Moments Hospice™

Moments are Forever

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 9:09 am, Dec 30, 2021

CN22-19

Moments Hospice of King, LLC

Certificate Of Need Application – Hospice Agency

December 30, 2021

Table of Contents

RECEIVED
By CERTIFICATE OF NEED PROGRAM at 9:09 am, Dec 30, 2021

Certificate of Need Application
Hospice Agency

CN22-19

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 DocuSigned by: 6DD538A256A14AB... Chief Executive Officer Email Address: Sol@MomentsHospice.com	Date December 30, 2021 12/29/2021 Telephone Number: 612-655-5242
Legal Name of Applicant Moments Hospice of King, LLC Address of Applicant: 820 Lilac Dr. N. Ste 210 Golden Valley, MN 55422	Provide a brief project description ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ Estimated capital expenditure: $__51,385___
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 be submitted for each county separately. King County, Washington	

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 246310-230).

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).

Moments Hospice of King, LLC is the legal name of the applicant and intended licensee of this proposed hospice program. Throughout the application, references to "The Applicant" or "Moments Hospice of King" refer to Moments Hospice of King, LLC. Owners with 10 percent of greater financial interest include Eli Jaffa (50%) and Shlomo ("Sol") Miller (50%).

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

The Applicant, Moments Hospice of King, LLC, is a for-profit, limited liability company (LLC), created on December 1, 2021. The UBI for Moments Hospice of King, LLC is 604-840-942. See Certificate of Formation, Exhibit 1.

This hospice program will be certified by Medicare and Medicaid. Hospice services will include nursing care, pastoral care, medical social work, respite services, home care, 24-hour continuous home care at critical periods, palliative care, and bereavement services for the family. Moments Hospice of King is not applying to construct a freestanding hospice inpatient facility. The program will provide services in the person's residence, which can be a private home, nursing home, or other type of long-term care facility, and for the homeless. Moments Hospice of King will contract with existing hospitals, skilled nursing facilities, other residential facilities in King County for any beds needed to care for homeless patients or patients needing general inpatient care. This is not an application for an addition to an existing health care facility.

Moments Hospice of King, LLC will enter into a Shared Services Agreement with Guardian Hospice MN, LLC, d/b/a Moments Hospice ("Moments Hospice"), an affiliated entity that provides a host of administrative and management functions, including, but not limited to, billing and collections, credentialing, compliance, financial management, bookkeeping, payroll, accounts receivable, accounts payable, group purchasing, marketing, and executive oversight. Moments Hospice provides the same administrative services to multiple affiliated Moments Hospice programs across the United States. See Exhibit 2, Shared Services Agreement, which contains full scope of services.

The Shared Services Agreement described above does not include any professional medical or hospice services. This arrangement, currently in effect with other Moments affiliates, will allow Moments Hospice of King to immediately realize efficiencies and economies of scale, access specialized skill sets and expertise, and avoid unnecessary replication of overhead expenses. The efficiencies gained will allow Moments Hospice of King to dedicate more resources to direct patient care and charity care, as demonstrated by the higher number of visits per week and other indicators for other Moments Hospice start-ups in other markets.

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

   Sol Miller
   Chief Executive Officer
   820 Lilac Dr. N. Ste 210
   Golden Valley, MN 55422
   Phone: (612) 655-5242
   Email: Sol@MomentsHospice.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).**

   Lindsay Myers-Bennett
   President
   Conrad Healthcare Administration Corp.
   11523 Palmbrush Trl, #375
   Lakewood Ranch, FL 34202
   Phone: (941) 404-9046
   Email: Lindsay@ConradHealthcare.com

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

Please reference Exhibit 3, organizational charts.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant or its affiliates with overlapping decision-makers. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:**
    - **Facility and Agency Name(s)**
    - **Facility and Agency Location(s)**
    - **Facility and Agency License Number(s)**
    - **Facility and Agency CMS Certification Number(s)**
    - **Facility and Agency Accreditation Status**
    - **If acquired in the last three full calendar years, list the corresponding month and year the sale became final**
    - **Type of facility or agency (home health, hospice, other)**

Moments Hospice of King, LLC is a stand-alone legal entity, with no parent company. Other affiliated Moments Hospices are shown in the table below. All entities listed are hospice agencies, with overlapping ownership and decision makers. All of the entities listed below are start-ups—none were acquired.

LOCATION NAME	STREET	CITY	STATE	ZIP	MEDICARE #	State Licence #	Survey
Guardian Hospice MN, LLC dba Moments	820 Lilac Drive Suite 210	Golden Valley	MN	55422	241602	399065	CHAP
Moments Hospice of St. Cloud	2229 Roosevelt Road Suite 1	St. Cloud	MN	56301	241608	398751	CHAP
Moments Hospice of Rochester	1816 2nd Street Suite B	Rochester	MN	55902	241607	398822	CHAP
Moments Hospice of Duluth	4897 Miller Trunk Hwy Suite 220	Hermantown	MN	55811	241609	397292	CHAP
Moments Hospice of Eau Claire	2263 East Ridge Center	Eau Claire	WI	54701	521604	2047	CHAP
Moments Hospice of Milwaukee	1139 S. Sunnyslope Drive Suite 200	Mount	WI	53406	521605	2049	CHAP
Moments Hospice of Madison	5315 Wall Street Suite 135	Madison	WI	53718	521607	2052	CHAP
Moments Hospice of Appleton	5517 Waterford Lane suite C	Appleton	WI	54913	521606	2051	CHAP
Moments Hospice of Des Moines	4150 Westown Parkway Suite 106	West Des	IA	50266	161612	N/A	CHAP
Moments Hospice of Chicago North	2860 River Road Ste 160	Des Plaines	IL	60018	Pending	2003205	CHAP
Moments Hospice of Chicago South	545 Plainfield RD, Suite G-1	Willowbrook	IL	60527	Pending	2003204	CHAP
Moments Hospice of South Dakota	5024 S Bur Oak Pl Ste 217	Sioux Falls	SD	57108-2238	Pending	DL203791	Awaiting CHAP Survey
Moments Hospice of Miami	7850 NW 146th St Suite 508	Miami Lakes	FL	33016	Pending	Awaiting State Licensing	Awaiting CHAP Survey

Project Description

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

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

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

This criterion is not applicable. The applicant entity does not own, operate or manage an existing hospice agency.

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

Moments Hospice of King, LLC has entered into a Letter of Intent (LOI) with Burien Pacific Professional Building, LLC, to rent an office space (suite number to be assigned upon approval of this CON application) at the following address:

Moments Hospice of King, LLC
15111 8th Ave. SW
Burien, WA 98166

Contingent upon a CON being issued in September, the lease would be finalized in that month, with a start date of October 1. The LOI and lease agreement can be found in Exhibit

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

Description of Proposed Project

This Certificate of Need (CON) application is to establish a Medicare and Medicaid certified hospice program in King County, Washington. The applicant is Moments Hospice of King, LLC. The company was formed on December 1, 2021, to establish a hospice program in King County. The cost for this project will be funded with cash on hand, as shown on audited financials from Moments Hospice of King, LLC shown in Exhibit 5.

Hospice services will include nursing care, pastoral care, medical social work, respite services, home care, 24-hour continuous home care at critical periods, palliative care, and bereavement services for the family. Moments Hospice of King is not applying to construct a freestanding hospice inpatient facility. The program will provide services in the person's residence, which can be a private home, nursing home, or other type of long-term care facility, and for the homeless. Moments of King will contract with existing hospitals, skilled nursing facilities, and other residential facilities in King County for any beds needed to care for homeless patients or patients needing general inpatient care. This is not an application for an addition to an existing health care facility.

Background

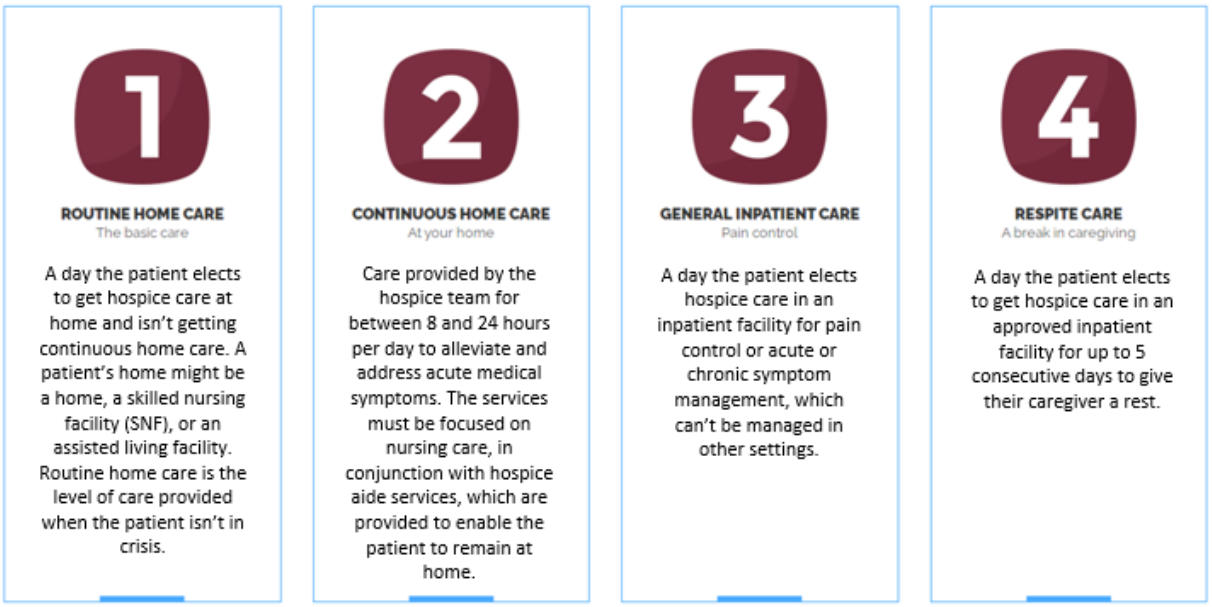
Moments Hospice of King filed this CON application to establish a hospice program in King County in response to the need identified by the Department of Health in the *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted November 10, 2021 (See Exhibit 6).

The Department of Health's need methodology projects the number of hospice patients for the service area, based on the projected number of service area resident deaths in each category (age 65+ and under 65 years of age), multiplied by the statewide hospice utilization rate for each category. For King County, the projected unmet need in terms of hospice admissions for the years 2022 and 2023, respectively, are 226 and 497. Therefore, The Department of Health has determined that King County can support two additional hospice providers.

Unlike hospitals or nursing homes, there is no physical limit on the number of patients each hospice can serve annually. In addition to the published need identified by the Department of Health, which looks at King County in the aggregate, and in two age cohorts, unmet needs for hospice services persist among marginalized and underserved subpopulations, such as racial/ethnic minorities, persons with certain non-cancer terminal diagnoses, homeless persons, LGBTQ+ persons, persons living in long term care facilities, and terminally ill persons and their families who are unaware of hospice services, or who, due to cultural factors, educational or other barriers, have initial reservations about utilizing hospice services. In addition to these underserved populations, many terminally ill residents of King County experience barriers to timely initiation of hospice care.

The Hospice Benefit

Hospices receive payment from many sources, including Medicare, Medicaid, and private insurance plans. However, the Medicare hospice benefit, enacted by Congress in 1982, pays for most hospice care. According to Medicare Cost Reports (2020), Washington hospices report 87.4% of hospice census patients have Medicare. Hospice patients may require differing intensities of care during the course of their disease. The Medicare Hospice Benefit affords patients four levels of care to meet their clinical needs: Routine Home Care, General Inpatient Care, Continuous Home Care, and Inpatient Respite Care. Moments Hospice of King will provide all four levels of care to residents of King County.



Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice

The Medicare hospice requirements at 42 CFR §418 of the Medicare Conditions of Participation ("CoP") require hospices to provide certain core and non-core services and staffing, including:

- Governing Body, Administrator, and Medical Director
- Physician Services
- Nursing Services
- Medical Social Services
- Counseling Services (bereavement, dietary, and spiritual)
- Therapy (physical, occupational, and speech-language pathology)
- Hospice Aide, Volunteers, and Homemaker Services

Hospices are reimbursed by Medicare or Medicaid through a capitated, per diem rate based on the four levels of care. Payment for each covers all aspects of the patient's care related to the terminal illness, including all services delivered by the interdisciplinary team, medication, medical equipment, and supplies. Many private insurance companies provide coverage and reimbursement for hospice care, similar to Medicare.

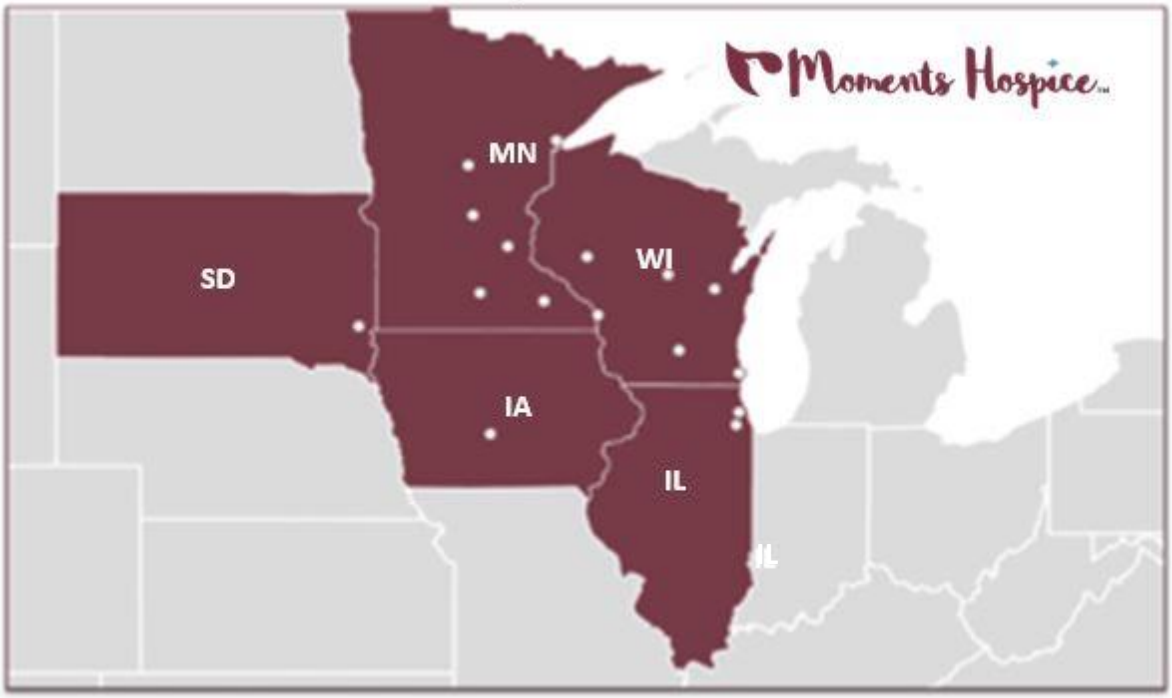
About The Applicant

Moments Hospice of King will be a new provider in Washington and in King County. It is closely affiliated with Moments Hospice (Moments), an experienced, Medicare-certified

hospice provider with its headquarters in Golden Valley, Minnesota. Moments served its first hospice patient in 2017 and has since grown to 13 licensed and Medicare-certified agencies and 17 offices serving 162 counties in 6 states. In 2020, Moments developed additional hospice agencies in the Miami, Florida and Sioux Falls, South Dakota areas. These two offices are awaiting licensure survey. Moments Hospice is the brand for these hospices that are under common ownership, programming, and leadership.

Moments has grown significantly in the last few years and has a strong reputation in the markets it serves. Moments' growth is attributable to its experienced staff and patient care obsession.

Moments Hospice Office Locations

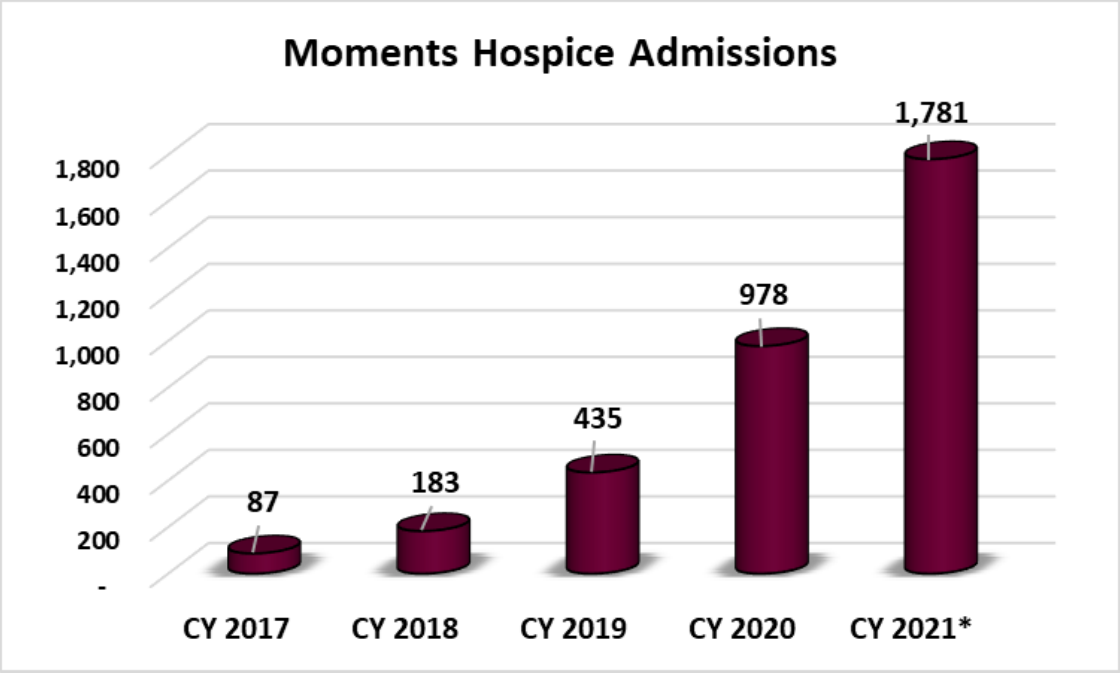


All Moments programs are licensed and certified in accordance with state and federal hospice regulations. All hospice offices receive Community Health Accreditation Partner (CHAP) accreditation within the first year of operation (See Exhibit 7). Moments will bring

its existing resources, programming, leadership, training, and high-quality services to King County.

Aside from Moments' new location in Miami-Dade and Monroe County, In Moments' other current services areas, there are no CON regulations. Many of Moments' current markets are served by up to 30 or 40 hospice agencies. Market share is dominated by hospital-owned agencies that control the majority of admissions for patients who receive hospice in their homes. Despite this fact, by providing high-quality and individualized patient care, focusing on hard-to-reach patients who require targeted educational campaigns, providing customized programs, and partnering with SNFs and ALFs, Moments has more than doubled its hospice patient admissions each year since opening, increasing overall hospice utilization in the markets Moments agencies serve.

Admission growth primarily reflects the opening of Moments' first hospice agencies in Minnesota. Recognizing the need for high quality hospice care in other states, Moments opened additional agencies in 2020 and 2021 which have been ramping up rapidly. 2021 is annualized based on year-to-date numbers through December 27, 2021:



OUR MISSION:

Changing the hospice experience, one moment at a time.

Sol Miller and Eli Jaffa founded Moments in response to the lack of high-quality hospice services in the Minneapolis-St. Paul metro area and in the surrounding Golden Valley, Minnesota area. In their former positions working at SNFs and ALFs, Mr. Miller and Mr. Jaffa found their patients did not receive the end-of-life care they deserved. The cofounders saw slow responses and poor quality in the existing hospice programs available. Because of those experiences, they joined forces to create patient-first hospices that strive to exceed patient and family expectations.

Moments has many unique attributes. It is a lean organization with senior leadership on the ground supporting clinical staff and ensuring the care quality is up to its standards. The organizational structure allows Moments to be nimble and to solve problems creatively or create new programs quickly in response to need. Perhaps the most significant difference is its philosophy—do right by the patients, no matter the circumstance. With that philosophy, Moments has earned a remarkable reputation with the families and facilities that work with Moments. When other hospices are unwilling to admit a patient because of complex needs or high costs, Moments is there to provide the highest-quality comprehensive care to meet each patient's needs—even if the costs for a patient exceed the payments Moments receives.

Sol Miller
Cofounder and CEO of Moments Hospice

"Moments is driven by the philosophy that we always do right by our patients. We care deeply about patients and we put ourselves in the shoes of the families that are going through the difficult process of a loved one dying. We work very hard to impart that sensitivity to each and every person who works for Moments. It's a part of our culture at Moments. When a nurse or aide interacts with a patient's family, the sensitivity and genuine concern is palpable. That is why we have been successful in the areas we serve."

The Moments Hospice vision is:

- By keeping patients at the center of all we do, we seek to fulfill our promise of ensuring comfort and dignity from admission through bereavement.

- Utilizing “The Moments Way,” we serve patients, families, and referral partners with expertise and integrity, ensuring all patients die with dignity.

- We practice Open Access for eligible patients with high-complexity or individualized needs.

- Through educational empowerment, we create a better understanding and use of the hospice benefit.

- Investing in technology and resources to create an effective work environment to provide exceptional care.

- With humility, Moments Hospice utilizes each missed opportunity to create process improvement.

The Moments Way

In early 2018, while reevaluating its mission, vision, and values, Moments realized there was more to its hospice philosophy than what those statements reflect. Moments realized what was missing is what distinguishes Moments as a brand, and what makes it unique as a hospice provider. Moments’ clinical team realized it is not just what Moments does for its patients and families, but the way Moments does it. Thus, “The Moments Way” was developed and implemented across its affiliated hospice agencies.

Eli Jaffa
Cofounder and President of Moments Hospice

“The Moments Way is the fundamental foundation of our company’s culture, and exemplifies how we conduct ourselves, our business, and most importantly our care model. We instill The Moments Way in our culture through onboarding and training, and base many daily decisions around the Moments Way.”

Features of “The Moments Way”

The Moments Way is an approach to providing the highest-quality patient care possible, in a way that each staff member can be proud of. The Moments Way informs our staff’s approach with each patient, family, and care team with which they work. The Moments Way promotes a patient-centered approach that combines clinical expertise with integrity.

While it is difficult to completely capture The Moments Way on paper, the graphic below shows some of its most salient features.[1]

The Moments Way

We represent Moments Hospice with Pride	We make decisions based on the need of the patient, regardless of cost	We are present and in the moment We recognize we are guests in patients' homes, wherever that may be
We partner with the patient's family and any facility staff to deliver exceptional patient care and communication	We take extra time with patients and families If desired, we contact family members after each patient visit	We meet with patients and families within 2 hours of referral
We provide an individualized plan of care, being generous with our services	We document all care in electronic medical records so our teammates have timely information	We make every effort to attend all deaths to honor the patient and support the family

Instilling "The Moments Way" in Our Culture

Upon hire, each Moments employee goes through virtual interactive training exercise with executive leadership, delivered through Zoom. Every employee learns the history of The Moments Way, how it imbues all aspects of Moments' culture, and how staff are expected to exemplify The Moments Way in caring for patients, with each other and in relation to the community. The Moments Way informs staff members' daily decision-making, and the direction in which leadership takes the company.

The company celebrates The Moments Way, putting information on its website and in brochures for patients and families considering hospice care (See Exhibit 8). Moments believes The Moments Way is the gold standard for how hospices should care for patients, and has seen it improve the hospice experience in every market Moments agencies serve.

[1] When Moments developed The Moments Way in 2018, it pledged to respond to all referral requests within two hours. Moments' commitment to treat every admission as urgent has resulted in a consistently lower response time. Moments now responds to all referral requests and initiates the assessment process within 90 minutes, subject to physician, patient, and family availability.

Moments Hospice Executive Leadership

An experienced management team, which will include the executive leadership from Moments Hospice, will support Moments Hospice of King. Combined, the Moments management team has over 100 years of hospice and healthcare experience.

Sol Miller, Cofounder and Chief Executive Officer of Moments Hospice, manages hospice programs, growth initiatives, and clinical operations. A results-oriented healthcare executive with a successful track record in executing corporate strategy, he promotes operational improvements, market expansion, and positive culture as keys to success. In founding Moments, his passion for individualized patient care inspired him to develop a hospice unique in recognizing individualized needs and providing patients with a customized and meaningful hospice experience.

Sol developed an affinity for the healthcare business when he spent the early years of his career building and operating assisted living and skilled nursing facilities. Working with hospices from the perspective of the facility gave him insight into the greatest unmet needs of the patients and their families. These experiences inspired him to develop a high-quality hospice that truly prioritizes patient needs. As a result, Sol purposefully set out to build a unique hospice that exceeds expectations in guiding patients and their families through the final stages of life. Sol Miller is an avid water-skier and enjoys spending time with his two children.

Eli Jaffa is Cofounder and President of Moments Hospice, where his primary responsibilities include operational oversight, management of hospice programs, growth initiatives, strategic relationships, and human resource activities. A healthcare entrepreneur with a passion for enhancing patient care through operational improvement, culture setting, and forward-thinking solutions, he has proven leadership qualities and a record of success in creating and scaling businesses.

A graduate of Yeshivas Mayan Hatorah in Lakewood, New Jersey, Eli founded two successful startup companies before serving as operations manager for Diamond Healthcare, a chain of nursing homes in Minnesota. While managing Diamond’s business and financial operations, Eli became aware of the need for individualized and sensitive

hospice services with world-class medical care within existing facilities. After consulting with like-minded colleagues, such as Sol Miller, Moments Hospice was born.

In founding Moments, Eli sought to take the core values he learned in the nursing home business to put together a hospice program with elite clinical and hospice leadership. He wanted to surround himself and the founding team with individuals who had the knowledge base and expertise necessary to develop a program which would provide a level of hospice care currently unavailable in that market. Eli was—and remains—dedicated to the ideal that each patient's hospice experience is uniquely important and deserves individualized care delivered in a manner that preserves the dignity of the individual.

Eli enjoys the outdoors. He plays softball and goes on fishing excursions during his free time.

Jennifer Adamek, RN, Vice President of Clinical Operations, is a registered nurse with extensive experience in clinical leadership, she has worked for over twenty years in the overlapping fields of assisted living, long-term care, and hospice. She began her work at Moments in 2018 on the clinical team, and now oversees all Moments' clinical hospice programs. In addition to her managerial role, Jenny is responsible for hiring, training, marketing, community education, and quality assurance planning and implementation.

Jennifer is passionate about patient care and ensuring that patients' needs are met at the most critical times in their lives. She constantly looks for ways to improve quality of care for each patient, and emphasizes the importance of communication among hospice team members and with patients' family members. Her focus is on building the efficiency of the field staff, ensuring consistency and continuous momentum of care, and improving the quality indicators of Moments' programs. Jennifer is dedicated to the idea of hospice and to the patients, families, and employees she serves.

Jennifer spends her free time with her daughter and son, attending all of their extracurricular activities. Her daughter is a three-sport athlete.

Stacy Crep, RN, BSN, Corporate Compliance Officer for Moments Hospice. In addition to ensuring compliance of hospice programs across the group of Moments Hospice

agencies, she helps promote uniform operations and oversees the quality program and the quality review and education of nursing staff.

Stacy began her career in healthcare as an aide, and became passionate about hospice care as a nursing student. When her first clinical patient died of liver cancer, she immediately understood that she was meant to work with people who are dying. Stacy strongly believes in the holistic approach that hospice promotes and places an emphasis on nonpharmacological symptom management modalities. She is a reiki master, yoga teacher, and wellness coach, and is trained in meditation, guided imagery, essential oils, and progressive relaxation, among other CAM (complementary and alternative medicine) modalities.

Stacy has worked in a variety of roles—including case manager, on-call nurse, clinical manager, director of professional services, and Ethics Committee chair. She has worked predominantly in or with hospice organizations with an emphasis on the geriatric population since 1997. She brings her varied experiences and sensitivity to individuals' needs to Moments, while also overseeing its compliance with the complex labyrinth of governing rules and regulations.

Stacy loves traveling the world. She and her husband enjoy visiting new places. They also love spending their free time with their grandchildren.

Samuel Auerbach, Chief Financial Officer and Vice President of Corporate Strategy. His primary responsibilities include overseeing financial operations and managing bank relationships and capital needs. With a focus on developing strategic initiatives and supporting the growth of the organization, he also provides general leadership in developing and implementing the company mission and vision.

A graduate of Fairleigh Dickinson University, Sam has an extensive background in finance, and was a founding team member of a company which is a publicly traded leader in the technology lending space. He also has several years' experience on the investment side of a $1B investment management company, where he supported, among other things, financial analysis, capital raising, due diligence, and asset management. His

experience in implementing growth strategies and leading financial operations provides Moments with the necessary infrastructure to support continued rapid growth.

Sam is an avid outdoorsman who especially enjoys playing tennis and running. He spends his free time with his wife and three children.

Kevin Stock, Vice President of Moments Hospice, is responsible for its sales and operations teams. He has over sixteen years' experience in sales and operations management in the healthcare industry, specifically in the areas of palliative care and hospice, durable medical equipment, and emergency medical services. Site administrator for four Moments locations, he has assisted in the de novo process for many of Moments Hospice's agencies and has helped design marketing brochures, branding, and the company website. In helping Moments revise their "Mission, Vision, Values" statement, he has also helped create the Moments Way, a standard way of doing business and providing care.

Raised in a small farming town in Michigan, Kevin is a former Division One college athlete who learned early on the key roles of relationship, loyalty, and hard work in cultivating achievement. From these fundamental life lessons, he developed a powerful work ethic and a servant leadership style that have been a tremendous asset to Moments, both in laying the groundwork for providing world-class patient care and in establishing the foundation of the path toward future growth.

Kevin is an avid outdoorsman who enjoys traveling and spending time with his children and his dog.

Alan Schabes, General Counsel, has served as Moments' general counsel since its founding and advises on legal and regulatory matters. Alan practices law as a partner at Benesch, Friedlander, Coplan & Aronoff, LLP. He maintains a national health care law practice, including representation on transactional and regulatory matters of health care private equity and venture capital investment firms, hospitals, post-acute care providers, behavioral health providers, physician and dental management service organizations, integrated delivery systems, and ancillary service providers including retail institutional pharmacy and therapy companies.

Alan was elected as a fellow of the American Health Lawyers Association in 2019. He served as chair and vice-chair of the Long-Term Care and the Law Program of the American Health Lawyers Association from 2003 to 2014 and served on the Quality Committee of the American Health Lawyers Association from 2015 to 2018. He is a member of the Legal Committee of the American Health Care Association and of the Home Care and Hospice Financial Managers Association (HHFMA) Workgroup of the National Association for Home Care and Hospice. Alan served as the co-general editor and as a contributing editor of *The Long-Term Care Handbook, Second Edition*, published by the American Health Lawyers Association. He is a contributing editor and a member of the board of editors of the *United States Health Laws Compendium*, published by the American Health Lawyers Association and West Publishing Company, and to the *Health Law Handbook,* published by Thompson Publishing Company.

Alan has spoken nationally on a variety of health care topics to groups including the American Health Lawyers Association, the Health Care Compliance Association, the American Health Care Association, the National Association for Home Care and Hospice, and the Ohio Health Care Association. He has published numerous health care-related articles in national publications, including *Nursing Homes Magazine*.

Marsha Lambert, RN, MSN, PHN, Senior Advisor has advised the Moments team on various issues for over three years and has an extensive background in post-acute healthcare consulting and compliance. A registered nurse with thorough, hands-on clinical and business knowledge, she has over 30 years' experience in hospice, home health, and other key service areas of the post-acute healthcare continuum. She is the founder and current principal of Compliance Resources, LLC, a post-acute consulting firm specializing in regulatory compliance, mergers and acquisitions, due diligence, and operating solutions for home health and hospice.

Marsha holds a master's degree in nursing from San Diego State University, and formerly served as chief compliance officer and senior vice president for AccentCare, one of the largest post-acute organizations in the country. At AccentCare, Marsha led the compliance department and helped the company scale its business and achieve rapid growth. From 2014 to 2018, she was vice president for Corridor, where she led the National Consulting Services and Interim Management business lines. At Corridor, Marsha managed over 200

independent contractor associates and developed robust post-acute compliance offerings, including tools for corporate compliance reviews (CorridorComply) and outsourcing QAPI reviews (CorridorQ). With her broad experience in post-acute organizations, she is well positioned to assist clients with regulatory compliance and the emerging opportunities of the post-acute market.

Moments Hospice Foundation

The purpose of the Moments Hospice Foundation is to bring enhanced joy to patients and families at this most difficult time in their lives. The Foundation, a 501(c)3 nonprofit, was started after many patients' families expressed gratitude for the experience they had, and wanted a way to contribute and be part of creating wonderful experiences for others. Thus, the Moments Hospice Foundation was established (see brochure in Exhibit 9). The Moments Hospice Foundation is available to all hospice patients and families and will be available to patients and their families in King County.

Moments Hospice Foundation

Mission: Enrich the experience for patients and veterans to create lasting end-of-life memories.
Vision: A place where every individual has an end-of-life experience filled with dignity, support, and hope.

End-of-Life Wish Fulfillment

Many patients in hospice have a dying wish. Some are simple, such as getting a copy of a favorite book or a DVD player to watch their favorite movie. Others are more complex, such as a trip to the zoo or one last boating trip. The Moments Hospice Foundation strives to take any and every wish a dying hospice patient has and make it a reality. The foundation focuses on each individual patient's wishes and understands that end-of-life wish fulfillment can have a powerful impact on the patient and can completely transform the end-of-life grieving experience for the family. Some of the examples of how this program has honored patients and their families by providing them with a memorable and positive end of life experience are listed below.

- A Minnesota patient's favorite memory was going to the zoo with his children and grandchildren. He had not been to the zoo in many years, and wanted to go one final time. Moments Hospice Foundation arranged for the patient and his family to visit the Minnesota Zoo safely during the COVID-19 pandemic. The experience had a profound impact on the patient and the family.
- A hospice patient wished to go out on the lake one last time. Moments Hospice Foundation arranged for a boat that could safely accommodate the patient in his wheelchair. The patient and loved ones enjoyed taking one last trip to the lake.

Financial Assistance

Medicare, Medicaid, and most commercial insurance plans cover hospice services. However, patients and family members who cannot afford certain general expenses, such as airline flights to see their loved ones, utility payments to ensure comfortable conditions at home, gifts for the holidays, or transportation services to and from their residence, can have these expenses paid by the Moments Hospice Foundation. Financial hardship should never be a reason for a patient to miss out on the important benefits of hospice and essential needs that a terminally ill patient may have. The foundation serves as a means for patients and families who lack insurance or financial means to afford hospice care. All patients deserve to be supported and comforted at the end of life and to die with dignity, regardless of financial condition.

We Honor Veterans

We Honor Veterans is a national program to empower hospices and community organizations to meet the unique needs of America's veterans and their families in guiding them toward a more peaceful ending. The Moments Hospice Foundation has made veterans affairs a top focus. Veterans risk their lives to ensure America's citizens have a safe place to sleep at night. The unconditional giving that veterans have shown must be appreciated and addressed when caring for them. Veterans have a strong sense of comradery. The Moments Hospice Foundation works to create events and ceremonies that bring veterans together to share their pasts and find commonalities. More information about this program begins on page 47 of this application.

Hospice Education

Educators with industry-specific expertise conduct hospice and end-of life care education for healthcare professionals to strengthen community care for individuals. Education is a vital component of increasing access to hospice. Through the Moments Hospice Foundation, educators hold events such as lunch-and-learns and virtual provider meetings to increase hospice awareness and reach patients who otherwise may not have considered hospice care as an option.

Moments Hospice Foundation Leadership

Eli Jaffa, Cofounder and President of Moments Hospice, is also the president of the Moments Hospice Foundation. His bio can be found in the bio section above.

Rabbi Menachem Feller, board vice president, is the director of Lubavitch House in West St. Paul and associate director of Upper Midwest Merkos Jewish Educational Association. He is responsible for the educational social programs the Moments Hospice Foundation provides. He provides counseling and pastoral care for individuals from all walks of life. He is also a sought-after facilitator and speaker on social issues and challenges. He lives with his family in West St. Paul.

Roger Cloutier, board treasurer, is an experienced senior executive with both COO and CFO leadership experience in a wide variety of industries and in diverse business operating environments. He provides private consulting services (executive management, leadership, operational and financial) to several companies. He has extensive Board of Director experience with public and private companies and large charitable organizations.

Benjamin Herman, board secretary, was ordained by the Jewish Theological Seminary in May 2011, at which time he also received an MA in Jewish Education. He served as assistant rabbi at Congregation Anshei Israel and in several student pulpit and education positions. He also interned as a chaplain and for a social justice organization.

King County Hospice Needs Assessment

Moments Hospice conducted a thorough community needs assessment for King County. The starting point was an analysis of the most current state and federal hospice data. The Moments leadership team spent time in King County meeting with stakeholders and community leaders to identify unmet hospice needs and barriers to accessing hospice care. Moments' leadership met with health clinics, skilled nursing facilities (SNFs), assisted living facilities (ALFs), doctors, community leaders, cultural and religious leaders, homeless organizations, and veterans' organization leaders.

The table below, from the *King County Community Health Assessment 2021/2022*, shows the leading causes of death overall, and by race/ethnicity in King County:

Leading causes of death (ranked by the number of deaths)

King County (average: 2014 - 2018)

Cause category
- All causes
- Chronic disease
- Infectious disease
- Injury/violence
- Other

Rank	Total	AIAN	Asian	Black	Hispanic	NHPI	White
0	All causes 621.4 (12,958)	All causes 1,021.7 (112)	All causes 448.7 (1,146)	All causes 781.6 (785)	All causes 502.1 (360)	All causes 1,181.4 (88)	All causes 634.9 (10,231)
1	Cancer 140.6 (2,965)	Unintentional injuries 129.9 (18)	Cancer 111.3 (313)	Cancer 166.0 (172)	Cancer 105.7 (77)	Heart disease 259.1 (20)	Cancer 144.2 (2,320)
2	Heart disease 124.4 (2,593)	Cancer 155.1 (17)	Heart disease 79.2 (196)	Heart disease 154.8 (149)	Heart disease 95.7 (50)	Cancer 219.5 (19)	Heart disease 128.9 (2,128)
3	Alzheimer's disease 45.6 (924)	Heart disease 182.7 (16)	Stroke 33.8 (82)	Unintentional injuries 45.8 (59)	Unintentional injuries 33.7 (43)	Diabetes Mellitus 96.3 (7)	Alzheimer's disease 49.3 (822)
4	Unintentional injuries 34.9 (757)	Chronic liver disease 66.9 (9)	Alzheimer's disease 26.3 (56)	Diabetes Mellitus 47.3 (46)	Stroke 33.6 (17)	Stroke 109.4 (5)	Unintentional injuries 36.7 (557)
5	Stroke 31.6 (644)	Chronic lower resp. disease 42.0 (5)	Unintentional injuries 19.7 (55)	Stroke 43.7 (39)	Diabetes Mellitus 20.5 (14)	Unintentional injuries 25.8 (4)	Stroke 30.1 (490)
6	Chronic lower resp. disease 25.9 (523)	Stroke 59.7 (4)	Diabetes Mellitus 18.8 (47)	Chronic lower resp. disease 26.8 (27)	Chronic liver disease 12.2 (14) Suicide 6.6 (14)	Influenza/ pneumonia 21.8 (2)	Chronic lower resp. disease 28.4 (450)
7	Diabetes Mellitus 18.7 (389)	Diabetes Mellitus 31.2 (4)	Chronic lower resp. disease 11.1 (27)	Alzheimer's disease 34.6 (24)	--	Septicemia 26.9 (2)	Diabetes Mellitus 16.5 (265)
8	Suicide 12.1 (268)	Suicide 20.2 (3)	Suicide 7.3 (26)	Homicide 16.2 (23)	Alzheimer's disease 33.5 (12)	Essential (primary) hypertension 21.0 (2) Chronic lower resp. disease 42.9 (2)	Suicide 14.0 (203)
9	Chronic liver disease 9.6 (221)	Alzheimer's disease 41.2 (3)	Essential (primary) hypertension 8.8 (20)	Essential (primary) hypertension 19.2 (17)	Homicide 4.7 (11)	--	Chronic liver disease 10.2 (169)
10	Influenza/ pneumonia 9.9 (205)	Nephritis 14.4 (2)	Influenza/ pneumonia 8.4 (20)	Nephritis 12.6 (13)	Certain conditions orginating in the perinatal period 2.1 (7)	Suicide 8.4 (2)	Influenza/ pneumonia 10.0 (165)

Source: WA State Department of Health, Death Certificate data

Note: For each cause, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count for that cause over the 5-year period. For leading causes by age, the rates are age-specific. All other rates are age-adjusted. Multiple race data is not accurately reported on death certificates and is not recommended for analysis.

The need methodology utilized by the Department of Health relies on historical use rates to project future hospice need. However, historical use rates reflect conditions where some subpopulations are underserved. As such, the patient volume estimated by the methodology assume continued underservice to certain groups. In other words, the numeric need published does not account for the entire needs of King County, since the future needs of historically underserved populations in King County are understated by the methodology.

In addition to the numeric need published by the Department of Health, Moments Hospice of King's needs assessment determined that the specific populations below, in no particular order, are underserved for hospice care in King County:

Racial and Ethnic Minorities

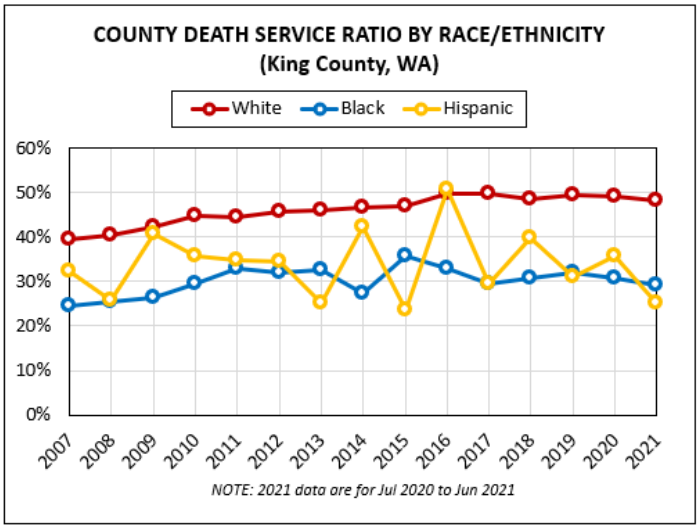
Racial and ethnic minorities are underserved in King County. County level hospice death service ratios indicate lower death service ratios among Black and Hispanic minorities compared to white residents, as shown in the table below. The chart below also demonstrates that this trend has persisted for more than a decade.

DEATH SERVICE RATIO BY RACE/ETHNICITY

King County, WA

NOTE: 2021 data are for Jul 2020 to Jun 2021

Year	All	White	Black	Hispanic
2007	38%	40%	25%	32%
2008	39%	40%	26%	26%
2009	41%	42%	26%	41%
2010	43%	45%	30%	36%
2011	43%	44%	33%	35%
2012	44%	46%	32%	35%
2013	44%	46%	32%	25%
2014	44%	47%	27%	42%
2015	45%	47%	36%	24%
2016	48%	50%	33%	51%
2017	47%	50%	30%	30%
2018	46%	48%	31%	40%
2019	47%	49%	32%	31%
2020	46%	49%	31%	36%
2021	45%	48%	29%	25%



Source: HealthPivots. Based on quarterly Medicare claims data.

Studies have demonstrated racial disparities in end-of-life care. Nationwide, Black end-of-life patients are 1.7 times more likely to be hospitalized and 1.6 times more likely to have an emergency department admission (See Exhibit 10).[2]

The Asian Community, which includes Chinese, Japanese, Filipinos, and others, comprises 19.7 percent of King County's population, according to the latest U.S. Census data. Ideally, in a situation of health equity, one would expect the racial composition of King County's hospice patients to generally mirror the overall population of King County. Yet the 2019 Medicare *Post-Acute Care Hospice By Provider* interactive data set shows that the percentage of Medicare hospice patients who are Asian, at individual King County

[2] Racial Disparities in Hospice Outcomes: A Race or Hospice-Level Effect? (nih.gov)

hospice providers, is much lower than the percentage of Asians who make up the general population.

Studies[3] have found that certain aspects of Asian culture, such as family (versus individual) decision making models, can be barriers to hospice admission. Another potential barrier is "filial piety":

> *"Filial piety (the moral obligation of children to care for elderly parents) is prominent in many Asian cultures. Filial piety may lead family members to want to "protect" the patient from the knowledge of a terminal prognosis in order to prevent despair and maintain hope. Thus, family members may not want to have the patient sign the statement choosing hospice care instead of curative therapies, as required by the Medicare Hospice Benefit*."[4] (See exhibit 11)

Hospice utilization among terminally ill Hispanic residents has also lagged behind utilization by white residents, as shown in the County Death Service Ratio data for King County in the chart above. This trend has been observed throughout the country, as noted in numerous studies. Studies have revealed cultural barriers to hospice care among Hispanics. A study conducted by a National Cancer Institute Community Network Program on Latinos from Central and South America found that family members are more secretive about death, prefer not to receive detailed information about the dying process, and know less about hospice than Anglo caregivers.[5] Some of this can be explained by the general Latino preference for indirect communication and, much like Asian and Jewish communities, a desire to shield the patient from information considered harmful. This reluctance makes the decision to sign a DNR order a difficult one, and many hospices require a DNR for admission.

[3] Ethnic Disparities in Hospice Use Among Asian-American and Pacific Islander Patients Dying with Cancer (nih.gov)

[4] Ethnic Disparities in Hospice Use Among Asian-American and Pacific Islander Patients Dying with Cancer (nih.gov)

[5] B. Kreling, C. Selsky, M. Perret-Gentilo, E. Huerta, J. Mandelblatt, "'The worst thing about hospice is that they talk about death': Contrasting Hospice Decisions and Experience among Immigrant Central and South American Latinos with US-born White, Non-Latino Cancer Caregivers," *Palliative Medicine* 24, no. 4 (June 2010), DOI 10.1177/0269216310366605, p. 7.

In June of 2020, Public Health Seattle and King declared racism a public health emergency (See Exhibit 13).[6] This multifaceted problem manifests in minority residents' housing status, mental health and stress levels, lack of trust in the healthcare system and providers, life expectancy, access to medical procedures and treatments, and health insurance coverage. Moments Hospice of King's needs assessment identified specific opportunities for Moments Hospice of King, as a new hospice agency, to address this public health problem through a multipronged approach. There is a need in King County for minority healthcare providers, minority healthcare staff, educational and occupational opportunities for minorities, cultural competencies and approaches that acknowledge and address the needs of King County minorities, and initiatives to promote equity and access to hospice services.

In summary, disparities in end-of-life hospice care persist for several racial/ethnic minorities, including Black, Hispanic, and Asian members of the King County community.

LGBTQ+ Persons

According to a study in *Palliative Care and Social Practices* (See Exhibit 14), 4.5 percent of the U.S. population consists of sexual and gender minorities. Among this group, one-third identify as Black or Latinx, and one quarter are over the age of 50. The older LGBTQ+ population is expected to grow over the next 10 years. This group faces numerous barriers to care, among them:

- Not accessing timely medical services
- Higher proportion of disability compared to the rest of the population
- Mental Health issues stemming from chronic, traumatic, discriminatory practices
- Financial barriers, especially among older transgender hospice patients
- Lack of stable/safe housing
- Legal/administrative barriers

Aging In Community: Addressing LGBT Inequities in Housing and Senior Services[7] (Exhibit 15) examined the housing and service-related needs of older LGBTQ residents of

[6] King County Community Health Needs Assessment, 2021-2022
[7] Seattle Rainbow Housing Report.pdf

Seattle/King County, noting that 8 percent of older adults (approximately 27,000 people) in Seattle/King County identify as LGBTQ—a substantially higher proportion of the population compared to national averages. The report also notes that older LGBTQ adults have higher rates of renting housing and tend to live alone more often, while three quarters of those surveyed stated that they struggle financially. All of these factors can impact end of life care. Disparities in care can be even more pronounced for people who are both LGBTQ+ and a racial/ethnic minority[8]. There is an opportunity to increase hospice utilization among terminally ill LGBTQ+ residents of King County by acknowledging their preferences, assuring them of nondiscriminatory, respectful care, and collaborating with the LGBTQ+ providers and organizations that they trust.

Terminally ill persons under the age of 65

The hospice use rate for the under 65 age cohort was only 25.67 percent in King County, according to the Department of Health's *2021-2022 Hospice Numeric Need Methodology*, posted on November 10, 2021. Terminally ill people under 65 years old often are not eligible for Medicare, and may face financial barriers to hospice care. Younger adults with cancer may not wish to discontinue palliative chemotherapy, which can be a barrier to hospice admission in the absence of a hospice provider like Moments Hospice of King, with Open Access policies.

Terminally ill patients at certain King County hospitals

In 2020, terminally ill patients with both cancer and non-cancer diagnoses who were discharged from certain King County hospitals died with hospice care at lower rates than state and/or national averages. Medicare FFS data by hospital facility shows that patients who died within 6 months of a hospital discharge (and thus are presumed to have been hospice-eligible) died without hospice at a greater rate than both state and national averages. Data suggests that certain hospitals in King County have an opportunity to identify hospice-eligible patients earlier. This would also reduce total spending on end of life care for Medicare beneficiaries.

[8] Palliative care needs, concerns, and affirmative strategies for the LGBTQ population - Noelle Marie Javier, 2021 (sagepub.com)

In addition to providing clinically appropriate services for terminally ill patients, this would also result in cost savings for COVID-burdened hospitals in King County, by reducing hospital average length of stay, emergency department use, and avoidable hospital readmissions.[9] Referring these patients to hospice would also reduce the overall cost of end of life care for Medicare beneficiaries across the entire healthcare system. Moments of King County has identified opportunities to collaborate with area hospital providers to improve access to hospice services.

Terminally ill patients within specific diagnosis groups, discharged from King County hospitals, are also dying with lower-than-average hospice utilization rates. At certain King County hospitals, during 2020, for all diagnoses, only 50 percent of Medicare FFS beneficiaries who died within 6 months of discharge—and thus were presumably hospice eligible—died in hospice. The statewide average for Washington for the same time period was 55 percent, and the national average was 57 percent.

Similarly, among patients with malignant neoplasms discharged from a large downtown tertiary medical center who died within 6 months of discharge, only 58 percent died in hospice, compared to 69 percent statewide and 71 percent nationally.[10]

Compared to Washington state and national averages, another major area hospital's patients who died within 6 months of discharge, and were therefore likely to be hospice eligible, died in hospice at lower rates than state and national averages.[11]

Nursing home residents

As shown in the tables below, according to Medicare data, King County overall and existing King County hospice providers show a downward trend in hospice nursing home census:

[9] HealthPivots, 2020-2021 Post-Acute Diagnosis Tool (Medicare FFS data)
[10] HealthPivots, 2020-2021 Post-Acute Diagnosis Tool (Medicare FFS data)
[11] HealthPivots 2020-2021 Post-Acute Diagnosis Tool (Medicare FFS data)

Based on Medicare Claims through Jun 2021

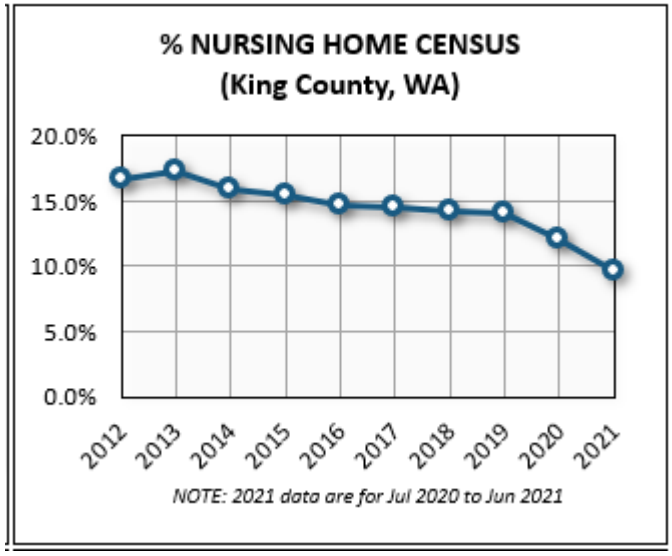
Select a County	Measure to Graph
Washington - King	NURSING HOME

KING COUNTY, WA

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012	58.1%	23.3%	16.6%	0.3%	1.0%	0.7%	100%
2013	56.4%	24.6%	17.3%	0.4%	0.9%	0.4%	100%
2014	56.4%	25.8%	15.9%	0.5%	0.8%	0.6%	100%
2015	55.4%	26.5%	15.5%	0.4%	0.8%	1.4%	100%
2016	55.7%	27.2%	14.7%	0.6%	0.8%	1.1%	100%
2017	56.4%	26.7%	14.5%	0.7%	0.8%	0.9%	100%
2018	60.8%	22.6%	14.2%	0.4%	0.8%	1.1%	100%
2019	61.7%	21.2%	14.0%	0.3%	0.9%	1.8%	100%
2020	61.0%	24.1%	12.0%	0.3%	0.8%	1.7%	100%
2021	62.5%	24.8%	9.7%	0.3%	0.8%	1.9%	100%

NOTE: 2021 data are for Jul 2020 to Jun 2021



Source: HealthPivots. Based on Medicare FFS data.

Based on Medicare Claims through Jun 2021

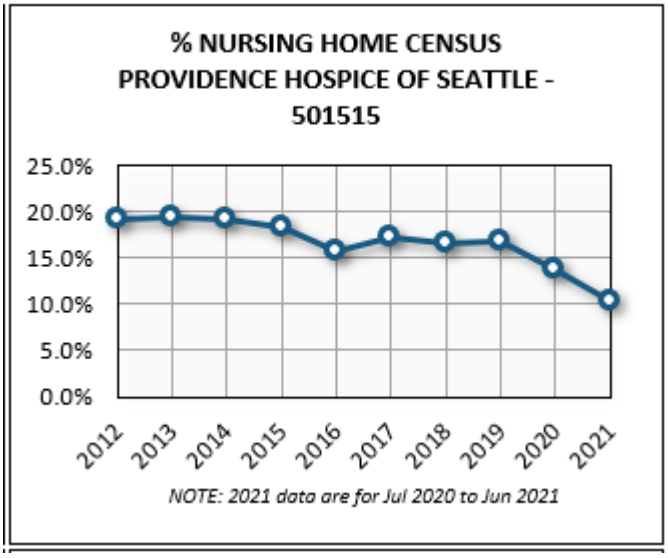
Select a Hospice	Measure to Graph
Washington - PROVIDENCE HOSPICE OF SEATTLE - 501515	NURSING HOME

PROVIDENCE HOSPICE OF SEATTLE - 501515

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012	41.0%	39.6%	19.2%	0.2%	0.0%	0.0%	100%
2013	43.7%	36.5%	19.4%	0.3%	0.0%	0.1%	100%
2014	42.8%	37.7%	19.1%	0.3%	0.0%	0.1%	100%
2015	40.6%	40.5%	18.3%	0.5%	0.0%	0.2%	100%
2016	41.8%	41.4%	15.8%	0.9%	0.0%	0.1%	100%
2017	43.7%	38.0%	17.2%	0.9%	0.0%	0.2%	100%
2018	59.7%	23.0%	16.5%	0.7%	0.0%	0.1%	100%
2019	65.8%	16.2%	16.7%	0.8%	0.0%	0.4%	100%
2020	64.0%	20.5%	13.8%	0.5%	0.1%	1.1%	100%
2021	66.9%	21.4%	10.3%	0.5%	0.2%	0.6%	100%

NOTE: 2021 data are for Jul 2020 to Jun 2021



Source: HealthPivots. Based on Medicare FFS data.

Based on Medicare Claims through Jun 2021

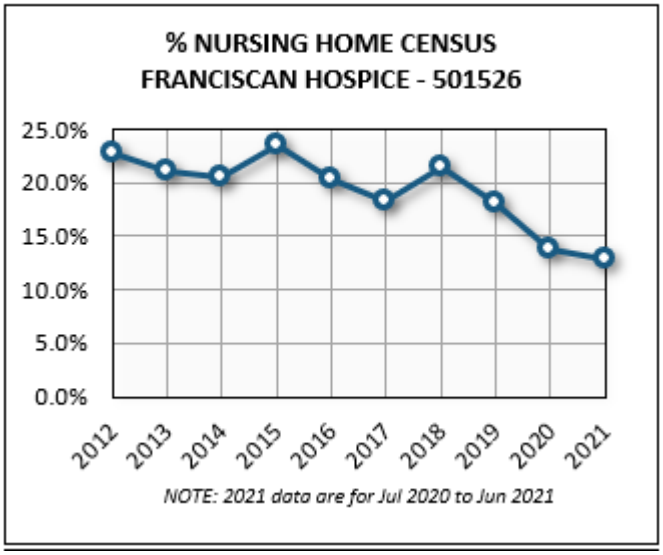
Select a Hospice	Measure to Graph
Washington - FRANCISCAN HOSPICE - 501526	NURSING HOME

FRANCISCAN HOSPICE - 501526

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012	53.2%	21.7%	22.8%	0.2%	2.0%	0.0%	100%
2013	50.1%	26.8%	21.2%	0.3%	1.6%	0.0%	100%
2014	54.0%	23.0%	20.5%	0.3%	1.9%	0.3%	100%
2015	54.0%	20.1%	23.5%	0.5%	1.5%	0.4%	100%
2016	51.3%	25.8%	20.4%	0.5%	1.3%	0.7%	100%
2017	51.8%	27.4%	18.3%	0.6%	1.4%	0.5%	100%
2018	49.2%	27.4%	21.4%	0.5%	1.1%	0.5%	100%
2019	53.7%	25.8%	18.0%	0.4%	1.5%	0.5%	100%
2020	56.6%	27.8%	13.7%	0.4%	1.0%	0.5%	100%
2021	55.6%	28.5%	12.9%	0.2%	1.2%	1.6%	100%

NOTE: 2021 data are for Jul 2020 to Jun 2021



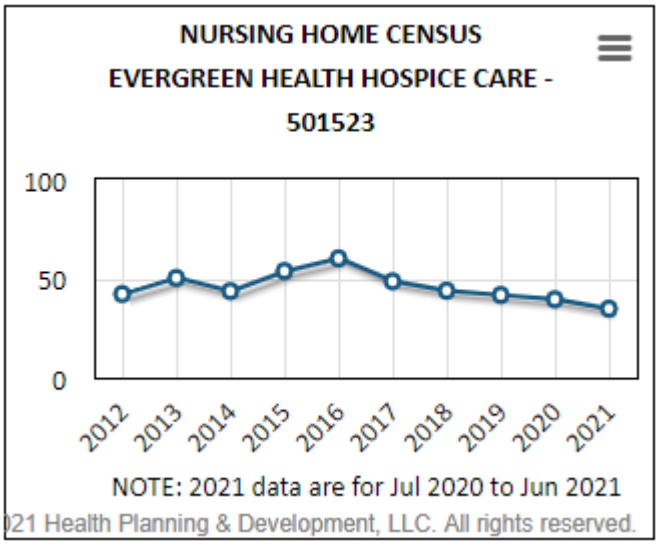
Based on Medicare Claims through Jun 2021

Select a Hospice	Measure to Graph
Washington - EVERGREEN HEALTH HOSPICE CARE - 501523	NURSING HOME

EVERGREEN HEALTH HOSPICE CARE - 501523

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012	69.9%	16.7%	11.0%	0.2%	2.0%	0.2%	100%
2013	67.9%	17.8%	12.3%	0.3%	1.8%	0.0%	100%
2014	69.1%	18.2%	10.6%	0.4%	1.7%	0.0%	100%
2015	68.2%	17.9%	11.7%	0.5%	1.8%	0.0%	100%
2016	66.9%	18.9%	12.0%	0.5%	1.6%	0.0%	100%
2017	69.9%	17.2%	10.4%	0.6%	1.7%	0.1%	100%
2018	70.2%	18.1%	9.4%	0.4%	1.7%	0.1%	100%
2019	69.5%	19.4%	8.7%	0.3%	1.9%	0.1%	100%
2020	71.7%	17.7%	8.2%	0.5%	1.7%	0.3%	100%
2021	74.3%	16.5%	7.0%	0.3%	1.6%	0.3%	100%



Source: HealthPivots. Based on Medicare FFS data.

The effects of COVID-19 have deprived nursing home residents of access to hospice services. There is a need for an innovative hospice provider with a strong Nursing Home and ALF background, such as Moments Hospice of King, to increase access for nursing home residents. Moments Hospice agencies developed innovative ways to continue service to nursing home facilities during the COVID-19 pandemic, which will be replicated by Moments Hospice of King.

In 2020, the Coronavirus pandemic presented unprecedented challenges that no healthcare organization has ever faced. At the beginning of the pandemic, Moments' leadership immediately assessed the situation and launched emergency response protocols to minimize the impact of COVID-19 on hospice patients and their families.

Moments created a COVID-19 team of leaders and clinicians, led by one point of contact responsible for any official communications related to Coronavirus. Moments followed all CDC guidelines consistently, down to every detail. Written letters and updates were sent out to all partnering SNFs and ALFs regarding any status updates or changes to keep all partner facilities informed from day to day as the pandemic evolved and developed. This enabled Moments to continue providing essential care and services to its current patients while also admitting new patients.

Like other Moments Hospice Agencies, Moments of King County is prepared to respond to King County facilities' needs. For example, in other areas, Moments Hospice agencies dedicated a special pandemic clinical team consisting of a COVID nurse and aide designated to treat COVID-positive patients only, to minimize the spread of the virus and its impact on other patients and their families.

Voluntary Conditions for King County

While the King County CON process does not require applicants to provide conditions (commitments upon which approval is contingent) within an initial application, Moments Hospice of King is voluntarily offering conditions which reflect careful consideration of the unique needs of King County. Consequently, Moments Hospice of King would agree to any of these conditions being placed on the award of a CON.

With regard to its commitment to hospice-appropriate residents of King County, Moments Hospice of King will accept additional conditions on its Certificate of Need based on any representations made in this application. Moments' extensive community needs assessment, and its discussions with healthcare providers and community leaders and organizations in King County documented significant gaps in access to hospice services. Moments would readily agree to any and all of the 10 conditions that follow, in order to address King County's specific needs and enhance equitable access to hospice services.

Because conditions to a CON application are actions the applicant commits to voluntarily, Moments has not listed as conditions services and procedures required by state and

federal law. Moments further commits to deliver the services and to meet these operational/programmatic conditions.

Moments Hospice of King is sincere in its dedication to complying with any or all these conditions in King County, and believes that they would improve hospice utilization and quality in King County, particularly among vulnerable and underserved populations, and reduce disparities in end-of-life care.

Condition 1: Open Access Program

King County is home to a diverse population with Hispanic, Black, and Asian communities that are underserved for hospice care, often because they are opposed to signing Do Not Resuscitate (DNR) orders and, in some cases, want to continue receiving interventions such as total parenteral nutrition (TPN) and intravenous fluids (IV). Therefore, Moments commits to admitting patients through the Open Access program discussed elsewhere in this application, upon commencement of operations. The Program will include these elements:

- Accepting eligible hospice patients, regardless of their code status.
- Accepting eligible hospice patients receiving treatments such as IV therapy, palliative blood transfusions, palliative TPN, hi-flow oxygen, etc.
- Evening and Weekend Admissions – On-call staff equipped to admit patients will be available 24 hours a day, 7 days a week, 365 days of the year.
- Palliative Care – Open Access includes palliative care to manage patients' pain and symptoms and provide patient and family education on disease management and advance care planning.

Condition 2: Charity Care

To ensure low-income, uninsured patients have the care they need, Moments Hospice of King would be willing to accept a condition on a CON award to provide charity care for at least 5 percent of total admissions.

Condition 3: Inclusion & Access Advisory Committees and Subcommittees

Moments recognizes the diverse communities in King County who experience cultural barriers to care: Hispanic, Black, Asian, and LGBTQIA+ residents. To identify and remove barriers to access hospice for members of these communities, Moments will create an Inclusion & Access Advisory Committee (IAAC) comprised of representatives from each of these communities. The IAAC will advocate, advise, and assist Moments in developing

programs to increase hospice utilization by these communities. Moments has developed an IAAC for an affiliate in a different market, and has gained a lot of knowledge and community awareness in that experience. King County is an ideal market to repeat the strategy.

Condition 4: Mobile Education Unit

Moments believes there is a lack of hospice outreach and education in King County. Enhanced outreach and education to residents of King County will be important for increasing hospice utilization. Moments Hospice of King would be willing to condition the award of a CON on dispatching a mobile education vehicle during the first year of operation. As explained elsewhere in this application, Moments successfully uses an education trailer for outreach in areas where Moments Hospice currently operates.

Condition 5: LGBTQIA+ Inclusion Program

There is a growing need for hospice care in the elderly LGBTQIA+ community in King County. As members of the community age, many find themselves alone with no spouse or children to care for them or guide them through decision-making processes related to advance care planning. To address this growing need, Moments will introduce the LGBTQIA+ Inclusion Program.

As part of its LGBTQIA+ Inclusion Program, Moments Hospice would accept a conditional award of a CON contingent upon obtaining SAGE Care Platinum Level Certification during the first two years of operations. SAGE is a highly trusted national organization dedicated to improving the lives of LGBTQIA+ elders. The SAGE Care Platinum Level Certification will demonstrate Moments is of open minds, pioneering hearts, brave spirits, healing presence, and shows that not only are all welcome, but that they will be provided with dignified and highly-specialized care. The SAGE Care Platinum Level Certification will ensure Moments' staff are knowledgeable and trained on sensitivities pertaining to the LGBTQIA+ community.

Condition 6: Assisted Living Facility (ALF) Outreach

Moments Hospice has successfully partnered with many assisted living facilities in its current service areas. Training will provide hospice staff the information they need to be better equipped to meet ALF residents' needs and partner with ALF staff. Moments Hospice of King would accept the condition of having all of its field staff complete ALF Training within the first year of operations.

Moments Hospice of King would also be willing to provide education to ALF staff on hospice services and collaboration between the ALF and hospice. Moments Hospice of King is willing to provide at least three trainings to ALF staff in its first year of operations.

Condition 7: Hospice Services to King County's Homeless Residents

A substantial population of individuals within King County experience homelessness. The lack of housing presents challenges to the delivery of hospice services. Moments Hospice of King believes that everyone deserves to die with dignity, and would accept a condition on a CON award to provide outreach to residents of King County experiencing homelessness through the Programs listed below.

- Moments Hospice of King will commit to providing free hospice care to uninsured individuals experiencing homelessness as part of its charity care commitment so that all hospice-eligible members of King County can experience dignity at the end of their lives.
- Donation to Area Homeless Organization: Moments Hospice of King would be willing to agree to a condition to donate $5,000 to a local nonprofit homeless organization during each of its first three years of operation.
  Moments Hospice Agency Trailers Food Distribution Events. Moments Hospice of King would agree to a condition to donate $15,000 towards Moments' trailer food drives to help homeless and other needy persons in King County.
- Offering Advance Care Planning and Education to those experiencing homelessness. Moments Hospice of King would be willing to provide information to homeless residents of King County regarding advance care planning and provide education and information on palliative care and hospice. Moments Hospice of King would also be willing to conduct quarterly advance care planning training for the staff and residents at homeless shelters in King County. Easy-to-understand advance care planning tools such as *The Five Wishes* will be used to assist in choosing end-of-life options.

Condition 8: Compliance Hotline

Moments Hospice of King's leadership learned through their experience with other agencies that in order to provide top level care, there need to be checks and balances in place, and a mechanism for employees to report concerns without fear of reprisal. Consequently, Moments Hospice of King will contract with Ethical Advocate, a company that provides a toll-free hotline for staff to report ethical and/or compliance concerns anonymously. Reports can be made anonymously, 24 hours a day, every day of the year. Moments wants to be alerted immediately to any possible ethical or compliance issues so they can be addressed immediately, and appropriate measures can be put in place immediately.

Moments hospices, including Moments Hospice of King, do not tolerate fraud of any kind. Moments takes ethical concerns very seriously; knowing about these concerns allows Moments to take action. The Ethics Committee meets to discuss any potential ethical issues raised. During orientation, staff learn that they can report any concerns through their supervisors or the compliance officer, or anonymously through the ethical advocate.

Moments commits to providing a compliance hotline to all Moments Hospice of King staff at commencement of operations.

Condition 9: Enterprise Fleet Car Lease Program

King County covers a large geographic area. Having reliable transportation is vital to performing hospice visits, but can often be a struggle for some patient care staff. Moments Hospice will provide car leases to qualifying staff members who otherwise could not work in hospice due to transportation difficulties. Removing this barrier will increase the number of qualified applicants and the diversity of Moments' IDG team members.

Condition 10: Annual Food Drives

As discussed elsewhere in this application, Moments has seen the benefits of food drives for community members in the areas it now serves. Food insecurity is a substantial problem in King County. Moments Hospice of King would accept a condition to the CON to conduct an annual food drive in King County similar to what other Moments hospice agencies do in Moments' other current markets.

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

Moments Hospice of King, LLC, confirms that this agency will be available and accessible to the entire geography of King County, Washington.

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
CON Approval	September 2022
Design Complete (if applicable)	Not Applicable.
Construction Commenced* (if applicable)	Not Applicable.
Construction Completed* (if applicable)	Not Applicable.
Agency Prepared for Survey	October 2022
Agency Providing Medicare and Medicaid hospice services in the proposed county.	November 2022

Moments Hospice of King is prepared to move quickly to serve King County's unserved residents. Moments has a proven record starting *de novo* hospices, with revenue generation in as little as 45 days in some cases. Moments Hospice of King is prepared to move quickly in King County, Washington, if this CON is awarded.

*** If no construction is required, commencement of the project is project completion, commencement of the project is defined in WAC 246-310-010(13) and project completion is defined in WAC 246-310-010(47).**

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.**

☒Skilled Nursing	☒ Durable Medical Equipment
☒ Home Health Aide	☒ IV Services
☒ Physical Therapy	☒ Nutritional Counseling
☒ Occupational Therapy	☒ Bereavement Counseling
☒ Speech Therapy	☒ Symptom and Pain Management
☒ Respiratory Therapy	☒ Pharmacy Services
☒ Medical Social Services	☒ Respite Care
☒ Palliative Care	☒ Spiritual Counseling

☒ Other (please describe) *See below.*

Moments Hospice of King's Unique Program and Therapies

Moments Hospice of King offers many unique programs that go beyond what hospice providers are required to offer. Although interdisciplinary care is both fundamental to hospice, and a key component of high-quality hospice care, these additional, unique Moments Hospice of King programs and therapies are not required components of the hospice interdisciplinary team under the Medicare Hospice Benefit. Because hospices are reimbursed on a per diem basis, Moments Hospice of King does not bill separately for these programs or therapies. Moments Hospice of King's unique programs and complementary alternative therapies focus on quality-of-life measures. Moments Hospice of King will bring these unique offerings to King County residents.

Open Access

To qualify for hospice care, a hospice physician and a patient's physician must certify the patient is terminally ill, meaning they have a life expectancy of six months or less if the illness runs its normal course. When a patient agrees to hospice care under the Medicare hospice benefit, they agree to a model of care for the terminally ill that emphasizes palliative care, not curative care.[12] As a result, many hospice providers do not admit terminally ill patients who are reluctant to forego medical treatments, such as terminal cancer patients on palliative chemotherapy, or terminal patients with renal disease who are not ready to quit dialysis. Additionally, eligible patients who are "Full Code" and unwilling to sign a Do Not Resuscitate ("DNR") order for religious, cultural, or other reasons are often denied hospice care and, as a result, cannot receive palliative care.[13] Some hospices will not care for patients on expensive medical treatments, such as TPN, an artificial nutrition treatment, even if the patient was receiving TPN before hospice referral. Often these patients have feeding issues that are unrelated to their hospice diagnosis.[14]

[12] https://www.medicare.gov/coverage/hospice-care.

[13] A do not resuscitate order (DNR), also known as "no code" or "allow natural death," is a legal order indicating a person does not want to receive cardiopulmonary resuscitation (CPR) if their heart stops beating. Sometimes it also prevents other medical interventions.

[14] Total parenteral nutrition (TPN) is a method of feeding that bypasses the gastrointestinal tract. Fluids are given into a vein to provide most of the nutrients the body needs. The method is used when a person cannot or should not receive feedings or fluids by mouth.

It is important to note that patients reserve the right to revoke hospice care at any time during their hospice experience if they decide that continuing curative treatments is in their best interest.

King County's increasingly diverse demographics require different approaches that reflect diverse population needs in order to impact hospice utilization. King County has a large Asian population (nearly 20 percent). Almost a quarter of residents are foreign-born. This unique demographic composition warrants a robust Open Access program, in order to improve access to end-of-life-care.

- In 2018, Asians represented 18 percent of King County's population. Asians have notably low hospice utilization rates due cultural factors, such as filial piety and family decision making models. Moments of King County's Open Access program can improve access for this underserved community.
- Moments Hospices have admitted numerous patients from the Jewish community who were unwilling to sign DNRs for religious reasons. According to the 2014 Greater Seattle Jewish Community Survey, 2.5 percent, or 63,400 people in King County are Jewish[15]. This population would also benefit from improved access under Moments' Open Access policy.
- Hispanics represented almost 10 percent of the King County population in 2018. Hispanics also have unique cultural considerations which can impact hospice admissions, and Open Access can also benefit this community.

Through the Moments Open Access program, Moments meets patients where they are, and accepts hospice patients who might have been turned away by other hospices or who may be hesitant to utilize hospice. These are often patients who are unwilling sign a DNR. The Moments team is trained to educate patients and their families on the implications of a DNR, but respects their final decision and provides compassionate care, with or without a DNR. All Moments care staff are CPR certified and can initiate resuscitation. Moment believes in meeting patients where they are, regardless of their DNR status.

Hospice providers often mention Open Access, but many hospice providers refuse to admit patients with costly medications, nutrition requirements, or other treatments. Many hospice providers require patients to sign a DNR. One reason for this position is related

[15] Berman Jewish DataBank

to the idea that hospice is intended to support a patient toward their eventual last breath. This position would reject the idea that a hospice patient can receive intervention that interferes with the natural progression.

Another reason a hospice may require a DNR is to prevent patient rehospitalization. If a hospice patient does not have an active DNR, CPR will be performed if needed, and 911 will be called. Paramedics will arrive and the patient will be transported to the hospital to be intubated, unless they are pronounced dead before arrival. CPR has a low success rate for terminally ill patients. Of those that are successful, many patients remain hospitalized for a sustained period of time. The process of going through CPR and calling EMS can be very traumatic for the family. The election of DNR is commonplace for hospice patients for these reasons, but a large portion of the population is either uneducated on the implications of DNR or remains resolute in the wish to maintain full code status. Moments tailors hospice care to fit the unique needs of the patient and their family. Moments provides education and encourages patients and their families to be involved in their care decisions, to enable them to make educated and thoughtful decisions.

Unfortunately, because many hospice providers are apprehensive about admitting Open Access patients, many patients get left behind and cannot receive the hospice benefit for themselves or their families. These are often people with cultural or religious beliefs who strongly oppose signing a DNR. Other people are so overwhelmed by their diagnosis (or their loved one’s diagnosis) that they cannot achieve presence of mind in making these difficult decisions. Often, people are uneducated on what it means to have a DNR order and therefore need time to do research or to continue to ask questions before they can make an informed decision that best suits them. According to the Family Caregiver Alliance, “It is normal, instinctive, to try to save life no matter what, and some people are concerned that not doing everything possible to preserve life is the same as ‘killing’ someone.” Moments Hospice respects the rights of all people to receive the education they need to make the decision that fits their comfort level.

Moments' Open Access

In December 2020, one of Moments' cofounders received a call from a distressed relative trying to admit her father to hospice in another service area. Due to his religious beliefs, the patient was unwilling to sign a DNR or stop the nutritional treatment he was receiving. He was terminally ill and in need of the nursing care and palliative care hospice provides. No hospice in the area was willing to admit him due to his insistence on not signing a DNR and continuing the treatment. He was asked to leave the hospital because of his declining condition and need for palliative care. The patient was stranded and given an ultimatum. This experience brought awareness to Moments' leadership that patients in other areas need an entrant like Moments Hospice that is dedicated to the Open Access philosophy.

Despite regularly admitting patients who are "Full Code," the Moments hospitalization rate average is less than 1.8 percent, a very low figure in hospice care.[16] Open Access patients rarely need resuscitation or hospitalization. Respecting patient and family choice on the direction of their healthcare is more important to Moments, and the results of working collaboratively with patients and their families has allowed Moments to successfully admit patients who have been left behind.

Moments has practiced Open Access since its founding and understands that some patients need expensive medications and treatments. This might be due to their religious beliefs, or purely as a comfort measure. Many terminally ill patients with very advanced diseases may still get symptom relief from certain treatments. Moments believes all people have the right to comprehensive hospice care, regardless of religious affiliation, care choices, or financial conditions.

Hospices often deny admission to patients under 65 with private health plans and high deductibles. Consistent with Moments' charity care policy and financial assistance policy (See Exhibit 20), Moments Hospice of King will ensure that the financial aspects of hospice care with Moments Hospice of King are not the primary or only consideration for these patients, and that charity care will be provided when needed. Moments Hospice of King believes that the final months of someone's life should be focused on spending time with the ones they love, and not being stressed about finances. Their final days should be

[16] TrellaHealth Data. Moments Hospice Golden Valley (1.8 percent) and Moments Hospice St. Cloud (1.4 percent). These are the two Moments hospices for which two years of data were available and are representative of Moments Hospice experience.

wrapped in the assurance and comfort provided by hospice care and the patient should die with dignity and peace of mind.

Examples of Other Moments Hospice Agencies' Open Access Patients

The following examples demonstrate different scenarios which Moments Hospice agencies have responded to with the Open Access philosophy. It is not an all-inclusive list of Open Access patients who have received Moments Hospice care.

- *A female patient was admitted to hospice with a full code status. Her brother was her next of kin for making decisions. He was in denial and having a hard time accepting that his beloved sister was dying. He could not accept that she was not a candidate for dialysis. After she had been on service for a month, her brother came to a place of acceptance and signed a DNR for his sister. She benefited from hospice care with all the additional support and focus on relief of her symptoms. She was able to attain relief from pain. She lived in a facility and rarely left her room. She benefited from the additional socialization that hospice provided. Her brother benefited from the support, education, and acceptance of where he was at in his journey.*
- *A male patient with esophageal cancer was admitted to services in summer 2020 after three hospice providers denied him care. He could not take in oral nutrition because of dysphagia caused by radiation treatments. He was receiving Total Parenteral Nutrition (TPN) via PICC line. His TPN also included fat emulsion, increasing the cost of his intravenous nutritional treatment. The patient had a Plurex Catheter to allow fluid to be drained from the space around his lungs. This decreased his dyspnea and increased his comfort.*
- *In March 2021, a female patient with peritoneal dialysis was referred to Moments Hospice. Moments Open Access provided the opportunity for her and her family to consider hospice without having to decide to immediately stop the peritoneal dialysis. She eventually decided to stop the peritoneal dialysis but, without the Open Access philosophy, might not have considered hospice as an option for her end-of-life pain and symptom management. This allowed her and her daughter to experience the support of hospice until she peacefully took her last breath with her daughter at her bedside.*

- *Early in 2021, Moments admitted an elderly female patient with an intrathecal pain pump for administering continuous pain relief medications and patient-controlled analgesia (PCA) to help keep her pain effectively controlled. She had an extensive history of chronic back pain. Moments took on the cost of her intrathecal pain medications and the refills, which occurred in her home, to ensure she would not have to undergo any unnecessary discomfort during a transition to oral medication. Continuing her intrathecal medication helped her remain comfortable through the end of her life.*
- *A patient admitted in summer 2020 had been receiving weekly IV hydration at a clinic. Moments' Open Access program continued the IV hydration for her comfort. She had just decided to stop chemotherapy and radiation treatment but was having significant difficulty with diarrhea and dehydration due to a Clostridium Difficile infection. Open Access allowed her to continue to receive IV hydration, which improved her comfort.*
- *A middle-aged male patient was admitted to Moments with metastatic cancer in summer 2020. He was receiving TPN and palliative chemotherapy. The patient had nausea and vomiting, and receiving TPN allowed him to get the nutrition he could not tolerate orally. He was the father of a young child. Receiving palliative chemotherapy and TPN allowed him to sign onto hospice with the peace of mind that he could discontinue these palliative interventions when the time was right for him and his family. The patient and his family benefited from the palliative care, counseling, and family support that hospice provides.*
- *An elderly male patient was admitted in early 2019 as a full code status even though he was unwilling to sign a DNR. He was unwilling even to discuss anything related to code status. The patient had a terminal heart condition complicated by bilateral lower extremity wounds and sepsis. Moments Open Access allowed him and his family to have the support and palliative care and symptom management that hospice provides. He did not believe signing a DNR was the right path for him, and Moments respected his right to make this decision. In partnership with the patient's primary care provider, the Moments IDG continued to provide education on code status options to the patient and his family. In the end, the decision was made to sign a DNR order. The patient died a peaceful and natural death with dignity.*

- *A female patient receiving blood transfusions was admitted in late 2020. She was not receiving the transfusions to prolong her life but to improve the quality of the life she had left. The transfusions helped her to be more alert and have more energy. She received the supportive services of hospice, which included the ability to reach a nurse 24 hours a day. This treatment allowed her to spend more time with her family and to be able to go out and visit them at their home. Her daughter stated she was relieved once Moments took over her mother's care and was elated to be able to spend time with her mother before her death.*
- *A male patient who is not a US citizen and does not receive the Medicare benefit is currently receiving care from Moments. Moments Hospice took over his care and forgave all of his payments so he can receive the benefits of hospice care, as one should, regardless of their citizenship status. The patient experienced severe pain before hospice admission and, due to financial concerns, his family opted not to have him receive treatment. Moments Open Access allowed him to receive palliation of his pain, and his daughter received bereavement support, without the burden or worry of increased financial strain at the end of her father's life.*
- *A relatively young patient in his 60s was admitted. A few months before admission to hospice he had still been working out regularly at his local health club. Moments admitted him even though he could not make the decision to sign a DNR. The patient was still processing his rapid change in health status. He was hospitalized and wanted to be discharged to receive hospice care at home. Moments Open Access allowed him to be admitted to hospice with a full code status and go home. With the support, respect, and patience of the Moments IDG, he eventually made the decision to sign a DNR and passed away peacefully at home.*
- *Moments admitted a patient who was discharged from a different hospice because of a "discharge for cause" situation. Moments committed to always sending two staff members at a time to ensure staff safety while still providing the patient with hospice care for palliation of their disease process and end-of-life support for the patient and family. The county adult protective services contacted Moments, knowing the dynamics involved in the patient's life would benefit from the support, counseling, and palliation of the end-of-life condition.*

- *Moments admitted a middle-aged female patient and agreed to not charge her for any out-of-pocket costs due to her inability to pay. This allowed her to get the supportive services from hospice for the palliation of her condition. It also allowed her sons to receive support to navigate having a mother who was approaching the end of life at a young age.*

Advance Directives

Open Access at Moments means a patient does not need to have a DNR order to be admitted. However, Moments provides education and resources to patients and their families to make an informed decision about whether a DNR is right for them. If the patient or their family needs clarification or discussion about a DNR status at any time, Moments will reengage in the discussion and further educate as needed. Moments focuses on sustaining quality of life by respecting patient and family choices while proving the best possible care and dignity to its patients.

Providing meaningful care in a patient's final days is one of the most important parts of hospice care. This ethos is something that Moments takes very seriously. From Open Access to Five Wishes, to patient and staff education, Moments does many things to ensure it follows patients' end-of-life wishes to the best of its ability. Moments utilizes the Five Wishes for advance care planning. Five Wishes is a comprehensive, person-centered advance care planning program that offers healthcare providers a proven, easy-to-use approach to having effective and compassionate conversations. Five Wishes includes an advance directive form that is legal in 42 states, including Washington, and can be used in conjunction with a state form in the other states. (See Exhibit 21 for a sample and Moments' advance directive policy.) It is available in multiple languages, including Spanish. Moments staff receive training on using the Five Wishes document for important conversations. It is one more tool that helps ensure Moments' patients receive the resources to make informed decisions. It also helps Moments have conversations to fully understand what is important to each patient in their final days.

Moments' patient admission booklets are reviewed at hospice admission with the patient and/or responsible party/caregiver (see Exhibit 22). Booklets are available in Spanish, among other needed languages specific to the community served, to ensure Moments patients fully understand the benefits of hospice at the end of life. The patient admission booklet covers many areas, including advance directives. This allows for printed materials to be left with the patient and family to discuss their choices regarding advance directives.

It also assists the hospice team in helping educate patients and families about their advance directive choices.

Training on advance directives is part of orientation for all Moments staff. More in-depth trainings are available and provided as opportunities and needs are determined for the Moments care team. The Moments team is experienced in discussing these topics and helping patients and their families talk about and decide what is important to them in the final moments of their lives.

Open Access at Moments Hospice Agencies Today

At Moments Hospice, Open Access is not just something we talk about. It is something we practice every day in the decisions we make as we help people find the care that is right for them. It is something we believe in and we practice with heartfelt intentions.

- **Approximately 10% of patients do not sign DNR orders.**
- **Approximately 30% of patients are on medications or treatments that qualify for Open Access (i.e., atypical for hospices to provide).**
- **Charity Care and Medicaid in 2020 was 7%.**
- **Charitable Donations 2020: 5.7% of net income to over 100 unique organizations.**

Note: these figures are in markets with less demand for Open Access. Charitable donations do not include Moments Hospice Foundation.

In summary, for Moments Hospice of King, Open Access is about everyone's right to equitable hospice care and dying with dignity. A patient's religious beliefs, financial situation, or need for more expensive comfort care measures should not be a cause for denial of hospice services. Moments Hospice of King will openly accept patients receiving transfusions, palliative radiation, palliative chemotherapy, TPN, and other expensive treatments. If the treatments are palliative and the patients qualify for hospice, Moments Hospice of King will admit them when other hospices turn them away. This further affirms that Moments Hospice of King is committed to always meeting patients where they are at and respecting their decisions.

Nonpharmacological Pain and Symptom Management Techniques

Moments strives to help patients reach their symptom management goals. Many effective medications are available to aid in the palliation of pain and other symptoms. However, these medications may have side-effects that can affect the quality of life. Moments uses a variety of techniques to achieve the optimal level of palliation with as few side-effects as possible. Nonpharmacological interventions provide additional benefit to patients and their families and caregivers. Moments' staff can teach caregivers safe, simple techniques for comforting the patient or for their own self-care.

Moments provides training in nonpharmacological pain and symptom management techniques to all direct care staff. These approaches can help provide symptom management for the patient who wants to be as alert as possible when a family member from across the country or world makes a special visit. These techniques can also increase the comfort that medications already achieve; for example, a breathing technique or position change can make a difference in the comfort of a patient who is very short of breath.

Scripts for providing progressive relaxation, guided imagery, and meditation equip direct care staff to apply these techniques when appropriate. They can also teach the family and/or caregivers how to use the script when hospice staff are not present. These scripts can also be used for interventions during telehealth visits.

Other nonpharmacological interventions may include positioning, distraction, Emotional Freedom Technique (EFT, also known as tapping), hot and cold therapy, prayer, mindfulness, art, acupressure and reflexology, expression of spiritual or emotional pain/fear, Reiki (by a trained practitioner), and caring touches such as fluffing pillows and straightening blankets. Multiple options are provided through training, so staff have many tools to personalize the plan of care for each individual.

At the core of its nonpharmacological interventions, Moments Hospice of King will provide patients with enhanced programs offering music, massage, pet, and virtual reality therapies, as well as Namaste Care. Each program is described below and more information is provided in Exhibit 23.

Music Therapy Program

The objective of the Music Therapy Program is to enhance patients' lives by using music as a therapeutic intervention. Music can take patients to the past, lift their souls, and provide comfort in difficult times. It provides an escape, allowing patients to drift away to soothing sounds. Music may help a patient remember a special period in their youth as a part of life review. Music may allow patients to express themselves. Often, nonverbal patients start to sing during music therapy sessions. Music can promote feelings of well-being in mind, body, and spirit.

Music Therapy is available to both patients and their families and may be requested through any Moments staff member, including the nurse case manager, social worker, chaplain, hospice aide, or volunteer. Moments Hospice of King wants to ensure that every patient or family member who could benefit from this therapy receives it. Patients and families express how much they look forward to these sessions. The number of sessions is not limited and the plan of care is created with patients' and families' preferences in mind.

Research has shown that music therapy interventions significantly improve quality of life and can help the patient, their family, and other caregivers enjoy their remaining time. Music experiences can have positive effects on many areas of life.

Moments Hospice of King will provide music therapy to all patients who want it, because of the consistent benefits it provides. It reduces agitation and emotional distress, and can calm breathing. Music therapists use music as a therapeutic modality to improve overall wellness. Music therapy includes relaxation sessions, songwriting, singing, instrument playing, emotional expression, and listening to live songs that bring meaning to the patient and their family. Moments' music therapists tailor the sessions to the needs of each patient and family they work with. A sing-along may help a family feel connected by hearing their voices raised together in songs meaningful to them. Another patient may find meaning in composing a song that expresses how they feel about their impending death.

Music therapy is an integral part of the Moments Hospice of King plan of care. The music therapist documents assessments and sessions in the patient's clinical records and notes. Clinical records include observations, objectives, plans, and results. Their documentation remains part of the patient's medical record.

Indications for music therapy include:

- Anxiety
- Depression
- Restlessness
- Agitation
- Emotional Distress (patient and family)
- Spiritual Distress
- Pain
- Social Isolation
- Need for Relaxation
- Communication Needs of Patient
- Family Support
- To Improve Quality of Life
- Anticipatory Grief (patient and family)
- Interest in Life Legacy / Review Interventions
- Bereavement

Contraindications for music therapy include:

1. Patient is hard of hearing or deaf
2. Patient does not enjoy music
3. Patients who become agitated or overstimulated by music

Music therapy is provided in the patient's home, whether that is a private home, nursing home, or assisted living facility. Sessions can be private or can include family members and caregivers. Music therapy looks different for each patient and is integrated in the care plan for each patient and family. All of Moments' Hospice agency music therapists are board certified.

Massage Therapy Program

Massage therapy can be beneficial in the end-of-life journey. Moments Hospice of King will offer massage therapy to all interested patients. Licensed massage therapists provide an array of massage techniques tailored to each patient's needs. Massage therapy has been shown to decrease anxiety, calm breathing, and stabilize blood pressure. Massage relaxes tight and tense muscles. Other therapeutic benefits include pain relief, decreased nausea, improved circulation, improved mobility, and decreased stiffness. Mayo Clinic research shows that massage therapy is beneficial for fibromyalgia and digestive

problems. According to a study in the *Journal of Alternative and Complementary Medicine*, it can boost immunity. Massage has also been shown to stimulate the release of endorphins, which cause euphoria, feelings of ease and calm, and reduced feelings of depression.[17]

There are substantial emotional and mental benefits to massage therapy. It creates a soothing presence to combat loneliness. Humans need touch, and massage is a good way for hospice patients to receive it. Massage has also proven beneficial in relieving insomnia and other sleep problems. Feeling well rested can help combat other forms of discomfort. Using massage therapy relieves psychological distress and promotes emotional balance[18]

Moments Hospice of King will individualize massage therapy to meet each patient's unique needs.Therapists will document assessments and sessions in the patient's clinical records and notes. Clinical records include observations, objectives, plans, and results. This documentation remains part of the patient's medical record.

Pet Therapy Program

Animals have a healing aspect. They make people smile, share unconditional love, and can bring calm to a stressful moment. Animals have been shown to have both physical and psychosocial benefits for those who receive this heartwarming therapy. A March 2017 study published in the National Library of Medicine found that pet therapy had emotional and social benefits for the elderly and improved quality of life. The *American Journal of Critical Care* (*AJCC*) published a study in November 2007 that showed pet therapy benefited heart failure patients. The study concluded that the animals' presence improved cardiopulmonary pressure and anxiety. According to Paws for People, an organization that certifies dogs as therapy animals, the benefits of pet therapy include lowering blood pressure, providing a calming effect (due to the release of oxytocin), improving comfort level, decreasing pain, providing relaxation, and decreasing feelings of isolation.

[17] https://www.liebertpub.com/doi/abs/10.1089/acm.2009.0634 and https://www.amtamassage.org/find-massage-therapist/25-reasons-to-get-a-massage/.

[18] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/massage/art-20045743.

All pets used in Moments' programs are certified therapy pets. If a volunteer wishes to have a pet certified as a therapy pet, Moments assists with certification. Moments volunteers bring certified animals to visit hospice patients. These animals go through reference checks, have references, and come into the Moments office for a meet-and-greet to assess the animal's temperament. The therapy pet's veterinary records are provided to ensure the pet is in good health and up to date on all vaccinations. Moments' Pet Therapy volunteers share the gift of these sweet and loving pets with the patients, families, and caregivers. Visits from the pets are meaningful and can turn a patient's bad day around. The act of petting the animal has a calming effect. An unspoken connection evolves between the patient and the pet therapy animal. This interaction does not have the same stress and social pressure as interactions with human visitors. It allows for a free exchange of emotion between the pet and patient.

Virtual Reality Program

The objective of the Virtual Reality program is to enhance patients' lives by providing virtual experiences with a real-life feel of places and experiences they have had or dreamed of having. Virtual reality provides an escape for the patient. Through its partnership with Virtual Inc., Moments uses *WellnessVR*, a VR-based platform developed with partners in health care and designed to enhance well-being in seniors and people living with disabilities. Virtual Inc.'s programming includes an ever-expanding library of 360° content where patients can relax on a beach in New Zealand, travel to Stonehenge, or sit in on a ballroom dance class, all without leaving their bed. The immersive 360° format makes them feel like they are right there.

The virtual reality experience often induces deep astonishment, enjoyment, excitement, and nostalgia. Patients have deep levels of engagement and motivation when using virtual reality. The therapeutic effects are well established and in line with many of the other therapeutic programs Moments offers. Virtual reality experiences promote mental well-being, which creates a long-term benefit to patients.

After participating in the virtual reality program, patients are more likely to increase social interaction, providing benefits to common conditions of loneliness and depression. Sessions last an average of fifteen minutes. They can be longer if the patient wishes, but

breaks are advisable and encouraged so as not to cause any side-effects, such as dizziness or nausea, due to prolonged engagement.

Moments Hospice of King staff and volunteers will be trained on equipment use and program administration. Training includes proper setup of headsets, software program demonstrations, scientific theory, and proper hygiene in line with Moments' equipment disinfection guidelines. Each staff member or volunteer receives training before administering the program in the field. Before each session, patients are informed about the duration of the session, what virtual experience they are embarking on, and how they can shut off the program at any time.

Virtual reality is a part of the care plan and the hospice team documents VR sessions in the patient's clinical records and notes. Family members can assess the program's benefits and opine on whether they feel the program might benefit the patient.

Namaste Care Program

Namaste Care was originally developed by Joyce Simard for patients with dementia. Moments has found it beneficial for patients of all diagnoses. One of the most important elements of the program is providing care in an unhurried way with a loving touch, creating a calming environment for the patient. Moments staff are trained on the Namaste Program upon hire, so all staff understand these important principles. Some elements of the program are to tidy up the patient's room, dim the lighting, play some soft music, and diffuse some lavender essential oil. This sets the space to be a tranquil and calm place in which care can occur. The patient is made as comfortable as possible. This may occur by tucking blankets around them or using soft pillows to position them. All members of the care team watch for any signs of pain or discomfort.

Moments Hospice of King seeks to help its patients live, not just exist. Namaste Care includes elements meant to trigger memories in hospice patients. Staff are provided with Namaste bags which contain supplies for use with patients. Some of the items include Ponds cold cream, Old Spice aftershave, and lavender oil. The scents of these items trigger memories from days gone by. The bags also contain emery boards, bubbles, lollipops, and items specific to the season of the year.

Staff are encouraged to bring in items from outside for patients to touch and smell. Items like dry leaves, spring flowers, new snow, and freshly cut grass help trigger memories and allow patients to talk about the season and things they remember from the past. The smell of pine can transport the patient to a forest or a holiday gathering. The crunch of dry leaves may remind a patient of raking with their parents when they were young, or preparing piles of leaves only to have their children jump into them.

Lavender essential oil is used for its calming effect. It is diluted and diffused into the air or placed on blankets or towels to provide a more lasting effect. A study published in the *Mental Health Clinician Journal* in 2018 showed it is beneficial for people with anxiety. Other studies have reported benefits with chronic pain and insomnia. It helps to create a calming environment for the patient. Physical touch is one of the most important human needs. It decreases stress and triggers the body to release oxytocin and other hormones that increase feelings of euphoria. Gentle hand massage is provided with unscented lotion to provide a caring touch to the patients. This aspect of the Namaste Care program allows patients to feel cared for and connected to others.

Moments Hospice of King staff provide all aspects of Namaste Care with the individual in mind, taking each patient's uniqueness into consideration. Aspects of the program that are a good fit for some patients may not be beneficial for others. Moments staff individualize the plan of care and incorporates elements from the Namaste Care program that are desirable to the patient. Any and all touch is always provided with patient's permission.

