   - 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 Hospice's ability to operate effectively is seriously impaired. Hospice must do the following before it seeks to discharge a patient for cause:
     - Advise the patient that a discharge for cause is being considered.
     - Make a concerted effort to resolve the problem(s) presented by the patient's (or other persons in the patient's home) behavior or situation.
     - Ascertain that the patient's proposed discharge is not due to the patient's necessary use of Hospice services.
     - Document the problem(s) and efforts made to resolve the problem(s) in the patient's record.
   - A Hospice patient is receiving treatment for a condition unrelated to the terminal illness or related conditions in a facility with which Hospice does not have a contract and Hospice is unable to provide Hospice services.

1. The patient is informed of discharge plan in a timely manner and acknowledges understanding of the reason.

3. Physician, Medical Director, IDG and other care providers will be informed and knowledgeable of discharge.

4. Prior to discharge a patient for any reason listed in #1, the IDG will obtain a written discharge order form the Medical Director. If a patient has an attending physician involved in his/her care, this physician will be consulted before discharge and the attending physician's review and decision included in the discharge note.

5. Hospice may notify its Medicare Administrative Contractor (MAC) and State Agency of the circumstances surrounding the impending discharge. Hospice will consider referrals to other appropriate and/or relevant state community agencies (e.g., Adult Protective Services) or other health care facilities before discharge.

6. A patient, upon discharge from Hospice during a particular election period for reasons other than immediate transfer to another hospice:
   - If no longer covered under Medicare for Hospice care.
   - Resumes coverage of previously waived Medicare benefits.
   - May at any time elect to receive hospice care if he/she is again eligible to receive the benefit.

7. Hospice has in place a discharge planning process that takes into account that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill. The process includes planning for any necessary family counseling, patient education or other services before the patient is discharged because he/she is no longer terminally ill.

8. Staff will be knowledgeable about discharge procedures including instructions and follow-up responsibilities.

9. The patient's continuing care needs, if any, are assessed at discharge.

10. Patients will receive verbal or written discharge instructions.

11. A complete list of reconciled medications will be provided to each patient on discharge. The list will be explained to patient/family and interaction documented. Patients and families will be reminded to discard all old medication lists and to update health records with physicians and retail pharmacies.

12. Hospice will not discontinue or reduce care to a patient because of the patient's inability to pay.

Discharge Policy – Addendum to Discharge Criteria

ADDITIONAL WASHINGTON STATE REQUIREMENTS

1. The patient is informed of discharge plan in a timely manner and acknowledges understanding of the reason.
    - Patients will be given a minimum of 48 hours written or verbal notice prior to discharge from Envision Hospice. Written and/or verbal notice will be documented in patient record.
    - 48-hour notice requirement is waived if patient is being discharged due to concern over Envision Hospice personnel safety, significant patient non-compliance, or patient's failure to pay for services rendered.

2. Envision Hospice may self-report to appropriate state agencies when discharging a patient that is concerned about their ongoing care and safety. This self-report identifies the reason for discharge and the steps taken to mitigate safety concerns.

WASHINGTON STATE REFERENCE

RCW 70.127.120 and 43.70.250; WAC 246-335-620

Discharge Summary

• POLICY

A *Discharge Summary* will be completed for patients as required by law and regulation.

• PURPOSE

To record a summary of care received by the patient from the start of care through discharge.

• REFERENCE

The Joint Commission CAMHC Standard: PC.04.02.01; Medicare CoP #: 418.104e; CHAP Standards: HCDT 37.D, HCDT 40 .1, HCDT 41.1; ACHC Standard: HSP5-8B

• RELATED DOCUMENTS

"*Discharge Summary*" form

• PROCEDURE

1. If the care of a patient is transferred to another Medicare/Medicaid-certified facility, Hospice will forward to the receiving facility, a copy of:
   - The Hospice discharge summary.
   - The patient's record, if requested.

2. If a patient revokes the election of Hospice care, or is discharged from Hospice, Hospice will forward to the patient's attending physician, a copy of:
   - The Hospice discharge summary.
   - The patient's record, if requested.

3. The Hospice discharge summary will include:
   - A summary of the patient's stay including treatments, symptoms, and pain management.
   - The patient's current plan of care.
   - The patient's latest physician orders.
   - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician of receiving facility.
   - The date and reason for discharge.
   - Any instructions or referral information given to the patient or family.
   - Patient identifying information.

- Patient's physician.
- Hospice diagnosis.
- Significant health history.
- Discharge orders, instructions, medication profile and allergies if discharge is other than patient death.
- A brief description of services provided and ongoing needs that cannot be met.
- Status of patient at the time of discharge.
- Presence of Advance Directives.
- End of life decisions.
- Any third-party revocation or termination.

Expedited Determination Policy

• POLICY

Each Medicare beneficiary will be notified in writing using the CMS 10123 "Generic Notice of Medicare Provider Non-Coverage," no later than 2 days before covered Hospice services(s) will end.

• PURPOSE

To define Hospice responsibility for implementation of BIPA (Benefits Improvement and Protection Act).

• REFERENCE

The Joint Commission CAMHC Standard: PC.04.01.03; Medicare CoP #: 418.116; CHAP Standard: HSRM 1.D; ACHC Standard: HSP5-8B

• RELATED DOCUMENTS

"*Instructions for Completing CMS 10123 Form: Notice of Medicare Provider Non-Coverage Generic Notice,*" "*Notice of Medicare Provider Non-Coverage*," "*Instructions for Completing CMS 10123 Form: Detailed Explanation of Non-Coverage*," "*Detailed Explanation of Non-Coverage.*"

• PROCEDURE

1. The BIPA (Benefits Improvement and Protection Act) mandates that Hospice is responsible for notifying each patient (utilizing the CMS 10123 form) regarding termination of Hospice services. There will be a copy of the CMS form 10123 placed in each admission packet.

2. Example of reasons for issuance of expedited appeal notices include:
   - Medical condition has stabilized.

3. Examples of when expedited appeal notices are NOT required include:
   - Beneficiary requests to discontinue care.
   - Unsafe patient situation.
   - Unsafe situation for Hospice staff.
   - Nursing home placement.
   - Beneficiary relocation.

4. Exceptions to the BIPA include:
   - The "two days prior" rule for delivering to the patient a "Notice of Provider Non-Coverage" does not apply when beneficiaries are on service fewer than two days or in cases of unanticipated changes to coverage, e.g., physician orders discontinuation of covered services. The notice still would have to be delivered, but the "two days prior" rule does not and, likely could not, apply.
   - Notices may be mailed rather than hand-delivered following telephone notification of beneficiaries if discontinuation of coverage is unexpected.

5. In the case of an unplanned/unexpected discharge, the provider may contact the beneficiary by phone to advise him/her that services are being terminated and mail the amended notice to the beneficiary.

6. If the beneficiary chooses to request an expedited review, he/she is responsible for contacting the Quality Improvement Organization (QIO) listed on notice (within the specified timeline). The QIO is then responsible for immediately contacting the provider once the beneficiary requests an expedited review.

7. Once the beneficiary requests an expedited review, the provider must then complete and deliver the **Detailed Explanation of Non-Coverage** (CMS form 10124) by close of business on the same day of the QIO's notification to the provider. The Explanation form must be delivered to the QIO via personal delivery, through a courier service or via e-mail or facsimile. **The form must contain a thorough explanation/reason of why service(s) are being terminated so it is clear to both the QIO and beneficiary.** A copy of this form must also be given to the beneficiary.

8. Notify physician about termination of services.

9. The QIO is expected to render a decision no later than 72 hours after receipt of the beneficiary's request. Providers are to cooperate with QIO's requests for assistance in obtaining information as indicated.

Revenue Assumptions & Staffing Summary, Envision Hospice, Pierce County Only

	2023	2024	2025	
Admissions (Unduplicated Patie	183	274	365	See Narrative: Need Question #4
Patient Days at ALOS 60	10,950	16,425	21,900	ALOS assumption based on WA average
AVERAGE DAILY CENSUS (ADC)	**30.0**	**45.0**	**60.0**	DOC/365

DAYS OF CARE (DOC)				
Routine Home Care	10,676	16,014	21,353	97.5% based on Utah & WA averages from CMS
General Inpatient Care	110	164	219	1.0% based on Utah & WA averages from CMS
Continuous Care	110	164	219	1.0% based on Utah & WA averages from CMS
Inpatient Respite Care	55	82	110	0.5% based on Utah & WA averages from CMS
TOTAL	**10,950**	**16,425**	**21,900**	**100%**

Per Diem Rates				
Routine Home Care	$ 212.62	$ 212.62	$ 212.62	blend of 75% of days at high rate and 25% at low rate
General Inpatient Care	$ 1,174.31	$ 1,174.31	$ 1,174.31	CMS 2021 Pierce County hospice rate
Continuous Care	$ 544.80	$ 544.80	$ 544.80	CMS 2021 Pierce County hospice rate x 8 hr. minimum
Inpatient Respite Care	$ 518.92	$ 518.92	$ 518.92	CMS 2021 Pierce County hospice rate

Gross Revenue by Type of Care				
Routine Home Care	$ 2,269,931	$ 3,404,896	$ 4,539,862	Days of Care x Per Diem Rates
General Inpatient Care	$ 128,587	$ 192,880	$ 257,174	Days of Care x Per Diem Rates
Continuous Care	$ 59,656	$ 89,483	$ 119,311	Days of Care x Per Diem Rates
Inpatient Respite Care	$ 28,411	$ 42,616	$ 56,822	Days of Care x Per Diem Rates
TOTAL	**$ 2,486,584**	**$ 3,729,876**	**$ 4,973,169**	

Payer Mix				
Medicare Fee For Service	50%	50%	50%	Based on Utah & WA Experience
Medicare Managed Care	35%	35%	35%	Based on Utah & WA Experience
Medicaid	10%	10%	10%	Based on Utah & WA Experience
Commercial /Other	5%	5%	5%	Based on Utah & WA Experience
TOTAL	100%	100%	100%	

Gross Revenue per Payer				
Medicare Fee For Service	$ 1,243,292	$ 1,864,938	$ 2,486,584	Gross Revenue Total x % Payer Mix
Medicare Managed Care	$ 870,305	$ 1,305,457	$ 1,740,609	Gross Revenue Total x % Payer Mix
Medicaid	$ 248,658	$ 372,988	$ 497,317	Gross Revenue Total x % Payer Mix
Commercial	$ 124,329	$ 186,494	$ 248,658	Gross Revenue Total x % Payer Mix

STAFFING SUMMARY - PIERCE

STAFFING INPUT - BY FTE'S		**2022**	**2023**	**2024**	
CLINICAL OPERATIONS	Salary				
Medical Director/Physician(s)	205,000	0.83	1.25	1.67	Physician FTE for every 36 ADC
Bereavement	60,000	-	0.30	1.00	Done by spiritual counselor until ADC reaches 40
Spiritual Counselor	79,000	0.81	1.22	1.62	1 per 37 ADC; does bereavement until ADC reaches 40
Volunteer coordinator	42,000	0.40	0.56	0.75	1 per 80 ADC; starts at minimum of .4 when MSW gets to .75
Manager of Patient Services	112,000	0.50	0.75	1.00	Done by admin until 20 ADC; starts at .5 ; .75 at 40 ADC; 1.0 at 50 ADC
RN's	95,000	3.00	4.50	6.00	1 per 10 ADC
Medical Social Worker	80,000	1.00	1.29	1.71	1 per 35 ADC, minimum of 1; does vol coord until reaching .75
HHA's	37,440	3.00	4.50	6.00	1 HHA per 10 ADC
TOTAL		**9.54**	**14.36**	**19.75**	

ADMINISTRATIVE					
Administrator/Director	120,000	0.75	1.25	1.75	Combines regional and county level admin: Regional is .25/County is .50 2021, 1 2022, 1.50 2023
Admin Asst./Medical Records	52,000	1.00	1.25	1.75	
Facility Liaison/Community Outre	70,000	2.00	2.50	3.00	
QAPI Coordinator	95,000	0.50	1.00	1.00	Administrator does until ADC of 30
TOTAL		**4.25**	**6.00**	**7.50**	

TOTAL FTE'S		**13.79**	**20.36**	**27.25**	

	2023	2024	2025	
ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	98,850	145,500	181,800	30% of Administrative Salaries
B&O Taxes	37,299	55,948	74,598	1.5% of gross revenue
Salaries - Administrative	142,000	215,000	301,000	See Staffing Summary
Salaries - Facility/Comm. Outre	140,000	175,000	210,000	See Staffing Summary
QAPI Coordinator	47,500	95,000	95,000	See Staffing Summary
Mileage	4,161	6,242	8,322	$0.38 per DOC
Advertising	24,000	24,000	24,000	$2,000 /month
Travel - admin	20,000	10,000	10,000	$20,000/year first year and $10,000 therafter
Legal & Professional	12,000	12,000	12,000	$1,000 /month
Consulting Fees	3,000	3,000	3,000	$250 /month
Software Costs	12,000	12,000	12,000	$1,000 /month
Computer @ Software Maintena	10,000	10,000	10,000	$833 /month
Office rent	17,556	17,556	17,556	$1,463 /month (See Allocation Table)
Repairs/Maintenance	1,800	1,800	1,800	$150 /month
Cleaning	600	600	600	$50 /month
Insurance	3,000	3,000	3,000	$250 /month
Office Supplies	3,000	3,000	3,000	$250 /month
Equipment Rental	2,000	2,000	2,000	$167 /month
Postage	600	600	600	$50 /month
Telephones/Pagers	14,400	14,400	14,400	$1,200 /month
Purchased Services/Utilities	6,000	6,000	6,000	$500 /month
Books & References Materials	1,200	1,200	1,200	$100 /month
Printing	1,500	1,500	1,500	$125 /month
Licenses & Certification	3,283	2,383	-	Per Renewal Fee table
Education and Training	24,000	24,000	24,000	$2,000 /month incl. palliative care, cultural competence, volunteer progran
Dues and Subscriptions	2,400	2,400	2,400	$200 /month
Corporate Allocation	118,187	177,281	236,375	5% Of Net Rev., includes Payroll, Billing, IT, HR Etc.
Total Administrative Costs	**750,336**	**1,021,410**	**1,256,150**	
Total Costs	**2,074,748**	**3,016,950**	**3,976,811**	
EBITDA	**288,999**	**528,671**	**750,683**	
EBITDA Margin %	12.2%	14.9%	15.9%	
Depreciation	1,229	1,229	1,229	See Depreciation Schedule
Amortization	-	-	-	None
EBIT	**287,770**	**527,442**	**749,455**	
Interest Expense	-	-	-	None
Earnings before Taxes	**287,770**	**527,442**	**749,455**	

Envision Hospice of Washington LLC
Pierce County Certificate of Need
Projected Statement of Operations 2023-2025

	2023	2024	2025	Notes and Assumptions
Average Daily Census	30.0	45.0	60.0	See Assumptions Page
Days of Care	10,950	16,425	21,900	See Assumptions Page
REVENUE				
Medicare Fee For Service	1,243,292	1,864,938	2,486,584	See Assumptions Page
Medicare Managed Care	870,305	1,305,457	1,740,609	See Assumptions Page
Medicaid	248,658	372,988	497,317	includes Healthy Options
Commercial/Other	124,329	186,494	248,658	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	**2,486,584**	**3,729,876**	**4,973,169**	
Deductions from Revenue				
Contractual Allowances	(49,732)	(74,598)	(99,463)	2% of Gross Revenue
Bad Debt	(24,866)	(37,299)	(49,732)	1% of Gross Revenue
Adj. For Charity Care	(48,240)	(72,360)	(96,479)	2% after Contractual and Bad Debt
Total Net Revenue	**2,363,747**	**3,545,621**	**4,727,494**	
PATIENT CARE COSTS				
Salaries and Benefits:				
Medical Director/Physician(s)	170,833	256,250	341,667	See Staffing Summary
Bereavement	-	18,000	60,000	See Staffing Summary
Spiritual Counselor	64,054	96,081	128,108	See Staffing Summary
Volunteer coordinator	16,800	23,625	31,500	See Staffing Summary
Manger of Patient Services	56,000	84,000	112,000	See Staffing Summary
RN's	285,000	427,500	570,000	See Staffing Summary
Medical Social Worker	80,000	102,857	137,143	See Staffing Summary
HHA's	112,320	168,480	224,640	See Staffing Summary
Payroll Taxes & Benefits	235,502	353,038	481,517	30% of Salaries
Total Salaries and Benefits	**1,020,510**	**1,529,831**	**2,086,575**	
Contract Labor:				
Physical Therapy	986	1,478	1,971	$ 0.09 per DOC
Occupational Therapy	329	493	657	$ 0.03 per DOC
Speech/Language	219	329	438	$ 0.02 per DOC
Dietary Counseling	219	329	438	$ 0.02 per DOC
Total Contract Labor	**1,752**	**2,628**	**3,504**	
Physician Consulting Fees	23,637	35,456	47,275	1% of net revenue
Pharmacy/IV's	52,341	78,512	104,682	$ 4.78 per DOC
DME Costs	50,370	75,555	100,740	$ 4.60 per DOC
Medical Supplies	18,177	27,266	36,354	$ 1.66 per DOC
Lab Costs	1,095	1,643	2,190	$ 0.10 per DOC
Chemotherapy	1,095	1,643	2,190	$ 0.10 per DOC
Radiation Therapy	1,095	1,643	2,190	$ 0.10 per DOC
Imaging Services	876	1,314	1,752	$ 0.08 per DOC
Ambulance Costs	3,833	5,749	7,665	$ 0.35 per DOC
General Inpatient Care Costs	90,338	135,506	180,675	$ 825 facility contracted GIP care rate x 1% of DOC
Inpatient Respite Care Costs	21,079	31,618	42,158	$ 385 facility contracted Inpatient Respite care rate x 0.5% of DOC
Net SNF Medicaid Costs	6,570	19,710	39,420	DOC x $12/day average x 5% for 2022, 10% for 2023, 15% for 2024
Mileage	31,646	47,468	63,291	$ 2.89 per DOC
Total Other Costs	**302,151**	**463,081**	**630,581**	
Total Patient Care Costs	**1,324,412**	**1,995,540**	**2,720,660**	

Envision Hospice of Washington, LLC - Pierce
Proforma Balance Sheet
For The Periods Ending December 31, 2023 Through 2025

	2023	2024	2025
ASSETS			
Current Assets			
Cash & Cash Equivalents	33,634	430,773	1,051,280
Accounts Receivable (Net)	354,562	531,843	709,124
Total Current Assets	388,196	962,616	1,760,405
Piuerce			
Fixed Assets	7,000	7,000	7,000
Accumulated Depreciation	(1,229)	(2,457)	(3,686)
Total Property and Equipment	5,771	4,543	3,314
Other Assets	-	-	-
Total Assets	**393,967**	**967,159**	**1,763,719**
LIABILITIES AND CAPITAL			
Current Liabilities			
Accounts Payable & Accrued Expenses	49,028	66,690	85,610
Accrued Payroll & Related Payables	57,170	85,256	113,442
Total Current Liabilities	106,197	151,947	199,052
Long-Term Liabilities	-	-	-
Total Liabilities	106,197	151,947	199,052
Shareholder Equity (Deficit)	287,770	815,212	1,564,667
Total Liabilities & Capital	**393,967**	**967,159**	**1,763,719**

Envision Hospice of Washington LLC - Pierce
Proforma Cash Flow
For The Periods Ending December 31, 2023 Through 2025

	2023	2024	2025
Cash Flows from operating activities			
Net Income After Depreciation and Amortization	287,770	527,442	749,455
Adjustments to reconcile net income to cash provided by Operations			
Depreciation & Amortization Change	1,229	1,229	1,229
Accounts Receivable Change	(354,562)	(177,281)	(177,281)
Accounts Payable Change	49,028	17,663	18,920
Payroll Payable Change	57,170	28,087	28,185
Total Adjustments	(247,136)	(130,303)	(128,947)
Net Cash provided by Operations	40,634	397,139	620,508
Cash Flows from investing activities Used For:			
Capital equipment and furniture	(7,000)	-	-
Net cash used in investing	(7,000)	-	-
Cash Flows from financing activities			
Proceeds From:			
Capital Contributions	-	-	-
Used For:			
Dividends	-	-	-
Net cash used in financing	-	-	-
Net increase <decrease> in cash	33,634	397,139	620,508
Summary			
Cash Balance at Beg of Period	-	33,634	430,773
Cash Balance at End of Period	33,634	430,773	1,051,280

Envision Of Washington Existing HHA & Hospice Combined
Proforma Revenue and Expenses
For The Periods Ending December 31, 2022 Through 2025

	2022	2023	2024	2025
VOLUMES				
Total Home Health Admissions	900	950	975	1,025
Total Home Health Visits	16,169	17,067	17,516	18,414
Average Daily Hospice Census	45.2	53.4	61.6	74.0
REVENUE				
Total Gross Revenue	8,060,707	8,984,421	9,788,923	11,055,281
Total Deductions from Revenue	(400,745)	(446,518)	(486,331)	(549,030)
Total Net Revenue	7,659,963	8,537,903	9,302,592	10,506,251
EXPENSES				
Total W2 Salaries and Benefits	2,477,190	2,810,122	3,146,279	3,663,895
Total Contract Labor	984,210	1,038,821	1,066,367	1,121,219
Other Patient Care costs	597,340	688,248	788,761	940,128
Total Direct Patient Care Costs	4,058,740	4,537,191	5,001,407	5,725,241
Total Administrative Costs	2,696,055	2,999,991	3,114,922	3,379,117
Total Costs	**6,754,795**	**7,537,181**	**8,116,329**	**9,104,359**
EBITDA	**$ 905,168**	**$ 1,000,722**	**$ 1,186,264**	**$ 1,401,893**
EBITDA Margin %	11.8%	11.7%	12.8%	13.3%
Depreciation	9,673	8,823	7,986	7,986
Amortization	0	0	0	0
Net Income	**$ 895,495**	**$ 991,899**	**$ 1,178,278**	**$ 1,393,907**