Death With Dignity

Moments Hospice of King will comply and cooperate with Washington State's Death with Dignity Act, which allows terminally ill adults seeking to end their life to request lethal doses of medication from medical and osteopathic physicians. Moments Hospice of King's goal is to respect and accommodate terminally ill patients' wishes, while also respecting the religious and other beliefs of Moments Hospice of King's team members. Exhibit 24, Death With Dignity Policy, describes in detail Moments Hospice of King's policy and procedures related to the Death With Dignity Act.

Diagnosis-Specific Programs at Moments

Moments cares for many patients who come to hospice with diagnoses that are cardiac, pulmonary, and dementia related. As a result, Moments has developed programs to ensure these patients receive the care they deserve, in order to meet their unique needs. All programs include body system-specific training for the hospice care team. Each program brings unique features to help patients with a specific disease process who have been admitted to hospice under those diagnoses.

Moments Heart Program

Cardiac diagnoses are one of the leading causes of hospital readmissions, due to unmanaged symptoms and frequent exacerbations. The Moments Heart Program takes an aggressive approach to symptom management for patients with cardiac diagnoses, to provide lasting outcomes that promote patient quality of life while reducing hospital readmission rates and maintaining the hospice benefit for the patient.

All cardiac patients are educated on end-stage disease management and taught to track their weight and vital signs to monitor for exacerbations requiring rapid intervention. Interventions may include but are not limited to:

- Oral drug therapy: Management of oral cardiac medications, including antihypertensives and diuretics, with the attending physician and hospice medical director to optimally treat symptoms.
- IM/IV Diuretics: When oral medications alone are not enough to manage a patient in fluid overload effectively and efficiently, IV/IM medications are provided. Vials are kept in the home for acute exacerbations to control symptoms quickly as part of the standing orders of a patient's care.
- Inotropic drips: Although costly, medications like Dobutamine and Milrinone can significantly increase patients' quality of life by improving cardiac contractility and vasodilation, providing more energy and less malaise.
- Nonpharmacological Interventions:
    - Patients have access to supplies and treatments beyond medication management to treat symptoms. Moments provides fluid management

through Unna Boots, Tubigrips, venous or arterial stasis ulcer treatments, and positioning devices, to allow proper fluid shifts.

- Music therapy and massage therapy services are encouraged.
- Scripts for progressive relaxation and guided meditation are given to nurses to assist them in facilitating and teaching families how to use these helpful tools. The calming effect of these modalities can decrease the need for medications or help manage symptoms until oral medications reach their peak effect.
- The Power of Feeling Heard is incorporated into the Moments Heart Program. The heart is associated with feelings of love, tenderness, and care. Having a damaged heart can bring up many different emotions for a patient. Feeling fully heard when the patient begins to express some of these emotions can encourage them to continue to verbalize these feelings. By providing a safe space for the patient to do this, the Moments care team ensures the beneficial effects of feeling heard for the patient.

Moments Heart Program also manages left ventricular assist devices (LVADs). Life expectancy for patients with LVADs is approximately four to six years. Many of these patients die in hospitals, as many hospices are ill equipped to provide care in the home. Moments partners with local cardiac clinics to ensure a peaceful end-of-life experience for the LVAD patient in the setting of their choice. Standing orders and delivering LVAD supplies set patients' and families' minds at ease, knowing they have everything in their homes to manage changes in condition quickly. These devices are used as a destination therapy, allowing patients to choose where they are when their hearts beat for the last time.

More information on the Moments Heart Program can be found in Exhibit 25.

Moments Breathe Program

Much like cardiac diagnoses, pulmonary conditions cause frequent hospitalizations due to unmanaged dyspnea and anxiety. Traditional hospice care provides oxygen concentrators that can administer up to 20L of oxygen. Patients with respiratory failure or pulmonary fibrosis may need humidified, higher-liter flows to sustain comfort. With the Open Access philosophy of care, Moments provides Airvo units that can provide up to 60L of continuous,

humidified oxygen via nasal cannula or mask. This is similar to the hospital-provided intervention called Optiflow.

Teaching families about medications, symptom management techniques, and when to call hospice is integral to the program. Guided meditation and progressive relaxation scripts are included to help manage periods of anxiety and discomfort, to allow for fewer medications or time for medications to take effect. Breathing exercises are taught to help the patient during periods of dyspnea, so they can feel a sense of control.

The Power of Feeling Heard comes into play as well. Patients with diseases of the lungs lose much control over their lives. Their mobility is limited and they must rely on others more than they once did. Having a safe space to express these frustrations and the impact on their self-esteem is an important part of the hospice journey. Knowing they have a safe space to share their deepest feelings will allow them to continue to express what they feel. They may have feelings of guilt if something they did, such as smoking, caused their disease, thus creating hardship for their families.

Moments is instituting ventilator management and assistance in planning for ventilator removal into the Breathe Program. Moments Hospice of King staff will guide the family and patient, if possible, through each step of the decision-making process. To ensure a peaceful experience, the Breathe Program follows an interdisciplinary approach that includes:

- Hospice medical director: Provide medication management to mitigate symptoms in line with the patient’s wishes.
- Nursing: Provides medication management at the bedside before, during, and after ventilator removal.
- Music Therapy: Provides music of patient’s choice before, during, and after ventilator removal.
- Massage Therapy: Provides gentle massage to ease anxiety.
- Social Work: Provides supportive presence and intervention to family and patient.
- Chaplain: Provides prayer and supportive presence to family and patient

More information on the Moments Breathe Program can be found in Exhibit 26.

Moments Respect Program

The Respect Program is Moments' dementia program. It emphasizes that respect is especially important in patients with Alzheimer's or another type of dementia. A person with dementia has already lost so much that respect cannot be compromised. This program integrates creative initiatives to help these unique patients.

An interdisciplinary approach by the kind and caring Moments team is just the beginning of this innovated program. Medication management gives these patients as much comfort and peace as possible, but nonpharmacological methods are used as well. These methods help maintain the patient's dignity, show respect for who they are and the life they have lived, and possibly reduce the need for medications to manage behaviors. These methods include but are not limited to, robotic pets; the Namaste Care program; weighted blankets; fidget blankets; adaptive cups, plates, and silverware; lavender-scented teddy bears; busy boxes; and The Power of Feeling Heard program.

Alzheimer's Pets (Robotic)

- Robotic pets help the whole person physically, psychologically, and socially.
- Benefits include companionship, reducing anxiety and agitation, an excuse to get exercise, and improving interactions and socialization.
- Robotic pets' presence can help reduce effects of dementia such as anxiety, agitation, irritability, depression, and loneliness.
- Robotic pets help dementia patients be more interactive, especially when they cannot do so in other social settings. This gives them a sense of purpose and can bring them back to a time in their lives when they felt useful. It gives them a break from the world in which someone is always caring for them.
- Robotic pets help increase serotonin, a feel-good hormone.

Namaste Care

- The two basic principles of the Namaste Care are creating a calm environment and providing all activities and interactions with an unhurried, loving touch approach.
- This can be done in group sessions or individual sessions.

- Examples of products in a Namaste Care kit include Ponds cold cream, Old Spice aftershave, lavender spray, unscented lotion, emery boards, bubbles, and lollipops.
- Namaste Care sets the atmosphere, by dimming the lights, playing soft, calming music, etc.
- Namaste Care uses gentle touch, with hand massage and facial massages.

Weighted Blankets:

- Dementia causes confusion, agitation, stress, mood swings, and insomnia. Using a weighted blanket can give a dementia patient the feeling of being warmly embraced. This gives them a sense of security, calmness, and being grounded.

Fidget Blankets:

- Help decrease agitation and anxiety
- Give patients a sense of purpose
- Help keep patients' hands busy

Adaptive Cups, Plates, and Silverware:

- Help patients eat independently for longer periods of time

Lavender-Scented Teddy Bears:

- Have a calming effect
- Help with the need to care for something
- Provide tactile stimulation
- Provide a sense of security and distraction during personal care

Busy Boxes:

- Meaningful dementia activities bring back old memories
- Individualized to each patient, based on family history obtained
- Picture books (could be of places they traveled or pertain to their field of work or hobbies they enjoyed)

- Examples of other things that may be in the box: PVC pipe, Nuts/bolts/washers, Unfolded laundry, Office supplies

The Power of Feeling Heard Program:

- Gives patients time to express what they want to say
- Gives the ability to share stories from the past
- Allows families express what they need to be heard while they witness changes in their loved ones
- Provides a calming effect

More information on the Moments Respect Program can be found in Exhibit 27.

Moments' Participation in We Honor Veterans

Moments Hospice agencies have participated in the We Honor Veterans Program since 2017, which is one of the cornerstones of its veteran care program. All Moments' hospice locations participate in We Honor Veterans, with the goal of attaining level 4 status at each site. Moments takes great pride in honoring those who have fought for the nation's freedoms, and in ensuring that all Moments staff provide care at or above the expectations of the

We Honor Veterans program. Moments staff engage, honor, and recognize veterans in these ways:

- Give veterans an opportunity to tell and share their stories
- Respect veterans' service, their feelings, and any suggestions they might offer
- Thank veterans for their service to our country
- When approaching veterans for their participation, consider bringing another veteran with you
- Show appreciation for veterans' families
- Always be sincere, caring, compassionate, and ready and able to listen to what a veteran or their family member has to share about the situation they are dealing with
- Be supportive and non-judgmental, and always validate their feelings and concerns
- Be honest, sincere, caring, and respectful
- Accept, without judgment, the veteran as they are

- It might take longer for some veterans to trust you; be patient and listen
- Expect the veteran's sharing to occur over time

Over the past several years, Moments has participated in We Honor Veterans through these programs:

- Pinning ceremonies
- Educational events in the community and at healthcare facilities
- Partnering with local Veterans of Foreign Wars (VFW) and American Legion posts to provide vet-to-vet support
- Sponsoring coffee events for veterans to discuss their time in the service and some of the hardships they are going through
- Providing veteran patients with personalized flag cases custom made by other veterans
- Donating veteran walls in healthcare facilities in the communities Moments serves
- A We Honor Veterans mask campaign that provided a mask to every veteran patient and veterans in the community through partnership with the VFW, American Legion, nursing homes, and assisted living facilities

Moments' We Honor Veterans Participation: 2020 Highlights Pinning Ceremonies

In 2020, Moments provided pinning ceremonies for over 250 veterans. Each veteran received a certificate, a flag pin, and a branch service pin. These events ranged from individual bedside pinnings, which are offered to each veteran patient upon admission, to group pinning events that followed CDC guidelines.

Partnership with Fort Snelling Memorial Rifle Squad

In the spring, Moments learned that the veteran volunteers of the Fort Snelling Memorial Rifle Squad in Minnesota were ordered to stop operations due to the COVID-19 pandemic. Since 1979, the volunteer rifle squad at Fort Snelling National Cemetery has provided military funeral honors for those who served, and they did not miss a funeral for over 41 years, until the pandemic. After hearing the story on the news, Moments' hospice chaplain and retired Air Force officer Steve Solmonson stated: "It absolutely

broke my heart when I heard they will not be able to honor our veterans and their surviving family members. I felt an overwhelming desire to do something to say thank you and to show our support for all they have done."

Chaplain Solmonson contacted rifle squad commander Mike Pluta with the idea of providing pizzas to thank each of the squad's volunteers. Commander Pluta expressed his appreciation but preferred to pay the thanks forward to those on the front lines helping others during the pandemic. The Moments Hospice Foundation partnered with a local restaurant to provide pizzas and discount coupons to the staff at Meadow Ridge Senior Living and at Interfaith Outreach & Community Partners (IOCP). The effort provided support to 50 staff members at IOCP and 50 of the people it serves, to help during this difficult time.

Veteran of the Day Program

During October and November, Moments highlighted elderly veterans across Minnesota, Wisconsin, and Iowa. Moments teamed up with local nursing homes and assisted living facilities in each area it serves to highlight veterans living in those communities. This was a month-long campaign that concluded on Veterans Day. Each day, Moments spotlighted a "Veteran of the Day" on social media with their story and pictures. Below is an example of a daily veteran spotlight.

Lasting Moments Program

Moments' Lasting Moments Program has a dual purpose. First, hospice social workers, chaplains, music therapists, and volunteers work with patients on projects to help them with life review, closure, or unresolved issues. These projects are individualized with the patient to meet their specific needs. The program's second purpose is to leave a legacy item for the patient's family, by creating something that can be passed down in remembrance of a special loved one. Life review projects help hospice patients work through Erikson's final stage of development, integrity vs. despair. In this stage, patients are trying to figure out whether their lives had meaning. Processing past events, reflecting of their lives, and looking at past regrets and successes allow them to work through this

stage. It is an opportunity for them to gain wisdom and share it with their loved ones if they so desire.

Legacy items are important to hospice patients because they help patients feel they can leave something special for their loved ones. Families appreciate these gifts, which allow them to hold on to a little piece of their loved one once they are gone. Some of the legacy projects from the Lasting Moments Program are listed below, but the list is not all inclusive. Other ideas may be to journal, scroll, make a collage, paint, or create a box of special items. The Lasting Moments Project should be as unique as the individual creating it. Families can also be included in creating the projects.

- Hand Molds: A plaster cast is taken of the patient holding hands with family members. The kit mix is poured into the cast and, when dried, a beautiful memory is created. These molds show intricate details of the hands, including any jewelry, scars, or lines. Patients may choose to have molds made with their spouse, their children, or any other loved one.

- Greeting Cards: The patient, with help of a team member, fills out greeting cards for special events that come up post death. These may include holidays or loved ones' birthdays, anniversaries, graduations, weddings, births, etc.

- Letter Writing: The hospice team assists the patient in writing letters to loved ones or friends. These letters can be about making amends, reaffirming/validating relationships, or offering closure.

- Vlogs/Videos: Patients can record messages to their loved ones, tell their life stories, or discuss specific events in their lives. For example, a patient who was going to die before his daughter's wedding recorded a speech to be played at the wedding to surprise her. Another gentleman was a Baptist preacher and really missed preaching. Moments staff set up a YouTube channel for him and recorded him giving a sermon each week. The sermons were uploaded to his channel and the hospice care team worked with him to respond to comments weekly. He even recorded a final sermon in which he was able to say good-bye to his followers.

- Memory Bears: A hospice volunteer creates a stuffed bear out of the patient's favorite clothing to give to the family for comfort.

- Fingerprint jewelry: Patients' fingerprints are taken and placed in the shape of a heart on a pendant and sealed for preservation.

- Song Writing: Working with music therapists, patients can write songs or poetry and put them to music that the music therapist writes and records.

- Heartbeat Recordings: The music therapist records the patient's heartbeat and puts it to music. This may be an original song written by the patient or a song the patient chooses for a specific loved one.

Birthdays Program

Showing someone they are special and not just another patient is important to Moments Hospice of King. One way of doing this is honoring birthdays. The Moments team celebrates every patient's birthday. This has been especially important during the pandemic, since families have not been able to celebrate with their loved ones. The hospice care team brings in the patient's favorite dessert, a balloon, and a card signed by all hospice team members. The family is invited to attend in person, if possible.

If COVID restrictions or distance prevent in-person attendance, the hospice team sets up a Zoom meeting for family to participate. This form of honoring the patient as an individual can be deeply moving for the patient. Helping hospice patients celebrate another trip around the sun not only shows them they matter, but also helps them live and enjoy the time they have left. It shows them they are still alive and it is important to celebrate each special moment as it arrives.

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

This criterion is not applicable, because Moments Hospice of King, LLC does not own, operate, or manage an existing hospice.

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

This criterion is not applicable, because the Applicant does not own, operate, or manage an existing hospice.

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

Patients Served

Moments Hospice of King will continually monitor the service area to identify populations with unmet needs and barriers to timely access of hospice services. As other Moments hospice agencies currently do in other markets, Moments Hospice of King will fill gaps in service, thereby increasing hospice utilization, without negatively impacting existing King County hospice providers.

Because Moments Hospice of King is different from existing hospice providers in terms of health system versus private ownership, experience in other markets, niche areas, and program and services, Moments is less likely to compete with existing hospice providers for the same King County patients, compared to lookalike hospices.

Pediatric Hospice Patients

Moments hospice of King will serve King County terminally ill residents of all ages. However, Moments Hospice of King does not have a pediatric hospice program. Because King County's pediatric hospice population is small, and already served by existing King County hospice providers, Moments will provide resources for families of pediatric hospice-eligible patients and refer to area hospice providers with a pediatric-focus. This is one of many ways Moments will complement, rather than compete with, existing King County hospice providers.

Adults Under Age 65

Moments Hospice of King will serve adult patients under 65 years old. In King County, the Hospice use rate for patients under age 65 is only 25.67%, per the *2021-2022 Hospice Numeric Need Methodology* posted on November 10, 2021 by the Department of Health. Some of the ways Moments Hospice of King will remove barriers to hospice care and increase utilization for this age group include:

- **Open Access program.** For example, Moments Hospice of King's Open Access options should appeal to younger cancer patients who may not wish to stop palliative chemotherapy. The Open Access program will also appeal to King County's racial and ethnic minorities who have cultural barriers to accessing hospice services, regardless of diagnosis.
- **Charity care.** Without access to Medicare benefits, terminally ill patients under 65 may not have health insurance, or may lose their employer health benefits due to being unable to work as their illness progresses. Moments Hospice of King has committed to providing charity care of *at least* 5 percent of its total net patient service revenue annually.
- **Credentialing with health plans.** By credentialing with multiple area health plans, Moments will increase access for persons under age 65 who are not eligible for Medicare.

Moments Hospice of King will reach terminally ill patients under age 65 with non-cancer diagnoses, such as HIV/AIDS. Homelessness is also prevalent among persons with HIV/AIDS.[19]

Patients Over Age 65

Moments Hospice of King will serve patients over 65 years old. Long term care settings have been a niche area for Moments Hospice agencies, due to the founders' nursing home and ALF backgrounds. Moments hospice agencies currently partner with over 300 long term care facilities to provide hospice care for residents. Patients in nursing homes make up 39.1 percent of Moments Hospice in Minnesota's census. ALF patients make up 44.9

[19] HIV/AIDS annual reports - King County

percent of Moments Hospice's census in Minnesota. Combined, nursing homes and ALFs represent 84 percent of Moments Hospice's census in Minnesota. The successful strategies behind these results will be replicated by Moments Hospice of King, to improve access to hospice services for residents of long term care facilities.

MOMENTS HOSPICE - 241602

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012							
2013							
2014							
2015							
2016							
2017	0.4%	93.5%	4.5%	0.0%	0.0%	1.5%	100%
2018	5.2%	71.1%	20.8%	0.0%	0.0%	2.9%	100%
2019	5.5%	53.6%	40.7%	0.0%	0.0%	0.3%	100%
2020	14.2%	42.3%	42.8%	0.0%	0.0%	0.6%	100%
2021	15.6%	44.9%	39.1%	0.0%	0.0%	0.4%	100%

Source: Healthpivots. Hospice Market Share by Setting. Medicare FFS data.

Additionally, Moments Hospice of King offers disease-specific programs related to the diagnoses which are common among older patients. In King County, 2020 Medicare Cost Report data shows that among Mediare FFS hospice patients (who are typically over age 65) served in King County,

- 27 percent had a Cancer diagnosis
- 15 percent had Heart Disease
- 12 percent had Alzheimers
- 9 percent suffered Stroke
- 4 percent had COPD

Moments Hospice of King's disease-specific programs include *Moments Breathe* for patients with respiratory diseases, *Moments Respect* for Alzheimers patients, and *Moments Heart* for patients with cardiovascular illnesses. These programs reflect Moments Hospice of King's understanding of the specific needs of these populations, and commitment to providing high-quality, individualized hospice services.

Homeless Persons

The 2020 Washington State Department of Commerce Annual Point In Time Count of the homeless identified 11,000 homeless persons in King County. See Exhibit 28. By its nature, this form of data collection can understate the actual homeless population, due to the inability of surveyors to locate the homeless, and the reluctance of many homeless persons to participate in the count.

Among the homeless counted, 47 percent were “unsheltered”—meaning they lived somewhere not meant for human habitation, such as on sidewalks, in parks, in cars, etc. While the sheltered homeless face financial barriers to hospice care, the unsheltered homeless face additional barriers to receiving hospice care, such as lacking a safe and appropriate place to receive visits.

Moments Hospice agencies have experience serving other counties with significant homeless populations, such as Miami/Dade County. In addition to collaborating with local King County homeless shelters, Moments Hospice of King County, through the Moments Hospice Foundation, will pay for accommodations so that otherwise unsheltered homeless hospice patients will have a safe, sheltered place for interdisciplinary hospice visits to take place. Moments Hospice of King is committed to honoring the dignity of homeless patients. Additionally, as described in the Voluntary Conditions section of this application, Moments Hospice of King will contribute to community organizations helping homeless King County residents.

Racial / Ethnic Minorities

As identified and described in detail in the Moments Hospice of King’s Community Needs Assessment, racial and ethnic minorities represent a significant portion of King County’s population, and are historically and currently underserved. Moments Hospice of King is dedicated to serving terminally ill King County residents who belong to racial / ethnic minorities by identifying their unique needs and barriers to care, and developing inclusionary strategies to increase access and hospice utilization. Furthermore, Moments Hospice of King, in conjunction with the IACC described in the Voluntary Conditions section of this application, will develop strategies to dismantle systemic racism in all aspects of the new hospice agency’s operations, including provider and staff recruitment,

staff education and training, and strategic partnerships with community stakeholders and organizations.

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).**

Please reference Letter of Intent, Exhibit 29.

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.**

IHS.FS._____Not applicable_____

Medicare #:_____Not applicable_____

Medicaid #:_____Not applicable_____

Moments Hospice of King will be licensed and certified by Medicare and Medicaid. As a new legal entity, Moments Hospice of King has not yet been assigned HIS.FS, Medicare, or Medicaid numbers.

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.**

COUNTY	Identify Year	Identify Year	Identify Year
Total number of admissions			
Total number of patient days			
Average daily census			

Moments Hospice of King, LLC is a new entity, therefore this question is not applicable.

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.**

KING COUNTY	2023	2024	2025
Total number of admissions	140	228	255
Total number of patient days	8,697	14,163	15,841
Projected average daily census	24	39	43

Assumptions were developed using the methodologies described below:

Admissions

The projected volumes are based on several analyses:

- **Unmet needs in King County.** The *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted November 10, 2021[20] published a need for 226 incremental new admissions in 2022, and 497 incremental new admissions in 2023. Moments Hospice of King projects that by using Moments agencies' proven strategies to reach difficult to reach, historically underserved terminally ill residents, Moments will admit 140 hospice patients during its first full year of operation in 2023, 228 of the King County patients with unmet needs in 2024, and admit 255 King County hospice patients in year 3.

- **Moments Hospice's substantial start-up experience in multiple, heterogenous markets.** Since 2017, Moments has started 12 de novo hospices (with 2 more currently awaiting licensure) in both urban and rural areas in heterogenous markets, including Minnesota, Wisconsin, Iowa, Illinois, South Dakota, and Florida. Moments has substantial experience entering competitive markets without CON requirements, in which Moments has been able to quickly ramp up hospice admissions.

Additionally, Moments recently started a new hospice in Miami-Dade and Monroe counties in Florida—a competitive market with a CON requirement. Moments agencies'

[20] 2021 Hospice Final Methodology (wa.gov)

demonstrated ability to generate hospice admissions in both small, rural communities, as well as large, diverse urban areas can be replicated in King County, as evidenced by Moments Hospice of King's affiliates' success in multiple other heterogenous markets throughout the country. We believe Moments' success in these communities is the result of Moments' willingness to devote resources to outreach. Moments has been able to quickly assimilate information from community stakeholders and data sources in order to formulate strategies to reach difficult to reach patients.

Moments has a solid track record for finding new hospice admissions in communities that share similarities with King County. Consequently, we believe the projected admissions are well-supported by a demonstrated ability which has now been successfully replicated in multiple areas across the U.S.

- **Internal data on Hospice Care Consultants as a driver of hospice admissions.** Hospice Care Consultants (HCCs) serve a key role in Moments Hospice of King's patient access strategy. Moments has utilized historical, internal data, correlating HCCs with hospice admissions. Provider and community education on the benefits and availability of hospice services, as well as the ability to facilitate timely admission of hospice referrals, are key drivers of hospice admissions. Moments utilized internal data on its affiliates' Hospice Care Consultants' historical ability to generate hospice admissions, as another means of projecting King County admissions, with adjustments for initial training and onboarding.

  Moments has considered the impact of COVID-19 in other markets, and it is reflected in the assumptions for the start-up months, and particularly the conservative nursing home census forecasted.

- **Attainable Market Share.** While Moments Hospice of King anticipates that admissions will come from currently unserved terminally ill patients, and not from the market share of other King County hospice providers, market share can nonetheless be used as a "reasonableness check" for projected admissions. Thus, Moments of King has considered what percentage of overall market share has been attainable in other competitive counties. Thus, we also reviewed the

percentage of overall hospice market share in King County attained by new entrants historically, as another reasonableness test. Additionally, we relied upon data related to Moments' own start up hospice market share attainment in the first years of operation in other areas.

Of note, Moments Hospice of King, and all Moments affiliates, are not hospital/health-system owned hospice entities. Therefore, Moments Hospice of King's and Moments Hospice affiliates' operations are not subsidized by a larger health system. Similarly, funding for Moments hospices does not come from donations. Moments' affiliates' admissions and financial strength in other new markets are solely due to the success of Moments' strategies for reaching underserved patients in new markets, Moments' provision a valuable, patient-centered service that patients and families want, and Moments' ability to admit patients timely and deliver services in an efficient, cost-effective manner.

	Year 1 (2023)	Year 2 (2024)	Year 3 (2025)
Market Share Assumption	1.6%	2.6%	2.9%
King County Estimated Market	8,328	8,495	8,664
Estimated Patients Served	136	221	247
Admissions: Patients Served	1.033	1.033	1.033
Estimated Admissions	140	228	255
Avg. Admissions Per Month	12	19	21

The table above shows the underlying assumptions for admissions. The market share assumptions were determined based on affiliated Moments Hospice's performance in other highly competitive U.S. markets. The King County market size in year one is based on adding the projected need in terms of admissions for the two age cohorts in the Department of Health's *2021-2022 Hospice Numeric Need Methodology*. Year 2 and 3 market size estimates assume a 2 percent average annual growth rate, based on the most recent U.S. Census data for the King County population.

Because the data utilized included patients served, rather than admissions, and since some patients will have more than one hospice admission, we multiplied estimated patients served by "Admissions:Patients Served"—the historical ratio of admissions to patients served at other Moments hospice affiliates. This resulted in admission projections of 140, 228, and 255 for the first full 3 years of operation, respectively.

In summary, Moments believes the projected admissions volumes for Moments Hospice of King are reasonable, attainable estimates.

Average Length of Stay

We utilized the Washington State average length of stay of 62.12 days published in the *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted in November 10, 2021[21]. As is typically the case with de novo hospices, we expect a shorter length of stay initially, in the first months, as admissions ramp up. However, we expect the average length of stay to quickly reach the Washington state average. CMS data in other markets demonstrates Moments' ability to quickly attain higher lengths of stay. This is due to Moments' ability to identify and admit terminally ill patients earlier in their illness, as well as Moments' demonstrated ability to reach patients with non-cancer diagnoses which typically are associated with longer lengths of stay, and Moments agencies' historical success in ALF and Nursing Home facilities.

Patient Days

Patient days were calculated by multiplying Moments Hospice of King's projected admissions by the King County ALOS published in the November 10, 2021 *Department of Health 2021-2022 Hospice Numeric Need Methodology*, with the exception of a 4 month ramp up period, when initial length of stay was assumed to be 50 days for patients admitted during the first month of operation, ramping up monthly to reach the King County ALOS by the end of the fourth month of operation.

Average Daily Census (ADC)

ADC is the result of a formula summing the total patient days within the specified time frame, divided by the sum of calendar days within the same time frame.

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

King County's uniquely diverse population faces numerous barriers to patient access. Some of these barriers include:

[21] 2021 Hospice Final Methodology (wa.gov)

- **Community lack of education** and misperceptions regarding hospice services and eligibility.
- **Provider lack of education** regarding hospice services and eligibility, as well as individual provider comfort level with initiating difficult discussions with patients and families.
- **Lack of hospice agency responsiveness**. Lack of timely admission to hospice / timely initiation of hospice services deprives King County residents of the full benefits of hospice, including, but not limited to, symptom stabilization, averted unnecessary hospitalizations, irreplaceable time with loved ones, planning, and legacy activities.

- **Obstacles to discharge planning.** Area hospitals struggle to discharge patients to hospice care due to:
    - Staffing challenges such as staffing shortages and staff turnover
    - Lack of / inconsistent provider and staff education about hospice services and hospice eligibility
    - Lack of hospice agency responsiveness
    - Patient lack of health insurance
    - Homelessness

- **Cultural factors.** Family decision-making models (vs. individual autonomy) in Hispanic and Asian cultures and "filial piety" and other cultural concepts can create barriers to hospice admission, for example when family members feel a duty to protect the terminally ill from a terminal prognosis. Additionally, patients often have spiritual beliefs that conflict with hospice admission procedures, such as signing a DNR order.

  As shown elsewhere in this application, Black King County residents have death service ratios lower than those of their white counterparts. Some of the most commonly cited barriers to hospice use among Black individuals are preferences for life-sustaining therapies, lack of knowledge about hospice, general mistrust of the health care system, and spiritual beliefs.[22] A 2016 study found that while 75 percent of Black patients enrolled in a study on end-of-life care for chronic

[22] Tim Pittman, "Hospice Use Lower Among African Americans," DukeHealth Geriatrics, January 15, 2018, https://physicians.dukehealth.org/articles/hospice-use-lower-among-african-americans

kidney disease had heard of hospice, only 17 percent had good knowledge of what hospice care provided. Over 60 percent of their white counterparts had good knowledge of hospice care. Similarly, a significantly higher percent of Black patients than white patients in the study reported never discussing end-of-life preferences.[23] Black Americans are also more likely than their white counterparts to choose aggressive medical care at the end of life.[24] Other studies have shown that providers' conscious or unconscious stereotyping of patients has led to disparities in healthcare.[25]

The types of services a hospice offers also affect Black patients' access to hospice care. A 2016 study on hospice admission practices found hospices that do not provide higher-cost palliative care therapies or allow for hospice care that does not require a primary caregiver in the home serve a disproportionately low number of Black patients. The study states:

"Among potential barriers to hospice use for African Americans are greater preferences for the use of expensive, life-prolonging therapies at the end of life, less traditional social support systems, such as the more frequent absence of a single, full-time primary caregiver in the home and a caregiver structure that may include multiple caregivers in different locations (24–33). As such, hospices that restrict enrollment of patients who desire high-cost palliative therapies or without a primary caregiver in the home may serve disproportionately fewer African Americans than Whites"[26]

The 2013 study that found Black Americans were more likely to choose aggressive medical care at the end of life also found that these patients changed

[23] Nwamaka Eneanya et al., "Racial Disparities in End-of-Life Communication and Preferences among Chronic Kidney Disease Patients," *American Journal of Nephrology* 44, no. 1 (2016): 46–53, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4961563/.

[24] Kathleen Benton, James Stephens, Robert Vogel, "The Influence of Race on End-of-Life Choices Following a Counselor-Based Palliative Consultation," *American Journal of Hospice and Palliative Care* 32, no. 1 (Feb. 2015): 84–89, DOI 10.1177/1049909113506782, Epub October 1, 2013.

[25] Ramona Rhodes, "Racial Disparities in Hospice: Moving from Analysis to Intervention," *AMA Journal of Ethics* (Sept.2006), https://journalofethics.ama-assn.org/article/racial-disparities-hospice-moving-analysis-intervention/2006-09.

[26] Kimberly Johnson, Richard Payne, Maragatha Kuchibhatia, and James Tulsky, "Are Hospice Admissions Practices Associated with Hospice Enrollment for Older African Americans and Whites?" *Journal of Pain Symptom Management* 51, no. 4 (2016): 697–705, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833599/pdf/nihms751454.pdf.

their choices after consultation with a palliative care team. Although more Black than White patients still chose to remain full code (i.e., did not sign who chose to receive only comfort care increased.[27] The National Hospice and Palliative Care Organization has recognized the disparity in hospice use among Black patients and has released a Black and African-American Outreach Guide to help hospices "develop business strategies, contribute to health equity, and build health outreach programs that represent organizational excellence, quality care delivery and social responsibility."[28]

Studies have also revealed cultural barriers to hospice care among Hispanics. A study conducted by a National Cancer Institute Community Network Program on Latinos from Central and South America found that family members are more secretive about death, prefer not to receive detailed information about the dying process, and know less about hospice than Anglo caregivers. Some of this can be explained by the general Latino preference for indirect communication and, much like in the Jewish community, a desire to shield the patient from information considered harmful. This reluctance makes the decision to sign a DNR order a difficult one. Moments Hospice of King understands it may be helpful for a hospice provider to be less direct when discussing end-of-life matters with Latino families.

- **Financial barriers to care.** The uninsured and underinsured suffer from lack of access to hospice services. In King County, terminally ill residents under the age of 65, and immigrants who do not have Medicare coverage, may be particularly vulnerable.

- **Systemic racism.** Systemic racism has deprived many residents of King County of healthcare system access, and has created other barriers to care, such as mistrust, housing insecurity, financial barriers, and a lack of minority providers and hospice staff.

[27] Kathleen Benton, James Stephens, Robert Vogel, "The Influence of Race on End-of-Life Choices Following a Counselor-Based Palliative Consultation," *American Journal of Hospice and Palliative Care* 32, no. 1 (Feb. 2015): 84–89, DOI 10.1177/1049909113506782, Epub October 1, 2013.

[28] National Hospice and Palliative Care Organization. 2021. African-American Outreach Guide. Available at: https://www.nhpco.org/wp-content/uploads/African_American_Outreach_Guide.pdf.

- **Lack of trust in the healthcare system.** LGBTQ+ persons and racial/ethnic minorities in particular may harbor a general lack of trust in the medical system and healthcare providers.[29],[30]

- **Pandemic effect on health system utilization.** The COVID-19 pandemic has created a new set of barriers to hospice access. The pandemic has affected patient visits to providers who would potentially refer patients to hospice, nursing homes lock downs have affected access for hospice providers as well as family decision-makers**,** and many people continue to isolate themselves due to fear.

- **Communication barriers.** King County' foreign-born population makes up nearly a quarter of its population, according to the U.S. Census Bureau. 28 percent of foreign-born residents live in "linguistically isolated households," and 43 percent "speak English less than 'very well'"[31] Language barriers create barriers to hospice care on many levels, including understanding the nature and availability of hospice services, the admissions process, and comfort levels with allowing hospice care staff into the home.

Moments Hospice of King has formulated strategies, based on an in-depth analysis of the unique needs of King County, to address these barriers to care. These strategies are summarized in response to question #6 in this section, below. Moments affiliates and Moments leadership have a proven track record reaching underserved patients in diverse communities with unique needs.

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.**

All hospice providers are not the same. Moments Hospice of King believes that the underserved residents of King County would be best served by multiple providers with

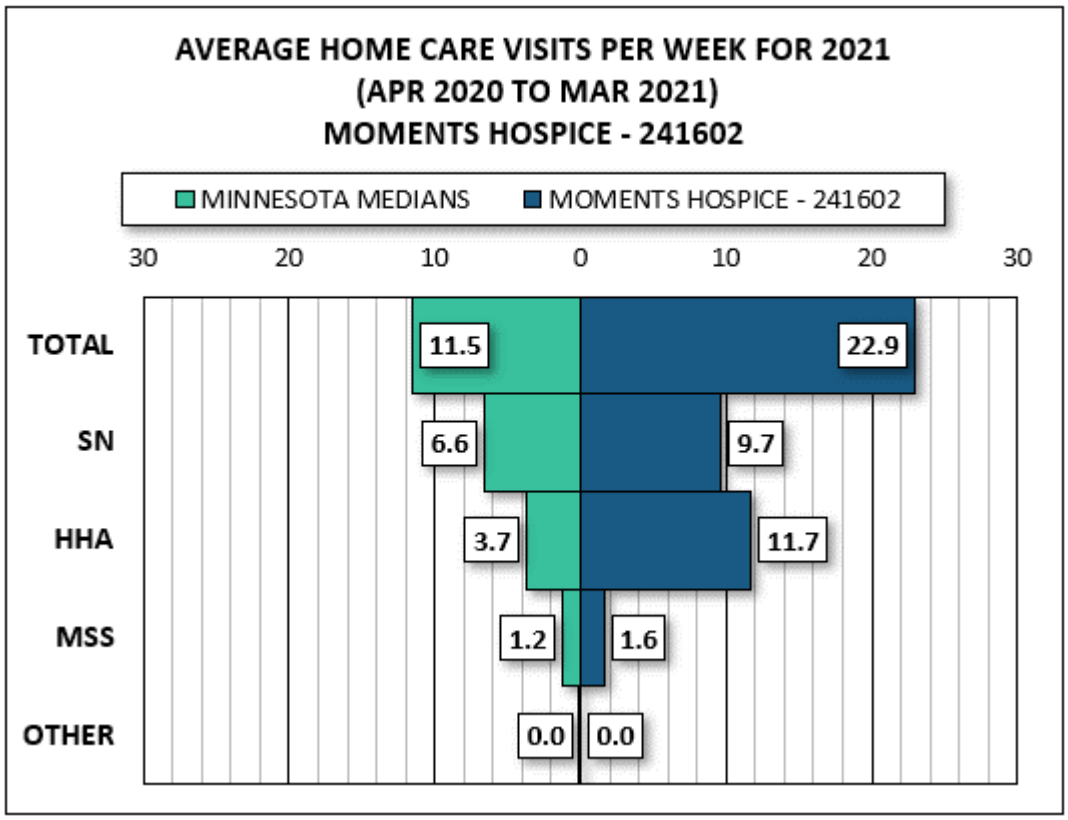
[29] Understanding the Influence of Stigma and Medical Mistrust on Engagement in Routine Healthcare Among Black Women Who Have Sex with Women (nih.gov)
[30] Disparities in Palliative and Hospice Care and Completion of Advance Care Planning and Directives Among Non-Hispanic Blacks: A Scoping Review of Recent Literature - Mohsen Bazargan, Shahrzad Bazargan-Hejazi, 2021 (sagepub.com)
[31] 2016_OIRA_DataSnapshot_r03_v01-1 (seattle.gov)

differing approaches. Having multiple, “lookalike” hospices, with the same philosophies, programs and services, and strategies will further exacerbate gaps in service to currently and historically underserved populations, while depriving residents of a choice of the provider who fits *their* unique needs.

Moments Hospice agencies demonstrate a higher-than-average number of weekly visits to patients, and Moments offers numerous benefits to patients and families, above and beyond the standard hospice benefit. The table and chart below show how Moments Hospice agencies exceed state averages in the markets they serve, due to Moments hospice agencies’ robust staffing and commitment to patient care:

MOMENTS HOSPICE - 241602

VISIT TYPE	MOMENTS HOSPICE - 241602	MINNESOTA MEDIANS
TOTAL	22.9	11.5
SN	9.7	6.6
HHA	11.7	3.7
MSS	1.6	1.2
OTHER	0.0	0.0



Source: HealthPivots. Based on 12 months of Medicare FFS claims through March, 2021

If the additional visits are not being provided, then this is not a duplication of services in King County.

King County already has several health system owned providers. Moments Hospice of King, and the affiliated Moments hospice agencies, were founded in response to unmet needs identified in nursing home and ALF settings. Therefore, a hospice provider like Moments Hospice of King would complement the existing hospice providers in King County.

Moments Hospice of King has conducted a needs analysis of King County and has developed strategies to reach currently and historically underserved populations. By definition, this is not a duplication of services, since these subpopulations are currently not already receiving services.

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

The proposed agency, Moments Hospice of King, will be available and accessible to the entirety of King County (the entire planning area).

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

Racial / Ethnic Minorities

Moments Hospice of King is committed to recognizing individual patient's needs and removing barriers to care. In its Midwest hospices, Moments has served culturally diverse patients, including Native American, Hmong, and Jewish patients. Serving people from different cultures or communities is a matter of respect and seeking to understand what is important to that specific person. This same philosophy applies to Moments Hospice of King. The stories below from other Moments hospice agencies exemplify the philosophy that will also extend to Moments Hospice of King:

- An affiliated Moments hospice treated a Native American patient who was part of an Ojibwe tribe that lives about 300 miles from his residence. Moments contacted his tribe, who connected them with a tribe close by. An elder from that tribe now made regular visits, spoke the native language with him, and performed ceremonies. Moments helped the patient plan to attend a traditional tribal gathering once public events were reinstated.
- Another Moments affiliate provided pro bono care for a French-speaking patient who was not a U.S. citizen. The Moments team worked with the patient's daughter and brought in interpreters as needed to communicate effectively with him.
- The Twin Cities Metro area has the largest population of Hmong people in the US. The Hmong are an ethnic group living primarily in southern China, Vietnam, Laos, Thailand, and Myanmar. They traditionally care for their own family members at the end of their lives. The Hmong population in the Twin Cities consists primarily of immigrants from the mountainous regions of Laos who came to the area after the Vietnam War. Moments provided hospice care to Hmong individuals, and recently cared for a female Hmong patient in a senior living facility. Moments partnered with the patient's family to create a communication board to help her communicate her needs. Moments also worked with her family to ensure that specific cultural rituals

occurred at the time of her death. Moments also worked with the facility so that the family could bring in cultural dishes for the patient to eat.

Additionally, Moments Hospice of King will recruit and retain a diverse workforce, reflective of the communities it serves. Moments Hospice of King's will hire staff from the communities the new hospice agency serves.

As described in detail elsewhere in this application, Moments Hospice of King's Open Access philosophy will address common barriers to care found among Black, Hispanic, and Asian populations.

Moments Hospice of King accommodates diverse religious beliefs, which improves access for minority patients. For example,

- Moments chaplains support patients of all faith traditions and are always included in the plan of care, unless the patient specifically requests not to receive chaplaincy. "I define spirituality as 'what is most important to you,' so we can always connect spiritually," said Kellan Weyer, M.Div, Moments chaplain. The chaplains always respect the faith of each patient.
- Moments chaplains have worked with Native American patients who follow their traditional religion.

LGBTQIA+ Persons

In its needs assessment of King County, Moments Hospice of King identified a critical need for LGBTQIA+ senior outreach. LGBTQIA+ seniors find themselves confronting the traditional challenges of aging while also encountering issues particular to the LGBTQIA+ community., LGBTQIA+ seniors often lack traditional sources of support and caregiving, experience a greater likelihood of living alone, renting, and higher rates of poverty. These issues, which LGBTQIA+ elders are facing in King County, are common barriers to accessing hospice. Healthcare disparities among the LGBTQIA+ community are also caused by lack of health insurance, fear of discrimination, embarrassment, and previous negative experiences with healthcare providers. One barrier to high-quality care for LGBTQIA+ community members is staff who do not have the knowledge and training to treat people from all walks of life.

In other markets, affiliated Moments hospice agencies serve LGBTQIA+ patients, with one office reporting 10 percent of its census from the LGBTQIA+ community. Moments hospices share common training and policies, and Moments Hospice of King will replicate the inclusionary practices already demonstrated by affiliated agencies.

Additionally, Moments Hospice of King will identify and partner with LGBTQ and LGBTQ-friendly clinics and providers, as well as register with LGBTQ provider directories.

As part of its LGBTQIA+ Inclusion Program, Moments conditioned this application on obtaining SAGE Care Platinum Level Certification during the first two years of operations. SAGE is a highly trusted national organization dedicated to improving the lives of LGBTQIA+ elders. The SAGE Care Platinum Level Certification will demonstrate Moments Hospice of King is of open minds, pioneering hearts, brave spirits, and healing presence, and shows not only that are all welcome, but that they will be provided with dignified and highly specialized care. The SAGE Care Platinum Level Certification will ensure Moments' staff are knowledgeable and trained on sensitivities pertaining to the LGBTQIA+ community.

Becoming a platinum-level SAGE Care provider means 80 percent of Moments' employees will undergo at least one hour of LGBTQIA+ Aging Training, and 80 percent of its executive team and administrators will receive four hours of LGBTQIA+ training. SAGE Care training covers the basics about what LGBTQIA+ means, and uses real-life stories from older LGBTQIA+ adults to educate hospice providers on changes in how society has treated these individuals throughout their lives. The training also provides skills in working with older LGBTQIA+ adults and suggests improvements for programming, marketing, and recruitment.

In addition to SAGE Care training, Moments will include the following topics in its orientation program for all staff and providers:

- Discovering Hidden Biases – knowing what biases are is the first step to moving beyond them
- Moments Hospice Antidiscrimination Policy
- Terminology (i.e., pansexual, cisgender, non-binary, etc.)
- Use of preferred pronouns and preferred names

- Difference of chosen family vs. family of origin
- Allowing patients to define their families
- Healthcare disparities
- Discrimination against marginalized populations within healthcare
- Culturally competent training
- Generational differences for LGBTQIA+ individuals

Moments Hospice of King will also enhance its electronic medical records to ensure they properly capture patients' gender identity and preferred names. The system will have fields for both the gender assigned to the person at birth and their current gender identity, with options beyond just "male" and "female." The system will include an indication of the person's preferred pronouns and preferred name, as well as information on how the patient self-identifies in terms of sexual orientation. This will ensure Moments staff can address all patients properly.

A letter from SAGE expressing an interest in building a partnership with Moments Miami is included in Attachment 31

Homeless Persons

Moments Hospice agencies have experience serving other counties with significant homeless populations, such as Miami/Dade County. In addition to collaborating with local King County homeless shelters, Moments Hospice of King County will devote resources to helping homeless persons apply for Medicaid benefits. Moments Hospice of King has also offered to condition a CON award on providing charity care equal to at least 5 percent of annual admissions. Through the Moments Hospice Foundation, Moments Hospice of King will pay for accommodations so that otherwise unsheltered homeless hospice patients will have a safe, sheltered place for interdisciplinary hospice visits to take place. Moments Hospice of King is committed to honoring the dignity of homeless patients. Additionally, as described in the Voluntary Conditions section of this application, Moments Hospice of King will contribute to community organizations helping homeless King County residents.

Nursing Home Patients

Long term care settings have been a niche area for Moments Hospice agencies, due to the founders' nursing home and ALF backgrounds. Moments hospice agencies currently partner with over 300 long term care facilities to provide hospice care for residents. Patients in nursing homes make up 39.1 percent of Moments Hospice in Minnesota's census. ALF patients make up 44.9 percent of Moments Hospice's census in Minnesota. Combined, nursing homes and ALFs represent 84 percent of Moments Hospice's census in Minnesota. The successful strategies behind these results will be replicated in King County, to improve access to hospice services for residents of long term care facilities.

Additionally, Moments Hospice of King offers disease-specific programs related to the diagnoses which are common among older patients. In King County, 2020 Medicare Cost Report data shows that among Mediare FFS hospice patients (who are typically over age 65) served in King County,

- 27 percent had a cancer diagnosis
- 15 percent had Heart Disease
- 12 percent had Alzheimers
- 9 percent suffered Stroke
- 4 percent had COPD

Moments Hospice of King's disease-specific programs include *Moments Breathe* for patients with respiratory diseases, *Moments Respect* for Alzheimers patients, and *Moments Heart* for patients with cardiovascular illnesses. These programs reflect Moments Hospice of King's understanding of the specific needs of these populations, and commitment to providing high-quality, individualized hospice services.

Moments Hospice of King also has proven strategies, tested at affiliated Moments hospice agencies, for continuing to build census during COVID restrictions. Moments hospice agencies have used dedicated COVID teams, technology, and other means to quickly adapt and deliver services despite pandemic restrictions.

Adult patients under age 65

Some of the ways Moments Hospice of King will make services available and increase utilization for this age group include:

- **Open Access program.** For example, Moments Open Access options should appeal to younger cancer patients who may not wish to stop palliative chemotherapy. The Open Access program will also appeal to racial and ethnic minorities who have cultural barriers to accessing hospice services, regardless of diagnosis.
- **Charity care.** Without access to Medicare benefits, terminally ill patients under 65 may not have health insurance, or may lose their employer health benefits due to being unable to work as their illness progresses. Moments Hospice of King has committed to providing charity care of *at least* 5 percent of its total net patient service revenue annually.
- **Credentialing with health plans.** By credentialing with multiple area health plans, Moments will increase access for persons under age 65 who are not eligible for Medicare.

Foreign-born and patients with limited English proficiency

Moments utilizes translation services and will make efforts to recruit and employ staff from diverse communities, representative of King County's demographics.

Other strategies Moments Hospice of King will employ to make this project available and accessible to underserved groups, include:

Education and Outreach

Moments understands that community members and healthcare providers need education on what hospice is, its benefits, and how to access it. Often, a non-hospice healthcare provider or family member is with a person when they receive an end-of-life diagnosis. To be able to determine whether hospice care is the right choice for each patient, it is vital that healthcare providers be well informed on hospice.

Provider Education

Moments provides outreach and education to healthcare providers at skilled nursing facilities, assisted living facilities, and hospitals in the communities it serves, and intends to do the same in King County. Moments staff use outreach events as an opportunity not only to provide end-of-life-specific education, but also to nurture relationships with other healthcare providers and welcome open conversations about hospice care. Several of the educational offerings Moments has developed for healthcare providers are summarized below. Moments has also developed a Physicians Guide to Hospice Eligibility brochure that serves as a reference for hospice admissions. This 36-page educational material provides detailed clinical guidelines designed to assist physicians in determining when their patients are eligible for hospice. It includes tools such as the Palliative Performance Scale and Functional Assessment Scale. Moments sees physicians in hospitals, nursing homes, and assisted living facilities as partners in care, and is committed to providing them with information that helps them make determinations on the best options for their patients at the end of their lives. A copy of the *Physicians Guide to Hospice Eligibility* and copies of the educational materials used for outreach is in Exhibit 32.

Community and Patient Education

Before COVID-19, Moments conducted in-person community education events in the areas it serves. Moments understands that facing an end-of-life care decision is very difficult for patients and their families. To ease the burden and make decision-making a less overwhelming process, Moments has developed concise, easy-to-digest educational materials for potential patients and their families. These materials were created in keeping with Moments' vision to create a better understanding of the hospice benefit "through educational empowerment."

Besides brochures with basic hospice eligibility information and contact information for Moments' local admissions teams, Moments has developed brochures that give information on Moments' Circle of Care approach to hospice. Having detailed information on the interdisciplinary team approach to end-of-life care in a printed format allows patients and families to process the information in their own time. Moments also has brochures on its specific programs, such as music therapy, with information on how those programs can benefit patients by providing pain management, opportunities for socialization, and an

outlet for spiritual and emotional distress. Copies of these materials, including a Circle of Care brochure, are included in Exhibit 33. Moments Hospice of King will utilize these materials and approaches.

The Moments Hospice Education Trailer

When the COVID-19 pandemic hit in spring 2020, Moments searched for a safe way to continue offering education to its referral partners and the communities it serves, particularly for people without access to or the ability to use online meeting platforms. Moments decided to invest in a trailer that was originally designed as a food trailer. As shown in the picture below, Moments modified the trailer to bring its educational efforts on the road. The trailer allows Moments staff to bring educational materials, supplies, and complimentary food on the road for safe, socially distanced outdoor education events. Moments also plans to use the trailer to host veteran ceremonies, to give back to those who have fought for our freedoms and to honor our commitment to the We Honor Veterans program.

7. **Provide a copy of the following policies:**
    - **Admissions policy:** Please reference Exhibit 34.
    - **Charity care or financial assistance policy: :** Please reference Exhibit 20.
    - **Patient Rights and Responsibilities policy: :** Please reference Exhibit 36.
- **Non-discrimination policy: :** Please reference Exhibit 37.

Please note that the attached policies reference “Moments Hospice.” Moments Hospice affiliates share many policies and procedures. Moments Hospice’s latest policies will be used by Moments Hospice of King.

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

Please reference the following additional policies: Death with Dignity (Exhibit 24), Discharge Policy and Homeless Policy (found in Exhibit 38).

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.

The Department of Health has published a need which supports this project, therefore this question is 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.**

If the Department of Health has any questions, please ask for additional information.

Utilization Summary

Utilization projections for Moments Hospice of King are summarized in the table below:

Moments Hospice℠
Moments are Forever

	2023	2024	2025
Key Statistics			
Admissions	140	228	255
Patient Days	8,678	14,163	15,841
ALOS	62	62	62
ADC	24	39	43

Moments Hospice of King has used multiple methods to test the reasonableness of volume assumptions.

Pro Forma Assumptions

Admissions

The projected volumes are based on several analyses:

- **Unmet needs in King County.** The *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted November 10, 2021[32] published a need for 226 incremental new admissions in 2022, and 497 incremental new admissions in 2023. Moments projects that by using Moments' proven strategies to reach difficult to reach, historically underserved terminally ill residents, Moments will admit 140 hospice patients during its first full year of operation in 2023, 228 of the King County patients with unmet needs in 2024, and admit 255 King County hospice patients in year 3.

- **Moments Hospice's substantial start-up experience in multiple, heterogenous markets.** Since 2017, Moments has started 12 licensed de novo hospices (with 2 more currently awaiting licensure) in both urban and rural areas in heterogenous markets, including Minnesota, Wisconsin, Iowa, Illinois, South Dakota, and Florida. Moments has substantial experience entering competitive markets without CON requirements, in which Moments has been able to quickly ramp up hospice admissions.

Additionally, Moments recently started a new hospice in Miami-Dade County, Florida—a competitive market with a CON requirement. Moments' demonstrated ability to generate hospice admissions in both small, rural communities, as well as large, diverse urban areas can be replicated in King County, as evidenced by Moments' success in multiple other heterogenous markets throughout the country. We believe Moments affiliated hospices' success in these communities is the result of Moments' willingness to devote resources to outreach. Moments leadership has been able to quickly assimilate information from

[32] 2021 Hospice Final Methodology (wa.gov)

community stakeholders and data sources in order to formulate strategies to reach difficult to reach patients.

Moments has a solid track record for finding new hospice admissions in communities that share similarities with King County. Consequently, we believe the projected admissions are well-supported by a demonstrated ability which has now been successfully replicated in multiple areas across the U.S.

- **Internal data on Hospice Care Consultants as a driver of hospice admissions.** Hospice Care Consultants (HCCs) serve a key role in Moments Hospice of King's patient access strategy. Moments has utilized historical, internal data, correlating HCCs with hospice admissions. Provider and community education on the benefits and availability of hospice services, as well as the ability to facilitate timely admission of hospice referrals, are key drivers of hospice admissions. Moments utilized internal data on its affiliated hospices' Hospice Care Consultants' historical ability to generate hospice admissions, as another means of estimating King County admissions. The initial months were adjusted to reflect the ramp up that would be anticipated when training new hires, entering new facilities, and making adjustments for feedback in a new market.
- **Attainable Market Share.** While Moments Hospice of King anticipates that admissions will come from currently unserved terminally ill patients, and not from the market share of other King County hospice providers, market share can nonetheless be used as a "reasonableness check" for projected admissions. Thus, Moments of King has considered what percentage of overall market share has been attainable in other competitive counties. We also reviewed the percentage of overall hospice market share in King County attained by other new entrants historically, as a reasonableness test. We also relied upon data related to Moments affiliates' own start up hospice market share attainment in the first years of operation in other areas.

Of note, Moments Hospice of King, and all Moments affiliates, are not a hospital/health-system owned hospice entities. Therefore, Moments Hospice of King's and Moments Hospice affiliates' operations are not subsidized by a larger health system. Similarly, funding for Moments hospice agency operations does not come from donations. Moments' affiliates' admissions in other new markets are solely due to the success of Moments'

strategies for reaching underserved patients in new markets, Moments' provision of a valuable, patient-centered service that patients and families want, and Moments' ability to admit patients timely and deliver services in an efficient, cost-effective manner.

	Year 1 (2023)	Year 2 (2024)	Year 3 (2025)
Market Share Assumption	1.6%	2.6%	2.9%
King County Estimated Market	8,328	8,495	8,664
Estimated Patients Served	136	221	247
Admissions: Patients Served	1.033	1.033	1.033
Estimated Admissions	140	228	255
Avg. Admissions Per Month	12	19	21

The table above shows the underlying assumptions for admissions. The market share assumptions were determined based on affiliated Moments Hospice's performance in other highly competitive U.S. markets. The King County market size in year one is based on adding the projected need in terms of admissions for the two age cohorts in the Department of Health's *2021-2022 Hospice Numeric Need Methodology*. Year 2 and 3 market size estimates assume a 2 percent average annual growth rate, based on the most recent U.S. Census data for King County.

The data utilized included patients served, rather than admissions. Since admissions are typically greater than patients served, because of the fact that some patients have more than one hospice admission, we multiplied projected patients served by affiliated Moments hospices' historical ratio of Admissions to Patients Served. This resulted in admission projections of 140, 228, and 255 for the first full 3 years of operation, respectively.

Moments Hospice of King believes the projected admissions volumes for Moments Hospice of King are reasonable, attainable estimates.

Average Length of Stay

We utilized the Washington State average length of stay of 62.12 published in the *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted in November 10, 2021[33]. We expect a shorter length of stay initially, in the first months, as admissions ramp up. However, we expect the average length of stay to quickly reach the Washington state average. CMS data in other markets demonstrates Moments' ability to

[33] 2021 Hospice Final Methodology (wa.gov)

quickly attain higher lengths of stay. This is due to Moments' ability to identify and partner with facilities to admit terminally ill patients earlier in their illness, as well as Moments' demonstrated ability to reach patients with non-cancer diagnoses which typically are associated with longer lengths of stay, and Moments historical success in ALF and Nursing Home facilities.

Patient Days

Patient days were calculated by multiplying Moments Hospice of King's projected admissions by the King County ALOS published in the November 10, 2021 *Department of Health 2021-2022 Hospice Numeric Need Methodology*, with the exception of 4 month ramp up period, when initial length of stay was assumed to be 50 days for patients admitted during the first month of operation, ramping up monthly to reach the King County ALOS by the end of the fourth month of operation.

Average Daily Census (ADC)

ADC is the result of a formula summing the total patient days within the specified time frame, divided by the sum of calendar days within the same time frame.

- **Pro Forma revenue and expense projections for at least the first three full calendar years of operation using at a minimum the following Revenue and Expense categories identified at the end of this question. Include all assumptions.**

The Pro Forma Income Statement for Moments Hospice of King is shown below. The pro forma income statement shows Moments Hospice of King becoming profitable during 2023. Assumptions for each line on the income statement are described below:

Moments Hospice of King County, LLC

Pro Forma Income Statement

--

	2022	2023	2024	2025
Revenue	**177,920**	**2,033,745**	**3,319,800**	**3,718,464**
MCR Net Patient Service Revenue	241,624	1,883,341	3,074,792	3,444,394
MCD Net Patient Service Revenue	8,197	62,191	101,348	113,397
Other Net Patient Service Revenue	23,515	176,754	287,857	321,945
Charity Care	(95,416)	(88,542)	(144,196)	(161,272)
Other Revenue	--	--	--	--
Other Operating Revenue	--	--	--	--
Other Non-Operating Revenue	--	--	--	--
Total Revenue	**177,920**	**2,033,745**	**3,319,800**	**3,718,464**
Direct Expenses	**(19,191)**	**(188,383)**	**(306,745)**	**(343,178)**
Drugs and Pharmacy	(6,653)	(65,226)	(106,225)	(118,805)
Medical Supplies	(2,163)	(21,426)	(34,844)	(39,077)
Labs/ Other	(2,661)	(26,090)	(42,490)	(47,522)
DME/ Oxygen	(5,766)	(56,529)	(92,062)	(102,964)
Room and Board (net)	(1,151)	(11,285)	(18,378)	(20,554)
Radiology	(222)	(2,174)	(3,541)	(3,960)
Physical Therapy	(44)	(435)	(708)	(792)
Speech Therapy	(44)	(435)	(708)	(792)
Occupational Therapy	(44)	(435)	(708)	(792)
Respiratory Therapy	(444)	(4,348)	(7,082)	(7,920)
SG&A Expenses	**(283,955)**	**(1,616,019)**	**(2,318,219)**	**(2,531,391)**
Salaries and Wages	(143,877)	(888,306)	(1,319,006)	(1,460,232)
Employee Benefits	(21,582)	(133,246)	(197,851)	(219,035)
Payroll Taxes	(12,588)	(75,853)	(109,769)	(120,175)
Equipment Rental	(1,500)	(6,000)	(6,000)	(6,000)
Rental/ Lease and Utilities	(7,682)	(30,995)	(32,080)	(33,202)
B & O Taxes	(2,669)	(30,506)	(49,797)	(55,777)
Accounting	(1,500)	(6,000)	(6,000)	(6,000)
Consultants	(1,500)	(6,000)	(6,000)	(6,000)
Legal and Professional	(3,000)	(12,000)	(12,000)	(12,000)
Software Licenses	(18,432)	(14,782)	(27,363)	(20,638)
Dues & Subscriptions	(577)	(5,714)	(9,292)	(10,421)
Insurance	(1,800)	(7,200)	(7,200)	(7,200)
Advertising & Marketing	(750)	(3,250)	(6,000)	(6,000)
Education & Training	(575)	(3,850)	(5,775)	(6,400)
Office Supplies	(1,150)	(7,700)	(11,550)	(12,800)
Telephones	(1,150)	(7,700)	(11,550)	(12,800)
Postage & Printing	(450)	(1,800)	(1,800)	(1,800)
Repairs & Maintenance	(750)	(3,000)	(3,000)	(3,000)
Other: Travel, Meals, & Entertainment	(1,500)	(6,000)	(12,000)	(12,000)
Other: Auto / Mileage	(9,287)	(80,488)	(129,183)	(144,163)
Other: Contract Labor	(39,321)	(156,000)	(156,600)	(156,000)
Other: Miscellaneous	(3,421)	(27,942)	(32,415)	(33,826)
Management Fees	(8,896)	(101,687)	(165,990)	(185,923)
Total Expenses	**(303,146)**	**(1,804,402)**	**(2,624,965)**	**(2,874,569)**
EBITDA	**(125,226)**	**229,343**	**694,836**	**843,895**
EBITDA Margin	(70.4 %)	11.3 %	20.9 %	22.7 %
Depreciation & Ammortization	(2,892)	(10,277)	(10,277)	(10,277)
EBIT	(128,118)	219,066	684,559	833,618
Interest expense	--	--	--	--
Taxable income	--	--	--	--
Carry forward loss	(128,118)	--	--	--
Federal Income Tax	--	--	--	--
State income tax	--	--	--	--
Net Profit / (Loss)	**(128,118)**	**219,066**	**684,559**	**833,618**
Net Margin	(72.0 %)	10.8 %	20.6 %	22.4 %

Drivers of revenue and expenses are discussed in detail in the utilization section.

Net patient services revenues are projected net of deductions from revenue. Since most hospice payments are determined contractually and by payer fee schedule, rather than by gross charges, Moments shows net patient services revenue on the income statement above, consistent with other Moments affiliates. Moments Hospices do not have historical data on deductions from revenue, since net collections are recorded on financial statements. All net patient services revenues on the pro forma income statement are net of any contractual deductions from revenue, but do not include charity care.

For the purposes of this pro forma, we assumed charges equal to the 2022 Medicare Hospice payment rates for King County, which are shown in the table below:

Level of Care:	RHC 1-60	RHC 61+	CC	Respite	GIP
2022 Base Rate	$ 203.40	$ 160.74	$1,462.52	$ 473.75	$1,068.28
Labor Portion	66%	66%	75.2%	61%	63.5%
Non-Labor Portion	34%	34%	24.8%	39%	37%
Wage Index	1.1851	1.1851	1.1851	1.1851	1.1851
Wage Index Adj'd Labor Portion	$ 159.09	$ 125.73	$1,303.39	$ 342.48	$ 803.92
Non-Labor Portion	$ 69.16	$ 54.65	$ 362.70	$ 184.76	$ 389.92
King County Reimbursement Rate	**$ 228.25**	**$ 180.38**	**$1,666.10**	**$ 527.24**	**$1,193.84**

Base rate CC per Hour	$ 60.94
Wage-adjusted CC per Hour	$ 69.42

Since Medicaid reimburses hospices at the same rate as Medicare in King County, there are no deductions from revenue applied to Medicare and Medicaid revenue. We applied a 9 percent contractual adjustment / deduction from revenue rate to “Other” revenues, as well as an additional 1% for bad debt related to copays, etc., for commercial insurance plans, Tricare, etc. This was based on a basket of contracts in other markets that Moments affiliates serve, and is a conservative estimate.

Charges and Contractual Allowances/Deductions from Revenue Assumptions:

Payer Category	Charges	% Deductions Applied
Medicare Care	Modeled at Medicare Fee Schedule Rates	0%
Medicaid	Modeled at Medicare Fee Schedule Rates	0%
Other (Commercial, Tricare, etc.)	Modeled at Medicare Fee Schedule Rates	9% (plus an additional 1% for bad debt write-offs)

- Self-pay was assumed to be 100 percent charity care.
- Charity Care was calculated separately as 5 percent of total net patient services revenue
- Medicaid rates in Washington State mirror Medicare rates for each of the 4 levels of care

The following assumptions were used to calculate net patient service revenue:

Level of Care Mix (LOC)

The level of care mix (patient days) in the pro forma is based on The Medicare Payment Advisory Committee (MedPac) *2020 Report to Congress* (See Exhibit 39). The Routine Home Care (RHC) split between 0 to 60 days and Routine Home Care for days of stay 61 and beyond was then adjusted to reflect the proportion of days 0-60 and 61+ that would correspond with the published average length of stay of 62 days in the *Department of Health 2021-2022 Hospice Numeric Need Methodology* posted on November 10, 2021[34]

Payer Mix

The Washington State hospice census-based payer mix, based on 2020 Medicare Hospice Cost Reports, comprises 87.4 percent Medicare, 1.8 percent Medicaid, and 10.8 percent “Other”. This data does not separate commercial insurers from government plans such as Tricare. Moments Hospice of King used HealthPivots Medicare Cost Report data to analyze the payer mix of other hospices in King County. Because of the substantial

[34] 2021 Hospice Final Methodology (wa.gov)

variation between individual hospice providers in King County, Moments Hospice of King began its projection with a baseline equal to the Washington state hospice payer mix. We then increased the share of Medicaid to 3 percent of the payer mix. We believe this is reasonable because

- Moments anticipates serving a greater percentage of Medicaid enrollees due to targeting underserved populations.
- Racial/ethnic minorities represent a greater proportion of Medicaid recipients versus their respective proportion of the overall population of King County, and Moments initiatives are expected to reach underserved minorities who are more likely to have Medicaid[35] (See Exhibit 13, King County Community Health Needs Assessment 2021/2022).
- CMS data show that Moments exceeds state averages of hospice Medicaid patients served in other markets. For example, in Hennepin County, Minnesota, Moments served 20 percent more Medicaid patients as a percent of its total payer mix compared to the Minnesota state average.
- Reaching underserved hospice patients in nursing home and ALF settings has been a "niche" area for Moments. Data shows that nursing home patients represented 39.1 percent of other Moments affiliates' 2021 census, compared to 9.7 percent in King County. *The tables showing this appear under the "Patient Days by Care Setting" heading, later in this section.*
- Moments' founders/executives have long term care backgrounds, and created the organization in response to unmet needs in the nursing home and ALF settings, and have specialized knowledge of the specific needs of this population—a population which is characterized by a high percentage of Medicaid residents.

We combined the categories "Private Pay" and "Other" under the "Other Net Patient Service Revenue" line on the pro forma for several reasons:

- The payer mix used for Moments of King County projections is not so granular as to include individual payer contracts.
    - The Hospice-specific data sources we used, which utilize Medicare cost report and other data, do not have payer information at this level of detail.

[35] King County Community Health Needs Assessment, 2021-2022

- Commercial payer-provider contracts generally contain confidentiality clauses.
- Commercial insurance plans vary by state and even by city. Large employers who utilize a particular carrier can change the payer mix for the local area. Therefore, we do not feel that internal data from other markets is predictive of Moments Hospice of King County's experience.

Moments has projected that 9.6 percent of its payer sources will come from non-Medicare, non-Medicaid ("Other") sources, such as commercial plans and Tricare, etc. This assumption reflects:

- Moments Hospice of King's aim to serve terminally ill residents under the age of 65, who are typically do not have Medicare benefits, and who are currently underserved.
- Persons with HIV and Cancer diagnoses, who are often under the age of 65, and who also may not yet be Medicare eligible.
- Moments' focus on Veterans, includes partnering with area military medical facilities and physicians
- Immigrants who may not be eligible for Medicare
- Self pay / uninsured patients, particularly homeless persons

Just as in other markets, Moments Hospice of King will credential with as many area payers as possible, to give all King County terminally ill residents access to hospice care Currently, Moments affiliates participate in approximately 12 insurance plans including major commercial payers such as Blue Cross and Aetna, as well as veterans plans, including VA Community Care

Additionally, Moments is hiring a Revenue Cycle Management executive during the first quarter of 2022, to lead the expansion of commercial and other contracts. This role, and contracting and credentialing in general, are included in the Shared Services Agreement. The cost is included in the Management Fees line item on the pro forma income statement.

Consequently, Moments believes this projected payer mix to be realistic.

Patient Days by Care Setting

Patient days by care setting were based on the 2021 Washington State average for all hospices for census by setting as a starting point, and adjusted slightly to reflect Moments' affiliates experience in other markets.

For the Pro Forma, Moments Hospice of King County used the following care setting assumptions:

Admissions by Setting	% Adm by Setting
Home	62.1 %
ALF	24.5 %
Nursing Home	10.6 %
Inpatient - Hospital	0.3 %
Inpatient - Hospice House	0.7 %
Other	1.8 %
Total Admissions	**100.0 %**

Of note, Moments has typically had a bigger presence in nursing homes and ALFs than state averages and compared to many competitors. Because Moments has strategies specific to these care settings, we adjusted the King County averages slightly (i.e., reduced the percentage in the home setting, increased the nursing home percentage, etc.)

KING COUNTY, WA

% DISTRIBUTION OF HOSPICE CENSUS BY CARE SETTING

YEAR	HOME	ALF	NURSING HOME	HOSPITAL	HOSPICE FACILITY	OTHER	TOTAL
2012	58.1%	23.3%	16.6%	0.3%	1.0%	0.7%	100%
2013	56.4%	24.6%	17.3%	0.4%	0.9%	0.4%	100%
2014	56.4%	25.8%	15.9%	0.5%	0.8%	0.6%	100%
2015	55.4%	26.5%	15.5%	0.4%	0.8%	1.4%	100%
2016	55.7%	27.2%	14.7%	0.6%	0.8%	1.1%	100%
2017	56.4%	26.7%	14.5%	0.7%	0.8%	0.9%	100%
2018	60.8%	22.6%	14.2%	0.4%	0.8%	1.1%	100%
2019	61.7%	21.2%	14.0%	0.3%	0.9%	1.8%	100%
2020	61.0%	24.1%	12.0%	0.3%	0.8%	1.7%	100%
2021	62.5%	24.8%	9.7%	0.3%	0.8%	1.9%	100%

Source: HealthPivots. Hospice Market Share by Setting, King County, 2021 Medicare FFS Claims data

Care Setting has implications for nursing home room and board revenue and expenses, employee mileage assumptions, SIA payment eligibility, etc. Each of these items is discussed in greater detail below.

Medicare Net Patient Services Revenue

We multiplied total projected patient days by the projected Medicare percentage of the total payer mix to calculate the percentage of patient days attributable to Medicare patients. Level of Care mix assumptions are described above. Medicare payment rates specific to King County were calculated in accordance with the methodology in the *Medicare Payments Fiscal Year 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements*, published in the Federal Register[36] on August 4, 2021.

With regard to Continuous Care services, we assumed that an average of 16 of the 24 potential hours per day would be eligible at the hourly rate. This was based on Moments' other affiliates experience. Moments Hospice of King will, as all other Moments affiliates do, use Muse artificial intelligence software. Muse integrates with and mines data within the EMR system to predict the likelihood a patient will die within the next two weeks. It categorizes patients based on this risk. Moments Hospice of King constantly receives real-time data that Moments Hospice of King uses to adjust the plan of care and visit frequency of the care team. When the patient enters a high or critical level of risk, Final Moments is initiated. Visit frequencies are increased and the patients and family are wrapped in even more comforting care to ensure that their final moments are meaningful and compassionate and they feel supported. This technology and the historical experience of other Moments affiliates was also used to calculate Service Intensity Add-on (SIA) payments.

Projected SIA payments are also included in the Medicare and Medicaid Net Patient Services Revenue line items. (Please note that because SIA payments only apply to the last days of life, they are not included in the first month of Medicare revenue, as patients

[36] Federal Register :: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

would not yet expire based on the assumed length of stay. This makes the average Medicare revenue per patient day slightly lower in month 1.)

Moments Hospice of King assumes that 50 percent of eligible SIA hours will be achieved. To approximate expired patients discharged from hospice, we assumed that 90 percent of patients expire 2 months later (consistent with the ALOS published by the Department of Health for King County). The 90 percent assumption was based on actual data for Moments (Minnesota) showing a 10 percent live discharge rate. We also evaluated live discharges by other hospices in King County, but found significant variation between the other providers (6 percent to 23 percent live discharge rates among Medicare FFS patients in 2021[37]). Consequently, we believe Moments' internal, affiliate data is the best source for this estimate.

Medicaid Net Patient Services Revenue

The Washington State Health Authority's hospice payment rates for each level of care (see Exhibit 40), effective October 1, 2021, were multiplied by corresponding level of care Medicaid patient days, as determined by applying the projected payer mix.

SIA payments included in the Medicaid Net Patient Services Revenue line were calculated by applying the Medicaid percentage of payer mix to estimated eligible SIA hours, then multiplying the result by the Washington State Health Authority's published reimbursement rate for SIA.

Charity Care

Moments Hospice of King has projected Charity Care equal to 5 percent of total net patient service revenue for the first three full years of operations. However, there is no cap on the amount of charity care that will be provided to King County residents. The five percent assumption was based on Moments affiliates' recent, actual financial results in other markets.

During the first months of operations, while Moments Hospice of King is still in the process of credentialing with payers, we assume that the first patients will be pro bono patients. Charity care was projected at 100 percent of net revenue during the first 6 weeks of operations, to account for credentialing lag time.

[37] Healthpivots "Hospice Provider Profile Report" based on Medicare data during the 12 months through June 2021, for various hospice providers including Providence Seattle, Franciscan, and Whatcom.

Other Operating Revenue

Per the medical director contract (Exhibit 41), physician services are contracted, so any Medicare Part B revenue from physician visits would be billed and collected directly by the physician, and would therefore not appear in Moments Hospice of King financial statements. Moments Hospice of King does not anticipate any material amounts of other operating revenue during the first three full years of operation.

Other Non-Operating Revenue

Moments Hospice of King has not projected any other non-operating revenue, as none is anticipated.

Direct Expenses

Direct patient care expenses were projected on a per patient day basis, based on other Moments affiliates' experience. The exception to this is medical supplies, which were projected on a per census basis. Direct patient care expense assumptions are summarized in the table below:

Direct Expenses1	Cost PPD
Drugs and Pharmacy	$ 7.50
Medical Supplies	75/ census
Labs/ Other	$ 3.00
DME/ Oxygen	$ 6.50
Radiology	$ 0.25
Physical Therapy	$ 0.05
Speech Therapy	$ 0.05
Occupational Therapy	$ 0.05
Respiratory Therapy	$ 0.50

Nursing Home Room and Board expense was calculated using the per diem rate of $232.58 published in the Washington State Department of Social and Health Services *Nursing Facility and Rate Reports*[38] using the current rate in effect from July 1, 2021 through Jun 30, 2022. Nursing Room and Board revenue was projected as 95 percent of Moments Hospice of King's Nursing Home Room and Board expense, based on similar contracts for other Moments affiliates.

Salaries and Wages

[38] Nursing Facility Rates and Reports | DSHS (wa.gov)

Salaries and wages expenses were computed based on Moments Hospice of King's census-driven staffing ratios. Detailed assumptions pertaining to the staffing model can be found elsewhere in this application.

Using Moments Hospice's paid time off policy, which is standard across all Moments affiliates, we computed a 91 percent productive time / 9 percent nonproductive time split. Because certain field staff roles who provide direct patient care, such as RNs and PCAs, requirement replacement by another person when an employee is out due to illness, vacation, etc. (For example, if the patient census requires 2 RN FTEs, not all of the 2,080 hours of that FTE will be available for patient care, since the employee has paid time off approximately 9 percent of the time).

Patient care visits do not stop when someone is using paid time off. Therefore, we "grossed up" clinical, patient-facing FTEs by taking the FTEs required per the staffing model for patient care, divided by the percentage of productive hours. This accounts for the cost of replacing those staff who are receiving paid time off. (When a staff member is out for paid time off, they are still paid, as is the replacement team member who must provide patient care in their absence. Thus, one direct patient care FTE is really equal to approximately 1.1 paid FTEs. The Moments Hospice of King Pro Forma accounts for these costs.

Other roles, such the Regional Director of Operations, do not require replacement when they are out of the office for paid time off. Consequently, the paid hours associated roles that are not essential to direct patient care were not adjusted for replacement.

Full time equivalents (FTEs) generated by the staffing model were multiplied by the full time equivalent hours (1 FTE = 2080 hours per year, and 2088 hours in 2024 due to the extra day in the leap year) to calculate the number of hours paid. Paid hours were then multiplied by local average and mean salary/wage rates specific to the King County and Seattle area. Average rates of pay and average annual salaries were estimated from various sources such as Salary.com, Indeed.com, and local health system job postings.

Per the CON guidelines, no wage inflation was projected. There are no applicable contracts containing any wage increases for employed staff.

If the department has any questions, please ask for additional information.

Employee Benefits

Based on the common benefits packaged shared among Moments Affiliates, we estimated benefits to be 15 percent of salaries and wages expenses. This reflects employer-funded health insurance benefits, paid time off, employer 401K contributions, and dental and vision benefits. The E-fleet car leasing benefit is reflected in the "Other – Auto/Mileage" line item, and is discussed in greater detail later in this application, in relation to recruitment and retention strategies.

Payroll taxes

Payroll tax assumptions were based on 2022 federal and state rates for employer-paid taxes of 6.2% Social Security capped at 147,000 per year, 1.45% Medicare, FUTA 0.60% capped at $7,000 and SUTA/SUI estimated at 1.06% with a cap of $57,500.

Equipment Rental

Equipment rental expense of $500 per month includes office equipment, such as a copier / scanner.

Rental / Lease

Moments Hospice of King County has entered into a Letter of Intent to execute a lease agreement (Exhibit 4). Per the terms of the agreement, Moments Hospice of King will pay an all-inclusive (no separate fees, and utilities are included) rate of $18 per square foot for a 1707 office space. The LOI states that the price shall increase by 3.5 percent each year. The purpose of this space is for meetings, training events, etc., as field staff will travel directly from their own homes to the patient's location to provide services. Therefore, the space should be adequate to meet the agency's needs during the first three full years in the pro forma.

Utilities

Utilities are included in the lease agreement, and therefore are already represented in the costs on the "Rental/Lease" line.

B & O Taxes

Business and Occupation taxes were assumed to be equal to 1.5 percent of total revenue.

Accounting

Accounting expenses of $500 per month represent Certified Professional Accountant fees, paid to a CPA firm external to the organization. Bookkeeping and general accounting expenses are included in the Management Fee described in the shared services agreement. CPA costs were estimated based upon other Moments affiliates' actual experience.

Consultants

Consulting fees of $500 per month were estimated based on other Moments affiliates' experience.

Legal and Professional

Legal and professional fees of $1,000 per month were estimated based on other Moments affiliates' experience.

Software Licenses

Software and license fees were modeled based upon contracts with vendors. Drivers of software and licensing expenses include role-based EMR and CRM licenses (PCA EMR licensing costs differ from other clinical team member EMR licenses). The staffing model drives user, role-based fees in the pro forma. This line item also includes per patient day-driven expenses for clinical software (MUSE data mining tool). The amounts in this line also include software licenses for HCCs, which are also staffing model driven.

Dues & Subscriptions

Dues and Subscriptions expense assumptions were based on historical, internal data from other Moments affiliates, and equate to $20 per FTE per month.

Insurance

Insurance expenses of $600 per month include both general and professional liability insurance, and were based on quotes from Moments' insurance carrier for other Moments recent start up hospice agencies.

Advertising & Marketing

Advertising and marketing expense was estimated based on historical spending of $250 per month per Hospice Care Consultant FTE at other Moments affiliates, and is aligned with staffing projections in the pro forma.

Education & Training

Education and training expense assumptions are based $25 per FTE per month, based on historical spending per at other Moments affiliates.

Office Supplies

Office supplies expense assumptions of $50 per FTE per month reflect Moments affiliated start-up hospices' experience in other markets.

Telephones

Telephones expense assumes $50 per FTE based on typical reimbursement amounts at other Moments hospice affiliates.

Postage & Printing

Postage and printing expense was estimated at $150 per month per office location based on other Moments affiliates' historical expenses.

Repairs & Maintenance

Repairs and maintenance expenses were based on historical expenses of $250 per month per office location for other Moments affiliates.

Other: Travel, Meals, & Entertainment

Travel, meals, and entertainment expense assumptions of $500 per month in year 1, and $1000 per month in subsequent years excludes field staff travel and mileage (which is

include under “Other: Auto / Mileage”). This reflects anticipated travel by Moments executives and other key staff.

Other: Auto / Mileage

Auto / mileage expense assumptions include the 2022 mileage reimbursement rate of $0.585 published by the IRS. It was assumed that 65 percent of staff would elect to be reimbursed on a per mile basis, while 35 percent of team members would use the E-Fleet benefit, at a cost of $600 per month per team member. Auto and mileage expenses per patient day were also compared to Moments affiliates in other large counties as a reasonableness test.

Other: Contract Labor

Other: Contract Labor expense includes fees paid to the Medical Director. Paid hours were estimated based on Moments Hospice of King’s staffing model, which has a minimum of 0.3 FTEs for a medical director, and ramps up with census. It is assumed that even with low initial census levels, the Medical Director will be paid for training related to the EMR and Muse systems, on Moments Hospice of King’s policies and procedures, etc. The rate is contained within the Medical Director LOI, which is attached as Exhibit 41.

Other: Miscellaneous

This line on the income statement includes items such as forms, IT support, medical waste disposal, individual employee computer expenses that do not meet the IRS capital threshold, and the contributions listed in the commitments. Other than the contributions, amounts are based on Moments Hospice affiliates actual experience with other de novo hospice agencies.

Management Fees

Management fees match the terms described in the Shared Services Agreement, and are equal to 5 percent of operating revenue.

- **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**

1.

- **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.**

Revenue	Expenses
Medicare, including Managed Care	Advertising
Medicaid, including Managed Care	Allocated Costs
Private Pay	B & O Taxes
Other, [TriCare, Veterans, LNI, etc.] detail what is included	Depreciation and Amortization
Non-operating revenue	Dues and Subscriptions
	Education and Training
	Employee Benefits
	Equipment Rental
	Information Technology/Computers
Deductions from Revenue:	Insurance
(Charity)	Interest
(Provision for Bad Debt)	Legal and Professional
(Contractual Allowances)	Licenses and Fees
	Medical Supplies
	Payroll Taxes
	Postage
	Purchased Services (utilities, other)
	Rental/Lease
	Repairs and Maintenance
	Salaries and Wages (DNS, RN, OT, clerical, etc.)
	Supplies
	Telephone
	Travel (patient care, other)
	Other, detail what is included

Moments Hospice of King

Pro Forma Balance Sheet

	Jul - Dec 2022	2023	2024	2025
Assets	**284,870**	**513,135**	**1,203,097**	**2,040,830**
Current assets	**236,377**	**474,919**	**1,175,158**	**2,023,168**
Cash and cash equivalents	113,402	157,047	621,240	1,242,445
Prepaid expenses	--	--	--	--
Accounts Receivable	114,079	207,289	277,344	318,226
Provision for doubtful accounts	8,896	110,583	276,573	462,496
Other current assets	--	--	--	--
Net PP&E	**15,476**	**12,274**	**9,072**	**5,870**
Buildings	--	--	--	--
Furniture & Fixtures	--	--	--	--
Office Equipment	10,643	8,441	6,239	4,037
Equipment	4,833	3,833	2,833	1,833
Vehicles	--	--	--	--
Accumulated Depreciation	267	267	267	267
Intangible assets	**33,017**	**25,942**	**18,867**	**11,792**
Industrial & similar rights	--	--	--	--
Other Capitalized Expenses	33,017	25,942	18,867	11,792
Amortization	590	590	590	590
Liabilities and Equity	**284,870**	**513,135**	**1,203,097**	**2,040,830**
Current liabilities	**12,988**	**22,187**	**27,590**	**31,706**
Accounts Payable	7,899	14,100	18,800	21,620
Income taxes payable	--	--	--	--
Unearned revenue	--	--	--	--
Payroll Taxes Payable	5,089	8,087	8,790	10,086
Deferred tax liabilities	--	--	--	--
Accrued expenses on notes	--	--	--	--
Long-term Liabilities	**400,000**	**400,000**	**400,000**	**400,000**
Long-term notes	400,000	400,000	400,000	400,000
Convertible notes	--	--	--	--
SBA loan	--	--	--	--
Other non-current liabilities	--	--	--	--
Equity	**(128,118)**	**90,948**	**775,507**	**1,609,125**
Common stocks	--	--	--	--
Additional Paid-In Capital	--	--	--	--
Capital reserves	--	--	--	--
Retained Earnings	(128,118)	90,948	775,507	1,609,125

Balance sheet assumptions include the following:

- Cash comes from earnings after the initial $400,000 zero-interest loan from another Moments affiliate.
- Payback of the $400,000 loan is deferred for 5 years.
- "Long term note" refers to the zero-interest loan from the other Moments Affiliate. See term sheet in Exhibit 43.
- Accounts Receivable: Patient care revenue will be collected in the month following the month in which services were performed, based on payer mix assumptions and historical payer payment patterns.
- Provision for Doubtful accounts refers to the 5 percent Charity Care assumption
- Accounts payable: The pro forma assumes that 30 percent of amounts payable to vendors will be paid in the same month, and the remaining 70 percent the following month, based on other Moments affiliates' experience.
- Depreciation and amortization relate to the items listed on the Capital Expenditures schedule.

If the Department of Health has any questions, please ask for additional information.

2. **Provide the following agreements/contracts:**
    - **Management agreement**.See Shared Services Agreement.
    - **Operating agreement** See Exhibit 42.
    - **Medical director agreement** See Exhibit 41.
    - **Joint Venture agreement** – Not applicable, as Moments Hospice of King is not part of a joint venture.

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

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 third full year following the completion of the project. 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.**

Please reference LOI and lease agreement, Exhibit 4.

4. **Complete the following table 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	$
b. Utilities to Lot Line	$
c. Land Improvements	$
d. Building Purchase	$
e. Residual Value of Replaced Facility	$
f. Building Construction	$
g. Fixed Equipment (not already included in the construction contract)	$
h. Movable Equipment	$15,000

i. Architect and Engineering Fees	$
j. Consulting Fees	$35,375
k. Site Preparation	$
l. Supervision and Inspection of Site	$
m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction)	
1. Land	$
2. Building	$
3. Equipment	$
4. Other	$
n. Washington Sales Tax	$ 1,010
Total Estimated Capital Expenditure	**$51,385**

Assumptions utilized include $10,000, to furnish the office space with conference tables, chairs, desks, and similar items. The estimate was based on purchases of similar items for other Moments start up hospices in other areas. Sales tax was computed at the Seattle rate of 10.1 percent of the cost of office furniture. $5,000 was allocated for wiring the new office (no sales tax applied). Consulting fees consist of CON application consulting expenses, and are based on similar, recent expenditures on other CON applications by Moments affiliates.

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.**

Moments Hospice of King County, LLC is responsible for the estimated capital costs identified above.

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.**

Estimated start-up costs were based on the experience of other recent Moments hospice start-ups in other areas, and include: Fees for the CON application equal to $21,968, a $5,000 deposit to hold office space until the CON is granted and the lease of office space fully executed, and $5,000 in estimated travel expenses for Moments Hospice executives' travel to King County related to start up activities. Additionally, due to the recruiting and onboarding timeline, we estimated half of the first month of operation's salaries, wages, taxes, and benefits expenses prior to opening.

If the Department of Health has any questions, please ask for additional information.

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.**

Moments Hospice of King County, LLC is responsible for the estimated capital costs identified above.

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

The majority of hospice patients are Medicare patients. As described in the *Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements* published in the *Federal Register*, the Medicare program has mechanisms in place, in the form of per beneficiary cost caps and inpatient care limits, which cap Medicare's exposure to financial risk and shift the risk back to the hospice provider.[39]

Moments hospice of King's gross charges for services provided under this project were set equal to Medicare rates, are competitive for the services provided, and would not result in unreasonable charges. Unlike other hospice providers, Moments Hospice of King does not charge patients for separately for additional services which are not required by Medicare, such as massage therapy. Moments Hospice of King includes these services under the per diem charges.

[39] Federal Register :: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

The aggregate impact to cost and charges for health services in the planning area include costs savings for area hospitals in the form of reduced hospital average length of stay as terminally ill patients are discharged to hospice care earlier and more often. Also, area hospitals could experience reduced avoidable readmissions. Another potential cost impact for King County would be reduced spending per Medicare beneficiary, since studies show that end of life care provided by hospice is less expensive.

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.**

There are no construction costs associated with this project.

The majority of hospice patients are Medicare patients. As described in the *Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements* published in the *Federal Register*, the Medicare program has mechanisms in place, in the form of per beneficiary cost caps and inpatient care limits, which cap Medicare's exposure to financial risk and shift the risk back to the hospice provider.[40]

Moments hospice of King's gross charges for services provided under this project were set equal to Medicare rates, are competitive for the services provided, and would not result in unreasonable charges. Unlike other hospice providers, Moments Hospice of King does not charge patients for separately for additional services which are not required by Medicare, such as massage therapy. Moments Hospice of King includes these services under the per diem charges.

The aggregate impact to cost and charges for health services in the planning area include costs savings for area hospitals in the form of reduced hospital average length of stay as terminally ill patients are discharged to hospice care earlier and more often. Also, area hospitals could experience reduced avoidable readmissions. Another potential cost impact

[40] Federal Register :: Medicare Program; FY 2022 Hospice Wage Index and Payment Rate Update, Hospice Conditions of Participation Updates, Hospice and Home Health Quality Reporting Program Requirements

for King County would be reduced spending per Medicare beneficiary, since studies show that end of life care provided by hospice is less expensive.

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."**

Payer Mix	Percentage of Gross Revenue	Percentage by Patient
Medicare	87.4%	87.4%
Medicaid	3%	3%
Other Payers (list in individual lines)	9.6%	9.6%
Total	100%	100%

Payer mix assumptions were applied to admissions. Because the average length of stay is assumed to be the same—the Washington State average published in the *2021-2022 Hospice Numeric Need Methodology* posted on November 10, 2021—the ALOS and patient days per admission are presumed to be the same across all payers.

Because *gross* charges are the same for all payers, while net revenue varies by payer due to differing fee schedules and contractual arrangements, the payer mix by gross revenue is the same as payer mix by patient (admission) in the pro forma.

The payer mix for Moments Hospice of King was developed starting with the Washington State hospice census-based payer mix. Based on 2020 Medicare Hospice Cost Reports, the Washington State hospice payer mix comprises 87.4 percent Medicare, 1.8 percent Medicaid, and 10.8 percent "Other". This data does not separate commercial insurers from government plans such as Tricare.

Moments Hospice of King used HealthPivots Medicare Cost Report data to analyze the payer mix of other hospices in King County. Because of the substantial variation between individual hospice providers in King County, Moments Hospice of King began its projection

with a baseline equal to the Washington state hospice payer mix. We then increased the share of Medicaid to 3 percent of the payer mix. We believe this is reasonable because

- Moments anticipates serving a greater percentage of Medicaid enrollees due to targeting underserved populations.
- Racial/ethnic minorities represent a greater proportion of Medicaid recipients versus their respective proportion of the overall population of King County, and Moments initiatives are expected to reach underserved minorities who are more likely to have Medicaid[41] (See Exhibit 13, King County Community Health Needs Assessment 2021/2022)
- CMS data show that Moments exceeds state averages of hospice Medicaid patients served in other markets. For example, in Hennepin County, Minnesota, Moments served 20 percent more Medicaid patients as a percent of its total payer mix compared to the Minnesota state average.
- Reaching underserved hospice patients in nursing home and ALF settings has been a "niche" area for Moments. Data shows that nursing home patients represented 39.1 percent of other Moments affiliates' 2021 census, compared to 9.7 percent in King County. *The tables showing this appear under the "Patient Days by Care Setting" heading, later in this section.*
- Moments' founders/executives have long term care backgrounds, and created the organization in response to unmet needs in the nursing home and ALF settings, and have specialized knowledge of the specific needs of this population—a population which is characterized by a high percentage of Medicaid residents.

All other non-Medicare, non-Medicaid plans, including commercial plans, Tricare, Veterans, etc., are combined under the "Other Net Patient Service Revenue" line, because:

- The payer mix used for Moments of King County projections is not so granular as to include individual payer contracts.
    - The Hospice-specific data sources we used, which utilize Medicare cost report and other data, do not have payer information at this level of detail.

[41] King County Community Health Needs Assessment, 2021-2022

- Commercial payer-provider contracts generally contain confidentiality clauses.
- Commercial insurance plans vary by state and even by city. Large employers who utilize a particular carrier can change the payer mix for the local area. Therefore, we do not feel that internal data from other markets is predictive of Moments Hospice of King County's experience.

Moments has projected that 9.6 percent of its payer sources will come from non-Medicare, non-Medicaid ("Other") sources, such as commercial plans and Tricare, etc. This assumption reflects:

- Moments Hospice of King's aim to serve terminally ill residents under the age of 65, who are typically do not have Medicare benefits, and who are currently underserved.
- Persons with HIV and Cancer diagnoses, who are often under the age of 65, and who also may not yet be Medicare eligible.
- Moments' focus on Veterans, includes partnering with area military medical facilities and physicians
- Immigrants who may not be eligible for Medicare
- Self pay / uninsured patients, particularly homeless persons

Just as in other markets, Moments Hospice of King will credential with as many area payers as possible, to give all King County terminally ill residents access to hospice care. Currently, Moments affiliates participate in approximately 12 insurance plans including major commercial payers such as Blue Cross and Aetna, as well as veterans plans, including VA Community Care

Additionally, Moments is hiring a Revenue Cycle Management executive during the first quarter of 2022, to lead the expansion of commercial and other contracts. This role, and contracting and credentialing in general, are included in the Shared Services Agreement. The cost is included in the Management Fees line item on the pro forma income statement.

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.**

Moments Hospice of King is a new legal entity, not an existing agency, therefore this question is not applicable.

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 expenditure estimate of $15,000 for fixed equipment includes $10,000 for all furnishings for the office, including conference room furniture (large table, chairs), break area furnishings and appliances such as a refrigerator, and reception / waiting area furniture, as well as sales tax of 10.1%. Another $5,000 was included for wiring in the new office building .

The equipment rental line item on the income statement reflects the rental of a copier/scanner for the main office.

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.**

Moments Hospice of King was financed with a loan according to the term sheet attached in Exhibit 43

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

This project will not be debt financed through a financial institution, therefore this question is not applicable.

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

The audited financial statements for Moments Hospice of King, LLC are provided in Exhibit 5. Moments Hospice of King is an independent legal entity, without a parent company, therefore the second part of this question is not applicable.

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.**

Position	FY 2022	FY 2023	FY 2024	FY 2025
Corporate Staff				
Intake Coordinator (Admissions Department)	0.0	0.2	0.7	1.0
Administrative Staff				
Regional Director of Operations	0.0	1.0	1.0	1.0
Regional Medical Director	0.0	0.3	0.3	0.3
Regional Team Assistant	0.0	1.0	1.0	1.0
Field Staff - IDG and Non-Clinical				
Hospice Care Consultants / Clinical Liasons	1.0	1.1	2.0	2.0
Volunteer Coordinator	0.3	0.5	1.0	1.0
Clinical Manager	1.0	1.0	1.0	1.0
Nurses	0.8	2.3	3.3	4.3
On Call RN/LPN	0.0	0.0	0.5	0.7
C.N.A's	1.5	3.5	5.4	5.9
Chaplains	0.4	0.5	0.8	0.9
Social Worker	0.4	0.8	1.1	1.1
Massage Therapist	0.2	0.2	0.5	0.5
Music Therapist	0.2	0.2	0.5	0.5
Dietician	0.3	0.3	0.3	0.3
Total FTEs	**7.4**	**13.0**	**19.4**	**21.5**

The FTEs in the table above are for King County based positions. Many of the corporate and administrative positions are provided through the Shared Services Agreement located in Exhibit 2.

The Medical Director FTEs generated by the staffing model equal 0.3 for the first 3 years, but since this is not an employed position (the Medical Director is an independent contractor), the hours are not shown in the table above.

If the Department of Health has any questions, please ask for additional information.

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.**

Moments Hospice of King is not an existing agency, therefore this question is not applicable.