Envision Of Washington Existing HHA & Hospice Combined
Proforma Balance Sheet
For The Periods Ending December 31, 2022 Through 2025

	2022	2023	2024	2025
ASSETS				
Current Assets				
Cash & Cash Equivalents	1,343,003	1,226,052	815,009	261,001
Accounts Receivable (Net)	1,556,700	1,711,042	1,837,070	2,040,269
Total Current Assets	2,899,703	2,937,094	2,652,079	2,301,271
Property and Equipment				
Fixed Assets	57,965	57,965	57,965	57,965
Accumulated Depreciation	(18,614)	(27,437)	(35,422)	(43,408)
Total Property and Equipment	39,351	30,528	22,543	14,557
Other Assets	-	-	-	-
Total Assets	**2,939,054**	**2,967,622**	**2,674,622**	**2,315,828**
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	128,457	140,417	152,262	169,275
Accrued Payroll & Related Payables	203,005	227,714	244,591	274,877
Total Current Liabilities	331,462	368,131	396,853	444,152
Long-Term Liabilities	-	-	-	-
Total Liabilities	331,462	368,131	396,853	444,152
Shareholder Equity (Deficit)	2,607,592	2,599,491	2,277,769	1,871,676
Total Liabilities & Capital	**2,939,054**	**2,967,622**	**2,674,622**	**2,315,828**

Envision Of Washington Existing HHA & Hospice Combined
Proforma Cash Flow
For The Periods Ending December 31, 2022 Through 2025

	2022	2023	2024	2025
Cash Flows from operating activities				
Net Income After Depreciation and Amortization	895,495	991,899	1,178,278	1,393,907
Adjustments to reconcile net income to cash provided by Operations				
Depreciation & Amortization Change	9,673	8,823	7,986	7,986
Accounts Receivable Change	(426,700)	(154,341)	(126,028)	(203,199)
Accounts Payable Change	39,457	11,960	11,845	17,013
Payroll Payable Change	43,005	24,709	16,877	30,286
Total Adjustments	(334,565)	(108,850)	(89,321)	(147,914)
Net Cash provided by Operations	560,930	883,049	1,088,957	1,245,993
Cash Flows from investing activities Used For:				
Capital equipment and furniture	-	-	-	-
Net cash used in investing	-	-	-	-
Cash Flows from financing activities				
Proceeds From:				
Capital Contributions	-	-	-	-
Used For:				
Dividends	-	(1,000,000)	(1,500,000)	(1,800,000)
Net cash used in financing	-	(1,000,000)	(1,500,000)	(1,800,000)
Net increase <decrease> in cash	560,930	(116,951)	(411,043)	(554,007)
Summary				
Cash Balance at Beg of Period	782,073	1,343,003	1,226,052	815,009
Cash Balance at End of Period	1,343,003	1,226,052	815,009	261,001

Projected Statement of Operations - Combination of Existing Envision Operations with Envision Hospice - Pierce County

Part 1 of 3: Projected Statement of Operations -Existing Envision HHA & Hospice

	2022	2023	2024	2025
VOLUMES				
Total Home Health Admissions	900	950	975	1,025
Total Home Health Visits	16,169	17,067	17,516	18,414
Average Daily Hospice Census	45.2	53.4	61.6	74.0
REVENUE				
Total Gross Revenue	8,060,707	8,984,421	9,788,923	11,055,281
Total Deductions from Revenue	(400,745)	(446,518)	(486,331)	(549,030)
Total Net Revenue	**7,659,963**	**8,537,903**	**9,302,592**	**10,506,251**
EXPENSES				
Total W2 Salaries and Benefits	2,477,190	2,810,122	3,146,279	3,663,895
Total Contract Labor	984,210	1,038,821	1,066,367	1,121,219
Other Patient Care costs	597,340	688,248	788,761	940,128
Total Direct Patient Care Costs	4,058,740	4,537,191	5,001,407	5,725,241
Total Administrative Costs	2,696,055	2,999,991	3,114,922	3,379,117
Total Costs	**6,754,795**	**7,537,181**	**8,116,329**	**9,104,359**
EBITDA	**905,168**	**1,000,722**	**1,186,264**	**1,401,893**
EBITDA Margin %	11.8%	11.7%	12.8%	13.3%
Depreciation	9,673	8,823	7,986	7,986
Amortization	-	-	-	-
Earnings Before Taxes	**895,495**	**991,899**	**1,178,278**	**1,393,907**

Part 2 of 3: Envision Hospice of Washington LLC
Pierce County Certificate of Need
Projected Statement of Operations

	2023	2024	2025	Notes and Assumptions
Average Daily Census	30.0	45.0	60.0	See Assumptions Page
Days of Care	10,950	16,425	21,900	See Assumptions Page
REVENUE				
Medicare Fee For Service	1,243,292	1,864,938	2,486,584	See Assumptions Page
Medicare Managed Care	870,305	1,305,457	1,740,609	See Assumptions Page
Medicaid	248,658	372,988	497,317	includes Healthy Options
Commercial/Other	124,329	186,494	248,658	Comm.,BHP,TriCare, CHAMPUS
Total Gross Revenue	**2,486,584**	**3,729,876**	**4,973,169**	
Deductions from Revenue				
Contractual Allowances	(49,732)	(74,598)	(99,463)	2% of Gross Revenue
Bad Debt	(24,866)	(37,299)	(49,732)	1% of Gross Revenue
Adj. For Charity Care	(48,240)	(72,360)	(96,479)	2% after Contractual and Bad Debt
Total Net Revenue	**2,363,747**	**3,545,621**	**4,727,494**	
PATIENT CARE COSTS				
Salaries and Benefits:				
Medical Director/Physician(s)	170,833	256,250	341,667	See Staffing Summary
Bereavement	-	18,000	60,000	See Staffing Summary
Spiritual Counselor	64,054	96,081	128,108	See Staffing Summary
Volunteer coordinator	16,800	23,625	31,500	See Staffing Summary
Manger of Patient Services	56,000	84,000	112,000	See Staffing Summary
RN's	285,000	427,500	570,000	See Staffing Summary
Medical Social Worker	80,000	102,857	137,143	See Staffing Summary
HHA's	112,320	168,480	224,640	See Staffing Summary
Payroll Taxes & Benefits	235,502	353,038	481,517	30% of Salaries
Total Salaries and Benefits	**1,020,510**	**1,529,831**	**2,086,575**	
Contract Labor:				
Physical Therapy	986	1,478	1,971	$ 0.09 per DOC
Occupational Therapy	329	493	657	$ 0.03 per DOC
Speech/Language	219	329	438	$ 0.02 per DOC
Dietary Counseling	219	329	438	$ 0.02 per DOC
Total Contract Labor	**1,752**	**2,628**	**3,504**	
Physician Consulting Fees	23,637	35,456	47,275	$ 0.01 of net revenue
Pharmacy/IV's	52,341	78,512	104,682	$ 4.78 per DOC
DME Costs	50,370	75,555	100,740	$ 4.60 per DOC
Medical Supplies	18,177	27,266	36,354	$ 1.66 per DOC
Lab Costs	1,095	1,643	2,190	$ 0.10 per DOC
Chemotherapy	1,095	1,643	2,190	$ 0.10 per DOC
Radiation Therapy	1,095	1,643	2,190	$ 0.10 per DOC
Imaging Services	876	1,314	1,752	$ 0.08 per DOC
Ambulance Costs	3,833	5,749	7,665	$ 0.35 per DOC
General Inpatient Care Costs	90,338	135,506	180,675	$ 835 facility contracted GIP care rate x 1% of DOC
Inpatient Respite Care Costs	21,079	31,618	42,158	$ 385 facility contracted Inpatient Respite care rate x 0.5% of DOC
Net SNF Medicaid Costs	6,570	19,710	39,420	DOC x $12/day average x 5% for 2022, 10% for 2023, 15% for 2024
Mileage	31,646	47,468	63,291	$ 2.89 per DOC
Total Other Costs	**302,151**	**463,081**	**630,581**	
Total Patient Care Costs	**1,324,412**	**1,995,540**	**2,720,660**	

ADMINISTRATIVE COSTS				
Payroll Taxes & Benefits	98,850	145,500	181,800	30% of Administrative Salaries
B&O Taxes	37,299	55,948	74,598	1.5% of gross revenue
Salaries - Administrative	142,000	215,000	301,000	See Staffing Summary
Salaries - Facility/Comm. Outreach	140,000	175,000	210,000	See Staffing Summary
QAPI Coordinator	47,500	95,000	95,000	See Staffing Summary
Mileage	4,161	6,242	8,322	$0.38 per DOC
Advertising	24,000	24,000	24,000	$2,000 /month
Travel - admin	20,000	10,000	10,000	$20,000/year first year and $10,000 therafter
Legal & Professional	12,000	12,000	12,000	$1,000 /month
Consulting Fees	3,000	3,000	3,000	$250 /month
Software Costs	12,000	12,000	12,000	$1,000 /month
Computer @ Software Maintenance	10,000	10,000	10,000	$833 /month
Office rent	17,556	17,556	17,556	$1,463 /month (See Allocation Table)
Repairs/Maintenance	1,800	1,800	1,800	$150 /month
Cleaning	600	600	600	$50 /month
Insurance	3,000	3,000	3,000	$250 /month
Office Supplies	3,000	3,000	3,000	$250 /month
Equipment Rental	2,000	2,000	2,000	$167 /month
Postage	600	600	600	$50 /month
Telephones/Pagers	14,400	14,400	14,400	$1,200 /month
Purchased Services/Utilities	6,000	6,000	6,000	$500 /month
Books & References Materials	1,200	1,200	1,200	$100 /month
Printing	1,500	1,500	1,500	$125 /month
Licenses & Certification	3,283	2,383	-	Per Renewal Fee table
Education and Training	24,000	24,000	24,000	$2,000 /month incl. palliative care, cultural competence, volunteer pr
Dues and Subscriptions	2,400	2,400	2,400	$200 /month
Corporate Allocation	118,187	177,281	236,375	5% Of Net Rev., includes Payroll, Billing, IT, HR Etc.
Total Administrative Costs	**750,336**	**1,021,410**	**1,256,150**	
Total Costs	**2,074,748**	**3,016,950**	**3,976,811**	
EBITDA	**288,999**	**528,671**	**750,683**	
EBITDA Margin %	12.2%	14.9%	15.9%	
Depreciation	1,229	1,229	1,229	See Depreciation Schedule
Amortization	-	-	-	None
EBIT	**287,770**	**527,442**	**749,455**	
Interest Expense	-	-	-	None
Earnings before Taxes	**287,770**	**527,442**	**749,455**	

PART 3 of 3: Combinataion of Parts 1 and 2: Exiting Envision Of WA operations Plus Envision Hospice - Pierce

	2022	2023	2024	2025	
REVENUE					
Total Gross Revenue	8,060,707	11,471,005	13,518,799	16,028,450	
Total Deductions from Revenue	(400,745)	(569,355)	(670,587)	(794,705)	
Total Net Revenue	**7,659,963**	**10,901,650**	**12,848,213**	**15,233,745**	
EXPENSES					
Total W2 Salaries and Benefits	2,477,190	3,830,632	4,676,110	5,750,470	
Total Contract Labor	984,210	1,040,573	1,068,995	1,124,723	
Other Patient Care costs	597,340	990,398	1,251,842	1,570,709	
Total Direct Patient Care Costs	4,058,740	5,861,603	6,996,947	8,445,902	
Total Administrative Costs	2,696,055	3,732,771	4,118,776	4,617,712	Does not double count 20% of Tacoma rent allocated to Pierce
Total Costs	**6,754,795**	**9,594,374**	**11,115,723**	**13,063,613**	
EBITDA	**905,168**	**1,307,277**	**1,732,490**	**2,170,132**	
EBITDA Margin %	11.8%	12.0%	13.5%	14.2%	
Depreciation	9,673	10,052	9,214	9,214	
Amortization	-	-	-	-	
Earnings Before Taxes	**895,495**	**1,297,225**	**1,723,276**	**2,160,918**	

Envision Existing Operations Combined with Envision Hospice - Pierce County
Proforma Balance Sheet
For The Periods Ending December 31, 2022 Through 2025

	2022	2023	2024	2025
ASSETS				
Current Assets				
Cash & Cash Equivalents	1,343,003	1,277,242	1,280,894	1,364,950
Accounts Receivable (Net)	1,556,700	2,065,604	2,368,913	2,749,393
Total Current Assets	2,899,703	3,342,846	3,649,807	4,114,343
Property and Equipment				
Fixed Assets	57,965	64,965	64,965	64,965
Accumulated Depreciation	(18,614)	(28,665)	(37,880)	(47,094)
Total Property and Equipment	39,351	36,300	27,085	17,871
Other Assets	-	-	-	-
Total Assets	**2,939,054**	**3,379,146**	**3,676,892**	**4,132,215**
LIABILITIES AND CAPITAL				
Current Liabilities				
Accounts Payable & Accrued Expenses	128,457	189,445	218,952	254,885
Accrued Payroll & Related Payables	203,005	284,884	329,847	388,319
Total Current Liabilities	331,462	474,329	548,799	643,204
Long-Term Liabilities	-	-	-	-
Total Liabilities	331,462	474,329	548,799	643,204
Shareholder Equity (Deficit)	2,607,592	2,904,817	3,128,093	3,489,011
Total Liabilities & Capital	**2,939,054**	**3,379,146**	**3,676,892**	**4,132,215**

Envision Existing Operations Combined with Envision Hospice - Pierce County
Proforma Cash Flow
For The Periods Ending December 31, 2022 Through 2025

	2022	2023	2024	2025
Cash Flows from operating activities				
Net Income After Depreciation and Amortization	895,495	1,297,225	1,723,276	2,160,918
Adjustments to reconcile net income to cash provided by Operations				
Depreciation & Amortization Change	9,673	10,052	9,214	9,214
Accounts Receivable Change	(426,700)	(508,903)	(303,310)	(380,480)
Accounts Payable Change	39,457	60,987	29,508	35,933
Payroll Payable Change	43,005	81,879	44,963	58,472
Total Adjustments	(334,565)	(355,986)	(219,624)	(276,861)
Net Cash provided by Operations	560,930	941,239	1,503,651	1,884,056
Cash Flows from investing activities Used For:				
Capital equipment and furniture	-	(7,000)	-	-
Net cash used in investing	-	(7,000)	-	-
Cash Flows from financing activities				
Proceeds From:				
Capital Contributions	-	-	-	-
Used For:				
HHS Stimulus payback				
Dividends	-	(1,000,000)	(1,500,000)	(1,800,000)
Net cash used in financing	-	(1,000,000)	(1,500,000)	(1,800,000)
Net increase <decrease> in cash	560,930	(65,761)	3,651	84,056
Summary				
Cash Balance at Beg of Period	782,073	1,343,003	1,277,242	1,280,894
Cash Balance at End of Period	1,343,003	1,277,242	1,280,894	1,364,950

Table of Contents
Rights and Responsibilities of the Individual
(RI)

POLICIES

Patient Rights

POLICY

Hospice will provide each patient with a written notice of the patient's rights in advance of furnishing care to the patient and during the initial assessment visit. If the patient is mentally or physically incapacitated, the rights will be explained to the patient's representative.

PURPOSE

Hospice protects and promotes the rights of each individual in its care.

REFERENCE

The Joint Commission CAMHC Standards: RI.01.01.01, RI.01.01.03, RI.01.01.05, RI.01.02.01, RI.01.06.05, RI.01.06.09; Medicare CoP #s: 418.52a, 418.52b, 418.52c, 418.54a, 418.54b; CHAP Standards: HPFC 1.D, HPFC 2.D, HPFC 3.1, HPFC 4.1; ACHC Standard: HSP2-1A

RELATED DOCUMENTS

"*Patient's Rights/Responsibilities*" form

PROCEDURE

1. Hospice protects and promotes the rights of each patient. In advance of furnishing care to the patient and during the initial assessment visit, the patient is informed both verbally and in writing of all rights.
2. For a patient who does not speak or understand English, Hospice will make reasonable efforts to secure a professional, objective translator for Hospice-patient communications, including those involving the notice of patient rights and responsibilities. Hospice will only use family and friends as translators for the patient when an objective translator cannot be secured or if the patient specifically requests. Hospice will make reasonable efforts to have written copies of the notice of rights and responsibilities available in the language(s) that are commonly spoken in Hospice's service area. For those patients who speak languages in areas where professional translators for those languages are not readily available, using family and friends of the patient is an acceptable option if the patient agrees.
3. If a patient has been adjudged incompetent under state law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf.

4. If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law.

5. Hospice maintains documentation in the patient's medical record demonstrating compliance with informing each patient about their rights. The patient or representative's signature will be obtained confirming receipt of the notice of rights and responsibilities.

6. Patients will be informed of their rights on an ongoing basis as indicated.

ADDITIONAL WASHINGTON STATE REQUIREMENTS

.RESPECT AND CONSIDERATION – YOU HAVE THE RIGHT TO:

1. Be free from discrimination, mistreatment, neglect, verbal, mental, sexual, and physical abuse, including injuries of an unknown source and misappropriation of your property (exploitation), and unlawful use of restraint or seclusion. Any Envision staff who identify, notice, or recognize these incidences or circumstances must report their findings immediately to DSHS and Envision Hospice's administrator.

FILING A GRIEVANCE – YOU HAVE THE RIGHT TO:

1. Envision Hospice must document both the existence and the resolution of the complaint within our complaint log.
2. Be advised when you are accepted for treatment for care, of the availability of Washington State Department of Health's end harm hotline @ 1-866-363-4276. This number is available 24 hours per day, 7 days per week to report suspected abuse of vulnerable adults or children. Washington State also has a hotline to report complaints about licensed agencies or credentialed health care providers. The Department of Social and Health Services (DSHS) Complaint Resolution Unit phone number is 1-800-737-0617.

DECISION MAKING – YOU HAVE THE RIGHT TO:

1. Participate in, consent to, or refuse care in advance of and during treatment and be fully informed in advance about your care/services, where appropriate, including:
    a. The disciplines that will provide the care, including the name(s), contact information, and responsibilities of staff members who are providing and responsible for your care;
    b. A list of services offered by Envision Hospice
2. Be informed of our transfer and discharge policies, including circumstances that may cause Envision Hospice to discharge a patient.
3. Be informed of advance directive options, including the Physician Ordered Life Sustaining Treatments (POLST) form used to specify patient end-of-life wishes.
4. Have your wishes concerning end-of-life decisions addressed and to have health care providers comply with your advance directives in accordance with Washington State laws.

QUALITY OF CARE – YOU HAVE THE RIGHT TO:

1. Have a pain assessment completed and to receive effective pain management and symptom control for conditions related to your terminal illness.
2. Receive instruction on back-up care available when scheduled services are unavailable.

WASHINGTON STATE REFERENCE

RCW 70.127.120 and 43.70.250; WAC 246-335-635

Election of Hospice Care Policy/
Designation of Attending Physician

POLICY

Hospice will follow applicable Medicare rules for filing an election statement. The Hospice chosen by the eligible individual (or his or her representative) must file the Notice of Election (NOE) with its Medicare contractor within 5 calendar days after the effective date of the election statement.

PURPOSE

To define the election of Hospice services and designation of attending physician.

REFERENCE

The Joint Commission CAMHC Standards: RI.01.02.03, RC.02.02.01; Medicare CoP #: 418.24; CHAP Standards: HCPC 8.1, HCPC 9.1; ACHC Standards: HSP5-1A, HSP5-1A.01

PROCEDURE

1. At time of admission, each patient will be informed of the Hospice philosophy of care and required to sign an election statement.
   - If the patient is physically or mentally incapacitated, the patient's representative may file the election statement.

2. The election statement must include the following:
   - Identification of the particular Hospice that will provide care to the patient.
   - The patient's or 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.
   - Acknowledgement that certain Medicare services are waived by the election.
   - The effective date of the election, which may be the first day of Hospice care or a later date, but may be no earlier that the date of the election statement.
   - The signature of the patient or representative.

3. 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 Hospice.

4. For the duration of an election of Hospice care, a patient waives all rights to Medicare payments for the following services:
   - Hospice care provided by a Hospice other than the Hospice designated by the patient (unless provided under arrangements made by the designated Hospice). Any Medicare services that are related to the treatment of the terminal condition for which Hospice care was elected or a related condition or that are equivalent to Hospice care, except for services:
     a. Provided by the designated Hospice.
     b. Provided by another Hospice under arrangements made by the designated Hospice.
     c. Provided by the patient's attending physician, if that physician is not an employee of the designated Hospice or receiving compensation from Hospice for those services.

5. The election statement must include the patient's choice of attending physician.
   - Information identifying the attending physician should be recorded on the election statement in enough detail so that it is clear which physician or nurse practitioner was designated as the attending physician. Hospice has the flexibility to include this information on the election statement in whatever format works best, provided the content requirements in are met. This should include, but is not limited to:
     - The attending physician's full name, office address, National Provider Identifier (NPI) or any other detailed information.
   - Language on the election form should include an acknowledgement by the patient (or representative) that the designated attending physician was the patient's (or representative's) choice.
   - If a patient (or representative) wants to change his or her designated attending physician, he or she must follow a procedure similar to that which currently exists for changing the designated Hospice. Specifically, the patient (or representative) must file a signed statement, with the Hospice, that identifies the new attending physician in enough detail so that it is clear which physician or nurse practitioner was designated as the new attending physician. The statement needs to include the date the change is to be effective, the date that the statement is signed and the patient's (or representative's) signature, along with an acknowledgement that this change in the attending physician is the patient's (or representative's) choice. The effective date of the change in attending physician cannot be earlier than the date the statement is signed.