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

Moments Hospice of King maintains high nurse and hospice aide staffing ratios so patients have the resources they need and the care team is not over-worked. Moments Hospice of King has a 1:12 nurse to patient ratio and a 1:7 aide to patient ratio. As patient census grows at a Moments hospice agency, additional staff are added to maintain the ratios.

Moments Hospice Staffing Ratios

Nurses		Aides	
1:12 Patient Ratio	3–4 Visits per Week	1 to 7 Patient Ratio	5–7 Visits per Week

With the Moments staffing model, Moments hospice agencies can provide aide visits 5–7 times per week and RN visits 3–4 times per week on average. Visits last an average of 50 minutes. Social workers average weekly visits, and chaplains average visits every other week. However, these are only averages. Moments Hospice does not limit visits for any disciplines, continuing its mission to do whatever its patients need and always provide top-level care to patients and their families. The Moments staffing model allows Moments to provide enhanced services while ensuring its teams have manageable workloads and can provide the attention each patient needs.

If the Department of Health has any questions, please ask for additional information.

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

Moments Hospice of King will meet all state and federal service and staffing requirements. However, Medicare hospice staffing requirements are limited, with a nurse mandate for an immediate needs assessment within 48 hours; a more comprehensive physical, psychosocial, emotional, and spiritual needs assessment and integrated care plan within 5 days; and a patient visit every 14 days. The frequency of certified nurse aid visits is not

mandated. While all hospice providers may have the same basic philosophy of care and must meet minimum state and federal requirements, each is different in some way.

Moments' robust staffing model and specialized staff training programs that far exceed minimum requirements are important indicators of its investment in the provision of high-quality hospice care and differentiates Moments Hospice of King from other hospices. Moments has high staffing ratios and low response times. Moments' triage nurses enable enhanced quality control for patient needs. Music therapists and massage therapists are all employed or contracted at the start of any Moments program. In 2020, Moments developed a COVID response team. Volunteers participate in therapy visits, assist with administrative work, and are offered training to become Death Doulas to provide more hands-on care to patients in the Final Moments Program.

Moments' Response Times

Moments maintains high nurse and hospice aide staffing ratios so patients always have the resources they need. Robust staffing also lets Moments provide short response times. Moments is onsite within 2 hours of receiving an admission request. Beyond its high staffing ratios, all Moments staff members, including executive clinical team members, are expected to perform field duties periodically, because Moments wants its leadership to be intimately involved in the care process and to further improve where possible.

Triage Nurses

Moments has in-house triage nurses. These registered nurses (RNs) are a part of the interdisciplinary team, and understand expectations related to high-quality care. The triage nurses answer the phones so patients and families can reach a live person anytime they need help. If the triage nurse is on another call, the incoming call rolls to another nurse or a member of the leadership team. Triage nurses have access to the electronic medical record (EMR) to view the most recent information on the patient's status and orders. Moments' staff complete most documentation at the bedside so the EMR has current information. The triage nurses can answer questions, provide triage support, and even perform telehealth visits with patients. If a patient needs an in-person visit, the triage nurse will dispatch the on-call nurse.

The triage nurses can facilitate medications and durable medical equipment (DME) to meet patients' needs at any time of the day or day of the week. As registered nurses, they can contact physicians, share assessment data, and obtain new physician orders. They can get orders for new medication and order delivery from a local pharmacy so the medication is available when the on-call nurse arrives at the patient's residence, to help the patient obtain an optimal level of comfort quickly. Besides the triage nurses, Moments always has an administrator RN member of the leadership team on call 24/7/365 as an administrator on call (AOC).

Moments will build a strong clinical program in King County, from the experienced leadership team to the direct care clinicians and aides. Having in-house triage nurses supports Moments' commitment to quality care and customer service. When someone calls during the night, there is an important need, or they would not be calling. Moments believes its patients' care is too important to rely on an answering service to contact the on-call nurse. Having RNs answering these calls ensures Moments' patients get the best quality of help and support quickly.

Triage nurses are accounted for in the Shared Services Agreement, under the Management Fees line item on the income statement.

Music and Massage Therapists

Music therapists are part of the Moments interdisciplinary team and attend team meetings. They participate in quality improvement discussions and provide data on their therapy. They also participate in the bereavement program, bringing the benefits of music therapy to families who have lost a loved one. Moments employs board-certified music therapists[42] who participate in continuing education to maintain their certification and improve their abilities to provide meaningful therapy.

Massage therapists are members of the interdisciplinary group and attend team meetings. They share data and insights on patients from a unique viewpoint. They participate in quality assessment performance improvement (QAPI) discussions and provide data on therapy impact. Massage therapists are licensed as required by each state. They

[42] Certification Board for Music Therapists (CBMT) is a member of the Institute for Credentialing Excellence. CBMT's Music Therapist Board Certification (MT-BC) program has been fully accredited by the National Commission for Certifying Agencies since 1986.

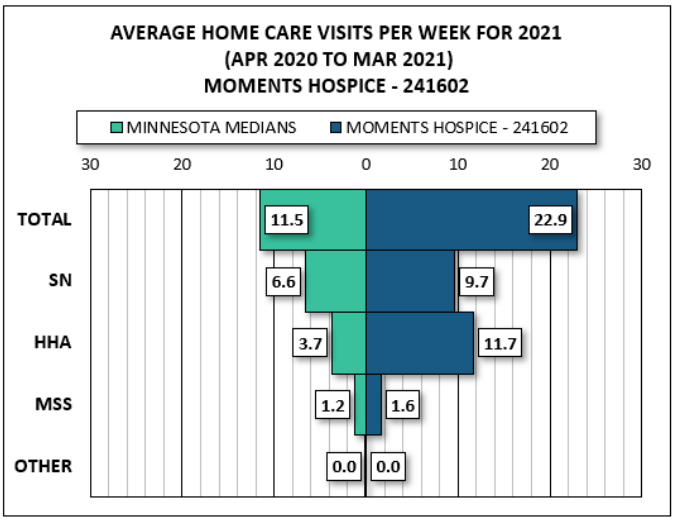
participate in continuing education to maintain their licensure and further their abilities to provide meaningful therapy.

The staffing model proposed for Moments Hospice of King is also used by other Moments Hospice affiliates. CMS data shows that Moments provides more patient care visits than state averages in the areas where other Moments Hospice's operate, and more average visits per week than competitors in those areas:

AVERAGE HOME CARE VISITS PER WEEK FOR 2021 (APR 2020 TO MAR 2021)

MOMENTS HOSPICE - 241602

VISIT TYPE	MOMENTS HOSPICE - 241602	MINNESOTA MEDIANS
TOTAL	22.9	11.5
SN	9.7	6.6
HHA	11.7	3.7
MSS	1.6	1.2
OTHER	0.0	0.0



Source: HealthPivots

Moments Hospice of King's pro forma projections are based on the same census-driven staffing models as other Moments affiliates engaged in providing the same services described herein. Therefore, Moments Hospice of King's projected staffing is adequate for the number of patients and visits projected.

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.**

Dr. John H. Addison, License # MD00018359. The Medical Director is under contract, found in Exhibit 41.

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

This question is not applicable because the Medical Director is/will be an independent contractor and not an employee of Moments Hospice of King.

7. **Identify key staff by name and professional license number, if known. If not yet known, provide a timeline for staff recruitment and hiring (nurse manager, clinical director, etc.)**

The employed staff listed in the FTE chart will be recruited within one to two months prior to opening, and will begin training approximately half a month prior to opening. Many of the team members associated with this project, such as the leadership team, triage nurses, etc., are already working for Moments Hospice, and are allocated to this project through the Shared Services Agreement referenced earlier in this application.

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

Moments Hospice of King is not an existing agency; therefore, this question is not applicable.

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.**

Moments culture, which is common to all Moments affiliates, including King County, is key to employee recruitment and retention. Moments Hospice of King, and all Moments hospice agencies have a family-like atmosphere. Moments leadership cares deeply about the team and assures that every employee is treated with respect. Moments Hospice has a 5-star rating on Indeed.com with a high number of reviews.

Moments Hospice of King's IACC will include local stakeholders who will help guide recruitment efforts locally to ensure a diverse workforce.

Moments offers employees a highly competitive benefits package, with Hospice care can be emotionally difficult for field staff, and Moments is cognizant of the real issue of caregiver burnout. Fun offsite activities and team building exercises help combat burnout.

Healthcare providers all over the country face staffing shortages, which makes recruitment and retention strategies essential to maintain continuity of care. Just as Moments listens to patients and seeks to understand what is important to them, Moments listens to

employees and seeks innovative ways to meet their needs. One example is the Enterprise Fleet Car Lease Program.

Moments' service areas cover a large geographic area, and many employees must drive fairly long distances to care for patients—especially in rural areas. Moments discovered that access to reliable transportation was a struggle for some of its staff and well-qualified applicants. In order to ensure all staff have the resources they need to perform their job, Moments began offering the Enterprise Fleet Management car lease program to qualifying staff members. This program provides a vehicle to staff members which they can use for work travel as well as personal needs. The program includes roadside assistance and all fuel, maintenance and insurance costs. The program does not require staff to make a down payment on the vehicle.

The flyer below from Enterprise provides information on the program and a cost comparison of the Enterprise Fleet program versus the cost for personal ownership of a 2022 Nissan Rogue, as an example. As the example shows, participating in the program offers a cost-effective avenue for employees to secure reliable transportation for their work and personal needs.

COMPANY CAR PROGRAM BENEFITS

- New vehicle every 3-5 Years based on mileage
- Personal use included
- Spouses authorized to drive vehicles
- All fuel, maintenance, insurance included
- 24/7 roadside service
- No wear and tear on your own vehicle for business use
- No out of pocket expenses for surprise repairs & routine maintenance
- Tab renewals handled by EFM
- No down payment on your vehicle
- No credit checks

COST COMPARISON

Company Vehicle

2022 Nissan Rogue

$250 - Monthly Contribution

Personal Vehicle

Based on a loan on a $20,000 vehicle

20,000 annual miles

Monthly Payment	$425
Maint. & Repairs	$ 50
Insurance	$100
Gas	$250
Tax, lic, Registration	$ 35
Total	**$860**

Assuming 10,000 are business miles being reimbursed at

$0.535 per mile, you would receive $445/month from the company.

Your net cost is still $415 month!

enterprise FLEET MANAGEMENT

In King County, Moments Hospice of King will continue to listen to employees and applicants and seek innovative ways to update the benefits offered in order to recruit and retain talent. Because Moments is a lean organization, without numerous layers of management, Moments Hospice of King can be responsive to employee needs.

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

Moments Hospice of King's hours of operation are 24 hours a day, 7 days a week. The administrative office will be open from 8:00 A.M. to 5:00 P.M., Monday through Friday. Moments Hospice's call center and triage nurses will be available to patients and their providers and family members 24 hours a day, 7 days a week, including during times when the administrative office is shut down due to holiday or weather-related closures.

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

This item is not applicable, since Moments Hospice of King, LLC is a new entity.

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

This item is not applicable, since Moments Hospice of King, LLC is a new entity.

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

Because Moments Hospice of King, LLC is a new entity, this item is not applicable. Please reference C.14.

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

Durable medical equipment, pharmacy, lab, hospital, and nursing home care are some of the support services that will be established.

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

This item is not applicable, since Moments Hospice of King, LLC is a new entity.

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

This item is not applicable, since Moments Hospice of King, LLC is a new entity. See instead response to C.17.

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

Moments Hospice of King will proactively strive to develop partnerships with King County hospital, nursing home, and ALF facilities. The table below[43] shows a list of hospitals serving King County hospice patients. Moments Hospice of King will analyze data from King County hospital facilities to identify opportunities to reach hospice eligible patients.

Hospital	Hospital Location (County)	Market Share
SWEDISH MEDICAL CENTER - 500027	King, WA	13.2%
VALLEY MEDICAL CENTER - 500088	King, WA	11.9%
OVERLAKE HOSPITAL MEDICAL CENTER - 500051	King, WA	9.6%
UW MEDICINE/NORTHWEST HOSPITAL - 500001	King, WA	7.7%
EVERGREENHEALTH MEDICAL CENTER - 500124	King, WA	6.8%
VIRGINIA MASON MEDICAL CENTER - 500005	King, WA	6.3%
UNIVERSITY OF WASHINGTON MEDICAL CTR - 500008	King, WA	6.1%
HARBORVIEW MEDICAL CENTER - 500064	King, WA	5.3%
SWEDISH MEDICAL CENTER / CHERRY HILL - 500025	King, WA	4.4%
ST ANNE HOSPITAL - 500011	King, WA	4.2%
SWEDISH ISSAQUAH - 500152	King, WA	4.2%
ST FRANCIS COMMUNITY HOSPITAL - 500141	King, WA	4.2%
MULTICARE AUBURN MEDICAL CENTER - 500015	King, WA	3.7%
SWEDISH EDMONDS HOSPITAL - 500026	Snohomish, WA	1.4%
ST JOSEPH MEDICAL CENTER - 500108	Pierce, WA	1.4%
TACOMA GENERAL ALLENMORE HOSPITAL - 500129	Pierce, WA	1.3%
MULTICARE GOOD SAMARITAN HOSPITAL - 500079	Pierce, WA	0.8%
ST ELIZABETH HOSPITAL - 501335	King, WA	0.7%
PROVIDENCE REGIONAL MEDICAL CENTER EVERETT - 500014	Snohomish, WA	0.6%
MULTICARE COVINGTON MEDICAL CENTER - 500154	King, WA	0.4%
SEATTLE CANCER CARE ALLIANCE - 500138	King, WA	0.1%
KITTITAS VALLEY COMMUNITY HOSPITAL - 501333	Kittitas, WA	0.1%
EVERGREENHEALTH MONROE - 500084	Snohomish, WA	0.1%
SEATTLE CHILDREN'S HOSPITAL - 503300	King, WA	0.1%
SNOQUALMIE VALLEY HOSPITAL - 501338	King, WA	0.1%
LAKE CHELAN COMMUNITY HOSPITAL - 501334	Chelan, WA	0.0%
KAISER PERMANENTE CENTRAL HOSPITAL - 500052	King, WA	0.0%

Source: HealthPivots

The Washington State Department of Social and Health Services lists the following nursing home licensees in King County[44]:

[43] HealthPivots, 2018 Hospital Market Share
[44] NH Facility Search (wa.gov)

Licensee Name	County
WA3 OP Talbot LLC	King
WA3 OP Renton LLC	King
Fort Ebey Holdings, LLC	King
AVALON CARE CENTER - FEDERAL WAY LLC	King
VIRGINIA MASON MEDICAL CENTER	King
820 NW 95th Street Operations LLC	King
BAYVIEW MANOR HOMES	King
AVALON CARE CENTER - KENT LLC	King
Timber Ridge OpCo LLC	King
BURIEN POST-ACUTE SERVICES, INC.	King
Evergreen Washington Healthcare Auburn LLC	King
THE CAROLINE KLINE GALLAND HOME	King
COLUMBIA LUTHERAN MINISTRIES	King
EASTSIDE RETIREMENT ASSOCIATION	King
Covenant Living West	King
Evergreen Washington Healthcare Enumclaw LLC	King
STATE OF WASHINGTON	King
FOSS HOME AND VILLAGE	King
FEDERAL WAY MEDICAL INVESTORS LLC	King
CONSOLIDATED RESOURCES HEALTH CARE FUND I LP	King
LUTHERAN RETIREMENT HOME OF GREATE	King
NORTHWEST CARE - ISSAQUAH, INC.	King
HumanGood Washington	King
KIN ON HEALTH CARE CENTER	King
Wesley Homes Lea Hill LLC	King
CONSOLIDATED RESOURCES HEALTH CARE FUND I LP	King
LAKE VUE OPERATIONS, LLC	King
MIRABELLA	King
Mission Healthcare at Bellevue JV	King
Mission Healthcare at Bellevue JV	King
North Auburn Health, LLC	King
Middles Holdings, LLC	King
NORTHWEST CARE - SHORELINE, INC.	King
PRESBYTERIAN RETIREMENT COMMUNITIE	King
NORTHWEST CARE - WEST SEATTLE, INC.	King
Providence Health & Services - Washington	King
Providence Health & Services - Washington	King
SEATTLE OPERATIONS LLC	King
UNION HILL HEALTHCARE INC	King
RICHMOND BEACH REHAB LLC	King
SAINT ANNE CORPORATION	King
Evergreen Washington Healthcare Seattle LLC	King
Lake Washington Healthcare, Inc.	King
STAFFORD HEALTHCARE, SEATAC, LLC	King
SUNRISE HAVEN	King
Watermark Bellevue LLC	King
FH LLC	King
EmpRes at Seattle, LLC	King
WCC Operator LLC	King
Wesley Homes Des Moines LLC	King

A list of King County Assisted Living Facilities is attached in Exhibit 46.

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.**

Moments Hospice of King is a new legal entity, which has not commenced operation yet, and therefore the facility portion of this question does not apply. The practitioner associated with this application has no history of any of the actions listed in parts a, b, c, or d or this question.

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**

Moments Hospice of King will coordinate care for hospice patients. Continuity of care will be promoted through the interdisciplinary approach. By avoiding unnecessary hospitalizations, hospital readmissions, and emergency department visits, Moments Hospice of King will reduce fragmentation of care. Moments Hospice agencies partner with over 300+ nursing homes and ALFs. The relationships and communication with these facilities contributes to continuity in the provision of health care services.

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.**

Moment Hospice of King's leadership team oversees the implementation of de novo hospice programs. The Moments' leadership team's extensive experience and successful track record with start-up hospices in different parts of the country ensures appropriate integration with the existing healthcare infrastructure in King County.

The Moments Hospice of King leadership team is well-acquainted with federal and other program requirements, and has a replicable start-up model which has been successfully deployed in multiple new markets and which will all Moments Hospice of King to quickly establish a new hospice agency in King County.

Moments Hospice of King is able to tap into Moments Hospice's leadership's teams experience working for other providers, such as hospitals, nursing homes, ALFs, and physicians. Consequently, Moments Hospice of King will be able to effectively partner with the other providers in the existing healthcare system to increase hospice utilization, while understanding and maximizing the benefits of hospice for other provider types. For example, Moments Hospice of King's presence in nursing homes will allow nursing home staff to focus on providing appropriate care to patients, while leaving end of life care to hospice. Moments Hospice of King will collaborate with hospitals to reduce hospital mortality rates, avoidable readmissions, and reduce hospital average length of stay. Moments will work with physicians to address end of life care for their patients.

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.**

Moments Hospice of King is a new legal entity, therefore this question is not applicable. Furthermore, affiliated Moments Hospices's do not have a pattern of condition-level findings, therefore this question is 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.**

This question is not applicable, as there is no history of condition-level findings against the Applicant or any affiliated Moments entities.

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.**

Moments Hospice of King is responding to the Department of *Health's 2021-2022 Hospice Numeric Need Methodology* posted on November 10, 2021, which publicized the need for two additional hospice providers in King County. Moments Hospice expanded outside of

the Midwest after one of Moments' executives experienced, firsthand, the need for hospice services in Florida. Moments responded to this need and obtained certificate of need approval for Miami-Dade and Monroe counties. Moments identified King County, Washington because of its mission to bring hospice services to areas with a need. Therefore, Moments selected King County over other areas without a published need.

Moments Hospice has carefully weighed the costs and benefits of pursing the creation of a new hospice agency in King County versus not pursuing the creation of a new hospice in King County ("this project versus no project"). The alternative to this project would be for Moments Hospice of King to not respond to the needs of King County's terminally ill residents.

Moments has successfully launched several start-up hospices in diverse communities, including other counties with similarities to King County (including, but not limited to, counties with diverse populations, counties with a mix of urban and rural residents, counties with a large foreign-born population, counties with underserved LGBTQ+ patients). Moments has proven capabilities with respect to entering competitive markets and quickly ramping up new hospice admissions by meeting the unmet needs of underserved subpopulations. Moments Hospice of King is a lean, nimble, cost-effective organization which, upon CON approval, could move very quickly obtain licensure and begin immediately serving King County's underserved terminally ill residents. Therefore, establishing Moments Hospice of King in King County fit the criteria for the best project to pursue.

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.**

Moments Hospice of King rejected the idea of not pursuing a new hospice agency in King County, based on the following factors:

Patient access to healthcare services. Moments brings relevant experience in niche areas as well as the replicable ability to quickly launch financially sound de novo hospices

while giving back to the communities it serves. Were Moments Hospice of King not to pursue this project, then other hospice providers who are “more of the same” in King County would be unlikely to bring hospice serves to currently underserved populations.

Capital cost. Moments Hospice if King is a lean organization with an effective shared services model which allows Moments to invest in direct patient care. Capital costs are minimal, allowing Moments to quickly respond to King County’s needs. Not pursuing the project would have minimal impact in terms of capital.

Legal restrictions. Not pursuing the project would result in legal constraints upon future attempts to serve the underserved in King County, due to CON related time frames and requirements. Moments Hospice of King is ready to respond to King County residents’ needs now, in this CON cycle**.**

Staffing impacts. King County represents a new service area, and as such, new jobs will be created for patient care and other roles. Were Moments Hospice of King not to pursue this project, then the new King County jobs associated with this project would not be created and available to King County residents and the King County economy. Staff allocated through the shared services agreement would not be impacted by a decision not to pursue the project.

Quality of care. Moments Hospice of King offers quality of care and patient choice. To not pursue the project would deprive King county residents of the quality care specific to the Moments brand.

Cost / operational efficiency. Through growth, Moments hospice agencies realize additional efficiencies and cost savings, which allow Moments hospice agencies to expand program and service offerings, give back to the communities they serve, and invest in infrastructure and capabilities. Not pursuing this project would restrict the growth that furthers cost and operational efficiencies.

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.**

The proposed project does not involve construction; therefore, this question is 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.**

This project will improve and innovate the financing and delivery of healthcare, while fostering cost containment/ cost effectiveness and promoting quality assurance in the following ways:

- **Economies of scale and efficiencies** through an established shared services model, Moments Hospice of King can allocate greater resources to direct patient care, including a high level of visits.
- **Innovation.** Moments Hospice of King's access to technology, including the Home Care Home Base EMR system, artificial intelligence and data mining tools such as MUSE, and telehealth will bring innovation and better quality to King County's terminally ill residents
- **Healthy competition** spurs area hospices to engage in continuous improvement in quality and service offerings.
- **Relief of cost pressure on pandemic-stressed hospitals**. Moments Hospice of King will facilitate timely discharge to hospitals from inpatient hospital beds, reducing hospital ALOS and the associated labor, supply, and other costs. Through its disease-specific clinical programs, 24-7 access to clinical staff, and patient education, Moments will reduce costly emergency room visits.
- **Allow patients to die at home**. Moments Hospice of King will reduce end of life hospitalizations and allow patients to die in their own homes. Homeless hospice patients will be provided with shelter and dignity during the end-of-life period.
- **Enable long term care facilities** to focus on their core business. By collaborating with facilities, so that nursing home staff do not need to provide the end of life care that is best provided by hospice.

- **Access to timely initiation of hospice services, and therefore increased hospice benefits.**

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.

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.

   No.

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

This question is not applicable, due to the response to the first question in this section.

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

This question is not applicable, due to the response to the first question in this section.

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.**

This question is not applicable, due to the response to the first question in this section.

Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310 Certificate of Need Program 'Frequently Asked Questions'

Commonly Referenced Rules for Hospice Projects:

WAC Reference	Title/Topic
246-310-010	Certificate of Need Definitions
246-310-200	Bases for findings and action on applications
246-310-210	Determination of Need
246-310-220	Determination of Financial Feasibility
246-310-230	Criteria for Structure and Process of Care
246-310-240	Determination of Cost Containment
246-310-290	Hospice services—Standards and need forecasting method.

Certificate of Need Contact Information:
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

Licensing Resources:
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335

Hospice Agencies Program Web Page

UNITED STATES OF AMERICA

The State of Washington

Secretary of State

I, STEVE R. HOBBS, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

CERTIFICATE OF FORMATION

to

MOMENTS HOSPICE OF KING, LLC

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

Effective Date: 12/01/2021
UBI Number: 604 840 942

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

Steve R. Hobbs, Secretary of State

Date Issued: 12/01/2021

SHARED SERVICES AGREEMENT

THIS SHARED SERVICES AGREEMENT (the "Agreement") is entered into effective as of the 1st day of January, 2022, by and between Guardian Hospice MN, LLC, a Minnesota corporation ("Service Provider"), and Moments Hospice of King, LLC, a Washington limited liability company, its subsidiaries, affiliates, successors and assigns ("Company"). Service Provider and Company may be referred to in this Agreement separately as a "Party" or collectively as the "Parties."

WITNESSETH:

WHEREAS, Company desires to receive certain administrative and support services from Service Provider, subject to the terms and conditions described in this Agreement; and

WHEREAS, in order to assist Company in general operations, Service Provider desires to provide such services to Company, subject to the terms and conditions described in this Agreement.

NOW, THEREFORE, in consideration of the covenants and agreements set forth in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties, intending to be legally bound hereby, agree as follows:

ARTICLE I
SERVICES

SECTION 1.1 SERVICES. Subject to the terms and conditions of this Agreement, Service Provider, acting directly or through its Affiliates (as hereafter defined) or their respective employees, agents, contractors or independent third parties, agrees to provide or cause to be provided to Company, its Affiliates and its subsidiaries the services set forth on Exhibit "A" (with any additional services provided pursuant to Section 1.3 being collectively referred to as the "Services"). Company acknowledges and agrees that, except as may be expressly set forth in this Agreement as to a Service, Service Provider shall not be obligated to provide, or cause to be provided, any service or goods to Company. For purposes of this Agreement, "Affiliate" shall mean as to any person another person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with, such person, and "control" shall mean the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person controlled, whether through ownership of voting securities, by contract or otherwise.

SECTION 1.2 SERVICE COORDINATORS. Each Party will nominate a representative to act as its primary contact with respect to the provision of the Services as contemplated by this Agreement (collectively, the "Service Coordinators"). Unless otherwise agreed, all notices and communications relating to this Agreement other than those day to day communications and billings relating to the actual provision of the Services shall be directed to the Service Coordinators.

SECTION 1.3 ADDITIONAL SERVICES. Subject to any limitations set forth in this Agreement and Exhibit "A", Company may request additional Services from Service Provider by

providing written notice. Upon the mutual written agreement as to the nature, cost, duration and scope of such additional Services, the Parties shall supplement in writing Exhibit "A" to include such additional Services. In accordance with Section 3.2, the Parties may discontinue one or more Services under this Agreement.

SECTION 1.4 EMPLOYEES, STANDARD OF PERFORMANCE AND LEGAL COMPLIANCE.

(a) Service Provider shall cause its employees (collectively, the "Employees") to devote such time and effort to the business of Company as shall be reasonably necessary to perform the Services; provided, that the Employees shall not be precluded from engaging in other business activities for or on behalf of Company or its Affiliates. All duties and services of the Employees shall be rendered at the offices of Company, unless such duty or service is determined to be of a remote nature. Unless otherwise expressly provided for in this Agreement, all matters pertaining to the employment of the Employees are the sole responsibility of Service Provider, which shall in all respects be the employer of such Employees. At no time shall the employees, agents and consultants of Service Provider, any independent contractors engaged by Service Provider and/or the employees of any such independent contractors be considered employees of Company. This Agreement is not one of agency between Service Provider and Company, but one with Service Provider engaged independently in the business of providing services as an independent contractor. All employment arrangements are therefore solely Service Provider's concern, and Company shall not have any liability with respect thereto except as otherwise expressly set forth in this Agreement.

(b) The Services shall be performed with the same general degree of care as when performed within Service Provider's organization. In the event Service Provider fails to provide, or cause to be provided, the Services, the sole and exclusive remedy of Company shall be to, at Company's sole discretion, either (i) have the Service performed until satisfactory, or (ii) not pay for such Service, or if payment has already been made, receive a refund of the payment made for such defective service; provided that in the event Service Provider defaults in the manner described in Section 3.3, Company shall have the further rights set forth in Section 3.3.

(c) Service Provider further covenants and represents to Company that it shall comply in all material respect with all applicable laws, rules, regulations and requirements of any governmental body which may be applicable to the Services provided by Service Provider. Service Provider shall obtain and maintain all material permits, approvals and licenses necessary or appropriate to perform its duties and obligations (including all Services) under this Agreement and shall at all times comply with the terms and conditions of such permits, approvals and licenses. Service Provider shall notify Company's service coordinator immediately upon receipt of notice of (i) any material threatened or pending governmental orders, proceedings or lawsuit involving Service Provider or (ii) any material violations relating to the use or maintenance of Service Provider's assets.

SECTION 1.5 CONFLICT WITH LAWS. Notwithstanding any other provision of this Agreement, Service Provider shall not be required to provide a Service to the extent the provision thereof would violate or contravene any applicable law. To the extent that the provision of any such Service would violate any applicable law, the Parties agree to work together in good faith to provide such Service in a manner which would not violate any law.

ARTICLE II
SERVICE CHARGES

SECTION 2.1 COMPENSATION. As compensation for the Services and any expenses reasonably incurred by Service Provider in providing the Services during the term of this Agreement, Company shall pay Service Provider as provided in Exhibit "A" or at such hourly rates or other amounts that are otherwise mutually agreed to in writing between the Parties.

SECTION 2.2 PAYMENT. Any amounts due to Service Provider from Company for the Services shall be due and payable within thirty (30) days after the calendar month in which the Services were provided. All invoices should be paid in their entirety and any disputed charges should be stated in writing to Service Coordinator identified in Section 1.2 of this agreement.

ARTICLE III
TERM AND DISCONTINUATION OF SERVICES

SECTION 3.1 TERM. The term of this Agreement shall be effective as of the date first written above and shall continue in force until the earlier of (i) two (2) years from the date of this Agreement or (ii) the termination of all Services in accordance with Section 3.3. Upon the expiration of the term, this Agreement shall continue on a month-to-month basis until canceled by either Party upon thirty (30) days prior written notice. Any extension of this Agreement must be made by the Parties in writing.

SECTION 3.2 DISCONTINUANCE OF SERVICES. Either Party may, upon not less than sixty (60) days prior written notice, elect to discontinue any individual Service from time to time. In the event of any termination with respect to one or more, but less than all, of the Services, this Agreement shall continue in full force and effect with respect to any remaining Services. The Parties shall supplement Exhibit "A" to reflect the termination of any such Services.

SECTION 3.3 TERMINATION. This Agreement may be terminated as follows: (i) Either Party may terminate this Agreement at any time upon not less than sixty (60) days written notice to the other Party; or (ii) either Party may terminate this Agreement upon immediate written notice if the other Party is in material breach or default with respect to any term or provision of this Agreement and fails to cure the same within thirty (30) days of receipt of notice of such breach or default. Company's right to terminate this Agreement as provided in this Section 3.3 and the rights set forth in Sections 1.4(b) and 4.1 shall constitute Company's sole and exclusive rights and remedies for a breach by Service Provider under this Agreement including, but not limited to, any breach caused by an Affiliate of Service Provider or other third party providing a Service. Upon the termination of this Agreement by Company, Service Provider shall be entitled to immediate payment of any unpaid balance of any amounts due or to be due to Service Provider through the date of termination. Regardless of the reason for the termination of this Agreement, Company's rights under Section 4.2 shall survive any termination of this Agreement.

SECTION 3.4 FILES. Service Provider will maintain files related to the Services that, in its sole judgment, it determines are necessary for the conduct of this Agreement. After termination of this Agreement, Service Provider will maintain all files related to the Services for one year.

During the period in which Service Provider maintains the files, Company may request to examine the files and to copy documents in the files, up to not later than one year after termination of this Agreement, after which Service Provider may destroy the files in accordance with its then-existing records retention policy.

ARTICLE IV
INDEMNIFICATION

SECTION 4.1 BY COMPANY. Company, its Affiliates and their respective shareholders, members, partners, directors, managers, officers, employees and agents shall have no liability for any damages, losses, deficiencies, obligations, penalties, judgments, settlements, claims, payments, fines, interest costs and expenses, including the costs and expenses of any and all actions and demands, assessments, judgments, settlements and compromises relating thereto and the costs and expenses of attorneys, accountants, consultants and other professionals fees and expenses incurred in the investigation or defense thereof or the enforcement of rights hereunder (collectively, the "Losses") to Company, its Affiliates or their respective shareholders, members, partners, directors, managers, officers, employees or agents (the "Service Provider Indemnified Parties") with respect to any Services, except that Service Provider shall be liable to the Company Indemnified Parties for Losses arising out of or resulting from the gross negligence or willful misconduct of Service Provider. Service Provider will indemnify, defend and hold harmless the Company Indemnified Parties from and against any Losses arising out of or resulting from such gross negligence or willful misconduct by Service Provider.

SECTION 4.2 BY SERVICE PROVIDER. Service Provider shall indemnify, defend and hold harmless Company, its Affiliates and their respective shareholders, members, partners, directors, managers, officers, employees and agents from and against any Losses arising out of or resulting from Service Provider providing the Services, except for Losses arising out of or resulting from the gross negligence or willful misconduct of Service Provider.

ARTICLE V
CONFIDENTIALITY

SECTION 5.1 CONFIDENTIALITY. The Parties shall hold and shall cause their respective shareholders, members, partners, directors, managers, officers, employees, agents, consultants and advisors to hold, in strict confidence and not to disclose or release without the prior written consent of the other Party, any and all Confidential Information (as hereafter defined); provided, that the Parties may disclose, or may permit disclosure of, Confidential Information (i) to their respective auditors, attorneys, financial advisors, bankers and other appropriate consultants and advisors who have a need to know such information and are informed of their obligation to hold such information confidential to the same extent as is applicable to the Parties and in respect of whose failure to comply with such obligations, Service Provider or Company, as the case may be, will be responsible, or (ii) to the extent any member of a Party is compelled to disclose any such Confidential Information by judicial or administrative process or, in the opinion of legal counsel, by other requirements of law.

SECTION 5.2 PROTECTIVE ORDER. Notwithstanding the foregoing, in the event that any demand or request for disclosure of Confidential Information is made pursuant to Section 5.1(ii) above, either Party, as the case may be, shall promptly notify the other Party of

the existence of such request or demand and shall provide the other Party with a reasonable opportunity to seek an appropriate protective order or other remedy, which both Parties will cooperate in seeking to obtain. In the event that such appropriate protective order or other remedy is not obtained, the Party whose Confidential Information is required to be disclosed shall or shall cause the other Party to furnish, or cause to be furnished, only that portion of the Confidential Information that is legally required to be disclosed.

SECTION 5.3 CONFIDENTIAL INFORMATION DEFINED. For purposes of this Agreement, "Confidential Information" shall mean any and all proprietary, technical or operational information, data or material of a Party of a non-public or confidential nature, whether marked as such or not, which has been disclosed by a Party to the other Party in written, oral (including by recording), electronic, or visual form to, or otherwise has come into the possession of, the other Party, (except to the extent that such Confidential Information can be shown to have been (a) in the public domain through no fault of a Party or (b) later lawfully is acquired by the Receiving Party from another source that does not have any confidentiality obligations to the other Party).

SECTION 5.4 INTELLECTUAL PROPERTY. All intellectual property, including without limitation, recommendations, specifications, maps, cross-sections, technical data, drawings, plans, calculations, analyses, reports and other documents or digital information prepared by Company, its employees and contractors under the Agreement, shall remain the property of Company. At Company's request, such intellectual property shall be delivered to Company upon completion of Service Provider's services under the Agreement. All copyrights, patents, trade secrets, or other intellectual property rights associated with any ideas, concepts, techniques, inventions, processes, or works of authorship developed or created by Service Provider during the course of performing work for Company shall belong exclusively to Company.

ARTICLE VI
FORCE MAJEURE

SECTION 6.1 PERFORMANCE EXCUSED. Continued performance of a Service may be suspended immediately to the extent caused by any event or condition beyond the reasonable control of the Party suspending such performance including, but not limited to, any act of God, fire, labor or trade disturbance, war, civil commotion, compliance in good faith with any law, unavailability of materials or other event or condition whether similar or dissimilar to the foregoing (each, a "Force Majeure Event").

SECTION 6.2 NOTICE. The Party claiming suspension due to a Force Majeure Event will give prompt notice to the other Party of the occurrence of the Force Majeure Event giving rise to the suspension and of its nature and anticipated duration.

SECTION 6.3 COOPERATION. The Parties shall cooperate with each other to find alternative means and methods for the provision of the suspended Service.

ARTICLE VII
REPRESENTATIONS AND WARRANTIES

SECTION 7.1 Service Provider. Service Provider represents and warrants to Company that as of the date of this Agreement:

(a) Service Provider is a limited liability company duly organized, validly existing and in good standing under the laws of the State of Minnesota and has full power and authority to execute, deliver and perform this Agreement.

(b) The execution, delivery and performance of this Agreement have been duly authorized by all necessary action on the part of Service Provider and do not violate or conflict with its organizational documents, as amended, any material agreement to which Service Provider or its assets are bound or any provision of law applicable to Service Provider.

(c) All consents, authorizations and approvals of, and registrations and declarations have been obtained and are in full force and effect, and all conditions thereof have been materially complied with.

(d) This Agreement constitutes the legal, valid, and binding obligation of Service Provider enforceable against Service Provider in accordance with its terms, subject, as to enforcement, to bankruptcy, insolvency, reorganization and other laws of general applicability relating to or affecting creditors' rights and to general equity principles.

SECTION 7.2 Company. Company represents and warrants to Service Provider that as of the date of this Agreement:

(a) Company is a corporation duly organized, validly existing and in good standing under the laws of the State of Washington and has full power and authority to execute, deliver and perform this Agreement.

(b) The execution, delivery and performance of this Agreement have been duly authorized by all necessary action on the part of the Company and do not violate or conflict with its organizational documents, as amended, any material agreements to which Company or its assets are bound or any provision of law applicable to Company.

(c) All consents, authorizations and approvals of, and registrations and declarations with, any governmental authority necessary for the due execution, delivery and performance of this Agreement have been obtained and are in full force and effect and all conditions thereof have been materially complied with, and no other action by, and no notice to or filing with, any governmental authority is required in connection with the execution, delivery or performance of this Agreement.

(d) This Agreement constitutes the legal, valid and binding obligation of Company enforceable against Company in accordance with its terms, subject, as to enforcement, to bankruptcy, insolvency, reorganization, and other laws of general applicability relating to or affecting creditors' rights and to general equity principles.

ARTICLE VIII
MISCELLANEOUS

SECTION 8.1 CONSTRUCTION RULES. The article and section headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or

interpretation of this Agreement. Words used in this Agreement in the singular, where the context so permits, shall be deemed to include the plural and vice versa. Words used in the masculine or the feminine, where the context so permits, shall be deemed to mean the other and vice versa. The definitions of words in the singular in this Agreement shall apply to such words when used in the plural where the context so permits and vice versa, and the definitions of words in the masculine or feminine in this Agreement shall apply to such words when used in the other form where the context so permits and vice versa. Any reference to a section number in this Agreement shall mean the section number in this Agreement unless otherwise expressly stated. All exhibits attached to this Agreement are hereby incorporated by reference, and any reference to an exhibit in this Agreement shall mean the exhibit attached to this Agreement unless otherwise expressly stated. The words "hereof," "herein" and "hereunder" and words of similar import referring to this Agreement refer to this Agreement as a whole and not to any particular provision of this Agreement.

SECTION 8.2 NOTICES. Any notices or communications required or permitted to be given by this Agreement must be (i) given in writing, and (ii) be personally delivered or mailed by prepaid mail or overnight courier, or by facsimile or electronic transmission delivered or transmitted to the Party to whom such notice or communication is directed, to the address of such Party as follows:

If to Service Provider: Guardian Hospice MN, LLC
820 Lilac Dr. N, Suite 210
Golden Valley, MN 55422
Attn: Chief Executive Officer

If to Company: Moments Hospice of King, LLC
820 Lilac Dr. N, Suite 210
Golden Valley, MN 55422
Attn: Chief Executive Officer

Any such notice or communication shall be deemed to have been given on (i) the day such notice or communication is personally delivered, (ii) three (3) days after such notice or communication is mailed by prepaid certified or registered mail, (iii) one (1) working day after such notice or communication sent by overnight courier, or (iv) the day such notice or communication is faxed or sent electronically and the sender has received a confirmation of such fax or electronic transmission. A Party may, for purposes of this Agreement, change its address, fax number, email address or the person to whom a notice or other communication is marked to the attention of, by giving notice of such change to the other Party pursuant hereto.

SECTION 8.3 ASSIGNMENT; BINDING EFFECT. Neither Party may assign or delegate any of its respective rights, duties or obligations under this Agreement (whether by operation of law or otherwise) without the prior written consent of the other Party; provided, that the foregoing shall in no way restrict the assignment of this Agreement by Service Provider for the performance of a Service by an Affiliate of Service Provider or a third party as otherwise allowed under this Agreement, without prior notice to Company. This Agreement shall be binding upon, and shall inure to the benefit of, the Parties and their respective successors and permitted assigns.

SECTION 8.4 NO THIRD PARTY BENEFICIARIES. Except as specifically set forth in this Agreement, nothing in this Agreement is intended to or shall confer upon any party (other than the Parties) any legal or equitable right, benefit or remedy of any nature whatsoever under or by reason of this Agreement, and no party (except as so specified) shall be deemed a third-party beneficiary under or by reason of this Agreement.

SECTION 8.5 AMENDMENT. No amendment, addition to, alteration, modification or waiver of any part of this Agreement shall be of any effect, whether by course of dealing or otherwise, unless explicitly set forth in writing referencing this Agreement and the provision(s) to be amended, altered, modified or waived and executed by the Parties. If the provisions of this Agreement and the provisions of any purchase order or order acknowledgment written in connection with this Agreement conflict, the provisions of this Agreement shall prevail.

SECTION 8.6 WAIVER; REMEDIES. The waiver by a Party of any breach of any provision of this Agreement shall not operate or be construed as a waiver of any subsequent breach. The failure of a Party to require strict performance of any provision of this Agreement shall not affect such Party's right to full performance thereof at any time thereafter. No right, remedy or election given by any term of this Agreement or made by a Party shall be deemed exclusive, but shall be cumulative with all other rights, remedies and elections available at law or in equity. The Parties acknowledge that the rights created hereby are unique and recognizes and affirms that in the event of a breach of this Agreement irreparable harm would be caused, money damages may be inadequate and an aggrieved Party may have no adequate remedy at law. Accordingly, the Parties agree that the other Party shall have the right, in addition to any other rights and remedies existing in its favor at law or in equity, to enforce such Party's rights and the obligations of the other Party not only by an action or actions for damages but also by an action or actions for specific performance, injunctive and/or other equitable relief (without posting of a bond or other security).

SECTION 8.7 SEVERABILITY. If any provision contained in this Agreement shall for any reason be held to be invalid, illegal, void or unenforceable in any respect, such provision shall be deemed modified so as to constitute a provision conforming as nearly as possible to the invalid, illegal, void or unenforceable provision while still remaining valid and enforceable and the remaining terms or provisions contained in this Agreement shall not be affected thereby.

SECTION 8.8 MULTIPLE COUNTERPARTS. This Agreement may be executed in one or more counterparts, by facsimile or otherwise, each of which shall be deemed to be an original but all of which together will constitute one and the same instrument.

SECTION 8.9 RELATIONSHIP OF PARTIES. Notwithstanding the actual relationship between the Parties, this Agreement does not create a fiduciary relationship, partnership, joint venture or relationship of trust or agency between the Parties.

SECTION 8.10 FURTHER ACTIONS. From time to time, the Parties agree to execute and deliver such additional documents, and take such further actions, as may be requested or necessary to carry out the terms of this Agreement.

SECTION 8.11 REGULATIONS. All employees of Service Provider and its Affiliates shall, when on the property of Company, conform to the rules and regulations of Company

concerning safety, health and security which are made known to such employees in advance in writing.

SECTION 8.12 ENTIRE AGREEMENT. This Agreement and the exhibits constitute the entire agreement of the Parties with respect to the subject matter hereof and supersedes and cancels all prior agreements and understandings, either oral or written, between the Parties with respect to the subject matter hereof.

SECTION 8.13 CONSTRUCTION. In the event an ambiguity or question of intent or interpretation arises, this Agreement shall be construed as if drafted by the Parties, and no presumption or burden of proof shall arise favoring or disfavoring any Party by virtue of the authorship of any of the provisions of this Agreement.

SECTION 8.14 GOVERNING LAW; VENUE; JURISDICTION. All issues and questions concerning the construction, validity, enforcement and interpretation of this Agreement shall be governed by, and construed in accordance with, the laws of the State of California, without giving effect to any choice of law or conflict of law rules or provisions (whether of the State of California or any other jurisdiction) that would cause the application of the laws of any jurisdiction other than the State of California. The Parties further agree that any dispute arising out of this Agreement shall be decided by either the state or federal court in Los Angeles County, California. The Parties shall each submit to the jurisdiction of those courts and agree that service of process by certified mail, return receipt requested, shall be sufficient to confer said courts with *in personam* jurisdiction.

SECTION 8.15 LIMITATION OF LIABILITY. UNDER NO CIRCUMSTANCES AND UNDER NO LEGAL OR EQUITABLE THEORY, WHETHER IN TORT, CONTRACT, STRICT LIABILITY OR OTHERWISE, SHALL EITHER PARTY, ITS AFFILIATES OR THEIR RESPECTIVE SHAREHOLDERS, MEMBERS, PARTNERS, DIRECTORS, MANAGERS, OFFICERS, EMPLOYEES OR AGENTS BE LIABLE TO THE OTHER PARTY OR TO ANY OTHER PERSON FOR ANY INDIRECT, SPECIAL, INCIDENTAL OR CONSEQUENTIAL LOSSES OR DAMAGES OF ANY NATURE ARISING OUT OF OR IN CONNECTION WITH THIS AGREEMENT OR THE SERVICES INCLUDING, BUT NOT LIMITED TO, DAMAGES FOR LOST MARKETING, LOST PROFITS, LOSS OF GOODWILL, LOSS OF DATA OR WORK STOPPAGE, EVEN IF AN AUTHORIZED REPRESENTATIVE OF SUCH PARTY HAS BEEN ADVISED OF OR SHOULD HAVE KNOWN OF THE POSSIBILITY OF SUCH DAMAGES. SERVICE PROVIDER'S LIABILITY HEREUNDER SHALL BE LIMITED TO THE AMOUNT OF FEES RECEIVED FROM COMPANY DURING THE TWELVE MONTH PERIOD PRIOR TO THE DATE OF THE CLAIM.

SECTION 8.16 WAIVER OF JURY TRIAL. THE PARTIES HEREBY WAIVE ANY RIGHT TO TRIAL BY JURY OF ANY ISSUE TRIABLE BY A JURY FULLY TO THE EXTENT THAT ANY SUCH RIGHT NOW OR HEREAFTER EXISTS WITH REGARD TO THIS AGREEMENT, OR ANY CLAIM, COUNTERCLAIM OR OTHER ACTION ARISING IN CONNECTION THEREWITH. THIS WAIVER OF RIGHT TO TRIAL BY JURY IS GIVEN KNOWINGLY AND VOLUNTARILY BY THE PARTIES AND IS INTENDED TO ENCOMPASS INDIVIDUALLY EACH INSTANCE AND EACH ISSUE AS TO WHICH THE RIGHT TO A TRIAL BY JURY MAY OTHERWISE ACCRUE. THE PARTIES ARE

EACH HEREBY AUTHORIZED TO FILE A COPY OF THIS SECTION IN ANY PROCEEDING AS CONCLUSIVE EVIDENCE OF THIS WAIVER BY THE OTHER PARTY.

[Remainder of the page intentionally left blank. Signature page to follow]

IN WITNESS WHEREOF, the undersigned, intending to be legally bound, have caused this Agreement to be executed as of the date first written above.

Service Provider

Guardian Hospice MN, LLC

By: Sol Miller

Title: Chief Executive Officer

Company

Moments Hospice of King, LLC

By: Sol Miller

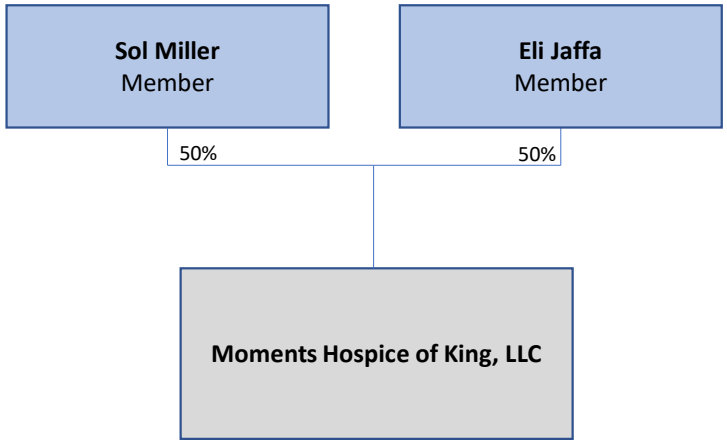
Title: Chief Executive Officer

EXHIBIT A

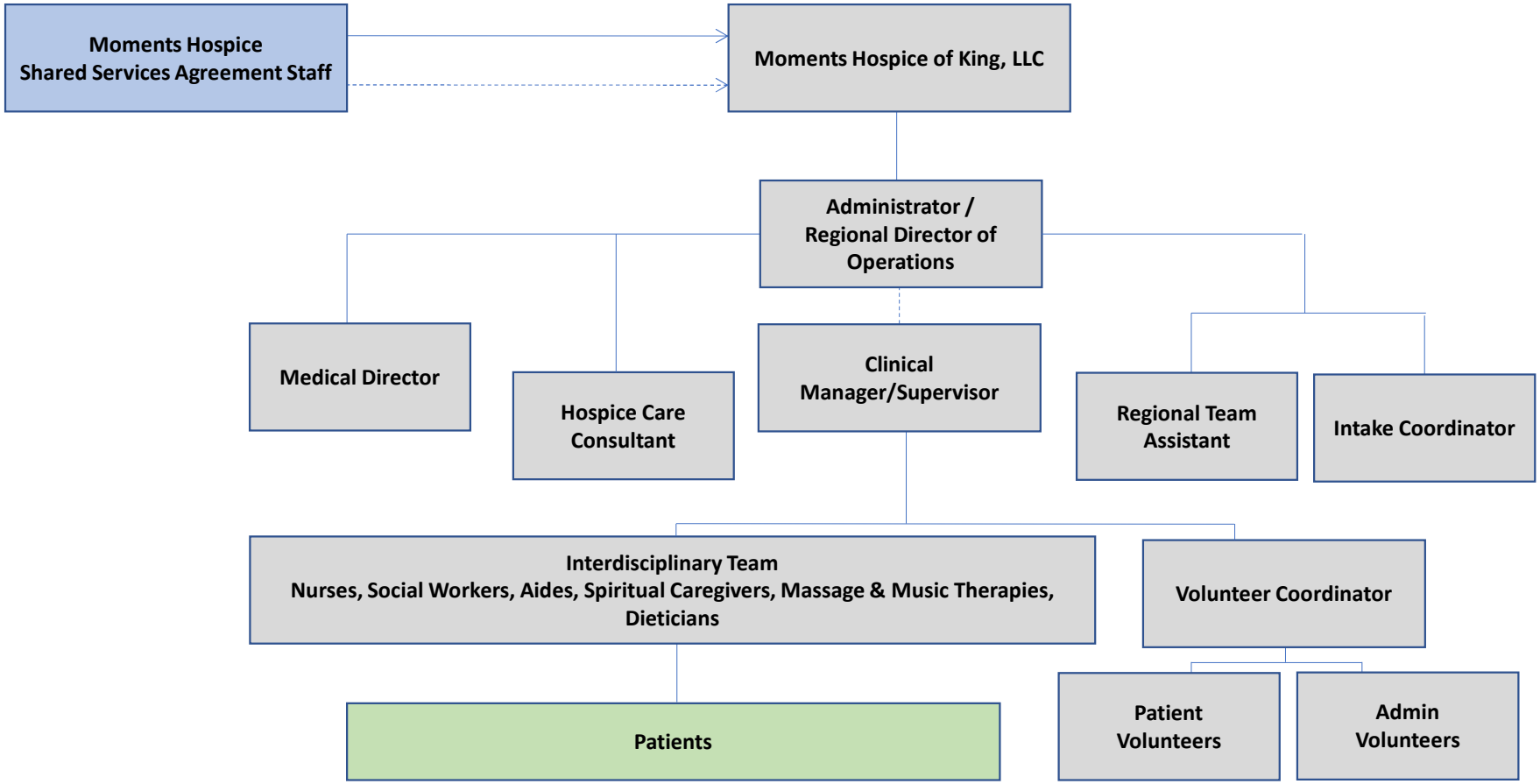
Description of Services and Cost

Description of Services	Cost
The following services are to be provided by Guardian Hospice MN, LLC to Moments Hospice of King, LLC: • Financial management and oversight • Management of accounts receivable and accounts payable • Bookkeeping and Payroll • Accounting Services (not to include tax planning or preparation) • Credentialing and contracting with insurance payers • Billing and collection services, including preparation of cost reports • Travel services • Group purchasing services of medical supplies, office supplies, computer and technology, telephones, uniforms, pharmacy, durable medical equipment, and other related items and services • Compliance • Information Technology Systems • The use of Call Center Support services such as the 24 hour / 7 days per week availability of Registered Nurses to triage calls and coordinate care • Employee training on software • Employee training on the Moments Way • Marketing strategy and resources • Website • Translation Services • Executive leadership and management of day-to-day operations Staff, shown below, will be provided by Service Provider until Company achieves an average daily census high enough to support direct hires: - Human Resource Generalist - Project Manager - Compliance Manager - Staff Recruiter - Intake Coordinator - Bereavement Coordinator - Director of Business Development - Director of Education and Quality - Internal Educator - Director of Supportive Care - Director of Patient Services - Director of Continuous Care - Scheduler The above services may include material items purchased on behalf of Company, services provided on behalf of Company, or personnel dedicated on behalf of Company.	5% of patient service revenue

Moments Hospice of King, LLC – Ownership Structure



Moments Hospice of King, LLC – Organizational Chart



Moments Hospice of King, LLC
ATTN: Sam Auerbach
820 Lilac Dr. N Suite 210
Golden Valley, MN 55422

December 20, 2021

Ownership/ Management at
15111 8TH AVE SW, BURIEN, WA 98166 **Via E-mail**

RE: Offer to lease a suite in the Building known as Burien Pacific Professional Building ("Building")

Dear Sir/Madam:

Please accept this formal letter of intent setting forth the conditions on which we are willing to lease a suite of our choosing at the Building.

1. **Lessee:** Moments Hospice of King, LLC and/or assigns ("**Lessee**")

2. **Lessor:** Burien Pacific Professional Building, LLC ("**Lessor**")

3. **Building and Suite:** The Building known as Burien Pacific Professional Building located at 15111 8TH AVE SW, BURIEN, WA 98166. The Building currently has suites available for rent, as further described on Exhibit A. Each of the suites is available for rent on a Full Service, gross rental amount of $18.00 per rentable square feet ("RSF Rent") which includes taxes, utilities, insurance, and maintenance. The Lessee is prepared to lease from Lessor any suite at the Building with a total RSF of 1,707 or less at any point between the Date of this Letter of Intent and December 31, 2022 on the terms and conditions of the formal Lease Agreement as shown in Exhibit A of this Agreement.

4. **Lease Payment:** The annual lease payments shall be the total number of RSF in any of the then available Suites, multiplied by the annual RSF Rent. The Lease shall be for a term of three (3) years from the date of the signing of the lease, and shall encompass one (1), two (2) year extension option. The rent rate shall increase by 3.5% annually. To be defined in formal lease agreement

5. **Lease Option:** During the year beginning on the date of signing of this LETTER OF INTENT, through the December 31, 2022 ("Lease Option Term"), Lessee shall have the option, but not the obligation to lease from Lessor any of the then available suites in the Building on the terms of the attached Lease Agreement. Lessor shall notify Lessee when the Lessor has received an offer to Lease any suite available for rent which is less than 1,707 RSF. After such notification, Lessee has 10 days to notify Lessor of its intent to exercise this Lease Option. In the event that Lessee does not elect to lease the offering suite from the Lessor in accordance with the terms of the formal Lease Agreement, this Lease Option shall survive and remain in place for the remainder of the Lease Option Term and shall apply to any suite in the Building that becomes available at any point through the end of the Lease Option Term.

6. **Lease Option Compensation:** Upon signing this Letter of Intent, Lessee shall make a one-time Lease Option Payment in the amount of Five Thousand Dollars ($5,000), which shall be non-refundable and non applicable to any future Lease Payments. This Option payment shall be compensation for Lessee having such option to lease the premises.

7. **Interim Address Notice:** Effective on the date of this LETTER OF INTENT, Lessee shall be granted permission by Lessor to list the address of the Building on the Lessee's application to the applicable state licensing divisions, in connection with its application to obtain a Certificate of Need ("CON") to operate a hospice business in the state of Washington. But it is understood that no hospice patients are permitted to be treated on the subject property. Such office location is meant to be for administrative services, supply storage, and general office needs.

8. **Broker & Commissions**: Lessor and Lessee shall not be responsible for any brokerage commissions connected with this agreement or any formal Lease Agreement. Neither Lessor nor Lessee are represented by any brokers that would be entitled to a Lease Commission.

9. **Definitive Agreement:** The Lease Agreement in Exhibit A is agreed to by both Parties and shall serve as the Definitive Agreement upon Lessee's exertion of the Lease Option

10. **Governing Law.** This Agreement and the rights of the Parties shall be interpreted and determined in accordance with the laws of the State of Washington**.**

11. **Representations**. As a material inducement to entering into this Agreement, the Parties hereby represents and warrants to the other Party as follows:

    a. It is duly organized, validly existing and in good standing under the laws of the jurisdictions necessary to perform this Agreement;
    b. The execution, delivery and performance of this Letter of Intent and Option Agreement are within its powers, have been duly authorized by all necessary action and do not violate any of the terms or conditions in its governing documents or any contract to which it is a party or any law, rule, regulation, order, writ, judgment, decree or other legal or regulatory determination applicable to it;
    c. This Agreement constitutes a legal, valid and binding obligation of such Party enforceable against it in accordance with its terms, subject to bankruptcy, insolvency, reorganization and other laws affecting creditor's rights generally, and with regard to equitable remedies, to the discretion of the court before which proceedings to obtain same may be pending;

12. **Notices**. Any and all notices provided by the Lessor or the Lessee can be delivered via Certified mail or electronic mail (E-Mail) to the address first above noted, or at such other address provided by the other party from time to time.

13. **Entire Agreement and Modification**. This Letter of Intent and Option Agreement (i) may only be amended, modified or supplemented by an instrument in writing executed by duly authorized representatives of Lessor and Lessee, (ii) constitute the entire agreement and understanding between Lessor and Lessee with respect to the subject matter thereof, and supersedes all prior agreements relating to the subject matter hereof, which are of no further force or effect, and (iii) if any term, covenant or condition in this Letter of Intent and Option Agreement shall, to any extent, be invalid or unenforceable in any respect under applicable law, the remainder of the Agreement shall not be affected thereby, and each term, covenant or condition hereof shall be valid and enforceable to the fullest extent permitted by applicable law and, if appropriate, such invalid or unenforceable provision shall be modified or replaced to give effect to the underlying intent of the Parties and to the intended economic benefits of the Parties.

This Letter of Intent shall be binding on all the parties hereto, and shall not simply serve as an expression of good faith negotiations and understandings of the Parties. Accordingly, this Agreement shall impose a contractual and legal obligation on the Parties to perform and be bound by the terms of this Letter of Intent.

If the terms and conditions set forth in this letter meet your requirements and are generally acceptable, please execute below.

Sincerely,

MOMENTS HOSPICE OF KING, LLC

By: _____

Moments Hospice of King, LLC

Authorized Member

AGREED AND ACCEPTED

Lessor:

By: _____

Burien Pacific Professional Building, LLC

Its: Authorized Signor

Exhibit A

OFFICE LEASE

THIS OFFICE LEASE ("Lease") is made and entered into as of this ____ day of _____, 20__ by and between Burien Pacific Professional Building, LLC., a Washington limited liability company ("Landlord") and _____, a _____ ("Tenant")

WITNESSETH:

ARTICLE 1. BASIC PROVISIONS

This Article contains the basic lease provisions between Landlord and Tenant.

A. Building: Burien Pacific Professional Building located at 15111 8th Avenue SW, in Burien, Washington, (the "Property", as further described in Article 32 and Exhibit A-1).

B. Premises: Suite 207 (or subject suite TBD) in the Building on Exhibit A-2.

C. Commencement Date: _____, subject to Article 3.

D. Expiration Date: _____, subject to Article 3.

E. Base Year: None

F. Rentable Area: The rentable area of the Premises shall be deemed to be _____ square feet for purposes of this Lease, subject to Article 32 and Article 20.

G. Rent: From the Commencement Date through the Expiration Date, as further described in Article 4

H. Intentionally Omitted

I. Permitted Use: General office use, subject to Article 7.

J. Security Deposit: The sum of Four Thousand Dollars ($4,000.00), which shall be subject to Article 16.

K. Broker (if any): **Tenant's Broker:** None.

Landlord's Broker: Jonathan Tran of Rainier Pacific Properties.

L. Guarantor(s): **In addition to this Lease, Personal Guaranty of Sol Miller (pending approval of credit check), is required.**

M. Riders/Exhibits: Exhibit A-1 (Property), Exhibit A-2 (Premises), Exhibit B (Omitted) and Rider One (Rules), Exhibit C (Form of Guaranty)

N. Landlord's Notice Address (subject to Article 25):

BURIEN PACIFIC PROFESSIONAL BUILDING, L.L.C.
C/O Rainier Pacific Management, LLC
1618 S Lane Street, Suite 203
Seattle, WA. 98144

O. Tenant's Notice Address (subject to Article 25):

15111 8th Ave SW, Suite 207
Burien, WA 98166

P. Rent Payments: Rent shall be paid to:

Burien Pacific, L.L.C.,
C/O Rainier Pacific Management, LLC
1618 S Lane Street, Suite 203
Seattle, WA. 98144

or such other parties and addresses as to which Landlord shall provide advance notice.

Q. Tenant's Proportionate Share: Approximately 4.0%, subject to Article 20.

The foregoing provisions shall be interpreted and applied in accordance with the other provisions of this Lease. The terms of this Article, and the terms defined in Article 31 and other Articles, shall have the meanings specified therefor when used as capitalized terms in other provisions of this Lease or related documentation (except as expressly provided to the contrary therein).

ARTICLE 2. PREMISES

Landlord hereby leases to Tenant and Tenant hereby leases from Landlord the Premises subject to the provisions herein contained. Tenant has inspected the Premises (and portions of the Property, Systems and Equipment providing access to or serving the Premises) or has had an opportunity to do so, and agrees to accept the same "**AS IS**", without any additional agreements, representations, understandings or obligations on the part of Landlord to perform any alterations, repairs or improvements beyond those described above unless expressly provided under this Lease.

ARTICLE 3. TERM AND COMMENCEMENT

The term ("Term") of this Lease shall commence on the Commencement Date and end on the Expiration Date, unless sooner terminated as provided herein, subject to adjustment as provided below and the other provisions hereof.

ARTICLE 4. RENT AND ADDITIONAL RENT

A. Rent. Tenant shall pay Landlord the monthly Rent of $18.00 PSF per annum for the first year of Lease term in advance on or before the first day of each calendar month during the Term. Every annum, the rent shall increase by ~~.75 cents PSF~~ 3.5%. Such rent is on a Full Service basis.

B. Payments. Tenant shall pay such amounts as follows:

Dates	Monthly Base
TBD	$TBD per month Full Service.

C. Prorations. If the Term commences on a day other than the first day of a calendar month or ends on a day other than the last day of a calendar month, the Base Rent or any other amounts payable on a monthly basis shall be prorated on a per diem basis for such partial calendar months. If the Term commences other than on the first day of the Landlord's Fiscal Year, or ends other than on the last day of the Landlord's Fiscal Year, Tenant's obligations to pay Tenant's Proportionate Share of the Base

Increases for such first or final Landlord's Fiscal Years shall be prorated on a per diem basis to reflect the portion of such years included in the Term.

D. General Payment Matters. Base Rent, Tenant's Proportionate Share of the Base Increase and any other amounts which Tenant is or becomes obligated to pay Landlord under this Lease or other agreement entered in connection herewith, are sometimes herein referred to collectively as "Rent," and all remedies applicable to the non-payment of Rent shall be applicable thereto. Rent shall be paid in good funds and legal tender of the United States of America. Tenant shall pay Rent without any deduction, recoupment, set-off or counterclaim, and without relief from any valuation or appraisement laws. Rent obligations hereunder are independent covenants. No delay by Landlord in providing the Statement (or separate statements) shall be deemed a default by Landlord or a waiver of Landlord's right to require payment of Tenant's obligations for actual Tenant's Base Rent. Landlord may apply payments received from Tenant to any obligations of Tenant then accrued.

ARTICLE 5. QUIET ENJOYMENT

Landlord agrees that if Tenant timely pays the Rent and otherwise performs as required by the terms and provisions herein, Tenant shall hold the Premises during the Term, free of lawful claims by any party acting by or through Landlord, subject to all other terms and provisions of this Lease.

ARTICLE 6. UTILITIES AND SERVICES

A. Standard Landlord Utilities and Services. Landlord shall provide the following utilities and services (the cost of which shall be included in Base Rent, except as provided below):

(i) Heat and air-conditioning to provide a temperature required, in Landlord's reasonable opinion, for occupancy of the Premises as offices, from 8:00 a.m. until 8:00 p.m. Monday through Friday, excluding all Holidays.

(ii) Water from city mains for drinking, lavatory and toilet purposes only, at those points of supply provided for nonexclusive general use of tenants at the Property, or points of supply in the Premises installed by or with Landlord's written consent for such purposes.

(iii) Cleaning and trash removal service in and about the Premises as is customary for office space in office buildings, excluding all Holidays.

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

B. Additional Utilities and Services. Landlord shall not be responsible for inadequate air-conditioning or ventilation whenever the use or occupancy of the Premises exceeds the normal capacity or design loads of, affects the temperature or humidity otherwise maintained by, or otherwise adversely affects the operation of, the

Systems and Equipment for the Property, whether due to items of equipment or machinery generating heat, above normal concentrations of personnel or equipment, alterations to the Premises made by or through Tenant without balancing the air or installing supplemental HVAC equipment. Without limiting the generality of the foregoing, Landlord shall not be responsible for inadequate air conditioning or ventilation to the extent that the same occurs because Tenant, without providing adequate air conditioning and ventilation: (i) uses or permits the use of any item, or concentrated group, of equipment consuming more than 500 watts in the aggregate at rated capacity, or (ii) occupies or permits the Premises to be occupied with concentrations of personnel greater than one person per 250 usable square feet. In any such case, Landlord may elect to balance the air, install, operate, maintain and replace such supplemental HVAC equipment during the Term, at Tenant's expense, as an extra utility or service (or require that Tenant arrange for the same as Work under Article 9). Landlord shall seek to provide such extra utilities or services as Tenant may from time to time request, if the same are reasonable and feasible for Landlord to provide and do not involve modifications or additions to the Property or existing Systems and Equipment, and if Landlord shall receive Tenant's request within a reasonable period prior to the time such extra utilities or services are required. Tenant shall pay, for any extra utilities or services, such standard charges as Landlord shall from time to time establish, including Landlord's out-of-pocket costs for architects, engineers, consultants and other parties relating to such extra utilities or services, and a fee equal to fifteen percent (15%) of such costs, except that after-hour air conditioning services shall be provided by Landlord to Tenant at the cost of $20 per hour, subject to change, without notice, from time to time by Landlord. All payments for such extra utilities or services shall be due at the same time as the installment of Base Rent with which the same are billed, or if billed separately, shall be due within ten (10) days after such billing. Notwithstanding any of the foregoing to the contrary, in lieu of charging separately for additional utilities and services, Landlord may reasonably elect from time to time to expand or modify the amounts of services and utilities available without separate charge, in which case the costs thereof shall be included in the Base Rent. Tenant would only be included in such costs and expenses if required by request of Tenant.

C. Monitoring. Landlord may install and operate meters, submeters or any other reasonable system for monitoring or estimating any services or utilities used by Tenant in excess of those required to be provided by Landlord under this Article (including a system for Landlord's engineer to reasonably estimate any such excess usage). If such system indicates such excess services or utilities, Tenant shall pay Landlord's charges and fees as described in Paragraph B, above, for installing and operating such system and any supplementary air-conditioning, ventilation, heat, electrical or other systems or equipment (or adjustments or modifications to the existing Systems and Equipment) which Landlord may make, and Landlord's charges for such amount of excess services or utilities used by Tenant.

D. Interruptions and Changes. Landlord shall have no liability for interruptions, variations, shortages, failures, changes in quality, quantity, character or availability of any utilities or services caused by repairs, maintenance, replacements, alterations (including any freon retrofit work), labor controversies, accidents, inability to obtain services, utilities or supplies, governmental or utility company acts or omissions, requirements, guidelines or requests, or other causes beyond Landlord's reasonable control (or under any circumstances with respect to utilities or services not required to be provided by Landlord hereunder). Under no circumstances whatsoever shall any of

the foregoing be deemed an eviction or disturbance of Tenant's use and possession of the Premises or any part thereof, serve to abate Rent, or relieve Tenant from performance of Tenant's obligations under this Lease. Landlord in no event shall be liable for damages by reason of loss of profits, business interruption or other consequential damages in connection with the foregoing events. Nevertheless, in any such events after receiving notice, Landlord shall use reasonable efforts to restore such utilities or services required to be provided hereunder to reasonable levels.

ARTICLE 7. USE, COMPLIANCE WITH LAWS, AND RULES

A. Use of Premises. Tenant shall use the Premises only for the permitted use identified in Article 1, and no other purpose whatsoever, subject to the other provisions hereof and of this Lease.

B. Laws and Other Requirements. Tenant shall not use or permit within the Premises anything that will: (i) violate the requirements of Landlord's insurers, the American Insurance Association, or any board of underwriters, (ii) cause a cancellation of Landlord's policies, impair the insurability of the Property, or increase Landlord's premiums (any such increase shall be paid by Tenant without such payment being deemed permission to continue such activity or a waiver of any other remedies of Landlord), or (iii) violate the requirements of any Lenders, the certificates of occupancy issued for the Premises or the Property, or any other requirements, covenants, conditions or restrictions affecting the Property at any time. Tenant shall comply with all Laws relating to the Premises and Tenant's use of the Premises and Property, including Laws governing Hazardous Materials as described in Article 29, and the Disabilities Acts as described in Article 30. Tenant's obligations to comply with Laws shall include, without limitation: (a) obtaining all permits, licenses, certificates and approvals to conduct its business in the Premises, or any necessary waivers or variances, without thereby subjecting Landlord, the Property or other occupants to any costs, requirements, liabilities or restrictions, (b) any work to or for the Premises (or any systems or equipment exclusively serving the Premises, including any freon retrofitting work for such exclusive systems and equipment) required by Laws, and (c) any work outside the Premises (if Landlord permits such work) required by Laws based on Tenant's use of, work within, or systems or equipment exclusively serving, the Premises, whether any such work is deemed structural, involves a capital expenditure or results in a benefit extending beyond the Term. Any work hereunder shall be deemed "Work" subject to Article 9.

C. Rules. Tenant shall comply with the Rules set forth in Rider One attached hereto (the "Rules"). Landlord shall have the right, by notice to Tenant or by posting at the Property, to reasonably amend such Rules and supplement the same with other reasonable Rules relating to the Property, or the promotion of safety, care, efficiency, cleanliness or good order therein. Nothing herein shall be construed to give Tenant or any other Person any claim, demand or cause of action against Landlord arising out of the violation of such Rules by any other tenant or visitor of the Property, or out of the enforcement, modification or waiver of the Rules by Landlord in any particular instance.

ARTICLE 8. MAINTENANCE AND REPAIRS

Except for customary cleaning and trash removal provided by Landlord under Article 6, and casualty damage to be repaired by Landlord under Article 11, Tenant shall keep and maintain (or cause to be kept and maintained) the leased Premises in good and sanitary condition, working order and repair, in compliance with all applicable Laws

as described in Article 7, and as required under other provisions of this Lease, including the Rules (including any carpet and other flooring material, paint and wall-coverings, doors, windows, ceilings, interior surfaces of walls, non-standard lighting (including lamps, bulbs, ballasts and starters), plumbing and other fixtures, alterations, improvements, and systems and equipment in or exclusively serving the Premises whether installed by Landlord or Tenant). In the event that any repairs, maintenance or replacements are required, Tenant shall promptly notify Landlord and arrange for the same either: (i) through Landlord for such reasonable charges as Landlord may establish from time to time, payable within ten (10) days after billed, or (ii) at Landlord's option, by engaging such contractors as Landlord shall first designate or approve in writing to perform such work, all in a first class, workmanlike manner approved by Landlord in advance in writing and otherwise in compliance with Article 9 respecting "Work". Tenant shall promptly notify Landlord concerning the necessity for any repairs or other work hereunder and upon completion thereof. Tenant shall pay Landlord for any repairs, maintenance and replacements to areas of the Property outside the Premises, caused, in whole or in part, as a result of moving any furniture, fixtures, or other property to or from the Premises, or otherwise by Tenant or its employees, agents, contractors, or visitors (notwithstanding anything to the contrary contained in this Lease). Except as provided in the preceding sentence, or for damage covered under Article 11, Landlord shall keep the common areas of the Property in good and sanitary condition, working order and repair (the cost of which shall be included in the Base Rent).

ARTICLE 9. ALTERATIONS AND LIENS

A. Alterations and Approval. Tenant shall not attach any fixtures, equipment or other items to the Premises, or paint or make any other additions, changes, alterations or improvements to the Premises or the Systems and Equipment serving the Premises (all such work is referred to collectively herein as the "Work"), without the prior written consent of Landlord. Landlord reserves the right to withhold consent in Landlord's sole discretion for any reason, including but not limited to cases where the Work affects the structure, safety, efficiency or security of the Property or Premises, the Systems and Equipment, or the appearance of the Premises from any common or public areas. In seeking approval, Tenant shall submit for Landlord's prior written approval: (i) the names, addresses and background information concerning all architects, engineers, contractors, subcontractors and suppliers Tenant proposes to use, and (ii) detailed plans and specifications prepared by the approved architects and engineers. In addition, Tenant shall provide Landlord with notice of whether the Work will involve or affect any Hazardous Materials, whether such materials are customary and usual based on standard industry practices, and all other details relating thereto.

B. Approval Conditions. Landlord reserves the right to impose requirements as a condition of such consent or otherwise in connection with the Work, including requirements that Tenant: (i) obtain and post permits, (ii) provide bonds, additional insurance, and/or a cash deposit of the total amount required to pay for the Work (including plans, specifications, engineering and other lienable costs, and Landlord's fee described below) for Landlord to release or apply as the Work is properly completed and lien waivers, affidavits and other documentation satisfactory to Landlord are submitted, (iii) submit architect, engineer, contractor, subcontractor and supplier affidavits of payment and recordable lien waivers in compliance with the Laws of the State of Washington, (iv) use union labor (if Landlord uses union labor), (v) permit Landlord or its representatives to inspect the Work at reasonable times, (vi) comply with

such other requirements as Landlord may impose concerning the manner and times in which such Work shall be done, and (vii) remove, at Tenant's cost and expense, any improvements upon the expiration or earlier termination of this Lease and restore the Premises to its condition prior to the Work. Landlord may require that all Work be performed under Landlord's supervision, and Landlord reserves the right to designate the architects, engineers, contractors, subcontractors and suppliers who will design and perform all Work and supply all materials affecting the Systems and Equipment or structure of the Property. If Landlord approves, inspects, supervises, recommends or designates any architects, engineers, contractors, subcontractors or suppliers, the same shall not be deemed a warranty as to the adequacy of the design, workmanship or quality of materials, or compliance of the Work with the plans and specifications or any Laws.

C. Performance of Work. All Work shall be performed: (i) in a thoroughly first class, professional and workmanlike manner, (ii) only with materials that are new, high quality, and free of material defects, (iii) strictly in accordance with plans, specifications, parties and other matters approved or designated by Landlord in advance in writing, (iv) not to adversely affect the Systems and Equipment or the structure of the Property, (v) diligently to completion and so as to avoid any disturbance, disruption or inconvenience to other tenants and the operation of the Property, and (vi) in compliance with all Laws, the Rules and other provisions of this Lease, and such other requirements as Landlord may impose concerning the manner and times in which such Work shall be done. Any floor, wall or ceiling coring work or penetrations or use of noisy or heavy equipment which may interfere with the conduct of business by other tenants at the Property shall, at Landlord's option, be performed at times other than Landlord's normal business hours (at Tenant's sole cost). If Tenant fails to perform the Work as required herein or the materials supplied fail to comply herewith or with the specifications approved by Landlord, and Tenant fails to cure such failure within 48 hours after notice by Landlord (except notice shall not be required in emergencies), Landlord shall have the right to stop the Work until such failure is cured (which shall not be in limitation of Landlord's other remedies and shall not serve to abate the Rent or Tenant's other obligations under this Lease). Upon completion of any Work hereunder, Tenant shall provide Landlord with "as built" plans, copies of all construction contracts, and proof of payment for all labor and materials.

D. Liens. Tenant shall pay all costs for the Work when due. Tenant shall keep the Property, Premises and this Lease free from any mechanic's, materialman's, architect's, construction, engineer's or similar liens or encumbrances, and any claims therefor, or stop or violation notices, in connection with any Work. Tenant shall give Landlord notice at least ten (10) days prior to the commencement of any Work (or such additional time as may be necessary under applicable Laws), to afford Landlord the opportunity of posting and recording appropriate notices of non-responsibility. Tenant shall remove any such claim, lien or encumbrance, or stop or violation notices of record, by bond or otherwise within ten (10) days after notice by Landlord. If Tenant fails to do so, Landlord may pay the amount (or any portion thereof) or take such other action as Landlord deems necessary to remove such claim, lien or encumbrance, or stop or violation notices, without being responsible for investigating the validity thereof. The amount so paid and costs incurred by Landlord shall be deemed additional Rent under this Lease payable upon demand, without limitation as to other remedies available to Landlord. Nothing contained in this Lease shall authorize Tenant to do any act which shall subject Landlord's title to, or any Lender's interest in, the Property or Premises to

any such claims, liens or encumbrances, or stop or violation notices, whether claimed pursuant to statute or other Law or express or implied contract.

E. Removal of Work Upon Termination of Lease. All Work hereunder shall remain or be removed from the Premises upon expiration or earlier termination of this Lease to the extent required under Article 23.

F. Landlord's Fees and Costs. Tenant shall pay Landlord a fee for reviewing, scheduling, monitoring, supervising, and providing access for or in connection with the Work, in an amount equal to five percent (5%) of the total cost of the Work (including costs of plans and permits therefor), and Landlord's out-of-pocket costs, including any costs for security, utilities, trash removal, temporary barricades, janitorial, engineering, architectural or consulting services, and other matters in connection with the Work, payable within ten (10) days after billed.

ARTICLE 10. INSURANCE AND WAIVER OF CLAIMS

A. Required Insurance. Tenant shall maintain at its expense during the Term with respect to the Premises and Tenant's use thereof and of the Property:

(i) Worker's Compensation Insurance in the amounts required by statute, and Employer Liability Insurance in at least the following amounts: (a) Bodily Injury by Accident - $1,000,000 per accident, (b) Bodily Injury by Disease - $1,000,000 per employee, and (c) Aggregate Limit - $2,000,000 per policy year.

(ii) Property Damage Insurance for the protection of Tenant and Landlord, as their interests may appear, covering any alterations or improvements in excess of any work provided or paid for by Landlord under this Lease, Tenant's personal property, business records, fixtures and equipment, and other insurable risks in amounts not less than the full insurable replacement cost of such property and full insurable value of such other interests of Tenant, with coverage at least as broad as the most recent editions published by Insurance Services Office, Inc. or any successor organization ("ISO"), of: (a) Building and Personal Property Coverage Form (CP0010), (b) Business Income Coverage Form (CP0030), covering at least one year of anticipated income, (c) Boiler and Machinery Coverage Form (BM0025), (d) Causes of Special Loss Form (CP1030), and (e) Sprinkler Leakage - Earthquake Extension (CP1039).

(iii) Commercial General Liability Insurance ("CGL") at least as broad as the most recent ISO edition of Commercial General Liability Coverage Form (CG0001) with limits of at least the following amounts: (a) Death or Bodily Injury - $2,000,000, (b) Property Damage or Destruction (including loss of use thereof) - $1,000,000, (c) Products/Completed Operations - $1,000,000, (d) Personal or Advertising injury - $1,000,000, (e) Each Occurrence Limit - $2,000,000, and (f) General Aggregate Limit - $3,000,000 per policy year. Such policy shall include endorsements: (1) for contractual liability covering Tenant's indemnity obligations under this Lease, and (2) adding Landlord, the management company for the Property, and other parties designated by Landlord, as additional insureds, on a form at least as broad as the most recent edition of Additional Insured - Manager or Lessor of Premises Endorsement Form (CG2011) published by ISO.

B. Certificates, Subrogation and Other Matters. Tenant shall provide Landlord with certificates evidencing the coverage required hereunder prior to the Commencement Date, or Tenant's entry to the Premises for construction of improvements or any other purpose (whichever first occurs). Such certificates shall: (i) be on ACORD Form 27 or such other form approved or required by Landlord,

(ii) state that such insurance coverage may not be changed, canceled or non-renewed without at least thirty (30) days' prior written notice to Landlord, and (iii) include, as attachments, originals of the Additional Insured endorsements to Tenant's CGL policy required above. Tenant shall provide renewal certificates to Landlord at least thirty (30) days prior to expiration of such policies. Except as expressly provided to the contrary herein, coverage hereunder shall apply to events occurring during the policy year regardless of when a claim is made. Landlord may periodically require that Tenant reasonably increase or expand the aforementioned coverage, in accordance with industry or market standards. Except as provided to the contrary herein, any insurance carried by Landlord or Tenant shall be for the sole benefit of the party carrying such insurance. If Tenant obtains insurance under "blanket policies," Tenant shall obtain an endorsement providing that the insurance limits required hereunder are not subject to reduction or impairment by claims or losses at other locations. Tenant's insurance policies shall be primary to all policies of Landlord and any other additional insureds (whose policies shall be deemed excess and non-contributory). All insurance required hereunder shall be provided by responsible insurers licensed in the State of Washington, and shall have a general policy holder's rating of at least A and a financial rating of at least X in the then current edition of Best's Insurance Reports. The parties mutually hereby waive all rights and claims against each other for all losses covered by their respective insurance policies (or required to be covered by insurance under this Lease), and waive all rights of subrogation of their respective insurers. The parties agree that their respective insurance policies are now, or shall be, endorsed such that said waiver of subrogation shall not affect the right of the insured to recover thereunder. Landlord disclaims any representation as to whether the foregoing coverages will be adequate to protect Tenant, and Tenant agrees to carry such additional coverage as may be necessary or appropriate.

C. Waiver of Claims. Except for claims arising from Landlord's intentional or grossly negligent acts which are not covered or required to be covered by Tenant's insurance hereunder, Tenant waives all claims against Landlord for injury or death to persons, damage to property or to any other interest of Tenant sustained by Tenant or any party claiming by or through Tenant resulting from: (i) any occurrence in or upon the Premises, (ii) leaking of roofs, bursting, stoppage or leaking of water, gas, sewer or steam pipes or equipment, including sprinklers, (iii) wind, rain, snow, ice, flooding (including flooding of basements and other subsurface areas), freezing, fire, explosion, earthquake, excessive heat or cold, dampness, fire or other casualty, (iv) the Property, Premises, Systems and Equipment being defective, out of repair, or failing, and (v) vandalism, malicious mischief, theft, misappropriation or other acts or omissions of any parties including Tenant's employees, other tenants, and their respective agents, employees, invitees and contractors (and Tenant shall give Landlord immediate notice of any such occurrences). This provision is in addition to, and not in limitation of, other provisions of this Lease limiting Landlord's liability.

ARTICLE 11. CASUALTY DAMAGE

A. Restoration. Tenant shall promptly notify Landlord of any damage to the Premises by fire or other casualty. If the Premises or any common areas of the Property providing access thereto shall be damaged by fire or other casualty, Landlord shall use available insurance proceeds to restore the same. Such restoration shall be to substantially the same condition prior to the casualty, except for modifications required by zoning and building codes and other Laws or by any Lender, any other modifications to the common areas deemed desirable by Landlord (provided access to

the Premises is not materially impaired), and except that Landlord shall not be required to repair or replace any of Tenant's furniture, furnishings, fixtures or equipment, or any alterations or improvements in excess of any work provided or paid for by Landlord under this Lease. Landlord shall not be liable for any inconvenience or annoyance to Tenant or its visitors, or injury to Tenant's business resulting in any way from such damage or the repair thereof. Promptly following completion of Landlord's restoration work, Tenant shall repair and replace Tenant's furniture, furnishings, fixtures, equipment, and any alterations or improvements made by Tenant in excess of those provided or paid for by Landlord, subject to and in compliance with the other provisions of this Lease.

B. Abatement of Rent. Landlord shall allow Tenant a proportionate abatement of Base Rent from the date of the casualty through the date that Landlord substantially completes Landlord's repair obligations hereunder (or the date that Landlord would have substantially completed such repairs, but for delays by Tenant or any other occupant of the Premises, or any of their agents, employees, invitees, Transferees and contractors), provided such abatement: (i) shall apply only to the extent the Premises are untenantable for the purposes permitted under this Lease and not used by Tenant as a result thereof, based proportionately on the square footage of the Premises so affected and not used, and (ii) shall not apply if Tenant or any other occupant of the Premises, or any of their agents, employees, invitees, Transferees or contractors caused the damage.

C. Termination of Lease. Notwithstanding the foregoing to the contrary, in lieu of performing the restoration work, Landlord may elect to terminate this Lease by notifying Tenant in writing of such termination within sixty (60) days after the date of damage (such termination notice to include a termination date providing at least thirty (30) days for Tenant to vacate the Premises), if the Property shall be materially damaged by Tenant or its employees or agents, or if the Property shall be damaged by fire or other casualty or cause such that: (a) repairs to the Premises and access thereto cannot reasonably be completed within 120 days after the casualty without the payment of overtime or other premiums, (b) more than twenty-five percent (25%) of the Premises is affected by the damage and fewer than twenty-four (24) months remain in the Term, or any material damage occurs to the Premises during the last twelve (12) months of the Term, (c) any Lender shall require that the insurance proceeds or any portion thereof be used to retire the Mortgage debt (or shall terminate the ground lease, as the case may be), or the damage is not fully covered, except for deductible amounts, by Landlord's insurance policies, or (d) the cost of the repairs, alterations, restoration or improvement work would exceed twenty-five percent (25%) of the replacement value of the Building (whether or not the Premises are affected by the damage). Tenant agrees that the abatement of Rent provided herein shall be Tenant's sole recourse in the event of such damage, and waives any other rights Tenant may have under any applicable Law to perform repairs or terminate the Lease by reason of damage to the Premises or Property.

ARTICLE 12. CONDEMNATION

If at least fifty percent (50%) of the rentable area of the Premises shall be taken by power of eminent domain or condemned by a competent authority or by conveyance in lieu thereof for public or quasi-public use ("Condemnation"), including any temporary taking for a period of one year or longer, this Lease shall terminate on the date possession for such use is so taken. If: (i) less than fifty percent (50%) of the Premises

is taken, but the taking includes or affects a material portion of the Building or Property, or the economical operation thereof, or (ii) the taking is temporary and will be in effect for less than one year but more than thirty (30) days, then in either such event, Landlord may elect to terminate this Lease upon at least thirty (30) days' prior notice to Tenant. The parties further agree that: (a) if this Lease is terminated, all Rent shall be apportioned as of the date of such termination or the date of such taking, whichever shall first occur, (b) if the taking is temporary, Rent shall not be abated for the period of the taking, but Tenant may seek a condemnation award therefor (and the Term shall not be extended thereby), and (c) if this Lease is not terminated but any part of the Premises is permanently taken, the Rent shall be proportionately abated based on the square footage of the Premises so taken. Landlord shall be entitled to receive the entire award or payment in connection with such Condemnation and Tenant hereby assigns to Landlord any interest therein for the value of Tenant's unexpired leasehold estate or any other claim and waives any right to participate therein, except that Tenant shall have the right to claim damages for a temporary taking of the leasehold as described above, and for moving expenses and any taking of Tenant's personal property.

ARTICLE 13. ASSIGNMENT AND SUBLETTING

A. Transfers. Tenant shall not, without the prior written consent of Landlord: (i) assign, mortgage, pledge, hypothecate, encumber, or permit any lien to attach to, or otherwise transfer, this Lease or any interest hereunder, by operation of Law or otherwise, (ii) sublet the Premises or any part thereof, (iii) permit the use of the Premises by any Persons other than Tenant and its employees (all of the foregoing are hereinafter sometimes referred to collectively as "Transfers" and any Person to whom any Transfer is made or sought to be made is hereinafter sometimes referred to as a "Transferee"), or (iv) advertise the Premises for Lease for Transfers. If Tenant shall desire Landlord's consent to any Transfer, Tenant shall notify Landlord in writing, which notice shall include: (a) the proposed effective date (which shall not be less than thirty (30) nor more than 180 days after Tenant's notice), (b) a description of the portion of the Premises to be Transferred (herein called the "Subject Space"), (c) the terms of the proposed Transfer and the consideration therefor, the name, address and background information concerning the proposed Transferee, and a true and complete copy of all proposed Transfer documentation, and (d) financial statements (balance sheets and income/expense statements for the current and prior three (3) years) of the proposed Transferee, in form and detail reasonably satisfactory to Landlord, certified by an officer, partner or owner of the Transferee, and any other information to enable Landlord to determine the financial responsibility, character, and reputation of the proposed Transferee, nature of such Transferee's business and proposed use of the Subject Space, and such other information as Landlord may reasonably require. Any Transfer made without complying with this Article shall at Landlord's option be null, void and of no effect, or shall constitute a Default under this Lease. Whether or not Landlord shall grant consent, Tenant shall pay a reasonable fee (but not less than $500.00) towards Landlord's review and processing expenses, as well as any reasonable legal fees incurred by Landlord within ten (10) days after written request by Landlord.

B. Approval. Landlord, in its sole discretion, may give or withhold its consent to a proposed Transfer. If Tenant disagrees with Landlord's decision to deny approval, Tenant's sole remedy shall be to seek injunctive relief.

C. Transfer Premiums. If Landlord consents to a Transfer, and as a condition thereto which the parties hereby agree, Tenant shall pay Landlord any

Transfer Premium derived by Tenant from such Transfer. "Transfer Premium" shall mean, for a lease assignment, all consideration paid or payable therefor. "Transfer Premium" shall mean, for a sublease, all rent, additional rent or other consideration paid by such Transferee in excess of the Rent payable by Tenant under this Lease (on a monthly basis during the Term, and on a per rentable square foot basis, if less than all of the Premises is transferred). "Transfer Premium" shall also include so-called "key money," or other bonus amount paid by Transferee to Tenant, and any payment in excess of fair market value for services rendered by Tenant to Transferee or in excess of Tenant's depreciated tax basis for assets, fixtures, inventory, equipment or furniture transferred by Tenant to Transferee. If part of the consideration for such Transfer shall be payable other than in cash, such non-cash consideration shall be paid to Landlord in such form as is reasonably satisfactory to Landlord. The Transfer Premium due Landlord hereunder shall be paid within ten (10) days after Tenant receives any Transfer Premium from the Transferee.

D. Recapture. Notwithstanding anything to the contrary contained in this Article, Landlord shall have the option, by giving notice to Tenant within thirty (30) days after receipt of Tenant's notice of any proposed Transfer, to recapture the Subject Space. Such recapture notice shall cancel and terminate this Lease with respect to the Subject Space as of the date stated in Tenant's notice as the effective date of the proposed Transfer (or at Landlord's option, shall cause the Transfer to be made to Landlord or its agent or nominee, in which case the parties shall execute reasonable Transfer documentation promptly thereafter). If this Lease shall be canceled with respect to less than the entire Premises, the Rent herein shall be prorated on the basis of the number of rentable square feet retained by Tenant in proportion to the number of rentable square feet contained in the Premises, this Lease as so amended shall continue thereafter in full force and effect, and upon request of either party the parties shall execute written confirmation of the same. Tenant shall surrender and vacate the Subject Space when required hereunder in accordance with Article 23 and any failure to do so shall be subject to Article 24.

E. Terms of Consent. If Landlord consents to a Transfer: (i) the terms and conditions of this Lease, including Tenant's liability for the Subject Space, shall in no way be deemed to have been waived or modified, (ii) such consent shall not be deemed consent to any further Transfer by either Tenant or a Transferee, (iii) no Transferee shall succeed to any rights provided in this Lease or any amendment hereto to extend the Term of this Lease, expand the Premises, or lease other space, any such rights being deemed personal to the initial Tenant, (iv) Tenant shall deliver to Landlord promptly after execution, an original executed copy of all documentation pertaining to the Transfer in form reasonably acceptable to Landlord, and (v) Tenant shall furnish a complete statement, certified by an independent certified public accountant, or Tenant's chief financial officer, setting forth in detail the computation of any Transfer Premium that Tenant has derived and shall derive from such Transfer. Landlord or its authorized representatives shall have the right at all reasonable times to audit the books, records and papers of Tenant and any Transferee relating to any Transfer, and shall have the right to make copies thereof. If the Transfer Premium respecting any Transfer shall be found understated, Tenant shall within thirty (30) days after demand pay the deficiency, and if understated by more than two percent (2%) Tenant shall pay Landlord's costs of such audit. Any sublease hereunder shall be subordinate and subject to the provisions of this Lease, and if this Lease shall be terminated during the term of any sublease, Landlord shall have the right to: (a) deem such sublease as merged and canceled and

repossess the Subject Space by any lawful means, or (b) deem such termination as an assignment of such sublease to Landlord and not as a merger, and require that such subtenant attorn to and recognize Landlord as its landlord under any such sublease. If Tenant shall commit a Default under this Lease, Landlord is hereby irrevocably authorized, as Tenant's agent and attorney-in-fact, to direct any Transferee to make all payments under or in connection with the Transfer directly to Landlord (which Landlord shall apply towards Tenant's obligations under this Lease).

F. Certain Transfers. For purposes of this Lease, the term "Transfer" shall also include, and all of the foregoing provisions shall apply to: (i) the conversion, merger or consolidation of Tenant into a corporation, limited liability company or limited liability partnership, (ii) if Tenant is a partnership or limited liability company, the withdrawal or change, voluntary, involuntary or by operation of law, of a majority of the partners or members, or a transfer of a majority of partnership or membership interests, within a twelve month period, or the dissolution of the partnership or company, and (iii) if Tenant is a closely held corporation (i.e., whose stock is not publicly held and not traded through an exchange or over the counter), the dissolution, merger, consolidation or other reorganization of Tenant, or within a twelve month period: (a) the sale or other transfer of more than an aggregate of fifty percent (50%) of the voting shares of Tenant (other than to immediate family members by reason or gift or death) or (b) the sale, mortgage, hypothecation or pledge of more than an aggregate of fifty percent (50%) of Tenant's net assets.

ARTICLE 14. PERSONAL PROPERTY, RENT AND OTHER TAXES

Tenant shall pay prior to delinquency all taxes, charges or other governmental impositions assessed against or levied upon all fixtures, furnishings, personal property, systems and equipment located in or exclusively serving the Premises, and any Work to the Premises under Article 9 or other provisions of this Lease or related documentation. Whenever possible, Tenant shall cause all such items to be assessed and billed separately from the other property of Landlord. In the event any such items shall be assessed and billed with the other property of Landlord, Tenant shall pay Landlord its share of such taxes, charges or other governmental impositions within ten (10) days after Landlord delivers a statement and a copy of the assessment or other documentation showing the amount of impositions applicable to Tenant's property. Tenant shall pay any rent tax, sales tax, service tax, transfer tax, value added tax, or any other applicable tax on the Rent, utilities or services herein, the privilege of renting, using or occupying the Premises, or collecting Rent therefrom, or otherwise respecting this Lease or any other document entered in connection herewith.

ARTICLE 15. LANDLORD'S REMEDIES

A. Default. The occurrence of any one or more of the following events shall constitute a "Default" by Tenant and shall give rise to Landlord's remedies set forth in Paragraph B below: (i) failure to make when due any payment of Rent, unless such failure is cured within ten (10) days; (ii) failure to observe or perform any term or condition of this Lease other than the payment of Rent (or the other matters expressly described herein), unless such failure is cured within any period of time following notice expressly provided with respect thereto in other Articles hereof, or otherwise within a reasonable time, but in no event more than twenty (20) days following notice (provided, if the nature of Tenant's failure is such that more time is reasonably required in order to cure, Tenant shall not be in Default if Tenant commences to cure promptly within such period, diligently seeks and keeps Landlord reasonably advised of efforts to cure such

failure to completion, and completes such cure within sixty (60) days following Landlord's notice); (iii) failure to cure immediately upon notice thereof any condition which is hazardous, interferes with another tenant or the operation or leasing of any portion of the Property, or may cause the imposition of a fine, penalty or other remedy on Landlord or its agents or affiliates, (iv) violating Article 13 respecting Transfers, or abandoning, vacating or failing to occupy the Premises for more than ten (10) days, or removing or making arrangements to remove substantial portions of the furniture or other personal property from the Premises or any material portion thereof, or (v) (a) making by Tenant or any guarantor of this Lease ("Guarantor") of any general assignment for the benefit of creditors, (b) filing by or for reorganization or arrangement under any Law relating to bankruptcy or insolvency (unless, in the case of a petition filed against Tenant or such Guarantor, the same is dismissed within thirty (30) days), (c) appointment of a trustee or receiver to take possession of substantially all of Tenant's assets located in the Premises or of Tenant's interest in this Lease, where possession is not restored to Tenant within thirty (30) days, (d) attachment, execution or other judicial seizure of substantially all of Tenant's assets located in the Premises or of Tenant's interest in this Lease, (e) Tenant's or any Guarantor's convening of a meeting of its creditors or any class thereof for the purpose of effecting a moratorium upon or composition of its debts, (f) Tenant's or any Guarantor's insolvency or failure, or admission of an inability, to pay debts as they mature, or (g) a violation by Tenant or any affiliate of Tenant under any other lease or agreement with Landlord or any affiliate thereof which is not cured within the time permitted for cure thereunder. If Tenant violates the same term or condition of this Lease on two (2) occasions during any twelve (12) month period, Landlord shall have the right to exercise all remedies for any violations of the same term or condition during the next twelve (12) months without providing further notice or an opportunity to cure. The other notice and cure periods provided herein are in lieu of, and not in addition to, any notice and cure periods provided by Law; provided, Landlord may elect to comply with such notice and cure periods provided by Law in lieu of the notice and cure periods provided herein.

B. Remedies. If a Default occurs, Landlord shall have the rights and remedies hereinafter set forth to the extent permitted by Law, which shall be distinct, separate and cumulative with and in addition to any other right or remedy allowed under any Law or other provision of this Lease:

(1) Landlord may terminate this Lease and Tenant's right of possession, reenter and repossess the Premises by detainer suit, summary proceedings or other lawful means, and recover from Tenant: (i) any unpaid Rent as of the termination date, (ii) the amount by which: (a) any unpaid Rent which would have accrued after the termination date during the balance of the Term exceeds (b) the reasonable rental value of the Premises under a lease substantially similar to this Lease, taking into account among other things the condition of the Premises, market conditions and the period of time the Premises may reasonably remain vacant before Landlord is able to re-lease the same to a suitable replacement tenant, and Costs of Reletting (as defined in Paragraph H below) that Landlord may incur in order to enter such replacement lease, (iii) any other amounts necessary to compensate Landlord for all damages proximately caused by Tenant's failure to perform its obligations under this Lease. The amounts computed in accordance with the foregoing subclauses (a) and (b) shall both be discounted in accordance with accepted financial practice at the rate of seven percent (7%) per annum to the then present value.

(2) Landlord may terminate Tenant's right of possession, reenter and repossess the Premises by detainer suit, summary proceedings or other lawful means, without terminating this Lease, and recover from Tenant: (i) any unpaid Rent as of the date possession is terminated, (ii) any unpaid Rent which thereafter accrues during the Term from the date possession is terminated through the time of judgment (or which may have accrued from the time of any earlier judgment obtained by Landlord), less any consideration received from replacement tenants as further described and applied pursuant to Paragraph H, below, and (iii) any other amounts necessary to compensate Landlord for all damages proximately caused by Tenant's failure to perform its obligations under this Lease, including all Costs of Reletting (as defined in Paragraph H below). Tenant shall pay any such amounts to Landlord as the same accrue or after the same have accrued from time to time upon demand. At any time after terminating Tenant's right to possession as provided herein, Landlord may terminate this Lease as provided in clause (1) above by notice to Tenant, and Landlord may pursue such other remedies as may be available to Landlord under this Lease or applicable Law.

C. Mitigation of Damages. Except to the extent required by applicable law, if Landlord terminates this Lease or Tenant's right to possession or if Landlord has not terminated this Lease or Tenant's right to possession, Landlord shall have no obligation to mitigate Landlord's damages. Landlord shall have no obligation to mitigate under any circumstances and may permit the Premises to remain vacant or abandoned; in such case, Tenant may seek to mitigate damages by attempting to sublease the Premises or assign this Lease pursuant to Article 13. If Landlord is required to mitigate damages: (i) Landlord shall be required only to use reasonable efforts to mitigate, which shall not exceed such efforts as Landlord generally uses to lease other space at the Property, (ii) Landlord will not be deemed to have failed to mitigate if Landlord or its affiliates lease any other portions of the Property or other projects owned by Landlord or its affiliates in the same geographic area, before reletting all or any portion of the Premises, and (iii) any failure to mitigate as described herein with respect to any period of time shall only reduce the Rent and other amounts to which Landlord is entitled hereunder by the reasonable rental value of the Premises during such period, taking into account the factors described in clause B(1) above. In recognition that the value of the Property depends on the rental rates and terms of leases therein, Landlord's rejection of a prospective replacement tenant based on an offer of rentals below Landlord's published rates for new leases of comparable space at the Property at the time in question, or at Landlord's option, below the rates provided in this Lease, or containing terms less favorable than those contained herein, shall not give rise to a claim by Tenant that Landlord failed to mitigate Landlord's damages.

D. Reletting. If this Lease or Tenant's right to possession is terminated, or Tenant abandons the Premises, Landlord may: (i) enter and secure the Premises, change the locks, install barricades, remove any improvements, fixtures or other property of Tenant therein, perform any decorating, remodeling, repairs, alterations, improvements or additions and take such other actions as Landlord shall determine in Landlord's sole discretion to prevent damage or deterioration to the Premises or prepare the same for reletting, and (ii) relet all or any portion of the Premises (separately or as part of a larger space), for any rent, use or period of time (which may extend beyond the Term hereof), and upon any other terms as Landlord shall determine in Landlord's sole discretion, directly or as Tenant's agent (if permitted or required by applicable Law). The consideration received from such reletting shall be applied pursuant to the terms of Paragraph H hereof, and if such consideration, as so applied, is

not sufficient to cover all Rent and damages to which Landlord may be entitled hereunder, Tenant shall pay any deficiency to Landlord as the same accrues or after the same has accrued from time to time upon demand, subject to the other provisions hereof.

E. Specific Performance, Collection of Rent and Acceleration. Landlord shall at all times have the right without prior demand or notice except as required by applicable Law to: (i) seek any declaratory, injunctive or other equitable relief, and specifically enforce this Lease or restrain or enjoin a violation of any provision hereof, and Tenant hereby waives any right to require that Landlord post a bond or other security in connection therewith, and (ii) sue for and collect any unpaid Rent which has accrued. Notwithstanding anything to the contrary contained in this Lease, to the extent not expressly prohibited by applicable Law, in the event of any Default by Tenant, Landlord may terminate this Lease or Tenant's right to possession and accelerate and declare all Rent reserved for the remainder of the Term to be immediately due and payable; provided the Rent so accelerated shall be discounted in accordance with accepted financial practice at the rate of seven percent (7%) per annum to the then present value, and Landlord shall, after receiving payment of the same from Tenant, be obligated to turn over to Tenant any actual net reletting proceeds (net of all Costs of Reletting) thereafter received during the remainder of the Term, up to the amount so received from Tenant pursuant to this provision.

F. Late Charges, Interest, and Returned Checks. Tenant shall pay, as additional Rent, a service charge of Two Hundred Dollars ($200.00) or five percent (5%) of the delinquent amount, whichever is greater and any collection costs (including attorneys fees), if any portion of Rent is not received when due. In addition, any Rent not paid when due shall accrue interest from the due date at the Default Rate until payment is received by Landlord. Such service charges and interest payments shall not be deemed consent by Landlord to late payments, nor a waiver of Landlord's right to insist upon timely payments at any time, nor a waiver of any remedies to which Landlord is entitled as a result of the late payment of Rent. If Landlord receives two (2) or more checks from Tenant which are returned by Tenant's bank for insufficient funds, Landlord may require that all checks thereafter be bank certified or cashier's checks (without limiting Landlord's other remedies). All bank service charges resulting from any returned checks shall be borne by Tenant.

G. Landlord's Cure of Tenant Defaults. If Tenant fails to perform any obligation under this Lease for three (3) days after notice thereof by Landlord (except that no notice shall be required in emergencies), Landlord shall have the right (but not the duty), to perform such obligation on behalf and for the account of Tenant. In such event, Tenant shall reimburse Landlord upon demand, as additional Rent, for all expenses incurred by Landlord in performing such obligation together with an amount equal to fifteen (15%) thereof for Landlord's overhead, and interest thereon at the Default Rate from the date such expenses were incurred. Landlord's performance of Tenant's obligations hereunder shall not be deemed a waiver or release of Tenant therefrom.

H. Other Matters. No re-entry or repossession, repairs, changes, alterations and additions, reletting, or any other action or omission by Landlord shall be construed as an election by Landlord to terminate this Lease or Tenant's right to possession, nor shall the same operate to release Tenant in whole or in part from any of Tenant's obligations hereunder, unless express notice of such intention is sent by Landlord to

Tenant. Landlord may bring suits for amounts owed by Tenant hereunder or any portions thereof, as the same accrue or after the same have accrued, and no suit or recovery of any portion due hereunder shall be deemed a waiver of Landlord's right to collect all amounts to which Landlord is entitled hereunder, nor shall the same serve as any defense to any subsequent suit brought for any amount not therefor reduced to judgment. Landlord may pursue one or more remedies against Tenant and need not make an election of remedies until findings of fact are made by a court of competent jurisdiction. All rent and other consideration paid by any replacement tenants shall be applied at Landlord's option: (i) first, to the Costs of Reletting, (ii) second, to the payment of all costs of enforcing this Lease against Tenant or any Guarantor, (iii) third, to the payment of all interest and service charges accruing hereunder, (iv) fourth, to the payment of Rent theretofore accrued, and (v) with the residue, if any, to be held by Landlord and applied to the payment of Rent and other obligations of Tenant as the same become due (and with any remaining residue to be retained by Landlord). "Costs of Reletting" shall include without limitation, all costs and expenses incurred by Landlord for any repairs or other matters described in Paragraph D above, brokerage commissions, advertising costs, attorneys' fees, any economic incentives given to enter leases with replacement tenants, and costs of collecting rent from replacement tenants. Landlord shall be under no obligation to observe or perform any provision of this Lease on its part to be observed or performed which accrues while Tenant is in Default hereunder. The times set forth herein for the curing of Defaults by Tenant are of the essence of this Lease. Tenant hereby irrevocably waives any right otherwise available under any Law to redeem or reinstate this Lease, or Tenant's right to possession, after this Lease, or Tenant's right to possession, is terminated based on a Default by Tenant.

ARTICLE 16. SECURITY DEPOSIT

Tenant shall deposit with Landlord the amount set forth in Article 1 ("Security Deposit"), upon Tenant's execution and submission of this Lease. The Security Deposit shall serve as security for the prompt, full and faithful performance by Tenant of the terms and provisions of this Lease. If Tenant commits a Default, or owes any amounts to Landlord upon the expiration or other termination of this Lease, Landlord may use or apply the whole or any part of the Security Deposit for the payment of Tenant's obligations hereunder. The use or application of the Security Deposit or any portion thereof shall not prevent Landlord from exercising any other right or remedy provided hereunder or under any Law and shall not be construed as liquidated damages. In the event the Security Deposit is reduced by such use or application, Tenant shall deposit with Landlord within ten (10) days after notice, an amount sufficient to restore the full amount of the Security Deposit. Landlord shall not be required to keep the Security Deposit separate from Landlord's general funds or pay interest on the Security Deposit. Any remaining portion of the Security Deposit shall be returned to Tenant (or, at Landlord's option, to the last assignee of Tenant's interest in this Lease) within sixty (60) days after Tenant (or such assignee) has vacated the Premises in accordance with Article 23. If the Premises shall be expanded at any time, or if the Term shall be extended at an increased rate of Rent, the Security Deposit shall thereupon be proportionately increased. Tenant shall not assign, pledge or otherwise transfer any interest in the Security Deposit except as part of an assignment of this Lease approved by Landlord under Article 13, and any attempt to do so shall be null and void.

ARTICLE 17. ATTORNEYS' FEES, JURY TRIAL, COUNTERCLAIMS AND VENUE

In the event of any litigation or arbitration between the parties relating to this Lease, the Premises or Property (including pretrial, trial, appellate, administrative, bankruptcy or insolvency proceedings), the prevailing party shall be entitled to recover its attorneys' fees and costs as part of the judgment, award or settlement therein. In the event of a breach of this Lease by either party which does not result in litigation but which causes the non-breaching party to incur attorneys' fees or costs, the breaching party shall reimburse such fees and costs to the non-breaching party upon demand. If either party or any of its officers, directors, trustees, beneficiaries, partners, agents, affiliates or employees shall be made a party to any litigation or arbitration commenced by or against the other party and is not at fault, the other party shall pay all costs, expenses and attorneys' fees incurred by such parties in connection with such litigation. **IN THE INTEREST OF OBTAINING A SPEEDIER AND LESS COSTLY HEARING OF ANY DISPUTE, LANDLORD AND TENANT HEREBY WAIVE TRIAL BY JURY IN ANY ACTION, PROCEEDING OR COUNTERCLAIM BROUGHT BY EITHER PARTY AGAINST THE OTHER ARISING OUT OF OR RELATING TO THIS LEASE, THE PREMISES OR THE PROPERTY.** Although such jury waiver is intended to be self-operative and irrevocable, Landlord and Tenant each further agree, if requested, to confirm such waivers in writing at the time of commencement of any such action, proceeding or counterclaim. If Landlord commences any detainer suit, summary proceedings or other action seeking possession of the Premises, Tenant agrees not to interpose by consolidation of actions, removal to chancery or otherwise, any counterclaim, claim of set-off, recoupment or deduction of Rent, or other claim seeking affirmative relief of any kind (except a mandatory or compulsory counterclaim which Tenant would forfeit if not so interposed). Any action or proceeding brought by either party against the other for any matter arising out of or in any way relating to this Lease, the Premises or the Property, shall be heard, at Landlord's option, in the court having jurisdiction located closest to the Property.

ARTICLE 18. SUBORDINATION, ATTORNMENT AND LENDER PROTECTION

This Lease is subject and subordinate to all Mortgages now or hereafter placed upon the Property, and all other encumbrances and matters of public record applicable to the Property. Whether before or after any foreclosure or power of sale proceedings are initiated or completed by any Lender or a deed in lieu is granted (or any ground lease is terminated), Tenant agrees upon written request of any such Lender or any purchaser at such sale, to attorn and pay Rent to such party, and recognize such party as Landlord (provided such Lender or purchaser shall agree not to disturb Tenant's occupancy so long as Tenant does not Default hereunder, on a form customarily used by, or otherwise reasonably acceptable to, such party). However, in the event of attornment, no Lender shall be: (i) liable for any act or omission of Landlord, or subject to any offsets or defenses which Tenant might have against Landlord (arising prior to such Lender becoming Landlord under such attornment), (ii) liable for any security deposit or bound by any prepaid Rent not actually received by such Lender, or (iii) bound by any modification of this Lease not consented to by such Lender. Any Lender may elect to make this Lease prior to the lien of its Mortgage by written notice to Tenant, and if the Lender of any prior Mortgage shall require, this Lease shall be prior to any subordinate Mortgage; such elections shall be effective upon written notice to Tenant, or shall be effective as of such earlier or later date set forth in such notice. Tenant agrees to give any Lender by certified mail, return receipt requested, a copy of

any notice of default served by Tenant upon Landlord, provided that prior to such notice Tenant has been notified in writing (by way of service on Tenant of a copy of an assignment of leases, or otherwise) of the address of such Lender. Tenant further agrees that if Landlord shall have failed to cure such default within the time permitted Landlord for cure under this Lease, any such Lender whose address has been provided to Tenant shall have an additional period of thirty (30) days in which to cure (or such additional time as may be required due to causes beyond such Lender's control, including time to obtain possession of the Property by appointment of receiver, power of sale or judicial action). Should any current or prospective Lender require a modification or modifications to this Lease which will not cause an increased cost or otherwise materially and adversely change the rights and obligations of Tenant hereunder, Tenant agrees that this Lease shall be so modified. Except as expressly provided to the contrary herein, the provisions of this Article shall be self-operative; however Tenant shall execute and deliver, within ten (10) days after requested, such documentation as Landlord or any Lender may request from time to time, whether prior to or after a foreclosure or power of sale proceeding is initiated or completed, a deed in lieu is delivered, or a ground lease is terminated, in order to further confirm or effectuate the matters set forth in this Article in recordable form (and Tenant hereby authorizes Landlord acting in good faith to execute any such documentation as Tenant's agent and attorney-in-fact). Tenant hereby waives the provisions of any Law (now or hereafter adopted) which may give or purport to give Tenant any right or election to terminate or otherwise adversely affect this Lease or Tenant's obligations hereunder if foreclosure or power of sale proceedings are initiated, prosecuted or completed.

If Lender succeeds to Landlord's interest under the Lease and is advised by its counsel that all or any portion of the rent payable under the Lease is or may be deemed to be unrelated business income within the meaning of the Code or regulations issued thereunder, Lender may elect to unilaterally amend the calculation of rent so that none of the rent payment to the Lender under the Lease will constitute unrelated business income but the amendment will not increase the Tenant's payment obligations or other liability under the Lease or reduce Landlord's obligations under the Lease. Should the Lender request, Tenant shall be obligated to execute any document Lender deems reasonably necessary to effect the amendment thereof.

ARTICLE 19. ESTOPPEL CERTIFICATES

Tenant shall from time to time, within five (5) days after written request from Landlord for itself or for a current or prospective lender or prospective purchaser, execute, acknowledge and deliver a statement certifying: (i) that this Lease is unmodified and in full force and effect or, if modified, stating the nature of such modification and certifying that this Lease as so modified, is in full force and effect (or specifying the ground for claiming that this Lease is not in force and effect), (ii) the dates to which the Rent has been paid, and the amount of any Security Deposit, (iii) that Tenant is in possession of the Premises, and paying Rent on a current basis with no offsets, defenses or claims, or specifying the same if any are claimed, (iv) that there are not, to Tenant's knowledge, any uncured defaults on the part of Landlord or Tenant which are pertinent to the request, or specifying the same if any are claimed, and (v) certifying such other matters, and including such current financial statements, as Landlord may reasonably request, or as may be requested by Landlord's current or prospective Lenders, insurance carriers, auditors, and prospective purchasers (and including a comparable certification statement from any subtenant respecting its sublease). Any such statement may be relied upon by any such parties. If Tenant shall

fail to execute and return such statement within the time required herein, Tenant shall be deemed to have agreed with the matters set forth therein, and Landlord acting in good faith shall be authorized as Tenant's agent and attorney-in-fact to execute such statement on behalf of Tenant (which shall not be in limitation of Landlord's other remedies).

ARTICLE 20. RIGHTS RESERVED BY LANDLORD

Except to the extent expressly limited herein, Landlord reserves full rights to control the Property (which rights may be exercised without subjecting Landlord to claims for constructive eviction, abatement of Rent, damages or other claims of any kind), including more particularly, but without limitation, the following rights:

A. General Matters. To: (i) change the name or street address of the Property or designation of the Premises, (ii) install and maintain signs on the exterior and interior of the Property, and grant any other Person the right to do so, (iii) retain at all times, and use in appropriate instances, keys to all doors within and into the Premises, (iv) grant to any Person the right to conduct any business or render any service at the Property, whether or not the same are similar to the use permitted Tenant by this Lease, (v) grant any Person the right to use separate security personnel and systems respecting access to their premises, (vi) have access for Landlord and other tenants of the Property to any mail chutes located on the Premises according to the rules of the United States Postal Service (and to install or remove such chutes), and (vii) in case of fire, invasion, insurrection, riot, civil disorder, public excitement, terrorist activity or other dangerous condition, or threat thereof: (a) limit or prevent access to the Property, (b) shut down elevator service, (c) activate elevator emergency controls, and (d) otherwise take such action or preventative measures deemed necessary by Landlord for the safety of tenants of the Property or the protection of the Property and other property located thereon or therein (but this provision shall impose no duty on Landlord to take such actions, and no liability for actions taken in good faith).

B. Access To Premises. To enter the Premises in order to: (i) inspect, (ii) supply cleaning service or other services to be provided Tenant hereunder, (iii) show the Premises to current and prospective Lenders, insurers, purchasers, tenants, brokers and governmental authorities, (iv) decorate, remodel or alter the Premises if Tenant shall abandon the Premises at any time, or shall vacate the same during the last 120 days of the Term (without thereby terminating this Lease), and (v) perform any work or take any other actions under Paragraph C, below, or exercise other rights of Landlord under this Lease or applicable Laws. However, Landlord shall: (a) provide reasonable advance written or oral notice to Tenant's on-site manager or other appropriate person for matters which will involve a significant disruption to Tenant's business (24 hours prior to entry except in emergencies), (b) take reasonable steps to minimize any significant disruption to Tenant's business, and following completion of any work, return Tenant's leasehold improvements, fixtures, property and equipment to the original locations and condition to the fullest extent reasonably possible, and (c) take reasonable steps to avoid materially changing the configuration or reducing the square footage of the Premises, unless required by Laws or other causes beyond Landlord's reasonable control (and in the event of any permanent material reduction, the Rent and other rights and obligations of the parties based on the square footage of the Premises shall be proportionately reduced). Tenant shall not place partitions, furniture or other obstructions in the Premises which may prevent or impair Landlord's access to the Systems and Equipment for the Property or the systems and equipment for the

Premises. If Tenant requests that any such access occur before or after Landlord's regular business hours and Landlord approves, Tenant shall pay all overtime and other additional costs in connection therewith.

C. Changes To The Property. To: (i) paint and decorate, (ii) perform repairs or maintenance, and (iii) make replacements, restorations, renovations, alterations, additions and improvements, structural or otherwise (including freon retrofit work), in and to the Property or any part thereof, including any adjacent building, structure, facility, land, street or alley, or change the uses thereof (including changes, reductions or additions of corridors, entrances, doors, lobbies, parking facilities and other areas, structural support columns and shear walls, elevators, stairs, escalators, mezzanines, solar tint windows or film, kiosks, planters, sculptures, displays, and other amenities and features therein, and changes relating to the connection with or entrance into or use of the Property or any other adjoining or adjacent building or buildings, now existing or hereafter constructed). In connection with such matters, Landlord may among other things erect scaffolding, barricades and other structures, open ceilings, close entry ways, restrooms, elevators, stairways, corridors, parking and other areas and facilities, and take such other actions as Landlord deems appropriate. However, Landlord shall: (a) take reasonable steps to minimize or avoid any denial of access to the Premises except when necessary on a temporary basis, and (b) in connection with entering the Premises shall comply with Paragraph B above.

D. New Premises. To substitute for the Premises other premises (herein referred to as the "new premises") in the Property, provided: (i) the new premises shall be reasonably similar to the Premises in size unless Tenant is upgrading space due to growth (ii) Landlord shall provide the new premises in a condition substantially comparable to the Premises at the time of the substitution (and Tenant shall diligently cooperate in the preparation or approval of any plans or specifications for the new premises as requested by Landlord or Landlord's representatives), (iii) the parties shall execute an appropriate amendment to the Lease confirming the change within sixty (60) days after Landlord requests, (iv) Landlord shall pay the direct, out-of-pocket, reasonable expenses of Tenant in moving from the Premises to the new premises, if only requested by Landlord and (v) Landlord shall give Tenant at least sixty (60) days' notice before making such change, and so as to incur the least inconvenience to Tenant. Tenant shall surrender and vacate the Premises on the date required in Landlord's notice of substitution, in the condition and as required under Article 23, and any failure to do so shall be subject to Article 24.

ARTICLE 21. LANDLORD'S RIGHT TO CURE

If Landlord shall fail to perform any obligation under this Lease required to be performed by Landlord, Landlord shall not be deemed to be in default hereunder nor subject to any claims for damages of any kind, unless such failure shall have continued for a period of thirty (30) days after notice thereof by Tenant (provided, if the nature of Landlord's failure is such that more time is reasonably required in order to cure, Landlord shall not be in default if Landlord commences to cure within such period and thereafter diligently seeks to cure such failure to completion). If Landlord shall default and fail to cure as provided herein, Tenant shall have such rights and remedies as may be available to Tenant under applicable Laws, subject to the other provisions of this Lease; provided, Tenant shall have no right of self-help to perform repairs or any other obligation of Landlord, and shall have no right to withhold, set-off, or abate Rent, or

terminate this Lease, and Tenant hereby expressly waives the benefit of any Law to the contrary.

ARTICLE 22. INDEMNIFICATION

Tenant shall defend, indemnify and hold Landlord harmless from and against any and all claims, demands, losses, penalties, fines, fees, charges, assessments, liabilities, damages, judgments, orders, decrees, actions, administrative or other proceedings, costs and expenses (including court costs, attorneys' fees, and expert witness fees), including consequential damages, and any diminution in value or loss or interference with the transfer, use or enjoyment of the Premises, Property or other property or business or affecting title thereto, howsoever caused, which directly or indirectly relate to or result wholly or in part from, or are alleged to relate to or arise wholly or in part from: (i) any violation or breach of this Lease or applicable Law by any Tenant Parties (as defined below), (ii) damage, loss or injury to persons, property or business occurring in, about or from the Premises, (iii) damage, loss or injury to persons, property or business directly or indirectly arising out of any Tenant Party's use of the Premises or Property, or out of any other act or omission of any Tenant Parties. For purposes of this provision, "Tenant Parties" shall mean Tenant, any other occupant of the Premises and any of their respective agents, employees, invitees, Transferees and contractors. Without limiting the generality of the foregoing, Tenant specifically acknowledges that the undertaking herein shall apply to claims in connection with or arising out of any "Work" as described in Article 9, the transportation, use, storage, maintenance, generation, manufacturing, handling, disposal, release, discharge, spill or leak of any "Hazardous Material" as described in Article 29, and violations of Tenant's responsibilities respecting the Disabilities Acts as described in Article 30 (whether or not any of such matters shall have been theretofore approved by Landlord). Notwithstanding the foregoing to the contrary, the foregoing indemnity shall not apply to claims finally determined by a court of competent jurisdiction to have been caused solely by the gross negligence or willful misconduct of the party seeking to be indemnified.

ARTICLE 23. RETURN OF POSSESSION

At the expiration or earlier termination of this Lease or Tenant's right of possession, Tenant shall vacate and surrender possession of the entire Premises in the condition required under Article 8 and the Rules, ordinary wear and tear excepted, shall surrender all keys and key cards, and any parking transmitters, stickers or cards, to Landlord, and shall remove all personal property and office trade fixtures that may be readily removed without damage to the Premises or Property. All improvements, fixtures and other items, including ceiling light fixtures, HVAC equipment, plumbing fixtures, hot water heaters, fire suppression and sprinkler systems, interior stairs, wall coverings, carpeting and other flooring, blinds, drapes and window treatments, in or serving the Premises, whether installed by Tenant or Landlord, shall be Landlord's property and shall remain upon the Premises, all without compensation, allowance or credit to Tenant, unless Landlord elects otherwise as provided herein. If prior to such termination or within three (3) months thereafter Landlord so directs by notice, Tenant shall promptly remove such of the foregoing items as are designated in such notice and restore the Premises to the condition prior to the installation of such items in a good and workmanlike manner; provided, Landlord shall not require removal of customary office improvements installed with Landlord's written approval (except as expressly and reasonably required by Landlord in connection with granting such approval). If Tenant

shall fail to perform any repairs or restoration, or fail to remove any items from the Premises required hereunder, Landlord may do so and Tenant shall pay Landlord's charges therefor upon demand. All property removed from the Premises by Landlord pursuant to any provisions of this Lease or any Law may be handled or stored by Landlord at Tenant's expense, and Landlord shall in no event be responsible for the value, preservation or safekeeping thereof. All property not removed from the Premises or retaken from storage by Tenant within thirty (30) days after expiration or earlier termination of this Lease or Tenant's right to possession, shall at Landlord's option be conclusively deemed to have been conveyed by Tenant to Landlord as if by bill of sale without payment by Landlord. Unless prohibited by applicable Law, Landlord shall have a lien against such property for the costs incurred in removing and storing the same. Tenant hereby waives any statutory notices to vacate or quit the Premises upon expiration of this Lease.

ARTICLE 24. HOLDING OVER

Unless Landlord expressly agrees otherwise in writing, Tenant shall pay Landlord 150% of the amount of Rent then applicable prorated on a per diem basis for each day Tenant shall fail to vacate or surrender possession of the Premises or any part thereof after expiration or earlier termination of this Lease as required under Article 23, together with all damages (direct and consequential) sustained by Landlord on account thereof. Tenant shall pay such amounts on demand, and, in the absence of demand, monthly in advance. The foregoing provisions, and Landlord's acceptance of any such amounts, shall not serve as permission for Tenant to hold-over, nor serve to extend the Term (although Tenant shall remain a tenant-at-sufferance bound to comply with all provisions of this Lease until Tenant properly vacates the Premises, and shall be subject to the provisions of Article 23). Landlord shall have the right at any time after expiration or earlier termination of this Lease or Tenant's right to possession to reenter and possess the Premises and remove all property and Persons therefrom, and Landlord shall have such other remedies for holdover as may be available to Landlord under other provisions of this Lease or applicable Laws.

ARTICLE 25. NOTICES

Except as expressly provided to the contrary in this Lease, every notice or other communication to be given by either party to the other with respect hereto or to the Premises or Property, shall be in writing and shall not be effective for any purpose unless the same shall be served personally or by national air courier service, or United States certified mail, return receipt requested, postage prepaid, to the parties at the addresses set forth in Article 1, or such other address or addresses as Tenant or Landlord may from time to time designate by notice given as above provided. Every notice or other communication hereunder shall be deemed to have been given as of the third business day following the date of such mailing (or as of any earlier date evidenced by a receipt from such national air courier service or the United States Postal Service) or immediately if personally delivered. Notices not sent in accordance with the foregoing shall be of no force or effect until received by the foregoing parties at such addresses required herein.

ARTICLE 26. REAL ESTATE BROKERS

Tenant represents that Tenant has dealt only with the broker, if any, designated in Article 1 (whose commission, if any, shall be paid by Landlord pursuant to separate agreement) as broker, agent or finder in connection with this Lease, and agrees to

indemnify and hold Landlord harmless from all damages, judgments, liabilities and expenses (including reasonable attorneys' fees) arising from any claims or demands of any other broker, agent or finder with whom Tenant has dealt for any commission or fee alleged to be due in connection with its participation in the procurement of Tenant or the negotiation with Tenant of this Lease.

ARTICLE 27. NO WAIVER

No provision of this Lease will be deemed waived by either party unless expressly waived in writing and signed by the waiving party. No waiver shall be implied by delay or any other act or omission of either party. No waiver by either party of any provision of this Lease shall be deemed a waiver of such provision with respect to any subsequent matter relating to such provision, and Landlord's consent or approval respecting any action by Tenant shall not constitute a waiver of the requirement for obtaining Landlord's consent or approval respecting any subsequent action. Acceptance of Rent by Landlord directly or through any agent or lock-box arrangement shall not constitute a waiver of any breach by Tenant of any term or provision of this Lease (and Landlord reserves the right to return or refund any untimely payments if necessary to preserve Landlord's remedies). No acceptance of a lesser amount of Rent shall be deemed a waiver of Landlord's right to receive the full amount due, nor shall any endorsement or statement on any check or payment or any letter accompanying such check or payment be deemed an accord and satisfaction, and Landlord may accept such check or payment without prejudice to Landlord's right to recover the full amount due. The acceptance of Rent or of the performance of any other term or provision from, or providing directory listings or services for, any Person other than Tenant shall not constitute a waiver of Landlord's right to approve any Transfer. No delivery to, or acceptance by, Landlord or its agents or employees of keys, nor any other act or omission of Tenant or Landlord or their agents or employees, shall be deemed a surrender, or acceptance of a surrender, of the Premises or a termination of this Lease, unless stated expressly in writing by Landlord.

ARTICLE 28. SAFETY AND SECURITY DEVICES, SERVICES AND PROGRAMS

The parties acknowledge that safety and security devices, services and programs provided by Landlord, if any, while intended to deter crime and ensure safety, may not in given instances prevent theft or other criminal acts, or ensure safety of persons or property. The risk that any safety or security device, service or program may not be effective, or may malfunction, or be circumvented by a criminal, is assumed by Tenant with respect to Tenant's property and interests, and Tenant shall obtain insurance coverage to the extent Tenant desires protection against such criminal acts and other losses, as further described in Article 10. Tenant agrees to cooperate in any reasonable safety or security program developed by Landlord or required by Law.

ARTICLE 29. HAZARDOUS MATERIALS

A. Hazardous Materials Generally Prohibited. Tenant shall not transport, use, store, maintain, generate, manufacture, handle, dispose, release, discharge, spill or leak any "Hazardous Material" (as defined below), or permit Tenant's employees, agents, contractors, or other occupants of the Premises to engage in such activities on or about the Property. However, the foregoing provisions shall not prohibit the transportation to and from, and use, storage, maintenance and handling within, the Premises of substances customarily and lawfully used in the business which Tenant is permitted to conduct in the Premises under this Lease, but only as an incidental and

minor part of such business, and provided: (i) such substances shall be properly labeled, contained, used and stored only in small quantities reasonably necessary for such permitted use of the Premises and the ordinary course of Tenant's business therein, strictly in accordance with applicable Laws, highest prevailing standards, and the manufacturers' instructions therefor, and as Landlord shall reasonably require, (ii) Tenant shall provide Landlord with ten (10) days advance notice and current Material Safety Data Sheets ("MSDSs") therefor, and Landlord reserves the right to prohibit or limit such substances in each such instance, (iii) such substances shall not be disposed of, released, discharged or permitted to spill or leak in or about the Premises or the Property (and under no circumstances shall any Hazardous Material be disposed of within the drains or plumbing facilities in or serving the Premises or Property or in any other public or private drain or sewer, regardless of quantity or concentration), (iv) if any applicable Law or Landlord's trash removal contractor requires that any such substances be disposed of separately from ordinary trash, Tenant shall make arrangements at Tenant's expense for such disposal in approved containers directly with a qualified and licensed disposal company at a lawful disposal site, (v) any remaining such substances shall be completely, properly and lawfully removed from the Property upon expiration or earlier termination of this Lease, and (vi) for purposes of removal and disposal of any such substances, Tenant shall be named as the owner, operator and generator, shall obtain a waste generator identification number, and shall execute all permit applications, manifests, waste characterization documents and any other required forms.

B. Notifications and Records. Tenant shall immediately notify Landlord of: (i) any inspection, enforcement, cleanup or other regulatory action taken or threatened by any regulatory authority with respect to any Hazardous Material on or from the Premises or the migration thereof from or to other property, (ii) any demands or claims made or threatened by any party relating to any loss or injury claimed to have resulted from any Hazardous Material on or from the Premises, (iii) any release, discharge, spill, leak, disposal or transportation of any Hazardous Material on or from the Premises in violation of this Article, and any damage, loss or injury to persons, property or business resulting or claimed to have resulted therefrom, and (iv) any matters where Tenant is required by Law to give a notice to any regulatory authority respecting any Hazardous Materials on or from the Premises. Landlord shall have the right (but not the obligation) to notify regulatory authorities concerning actual and claimed violations of this Article. Tenant shall immediately upon written request from time to time provide Landlord with copies of all MSDSs, permits, approvals, memos, reports, correspondence, complaints, demands, claims, subpoenas, requests, remediation and cleanup plans, and all papers of any kind filed with or by any regulatory authority and any other books, records or items pertaining to Hazardous Materials that are subject to the provisions of this Article (collectively referred to herein as "Tenant's Hazardous Materials Records").

C. Clean Up Responsibility. If any Hazardous Material is released, discharged or disposed of, or permitted to spill or leak, in violation of the foregoing provisions, Tenant shall immediately and properly clean up and remove the Hazardous Materials from the Premises, Property and any other affected property and clean or replace any affected personal property (whether or not owned by Landlord) in compliance with applicable Laws and then prevailing industry practices and standards, at Tenant's expense (without limiting Landlord's other remedies therefor). Such clean up and removal work ("Tenant Remedial Work") shall be considered Work under Article 9 and subject to the provisions thereof, including Landlord's prior written approval

(except in emergencies), and any testing, investigation, feasibility and impact studies, and the preparation and implementation of any remedial action plan required by any court or regulatory authority having jurisdiction or reasonably required by Landlord. In connection therewith, Tenant shall provide documentation evidencing that all Tenant Remedial Work or other action required hereunder has been properly and lawfully completed (including a certificate addressed to Landlord from an environmental consultant reasonably acceptable to Landlord, in such detail and form as Landlord may reasonably require). If any Hazardous Material is released, discharged, disposed of, or permitted to spill or leak on or about the Property and is not caused by Tenant or other occupants of the Premises, or their agents, employees, Transferees, or contractors, such release, discharge, disposal, spill or leak shall be deemed casualty damage under Article 11 to the extent that the Premises and Tenant's use thereof is affected thereby; in such case, Landlord and Tenant shall have the obligations and rights respecting such casualty damage provided under this Lease.

D. Hazardous Material Defined. The term "Hazardous Material" for purposes hereof shall include, but not be limited to: (i) any flammable, explosive, toxic, radioactive, biological, corrosive or otherwise hazardous chemical, substance, liquid, gas, device, form of energy, material or waste or component thereof, (ii) petroleum-based products, diesel fuel, paints, solvents, lead, radioactive materials, cyanide, biohazards, medical and infectious waste and "sharps", printing inks, acids, DDT, pesticides, ammonia compounds, and any other items which now or subsequently are found to have an adverse effect on the environment or the health and safety of persons or animals or the presence of which require investigation or remediation under any Law or governmental policy, and (iii) any item defined as a "hazardous substance", "hazardous material", "hazardous waste", "regulated substance" or "toxic substance" under any federal, state or local Laws, and all regulations, guidelines, directives and other requirements thereunder, all as may be amended or supplemented from time to time.

E. Fees, Taxes, Fines and Remedies. Tenant shall pay, prior to delinquency, any and all fees, taxes (including excise taxes), penalties and fines arising from or based on Tenant's activities involving Hazardous Material on or about the Premises or Property, and shall not allow such obligations to become a lien or charge against the Property or Landlord. If Tenant violates any provision of this Article with respect to any Hazardous Materials, Landlord may: (i) require that Tenant immediately remove all Hazardous Materials from the Premises and discontinue using, storing and handling Hazardous Materials in the Premises, and/or (ii) pursue such other remedies as may be available to Landlord under this Lease or applicable Law.

ARTICLE 30. DISABILITIES ACTS

The parties acknowledge that the Americans With Disabilities Act of 1990 (42 U.S.C. §12101 et seq.) and regulations and guidelines promulgated thereunder ("ADA"), and any similarly motivated state and local Laws ("Local Barriers Acts"), as the same may be amended and supplemented from time to time (collectively referred to herein as the "Disabilities Acts") establish requirements for business operations, accessibility and barrier removal, and that such requirements may or may not apply to the Premises and Property depending on, among other things: (i) whether Tenant's business is deemed a "public accommodation" or "commercial facility", (ii) whether such requirements are "readily achievable", and (iii) whether a given alteration affects a "primary function area"

or triggers "path of travel" requirements. The parties hereby agree that: (a) Landlord shall perform any required ADA Title III and related Local Barriers Acts compliance in the common areas, except as provided below, (b) Tenant shall perform any required ADA Title III and related Local Barriers Acts compliance in the Premises, and (c) Landlord may perform, or require that Tenant perform, and Tenant shall be responsible for the cost of, ADA Title III and related Local Barriers Acts "path of travel" and other requirements triggered by any public accommodation or other use of, or alterations in, the Premises. Tenant shall be responsible for ADA Title I and related Local Barriers Acts requirements relating to Tenant's employees, and Landlord shall be responsible for ADA Title I and related Local Barriers Acts requirements relating to Landlord's employees.

ARTICLE 31. DEFINITIONS

(A) "Building" shall mean the structure (or the portion thereof owned by Landlord) identified in Article 1.

(B) "Default Rate" shall mean eighteen percent (18%) per annum, or the highest rate permitted by applicable Law, whichever shall be less.

(C) "Expenses" shall mean all expenses, costs and amounts (other than Taxes) of every kind and nature relating to the ownership, management, repair, maintenance, replacement, insurance and operation of the Property, including any amounts paid for: (i) utilities for the Property, including electricity, power, gas, steam, oil or other fuel, water, sewer, lighting, heating, air conditioning and ventilating, (ii) permits, licenses, inspections, warrants and certificates necessary to operate, manage and lease the Property, (iii) costs of complying with Laws, including any freon retrofitting and compliance with the "Disabilities Acts" (as described in Article 30), (iv) insurance applicable to the Property, not limited to that required under this Lease, and which may include earthquake, boiler, rent loss, workers' compensation and employers' liability, builders' risk, automobile, terrorist and other coverages, including a reasonable allocation of costs under any blanket policies, (v) supplies, materials, tools, equipment, uniforms, and vehicles used in the operation, repair, maintenance, security, and other services for the Property, including rental, installment purchase and financing agreements therefor and interest thereunder, (vi) accounting, legal, inspection, consulting, concierge, alarm monitoring, security, janitorial, trash removal, snow and ice removal, and other services, (vii) management company fees, (viii) wages, salaries and other compensation and benefits (including health, life and disability insurance, savings, retirement and pension programs, and the fair value of any parking privileges, including those provided through collective bargaining agreements) for any manager and other personnel or parties engaged in the operation, repair, maintenance, security or other services for the Property, and employer's FICA contributions, unemployment taxes or insurance, any other taxes which may be levied on such wages, salaries, compensation and benefits, and data or payroll processing expenses relating thereto (if the manager or other personnel handle other properties, the foregoing expenses shall be allocated appropriately between the Property and such other properties), (ix) payments pursuant to any easement, cross or reciprocal easement, operating agreement, development and/or parking rights agreement, declaration, covenant, or other agreement or instrument pertaining to the payment or sharing of costs for common or parking areas or other matters (except to the extent included in Taxes hereunder), (x) parking surcharges or fees that may result from any environmental or other Law or guideline, and any sales, use, value-added or other taxes on supplies or services for the Property, (xi) the costs

of operating and maintaining any on-site office at the Property or an adjoining property (such costs to be appropriately allocated between the Property and any such adjoining property served by such office), including the fair rental value thereof, telephone charges, postage, stationery and photocopying expenses, and telephone directory listings, (xii) the amount of insurance premiums saved by electing higher than customary deductibles, if Landlord does not also include in Expenses the losses incurred as a result of having such higher deductibles, and (xiii) operation, maintenance, repair, installation, replacement, inspection, testing, painting, decorating and cleaning of the Property, and any items located off-site but installed for the benefit of the Property, including: (a) Property identification and pylon signs, directional signs, traffic signals and markers, flagpoles and canopies, (b) sidewalks, curbs, stairways, parking structures, lots, loading and service areas and driveways, (c) storm and sanitary drainage systems, including disposal plants, lift stations and detention ponds and basins, (d) irrigation systems, (e) elevators, escalators, "Lines" under Article 29, and other Systems and Equipment, (f) interior and exterior flowers and landscaping, and (g) all other portions, facilities, features and amenities of the Property, including common area fixtures, equipment and other items therein or thereon, floors, floor coverings, corridors, ceilings, foundations, walls, wall-coverings, restrooms, lobbies, trash compactors, doors, locks and hardware, windows, gutters, downspouts, roof flashings and roofs. The foregoing provision is for definitional purposes only and shall not be construed to impose any obligation upon Landlord to incur such expenses. Landlord may retain independent contractors (or affiliated contractors at market rates) to provide any services or perform any work, in which case the costs thereof shall be deemed Expenses. Expenses shall not, however, include:

(1) costs relating to non-office rentable areas of the Property to the extent that Landlord deducts such rentable areas in determining Tenant's Share of Expenses under Article 4; and costs relating solely to any parking garage for the Property (such as utilities, attendants, cashiers, scavenger and janitorial services), except to the extent that Landlord elects to credit parking revenues, if any, derived from such garage against Expenses;

(2) depreciation, interest and amortization on any Mortgages and other debt costs or ground lease payments (except interest on the cost of capital expenditures to the extent permitted below, and ground lease payments for Taxes and Expenses); legal fees in connection with leasing, tenant disputes or enforcement of leases; real estate brokers' leasing commissions; improvements or alterations to tenant spaces; the cost of providing any service directly to, and paid directly by, any tenant; costs of any items to the extent Landlord receives reimbursement from insurance proceeds or from a third party (excluding payments by tenants for Taxes and Expenses); and

(3) capital expenditures, except those: (i) made primarily to reduce Expenses, or to comply with Laws or insurance requirements imposed after the Property was constructed, or (ii) for replacements or upgrades of nonstructural items located in the common areas of the Property required to keep such areas in first class condition. To the extent that any such permitted capital expenditure exceeds $5,000, such excess shall be amortized for purposes of this Lease over the shorter of: (x) the period during which the reasonably estimated savings in Expenses equals the expenditure, (y) the shortest period over which Landlord may depreciate such item under the Federal Tax Code then in effect, or (z) the useful life of the item, but in no event more than ten (10) years; provided, Landlord may elect any longer period in Landlord's discretion. In each such case, Landlord may include interest on the

unamortized amount at the prevailing loan rate available to Landlord when the cost was incurred. Expenses shall include any remaining amortization of such permitted capital expenditures made prior to the date of this Lease.

(D) "Holidays" shall mean all federal holidays, and holidays observed by the State of Washington, including New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day, Christmas Day, and to the extent of utilities or services provided by union members engaged at the Property, such other holidays observed by such unions.

(E) "Landlord" shall mean only the landlord from time to time, except for purposes of any provisions defending, indemnifying and holding Landlord harmless hereunder, "Landlord" shall include past, present and future landlords and their respective partners, beneficiaries, trustees, officers, directors, employees, shareholders, principals, agents, affiliates, successors and assigns.

(F) "Law" or "Laws" shall mean all federal, state, county and local governmental and municipal laws, statutes, ordinances, rules, regulations, codes, decrees, orders and other such requirements, applicable equitable remedies and decisions by courts in cases where such decisions are considered binding precedents in the State of Washington, and decisions of federal courts applying the Laws of such State, at the time in question. This Lease shall be interpreted and governed by the laws of the State of Washington.

(G) "Lender" shall mean the holder of any Mortgage at the time in question, and where such Mortgage is a ground lease, such term shall refer to the ground lessor (and the term "ground lease" although not separately capitalized is intended through out this Lease to include any superior or master lease).

(H) "Market Growth Rate" shall mean the greater of 3.5% or the then-prevailing Consumer Price Index for Seattle, Washington, or, if unavailable, the Consumer Price Index published by the U.S. Department of Labor, Bureau of Labor Statistics.

(I) "Market Rental Rate" shall mean the then prevailing fair market, arms length base rental rate for the lease of comparable space in the Building and other Class A office buildings in Seattle, Washington on comparable terms and conditions, on a "gross", as opposed to "net" lease, basis for tenants of comparable size and creditworthiness.

(J) "Mortgage" shall mean all mortgages, deeds of trust, ground leases and other such encumbrances now or hereafter placed upon the Property or Building, or any part thereof, and all renewals, modifications, consolidations, replacements or extensions thereof, and all indebtedness now or hereafter secured thereby and all interest thereon.

(K) "Person" shall mean an individual, trust, partnership, limited liability company, joint venture, association, corporation and any other entity.

(L) "Premises" shall mean the area within the Building identified in Article 1 and Exhibit A. Possession of areas necessary for utilities, services, safety and operation of the Property, including the Systems and Equipment, fire stairways, perimeter walls, space between the finished ceiling of the Premises and the slab of the floor or roof of the Property thereabove, and the use thereof together with the right to install, maintain, operate, repair and replace the Systems and Equipment, including any of the same in, through, under or above the Premises in locations that will not materially

interfere with Tenant's use of the Premises, are hereby excepted and reserved by Landlord, and not demised to Tenant.

(M) "Property" shall mean the Building, and any common or public areas or facilities, easements, corridors, lobbies, sidewalks, loading areas, driveways, landscaped areas, air rights, development rights, parking rights, skywalks, parking garages and lots, and any and all other rights, structures or facilities operated or maintained in connection with or for the benefit of the Building, and all parcels or tracts of land on which all or any portion of the Building or any of the other foregoing items are located, and any fixtures, machinery, apparatus, Systems and Equipment, furniture and other personal property located thereon or therein and used in connection therewith. If the Building shall be part of a complex, development or group of buildings or structures collectively owned or managed by Landlord or its affiliates or collectively managed by Landlord's managing agent, the Property shall, at Landlord's option, also be deemed to include such other of those buildings or structures as Landlord shall from time to time designate, and shall initially include such buildings and structures and related facilities and parcels on which the same are located.

(N) "Rent" shall have the meaning specified therefor in Article 4.

(O) "Systems and Equipment" shall mean any plant, machinery, transformers, duct work, cable, wires, and other equipment, facilities, and systems designed to supply light, heat, ventilation, air conditioning and humidity or any other services or utilities, or comprising or serving as any component or portion of the electrical, gas, steam, plumbing, sprinkler, communications, alarm, security, or fire/life/safety systems or equipment, or any elevators, escalators or other mechanical, electrical, electronic, computer or other systems or equipment for the Property, except to the extent that any of the same serves particular tenants exclusively (and "systems and equipment" without capitalization shall refer to such of the foregoing items serving particular tenants exclusively).

(P) "Taxes" shall mean all amounts (unless required by Landlord to be paid under Article 14) for federal, state, county, or local governmental, special district, improvement district, municipal or other political subdivision taxes, fees, levies, assessments, charges or other impositions of every kind and nature in connection with the ownership, leasing and operation of the Property, whether foreseen or unforeseen, general, special, ordinary or extraordinary (including real estate and ad valorem taxes, general and special assessments, interest on special assessments paid in installments, transit taxes, water and sewer rents, license and business license fees, use or occupancy taxes, taxes based upon the receipt of rent including gross receipts or sales taxes applicable to the receipt of rent or service or value added taxes, personal property taxes, taxes on fees for property management services, and taxes or charges for fire protection, streets, sidewalks, road maintenance, refuse or other services). If the method of taxation of real estate prevailing at the time of execution hereof shall be, or has been, altered so as to cause the whole or any part of the Taxes now, hereafter or heretofore levied, assessed or imposed on real estate to be levied, assessed or imposed on Landlord, wholly or partially, as a capital stock levy or otherwise, or on or measured by the rents, income or gross receipts received therefrom, then such new or altered taxes attributable to the Property shall be included within the term "Taxes," except that the same shall not include any portion of such tax attributable to other income of Landlord not relating to the Property. Tenant shall pay increased Taxes whether Taxes are increased as a result of increases in the assessment or valuation of

the Property (whether based on a sale, change in ownership or refinancing of the Property or otherwise), increases in tax rates, reduction or elimination of any rollbacks or other deductions available under current law, scheduled reductions of any tax abatement, as a result of the elimination, invalidity or withdrawal of any tax abatement, or for any other cause whatsoever. If Taxes are reduced by, or credited with, any abatement or exemption issued by a taxing authority to help finance or reimburse Landlord for costs incurred to comply with Laws or otherwise, Taxes hereunder shall be computed without regard to such abatement or exemption (Tenant hereby acknowledging that Landlord, having incurred such costs, is solely entitled to such abatement or exemption), except to the extent that Landlord includes such costs in Expenses under this Lease. Notwithstanding the foregoing, there shall be excluded from Taxes all excess profits taxes, franchise taxes, gift taxes, capital stock taxes, inheritance and succession taxes, estate taxes, federal and state income taxes, and other taxes to the extent applicable to Landlord's general or net income (as opposed to rents, receipts or income attributable to operations at the Property).

(Q) "Tenant" shall be applicable to one or more Persons as the case may be, the singular shall include the plural, and if there be more than one Tenant, the obligations thereof shall be joint and several. When used in the lower case, "tenant" shall mean any other tenant, subtenant or occupant of the Property.

ARTICLE 32. OFFER

The submission and negotiation of this Lease shall not be deemed an offer to enter the same by Landlord (nor an option or reservation for the Premises), but the solicitation of such an offer by Tenant. Tenant agrees that its execution of this Lease constitutes a firm offer to enter the same which may not be withdrawn for a period of thirty (30) days after delivery to Landlord. During such period and in reliance on the foregoing, Landlord may, at Landlord's option, deposit any Security Deposit and Rent, proceed with any plans, specifications, alterations or improvements, and permit Tenant to enter the Premises, but such acts shall not be deemed an acceptance of Tenant's offer to enter this Lease, and such acceptance shall be evidenced only by Landlord signing and delivering this Lease to Tenant.

ARTICLE 33. MISCELLANEOUS

A. Captions and Interpretation. The captions of the Articles and Paragraphs of this Lease, and any computer highlighting of changes from earlier drafts, are for convenience of reference only and shall not be considered or referred to in resolving questions of interpretation. Tenant acknowledges that it has read this Lease and that it has had the opportunity to confer with counsel in negotiating this Lease; accordingly, this Lease shall be construed neither for nor against Landlord or Tenant, but shall be given a fair and reasonable interpretation in accordance with the meaning of its terms. The neuter shall include the masculine and feminine, and the singular shall include the plural. The term "including" shall be interpreted to mean "including, but not limited to."

B. Survival of Provisions. All obligations (including indemnity, Rent and other payment obligations) or rights of either party arising during or attributable to the period prior to expiration or earlier termination of this Lease shall survive such expiration or earlier termination.

C. Severability. If any term or provision of this Lease or portion thereof shall be found invalid, void, illegal, or unenforceable generally or with respect to any particular party, by a court of competent jurisdiction, it shall not affect, impair or invalidate any other terms or provisions or the remaining portion thereof, or its enforceability with respect to any other party.

D. Short Form Lease. Neither this Lease nor any memorandum of lease or short form lease shall be recorded by Tenant, but Landlord or any Lender may elect to record a short form of this Lease, in which case Tenant shall promptly execute, acknowledge and deliver the same on a form prepared by Landlord or such Lender.

E. Light, Air and Other Interests. This Lease does not grant any legal rights to "light and air" outside the Premises nor any particular view visible from the Premises, nor any easements, licenses or other interests unless expressly contained in this Lease.

F. Authority. If Tenant is any form of corporation, limited liability company, partnership, association or other organization, Tenant and all Persons signing for Tenant below hereby represent that this Lease has been fully authorized and no further approvals are required, and Tenant is duly organized, in good standing and legally qualified to do business in the Premises (and has any required certificates, licenses, permits and other such items).

G. Financial Statements. Tenant shall, within ten (10) days after requested from time to time, deliver to Landlord financial statements (including balance sheets and income/expense statements) for Tenant's then most recent full and partial fiscal year preceding such request, certified by an independent certified public accountant or Tenant's chief financial officer, in form reasonably satisfactory to Landlord.

H. Successors and Assigns; Transfer of Property and Security Deposit. Each of the terms and provisions of this Lease shall be binding upon and inure to the benefit of the parties' respective heirs, executors, administrators, guardians, custodians, successors and assigns, subject to Article 13 respecting Transfers and Article 18 respecting rights of Lenders. Subject to Article 18, if Landlord shall convey or transfer the Property or any portion thereof in which the Premises are contained to another party, such party shall thereupon be and become landlord hereunder and shall be deemed to have fully assumed all of Landlord's obligations under this Lease accruing during such party's ownership, including the return of any Security Deposit (provided Landlord shall have turned over such Security Deposit to such party), and Landlord shall be free of all such obligations accruing from and after the date of conveyance or transfer.

I. Limitation of Landlord's Liability. Tenant agrees to look solely to Landlord's interest in the Property for the enforcement of any judgment, award, order or other remedy under or in connection with this Lease or any related agreement, instrument or document or for any other matter whatsoever relating thereto or to the Property or Premises. Under no circumstances shall any present or future, direct or indirect, principals or investors, general or limited partners, officers, directors, shareholders, trustees, beneficiaries, participants, advisors, managers, employees, agents or affiliates of Landlord, or of any of the other foregoing parties, or any of their heirs, successors or assigns have any liability for any of the foregoing matters.

J. Confidentiality. Tenant (except for such details required in Tenant's application to the Washington State Department of Health) shall keep the content and

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

K. Consent. Whenever the Landlord's consent or approval is required under this Lease (or any other agreement between the parties), Landlord may give or withhold its consent in its sole discretion unless otherwise provided.

ARTICLE 34. ENTIRE AGREEMENT

This Lease, together with the Riders, Exhibits and other documents listed in Article 1 **(WHICH COLLECTIVELY ARE HEREBY INCORPORATED WHERE REFERRED TO HEREIN AND MADE A PART HEREOF AS THOUGH FULLY SET FORTH)**, contains all the terms and provisions between Landlord and Tenant relating to the matters set forth herein and no prior or contemporaneous agreement or understanding pertaining to the same shall be of any force or effect, except any such contemporaneous agreement specifically referring to and modifying this Lease, signed by both parties. **TENANT HAS RELIED ON TENANT'S INSPECTIONS AND DUE DILIGENCE IN ENTERING THIS LEASE, AND NOT ON ANY REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED, CONCERNING THE HABITABILITY, CONDITION OR SUITABILITY OF THE PREMISES OR PROPERTY FOR ANY PARTICULAR PURPOSE OR ANY OTHER MATTER NOT EXPRESSLY CONTAINED HEREIN.** Neither this Lease, nor any Riders or Exhibits referred to above may be modified, except in writing signed by both parties.

IN WITNESS WHEREOF, the parties have executed this Lease as of the date first set forth above.

LANDLORD:

Burien Pacific Professional Building, LLC,
a Washington limited liability company

By:_____

Name:_____

Its:_____

TENANT:

_____

By:_____

Name: _____

Its: Authorized Signor_____

Landlord Acknowledgment

STATE OF WASHINGTON)
COUNTY OF KING)

On this _____ day of _____, before me a Notary Public in and for said State, personally appeared Jonathan Tran, known to me to be the individual described in and who executed the foregoing instrument for BURIEN PACIFIC, L.L.C., a Washington limited liability company, and acknowledged to me that he executed the same as his own free act and deed for the purposes stated therein, and on oath, stated he was authorized to execute the said instrument on behalf of said limited liability company.

_____
Notary Public for the State of Washington
My commission expires: _____

Tenant Acknowledgment

STATE OF WASHINGTON)
COUNTY OF KING)

On this _____ day of _____, before me a Notary Public in and for said State, personally appeared _____, known to me to be the individual described in and who executed the foregoing instrument for Lucio Hernandez Martinez and acknowledged to me that s/he executed the same as her/his own free act and deed for the purposes stated therein, and on oath, stated he was authorized to execute the said instrument on behalf of said Corporation

_____
Notary Public for the State of _____
My commission expires: _____

EXHIBIT A-1

PROPERTY LEGAL DESCRIPTION

Block A, Dashley's Addition No. 1, according to the plat thereof recorded in Volume 20 of Plats, page 5, in King County, Washington; EXCEPT that portion conveyed to King County by Deed recorded under Recording Number 5298386.

EXHIBIT A-2

PREMISES

To be inserted

EXHIBIT B

Intentionally omitted.

RIDER ONE

RULES

(1) **Access to Property.** Tenant shall have access to the Premises 24 hours a day, 7 days a week, as necessary. On Saturdays, Sundays and Holidays, and on other days between the hours of 6:00 P.M. and 8:00 A.M. the following day, or such other hours as Landlord shall determine from time to time, access to and within the Property and/or to the passageways, lobbies, entrances, exits, loading areas, corridors, elevators or stairways and other areas in the Property may be restricted and access gained by use of a key to the outside doors of the Property, or pursuant to such security procedures Landlord may from time to time impose. Landlord shall in all cases retain the right to control and prevent access to such areas by Persons engaged in activities which are illegal or violate these Rules, or whose presence in the judgment of Landlord shall be prejudicial to the safety, character, reputation and interests of the Property and its tenants (and Landlord shall have no liability in damages for such actions taken in good faith). No Tenant and no employee or invitee of Tenant shall enter areas reserved for the exclusive use of Landlord, its employees or invitees or other Persons. Tenant shall keep doors to corridors and lobbies closed except when persons are entering or leaving.

(2) **Signs.** Tenant shall not paint, display, inscribe, maintain or affix any sign, placard, picture, advertisement, name, notice, lettering or direction on any part of the outside or inside of the Property, or on any part of the inside of the Premises which can be seen from the outside of the Premises without the prior consent of Landlord, and then only such name or names or matter and in such color, size, style, character and material, and with professional designers, fabricators and installers as may be first approved or designated by Landlord in writing. Landlord shall prescribe the suite number and identification sign for the Premises (which shall be prepared and installed by Landlord at Tenant's expense). Landlord reserves the right to remove at Tenant's expense all matter not so installed or approved without notice to Tenant. Landlord, at its sole cost and expense, shall provide Building standard Tenant signage in the lobby Building directory and in the fortieth floor elevator lobby, and Building standard graphics and signage at the Premises entry.

(3) **Window and Door Treatments.** Tenant shall not place anything or allow anything to be placed in the Premises near the glass of any door, partition, wall or window that Landlord deems to be unsightly from outside the Premises, and Tenant shall not place or permit to be placed any article of any kind on any window ledge or on the exterior walls. Blinds, shades, awnings or other forms of inside or outside window ventilators or similar devices, shall not be placed in or about the outside windows or doors in the Premises except to the extent, if any, that the design, character, shape, color, material and make thereof is first approved or designated by the Landlord. Tenant shall not install or remove any solar tint film from the windows.

(4) **Lighting and General Appearance of Premises.** Landlord reserves the right to designate and/or approve in writing all internal lighting that may be visible from the public, common or exterior areas. The design, arrangement, style, color, character,

quality and general appearance of the portion of the Premises visible from public, common and exterior areas, and contents of such portion of the Premises, including furniture, fixtures, signs, art work, wall coverings, carpet and decorations, and all changes, additions and replacements thereto shall at all times have a neat, professional, attractive, first class office appearance.

(5) **Property Tradename, Likeness, Trademarks.** Tenant shall not in any manner use the name of the Property for any purpose, or use any tradenames or trademarks used by Landlord, any other tenant, or its affiliates, or any picture or likeness of the Property for any purpose other than that of the business address of Tenant, in any letterheads, envelopes, circulars, notices, advertisements, containers, wrapping or other material.

(6) **Deliveries and Removals.** Furniture, freight and other large or heavy articles, and all other deliveries may be brought into the Property only at times and in the manner designated by Landlord, and always at the Tenant's sole responsibility and risk. Landlord may inspect items brought into the Property or Premises with respect to weight or dangerous nature or compliance with this Lease or Laws. Landlord may (but shall have no obligation to) require that all furniture, equipment, cartons and other articles removed from the Premises or the Property be listed and a removal permit therefor first be obtained from Landlord. Tenant shall not take or permit to be taken in or out of other entrances or elevators of the Property, any item normally taken, or which Landlord otherwise reasonably requires to be taken, in or out through service doors or on freight elevators. Landlord may impose reasonable charges and requirements for the use of freight elevators and loading areas, and reserves the right to alter schedules without notice. Any hand-carts used at the Property shall have rubber wheels and sideguards, and no other material handling equipment may be brought upon the Property without Landlord's prior written approval.

(7) **Outside Vendors.** Tenant shall not obtain for use upon the Premises ice, drinking water, vending machine, towel, janitor and other services, except from Persons designated or approved by Landlord. Any Person engaged by Tenant to provide any other services shall be subject to scheduling and direction by the manager or security personnel of the Property. Vendors must use freight elevators and service entrances.

(8) **Overloading Floors; Vaults.** Tenant shall not overload any floor or part thereof in the Premises, or Property, including any public corridors or elevators therein bringing in or removing any large or heavy articles, and Landlord may prohibit, or direct and control the location and size of, safes and all other heavy articles and require at Tenant's expense supplementary supports of such material and dimensions as Landlord may deem necessary to properly distribute the weight.

(9) **Locks and Keys.** Tenant shall use such standard key system designated by Landlord on all keyed doors to and within the Premises, excluding any permitted vaults or safes (but Landlord's designation shall not be deemed a representation of adequacy to prevent unlawful entry or criminal acts, and Tenant shall maintain such additional insurance as Tenant deems advisable for such events). Tenant shall not attach or permit to be attached additional locks or similar devices to any door or window, change existing locks or the mechanism thereof, or make or permit to be made

any keys for any door other than those provided by Landlord. If more than two keys for one lock are desired, Landlord will provide them upon payment of Landlord's charges. In the event of loss of any keys furnished by Landlord, Tenant shall pay Landlord's reasonable charges therefor. The term "key" shall include mechanical, electronic or other keys, cards and passes.

(10) **Utility Closets and Connections.** Landlord reserves the right to control access to and use of, and monitor and supervise any work in or affecting, the "wire" or telephone, electrical, plumbing or other utility closets, the Systems and Equipment, and any changes, connections, new installations, and wiring work relating thereto (or Landlord may engage or designate an independent contractor to provide such services). Tenant shall obtain Landlord's prior written consent for any such access, use and work in each instance, and shall comply with such requirements as Landlord may impose, and the other provisions of Article 6 respecting electric installations and connections, and Article 9 respecting Work in general. Tenant shall have no right to use any broom closets, storage closets, janitorial closets, or other such closets, rooms and areas outside the Premises whatsoever. Tenant shall not install in or for the Premises any equipment which requires more electric current than Landlord is required to provide under this Lease, without Landlord's prior written approval, and Tenant shall ascertain from Landlord the maximum amount of load or demand for or use of electrical current which can safely be permitted in and for the Premises, taking into account the capacity of electric wiring in the Property and the Premises and the needs of tenants of the Property, and shall not in any event connect a greater load than such safe capacity.

(11) **Plumbing Equipment.** The toilet rooms, urinals, wash bowls, drains, sewers and other plumbing fixtures, equipment and lines shall not be misused or used for any purpose other than that for which they were constructed and no foreign substance of any kind whatsoever shall be thrown therein.

(12) **Trash.** All garbage, refuse, trash and other waste shall be kept in the kind of container, placed in the areas, and prepared for collection in the manner and at the times and places specified by Landlord, subject to Article 29 respecting Hazardous Materials. Landlord reserves the right to require that Tenant participate in any recycling program designated by Landlord.

(13) **Alcohol, Drugs, Food and Smoking.** Landlord reserves the right to exclude or expel from the Property any person who, in the judgment of Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of these Rules. Tenant shall not at any time manufacture, sell, use or give away, any spirituous, fermented, intoxicating or alcoholic liquors on the Premises, nor permit any of the same to occur. Tenant shall not at any time cook, sell or give away food in any form by or to any of Tenant's agents or employees or any other parties on the Premises, nor permit any of the same to occur (other than in vending machines, microwave ovens and coffee makers properly maintained in good and safe working order and repair in lunch rooms or kitchens for employees as may be permitted or installed by Landlord, which does not violate any Laws or bother or annoy any other tenant, and as may be catered to the Premises in connection with Tenant's business). Tenant and its employees shall not smoke tobacco on any part of the Property

(including exterior areas) except those areas, if any, that are designated or approved as smoking areas by Landlord.

(14) **Use of Common Areas; No Soliciting.** Tenant shall not use the common areas, including areas adjacent to the Premises, for any purpose other than ingress and egress, and any such use thereof shall be subject to the other provisions of this Lease, including these Rules. Without limiting the generality of the foregoing, Tenant shall not allow anything to remain in any passageway, sidewalk, court, corridor, stairway, entrance, exit, elevator, parking or shipping area, or other area outside the Premises. Tenant shall not use the common areas to canvass, solicit business or information from, or distribute any article or material to, other tenants or invitees of the Property. Tenant shall not make any room-to-room canvass to solicit business or information or to distribute any article or material to or from other tenants of the Property and shall not exhibit, sell or offer to sell, use, rent or exchange any products or services in or from the Premise unless ordinarily embraced within the Tenant's use of the Premises expressly permitted in the Lease.

(15) **Energy and Utility Conservation.** Tenant shall not waste electricity, water, heat or air conditioning or other utilities or services, and agrees to cooperate fully with Landlord to assure the most effective and energy efficient operation of the Property and shall not allow the adjustment (except by Landlord's authorized Property personnel) of any controls. Tenant shall not obstruct, alter or impair the efficient operation of the Systems and Equipment, and shall not place any item so as to interfere with air flow. Tenant shall keep corridor doors closed and shall not open any windows, except that if the air circulation shall not be in operation, windows which are openable may be opened with Landlord's consent. If reasonably requested by Landlord (and as a condition to claiming any deficiency in the air-conditioning or ventilation services provided by Landlord), Tenant shall close any blinds or drapes in the Premises to prevent or minimize direct sunlight.

(16) **Unattended Premises.** Before leaving the Premises unattended, Tenant shall close and securely lock all doors or other means of entry to the Premises and shut off all lights and water faucets in the Premises (except heat to the extent necessary to prevent the freezing or bursting of pipes).

(17) **Going-Out-Of-Business Sales and Auctions.** Tenant shall not use, or permit any other party to use, the Premises for any distress, fire, bankruptcy, close-out, "lost our lease" or going-out-of-business sale or auction. Tenant shall not display any signs advertising the foregoing anywhere in or about the Premises. This prohibition shall also apply to Tenant's creditors.

(18) **Labor Harmony.** Tenant shall not use (and upon notice from Landlord shall cease using) contractors, services, workmen, labor, materials or equipment, or labor and employment practices that, in Landlord's sole discretion, may cause strikes, picketing or boycotts or disturb labor harmony with the workforce or trades engaged in performing other work, labor or services in or about the Property.

(19) **Prohibited Activities.** Tenant shall not: (i) use strobe or flashing lights in or on the Premises, (ii) install or operate any internal combustion engine, boiler, machinery, refrigerating, heating or air conditioning equipment in or about the Premises,

(iii) use the Premises for housing, lodging or sleeping purposes or for the washing of clothes, (iv) place any radio or television antennae other than inside of the Premises, (v) operate or permit to be operated any musical or sound producing instrument or device which may be heard outside the Premises, (vi) use any source of power other than electricity, (vii) operate any electrical or other device from which may emanate electrical, electromagnetic, energy, microwave, radiation or other waves or fields which may interfere with or impair radio, television, microwave, or other broadcasting or reception from or in the Property or elsewhere, or impair or interfere with computers, faxes or telecommunication lines or equipment at the Property or elsewhere, or create a health hazard, (viii) bring or permit any bicycle or other vehicle, or dog (except in the company of a blind person or except where specifically permitted) or other animal or bird in the Property, (ix) make or permit objectionable noise, vibration or odor to emanate from the Premises, (x) do anything in or about the Premises or Property that is illegal, immoral, obscene, pornographic, or anything that may, in Landlord's sole discretion, create or maintain a nuisance, cause physical damage to the Premises or Property, interfere with the normal operation of the Systems and Equipment, impair the appearance, character or reputation of the Premises or Property, create waste to the Premises or Property, cause demonstrations, protests, loitering, bomb threats or other events that may require evacuation of the Building, (xi) advertise or engage in any activities which violate the spirit or letter of any code of ethics or licensing requirements of any professional or business organization, (xii) throw or permit to be thrown or dropped any article from any window or other opening in the Property, (xiii) use the Premises for any purpose, or permit upon the Premises or Property anything, that may be dangerous to persons or property (including firearms or other weapons (whether or not licensed or used by security guards) or any explosive or combustible articles or materials), (xiv) place vending or game machines in the Premises, except vending machines for employees, (xv) adversely affect the indoor air quality of the Premises or Property, or (xvi) do or permit anything to be done upon the Premises or Property in any way tending to disturb, bother, annoy or interfere with Landlord or any other tenant at the Property or the tenants of neighboring property, or otherwise disrupt orderly and quiet use and occupancy of the Property.

(20) **Transportation Management.** Tenant shall comply with all present or future programs intended to manage parking, transportation or traffic in and around the Property, and in connection therewith, Tenant shall take responsible action for the transportation planning and management of all employees located at the Premises by working directly with Landlord, any governmental transportation management organization or any other transportation-related committees or entities.

OFFICE LEASE

BURIEN PACIFIC PROFESSIONAL BUILDING, LLC

"LANDLORD"

WITH

_____

"TENANT"

SUITE: 207

DATED: _____

TABLE OF CONTENTS

Page

MOMENTS HOSPICE OF KING, LLC

FINANCIAL STATEMENTS

DECEMBER 23, 2021

MR&CO
MAYER RISPLER
& COMPANY, P.C.
CERTIFIED PUBLIC ACCOUNTANTS

INDEPENDENT AUDITORS' REPORT

To The Members:

Moments Hospice of King, LLC

Opinion

We have audited the accompanying financial statements of Moments Hospice of King, LLC, which comprise the balance sheet as of December 23, 2021, and the related statement of operations and members' equity, and cash flows for the initial period December 1, 2021, to December 23, 2021, and the related notes to the financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of Moments Hospice of King, LLC as of December 23, 2021, and the results of its operations and its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of Moments Hospice of King, LLC and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about Moments Hospice of King, LLC's ability to continue as a going concern within one year after the date that the financial statements are available to be issued.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors'

report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements, including omissions, are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of Moments Hospice of King, LLC's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about Moments Hospice of King, LLC's ability to continue as a going concern for a reasonable period of time.

Mayer Hoffman & Company PC

Brooklyn, New York
December 27, 2021

MOMENTS HOSPICE OF KING, LLC
BALANCE SHEET
DECEMBER 23, 2021

ASSETS	
Current Assets:	
Cash	$400,000
TOTAL ASSETS	**$400,000**
LIABILITIES AND MEMBERS' EQUITY	
Liabilities	$ - 0 -
Members' Equity	400,000
TOTAL LIABILITIES AND MEMBERS' EQUITY	**$400,000**

See independent auditors' report and accompanying notes to the financial statements.

MOMENTS HOSPICE OF KING, LLC
STATEMENT OF OPERATIONS AND MEMBERS' EQUITY
FOR THE INITIAL PERIOD DECEMBER 1, 2021 TO DECEMBER 23, 2021

Revenue	$ - 0 -
Operating, General and Administrative Expenses	- 0 -
NET INCOME	$ - 0 -
MEMBERS' EQUITY – BEGINNING	$ - 0 -
Add: Members' Contributions	400,000
MEMBERS' EQUITY – ENDING	**$400,000**

See independent auditors' report and accompanying notes to the financial statements.

Cash Flow From Financing Activities:		
Members' Contributions	$400,000	
Net Cash Flow Provided by Financing Activities		$400,000
NET INCREASE IN CASH		400,000
CASH – BEGINNING		- 0 -
CASH – ENDING		**$400,000**

See independent auditors' report and accompanying notes to the financial statements.

NOTE 1 - ORGANIZATION AND NATURE OF BUSINESS

Moments Hospice of King, LLC (the "Company") is a Washington limited liability company organized and existing under the laws of the State of Washington. The Company was organized on December 1, 2021 for the purpose of providing health care services.

NOTE 2 - SUBSEQUENT EVENTS

In connection with the preparation of the financial statements for the initial period December 1, 2021 to December 23, 2021, the Company has evaluated subsequent events and transactions for potential recognition and/or disclosure in the financial statements through December 27, 2021, the date of the financial statements issuance and has concluded that no other subsequent events have occurred that would require recognition in the financial statements or disclosure in the notes to the financial statements.

See independent auditors' report.

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

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

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**

Exhibit 6

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)(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

Exhibit 6

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)(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

Exhibit 6

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

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

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.

Exhibit 6

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

DOH 260-028 November 2021

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

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 Survey 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

Washington State Department of Health

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.

Exhibit 6

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

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

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 Provider Utilization Surveys for Years 2018-2020
Prepared by DOH Program Staff

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

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

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

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

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

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
Prepared by DOH Program Staff

Department of Health
2021-2022 Hospice Numeric Need Methodology
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
Prepared by DOH Program Staff

Department of Health
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 Walla	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

Exhibit 6

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

Exhibit 6

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

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 7, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Appleton LLC dba Moments Hospice
806 Valley Rd, Suite 1
Menasha, WI 54952

Site Visit Dates:	November 23, 2020 - November 25, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	N/A
CHAP Accreditation Dates:	September 30, 2020 - September 20, 2023
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 23, 2020 - November 25, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: NOV2320_ZWJ
Ref: QZUU659889

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 7, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Appleton LLC dba Moments Hospice
806 Valley Rd, Suite 1
Menasha, WI 54952

Site Visit Dates:	November 23, 2020 - November 25, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	N/A
Effective Date of Accreditation:	November 25, 2020
Expiration Date of Accreditation:	November 25, 2023
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 23, 2020 - November 25, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

April 30, 2020

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending
	Location and/or Site Accredited: Moments Hospice Eau Claire LLC 2263 Eastridge Ctr Eau Claire, WI 54701	
	Site Visit Dates:	April 7, 2020 - April 9, 2020
	Type of Survey/Site Visit:	Initial
	Accreditation Determination:	Full Accreditation
	Plan of Correction Accepted Date:	April 23, 2020
	CHAP Accreditation Dates:	December 19, 2019 - September 20, 2020
	Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted April 7, 2020 - April 9, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Harold Hanson at hal.hanson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: APR0720_UMB
Ref: AJFW100690

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

April 30, 2020

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice Eau Claire LLC
2263 Eastridge Ctr
Eau Claire, WI 54701

Site Visit Dates:	April 7, 2020 - April 9, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	April 23, 2020
Effective Date of Accreditation:	April 23, 2020
Expiration Date of Accreditation:	April 23, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted April 7, 2020 - April 9, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Harold Hanson at hal.hanson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

October 13, 2017

Ms. Patricia Skogen
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Dr. N., Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Dr. N., Suite 210
Golden Valley, MN 55422

Site Visit Dates:	September 6, 2017 – September 8, 2017
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
CHAP Accreditation Dates:	September 20, 2017 – September 20, 2020

Dear Ms. Skogen,

I am pleased to inform you that based on the findings of the site visit conducted September 6, 2017 – September 8, 2017, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: SEP0617_VWG
Ref: ZLIP970390

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

October 13, 2017

Ms. Patricia Skogen
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Dr. N., Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Dr. N., Suite 210
Golden Valley, MN 55422

Site Visit Dates:	September 6, 2017 – September 8, 2017
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	September 20, 2017
Effective Date of Accreditation:	September 20, 2017
Expiration Date of Accreditation:	September 20, 2020
Method of Follow-up:	Acceptable POC

Dear Ms. Skogen,

I am pleased to inform you that based on the findings of the site visit conducted September 6, 2017 – September 8, 2017, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org | www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

November 29, 2017

Ms. Patricia Skogen
Administrator
Guardian Hospice MN LLC dba Moments Hospice
820 Lilac Dr N, Ste 210
Golden Valley, MN 55422

RE: **REVISED LETTER (Revised Plan of Correction)**

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Guardian Hospice MN LLC dba Moments Hospice
820 Lilac Dr N, Ste 210
Golden Valley, MN 55422

Site Visit Dates:	September 6, 2017 – September 8, 2017
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
CHAP Accreditation Dates:	September 20, 2017 – September 20, 2020

Dear Ms. Skogen,

I am pleased to inform you that based on the findings of the site visit conducted September 6, 2017 – September 8, 2017, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: SEP0617_VWG
Ref: ZLIP970390

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

November 29, 2017

Ms. Patricia Skogen
Administrator
Guardian Hospice MN LLC dba Moments Hospice
820 Lilac Dr N, Ste 210
Golden Valley, MN 55422

RE: **REVISED LETTER (Revised Plan of Correction)**

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Guardian Hospice MN LLC dba Moments Hospice
820 Lilac Dr N, Ste 210
Golden Valley, MN 55422

Site Visit Dates:	September 6, 2017 – September 8, 2017
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	November 20, 2017
Effective Date of Accreditation:	November 20, 2017
Expiration Date of Accreditation:	November 20, 2020
Method of Follow-up:	Acceptable POC

Dear Ms. Skogen,

I am pleased to inform you that based on the findings of the site visit conducted September 6, 2017 – September 8, 2017, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta Johnson at djohnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org | www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

September 16, 2019

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Rochester LLC
1816 2nd St SW, Suite B
Rochester, MN 55902

Site Visit Dates:	August 12, 2019 - August 14, 2019
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	August 23, 2019
CHAP Accreditation Dates:	February 4, 2019 - September 20, 2020
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted August 12, 2019 - August 14, 2019, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Jynon Miller at jynon.miller@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: AUG1219_UAJ
Ref: YTRV955670

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

September 16, 2019

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Rochester LLC
1816 2nd St SW, Suite B
Rochester, MN 55902

Site Visit Dates:	August 12, 2019 - August 14, 2019
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	August 23, 2019
Effective Date of Accreditation:	August 23, 2019
Expiration Date of Accreditation:	August 23, 2022
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted August 12, 2019 - August 14, 2019, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Jynon Miller at jynon.miller@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 3, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Des Moines LLC dba Moments Hospice
4150 Westown Parkway, Suite 106
West Des Moines, IA 50266

Site Visit Dates:	November 4, 2020 - November 6, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	November 13, 2020
CHAP Accreditation Dates:	July 8, 2020 - September 20, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 4, 2020 - November 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: NOV0420_FHW
Ref: AYXS106390

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

December 3, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Des Moines LLC dba Moments Hospice
4150 Westown Parkway, Suite 106
West Des Moines, IA 50266

Site Visit Dates:	November 4, 2020 - November 6, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	November 13, 2020
Effective Date of Accreditation:	November 13, 2020
Expiration Date of Accreditation:	November 13, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 4, 2020 - November 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO VII - Kansas City)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

April 30, 2020

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Duluth LLC dba Moments Hospice
4897 Miller Trunk Hwy, Suite 220
Hermantown, MN 55811

Site Visit Dates:	April 6, 2020 - April 8, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	April 23, 2020
CHAP Accreditation Dates:	December 19, 2019 - September 20, 2020
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted April 6, 2020 - April 8, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Harold Hanson at hal.hanson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: APR0620_HJL
Ref: AJFW100690

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

April 30, 2020

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Duluth LLC dba Moments Hospice
4897 Miller Trunk Hwy, Suite 220
Hermantown, MN 55811

Site Visit Dates:	April 6, 2020 - April 8, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	April 23, 2020
Effective Date of Accreditation:	April 23, 2020
Expiration Date of Accreditation:	April 23, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted April 6, 2020 - April 8, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Harold Hanson at hal.hanson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

October 6, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	24-1602

Location and/or Site Accredited:
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

Moments Hospice
124 E Walnut Street, 310
Mankato, MN 56001

Site Visit Dates:	September 1, 2020 - September 3, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	September 11, 2020
CHAP Accreditation Dates:	September 20, 2020 - September 20, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted September 1, 2020 - September 3, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: SEP0120_KQE
Ref: AYXS106390

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

October 6, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	24-1602

Location and/or Site Accredited:

Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

Moments Hospice
124 E Walnut Street, 310
Mankato, MN 56001

Site Visit Dates:	September 1, 2020 - September 3, 2020
Type of Survey/Site Visit:	Re-accreditation
Accreditation Determination:	Full Accreditation
Medicare Certification:	Recertification
Deemed Status Recommendation:	Continued Deemed Status
Plan of Correction Accepted Date:	September 11, 2020
Effective Date of Accreditation:	November 20, 2020
Expiration Date of Accreditation:	November 20, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted September 1, 2020 - September 3, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

August 26, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Milwaukee dba Moments Hospice
1139 S Sunnyslope Dr, Ste 200
Mt. Pleasant, WI 53406

Site Visit Dates:	August 4, 2020 - August 6, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	August 17, 2020
CHAP Accreditation Dates:	July 8, 2020 - September 20, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted August 4, 2020 - August 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: AUG0420_ALK
Ref: AYXS106390

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

August 26, 2020

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Milwaukee dba Moments Hospice
1139 S Sunnyslope Dr, Ste 200
Mt. Pleasant, WI 53406

Site Visit Dates:	August 4, 2020 - August 6, 2020
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	August 17, 2020
Effective Date of Accreditation:	August 17, 2020
Expiration Date of Accreditation:	August 17, 2023
Method of Follow-up:	Acceptable POC

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted August 4, 2020 - August 6, 2020, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended continued Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Claire Kraft at claire.kraft@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P 202.862.3413 / F 202.862.3419

CHAP

August 26, 2019

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of St Cloud LLC
1030 E 4th St SE, Suite 108
St Cloud, MN 56304

Site Visit Dates:	July 23, 2019 - July 25, 2019
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	August 14, 2019
CHAP Accreditation Dates:	February 4, 2019 - September 20, 2020
Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted July 23, 2019 - July 25, 2019, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Jynon Miller at jynon.miller@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: (202) 862-3413 | Fax: (202) 862-3419
fpetrella@chapinc.org | www.chapinc.org

ID: JUL2319_SRS
Ref: YTRV955670

Community Health Accreditation Partner
1275 K Street NW, Suite 800 / Washington, DC 20005
P (202) 862-3413 / F (202) 862-3419

August 26, 2019

Ms. Michelle Dubner
Administrator
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending
	Location and/or Site Accredited: Moments Hospice of St Cloud LLC 1030 E 4th St SE, Suite 108 St Cloud, MN 56304	
	Site Visit Dates:	July 23, 2019 - July 25, 2019
	Type of Survey/Site Visit:	Initial
	Accreditation Determination:	Full Accreditation
	Medicare Certification:	Pending
	Deemed Status Recommendation:	Deemed Status Recommended
	Plan of Correction Accepted Date:	August 14, 2019
	Effective Date of Accreditation:	August 14, 2019
	Expiration Date of Accreditation:	August 14, 2022
	Method of Follow-up:	Acceptable POC

Dear Ms. Dubner,

I am pleased to inform you that based on the findings of the site visit conducted July 23, 2019 - July 25, 2019, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Jynon Miller at jynon.miller@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Fran Petrella

Frances B. Petrella, BSN, RN
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
1275 K Street NW, Suite 800 | Washington, DC 20005
Office: 202.862.3413 | Fax: 202.862.3419
fpetrella@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

November 29, 2021

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:	Customer ID:	3003324
	Service:	Hospice [Deemed]
	CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Chicago South LLC
545 Plainfield Rd, Suite G-1
Willowbrook, IL 60527

Site Visit Dates:	November 17, 2021 - November 19, 2021
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	N/A
CHAP Accreditation Dates:	November 19, 2021 - November 19, 2024
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 17, 2021 - November 19, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

Should you wish to appeal, please email your Director of Accreditation, Frances Petrella, with the details of your appeal request within the next 10 days of notification receipt.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: NOV1721_EMP
Ref: VCUU853062

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

November 29, 2021

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Chicago South LLC
545 Plainfield Rd, Suite G-1
Willowbrook, IL 60527

Site Visit Dates:	November 17, 2021 - November 19, 2021
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	N/A
Effective Date of Accreditation:	November 19, 2021
Expiration Date of Accreditation:	November 19, 2024
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted November 17, 2021 - November 19, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact DeShanta (Niki) Johnson at niki.johnson@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

July 29, 2021

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Madison LLC
5315 Wall St, Suite 135
Madison, WI 53718

Site Visit Dates:	July 12, 2021 - July 14, 2021
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Plan of Correction Accepted Date:	N/A
CHAP Accreditation Dates:	July 14, 2021 - July 14, 2024
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted July 12, 2021 - July 14, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years.

Medicare Certification Recommendation: For organizations seeking Medicare certification, the CHAP Accreditation decision is accompanied by the enclosed notification copying the Centers for Medicare & Medicaid Services (CMS).

The continuation in good standing of this Accreditation is dependent upon your organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement.

Please note that CHAP may conduct surveys less than every three years depending upon any applicable CMS or state regulation and/or the level of any deficiencies cited.

As a CHAP accredited agency, you are required to list our toll-free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accreditation partner. Please contact Jessica Masko at jessica.masko@chapinc.org or (202) 862-3413 if you have any questions.

Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

ID: JUL1221_IML
Ref: QZUU659889

Community Health Accreditation Partner
2300 Clarendon Blvd, Suite 405, Arlington, VA 22201
Phone: 202.862.3413 / Fax: 202.862.3419

July 29, 2021

Ms. Stacy Crep
Regional Director of Compliance
Guardian Hospice MN, LLC dba Moments Hospice
820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

RE:

Customer ID:	3003324
Service:	Hospice [Deemed]
CCN/PTAN:	Pending

Location and/or Site Accredited:
Moments Hospice of Madison LLC
5315 Wall St, Suite 135
Madison, WI 53718

Site Visit Dates:	July 12, 2021 - July 14, 2021
Type of Survey/Site Visit:	Initial
Accreditation Determination:	Full Accreditation
Medicare Certification:	Pending
Deemed Status Recommendation:	Deemed Status Recommended
Plan of Correction Accepted Date:	N/A
Effective Date of Accreditation:	July 14, 2021
Expiration Date of Accreditation:	July 14, 2024
Method of Follow-up:	N/A

Dear Ms. Crep,

I am pleased to inform you that based on the findings of the site visit conducted July 12, 2021 - July 14, 2021, at the location and service referenced above, your organization is found to be in compliance with the CHAP Standards of Excellence. The CHAP Board of Review (BOR) has granted Full Accreditation to your organization for the term of three (3) years. Additionally, CHAP has recommended Medicare certification.

As part of the Medicare certification process, the Centers for Medicare & Medicaid Services (CMS) Regional Office will make a final determination regarding your Medicare certification and the effective date of participation in accordance with regulations at 42 CFR 489.13. If CMS does not accept CHAP's recommendation, you will be notified of next steps required.

Thank you for choosing CHAP as your national accreditation partner. Please contact Jessica Masko at jessica.masko@chapinc.org or (202) 862-3413 if you have any questions.

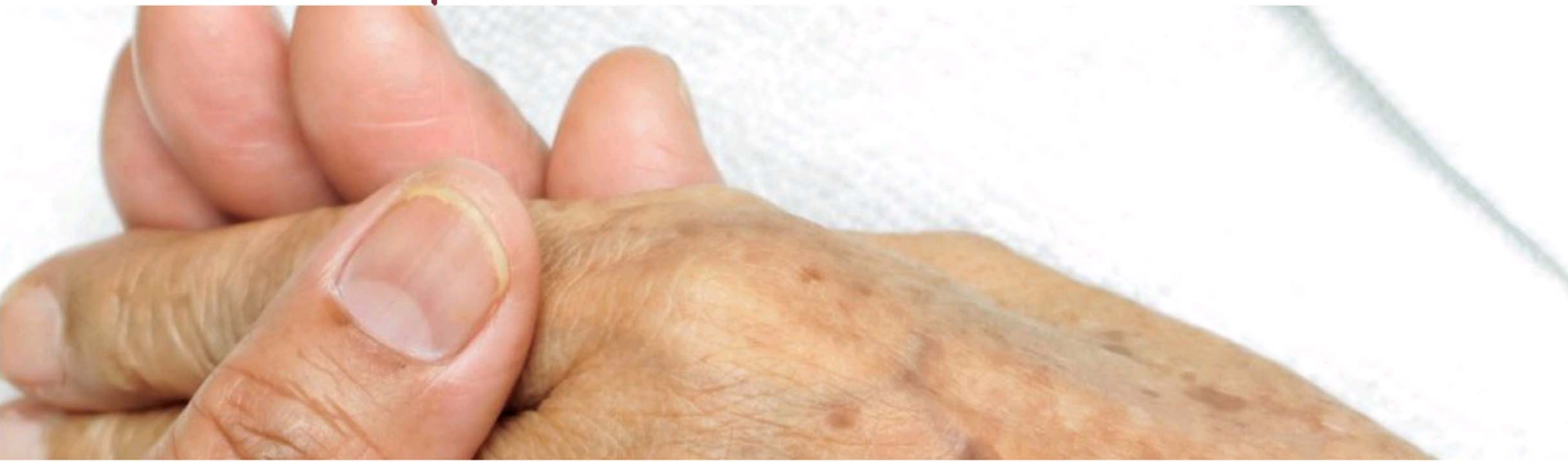
Sincerely,

Teresa Harbour

Teresa Harbour, RN, MBA, MHA
Senior Vice President, Accreditation

Community Health Accreditation Partner (CHAP)
2300 Clarendon Blvd. Suite 405 | Arlington, Virginia 22201
Office: 202.467.1701| Fax: 202.862.3419
Teresa.Harbour@chapinc.org| www.chapinc.org

CC: CMS Regional Office (CMS RO V - Chicago)
CMS Central Office
State Agency



THE MOMENTS WAY

- We represent the Moments Hospice brand professionally and with pride.
- We are present and in the moment.
- We take the extra time with patients and families.
- We are available 24 hours, 7 days a week putting patients and families first.
- We provide all 4 levels of care.
- We respond to calls within 30 minutes and emails within 24 hours.
- We meet patients and families within 2 hours of a referral (if they're ready to meet).
- We provide an Individualized Plan of Care for our patients and families, being generous with our services.
- We make decisions based on the need of the patient , regardless of cost.
- We recognize we are guests in patients' Homes, Nursing Facilities and Assisted Living Communities.
- We surround the patient/family to provide exceptional care and to determine the patients individual plan of care.
- We partner with the patient's families, facility staff, provider to deliver exceptional patient care and effective communication.
- We document during the visit in our EMR to help our teammates have the information timely.
- We contact families after every visit as they desire.
- We attend all deaths to honor the patient, providing support to the family and facility staff.

DONATE TODAY
to fulfill another patient's end-of-life wish

MOMENTS HOSPICE FOUNDATION

Enriching the experience of patients and veterans by creating lasting end-of-life memories

Use QR Code to Access our Social Media

OUR PROGRAMS

END-OF-LIFE WISH FULFILLMENT
We fund End-of-Life wishes for patients in hospice care. Grant requests range between $100-$2,000 per patient.

HOSPICE STAY FINANCIAL ASSISTANCE
We provide scholarships to individuals for hospice stays, providing approximately 1,200 free stays to patients per year.

WE HONOR VETERANS
This is a national program to empower hospices and community organizations to meet the unique needs of America's veterans and their families to be guided toward a more peaceful ending.

VIRTUAL REALITY VISITS
We are able to bring the outside world in to someone going through the dying process. Virtual reality can bring patients experiences they had once in their life, or one they always wanted.

HOSPICE EDUCATION
Our educators with industry-specific expertise conduct hospice and end-of life care education to healthcare professionals in order to strengthen community care for individuals.

Like, Share & Follow Moments Hospice Foundation on

CONNECT WITH US

info@momentsfoundation.com

momentsfoundation.com

820 Lilac Drive North, Suite 210
Golden Valley, MN 55422

763-316-4770

HHS Public Access

Author manuscript

J Am Geriatr Soc. Author manuscript; available in PMC 2019 February 01.

Published in final edited form as:

J Am Geriatr Soc. 2018 February ; 66(2): 407–413. doi:10.1111/jgs.15228.

Racial Disparities in Hospice Outcomes: A Race or Hospice-Level Effect?

Jessica Rizzuto, MPP[1] and **Melissa D. Aldridge, PhD, MBA**[1]

[1]Icahn School of Medicine at Mount Sinai

Abstract

Background/objectives—Black Americans receive more intensive and higher cost care at the end of life including higher rates of hospitalization and lower rates of hospice enrollment. We sought to determine if racial variation exists among hospice enrollees in rates of hospitalization and hospice disenrollment and whether variation is explained by systematic differences in hospice provider patterns.

Design—Longitudinal cohort study.

Participants—Medicare beneficiaries (N= 145,038) enrolled in a national random sample of hospices (N=577) from the National Hospice Survey and followed until death (2009–2010).

Measurements—We used Medicare claims data to identify the following after hospice enrollment: hospital admission, emergency department visits (ED), and hospice disenrollment. We estimated a series of hierarchical models including hospice-level random effects to compare outcomes between blacks and whites.

Results—In unadjusted models, black hospice patients were significantly more likely than white patients to be admitted to the hospital (14.9% vs 8.7%, OR =1.84, 95%CI=1.74–1.95), visit the ED (19.8% vs. 13.5%, OR=1.58, 95%CI=1.50–1.66), and disenroll from hospice (18.1% vs. 13.0%, OR=1.48, 95%CI=1.40–1.56). These results were largely unchanged after accounting for patient clinical and demographic covariates and hospice-level random effects. In adjusted models, blacks were at higher risk for hospital admission (OR =1.75, 95%CI=1.64–1.86), ED visits (OR=1.61, 95%CI=1.52=1.70), and hospice disenrollment (OR=1.54, 95%CI=1.45–1.63).

Conclusions—Racial differences in intensity of care at the end of life are not attributable to hospice-level variation in intensity of care. Differences in patterns of care between black and white hospice enrollees persist within the same hospice.

Corresponding Author: Melissa D. Aldridge, Icahn School of Medicine at Mount Sinai, One Gustave L. Levy Place, New York, NY 10029; T: 212-241-8994; Fax: 212-860-9737; Melissa.Aldridge@mssm.edu.