6. If an election has been revoked, the patient (or his or her representative if the patient is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the patient.

7. Effective January 1, 2019, Medicare will pay for medically reasonable and necessary services provided by Physician Assistants (PAs) to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician. PAs are paid 85 percent of the fee schedule amount for their services as designated attending physician.

- Attending physician services provided by PAs may be separately billed to Medicare only if:
  - The PA is the beneficiary's designated attending physician.
  - Services are medically reasonable and necessary.
  - Services would normally be performed by a physician in the absence of the PA, whether or not the PA is directly employed by the hospice.
  - Services are not related to the certification of terminal illness.
- If the PA is employed by Hospice, Hospice can bill Part A for physician services meeting the above criteria on a hospice claim. If the PA is not employed by Hospice, the PA can bill Part B for physician services meeting the above criteria. PAs are authorized to furnish physician services under their State scope of practice, under the general supervision of a physician. Services that are duplicative of what the Hospice nurse would provide are not separately billable.
- Since PAs are not physicians, they may not act as medical directors or physicians of Hospice or certify the beneficiary's terminal illness. Hospice may not contract with a PA for their attending physician services as described in section 1861(dd)(2)(B)(i)(lll) of the Act, which outlines the requirements of the interdisciplinary group as including at least one physician, employed by or under contract with the Hospice or organization. All of these provisions apply to PAs without regard to whether they are Hospice employees.
- Physician assistants cannot certify or re-certify an individual as terminally ill, meaning that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. In the event that a beneficiary's attending physician is a nurse practitioner or a physician assistant, Hospice Medical Director or the physician member of Hospice Interdisciplinary Group certifies the individual as terminally ill.
- The Hospice face-to-face encounter must be performed by a hospice physician or hospice nurse practitioner. PAs may not perform the face-to-face encounter.

8. When Hospice does not file the required Notice of Election for its Medicare patients within 5 calendar days after the effective date of election, Medicare will not cover and pay for days of Hospice care from the effective date of election to the date of filing of the Notice of Election. These days are a provider liability and the provider may not bill the beneficiary for them.

9. CMS may waive the consequences of failure to submit a timely-filed NOE. CMS will determine if a circumstance encountered by Hospice is exceptional and qualifies for waiver of the consequences. Hospice must fully document and furnish any requested documentation to CMS for a determination of exception. An exceptional circumstance may be due to, but is not limited to the following:
   - Fires, floods, earthquakes or similar unusual events that inflict extensive damage to Hospice's ability to operate.
   - A CMS or Medicare contractor systems issue that is beyond the control of Hospice.
   - a newly Medicare-certified Hospice that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its Medicare contractor.
   - Other situations determined by CMS to be beyond the control of Hospice.

10. Notice of Election requirements effective October 1, 2020:
    - Providing the individual with information indicating that services unrelated to the terminal illness and related conditions are exceptional and unusual and Hospice should be providing virtually all care needed by the individual who has elected Hospice.
    - Provide information on individual cost-sharing for Hospice services.
    - Hospice must provide notification of the individual's (or representative's) right to receive an election statement addendum, if there are conditions, items, services and drugs Hospice has determined to be unrelated to the individual's terminal illness and related conditions and would not be covered by Hospice.
    - Provide information on the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), including the right to immediate advocacy and BFCC-QIO contact information.

11. Hospice Election Statement Addendum effective October 1, 2020:
    - In the event that Hospice determines there are conditions, items, services or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services or drugs, or Medicare contractors may request a written list as an addendum to the election statement. If the election statement addendum is requested at the time of initial Hospice election (that is, at the time of admission to Hospice), Hospice must provide this information, in writing, to the individual (or representative) within 5 days from the date of the election. If this addendum is requested during the course of Hospice care, Hospice must provide this information, in writing, within 72 hours of the request to the requesting individual (or representative), non-hospice provider or Medicare contractor. If there are any changes to the content on the addendum during the course of Hospice care, Hospice must update the addendum and provide these updates, in writing, to the individual (or representative). The election statement addendum must include the following:
        - The addendum must be titled "Patient Notification of Hospice Non-Covered Items, Services, and Drugs."
        - Name of the Hospice.
        - Individual's name and Hospice medical record identifiers.
        - Identification of the individual's terminal illness and related conditions.
        - A list of the individual's conditions present on Hospice admission (or upon plan of care update) and the associated items, services and drugs not covered by Hospice because they have been determined by Hospice to be unrelated to the terminal illness and related conditions.
        - A written clinical explanation, in language the individual (or representative) can understand, as to why the identified conditions, items, services and drugs are considered unrelated to the individual's terminal illness and related conditions and not needed for pain or symptom management. This clinical explanation must be accompanied by a general statement that the decision as to whether or not conditions, items, services and drugs are related is made for each patient and that the individual should share this clinical explanation with other health care

providers from which they seek items, services or drugs unrelated to their terminal illness and related conditions.

- References to any relevant clinical practice, policy or coverage guidelines.
- Information on the following:
  - Purpose of Addendum. The purpose of the addendum is to notify the individual (or representative), in writing, of those conditions, items, services and drugs Hospice will not be covering because Hospice has determined they are unrelated to the individual's terminal illness and related conditions.
  - Right to Immediate Advocacy. The addendum must include language that immediate advocacy is available through the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if the individual (or representative) disagrees with Hospice's determination.
- Name and signature of the individual (or representative) and date signed, along with a statement that signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily the individual's (or representative's) agreement with Hospice'

Revoking the Election of Hospice Care Policy

POLICY

Hospice will follow applicable Medicare rules and honor a patient's right to revoke Hospice care. A patient or representative may revoke the patient's election of Hospice care at any time during an election period.

PURPOSE

To define Hospice revocation.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.02.03; Medicare CoP #: 418.28; CHAP Standard: HCDT 40.1; ACHC Standard: HSP5-11A

PROCEDURE

1. To revoke the election of Hospice care, the patient or representative must file a statement with Hospice that includes the following information:
   - A signed statement that the patient or representative revokes the patient's election for Medicare coverage of Hospice care for the remainder of that election period.
   - The date that the revocation is to be effective. (A patient or representative may not designate an effective date earlier that the date that the revocation is made.)
   - A verbal revocation of benefits is not acceptable.

2. A patient, upon revocation of the election of Medicare coverage of Hospice care for a particular election period:
   - Is no longer covered under Medicare for Hospice care.
   - Resumes Medicare coverage of the benefits waived.
   - May at any time elect to receive Hospice coverage for any other Hospice election periods that he or she is eligible to receive.

Change of the Designated Hospice

POLICY

Hospice will follow applicable Medicare rules and honor a patient's right to change the designated Hospice. A patient or representative may change, once in each election period, the designation of the particular Hospice from which Hospice care will be received. The change of the designated Hospice is not a revocation of the election for the period in which it is made.

PURPOSE

To define the procedure for changing Hospice programs.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.02.03; Medicare CoP #: 418.30; CHAP Standard: HSLG 1.1

PROCEDURE

1. To change the designation of Hospice programs, the patient or representative must file, with the Hospice from which care has been received and with the newly designated Hospice, a statement that includes the following information:
   - The name of the Hospice from which the patient has received care and the name of the Hospice from which he or she plans to receive care.
   - The date the change is to be effective.

Complaint Resolution

POLICY

To provide for a prompt and equitable resolution of complaints by patients and employees.

PURPOSE

To provide a mechanism for use by the patient or employee to assure response, and, if possible, resolution of a complaint in a timely manner. To provide administrative persons an opportunity to review responses to complaints as indicated.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.07.01; Medicare CoP #: 418.52b; CHAP Standards: HPFC 6.D, HSRM 1.D; ACHC Standard: HSP2-4A

PROCEDURE

1. A patient complaint may be formal or informal and in writing or verbal. The complaint may be made to any Hospice employee, volunteer or individual furnishing services under arrangement. The complaint may be made by the patient or patient representative.

2. Patients are encouraged to make suggestions for improving care and/or register complaints to Hospice without fear of coercion, discrimination or reprisal for doing so or unreasonable interruption of care.
   - Hospice will investigate complaints made by a patient, patient's family or guardian regarding treatment or care that is (or fails to be) furnished.
   - Hospice will investigate complaints made regarding a lack of respect for the patient's property by anyone furnishing services on behalf of Hospice.
   - Hospice will document both the existence and the resolution (or attempts at resolution) of the complaint. This documentation will be kept confidential, in a file titled "Complaints."

3. The designated individual to respond to and takes action to resolve complaints is the Administrator.
   - Intake information is obtained from the appropriate sources.
   - Investigative measures will be implemented based on the nature of the complaint.
   - Appropriate authorities are informed as applicable.
   - Corrective action is specific and directly related to the complaint and may be shared with complainant.
   - Patient and family rights are protected.
   - Complaint resolution is achieved in accordance with established time frames.
   - Complaints are logged, tracked and trended.
   - Complaint management is incorporated into QAPI activities.

4. Should the patient not receive a positive response to complaints within 24 hours, the patient is encouraged to speak to the Director. The patient will receive a response within three (3) business days.

5. Patients who feel further investigation is needed may appeal to the Hospice's Governing Body, who will respond to the patient within five (5) business days.

6. At any time the patient may register complaints about Hospice to the Department of Home Health Licensing and Certification. The patient may call the state Home Health Hospice hotline for complaints/grievances or questions about local home health agencies or complaints concerning advance directives. Hospice will advise patients in writing of the telephone number and hours of operation at time of admission.

7. Employees will follow the normal chain of command in pursuing resolutions to any problem. If a satisfactory resolution is not attained with the immediate supervisor, the employee:
   - Submits the written complaint to the next supervisory level.
   - This supervisor will respond to the grievance in writing within five (5) business days and work with the employee to pursue a resolution.

8. If an employee has a complaint related to what he/she determines to be discrimination based on handicap, the employee is to directly inform the Administrator.
   - The Administrator will assist the employee regarding knowledge of his/her rights and will investigate the incident which led to the allegation.
   - The employee must initiate the complaint within 30 days of the incident.

9. At admission each patient is informed regarding steps to take if he/she has any concerns related to care, treatment or services and patient safety issues.

ADDITIONAL ACHC REQUIREMENTS

1. Hospice maintains records of grievances/complaints and their outcomes and includes this information in the annual program review/evaluation. A summary of the grievances/complaints will be reported quarterly to the governing body/owner.

2. Hospice will also provide ACHC's telephone number in writing to each patient at time of admission.

Advance Directives

POLICY

Patients have the right to make decisions concerning their care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives as permitted under state statutory and case law. Hospice will honor each patient's known advance directives and inform an individual patient if Hospice has any limitations in respecting a patient's advance directives. A patient's admission to Hospice will not be affected by his/her desire to not formulate an advance directive or by the contents of an advance directive.

PURPOSE

To define and assure the rights of adult patients in health care decision-making.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.05.01; Medicare CoP #: 418.52a; CHAP Standards: HPFC 9.D, HPFC 10.1; ACHC Standard: HSP2-6A

RELATED DOCUMENTS

"*Patient Advance Directives Statement*," "*Community Education Regarding Advance Directives*" forms

PROCEDURE

1. Prior to coming under Hospice care, the patient will be provided with written information concerning the patient's rights under state law (both statutory and case law) to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
    - This information will be provided by Hospice employees at time of the initial assessment before care is provided and documented in the medical record.
    - Each patient will also be informed of Hospice's written policies regarding respecting the implementation of the patient's advance directive.
    - If an adult patient is incapacitated at the time of admission or at the start of care and is unable to receive information (due to a mental disorder or incapacitating condition) or articulate whether or not he/she has executed an advance directive, staff may give the information to the patient's family or surrogate in accordance with state law. Hospice is not relieved of the responsibility to provide this information to the patient once he/she is no longer incapacitated and able to receive such information. Staff will provide advance directives information to patient at this time.

2. Staff will document in the patient's medical record whether the adult patient has executed any advance directives. Copies will become a permanent part of the patient's medical record. If copies cannot be obtained during initial assessment, the RN or SW will document the patient's wishes. All staff involved in the patient's care will be informed of the patient's advance directive.

3. No individual will be discriminated against or have care conditioned upon whether an advance directive has been executed.

4. Advance directives include:
   - Living wills.
   - Durable power of attorney for health care.
   - Any written, signed and dated document executed by the patient, which expresses the patient's health care treatment decisions.
   - Any statement (verbal or written) that revokes or modifies a previous directive becomes the current directive to be honored. Such revocation is to be noted in the patient's medical record.
   - State law authorizing a written declaration directing the withholding or withdrawing of death-prolonging procedures does not also authorize withholding or withdrawing of nutrition and hydration (food and water).
   - State law authorizing durable powers of attorney for health care does not authorize the intent to cause death by withholding or withdrawing of nutrition and hydration (food and water) which are able to be ingested through natural means.

5. In the event that the patient does not have any advance directives but would like additional information, such information will be provided by staff. The patient will inform the Hospice of any updates to advance directives.

6. If the patient has been determined to have the capacity (whether verbally or non) to make a decision, the patient may state any advance directives to Hospice professional staff.
   - Any oral advance directive will be documented in the patient's medical record.
   - The patient's attending physician will be notified of any advance directives by Hospice professional staff within 24 hours.
   - If the patient's attending physician cannot be reached, the physician on-call or Medical Director will be contacted. This contact will be documented in the patient's medical record.

7. If the patient is returning to the care of Hospice and has previously provided copies of advance directives, the advance directives will be verified as being current to this admission.
   - Verification of the current validity of the advance directives will be documented in the patient's medical record.
   - The patient's attending physician will be notified within 24 hours of the preexisting advance directives and will be requested to write appropriate orders.

8. Staff will be educated about advance directives during orientation and ongoing.

9. Hospice will provide education to the community served about advance directives.
   - Education may be provided during health fairs or community forums. Such education will be provided at least annually and documented.
   - The educational materials provided will define what constitutes an advance directive, emphasize an incapacitated individual's control over medical treatment and describe applicable state law concerning advance directives.

10. Hospice will update and disseminate to staff and patients changes to state law on advance directives no later than 90 days from the effective date.

11. If Hospice cannot implement an advance directive based on conscience, Hospice has a clear statement of any limitations. The statement includes:
   - Clarification of any differences between organization-wide conscience objections and those raised by an individual physician.
   - Identification of the state legal authority permitting such objection.
   - A description of the range of medical conditions or procedures affected by conscience objection.

ADDITIONAL WASHINGTON STATE REQUIREMENTS

1. A Physician Order for Life Sustaining Treatment (POLST) form is used as an advance directive and Envision Hospice staff will follow the indicated wishes on the completed and signed form. Form must be signed by physician as well as patient or family member. Any portions of the Physician's Order for Life Sustaining Treatment left blank or not completed will be considered as full treatment desired by the patient.
   - If the patient does not have an advance directive or Physician's Order for Life Sustaining Treatment, the form will be given to the patient or representative by Envision Hospice staff.
   - In the event of a patient emergency with Envision Hospice staff present, Envision staff will present emergency personnel with the signed Physician's Order for Life Sustaining Treatment.

WASHINGTON STATE REFERENCE

RCW 70.127.120 and 43.70.250; WAC 246-335-620

Limited English Proficiency or Impairments in Communication

POLICY

Hospice will provide for communication with persons with impairments in communication, e.g., vision, cognitive, hearing or speech impaired or Limited English Proficient (LEP) persons, including current and prospective patients, family, interested persons, employees and potential employees to ensure an equal beneficial services opportunity.

PURPOSE

To ensure adequate provisions are made for meeting the communication needs of patients, staff and others.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.01.03; Medicare CoP #: 418.52a; CHAP Standard: HSRM 1.D; ACHC Standard: HSP2-8A.01

RELATED DOCUMENTS

"*Translator/Interpreter Availability"* form

PROCEDURE

1. Hospice will facilitate the provision of interpretation (including translation services) as necessary. If a translator is needed, the Director is responsible for contacting an interpreter. In order to ensure competency of translators, family members or friends may be used as the translator only if specifically requested by the patient.

2. Hospice maintains a list of community translators/interpreters.

3. Hospice will facilitate communication by utilizing other special devices or communication aids.

4. When a significant portion of the Hospice case load (25% or greater) understands one language that is not English, Hospice provides required written materials in that language to patients, e.g., Rights and Responsibilities, etc.

Guidelines for Effective Communication With Sensory Impaired Patients

POLICY

Hospice will provide a variety of communication resources to sensory impaired patients.

PURPOSE

To provide adaptive communication tools to promote communication between patient and staff.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.01.03; Medicare CoP #: 418.52a; CHAP Standard: HSRM 1.D; ACHC Standard: HSP2-8A.01

RELATED DOCUMENTS

"*Sensory Impaired Patient Information Sheet*" form

PROCEDURE

1. All hearing impaired patients will be consulted as to their preferred method of communications, which may include:
   - Use of a qualified sign language or oral interpreter.
   - Lip reading.
   - Handwritten notes.
   - Patient/caregiver/significant other.
   - Any combination of the above.

2. The Director will contact a qualified sign language or oral interpreter. If the patient designates a family member or friend as an interpreter, the request will be honored.
   - A note will be placed in the patient's medical record.

3. Sign language interpreters may be used in the following situations:
   - Explaining procedures, medications or treatments.
   - Obtaining consent for treatment.

- Taking histories.
- Explaining patient rights and responsibilities.
- Explaining financial responsibilities.

4. If a TDD (Telecommunications Device for the Deaf) or TTY (Teletypewriter) is needed for communication with a deaf patient, Hospice will make arrangements to provide this service.

5. For additional information, contact:

Office for Civil Rights
U.S. Dept. of Health and Human Services

Patient Security, Privacy and Property

POLICY

Hospice will establish measures regarding patient security and privacy.

PURPOSE

To provide measures to address privacy and security during the course of care and respect of patient's property.

REFERENCE

The Joint Commission CAMHC Standards: RI.01.01.01, RI.01.06.05; Medicare CoP #: 418.52b; CHAP Standard: HSRM 1.D

PROCEDURE

Security

- Patients are encouraged to keep emergency telephone numbers near telephone and to keep doors locked.
- Patients are instructed to only allow Hospice staff to enter their homes that have proper identification.
- Staff will wear identification badges during the provision of all Hospice services.

Privacy

- Employees are to keep the patient covered at all times while providing patient care.
- Visitors and others are asked to leave during patient care.
- Any photos taken are for the purposes of documentation are taken only with the written consent of the patient.

Property

- Patients are instructed to notify Hospice of missing/damaged property, money or valuables.
- In the event an admission of theft is made, every attempt will be made to recover the loss from the employee involved. The employee will be terminated.
- Hospice will offer full cooperation to police or any other investigative authority.
- Employees are to use care when performing care and in handling patient's property/possessions.
- If an employee damages a patient's property/possession, the employee will immediately notify his/her supervisor.

Do Not Resuscitate (DNR)

POLICY

Hospice will obtain current orders regarding resuscitation from patient's physician and proceed according to patient's wishes and applicable laws and regulations.

PURPOSE

To provide a mechanism for obtaining current Do Not Resuscitate (DNR) orders from a patient's physician and Hospice's policies regarding DNR.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.05.01; Medicare CoP #: 418.52a; CHAP Standard: HSLG 1.1; ACHC Standards: HSP2-6A, HSP2-6A.01

PROCEDURE

1. All patients served by Hospice will be resuscitated except those patients who have signed physician orders for DNR.

2. DNR orders are included in the IDG plan of care, if patient is a DNR at time of admission.

3. If a physician's order for DNR is obtained after patient admission and/or before the next IDG plan of care renewal is due, the Staff Nurse will take the verbal or telephone order from the physician and will send to the physician to authenticate. The order will subsequently be included on the next IDG plan of care update.

4. Staff should listen carefully to what patients are saying and take "cues" from a patient who verbally and nonverbally appears to desire to discuss the potential for impending death. Should the patient appear to be communicating to the staff member his/her wishes regarding life-sustaining measures and/or resuscitation, the staff member should encourage patient to ventilate feelings and involve the patient's family in such discussions as indicated and desired by the patient. The staff member should ascertain at the end of the discussion what the patient desires. Should the patient desire a DNR order, the staff member will consult with his/her supervisor. The appropriate professional staff member will then consult with the patient's attending physician regarding a DNR order.

5. All discussions with patients, families, significant others and/or physicians will be documented by the involved staff member(s) in the patient's medical record.

6. Resuscitation details (verbal and written) will be made available to all caregivers.

7. Copies of DNR orders will be kept in the patient's medical record.

8. All staff who is CPR certified will render CPR in the event of cardiac arrest to those patients who are not DNR's. Staff who is not CPR certified will summons "911" or emergency medical rescue assistance (whichever is available to service patient's residence).

Forego and/or
Withdraw Life-Sustaining Care

POLICY

All employees will report to the Director any patient/caregiver's requests to foregoing or withdrawing life-sustaining care.