Presented:
American Geriatrics Society 2017 Annual Meeting
Oral presentation in Health Service & Policy Research
Recipient of Clinical Student Research Award
Icahn School of Medicine at Mount Sinai Student Research Day
Oral presentation

Keywords

Hospice; Race Disparities; End of Life Care

Introduction

Multiple studies find disparities between blacks and whites in the intensity of care at the end of life. Black patients receive more intensive and higher cost treatments at the end of life including greater rates of hospital admission, Emergency Department (ED) visits, Intensive Care Unit (ICU) stays, gastrostomies for artificial nutrition, mechanical ventilation, and cardiopulmonary resuscitation.[1–6] Consistent with this pattern, blacks are less likely to enroll in hospice compared with non-minorities, despite the growth of hospice across the country during the past decade.[7–9] For example, using data from 2014, an estimated 76% of all hospice patients were white and only 7.6% were black.[7] In this same year, an estimated 47% of white patients died while under the care of hospice compared with 31% of black patients.[10] Even after enrolling in hospice, black patients are more likely to disenroll in order to seek curative treatment not covered under hospice care.[11] The greater use of high intensity healthcare at the end of life by blacks has been shown to be independent of sex, education, marital status, existence of a living will, income, religiosity, and neighborhood socioeconomic status.[9, 12–13] This pattern of healthcare use at the end of life for blacks compared with whites may be due to preferences not captured by these characteristics or to lack of knowledge of hospice.[8–9, 14–15]

Evidence suggests that for some outcomes, however, racial disparities in care are more likely rooted at the provider level rather than in patient-level differences in preferences for care. For example, a study of end-of-life ICU use found that the majority of observed differences in ICU use during terminal admissions among black and Hispanic patients compared with whites was attributed to their use of hospitals with a higher ICU use overall.[16] The impact of provider-level variation on intensity of end-of-life care may be particularly important in understanding the intensity of care for hospice enrollees. Recent studies indicate substantial variation across hospices in certain patient outcomes. Specifically, there is substantial hospice-level variation in the proportion of hospice enrollees who use the hospital (from 0% of patients at some hospices to 55.6% of patients at other hospices), ED (from 0% of patients at some hospices to 72.7% of patients at others), and ICU (from 0% of patients at some hospices to 26.6% of patients at others).[17] Similarly, the proportion of hospice enrollees who disenroll from hospice was found to range from 0% of patients at some hospices to 38% of patients at others.[18] Some of this hospice provider-level variation is associated with differences in hospice practices, ownership, and size,[17–18] including evidence that for-profit hospices and hospices that spend less on direct patient care (e.g., home visits) are more likely to be in the highest quartiles of these utilization outcomes.[19]

Although previous studies have found that black patients have higher rates of hospitalization after enrolling in hospice than white patients.[20–23] without accounting for provider level variation, the conclusions of these studies are limited. Specifically, it is unknown if blacks tend to be cared for by hospices with higher rates of hospital utilization and hospice

disenrollment *for all patients* or if racial differences in outcomes are due to within hospice differences by race. Accordingly, we examined the relationship between race and hospitalizations and ED visits following hospice enrollment and disenrollment from hospice. We estimated the extent to which observed differences in outcomes are attributable to blacks' enrollment in hospices with higher rates of hospital utilization and disenrollment rather than racial differences in these outcomes within the same hospice. Discerning these patterns is essential to understanding racial differences in end-of-life healthcare and ensuring access to optimal care for all patients.

Methods

Study Design and Sample

We used data from a longitudinal cohort study of Medicare beneficiaries (N= 213,495) enrolled in a national random sample of hospices (N=591) from the National Hospice Survey and followed until death (2009–2010). As reported elsewhere,[17, 24–26] we chose the random sample of hospices from the Medicare Provider of Services files, which includes all hospices that participate in the Medicare program. We collected completed surveys from 591 hospices, representing an 84% response rate. We linked 577 of these hospices (98%) to the Medicare claims data for beneficiaries; the claims data was unavailable for 14 of these hospices due primarily to these hospices having merged or closed during the survey period. This sample represents approximately 20% of all Medicare-certified hospices in the United States that were operating in 2009.

From this group, we excluded patients younger than 66 (N=15,003) to ensure individuals were eligible for Medicare in the year before hospice enrollment so that we could access data on preexisting chronic conditions. We excluded patients not eligible for both Medicare Parts A and B (N=2,111) or who were enrolled in a managed care organization (N=46,567). Race was collected from the Medicare claims data where it is recorded as one of six values (White, Black, Asian, North American Indian, Hispanic, Other, and unknown). A patient's race is populated in the Medicare enrollment database as it was voluntarily self-reported to the Social Security Association upon applying for or renewing a Social Security number.[27] Medicare claims data for black and white beneficiaries is considered more sensitive and less vulnerable to the biases and inaccuracies of coding recognized among the relatively smaller racial and ethnic groups.[27] We excluded patients who did not report their race and those who reported a race or ethnicity other than white or black (N= 4,776). After applying exclusion criteria, our total sample included 145,038 patients from 577 hospices.

Measures

For this analysis, we included questions regarding descriptive characteristics of hospices collected in this survey including: ownership (for profit, nonprofit, government/other), whether the hospice was part of a chain of hospices, size (number of patients per day in the past 12 months), whether the hospice was in an urban area, and the census region of the hospice.

From the Medicare claims data, we obtained patient demographic and clinical information including sex (male, female), age (categorized as 65–69, 70–74, 75–79, 80–84 and 85 years and above), and primary diagnosis based on International Classification of Diseases, Ninth Revision (ICD-9) codes. We obtained information regarding the number of chronic conditions by examining all Medicare hospital inpatient and outpatient claims for each individual for the 12 months before their hospice enrollment. We measured hospice length of stay for each patient using Medicare hospice claims data.

For our dependent variables, we measure the following utilization based outcomes, gathered from Medicare claims data, from the time of a beneficiary's hospice enrollment to his/her death: ≥ 1 hospitalization, ≥1 ED visits, and disenrollment from hospice (including those who voluntarily disenroll from hospice and those who no longer meet hospice eligibility criteria and are disenrolled by the hospice).

Statistical analysis

We estimated the association between race and demographic and clinical characteristics using chi-squared tests. We estimated the proportion of each hospice's patients who experienced the following utilization-based outcomes from the time of their hospice enrollment to their death: one or more hospitalizations, one or more ED visits, and hospice disenrollment. We compared the unadjusted proportion of black versus white hospice enrollees with each of these outcomes.

We undertook a series of steps to graphically depict hospital utilization and hospice disenrollment patterns across hospice providers and by race, paralleling prior research in racial disparities.[16] First, we calculated the proportion of patients hospitalized among white hospice enrollees at each hospice and arrayed hospices by decile from lowest to highest white hospitalization rate. We conducted an ordered logistic regression model to estimate the association between race and deciles of hospitalization rate. Second, using hospices with at least 5 black hospice enrollees (n=360 hospices), we determined the proportions of black and white hospice enrollees admitted to hospices within each decile. Third, we calculated the black and white hospitalization rates within each decile for comparison. We repeated these steps for the outcome of ED visits and the outcome of hospice disenrollment.

We used sequential hierarchical models to address the clustering of patients within hospices. We first estimated an unadjusted logistic regression model including only hospice enrollee race (black compared with white). Next, we estimated a hierarchical model including race and hospice random effects to adjust for unobserved hospice-level factors omitted from the model that systematically raise or lower utilization of all enrollees in that hospice. We then estimated a fully-adjusted model including race, hospice random effects, patient clinical and demographic characteristics (i.e., age, gender, cancer as a primary diagnosis, number of chronic conditions, and length of hospice stay). All analyses were performed in Stata Version 14 software (StataCorp LP, College Station, TX).

Results

Study Population

Our sample of Medicare beneficiaries was composed of 133,996 (92.4%) white patients and 11,072 (7.6%) black patients who were enrolled in the 577 hospices that responded to the National Hospice Survey. Approximately half of hospices were for profit, providing care to about one third of the population of patients in the sample, and approximately half of the hospices had <50 patients per day on average. About a quarter of hospices were members of a chain of hospices. Approximately 90% of patients were served in hospices in an urban area, representing about two thirds of hospices. Demographic and clinical characteristics of the black and white patients in the sample and the characteristics of the hospices they utilized can be found in Supplementary Table 1. Black patients were significantly more likely to be younger, female, and have a primary diagnosis of neoplasm than white patients in the sample. Black patients were more likely to be admitted to hospices that were larger, for-profit, and located in an urban area than white patients.

Hospice Admission Patterns

In examining hospice admission patterns, black hospice enrollees were not disproportionately cared for by hospices with higher rates of hospital admission, ED use, or hospice disenrollment (Supplementary Figure 1). The magnitudes of differences in black and white proportions across decile categories are fairly small and inconsistent in direction. Specifically, the largest difference between proportions of black and white patients in any one decile was 2.6 percent for hospital admission, 5.4 percent for ED visits, and 3.2 percent for hospice disenrollment. In addition, there are slightly higher proportions of black patients compared with white patients in both the highest and lowest deciles for each outcome. Quantitative comparison of the association between race and decile using ordered logistic regression was not statistically significant for any of the study outcomes. Yet within deciles of hospital admission, ED use, and hospice disenrollment, the rates among blacks are significantly higher than the rates among whites (Figure 1).

Hospital Utilization and Hospice Disenrollment Outcomes

Overall, 11,611 (8.7%) white patients in our sample were admitted to the hospital, 18,085 (13.5%) visited the ED, and 17,400 (13.0%) disenrolled from hospice, compared with 1,649 (14.9%) black patients admitted to the hospital, 2,191 (19.8%) visited the ED, and 2,001 (18.1%) disenrolled from hospice (Figure 2) ($p<0.01$ for each comparison). In unadjusted models (Table 1, Model 1), black hospice patients were significantly more likely than whites to be admitted to the hospital (OR =1.84, 95%CI=1.74–1.95), visit the ED (OR=1.58, 95%CI=1.50–1.66), and disenroll from hospice during the course of their care (OR=1.48, 95%CI=1.40–1.56). In models accounting for hospice random effects (Table 1, Model 2), black patients remained more likely than whites to have each measured outcome: hospital admission (OR=1.72, 95%CI=1.62–1.83), ED visits (OR=1.53, 95% CI=1.46,1.64), and hospice disenrollment (OR= 1.45, 95%CI=1.37, 1.53). Similarly, in the fully adjusted model including hospice random effects as well as demographic and clinical characteristics (Table 1, Model 3), blacks had higher odds of hospital admission (OR =1.75, 95%CI=1.64–1.86),

ED visits (OR=1.61, 95%CI=1.52=1.70), and disenrollment from hospice (OR=1.54, 95%CI=1.45–1.63).

Discussion

In a large, national sample of hospice users, blacks had significantly higher rates of hospital admission, ED visits, and hospice disenrollment at the end of life. Our results suggest that these higher rates of hospital utilization and hospice disenrollment by blacks compared with whites are attributable to racial differences *within* the same hospice rather than systematic differences between hospices in hospital utilization and hospice disenrollment rates.

There are a number of important potential explanations for our findings. First, a commonly proposed explanation for differences in intensity of end-of life care by race is differences in patient preferences. Black patients are more likely to have a preference for life-sustaining therapies and to hold spiritual beliefs that may conflict with the goals of hospice care than white patients.[11, 28–29] This preference is often attributed to a general distrust in the healthcare system based on the history of racism in medical research and persistent health disparities.[30] However, while it is true that blacks are more likely to prefer intensive treatment at the end of life, the majority still prefer to die at home.[31]

Second, our finding of patient-level difference between black versus white patients at the same hospice may also reflect differences in the patterns of communication between black versus white patients regarding hospice that result in a lack of understanding of hospice care and potentially inappropriate hospice enrollment. In a study of chronic kidney disease patients, blacks were less likely than whites to understand hospice or to have had end of life discussions with healthcare providers.[32] In the last year of life, blacks are less likely than whites to visit a primary care doctor, which has been associated with higher hospitalization rates and in-hospital deaths for these patients.[33] Poor interpersonal communication between doctors and their black patients has been proposed as a reason for their lack of trust in the healthcare system.[34] It is possible that improving provider communication and patient understanding of hospice could reduce these disparities.

A third potential explanation for our finding of higher rates of hospitalization and disenrollment for blacks compared with whites is differing availability of resources. Given that hospice care is primarily provided in a patient's home, the quality of care may be largely dependent on the resources of caregivers and availability of support at or near the home of the patient. Evidence suggests that black hospice patients may have a more difficult time accessing appropriate resources.[15, 35–38] Specifically, their local pharmacy may be less likely to stock adequate pain medication and they are less likely to receive regular visits by a health aide or other health professional.[35–37] Black patients may face particularly high barriers to access to certain resources, even when compared to white patients at the same hospice, causing them to resort to the hospital or disenroll from hospice.[15, 38]

Although many of the above factors are often cited as contributing to lower rates of hospice enrollment for blacks compared with whites, it is plausible that these same factors may contribute to differences in patterns of care after hospice enrollment. The specific individual

and family level causes of hospitalization after hospice enrollment and hospice disenrollment are not well known. A recent qualitative study asked hospice care providers why their patients were hospitalized after hospice enrollment and these providers cited the families' lack of understanding of hospice, caregiver burden, slow hospice response time compared to 911, and a preference for more intensive treatment.[39] A related study that interviewed family caregivers had similar findings.[40] Finally, it is important to note that although hospice provider level effects do not explain racial differences in study outcomes, the similar increase in proportions for each outcome across deciles for both whites and blacks depicted in Figure 1 suggests that hospice provider level effects impact these outcomes. This is consistent with existing evidence[17–19, 24–26] regarding provider level variation in hospital utilization and hospice disenrollment of hospice enrollees.

There are several limitations to our study. First, it is possible that differences in utilization outcomes are a result of unmeasured aspects of the patients' clinical or socioeconomic characteristics. Although our models adjusted for multiple characteristics of patients known to be associated with utilization outcomes, it is possible that there are unmeasured confounders.[15] Second, our analysis does not include information regarding patient or family preferences for care or if these preferences were met, including whether hospice disenrollment was voluntary or initiated by the hospice. Nor do we have information on patient or family satisfaction or quality of life. Understanding the extent to which high intensity outcomes align with patient and family preferences is essential for determining if and how to shape interventions to better align patient preferences and outcomes for black and white hospice patients. Third, our results are not generalizable to the hospices in the United States that do not participate in the Medicare program (approximately 7%), hospice patients who are not Medicare beneficiaries, or hospice patients who were enrolled in managed care organizations. Finally, our sample only analyzed black patients compared with white patients and does not provide information on hospice outcomes for patients of other races. While little is known about the end-of-life care of other races in America, some evidence suggests that Hispanic patients have higher healthcare costs and higher use of intensive care at the end of life than white or black patients.[2, 32] Less is known about Asian, Pacific Islander, or Native American patients warranting future research in these populations.

Our findings underscore the need to better understand racial disparities in outcomes after hospice enrollment. Differences in rates of hospital admission, ED visits, and hospice disenrollment are not driven by differential enrollment in hospices with varying rates of these outcomes. Rather, our findings suggest that blacks have higher hospital utilization and hospice disenrollment regardless of whether the hospice caring for them has high or low rates of these outcomes. In addition to increasing the financial costs of end-of-life care, greater use of the hospital and higher hospice disenrollment by black patients may adversely impact the quality of the end of their life and increase caregiver burden. Culturally sensitive interventions that increase understanding of hospice, address shortcomings in provider communication, and improve caregiver resources could help decrease these persistent differences in outcomes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

Funding sources: Medical Student Training in Aging Research Scholarship from the American Federation for Aging Research (Rizzuto); National Institute of Nursing Research 5R01NR013499 (Aldridge)

Conflict of Interest: None of the authors have any financial or other kind of conflict with this manuscript.

Author Contributions: All authors contributed to the concept and design, data analysis, interpretation of data, preparation of manuscript. Aldridge additionally contributed the data collection as well as critical revision of manuscript.

Sponsor's Role: The American Federation for Aging Research played no role in the design, methods, subject recruitment, data collections, analysis, or preparation of this paper.

References

1. Byhoff E, Harris JA, Langa KM, Iwashyna TJ. Racial and Ethnic Differences in End-of-Life Medicare Expenditures. J Am Geriatr Soc. 2016; 64:1789–97. [PubMed: 27588580]
2. Hanchate A, Kronman AC, Young-Xu Y, Ash AS, Emanuel E. Racial and ethnic differences in end-of-life costs: why do minorities cost more than whites? Arch Intern Med. 2009; 169:493–501. [PubMed: 19273780]
3. Smith AK, Earle CC, McCarthy EP. Racial and ethnic differences in end-of-life care in fee-for-service Medicare beneficiaries with advanced cancer. J Am Geriatr Soc. 2009; 57:153–8. [PubMed: 19054185]
4. Hernandez RA, Hevelone ND, Lopez L, Finlayson SR, Chittenden E, Cooper Z. Racial variation in the use of life-sustaining treatments among patients who die after major elective surgery. Am J Surg. 2015; 210:52–8. [PubMed: 25465749]
5. Abdollah F, Sammon JD, Majumder K, et al. Racial Disparities in End-of-Life Care Among Patients With Prostate Cancer: A Population-Based Study. J Natl Compr Canc Netw. 2015; 13:1131–8. [PubMed: 26358797]
6. Nayar P, Qiu F, Watanabe-Galloway S, et al. Disparities in end of life care for elderly lung cancer patients. J Community Health. 2014; 39:1012–9. [PubMed: 24643730]
7. NHPCO. NHPCO's Facts and Figured; Hospice Care in America. National Hospice and Palliative Care Organization; 2015.
8. Ramey SJ, Chin SH. Disparity in hospice utilization by African American patients with cancer. Am J Hosp Palliat Care. 2012; 29:346–54. [PubMed: 22025746]
9. Cohen LL. Racial/ethnic disparities in hospice care: a systematic review. J Palliat Med. 2008; 11:763–8. [PubMed: 18588409]
10. Estimates A. Centers for Disease Control; Mar, 2017 http://wonder.cdc.gov/
11. Johnson KS, Kuchibhatla M, Tulsky JA. What explains racial differences in the use of advance directives and attitudes toward hospice care? Journal of the American Geriatrics Society. 2008; 56:1953–8. [PubMed: 18771455]
12. Greiner KA, Perera S, Ahluwalia JS. Hospice Usage by Minorities in the Last Year of Life: Results from the National Mortality Followback Survey. Journal of the American Geriatrics Society. 2003; 51:970–8. [PubMed: 12834517]
13. Karikari-Martin P, McCann JJ, Farran CJ, Hebert LE, Haffer SC, Phillips M. Race, Any Cancer, Income, or Cognitive Function: What Inf luences Hospice or Aggressive Services Use at the End of Life Among Community-Dwelling Medicare Beneficiaries? Am J Hosp Palliat Care. 2016; 33:537–45. [PubMed: 25753184]
14. Johnson KS. Racial and ethnic disparities in palliative care. J Palliat Med. 2013; 16:1329–34. [PubMed: 24073685]

15. Crawley L, Payne R, Bolden J, Payne T, Washington P, Williams S. Palliative and end-of-life care in the African American community. Jama. 2000; 284:2518–21. [PubMed: 11074786]
16. Barnato AE, Berhane Z, Weissfeld LA, Chang CC, Linde-Zwirble WT, Angus DC. Racial variation in end-of-life intensive care use: a race or hospital effect? Health Serv Res. 2006; 41:2219–37. [PubMed: 17116117]
17. Aldridge MD, Epstein AJ, Brody AA, Lee EJ, Cherlin E, Bradley EH. The Impact of Reported Hospice Preferred Practices on Hospital Utilization at the End of Life. Med Care. 2016; 54:657–63. [PubMed: 27299952]
18. Carlson MD, Herrin J, Du Q, et al. Hospice characteristics and the disenrollment of patients with cancer. Health Serv Res. 2009; 44:2004–21. [PubMed: 19656230]
19. Aldridge MD, Epstein AJ, Brody AA, Lee EJ, Morrison RS, Bradley EH. Association between Hospice Spending on Patient Care and Rates of Hospitalization and Medicare Expenditures of Hospice Enrollees. J Palliat Med. 2017
20. Johnson KS, Kuchibhatla M, Tanis D, Tulsky JA. Racial differences in hospice revocation to pursue aggressive care. Arch Intern Med. 2008; 168:218–24. [PubMed: 18227371]
21. Phongtankuel V, Johnson P, Reid MC, et al. Risk Factors for Hospitalization of Home Hospice Enrollees: Development and Validation of a Predictive Tool. Am J Hosp Palliat Care. 2016
22. Kapo J, MacMoran H, Casarett D. “Lost to follow-up”: ethnic disparities in continuity of hospice care at the end of life. J Palliat Med. 2005; 8:603–8. [PubMed: 15992202]
23. Wang SY, Aldridge MD, Gross CP, et al. Transitions Between Healthcare Settings of Hospice Enrollees at the End of Life. J Am Geriatr Soc. 2016; 64:314–22. [PubMed: 26889841]
24. Carlson MD, Barry C, Schlesinger M, et al. Quality of palliative care at US hospices: results of a national survey. Med Care. 2011; 49:803–9. [PubMed: 21685811]
25. Aldridge MD, Schlesinger M, Barry CL, et al. National hospice survey results: for-profit status, community engagement, and service. JAMA Intern Med. 2014; 174:500–6. [PubMed: 24567076]
26. Aldridge Carlson MD, Barry CL, Cherlin EJ, McCorkle R, Bradley EH. Hospices’ enrollment policies may contribute to underuse of hospice care in the United States. Health Aff (Millwood). 2012; 31:2690–8. [PubMed: 23213153]
27. Eicheldinger C, Bonito A. More accurate racial and ethnic codes for Medicare administrative data. Health Care Financ Rev. 2008; 29:27–42. [PubMed: 18567241]
28. Smith AK, Davis RB, Krakauer EL. Differences in the quality of the patient-physician relationship among terminally ill African-American and white patients: impact on advance care planning and treatment preferences. J Gen Intern Med. 2007; 22:1579–82. [PubMed: 17879120]
29. Johnson KS, Elbert-Avila KI, Tulsky JA. The influence of spiritual beliefs and practices on the treatment preferences of African Americans: a review of the literature. J Am Geriatr Soc. 2005; 53:711–9. [PubMed: 15817022]
30. Cort MA. Cultural mistrust and use of hospice care: challenges and remedies. J Palliat Med. 2004; 7:63–71. [PubMed: 15000784]
31. Barnato AE, Anthony DL, Skinner J, Gallagher PM, Fisher ES. Racial and ethnic differences in preferences for end-of-life treatment. J Gen Intern Med. 2009; 24:695–701. [PubMed: 19387750]
32. Eneanya ND, Hailpern SM, O’Hare AM, et al. Trends in Receipt of Intensive Procedures at the End of Life Among Patients Treated With Maintenance Dialysis. Am J Kidney Dis. 2016
33. Kronman AC, Ash AS, Freund KM, Hanchate A, Emanuel EJ. Can primary care visits reduce hospital utilization among Medicare beneficiaries at the end of life? J Gen Intern Med. 2008; 23:1330–5. [PubMed: 18506545]
34. Gordon HS, Street RL Jr, Sharf BF, Kelly PA, Souchek J. Racial differences in trust and lung cancer patients’ perceptions of physician communication. J Clin Oncol. 2006; 24:904–9. [PubMed: 16484700]
35. Green CR, Ndao-Brumblay SK, West B, Washington T. Differences in prescription opioid analgesic availability: comparing minority and white pharmacies across Michigan. J Pain. 2005; 6:689–99. [PubMed: 16202962]
36. Teno JM, Plotzke M, Christian T, Gozalo P. Examining Variation in Hospice Visits by Professional Staff in the Last 2 Days of Life. JAMA Intern Med. 2016; 176:364–70. [PubMed: 26857275]

37. Morrison RS, Wallenstein S, Natale DK, Senzel RS, Huang LL. “We don’t carry that”--failure of pharmacies in predominantly nonwhite neighborhoods to stock opioid analgesics. N Engl J Med. 2000; 342:1023–6. [PubMed: 10749965]

38. O’Mahony S, McHenry J, Snow D, Cassin C, Schumacher D, Selwyn PA. A review of barriers to utilization of the medicare hospice benefits in urban populations and strategies for enhanced access. J Urban Health. 2008; 85:281–90. [PubMed: 18240022]

39. Phongtankuel V, Scherban BA, Reid MC, et al. Why Do Home Hospice Patients Return to the Hospital? A Study of Hospice Provider Perspectives. J Palliat Med. 2016; 19:51–6. [PubMed: 26702519]

40. Phongtankuel V, Paustian S, Reid MC, et al. Events Leading to Hospital-Related Disenrollment of Home Hospice Patients: A Study of Primary Caregivers’ Perspectives. J Palliat Med. 2017; 20:260–5. [PubMed: 27893951]

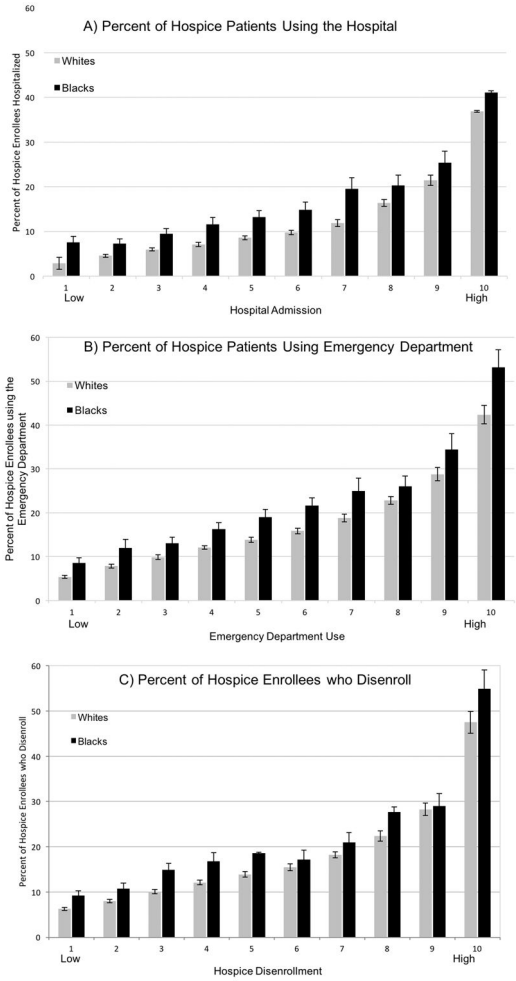


Figure 1. Hospital Utilization and Hospice Disenrollment among Hospice Patients by Decile of Hospice Treatment Intensity

We grouped hospices into deciles arrayed from hospices with the lowest to highest rates of hospital admission (A), Emergency Department visits (B), and hospice disenrollment (C). Each panel compares the percent of black and white patients with each outcome in each decile. Error bars represent 95 percent confidence intervals around the decile rate estimate.

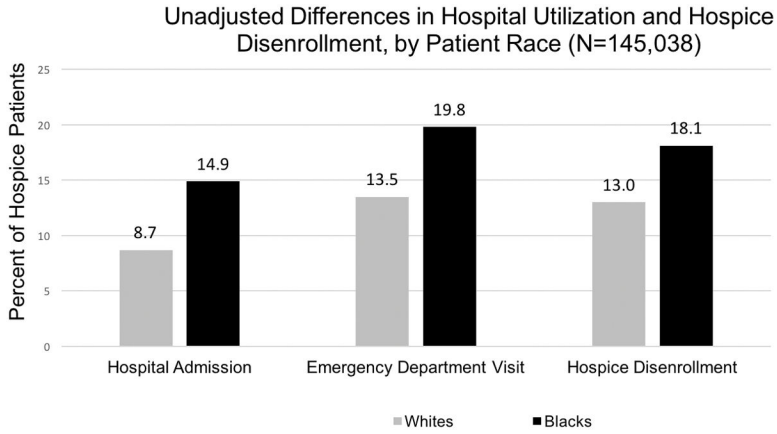


Figure 2.

Unadjusted Differences in Hospital Utilization and Hospice Disenrollment between Black and White Patients

Table 1

Hospital Utilization and Hospice Disenrollment:
Black Patients Compared to White Patients

	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)
Hospital Admission	1.84 (1.74,1.95)	1.72 (1.62, 1.83)	1.75 (1.64, 1.86)
ED Visits	1.58 (1.50, 1.66)	1.53 (1.46, 1.62)	1.61 (1.52, 1.70)
Disenrollment	1.48 (1.40, 1.56)	1.45 (1.37, 1.53)	1.54 (1.45, 1.63)

Model 1: Unadjusted

Model 2: Adjusted only for hospice random effects

Model 3: Adjusted for hospice random effects, average age, percent female, percent with cancer as a primary diagnosis, average number of chronic conditions and median length of hospice stay

Published in final edited form as:
J Am Geriatr Soc. 2008 January ; 56(1): 139–144. doi:10.1111/j.1532-5415.2007.01510.x.

Ethnic Disparities in Hospice Use Among Asian-American and Pacific Islander Patients Dying with Cancer

Quyen Ngo-Metzger, MD, MPH[*], **Russell S. Phillips, MD**[†], and **Ellen P. McCarthy, PhD, MPH**[†]

[*] Division of General Internal Medicine and Primary Care and the Center for Health Policy Research, School of Medicine, University of California at Irvine, Irvine, California

[†] Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts

Abstract

Asian Americans and Pacific Islanders (AAPIs) are a rapidly growing population in the United States, yet little is known about hospice use and length of stay in hospice of older AAPIs dying with cancer. A retrospective study was conducted of the last year of life of AAPI and white Medicare beneficiaries registered in the Surveillance, Epidemiology, and End Results Program. White (n = 175,467) and AAPI (n = 8,614) patients aged 65 and older who were dying with lung, colorectal, breast, prostate, gastric, or liver cancer were studied. Cox proportional hazards models were used to examine hospice use and length of stay in hospice. All AAPI subgroups studied had lower rates of hospice use (Chinese (adjusted hazard ratio (HR) = 0.62, 95% confidence interval (CI) = 0.55–0.69), Japanese (adjusted HR = 0.67, 95% CI = 0.60–0.73), Filipino (adjusted HR = 0.61, 95% CI = 0.54–0.70), Hawaiian/Pacific Islanders (adjusted HR = 0.78, 95% CI = 0.67–0.91), and other Asians (adjusted HR = 0.70), 95% CI = 0.55–0.90) than white patients, adjusting for patient demographic and clinical characteristics. Of those who enrolled in hospice (approximately 20% of the total sample), Japanese Americans had a shorter median length of stay (21 days), and Filipino Americans had a longer median length of stay (32 days) than white patients (26 days). Overall, approximately 20% of patients enrolled within 7 days of death, and only 6% had hospice stays that were longer than 2 months, with no significant differences across racial or ethnic groups. In conclusion, in every ethnic subgroup studied, AAPIs were less likely than whites to enroll in hospice. Further research is needed to understand these differences and eliminate potential barriers to hospice care.

Keywords

hospice; end of life; Asians; Pacific Islanders; palliative care

Of the 2.4 million Americans who die each year,[1] more than 70% are aged 65 and older.[2] As the population of “baby boomers” ages in the coming decades, it is more important than ever

Address correspondence to Quyen Ngo-Metzger, MD, MPH, 111 Academy, Suite 220, Irvine, CA 92697. Qhngo@uci.edu.

Sponsors’ Role: None.

Conflict of Interest: Dr. Ngo-Metzger was supported by the Asian American Network for Cancer Awareness, Research, and Training (Cooperative Agreement Number U01 CA86322 from the NCI). Dr. Phillips was supported by a Mid-Career Investigator Award from the National Center for Complementary and Alternative Medicine (K24-AT000589). Dr. McCarthy was the recipient of First Independent Research Support & Transition Award R29-CA79052 funded by the NCI. The authors have no financial disclosures and no conflict of interests to disclose related to this manuscript.

Author Contributions: Ngo-Metzger: study concept and design, interpretation of data, drafting and critical revision of manuscript, acquisition of funding. Phillips: study concept and design, interpretation of data, and critical revision of manuscript. McCarthy: study concept and design, acquisition of data, data analysis and interpretation of data, drafting and critical revision of manuscript.

to make sure that the dying process is as humane as possible. A recent Institute of Medicine report urged improvement in end-of-life care.[2] The Medicare Hospice Benefit was established more than 20 years ago to support hospice use at the end of life.[3] Hospice care has been shown to improve symptom management and quality of life at the end of life,[4,5] yet hospice is underused, especially by minority Americans.[6–9]

Asian Americans and Pacific Islanders (AAPIs) are one of the fastest-growing ethnic groups in the United States, with an increase of 72% (5.0 million people) between the 1990 and 2000 census.[10] The Census Bureau projects that, by 2050, the Asian-American population will grow to 37.6 million and constitute 9.3% of the population.[11] Cancer is the leading cause of death for AAPIs in the United States,[11] yet they have one of the lowest rates of hospice use.[9] Fewer than 2% of hospice patients are AAPIs,[9] although they represent approximately 5% of the U.S. population.[12] Previously, it was found that AAPIs, especially those who were foreign born, used hospice substantially less than non-Hispanic whites,[13] although AAPIs comprised more than 30 distinct ethnic groups that are culturally and linguistically heterogeneous.[14] Asian Americans include Japanese Americans (1.1 million), many of whom are second- or third-generation Americans whose families immigrated to the United States in the 19th century.[10] Asian Americans also include Chinese (2.7 million) and Filipino Americans (2.4 million), the two largest subgroups, who are more likely to be recent immigrants and foreign born.[10] Pacific Islanders comprise Native Hawaiians, Samoans, Tongans, and others from the Pacific Basin and include 874,000 individuals.[15] Little is known about the rates of hospice use in subgroups of older AAPI patients dying with cancer compared with those of white patients. Therefore, hospice enrollment of AAPI subgroups was examined. Furthermore, in those who enrolled in hospice, length of stay in hospice across subgroups was studied.

METHODS

Data Source

A retrospective analysis of the last year of life of patients diagnosed with cancer using the Linked Medicare–Tumor Registry Database was conducted. The linked database contains cancer information on patients aged 65 and older from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program and Medicare enrollment and utilization information from the Centers for Medicare and Medicaid Services. Specific information describing the linkage between SEER and Medicare has been published elsewhere.[16]

SEER Program

The SEER Program is an epidemiological surveillance system developed in 1973 to track cancer incidence and mortality for designated population-based cancer registries in diverse regions of the United States. These regions include five states (Connecticut, Hawaii, Iowa, New Mexico, and Utah) and six metropolitan areas (Atlanta, Detroit, Seattle-Puget Sound, San Francisco-Oakland, San Jose-Monterey, and Los Angeles). SEER captures approximately 13% of U.S. whites, 12% of African Americans, 27% of Native Americans, and 25% of Hispanics of all races.[17] Currently, 41% of AAPIs reside in SEER areas, including 43% of Chinese, 49% of Filipino, 60% of Japanese Americans, and 46% of Hawaiian/Pacific Islanders.[17] SEER tumor registries collect information on all newly diagnosed cancer cases that occur in patients residing in geographically defined SEER areas. Abstractors extract selected clinical and demographic data from the records of hospitals, clinics, and nursing homes and obtain mortality data from state death certificates and the Social Security Administration.[16,18] SEER data are considered to be highly valid, with a 98% program standard for the completeness of case ascertainment.[19]

Medicare Program

The Medicare Program covers medical services for more than 97% of persons aged 65 and older.[16] The Medicare enrollment and hospice files were used in this study. The enrollment file is updated annually and contains specific demographic and enrollment information for every Medicare beneficiary. The hospice file contains one or more claims for every beneficiary who received hospice services under the Medicare Hospice Benefit, including inpatient and outpatient hospice services provided to beneficiaries enrolled in managed care.

Study Sample

Hospice use in the last year of life was examined for patients who were diagnosed with a first primary lung, colorectal, gastric, liver, breast, or prostate cancer between January 1, 1973, and December 31, 1996, in one of nine SEER areas and who died between January 1, 1988, and December 31, 1998. These cancers were selected, because they are the most commonly diagnosed cancers in older adults (lung, colorectal, prostate, breast) and in AAPIs (gastric, liver). Only patients diagnosed with cancer at age 66 or older were included to ensure that all had Medicare coverage for at least 1 full year before their death (n = 235,849). A total of 6,735 patients diagnosed with in situ disease or with cancer after entering hospice care and 22,117 patients with unknown birthplace were excluded. Of the remaining 206,997 eligible patients, 85% were non-Hispanic whites (n = 175,467), 4% were AAPIs (n = 8,614), and 11% were of other race or ethnicity (n = 22,916), which were excluded from the study. The final study sample consisted of 184,081 patients with cancer who were non-Hispanic whites or AAPIs who died between 1988 and 1998.

Measures

The following sociodemographic information was obtained from the SEER file: age and marital status at diagnosis, sex, race or ethnicity, place of birth, year of diagnosis, and SEER area of residence. Race or ethnicity was categorized as non-Hispanic white, Chinese American, Japanese American, Filipino American, other Asian, or Hawaiian/Pacific Islander. Place of birth was categorized as foreign or U.S. born. There were 121 patients born in one of the U.S. territories in the Pacific (Guam, American Samoa, etc.) who were classified as U.S. born. Age at diagnosis was categorized as 66 to 69, 70 to 74, 75 to 79, 80 to 84, and 85 and older. Marital status was classified as married or not. SEER area was defined according to the tumor registry. Year of diagnosis was categorized in five groups: 1973 to 1981, 1982 to 1985, 1986 to 1989, 1990 to 1993, and 1994 to 1996. Individual socioeconomic information such as income and education are not available in SEER or Medicare data. Therefore, 1990 U.S. Census data were used to classify patients according to the median household income of their ZIP code of residence and grouped into quintiles. Medicare enrollment information was used to identify patients enrolled in managed care during the last 6 months of life.

SEER collects information regarding tumor stage at diagnosis using two systems. The historical staging system, collected by SEER since its inception, classifies tumors as local, regional, distant, and unstaged. In this study, the historical staging system was used for two reasons. First, SEER has collected the historical staging system since its inception, and it is available for all patients. Although SEER began collecting data according to the American Joint Committee on Cancer (AJCC) staging system for some cancers in 1988, it is available for few patients diagnosed before 1988. Second, the AJCC system is not available for patients with gastric or liver cancer (2 of the 6 cancers studied).

The two primary outcomes were time to hospice enrollment and length of stay in hospice care. Time to hospice enrollment was measured from patients' date of cancer diagnosis to hospice entry or death, whichever came first. Length of stay in hospice care was measured from the date of hospice enrollment until discharge or death.

Statistical Analyses

All statistical analyses were performed using SAS 9.1 (SAS Institute, Inc., Cary, NC). Bivariable analyses were conducted to characterize the study sample and examine variations in hospice use across ethnic groups. Because of the large sample size, *P*-values for bivariable comparisons were not presented; instead, the focus was on differences with meaningful magnitudes.

Multivariable Cox proportional hazards models were fitted for each outcome to determine whether ethnic differences in hospice utilization persisted after adjusting for demographic (sex, race or ethnicity, birthplace, marital status, residence in urban or rural area, median household income of ZIP code of residence, and type of insurance) and clinical (stage at diagnosis and type of primary cancer, e.g., lung, colorectal) factors. Additionally, adjustment for the effects of the different locations of the SEER tumor registries was done using a proportional hazards model that allowed a different underlying hazard for each tumor registry. The hospice enrollment model also adjusted for age and year of diagnosis, whereas the model incorporating length of stay in hospice adjusted for age and year at hospice entry and illness duration (measured as time from diagnosis until hospice entry). Adjusted hazard ratios (HRs) and corresponding 95% confidence intervals (CIs) were estimated from beta-coefficients and standard errors of the Cox models. For models predicting time to hospice enrollment, adjusted HRs less than 1.0 signify lower rates of hospice enrollment. For models predicting length-of-stay in hospice, adjusted HRs less than 1.0 indicate longer hospice stays.

For patients who enrolled in hospice, Kaplan–Meier estimates of median length of stay were computed, and log-rank tests were used to identify significant differences in hospice length of stay. The distribution of length of stay according to race or ethnicity was examined. First, proportions of patients who had enrolled in hospice within 7 days of death were examined as a potential indicator of late hospice enrollment.[20,21] Because there is no set standard of care and no consensus on what is considered the “optimal amount of time in hospice,” hospice enrollment for 2 months or longer was examined, because it has been used in previous research.[20,22]

RESULTS

Table 1 shows the demographic and clinical characteristics of non-Hispanic whites and AAPIs. Chinese (67.2%) and Filipino (90.6%) Americans were more likely to be foreign born than Japanese Americans (15.3%). In general, all AAPI subgroups were more likely than whites to have gastric and liver cancer. They were also more likely to have been diagnosed with distant metastases and were more likely than whites to die within 6 months of diagnosis.

Table 2 shows the percentage of hospice enrollment according to ethnic group and time to hospice enrollment after adjustment for demographic and clinical factors. For all ethnic groups, AAPIs had lower rates of hospice enrollment than white patients after adjustment for demographic and clinical factors.

Of those who enrolled in hospice (Table 3), Japanese Americans had a shorter median length of stay (21 days) and Filipino Americans had a longer median length of stay (32 days) than whites (26 days). These differences persisted after adjustment for demographic and clinical factors. Overall, approximately 20% of patients enrolled within 7 days of death, and only 6% had hospice stays that were longer than 2 months; there were no important differences across ethnic groups in the proportion who enrolled within 7 days of death and those who enrolled for more than 2 months (results not shown, available upon request).

DISCUSSION

To the authors' knowledge, this is the first study to examine hospice use in subgroups of older AAPIs with cancer. In every subgroup examined, AAPIs had lower rates of hospice enrollment than whites after adjustment for demographic and clinical characteristics. These findings are similar to those found in other racial or ethnic minority groups. Previous research has shown that African Americans and Latinos are also less likely to enroll in hospice than non-Hispanic whites.[6,8,9] Although ethnic minorities constitute more than 25% of the U.S. population, they represent only 18% of patients enrolled in hospice.[9]

Systemic barriers related to the Medicare Hospice Benefit legislation may result in lower enrollments among minorities. For example, Medicare requires that a full-time caregiver be present to care for the patient.[23] This requirement was a deterrent to hospice enrollment for minority patients who did not have family members nearby or whose family members were working.[23,24] Furthermore, to be eligible for the Medicare Hospice Benefit, patients must provide informed consent, which involves knowledge and acceptance of a terminal diagnosis and prognosis.[3] Inherent in this requirement are Western values of individual patient autonomy and informed consent. Many AAPIs prefer a family-centered model of decision-making.[25–27] This family-centered model of decision-making, along with the principle of "filial piety," may result in families not wanting patients to know about their terminal prognosis. Filial piety (the moral obligation of children to care for elderly parents) is prominent in many Asian cultures.[27,28] Filial piety may lead family members to want to "protect" the patient from the knowledge of a terminal prognosis in order prevent despair and maintain hope. Thus, family members may not want to have the patient sign the statement choosing hospice care instead of curative therapies, as required by the Medicare Hospice Benefit.

The current study found that, of AAPIs who enrolled in hospice, Japanese Americans were more likely to enroll later than whites. Studies have shown that many Japanese and Japanese Americans prefer nondisclosure of a terminal diagnosis and prognosis to the patient.[26,29,30] In Japan, terminally ill patients often rely more on the family and the physician to make end-of-life decisions, and there is less emphasis on patient autonomy. Hospice care may be interpreted as "giving up" on the patient, because disease-modifying treatments are commonly unavailable in hospice. This can result in high levels of emotional distress for family members who must make that decision.[31] In addition, non-verbal communication (*ishin-denshin*) is especially important in Japanese culture.[26] Thus, even in Japanese who favor the disclosure of a terminal prognosis, many desire that physicians use nonverbal cues and implicit communication rather than explicit statements. Thus, the requirements of Medicare Hospice Benefit for full patient disclosure may act as barriers to hospice enrollment. In Japan, in contrast to the United States, patients can be enrolled in hospice without signing "informed consent."[32]

The study also showed that Filipino Americans were more likely to enroll earlier and have longer hospice stays than white patients. The reasons for these findings are unclear. In contrast to other AAPI subgroups, many Filipino Americans tend to be more "Westernized" because of Spanish colonial influences; speak English, thus possibly having less of a language barrier when discussing sensitive end-of-life decisions with their providers; and are predominantly Roman Catholic.[33] Catholics believe in eternal life and see death as the ultimate union with God. Catholic institutions (such as Catholic-affiliated hospitals and healthcare systems) also have had long-standing involvement in the hospice movement.[34,35] Thus, as Catholics, Filipino Americans may regard hospice as an acceptable option at the end of life. Although patients' religious affiliations were not obtainable in this study, it is possible that patients' religions influenced their views of hospice.[36] The findings of the current study differ from those of another study that found that Filipinos in Hawaii were less accepting of hospice than other ethnic groups,[37] although those results were obtained from a random-digit survey of the general

population and may not reflect the views of older Filipino patients with terminal cancer like those in this sample.

This study has several limitations. First, SEER ascertains information on patients' race or ethnicity from medical records. Nevertheless, misclassification of race or ethnicity is unlikely to be related to hospice use and would bias the results toward the null. Second, the completeness and reliability of cancer registry data for place of birth vary between patient subgroups, although deceased patients are more likely to have complete data than living patients, possibly because of additional information obtained from patients' death certificates.[38] Third, data on patients' acculturation levels (degree of assimilation to the dominant culture) were not available in this dataset. More-acculturated patients may be more accepting of hospice. Fourth, information was not available on patient's preferences for care and on physician specialty or practice patterns that may lead to differences in hospice referral. Finally, these data reflect hospice use only until 1998, although it is unlikely that the patterns of hospice use of AAPIs have changed substantially since then.

A culturally sensitive model of hospice for AAPIs may involve simultaneous curative and hospice services, less emphasis on patient autonomy and "truth telling" and more emphasis on family-centered decision-making, and a home-based hospice model. In the last few years, new models of hospice have emerged that allow physicians to bridge the gaps between traditional "curative" and "hospice" care.[39,40] Physicians assess palliative needs continuously throughout treatment. As the disease progresses, physicians shift focus from more disease-directed to more palliation-directed therapy.[39] This gradual transition does not require the dichotomization of "curative" versus "hospice" care and may be more acceptable to AAPI patients. In addition, a hospice model that allows the patient to delegate decision-making to family members may be more culturally appropriate. In many AAPI cultures, medical decision-making is regarded as a duty of the family, whose responsibility is to protect the dying patient from the burden of making difficult decisions.[27] Clinicians establish with the patient who should receive all medical information and make medical decisions. If the patient designates someone other than himself to have this responsibility, this preference for a proxy can be documented in the medical chart and honored as the patient's wish.[27] Finally, home-based hospice models that allow patients to receive intense skilled palliative care while at home, often with family members as paid caregivers, may be more acceptable to AAPI patients.[40] Home-based hospice models allow the family to be the primary caretaker, thus fulfilling the cultural "filial piety" duty that is required. Fulfilling family obligations is especially important in Asian cultures, because how well families fulfill their duties is often open to community scrutiny and judgment. Thus, the family saves "face" if its members take care of their own at the end of life.

Decisions to use hospice services near the end of life exist in a cultural context.[27,41] For AAPIs, cultural values and norms that conflict with the Medicare Hospice Benefit requirements may result in low hospice enrollment. More research is needed on patients' values and preferences and physicians' hospice referral patterns for ethnically diverse patients. Physicians can be educated and trained to be sensitive to cultural barriers to hospice use.[41] These efforts may lead to better understanding and decreasing potential barriers to hospice care for older minority patients with cancer.

Acknowledgments

We thank Dr. Frederick Li and Dr. Moon Chen, members of the Asian American Network for Cancer Awareness, Research, and Training (AANCART) Network, for their support of this study. This study used the linked SEER–Medicare database. The interpretation and reporting of these data are the sole responsibility of the authors. We acknowledge the efforts of several groups responsible for the creation and dissemination of the Linked Database, including the Applied Research Program, Division of Cancer Control and Population Sciences, National Cancer Institute (NCI); the Office of Information Services and the Office of Research, Development, and Information, Centers

for Medicare and Medicaid Services; Information Management Services, Inc.; and the SEER Program Tumor Registries.

References

1. Institute of Medicine. Describing death in America: What we need to know. Washington, DC: National Academy of Sciences; 2003.
2. Institute of Medicine. Approaching death: Improving care at the end of life. Washington, DC: National Academy of Sciences; 2003.
3. Health Care Financing Administration. The Medicare hospice benefit. [Accessed August 9, 2007]. Publication No. HCFA 02154 [on-line]. Available at http://www.medicare.gov/Publications/Pubs/pdf/02154.pdf
4. Wallston KA, Burger C, Smith RA, et al. Comparing the quality of death for hospice and non-hospice cancer patients. Med Care 1988;26:177–182. [PubMed: 3339915]
5. Miller, GW.; Williams, JR.; English, DJ., et al. Delivering quality care and cost-effectiveness at the end of life. Alexandria, VA: National Hospice and Palliative Care Organization; Feb. 2002
6. Crawley L, Payne R, Bolden J, et al. Palliative and end-of-life care in the African-American Community. JAMA 2000;284:2518–2521. [PubMed: 11074786]
7. Krakauer EL, Crenner C, Fox K. Barriers to optimum end-of-life care for minority patients. J Am Geriatr Soc 2002;50:182–190. [PubMed: 12028266]
8. Omara AM, Arenella C. Minority representation, prevalence of symptoms, and utilization of services in a large metropolitan hospice. J Pain Symptom Manage 2001;21:290–297. [PubMed: 11312043]
9. National Hospice and Palliative Care Organization. NHPCO's Facts and Figures—2005 Findings. 2006
10. Barnes, JS.; Bennett, CE. The Asian Population: 2000. Washington, DC: U.S. Census Bureau; 2002. C2KBR/01-16
11. Asian American Populations. [Accessed July 18, 2007]. [on-line]. Available at http://www.cdc.gov/omh/Populations/AsianAm/AsianAm.htm
12. Reeves, T.; Bennett, C. The Asian and Pacific Islander Population in the United States: March 2002. Washington, DC: U.S. Census Bureau; May. 2003 p. P20-540.
13. Ngo-Metzger Q, McCarthy EP, Burns RB, et al. Older Asian Americans and Pacific Islanders dying of cancer use hospice less frequently than older white patients. Am J Med 2003;115:47–53. [PubMed: 12867234]
14. Shinagawa SM, Kagawa-Singer M, Chen MS, et al. Cancer registeries and data for Asian Americans and Native Hawaiians and Pacific Islanders: What registrars need to know. J Registry Manage 1999;26:128–141.
15. Grieco, EM. The Native Hawaiian and Other Pacific Islander Population: 2000. Washington, DC: U.S. Census Bureau; Dec. 2001 C2KBR/01-14
16. Potosky A, Riley G, Lubitz J, et al. Potential for cancer related health services research using a linked Medicare-tumor registry database. Med Care 1993;31:732–748. [PubMed: 8336512]
17. Surveillance Implementation Group (SIG). Cancer surveillance research implementation plan. National Cancer Institute, National Institutes of Health; [Accessed August 1, 2007]. [web]. March 1999 [on-line]. Available at http://cancercontrol.cancer.gov/sig/
18. Bach PB, Guadagnoli E, Schrag D, et al. Patient demographic and socioeconomic characteristics in the SEER-Medicare database applications and limitations. Med Care 2002;40(8 Suppl):IV-19–IV-25.
19. Warren JL, Klabunde CN, Schrag D, et al. Overview of the SEER-Medicare data: Content, research applications, and generalizability to the United States elderly population. Med Care 2002;40(8 Suppl):IV-3–IV-18.
20. McCarthy EP, Burns RB, Ngo-Metzger Q, et al. Hospice use among Medicare managed care and fee-for-service patients dying with cancer. JAMA 2003;289:2238–2245. [PubMed: 12734135]
21. Christakis NA, Escarce JJ. Survival of Medicare patients after enrollment in hospice programs. N Engl J Med 1996;335:172–178. [PubMed: 8657216]

22. Last Acts. Means to a better end: A report on dying in America today. [Accessed March 7, 2007]. [on-line]. Available at http://www.lastacts.org/files/misc/meansfull.pdf
23. Gordon AK. Hospice and minorities: A national study of organizational access and practice. Hosp J 1996;11:49–70. [PubMed: 8920311]
24. Pawling-Kaplan M, O'Connor P. Hospice care for minorities: An analysis of a hospital-based inner city palliative care service. Am J Hosp Care 1989;6:13–21. [PubMed: 2604978]
25. Blackhall LJ, Frank G, Murphy ST, et al. Ethnicity and attitudes towards life sustaining technology. Soc Sci Med 1999;48:1779–1789. [PubMed: 10405016]
26. Matsumura S, Bito S, Liu H, et al. Acculturation of attitudes toward end-of-life care: A cross-sectional survey of Japanese Americans and Japanese. J Gen Intern Med 2002;17:531–539. [PubMed: 12133143]
27. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "You got to go where he lives. JAMA 2001;286:2993–3001. [PubMed: 11743841]
28. McLaughlin LA, Braun KL. Asian and Pacific Islander cultural values: Considerations for health care decision making. Health Soc Work 1998;23:116–126. [PubMed: 9598394]
29. Fetters MD, Masuda Y. Japanese patients' preferences for receiving cancer test results while in the united states: Introducing an advance directive for cancer disclosure. J Palliat Med 2000;3:361–374. [PubMed: 15859685]
30. Ruhnke GW, Wilson SR, Akamatsu T, et al. Ethical decision making and patient autonomy: A comparison of physicians and patients in Japan and the United States. Chest 2000;118:1172–1182. [PubMed: 11035693]
31. Morita T, Akechi T, Ikenaga M, et al. Communication about the ending of anticancer treatment and transition to palliative care. Ann Oncol 2004;15:1551–1557. [PubMed: 15367417]
32. Suzuki S, Kirschling JM, Inoue I. Hospice care in Japan. Am J Hosp Palliat Care 1993;10:35–40. [PubMed: 7687141]
33. U.S. Census Bureau. General demographic characteristics for the Asian population. [Accessed February 2, 2007]. [on-line]. Available at http://www.census.gov/population/cen2000/phc-t15/tab01.pdf and http://www.census.gov/population/cen2000/phc-t15/tab04.pdf
34. Morrison RS, Maroney-Galin C, Kralovec PD, et al. The growth of palliative care programs in United States hospitals. J Palliat Med 2005;8:1127–1134. [PubMed: 16351525]
35. Care of the dying: A Catholic perspective. Part III: Clinical context—good palliative care eases the dying process. Catholic Health Assoc 1993;74:22–26. 31.
36. Puchalski CM, O'Donnell E. Religious and spiritual beliefs in end of life care: How major religions view death and dying. Tech Reg Anesth Pain Manage 2005;9:114–121.
37. Braun KL, Onaka AT, Horiuchi BY. Advance directive completion rates and end-of-life preferences in Hawaii. J Am Geriatr Soc 2001;49:1708–1713. [PubMed: 11844007]
38. Lin SS, O'Malley CD, Lui SW. Factors associated with missing birthplace information in a population-based cancer registry. Ethn Dis 2001;11:598–605. [PubMed: 11763284]
39. Meyers FJ, Linder J, Beckett L, et al. Simultaneous care: A model approach to the perceived conflict between investigational therapy and palliative care. J Pain Symptom Manage 2004;28:548–556. [PubMed: 15589080]
40. Ciemins EL, Stuart B, Gerber R, et al. An evaluation of the advanced illness management (AIM) program: Increasing hospice utilization in the San Francisco Bay Area. J Palliat Med 2006;9:1401–1411. [PubMed: 17187548]
41. Searight HR, Gafford J. Cultural diversity at the end of life: Issues and guidelines for family physicians. Am Fam Physician 2005;71:515–522. [PubMed: 15712625]

Table 1

Demographic and Clinical Characteristics of Non-Hispanic White and Asian-American and Pacific Islander Patients (AAPIs)

Characteristic	Whites (n = 175,467)	AAPIs				
		Chinese (n = 2,145)	Japanese (n = 3,510)	Filipino (n = 1,781)	Hawaiian/Pacific Islanders (n = 856)	Other Asians (n = 322)
Demographic factors						
Mean age at diagnosis	75.9	76.2	75.9	76.4	73.6	74.9
Male, %	60.0	61.3	65.8	79.5	56.8	64.9
Married, %	55.1	62.8	65.0	68.6	50.7	63.4
Enrolled in managed care, %	8.7	30.8	41.9	20.2	33.5	12.1
Lived in urban ZIP code, %	79.5	98.2	77.5	81.5	72.3	97.2
Lived in ZIP code with income < $25,000), %	14.0	14.6	6.4	9.9	9.3	12.4
Foreign born, %	9.1	67.2	15.3	90.6	3.0	71.4
Cancer characteristics						
Primary cancer type, %						
Lung	27.6	34.6	22.2	26.8	34.2	35.4
Colorectal	25.6	29.1	28.3	22.6	17.2	16.5
Breast	17.2	7.8	8.2	5.3	16.9	5.0
Prostate	25.1	15.0	20.7	35.3	18.7	14.3
Gastric	3.6	7.1	17.9	5.8	10.6	17.7
Liver	0.9	6.3	2.8	4.2	2.3	11.2
Diagnosed with distant metastases	24.6	32.3	26.2	30.5	30.5	31.7
Died within 6 months of diagnosis	20.9	27.2	21.6	22.3	23.3	37.6

J Am Geriatr Soc. Author manuscript; available in PMC 2009 November 11.

Table 2

Hospice Enrollment According to Race or Ethnicity and Place of Birth

Race or Ethnicity and Place of Birth	n	Enrolled in Hospice, n (%)	Hospice Enrollment, Adjusted HRs (95% Confidence Interval)*
Race or ethnicity			
Non-Hispanic white	175,467	35,569 (20.3)	1.00
Chinese	2,145	384 (17.9)	0.62 (0.55–0.69)
Japanese	3,510	702 (20.0)	0.67 (0.60–0.73)
Filipino	1,781	270 (15.2)	0.61 (0.54–0.70)
Hawaiian or Pacific Islander	856	209 (24.4)	0.78 (0.67–0.91)
Other Asians	322	67 (20.8)	0.70 (0.55–0.90)
Place of birth			
United States	164,331	34,002 (20.7)	1.00
Foreign born	19,750	3,199 (16.2)	0.97 (0.93–1.01)

*Adjusted hazard ratios (HRs)<1.0 signify lower rates of hospice enrollment. Adjusted for age at diagnosis; sex; marital status; managed care enrollment; residence in rural area; median household income of ZIP code of residence; Surveillance, Epidemiology, and End Results registry; year of diagnosis; primary cancer type; and stage at diagnosis.

Table 3

Length of Stay in Hospice According to Race or Ethnicity and Place of Birth

Race or Ethnicity and Place of Birth	n	Median Length of Stay in Hospice, Days (Q1, Q3)*	Length of Stay in Hospice, Adjusted HR (95% Confidence Interval)†
Race or ethnicity			
Non-Hispanic white	35,335	26 (9, 68)	1.00
Chinese	382	26 (9, 72)	1.00 (0.89–1.13)
Japanese	697	21 (9, 53)	1.20 (1.08–1.32)
Filipino	270	32 (12, 98)	0.83 (0.72–0.95)
Hawaiian or Pacific Islander	209	25 (9, 68)	0.97 (0.82–1.14)
Other Asian	67	31 (8, 88)	0.93 (0.73–1.29)
Place of birth			
United States	34,002	26 (9, 68)	1.00
Foreign born	3,199	26 (10, 70)	1.00 (0.96–1.04)

*Interquartile range: 25th and 75th percentiles.

†Adjusted hazard ratios (HRs)>1.00 indicate shorter length of stay and <1.00 indicate longer length of stay. Adjusted for age at hospice entry; sex; marital status; managed care enrollment; residence in rural area; median household income of ZIP code of residence; Surveillance, Epidemiology, and End Results registry; year of hospice entry; primary cancer type; stage at diagnosis; and illness duration.

Published in final edited form as:
Palliat Med. 2010 June ; 24(4): 427–434. doi:10.1177/0269216310366605.

"The Worst Thing About Hospice Is That They Talk About Death": Contrasting Hospice Decisions and Experience among Immigrant Central and South American Latinos to US-born White, Non-Latino Cancer Caregivers

Send Correspondence to: Jeanne Mandelblatt, MD, MPH, Department of Oncology, Cancer Control Program, Georgetown University Medical Center, 3300 Whitehaven St. NW, Ste 4100, Washington, DC 20007, mandelbj@georgetown.edu, Phone: 202-687-0812, Fax: 202-687-0305.

The Latin American Cancer Research Coalition includes:

Stacey Banks

Larisa Caicedo MA

Janet Cañar MD, MPH

Michael Dalious MA

Marguerite Duane MD, MHA

Kirsten Edmiston MD

Karol Espejo

Ronald Greger MD

Margarita Gutierrez

Elmer E. Huerta MD, MPH

Anna Maria Izquierdo-Porrera, MD

Barbara Kreling PHD, MPH

Maria Lopez-Class PhD, MPH

Gheorge Luta PhD

Jeanne Mandelblatt MD, MPH

Barbara Merritt RN

Noel Mueller MPH

Nancy Pallesen MSW

Margarita Paredes MD

Monique Perret-Gentil MD, MS

Jyl Pomeroy RN

Dino W. Ramzi MD, MPH

Christine Reesor MSN, FNP

Juan Romagoza, MD

Michael A. Sanchez MPH, CHES

Claire Selsky MA

Cherie Spencer MS

Alicia Wilson

Bin Yi MS

Barbara Kreling, PhD, MPH[1], **Claire Selsky, MA**[1], **Monique Perret-Gentil, MD, MS**[1], **Elmer E. Huerta, MD, MPH**[1], **Jeanne S. Mandelblatt, MD, MPH**[1], and **For the Latin American Cancer Research Coalition**

[1]Cancer Control Program, Lombardi Comprehensive Cancer Center, Georgetown University Medical Center, Washington, DC

Abstract

Hospice care is promoted as a model for improving end of life care and decreasing burden on caregivers. However, hospice use is low in Latinos and little is known about how Latinos make hospice decisions and experience hospice once enrolled. We used qualitative methods to conduct in-depth interviews and focus groups with 15 Latino bereaved hospice family caregivers and 15 White Non-Latino bereaved hospice family caregivers to describe hospice experiences and evaluate whether cultural factors affected the experience. We identified differences in decision-making and caregiving experience that were influenced by culture. For example, cultural values of denial, secrecy about prognosis and a collective, family-centered system influenced hospice decisions and experience in Latinos but not Non-Latinos. This study identifies a significant dilemma; that is, how to discuss hospice with a patient and family who prefer not to discuss a terminal prognosis. Future research is needed to extend these preliminary results; such results may be useful for designing interventions to improve end of life care and caregiving in Latinos.

Keywords

Hospice; Latino; End of Life; Cancer; Caregiving; Communication

Introduction

Latinos now make up approximately 15% of the U.S. population and are projected to be the largest minority group by the year 2015.[1–2] Cancer is the second leading cause of death in this growing population.[3] Over the coming decades these demographic trends, coupled with the aging of the Latino population, will create an increased need for end of life services for this group.

Hospice is a major model for end of life care. However, Latinos have been less likely than White Non-Latinos to use hospice services, even though their needs may be greater.[4–6] For instance, Latino patients may be under-treated for cancer pain,[7–9] and their caregivers may have more depression in the bereavement period than Non-Latino caregivers.[10] Recently, there has been an increased effort by hospice organizations to reach out to Latinos.[11] However, little is known about how Latinos make decisions about hospice care or how they experience hospice care once enrolled. Moreover, despite some research on ethnic and cultural differences in attitudes toward death and dying,[12–18] there are limited data on whether Latino cultural values affect hospice decisions. Latino cultural values that may affect end of life care decisions include the emphasis on the family vs. individuals (collectivism), family decision-making (familism), and preferences for indirect communication (e.g., prognosis is not discussed openly).[12,15,19–21] In contrast, studies of cancer communication in White non-Latino cancer patients show that this group generally wants prognostic information and values autonomy based on information.[22] Since hospice is based on the principles of patient autonomy and acceptance of death,[23] it is possible that Latino communication preferences and cultural norms may conflict with acceptance and use of hospice services. There is a paucity of data to address this question and most of what we do know about Latinos and end of life care comes from research with Mexican Americans.[12,16,19,24] The goal of this study is to begin to fill gaps in our knowledge about

cultural influences on hospice use by providing a qualitative description of the hospice decisions and experiences of Central and South American Latino hospice caregivers and comparing them to White non-Latino hospice caregivers from the same urban locale. Our results are intended to generate hypotheses for future research about how to best educate health care providers about Latinos' end of life preferences and to suggest potential interventions to improve the quality of care for broader groups of Latinos and their families at the end of life.

Methods

This study was conducted by members of the Latin American Cancer Research Coalition (LACRC). The LACRC is a National Cancer Institute (NCI-funded) Community Network Program based in the metropolitan Washington, DC area. The study protocol was approved by the Institutional Review Board of Georgetown University and the participating hospice.

Setting and Population

We recruited a purposive sample of Latino and White non-Latino cancer caregivers from a large hospice in the metropolitan Washington, DC area. Criteria for inclusion were being an adult (21 and older) primary caregiver for a cancer patient that had died in the US within the past 12 months and having used hospice for care of the patient. Participants were contacted by the hospice and asked to participate. They were given written and oral information about the study in English and Spanish and provided written or oral consent in the language they preferred. Caregivers either attended focus groups held at the hospice or were interviewed individually by telephone. Participants were given a $20.00 stipend for their time and participation.

We interviewed a total of 15 Latino hospice family caregivers and 15 White non-Latino hospice caregivers. Although recruitment methods were the same for both groups, Latinos were much more difficult to recruit than White non-Latinos, especially for focus groups. There were several reasons that Latinos were difficult to recruit for the study. First, there was only a small potential sample of Latino hospice users. Next, we had anecdotal evidence that many Latinos returned to their native countries at the end of life. Third, many of the Latino caregivers of cancer patients that did use hospice related that they were not comfortable talking in a group about this topic, since it was considered private, or secret, information. Therefore, we offered to interview these caregivers individually (n=5). This option was also offered to the White non-Latino group, but they were all comfortable with the focus group setting.

Focus groups and individual interviews were conducted in Spanish or English according to the respondent's language preference. Groups were moderated by Dr. Barbara Kreling of the LACRC and a trained bilingual hospice staff member. In-depth interviews followed the same guide as for the focus groups and were conducted by two bilingual staff members.

Instruments and Procedures

We developed a protocol and probes for group discussion and interviews based on themes suggested by the work of Colon (2003), Kagawa-Singer (2001) and Barclay (2007) concerning communication styles and the role of the family in end of life decisions.[5,25–26] The protocol was developed to encourage a discussion of the family's role and the caregivers' experiences. The protocol included establishing rapport and creating a respectful, listening environment. Examples of the primary prompts used in each group/interview included: 1) what did you, as a caregiver, know about hospice before the patient's illness; 2) how was the hospice decision made? Who referred the patient; 3) how did the

caregiver and patient communicate with doctors and with each other about prognosis; 4) who was in charge of decisions, the patient or family; 5) how were hospice care and the death in hospice experienced; and 6) did the family want more or less information about the death than they were given. Groups lasted approximately two hours and in-depth interviews ranged from 30 minutes to 90 minutes. Each caregiver also completed a brief demographic questionnaire.

All interviews and focus groups were audio-taped with permission. The tapes were transcribed and Spanish tapes were translated into English. Translations were reviewed by bilingual staff.

Data Analysis

Responses were compiled and two researchers read the complete set of transcripts to identify salient themes, recurring ideas or terms and patterns of beliefs.[27–29] Specific transcript passages were clustered under the themes within each interview question. This process was conducted separately for Latinos and White non-Latinos and results were then compared question by question. Contrasts that emerged were confirmed by reexamining all the data.

We linked resulting thematic data to cultural views using several steps.[30] First, we compared results for both groups to explore whether differences might represent an underlying cultural belief or value. Next, we compared our data with existing literature from both cultures and with established theories about cultural norms.[27–29] Last, we assumed that themes unique to the Latino participants were related to the group context or from cultural beliefs. For instance, the theme of secrecy was identified in our data. We compared this theme to existing literature about Latinos and end of life discussions and to existing literature about Whites and end of life discussions. This theme was consistent with other findings for Latinos but not for Whites, suggesting a cultural link. Following the process of identifying potential cultural linkages we selected representative quotations to provide depth and to illuminate salient themes.

Results

The hospice caregivers in this sample were well educated, with 100% of the White non-Latinos and 87% of the Latinos reporting some college or a college degree; similar proportions of each ethnic group were insured (100% and 87%, respectively for White non-Latinos and Latinos). Caregiver ages ranged from 38 to 88 years (mean 55.1 years, SD 13.3). Hospice caregivers were either daughters (14 of 30) or spouses of patients (13 of 30). The patient family members they cared for were between 17 and 93 years old and they had various types of cancer. Overall hospice length of stay ranged from 1 to 180 days (mean 39 days, SD 43.7); in this small sample there was no significant difference in the length of stay by ethnic group (p=.56).

The Latino caregivers were primarily from Central or South America and had been in the US for an average of 23.6 years (range 7 to 40 years); only two Latino caregivers had been in the US for less than 10 years. The Latinos were all bilingual, with 12 of 15 reporting “very good” English proficiency. There appeared to be differences between Latino and White non-Latino cancer caregivers in hospice knowledge, hospice decision-making, and communication and hospice experience (Table 1).

What did families know about hospice before the patient’s illness?

Most White non-Latino hospice caregivers had knowledge of hospice before the patient’s illness. Many had experience with hospice caring for another relative. In only one case did the caregiver think hospice was just a place rather than home and institutional services. In

contrast, few Latinos who used hospice had previous experience with hospice. Most had misconceptions about hospice or no knowledge before the patient was enrolled. For instance, most thought hospice was a place for poor, old people or a place for paralytic people:

> *"I didn't know what hospice was. I thought it was a place worse than a hospital*."

How was the hospice decision and referral made?

For White non-Latinos, a decision to use hospice was made by the patient and family after a recommendation from an oncologist and discussion about the effectiveness of treatment and prognosis:

> Following a discussion of the results of chemotherapy, the doctor said she doesn't have more than 6 months to live. *"He said she was terminal. Our three sons were there. The doctor suggested hospice*."
>
> All conversations with the doctor were with both patient and husband. They asked an oncologist, *"How much time?"* In this meeting, he said, *"call hospice"*.

In contrast, Latinos reported the hospice decision as taking place during a crisis hospitalization. They said they were referred by (various) persons in the hospital, not a physician, but that they didn't know the profession of the person who referred them:

> On an emergency hospital visit, *"As soon as we went inside the hospital there was a young lady that asked me if someone had ever explained to me about hospice. I told her no. Soon after I gave her my phone number I left. Just as I came in my door at home someone called me*."

Thus, it appears that there might be ethnic group differences in knowledge and referral processes.

Was the dying experience different for Latino than for White non-Latino caregivers?

In dealing with death and dying, White non-Latino caregivers were open about prognosis, acknowledging that hospice enrollment meant the patient would die. This information was also useful to the caregiver and patient:

> *"We asked the oncologist to tell us how much time she had. The doctor said, 'Call hospice.' So we called hospice. The hospice nurse told us how close she [the patient] was (to the death) and told him when to call our sons." "Hospice was so reassuring*," the husband said.

Latino caregivers did not express this openness about and acceptance of death. Rather, many Latino caregivers reported denial, preferences for less information, and maintaining secrecy about prognosis. For instance, persistent denial was maintained by many Latino caregivers, even after enrollment in hospice, despite information given by physicians and hospice staff:

> *"I had a lot of faith. I thought I was lucky and that he was getting better. He was already at hospice but I did not think he was going to die. Then the day the doctor called me and told me come tomorrow because 'he is dying'..... I never thought that he was leaving me…*."

White non-Latino caregivers reported valuing information about the details of what to expect when the patient was dying:

> *"Hospice made me 'comfortable' by telling me what was going to happen near the end*."

In contrast, Latino caregivers did not want detailed information about death and the dying process. One said:

> *"They gave me a pamphlet of what to expect. It explained all the steps my mother would go through until the day she would die. I did not want to read it. It was a plan or a guide I did not want to know or wanted to do. They told me I had to read it to be prepared. Even though it was practical advice about how to handle "the end" I felt it was very drastic*."

Non-Latino caregivers were comfortable with discussions of prognosis between doctor and patient and between doctor and family:

> A woman whose father was diagnosed with colon cancer said, *"....the Primary Care doctor told him. Dad then talked about 'passing' to all of us*."

Most Latinos, however, reported being surprised and disturbed by the open communication in hospice with patients and caregivers about death:

> *"The worst thing about using hospice care? The way they talk to you about death*."

Latino caregivers also reported feeling that truth telling about prognosis was harmful to the patient and cruel to the family. Latino caregivers felt that it was their responsibility to protect the patient from the knowledge of his or her illness, to deny death was imminent, and to act as if the patient were getting well. In most families, they would not discuss the family member's death among themselves because they didn't want to "hurt" each other:

> *"Well, as a Latino the fact that they tell you straightforward that your husband is dying..... the doctor tells you 'he is at the end of his life'; it sounds a little cruel… I knew there was no cure for him. Everything they were doing for him was palliative, that all the medicine that was used for nausea and vomiting was palliative only. However, still it made me angry when the doctor told me he is dying*."

Were there cultural differences in who was in control of decisions?

White non-Latino caregivers reported that patients felt they were in control of their own decisions, with few exceptions. Some maintained control by choosing when and how to tell other family members about their diagnosis or prognosis. For instance, some chose not to tell grown children about the recurrence of cancer until near the end.

> *A husband stated "My wife shared all her discussions with her doctor with me. The Doc said she had less than one year so we called hospice. My wife made all her own decisions. We have five children. She didn't let them know about her cancer until we got hospice*."

In Latino families, however, control resided with the family and the patient was "protected" from information and the responsibility of making decisions:

> One woman made decisions for her mother together with her five sisters. She said, *"Talking about hospice (to her mother) was tricky. The last chemo she was feeling really, really bad, it just was brutal on her.... we said Mom, we are going to stop treatment until you gain a little bit more weight… you can take the chemo again, we don't know how long it's going to be. And they (hospice staff) would use the badge that said palliative care. She didn't realize that she was having hospice care, no. I think that's probably because of what she and I had talked about way before during her first cancer that she just didn't want to know. And I think that's a pretty Latin American way of thinking*."

Were there differences in satisfaction with hospice?

White non-Latinos had positive expectations for hospice care because of previous knowledge or experience. Although they were mostly satisfied with care, some complained about not getting enough service or that hospice was not there at night when needed. Interestingly, Latinos were more satisfied with hospice than Whites since they had low or no expectations and were positively surprised by hospice services.

Discussion

This is one of the few studies of cancer caregiving in Central and South American Latinos. Our results suggest that there may be cultural differences between this Latino group and White non-Latinos. Although each case is unique and stereotyping is to be avoided, in our sample Latino caregivers reported being more secretive about death than White caregivers and preferred not to receive detailed information about the dying process. In addition, Latino families were the primary locus of decision making control while patients made more of their own decisions in White families. Finally, it seems that there were differences between Latinos and White non-Latinos in knowledge about hospice and pathways to utilization of hospice services.

Our finding that Central and South American Latinos held a lot of denial and preferred not to talk directly about end of life care is consistent with what is known about general Latino cultural preferences for indirect communication.[12,16,19,24] In addition, it appears from our results that the family is the locus of communication in Latino families, shielding the patient from information they believe might be harmful to the patient. A corollary of this family-centric channel of communication was that the family was the decision making body. Others have observed similar results about communication, family roles and/or denial in Latinos from Mexico, Central America and Cuba.[12,16,19,24]

The observation that White non-Latinos preferred more direct discussions and to gather more information than Latinos has also been noted in other studies.[12, 22] For instance, a recent study of 116,974 bereaved family members (97% White, non-Latino) found that regular and honest communication and information about the patient's condition was strongly associated with rating hospice care as "excellent".[31] Indeed, the standard medical practice is to speak openly and directly to patients about the death and dying process. However, our results support prior research on cultural communication preferences and suggest that providers may need to use a somewhat less direct approach when discussing end of life care with Latino families. Quantitative surveys of larger, more representative samples and direct observations of communication during encounters for end of life care will be important to better understand how to deliver bad news and prepare Latino patients and their families for death in a culturally competent manner. Approaches that have been suggested are to assess each case individually to avoid stereotyping by using case structured assessment tools and employing culturally tailored strategies for delivery of bad news.[12–13,25–26]

Hospice knowledge is low in the general US population.[32] Most persons believe hospice to be an institutional setting for end of life care, and do not know that hospice includes at-home services. As was seen in our study, minority group members seem to have even less information about hospice than the general population.[20,33] Hospice translates to *hospicio* in Spanish, meaning "orphanage" or "place for poor people." Thus, end of life discussions with Latinos may need to include more education about hospice than is required for Non-Latinos. Our results also suggest that educational materials may need to be culturally tailored to Latino communication preferences (i.e., using indirect means of talking about death) and be targeted to families, not just translated from English materials.

Latinos in our study were less likely to report being referred by an oncologist than White non-Latinos. Perhaps the family's preference for secrecy influenced the oncologist not to discuss and refer patients to hospice. Alternatively, providers may perceive Latino patients as being un- or under-insured for hospice care and so may not initiate these discussions. Another possible explanation for the patterns of referral we observed may be related to language barriers. This idea is supported by the result of Taxis and colleagues who noted that Mexican-American Latinos reported language barriers to using hospice services.[20] Colon also found that Latinos were less likely than other groups to be referred to hospice by a physician; when they were referred, it was usually by non-physician hospital staff.[5] There have been conflicting results in other studies of physician referral for Latinos at the end of life. For instance, Wallace and Lew-Ting found that minority patients were under-referred to hospice by physicians in the US but Karim and colleagues did not find referral differences by ethnicity in the UK.[34–35] These contradictory results may be related to differences in the health care systems and/or the demographic characteristics of the specific minority populations studied (e.g., related to legal status, insurance coverage, English ability). It will be important to conduct additional research on patient-physician-family communication about hospice in Latinos, given the central role of physicians as authority figures in Latino culture and as the gatekeepers to hospice services.

There are several caveats that should be considered in evaluating our results, including the sample size and characteristics, the use of two modes of data collection and methods of cultural attribution. Caregivers in this qualitative study were a small, purposive, convenience sample of hospice caregivers self-selected to participate. Thus, we could not study barriers to hospice enrollment among non-users. Our Latino caregiver participants were mostly from Central and South America and may be different than Latinos from other U.S. geographic areas that may have more Mexicans, Puerto Ricans, Dominicans, or Cubans. Latinos in our sample were also more acculturated than the population of Latinos in the DC area.[36] This is likely to underestimate the impact of culture on hospice experiences, since well acculturated Latinos are more likely to subscribe to more Americanized views of death and dying.[12]

Combining data from focus group interviews and in-depth telephone interviews may have biased results, although the question protocols were the same. The inclusion of individual interview data may have also resulted in an over-representation of participants reporting concerns about privacy and secrecy surrounding death and dying, although this theme has been reported in other Latino samples. [5,16,37] It will be important to extend our results and further compare Latinos and Whites using the same data collection methods.

The results of this preliminary study identify a potential significant dilemma; that is, how to discuss hospice with a Latino patient and family who may prefer not to discuss a terminal prognosis directly. If confirmed, this "secrecy dilemma" will challenge attempts not only to increase Latino participation in hospice but to provide care for Latinos who are in hospice care.[13–14,21,25–26] In the context of current knowledge, our preliminary results suggest three methods to address the "secrecy dilemma" and other cultural differences in end of life care. First is community education to raise the level of knowledge about palliative and hospice care in the Latino community. Next is the use of case assessment tools to ascertain communication preferences and the family's preferred role in decision-making.[12–13,25–26] Finally, providing culturally-sensitive end of life navigation may help Latino patients and families to communicate with their health care team and obtain hospice services earlier in the process. The cultural sensitivity required for such navigation may require a trained bilingual, bicultural community member who is aware of the values of secrecy and denial as well as familism. He or she could use wording that is sensitive (i.e. "future care" rather than "terminal care") and could assess the family's preferences for communication. Most importantly, he or she could be a familiar contact person and "sounding board" for

information along an unfamiliar journey. Providing high quality end of life care to patients of diverse backgrounds and beliefs remains an important challenge and unmet need.

Acknowledgments

Yosselyn Rodriguez and Janet Cañar, MD, MPH for organizing focus groups and Carlos Gomez, MD, PhD for expert guidance.

This work was supported by grants U01 CA114593 and 2K05CA096940 (JM) from the National Cancer Institute and PEP-08-230-01-PEP1 from the American Cancer Society (BK).

Reference List

1. United States Census Bureau. [Accessed 2008] U.S. Department of Commerce, Economics and Statistics Administration. Population by age, sex, race and Hispanic and Latino origin for the United States. http://www.census.gov/population/www/cen2000/briefs/phc-t9/tables/tab01.pdf
2. Passel, JS.; Cohn, DU. [Accessed 2008] U.S. Population Projections: 2005–2050. Pew Research Center Social and Demographic Trends. http://pewhispanic.org/files/reports/85.pdf
3. American Cancer Society. Cancer Facts & Figures. Atlanta: American Cancer Society; 2009.
4. National Hospice and Palliative Care Organization. Facts and figures on hospice care in America. Washington, DC: National Hospice and Palliative Care Organization; 2007.
5. Colon M, Lyke J. Comparison of hospice use and demographics among European Americans, African Americans, and Latinos. American Journal of Hospice and Palliative Medicine. 2003; 20(3):182–190. [PubMed: 12785039]
6. Lackan NA, Ostir GV, Freeman JL, Kuo YF, Zhang DD, Goodwin JS. Hospice use by Hispanic and non-Hispanic white cancer decedents. Health Serv Res. 2004; 39(1):969–983. [PubMed: 15230937]
7. Juarez G, Ferrell B, Borneman T. Influence of culture on cancer pain management in Hispanic patients. Cancer Pract. 1998; 6(5):262–269. [PubMed: 9767344]
8. Cleeland CS, Gonin R, Baez L, Loehrer P, Pandya KJ. Pain and treatment of pain in minority patients with cancer. The Eastern Cooperative Oncology Group Minority Outpatient Pain Study. Ann Intern Med. 1997; 127(9):813–816. [PubMed: 9382402]
9. Werth JL Jr, Blevins D, Toussaint KL, Durham MR. The influence of cultural diversity on end-of-life care and decisions. American Behavioral Scientist. 2002; 46:204–219.
10. Pinquart M, Sorensen S. Ethnic differences in stressors, resources, and psychological outcomes of family caregiving: a meta-analysis. Gerontologist. 2005; 45(1):90–106. [PubMed: 15695420]
11. National Hospice and Palliative Care Organization. [Accessed October, 2008] NHPCO's 2004 Facts and Figures. http://www.nhpco.org/files/public/Facts_Figures_for 2007
12. Blackhall LJ, Frank G, Murphy S, Michel V. Bioethics in a different tongue: the case of truth-telling. J Urban Health. 2001; 78(1):59–71. [PubMed: 11368203]
13. Koenig BA, Gates-Williams J. Understanding cultural difference in caring for dying patients. West J Med. 1995; 163(3):244–249. [PubMed: 7571587]
14. Crawley LM, Marshall PA, Lo B, Koenig BA. Strategies for culturally effective end-of-life care. Ann Intern Med. 2002; 136(9):673–679. [PubMed: 11992303]
15. Braun KL, Onaka AT, Horiuchi BY. End-of-life preferences in Hawaii. Hawaii Med J. 2000; 59(12):440–446. [PubMed: 11191257]
16. Gelfand DE, Balcazar H, Parzuchowski J, Lenox S. Mexicans and care for the terminally ill: family, hospice, and the church. Am J Hosp Palliat Care. 2001; 18(6):391–396. [PubMed: 11712720]
17. Scharlach AE, Kellam R, Ong N, Baskin A, Goldstein C, Fox PJ. Cultural attitudes and caregiver service use: lessons from focus groups with racially and ethnically diverse family caregivers. J Gerontol Soc Work. 2006; 47(1–2):133–156. [PubMed: 16901881]
18. Volker DL. Control and end-of-life care: does ethnicity matter? Am J Hosp Palliat Care. 2005; 22(6):442–446. [PubMed: 16329196]

19. Sabogal F, Marin G, Otero-Sabogal R, et al. Hispanic familism and acculturation: what changes and what doesn't? Hispanic Journal of Behavioral Sciences. 1987; 9(4):397–412.
20. Taxis JC, Keller T, Cruz V. Mexican Americans and Hospice Care: Culture, Control, and Communication. Journal of Hospice & Palliative Nursing. 2008; 10(3):133–141.
21. Tellez-Giron P. Providing culturally sensitive end-of-life care for the Latino/a community. WMJ. 2007; 106(7):402–406. [PubMed: 18030829]
22. Kaplowitz SA, Campo S, Chiu WT. Cancer patients' desires for communication of prognosis information. Health Commun. 2002; 14(2):221–241. [PubMed: 12046799]
23. Clark D. The philosophy of terminal cancer care. Originating a movement: Cicely Saunders and the development of St Christopher's Hospice, 1957–1967. Ann Acad Med Singapore. 1987; 16(1): 151–154. [PubMed: 3592584]
24. Klessig J. The effect of values and culture on life-support decisions. West J Med. 1992; 157(3): 316–322. [PubMed: 1413777]
25. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "You got to go where he lives". JAMA. 2001; 286(23):2993–3001. [PubMed: 11743841]
26. Barclay JS, Blackhall LJ, Tulsky JA. Communication strategies and cultural issues in the delivery of bad news. J Palliat Med. 2007; 10(4):958–977. [PubMed: 17803420]
27. Woolcott, HF. Transforming qualitative data: Description, analysis, and interpretation. Thousand Oaks, CA: Sage; 1994.
28. Marshall, C.; Rossman, GB. Designing qualitative research. Newbury Park, CA: Sage; 1989.
29. Morse, JM.; Field, PA. Qualitative Research Methods for Health Professionals. Thousand Oaks, CA: Sage Publications; 1995.
30. Pasick RJ, Burke NJ. A critical review of theory in breast cancer screening promotion across cultures. Annual Review of Public Health. 2008; 29:351–368.
31. Rhodes RL, Mitchell SL, Miller SC, Connor SR, Teno JM. Bereaved family members' evaluation of hospice care: what factors influence overall satisfaction with services? J Pain Symptom Manage. 2008; 35(4):365–371. [PubMed: 18294811]
32. National Hospice and Palliative Care Organization. Delivering Quality Care and Cost-Effectiveness at the End of Life: Building on the 20-Year Success of the Medicare Hospice Benefit. Washington, DC: National Hospice and Palliative Care Organization; 2002.
33. Rhodes RL, Teno JM, Welch LC. Access to hospice for African Americans: are they informed about the option of hospice? J Palliat Med. 2006; 9(2):268–272. [PubMed: 16629555]
34. Wallace SP, Lew-Ting CY. Getting by at home. Community-based long-term care of Latino elders. West J Med. 1992; 157(3):337–344. [PubMed: 1413781]
35. Karim K, Bailey M, Tunna K. Nonwhite ethnicity and the provision of specialist palliative care services: factors affecting doctors' referral patterns. Palliat Med. 2000; 14(6):471–478. [PubMed: 11219877]
36. Singer, A.; Friedman, S.; Cheung, I.; Price, M. The world in a zip code: Greater Washington, DC as a new region of immigration. Washington, DC: The Brookings Institution; 2001.
37. Smith AK, Sudore RL, Pérez-Stable EJ. Palliative care for Latino patients and their families: whenever we prayed, she wept. JAMA. 2009 Mar 11; 301(10):1047–1057. E1. [PubMed: 19278947]

Table 1

Differences in Caregiver Reports of Hospice Experience by Ethnicity

Topic	White non-Latino Caregivers	Latino Caregivers
Previous Knowledge of Hospice	Most had previous experience with and knowledge of hospice.	A few had previous experience; many had no knowledge or had misconceptions.
Who Referred the Family?	Oncologists as part of prognosis discussion.	Few by oncologist – most from other staff at hospital, such as social worker.
Insurance/Financial Issues	Not raised.	Believed they could not afford service.
Desire for Information	Wanted specific information about what to expect when a person is dying. Wanted information about timing so others could be present for death.	Didn't want death to be discussed openly. Didn't want information about symptoms of imminent death.
Appraisal of Prognosis	Acknowledged that hospice patient was dying.	Didn't fully believe hospice patient was dying.
Openness vs. Secrecy	Patient and caregiver wanted information for decision-making. Some caregivers didn't want to discuss death directly with patient.	Didn't want discussion of death even within the family.
Distrust	Not raised.	Some Latinos thought hospice was a place with inferior care for poor people who were dying.
Autonomy/patient control versus Collectivism/family control	Patient wanted information and made decisions with family. Patient was in charge when able.	Family wanted to receive information and make decisions – not patient. Family was in charge.
Expectations/Satisfaction	High expectations. Satisfied with hospice with some exceptions.	No expectations. Satisfied with hospice in spite of death talk.

King County Community Health Needs Assessment

2021/2022





King County Hospitals for a Healthier Community

Dear reader,

As King County Hospitals for a Healthier Community (HHC), we represent 10 hospitals and health systems throughout the county in partnership with Public Health – Seattle & King County (PHSKC). In June 2020, PHSKC declared racism a public health crisis. We collectively acknowledge the historical and present-day impacts of systemic oppression and racism on the well-being of children, youth, adults, and families in King County. The COVID-19 pandemic has further exposed the intersection of structural racism and health. We oppose racism and are committed to pursuing equity, diversity, and inclusion in the care we provide along with the communities we serve.

The HHC vision is to participate in a collaborative approach for a joint Community Health Needs Assessment (CHNA). We also work together to share ideas and programs in response to community needs and assets, which helps us in ensuring high-quality healthcare and engaging in effective community health improvement. Our goal is to achieve better health and health equity for all King County residents.

We know that access to affordable, high-quality, and equitable healthcare is a key contributor to physical and mental well-being as well as overall community wellness. We also know that clinical care accounts for only a small portion of what contributes to health. The social conditions in which we are born, live, learn, work, and play contribute more to overall well-being. Racism and systemic oppression influence health outcomes by affecting social conditions as well as contributing to trauma that spans generations and persists throughout an individual's life span. Beyond its impact on access to high-quality healthcare, racism impacts access to education, housing, employment, nutrition, joy, and wellness — everything that communities need to thrive.

To illustrate these continuing inequities, this CHNA provides information organized by race, ethnicity and place. We have also learned about community-identified priorities to help guide us in what needs to be done. These findings will help inform our Community Benefit strategies, programs, services, and partnerships.

In this report, you will find examples of how we have collaborated with community-based organizations, as well as opportunities for clinics, public health, neighborhoods, and families to work together in developing locally driven and supported strategies to foster healthier, more equitable communities. We are committed to continuing to learn and respond to pressing needs, such as the impacts of COVID-19 on residents across King County. We can continue to build our understanding of what factors influence disparities — as well as support assets and strengths — by building relationships and listening to local organizations and families.

Our goal to decrease health inequities and improve well-being requires ongoing dedication, as racism has persisted for generations. The CHNA report and companion Community Health Indicators dashboard will help us identify opportunities, build on strengths, and continue to invest in community health toward achieving more equitable healthcare. We look forward to investing in and building upon collaborations that support, enhance, and embrace the livelihood and health of the diverse communities we serve throughout King County.

In collaboration,

King County Hospitals for a Healthier Community

Contents

Acknowledgements

Public Health-Seattle & King County
Hannah Collins, Danny Colombara, Shuva Dawadi, Susan Hernandez, Kris Johnson, Eli Kern, Amy Laurent, Joie McCracken (Hsu), Nancy McGroder, Marguerite Ro, Sara Jaye Sanford, Abigail Schachter, Mike Smyser, Lin Song, Kim Tippens, Mariko Toyoji, and Eva Wong

EvergreenHealth
Trisha West and Susan Dyson

Kaiser Permanente
Kim Wicklund

MultiCare Health System
Lois Bernstein and Stefan Agyemang

Auburn Medical Center
Covington Medical Center

Navos

Overlake Medical Center & Clinics
Stephanie Hamrick

Seattle Cancer Care Alliance
Erin Burke

Seattle Children's
Lara Sim

Swedish Health Services
Pinky Herrera and Kim Anderson

Swedish Ballard Campus
Swedish Cherry Hill Campus
Swedish First Hill Campus
Swedish Issaquah Campus

UW Medicine
Tracy Gooding and Martine Pierre-Louis

Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason Franciscan Health
Ed Boyle and Douglas Baxter-Jenkins

St. Anne Hospital
St. Elizabeth Hospital
St. Francis Hospital
Virginia Mason Medical Center

Washington State Hospital Association
Chelene Whiteaker

Acknowledgements

Continued

WE ALSO WISH TO THANK THOSE WHO PROVIDED INPUT TO THIS REPORT:

CHNA HHC Advisory Committee
Stefan Agyemang (MultiCare Health System)
Douglas Baxter-Jenkins (Virgina Mason Franciscan Health)
Ed Boyle (Virginia Mason Franciscan Health)
Susan Dyson (EvergreenHealth)
Lara Sim (Seattle Children's)

Consultant
Elizabeth "Tizzy" Bennett

King County Department of Community & Human Services
Pear Moraras

Public Health – Seattle & King County
Roxana Chen
Brad Finegood
Sara Glick
Whitney Johnson
Vanessa Quince
Derrick Wheeler-Smith

King County Prosecuting Attorney's Office
David Martin

Urban Indian Health Institute
Adrian Dominguez
Amy Poel

Photo credits:
Cover, Eli Brownell, Danielle Elliott, © 2019 Seattle Children's
Pg. 6, Eli Brownell
Pg. 22, © 2020 Getty Images
Pg. 29, Sharon Chang
Pg. 41, © 2019 Seattle Children's
Pg. 91, Erin Murphy
Pg. 102, Erin Murphy
Pg. 106, Eli Brownell
Pg. 112, Eli Brownell
Pg. 117, Carol Cahill
Pg. 126, Hannah Johnson

Lead writer: Kim Tippens
Copy editor: Martin Stillion
Project management & graphic design: Joie McCracken (Hsu)

Executive Summary

King County Community Health Needs Assessment 2021/2022

Effective community health improvement programs respond to needs and build upon community strengths.

King County Hospitals for a Healthier Community (HHC) is a collaborative of 10 hospitals/health systems in King County, including Public Health – Seattle & King County. HHC jointly produces a Community Health Needs Assessment (CHNA) to learn about community inequities, strengths, and to fulfill Section 9007 of the Affordable Care Act. In accordance with those requirements, the report presents community identified priorities, a detailed description of the community, analyses of data on life expectancy and leading causes of death, and a review of levels of chronic illness throughout King County. In addition, this report provides a profile of the King County Medicaid beneficiary population as well as quantitative information about additional community health topics that were identified as priorities by HHC. The data presented in this report provides information about the health and social landscape in King County prior to the onset of COVID-19. As the COVID-19 pandemic has had unprecedented, widespread, and uneven impacts on community health and well-being, early data demonstrating these impacts are presented where available. Acknowledging that racism is a public health crisis and noting the importance of understanding and responding to inequities, this report continues to present data and key findings by race/ethnicity to highlight disparities, opportunities, and strengths among racial/ethnic groups.

COMMUNITY INPUT

Ongoing and meaningful community engagement can significantly improve hospital/health system efforts to address community health and social outcomes, in addition to improving patient experience. Local community needs assessments, strategic plans, and reports (from 2018 to 2020) that included aspects of community engagement were reviewed to identify needs, provide context to the quantitative data presented, and enhance our understanding of King County residents' priorities and strengths leading up to the COVID-19 pandemic. Key themes that emerged from these assessments of health and well-being include:

- Housing access and quality
- Access to healthcare and other services (such as transportation and food)

Executive Summary

Continued

- Support for youth and families (including mental health)
- Community growth and development

Descriptions of each theme are presented in the *Community Identified Priorities* section of the report.

COVID-19 IMPACTS

Many of the analyses included in this report highlight inequities that help us understand life in King County prior to the onset of the COVID-19 pandemic. These findings describe areas in which people may have been more vulnerable to the impacts of the pandemic and may continue to be disproportionately burdened even after the pandemic. The uneven economic impact of COVID-19 has increased many existing inequities, including poverty and unemployment for communities of color in King County. Communities of color are also overrepresented in COVID-19 cases, deaths, and hospitalizations. Since COVID-19 information changes quickly and data are updated frequently, the COVID-19 section of the report highlights some ongoing disparities throughout the pandemic. Links to resources and regularly updated dashboards, including the timeliest data, are included throughout the report. In addition, recent analyses (2020) and discussions of known COVID-19 impacts are integrated throughout the report.

MEDICAID PROFILE

Using data from 2019, the profile of the King County Medicaid beneficiary population[i] provides a demographic description with a focus on analyzing primary diagnoses to understand leading causes of emergency department (ED) visits based on Medicaid claims. This profile was identified by HHC to help inform quality improvement efforts within hospitals/health systems and identify ways to support Medicaid beneficiaries in accessing care, resources, and programs.

Key findings from the Medicaid profile include:

- In 2019, the King County Medicaid beneficiary population was more racially/ethnically diverse than the overall King County population. People of color made up the majority of Medicaid beneficiaries for both adults and children — white adults represent 49.9% of adult Medicaid beneficiaries and white children represent 35.4% of child Medicaid beneficiaries (children of color also represent the majority of the overall King County population for children).

- There were differences in leading causes of ED utilization among adults and children.