PURPOSE

To develop an awareness of patient/caregiver's desire to discontinue any life-sustaining treatment.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.05.01; Medicare CoP #: 418.52a; CHAP Standard: HSLG 1.1; ACHC Standard: HSP2-6A.01

PROCEDURE

1. The patient has the right to participate in the decision to forego and/or withdraw life-sustaining care. Hospice staff, the patient's physician and other allied health care professionals involved in the care of the patient will participate in informing the patient/caregiver of expected outcomes for the decision to forego and/or withdraw life-sustaining care. Hospice will respect the patient/caregiver's informed decision to forego and/or withdraw life-sustaining care according to Hospice's mission and philosophy.

2. Documentation regarding patient/caregiver's decisions to forego and/or withdraw life-sustaining care will be entered in the patient's medical record by the involved staff members. Such documentation will include any discussions between staff, patient, caregiver, physician and other allied health care professionals, as well as appropriately authenticated physician orders. Visit notes, progress notes, communication notes and physician summary reports may include such documentation.

3. Written or verbal notification will be given to the Director who will in turn notify the following:
   - The patient's physician.
   - The family that the patient's physician has been notified.
   - IDG members.

4. Hospice will not discontinue treatment except as required by law or court order.
   - Hospice will comply with patient's advance directive or durable power of attorney, in accordance with state and federal law.
   - Hospice will not be involved in removing mechanical life support or life-sustaining treatment as defined by state law.

Consent for Filming or Recording

POLICY

Hospice requires patient consent when filming or recording is to be used for any purpose other than identification, diagnosis or treatment. Filming and recording include photography, video, audio and/or electronic media.

PURPOSE

To define the process for consent for filming or recording.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.03.03; Medicare CoP #: 484.10c; CHAP Standard: HSRM 1.D

PROCEDURE

1. When a patient is to be filmed or recorded for any purpose other than identification, diagnosis or treatment, the patient will be required to give consent.
   - The consent will be documented.
   - The purpose of the filming or recording will be documented.

2. Consent must be obtained prior to the filming or recording. If the patient is not able to give consent in advance, the filming or recording:
   - Must be performed in an ethical manner.
   - Must remain in Hospice's possession until and unless consent is obtained.
   - If consent is not subsequently obtained, the film or recording is either destroyed or the non-consenting patient must be removed from the film or recording.

3. The patient will be informed of specific rights:
   - The patient has the right to request cessation of filming or recording.
   - The patient has the right to rescind consent for up to a reasonable time before the film or recording is used.

4. External persons (not employees of Hospice) who engage in filming or recording a patient must sign a confidentiality statement to protect the patient's identity and confidential information.

Patient/Family Responsibilities

POLICY

Patient/family are informed orally and in writing of their responsibilities related to the care provided.

PURPOSE

To ensure that the patient/family are informed regarding their responsibilities.

REFERENCE

The Joint Commission CAMHC Standard: RI.02.01.01; Medicare CoP #: 418.52b; CHAP Standard: HPFC 1.D; ACHC Standard: HSP2-2A

RELATED DOCUMENTS

"*Patient's Rights/Responsibilities*" form

PROCEDURE

1. In advance of furnishing care to a patient or during the initial assessment visit, the patient is informed both verbally and in writing of their responsibilities.

Consent

POLICY

Patients (and family members, if appropriate) will participate in the IDG plan of care, as well as planning for transfer, referral or discharge.

The patient will receive information regarding his/her condition, technical procedures and benefits and effects of the procedure. All patients will sign giving consent for Hospice to admit and treat patient.

PURPOSE

To inform the patient or appropriate family members of risks/benefits associated with any care provided in the home.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.03.01; CHAP Standard: HSRM 1.D

PROCEDURE

1. All care provided by Hospice requires consent for care.

2. At time of initial assessment, the RN will obtain consent for care.

3. If patient agrees with proposed care and physician's orders, the patient will be asked to sign the consent form.
   - A surrogate decision maker may give consent if:
     - Patient is not physically able to sign form.
     - Patient has been judged mentally incompetent.
     - Patient requests that surrogate decision maker sign consent.

4. The consent form will be included in the patient's medical record.

5. In the event of a patient emergency at time of initial assessment, e.g., patient experiences cardiopulmonary arrest during visit and is not a DNR, the admitting RN may render emergency care without consent.

6. The RN will include the patient in the IDG plan of care at the time of assessment and for the duration of care.

7. Special consents will be obtained and signed by the patient for experimental procedures.

8. Hospice provides no treatments or procedures that required informed consent.

9. At time of initial assessment and on an ongoing basis, each patient will be informed of the name of the staff member responsible for care and the name of the staff member providing care.

10. At the time of the initial assessment, each patient will be informed orally and in writing of payment responsibility (if any). The patient will also be informed orally and in writing on an ongoing basis of changes in payment responsibility, but no later than five (5) calendar days from the date that Hospice becomes aware of the change.

Outcomes of Care

POLICY

Hospice will inform the patient and family (when appropriate) about outcomes of care.

PURPOSE

To define Hospice's role regarding a patient's outcomes of care.

REFERENCE

The Joint Commission CAMHC Standard: RI.01.02.01; CHAP Standard: HSRM 1.D; ACHC Standards: HSP1-7A.01, HSP4-2J.02

PROCEDURE

1. Hospice staff will inform the patient and family (when appropriate) about outcomes of care that have been provided by staff.

2. The Administrator and/or Director will inform the patient and family (when appropriate) about any unanticipated outcomes of care that relate to sentinel events.

ADDITIONAL ACHC REQUIREMENTS

1. Negative outcomes affecting accreditation, licensure or Medicare/Medicaid certification are reported to ACHC within 30 days of the occurrence. The report includes all actions taken and plans of correction.

2. Incidents that must be reported to ACHC include, but are not limited to:
   - License suspension(s).
   - License probation; conditions/restrictions to license(s).
   - Non-compliance with Medicare/Medicaid Regulations identified during survey by another regulatory body.
   - Revocation of Medicare/Medicaid/Third-Party provider number.
   - Any open investigation by any regulatory or governmental authority.
   - Hospice agrees to a corporate integrity agreement.

Envision Goals for Additional Pierce County Hospice Services and Benefits

Program Detail

Goal 1: Respond with focused capabilities to specific clinical groups with special needs, in particular:

A. Patients with Alzheimer's or other dementias and their caregivers

B. Support to "pre-hospice" patients with advanced care planning & palliative care

Goal 2: Making hospice care as accessible as possible in the broadest array of settings including:

A. Telemedicine at home

B. Assisted living facilities

C. Adult family homes

D. Nursing homes

E. Homeless outreach

F. Mobile outreach clinics

Goal 3: Respond to specific cultural and demographic groups with appropriate and relevant communications and care with programming emphasis on:

A. Veterans

B. Latinos and Spanish-speaking residents

Goal 4: Reducing suffering through availability of:

A. Excellence in palliative care

B. "Your Hand in Mine"

C. Death with Dignity

Goal 1A: Specialty Program for Patients with End Stage Alzheimer's and Dementia

Approximately 5.5 million Americans have Alzheimer's dementia in 2017 and of the people who have Alzheimer's dementia, 82% are age 75 or older. The anticipated rise in Americans living with Alzheimer's by 2050 could be as high as 16 million. Specifically, in the State of Washington, the percentage change in the number of Americans age 65 and older with Alzheimer's dementia is projected to be over 27%.

In regard to hospice, 16.5% of patients have a principal diagnosis of dementia. Dementia is the third top principal diagnosis after cancer and cardiac; and more hospice patients will have secondary diagnoses of dementia. One in three seniors die with Alzheimer's or another dementia. Dementia diseases kill more than breast cancer and prostate cancer combined and it may cause even more deaths than official sources recognize. Furthermore, since the year 2000, deaths from heart disease (the leading cause of death) have decreased by 14% while deaths from Alzheimer's disease have increased by 89%.

The cost to the nation in 2017 was estimated at $259 billion and alarmingly by 2050 these costs could rise as high as $1.1 trillion. Other health costs that are difficult to measure are the physical decline of the family member or other caregivers caring for people with Alzheimer's or another dementia. 35% of caregivers for people with Alzheimer's or another dementia report that their health has gotten worse due to care responsibilities, compared to 19% of caregivers for older people without dementia.

Hence, due to the anticipated growing needs and financial impact on Medicare costs, Envision Hospice will provide a specialized care program for patients with Alzheimer's and Dementia that sets it apart. Components of this program include:

- Patient and family centered care –
    - Recognize the patient and family as the unit of care.

- Coordinated care planning includes bereavement needs, interventions, goals and outcomes for both the patient and family.

- Expectation that care provided conveys respect and dignity that is responsive to the needs of the patient and family.

- Assessments include acknowledging the individuality, culture, capacity, and abilities of each patient and family.

- Ethical behavior and consumer rights –

  - Education to the patient/family about the dementia disease process to ensure informed consent regarding treatment decisions and care planning

  - Expectation that staff ascertain and honor the wishes, preference, concerns, priorities and values of patients and their families consistent with local laws, regulations, and the organization's values and policies.

  - Ethical committee established to review policies and procedures.

- Clinical excellence and safety –

  - Follows evidence-based Alzheimer's Association Dementia Care Practice Recommendations.

  - Dementia specific care practices may include:

    - Aromatherapy
    - Music therapy
    - Therapeutic touch
    - Advanced feeding techniques
    - Pre-death bereavement support for families and caregivers
    - Other specific evidenced base interventions for dementia care

  - Understanding and assessing pain in patients who can't communicate verbally.

    - Case review with Hospice Medical Director to distinguish dementia from similar symptoms of delirium which may be reversible.

- Inclusion and access –

    - Dementia specific admission criteria are continuously reviewed to ensure best practices are followed (FAST scoring, etc.).

    - Collaboration with Alzheimer Association for patient and family resources.

    - Inclusiveness is assured so that all individuals have access to hospice programs and services regardless of disease or other characteristics.

- Organizational excellence –

    - Organizational leaders will complete Alzheimer Association's Certification Program and ensure services provided are appropriate.

    - Marketing materials describe services available for all patients regardless of diagnosis or disease.

    - Organizational leaders are expected to build and sustain a culture of quality and accountability that values collaboration and ensures ethical business and clinical practices.

    - Follows NHPCO Standards of Practice for Hospice Programs

- Workforce excellence –

    - Interdisciplinary team members have dementia specific training that addresses the following needs by utilizing the Alzheimer's Association essentials training:

        - Physical
        - Emotional
        - Spiritual
        - Grief and bereavement issues.

- Interdisciplinary team members demonstrate dementia specific competence in?
    - Assessment of prognosis/terminality
    - Documentation of prognosis/terminality
    - Care planning for Alzheimer's and dementia
    - Care interventions for people with Alzheimer's and dementia
    - Evaluation of dementia specific care outcomes.

- Performance measurement for Alzheimer's and dementia specialty program includes –
    - Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.
    - Collecting performance and outcome data related to patient care.
    - Participating in the collection of hospice comparison data as a means to determine areas for improvement.

Goal 1B: Pre-hospice and Advanced Care Planning

Many persons who face a terminal illness and are eligible for hospice care do not choose it. A combination of regulatory, reimbursement and cultural barriers stand in the way. These barriers result in there being a substantial unmet need that is not filled by the hospice benefit. Among those are three that Envision Hospice plans to address in Pierce County:

- Many are not aware of hospice or that their specific terminal illness makes them eligible.
- Many are aware of hospice but are uncomfortable with the Medicare hospice requirement to forego curative treatment.
- Many are not involved enough in their own care planning and direction to make a decision either way.

Palliative care - reducing suffering through treatment of pain and discomfort - has always been a cornerstone of hospice care. But the clinical skills available through hospice care are now becoming more widely available throughout the health care system. Over the last twenty years, health care providers including hospitals and physicians have taken the challenge to address their patients' need for palliative care regardless of their stage of illness.

Gradually, hospice organizations have also begun providing palliative care to terminally ill persons outside the hospice benefit. This trend has grown and, nationally, NHPCO reports that a majority of hospice agencies respond to this unmet need by offering "pre-hospice" or palliative care to non-hospice enrollees. The greatest barrier to a broader offering is the lack of reimbursement for these services and the lack of agency knowledge about billing for services outside the Medicare hospice benefit.

The typical setting for "pre-hospice" palliative care is the home or hospital. Envision's plan to offer its services in a broad array of settings will afford the opportunity to offer "pre-hospice" in patients' homes. Physicians, nurse practitioners and social workers with Envision's

hospice or with Envision Physician Group1 will be able provide services in retirement home, assisted living, adult family home and nursing home settings. Upon start-up, Envision will assess the need in Pierce County and tailor its services; among those:

- Advanced Care Planning, assistance with determining goals of care
- Pain and symptom management
- End-stage disease management
- Palliative care consultation
- Support and bereavement services to patients and families.

Hospitals are another location for "pre-hospice" or palliative care provided by the hospice but outside the hospice benefit. As an example, a palliative care consultation by a hospice agency's palliative care specialist can benefit patients during their hospital stay at a hospital that does not have its own palliative care team or palliative care specialist on its hospitalist team. Such a patient with terminal illness may even elect hospice enrollment, be referred to a hospice and continue his or her hospital stay as a GIP (General Inpatient) patient of the hospice.

Envision is committed to working with local providers to help fill this gap in the health care system. Each community will be different and require that Envision leaders and clinicians practice good communication, coordination, and collaboration with other providers. The specific services Envision can offer will be determined as it learns more about the programs that already exist in Pierce County.

[1] Hospice agencies can choose between offering these services directly through their Medicare agency or through establishment of a separate billing entity.

Goal 2A: Tele-medicine at home

Envision Hospice of Washington will include tele-medicine services as an adjunct to its in-home hospice visits. For patients and their caregivers who have access to Wi-Fi or cellular data in their homes, Envision will offer an electronic tablet to be used to communicate as needed with hospice staff or patients and their care-givers can use their own device.

By using video conferencing technology, an Envision hospice patient will have the ability to call his or her nurse directly and connect face to face with the press of a single button on an electronic tablet. This technology and service permits Envision to connect with and care for hospice patients remotely. Patients and their caregivers may also use a desktop application to connect face to face.

Benefits include:

- Improving response time and reducing hospitalizations – after-hours calls or unscheduled needs can get immediate real-time assessment and education from qualified clinicians that can assist in preventing unnecessary hospitalizations and decrease patient and family anxiety.
- Accurately prioritizing patients – know who needs help now and what kind of help each needs (clinical, behavioral, spiritual) via remote contact.
- Using resources efficiently – reduce windshield time of clinicians' driving by intervening with the right resource (MD, NP, RN, MSW, Spiritual Counselor) the first time, remotely or in person.
- Improving patient care and outcomes – increase patient and family confidence, reduce stress, and improve family satisfaction with care plans and better care team coordination.
- Expanding geographic reach – better serve remote and rural populations with secure video conferencing.

The simplicity of the connection via the electronic tablet in the hospice patient's home - as well as the application being device agnostic - makes Envision Hospice of Washington's tele-medicine project a differentiating factor in its delivery of available, accessible and cost-effective hospice and palliative care.

Goal 2B: Serving Residents of Assisted Living Facilities

When a Pierce County resident moves to an assisted living facility, that becomes the person's home These facilities provide an intermediate level of care for people who need assistance with their daily activities but wish to remain as independent as possible for as long as possible.

When a resident of an assisted living facility requires more care than can be provided by the facility he or she may require admission to a hospital or nursing home. But more and more services can be brought to the assisted living facility including hospice.

Envision has extensive experience providing hospice services, in concert with the staff at assisted living facilities, to the residents with terminal illness. Just as care is provided to residents in their own homes, hospice care is also provided in assisted living facilities.

Envision's affiliated mobile medical clinics, operated as Preferred Medical Group provides regular medical care using the services of contracted physicians and ARNP's. These services are designed for the resident who has difficulty making the trip to the doctor's office and are billed as a regular "physician visit." These mobile clinic services in **Pierce** County assisted living facilities will be able to offer Advanced Care Planning and pre hospice palliative care to residents who have not yet made the decision to enter hospice.

Once a resident selects hospice care, the resident may be able to remain in the facility during their last months of life instead of transferring to a facility with a more intense level of care. Envision's affiliated hospice, serving five counties in Utah has extensive experience providing hospice care in ALF's. Envision and the ALF staffs work closely together to provide the best possible care for the ALF resident. Good communication between the family, the assisted living staff, hospice staff and paid caregivers (if they are involved) can make all the difference in the hospice experience.

Goal 2C: Serving residents of Adult Family Homes

The Washington Department of Health reports active licenses for 386 Adult Family Homes in Pierce County. Department inventory shows the licensed beds in the county total 2208. Residential Care Services, the agency that regulates these homes, reports that 70% of the adult family home residents are over age 65. Assuming an occupancy rate of 90% overall, this means over 1,391 vulnerable persons ages 65 and over lived in these facilities in Pierce County in 2019.

Through planned outreach to Pierce County adult family homes, Envision Hospice of Washington will provide additional information about hospice and its benefits to both patients and to the managers and caregivers of those facilities. Since a very large number of adult family home residents are living with dementia, this outreach also corresponds to Envision of Washington's specialized program for hospice patients with Alzheimer's or other forms of dementia.

Goal 2D: Serving residents of Nursing Homes

The Washington Department of Health's 2015 data show that 1,312 persons died in Pierce County nursing homes out of a total of 6,667 county deaths for the year. This means 20%, or one out of five of all 2015 Pierce County deaths occurred in nursing homes. Yet, only 11% of the deaths by patients of hospices that serve Pierce County took place in long term care facilities. This comparison suggests there is substantial unmet need for hospice care among Pierce County nursing home residents.

Envision Hospice of Washington will reach out to Pierce County nursing homes with the goal of developing formal agreements with them to offer hospice care to their long-term residents. Under those arrangements, Envision hospice team members work closely with the nursing home staff to augment and support the care being provided.

In light of the great number of nursing home residents that suffer from Alzheimer's disease and other dementias, the nursing home resident population will be a focus of Envision's plan to provide specialized care and comfort to that clinical group and their families. Studies have shown that having hospice staff visit nursing home residents results in nursing home staff more quickly recognizing the need for hospice among more of their patients. Additionally, the Envision emphasis on expertise in palliative care will benefit not only its own hospice patients but will influence nursing home staff's awareness of pain management strategies for their other patients.

Goal 2E: Homeless outreach

Among the many underserved groups in Pierce County are those facing temporary homelessness and those living with chronic homelessness. Envision commits to serve homeless persons facing terminal illness. While Envision already serves a number of King and Pierce County homeless persons through its Medicare-certified home health agency, it also commits to serving homeless persons facing end-of life-illness.

Envision's current experience caring for homeless persons in the Puget Sound region reveals the extreme diversity in the needs and barriers to healthcare among this group. Its members cover a full spectrum of races, ethnicities, languages, ages, disabilities, chronic and acute healthcare problems. As a result, Envision has learned to approach the care of each homeless person it has served with a tailored plan – one that is developed in concert with the person's other providers and the support of the many advocates and services for homeless persons serving Puget Sound communities.

Envision's initial plan for serving homeless persons in Pierce County will prioritize the chronically-homeless, whether sheltered or not. In developing outreach and referral relationships, Envision's approach emphasizes three key points of contact:

- harm reduction services (needle exchange, etc.)
- medical respite (post-acute temporary housing)
- staff at homeless shelters and other community organizations serving the homeless

In Pierce County, development of specific contacts and relationships will initially include:

<u>Shelters and housing</u>

1) Pierce County Coordinated Entry
2) Tacoma Rescue Mission
3) Nativity House Shelter
4) Veteran Housing Option Group
5) CCS Family Day Center
6) Comprehensive Life Resources
7) HYPE Center

<u>Service providers and harm reduction</u>

1) ADRC Hospital to Home
2) Pierce County Alliance
3) Pioneer Counseling Services

4) Metropolitan Development Council
5) SeaMar Behavioral Health
6) Foundation El Camino
7) Consejo Counseling
8) Valley Cities Clinics
9) Muckleshoot Behavioral Health
10) Medically-assisted treatment programs
11) People's Harm Reduction Alliance, South Sound
12) Tacoma Needle Exchange - Puyallup, Central, Health Dept.
13) Dave Purchase Exchange Project

Goal 2F: Envision's Mobile Outreach Clinics

In many cases, terminally ill patients referred to hospice upon hospital discharge (e.g., by a hospitalist) or by family members have not been referred by their own physicians and may not have regular physicians. Under the Medicare hospice program, a patient may have an "attending physician" in addition to the hospice medical director who is responsible for the patient's hospice plan of care.

While the hospice patient has the entire medical community from which to choose, one choice is available through Envision Hospice's affiliated organization, Envision's Preferred Medical Group, a mobile outreach clinic staffed by physicians and ARNP's. This service provides regular medical care to persons who have difficulty traveling to a doctor's office. As an adjunct to its Pierce County home health agency, Envision's Preferred Medical Group already provides such mobile services to residents of assisted living facilities, adult family homes and in patients' own homes.

In addition to providing regular medical care to the patient, Preferred Medical Group hospice-related services by its providers can include:

- Advanced Care Planning (as defined by CMS Medicare Benefits)
- Palliative care/pre-hospice pain and symptom management
- Regular attending physician visits can be made to hospice patients in their places of residence

Goal 3A: Specialized services for Veterans

Nearly 1 in 4 deaths today is that of a veteran. In fact, Envision finds that 40% of its Pierce County home health patients have veteran status. And, Envision's Utah hospice experience includes service to many veterans and their families.

Envision Hospice of Washington will adopt a focus on the veteran population of Pierce County and is committed to providing compassionate care to terminally ill veterans and their families. The service and sacrifices that many veterans made results in trauma that shapes their needs at the end of life. Our services and capabilities tailored to veterans will include:

Staff training

Envision Hospice of Washington LLC will participate in "We Honor Veterans," an organized program developed by the National Hospice and Palliative Care Organization in collaboration with the Department of Veterans Affairs to improve the quality of care for US military veterans.

"We Honor Veterans" involves education and training to recognize the unique needs of veterans and their families. As part of the program Envision Hospice staff will receive training regarding the needs of veterans based on where and when they served, to better tailor services and understand the unique circumstances of each conflict and generation.

Training will address the difficult circumstances faced by some veterans near the end of life, including financial and benefit concerns, post-traumatic stress disorder, unresolved issues associated with the stresses of military service, depression and suicide.

Volunteer program

As part of its special services for veterans, Envision Hospice will develop a veteran-to-veteran volunteer program for both hospice outreach and information and for in home visits for veterans who are hospice patients whether they live in assisted living, adult family home or nursing home. Volunteer Program will include additional training for veteran services and we will recruit veterans as hospice volunteers.

Veteran outreach

Outreach and education to veteran groups and community providers to increase awareness and earlier access to hospice care for veterans.

Veterans Administration

Familiarity with the VA system and how to identify and access benefit options for veterans. Coverage of hospice care for veterans by the VA, TRICARE, Medicare, Medicaid, private insurance and other forms of reimbursement. Coordination of care with the staff of the local VA medical center, including joint visits when appropriate.

Bereavement and recognition

A full range of bereavement support, including grief and loss programs, support groups and memorial services for veterans' loved ones. Recognition and celebration of important events, including holidays such as Veteran's Day and military anniversaries.

Goal 3B: Latino Outreach

For cultural and ethnic minorities, language is a key barrier to optimum hospice care but not the only one. Cultural norms and traditions surrounding illness, death, and dying are major factors in outreach and care. In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Pierce County will be the most effective use of resources. It examined Pierce County demographics, census information and hospice utilization. Envision Hospice concluded that the large size, cultural differences, and increasing diversity of the Pierce County Latino population merits a program of special emphasis and resources in Envision hospice outreach and care.

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. But, rather than just adopt such a national model, Envision plans to tailor the NHPCO recommendations to the needs of Pierce County Latinos.

Envision recognizes the Department's interest in using the Certificate of Need Program and its decisions to expand hospice use among Washington's underserved groups. Its tiebreakers for concurrent review clearly call for applicants to

- identify groups in need in the selected service area
- quantify that need and
- describe their plans and resources to effectively meet that need.

In setting goals for cultural competence, Envision Hospice of Washington determined that a focused effort on a cultural group with large numbers in Pierce County will be the most effective use of resources and have the potential to have the greatest impact. It examined Pierce County demographics, census information and hospice utilization.

The table below is based on the OFM Small Area Demographics Estimates Program last updated in February 2020. It estimates the Pierce population by race and Hispanic origin through 2019. Envision's additional analysis of the estimates provides the percentage of each group as a portion of the total Pierce County population.

A table of this type is required since census-identified minority groups can be distinguished by either race, by cultural/language minority, or by both. This combined table allowed Envision to consider where its minority outreach efforts might result in the most impact on hospice utilization and end of life experiences in Pierce County.

Looking at this data along with other sources, Envision Hospice concluded that the large size of the Pierce County Hispanic population merits a program of special emphasis and resources in Envision hospice outreach and care. At 11% of the Pierce population, the Hispanic population is the second largest of the race and ethnic groups with the Asian being second largest at 7%. It is important to note that Pierce County's Hispanic population is larger than the total population of 25 of the counties in Washington, all of which have hospice agencies.

Table 2. Hispanic and Non-Hispanic Population by Race, Pierce County
Washington State Office of Financial Management, Forecasting and Research Division

	OFM 2019Estimate								
		----------Non-Hispanic ----------							
	Total	**Total Non-Hispanic**	**White**	**Black**	**AIAN**	**Asian**	**NHOPI**	**Two or More Races**	**Total Hispanic**
Pierce #	888,300	790,783	582,787	62,826	9,8299	62,295	14,049	58,997	97,517
Pierce %	100.0%	89.0%	65.6%	7.1%	1.1%	7.0%	1.6%	6.6%	11.0%

Fortunately, the National Hospice and Palliative Care Organization has developed useful materials for guiding the development of such a program. And, as part of its Latino outreach program, Envision plans to develop working relationship with organizations such as Centro Latino of Pierce County, Sea Mar, Community Health Care Clinics (FQHC's) and others that frequently address the needs of minority communities.

NHPCO 's guidance emphasizes a central theme:

"Build trust and develop plans together before acting on Latino outreach."

The outline below reflects Envision's plans to plan before it acts - to understand and build relationships with the goal of providing appropriate care that emphasizes the dignity of each person:

1. Research the geographic and national origin of Pierce County Spanish-speakers. While the majority of Washington's Latino population of nearly a million persons is Mexican by heritage, Central America is a growing source.

2. Recruit Spanish-speaking outreach staff and/or volunteers to assist in building initial relationships and trust. Incorporate Latino volunteers into Envision's ongoing corps of volunteers.

3. Interview local Latino leaders and hold focus groups in a learning mode. Explore interest in and create an advisory committee to guide planning and receive progress reports.

4. Interview local Latino leaders and hold focus groups in a learning mode. Explore interest in and create an advisory committee to guide planning and receive progress reports.

5. Provide cultural competence training to all Envision staff. Emphasize the importance of non-verbal communication for non-Spanish speakers.

6. Connect with other providers that serve Latinos and learn from them.

7. Based on what is learned, develop appropriate print material and media plan, e.g., use of Spanish-speaking radio or TV, social media, etc.

8. Building on relationships and advice, plan detailed outreach plan tailored to Latino community values and cultural norms. Prioritize groups for connections, e.g., churches, ESL classes, Latino providers, etc.

9. As a learning organization, seek feedback from Envision's Latino hospice patients and adjust outreach materials and approaches as needed.

10. Provide progress reports to Latino leadership and advisors, inviting suggestions for continual improvement.

Goal 4A: Distinction in Palliative Care

Envision Hospice of Washington is surveyed by ACHC as part of its Medicare-certification process. Envision Hospice will meet the rigorous standards for and apply for ACHC's extra level of hospice accreditation, its "Distinction in Palliative Care." ACHC reports that only one other hospice in Washington has achieved this distinction. Please see Appendix W for the ACHC standards for achieving this level of palliative care recognition.

Palliative medicine provides patients with relief from symptoms, pain and stress of a serious illness. It is appropriate for any diagnosis; it can be provided along with curative treatment or to a patient that has elected hospice. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient's primary care physician to provide an extra layer of support. Both palliative care and hospice address the wide range of quality of life issues. In particular, hospice is palliative medicine for patients for whom curative care is no longer viable and who have a prognosis of six months or less to live. While there is a movement among providers to offer palliative care more broadly to patients, it has always been a cornerstone of hospice care. Any hospice team must have training and experience in pain and symptom management.

Of particular interest are standards that relate to other Envision goals, e.g.,

- Written policies and procedures describe the mechanisms the palliative care program uses to provide care for patient/families of different cultural backgrounds beliefs, and religions. Team members make efforts to understand how cultural beliefs, perceptions and practices affect treatment options, services and the plan of care. Team members make efforts to accommodate dietary and ritual practices.
- The program supports a multi-cultural work environment. It does not discriminate on the basis of race, color, religion, sex, sexual orientation or national origin.

Other pertinent standards address:

- Complex ethical issues
- Role of volunteers in palliative care
- Discussion of emotional stress by patient care team
- Addressing misconceptions regarding use of opioids

- Addressing mental health issues of patients and family members
- Plan of care for the dying process developed with patient and family

Goal 4B: "Your Hand in Mine"

"Your Hand in Mine" is a volunteer program at Envision Hospice that provides the reassuring presence of a volunteer companion to dying patients who would otherwise be alone. Where Envision clinicians are providing Continuous Care to the dying patient, the Your Hand in Mine volunteer becomes an additional source of the comfort to the patient and family in the final hours of life.

The premise is that no one is born alone and therefore, no one should die alone. "Your Hand in Mine" also adds companionship and support to family members or other caregivers during the sacred time of the patient's last hours of life.

"Your Hand in Mine" objectives include:

- reducing anxiety and fear by being present and providing education,
- providing respite and companionship,
- advocating for the requests of the patient or family,
- providing communication conduit to the hospice interdisciplinary team, and
- providing balance/respite during a time of transition.

With the support of the nursing staff, companions are thus able to help provide patients with the most valuable of human gifts: a dignified death.

Volunteer training for "Your Hand in Mine" includes

- learning about the stages at end-of-life, including emotional, physical, and spiritual changes that often occur.
- an emphasis on how to provide simple, direct comfort care strategies, ways to create a sensitive environment,
- methods of self-care for those offering support in bedside situations, and
- sharing case examples of volunteer experiences to learn from and to train regarding near-death awareness.

"Your Hand in Mine" is unique program, exclusive to Envision Hospice. It is different than other similar programs with the optional use of music

and/or essential oils diffused in the room to create a calming environment.

"Your Hand in Mine" program is critical in providing support to patients and families at end-of-life and in helping to carry out its Envision Hospice belief that no one should die alone.

Goal 4C: Support terminally ill patients seeking Death with Dignity

Envision Hospice of Washington supports a patient's choice in planning and directing his or her end-of-life care. Its policies encourage employees and contractors to use compassionate inquiry in answering questions, in counseling, and providing information.

Envision's adopted policy states:

Envision Hospice is familiar with the Washington law known as Death with Dignity and has adopted policies that support patient choice and autonomy. Envision Hospice reaffirms a basic element of the hospice philosophy that states that because dying is a natural process, hospice neither seeks to hasten nor postpone death. Envision acknowledges that there may be hospice patients who will wish to avail themselves of their legal right to pursue medical aid-in-dying as their end-of-life option and Envision will not abandon these patients or their families.

Please see Appendix X for a full statement of Envision's policy and procedure that addresses Envision's important support of hospice patient self-determination and dignity.

Washington Death with Dignity Act

POLICY

Envision Hospice ("Envision") reaffirms a basic element of the hospice philosophy that states that because dying is a natural process, hospice neither seeks to hasten nor postpone death. Envision acknowledges that there may be hospice patients who will wish to avail themselves of their legal right to pursue medical aid-in-dying as their end-of-life option and Envision will not abandon these patients or their families.

PURPOSE

The Washington Death with Dignity Act (the "Act") allows terminally ill, mentally capable Washington residents that are adults (18 years or older) with a prognosis of six months or less the option to request medication from a medical or osteopathic physician that they can choose to self-administer to shorten their dying process and bring about a peaceful death.

PROCEDURE

General Description:

1.! It is the mission of Envision to meet the needs of patients and families in a way that honors how people want to live their final months or days. Envision is ready to discuss and support end-of-life decisions with our patients while being sensitive to individual values and/or belief systems.

2.! Patients requesting medication for medical aid in dying must satisfy all of the requirements of the Act in order to obtain a prescription for the medication. Envision, acknowledging the legal right of qualified patients to exercise this choice, supports patients in completing the requirements of the Act so that the patient may self-administer the medication and end his or her life as the law intends, "in a humane and dignified manner."

3.! Patients who inquire about the option of securing the medical aid-in-dying drug will be asked to contact their attending physician. Envision will continue to provide standard hospice services to patients, regardless of their stated interest or intent in pursuing their legal right.

4.! Envision permits hospice physicians and pharmacists (and other staff and volunteers) to participate in the Act if they so choose and permits other Envision staff and volunteers to treat patients in the same manner as all other patients.

5.! Staff and volunteers who are morally or ethically opposed to medical aid-in-dying will have the option of transferring care responsibilities to other staff if their patient states an intent to pursue medical aid in dying.

6.! If applicable, Envision permits the self-administration and ingestion of medication for medical aid in dying, under the Act, in its facilities. Under the Act, the patient must self-administer the medication.

7.! Envision shall honor Washington state law and shall honor our hospice patients' wishes regarding end of life. No patient will be denied medical care or treatment because of the patient's participation under the Act. We will continue to provide quality end-of-life care, symptom management and services to patients and families with the goal of providing excellent patient care, safe and comfortable dying and positive life closure.

8.! Envision provides procedures for staff involvement in discussions around requesting medical aid-in-dying medication under the Act;

- ! hospice support for patients who choose to pursue the Act;
- ! staff presence when patients ingest medication;
- ! hospice responsibilities following death;
- ! documentation standards around discussions and patient requests for medical aid-in-dying medication;
- ! staff conscientious objections.

9.! While recognizing that the request for medical aid-in-dying medication is a discussion between a patient and their attending physician, hospice staff will provide information, resources and support to patients who are exploring this option.

Process:

1.! As is customary, Envision will explore and evaluate patients' statements related to all end-of-life options, including medical aid in dying if they arise during intake and/or routine visits.

2.! If patient or family members make an inquiry about seeking medication for medical aid-in-dying, Envision will respond to inquiries or requests for information and refer them to their attending physician or the medical director, who may act as an Attending or Consulting Physician.

3.! Staff or volunteers who are aware that a patient is considering procuring medication for medical aid in dying will notify the appropriate designated staff (e.g.-Registered Nurse Case Manager and the Director of Hospice Care Services).

4.! Patients who verbalize this intent will be informed that this information will be shared with the hospice team for appropriate support

5.! Staff and volunteers working with a patient/family who has verbalized an interest in this end-of-life option will document all discussions with patient, family, other team members, and any other person who may be involved with the patient. This documentation will become part of the patient's permanent medical record.

6.! During Case Conference, or as needed, the interdisciplinary group will examine the patient's reasons for considering medical aid in dying and discuss how to address these issues with the patient without attempting to interfere with the patient's decisions.

7.! Staff having contact with such patients will consult with and be supported on an ongoing basis.

8.! If the patient chooses to pursue medical aid-in-dying as an option, the patient/family will be informed of the role of Envision regarding participation in the law, that is, Envision will continue to serve the patient and family; will offer customary hospice services, and seek to meet not only the physical needs of the patient/family, but the emotional, social, and spiritual needs as well.

9.! The Medical Director may serve, if he or she chooses, as the attending or consulting physician as defined in the Act to determine patient's eligibility.

10.! If a patient asks his/her physician for a prescription for medication for medical aid in dying, the patient and family will receive ongoing support.

11.! As is customary, bereavement support will be available to all families.

12.! Envision Ethics Committee will meet, as needed, to review cases involving medical aid in dying and to review our Washington Death with Dignity Act policies and procedures. The Committee will also meet at the request of staff to discuss any concerns, to review an individual case, or to review any and/or all of our Washington Death with Dignity Act policies.

13.! Envision will not administer the medication for medical aid-in-dying.

Staff Roles in the Washington Death with Dignity Act

1.! It is the responsibility of Envision staff to educate and inform patients and families regarding end-of-life options and care when patients ask.

2.! At time of admission or anytime the patient is under the care of Envision, if asked by a patient or family, staff will inform patients about their rights under the Act, as well as

our policy to continue to provide standard hospice services to patients regardless of their stated interest or intent in pursuing this legal right.

3.! This information will be contained in a Patient Information sheet regarding the Act which will be given to the patient/family upon request.

4.! If a patient indicates their wishes to participate in the Act, the interdisciplinary team, including the person's physician and/or Medical Director, should work to identify the factors contributing to the person's desire for medical aid in dying and to try to address them as part of the Care Plan.

5.! If a patient obtains a medical aid-in-dying prescription, staff will continue to provide standard hospice services.

6.! Envision staff can respectfully ask their supervisor to transfer patients who are considering or have obtained medical aid-in-dying medication to another staff person without any fear of discipline or retaliation.

7.! If upon arriving at a patient's home, a staff member discovers that a patient who had not divulged their intention to utilize the Act is in the process of or has taken the medical aid-in-dying prescription, you may leave the premises but must notify your supervisor immediately. If you arrive at a patient's home and find that the person has taken the medication and has died, you are to provide your professional services as in any other case and initiate the usual bereavement follow-up with the family/significant other(s).

Patient Discussions Related to the Washington Death with Dignity Act

1.! Patients may want to discuss the option of the Act with staff. Envision staff will respond to patient questions or statements regarding the end-of-life option with respect and compassion. Staff should inquire about the patient's concerns, fears, symptoms, etc. to encourage deeper exploration, to identify the patient's experience and priorities, with the goal to improve patient care.

2.! Patients who are requesting further information or who are seriously considering making a request for medical aid-in-dying medications should be advised of the need to begin the process by speaking to their physician [or the Medical Director] and start reviewing the Act forms with the patient.

3.! Envision staff will:

- •! Notify the appropriate staff (Registered Nurse Case Manager and Director of Hospice Care Services) of the patient's inquiry, along with patient name, medical ID, and a brief summary of the contact.
- •! Notify other involved members of the interdisciplinary team on a need-to-know basis; all staff will be respectful of patient's privacy.

- Obtain patient permission prior to any communication with a patient's family members or others. While it is recommended that patients inform their families of their wishes around obtaining medical aid-in-dying medication, patients are not legally required to inform their families or caregivers of their wishes.

Care of Patients Who Pursue Obtaining Medical Aid-in-Dying Medications

1. Envision staff will respect the patient's decision; continue to provide care as indicated by the patient's physical, emotional, and spiritual needs; communicate and coordinate, as needed, with the designated staff (Registered Nurse Case Manager and Director of Hospice Care Services).

2. Prior to the patient ingesting the medical aid-in-dying medication and while continuing to provide any usual hospice care, staff will assist with the following routine hospice care standards:

   - Ensuring the patient's POLST form is complete and in the home.
   - Making funeral arrangements, including discussion of disposition of remains, if needed.
   - Encouraging the patient to complete any other end-of-life arrangements.
   - Instructing caregivers around time of death and contacting hospice at time of death.
   - Identifying next of kin who are to be notified of death if they will not be in attendance.
   - Providing patient and family members or other caregivers with information around safe disposal of medications.
   - Complete any additional documentation needed in patient's chart, i.e. non-clinical notes, end-of-life notes, etc.
   - If patient dies without self-administering the medical aid-in-dying medication and these medications are in the home, staff will assess for safety and provide information around safe disposal of medications.

Staff Presence at Time of Patient Deaths

1. Envision staff may be present at the time of death to provide emotional support for the patient, family, and others in attendance, only under the following circumstances:

   - the patient specifically requests staff presence. No staff member shall assist the patient in the administration of medical aid-in-dying medications. This is not intended to prohibit the provision of appropriate comfort measures, even if such measures, such as symptom management for pain or nausea, have the consequence of hastening death;
   - staff member can be present in the home or with patient while medication is taken;

- staff member discusses patient request for presence at time of death with the appropriate or designated staff (Administrator and Director of Hospice Care Services) in a timely fashion and receives approval prior to agreeing to attend patient's death. This discussion should include planning for staff to inform the family that they may not remain in the home until patient dies if the dying process is prolonged;
- staff member will not assist with the preparation of medication;
- staff presence is to meet the needs of the patient and family; Registered Nurse Case Manager and Director of Hospice Care will consult with the Administrator prior to approving staff presence (staff may be required to have another clinician accompany them);
- the patient will be self-administering the medication in a private home, property, or residence, i.e. not a public place;
- patient is planning to self-administer medication during the staff member's normal work time; the patient will also have another adult present in addition to staff; the visit is treated like any other end-of-life visit in which symptom management and comfort are the focus. Staff member is not expected to remain in the home until the patient's death, as there will be considerable time variations between the time that a patient ingests medication until the time of death.

On-call and time of death instructions visit standards

1. Time of death visits will be handled according to normal procedures with on-call staff making a determination according to the individual family needs and specific circumstances.
2. Hospice staff will inform on-call if they are aware that the patient is planning to ingest medical aid-in-dying medication during on-call hours.
3. Time of death announcements to staff will not list information related to the Act.
4. Time of death calls to coroners, which are rarely required, will list patient's underlying illness as cause of death.

Specific medical record issues related to patients making requests for end-of-life medications

1. Staff will document discussions with patients requesting information about the Act or who are pursuing medical aid-in-dying medications including:
   - Case communication note indicating notification to designated/appropriate staff. (Director of Hospice Care Services and Administrator)
   - Medications dispensed under the Act.

- Documentation in notes that medical aid-in-dying medications have been dispensed and are in the patient's home.

2. Staff presence at time of death will be documented in routine visit and/or death notes as with any hospice death.

3. Documentation at time of death visit should include:
   - healthcare professional/staff presence
   - time of death
   - bereavement concerns

4. If Attending Physician or another licensed healthcare provider is present at death, there is an additional form to fill out and should go in medical records.

Reporting a Washington Death with Dignity Act Death

1. Envision will report a patient's cause of death after ingesting medical aid-in-dying medications as the patient's underlying hospice diagnosis. We do not report medical aid in dying or the Act as cause of death.

2. The underlying terminal disease must be listed as the cause of death.

3. The manner of death must be marked as "Natural."

4. The cause of death section may <u>not</u> contain any language that indicates that the Washington Death with Dignity Act was used, such as:

   - Suicide
   - Assisted suicide
   - Physician-assisted suicide
   - Death with Dignity
   - Mercy killing
   - Euthanasia
   - Medication

Conscientious Objections and Personal Responsibility Related to Patients Requesting Medical Aid-in-Dying Medications

1. The Envision management team and staff recognize that each staff member will need to thoughtfully consider whether it is within their own ability, values, and beliefs to provide care for patients who are requesting medical aid-in-dying medications.

2. It is not the intent of the management team to assume staff involvement. It is the staff member's responsibility to inform appropriate staff (their Administrator or Director of Hospice Care Services) of concerns or reluctance around caring for patients who are

requesting medical aid-in-dying prescriptions, including discussions and requests for information.