[i] *For this report, the Medicaid population is defined as Medicaid beneficiaries who had seven or more cumulative months of Medicaid full benefit coverage and less than five months of Medicare dual eligibility or third-party liability coverage in 2019.*

Executive Summary

Continued

- Top three for adults: Abdominal pain, pregnancy/childbirth complications, heart disease

- Top three for children: respiratory infections, fever of unknown cause, ear conditions

■ More than half (54%) of all Medicaid beneficiaries in King County with five or more ED visits had no visits to a primary care provider (PCP) in 2019. A majority (86%) of these individuals were adults (age 18+).

■ Analysis of Medicaid claims from January 1 to April 30, 2020 compared to the same time period for 2019 revealed a decrease in overall ED visits with no significant difference in causes of ED use. The decrease in ED visits in early 2020 from the avoidance of ED use during the first couple of months of the COVID-19 pandemic is consistent with national trends.[1]

The online dashboards available on community health indicators to accompany the results presented in the Medicaid profile include options to view all diagnoses. This resource may provide additional learnings about the underlying social and health context of individuals who seek care in the ED. The Medicaid profile section of the report also provides findings for individuals who have more than five visits to the ED without any visits to a primary care provider in 2019. These results can help hospitals/health systems understand barriers to accessing services, as well as inform outreach and engagement efforts to connect people with primary care providers or complex care coordination.

ACROSS KING COUNTY OVERALL, WHAT'S GETTING BETTER?

A review of recent King County data reveals key successes that stand out.

■ The overall obesity rate in King County has been stable and the rate of **obesity among American Indian/Alaska Native residents** appears to be declining. Since the 2010–2012 estimate, in which more than half of AIAN residents were obese, the obesity rate among this group has declined by more than 50%. While estimates may be imprecise due to small population numbers, a concurrent increase in the percentage of AIAN adults that are overweight, but not obese, signals improvement in overall body mass index (BMI), a measure used in healthcare to assess obesity.

■ **Cigarette smoking among adults** has continued to decline county-wide. The adult smoking rate dropped from 13.9% (2011–2013) to 11.1% (2014–2018). Though South Region adults are still significantly more likely to be smokers than the average King County resident, the adult smoking rate is steadily declining in the South Region.

■ Consumption of **sugar-sweetened beverages among youth** has decreased in King County. Comparing data from 2014 and 2018, fewer students reported daily consumption in all King County regions.

Executive Summary

Continued

- More pregnant mothers received **early and adequate prenatal care** — which is defined as initiating prenatal care in the first trimester and having at least 80% of the medically recommended number of prenatal visits. This county-wide success increases the likelihood of families having healthy pregnancies and births.

- **Homelessness has declined for unaccompanied youth and young adults.** From 2018 to 2019, the number of individuals, youth, and families experiencing homelessness as well as the percentage of the homeless population that were unsheltered declined. Most notably, the number of unaccompanied youths under the age of 18 decreased by more than 50%.

The previous 2018/19 CHNA report highlighted improvements in health insurance coverage as well as declining rates of cigarette smoking, youth substance use, and youth consumption of sugar-sweetened beverages. Among those previous successes, the rates for adult cigarette smoking and youth consumption of sugar-sweetened beverages continue to decline, and the previous improvement in decreasing rates of youth substance use was sustained.

ACROSS KING COUNTY OVERALL, WHAT HAS GOTTEN WORSE SINCE THE LAST CHNA?

Several indicators show little or no improvement since the previous report. However, the following indicators showed downward trends, or are worse compared to the last CHNA report, as new areas of concern. The findings presented here are reflective of data collected through population health surveys prior to the COVID-19 pandemic that should be closely monitored. Without substantial support, the strain that COVID-19 has placed on communities will likely result in worsening health and social conditions.

- While overall life expectancy of King County residents has not significantly changed, recent analyses reveal worsening racial/ethnic **disparities in life expectancy.** Life expectancy of Native Hawaiian/Pacific Islander King County residents (72.2) has declined by more than five years from the 2011–2013 average life expectancy of 77.8 years to the 2016–2018 average of 71.9 years for this group. Hispanic residents' life expectancy is declining as well — by 3.6 years during that same time period. Life expectancy among South Region residents has declined for the past 10 years.

- More county residents are dying from **unintentional injuries,** with poisoning (by legal

and illegal drugs, alcohol, gases and vapors, such as carbon monoxide and automobile exhaust, pesticides, and other chemicals and noxious substances), falls, and motor-vehicle-traffic incidents as the leading causes.

- While rates of **food insecurity** were declining overall and trending toward improvement, there was a large jump in food insecurity among Black residents even before the onset of the pandemic. The gap between white and Black food-insecure households quadrupled between 2013 and 2018.

- Communities of color continue to be disproportionately uninsured — before and after implementation of the Affordable Care Act. Racial/ethnic disparities in **insurance coverage** have widened following an initial narrowing of gaps in coverage in 2014.

- More King County youth are obese. After a relative decline in 2012, **youth obesity** rates have been increasing in King County. Youth obesity rates increased significantly between 2014 and 2018.

- Use of electronic cigarettes, also known as **e-cigs or vape pens,** among youth was not reported in the previous CHNA. However, as rates of youth who report smoking cigarettes have continued to decline in King County, the percentage of youth who report using e-cigarettes has significantly increased since 2016.

The previous 2018/19 CHNA report highlighted additional indicators that were worsening or not improving at that time, including insufficient physical activity for youth, youth mental health, and drug-induced deaths, which continue to worsen and are areas of concern in King County.

COVID-19: INITIAL CONCERNS AND AREAS TO MONITOR

While most data are available only for time periods prior to the onset of the pandemic, recent information from various sources during 2020 reveals the following concerning impacts of COVID-19. We will continue to monitor these new data sources alongside our ongoing population health data — see the COVID-19 section of this report for related dashboards and resources.

- **Unemployment:** Mandated closures of nonessential businesses began on March 15, 2020, in King County, as one of many community mitigation efforts to slow the spread of COVID-19. With the resulting job losses, the number of people seeking unemployment benefits increased rapidly. Roughly one in three workers (34.5%) in King County filed

Executive Summary

Continued

initial unemployment insurance (UI) claims with the Washington State Employment Security Department between March 1 and November 7, 2020, totaling 529,027 claims. Native Hawaiian/Pacific Islander workers filed the highest number of claims per capita, followed by Black workers. King County industries with the largest number of employees filing unemployment claims included accommodation and food services, manufacturing, retail, construction, and healthcare and social assistance.[2,3]

- **Food insecurity:** The number of local families experiencing food insecurity has increased throughout 2020. Food insufficiency has almost doubled after implementation of mitigation strategies to slow the spread of COVID-19, such as business closures and limits on nonessential work. Enrollment in the U.S. government's Basic Food assistance program increased by 18% among King County households from January to June 2020 — an increase of 17,300 households. Food needs were the second most common reason for King County residents to call seeking assistance with social services in spring 2020.[4] Food insecurity is especially high among households that are low-income, include children, or have recently had or expect job loss.

- **Access to healthcare:** Analysis of recommended vaccination rates (series 4:3:1:3:3:1:4) for children ages 19-35 months as of June 30, 2020 showed a decrease in vaccination coverage compared to rates as of December 31, 2019, likely reflecting decreased access to and use of healthcare services during the COVID-19 pandemic. Rates of incomplete vaccination coverage increased for the county overall, among South Region families, and among families living in high-poverty neighborhoods.

- **Mental and behavioral health:** While most of the data in the mental health and substance use section of this report were collected prior to 2020, it's important to note that during the COVID-19 pandemic, some patterns may be changing. Washington state survey data show the number of people with symptoms of depression had increased by more than 30% between April and May 2020. Those who expect to lose employment or lost employment, those with incomes less than $25,000 per year, and people self-identifying their race/ethnicity as 'other' or multiple race categories were most likely to report feeling depressed or hopeless. The number of calls to King County's behavioral health crisis line increased after the start of social distancing, and in April — as well as between June and October — were significantly higher than those in the same months of 2019. These measures will continue to be monitored given the expected increases in mental health concerns.[5,6]

Executive Summary

Continued

HOSPITALS FOR A HEALTHIER COMMUNITY (HHC) PRIORITIES

Throughout the production of this report in 2020, systemic racism and COVID-19 response and vaccine distribution have emerged as high priorities for hospitals, health systems, and public health. While historical and present-day impacts of systemic racism contribute to many of the health and social inequities described in the report, the COVID-19 pandemic has further exposed the intersection of structural racism and health. Furthermore, advancing equity throughout all elements of the COVID-19 response — assuring access to care including testing and vaccinations, promoting healthy behaviors, as well as community recovery — is critical. Systemic racism and the COVID-19 response will continue to shape and affect the health of King County communities and have been identified as both short- and long-term priorities across HHC members.

In addition to ***systemic racism*** and the ***COVID-19 response***, the HHC collaborative has also identified the following priority areas to address jointly, as well as individually:

- ***Mental health & substance use disorders***
- ***Access to healthcare***
- ***Chronic disease management - specifically obesity, cancer, diabetes, heart disease/ hypertension***
- ***Food insecurity***

As part of this prioritization, HHC will seek opportunities to align efforts across organizations, learn about best practices to support these areas, and encourage organizations to collectively invest in data, programs, and policies to promote health among King County residents. Collaboration and partnerships between public health, health systems, behavioral health systems, and community organizations will continue to be important in developing effective community health improvement plans to address these areas.

COVID-19

The COVID-19 pandemic has especially impacted communities that were already experiencing inequities in King County. As a compounded ailment, it aggravated existing burdens and introduced new ones.

By the time this report was created in 2020, the COVID-19 pandemic had touched nearly every aspect of life for communities and families across King County and Washington state. Washington state was the original national epicenter of COVID-19 as the first area in the United States to report a case. The public health response to early outbreaks in King County garnered national attention.[5,6] To slow the spread of COVID-19, community mitigation and social distancing measures were initiated county-wide, which have impacted the economic, social, mental, physical, and behavioral health of communities. Large-scale and coordinated actions to increase resources to communities and promote access to and knowledge of COVID-19 testing, isolation and quarantine facilities, and hospital care are priorities in our current local public health efforts. Thorough and ongoing review of timely data is essential to support these efforts to slow the spread of COVID-19. This section highlights some persistent patterns and includes links to relevant dashboards and resources developed by Public Health – Seattle & King County.

In King County, coronavirus has disproportionately affected communities of color and residents of South King County.[7] Communities of color are overrepresented in COVID-19 cases, deaths, and hospitalizations. They are also more likely to be negatively impacted by community mitigation strategies due to social or economic conditions preceding the pandemic. For example, communities of color are disproportionately reflected in many industry sectors that have been significantly impacted by COVID-19 and had the largest number of employees filing unemployment claims, including accommodation and food services, retail, and healthcare and social assistance.[2]

Racial/ethnic disparities: As of November 2020, case rates and hospitalization rates for nearly all communities of color are higher, with statistical difference, than for whites. The rate of confirmed cases is highest among Native Hawaiian/Pacific Islander (NHPI) and Hispanic communities, followed by Black and American Indian/Alaska Native (AIAN) populations.[i] Compared to white residents, Hispanic and NHPI residents are significantly more likely to die from COVID-19.

[i] *Small numbers, limited availability of testing, and missing data should be considered when interpreting the data.*

COVID-19

Continued

Geographic disparities: Patterns of testing, positivity, hospitalizations, and deaths differ by geography. Compared to other King County regions, South King County neighborhoods have some of the highest rates of positive cases, test positivity, hospitalizations, and deaths, with relatively lower rates of people getting tested.

A robust set of dashboards and surveillance systems inform ongoing community mitigation strategies, contact tracing, isolation and quarantine, and prioritization of community resources and supports during our county-wide pandemic response. Ongoing monitoring of case counts, hospitalizations, and death rates helps inform our hospitals and health systems to prepare to meet the needs of King County residents. Public Health – Seattle & King County is monitoring changes in selected measures of social, economic, and overall health in King County throughout the pandemic.

King County COVID-19 dashboards include:

- Race/ethnicity dashboard
- Economic, social, and overall health impacts dashboard
- Health insurance and access to healthcare
- Family violence
- 2-1-1 calls to identify community needs
- Behavioral health needs and services
- Daily traffic
- Food insecurity
- Unemployment claims
- King County Eviction Prevention and Rental Assistance Program

Data reports and infographics related to COVID-19 include:

- Computer and internet access in King County
- Economic, social, and overall health impacts
- Increases in food needs
- Behavioral health needs and services
- Changes in transportation patterns
- Unemployment claims

As of January 4, 2021

The CHNA report presents data on indicators prior to the onset of the pandemic, and highlights areas in which community members were most vulnerable and may continue to be disproportionately burdened. Data are presented for the most recent years we have data available — in most cases, from 2018 or before. Discussion of the known COVID-19 impacts to dates are included in the relevant sections of the report, where available. In some cases, this includes expected impacts and considerations for long-term monitoring. We also recognize the importance of monitoring key community health indicators along with ongoing community priorities and needs during and after the pandemic to support the longevity, health, and well-being of our diverse communities.

Introduction

The King County Hospitals for a Healthier Community (HHC) collaborative, which includes 10 hospitals/health systems in King County and Public Health – Seattle & King County, produces this joint community health needs assessment to better understand and serve the needs of families and communities in King County. As cornerstone institutions across the county, hospitals and health systems support community health through programs and investments that work to improve health through education and outreach, as well as address social conditions and determinants of health (such as housing, transportation, and food) that impact health outcomes.

The 2018/2019 King County Community Health Needs Assessment described a community that was rapidly being reshaped by an economic boom, growing diversity, and economic growth that disproportionately advantaged some residents over others. Community members and stakeholders identified a list of concerns to prioritize for improvement, which included inequities in access to services (such as childcare and healthcare), unaffordable housing, residential displacement, transportation barriers, and disparate access to high-quality education by race and place. The health and social indicators in the report revealed county-wide successes in health insurance coverage as well as improvement in a variety of health behaviors, such as cigarette smoking, youth substance use, and consumption of sugary beverages, alongside persistent disparities in a number of other health and social indicators, including youth mental health, tobacco use, and household income.

Regularly monitoring data and community experiences over time sheds light on emerging disparities and improvements as well as where continued investments need to occur. Three years later, this 2021/2022 report includes a set of health and social indicators similar to those in the previous report. Indicators describe community conditions after a period of continued economic growth, demographic change, and community investments to promote health and thriving. The impact of local investments and programs that focus on improving the social, physical, and mental health of populations requires ongoing investment, since changes in population data generally occur slowly and over time. As described in the *Executive Summary* and corresponding report sections for the 2021/2022 report, disparities and inequities remain in many health indicators, while some community and county-wide successes stand out.

Throughout 2020, COVID-19 has had a rapid and tremendous impact on every aspect of our lives as well as on the overall health and well-being of our communities. Many of the data analyses included

in this report highlight inequities that help us understand the conditions in King County prior to the onset of the COVID-19 pandemic along with more recent analysis, where available, to shed light on the initial impacts of COVID-19 on community health and priorities. King County hospitals and health systems have been a cornerstone of pandemic response by addressing the health needs of patients, as well as by partnering with local communities and organizations to support the recovery and resilience of King County residents.

KING COUNTY HOSPITALS FOR A HEALTHIER COMMUNITY

The King County Hospitals for a Healthier Community (HHC) collaborative comprises 10 hospitals/health systems and Public Health – Seattle & King County through the fiscal administrative support of the Washington State Hospital Association (see Appendix C for a full list of hospitals/health systems).

Formed in 2012, the HHC seeks to work together to identify community needs, assets, resources, and strategies toward ensuring better health and health equity for all King County residents. The collaborative was created to eliminate duplicative efforts; lead to the creation of an effective, sustainable process and stronger relationships between hospitals and public health; and, identify opportunities to improve the health and well-being of our communities.

Through the HHC, King County hospitals/health systems have identified opportunities to coordinate outreach and engagement efforts as well as share best practices and strategies. HHC members have worked jointly to support open enrollment under the Affordable Care Act (ACA), pledge to increase access to healthy food choices in their facilities, support food security for local communities, distribute safety items such as firearm lock boxes, as well as create tools to address the healthcare barriers and opportunities of LGBTQ+ youth and young adults. This shared approach helps to align efforts and ensure that hospital community benefit programs focus resources to address the community's most critical health needs.

COMMITMENT TO HEALTH EQUITY

HHC members are committed to providing services and resources that respond to the health and social conditions of local communities. To achieve and create systems that promote health equity, hospitals and health systems must engage in the ongoing assessment, monitoring, and quality improvement of the healthcare delivery system. This includes review of population data in several ways, including race/ethnicity, income, geography, and sexual orientation whenever possible, to inform improvements and initiatives.

Introduction

Continued

PURPOSE

This report documents the health needs of King County communities and provides a foundation to meet the Affordable Care Act (ACA) and Washington state requirement for nonprofit hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. This is the third CHNA conducted by HHC in collaboration with Public Health – Seattle & King County.

REPORT METHODS

HHC members used a population-based community health framework to identify indicators within each topic while also considering local and national priorities, actionable metrics, and timeliness of the information. Health is defined broadly to include social, cultural, and environmental factors that affect well-being. This joint CHNA report provides baseline data on community health indicators for all hospitals to use and apply to their own CHNAs. This work also supports hospital community benefit programs, systems, and services by providing data to describe community needs and highlight disparities. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area and populations served.

In accordance with the Affordable Care Act, this report includes:

- Community identified priorities
- Community description
- Leading causes of death
- Levels of chronic illness

In addition, this report provides quantitative information about the following additional priorities and health needs:

- COVID-19 deaths and hospitalizations by race/ethnicity
- Medicaid profile: Medicaid demographics, top 10 causes of emergency department (ED) visits, and high numbers of ED visits among people who have not had a primary care visit in the last year
- Access to healthcare and use of preventive services
- Mental health and substance use
- Maternal and child health
- Physical activity, nutrition, and weight
- Violence and injury prevention

Additional data for each indicator included in this report, as well as indicators for more health topics, are available online at www.kingcounty.gov/chi. Detailed data are reported, when available, for neighborhoods, cities, and regions in King County, and by race/ethnicity, age, income/poverty, gender, and other

demographic breakdowns. When possible, the latest single-year rate for King County also includes the approximate number of affected individuals.

Community themes and priorities were gleaned from an inventory of more than 48 community assessment/engagement reports conducted over the past three years.

REPORT LIMITATIONS

There are some notable limitations to this report. See *Appendix B* for more information about report definitions and structure, including data limitations.

TIMING OF DATA

Many of the ongoing population survey data included in this report reflect data from 2018 and 2019, which provides information on the health and social context of King County populations prior to COVID-19. Since COVID-19 has the potential to have long and lasting impacts on community needs and has already influenced population health and well-being through health, social, and economic impacts, it is critical to use the data presented in this report as a benchmark to assess and monitor impact moving forward. In addition, where applicable, we have included more timely data sources and information to shed light on the initial impact of COVID-19 in 2020.

BROAD CATEGORIES FOR RACE/ETHNICITY

Racial and ethnic comparisons are made using broad race categories based on a narrow range of options for self-identification in surveys. It is important to report data by race/ethnicity to track progress toward health equity. Comparisons made between groups throughout the report are meant to highlight inequities by race/ethnicity where they exist, and not to imply that any specific race/ethnicity is the standard to which others should be compared. However, the vast diversity within race/ethnicity categories does not allow us to distinguish among ethnic groups or nationalities within categories. Our ability to report data by the many ethnic groups and nationalities living in King County is also limited by small numbers and how various surveys collect self-reported racial and ethnic data. Also, for most data sources, the most recently available data comes from 2018, not 2019 or 2020. A positive change is that as of 2018, detailed Asian ethnic groups were available for the Healthy Youth Survey (HYS); some of these findings are included in the narrative of this report and results can be found at www.kingcounty.gov/chi.

LIMITED DATA AND RESOURCES

For some topics, we have incomplete or limited quantitative data and a lack of qualitative information to contextualize findings.

Introduction

Continued

Finally, space and resource limitations prevent us from mentioning all of the valuable organizations, hospital/health system collaborations, and assets in our communities. A continuously updated statewide database of health and human service information and referrals for Washington state can be found at https://search.wa211.org/.

RACISM AS A PUBLIC HEALTH CRISIS

Public Health – Seattle & King County leads with race and recognizes racism as a public health crisis underlying the health inequities that persist in our county and state. The uneven economic impact of COVID-19 has heightened many existing inequities, including poverty and unemployment for communities of color. This report helps us understand the conditions leading into the pandemic — in many cases setting the stage for disproportionate community impacts of COVID-19 and the measures to slow the spread of disease. It also highlights community assets and resilience factors that help in improving health and well-being.

The following sections describe what we have learned from data monitoring. Community needs are described in the *Community Identified Priorities* section of the report. We have primarily focused on differences by race/ethnicity while also recognizing how geography, rural, urban, and other indicators illustrate what's happening in our county.

WORKING TOGETHER TOWARDS HEALTHIER COMMUNITIES

During the previously conducted 2018/2019 Community Health Needs Assessment, HHC members focused on the following joint priorities for collective and individual focus:

- Mental health and substance use disorders
- Access to healthcare and transportation
- Physical health with a focus on obesity, cancer, and diabetes
- Housing and homelessness

Examples of how HHC members have been addressing these priorities are included as assets in the *Community Identified Priorities* section of this report. Based on the updated data, as well as community priorities highlighted in this 2021/2022 CHNA report, HHC members have identified new or ongoing priorities as described in the *Executive Summary* section of this report.

Examples of current Seattle and King County initiatives that include Public Health – Seattle & King County, hospitals/health systems, and community partnerships include:

Introduction

Continued

MEDICAID TRANSFORMATION

There are nine regional Accountable Communities of Health (ACHs) in Washington state, each bringing together community members, cross-sector partners, and other experts to explore new approaches to improving health and wellness as part of the Washington State Medicaid Transformation. HealthierHere serves as the ACH for King County, bringing people and organizations together from across sectors to improve health and advance equity in our community. To better support the health and social needs of people in King County, HealthierHere builds and strengthens partnerships, develops networks, shares resources, and tests innovations in the delivery of healthcare and social services.

COMMUNITIES OF OPPORTUNITY

Between 2019 and now, Communities of Opportunity (COO) has deepened and increased commitments to place-based and cultural community collaboratives and groups working for more equitable and just housing, health, and economic systems via policy, systems, and environmental changes. COO also launched the Learning Community strategy, which provides space and resources for the capacity building, transformational visioning, model development, and sustained relationship building of community partners. COO has supported more than 3,129 capacity-building, community, and workforce development events, 77 new community partnerships, over 410 community members to take on new leadership positions, and seven community-led policy changes — all work aligned toward transforming future conditions so that all families and communities in King County thrive.

BEST STARTS FOR KIDS

Approved by King County voters in 2015, Best Starts for Kids (BSK) supports safe and healthy childcare settings by consulting with childcare professionals, making the resources of nurses, nutritionists, and child health specialists available to childcare providers across King County. Best Starts for Kids partners with schools and community-based organizations to invest in programs that offer safe, supportive environments that create a sense of belonging and purpose through mentoring, leadership, positive identity development, healthy relationships, and participating in out-of-school opportunities.

In 2019–2020, BSK continued to expand partnerships and programs. Of note, in 2020 BSK expanded Help Me Grow in King County, building a network of coordinated access partners. Trusted community organizations play a key role in helping families

navigate resources, supporting successful connections to timely resources and services, and improving access to high-quality, holistic developmental screenings.

ZERO YOUTH DETENTION

The Zero Youth Detention (ZYD) initiative is King County's strategic plan not only to further reduce the use of secure detention for youth, but to launch King County on a journey to eliminate it. Building on 20 years of reducing the secure detention population, this region begins the journey to ZYD with momentum. Informed by youth and their families, communities, and employees whose work touches the lives of youth, the Road Map to Zero Youth Detention outlines practical solutions designed to improve community safety, help young people thrive, keep them from entering the juvenile legal system, divert them from further legal system involvement, and support strong, unified communities. ZYD is interested in creating conditions that allow young people to be healthy, hopeful, safe, and thriving to reduce the number of young people in secure detention.

KING COUNTY PLAY EQUITY COALITION

The King County Play Equity Coalition aims to increase the number of youth in King County who meet CDC guidelines for physical activity to improve the quality of life for youth. In order to achieve this, the coalition focuses on reducing inequities, increasing opportunities, and improving quality of sport and play opportunities for King County youth. Coalition members include health systems, such as Seattle Children's Research Institute and The Sports Institute at UW Medicine, as well as a variety of cities, organizations, schools, businesses, and foundations. Through policy advocacy, research and data, community-driven partnerships, information sharing, and programming, this coalition envisions a King County where:

- All youth are active to a healthy level
- Access to sport and outdoor recreation is not determined by ZIP code, language, or race
- Youth physical activity is a regional policy priority
- King County is a national model for inclusive and healthy youth sports, free play, and outdoor recreation

Community Identified Priorities

King County hospitals and health systems are uniquely positioned to improve community health by offering comprehensive healthcare services as well as through collaborations and investments that address the root causes of health outcomes and inequities, such as access to housing, transportation, food, and chronic disease prevention. To best serve the needs of the community, hospitals and health systems assess health and social outcomes across changing demographics, as well as engage with and listen to the emerging priorities voiced by local communities.

Since the last CHNA, community-based organizations and clinics, state and local agencies, coalitions, schools, and hospitals have continued to engage with the people they serve to help elevate specific community concerns and strengths. To enhance our understanding of King County residents' priorities leading up to the COVID-19 pandemic, we reviewed 48 community needs assessments, strategic plans, or reports produced between 2018 and 2020 (see Appendix A for a full list). We sought publicly available information representing regions throughout King County, specific populations, and focus areas including food, physical activity, housing, and transportation. Each resource had a community engagement component from which we summarized themes shared across the documents. Since this report was produced at the end of 2020,

Priorities expressed by multiple communities include housing and homelessness, access to healthcare and other services, support for youth and families, and community growth and development as areas of need.

Community Identified Priorities

Continued

emerging themes identified through this review illustrate vulnerabilities that have been amplified by the pandemic throughout 2020, warranting close monitoring and focused interventions in 2021 and beyond.

COMMUNITY IDENTIFIED PRIORITIES

- Housing access and quality
- Access to healthcare and other services (such as transportation and food)
- Support for youth and families (including mental health)
- Community growth and development

Some community needs have been compounded due to the pandemic, while others may have been de-prioritized by more pressing needs that have arisen. Many community-based organizations across King County are actively working toward addressing these and other community identified priorities. King County hospitals and health systems have opportunities to create partnerships with community members and organizations to address community needs via direct input and engagement.

There are several local programs, initiatives, and partnerships working to build on the strengths in King County and address community priorities. Examples of how HHC members and community organizations work together in collaboration to meet the needs of King County residents are shared throughout this section. Though not exhaustive or comprehensive, examples provided in each priority section include collaborative programs and initiatives between HHC members, community organizations, and Public Health – Seattle & King County.

HOUSING ACCESS AND QUALITY

Almost every referenced resource called out some aspect of homelessness, housing affordability, or housing quality as a priority. The COVID-19 pandemic has affected housing for many King County residents who have lost income or experienced disruptions in their housing and family structure. More than half of all calls to 2-1-1 between August and September 2020 requested housing-related assistance, and communities of color are disproportionately represented in these calls. Given the severe housing inequities that existed prior to the pandemic, we can anticipate that many housing needs and priorities outlined by the community are even greater today. Without support for social safety nets, such as shelters and transitional housing, and in the absence of efforts to intentionally increase the availability of affordable and safe housing, these inequities will continue to increase.

Community Identified Priorities

Continued

Homelessness is an ongoing crisis in King County, affecting children, families, older adults, and veterans, and disproportionately impacts transgender residents and certain communities of color. While King County is housing more people every year[8], there is a continued need for more shelters and resources for individuals experiencing homelessness or housing insecurity. Communities identify the need to expand services to prevent homelessness among low-income and housing-unstable families, and to support families who are experiencing homelessness with secure housing and social services.

Lack of affordable housing was a recurring theme across reports. High costs of living in many areas of the county create conditions where families living well above the poverty line struggle to make ends meet. Affordable housing has decreased county-wide as a result of rapid economic growth and gentrification. The impacts are felt by individuals and families all over the county, affecting neighborhood demographics, displacement, and community cohesion, as well as access to resources and services. Residents living in densely concentrated urban areas, as well as residents in rural areas, including in East King County, voice concern for the growing cost burden among renters and homeowners. King County residents from multiple communities — especially in South King County — called for more affordable housing; more options for older adults; and access to financial assistance programs, such as rent subsidies, utility assistance, and assistance for families who are forced to move or are otherwise displaced.

Community Collaborations

- **Housing security and homelessness:** Hospitals and health systems in King County continue to support advocacy efforts to address homelessness and increase access to safe and affordable housing. One example is Virginia Mason Franciscan Health's Bailey-Boushay House overnight shelter for homeless clients in their HIV Outpatient Program, which is the first – and only – homeless shelter in the country that exclusively serves people with HIV. Another example is Kaiser Permanente, which actively screens patients for housing instability in order to provide housing resources. Harborview Medical Center operates clinics within Plymouth Housing and Downtown Emergency Service Center (DESC). Furthermore, several HHC members — including those already mentioned as well as Overlake Medical Center & Clinics, MultiCare Health System, and Virginia Mason Franciscan Health — provide financial support or partner with community-based organizations to improve care for unsheltered patients who are discharged from the hospital, as well as address housing security and homelessness across King County.

Community Identified Priorities

Continued

- **Affordable housing advocacy and investments:** Opportunities exist for hospitals and health systems to advocate for affordable housing by making investments to increase the number of affordable housing units available to King County residents. Investments that direct funding for geographical areas and populations disproportionately impacted by unstable housing and homelessness can bolster a community's ability to provide adequate, affordable, and safe housing. For example, Navos provides safe and affordable housing in apartment buildings and family-sized homes for over 300 people with serious mental health conditions, which is notable given the difficulty for this population to secure safe and affordable housing. Virginia Mason Franciscan Health's Bailey-Boushay Housing Stability Project administers a federal rental assistance program to benefit homeless men and women with HIV in the Seattle area. Kaiser Permanente contributes funding to provide low-interest loans to affordable housing developers to build new or renovate existing affordable housing. In addition, Seattle Children's invests in affordable housing in partnership with HomeSight in Southeast Seattle, where Odessa Brown Children's Clinic, an early learning site, and direct access to public transportation create a community design that supports the housing, health, and transportation needs of families.

ACCESSING HEALTHCARE AND OTHER SERVICES

The COVID-19 pandemic is likely to have long-term effects on healthcare in the United States. Hospitals and health systems are challenged as they push to expand capacity, increase telehealth, and purchase equipment and supplies to meet the needs of patients with COVID-19 and other conditions.[9] Nationally, visits to primary care physicians and specialists have declined since the pandemic. It is expected that this shift in priorities will further compound mental and behavioral health concerns, increase suicide risk, and widen persistent gaps in access to affordable healthcare coverage, preventive services, and prevalence of chronic illnesses, especially for people of color.[10]

Disparities in access to basic needs, such as food and transportation, existed among communities of color and low-income residents in King County prior to COVID-19. Many of these same residents have been hit hardest by the pandemic in terms of economic instability due to job loss and business closures. This has further increased food insecurity risk, as well as disparities in accessing transportation and healthy food for thousands of King County residents.

Community Identified Priorities

Continued

ACCESS TO HEALTHCARE

Access to high-quality healthcare is a key contributor to physical, mental, and behavioral health. Barriers to access include economic, language, cultural, and/or geographic concerns.

Despite the large number of hospitals and healthcare providers in King County, community members continue to cite **barriers to accessing healthcare due to high cost, lack of health insurance, or the limited availability of services and providers.** Even among those with insurance, many express challenges with accessing services, such as specialty care, behavioral health, and dental care due to coverage limitations or limited providers. Young adults (18–25) and low-income residents are most likely to report problems finding a health provider.

- Finding **culturally competent providers** who demonstrate cultural awareness and respect is a barrier especially for immigrants, people of color, residents with limited English proficiency, and those seeking gender-affirming care. In order to effectively and appropriately serve diverse communities, it is also important to have translated materials, as well as interpretation services, available to community members.

- **Accessible transportation** to and from healthcare appointments is an additional barrier that community members identified. This is especially challenging when residents must travel long distances to get to clinics that provide specialty care or to services that are culturally and linguistically appropriate.

- Lack of **access to childcare** was cited as a barrier to scheduling time for medical appointments.

Community members also described specific needs related to healthcare and behavioral health, including:

- The need for **increased access to healthcare services** in the evening, on weekends and through telehealth was expressed as well as delivery of medications.

- Limited resources for **chronic disease management,** especially for diabetes, obesity, cancer, and heart disease/hypertension. Communities called for additional support within healthcare systems for culturally relevant materials and patient education as well as increasing opportunities to support a healthy lifestyle in the community through access to healthy food and physical activity.

- The need for increased access to **mental and behavioral health** resources, including subspecialty care providers and counseling services for mental health and substance use disorders.

Community Identified Priorities

Continued

ACCESS TO OTHER SERVICES

The lack of reliable and affordable transportation affects the ability to access services, particularly for older adults, youth, low-income adults, individuals with disabilities, and those experiencing homelessness in the community. Mobility and transportation affect economic stability and growth in multiple ways, impacting a person's ability to obtain and secure employment, healthy food, safe places to play, education, and healthcare. Some residents describe unsafe conditions related to poor lighting and lack of security at transit stops as an additional barrier. In addition, some areas of South King County have many streets without sidewalks and long distances to get to a bus stop, which can be difficult for older adults and individuals with disabilities and increases the risk of vehicle and pedestrian injuries.

Food insecurity, limited access to healthy food, and the lack of culturally relevant nutrition education were highlighted by diverse communities across King County. Access to healthy, nutrient-rich foods is limited in some low-income and rural areas, where residents are less likely to have a grocery store close to home. Families who use public transportation to purchase groceries or access food banks face longer travel times and are limited in how much they can carry at a time. In addition, the increasing costs of housing can affect families' ability to afford food. Chronic hunger and access to healthy food were specifically called out as issues affecting the health of older adults and parents, many of whom report cutting or skipping meals because they did not have enough money for food.

Language and cultural barriers impact the ability of many immigrant residents to access employment, public transportation, housing, healthcare, and educational opportunities — all of which are key to economic stability. Many fear asking for support. Examples that community members noted include:

- Public transportation signs and fare lists at bus stops are primarily only in English.
- Barriers to accessing services (e.g., scheduling appointments) based on limited availability of interpreters.
- Language and cultural barriers prevent youth from participating in recreation programs when registration is only in English or requires registering in person.
- First-generation families may lack information about the process to enroll their kids into college or technical schools.

Community Identified Priorities

Continued

- Cultural barriers may negatively impact access, even with shared language. For instance, American Indian/Alaska Native communities shared that non-Native healthcare providers should be aware of the importance of family and the long-term impacts of generational trauma on Native lives, behaviors, and choices in order to thoughtfully and appropriately serve them.

Community Collaborations

The following are examples of how HHC members have responded to address community needs related to accessing healthcare and other services in collaboration with community-based organizations.

- **Affordability of healthcare:** All HHC members provide information and help with financial assistance in multiple languages. Many HHC members, such as EvergreenHealth, Overlake Medical Center & Clinics, and Virginia Mason Franciscan Health, provide financial and clinical support to Project Access Northwest (PANW) and Seattle/King County Clinic to improve access to healthcare for low-income and uninsured patients. Numerous King County hospitals, including Virginia Mason Franciscan Health, help support Edward Thomas House Medical Respite at Harborview, which is a unique, harm-reduction program that provides recuperative care to people experiencing homelessness who are too sick to return to the shelter or streets, but do not require hospital-level care.

- **Chronic disease management:** Many HHC members invest in a variety of health outreach programs for patients and communities, such as diabetes education that integrates culturally relevant and translated materials. Furthermore, several have developed partnerships with resources in the community. As an example, Swedish Health Services, Overlake Medical Center & Clinics, and MultiCare Health System partner with the YMCA for chronic disease management programs. Seattle Cancer Care Alliance provides cancer prevention and screening through community outreach events that include other organizations. Harborview Medical Center's Community House Calls Program has two Diabetes Navigators who work with Spanish- and Somali-speaking patients to manage their disease in a culturally congruent manner.

- **Mental and behavioral health:** Mental and behavior health services continue to be a high need for communities and a high priority for HHC members. For example, Navos focuses entirely on providing culturally competent resources and services for King County residents vulnerable to mental illness and substance use disorders. All HHC members invest in a variety of services within their health systems and the broader community,

Community Identified Priorities

Continued

such as integrating behavioral and physical health within their health system; embedding therapists and counselors within school districts and teen centers; and organizing events and trainings for youth, adults, and providers. Several HHC members, including Overlake Medical Center & Clinics, Kaiser Permanente, and Virginia Mason Franciscan Health, partner with the National Alliance on Mental Illness to provide supportive mental health services to local communities. EvergreenHealth offers in-home mental health counseling for Medicaid beneficiaries. Navos provides training for community-based peer educators. Seattle Children's has partnered with ARC of King County to provide education to families about autism. A number of HHC members train youth and adults in Mental Health First Aid, including Virginia Mason Franciscan Health, which has trained over 5,000 people to date.

- **Language and culture:** HHC members provide patient education, health, and outreach materials that are translated and available in a variety of languages. Interpreters in person, via video, and/or through the telephone are also available to support patients during appointments. Several HHC members, including Seattle Cancer Care Alliance and MultiCare Health System, invest in clinical patient navigator programs to provide specialized outreach and support for a variety of demographic, diagnosis-specific, cultural, and race/ethnicity groups to provide cultural and language resources. Community health clinics, such as Sea Mar and International Community Health Services, are examples of healthcare settings that are primarily focused on specific communities. Over a dozen Community Health Boards — voluntary community-based organizations that represent and advocate for the health of specific cultural groups — help connect King County families to health and social support resources. Harborview Medical Center's Interpreter Services Department has a robust language interpretation and translation program for in-patient and ambulatory settings; houses the Community House Calls Program that connects with Limited English Proficient communities within and outside of the hospital; and EthnoMed.org, an educational website for providers to learn about the immigrant populations they serve and provide localized healthcare resources for their patients.

- **Transportation:** In response to concerns around transportation, many hospitals and health systems have invested resources in free or reduced-cost programs with community partners to:

  » Create transportation departments, provide shuttle services, or establish partnerships with local transit centers to help families and patients navigate between campuses, clinics, and neighboring communities. For example, Seattle Cancer Care Alliance has shuttles that are open to patients and

Community Identified Priorities

Continued

families to assist them in getting around UW Medicine and South Lake Union Housing, and EvergreenHealth supports patients to enroll in ADA Paratransit services.

» Set up a transportation help desk inside the lobby to coordinate rides, reduce patient wait time, and assist with other Medicaid transportation providers. Several HHC members contract with Hopelink for a transportation help desk, including UW Medicine, Overlake Medical Center & Clinics, Swedish Health Services, EvergreenHealth, and Seattle Children's

» Partner with and provide financial assistance to support local community partners. Virginia Mason Franciscan Health, for example, provides financial assistance to SeaTac-based Refugees Northwest for a free bus ticket program for clients to get to and from medical and childcare appointments.

■ **Food security:** Many HHC members provide financial support for the Fresh Bucks program in Seattle and SNAP Market Match across King County to support access to healthy, affordable food at farmers markets and selected grocers. To address food insecurity for their patients, Seattle Children's screens families for food insecurity so food-insecure families can access an onsite food pantry to get food that will help last until their next appointment. In addition, UW Medicine has a partnership to bring a weekly food/produce stand onsite, such as Clean Greens Farm & Market, to make organic produce easily accessible for staff and surrounding communities.

» Through the CARES Act Food Security Assistance Program, PHSKC has been able to support agencies across King County from September to December 2020 in distributing food vouchers and culturally appropriate foods to impacted populations across King County.

SUPPORT FOR YOUTH AND FAMILIES

Measures to control and limit the spread of COVID-19 — such as closures of school, childcare, and recreational facilities — have affected the social and emotional well-being of children and families. Learning disruptions, social isolation, and high levels of parental stress in balancing work and schooling impact physical and mental health for children and families.[11,12] The pandemic has also heightened the disparities in resources and services to support low-income families and families who have children with disabilities, and the permanent closure of several childcare facilities has limited available childcare slots. These impacts will have long-term adverse effects on education and academic performance for many youth and families who were already vulnerable.[13] Focused interventions will be needed to support vulnerable families with the resources required to enhance learning and development.

Community Identified Priorities

Continued

King County residents highlight the need for increased services in their neighborhoods to support families and youth development in order to help their communities thrive. This continues to be a recurring theme from past years, with requests for more:

- **Youth engagement opportunities,** including mentorship, after-school activities, educational supports, and job training programs that are ethnically and culturally responsive. This includes educational pathway navigation support for gang-influenced youth, first-generation and immigrant students, and those entering school from the foster system. Additional resources to engage families and youth with social and trauma-informed services would support positive mental and behavioral health for youth.

- **Childcare, early learning, and support for families to access affordable childcare.** The high cost of childcare is a barrier to economic growth for families, as well as to children's health and development. King County residents also highlight a need for more early learning programs to prepare young children to succeed in school, especially for low-income and working families.

- **Opportunities for physical activity and sports** for youth to participate in outside of school, such as city and neighborhood leagues and safe places to play.

Community Collaborations

- **Youth support:** Virginia Mason Franciscan Health invests in organizations led by communities of color in South King County to engage youth in positive activities with the goal to reduce youth violence and support youth of color to thrive. This has involved helping community members start their own culturally relevant non-profit organizations in Federal Way and Des Moines, including walking through how to register with the IRS, start a board, and fundraise.

- **Best Starts for Kids:** King County voters approved the Best Starts for Kids (BSK) Levy (Ordinance 18088) in late 2015, creating a vital six-year source of funding to ensure that children, families, and communities are happy, healthy, safe, and thriving. Now in its fifth year, BSK has funded more than 280 community partners and 480 programs and has increased access to services and supports for hundreds of thousands of children, youth, and families, with a focus on advancing racial equity. BSK also supports the workforce with whom families interact, builds capacity for the organizations families trust, and works to influence the systems that impact children and families. It is considered the most comprehensive approach to childhood development

Community Identified Priorities

Continued

in the United States. Best Starts for Kids outlined investments in five key areas:

» Invest Early: Support pregnant individuals, babies, very young children during their critical developmental years, and their parents, with a robust system of support services and resources that meet families where they are: at home, in community, and in childcare.

» Sustain the Gain: Continue the progress made with school- and community-based opportunities for children to learn, grow, and develop through childhood, adolescence, and into adulthood.

» Communities of Opportunity: Support communities to create safe, thriving places for children to grow up.

» Youth and Family Homelessness Prevention Initiative: Prevent young people and their families from losing housing.

» Results Focused and Data Driven: Use data and evaluation to know what strategies are benefiting children and communities.

COMMUNITY GROWTH AND DEVELOPMENT

Community mitigation efforts to limit the spread of novel coronavirus (COVID-19) have had profound impacts on the economic and social health of communities. The closures of nonessential businesses on March 15, 2020, resulted in a sudden and dramatic job loss for many residents, with more than 500,000 new unemployment claims filed between March and October 2020.[2] Job loss has especially impacted King County young adults, workers of color, and workers with a high school or equivalent education. The impacts of the pandemic on the economy will be far reaching. Community priorities related to educational attainment, economic security, employment opportunities, and community connectedness that were identified prior to the pandemic paint a picture of many unmet needs. These unmet needs made some communities especially vulnerable to the pandemic — underscoring the importance of ongoing monitoring and investment with renewed vigor to support community growth and development.

Community members continue to elevate the impacts of deeply rooted inequities by race and place on community health. King County residents face growing income inequality and unequal access

Community Identified Priorities

Continued

to economic opportunity. As the cost of living continues to rise across the county, more and more working families are living in poverty and unable to meet all their basic needs. Families of color are disproportionately impacted. A common set of needs were expressed to support families' ability to thrive:

- Support for **educational attainment** toward income/wealth generation. Residents note the need for expanded opportunities to attend school or job training programs to secure higher-quality jobs and earn higher wages.

- **Economic security,** including a higher minimum wage, and financial assistance for families living in poverty to access needed services. Communities request job training opportunities that align with growing industries to support workforce development.

- **Local economic opportunities for individuals and businesses,** including addressing wealth gaps, increasing home ownership among renters, and bolstering community development that brings economic opportunity and businesses to the local area, rather than displacing current residents and businesses.

- **Community connectedness and civic engagement** to support advocacy into action. South King County cities describe the importance of supporting a community's ability to organize, engage, and communicate with legislators and decision-makers to bring community voices to decision-making. Enhancing community connectedness was highlighted as a key area that could contribute to more community cohesion and social support for individuals and families to improve mental health for many community members.

Community Collaborations

- **Jobs skills for youth:** Partnering with Year Up since 2013 — a free, yearlong job skills training program — Swedish Health Services has provided 10 internships with the medical center's information technology help desk. The six-month internship prepares students to gain full-time employment in the community.

Description of Community

King County Community Health Needs Assessment 2021/2022

Surging economic growth, development, and growing demographic diversity continue to shape the landscape of King County. While King County has many meaningful initiatives, investments, programs, and organizations that support our increasingly diverse communities – such as by race and ethnicity, geography, sexual orientation, socioeconomic status, age, and disability status – notable disparities continue to exist. This section of the report highlights social determinants of health that significantly contribute to the overall quality of life, including the economic, behavioral, mental, and physical health of King County residents. A deep understanding of the local community, including how demographics and social outcomes are changing, further informs the priorities and assets described in the Community Identified Priorities section of the report. To address these underlying factors that impact health outcomes, community partners must be engaged and their voices elevated in identifying ways to change the systems, policies, and practices that influence these disparities. Many of the data and key findings included in this report describe conditions leading up to the onset of COVID-19. Where applicable, we have also integrated recent data collected during 2020 as well as some of the known impacts of COVID-19. COVID-19 has added to many of the vulnerabilities expressed in this report, and a renewed investment to support diverse communities will be critical to support the recovery and health of everyone in King County.

A review of inequities in health and social conditions among King County residents describes the environment leading into the COVID-19 pandemic — in many cases setting the stage for disproportionate impacts of COVID-19 and the measures taken to slow the spread of disease.

Description of Community

Continued

POPULATION TRENDS

King County and Seattle are the most populous county and city in Washington state, respectively. In addition to Seattle, King County includes 38 cities and towns as well as unincorporated areas. The county is divided into four geographic regions: Seattle, North, South, and East. Across four regions, 19 public school districts (as well as charter schools, private schools, and the Muckleshoot Tribal School) and many community health centers, hospitals, and health systems serve King County families.

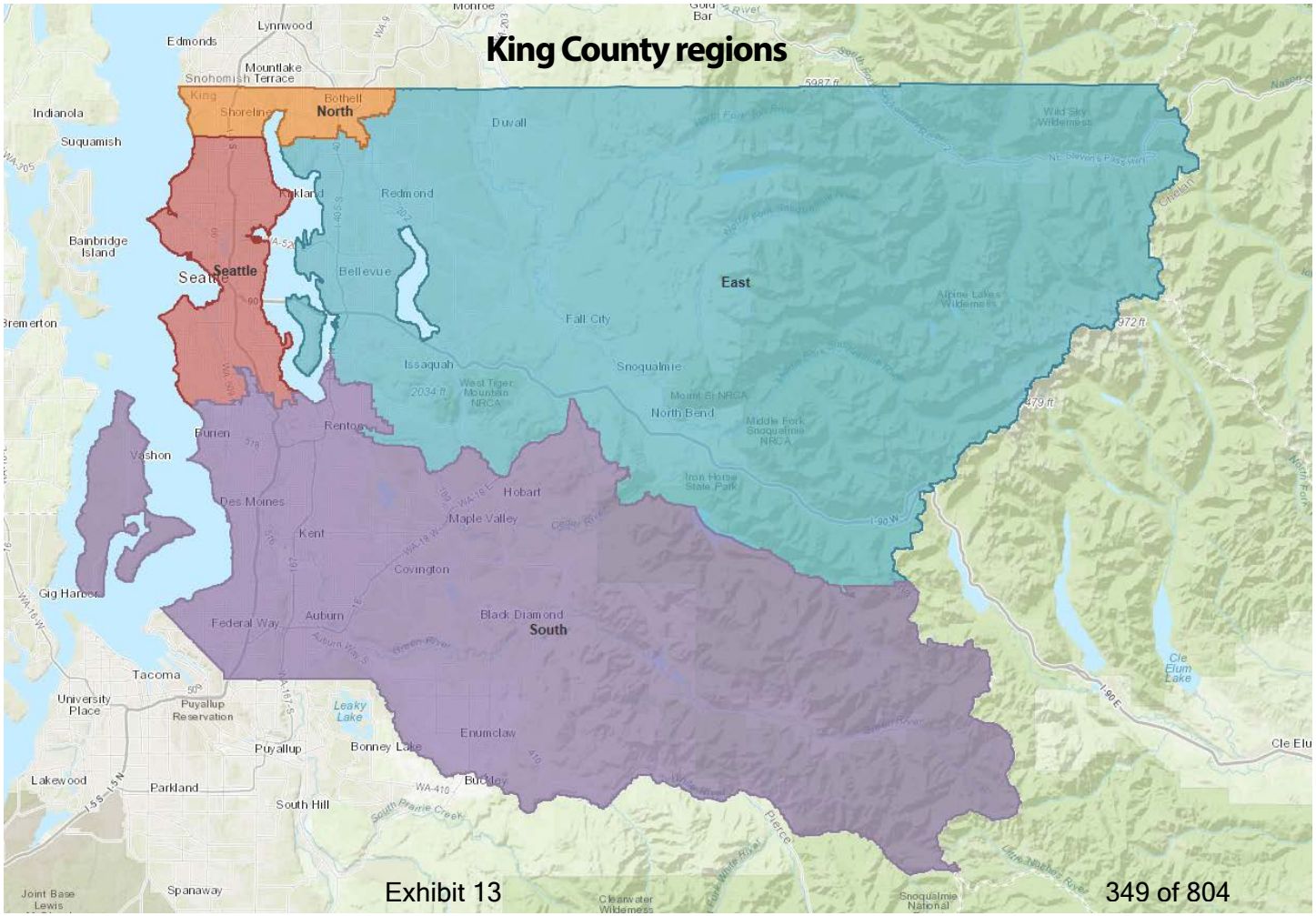


Exhibit 13

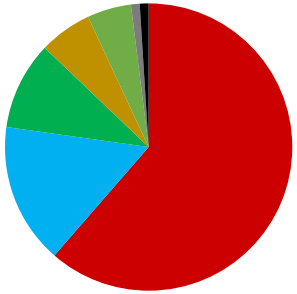
349 of 804

Description of Community

Continued

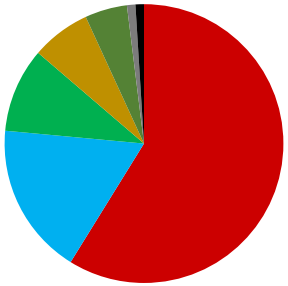
The county is continuing to experience population growth, though the rate of growth is slowing. In 2018, the King County population was 2,190,200, and state results from the 2020 Census will be available in early 2021. Between 2016 and 2018, the county population grew by more than 85,000 residents. It has approximately doubled since 1990, with increasing diversity and centered in cities.[14] King County is now 60% white, compared to 62% in 2016. The Asian population experienced growth in King County from 16% of the total population in 2016 to 18% in 2018. More than half of King County children are children of color. The growth rate has slowed in recent years, from ~2.6% in 2015–2016 to 1.7% in 2017–2018.[i] Despite declining annual growth rates county-wide since 2016, recent analyses show that King County has had the decade's third-largest growth among U.S. counties.[15]

King County, 2016
Population: 2,105,100



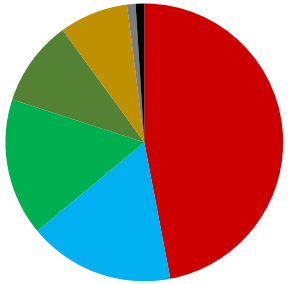
White/non-Hispanic	62%
Asian/non-Hispanic	16%
Hispanic/Latino	10%
Black/African American non-Hispanic	6%
Multiple race	5%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

King County, 2018
Population: 2,190,200



White/non-Hispanic	60%
Asian/non-Hispanic	18%
Hispanic/Latino	10%
Black/African American non-Hispanic	7%
Multiple race	5%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Population under age 18, King County, 2018
Population: 454,526



White/non-Hispanic	47%
Asian/non-Hispanic	17%
Hispanic/Latino	16%
Multiple race	10%
Black/African American non-Hispanic	8%
American Indian/Alaska Native/non-Hispanic	1%
Native Hawaiian/Pacific Islander/non-Hispanic	1%

Data source: WA Office of Financial Management 2016 & 2018

Percentages may not add up to 100% due to rounding

[i] *Growth rate from 2014 to 2018 was calculated by taking the population difference between years divided by the total population of the previous year, i.e., (2015 population - 2014 population) / 2014 population.*

Description of Community

Continued

HEALTH AND WEALTH

King County continues to rank among the top counties in the U.S. on county-level measures of health and wealth.

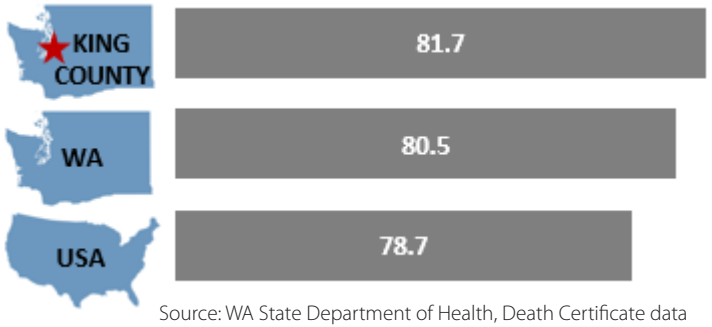
Averaging data from 2014–2018 for King County, life expectancy at birth was 81.7 years. Life expectancy in King County has been stable since 2014, averaging 81.7 years. In 2018, King County life expectancy exceeded the national and state averages. After implementation of the Affordable Care Act, the rate of uninsured King County adults decreased significantly. Strong and coordinated local efforts to increase enrollment among county residents contributed to a historic low rate of 6.7% uninsurance in 2016 (7.2% in 2019) compared to over 16% prior to implementation of the ACA.

Disparities in life expectancy reveal the impacts of differences in experiences throughout the life course. In King County, Native Hawaiian/Pacific Islander, America Indian/Alaska Native, and Black adult life expectancy is four to nine years shorter than the life expectancy of white adults.

Communities of color continue to be disproportionately uninsured — before and after implementation of the ACA. Racial/ethnic disparities

Life expectancy (years)

King County, Washingon state, USA (2018)



Source: WA State Department of Health, Death Certificate data

in insurance coverage have increased since an initial narrowing of gaps in coverage in 2014. In 2019, Hispanic adults were seven times as likely as non-Hispanic whites to be without health insurance coverage. American Indian/Alaska Natives and Black adults were two to three times less likely to have insurance compared to white adults.

While resources like increased access to telehealth visits, drive-through flu vaccinations, and free COVID-19 testing have eliminated barriers for many, the shift to COVID-19 response has introduced new barriers to accessing primary and preventive care in some areas. Access to healthcare is additionally challenged in the current era of COVID-19 among the most vulnerable communities, when many have lost access to employee-sponsored healthcare plans and reliable income. Medicaid enrollment is increasing in King County, particularly among adults

Description of Community

Continued

Household income has increased rapidly over the past 20 years, as the number and types of high-paying, tech-sector jobs increased, along with increasing wages. In 2018, median household income in King County was $95,009 — higher than other U.S. counties that are comparable in size by employment (as measured by the U.S. Bureau of Labor Statistics).[16] In 2019, median household income in King County reached six figures ($102,594) for the first time.[17]

The median net worth of a household in King and Snohomish counties is nearly $400,000, which ranks 10th among more than 100 metro areas.[18] However, despite the appearance of county-wide prosperity, **racial gaps in health and wealth** have been repeatedly documented in King County.

In Seattle, the median net worth for Black households represents only 5% of the median net worth of white households. Homeownership is a path to building wealth, and one of the biggest assets for a household. The median net worth for a household that owns its home in the Seattle area is nearly $900,000 — 25 times the median net worth for renter households ($36,000).[18]

Historic systems of racist policies and practices have shaped and continue to shape access to resources and opportunities for communities of color. Real estate practices that denied homes to Black residents, along with disparities in educational attainment and employment add to a list of challenges that make home ownership and wealth accumulation a challenge for Black and brown families in King County.

Growing inequities shape the landscape of King County — mapping the conditions that have made low-income residents and communities of color vulnerable to chronic diseases, disruptions in the economy, and most recently — the impacts of the COVID-19 pandemic. The amount of wealth and disposable outcome that a family has after accounting for daily living expenses impacts that family's risk of financial instability, as well as their ability to sustain sudden disruptions in work or health that have been compounded during the pandemic. Similarly, people with underlying medical conditions — like heart disease, diabetes, and lung disease — are at higher risk for COVID-19 death. In King County, all of these conditions are more prevalent in communities of color, making them more vulnerable to the disease.

Description of Community

Continued

A CHANGING SOCIAL AND POLITICAL ENVIRONMENT: RACISM AS A PUBLIC HEALTH CRISIS

Recent events have prompted shifting social and political environments — locally and nationally. Communities across the county have been deeply impacted as people who live and work here react to COVID-19 and community mitigation measures, massive unemployment, a challenging housing market, and political unrest. A large and sustained movement for Black lives has taken the spotlight in Seattle following the murder of George Floyd in Minneapolis on May 25, 2020. The ongoing dialogue, demonstrations, and protests in Seattle and across King County have brought more attention to equity, social justice, anti-racism, and community empowerment in all sectors, including healthcare and public health.

On June 11, 2020, King County government declared racism a public health crisis, underscoring the importance of centering the voices and lived experiences of local communities most impacted by systemic racism and economic inequity in policy decisions.[19] Public Health – Seattle & King County is committed to helping to build stronger and appropriately resourced partnerships with community organizations and leaders to disrupt and dismantle racism. The presentation of data throughout this report illustrates how racism contributes to inequities in social determinants of health in King County. It serves as a foundation to inform hospitals, health systems, and community investments, resources, programs, and policies to dismantle structures that sustain inequities and improve the health of our community.

Description of Community

Continued

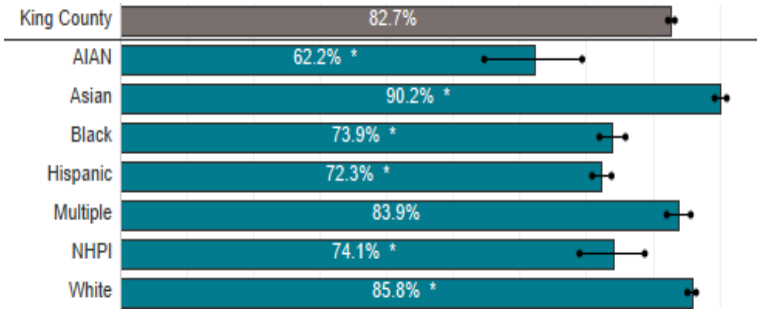
EDUCATIONAL ATTAINMENT

Educational attainment is an important determinant of health, as it is associated with income, employment, housing, and access to services. Averaging data from 2014–2018, close to half (48.6%) of King County adults do not have a **bachelor's degree**. There are disparities in educational attainment by race/ethnicity — Native Hawaiian/Pacific Islander (87.0%), American/Indian Alaska Native (85.1%), Hispanic (74.5%), and Black (73.2%) adults are at least 1.5 times as likely to be without a bachelor's degree compared to white (45.3%) adults.

Averaging data from 2014–2018, 29.3% of Hispanic residents have less than a **high school education,** compared to 7.0% county-wide and only 3.1% among white residents. Among South Region residents, 11.1% have less than a high school diploma — nearly double the rate in Seattle (5.4%) and the North Region (5.6%), and more than three times the rate in the East Region (3.5%).

During the 2018–2019 school year, 82.7% of students in King County **graduated from high school** within four years. However, Black, Hispanic, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander students were significantly less likely to graduate from high school on time. The likelihood of graduating on time was even lower for English language learners, students experiencing homelessness, and students from migrant families. Fewer than 50% of students in foster care graduate on time. In the Tukwila School District, one in four students did not graduate on time.

High school graduation
King County (2018-2019)



Source: The Office of Superintendent of Public Instruction
* Significantly different from King County average

Description of Community

Continued

HOUSEHOLD INCOME

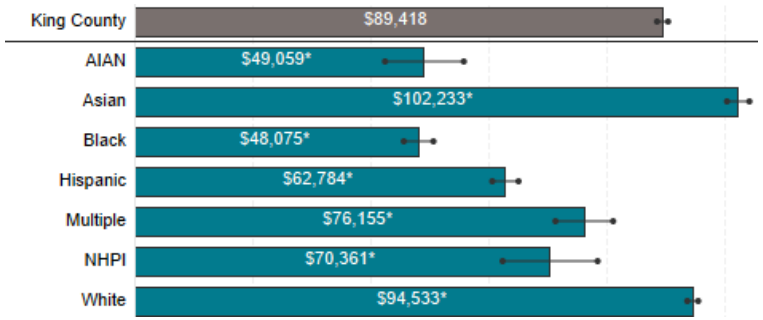
Income inequality affects a wide range of social and economic outcomes.[20] Median household income is closely tied to educational opportunities, employment, and health outcomes.

Averaging data from 2014–2018, the median household income for King County residents was $89,418. There are racial/ethnic gaps in household income, with Black households reporting significantly less than the average household, and Asian households reporting significantly more. The median income for Black households is $48,075, which is less than half the median income of Asian households ($102,233) and white households ($94,533).

Widening gaps in household income increase the advantages for those with higher median household incomes to access opportunities to thrive, including educational attainment, access to healthcare, and political power. It is predicted that the Black-white wealth gap will widen existing educational disparities during the coronavirus pandemic. This is especially concerning as families with fewer economic resources struggle to access the tools and resources that are needed to create home environments that support successful remote learning during pandemic-related school closures.[21]

Median household income

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

Description of Community

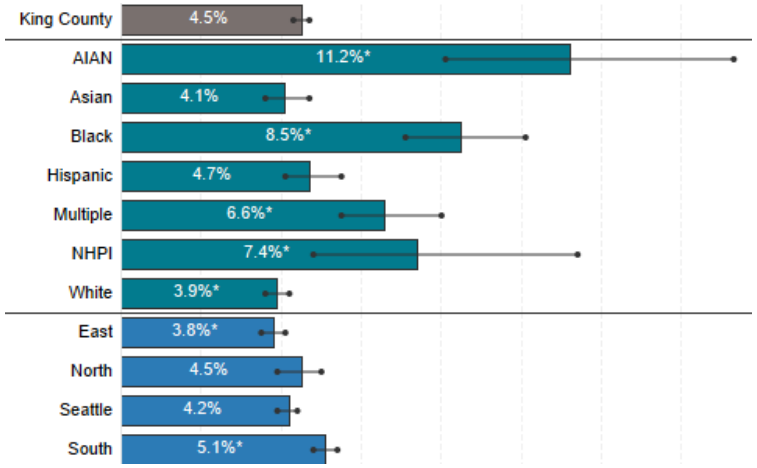
Continued

UNEMPLOYMENT

Mirroring the pattern for Washington state, the rate of unemployment in King County has been steadily declining from a peak of 9.4% in 2010, until 2020, when we experienced large increases in new unemployment claims per capita[ii] due to COVID-19. Roughly one in three workers (35.5%) in King County filed initial unemployment insurance (UI) claims with the Washington State Employment Security Department between March 1 and November 7, 2020, totaling 529,027 claims. As of November 7, initial claims filed per capita show that the industries with the highest percentage of claims were accommodation/food service, manufacturing, retail, construction, and healthcare and social assistance. Furthermore, Native Hawaiian/Pacific Islanders, Black/African American, and American Indian/Alaska Native workers had the highest percentage of claims per capita.

Averaging data from 2014–2018, the King County unemployment rate among residents age 16 and older is 4.5%. As with other indicators of economic health, glaring disparities exist by race and place. Unemployment among American Indian/Alaska Native residents (11.2%) is 2.5 times the county average. The unemployment rate is highest in the South Region (5.1%) and reaches up to 6.5% in Southeast Seattle and areas of Federal Way. Rates are lowest in the East Region (3.8%), where residents also have the lowest poverty rate and highest educational attainment compared to other county regions.

Unemployment rate (age 16+)
King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

[ii] *The unemployment claims due to COVID-19 reflect unemployment per capita.*

Description of Community

Continued

DISABILITY

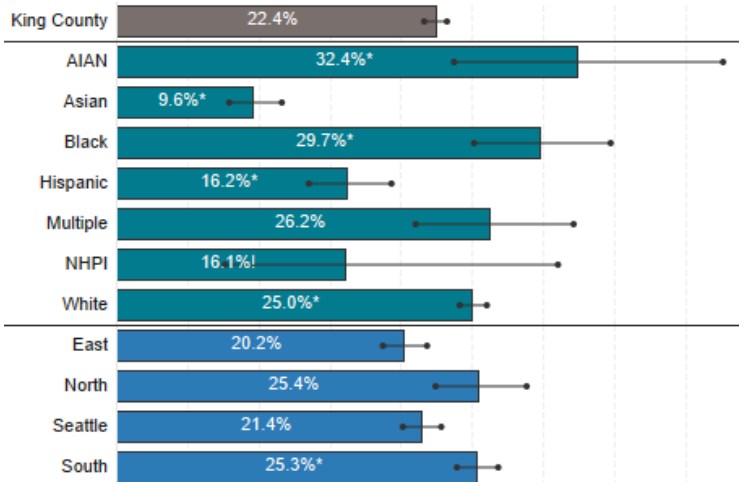
Averaging data from 2012–2016, the most recent years for which we have data, 22.4% of King County adults were limited in some way with activities because of physical, mental, or emotional conditions or have health conditions that require them to use special equipment, such as a cane, wheelchair, a special bed, or a special telephone. The rate of disability is significantly higher among adults who identify as LGB (29.5%). There are also significant differences for adults with disabilities among race, military service, and age groups. Thirty-four percent of North Highline residents reported a disability — the highest of all King County neighborhoods, followed by Vashon Island (32.5%).

While demographic characteristics of individuals with disabilities in King County are described here, it is important to review additional health and social indicators for individuals with disabilities. Therefore all American Community Survey (ACS) indicators[iii] available online have disability status included as a demographic variable.

[iii] *The American Community Survey (ACS) data source provides detailed demographic and population data such as education, housing, employment, and transportation. Generally, ACS indicators can be found online in the "Demographics" topic area.*

Disability (adults)

King County (average: 2012-2016)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Description of Community

Continued

CHANGING DEMOGRAPHICS

Increasing racial and ethnic diversity among children is a continuing county-wide demographic trend. The population of children under age 18 is now 53% people of color. In 2018, 23.5% of King County residents and nearly 20% of Seattle residents were foreign born — a significant increase from 2016 in Seattle.

King County has a wide range of cultural and linguistic diversity. One in four King County residents live in a household where a language other than English is spoken. In 2019, Chinese, Spanish, and Vietnamese were the most commonly spoken languages outside of English across King County regions. Among the languages ranked 2nd, 3rd, and 4th across King County regions, Spanish; Chinese; Vietnamese; Hindi; Amharic, Somali, or other Afro-Asiatic languages; Telugu; Korean; and Urdu rise to the top.

Top 10 languages by region

King County (2019)

Rank	King County	East	North	Seattle	South
0	English Only	English Only	English Only	English Only	English Only
1	Spanish	Chinese	Spanish	Chinese	Spanish
2	Chinese	Spanish	Chinese	Spanish	Vietnamese
3	Vietnamese	Hindi	Korean	Amharic, Somali, or other Afro-Asiatic languages	Amharic, Somali, or other Afro-Asiatic languages
4	Amharic, Somali, or other Afro-Asiatic languages	Telugu	Urdu	Vietnamese	Chinese
5	Hindi	Russian	Tamil	Tagalog (inc. Filipino)	Tagalog (inc. Filipino)
6	Tagalog (incl. Filipino)	Japanese	Amharic, Somali, or other Afro-Asiatic languages	Korean	Punjabi
7	Korean	Malayalam, Kannada, or other Dravidian languages	Tagalog (incl. Filipino)	Japanese	Ukranian or other Slavic languages
8	Russian	Korean	Russian	Hindi	Korean
9	Japanese	Tamil	Other languages of Asia	French	Ilocano, Somoan, Hawaiian, or other Austronesian languages
10	French	Persian (incl. Farsi, Dari)	Japanese	Arabic	Russian

Source: American Community Survey Public Use Microdata Sample (PUMS)

Description of Community

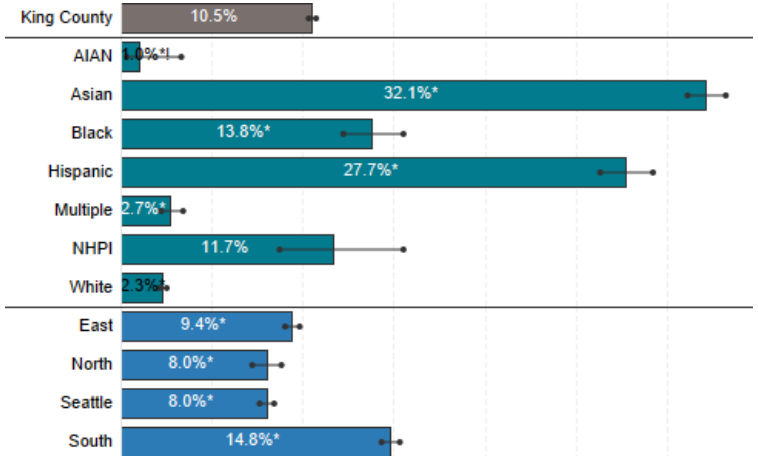
Continued

Averaging data from 2014–2018, 10.5% of King County residents over the age of five (including 40% of foreign-born residents) spoke English less than "very well." The percentage of Seattle residents reporting limited English proficiency has decreased from 11.8% in 2006 to 7.9% in 2018, while the King County rate hovered around 11% during that same period. The rate is higher in the South Region (14.8%) — limited English proficiency in SeaTac/Tukwila (25.5%) and Beacon Hill/Georgetown/South Park (27.1%) is more than twice the county average.

English language proficiency is directly associated with household income. More than 20% of residents with income less than $20,000 per year spoke English less than "very well" compared to 5.8% of people with an income of $150,000 or more. Language barriers also limit access to education, employment, and healthcare, presenting challenges for immigrant families to meet their basic needs.

Limited English proficiency (age 5+)

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Description of Community

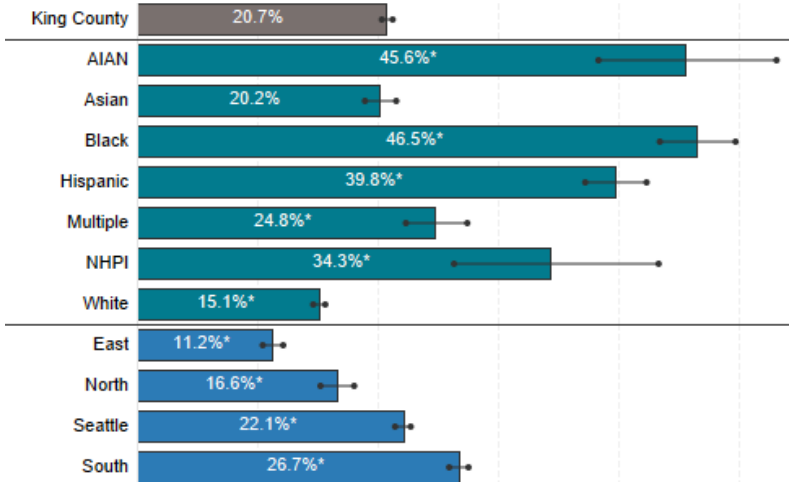
Continued

ECONOMIC INEQUITIES

Although poverty rates are declining in Seattle, King County, and Washington state, disparities persist by race, place, and disability. King County poverty[iv] rates are down from a 10-year peak of 25.4% in 2012. Averaging data from 2014–2018, one in five King County residents live in poverty or near poverty. More than 38% of young adults (18–24) and nearly half of Black and American Indian/Alaska Native residents lived below 200% of the federal poverty level (FPL). Black adults are more than 2.9 times as likely to be living in poverty or near poverty compared to white adults. The poverty rate among persons with disabilities is 1.8 times the county average. The South Region is disproportionately impacted, with two of the highest-poverty neighborhoods — SeaTac/Tukwila (35.7%) and Beacon Hill/Georgetown/South Park (36.5%).

Income <200% of Federal Poverty Level

King County (average: 2014-2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

[iv] *Household income <200% of federal poverty level.*

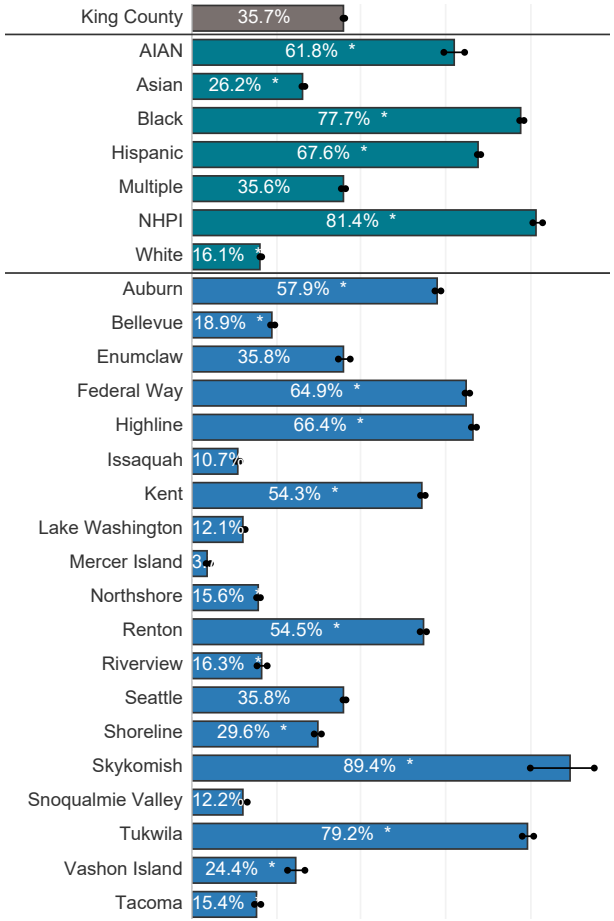
Description of Community

Continued

Eligibility for free and reduced-price school lunch is another sign of underlying economic inequities and varies widely across school districts. In King County (2017–2018 school year), 35.7% of students qualified for free and reduced price lunch. Compared to white students (16.1%), Native Hawaiian/Pacific Islander students are five times (81.4%), Black students are 4.8 times (77.7%), Hispanic students are 4.2 times (67.6%), and American Indian/Alaska Native students are 3.8 times (61.8%) as likely to qualify. The Tukwila school district has the second highest rate of students qualified for free and reduced-price lunch (79.2%).

Free and reduced price lunch

King County (2017-2018)



Source: The Office of Superintendent of Public Instruction
* Significantly different from King County average

Description of Community

Continued

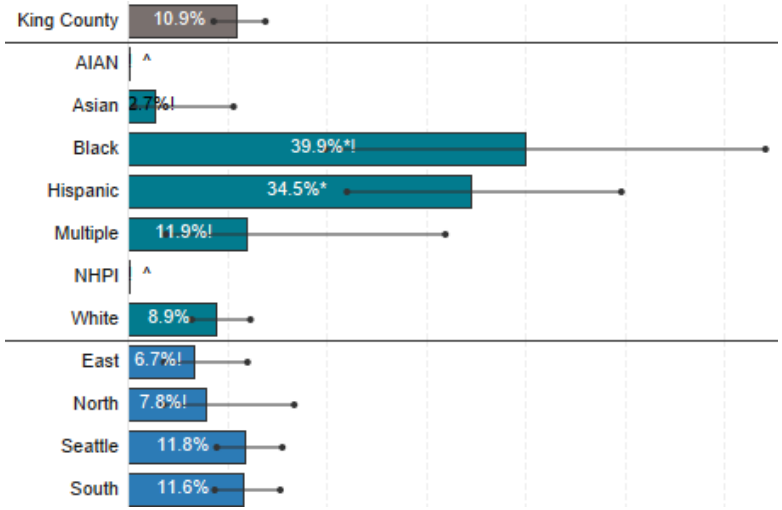
Disparities in food security reveal staggering racial inequities and signal serious vulnerabilities for communities of color to pandemic-related economic impacts. Food insecurity is defined as running out of food without enough money to purchase more. In 2018, 10.9% of King County adults bought food that sometimes/often didn't last and didn't have money to get more (last 12 months).

According to recent estimates, nearly 40% of Black adults are food insecure — more than any racial/ethnic group. Black adults are more than four times as likely to run out of food without money to purchase more than white adults. Uncertainty about food has increased among King County residents as a result of the staggering economic impacts of the COVID-19 pandemic. The gap between white and Black food-insecure households has increased fourfold over a five-year period — from 2013 (10.4% white, 17.3% Black) to 2018 (8.9% white, 39.9% Black).

Food insecurity among young adults (18–24) (19.3%) is nearly twice the county average. Adults who identify as LGB (22.4%) were 2.5 times as likely as heterosexual adults (8.8%) to report food insecurity. Southeast Kent reported the highest rate of food insecurity among all King County neighborhoods in 2018 (25.9%).

Food insecurity (adults)

King County (2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Description of Community

Continued

Following implementation of strategies to slow the spread of COVID-19, the number of local families experiencing food insecurity has increased throughout 2020. Enrollment in the Basic Food assistance program increased by 21.6% among King County households from January to June 2020 — an increase of 28,135 households — and food needs were the second most common reason for King County residents to call seeking assistance with social services in spring 2020.

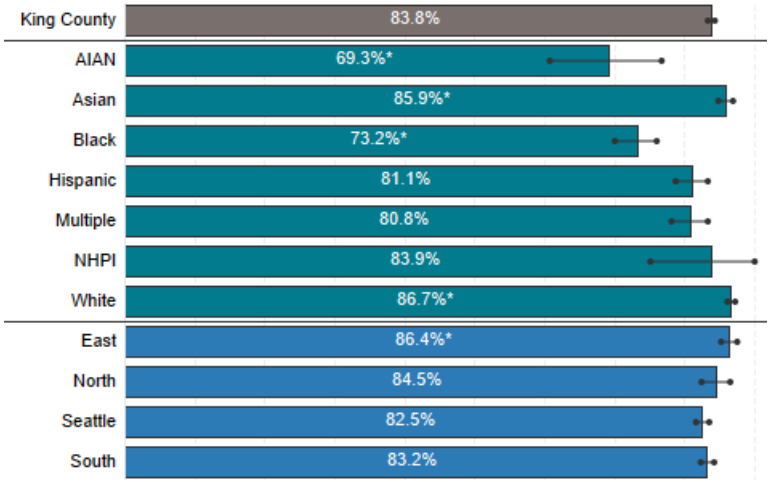
HOUSING AND TRANSPORTATION BARRIERS

With population and economic growth, King County has experienced escalating housing costs for renters and owners. Households with no severe housing cost burden are those paying less than 50% of household income for housing, including rent, mortgages, and housing owned free and clear (no mortgage).

Averaging data from 2014–2018, 83.8% of King County households paid less than 50% of their household income for housing. Compared to the average King County household, Asian and white households are significantly more likely to not experience a severe housing cost burden. There are persistent gender disparities in housing cost burden. Male residents (renters, owners with mortgages, and owners without mortgages) are significantly more likely than females to pay less than 50% of their income for housing costs. Increasing housing costs also affect affordability of other daily living expenses, such as food, transportation, and childcare.

Households that pay less than 50% of their income for housing costs

King County (average: 2014 - 2018)



Source: American Community Survey Public Use Microdata Sample (PUMS)
* Significantly different from King County average

Description of Community

Continued

Housing cost burden has been greatly impacted by the COVID-19 pandemic. As of September 8, 2020, weekly requests for housing-related assistance account for approximately 50% or more of calls to the 2-1-1 service hotline since April 2020. Increased housing needs are expected as families face evictions or loss of housing once local eviction moratoria and renter protections end.

While homelessness is an ongoing community concern, King County is housing more people every year. The 2019 Point-in-Time Count identified 11,199 individuals, youth, and members of families experiencing homelessness in Seattle/King County — a decrease of 8% from 2018. Almost 70% of King County's homeless population lives in Seattle. Forty-seven percent of the homeless population was unsheltered, living on the street, or in parks, tents, vehicles, or other places not meant for human habitation — a decrease from 52% of the population in 2018. Compared to 2018, the number of unaccompanied youth and young adults experiencing homelessness decreased by 28%. The number of unaccompanied youths under the age of 18 decreased by 52%.

Compared to the overall population of Seattle/King County, homelessness disproportionately impacts people and households of color. The homeless response system in King County includes a diverse set of programs and organizations that provide shelter, housing, and services to people experiencing homelessness. This includes emergency shelters, transitional housing, rapid re-housing (i.e., housing identification with case management and rental assistance), and permanent supportive housing programs. These programs/agencies are required to collect information about the people they serve in a central database, the King County Homeless Management Information System (HMIS). Reporting data from September 30, 2020, the King County HMIS Regional Homelessness dashboard shows that 10,301 King County households experienced homelessness and received services in the homeless response system. Most heads of these households identified as people of color.

While King County is 6% Black, 29% of households in the homeless response system identified as Black or African American. American Indian/Alaska Native individuals make up just 1% of the King County population, but they make up 4% of the homeless response system. However, more than half of households who exited the homeless response system were households of color, and Black

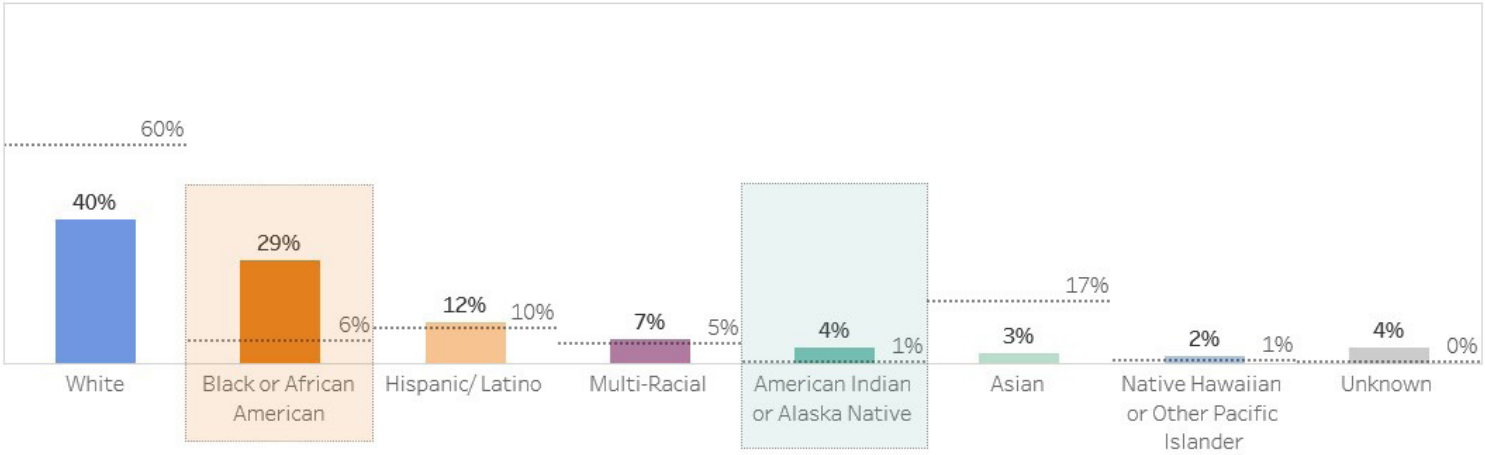
Description of Community

Continued

households were more likely to exit to permanent housing compared to other households by race/ethnicity. The 2020 Point-in-Time Count (January 2020)[v] report highlights similar racial/ethnic disparities in homelessness. It is anticipated that the COVID-19 pandemic will increase homelessness, so these figures may be significantly different in 2021. However, in light of the pandemic and due to safety concerns, the unsheltered count for the 2021 Point-in-Time Count will not occur as scheduled. King County received a waiver from the U.S. Department of Housing and Urban Development to cancel the 2021 unsheltered count due to the risks of gathering large numbers of volunteers and need for staff to focus on pandemic response efforts.

King County's Homeless Response System (10,301 total households)

King County (as of 9/30/2020)



[v] *Since the methodology and research team for the 2020 Point-in-Time count were different from the past three years, estimates are not directly comparable to previous years.*

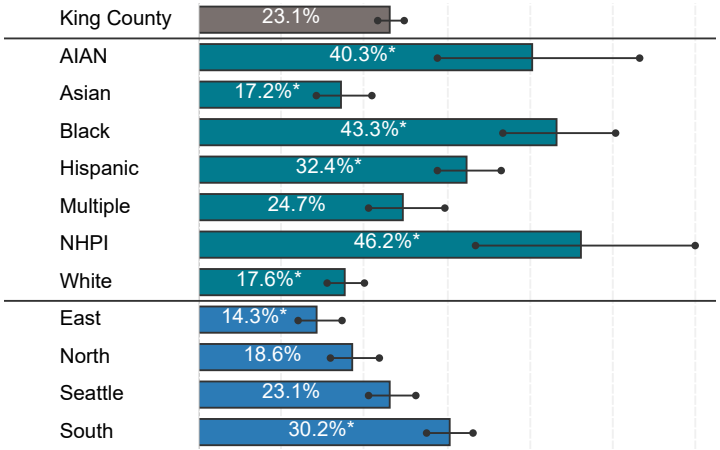
Description of Community

Continued

Access to affordable and reliable transportation is a basic need, especially for families with young children. Averaging data from 2017 and 2019, in King County, 23.1% of children lived in families that had found it difficult to afford transportation at least some of the time since the child was born. Apart from Asian residents, residents of color are more likely to report that they struggle to afford transportation compared to white residents. As people move further away from the city centers in search of affordable housing, transportation resources are even more important. In 2018, nearly 15% of King County residents reported commuting by public transit — an increasing trend in recent years. This is a significant concern when families are unable to access healthcare due to transportation issues. There are also growing implications for accessing employment during the COVID-19 pandemic, as many essential employees are unable to telecommute and may rely heavily on public transportation if they do not have a choice to use a private vehicle — potentially increasing their risk of exposure to the virus.

Families with children (ages 6 months - 5th grade) that found it difficult to afford transportation

King County (2017 & 2019)



Source: Best Starts for Kids Health Survey (BSKHS)
* Significantly different from King County average

Description of Community

Continued

RECURRING THEMES: INEQUITIES KEEP COMMUNITIES FROM THRIVING

Inequities by income, race, and place continue to shape the distribution of poor health and social outcomes in King County. Many of these inequities are driven by persistent systems, policies, and practices that are centered on racist or oppressive practices, which is made clear by the stark disparities and inequities across King County, especially when looking at indicators by race/ethnicity.

With few exceptions when viewing data over time, the health and well-being of communities of color have not improved significantly, and COVID-19 is likely to slow or even turn back progress if greater investments are not made to support communities and help them thrive. We also know that communities do not experience social and health factors in isolation. Rather, the cumulative effect of all these experiences is what impacts health and social outcomes. Furthermore, it is often the same communities that are impacted — underscoring the need for solutions that are culturally tailored and directed toward the places that are most affected.

Life Expectancy & Leading Causes of Death

Life expectancy is the culmination of all the health-promoting and debilitating factors that individuals face. As such, life expectancy and leading causes of death are key measures used to monitor progress in preventing disease and disability. Life expectancy in King County has been stable for the past decade, and generally higher than the national average. However, disparities in life expectancy and death rates by socioeconomic factors persist and have grown in some cases. Changes in causes of death and disability can help us understand trends in life expectancy.

Additional indicators available online include heart disease deaths, fair or poor health (adults), cancer deaths, and influenza/pneumonia deaths.

Public Health – Seattle & King County conducts investigations to help understand the circumstances and burden of deaths attributable to COVID-19. Death counts and trends are updated daily and available on the COVID-19 Outbreak Summary dashboard. Underlying health conditions such as diabetes and heart disease increase the risk of poor health outcomes due to COVID-19. As of September 1, 2020:

- The greatest burden of death is among those above 60 years old.
- Through September 1, more than eight out of 10 COVID-19 decedents had underlying medical conditions, such as heart disease, diabetes, chronic kidney disease, chronic lung disease, or immunosuppression.

Life expectancy among South Region residents has declined for the past 10 years.

- Although most COVID-19 deaths are among whites, the age-adjusted rate of death is highest among Native Hawaiian/Pacific Islanders (NHPI) and Hispanics. Among those under 60 years old, Hispanics make up less than 12% of the population but accounted for 42% of COVID-19 related deaths.

The data included in the rest of this section highlight the disproportionate deaths and vulnerabilities that many populations faced prior to COVID-19, which should be monitored closely to support populations that may be most impacted by COVID-19.

Life Expectancy & Leading Causes of Death

Continued

LIFE EXPECTANCY

Life expectancy is defined as the total number of years a newborn can expect to live given current death rates. Averaging data from 2014–2018 for King County, life expectancy at birth was 81.7 years and remained stable throughout this time period. In 2018, King County life expectancy exceeded the national average of 78.7 years and Washington state average of 80.2 years.[22] However, we still experience noteworthy differences in life expectancy by place and race/ethnicity in King County.

- The North Region (81.2 years) and the South Region (79.3 years) have significantly lower life expectancy compared to the King County average, whereas the East Region (83.9 years) and Seattle (83.4 years) both had significantly higher life expectancies than the North and South regions.

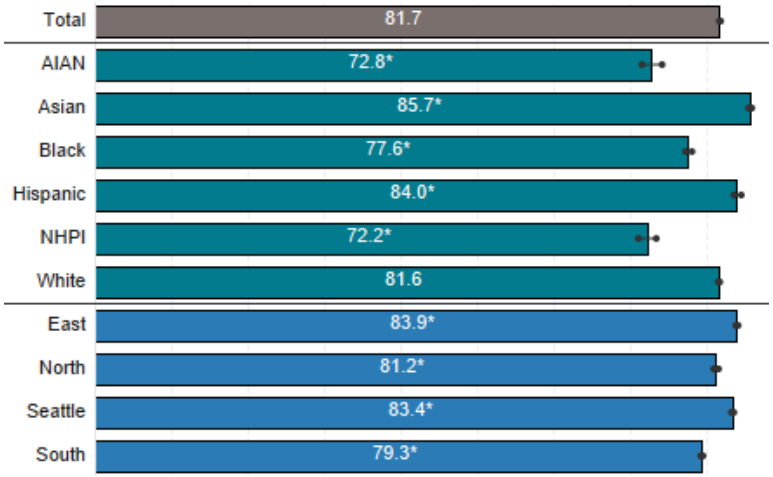
- Life expectancy among South Region residents has declined for the past 10 years. East Region (83.9 years) residents are expected to live 4.6 years longer than residents of the South Region.

- Residents of Mercer Island/Point Cities have a life expectancy of 86.7 years, while South Auburn residents have a life expectancy of 75.2 years — a difference of 11.5 years.

- Gender differences in life expectancy mirror national trends. Female residents (83.9 years) are expected to live on average 4.5 years longer than males (79.4 years). Nationally, females live on average five years longer than males.[23]

Life expectancy

King County (average: 2014 - 2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average

- Life expectancy is highest among Asian (85.7 years) and Hispanic residents (84.0 years).

- While Hispanic life expectancy is higher than the King County average, it has declined significantly from the 2011–2013 average of 86.7 years.

- Among Black residents (77.6 years), life expectancy is four years shorter than life expectancy

Life Expectancy & Leading Causes of Death

Continued

of white residents (81.6 years). This gap is even greater by race and gender: life expectancy for a Black male is nine years less than for a white female (74.7 to 83.7 years, respectively).

- While estimates may be imprecise due to small population numbers, at 72.2 years, Native Hawaiian/ Pacific Islander residents have the lowest life expectancy of all racial/ethnic groups in King County. This is a decline of 5.6 years from the 2011–2013 average life expectancy of 77.8 years for this group.

- Residents living in low-poverty neighborhoods (83.8 years) live an average of 4.8 years longer than those in high-poverty neighborhoods (79.0 years).

LEADING CAUSES OF DEATH

Leading causes of death among King County residents vary by age and race/ethnicity. Averaging data from 2014–2018, heart disease and cancer remain the top two leading causes of death in King County overall. Heart disease was the leading cause of death for adults 65 years and older. While cancer was the leading cause of deaths for children 1–14 and adults 45–65, unintentional injury was the leading cause of death among teens (15–24) and young adults (25–44).

The five-year average rate and average annual counts for each cause of death are available online.

- Cancer and heart disease are the 1st and 2nd leading cause of death, respectively, for both males and females. Unintentional injuries were the 3rd leading cause of death among males, while Alzheimer's disease was 3rd among females.

- Among children age 1–14, the average all-cause death rate was 9.9 per 100,000. The top three leading causes of death among children were cancer (2.1 per 100,000), unintentional injuries (1.9 per 100,000), and congenital malformations (0.9 per 100,000).

- The death rate among men in King County is 1.4 times the rate among women. Gender differences are widened in certain age groups and causes of death.

Life Expectancy & Leading Causes of Death

Continued

In the 15–24 age group, males die at a rate three times that of females. In the same age group, the average death rate from unintentional injuries among males is nearly four times the rate among females.

- Suicide is the 8th leading cause of death overall, but 2nd in the 15–24 and 25–44 age groups. The male suicide rate is nearly four times the female rate in the 15–24 age group and nearly three times the female rate in the 25–44 age group.

- Males age 15–24 are nearly six times as likely as females of that age group to be killed by another person. In the 25–44 age group, the male homicide death rate is 3.2 times that of females.

- Alzheimer's disease remains the 3rd leading cause of death, affecting women more than men. Among adults older than 65, the rate of death from Alzheimer's among females was 1.8 times that of males.

- Heart disease death rates among men are 1.8 times those among women.

- While unintentional injury was the 4th leading cause of death overall, it was the leading cause of death among American Indian/Alaska Native residents. This has shifted from cancer as previously reported in the last CHNA (average 2011–2015), which is now the second leading cause of death for the American Indian/Alaska Native population.

- Among American Indian/Alaska Native residents, the rate of death from unintentional injury is 2.8 times the rate among Blacks, 3.5 times the rate among whites, and 6.6 times the rate among Asian residents.

- Diabetes is the 7th leading cause of death overall and the 3rd leading cause among Native Hawaiian/Pacific Islander residents.

Life Expectancy & Leading Causes of Death

Continued

Cause category
- All causes
- Chronic disease
- Infectious disease
- Injury/violence
- Other

Leading causes of death (ranked by the number of deaths)

King County (average: 2014 - 2018)

Rank	Total	AIAN	Asian	Black	Hispanic	NHPI	White
0	All causes 621.4 (12,958)	All causes 1,021.7 (112)	All causes 448.7 (1,146)	All causes 781.6 (785)	All causes 502.1 (360)	All causes 1,181.4 (88)	All causes 634.9 (10,231)
1	Cancer 140.6 (2,965)	Unintentional injuries 129.9 (18)	Cancer 111.3 (313)	Cancer 166.0 (172)	Cancer 105.7 (77)	Heart disease 259.1 (20)	Cancer 144.2 (2,320)
2	Heart disease 124.4 (2,593)	Cancer 155.1 (17)	Heart disease 79.2 (196)	Heart disease 154.8 (149)	Heart disease 95.7 (50)	Cancer 219.5 (19)	Heart disease 128.9 (2,128)
3	Alzheimer's disease 45.6 (924)	Heart disease 182.7 (16)	Stroke 33.8 (82)	Unintentional injuries 45.8 (59)	Unintentional injuries 33.7 (43)	Diabetes Mellitus 96.3 (7)	Alzheimer's disease 49.3 (822)
4	Unintentional injuries 34.9 (757)	Chronic liver disease 66.9 (9)	Alzheimer's disease 26.3 (56)	Diabetes Mellitus 47.3 (46)	Stroke 33.6 (17)	Stroke 109.4 (5)	Unintentional injuries 36.7 (557)
5	Stroke 31.6 (644)	Chronic lower resp. disease 42.0 (5)	Unintentional injuries 19.7 (55)	Stroke 43.7 (39)	Diabetes Mellitus 20.5 (14)	Unintentional injuries 25.8 (4)	Stroke 30.1 (490)
6	Chronic lower resp. disease 25.9 (523)	Stroke 59.7 (4)	Diabetes Mellitus 18.8 (47)	Chronic lower resp. disease 26.8 (27)	Chronic liver disease 12.2 (14) Suicide 6.6 (14)	Influenza/ pneumonia 21.8 (2)	Chronic lower resp. disease 28.4 (450)
7	Diabetes Mellitus 18.7 (389)	Diabetes Mellitus 31.2 (4)	Chronic lower resp. disease 11.1 (27)	Alzheimer's disease 34.6 (24)	--	Septicemia 26.9 (2)	Diabetes Mellitus 16.5 (265)
8	Suicide 12.1 (268)	Suicide 20.2 (3)	Suicide 7.3 (26)	Homicide 16.2 (23)	Alzheimer's disease 33.5 (12)	Essential (primary) hypertension 21.0 (2) Chronic lower resp. disease 42.9 (2)	Suicide 14.0 (203)
9	Chronic liver disease 9.6 (221)	Alzheimer's disease 41.2 (3)	Essential (primary) hypertension 8.8 (20)	Essential (primary) hypertension 19.2 (17)	Homicide 4.7 (11)	--	Chronic liver disease 10.2 (169)
10	Influenza/ pneumonia 9.9 (205)	Nephritis 14.4 (2)	Influenza/ pneumonia 8.4 (20)	Nephritis 12.6 (13)	Certain conditions orginating in the perinatal period 2.1 (7)	Suicide 8.4 (2)	Influenza/ pneumonia 10.0 (165)

Source: WA State Department of Health, Death Certificate data

Note: For each cause, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count for that cause over the 5-year period. For leading causes by age, the rates are age-specific. All other rates are age-adjusted. Multiple race data is not accurately reported on death certificates and is not recommended for analysis.