3.! The Director of Hospice Care Services and Registered Nurse Case Managers will be responsible for assessing and, if needed, re-assigning staff to ensure excellent patient care.

4.! Staff should think about and discuss this issue in order to clarify their personal and professional understanding of the ramifications of the Act. Education and training on the Act will be available on an as-needed basis.

5.! Envision staff may never coerce or exert undue influence on a patient with respect to these issues.

6.! If at any time staff do not desire to continue to provide care to a person because their decision to participate in the Act conflicts with your personal values, please inform the patient's designated staff (Registered Nurse Case Manager and Director of Hospice Services) and they will identify another staff member who can provide the necessary care.

REFERENCES

Washington Death with Dignity Act, Initiative 1000, codified as RCW 70.245

Washington State Medical Association website https://wsma.org/

Washington State Hospital Association website https://www.wsha.org/for-patients/end-of-life/

APPENDIX P COMMITMENT LETTER FROM CHIEF FINANCIAL OFFICER

1345 W 1600 N, Suite 202
Orem, UT 85057

January 28, 2022

Eric Hernandez, Manager
Certificate of Need Program
Office of Certification and Enforcement Department of Health
P.O. Box 47852
Olympia, WA 98504-7852

Dear Mr. Hernandez,

The Certificate of Need program's application for a Medicare-certified hospice agency asks for a financial letter of commitment.

The Board of Envision Hospice of Washington, LLC has committed the necessary working capital to finance the establishment and operation of a Medicare-certified hospice agency in Pierce County, Washington.

Sincerely,

Al VanLeeuwen
Chief Financial Officer
al.vanleeuwen@envhh.com

Envision Home Health and Hospice of Washington
Historical Revenues and Expenses
For The Periods Ending Deceber 31, 2019 through 2021

	2018	2019	2020	2021
REVENUE				
Medicare	4,326,577	4,653,410	4,173,473	6,477,746
Medicaid	75,570	118,445	25,832	20,412
Commercial/Other	230,550	494,501	1,306,939	1,095,209
Deductions & Adjustments	(181,636)	(415,844)	(458,804)	(287,430)
Total Net Revenue	**4,451,061**	**4,850,512**	**5,047,440**	**7,305,936**
PATIENT CARE COSTS				
Total Direct Labor Costs	2,323,348	2,742,248	2,530,382	3,403,749
Medical Supplies	74,532	90,455	172,757	330,829
External Coding	62,967	70,536	55,730	49,873
Other Costs	9,347	8,836	11,819	113,167
Total Patient Care Costs	**2,470,194**	**2,912,075**	**2,770,688**	**3,897,618**
ADMINISTRATIVE COSTS				
Salaries & Wages-General and Admin	666,775	523,032	712,634	1,167,255
Salaries & Wages-Sales and Marketing	409,335	364,505	267,997	430,963
Benefits	86,144	35,017	106,724	162,654
B&O Taxes & Licenses	100,566	98,174	136,929	148,594
Computer/Software & Other Equip	37,171	44,273	71,735	121,803
Consulting/Outside Services	152,577	207,922	151,447	351,889
Dues and Subscriptions	8,401	1,357	27,813	43,824
Facilities	103,554	118,040	151,813	195,622
Insurance	13,071	20,542	16,222	58,328
Marketing & PR	18,100	29,708	53,563	68,940
Materials & Supplies	10,733	15,014	15,023	33,534
Postage and Delivery	593	517	1,083	4,494
Printing and Reproduction	9,523	1,933	1,829	2,702
Repairs & Maintenance	-	-	-	14,629
Telecommunications	36,240	35,978	36,691	59,384
Travel & Ent	31,103	33,325	18,276	65,981
Corporate Allocation	60,000	60,000	60,000	60,000
Total Administrative Costs	**1,743,886**	**1,589,337**	**1,829,779**	**2,990,596**
Total Costs	**4,214,080**	**4,501,412**	**4,600,467**	**6,888,214**
EBITA	**236,981**	**349,100**	**446,973**	**417,722**
Depreciation Expense	1,595	571	571	466

Envision Home Health and Hospice of Washington
Historical Balance Sheets
For The Periods Ending Deceber 31, 2019 through 2021

	2018	2019	2020	2021
Assets				
Current Assets				
Cash & Cash Equivalents	48,686	238,861	662,073	284,773
Accounts Receivable (Net)	1,155,671	1,224,010	1,309,038	811,851
Total Current Assets	1,204,357	1,462,871	1,971,111	1,096,625
Property and Equipment				
Fixed Assets	11,465	11,465	13,621	13,621
Accumlated Depreciation	(6,634)	(7,205)	(7,775)	(8,241)
Total Property and Equipment	4,831	4,260	5,845	5,380
Security Deposits and Prepaids	35,351	27,508	23,296	27,376
Total Assets	**1,244,539**	**1,494,639**	**2,000,253**	**1,129,381**
Liabilities and Capital				
Current Liabilities				
Accounts Payable & Accrued Expenses	89,784	652	18,702	89,851
Accrued Payroll & Related Payables	83,681	82,227	126,972	5,429
Total Current Liabilities	173,464	82,879	145,674	95,280
Long-Term Liabilities	-	-	-	-
Total Liabilities & Capital	173,464	82,879	145,674	95,280
Shareholder Equity (deficit)	1,071,074	1,411,760	1,854,578	1,034,101
Total Liabilities & Capital	**1,244,539**	**1,494,639**	**2,000,253**	**1,129,380**

Envision Home Health and Hospice of Washington
Historical Cash Flows
For The Periods Ending Deceber 31, 2019 through 2021

	2018	2019	2020	2021
Cash Flows from operating activties				
Net Income After Deprreciation and Amortization	235,386	348,528	447,031	417,722
Adjusments to reconcile net income to cash provided by Operations				
Depreciation & Amortization Change	1,595	571	571	466
Accounts Receivable Change	(446,259)	(68,339)	(85,029)	497,187
Accounts Payable Change	62,414	(89,131)	18,050	71,149
Payroll Payable Change	11,785	(1,454)	44,745	(121,543)
Total Adjustments	(370,465)	(158,353)	(21,663)	447,258
Net Cash provided by Operations	(135,079)	190,175	425,368	864,980
Cash Flows from investing activities Used For:				
Capital equipment and furniture	(1,713)	-	(2,156)	-
Net cash used in investing	(1,713)	-	(2,156)	
Cash Flows from financing activities				
Proceeds From:				
Capital Contributions	-	-	-	-
Used for:				
Dividends	(185,568)	-	-	(1,242,280)
Net cash used in financing	(185,568)	-	-	(1,242,280)
Net increase (decrease) in cash	(322,360)	190,175	423,212	(377,300)
Summary				
Cash Balance at Beg of Period	371,046	48,686	238,861	662,073
Cash Balance at End of Period	48,686	238,861	662,073	284,773

Appendix R	Staff recruitment detail

Additional Envision information about recruitment and retention for both Pierce and Kitsap County proposed hospices

Fortunately, neither Envision Home Health in King and Pierce Counties or Envision Hospice in Thurston County have had difficulty recruiting and retaining the staff required. In both Utah and Washington, Envision places a high priority on its recruitment and retention efforts.

At start-up in King County, Envision HHA successfully used the wide range of available resources to attract, screen, select, and hire both clinical and administrative employees. These included: local job fairs; the online job-search websites; using recruitment agencies; word of mouth through existing employees; outreach through existing employee relationships with professional organizations.

Due to its ownership and operation by clinicians and rehabilitation specialists themselves, Envision has been very successful in attracting and retaining the clinical staffing it requires. Envision-Hospice of Washington also has access to an active recruiting function for the relevant professionals.

Envision has also been very fortunate that its existing staff has been a substantial source of professional contacts in the area and that those have frequently resulted in new hires.

The greatest factor in Envision's success has been a low turnover rate in staff:

- Envision-home health and hospice pay and benefits are competitive for both recruitment and retention. Benefits include medical, dental/orthotics, vision, life insurance, and 401k with company matching.
- At start-up. Envision adopted the practice of paying stable, reliable salaries to its professionals rather than just paying them for hourly work. This resulted in a committed group of employees from the outset and has reduced turnover to near zero.
- Rather than taking an "agency" or "pay per visit" approach to staffing, Envision uses a "primary care" model where possible. If an RN takes on a specific patient, that patient's prescribed Plan of Care becomes his or hers to manage. The primary care nurse that cannot make it to a patient's scheduled visit will take responsibility to find coverage from other appropriate Envision staff. This model appeals to the staff's professionalism and increases employee satisfaction and sense of control over the work environment.

As Envision has grown rapidly, its strong reputation has too. It relies less on the typical recruitment practices it used at start-up. Now, word of mouth among employees and their social and professional networks provide Envision with ample numbers of

candidates when agency growth or start up permits addition of new positions. Word of mouth has resulted in numerous inquiries and new hires when conditions change at other area agencies.

Adding hospice in Pierce County - and Kitsap County if both are approved

Envision's reputation as a good place to work is allowing it to build a "brand" name that is becoming familiar in the region among health care professionals attracted to the provision of in-home care services. It has attracted experienced, mid-career nurses who are comfortable meeting the varied demands of in-home nursing. Since many current Envision home health patients are terminally ill, existing Envision staff is accustomed to pain management and palliative care protocols. In Pierce County, Envision found it took about a year before its own employees become the chief source of potential employment candidates. Envision expects its home health presence in the region and its existing staff will both contribute to successful recruitment of hospice staff.

Envision's current Pierce, King and Thurston County employees have colleagues and friends throughout the region, including Kitsap County, and that can generate strong candidates for many positions. It has been Envision's consistent experience that satisfied employees not only bolster its recruitment efforts but also reduce the volume of recruitment needed when so few employees leave and need to be replaced.

Nevertheless, Envision's Kitsap hospice would serve a county in which it is not yet well known. For that reason, recruitment in Kitsap will also use more traditional methods until word of mouth reputation begins to generate interest among both professional and administrative candidates for new positions.

Envision Hospice

Volunteer Recruitment Plan and Timeline

WEEK 1

- Finalize calendar, benchmarks, logistics for volunteer recruitment.
- Review forms, volunteer recruitment activities, and application process.
- Review and update information to be posted on website regarding volunteer opportunities.
- Review and update if needed volunteer job description for both direct care and administrative positions.
- Print volunteer applications, flyers, or any other needed forms to have in stock.

WEEK 2

- Go LIVE with website information for volunteer opportunities in Washington and information with link for on-line application.
- Initiate campaign activities to recruit volunteers; special emphasis on military veteran volunteers and Spanish speaking volunteers. These activities include may include involvement with the following:
  - VFW (Veterans of Foreign Wars)
  - American Legion
  - Branch specific leagues (i.e. Marine Corps League)
  - Assisted Living Facilities – veteran clubs
  - VA Clinics and Hospitals
  - Veteran Centers
  - Veteran Events
  - Radio/Other Media
  - Hospitals
  - Churches/Faith Communities
  - Parish Nurse Ministry/Assoc
  - Senior Centers
  - Barber Shops/Hair Salons
  - Grocery Stores
  - Social Media
  - Health Fairs
  - Employee referrals
  - On-line Recruitment Websites
- Initiate other campaign activities to recruit volunteers that can assist with Palliative arts (i.e. pet visits, music, and massage):
  - Pet certification organizations (i.e. American Kennel Club)
  - Pet rescue groups
  - Veterinarians
  - Pet specialty stores
  - Music Stores
  - Music club/groups
  - College/Universities' School of Music
  - Spas/massage studios
- Document all volunteer recruitment and retention activities.
- Document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Receive and process applications.

WEEK 3

- Continue outreach campaign to recruit volunteers.
- Interview any applicants.
- Ensure background check is submitted after any successful interview.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Analyze recruitment data: what gives best outcomes; what can be replicated; what efforts can be increased.

WEEK 4

- Initiate training and orientation for volunteers.
- Continue outreach campaign to recruit volunteers.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Continue interviewing applicants and ensuring background check is submitted after any successful interview.
- Continue to analyze recruitment data.
- Adjust volunteer opportunities and programs as needed.

WEEK5 AND ONGOING CONTINUOUS PROCESS

- Induct them into their roles, providing support and feedback regularly.
- Place volunteers after completion of orientation.
- Involve volunteers in team meeting and in matters that affect them.
- Manage, support, and evaluate volunteer performances. Provide opportunities for training.
- Reward and recognize volunteers appropriately.
- Create volunteer database with volunteers' availability and specialties; update routinely.
- Continue training and orientation for on-boarding volunteers.
- Continue outreach campaign to recruit volunteers. Conduct a "Refer a Friend" lunch every 6 months for employees and volunteers to bring in prospective volunteers to learn more about volunteer opportunities.
- Continue to document all volunteer recruitment and retention activities.
- Continue to document all volunteer inquires and ask how people hear of our volunteer opportunities.
- Continue to receive and process applications.
- Continue interviewing applicants and ensuring background check is submitted after any successful interview.
- Continue to analyze recruitment data. Review recruitment strategies regularly.
- Adjust volunteer opportunities and programs as needed.

Appendix T	Envision Hospice Training Policies

Employee Recruitment Process

POLICY

Hospice is an Equal Opportunity Employer which strives to employ the most qualified individuals for all positions and to ensure the adequate number of appropriate staff.

PURPOSE

To establish guidelines for the recruitment and hiring processes.

REFERENCE

The Joint Commission CAMHC Standard: LD.01.04.01; CHAP Standards: CI.5d, CIII.1a, CIII.1b; ACHC Standards: HSP4-1B.01, HSP4-2I.01

PROCEDURE

1. Each position will have a job description. Internal postings for all positions will be advertised before filling.

2. Established procedures for application and interviewing process will be followed.
   - Reference information or work history will be obtained on all applicants. A minimum of one reference is required for new employees.
   - Equal employment opportunities will be available to all candidates.
   - Education, training, licensure, competency and other required credentials will be verified.

3. Employment opportunities will be posted internally.

4. Internal advancement in employment status will be based on eligibility, position specific criteria and established procedures.

5. Compensation packages will be reviewed on a periodic basis, giving consideration to changes in job function according to industry norms.

Retention of Personnel

POLICY

Hospice promotes retention of staff.

PURPOSE

To define staff retention efforts.

REFERENCE

The Joint Commission CAMHC Standard: HR.01.02.01; CHAP Standard: CI.5d; ACHC Standard: HSP4-2I.01

PROCEDURE

Hospice has established retention of qualified and competent personnel as a high priority. Retention efforts include:

- An orientation and training program for new employees.
- Competency assessment program for patient care staff.
- Competitive wages and salaries based on each job description and market area.
- Ongoing education and training.
- Hospice-sponsored benefits for eligible employees.
- Performance evaluation to assist in each employee's growth and development.

Inservice Education

POLICY

Regularly scheduled and appropriate in-service programs will be made available for all employees.

PURPOSE

To ensure the continuing education of all Hospice personnel.

REFERENCE

The Joint Commission CAMHC Standard: HR.01.05.03; Medicare CoP #s: 418.76d, 418.100g; CHAP Standards: CI.5d, CII.7a, CIII.1l, HIII.1g, HIII.1m; ACHC Standards: HSP4-6A, HSP4-6A.01, HSP4-7A

PROCEDURE

1. The employee will be responsible for attending in-service programs and maintaining compliance with the in-service requirements for his/her position.

2. Certain in-service programs are determined by Hospice to be mandatory initially and annually for all staff. These include, but are not limited to:
   - OSHA bloodborne pathogens.
   - TB risk program.
   - Hazardous materials in the workplace (Right-to-Know Program).

3. Hospice may allow employees to attend in-service programs during the course of their work day and may give time off with pay.

4. Inservice programs not sponsored or authorized by Hospice may be attended during the work day with express approval of Hospice.

5. Hospice may, as indicated, offer programs providing continuing education credits where such credits are required for maintenance of licensure, certification or registration. Continuing education units will be validated for clinical staff, if required by state law. Opportunities for clinical education include:
   - Independent study.
   - Satellite learning.
   - Specialized conferences.
   - Formal courses of study.
   - Mentoring.

6. Payment of registration fees and related expenses will be at the discretion of Hospice with prior approval from the appropriate supervisor(s).

7. An absence will not be counted against an employee when he/she is authorized or assigned to attend a conference, convention or training program directly related to his/her working position. The employee will be considered as working.

8. Each Hospice Aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. Hospice may fulfill the annual 12-hour in-service training requirement on a calendar year basis, an employment anniversary basis or a rolling 12-month basis as long as each aide meets this in-service training requirement. Hospice Aide in-service training, that occurs with a patient in a place of residence, supervised by an RN, can occur as part of every 14 day supervisory visit, but the exact new skill or theory taught must be documented. In-service training taught in the patient's environment should not be a repetition of a basic skill.

9. Employee feedback will be obtained through random surveys regarding educational needs and areas of knowledge deficit when planning in-service education.

10. Ongoing education, including in services are provided:
    - To increase staff knowledge of work-related issues.
    - To meet the needs of the patients served.
    - When job duties for an employee change.
    - To comply with applicable law and regulation (e.g., OSHA).
    - To emphasize safety and infection prevention and control as applicable to each employee's job responsibilities.
    - To continually reinforce the need and ways to report unanticipated adverse events.

11. Education programs will incorporate team training methods, as appropriate.

12. All in-services and education programs will be documented.

ADDITIONAL ACHC REQUIREMENTS

1. Non-direct care personnel have a minimum of 8 hours of ongoing education per year.

2. Direct care personnel must have a minimum of 12 hours of ongoing education during each 12-month period.

3. The annual education plan minimally addresses:
    - Emergency/disaster training.
    - How to handle complaints/grievances.
    - Infection control training.
    - Cultural diversity.

- Communication barriers.
- Ethics training.
- Work place and patient safety.
- OSHA (Right to Know laws).
- Methods for coping with work related issues of grief, loss and change.
- Patient Right and Responsibilities.
- Pain and symptom management.

Staff Personal Safety Education

POLICY

Personal safety for employees is addressed through an educational process available to all staff.

PURPOSE

To ensure personal safety in the work environment.

REFERENCE

The Joint Commission CAMHC Standard: EC.02.02.01; CHAP Standards: CI.5b, CI.5c; ACHC Standard: HSP7-2A.01

PROCEDURE

During new employee orientation and on an ongoing basis, an in-service is provided for all employees that include:

- Safety while making home visits.
- General safety practices.
- Self-defense measures.
- Obtaining an escort.
- Handling unsafe situations.
- Car accident reporting.

Roles and Responsibilities Related to Safety

POLICY

Hospice will train staff and students about their roles and responsibilities related to safety.

PURPOSE

To minimize risks to patients and employees.

REFERENCE

The Joint Commission CAMHC Standards: HR.01.04.01, HR.01.02.07; CHAP Standards: CI.5c, CI.5d; ACHC Standard: HSP4-2I.01

PROCEDURE

1. During orientation and on an ongoing basis staff and students will be trained regarding risks about:
   - Hazardous materials and wastes.
   - Infectious materials and wastes.
   - Emergency operations planning.
   - Patient and staff safety.
   - Patient and staff security issues.
   - Appropriate actions to eliminate and/or minimize safety risks.
   - Incident/risk, failures and/or user error reporting, including appropriate procedures to follow.

2. All staff and students are required to implement Hospice policies, procedures and processes for risk reduction and patient safety.

Hospice Aide Services and Training Program

POLICY

All Hospice Aides employed by Hospice will satisfactorily complete a Hospice Aide training program and/or competency evaluation program prior to performing patient care. Hospice Aides are selected on the basis of such factors as sympathetic attitude toward the care of the sick, ability to write, read and carry out directions, and maturity and ability to deal effectively with the demands of the job.

PURPOSE

To define the scope of Hospice Aide services and to ensure the competence of Hospice Aides employed by Hospice.

REFERENCE

The Joint Commission CAMHC Standards: HR.01.02.01, HR.01.02.07, HR.01.05.01, PC.01.03.01, PC.02.01.03; Medicare CoP #s: 418.76a, 418.76b, 418.76c, 418.76e, 418.76f, 418.76g, 418.114b; CHAP Standards: CI.5d, HII.2l.5, HII.5e, HII.6a, HIII.1c, HIII.1d, HIII.1e, HIII.1f, HIII.1g; ACHC Standards: HSP4-6A, HSP4-6B, HSP4-7B, HSP4-7C, HSP4-8A, HSP4-11L, HSP4-13A

RELATED DOCUMENTS

"*Initial Competency Hospice Aide*" form

PROCEDURE

1. A Hospice Aide is a person who has successfully completed a state-established or other training program that meets the requirements outlined below and a competency evaluation program or state licensure program.

2. The Hospice Aide training program must address each of the following subject areas through classroom and supervised practical training totaling at least 75 hours, with at least 16 hours devoted to supervise practical training. The individual being trained must complete at least 16 hours of classroom training before beginning the supervised practical training. Training must include:
   - Communication skills, including the ability to read, write and verbally report clinical information to patients, caregivers and other Hospice staff.
   - Observation, reporting and documentation of patient status and the care or service furnished.
   - Reading and recording blood pressure, temperature, pulse and respiration
   - Basic infection control procedures.

- Basic elements of body functions and changes that must be reported to the supervisor.
- Maintenance of a clean, safe and healthy environment.
- The physical, emotional and psychological needs of and ways to work with the population served by Hospice, including the need for respect for the patient, his/her privacy and property.
- Appropriate and safe techniques in personal hygiene and grooming that include:
  - Bed bath.
  - Sponge, tub and shower bath.
  - Shampoo: sink, tub and bed.
  - Oral hygiene.
  - Normal range of motion and positioning.
  - Safe transfer techniques and ambulation.
  - Toileting and elimination.
  - Adequate nutrition and fluid intake.
- Safe use of appropriate equipment.
- Recognizing emergencies and knowledge of emergency procedures.
- Any other tasks that Hospice may choose to have Hospice Aides perform.

3. Supervised practical training is defined as training in a laboratory or other setting in which the Hospice Aide demonstrates knowledge while performing tasks on an individual under the direct supervision of a RN.

4. The duties of the Hospice Aide are to provide services that are ordered by the IDG, included in the plan of care and are permitted to be performed by applicable state(s) laws and are consistent with Hospice Aide training. Duties include:
   - Providing hands-on personal care and assisting with personal hygiene.
   - Performing simple procedures as an extension of nursing or therapy services.
   - Assisting in ambulation or exercises.
   - Assisting in administering medications that are normally self-administered (as permitted by state law).
   - Reporting changes in the patient's medical, nursing, rehabilitative and social needs to a RN, as the changes related to the plan of care and QAPI activities.
   - Providing nutritional support.
   - Performing other supportive tasks as assigned.
   - Completing appropriate records in compliance with policies and procedures.

5. Classroom and supervised practical training must be performed by a registered nurse who possesses a minimum of two (2) years of nursing experience, at least one (1) year of which must be in the provision of home care, or by individuals under the general supervision of a registered nurse.

5. Documentation is maintained to demonstrate that the training requirements are met and includes:
   - A description of the training/competency evaluation program, including the qualifications of the instructions.

- A record that distinguishes between skills taught at a patient's bedside with supervision, and those taught in a laboratory using a real person (not a mannequin) and indicators of which skills each aide was judged to be competent.
- How additional skills (beyond the basic skills listed in the regulation) are taught and tested, if Hospice's admission policies and case-mix of Hospice patients require aides to perform more complex procedures.

7. The Hospice Aide will not perform that particular task without direct supervision by a RN and until subsequent retraining is completed and a "satisfactory" evaluation is achieved.

8. If the Hospice Aide has an unsatisfactory rating in more than one of the required areas, he/she is not considered to have successfully passed the competency evaluation.

9. Hospice will complete a performance review of each Hospice Aide no less frequently than every 12 months.

10. Documentation is maintained to demonstrate that the competency evaluation, inservice and performance review requirements are met.

11. Hospice Aides are assigned to a specific patient by a RN that is a member of the IDG. Written patient care instructions for a Hospice Aide must be prepared by a RN who is responsible for the supervision of a Hospice Aide.

12. Hospice may offer a Hospice Aide competency evaluation program, unless within the previous two (2) years, Hospice has:
    - Permitted a person who does not meet the definition of a "qualified home health aide" to furnish Hospice Aide services (except for volunteers or licensed health professionals).
    - Been subjected to a partial extended or extended survey as a result of having been found to have furnished substandard care (or other reasons at the discretion of CMS or the state).
    - Been assessed a civil monetary penalty of not less than $5000.00 as an intermediate sanction.
    - Had all or part of Medicare payments suspended.
    - Been found to have compliance deficiencies that endanger the safety and health of patients and has had a temporary management appointment to oversee the management of Hospice.
    - Under any state or federal law:
        - Had its participation in the Medicare program terminated.
        - Was closed or had its patients transferred by the state.
        - Was subjected to a suspension of Medicare payments to which Hospice otherwise would be entitled.
        - Been assessed a penalty of not less than $5000.00 for deficiencies in state or federal standards for Home Health Agencies.
        - Had operated under a temporary management that was appointed by a governmental authority to oversee the operation of Hospice to ensure safety and health of Hospice's patients.

Employee Orientation

POLICY

Each employee and contracted staff who has patient and family contact will receive an orientation about the Hospice philosophy.

PURPOSE

To provide a mechanism whereby all employees are oriented to and become acquainted with Hospice policies and procedures.

REFERENCE

The Joint Commission CAMHC Standard: HR.01.04.01; Medicare CoP #s: 418.60, 418.100g; CHAP Standards: CI.5d, CI.5g, CII.3b, CII.7a, CIII.1k, HIII.1f, HIII.1m; ACHC Standards: HSP2-2A, HSP4-4A, HSP4-4A.01

RELATED DOCUMENTS

"*Orientation Checklist*" form

PROCEDURE

1. Orientation for all employees will be performed and documented by supervisory staff and preceptors.

2. The *Orientation Checklist* will be used to document orientation for all staff, including contract staff.

ADDITIONAL ACHC REQUIREMENTS

1. Orientation for each employee will minimally include:
   - Review of the individual's job description and duties performed and their role in the organization.
   - Organization chart.
   - Mission statement.
   - Hospice philosophy.
   - Record keeping and reporting.
   - Confidentiality and privacy of Protected Health Information.

- Patient's rights.
- Advance Directives.
- Conflict of interest.
- Written policies and procedures.
- Emergency Plan.
- Training specific to job requirements.
- Additional training for special populations, if applicable (e.g., pediatrics).
- Cultural diversity.
- Communication barriers.
- Ethical issues.
- Professional boundaries.
- Quality Assessment/Performance Improvement Plan.
- Corporate Compliance Program.
- Conveying of charges for care/services.
- OSHA requirements, safety and infection control.
- Orientation to equipment, if applicable as outlined in job description.
- Incident/variance reporting.
- Handling of patient complaints/grievances.
- Concepts of death and dying and bereavement.
- Emotional support, psychosocial and spiritual issues.
- Pain and symptom management.
- Diseases and medical conditions common to hospice.
- Stress management.

Staff Competency Program

POLICY

Hospice will provide for initial and ongoing competency assessments for all patient care staff by qualified individuals.

PURPOSE

To define the staff competency program.

REFERENCE

The Joint Commission CAMHC Standard: HR.01.06.01; Medicare CoP #s: 418.76c, 418.76h, 418.100g; CHAP Standards: CI.5d, CIII.1g, HI.5c, HIII.1g, HIII.1h, HIII.1i; ACHC Standards: HSP4-7A, HSP4-10A.03

RELATED DOCUMENTS

"*Initial Competency*" and "*Ongoing Competency*" discipline-specific checklists

PROCEDURE

1. Patient care staff will be competency assessed at defined intervals:
   - For each new employee (including contract employees) during orientation.
   - At least every three (3) years for all patient care staff.
   - Hospice Aides will be competency assessed by an RN at least annually (every 12 months) onsite at the location where patient is receiving care.
   - When introducing new procedures/techniques/equipment.

2. Patient care staff's competencies are maintained and improved through:
   - Inservice and/or continuing education.
   - Trends in infection control, incident reporting and performance improvement activities.
   - Specialty certification.

3. Hospice has established competency criteria for each job category. Qualified individuals will observe the employee during competency evaluation. The competency evaluation checklist will be completed and retained in the employee's record.

4. Examples of qualified individuals to perform competency assessments may include:
   - Hospice Aide: competency assessed by RN.
   - Licensed Practical Nurse: competency assessed by RN.

- Registered Nurse: competency assessed by a peer RN.
- Social Worker: competency assessed by a peer SW.
- Social Work Assistant: competency assessed by SW.
- Medical Director: another physician, Director and/or Executive Director.
- Volunteer Coordinator: Director.
- Patient Care Volunteer: Volunteer Coordinator.
- Chaplain: another chaplain or clergy representative.
- Bereavement Coordinator: Director.
- Physical Therapist: competency assessed by a peer PT or Rehab. Supervisor.
- Licensed Physical Therapy Assistant: competency assessed by PT.
- Occupational Therapist: competency assessed by a peer OT or Rehab. Supervisor.
- Certified Occupational Therapy Assistant: competency assessed by OT.
- Speech Language Pathologist: competency assessed by a peer SLP or Rehab. Supervisor.
- Homemaker: competency assessed by RN

ORIENTATION CHECKLIST

EMPLOYEE: _____ POSITION: _____

ORIENTATION TO	YES	N/A	SIGNATURE/DATE
1. Basic Home Safety: bathroom, electrical, environmental and fire			
2. Safety program:			
a. Risks within Hospice and patient's home			
b. Actions to eliminate, minimize or report risks			
c. Incident reporting and procedures to follow			
d. Reporting processes for common problems, failures and user errors.			
3. Storage/handling/access to/transport of supplies/medical gases/drugs			
4. ID/handling/disposal of infectious wastes (blood & body fluids/precautions)			
5. ID/handling/disposal of hazardous waste (cytotoxic/chemotherapy drugs)			
6. Infection Control and Prevention			
a. Personal hygiene (e.g., PPE & hand hygiene)			
b. Aseptic procedures			
c. Communicable infections (TB, AIDS, etc.)			
d. Cleaning/disinfecting reusable equipment			
e. Precautions to be taken (Standard Precautions, airborne transmission, direct/indirect contact, compromised immunity)			
7. Confidentiality of patient information/HIPAA policies and practices			
8. Community resources			
9. Policies/procedures			
10. Responsibilities related to safety and infection control			
11. Advanced directives policies/procedures			
12. Specific job duties/responsibilities and any limitations; performance standards			
13. Screening for alleged or suspected victims of abuse/neglect reporting			
14. Emergency operations plan & role			
15. Equipment use/management relevant to job description			
16. Tuberculosis Program/Plan (OSHA)			
17. Hazardous Materials in the Workplace Program (SDS) (OSHA)			
18. Bloodborne Pathogen Program (OSHA)			
19. Managing the environment of care: (pt &Hospice site)			
a. Safety			

ORIENTATION TO	YES	N/A	SIGNATURE/DATE
b. Fire safety – fire escape, fire alarm system, fire extinguishers – and prevention			
c. Security – Personal safety during home visits			
d. Utilities			
e. Responding to emergencies			
20. Pt rights/responsibilities			
21. Hospice complaint mechanism/Medicare state hotline # and purpose			
22. QAPI program & role			
23. On-call & answering service			
24. Ethical aspects pt care, treatment and services and process to address ethical issues			
25. Philosophy/mission/purpose/vision/goals			
26. Interpreters/communicating with hearing/speech/ visually impaired			
27. Sentinel event policy/process			
28. Physical safety (e.g., body mechanics and safe lifting)			
29. Cultural diversity and sensitivity			
30. Conflict of interest			
31. Patient, family and volunteer role in Hospice care			
32. Organizational structure, lines of authority & responsibility; supervision process			
33. Documentation requirements (record keeping and reporting)			
34. Communication skills and barriers			
35. Care and comfort measures			
36. Assessing and managing pain and symptoms			
37. Concept of death and dying			
38. Psychosocial and spiritual issues related to death and dying			
39. Bereavement			
40. Stress management, including emotional support			
41. Completion of Hospice Training Program			
42. Professional boundaries			
43. Corporate Compliance Plan			
44. Diseases and medical conditions common to Hospice.			

(Note: See Job-specific Competency Checklist for Skills)

_____ _____

Employee Signature *Date*

_____ _____

Supervisor Signature *Date*

INITIAL COMPETENCY

Hospice Aide

NAME: _____

SKILLS	COMPETENT		COMMENTS	DATE & INITIAL
	YES	NO		
T, P, R, BP: reading & recording				
Bed Bath				
Sponge, tub & shower bath				
Shampoo: sink, tub & bed				
Oral hygiene				
Toileting & elimination				
Normal range of motion				
Positioning				
Safe transfer techniques				
Ambulation				
Fluid intake				
Adequate nutrition				
Communication skills				
Complies with infection control: policies & procedures				
Observing & reporting changes in pt condition & care furnished				
Documenting pt status & care furnished				
Maintenance of clean, safe & healthy environment				
Elements of body function & changes to report to supervisor				
Recognition of emergencies				
Knowledge of emergency procedures				
Physical, emotional & developmental needs & ways to work with patients				
Follows care plan				
Creates successful interpersonal relationships with pt & family				

Completion Date: _____

Observed in home with patient: YES _____ NO _____

Hospice Aide Competent to Provide Care: YES _____ NO _____

_____ _____

RN Signature/Title *Date*

_____ _____

Employee Signature *Date*

ANNUAL ONSITECOMPETENCY

Hospice Aide

NAME: _____

Competency assessed on-site: in pt home ____ in lab setting ____

DEMONSTRATED COMPETENCY IN:	COMPETENCY	NEEDS IMPROVEMENT
Reporting changes in patient condition		
Hospice complaint mechanism		
Respect of patient property		
Basic home safety		
Complies with infection control: policies & procedures		
Creates successful interpersonal relationships with patient & families		
Follows plan of care for completion of tasks assigned by RN		
Hospice record documentation		

Care Observed:

Bath: Type _____: Competent YES_____ NO_____
Vital Signs: Competent YES_____ NO_____
Other Care Observed: _____
Competent YES_____ NO_____

Demonstrated competency with assigned task? YES_____ NO_____
Employee competent to provide care? YES_____ NO_____
Needs improvement? YES_____ NO_____

If needs improvement, explain: _____
_____

_____ _____
RN Signature/Title *Date*

_____ _____
Employee Signature *Date*

Appendix U	List of proposed vendors

Vendor List, Envision Hospice of Washington LLC

Alphagraphics	business cards
BKD CPA's/Advisors	cost reports and consulting services
Blue Fin Office Group	office supplies
Briggs Corporation	medical forms
Comcast Business	Communications technology
Comprehensive Home & Companion Svcs. LLC	Temporary staffing agency
Copiers NorthWest	Copier service
Corporation Service Company	Marketing services
De Lage Landen	Office equipment
Ducky's Office Furniture	Office furniture
FastSigns	Signage
First Advantage Background Services Corp	Background checks
GoDaddy.com	Website design
Gordon's Copy Print	Printing
Gulf South Medical Supply	medical supplies
Hansen Creative	marketing designs and layouts
Heath & Company CPA, LLC	Accountants
Home Health Coding Solutions	Medical records management
Independence Rehab	contract therapy services
Integra Telecom	Internet and phone
Kleenwell Biohazard Waste	Bio-waste management
Les Olson Company	Office equipment
McGee's Stamp & Trophy Co	name badges
McKesson Medical Surgical	Medical supplies
MedForms, Inc.	Medical forms
Medical Forms Management, Inc.	Medical forms
Oldham Technology	IT services
Optum Healthbank	health savings account
Payroll Experts	Payroll processing
Philadelphia Insurance	liability insurance
Quality Logo Products	Marketing
Roadrunner Print & Copy	Printing
Seagull Printing	printing services
Shred-IT USA	Document shredding
Smart Scrubs	nursing and aides scrubs/uniforms
Stericycle, Inc.	Sharps management & hazardous waste
Strategic Healthcare Programs, LLC	Clinical & financial benchmarking
T-Mobile	Mobile phones
The UPS Store	Document shipping
United Health Care	company health benefits
USPS	Document shipping
Verizon Wireless	cell phone service
Washington Labor & Industries department	workers compensation
Waste Management	Waste management & recycling

Legal Name	DBA	Address	Phone	UBI	NPI	Medicare Number	Medicaid Number	State License Number	Counties Served
Envision Home Health of Washington LLC	Envision Home Health	1818 S Union Ave, STE 1A, Tacoma, WA 98405	206-452-0058	603282417	1881023026	50-7125	2056820	IHS.FS.60521160	King, Pierce WA (CN)
Envision Hospice of Washington LLC	Envision Hospice	402 Black Hills Lane SW, STE 402-B, Olympia, WA 98502	360-350-4875	604174080	1477010940	50-1544	2157808	IHS.FS.60952486	Thurston, Kitsap, King, Snohomish, and Pierce (State license only)
Envision Home Health LLC	Envision Home Health	1345 W 1600 N, STE 202, Orem, UT 84057	801-225-7971	n/a	1386793123	46-7221	n/a	2020-HHA-69918	Utah County, UT
Envision Home Health LLC	Envision Home Health	990 West Atherton Drive, STE 100, Taylorsville, UT 84123	801-359-7600	n/a	1386793123	46-7221	n/a	2020-HHA-69918	Salt Lake County, UT
Envision Home Health LLC	Envision Home Health	4255 Harrison Blvd. STE 102, Ogden, UT 84403	801-317-8099	n/a	1386793123	46-7221	n/a	2020-HHA-69918	Weber and Davis County, UT
Envision Home Health LLC	Envision Hospice	990 West Atherton Drive, STE 100, Taylorsville, UT 84123	801-359-7600	n/a	130694642	46-1573	1009241	2020-HOSPICE-80460	Salt Lake and Utah County, UT
Envision Home Health LLC	Envision Hospice	4255 Harrison Blvd. STE 102, Ogden, UT 84403	801-317-8099	n/a	130694642	46-1573	1009241	2020-HOSPICE-80460	Weber and Davis County, UT

Appendix W	Accreditation standards for ACHC Palliative Care Distinction

Section 13: Distinction in Palliative Care

For an organization to earn accreditation with a Distinction in Palliative Care, the provider must have ACHC Home Health, Hospice or Private Duty Accreditation. This additional recognition focuses on patient and family centered care that optimizes quality of life throughout the continuum of illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. ACHC Palliative Care Standards are based on the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care.

Standard PC1-A: The provision of palliative care occurs in accordance with professional state and federal laws, regulations and current accepted standards of care. (Guideline 8.3)

Interpretation: The palliative care program is in compliance with federal and state statutes, regulations and laws regarding:

- Disclosure of medical records and health information
- Medical decision-making
- Advance care planning and directives
- The roles and responsibilities of surrogate decision-makers
- Appropriate prescribing of controlled substances
- Death pronouncement and certification processes
- Autopsy requests, organ and anatomical donation
- Health care documentation
- Palliative care program policies and procedures

Palliative care team members make efforts to understand how patient/family cultural beliefs, perceptions and practices may affect palliative care treatment options, services and the plan of care. The palliative care team is knowledgeable about legal and regulatory aspects of palliative care and has access to legal advice and counsel as needed.

Palliative care practice is modeled on and consistent with existing professional codes of ethics, scopes of practice and standards of care for all relevant disciplines.

Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-A: Written policies and procedures are established and implemented in regard to the palliative care program coordinating care and collaborating with community resources to ensure continuity of care for the patient and family. (Guideline 1.8)

Interpretation: Written policies and procedures are established and implemented regarding:

- Coordination of care with community resources to ensure continuity of care
- Communication and collaboration with hospices and other community service providers involved in the patient’s care
- Referrals are only made with the patient or appropriate representative's consent
- Timely and effective sharing of information among healthcare teams while safeguarding privacy

The palliative care program supports and promotes continuity of care throughout the patient’s illness.

Non-hospice palliative care programs have relationships with one or more hospices and other community resources to ensure continuity of care. Non-hospice palliative care programs inform patients and families about hospice and other community resources.

The palliative care team informs the patient’s health care providers of the availability of hospice services and other community resources.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-B: Written policies and procedures are established and implemented in regard to palliative care services being provided to the patient and family to the extent that their preferences and needs can be met in their physical environment. (Guideline 1.9)

Interpretation: Written policies and procedures are established and implemented that describe the different environments of care available to the patient and family.

The palliative care team provides care in a setting preferred by the patient or family. When care is provided outside of the family's home, the interdisciplinary team (IDT) collaborates with other service providers to ensure the patient's safety and sense of control. When possible, the environment provides flexible visiting hours and space for a family visiting area, rest area, eating area, and privacy for the patient and family.

Unique care needs of pediatric/adolescent patients or family members/visitors will be addressed by the palliative care team.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-C: Written policies and procedures are established and implemented in regard to the palliative care program providing care/service to patients and families of various belief systems. (Guideline 6.1)

Interpretation: Written policies and procedures describe the mechanisms the palliative care program uses to provide care for the patients/families of different cultural backgrounds, beliefs and religions.

Palliative care team members make efforts to understand how cultural beliefs, perceptions and practices may affect treatment options, services and the plan of care. Palliative care team members make efforts to understand and accommodate patient/family dietary and ritual practices.

Palliative care team members communicate in a language and manner the patient and family can understand.
Options may include:

- Language line
- Interpreters
- Written material in patient's preferred language

During the assessment process the interdisciplinary team (IDT) elicits and documents the patient/family cultural identification, strengths, concerns and/or needs.

Referrals to culture-specific or culturally based community resources are made as appropriate.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-D: Written policies and procedures are established and implemented in regard to the palliative care program striving to enhance its cultural and linguistic competence. (Guideline 6.2)

Interpretation: The palliative care program has written policies and procedures that describe methods to enhance cultural and linguistic awareness and services.

The palliative care program supports a multicultural work environment. It is an equal opportunity employer and does not discriminate on the basis of race, color, religion, sex, sexual orientation or national origin.

Palliative care staff identify differences in their own beliefs and the patient's beliefs and find ways to support the patient.

Ongoing education is provided to staff on cultural awareness and cultural competency.

The palliative care program regularly evaluates its services, policies and responsiveness to the multicultural population and makes changes as appropriate.

Evidence: Written Policies and Procedures
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC2-E: Written policies and procedures are established and implemented in regard to the palliative care program identifying and assessing complex ethical issues arising in the care of people with life-threatening illnesses. (Guideline 8.2)

Interpretation: Written policies and procedures describe mechanisms for identifying and addressing ethical issues in providing palliative care.

Existing or potential ethical issues are identified by the palliative care team. The palliative care team assesses for possible ethical issues such as withholding or withdrawing treatments, instituting a do not resuscitate (DNR) order, and the use of sedation in palliative care.

Ethical concerns are addressed with the patient or family and are documented in the clinical record.

Referrals are made to ethics consultants or the agency's ethics committee as appropriate. An ethics committee or consultant may be contacted for guidance on policy development, clinical care issues, conflict resolution and staff education.