Life Expectancy & Leading Causes of Death

Continued

UNINTENTIONAL INJURY DEATHS

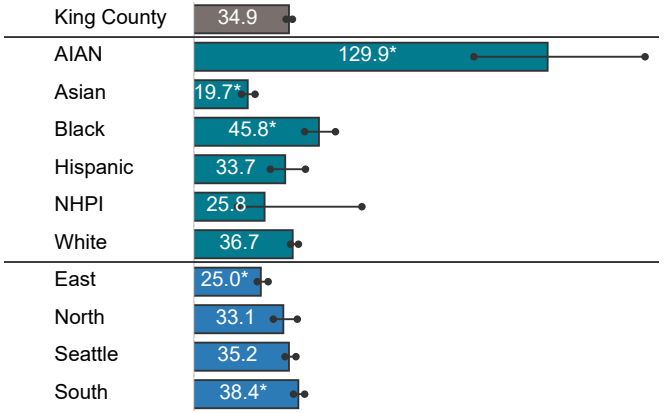
Unintentional injury deaths are tabulated separately from homicide, suicide, police/legal intervention, acts of war, or undetermined causes of death.[24] In King County, the leading causes of unintentional injury death (in order) are poisoning, falls, and motor-vehicle-traffic incidents.

Averaging data from 2014–2018, King County's annual rate of unintentional injury deaths was 34.9 per 100,000. This rate has increased over time from 32.5 per 100,000 (2013–2015 average) to 35.7 per 100,000 (2016–2018 average).

- The death rate from unintentional injury among American Indian/Alaska Native county residents (129.9 per 100,000) is 2.8 or more times the rate among other racial/ethnic groups.
- Adults in high-poverty neighborhoods (48.8 per 100,000) were more likely than those in medium- (32.8 per 100,000) or low-poverty neighborhoods (27.1 per 100,000) to die from unintentional injuries.
- For adults age 75 and older, the rate of death from unintentional injury (209.9 per 100,000) was six times the county average. The majority of unintentional injuries in this age group are due to falls (153.1 per 100,000).

Unintentional injury deaths

King County (average: 2014 - 2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average

- Among King County neighborhoods, Downtown Seattle has the highest rate of unintentional injury death, at 77.1 per 100,000. The Federal Way neighborhood of Dash Point has the next highest rate at 53.2 per 100,000.

Chronic Illnesses

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.[25] Chronic illnesses are among the leading causes of death, disability, and hospitalization in King County and contribute to significant economic costs for individuals and healthcare systems. Risk behaviors, such as tobacco and substance use, poor nutrition, and lack of physical activity — described in other sections of this report — increase the risk of developing chronic illness and are key areas for focused prevention and health promotion strategies.

Additional indicators available online include asthma prevalence (adults), chronic respiratory disease (adults), fair or poor health (adults), and stroke prevalence (adults).

Low-income adults are three times as likely as high-income adults to have diabetes.

Chronic Illnesses

Continued

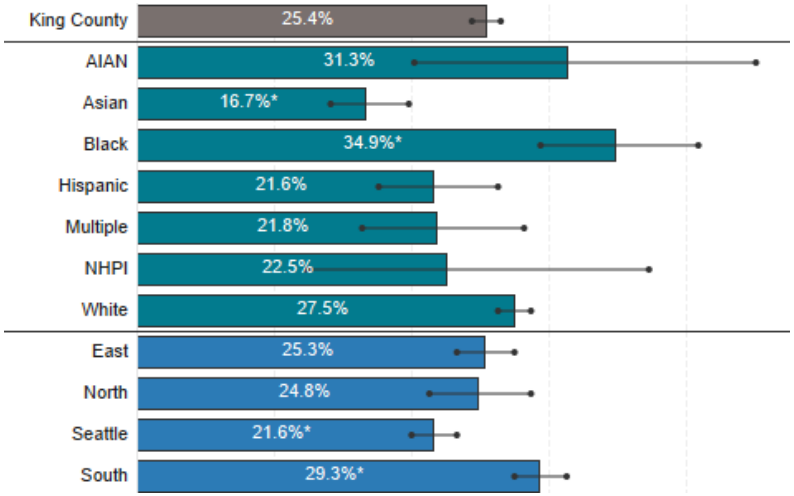
ADULT HYPERTENSION

Averaging data from 2013, 2015, & 2017[i], 25.4% of King County adults were ever told by a doctor, nurse, or other health professional that they have high blood pressure.

- The prevalence of hypertension among Black residents (34.9%) was significantly higher than the King County average. Compared to other racial/ethnic groups, Asian adults had the lowest rate of hypertension (16.7%).
- The rate of hypertension among adults with a household income of $75,000+ was significantly lower than the King County average and all other income categories.
- The rate of high blood pressure among South Region adults was 29.3% — higher than the King County average. The city/neighborhood with the highest rate of adult hypertension was Auburn-South (37.8%), more than 2.5 times the rate of the city/neighborhood with the lowest rate — Northeast Seattle (14.6%).

Hypertension (adults)

King County (average: 2013, 2015 & 2017)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

[i] *Question asked every other year (BRFSS).*

Chronic Illnesses

Continued

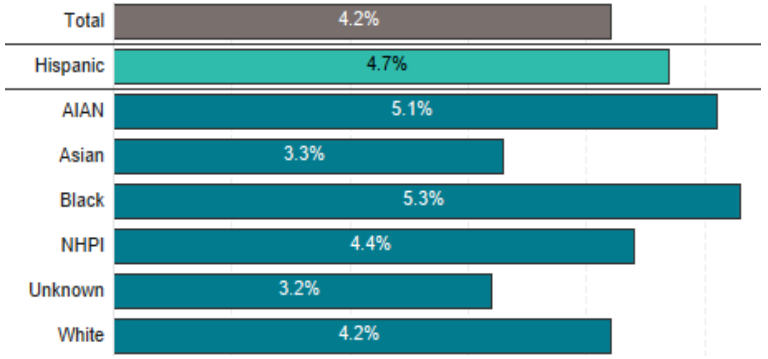
CHILDHOOD ASTHMA (MEDICAID)

In 2019, 4.2% of Medicaid-enrolled children[ii] (ages 0–17) had an asthma diagnosis.[iii]

- Asthma rates were highest among Black (5.3%) and American Indian/Alaska Native (5.1%) Medicaid-enrolled children.
- Auburn-North (5.3%) had the highest childhood asthma rate — nearly 2.5 times the rate of Vashon Island (2.2%), which had the lowest asthma rate among all King County cities/neighborhoods.

Asthma diagnosis (Medicaid children)

King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

[ii] This analysis includes Medicaid-enrolled children ages 0–17 who had seven or more cumulative months of Medicaid coverage in 2019.

[iii] Results from the analyses presented reflect the Medicaid beneficiary population receiving healthcare services. Therefore, these estimates are likely an underestimate of the true population rate, as we do not have information on individuals who do not seek healthcare.

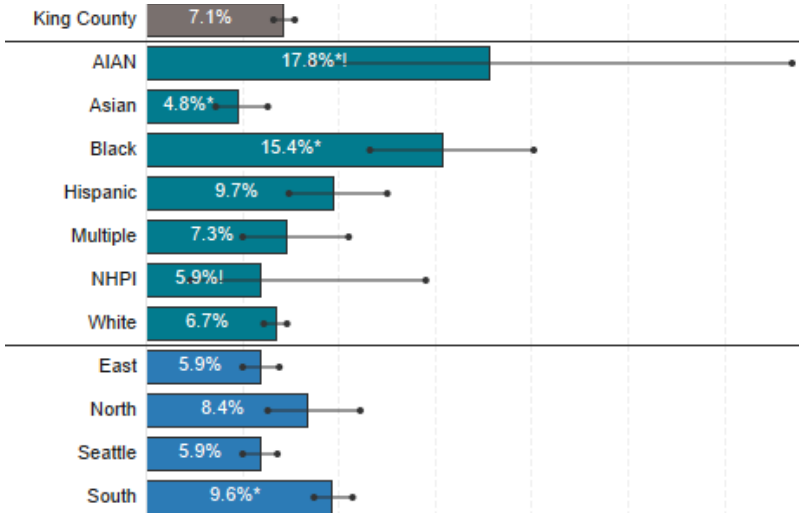
ADULT DIABETES

Averaging data from 2014–2018, 7.1% of King County adults reported having been told by a doctor, nurse, or other health professional that they have diabetes (excluding diabetes during pregnancy or pre-diabetes). This rate has not changed since 2009.

- Diabetes rates among young adults were low but increased with age. The diabetes rate among adults age 45–64 (10.3%) was more than four times the rate among adults age 25–44 (2.4%).
- In King County, the diabetes rate among military veterans (16.0%) was 2.5 times the rate among nonveterans (6.4%).
- The diabetes rate among adults over age 75 (18.9%) was more than 2.5 times the county average.
- Black adults (15.4%) were more than three times as likely as Asian adults (4.8%) to have diabetes.
- The likelihood of receiving a diabetes diagnosis decreased with higher household income.
- Adults with annual income lower than $15,000 (15.0%) were more than three times as likely as those with household income greater than $75,000 (4.4%) to have diabetes.

Diabetes prevalence (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- South Region adults (9.6%) were more likely to have diabetes than adults in Seattle (5.9%) and East Region (5.9%).

LEADING CAUSES OF HOSPITALIZATION

Averaging data from 2016–2018 for the leading causes of hospitalization[iv] provides information about the impact of chronic disease and injuries on the inpatient healthcare delivery system in King County. At this time, we are able to look at data only from 2016 forward, as the diagnostic coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance on understanding the impact of the coding structure is not finalized, it is recommended that comparisons of data not be made before and after October 1, 2015. To focus this analysis on diseases and injuries that lead to hospitalization, this analysis excludes hospitalizations for normal pregnancy or delivery, normal childbirth, and injury sequelae.

- The top three leading causes of hospitalization among adults, in order, were unintentional injury (560.2 per 100,000), septicemia (456.8 per 100,000), and osteoarthritis (294.2 per 100,000).
- While schizophrenia and other psychotic disorders (139.1 per 100,000) were the 6th leading cause of hospitalization overall, they were the 3rd leading cause among residents from high-poverty neighborhoods (490.1 per 100,000).
- Pregnancy and birth complications account for six of the top 10 leading causes of hospitalization among women.
- For children ages 1–14, the top three leading causes of hospitalization, in order, were asthma, unintentional injuries, and depressive disorders.
- Among adolescents and young adults (ages 15–24), the top three leading causes of hospitalization, in order, were depressive disorders, complications during childbirth, and schizophrenia and other psychotic disorders.

[iv] *Leading causes for hospital admission include both noninjury causes (e.g., diabetes) and injury causes (e.g., self-harm). Non-injury admits were identified using only the primary or first diagnosis code from categories defined by the Healthcare Cost and Utilization Project (HCUP) of the US Agency for Healthcare Research and Quality (AHRQ). Categories defined by the HCUP Clinical Classifications Software Refined (CCSR) version 2020-3 were used to map ICD–10-CM diagnosis codes. Injury admits were identified using all diagnosis codes, with injury intent (e.g., unintentional) and mechanism (e.g., fall) assigned using categories defined by the ICD–10-CM External Cause Matrix of the Centers for Disease Control and Prevention (CDC).*

Leading causes of hospitalizations (ranked by number of hospitalizations)

King County (average: 2016-2018)

Rank	Total	Female	Male
0	All causes 6,545.4 (145,188)	All causes 7,217.3 (84,149)	All causes 6,003.0 (61,038)
1	Unintentional injury 560.2 (12,032)	Unintentional injury 517.2 (6,158)	Unintentional injury 598.2 (5,874)
2	Septicemia 456.8 (10,018)	Septicemia 408.6 (4,832)	Septicemia 520.3 (5,187)
3	Osteoarthritis 294.2 (6,783)	Complications during childbirth 397.1 (4,695)	Osteoarthritis 254.6 (2,765)
4	Complications during childbirth 194.0 (4,695)	Osteoarthritis 328.2 (4,018)	Heart failure 259.1 (2,374)
5	Heart failure 214.7 (4,546)	Malposition, disproportion or other labor complications 233.1 (2,771)	Schizophrenia and other psychotic disorders 172.5 (2,005)
6	Schizophrenia and other psychotic disorders 139.1 (3,192)	Prolonged pregnancy 228.7 (2,755)	Acute myocardial infarction 171.7 (1,764)
7	Malposition, disproportion or other labor complications 113.8 (2,771)	Previous C-section 229.8 (2,667)	Stroke 140.9 (1,356)
8	Prolonged pregnancy 111.6 (2,755)	OB-related trauma to perineum and vulva 194.1 (2,320)	Alcohol-related disorders 113.1 (1,317)
9	Acute myocardial infarction 122.3 (2,717)	Heart failure 179.2 (2,172)	Skin and subcutaneous tissue infections 120.3 (1,297)
10	Previous C-section 112.1 (2,667)	Hypertension and hypertensive-related conditions complicating pregnancy, childbirth, and puerperium 165.0 (1,918)	Diabetes mellitus with complication 111.4 (1,208)

Cause category
- All causes
- Chronic Disease
- Infectious Disease
- Drug or Alcohol disorder
- Mental health disorder
- Pregnancy or birth complication
- Not classified

Source: Comprehensive Hospital Abstract Reporting System (CHARS)

Note: Under each cause, the first number shown is the 3-year average rate per 100,000 and the number in parenthesis is the average annual count from that cause over the 3-year period. For the leading causes by age, the rates are age-specific. All other rates are age-adjusted rates.

LEADING CAUSES OF CANCER INCIDENCE

Analysis of the leading causes of cancer ranks the 10 most common types of cancer based on the total number of new invasive cases during a five-year period. Cancer types that have less than 10 new cases during the five-year period were not included in the ranking. The analysis highlights disease burden as well as where to provide focused interventions if effective prevention measures are available. Averaging data from 2013–2017:

- The leading causes of cancer in King County were breast (female; 144.4 per 100,000) and prostate (male; 110.9 per 100,000).
- In Native Hawaiian/Pacific Islanders, female uterine cancer (88.5 per 100,000) took the second spot over prostate cancer (133.6 per 100,000), which was the 4th leading cause of cancer in this population.
- Among residents reporting multiple races, lung cancer (44.9 per 100,000) was the second most common cancer type.
- Cancer among children and young adults is relatively rare compared to adults. Leukemia was the most common cancer type in children age 1–14 (5.1 per 100,000). Among adolescents and young adults age 15–24, thyroid cancer was the leading type of cancer (5.7 per 100,000).
- Lung cancer was the most common type of cancer among adults over age 65 (278.8 per 100,000).

Most common cancer types (new cases)

King County (average: 2013-2017)

Rank	Total	Female	Male
1	Breast (Female) 144.4 (1,646)	Breast (Female) 144.4 (1,646)	Prostate (Male) 110.9 (1,156)
2	Prostate (Male) 110.9 (1,156)	Lung 43.7 (490)	Lung 53.4 (489)
3	Lung 47.9 (980)	Colorectal 31.1 (356)	Colorectal 41.1 (413)
4	Colorectal 35.8 (769)	Uterine (Female) 27.4 (328)	Skin Melanoma 37.0 (362)
5	Skin Melanoma 29.8 (642)	Skin Melanoma 24.5 (280)	Non-Hodgkin Lymphoma 26.7 (257)
6	Non-Hodgkin Lymphoma 21.0 (444)	Thyroid 19.4 (215)	Kidney 19.8 (198)
7	Uterine (Female) 27.4 (328)	Non-Hodgkin Lymphoma 16.4 (187)	Oral/Pharynx 18.1 (189)
8	Leukemia 15.1 (314)	Pancreas 11.4 (130)	Leukemia 19.8 (188)
9	Kidney 14.2 (307)	Leukemia 11.4 (126)	Urinary Bladder 17.9 (154)
10	Thyroid 13.5 (298)	Ovary (Female) 10.9 (123)	Liver 13.9 (153)

Source: Washington State Cancer Registry

Note: Cancers at the invasive stages only. Cancers at the in situ stage are excluded.

Under each cancer site, the first number shown is the 5-year average rate per 100,000 and the number in parentheses is the average annual count from that cause over the 5-year period. For the leading types by age, the rates are age-specific rates. All other rates are age-adjusted rates.

Medicaid profile

INTRODUCTION

HHC members chose to include this Medicaid profile in the CHNA report to describe the overall demographics of Medicaid beneficiaries in King County and to understand what is happening with emergency department (ED) use based on Medicaid claims. Using data from 2019, we reviewed leading causes of ED visits (defined as healthcare visits that include a revenue or procedure code for emergency services — urgent care visits are not included) by ranking the top 10 primary diagnoses for ED visits among different demographic categories and among individuals who had five or more visits to the ED without a visit to a primary care provider. These results can help inform quality improvement efforts within hospitals as well as highlight opportunities to support Medicaid beneficiaries in accessing care, resources, and programs.

Washington State Medicaid (i.e., Apple Health) covers a broad range of health services to address the diverse needs of beneficiaries in King County. For this profile, Medicaid beneficiaries are defined as individuals with seven or more months of Medicaid full medical benefit coverage, and less than five months of Medicare dual eligibility or third-party liability coverage in 2019. This definition accounts for some Medicaid enrollment changes throughout

Over half of adult King County Medicaid beneficiaries with five or more emergency department visits in 2019 had not visited a primary care provider that year.

Medicaid profile

Continued

the year while maximizing the inclusion of Medicaid claims to reflect patterns of healthcare utilization for those individuals.

DEMOGRAPHIC CHARACTERISTICS

MEDICAID OVERALL (ALL AGES)

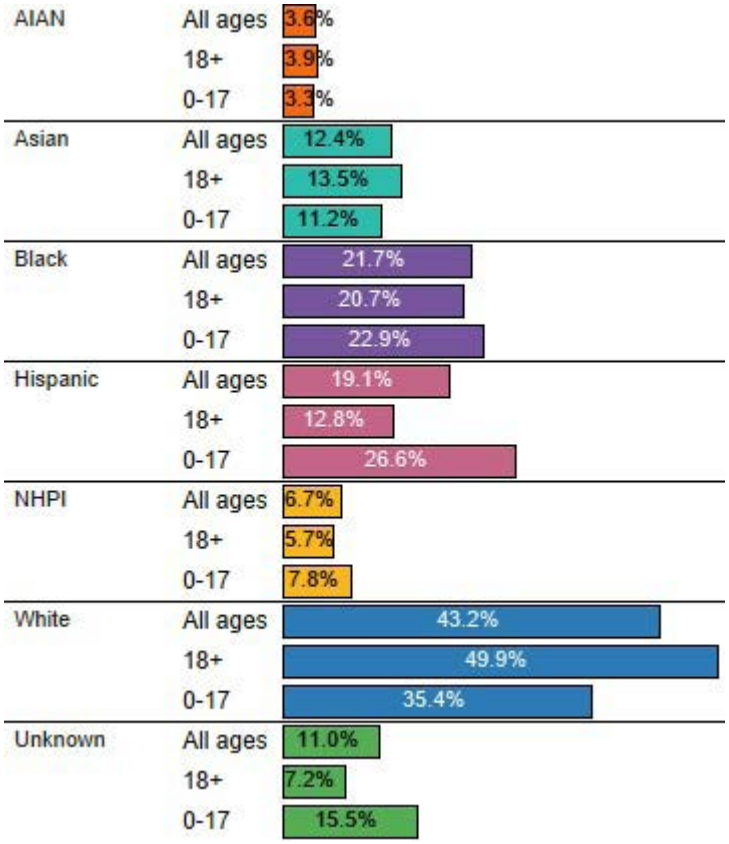
In 2019, there were 319,378 Medicaid beneficiaries with seven or more months of Medicaid full medical benefit coverage and less than five months of Medicare dual eligibility or third-party liability coverage in King County. This represents 64.7% of all Medicaid beneficiaries in King County and approximately 14% of King County's total population. Compared to the racial/ethnic makeup of King County overall, our defined King County Medicaid population is more diverse.

The representation of race/ethnicity among Medicaid beneficiaries was as follows:

- 43.2% white
- 21.7% Black
- 19.1% Hispanic
- 12.4% Asian
- 6.7% Native Hawaiian/Pacific Islander
- 3.6% American Indian/Alaska Native

Medicaid member demographics (Overall, adults, children)

King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

Medicaid profile

Continued

There are different Apple Health programs with different age limits and income eligibility. Generally, adult eligibility for Medicaid is age 19. The analysis by age in this report categorizes children as 0–17 and adults as 18 and over. Adults (ages 18+) represent 53.8% of Medicaid beneficiaries and children (ages 0–17) represent 46.2%. Most Medicaid beneficiaries (89.0%) chose English as their preferred language.

Neighborhoods in South King County had higher percentages of Medicaid beneficiaries in 2019. The five King County neighborhoods with the highest percentage of Medicaid beneficiaries were all in the South Region: Federal Way, Southeast Kent, SeaTac/Tukwila, North Auburn, and South Renton.

MEDICAID ADULTS (AGES 18+)

Roughly half of adult Medicaid beneficiaries were white (49.9%). Black adults (20.7%) represent the second highest percentage, followed by Asian adults (13.5%), Hispanic adults (12.8%), Native Hawaiian/Pacific Islander adults (5.7%) and American Indian/Alaska Native adults (3.9%).

MEDICAID CHILDREN (AGES 0-17)

Among children with Medicaid, children of color made up the majority of beneficiaries in this age bracket. The percentage of white Medicaid-enrolled children (35.4%) was lower than the percent of white Medicaid adults (49.9%). The percentages of Black (22.9%), Hispanic (26.6%), and Native Hawaiian/Pacific Islander children (7.8%) were all higher than the proportion of each race/ethnicity among adult Medicaid beneficiaries. Unknown race accounted for 15.5% of Medicaid-enrolled children — almost double compared to adults. Among children, 16.7% of beneficiaries listed Spanish as their (or their parent's/guardian's) preferred language, which was more than three times the rate of Spanish preference among adult beneficiaries.

LEADING CAUSES OF EMERGENCY DEPARTMENT (ED) VISITS BY NUMBER OF VISITS

Leading reasons for emergency department (ED) visits provide information to help tailor more effective programs to meet patient needs, address barriers in accessing healthcare services, and decrease potentially avoidable ED utilization. Visits to the ED represent a combination of true emergency needs, as well as visits that could be better addressed through primary care or other preventive services.

While this report focuses on the primary diagnosis listed on the health insurance claim for each ED visit, the accompanying online dashboards on CHI allows users to view all diagnoses reported for each ED visit

(e.g., up to a possible 12 diagnosis codes for each visit). This additional information often highlights underlying conditions that may contribute to the reasons for why individuals seek care at the ED.

This analysis of leading causes of ED visits ranks primary diagnosis by number of visits as opposed to number of people in order to present leading causes of ED visits based on what is most common. This analysis stratifies leading causes of ED visits by children, adults, and race/ethnicity. Further stratification by gender, age, or utilization rate would likely result in differing patterns.

LEADING CAUSES OF ED VISITS: *MEDICAID OVERALL (ALL AGES)*

In 2019, the top 10 leading causes of ED visits by number of visits for all Medicaid beneficiaries, adults, and children were:

Table 1. Top 10 leading causes of ED use (by primary diagnosis)

	Medicaid Overall (all ages)		Medicaid Adults (ages 18+)		Medicaid Children (ages 0-17)
1.	Respiratory infections	1.	Abdominal pain	1.	Respiratory infections
2.	Abdominal pain	2.	Pregnancy/childbirth complications	2.	Fever of unknown cause
3.	Pregnancy/childbirth complications	3.	Heart disease	3.	Ear conditions
4.	Heart disease	4.	Skin infections	4.	Abdominal pain
5.	Skin infections	5.	Respiratory infections	5.	Nausea and vomiting
6.	Sprain and strains	6.	Alcohol use disorders	6.	Open wounds
7.	Open wounds	7.	Sprain and strains	7.	Viral infection
8.	Minor injuries	8.	Urinary system disease	8.	Minor injuries
9.	Ear conditions	9.	Minor injuries	9.	Broken bones
10.	Urinary system disease	10.	Substance use disorders	10.	Sprains and strains

Source: Medicaid claims data, WA State Health Care Authority (HCA)

When we include all diagnoses (versus primary diagnosis only) listed on an ED visit's health insurance claim, substance use disorders (SUD) are the most frequently seen diagnosis for Medicaid beneficiaries overall. Though this finding does not mean that SUD is the primary reason for why these individuals use the ED, it does indicate that SUD is a common underlying condition among individuals who use the ED.

LEADING CAUSES OF ED VISITS *BY RACE/ETHNICITY: MEDICAID OVERALL (ALL AGES)*

The top three leading causes of ED visits by race/ethnicity for all Medicaid beneficiaries are reflected in the chart below.

- Among Asian, Black, Hispanic, Native Hawaiian/Pacific Islander and white Medicaid beneficiaries, respiratory infections were the leading cause of ED visits, largely driven by children. Among American Indian/Alaska Native Medicaid beneficiaries, alcohol use disorder was the leading cause of ED visits.

Top three leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Overall (all ages)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Respiratory infections	1	3	1	1	1	1	1
Abdominal pain	2	2	2	2	3	3	2
Pregnancy/childbirth complications	3		3	3	2	2	
Alcohol use disorders		1					
Skin infections							3

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Historical and present-day experiences of American Indian/Alaska Native (AIAN) individuals may influence these results. The high number of alcohol use disorder-related ED visits may be reflective of community experiences and structural barriers that disproportionately impact this population. Furthermore, since we have ranked leading causes by the number of ED visits, a small number of male AIAN Medicaid adult beneficiaries who frequently visit the ED due to alcohol use disorder impact the results for the overall AIAN Medicaid population.

- Respiratory infections, abdominal pain, and pregnancy/childbirth complications were the top three causes of ED use, among Asian, Black, Native Hawaiian/Pacific Islander, and Hispanic Medicaid beneficiaries. Respiratory infections, abdominal pain, and skin infections were the leading causes of ED use for white beneficiaries. Among American Indian/Alaska Native beneficiaries, alcohol use disorder, abdominal pain, and respiratory infections were the top three causes of ED use.

Medicaid profile

Continued

LEADING CAUSES OF ED VISITS: *MEDICAID ADULTS (AGES 18+)*

The top 10 causes of ED use for adult Medicaid beneficiaries (ages 18+) were similar to the overall pattern of leading causes of ED use for all Medicaid beneficiaries as listed above — with the exception of open wounds and ear conditions for all beneficiaries, which are replaced with alcohol use disorder and substance use disorders for adult beneficiaries.

LEADING CAUSES OF ED VISITS *BY RACE/ETHNICITY: MEDICAID ADULTS (AGES 18+)*

The top three leading causes of ED visits by race/ethnicity for adult Medicaid beneficiaries (ages 18+) are reflected in the chart below.

Top three leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Abdominal pain	1	2	2	2	2	2	1
Pregnancy/childbirth complications	2		1	1	1	1	
Heart disease	3	3	3	3	3		3
Alcohol use disorders		1					
Respiratory infections						3	
Skin infections							2

Source: Medicaid claims data, WA State Health Care Authority (HCA)

These racial and ethnic disparities in pregnancy/childbirth complications reflect national trends for communities of color. For example, Black women are more likely to experience pregnancy-related complications compared to white women.[26,27] Different patterns emerge when looking at results by race/ethnicity and gender, since these results reflect the large proportion of adult Medicaid beneficiaries who are women of childbearing age. See results described by gender and race/ethnicity below.

- Among adults and racial/ethnic groups, the overall leading cause of ED use was pregnancy/childbirth complication.
- For American Indian/Alaska Native adult beneficiaries, the leading cause of ED use was alcohol use disorder,

and for white adult Medicaid beneficiaries, the leading cause of ED use was abdominal pain.

- Heart disease was the third leading cause of ED visits for all races and ethnicities, with the exception of Native Hawaiian/Pacific Islander adults, among whom respiratory infections were the third leading cause and heart disease was the fourth leading cause.

LEADING CAUSES OF ED VISITS *BY GENDER AND RACE/ETHNICITY: MEDICAID ADULTS (AGES 18+)*

For adults (18+) by gender, patterns for leading causes of ED use vary.

Among males:

- Heart disease was the leading cause of ED visits in males. It ranks first among Asian, Black, and Native Hawaiian/Pacific Islander male Medicaid beneficiaries, 2nd among whites, and 3rd among American Indian/Alaska Native and Hispanic males.
- Skin infections were the 2nd leading cause of ED visits in males overall, but ranked among the top three only for white, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native males.
- The 3rd leading cause of ED visits among males overall was alcohol use disorder. This was the 1st leading cause of ED visits for AIAN males, 2nd for Hispanic males, 3rd for white males, and 6th for Asian and Black males.
- While substance use disorders were the 5th leading cause of ED visits among males overall, they were the 4th leading cause among American Indian/Alaska Native males.
- Although schizophrenia and other psychotic disorders did not rank in the top 10 leading causes of ED visits for males overall, they were the 4th leading cause of ED use for Asian males.

Among females:

- Pregnancy/childbirth complications were the leading cause of ED visits for female Medicaid beneficiaries.
- Abdominal pain and heart disease are 2nd and 3rd.
- Respiratory infections were the 4th leading cause among females overall, but 3rd among Black, Hispanic, and Native Hawaiian/Pacific Islander female Medicaid beneficiaries.
- While alcohol use disorders were not listed in the top 10 leading causes of ED visits for females overall, they

were the 4th leading cause of ED visits for American Indian/Alaska Native females.

- Substance use disorders were not in the top 10 leading causes of ED visits for females overall or for any racial/ethnic group.
- Schizophrenia and other psychotic disorders were not in the top 10 leading causes of ED visits among females overall or for any race/ethnicity.

Top five leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Male Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Heart disease	1	3	1	1	3	1	2
Skin infections	2	2		5	1	3	1
Alcohol use disorders	3	1			2		3
Abdominal pain	4	5	2	2	4	4	4
Substance use disorders	5	4			5	5	5
Respiratory infections			3	3		2	
Schizophrenia and other psychotic disorders			4				
Sprains and strains				4			
Open wounds			5				

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Top five leading causes of ED use *by race/ethnicity* (by primary diagnosis), *Medicaid Female Adults (ages 18+)*
King County (2019)

Cause of visit	Overall	AIAN	Asian	Black	Hispanic	NHPI	White
Pregnancy/childbirth complications	1	2	1	1	1	1	1
Abdominal pain	2	1	2	2	2	2	2
Heart disease	3	3	3	4	4	4	3
Respiratory infections	4		4	3	3	3	5
Urinary system disease	5				5	5	
Alcohol use disorders		4					
Skin infections		5					4
Sprains and strains				5			
Headache			5				

Source: Medicaid claims data, WA State Health Care Authority (HCA)

Medicaid profile

Continued

LEADING CAUSES OF ED VISITS: *MEDICAID CHILDREN (AGES 0-17)*

The top 10 causes of ED use for children on Medicaid (ages 0–17) are listed in Table 1. These common childhood illnesses and symptoms are similar to national leading causes of pediatric ED visits.[28]

LEADING CAUSES OF ED VISITS *BY RACE/ ETHNICITY: MEDICAID CHILDREN (AGES 0-17)*

There were no obvious trends by race/ethnicity in the leading causes of ED visits among children. The leading cause of ED use in children of all races and ethnicities was respiratory infections. Fever of unknown origin was the second leading cause for all races and ethnicities, except for American Indian/ Alaska Native children, among whom fever was the third leading cause and open wounds were the second leading cause.

MEDICAID BENEFICIARIES WITH 5+ ED VISITS AND NO PCP VISITS

The emergency department (ED) is a critical healthcare setting for addressing medical emergencies and urgent care. While very few patients come to the ED frequently, those who do account for a disproportionately large share of overall visits and related costs. One study estimated that 4.5% to 8% of patients revisit the ED four or more times per year but account for 21% to 28% of all ED visits.[29] For many patients, the ED may be their only reliable source of healthcare. Patients may not have access to a primary care provider (PCP) or lack knowledge of where to seek appropriate care. A high rate of ED utilization may indicate inadequate access to care or poor coordination of care.[30]

We identified King County Medicaid beneficiaries with a high number of ED visits and no primary care visits (defined as healthcare visits that include a procedure or ICD-CM-10 code for primary care services, plus a provider taxonomy relevant to primary care) in 2019. For our analyses, we defined someone with a high number of ED visits as a Medicaid beneficiary with five or more ED visits in 2019.

Approximately 54% of all Medicaid beneficiaries in King County with five or more ED visits had no visits to a PCP in 2019. A majority (86%) of these individuals were adults (age 18+).

MEDICAID OVERALL (ALL AGES)

For all ages, among all races/ethnic groups, over half of Medicaid beneficiaries with a high number of ED visits did not have any visits to a PCP in 2019.

Medicaid profile

Continued

MEDICAID ADULTS (AGES 18+)

For adults (18+), among each race/ethnicity group, over half of Medicaid beneficiaries with a high number or ED visits did not have any PCP visits in 2019.

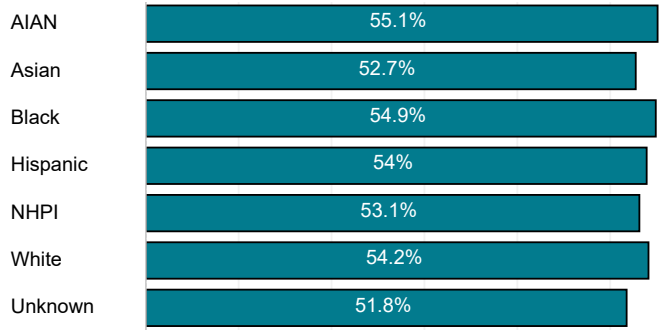
MEDICAID CHILDREN (AGES 0-17)

Given the small number of Medicaid-enrolled children with number of visits to the ED, we have excluded this analysis from the report. Most younger Medicaid child beneficiaries, regardless of number of visits to the ED, are engaged with their PCPs for vaccinations and well-child visits. Medicaid child beneficiaries who have visited the ED more than five times in the past year may be visiting the ED for management of chronic diseases, which may represent appropriate use of this acute care setting.

The ED is an important healthcare setting for quickly addressing medical emergencies. However, frequent visits to the ED and/or urgent care department can disrupt continuity of care and optimal health and place a heavy cost burden on patients, as well as the healthcare system. Individuals who do not have stable health coverage, or a regular source of primary care, are more likely to go to the ED for their care. Understanding the primary and underlying causes of ED visits, identifying barriers to accessing care, and

Among each race/ethnicity group, Medicaid adults with 5+ visits to the ED without any visits to a Primary Care Provider

King County (2019)



Source: Medicaid claims data, WA State Health Care Authority (HCA)

connecting patients to culturally competent primary care providers may assist in decreasing potentially avoidable ED visits. It is important to understand the factors that influence disparities by race/ethnicity to inform the development of tailored programs to improve healthcare experiences and health outcomes.

Medicaid profile

Continued

VISITS TO THE ED AND COVID-19

Early in the COVID-19 pandemic, public messaging advised individuals to avoid unnecessary healthcare use to reduce transmission of the virus and to ensure hospital and provider capacity for surges in COVID-19 cases. Early analyses suggest that ED use decreased nationally through June of 2020.[1] Respiratory infections were already the leading cause of ED visits before the COVID-19 pandemic in 2019. We anticipate COVID-19 symptoms will impact the leading cause of ED visits throughout the course of the pandemic.

To understand the impact that COVID-19 has had on ED visits in early 2020, we analyzed Medicaid claims from January 1 to April 30, 2020, and compared them to the same time period for 2019. Based on this analysis, we observed a decrease in overall ED visits with no significant difference in causes of ED use. The decrease in ED visits in early 2020 is likely resulting from the avoidance of ED use during the first couple of months of the COVID-19 pandemic, and consistent with national trends.

Access to Healthcare & Use of Preventive Services

Improving access to comprehensive quality healthcare services is a long-standing national public health goal. The ability to access health services in a timely matter is crucial to prevent, detect, and manage disease as well as to support overall quality of life. Health insurance coverage is a key component of entry to the healthcare system, and monitoring insurance coverage can indicate the degree to which the health needs of a community are met.

Healthcare coverage increased dramatically in King County following implementation of the Affordable Care Act (ACA). From 2010 to 2016, lack of health insurance dropped by more than 2/3 among young adults ages 18–24, as more young adults could remain on their parents' health insurance plans. With the initiation of the individual mandate in 2014, access to private insurance was expanded and more adults became eligible for Medicaid.

In December 2017, the individual mandate penalty was eliminated — effective in 2019. The Congressional Budget Office (CBO) estimated that eliminating the individual mandate penalty would cause 3–6 million individuals to lose insurance coverage between 2019 and 2021.[31,32] In the United States, early assessment of COVID-19's impact on health insurance showed that one in five adults who previously had health insurance coverage for either themselves, a spouse, or partner through their job reported that at least one of them had become uninsured in 2020.[33] The impacts of the pandemic and national policy changes on insurance enrollment and population health will require ongoing monitoring.

Additional indicators available online include adults without a usual primary care provider, adults who did not receive a flu vaccination in the past year, and youth who did not have a dental checkup in the past year.

Despite improvements in health insurance coverage since implementation of the Affordable Care Act in 2010, disparities in health insurance coverage persist and have worsened since 2014.

Access to Healthcare & Use of Preventive Services

Continued

INCOMPLETE VACCINE COVERAGE (AGE 19–35 MONTHS)

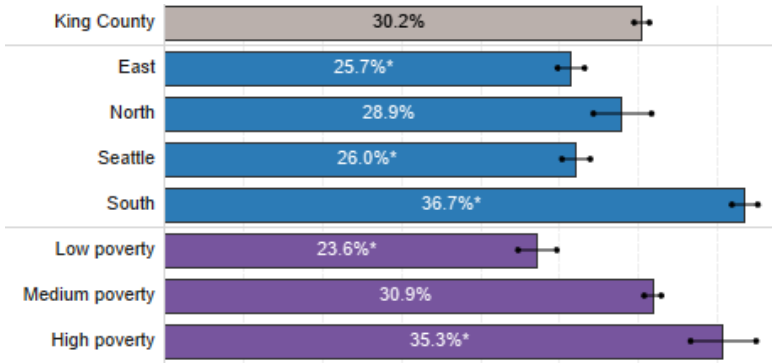
This indicator presents the percentage of children 19–35 months of age who have not completed the routine series of recommended vaccinations, referred to as the 4:3:1:3:3:1:4 series.[i] As of December 31, 2019, the rate of incomplete vaccination coverage for King County children age 19–35 months was 30.2%, which was an improvement on the previously reported rate of 33.4% in 2017. King County has not met the Healthy People 2020 objective of reducing incomplete vaccination coverage to 20% of children age 19–35 months.[34]

- In December 2019, the rate of incomplete vaccination in the South Region (36.7%) was significantly higher than all other King County regions.
- Incomplete vaccination rates were highest in high-poverty neighborhoods (35.3%). The two ZIP codes with the highest rates were 98057 (45.2%) and 98032 (44.9%), which includes Renton as well as the Des Moines/Kent area.

[i] *This routine series of vaccinations is defined as having four or more doses of diphtheria, tetanus, acellular pertussis (Dtap), 3 or more doses of polio vaccines, 1 measles containing vaccine, 3 or more doses of Haemophilus influenzae type b (Hib), 3 or more doses of hepatitis B (Hep B) vaccine, 1 or more doses of varicella vaccine, and 4 or more doses of pneumococcal conjugate vaccine (PCV).*

Incomplete vaccination coverage (age 19-35 months)

King County (2019)



Source: WA State Immunization Information System (Child Profile Health Promotion & Immunization Registry System)
* Significantly different from King County average

Analysis of vaccination rates as of June 30, 2020 showed a decrease in vaccination coverage compared to rates as of December 31, 2019, likely reflecting decreased access to and use of healthcare services during the COVID-19 pandemic. As of June 30, 2020, the King County rate of incomplete vaccination coverage had increased to 33.4%. Rates of incomplete vaccination increased among South Region families (40.7%) and families living in high-poverty neighborhoods (39.9%).

Access to Healthcare & Use of Preventive Services

Continued

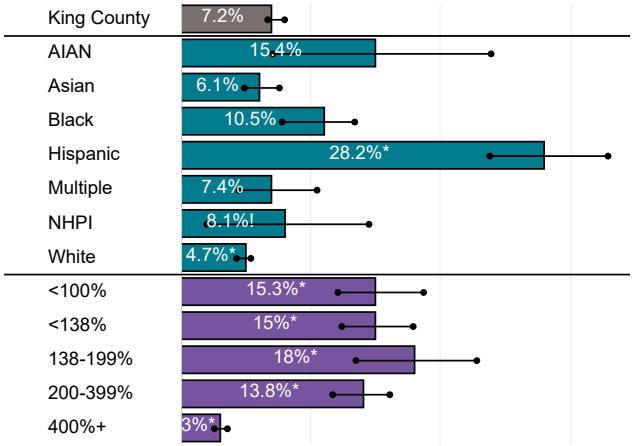
UNINSURED ADULTS

After ACA implementation, the rate of uninsured King County adults decreased significantly — from 16.4% in 2013 (prior to the ACA individual mandate)[ii] to 6.7% in 2016. Since 2016, the rate of uninsured King County residents has slightly risen, reaching 7.2% in 2019.

- Communities of color continue to be disproportionately uninsured — before and after implementation of the ACA. Racial/ethnic disparities in insurance coverage have increased since an initial narrowing of gaps in coverage in 2014.
- In 2019, Black adults (10.5%) were more than two times as likely to be uninsured compared to white adults (4.7%).
- Hispanic adults (28.2%) had the highest rate of uninsurance and were six times as likely as white adults (4.7%) to be without coverage.
- Burien residents (16.0%) and Tukwila residents (15.6%) were uninsured at rates more than twice the county average.
- Adults with household income below 100% of the federal poverty level (15.3%) were more than five times as likely as those in the highest-income households (3.0%) to be uninsured.

Preliminary data modeling the impacts of COVID-19 on Washington state's health coverage estimate that the King County uninsurance rate reached its highest level in late May 2020 (19.4%), compared to 5.6% before COVID-19. While the uninsurance rate has slowly declined since its peak in May, it is important to continue to monitor for impacts to access to care — especially among populations with high rates of uninsurance prior to the pandemic, which are also the same populations hardest hit by the pandemic.[35]

Uninsured adults
King County (2019)



Source: American Community Survey
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

[ii] *January 2014: ACA requires all Americans to have health insurance; more adults became eligible for Medicaid and tax rebates; private insurance available through the state's Health Benefit Exchange (Washington Healthplanfinder).*

Access to Healthcare & Use of Preventive Services

Continued

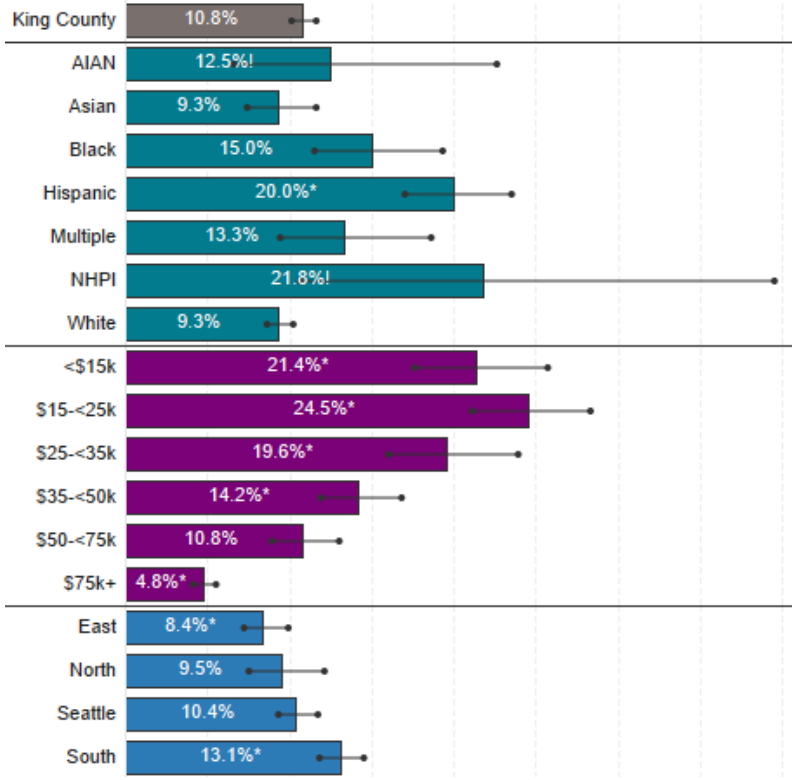
UNMET MEDICAL NEEDS

Individuals without health insurance are more likely to have unmet healthcare needs due to cost. As insurance coverage has improved, fewer King County adults report cost as a barrier to seeking needed medical care. Averaging data from 2014 to 2018, 10.8% of King County adults reported they needed to see a doctor in the past 12 months but could not due to cost — down from 15% during the period preceding ACA implementation (2011–2013 average).

- Among adults age 25–44, 13.1% reported unmet healthcare needs due to cost — higher than the King County average.
- Compared to Asian (9.3%) adults and white (9.3%) adults — the racial/ethnic groups with the lowest rates of uninsurance — Black (15.0%) adults were more than 1.5 times as likely and Hispanic (20.0%) adults were more than two times as likely to report unmet medical needs due to cost.
- Adults who identify as lesbian, gay, or bisexual (18.8%) were twice as likely to report unmet healthcare needs compared to adults who identify as heterosexual (9.5%).
- Adults with household income below $15,000 (21.4%) were more than four times as likely as those earning more than $75,000 (4.8%) to report unmet medical needs, though this income-based disparity has decreased over time.

Unmet medical needs due to cost (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Access to Healthcare & Use of Preventive Services

Continued

COLORECTAL CANCER SCREENING

The U.S. Preventive Services Task Force (USPSTF) highlights strong evidence that colorectal cancer screening substantially reduces deaths from the disease among adults aged 50 to 75 years and that not enough adults in the United States are using this effective preventive intervention. The USPSTF recommends that adults be screened for colorectal cancer starting at age 50 and continuing until age 75 years.[36]

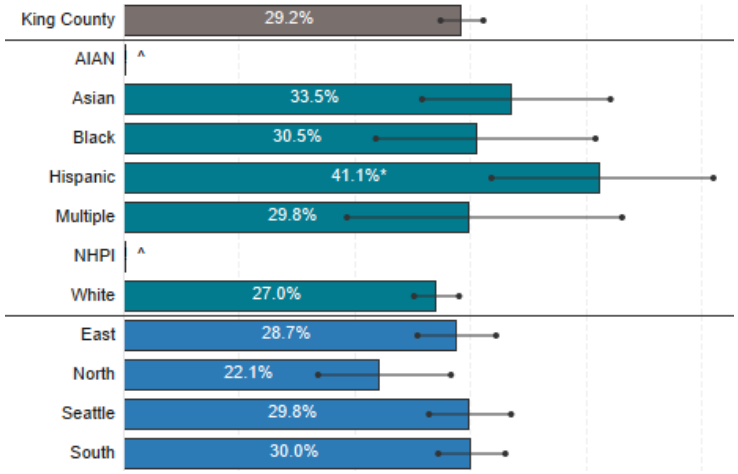
To assess adherence to colorectal cancer screening recommendations, the Behavioral Risk Factor Surveillance System (BRFSS) asks adults whether they have received a colorectal cancer screening. This indicator reports individuals age 50–75 who have received a fecal occult blood test (FOBT) within one year, flexible sigmoidoscopy within five years + FOBT within three years, or colonoscopy within 10 years. Averaging data from 2014–2016 and 2018,[iii] 29.2% of King County adults age 50–75 failed to meet these colorectal cancer screening recommendations — an improvement when looking at trends for the latest non-overlapping average years of 2011–2013, in which 32.5% did not meet screening recommendations.

- Colorectal cancer screening rates have been improving in King County since 2010. In 2018 — the most recent year for which we have data — 27.0% of adults age 50–75 had not met screening guidelines.

[iii] *Question was not asked in 2017.*

Colorectal cancer screening recommendation not met (adults 50-75)

King County (average: 2014, 2015, 2016, & 2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

- Among Hispanic residents, 41.1% did not meet screening guidelines — higher than the King County average. Cancer is the leading cause of death among Hispanic King County residents, with colorectal cancer as the third most common cancer type among this group.

- Adherence to screening guidelines increased with household income.

- Residents of the North Region in King County had the highest rate of adherence, with only 22.1% of adults 50–75 not meeting colorectal cancer screening guidelines.

Exhibit 13

396 of 804

Access to Healthcare & Use of Preventive Services

Continued

ADULT DENTAL VISITS

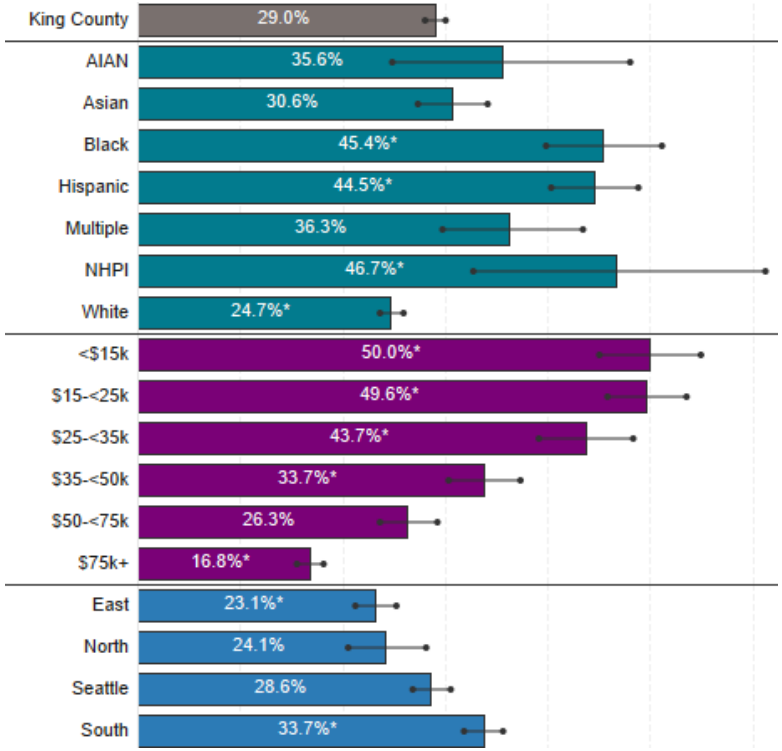
Averaging data from 2012 and 2014–2016[iv], 29.0% of King County adults reported they did not visit a dentist or dental clinic for any reason in the past year. This rate has been consistent for the past 10 years.

- Male residents (32.4%) were significantly more likely than female residents (25.6%) not to have visited a dentist or dental clinic in the past year.
- Half of adults with household income below $15,000 (50.0%) had not visited a dentist in the past year, reflecting long-standing income disparities for dental care.
- Native Hawaiian/Pacific Islander (46.7%), Black (45.4%), Hispanic (44.5%), and multiple race (36.3%) residents were significantly more likely not to have visited a dentist or dental clinic in the previous year compared to white residents (24.7%).
- Adults in South Region (33.7%) were most likely to report that they had not seen a dentist in the previous year compared to residents in other King County regions.

[iv]*Question was not asked in 2013.*

No dental checkup in last year (adults)

King County (average: 2012, 2014, 2015, & 2016)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

Mental Health & Substance Use

Mental health includes our emotional, psychological, and social well-being. Protecting our mental health is important to protecting our physical health and quality of life. Mental illness, such as depression, can increase the risk for many types of physical health problems and chronic conditions, including stroke, type 2 diabetes, and heart disease.[37] Substance use may or may not be independent of mental health conditions and may be causal or exacerbate other quality of life indicators.[38]

Additional indicators available online include binge drinking (youth and adults), adolescents with an adult they can talk with, serious psychological distress (adults), and driving or riding in a car while high (youth).

High-income adults are nearly twice as likely to have the social and emotional support they need, compared to low-income adults.

Mental Health & Substance Use

Continued

ADULT FREQUENT MENTAL DISTRESS

Averaging data from 2014–2018, 10.8% of adults in King County had 14 or more days with poor mental health in the past 30 days.

- Frequent mental distress was most often reported among adults age 18–24 (16.8%). The percentage of adults reporting this indicator decreased with age.

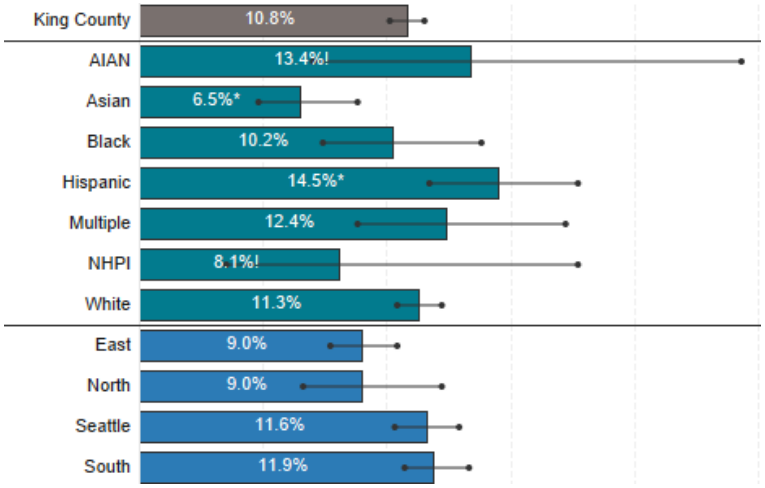
- The rate for adults with household income below $15,000 (26.9%) was almost 2.5 times the county average and four times the rate for adults with household income at or above $75,000 (7.1%). The prevalence of frequent mental distress decreases with each increasing income category.

- Frequent mental distress among Hispanic adults (14.5%) is significantly higher than the King County average.

- Adults who identified as lesbian, gay, or bisexual (LGB) (22.3%) were more than twice as likely as heterosexual adults (10.1%) to report frequent mental distress. The percent of adults reporting frequent mental distress has remained stable when looking at the overall county population, but LGB adults have seen a steady increase over the past several years, from 18.2% in 2012–2014 to 24.4% in 2016–2018.

Frequent mental distress (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- South Region adults reported frequent mental distress at a rate of 11.9%.

- The highest rates across all cities/neighborhoods in King County included areas in the South Region, where 17.9% of adults in North Auburn and Federal Way – Dash Point/Woodmont reported frequent mental distress.

Mental Health & Substance Use

Continued

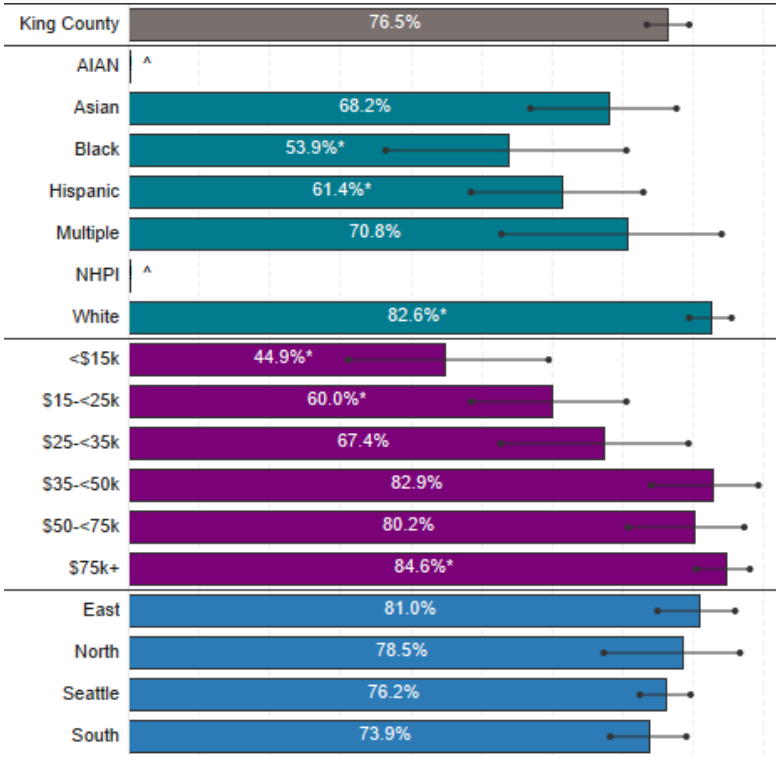
ADULT SOCIAL AND EMOTIONAL SUPPORT

Social and emotional support contribute to psychological health and well-being and are associated with healthy behaviors as well as self-rated health status. Averaging data from 2017–2018, in King County, 76.5% of adults always or usually get the social and emotional support they need.

- While there were no significant differences in this indicator by age, gender, or sexual orientation, differences by race/ethnicity and income are noteworthy.
- A majority of white residents (82.6%) report that they always or usually get the social and emotional support they need — significantly higher than Black (53.9%), Hispanic (61.4%), and Asian (68.2%) adults.
- Among adults with a household income of less than $15,000, 44.9% always or usually get the social and emotional support they need. This percentage is lower than the King County average and just over half the rate among residents with a household income of $75,000 or more (84.6%).

High social & emotional support (adults)

King County (average: 2017-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Mental Health & Substance Use

Continued

TEEN DEPRESSION

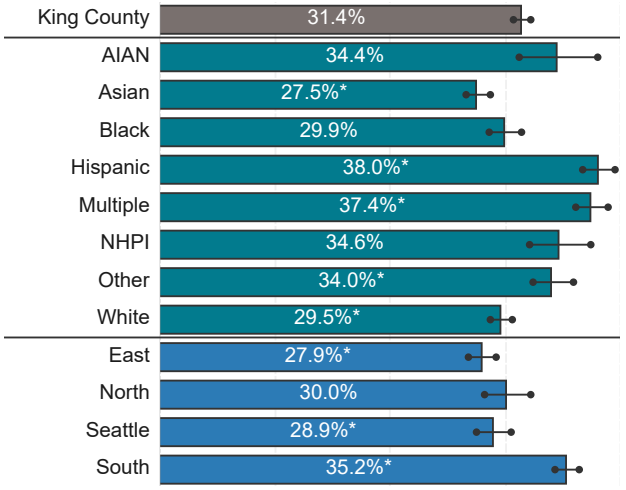
The prevalence of depression has been rising among King County youth for the past 10 years. This indicator reports whether students, during the past year, have felt so sad or hopeless for two weeks or more that they stopped doing some of their usual activities. Averaging data from 2016 and 2018, one in three (31.4%) King County 8th-, 10th-, and 12th-grade students experienced depressive feelings.

- The percentage of youth reporting depressive feelings increases significantly with each grade level from 25.7% of 8th-grade students to 35.6% of 12th-grade students reporting depressive feelings.

- Youth identifying as LGB+ (57.2%) were more than twice as likely to report depressive feelings compared to youth who identified themselves as heterosexual (26.4%).

- Hispanic (38.0%), Native Hawaiian/Pacific Islander (34.6%), American Indian/Alaska Native (34.4%), and multiple-race (37.4%) youth were more likely than Asian (27.5%), Black (29.9%), and white (29.5%) youth to report depressive feelings. However, differences exist among detailed Asian ethnic groups for youth — the depression rate exceeds the county average among Filipino students (36.5%) and is lower than average among Asian Indian students (23.2%).

Depression prevalence (8th, 10th, 12th grades)
King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Youth in the South Region (35.2%) were more likely than youth in other King County regions to report depressive feelings.

Mental Health & Substance Use

Continued

ADULT SMOKING

Cigarette smoking continues to decline among King County adults. Averaging data from 2014–2018, 11.1% of King County adults reported that they currently smoked cigarettes every day or on some days — down from 13.9%, which was the average rate of current smoking for 2011–2013.

- Smoking among residents with household income less than $15,000 (24.4%) was almost four times the rate among higher-income households earning $75,000 or more (6.9%).

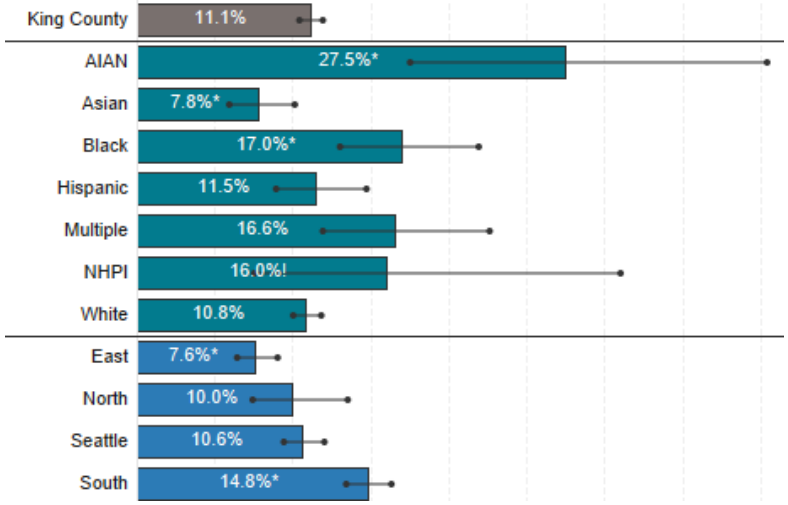
- Gender differences in cigarette smoking persist, with males (12.6%) more likely than females (9.6%) to smoke cigarettes.

- The rate of current smoking among adults identifying as LGB was 18.6% — higher than the county average and higher than the rate of smoking among adults identifying as heterosexual (10.6%).

- Though rates of cigarette smoking among American Indian/Alaska Native residents have been declining, 27.5% are current smokers — nearly 2.5 times the county average.

- Though declining in the South Region — from 18.6% (2009–2011) to 14.8% (2014–2018) — South Region adults are still significantly more likely to be current smokers than the average King County resident, and nearly twice as likely as adults in the East Region (7.6%).

Cigarette smoking (adults)
King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Exhibit 13

Mental Health & Substance Use

Continued

TEEN SUBSTANCE USE

E-CIG OR VAPE PEN USE

Electronic cigarettes, also called e-cigs or vape pens, are electronic devices that heat a liquid and produce an aerosol — a mix of small chemical particles that are inhaled. Most contain nicotine, which is highly addictive and can harm adolescent brain development.[39,40]

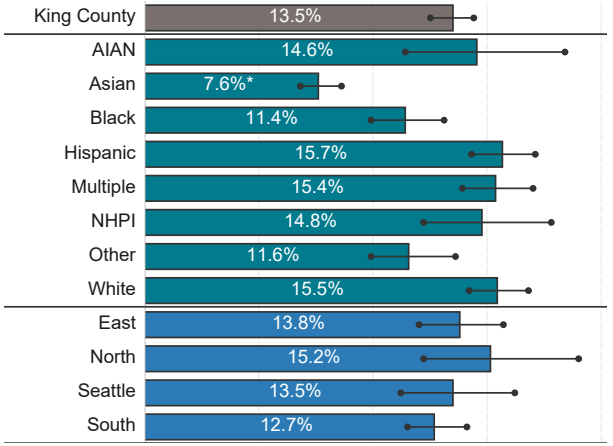
As rates of youth who report smoking cigarettes have continued to decline in King County, youth who report using e-cigarettes have continued to increase. This shift is especially concerning, since current e-cig use among youth (16.8%) is more than four times the reported rate of current cigarette smoking among youth in 2018 (4.2%). Considering this behavior change, this report has replaced the previously reported cigarette smoking indicator to focus on e-cigarettes use in youth.

This indicator reports on whether school-age youth in King County had used an electronic cigarette, also called e-cig or vape pen, on one or more days in the past 30 days[i]. Averaging data from 2016 and 2018, 13.5% of King County's 8th-, 10th-, and 12th-graders currently used e-cigs or vape pens.

[i]*The definition of current cigarette, e-cigarette, or vape pen use is using one or more days in the past 30 days.*

Current e-cigarette or vape pen use (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Among 12th-graders (20.6%), one in five were current e-cig users — more than 3 times the rate for 8th-graders (5.8%).
- Youth identifying as LGB+ were significantly more likely (21.0%) than youth identifying as heterosexual (13.4%) to report current e-cig use.
- E-cig use was lowest among Asian (7.6%), Black (11.4%), and students reporting "other" race/ethnicity (11.6%).

Mental Health & Substance Use

Continued

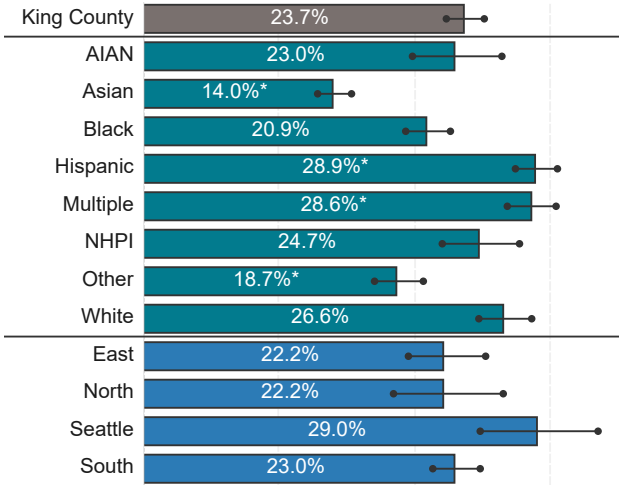
ALCOHOL, MARIJUANA, PAINKILLER, OR ANY ILLICIT DRUG USE

This indicator reports on 8th-, 10th-, and 12th-graders' high-risk substance use, including alcohol, marijuana, painkillers, or other illegal drugs (not including tobacco or vape pen use) in the past 30 days. When combining all high-risk substances, overall use among local public high school students has been declining for the past 10 years (though there are variations among individual substances, such as marijuana use among youth, described below). Averaging data from 2016 and 2018, 23.7% of King County youth attending public schools in the 8th, 10th, and 12th grades reported using high-risk substances, including alcohol, marijuana, painkillers, or other illegal drugs during the past 30 days.

- Seattle students reported the highest rate of substance use (29.0%) compared to East (22.2%), North (22.2%), and South (23.0%) regions.
- The percentage of students reporting substance use increased 2.5 times between 8th (9.1%) and 10th (23.2%) grades and increased another 1.6 times between 10th and 12th (37.4%) grades.
- Hispanic (28.9%) and multiple-race (28.6%) youth were significantly more likely to report substance use compared to the King County average.

Alcohol, marijuana, painkiller or any illegal drug use in the past 30 days (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- Among youth identifying as LGB+, 34.4% reported substance use — higher than youth identifying as heterosexual (23.5%) and higher than the overall King County average.

Mental Health & Substance Use

Continued

MARIJUANA USE

Averaging data from 2016 and 2018, when asked specifically about the use of marijuana or hashish, 15.0% of 8th-, 10th-, and 12th-graders reported using one or both in the past 30 days. When looking over time, while marijuana use among youth was declining since the peak in 2012 (17.9%) with a significantly lower rate in 2016 (14.8%), the most recent data from 2018 (15.2%) appear to be leveling previous declines.

- Seattle students (19.7%) reported the highest rate of marijuana or hashish use compared to the South (15.5%), North (14.2%), and East (11.9%) regions.

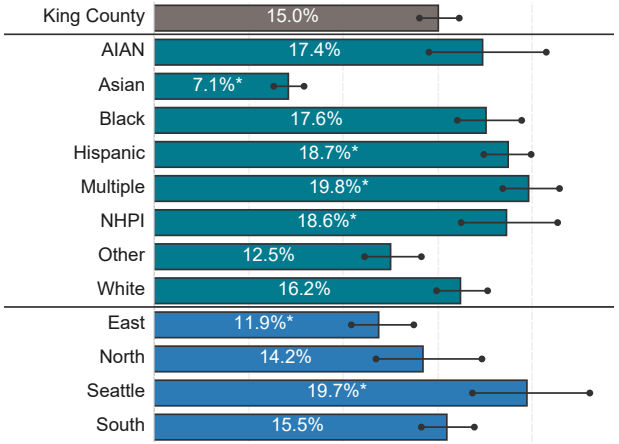
- The percentage of students reporting use of marijuana or hashish increased three times between 8th (4.8%) and 10th (14.8%) grades, and another 1.7 times between 10th and 12th (24.5%) grades.

- Students identifying as LGB+ (23.3%) were more than 1.5 times as likely as students who identified as heterosexual (14.4%) to report use of marijuana or hashish.

- Use of marijuana or hashish was highest among Native Hawaiian/Pacific Islander, Hispanic, and multiple-race students, and lowest among Asian (7.1%) students, though differences exist among detailed Asian ethnic groups — with Japanese (14.6%), Cambodian/Khmer (14.4%), and Filipino students (13.6%) reporting rates closer to the King County average.

Marijuana use (8th, 10th, 12th grades)

King County (average: 2016&2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Mental Health & Substance Use

Continued

DRUG-INDUCED DEATHS

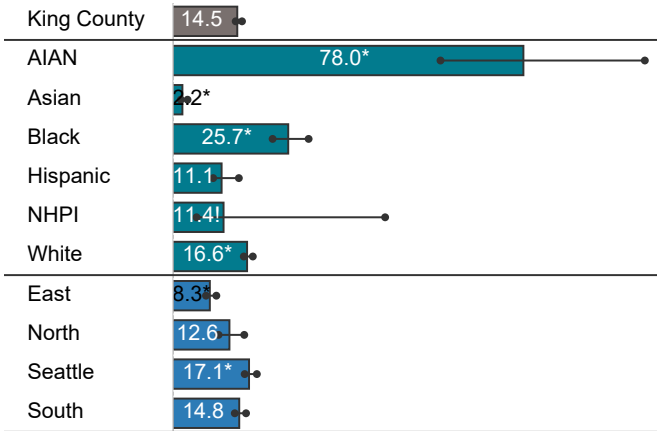
Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use. This includes death resulting from the use of illicit drugs, such as heroin and cocaine, as well as legal prescriptions and over-the-counter drugs (alcohol is not included).

The rate of drug-induced death in King County has slowly increased over the past 10 years, and opioid overdose deaths continue to be a major concern in King County. As of December 1, 2020, a review of characteristics of King County residents with a confirmed drug- or alcohol-caused death shows a sharp increase among residents <30 years old over the past five years — from 13% in 2015 to 24% in 2020. The number of confirmed overdose deaths involving methamphetamine have increased drastically in King County — from 88 deaths in 2015 to 209 deaths in 2019. Similarly, overdose deaths from fentanyl have skyrocketed — from three deaths in 2015 to 113 deaths in 2019. Fentanyl is a synthetic opioid that is 50-100 times more powerful than heroin.

The average drug-induced death rate of King County residents between 2014–2018 was 14.5 per 100,000 — significantly higher than 2011–2013, when the rate was 12.3 per 100,000.

Drug-induced deaths

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

- Comparing King County neighborhoods, the average death rate from drugs is highest among people in Seattle – Downtown at 56.8 per 100,000. The next highest rate is Seattle – Beacon Hill/Georgetown/ South Park with 22.6 per 100,000.

- In King County, drug-induced deaths occurred most commonly between the ages of 45 and 64 (28.2 per 100,000). Victims were twice as likely to be male (19.3 per 100,000) as female (9.7 per 100,000) and were most likely to live in high-poverty neighborhoods (27.1 per 100,000) prior to their deaths.

Mental Health & Substance Use

Continued

- Drug-induced deaths for American Indian/Alaska Native residents were 78.0 per 100,000, which is more than five times the King County average.
- Drug-induced deaths were lowest among Asian residents (2.2 per 100,000).

Reviewing data from early 2020, overdose deaths were 44% higher in March 2020 compared to March 2019, and 72% higher in April 2020 compared to 2019. This increase was driven by fentanyl-involved overdoses.[41]

Mental Health & Substance Use

Continued

INJECTION DRUG USE BEHAVIOR

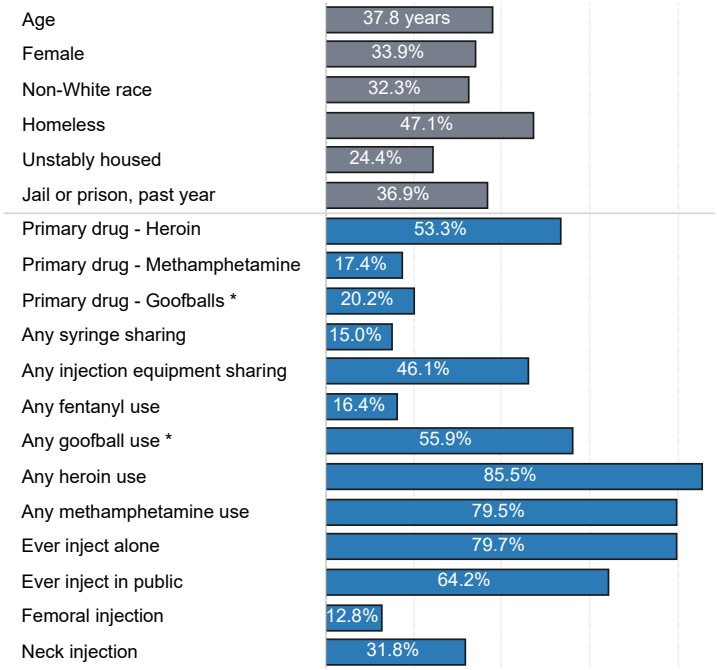
Public Health – Seattle & King County (PHSKC) conducts a biennial survey of syringe services program clients to monitor demographics, health, and behavior trends among people who inject drugs. In July 2019, PHSKC syringe services program staff surveyed 432 clients who visited a syringe services program site. Among these respondents:

- The mostly commonly reported primary drug used in the previous three months was heroin (53.3%), followed by methamphetamine and heroin mixed together, also known as "goofball" (20.2%), and methamphetamine (17.4%).
- One out of three surveyed syringe services program clients were actively in treatment for substance use.
- Nearly half (47.1%) of syringe services program clients were homeless.
- Most clients (85.5%) reported any heroin use in the past three months and 79.5% reported any methamphetamine use.
- A majority (79.7%) reported ever injecting drugs alone, and 64.2% reported ever injecting in public within the past three months.
- In 2018, there were close to 8 million syringes exchanged by the King County Needle Exchange Program.

Injection drug use behavior, reported by syringe services program survey respondents

(demographics & injection-related behaviors in the past 3 months)

King County (2019)



Source: King County Needle Exchange Survey, 2019
* Methamphetamine and heroin mixed together

Maternal & child health

The health and well-being of mothers, infants, and children are markers of overall community health. A mother's mental, physical, emotional, and socioeconomic well-being can affect pregnancy and birth outcomes as well as the health of their children into adulthood and subsequent generations. Improving birth outcomes, such as preterm birth and infant mortality, is among the nation's most pressing public health priorities. While King County does well compared to other parts of Washington state on many maternal and child health indicators, disparities in birth outcomes persist, particularly among Black, Hispanic, Native Hawaiian/Pacific Islander, and American Indian/Alaska Native populations. When comparing average three-year trend estimates with non-overlapping years from 2013–2015 to 2016–2018, the only indicator that has significantly[i] improved was the percentage of mothers who received early and adequate prenatal care from 71.5% to 72.8%.

Additional indicators available online include adolescent birth rate, breastfeeding initiation, and preterm birth rate.

In King County, infant mortality among Black mothers is more than 2.5 times the rate among white mothers. The disparity is even greater among American Indian/Alaska Native mothers, with an infant mortality rate four times the rate of white mothers.

[i] *Significance is determined by non-overlapping confidence intervals.*

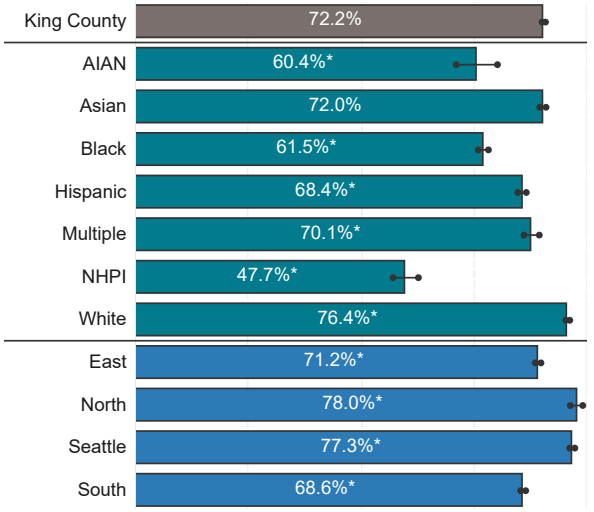
EARLY AND ADEQUATE PRENATAL CARE

Early and adequate prenatal care is important to increase the likelihood of a healthy pregnancy and birth. Ongoing prenatal care ensures that healthcare providers routinely assess the health of mother and baby to monitor fetal development and address potential problems and complications. This indicator analyzes mothers who initiated prenatal care in the first trimester and had at least 80% of the medically recommended number of prenatal visits.

Averaging data from 2014–2018, more than seven out of 10 expectant mothers (72.2%) in King County received early and adequate prenatal care. King County did not achieve the Healthy People 2020 objective that at least 83.2% of expectant mothers receive early and adequate prenatal care.[42] The updated Healthy People 2030 objective is that at least 80.5% of expectant mothers receive early and adequate prenatal care.[43]

- Native Hawaiian/Pacific Islander expectant mothers (47.7%) were significantly less likely to have early and adequate prenatal care compared to any other race/ethnicity. American Indian/Alaska Native (60.4%) and Black (61.5%) expectant mothers were the second and third less likely, respectively. White expectant mothers (76.4%) were most likely to have early and adequate prenatal care.

Early and adequate prenatal care
King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average

- The likelihood of receiving early and adequate prenatal care increases with age. Young expectant mothers age 10–17 were least likely (48.4%) to have received prenatal care. Expectant mothers 18–24 years old had the second lowest percentage (60.8%).

- Disparities in early and adequate prenatal care exist by neighborhood poverty. Expectant mothers in high-poverty neighborhoods have the lowest likelihood (67.2%) of receiving early and adequate prenatal care.

Exhibit 13

LOW BIRTHWEIGHT

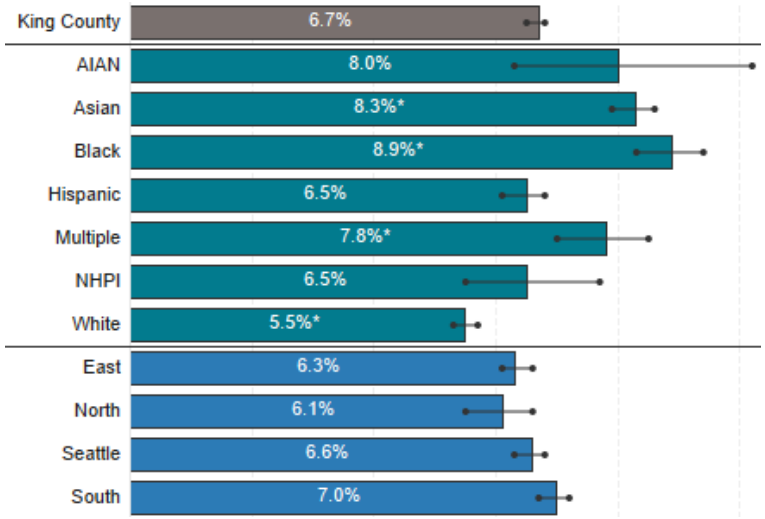
Low-birthweight babies are more likely to experience health complications and are at higher risk of infant mortality, respiratory disorders, and neurological problems. Low birthweight is defined as babies weighing less than 2500 grams or 5 pounds, 8 ounces at birth.

Averaging data from 2014–2018, 6.7% of babies in King County were low birthweight.

- Babies born to Black mothers (8.9%) were most likely to be low birthweight, followed by babies born to Asian mothers (8.3%). Both are significantly higher than the King County average.
- Mothers over 45 years old (13.8%) were more likely than any other demographic group to have low-birthweight babies, highlighting the risk that increasing age has on the likelihood of complications with birth outcomes.[ii]
- Mothers living in high-poverty neighborhoods (7.4%) were more likely than those in low-poverty neighborhoods (5.9%) to have low-birthweight babies

Low birthweight (all births)

King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average

[ii] *This includes all infants, including multiples/higher-order births. Incidence of multiple births increases with age.*

Maternal & child health

INFANT MORTALITY

Infant mortality is defined as the death of an infant before their first birthday. Infant mortality rate is widely used as a measure of population health, as it is a general indicator of unmet need in a population and is associated with determinants of health, such as socioeconomic status, quality of medical care, nutrition, and education.

Averaging data from 2014–2018, 3.9 per 1,000 infants born to King County residents died within 365 days after birth. The King County rate is lower than the Washington state infant mortality rate of 4.7 infant deaths per 1,000 live births (2018)[44] and well below the Healthy People 2020 target of 6.0 per 1,000 live births.[45] Still, disparities persist by race/ethnicity, socioeconomic status, and neighborhood.

Averaging data from 2014–2018, 6.7% of babies in King County were low birthweight.

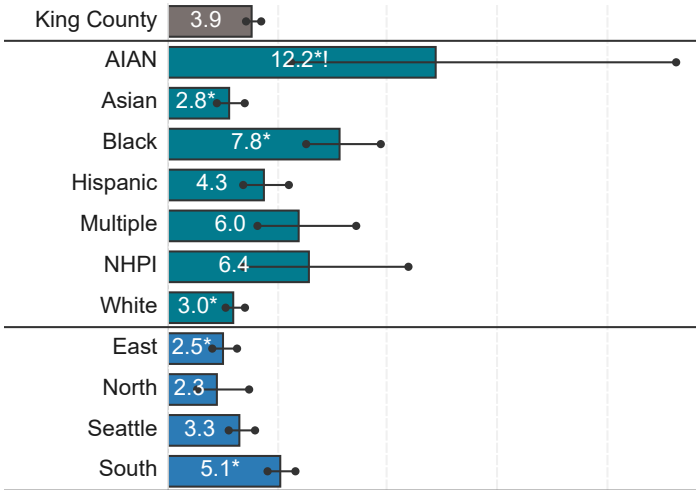
- Infants born to American Indian/Alaska Native mothers (12.2 per 1,000) die at rates more than four times the rate among Asian (2.8 per 1,000) or white mothers (3.0 per 1,000). Infants born to Black mothers (7.8 per 1,000) die at rates more than 2.5 times the rate of infants born to Asian or white mothers.

- Infant mortality in the South Region (5.1 per 1,000) is significantly higher than the county average, reaching as high as 8.3 per 1,000 in Federal Way – Dash Point/Woodmont — more than twice the county average and higher than any other King County neighborhood. Babies born in the South Region are twice as likely to die before their first birthday than babies born in the East Region.

- Infant mortality among mothers age 24 and younger is higher than the King County average.

Infant mortality

King County (average: 2014-2018)



Source: WA State Department of Health, Birth Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

Physical Activity, Nutrition, & Weight

Consuming a nutrient-rich diet and getting regular exercise are key behaviors for maintaining a healthy weight as well as reducing the risk of chronic conditions, such as obesity, type 2 diabetes, heart disease, and stroke — all of which are associated with leading causes of death. Regular physical activity also provides additional benefits related to stress management and mental health among youth and adults. Disparities in these health behaviors are evident by race/ethnicity, economic status, and geographic location nationally as well as in King County.

Additional indicators available online include no breakfast today (youth), excessive screen time (youth), and sedentariness (adults).

Consumption of sugar-sweetened beverages is decreasing among youth in all King County regions and racial/ethnic groups.

Physical Activity, Nutrition, & Weight

Continued

ADULT PHYSICAL ACTIVITY

Averaging data from 2013, 2015, and 2017,[i] 24.2% of adults in King County met CDC recommendations for aerobic and strengthening exercise, defined as 150 minutes of moderate-intensity aerobic activity every week and muscle-strengthening activities on two or more days a week that work all major muscle groups. The percentage of King County adults meeting physical activity guidelines has gradually increased over the past 10 years.

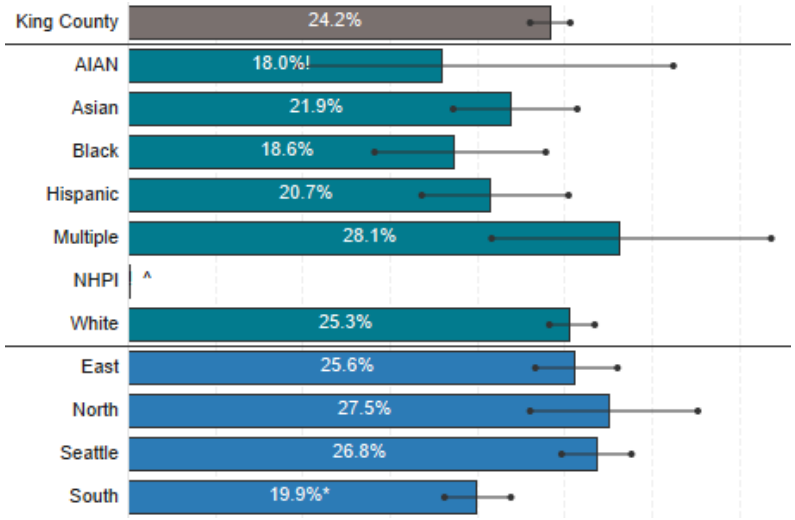
- Among adults, adherence to physical activity guidelines increases with income. Only 16.3% of adults with household income less than $15,000 met physical activity recommendations — lower than the King County average. Among higher-income families making more than $75,000, 26.4% of adults met physical activity recommendations.

- At 19.9%, South Region adults were significantly less likely to meet physical activity guidelines compared to other King County regions. Only 8.5% of South Auburn adults met physical activity recommendations.

[i]*Question not asked in 2014 or 2016.*

Physical activity (adults)

King County (average: 2013, 2015, & 2017)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise
^ Data suppressed if too few cases to protect confidentiality and/or report reliable rates

Physical Activity, Nutrition, & Weight

Continued

ADULT OBESITY

Averaging data from 2014–2018, 21.5% of King County adults were obese, reporting a body mass index (BMI) greater than or equal to 30. Obesity rates among King County adults have been relatively stable for the past 10 years.

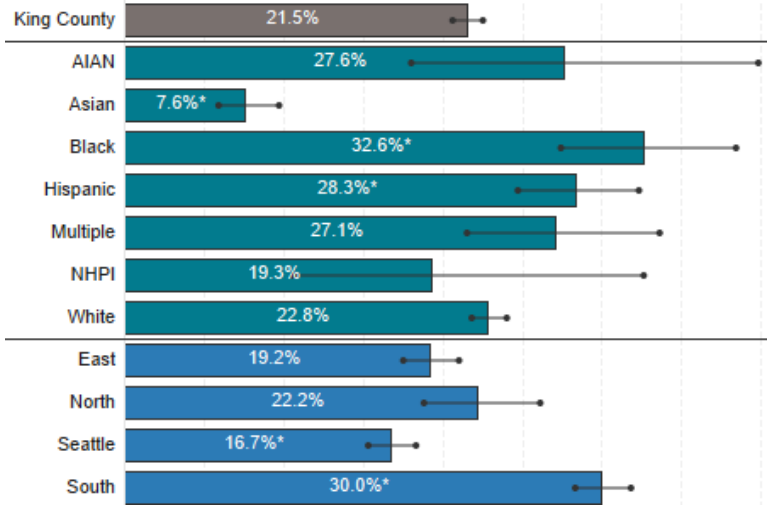
- Obesity prevalence among Black (32.6%) and Hispanic (28.3%) adults was significantly higher than the King County average and more than 3.5 times the rate among Asian (7.6%) residents.

- At 30.9%, obesity was most prevalent among residents with the lowest annual household income (less than $15,000), and least prevalent among those with annual household income greater than $75,000 (18.1%).

- Although the overall obesity rate in King County has been stable, obesity rates among American Indian/Alaska Native residents appear to be declining when comparing average three-year trend estimates from 2013–2015 (34.9%) to 2016–2018 (20.2%). This trend continues to build upon improvements in adult obesity rates going back to 2010–2012, when the average for AIAN residents was 55.4%.[ii] During this same period, among American Indian/Alaska Native residents, overweight but not obese rates appear to be increasing, signaling improvements in overall BMI.

Obese (adults)

King County (average: 2014-2018)



Source: Behavioral Risk Factor Surveillance System
* Significantly different from King County average

[ii] *Estimates may be imprecise due to small population numbers*

Physical Activity, Nutrition, & Weight

Continued

YOUTH PHYSICAL ACTIVITY

The physical activity guidelines issues by the U.S. Department of Health and Human Services recommend that children and adolescents should have 60 minutes or more of physical activity each day.[46]

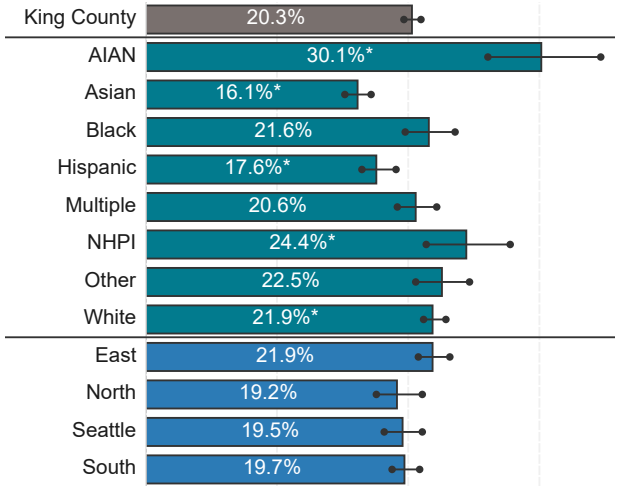
Averaging data from 2016 and 2018, only one in five students (20.3%) in 8th, 10th, and 12th grades participated in physical activity for 60 minutes or more on seven of the previous seven days. Based on these data, King County did not meet the Healthy People 2020 objective of 31.6% of adolescents meeting federal physical activity guidelines.[47]

- As grade level increases, student participation in physical activity declines. By 12th grade, only 16.6% of students met recommendations compared to 25.4% of 8th graders.

- Males (25.7%) were more than 1.5 times as likely to meet physical activity guidelines as females (14.5%). At all grade levels, female students were significantly less likely than male students to meet physical activity recommendations; by 12th grade, only 10.9% of female students met recommendations.

Physical activity (8th, 10th, 12th grades)

King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

- While health behaviors take time to improve, when viewing trends, it is evident that the percentage of students who meet physical activity recommendations has been declining recently for King County overall, including significantly for 8th and 12th graders, males, and South Region students.

Physical Activity, Nutrition, & Weight

Continued

YOUTH SUGAR-SWEETENED BEVERAGE CONSUMPTION

Regularly drinking sugar-sweetened beverages is associated with weight gain, tooth decay, and chronic health conditions, such as obesity, diabetes, and heart disease.[48] Consumption of sugar-sweetened beverages is decreasing among youth in all King County regions and racial/ethnic groups.

Averaging data from 2016 and 2018, 12.3% of King County students in 8th, 10th, and 12th grades consumed nondiet sodas or sugar-sweetened beverages daily — a continued decline from previous years (17.4% in 2014).

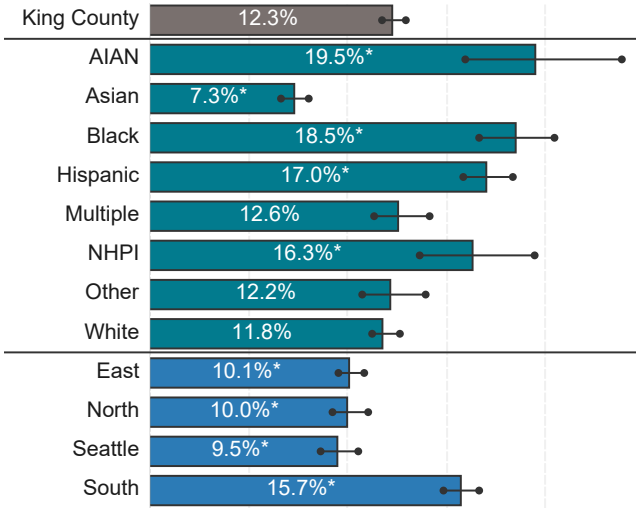
- Male students (15.1%) were more than 1.6 times as likely as female students (9.3%) to drink nondiet sodas or sugar-sweetened beverages daily.

- Daily consumption of sugar-sweetened beverages was lowest among Asian students (7.3%) compared to other racial/ethnic groups, though differences existed among detailed Asian ethnic groups — with Cambodian/Khmer (15.1%), Filipino (11.8%), and Japanese students (10.8%) reporting rates similar to the King County average.

- Despite a steady decline, South Region youth were still more than 1.5 times as likely as youth in other King County regions to drink sugar-sweetened beverages daily.

Drink soda or sugar-sweetened beverages daily (8th, 10th, 12th grades)

King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Physical Activity, Nutrition, & Weight

Continued

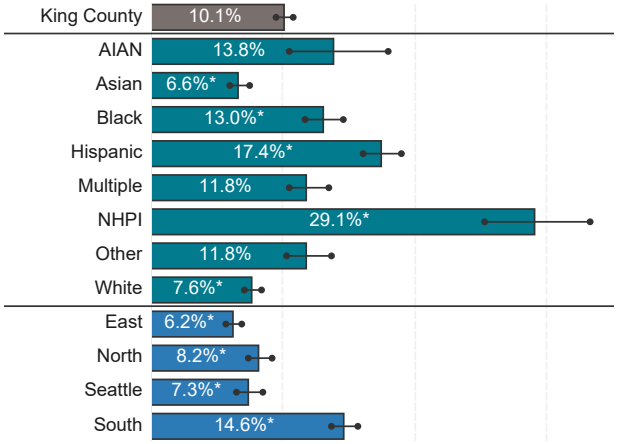
YOUTH OBESITY

Youth are considered obese if their body mass index (BMI) is in the top 5% for their age and gender. After a relative decline in 2012, student obesity rates have been increasing in King County.

Averaging data from 2016 and 2018, 10.1% of students attending King County public schools in 8th, 10th, and 12th grades were obese. King County youth obesity rates increased significantly between 2014 (8.8%) and 2018 (10.7%).

- Male students (12.4%) were more likely than female students (7.5%) to be obese.
- Youth obesity was highest among Native Hawaiian/Pacific Islander students (29.1%), at nearly three times the King County average.
- At all grade levels, students who identified as lesbian, gay, or bisexual (13.4%) were significantly more likely to be obese than heterosexual students (8.4%).
- Students in the South Region (14.6%) were most likely to be obese compared to all other regions. When compared to East Region students (6.2%), South Region students were more than twice as likely to be obese.

Obese (8th, 10th, 12th grades)
King County (average: 2016 & 2018)



Source: Healthy Youth Survey
* Significantly different from King County average

Violence & Injury Prevention

This section reports on hospitalizations and deaths related to suicide, firearm-related deaths, and hospitalizations from falls. While most of the data in this section were collected prior to 2020, it's important to note that during the COVID-19 pandemic, some patterns — especially around violence, suicide, and mental health — may be changing. Early numbers from 2020 suggest that firearm homicides may be on the rise around the county.[49] In addition, local officials have reported a sharp spike in domestic violence cases since the onset of COVID-19. In King County, 17 out of the 18 domestic violence homicide deaths reported through December 2020 occurred after the onset of the pandemic in March 2020. This is more than the number of domestic violence homicides reported in 2018 and 2019 combined. Six of those domestic violence homicide deaths in 2020 were committed by firearm.[i] While domestic violence has not been a standard indicator in the CHNA, these alarming trends underscore the importance of continued monitoring and focused support for mental health.

It is also important to emphasize that suicide is an ongoing concern among King County youth. The rate of suicidal ideation among youth (defined as having seriously considered attempting suicide within the past year) jumped from 16.7% in 2016 to 19.0% in 2018. During this same time, the rate of youth who had made a plan to attempt suicide within the past year also significantly increased from 14.1% in 2016 to 15.5% in 2018. Averaging data from 2016 and 2018, rates are alarmingly high among LGB+ youth for both suicidal ideation (42.1%) and suicide plan (35.0%).

Additional violence and injury prevention indicators available online include youth who felt safe at school, firearms stored in the home, youth who made a plan to attempt suicide, and adults (45+) who were recently injured in a fall.

The rate of firearm-related deaths in South Region has been rising for the past 10 years.