Interdisciplinary team (IDT) members have education or training in ethical principles of palliative care.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-A: Written policies and procedures are established and implemented in regard to the palliative care program option to use volunteers to provide services to the patient and family. (Guideline 1.4)

Interpretation: Written policies and procedures describe the role and practices of volunteers in the palliative care program.

- Volunteers must comply with all personnel policies and procedures, including background checks and training.
- Volunteers are trained, coordinated and supervised by a palliative care team member.
- Services provided by volunteers will be included in the plan of care.

Evidence: Written Policies and Procedures
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-B: A written education plan is established and implemented that defines the content and frequency of evaluations as well as the amount of ongoing in-service training. (Guideline 1.5)

Interpretation: The palliative care program has a written education plan.

- The education plan includes training provided during orientation as well as ongoing in-service education. The palliative care program provides this training directly or arranges for personnel to attend sessions offered by outside sources.
- The ongoing education plan is a written document that outlines the education to be offered for personnel throughout the year. The plan is based on a reliable and valid assessment of needs relevant to individual job responsibilities.
- Education activities also include a variety of methods for providing personnel with current, relevant information to assist with their learning needs. These methods include provision of journals, reference materials, books, internet learning, in-house lectures and demonstrations.
- The palliative care program has an ongoing education plan that includes, but is not limited to:
    - The domains of palliative care
    - Pain and symptom management
    - Communication skills
    - Medical ethics
    - Grief and bereavement
    - Family and community resources
    - Hospice care and philosophy as well as eligibility
    - Advance care planning
    - Cultural considerations
    - Spiritual beliefs
- The program supports professional development through discipline-specific certifications, mentoring, preceptorships and supervision.
- There is written documentation confirming attendance at ongoing education programs.
- Personnel hired for specific positions within the palliative care program meet the minimum qualifications for those positions in accordance with applicable laws or regulations, licensure requirements, and the program's policies/ procedures and job

descriptions.

Evidence: Written Policies and Procedures
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC4-C: The palliative care program provides support services to its team members. (Guideline 1.7)

Interpretation: The palliative care program describes the mechanisms of support services available to staff.

- The palliative care program provides regular support meetings for staff and volunteers to encourage discussion of emotional stress/impact when caring for patients and families with serious or life-threatening illnesses.
- The palliative care program and interdisciplinary team (IDT) implements interventions to promote staff support and sustainability.
- Opportunities for additional counseling services are available.

Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-A: Written policies and procedures are established and implemented in regard to an initial evaluation of the patient and family being completed in a timely manner; this assessment forms the basis of the plan of care. (Guideline 1.1)

Interpretation: Written policies and procedures describe the palliative care program's mechanisms for completing an initial evaluation. Members of the interdisciplinary team (IDT) completes an initial evaluation and subsequent re-evaluations through patient and family interviews; review of medical and other available records; discussion with other providers; and physical exam and assessment. Initial contact occurs within two business days of palliative care referral.

The initial evaluation includes, but is not limited to:

- Assessments of the patient's current medical status, diagnosis and treatment options, a review of medical history and the patient's response to past treatments.
- Assessment includes documentation of the patient's diagnoses and prognosis, comorbid medical and psychiatric disorders, physical and psychological symptoms, functional status, social, cultural and spiritual needs, advance care planning concerns and patient/family goals for quality of life.
- Assessment of neonates, children and adolescents must be conducted with consideration of age and stage of neurocognitive development.
- Assessment of the patient/family perception and understanding of the life-limiting illness, including goals for quality of life and preferences for care.

Needs identified during the initial evaluation are referred to the appropriate IDT member for completion of a comprehensive assessment. Timeframes for completion of the comprehensive assessments are defined in agencies policies and procedures.

The palliative care program has policies in place for prioritizing and responding to referrals as well as responding timely to patient/family crises.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-B: Written policies and procedures are established and implemented in regard to patient and family participation in the formation of the plan of care. (Guideline 1.2)

Interpretation: The palliative care program ensures participation by the patient and family in the plan of care. The family is defined by the patient.

The plan of care is developed with professional guidance and support for patient/ family decision-making.

The care plan is based upon ongoing assessments and reflects goals set by the patient/family or surrogate in collaboration with the interdisciplinary team (IDT) and community providers (if applicable).

The care plan is updated as needed based on the evolving needs and presence of the patient and family.

Treatment options and alternatives are communicated to the patient and family to promote informed decision-making.

Complementary and alternative therapies may be included in the plan of care.

The plan of care includes values, goals, and needs that have been expressed by the patient/family.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-C: The interdisciplinary team (IDT) provides services to the patient and family in accordance with the plan of care. (Guideline 1.3)

Interpretation: The palliative care program has mechanisms in place for the IDT to provide services in accordance with the plan of care.

The IDT for the palliative care program consists of spiritual care professionals, nurses, physicians and social workers based on patient and family needs. It may also include other therapeutic disciplines as requested by the patient and family or when a need is identified by IDT members.

The IDT includes palliative care professionals with appropriate education, certifications or training in hospice and/or palliative care to meet the physical, psychological, social and spiritual needs of both the patient and family. If the palliative care program provides services for pediatric or adolescent patients or family members, the IDT members have specialized training in caring for children and or adolescents.

The palliative care program provides services 24 hours a day, seven days a week as necessary to meet patient needs. An on-call coverage system for care/services should be used to provide this coverage during evenings, nights weekends and holidays. If the palliative care program does not provide services 24/7, the IDT will ensure that the patient and family know how to contact the primary care physician for coverage after hours.

The palliative care program may provide respite services to the patient and family.

The IDT communicates frequently to discuss, review or update the patient's plan of care.

The IDT meets regularly to discuss care provided, staffing issues, policies, clinical practices and quality improvement activities.

Evidence: Patient Records
Evidence: Personnel Files
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-D: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) assessing and managing the patient's pain and/or other physical symptoms. (Guideline 2.1, 2.2)

Interpretation: Written policies and procedures are established for pain and symptom management. The palliative care program provides individualized care and disease-specific symptom management. Treatment plans for physical symptoms are individualized based on the disease, prognosis, patient functional limitations and patient-centered goals.

Patient/family understanding of the disease, treatment options, symptoms and side effects is assessed by the palliative care team and incorporated in the treatment plan. The goal of pain and symptom management is the safe and timely reduction of physical symptoms to a level acceptable to the patient.

A complete pain and symptom assessment is conducted initially and on an ongoing basis. The assessment includes, but is not limited to:

- Pain history and interventions
    - Pain severity
    - Use of a standardized pain tool
    - Use of an opioid analgesic risk assessment
- Shortness of breath
- Nausea
- Fatigue
- Anorexia
- Insomnia
- Restlessness
- Confusion
- Constipation

The palliative care program develops and uses symptom management tools, treatment policies, standards and guidelines appropriate to the care of patients. The palliative care team regularly documents ongoing assessments of pain and other physical symptoms and

functional capacity. Validated symptom assessment tools are used when available. The assessments are appropriate to the patient's age and diagnoses.

Treatment options for pain, symptom management and side effects include pharmacological, interventional, behavioral and complementary therapies. The program maintains documentation of symptom management in the patient's health record and communicates interventions and treatments with other health providers as appropriate.

Education regarding use of opioids and misconceptions are discussed with the patient and family members. The palliative care program uses an opioid analgesic risk assessment and management plan consistent with state and federal regulations for patients with chronic pain syndromes. Education regarding safe use of opioids, including driving or operating machinery, storage of medication, inventory and appropriate disposal, are discussed with the patient and family members.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-E: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) assessing the psychological and psychiatric aspects of the patient/family coping abilities and quality of life. (Guideline 3.1)

Interpretation: Written policies and procedures are established describing the mechanisms for assessing the psychological and psychiatric aspect of care.

The IDT includes professionals with specialized training in psychological and psychiatric issues such as depression, anxiety, delirium and cognitive impairment.

The IDT completes regular and ongoing assessments of patient/family reactions related to the illness including, but not limited to:

- Level of stress
- Coping strategies
- Anticipatory grieving
- Psychiatric conditions
- Age and developmentally appropriate assessments for pediatric patients and/or family members

Whenever possible and appropriate, a validated and context-specific assessment tool is used.

The IDT educates the patient and family on topics including:

- Disease or condition
- Symptoms
- Side effects
- Treatments
- Caregiver needs
- Decision-making capacity
- Coping strategies

Based on patient and family goals, interventions include assessing psychological needs, treating psychiatric diagnoses, and promoting adjustment to the physical condition or illness. Patient/family psychological stress and/or psychiatric syndromes are treated promptly with pharmacologic, non-pharmacologic and/or complementary therapies.

Patient and family members are informed of treatment options/alternatives. The IDT documents treatment options/alternatives discussed and the patient and/or family's decision.

Ongoing patient/family assessments regarding response to treatments and treatment efficacy are completed by the palliative care team and documented.

When necessary the IDT refers the patient and/or family members to appropriate healthcare professionals for ongoing psychological or psychiatric treatment.

The agency provides staff education and training in recognition and treatment of common psychological and psychiatric syndromes such as:

- Anxiety
- Depression
- Delirium
- Hopelessness
- Suicidal ideation

- Substance withdrawal symptoms
- Professional coping strategies to manage anticipatory grief and loss

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Personnel Files
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-F: The interdisciplinary team (IDT) assesses the social aspects of care to meet and promote patient/family needs and goals and to maximize patient/family strengths and well-being. (Guideline 4.1)

Interpretation: The IDT facilitates and enhances several social aspects of patient/family care, including:

- Patient/family understanding of and coping with illness and grief
- Support for patient/family decision-making
- Discussion of patient/family goals for care
- Emotional and social support
- Communication within the family, between patient/family and with the IDT

The IDT includes a social worker who has a bachelor's degree and/or graduate degree from an accredited school and experience in hospice and palliative care or a related health care field.

The IDT includes health professionals with expertise in the developmental needs and capacities of pediatric and adolescent patients and/or family members.

Evidence: Patient Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-G: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) conducting a social assessment to identify the patient/family social strengths, needs and goals based on findings from the initial evaluation or subsequent evaluations. (Guideline 4.2)

Interpretation: Written policies and procedures are established and implemented that address the interdisciplinary team (IDT) completing a social assessment.

- The palliative care program completes a social assessment that includes:
    - Family structure and function
        - Roles
        - Communication
        - Decision-making patterns
    - Strengths and vulnerabilities
        - Resiliency
        - Social
        - Spiritual and cultural support
        - Effect of illness or injury on intimacy and sexual expression
        - Prior experiences with illness, disability and loss
        - Risk of abuse, neglect or exploitation
    - Changes in family members' activities
        - Schooling
        - Employment or vocational roles
        - Recreational activities
        - Economic security
    - Patient/family living environment and/or living arrangement
    - Patient/family perceptions about care giving needs, availability and capacity
    - Needs for adaptive equipment, home modifications or transportation
    - Access to medications and nutritional products
    - Access to community resources, financial support and respite care
    - Advance care planning and legal concerns

The IDT develops a social care plan that reflects patient/family culture, values, strengths, goals and preferences.

The IDT implements interventions such as education and family meetings to maximize social well-being and coping skills of both the patient and family.

The IDT refers the patient and family to appropriate resources and services as needed.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-H: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) conducting a spiritual assessment to identify religious or spiritual/existential background, preferences and related beliefs; rituals and practices of the patient and family; and symptoms such as spiritual distress and/or pain, guilt, resentment, despair and hopelessness based on needs identified during the initial evaluation or subsequent evaluations. (Guideline 5.1, 5.2)

Interpretation: Written policies and procedures are established and implemented in regard to the IDT conducting a spiritual assessment that includes spiritual and existential concerns recognizing spirituality as a fundamental aspect of compassionate patient and family-centered care.

The IDT documents spiritual themes including but not limited to:

- Life review
- Assessment of hopes, values and fears
- Meaning, purpose and beliefs about afterlife
- Spiritual or religious practices
- Cultural norms and beliefs
- Coping, guilt, forgiveness and life-completion tasks
- Whenever possible, a standard instrument is used

The patient's resources of spiritual strength are supported and documented. Spiritual/existential care needs, goals and concerns identified by patients, family members, IDT members or spiritual care professionals are documented and addressed in the IDT care plan.

The IDT re-evaluates spiritual/existential interventions and updates them as needed.

The IDT includes spiritual care professionals who have documented education and training in spirituality and existential issues, or other experience based on agency policies and/or job description.

All palliative care team members are respectful of patient/family religious and spiritual beliefs, rituals and practices.

The IDT refers the patient to appropriate community resources (pastoral counselor, spiritual director or spiritual care professional) when requested.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews
Evidence: Personnel Files
Evidence: Observation

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-I: Written policies and procedures are established and implemented in regard to the palliative care program facilitating religious, spiritual and/or cultural services as requested by the patient or family at and after the time of death. (Guideline 5.3)

Interpretation: Written policies and procedures are established and implemented by the palliative care program in regard to providing spiritual care services at and after the time of death.

The palliative care program provides spiritual counseling and services in accordance with patient/family acceptance of these services and with their beliefs and desires. This may include:

- Performing religious rituals
- Assisting with funerals and memorial services

The patient and family are supported in their desires to display and use their own religious, spiritual and/or cultural symbols.

The spiritual team facilitates communication with spiritual/religious communities or individuals as desired by the patient and/or family.

The palliative care team follows up post death with phone calls, home visits or attendance at the funeral or wake to offer support, identify

any additional needs/referrals and to assist the family with bereavement.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Observations
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-J: Written policies and procedures are established and implemented in regard to a core component of the palliative care program being the provision of grief and bereavement services for patients and families, based on assessment of needs. (Guideline 3.2)

Interpretation: Written policies and procedures are established and implemented by the palliative care program for the provision of bereavement services.

Bereavement counseling services must be available to the patient and family to assist in minimizing the stress and problems that arise from living with a serious or life-threatening illness.

Bereavement services must be an organized program with services provided by qualified professionals who have experience and education in grief, loss and bereavement. Bereavement services may be provided by members of the interdisciplinary team (IDT) or through referrals to community resources.

An initial grief and bereavement assessment is completed upon admission to the palliative care program. The assessment shall include an evaluation of patient/family risks for complicated grief, bereavement and comorbid complications.

Information on loss, grief and the availability of bereavement services that are culturally appropriate and in a language the patient/family can understand is communicated to the family before and after death. Information on community services including support groups, counselors, collaborated partnerships with hospices and other community resources is also provided.

Patients/families who have been identified as at risk for complicated grief and bereavement shall receive intensive psychological support and prompt referrals to appropriate professionals.

Ongoing bereavement assessments and reassessments are completed by the palliative care team during the continuum of the patient's illness.

The IDT provides grief support and interventions appropriately determined by the cultural, spiritual and developmental needs and expectations of the patient and family.

Bereavement services and follow-up are recommended for the family for a minimum of 12 months after the death of the patient.

The palliative care program provides staff and volunteers with ongoing education, supervision and support in coping with their own grief as well as guidelines for effectively responding to patient/family grief.

Evidence: Written Policies and Procedures
Evidence: Patient and Bereavement Records
Evidence: Observation
Evidence: Personnel Files

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-K: Written policies and procedures are established and implemented in regard to the interdisciplinary team (IDT) providing a continuum of care for the patient and family through the transition of dying to the time of death and bereavement follow-up. (Guideline 7.1)

Interpretation: Written policies and procedures describe the types of services and mechanisms the palliative care program uses to provide care for the patient at the end of life to meet the physical, psychosocial, spiritual, social and cultural needs of patients and families.

The palliative care team identifies the needs of the patient and family during end-of-life care. The care of the patient is divided into three phases: pre-death, peri-death and post-death.

The palliative care team provides support and ongoing care of the patient and family during the end of life.
The IDT addresses:

- Concerns
- Hopes
- Fears and expectations about the dying process
- Symptom management and pain management

Care is provided with respect for the patient and family values, preferences, beliefs, culture and religion.

The IDT educates the family on signs and symptoms of imminent death and provides emotional support.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-L: Written policies and procedures are established and implemented in regard to the palliative care team presenting the patient and family with an end-of-life plan of care that addresses the dying process, treatments, symptom management, family preferences and other requests. (Guideline 7.2)

Interpretation: Written policies and procedures are established and implemented in regard to providing care at the time of death.

The palliative care team assesses the patient for symptoms and prepares family and other caregivers on the dying process and the management of symptoms. The plan of care during the dying process is discussed and updated as needed to meet the needs of the patient and family. Any discussion prior to the patient's death about an autopsy, organ or tissue donation, or other anatomical gifts is documented. Any inability to honor the patient/family expressed wishes for care during the dying process and at the time of death is documented in the clinical record.

The palliative care team will have an appropriately timed discussion with the patient/family regarding hospice services that adhere to patient/family preferences.

Evidence: Written Policies and Procedures
Evidence: Patient Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-M: Written policies and procedures are established and implemented in regard to the provision of post-death care based on care setting. (Guideline 7.3)

Interpretation: Written policies and procedures are established and implemented in regard to the palliative care program providing post-death care in a respectful manner that honors patient/family cultural and religious practices. The policies and procedures include, but are not limited to:

- Post-death care is provided in a respectful manner.
- Cultural and religious practices are honored in accordance with institutional practices, local laws and state regulations.
- Family has sufficient time with the patient after death.
- Preparation and disposition of the body in accordance with applicable law and regulations, taking into account patient/family wishes

Evidence: Written Policies and Procedures
Evidence: Patient Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-N: The palliative care program implements the bereavement plan post death. (Guideline 7.4)

Interpretation: Bereavement services for the patient's family are implemented post death by the interdisciplinary team (IDT). The bereavement plan is based on a social, cultural and spiritual grief assessment.

A palliative care team member is assigned to support the family and assist with religious practices, funeral arrangements, burial planning and emotional/grief support as appropriate.

Evidence: Patient Records
Evidence: Bereavement Records

Services applicable: PCHH, PCHSP, PCPD

Standard PC5-O: Written policies and procedures are established and implemented in regard to the palliative care program respecting the patient's or surrogate's goals, preferences and choices for care within the limits of applicable state and federal laws, current accepted standards of medical care, and professional standards of practice. (Guideline 8.1)

Interpretation: Written policies and procedures are established and implemented in regard to ethical and legal principles in providing palliative care.

The interdisciplinary team (IDT) includes the patient's or surrogate's goals, preferences and choices in the development of the plan of care. The IDT discusses achievable goals for care in regard to the patient's or surrogate's desires and preferences and addresses advance directives. Patient and family members are encouraged to seek professional help with updating or completing legal and financial documents. A palliative care team member assists with completing advance directives as appropriate, communicates to other team members the patient's or surrogate's wishes, and documents the advance directives in the clinical record.

The IDT assesses the ability of the patient and family in the decision-making process. For care of pediatric patients, the child's views and preferences are documented and discussed with the patient and family as appropriate. The IDT advocates for the patient's wishes and preferences. In the absence of advance directives and if the patient is unable to communicate, the IDT will assess whether the patient previously expressed any wishes, values or preferences in regard to care. The IDT will support and assist the surrogate with decision-making concerns, questions, and legal or ethical issues in determining to honor the patient's preferences or wishes.

Failure to honor the patient's or surrogate's preferences is documented and addressed by the IDT.

The IDT includes professionals with knowledge and skill in ethical, legal and regulatory aspects of medical decision-making.

Evidence: Written Policies and Procedures
Evidence: Patient Records
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD

Standard PC6-A: The palliative care program develops, implements and maintains an effective, ongoing Quality Assessment and Performance Improvement (QAPI) program. The program measures, analyzes and tracks quality indicators and other aspects of performance that enable the program to assess processes of care, services and palliative care outcomes. (Guideline 1.6)

Interpretation: Written policies and procedures are established and implemented that describe the palliative care program's QAPI plan.

The palliative care program designates someone to coordinate and implement a QAPI program.

The QAPI program measures, analyzes and tracks quality indicators and other aspects of performance that enable the palliative care program to assess processes of care and operations.

Quality care follows the National Quality Strategy set forth by the U.S. Department of Health and Human Services described in the following provisions in the Affordable Care Act. These include, but are not limited to:

- Making care safer by reducing harm caused in the delivery of care
- Ensuring patients and families are engaged as partners in care
- Promoting effective communication and coordination of care
- Promoting the most effective treatment practices for the leading cause of mortality
- Making quality care more affordable

The QAPI program reviews all of the palliative care domains including organizational structure, education, team utilization and assessment. The review includes the effectiveness of physical, psychological, psychiatric, social, spiritual, cultural and ethical assessment and interventions to manage these aspects of care. CMS quality reporting requirements will be included in the review.

Quality improvement processes may include the development and testing of screening, history and assessment tools, protocols for diagnoses and interventions. Examples include:

- Structure and processes
- Physical aspects of care
- Psychological and psychiatric aspects of care
- Social aspects of care
- Spiritual, religious and existential aspects of care
- Cultural aspects of care
- Care of the patient at the end of life
- Ethical and legal aspects of care

Quality improvement activities for clinical services are collaborative, interdisciplinary, and focused on meeting patient/family goals.

The QAPI program must be ongoing and have a written plan of implementation. Ongoing means that there is a continuous and periodic collection and assessment of data. Opportunities to improve care should be applied on a program-wide basis, when appropriate. The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.

From the QAPI process, the palliative care program establishes quality improvement policies and procedures.

The QAPI program includes evaluations of the palliative care program from patients, families, staff and the community.

Evidence: Written Policies and Procedures/QAPI Implementation Plan
Evidence: QAPI Reports and Documentation
Evidence: Observation
Evidence: Response to Interviews

Services applicable: PCHH, PCHSP, PCPD