[i] *Personal communication – King County Prosecuting Attorney's Office, November 19, 2020.*

SELF-HARM AND ATTEMPTED SUICIDE HOSPITALIZATIONS

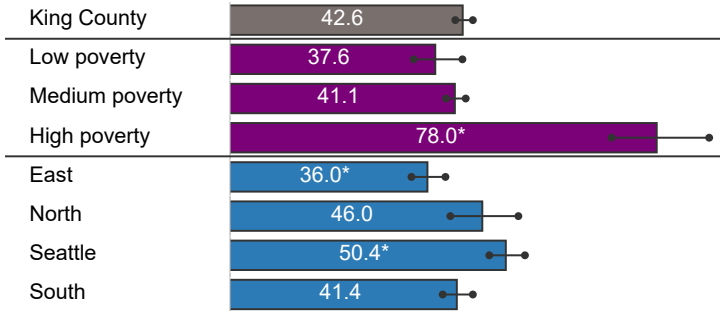
Averaging data from 2016–2018, the hospital admission rate for self-harm and attempted suicides[ii] was 42.6 per 100,000 residents in King County, which represents an average of 917 admissions each year. At this time, we are able to look at data only from 2016 forward, as the coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance on understanding the impact of the coding structure is not finalized, it is recommended that comparisons should not be made between data before and after October 1, 2015. This analysis excludes deaths and injury sequelae.

- Compared to other age groups, the rate of attempted suicide hospitalization was highest among young adults age 18–24 (77.0 per 100,000).
- Females (52.0 per 100,000) were significantly more likely than males (33.7 per 100,000) to be hospitalized for suicide.
- The hospital admission rate for self-harm and attempted suicides for people in the high-poverty group was 78.0 per 100,000 — higher than the King County average and more than two times the rate among the low-poverty group (37.6 per 100,000).
- The hospital admission rate for self-harm and attempted suicides in Seattle (50.4 per 100,000) was significantly higher than the King County average, and significantly lower in the East Region of the county (36.0 per 100,000).

[ii] *Excludes deaths and sequalae. Incudes subsequent encounters.*

Self-harm & attempted suicide hospitalizations

King County (average: 2016-2018)



Source: Comprehensive Hospital Abstract Reporting System (CHARS)
* Significantly different from King County average

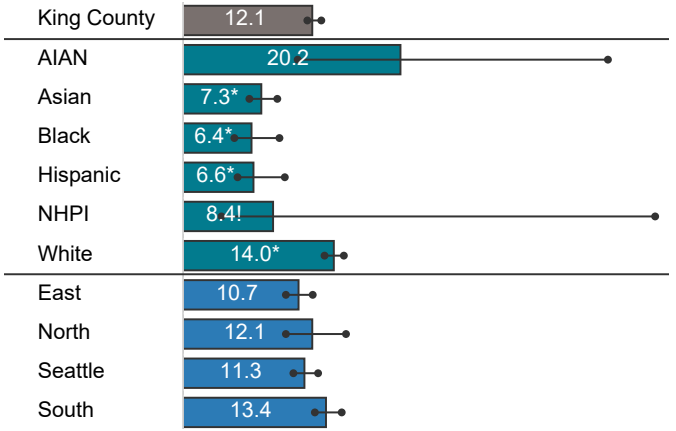
SUICIDE DEATHS

Averaging data from 2014–2018, the suicide death rate of King County residents of all ages was 12.1 per 100,000, which represents an average of 268 suicide deaths per year. For King County overall, this rate has not changed dramatically when comparing average three-year trend estimates from 2013–2015 to 2016–2018. The mental and behavioral health impact of COVID-19 is an important area to monitor. Recent data to assess the impact of COVID-19 indicate an increase in the percentage of adults who report feeling depressed, worried, and anxious from April through July 2020.

- The suicide death rate among children and adolescents (<18 years old) was 1.9 per 100,000.
- The rate for adults age 75+ was 20.0 per 100,000 — significantly higher than the King County average.
- Males (18.9 per 100,000) were 3.3 times as likely as females (5.8 per 100,000) to die from suicide.
- Suicide rates for Hispanic (6.6 per 100,000), Asian (7.3 per 100,000), and Black (6.4 per 100,000) populations were significantly lower than the county average of 12.1 per 100,000. The rate for white residents exceeded the county average at 14.0 per 100,000.
- The suicide rate among American Indians/Alaska Natives (AIAN) was 20.2 per 100,000 — the highest of all racial/ethnic groups, although due to small sample sizes, this estimate is imprecise and should be interpreted with caution.
- The death rate from suicide for people in Auburn – South was 22.3 per 100,000. This rate is higher than the King County average and the highest of all King County neighborhoods.

Suicide

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

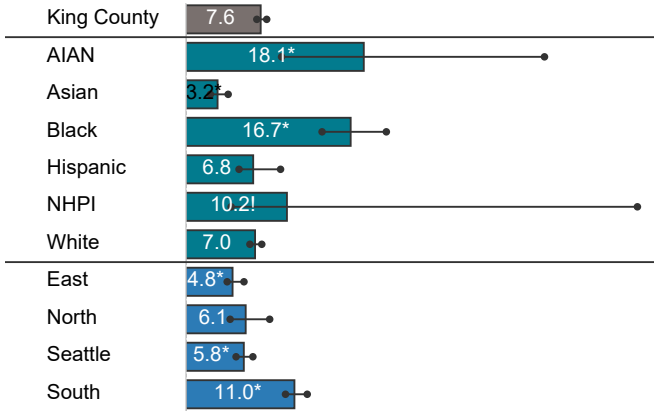
FIREARM-RELATED DEATHS

Averaging data from 2014–2018, the rate of firearm-related deaths (including unintentional death, suicide, and homicide by firearm) was 7.6 per 100,000 King County residents, which represents an average of 163 deaths per year. For King County overall, this rate appears to be increasing when comparing average three-year trend estimates from 2013–2015 to 2016–2018. For these same time periods, dramatic increases in firearm death rates are apparent for high-poverty neighborhoods, Native Hawaiian/Pacific Islanders, and the South Region of King County.

- Males (13.5 per 100,000) were more than seven times as likely to die due to firearms as females (1.9 per 100,000).
- Firearm-related deaths were more prevalent in high-poverty neighborhoods (10.3 per 100,000) compared to low-poverty neighborhoods (5.3 per 100,000).
- For young adults (age 18–24), the rate of firearm-related deaths (15.6 per 100,000) was two times the county average.
- Black residents (16.7 per 100,000) were 2.4 times, American Indian/Alaska Native residents (18.1 per 100,000) were 2.6 times, and Native Hawaiian/Pacific Islander residents (10.2 per 100,000) were 1.5 times as likely to die by firearm as white residents (7.0 per 100,000). Asian residents (3.2 per 100,000) were half as likely to die by firearms compared to white residents.
- The rate of firearm-related deaths in the South Region (11.0 per 100,000) remained higher than in the other regions and has been slowly rising for the past 10 years — significantly higher than the average firearm-related death rate in the South Region from 2009–2011 (7.8 per 100,000).
- The top three neighborhoods in King County with the highest firearm-related death rates were all in South Region — Kent-West (19.0 per 100,000), North Highline (16.7 per 100,000), and Auburn – North (15.3 per 100,000). Neighborhoods with the lowest rates of firearm-related deaths were Northeast Seattle (2.0 per 100,000), Sammamish (2.5 per 100,000), and Mercer Island/Point Cities (2.6 per 100,000).

Firearm-related deaths

King County (average: 2014-2018)



Source: WA State Department of Health, Death Certificate data
* Significantly different from King County average
! Interpret with caution: sample size is small, so estimate is imprecise

FALL HOSPITALIZATIONS

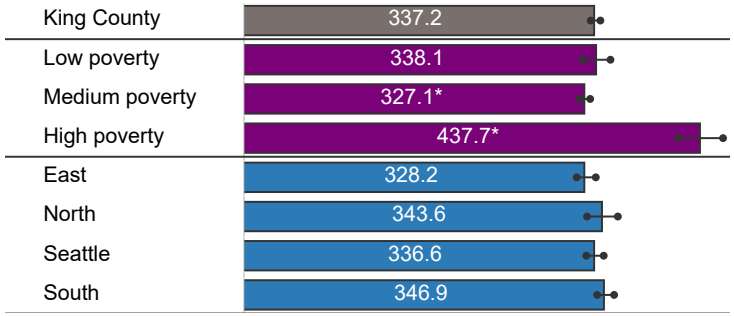
This indicator incudes unintentional nonfatal fall-related hospital admissions.[iii] Unintentional falls are a leading cause of death and injury, particularly for people over age 65. Having one serious fall doubles the chances to have another one fall.[50] Averaging data from 2016–2018, the admission rate for falls was 337.2 per 100,000 King County residents, which represents an average of 7,113 admissions per year. At this time, we are able to look at data only from 2016 forward, as the coding structure for healthcare claims data has changed, and the current guidance is that the two structures are not comparable. Since the transition occurred in the last quarter of 2015 and guidance is not finalized, it is recommended that comparisons should not be made between data before and after October 1, 2015.

- Fall hospitalizations rarely occur among children and young adults. The rate for adults age 65–74 was 789.3 per 100,000 — more than 12 times the rate among adults age 25–44 (65.0 per 100,000).
- Fall hospitalizations were most common among adults age 75 and older — 3,575.7 per 100,000 residents.

[iii] *Fall-related deaths and hospitalizations due to sequelae from falls are excluded. Subsequent encounters are included.*

Fall hospitalizations

King County (average: 2016-2018)



Source: Comprehensive Hospital Abstract Reporting System (CHARS)
* Significantly different from King County average

- Compared to females (341.4 per 100,000), males were less likely to be hospitalized for falls (325.5 per 100,000).
- The hospitalization rate from falls for people in the high-poverty group was 437.7 per 100,000 — higher than the King County average.

Determinants of Equity

RELATIONSHIPS BETWEEN RACE/ ETHNICITY AND HEALTH

Racial and ethnic disparities in health and social outcomes persist throughout the county. Similar to patterns shared in the previous CHNA, white and Asian populations in King County fare better than others across a number of health and social indicators. Since the aggregate "Asian" category masks disparities within, findings among detailed Asian ethnicities are presented when available. Current data do not permit us to disaggregate multigenerational African American communities from Somali, Ethiopian, and other emerging African communities within the Black race category, or to disaggregate among Hispanic groups. Comparisons between groups are meant to highlight inequities by race/ethnicity where they exist, and not to imply that any specific race/ethnicity is the standard to which others should be compared.

DETERMINANTS OF HEALTH BY RACE/ ETHNICITY

Access to care and use of preventive services

- In 2019, Hispanic adults had the highest rate of uninsurance and were six times as likely as white adults to be without coverage. Black adults were more than two times as likely to be **uninsured** compared to white adults.
- Compared to white and Asian adults (the racial/ethnic groups with the lowest rates of uninsurance), Black adults were more than 1.5 times as likely and Hispanic adults were more than two times as likely to report **unmet medical needs** due to cost.
- Hispanic adults are more likely not to have met **colorectal cancer screening** guidelines compared to the King County average. Cancer is the leading cause of death among the Hispanic community in King County, with colorectal cancer as the third most common cancer type in this group.
- Native Hawaiian/Pacific Islander, Black, Hispanic, and multiple-race residents were significantly more likely to have not **visited a dentist** or dental clinic in the previous year compared to white residents.

Maternal and child health

- Native Hawaiian/Pacific Islander expectant mothers were least likely to have **early and adequate prenatal care** compared to other racial/ethnic groups. White expectant mothers were most likely to have early and adequate prenatal care.
- Babies born to Black mothers were most likely to be **low birthweight,** followed by babies born to Asian mothers.

Determinants of Equity

Continued

Mental health and substance use

- Hispanic adults are more likely than the King County average to experience **frequent mental distress.**

- Eight out of 10 white residents report that they always or usually get the **social and emotional support** they need — significantly higher than Black, Hispanic, and Asian adults.

- Hispanic, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and multiple-race youth were more likely than Asian, Black, and white youth to report **depressive feelings**. However, among Asian ethnicities analyzed, the depression rate exceeds the county average among Filipino students but is lower than average among Asian Indian students.

- Cigarette **smoking** among American Indian/Alaska Native residents has been declining, though the rate of current smokers was still nearly 2.5 times the county average.

- Hispanic and multiple-race youth were significantly more likely to report **substance use** (including alcohol, marijuana, painkillers, or any illicit drug use) compared to the King County average. Use of **marijuana** was highest among Native Hawaiian/Pacific Islander, Hispanic, and multiple-race students, and lowest among Asian students, though differences exist among detailed Asian ethnic groups — with Japanese, Cambodian/Khmer, and Filipino students reporting higher rates that are closer to the King County average.

- **Drug-induced deaths** (all deaths for which drugs are the underlying cause) for American Indian/Alaska Native residents were more than five times the King County average. Drug-induced deaths were lowest among Asian residents.

Physical activity, nutrition, and weight

- Daily consumption of **sugar-sweetened beverages** was lowest among Asian students compared to other racial/ethnic groups, though differences existed among detailed Asian ethnic groups — with Cambodian/Khmer, Filipino, and Japanese students reporting higher rates that are similar to the King County average.

- **Obesity** prevalence among Black and Hispanic adults was significantly higher than the King County average and more than 3.5 times the rate among Asian residents. Youth obesity was highest among Native Hawaiian/Pacific Islander students, at nearly three times the King County average.

Determinants of Equity

Continued

HEALTH OUTCOMES BY RACE/ETHNICITY

Chronic illness

- The prevalence of **hypertension** among Black residents was significantly higher than the King County average. Compared to other racial/ethnic groups, Asian adults have the lowest rate of hypertension.

- **Asthma** rates are highest among Black and American Indian/Alaska Native Medicaid-enrolled children.

- Black adults were 3.2 times as likely as Asian adults to have **diabetes**.

Life expectancy and causes of death

- **Life expectancy** is highest among Asian (85.7 years) and Hispanic (84.0 years) residents. While Hispanic life expectancy is higher than the King County average, it has been declining in recent years. Life expectancy among Black residents (77.6 years) is four years shorter than life expectancy for white residents (81.6 years). While estimates may be imprecise due to small population numbers, at 72.2 years, Native Hawaiian/ Pacific Islander residents have the lowest life expectancy of all racial/ethnic groups in King County. This is a decline of 5.6 years from the 2011–2013 average life expectancy of 77.8 years for this group.

- The death rate from **unintentional injury** among American Indian/Alaska Native county residents (129.9 per 100,000) is 2.5 or more times the rate among other racial/ethnic groups.

RELATIONSHIPS BETWEEN INCOME AND HEALTH

Our review of health and social indicators reveals consistent income/poverty gradients in social determinants and health outcomes. Unless otherwise indicated, low-income is defined as households with an annual income of less than $15,000. High-income is defined as households with incomes above $75,000. Neighborhood poverty level is based on the proportion of households in a census tract in which annual household income falls below the federal poverty threshold. High-poverty neighborhoods are defined as those where 20% or more households are below the poverty threshold, medium poverty as 5% to 19% of households below the poverty threshold, and low poverty as less than 5% of households below the poverty threshold.

[ii] *The national poverty threshold for a family of four with two related children under 18 in 2018 was $25,465. https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html*

Determinants of Equity

Continued

DETERMINANTS OF HEALTH BY INCOME AND POVERTY LEVEL

Access to care and use of preventive services

- Adults with a household income below 100% of the federal poverty level[ii] were more than five times as likely as those with a household income at 400% or more of the federal poverty level to be **uninsured**.

- Low-income adults (household income <$15,000) were more than four times as likely as high-income adults (household income $75,000+) to report **unmet medical needs.**

- Adherence to **colorectal cancer screening** guidelines increases with household income.

- Half of all low-income adults had not **visited a dentist** in the past year, reflecting long-standing income disparities for dental care.

- Incomplete **vaccination rates** for children (19–35 months) are highest in neighborhoods with a high proportion of households in poverty.

Maternal and child health

- Disparities in **early and adequate prenatal care** exist by neighborhood poverty. Expectant mothers living in neighborhoods with a high proportion of households in poverty have the lowest likelihood of receiving early and adequate prenatal care.

- Mothers living in neighborhoods with a high proportion of households in poverty were more likely than mothers living in neighborhoods with a low proportion of households in poverty to have **low birthweight** babies.

Mental health and substance use

- The rate of **frequent mental distress** among low-income adults was almost 2.5 times the county average and four times the rate for high-income adults. The prevalence of frequent mental distress decreases with each increasing income category.

- Less than half of low-income adults report that they always or usually get the **social and emotional support** they need. High-income adults were twice as likely to report that they have the social and emotional support they need.

- **Smoking** among low-income adults was almost four times the rate among high-income adults.

Determinants of Equity

Continued

Physical activity, nutrition, and weight

- Among adults, adherence to **physical activity** guidelines increases with income, though it is low overall for all groups. Adults from higher-income households are 1.5 times as likely as low-income adults to have met physical activity recommendations.

- **Obesity** was most prevalent among low-income adults, and least prevalent among high-income adults.

HEALTH OUTCOMES BY INCOME AND POVERTY LEVEL

Chronic illness

- Adults with an annual income lower than $55,000 were more than three times as likely as high-income adults to have **diabetes**.

- The rate of **hypertension** among high-income adults was significantly lower than the King County average and all other income categories.

Life expectancy and causes of death

- Residents in neighborhoods with a low proportion of households in poverty live nearly five years longer than those in neighborhoods with a high proportion of households in poverty.

- Adults living in neighborhoods with a high proportion of households in poverty were more likely than those living in neighborhoods with a medium- or low-proportion of households in poverty to die from **unintentional injuries.**

RELATIONSHIPS BETWEEN PLACE AND HEALTH

Recent analyses also found persistent (and increasing) disparities by geographic location, or place. This signals the high degree of geographic variability of community resources, such as access to healthy and affordable food, safe places to play, and distance to work, as well as availability of schools and healthcare systems throughout cities/neighborhoods and regions.

DETERMINANTS OF HEALTH BY LOCATION

Access to care and use of preventive services

- The percentage of children 19–35 months of age in the South Region with **incomplete vaccination coverage** (have not completed the routine series of recommended vaccinations) is higher than in all other King County regions.

- Rates of **uninsurance** in Burien and Tukwila are more than twice the county average.

Determinants of Equity

Continued

- Compared to other regions, residents of the North Region were most likely to have met **colorectal cancer screening** guidelines. South Region adults were most likely to report that they had *not* **seen a dentist** in the previous year.

Maternal and child health

- **Infant mortality** is highest in the South Region, where babies are twice as likely to die before their first birthday than babies born in the East Region.

Mental health and substance use

- Adults and youth in the South Region were more likely than residents in other regions to report **frequent mental distress** (adults) and **depressive feelings** (youth).

- South Region adults are significantly more likely to be current **smokers** than the average King County resident, and nearly twice as likely as adults in the East Region.

- Seattle students reported the highest rate of **substance use** compared to all other King County regions.

Physical activity, nutrition, and weight

- South Region adults are significantly less likely to meet **physical activity** guidelines compared to other King County regions.

- Youth in the South Region — compared to other county regions — are most likely to drink **sugar-sweetened beverages** daily and to be **obese**. The obesity rate among South Region students is twice the rate in the East Region.

HEALTH OUTCOMES BY LOCATION

Chronic illness

- Compared to the average King County resident, South Region adults are more likely to have **hypertension**. Among residents of South Auburn, hypertension was more than 2.5 times as prevalent as among Northeast Seattle residents. South Region adults are also more likely to have **diabetes** than adults in other King County regions.

- North Auburn has the highest **childhood asthma** rate for Medicaid-enrolled children of all King County neighborhoods — nearly 2.5 times the rate of Vashon Island (2.2%), where asthma rates were the lowest.

Life expectancy and causes of death

- The North and South regions have significantly lower **life expectancy** compared to the King County average, whereas the East Region and Seattle both had significantly higher life expectancies than the North and South regions. Life expectancy among South Region residents has declined in the last

Exhibit 13

10 years. East Region residents are expected to live nearly five years longer than residents of the South Region

- Among King County neighborhoods, Downtown Seattle has the highest rate of **unintentional injury death**, followed by the Federal Way neighborhood of Dash Point.

RELATIONSHIPS BETWEEN SEXUAL ORIENTATION, GENDER IDENTITY, AND HEALTH

The previous 2018/2019 CHNA report included a spotlight on LGBTQ+ youth and young adults to learn about barriers and opportunities for populations to access healthcare. As described in the LGBTQ Community Spotlight, the impacts of racism, ageism, poverty, and other forms of discrimination on health have overlapping effects for sexual and gender minorities.

In addition to disparities by race and place, we also see a relationship between sexual orientation and health in several adult and youth indicators. The way in which sexual orientation data is collected varies across surveys. In this report, adult indicators from the Behavioral Risk Factor Surveillance System (BRFSS) present sexual orientation as "LGB" (lesbian, gay, bisexual), whereas youth indicators from the Healthy Youth Survey (HYS) present sexual orientation as "LGB+" to reflect the category response that "something else fits better" in that survey. Comparisons between groups are meant to highlight inequities by sexual orientation where they exist, and not to imply that heterosexuality is the norm or a standard to which others should be compared. While information about sexual orientation is not available for all indicators, analyses of recent data show noteworthy disparities in some areas.

- Adults who identified as lesbian, gay, or bisexual (LGB) were more than twice as likely as heterosexual adults to report **frequent mental distress.** The percent of adults reporting frequent mental distress has remained stable when looking at the overall county population, but LGB adults have seen a steady increase over the past several years, from 18% in 2012–2014 to 24% in 2016–2018.

- LGB adults were twice as likely to report **unmet medical needs** and were more likely to be current **smokers** compared to adults who identify as heterosexual.

- Youth identifying as LGB+ were more likely to report current **substance, marijuana, and e-cigarette use** compared to youth identifying as heterosexual.

End Notes

REFERENCES

1. Hartnett KP, Kite-Powell A, DeVies J, et al. Impact of the COVID-19 pandemic on emergency department visits — United States, January 1, 2019–May 30, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(23):699-704. doi:10.15585/mmwr.mm6923e1.

2. Schachter A, Neal S, Pajimula F, Johnson K, Wong E, Laurent. A. Unemployment claims in King County, WA March – Early May 2020.; 2020. Public Health Seattle & King County; Assessment Policy Development and Evaluation Unit. https://www.kingcounty.gov/depts/health/covid-19/data/impacts/~/media/depts/health/communicable-diseases/documents/C19/unemployment-claims.ashx. Accessed December 15, 2020.

3. Schachter A, Song L, Neal S, et al. Increases in food needs in King County, WA Spring-Summer 2020.; 2020. Public Health Seattle & King County; Assessment Policy Development and Evaluation Unit. https://www.kingcounty.gov/depts/health/covid-19/data/impacts/~/media/depts/health/communicable-diseases/documents/C19/food-insecurity-brief-report-august-2020.ashx. Accessed December 15, 2020.

4. Ta M, Song L, Johnson C, et al. Behavioral health needs and services in King County, WA: March – May 2020.; 2020. Public Health Seattle & King County; Assessment, Policy Development and Evaluation Unit. https://www.kingcounty.gov/depts/health/~/media/depts/health/communicable-diseases/documents/C19/report-behavioral-health-needs.ashx. Accessed December 15, 2020.

5. Tobolowsky FA, Gonzales E, Self JL, et al. COVID-19 outbreak among three affiliated homeless service sites — King County, Washington, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(17):523-526. doi:10.15585/mmwr.mm6917e2.

6. McMichael TM, Clark S, Pogosjans S, et al. COVID-19 in a long-term care facility — King County, Washington, February 27–March 9, 2020. MMWR Morb Mortal Wkly Rep. 2020;69(12):339-342. doi:10.15585/mmwr.mm6912e1.

7. Blethen R. South King County has been disproportionately affected by the coronavirus. The Seattle Times. https://www.seattletimes.com/seattle-news/health/high-covid-19-rates-persist-in-south-king-county-as-public-health-officials-urge-more-testing/. Published October 28, 2020. Accessed December 15, 2020.

8. Homelessness in King County 2019. Count Us In. AllHome. https://regionalhomelesssystem.org/wp-content/uploads/2020/06/2019_SKC-PIT-Infographic.pdf. Published 2019. Accessed December 16, 2020.

9. American Hospital Association. Hospitals and health systems face unprecedented financial pressures due to COVID-19.; 2020. https://www.aha.org/guidesreports/2020-05-05-hospitals-and-health-systems-face-unprecedented-financial-pressures-due. Accessed December 16, 2020.

10. Cole B. The impact of the covid-19 pandemic on access to health care. Heal Policy Br. 2020;17(2020). https://www.nasi.org/research/2020/impact-covid-19-pandemic-access-health-care. Accessed December 16, 2020.

End Notes

Continued

11. Garfield R, Chidambaram O. Children's health and well being during the coronavirus pandemic.; 2020. https://www.kff.org/coronavirus-covid-19/issue-brief/childrens-health-and-well-being-during-the-coronavirus-pandemic/. Accessed December 16, 2020.

12. Castaneda L. Negative Impacts during a COVID-19 pandemic on children, adolescents and families. Heal Sci J. 2020;14(6):761. https://www.hsj.gr/medicine/negative-impacts-during-a-covid19pandemic-on-children-adolescents-families.php?aid=32724. Accessed December 16, 2020.

13. García E, Weiss E. COVID-19 and student performance, equity, and US education policy: lessons from pre-pandemic research to inform relief, recovery, and rebuilding.; 2020. https://www.epi.org/publication/the-consequences-of-the-covid-19-pandemic-for-education-performance-and-equity-in-the-united-states-what-can-we-learn-from-pre-pandemic-research-to-inform-relief-recovery-and-rebuilding/. Accessed December 16, 2020.

14. King County Office of Economic and Financial Analysis. Demographic trends of King County. King County Economic Indicators. https://www.kingcounty.gov/independent/forecasting/King County Economic Indicators/Demographics.aspx. Published 2020. Accessed December 15, 2020.

15. Balk G. King County had decade's third-largest population growth among U.S. counties. The Seattle Times. https://www.seattletimes.com/seattle-news/data/king-county-had-decades-third-largest-population-growth-among-u-s-counties/. Published April 2, 2020. Accessed December 15, 2020.

16. Household income in King County, WA. King County Economic Indicators. King County. https://kingcounty.gov/independent/forecasting/King County Economic Indicators/Household Income.aspx. Published 2020. Accessed December 17, 2020.

17. United States Census Bureau. Income in the past 12 months (in 2019 inflation-adjusted dollars) - King County, Washington. Measuring America's People, Places and Economy. https://data.census.gov/cedsci/table?q=median household income&g=0500000US53033&tid=ACSST1Y2019.S1901&hidePreview=false. Published 2020. Accessed December 15, 2020.

18. Balk G. Seattle household net worth ranks among top in nation — but wealth doesn't reach everyone. The Seattle Times. https://www.seattletimes.com/seattle-news/data/seattle-household-net-worth-ranks-among-top-in-nation-but-wealth-doesnt-reach-everyone/. Published February 19, 2019. Accessed December 15, 2020.

19. Racism as a public health crisis in King County. King County. https://www.kingcounty.gov/elected/executive/constantine/initiatives/racism-public-health-crisis.aspx. Published 2020. Accessed December 15, 2020.

20. Jackson M, Holzman B. A century of educational inequality in the United States. Proc Natl Acad Sci U S A. 2020;117(32):19108-19115. doi:10.1073/pnas.1907258117.

End Notes

Continued

21. Francis BD, August CEW. The black-white wealth gap will widen educational disparities during the coronavirus pandemic. Cent Am Prog. 2020. https://www.americanprogress.org/issues/race/news/2020/08/12/489260/black-white-wealth-gap-will-widen-educational-disparities-coronavirus-pandemic/. Accessed December 15, 2020.

22. Xu J, Murphy SL, Kochanek KD, Arias E. Mortality in the United States, 2018 key findings data from the national vital statistics system. Hyattsville, MD; 2020. https://www.cdc.gov/nchs/data/databriefs/db355_tables-508.pdf#1. Accessed December 15, 2020.

23. Kochanek KD, Anderson RM, Arias E. Changes in life expectancy at birth, 2010–2018. National Center for Health Statistics, Health E-Stat. 2020.

24. Bergen G, Chen L, Warner M, Fingerhut L. Injury in the United States: 2007 Chartbook. Hyattsville, MD; 2008. National Center for Health Statistics. 2008.

25. Centers for Disease Control and Prevention. About Chronic Diseases. National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). https://www.cdc.gov/chronicdisease/about/index.htm. Published 2019. Accessed December 15, 2020.

26. Howell EA. Reducing disparities in severe maternal morbidity and mortality. Clin Obstet Gynecol. 2018;61(2):387-399. doi:10.1097/GRF.0000000000000349.

27. Petersen EE, Davis NL, Goodman D, Cox S, Syverson C, Seed K. Racial / ethnic disparities in pregnancy-related deaths — United States , 2007 – 2016. 2016.

28. McDermott KW, Stocks C, Freeman WJ. Overview of pediatric emergency department visits, 2015: Statistical Brief #242. In: Healthcare Cost and Utilization Project (HCUP) Statistical Briefs. Agency for Healthcare Research and Quality (US), Rockville (MD); 2006. 2018 Aug 7.

29. Hunt KA, Weber EJ, Showstack JA, Colby DC, Callaham ML. Characteristics of frequent users of emergency departments. Ann Emerg Med. 2006;48(1):1-8. doi:10.1016/j.annemergmed.2005.12.030.

30. Dowd B, Karmarker M, Swenson T, et al. Emergency department utilization as a measure of physician performance. Am J Med Qual. 2014;29(2):135-143. doi:10.1177/1062860613487196.

31. Congressional Budget Office. Federal subsidies for health insurance coverage for people under age 65: 2018 to 2028. Support for nongroup coverage federal subsidies for health insurance coverage for people at a glance.; 2018. www.cbo.gov/publication/53826. Accessed December 15, 2020.

32. Eibner C, Nowak SA. The effect of eliminating the individual mandate penalty and the role of behavioral factors. Affordable Quality Health Care For Everyone. https://www.commonwealthfund.org/publications/fund-reports/2018/jul/eliminating-individual-mandate-penalty-behavioral-factors. Published 2018. Accessed December 15, 2020.

End Notes

Continued

33. Collins SR, Gunja MZ, Aboulafia GN, et al. Early look at implications COVID-19 pandemic for health coverage. https://www.commonwealthfund.org/publications/issue-briefs/2020/jun/implications-covid-19-pandemic-health-insurance-survey. Published 2020. Accessed December 15, 2020.

34. Immunization and Infectious Disease - Healthy People 2020. IID-8 Data Details. Office of Disease Prevention and Health Promotion [ODPHP]. https://www.healthypeople.gov/2020/data-search/Search-the-Data#objid=4722; Published 2020. Accessed December 15, 2020.

35. Washington State Office of Financial Management (OFM), Forecasting and Research Division. Estimated Impact of COVID-19 on Washington State's Health Coverage.; December 2, 2020. https://www.ofm.wa.gov/sites/default/files/public/dataresearch/healthcare/healthcoverage/COVID-19_impact_on_uninsured.pdf. Accessed December 15, 2020.

36. United States Preventive Services Taskforce. Final recommendation statement: colorectal cancer: screening. https://www.uspreventiveservicestaskforce.org/uspstf/document/RecommendationStatementFinal/colorectal-cancer-screening#bootstrap-panel--6. Published 2016. Accessed December 15, 2020.

37. Mental Health. Centers for Disease Control and Prevention. https://www.cdc.gov/mentalhealth/learn/index.htm. Published 2018. Accessed December 15, 2020.

38. Mental Health and Substance Use Disorders. U.S. Department of Health & Human Services. https://www.mentalhealth.gov/what-to-look-for/mental-health-substance-use-disorders. Published 2019. Accessed December 15, 2020.

39. Quick Facts on the Risks of E-cigarettes for Kids, Teens, and Young Adults. Centers for Disease Control and Prevention. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/Quick-Facts-on-the-Risks-of-E-cigarettes-for-Kids-Teens-and-Young-Adults.html. Published 2020. Accessed December 15, 2020.

40. U.S. Department of Health and Human Services. E-cigarette use among youth and young adults. a report of the Surgeon General. Atlanta, GA; 2016. https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf.

41. Collins H, Ta M, Hood J, et al. Substance use patterns in King County, WA: March – October 2020. Seattle, WA; 2020. Public Health Seattle & King County; Assessment, Policy Development and Evaluation Unit. https://www.kingcounty.gov/depts/health/covid-19/data/impacts/~/media/depts/health/communicable-diseases/documents/C19/report-substance-use-patterns.ashx. Accessed December 15, 2020.

42. Maternal, Infant, and Child Health - Healthy People 2020. MICH-10.2 Data Details. Office of Disease Prevention and Health Promotion [ODPHP]. https://www.healthypeople.gov/node/4834/data_details. Accessed December 15, 2020.

43. Pregnancy and Childbirth - Healthy People 2030. MICH-08 Data Details. Office of Disease Prevention

End Notes

Continued

and Health Promotion [ODPHP]. https://health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08. Accessed December 15, 2020.

44. Washington. https://www.cdc.gov/nchs/pressroom/states/washington/wa.htm. Accessed December 15, 2020.

45. Maternal, Infant, and Child Health - Healthy People 2020. MICH-10.3 Data Details. Office of Disease Prevention and Health Promotion [ODPHP]. https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Maternal-Infant-and-Child-Health/data#infant. Accessed December 15, 2020.

46. Centers for Disease Control and Prevention. Youth physical activity guidelines toolkit. https://www.cdc.gov/healthyschools/physicalactivity/guidelines_backup.htm. Accessed December 15, 2020.

47. Physical Activity - Healthy People 2020. PA-3 Data Details. Office of Disease Prevention and Health Promotion [ODPHP]. https://www.healthypeople.gov/2020/topics-objectives/topic/physical-activity/objectives. Accessed December 15, 2020.

48. Get the Facts: Sugar-Sweetened Beverages and Consumption. Centers for Disease Control and Prevention. https://www.cdc.gov/nutrition/data-statistics/sugar-sweetened-beverages-intake.html. Accessed December 15, 2020.

49. King County Prosecuting Attorney's Office - Crime Strategies Unit. 2020 King County firearm violence Q1-Q2. July 2020. https://kingcounty.gov/~/media/depts/prosecutor/documents/2020/Jan,-d-,-June_2020_King_County_gun_report.ashx?la=en.

50. Important Facts about Falls. Centers for Disease Control and Prevention. https://www.cdc.gov/homeandrecreationalsafety/falls/adultfalls.html. Accessed December 15, 2020.

Appendix A: Methods

IDENTIFICATION OF HEALTH NEEDS & SELECTION OF INDICATORS

For the 2021/2022 King County Community Health Needs Assessment (CHNA), a CHNA Advisory Committee (composed of five hospital/health system representatives from the King County Hospitals for a Healthier Community (HHC)) facilitated by Public Health – Seattle & King County (PHSKC) staff met over a series of months to develop a comprehensive plan for the report. In developing a plan, the CHNA Advisory Committee and PHSKC sought feedback from public health and hospital staff when considering how to describe and identify community health needs, discussing the selection criteria and indicators used to measure health needs, and determining standards for analyzing data, as well as presenting key findings. The CHNA Advisory Committee and PHSKC presented a recommendation and plan for the 2021/2022 CHNA report, which was approved by all members of HHC.

Committee members planned a succinct report focused on key indicators that relate to the hospitals' and communities' assets and resources to inform future collective strategies. Selected indicators focus on population-based preventive strategies and promote policy/systems/environmental change for maximum population health impact. The committee continues to recognize that partnerships between hospitals, community organizations, and communities are key to successful strategies to address common health needs.

The 2021/2022 CHNA report continues to build upon the population-based community health framework. To identify community concerns and assets, this report continues to consult and review a variety of existing community engagement reports from 2018–2019 to inform community identified priorities and overall themes. In addition to the required section of the report, HHC continues to focus on additional priorities, including access to care and use of preventive services, mental health and substance use, maternal and child health, physical activity, nutrition and weight, and violence and injury prevention. Furthermore, for the 2021/2022 CHNA report, a new section on COVID-19 was added as well as a Medicaid profile focusing on King County Medicaid demographics, top 10 causes of emergency department (ED) utilization, and high ED utilizers without a visit to a primary care provider in the last year. While hospitals and health systems reached consensus on a core set of topic areas, each hospital may also gather additional information specific to its service area.

Recognizing that the CHNA is not intended to provide comprehensive data for each specialized topic, indicators continue to be selected according to

Appendix A: Methods

Continued

the following criteria:

1. Availability of high-quality data that are population-based (where possible), measurable, accurate, reliable, and regularly updated. Data should focus on rates rather than counts.
2 Ability to make valid comparisons to a baseline or benchmark.
3. Prevention orientation with clear sense of direction for action by hospitals for individual, community, system, health service, or policy interventions that will lead to community health improvement.
4. Ability to measure progress of a condition or process that can be improved by intervention/ policy/system change, and there exists a capacity to affect change.
5. Ability to address health equity, particularly by age, gender, race/ethnicity, geography, socioeconomic status, although not all demographic breakdowns may be available for all indicators.
6. Alignment with local and national healthcare reform efforts, including the triple aim.

For the purpose of the 2021/2022 CHNA Report, eleven (11) indicators were removed for which timely and/or actionable data are not currently available in King County. Eighteen (18) new indicators were added to the CHNA to reflect emerging or more widely accepted community health needs, such as firearm-related deaths and e-cig or vape pen use. All removal and addition of indicators was conducted in a manner consistent with the aforementioned selection criteria.

The final set of indicators were analyzed, using appropriate statistical methods, by Public Health – Seattle & King County. Data were compiled from local, state, and national sources such as the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Washington State Department of Health, and King County.

COMMUNITY ASSESSMENTS AND REPORTS

Recent reports, including broad community needs assessments, strategic plans, or reports on specific health needs were reviewed for context and relevant assets, resources, and opportunities. The following reports were reviewed:

Appendix A: Methods

Continued

#	Report Name	Organization
1	City of Burien Community Assessment Survey	City of Burien
2	City of SeaTac Human Services Needs Assessment	City of SeaTac
3	Puget Sound Educational Service District — Early Learning Programs Community Assessment 2018 / Supplement to the 2018 Community Needs Assessment	Puget Sound Educational Service District
4	South King County Mobility Coalition Food Access and Transportation Needs Assessment January 2019	Hopelink, South King County Mobility Coalition
5	And So We Press On: A Community View on African American Health in Washington State (2019 Research Report)	Byrd Barr Place
6	Affordable Housing Advisory Board 2018 Affordable Housing Update	Washington State Department of Commerce
7	Affordable Housing Update: 2019 Affordable Housing Update Pursuant to RCW 43.185B.040	Washington State Department of Commerce
8	Transportation Barriers and Needs for Immigrants and Refugees: An Exploratory Needs Assessment. June 2019.	UW Evans School of Public Policy and Governance Graduate Consulting Lab for Hopelink, King County Mobility Coalition
9	King County American Indian and Alaska Native Housing Needs Assessment	Seattle Indian Services Commission
10	King County Fare Structure Needs Assessment: KCMC Access to Work and School Committee. February 2018.	King County Mobility Coalition
11	Puget Sound Food Infrastructure Exploration	Ecotrust for Sustainable Communities Funders and the Bullitt Foundation
12	State of Play: Seattle-King County — Analysis and Recommendations	Aspen Institute Project Play
13	Seattle Rental Housing Study — Final Report (June 2018)	UW Center for Studies in Demography and Ecology
14	Snoqualmie Valley A Supportive Community for All: Community Needs Assessment	A Supportive Community for All
15	Community Input Summary: Puget Sound Taxpayers Accountability Account	Puget Sound Taxpayers Accountability Account
16	Chinatown International District Framework and Implementation Plan 2018 Status Report	City of Seattle
17	Youth update 2019 — City of Kent	City of Kent
18	City of Kirkland — 2018 Survey	City of Kirkland
19	Age Friendly Seattle Action Plan	City of Seattle
20	Sammamish Health and Human Services Needs Assessment	City of Sammamish
21	Seattle–King County Aging and Disability Area Plan Update 2018–19	Aging and Disability Services

Appendix A: Methods

Continued

22	Seattle Goodwill CAN	Seattle Goodwill
23	Solid Ground Community Report 2018	Solid Ground
24	SESE Family Engagement Survey Data	Southeast Seattle Education Coalition
25	Healthy Food Availability and Food Bank Network Report	City of Seattle
26	City of Seattle 2019 Annual Action Plan	City of Seattle
27	Area Plan 2020–2023 Seattle King County	City of Seattle
28	Fulfilling the Commitment to our Community: Needs Assessment for Urban Disabled and Elder Natives	Urban Indian Health Institute
29	Our Bodies, Our Stories	Urban Indian Health Institute
30	White Center CDA Annual Summit Strong Voices 2018 Report	White Center CDA
31	White Center 2019 Summit	White Center CDA
32	2019 Gender Affirming Healthcare Access Report	Ingersoll Gender Center
33	Celebrating the Power of Bilingualism	OneAmerica
34	Seattle's 2018–2022 Consolidated Plan for Housing and Community Development	City of Seattle
35	Lessons Learned from Community Engagement	SOAR
36	Consumer Voice Listening Project and Community Grants Program (2018)	HealthierHere
37	Consumer Voice Listening Project and Community Grants Program (2019)	HealthierHere
38	2019 Community Health Needs Assessment	Kaiser Foundation Health Plan of Washington
39	Community Health Needs Assessment 2018	Overlake Medical Center and Clinics
40	Community Health Needs Assessment 2018 Swedish Ballard	Swedish Ballard
41	Community Health Needs Assessment 2018 Swedish Edmonds	Swedish Edmonds
42	Community Health Needs Assessment 2018 Swedish (Seattle) Cherry Hill/ First Hill	Swedish (Seattle) Cherry Hill/First Hill
43	Community Health Needs Assessment 2018 Swedish Issaquah	Swedish Issaquah
44	Community Health Needs Assessment 2018 Swedish Cancer Institute	Swedish Cancer Institute
45	SCCA 2019 Community Health Needs Assessment (CHNA)	Seattle Cancer Care Alliance
46	Seattle Children's 2019 Community Health Assessment	Seattle Children's
47	Everything Is Medicine	Community Health Board Coalition
48	Report on Gun Violence Among Youth and Young Adults	Public Health – Seattle & King County

Appendix B: Report Definitions & Structure

REPORT DEFINITIONS AND STRUCTURE

For each indicator, this report includes:

- A description of the indicator
- Overall estimate for King County
- Multiple-year averaged estimates for select sub-populations (e.g. race/ethnicity and region) in either a bar chart or map
- Narrative interpretation that highlights important findings – typically of disparities (by race, place, income, gender, or sexual orientation) and trends

The Community Health Indicators (CHI) website includes additional data for each indicator included in this report as well as many other indicators. Additional indicators that are available online have been included at the beginning of each report topic section.

When available, CHI indicators include:

- King County estimate from the most recent year available, including rate and number of people affected (this estimate may differ from the multiple-year averaged estimates presented in the report). NOTE: For most analyses, data from multiple years are combined to improve the reliability of the estimates.
- A bar chart that shows multiple-year averaged estimates for all demographic breakdowns (e.g., age, gender, region, race/ethnicity, and income or neighborhood poverty level as a measure of socioeconomic status).
- A map of multiple-year averaged estimates by neighborhoods/cities, ZIP codes, or regions.
- A line chart of rolling-averaged estimates for King County and each region over time to show trends (please see definition of rolling averages below).
- More detail about each data point appears in a tool tip box when the pointer hovers over a bar or line on the chart.
- The following symbols are used in graphs throughout the report (*, ^, !):

  * Denotes values that are significantly different from the King County average

  ^ There are too few cases to protect confidentiality and/or report reliable rates

  ! While rates are presented, there are too few cases to meet a precision standard, and results should be interpreted with caution.

- To protect confidentiality, presentation of data follows various reliability and suppression guidelines per data sharing agreements.

Appendix B: Report Definitions & Structure

Continued

Confidence Interval (also known as error bar) is the range of values that includes the true value 95% of the time. If the confidence intervals of two groups do not overlap, the difference between groups is considered statistically significant (meaning that chance or random variation is unlikely to explain the difference).

Confidence intervals on the CHI website are turned off by default. Users may turn them on by clicking the appropriate radio button.

Crude, Age-Specific, and Age-Adjusted Rates

- Rates are usually expressed as the number of events per 100,000 population. When this applies to the total population (all ages), the rate is called the **crude rate.**

- Infant mortality, maternal smoking, and other maternal/child health measures are calculated with live births as the denominator and presented as a rate per 1,000 live births (infant mortality) or percent of births (preterm, low birth weight, etc.).

- When the rate applies to a specific age group (e.g., age 15–24), it is called the **age-specific rate.**

- The crude and age-specific rates present the actual magnitude of an event within a population or age group.

- When comparing rates between populations, it is useful to calculate a rate that is not affected by differences in the age composition of the populations. This is the **age-adjusted rate**. For example, if a neighborhood with a high proportion of older people also has a higher-than-average death rate, it will be difficult to determine if that neighborhood's death rate is higher than average for residents of all ages or if it simply reflects the higher death rate that naturally occurs among older people. The age-adjusted rate mathematically removes the effect of the population's age distribution on the indicator.

- Prevalence rates from the Behavioral Risk Factor Surveillance Survey (BRFSS) are expressed as a percentage of the adult population, usually ages 18+. Exceptions to the age range are noted. These rates are not age-adjusted.

- Prevalence rates from the Healthy Youth Survey (HYS) are for public school students in the specified grades and weighted to the population. HYS is asked only of students in grades 6 (abbreviated version), 8, 10, and 12 every other year.

Geographies: Whenever possible, indicators are reported for King County as a whole and for four regions within the county. If enough data are available for a valid analysis, they may also be reported by smaller geographic areas (cities,

Appendix B: Report Definitions & Structure

Continued

neighborhoods within large cities, and groups of smaller cities and unincorporated areas). Education data are reported by school district. For more detail, plus maps, see About King County Geographies or our geographic definitions page.

Cities/Neighborhoods (also known as Health Reporting Areas or HRAs): In 2011, new King County Health Reporting Areas (HRAs) were created to coincide with city boundaries in King County. These areas, recently renamed "Cities/Neighborhoods," are based on aggregations of US Census Bureau-defined blocks. Where possible, Cities/Neighborhoods correspond to cities and, for larger cities, to neighborhoods within cities, and delineate unincorporated areas of King County. These geographical designations were created to help cities and planners as they consider issues related to local health status or health policy. Cities/Neighborhoods are used whenever we have sufficient sample size to present the data. These are represented in the report as "city/neighborhood" data.

Federal Poverty Guidelines, issued by the Department of Health and Human Services, are a simplified version of the federal poverty thresholds. The guidelines are used to determine financial eligibility for various federal, state, and local assistance programs. For a family of four, the federal poverty guideline was $25,100 in 2018; in 2019 it was $25,750.

Neighborhood poverty levels are based on the proportion of people in a census tract in which their annual household income (as reported in the US Census Bureau's American Community Survey) falls below the federal poverty level.

- **High poverty:** 20% or more of the population in the neighborhood is below the federal poverty level. Using this criterion, 14.0% of the King County population lives in high-poverty neighborhoods.
- **Medium poverty:** 5% to 19% of the population is below the federal poverty level. Using this criterion, 62.7% of the King County population lives in medium-poverty neighborhoods.
- **Low poverty:** fewer than 5% of the population is below the federal poverty level. Using this criterion, 23.3% of the King County population lives in low-poverty neighborhoods.

This neighborhood-level characteristic is used where individual measures of income or poverty level are not available. The high-poverty area follows the definition of a Federal Poverty Area. The 5% limit for low-poverty areas was chosen to create a group markedly different from Federal Poverty Areas, and thus sensitive to differences in health outcomes that may be associated with socioeconomic differences, while maintaining enough tracts in each group for robust comparisons.

Appendix B: Report Definitions & Structure

Continued

For area-based measures of poverty, a census tract is considered a neighborhood. Data sources where census tract information is not available use ZIP codes to designate the neighborhood.

Race/Ethnicity and Discrimination: Race and ethnicity are markers for complex social, economic, and political factors that can influence community and individual health in important ways. Many communities of color have experienced social and economic discrimination and other forms of racism that can negatively affect the health and well-being of these communities. We continue to analyze and present data by race/ethnicity because we believe it is important to be aware of racial and ethnic group disparities in these indicators.

Race/Ethnicity Analysis in CHNA Report and CHI: The majority of indicators included in this report reflect race/ethnicity as mutually exclusive categories (where all race groups are mutually exclusive, and Hispanics are counted only once). In addition to mutually exclusive categories, where applicable on the Community Health Indicators website, there is an option for users to view race/ethnicity alone or in combination categories (where Hispanic is analyzed as an ethnicity and Hispanics are also counted in their preferred race group). NOTE: The Medicaid profile analysis uses mutually inclusive racial/ethnic groups to mirror the analyses included in various HealthierHere ACH dashboards, which present additional data for the King County Medicaid population.

Race/Ethnicity Terms: Federal standards mandate that race and ethnicity (Hispanic origin) are distinct concepts requiring two separate questions when collecting data from an individual. "Hispanic origin" is meant to capture the heritage, nationality group, lineage, or country of birth of an individual (or their parents) before arriving in the United States. Persons of Hispanic ethnicity can be of any race. 2010 Census terms: (One race) white, Black or African American, American Indian and Alaska Native, Asian, Native Hawaiian and Other Pacific Islander, Some Other Race; (Two or more races) Hispanic or Latino origin, white alone (not Hispanic or Latino). Persons of Hispanic ethnicity are also counted in their preferred race categories. Racial/ethnic groups are sometimes combined when sample sizes are too small for valid statistical comparisons of more discrete groups. For small groups (American Indian and Alaska Native, Native Hawaiian/Pacific Islander) in which a high proportion of King County residents are that race and one or more other races, the group "(race) alone or in combination" is sometimes used to include all who identify as that group.

Some surveys collect racial/ethnic information using only one question on race. These terms are:

Appendix B: Report Definitions & Structure

Continued

- **Terms:** Hispanic, white non-Hispanic, Black, American Indian/Alaska Native (AIAN), Asian, Native Hawaiian/Pacific Islander (NHPI), white, and Multiple Race (Multiple).

- Generally, the CHNA report uses the following race/ethnicity terms (when available): American Indian/Alaska Native (AIAN), Asian, Black, Hispanic, Multiple, Native Hawaiian/Pacific Islander (NHPI), and white.

Limitations of Race/Ethnicity Categories: When asked to identify their race/ethnicity in surveys, respondents are often offered a narrow range of options (see terms above); those broad categories are then used to make expansive race/ethnicity comparisons. The vast diversity within race/ethnicity categories does not allow us to distinguish among ethnic groups or nationalities within categories. Combining groups with wide linguistic, social, and cultural differences — such as African immigrants with Black Americans; Vietnamese, Korean, and East Indians in one Asian category; white Americans with eastern Europeans; or Brazilians with Mexicans — does not allow for a careful analysis of the potential disparities within groups, or the varied sociocultural influences on those disparities. In addition, some racial/ethnic samples in King County are too small to allow for informative comparisons or generalizations.

Rolling Averages: When the frequency of an event varies widely from year to year, or sample sizes are small, the yearly rates are aggregated into averages — often in three-year intervals — to smooth out the peaks and valleys of the yearly data in trend lines. For example, for events occurring from 2001 to 2015, rates may be graphed as three-year rolling averages: 2001–2003, 2002–2004…2011–2015. Adjacent data points will contain overlapping years of data.

Rounding Standards: Rates for all data sources are rounded to one decimal point (for example, 15.4%).

Statistical Significance: Differences between subpopulation groups and the overall county are examined for each indicator. Unless otherwise noted, all differences mentioned in the text are statistically significant (unlikely to have occurred by chance).

The potential to detect differences and relationships (termed the statistical power of the analysis) is dependent in part on the number of events and size of the population, or, for surveys, the number of respondents, or sample size. Differences that do not appear to be significant might reach significance with a large enough population or sample size.

Citation Request:

The data published in this Community Health Needs Assessment report and on the Community Health Indicators website may be reproduced without permission. Please use the following citation when reproducing:

"Retrieved (date) from Public Health – Seattle & King County, Community Health Indicators, www.kingcounty.gov/chi"

Appendix C: About Hospitals for a Healthier Community

ABOUT HOSPITALS FOR A HEALTHIER COMMUNITY

King County Hospitals for a Healthier Community (HHC) comprises 10 hospitals/health systems in King County and Public Health – Seattle & King County (PHSKC) with the fiscal administrative support of the Washington State Hospital Association (WSHA). This collaborative was formed in 2012 to identify the greatest needs and assets of the communities its members serve in order to develop coordinated plans to support the health and well-being of King County residents. One of the primary goals of HHC has been to collaborate on a joint community health needs assessment (CHNA) in order to avoid duplication of efforts, which, in turn, would help focus available resources on a community's most important health needs. HHC has collectively produced three CHNA reports: the 2015/2016 report, the 2018/2019 report, and this most recent 2021/2022 report.

PARTICIPATING HOSPITALS AND HEALTH SYSTEMS

EvergreenHealth

Kaiser Permanente

MultiCare Health System
Auburn Medical Center
Covington Medical Center

Navos

Overlake Medical Center & Clinics

Seattle Cancer Care Alliance

Seattle Children's

Swedish Health Services
Swedish Ballard Campus
Swedish Cherry Hill Campus
Swedish First Hill Campus
Swedish Issaquah Campus

UW Medicine
Harborview Medical Center
Northwest Hospital & Medical Center
UW Medical Center
Valley Medical Center

Virginia Mason Franciscan Health
St. Anne Hospital
St. Elizabeth Hospital
St. Francis Hospital
Virginia Mason Medical Center

Palliative care needs, concerns, and affirmative strategies for the LGBTQ population

Palliative Care & Social Practice

2021, Vol. 15: 1–17

DOI: 10.1177/26323524211039234

Noelle Marie Javier

***Abstract*:** The Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning population, also known as sexual and gender minorities, are an incredibly marginalized and vulnerable population that have been disproportionately affected by the provision, delivery, and optimal access to high-quality medical care including palliative, hospice, and end-of-life care. The long-standing and unique experiences shaped by positive and negative historical events have led to a better understanding of significant barriers and gaps in equitable healthcare for this population. The intersection of both internal and external stressors as well as minority identities in the context of discriminatory political and societal infrastructures have resulted in variable health outcomes that continues to be plagued by economic barriers, oppressive legislative policies, and undesirable societal practices. It could not be more urgent and timely to call upon the government and healthcare systems at large to execute reforms in policies and regulations, engage in cultural competency training, and promote cultural shifts in beliefs, attitudes, and practices that will ultimately recognize, prioritize, and address the needs of this population. After all, health care access is a universal right regardless of personal, social, political, and economic determinants of comprehensive medical care.

Keywords: advance directives, bisexual, gay, health disparities, lesbian, LGBTQ, life-limiting illness, palliative care, queer, questioning, sexual and gender minorities, transgender

Received: 3 February 2021; revised manuscript accepted: 23 July 2021.

Introduction

According to the 2017 Gallup Poll conducted by the Williams Institute, sexual and gender minorities (SGMs) account for 4.5% of the 325.1 million Americans. About a third of the SGMs identified as Latino or Black while adults older than 50 years and above comprised about a quarter.[1] It is expected that the older Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning (LGBTQ) adult population will continue to rise over the next 10 years.[2]

Given the significant proportion of LGBTQ adults, there are still ongoing gaps to support public health research and advocacy to address their core needs and concerns.[3] In 2011, the Institute of Medicine identified that there are significant healthcare disparities affecting the LGBTQ population and that there are opportunities to advance research in this area.[4] There is underreporting of pertinent and inclusive demographic data (e.g. sexual orientation and gender identity) toward the LGBTQ population. This gap further heightens the risk for more invisibility of this marginalized population even in basic aspects of daily life including healthcare. There are currently insufficient data on the gender non-binary (GNB) or gender non-conforming (GNC) subgroup. Other *minority within minority groups* include the older adults and those living with HIV/AIDS who are also disproportionately impacted by healthcare resources.[5] There is a continuing need to provide high-quality and comprehensive medical care including palliative, hospice, and end-of-life (EOL) care. Under President Biden's administration in the United States, there is renewed hope to

Correspondence to:
Noelle Marie Javier MD
Icahn School of Medicine at Mount Sinai, One Levy Place, 1070, New York, NY 10029, USA
noelle.javier@mssm.edu

address the healthcare needs of the LGBTQ population by enhancing non-discriminatory policies and investing in more research and resources to address the unique needs and priorities of this population. This review article aims to provide a conceptual framework in understanding the palliative care needs of the LGBTQ population and how the unique identities and stressors could impact its provision and delivery. This article also provides recommendations on affirmative and inclusive strategies to care for them in a holistic and compassionate way.

Understanding the LGBTQ population: review of essential concepts impacting overall health including palliative, hospice, and EOL care

LGBTQ people have experienced multiple societal barriers to living life fully and safely as well as aging gracefully. An initial step for any healthcare provider is to understand the unique and long-standing historical events and milestones (Table 1) that this population has experienced over their lifetime including trauma, widespread oppression, prejudice, victimization, and abuse.[5,6] A 2019 United States poll showed that the LGBTQ population have been subjected to intolerance and ostracization by society at large and therefore has faced heightened discrimination including vicious hate crimes.[7] There are multiple internal and external stressors that contribute to the marginalized identities of this population. Table 1 shows an abridged version of significant milestones that the LGBTQ population born in the United States before 1950 has gone throughout their lifetime. These events have shaped how they might perceive access to various aspects of healthcare. Furthermore, these historical points may serve as triggers for physical and psychological trauma thereby delaying or avoiding medical care and not disclosing sexual orientation and gender identity (SOGI) status to healthcare providers.

Historical timeline for the LGBTQ population in the United States

The following general concepts aim to allow medical providers to have a lens of understanding, sensitivity, and empathy while caring for their LGBTQ patients:

1. *Intersectionality.* This refers to the confluence of numerous external and internal factors that shape the experience and identities of the LGBTQ adult. These factors may have equal or variable degree of influence that subjects them to prejudice and discrimination.[9] Intersectionality provides a structural framework to understand how these factors are interrelated and oftentimes interdependent. There are polarizing systems of privilege and oppression at both the general and microscopic levels.[10] For example, an older adult transgender and bisexual woman of color with metastatic cancer to the bone requiring a cane to ambulate maybe discriminated against due to her disability, older age, bisexual orientation, Black race, and gender among others (see Figure 1).
2. *Minority Stress Model.* Initially conceptualized by Ilan Meyer, this refers to the excess stress to which individuals from stigmatized social categories are exposed as a result of their social and minority position.[11] Moreover, Meyer conceptualized these stressors as unique and described them in three categories: (1) *additive* to general stressors that are experienced by all people and therefore require adaptations above and beyond those required of the non-stigmatized; (2) *chronic* in that they are related to relatively stable social structures such as laws and social policies; and (3) *socially based* in that they stem from social and structural forces rather than individual events or conditions.[11] A concrete illustration is an American LGTBQ older adult with advanced heart disease who was born in the 1950s and whose life course was influenced by both positive and negative effects of the Stone Wall riots and the Harvey Milk assassination. Over time, the Supreme Court Ruling on same-sex marriage in 2015 would have also impacted this individual and the significant other who would have waited for decades to be recognized at a federal level. The various stressors faced by this individual would have resulted in significant physical and mental health outcomes.
3. *Lived experiences.* There are two operational theories that can complement the understanding of the minority stress model. Aldwin and Gilmer described two theories namely the *Life Course Theory* and *Goal-Oriented Theory*.[12] While the former posits that transitional points are impacted by society, history, and gender roles, the latter

Table 1. Historical timetable of important milestones in American LGBTQ history.[8]

Date	Milestone
1950	• US Senate issued: 'Employment of homosexuals and other sex perverts in government' • First gay organization, Mattachine Society, established in California
1952	• American Psychiatric Association (APA) listed homosexuality as a sociopathic personality disturbance • Christine Jorgensen became the first visible American transgender woman who underwent sex reassignment surgery
1953	US President Eisenhower banned homosexuals from working for the federal government
1956	• Psychologist Evelyn Hooker concluded that heterosexual and homosexual persons did not differ significantly in adjustment • James Baldwin published first novel on bisexuality
1966	Compton Cafeteria riot broke out in San Francisco when transgender women were denied service and arrested for wearing feminine clothing
1967	Look Magazine article released: 'The Sad Life of the Homosexual'
1969	Stone Wall Riots: birth of the modern gay rights movement
1970	First Gay Liberation March held in New York City
1973	APA voted to remove homosexuality as a psychiatric disorder
1977	Harvey Milk was elected as the first openly gay public official to the San Francisco Board of Supervisors
1979	National march in Washington for lesbians and gays
1982	Nearly 800 people were infected with Gay-Related Immunodeficiency Disorder later known as HIV-AIDS
1986	US Supreme Court upheld the rights of states to criminalize between consenting same sex adults
1987	National AIDS advocacy group, ACT-UP was founded
1993	Military issued 'Don't Ask, Don't Tell' policy
1996	President Clinton signed 'Defense of Marriage Act' defining marriage between a man and a woman
1997	Ellen Degeneres came out publicly on national TV as the first gay/lesbian lead character in a popular show
1998	Matthew Shepard was brutally murdered in Wyoming USA
2003	US Supreme court ruled that sodomy laws are unconstitutional
2004	Massachusetts was the first US state to legalize gay marriage
2006	Attorney Kim Coco Iwamoto became the first transgender woman to be elected at a state level office in Hawaii USA
2011	US President Obama administration ended Don't Ask Don't Tell in the military
2013	US Supreme Court struck down 'Defense of Marriage Act'
2015	• US Supreme Court legalized same sex marriage • Cincinnati Ohio banned conversion therapy for LGBTQ youth
2016	US President Obama designated the new Stone Wall as a national monument
2017	Trump administration rolled back SOGI information on national surveys and demographic questionnaires
2020	US Supreme Court voted against discrimination by employers on the basis of sexual orientation or gender identity
2021	The US Equality Act passed in Congress

Source: Obtained with permission, Greg Hinrichsen PsyD. (https://www.glsen.org/sites/default/files/LGBTQ-History-Timeline-References.pdf).

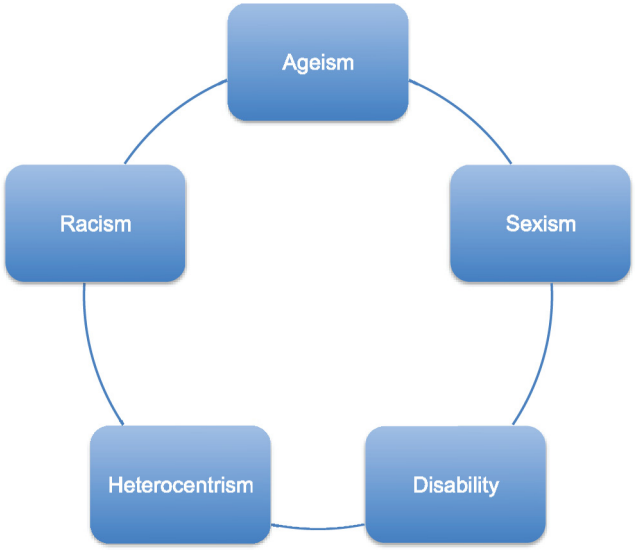


Figure 1. The intersectionality framework (created by Noelle Marie Javier MD).

presupposes that as adults evolve over time, their experiences are shaped by challenges and triumphs as they strive to pursue life's goals while striving to develop their core sense of being.[12] A study by Witten[13] showed an association between discrimination and sociocultural factors that affect the life trajectory of an LGBTQ adult. For example, an LGBTQ adult who grew up at a time when homosexuality was considered a mental health disorder and traumatized by conversion and other therapies will have a different life journey compared to another LGBTQ adult living in the current century with the depathologization of homosexuality and the existence of more progressive and non-discriminatory laws around healthcare, employment, education, and public accommodations among others. The lived experiences of these two adults are invariably shaped by the historical, social, and political context they both grew up in and may lead to significant impact on their overall health outcomes as the convergence of multiple minority stressors become apparent in day-to-day living.

4. *Stigma toward SGMs.* A concept best described by sociologist Erving Goffman as 'undesired differentness' within a specific social interaction or across many social interactions.[14] Moreover, the characterization of the state of differentness may be based on abominations of the body, blemishes of individual character, and tribal membership. This can take many forms ranging from structural to personal or individual. Herek further distinguishes stigma based on sexual orientation (sexual stigma) and gender identity (gender minority stigma). Structural gender minority stigma leads to the invisibility of this vulnerable population and furthermore oppressed when visibly represented as problematic, abnormal, inferior, and unnatural beings. Stigma can take many forms such as enacted (e.g. outright abuse) versus perceived (e.g. living in stealth/closeted for fear of explicit discrimination) versus internalized (e.g. self-loathing or punishment for being LGBTQ). These can then result in deleterious health effects that are additive to general health risks of the LGBTQ population.[15] The Minority Stress Model provides a great example on the overlapping and intersectional effects of multiple stigmas that the LGBTQ population face. For example, a transgender man of color experiences personal, interpersonal, and structural stigmas by virtue of being transgender. He could experience internalized transphobia, be isolated from his nuclear family, and discriminated against at work or in public accommodations for living authentically. The accretion of all of these stigmas could lead to undesirable physical and mental health outcomes such as cardiovascular disease and suicide, respectively.
5. *Resilience and robustness.* The LGBTQ population has developed affirmative health-promotion strategies such as resilience and robustness in spite of multiple stressors and stigmas. *Resilience* is defined as the person's ability to mitigate the adverse impact of stress while successfully thriving in society.[16] The three factors for resilience development are supportive environments, protective interpersonal relationships, and intrapersonal characteristics.[17,18] Coping is distinctive from resilience in that this refers to the effort an individual puts into adapting or responding to stress.[19] Resilience has also been defined by Singh and McKleroy[20] as a set of learned behaviors and interpersonal relationships that precedes one's ability to cope with adversity. While resilience may be described as essentially stress-buffering,[19–22] *Robustness* pertains to the individual or system's ability to resist disruption from external stressors.[23] Examples of adaptive resources that lead to resilience

and robustness include spirituality, community supports, activism, and societal infrastructures that allow the individual to feel supported.[23] These were especially evident in the Trans MetLife Survey highlighting that older transgender adults tapped into internal and external resources for resilience and robustness allowing for successful aging to some degree.[23] Meyer has observed that gay men of color do not necessarily have a higher risk for mental health issues in part because of resilience resources stemming from strong intrapersonal coping skills (e.g. religiosity and faith) and community connections and supports (e.g. religious congregations).[24]

Overview of healthcare barriers, inequities, and disparities

Physical health disparities

The impact of the oppressive and stigmatizing historical points experienced by the LGBTQ population has resulted in challenging and oftentimes undesirable relationships with their healthcare providers. Although SOGI data collection may potentially induce fear among LGBTQ people for possible discrimination in healthcare settings, there are data to support that its collection allows for visibility resulting in a nuanced and customizable approach in addressing the unique healthcare needs of this population.[25] One large study showed that about half of SGM patients and more than two thirds of patients with transgender experience have received disproportionate medical care in various clinical settings.[26] Another study of over 200,000 healthcare providers showed a heteronormative preference in taking care of LGBTQ patients.[27] Discrimination in healthcare is even more overt among transgender and gender nonconforming (TGNC) individuals as evidenced by a 2015 survey of transgender participants in the United States.[28] It was also reported that these respondents had to educate medical providers about transgender health. Clinical providers were observed to have used abusive language in about 5% of them. The intersectionality of multiple minority identities leads to significant minority stress that have led to limited medical care access and negative outcomes for these individuals.[29–31] For example, SGM people of color may experience mental health distress resulting from multiple stigmas and prejudices related to their race, sexual orientation, and gender identity.[32,33] This could lead to direct and indirect effects of mental health such as depression, anxiety, insomnia, and alcohol drinking toward known physical conditions like cardiovascular disease and liver dysfunction.[34] In addition, LGBTQ people and especially the older LGBTQ adults often live with limited means that further impact access to the provision of good healthcare resources such as medical insurance, food access, transportation, and safe housing.[35,36] There is also a higher proportion of disability compared to their heterosexual counterparts as evidenced by SGM women having a higher likelihood of experiencing physical disability.[37] Moreover, bisexual and lesbian older women are more likely to engage in high-risk health behaviors (e.g. smoking and alcohol drinking).[38] Furthermore, bisexual women have invariably poorer health indicators than lesbian women.[39] In general, LGBTQ women are at high risk for coronary artery disease (CAD), obesity, gynecologic and breast neoplasms in contrast to straight women.[39] SGM men have a higher proportion of having cardiovascular disease, hypertension, diabetes, psychological distress, and physical disability.[37–39] Bisexual older men and transgender older adults reported poorer overall physical health compared to gay older men and cisgender older adults, respectively. Moreover, older bisexual and gay men engage in cigarette smoking, alcohol drinking, and risky sexual behaviors.[38,39] Among transgender individuals, Kenagy's study found that transgender women have a higher incidence of mental health issues, immunodeficiency disorders, and different types of abuse.[40]

Inasmuch as the physical health disparities are significant to point out, it is equally important to identify protective factors that allow this population to thrive amid their illnesses. A 2020 study showed that SGMs have a higher prevalence of engaging in low leisure-time physical activity compared with their heterosexual cohorts. Exercise not only improves the general sense of well-being but also provides benefits in regulating blood pressure, reducing undesirable body fat, improving insulin action, and mitigating further functional disability.[41,42] Studies have also pointed that a good support network could facilitate an active engagement in health-promoting lifestyle such as diet and exercise.[43] Among older LGBTQ adults, health-promoting behaviors such as substance non-use, physical activity, leisure activity, and participation in religious and spiritual activities have been observed.[44]

Palliative care implications on physical health outcomes in serious illness

A key step in providing holistic palliative care is collecting SOGI information. Not only will this create a therapeutic and trusting relationship but will also provide a deeper understanding of the LGBTQ patient's intersectional identities, multiple minority stressors, and lived experiences including stigma and resiliency.[45] SOGI collection through routine intake forms on paper or via the electronic medical record is essential in creating systemic change toward LGBTQ-inclusive healthcare.[46] In addition, it is recommended that palliative care providers invite and allow SOGI disclosure in a safe and comfortable space. Utilizing respectful and sensitive ways to elicit SOGI information allows for an organic conversation and relationship to evolve. These actions result in greater comfort level, higher overall healthcare satisfaction rates, improved patient-caregiver-provider alignment, better sense of well-being, and enhanced quality of care for the LGBTQ patients and their caregivers.[47] Furthermore, this will allow for a tailored approach in considering their unique experiences. Obtaining SOGI information opens up a gateway to recognize the patient's values, healthcare needs, existential/spiritual issues, and priorities in healthcare. Intrinsic to empathic communication and relationship building is the thoughtful inclusion of informal caregivers and families of choice. Comprehensive palliative care support could then be expanded to include implementation of resources needed for documentation, legal provisions in advance care planning (ACP), and navigating challenges in various medical settings.[48] After obtaining SOGI, the next step involves understanding the lived experiences of the LGBTQ patients through their experiences of multiple external and internal stressors, implicit and explicit bias, oppressive and discriminatory encounters, and destructive healthcare systems. A core aspect in history taking is to explore the supportive networks and resources from both individual and community levels. It is reported that SGM men of color have greater resiliency compared with their White cohorts.[19] Hence, looking into both stressors and positive factors that allow LGTBQ people to thrive and survive could play an impact on the care plan and future physical health outcomes. A customized palliative care plan can be created to focus on (1) physical, psychological, and spiritual symptom management; (2) early utilization of other members of the palliative care team such as social workers and chaplains; (3) timely referral to hospice services; and (4) ACP to include funeral planning and disposition of remains. The physical examination component of a palliative care encounter starts with showing respect by obtaining permission to proceed with the examination and allowing the patients to take the lead based on comfort level. For instance, for TGNC individuals, the identification and labeling of body parts may be extremely sensitive and fraught with dread and anxiety, as this action could be deemed invasive and inappropriate. It is essential to openly discuss the purpose of doing the examination. Allowing patients to teach providers about naming anatomic parts and the significance of respectful touch will foster trust and build rapport.

For LGBTQ patients who are now facing serious illness, significant blame and shame could serve as triggers for not accessing timely medical care. Formulating a comprehensive care plan for addressing symptom distress and quality of life issues for LGBTQ patients with serious illness also requires a timely approach to ACP. Stein and Bonuck's 2001 study identified that in a sample of 575 lesbian and gay respondents, about 90% of them had high levels of knowledge on the use of living wills and 72% of them understood the necessity for health care proxy (HCP) designation. However, only 38% completed a living will and 42% of them appointed a HCP.[49] ACP refers to the dynamic process of verbal and legal expression and documentation of an individual's preferences for care should the individual become incapacitated when faced with serious illness. Specific examples of ACP include living will, HCP, or combination of both. The FIVE Wishes document formalizes the care preferences according to a patient's goals and values and reflected as five wishes for medical care. This is a valid document that can cross state lines and provide guidance to healthcare providers.[50] On the contrary, the medical orders for life-sustaining treatment (MOLST), also known as provider order for life-sustaining treatment in other states (POLST), is a similar yet unique portable document that takes into account the patient's wishes and preferences for care in very specific medical situations.[51,52] MOLST AND POLST forms are very targeted on interventions including antimicrobial therapy use, transfusions of blood products, artificial nutrition/hydration, and code or resuscitation status. The state-specific HCP form or durable power of attorney (POA) for health is the designated spokesperson and decision maker for an

incapacitated patient. The person(s) chosen could be family members, relatives, and friends. In 2012, Cartwright cited specific challenges to successful documentation of care preferences. These included inadequate knowledge on EOL legal rights, lack or prioritization, proper timing of conversations, and heteronormative assumptions made by medical providers.[53] Hughes and Cartwright[54] found that TGNC patients avoided EOL care decision making. Having an understanding of overall goals of care in the setting of big picture planning will allow for appropriate utilization and delivery of palliative and hospice care services that may be provided in a variety of settings such as home, inpatient, outpatient, and long-term care facilities depending on other variables.

Mental health disparities

LGBTQ people also suffer from unwanted and distressing mental health outcomes that have been associated with chronic traumatic discriminatory practices toward them.[6] Same-sex attraction was once described as 'paraphilia' or 'sexual orientation disturbance' in the psychiatric literature.[55] Consequentially, aggressive psychiatric interventions such as conversion and shock therapies to 'correct or cure their mental disorders'[56,57] have resulted in negative and traumatic experiences for this population. In the past, *DSM* referred to Transgender Identity as a 'Gender Identity Disorder' until it was renamed Gender Dysphoria 8 years ago.[58] This term describes the persistent emotional discomfort and stress that occurs among individuals whose anatomy does not match their gender identity. Although the current terminology maybe less stigmatizing, its purpose as a pathologic classification allows for transgender persons seeking medical care to access insurance coverage and reimbursement for transition-related medical and surgical therapies.

There is some evidence that links genetic vulnerability or susceptibility to these experiences. Overt acts of abuse lead to depression, anxiety, suicide, and other mental health issues.[59] Bisexual patients showed worse psychological outcomes compared with gay men and women. Gay and bisexual men were observed to have greater risk for depression, suicidal ideation, and alcohol abuse compared to lesbian and bisexual women.[59] Furthermore, Wight's study confirmed more depression for gay men who have experienced internalized gay ageism.[60] For the transgender population, they have a great degree of poor psychological outcomes compared to cisgender patients.[39] In fact, Fredriksen-Goldsen found that transgender patients reported to have more depression than the rest of the SGM cohorts.[39] A 2013 study specifically looking at suicidal ideation showed that about a third of SGM participants thought about committing suicide.[39] It is important to note that the occurrence of suicide attempts was more apparent in SGM respondents younger than 60 years old.[2,59] A large study of transgender respondents showed that 41% of respondents reported suicide attempts over their lifetime that were associated with external stressors such as unemployment, physical harassment, poverty, and physical and sexual assault.[61] This was affirmed 4 years later by the 2015 US Transgender Survey.[28] Moreover, there are two other major health problems linked to psychological distress including substance use disorder (SUD) and high-risk sexual behavior that are commonly influenced by numerous factors such as mood disorder, abuse, and discrimination, among others.[62] Despite the statistics shown, there is a higher likelihood for LGBTQ persons seeking professional help compared to non-LGBT group.[63,64]

Palliative care implications on mental health outcomes. It is undeniable that the implications on mental health are quite jarring given the data that exist in the literature. That said, there are a number of positive coping and resilient mechanisms that palliative care clinicians should be knowledgeable about. Examples include community support networks, spiritual affiliations, and resiliency.[65] Monin and colleagues[66] concluded that older SGM veterans are at greater risk for social isolation though more resilient overall compared with the younger cohort. The interprofessional members of the palliative and hospice care teams such as social workers, chaplains, and bereavement counselors are well positioned to offer tremendous support by identifying supportive resources that will allow a multidimensional approach to medical care. Timely referrals to psychologists, psychiatrists, and other mental health experts can assist the LGBTQ population with serious illness by recommending counseling, psychotherapies, and pharmacotherapy when necessary. Early referrals to support groups can be offered as well. Mobilizing statewide mental health organization referrals may also allow for additional structured community supports to patients and their caregivers. In a 2020 study by

Stein and colleagues,[67] among 865 hospice and palliative care providers and clinicians, 53.6% of them thought that LGB patients were more likely than non-LGB patients to experience discrimination at their institution while 15% of them observed that the spouse/partner of LGBT patients had their treatment decisions disregarded or minimized or overtly disrespected. It is also important to address grief and bereavement including disenfranchised grief for patients and families experiencing serious illness. Concrete interventions include timely referral to bereavement counselors, support groups, mental health counselors, and chaplaincy among others.

Regulatory and policy challenges and limitations

The evolving trajectory of governmental regulations on expanding protective policies for this population has been rooted in years of restrictive laws and practices that have resulted in further marginalization of this population. As the country progressed however, we have seen significant strides in the creation and implementation of regulations, policies, and practices that reflect more inclusivity and acceptance. A specific example is the 2014 California *Assembly Bill 496* that required clinical providers to receive cultural competency training on SOGI information.[53] This orchestrated a call to address gaps in the medical providers' training in LGBTQ medicine as well as the provision of relevant resources.[68,69] Despite these changes, there is an ongoing fight for civil rights and equity especially seen in the current pandemic of COVID-19 and the aftermath of the George Floyd tragedy. With the previous Trump presidency, there have been numerous attempts to amend state and federal legislative policies against the protection of LGBTQ individuals by invoking religious rights and beliefs to justify the refusal and abandonment of health and psychosocial services.[70,71] This included sweeping revisions and further restrictions on health care access such as medical insurance and other service benefits.[71] In addition, the Trump administration had argued before the Supreme Court that gender-based protections under Title VII of the Civil Rights Act of 1964 do not apply to claims of discrimination based on sexual orientation or gender identity.[67] Moreover, there is also the application of the *conscience rule* which serves as an inflammatory practice that allows healthcare professionals receiving federal support to decline medical care that goes against their moral or spiritual beliefs.[67] Finally, there is a roll-back on data collection of SOGI information in national surveys and government programs that will impact their visibility as essential members of this country.[70,71] With US president Biden, there is renewed hope that more inclusive and affirmative healthcare policies for the LGBTQ population will be reinstated. A couple of major landmarks are the 2020 US Supreme Court ruling that employers cannot discriminate employees based on their SOGI. In April 2021, the Equality Act has been passed in the House of Congress. If passed by the US Senate, this will provide federal protections for the LGBTQ population in various aspects of life such as housing, education, employment, public accommodations, and healthcare among others.[71–73]

Palliative care implications on the regulatory and policy barriers. Healthcare organizations that offer hospice and palliative care services could ensure inclusivity and equity by upholding non-discrimination and zero-tolerance to prejudicial policies within their respective systems. There should be a safety net for all staff, patients, and their families/caregivers to report evidence of discriminatory and hostile practices without fear of retaliation and punishment. There should also be systems of accountability within the organizations that will include additional measures of remediation and further training and education.[47] It is vital to implement visible indicators of inclusion such as rainbow flags and system policies online and on-site within care settings to reassure the LGBTQ patients that they are in a safe environment. Ongoing staff training is necessary to affirm commitment to high-quality care. It is also worthwhile for these organizations to build a community outreach and partnership so that appropriate services and resources could be offered in a meaningful and effective manner. Beyond the institutional settings, leaders of palliative care organizations such as the American Academy of Hospice and Palliative Medicine and the Center to Advance Palliative Care should continue to engage in efforts to advocate and lobby for major changes to the provision of equitable healthcare at the state and federal levels.

Economic factors

A major contributor to the existing healthcare inequities involves economic factors such as the presence or absence of financial resources. The

geriatric LGBTQ adults face economic hardships more than their younger counterparts.[61] About 30% of them live at or below the economic threshold.[65] Older transgender adults are even more disproportionately affected by financial constraints.[38] Hence, access to appropriate medical and surgical treatments remain challenging for this population. In one study, significant differences were noted in the diverse subgroups of SGM older adults.[74,75] The expansion of the Affordable Care Act allowed for non-discriminatory health care by: (1) providing protection on medical insurance plans, (2) expanding Medicaid programs to all persons at or below 133% of the federal poverty level, and (3) providing financial subsidies to help those making between 100% and 400% of the federal poverty level purchase insurance on the federal and state market place exchanges.[76]

Palliative care implications on economic barriers. A major step in providing inclusive and affirmative palliative care is to reassure LGBTQ patients that they will receive high-quality care without regard to their financial status and insurance coverage. The palliative care social workers have a vital role in exploring the financial situation of patients and their families/caregivers especially when this affects the provision and extension of healthcare services as well as transitions in care settings along the continuum of care. Healthcare organizations at large have unique positions to expand coverage of hospice and palliative care services regardless of financial capabilities and insurance coverage.[77,78] Often times these organizations accommodate indigent and undocumented patients through charity care services that would eliminate interruption in palliative care services. With federal protections looming in the horizon, there is hope that all affirmative medical and surgical therapies for LGBTQ patients will eventually have medical insurance coverage.

Affirmative, inclusive, compassionate, and interprofessional approach to high-quality palliative care

The provision and delivery of affirmative, inclusive, compassionate, and interprofessional high-quality palliative care builds on the construct of *cultural humility* which posits that openness, self-awareness, egoless, and supportive interactions marked by self-reflection and self-critique by the clinical providers is a fundamental responsibility for care toward SGM patients.[79] By incorporating the salient conceptual frameworks of intersectionality, minority stress, lived experiences, stigma, and resilience, palliative care providers are well positioned to create inclusive and affirmative healthcare practices and environments that will bridge the gap of the disparities in healthcare experienced by the LGBTQ population. This section provides recommendations for these strategies in affirming commitment to holistic, culturally humble, compassionate high-quality palliative care. This is a compilation of resources from various studies[47,78] and complemented by anecdotal experiences. Moreover, though these strategies are applicable to both LGBTQ and non-LGBTQ population, some nuances in the approach have been highlighted.

Best Practice Strategies for ALL disciplines:

- Taking cultural competency courses and being trained in proper communication will be advantageous to establishing rapport and developing a collaborative and trusting relationship. Getting certified in continuing medical education courses and workshops boosts the competency training.[79]
- Collect SOGI at the first visit and on intake forms from the outset. A few examples of appropriate scripting are as follows: 'How do you want to be called/addressed? What pronouns do you go by? How do you identify in terms of gender identity (e.g. male, female, non-binary, transgender, other) and sexual orientation (e.g. gay straight lesbian bisexual, pansexual, asexual, other)?'
- Avoid heteronormative assumptions and misconceptions toward patients and their caregivers. Take time out to apologize when the wrong name, pronoun, or false assumptions are used.
- Take time out to include both patients and families/caregivers in clinical visits and explore the support system.
- Clinical providers along with interprofessional team members can create an open and safe forum to discuss complex cases including LGBTQ issues to help improve care for future patients.

Best Practice Strategies for: Physicians, Nurse Practitioners, Physician Assistants

- Holistic approach to history taking and physical examination including psychosocial, mental, sexual health, and well-being

- Follow standards of care with an evidence-based approach on total pain and symptom management with considerations to sociocultural and mental health factors that may impact total pain control such as the LGBTQ population's experience of inadequate pain assessment and treatment access to opioids (e.g. insurance issues) and preconceived judgments on their lifestyles (e.g. substance use).
- Understanding the LGBTQ patient medical needs in the context of minority stress is essential in offering holistic approach.[80]
- Be proactive in referring patients and their families/caregivers to other members of the interprofessional palliative care team after the needs assessment. These may include but not limited to social workers, chaplains, psychologists, rehabilitation therapists, child life therapists, creative arts specialists, integrative therapists, and so on. when these resources are available.
- Engage patients and families/caregivers in ACP discussions and proper documentation.

Best Practice Strategies for: Social Workers, Grief Counselors

- Explore psychosocial history including support networks. Be sensitive to families of choice. Understanding the lived experiences and unique journeys is the foundation for inclusive care.[81]
- Assistance with patient and caregiver burnout as families of choice might not be recognized as partners in care even though they may directly provide care for the patient. Furthermore, they are at risk for disenfranchised grief.
- Assist in goals of care conversations including filling out of relevant forms such as HCP and living will.
- Assistance with funeral planning, disposition of remains, permanency planning, hospital visitation, custody of children, and so on.
- Optimal and appropriate use of psychodynamic therapies within the scope of social work expertise. Examples include biofeedback and cognitive behavioral therapy. These are standard therapies that are not only offered to cisgender and heterosexual patients but to all patients regardless of SOGI.
- Provision of anticipatory grief and bereavement services are two key palliative care strategies for patients, families, and caregivers. Disenfranchised grief and survivor guilt especially for families of choice are significant issues that need professional support.

Best Practice Strategies for: Chaplains and Spiritual Care Counselors

- Understanding the life story and assisting in life review may be therapeutic for patients and families. Involving families of choice and caregivers in comprehensive assessment of spiritual needs is necessary to provide holistic care.[78]

Exploring spirituality and spiritual journey when applicable can be helpful for patients and families/caregivers. Use of the FICA tool could prove useful. FICA stands for Faith, Importance, Community, and Address spirituality.[82] The LGBTQ population has been subjected to rejection and bias from faith-based communities and organizations that perpetuate mistrust toward healthcare systems affecting the provision of optimal pastoral care for those interested in it. Understanding different coping strategies practiced by patients can allow the chaplain to consider them when offering management strategies. In addition, positive coping strategies and resilience should be explored as well.[21,22]

- May use Chochinov's Dignity Question: 'What should I know about you to help me provide the best care for you?'[83]

Best Practice Strategies for: Hospice and Palliative Care Organizations/Institutions

- Implementing policies against discrimination and bias while keeping up-to-date with expanded legal protections conveys an affirming message of support to all LGBTQ patients and employees.
- Identification, assessment, and management of unconscious bias using tools that will allow to capture this data in order to address barriers to diversity, equity, and inclusion.
- Mandatory cultural competency training for all providers and staff with opportunities for continuing medical education is vital to all-inclusive palliative and hospice care. The creation of a standard LGBTQ educational curriculum with ongoing evidence-driven revisions should be part of this cultural competency training. This could be available online for easy access by staff. In addition, opportunities for certification and recertification should be part of professional growth for all providers.
- Standardization and normalization of SOGI data collection allows everyone to be sensitive to an LGBTQ individual's personhood and creates a trusting relationship with the provider.

- Having internal resources to safeguard and address complaints and concerns toward outright discrimination and prejudice on patients and staff is an advantageous step impacting meaningful change toward welcoming environment.
- An investment in research studies regarding the palliative care needs and preferences for the care of LGBTQ patients should be carried out given that there are existing gaps in addressing them.
- A collaborative partnership with local, national, and international hospice and palliative care organizations should be forged to unify standards of medical care. Examples include the American Academy of Hospice and Palliative Medicine, Center to Advance Palliative Care, and the National Hospice and Palliative Care Organization.
- Use of visible indicators in offices, hospitals, clinics, and other health care settings that promote a welcoming environment. These include rainbow flags, LGBTQ-related brochures, magazines, and so on.
- Healthcare organizations can also participate in open-access registries that monitor quality metrics pertaining to culturally competent LGBTQ patient care and receive accreditation for their strong efforts in advocating for this vulnerable population.

Palliative care considerations in special populations (minority within a minority population)

This section aims to provide an overview of the palliative care considerations in special LGBTQ adult populations to include the older adults, people with HIV/AIDS, and the TGNC population, all of which have unique needs and concerns that should be taken into account when providing high-quality palliative and hospice care. These groups are truly minorities within minorities, having to face multiple and intersectional layers of internal and external stressors, stigmas, and prejudices leading to significant physical and mental health outcomes.

Older adult population

In general, the aging health concerns of the LGBTQ population exist in a continuum from pre-hospital to hospital and post-acute care including palliative and hospice care. Much like their younger counterparts, older LGBTQ adults have multiple intersectional identities, minority stressors, and experiences of stigma that render them vulnerable to disproportionate healthcare access. The disability that comes with chronic and serious illness impacts which care settings they are eligible for. A key palliative care consideration is goal-concordant medical care in the appropriate care setting such as home or facility.[84] Institutionalized older adults have expressed concerns about how they might be treated by other residents and staff.[85] The desired visibility and presentation of older patients consistent with their preferred gender expression or as a manifestation of a specific stage in medical transition (e.g. TGNC) can draw attention and make them easy targets for further stigma and abuse while already living with serious illness.[85] Moreover, care providers might not be properly trained to advocate for and provide safety nets for them. An important affirmative strategy is the organization of support groups with a large network of allies and advocates. The literature is clear that there is some form of abuse that occur in long-term care facilities such as the lack of SOGI recognition and not honoring ACP documents.[85] Organizations should step up and institute non-discriminatory policies and practices in place. When geriatric LGBTQ patients experience serious illness, documentation of ACP discussions should take place as early as possible. It is not surprising that the care preferences could be reframed around quality of life rather than life-extending therapies. Rawlings found that SGM patients are at high risk for disparate persecution and devaluation.[86] Therefore, ACP is a top priority, and immediate designation of a HCP (e.g. friend, family of choice) could not be overlooked. This is further supported by the Metlife study that affirmed the role of informal caregiving to another ailing SGM person.[87] That said, older LGBTQ adults have developed affirmative and protective strategies as a result of resiliency and robustness built over decades of oppression and discrimination in order to survive and live their authentic selves.[88,89] This crisis competence is observed in a 2015 Fredriksen-Goldsen and colleagues' study on a multidimensional Resilience Framework in which the findings point to the interconnections between successful aging, physical and mental health outcomes, and social connectedness within the context of the unique experiences of older LGBTQ adults (e.g. positive sexual identity and lifetime victimization). Physical activity, leisure activity, and substance non-use were related to better mental and physical health-related quality of life.

In addition, a better positive self-evaluation led to better mental health.[44] Several studies have also reported resiliency and successful coping among older gay men with HIV. Strength-based resources observed include self-acceptance, optimism, will to live, self-management, relational living, and independence. Furthermore, other stress buffers include gay community supports, knowledge on HIV/AIDS, and other self-care activities.[90]

HIV disease

Historically, the first experiences on the provision of hospice and palliative care in the LGBTQ population started in the 1980s at the height of the HIV-AIDS epidemic and before the introduction of the anti-retroviral therapy (ART).[78] Much of the research studies centered around the care of gay men and their caregivers who had to endure the stigma around how they were viewed and managed medically. The barriers to care included estrangement from families, lack of respect by providers on chosen families to make medical decisions even if clearly appointed by patient, visitation restrictions on the chosen families and caregivers, discrimination by health care staff, variable levels of SOGI disclosure, strong mistrust in faith-based organizations who frowned on their lifestyles, and lack of legal protections.[78,91] Collectively, these spurred the need for inclusive and culturally competent palliative care, caregiver support, bereavement services, and creation of protective policies. The general palliative care strategies for the LGBTQ adult outlined previously mirror the approach to palliative care for the LGBTQ adult with HIV/AIDS. However, there are some nuances given that there are two stigmatizing dimensions affecting this population with their set of upheavals and impact. It is important to note that with the advent of ART, HIV patients are living longer and the disease is no longer considered terminal. Having said that, this immunodeficiency syndrome now invariably affects the life course of the individual who may be faced with tremendous symptom burden with risk for advancement of disease if not treated.[92]

Recommendations on Best Practices for LGBTQ Adults with HIV/AIDS

- Collaboration with HIV experts and primary care providers is critical to ensuring seamless collaboration with the palliative and hospice care providers.
- For comprehensive planning, focus on quality-of-life indicators such as pain and symptom distress, illness trajectory and future planning, overall well-being and mental health, addiction, and suicide risk, among others.
- Engage in early advance planning discussions by completing advance directive forms, for example, healthcare proxy and living will. Completion of a MOLST/POLST form is prudent as well. Two older studies showed that gay and bisexual men were more likely to have a prior directive or more likely to discuss EOL care.[93,94]
- Regarding continuation or cessation of anti-retroviral therapy (ART), this becomes a shared decision-making approach depending on overall goals of care in the setting of disease trajectory and complications.

TGNC population

TGNC patients continue to be understudied in the palliative care literature. Lambda Legal survey showed a high level of mistrust by this population toward the healthcare systems at large.[26] Harding's systematic review revealed that the presence of family and other support systems was important for emotional support and medical decision making even though a heteronormative assumption was observed among healthcare providers.[95] The study also emphasized the importance of quality of life more than life-sustaining therapies at the end of life.[96] Regardless, TGNC patients have reported concerns about consistent, respectful, and sensitive treatment approach especially in the areas of wound and genital care even in hospice and palliative care settings. There is no universal standard regarding continuation or cessation of hormonal therapy in relation to serious illness and the dying trajectory. The current practice hinges on shared decision making between patients and providers while taking into consideration the risks and benefits to hormonal use and quality of life metrics. In addition, the provision of palliative and hospice care in various settings poses tangible challenges toward SOGI use and physical care that might expose further vulnerabilities when faith-based organizations take the lead in their care. As a result, TGNC older adults are pressured to hide their authentic selves and not live openly about who they are.[68] There is a wide gap in the literature regarding EOL and post-mortem care for this population. There is grave concern that their SOGI and other preferences for care will be ignored.[81] Use of the names assigned at birth might be engraved upon

burial. Their chosen families might not get recognized in burial planning. Moreover, when after their demise if they become a coroner's responsibility, appropriate SOGI might not be reflected on their death certificates and autopsy results. The National Resource Center on LGBT Aging is a good resource to look into documents and videos detailing wills, social security benefits, and funeral directives.[63]

Recommendations on Best Practice Strategies for Palliative Care Clinicians

- Clinicians can provide holistic care by understanding and validating the lived experiences of TGNC patients. Chochinov's 'Dignity Question' is always an effective tool to start the conversation on their lived experiences.
- As described previously, during the physical examination of TGNC patients, it is respectful for the clinician to obtain permission before examining any body part; asking the patient to take the lead in sharing how they name their body parts; providing a thorough explanation of the rationale for the physical exam and any concerning findings that warrant further investigation; and collaborating on the next steps in a tailored comprehensive plan of care.
- Sexual issues in palliative care should be explored inasmuch as other physical needs are being addressed.[97,98]
- It is advisable to closely collaborate with the primary care providers and endocrine specialists who are managing the hormonal use of TGNC patients. Being familiar with the World Professional Association of Transgender Health (WPATH) and University of California San Francisco (UCSF) standard of medical care for TGNC patients may be helpful for the palliative care specialists to integrate current medical therapies with symptom management.
- ACP should be done as soon as possible. Filling out forms such as HCP, living will, and MOLST is necessary and best done while healthier.
- Interprofessional support should be part of the care from the outset to explore psychosocial, spiritual, and bereavement needs.
- Planning around future finances, burial services, adoption/custody issues for TGNC patients with children, and so on should be addressed as soon as possible.[96]

Conclusion

The provision and delivery of high-quality palliative, hospice, and EOL care starts with an understanding of the cultural framework that has shaped the life course of the LGBTQ population and the minorities within minorities subgroups. The long-standing prejudice, stigma, discrimination, and oppression have resulted in delays and avoidance in seeking medical care, disparate physical and mental health outcomes, and mistrust with the healthcare system as a whole. The barriers to comprehensive palliative care include gaps in competency training for providers, paucity in research studies, variable resource allocation, financial constraints, and non-protective regulatory policies and practices. There are key strategies to mitigate these barriers while providing affirmative and inclusive care toward SGM patients that can create a therapeutic alliance, improved patient and caregiver satisfaction, enhanced quality of life, and overall well-being. A holistic team-based approach coupled with empathic communication and non-judgmental mind-set are fundamental steps that offer an effective, successful, and trusting relationship to both patients and caregivers. There is renewed hope with the Biden administration that legal protections for the healthcare of the LGBTQ population in the United States will be enforced and expanded to affirm commitment for universal healthcare for all people irrespective of their backgrounds.

Conflict of interest statement

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Noelle Marie Javier https://orcid.org/0000-0003-3498-7627

References

1. https://williamsinstitute.law.ucla.edu/visualization/lgbt-stats/?topic=LGBT#demographic (accessed 2 July 2021).
2. Choi SK and Meyer IL. *LGBT aging: a review of research findings, needs, and policy implications*.

Los Angeles, CA: The Williams Institute, UCLA School of Law, 2016.

3. Snyder JE. Trend analysis of medical publications about LGBT persons: 1950-2007. *J Homosex* 2011; 58: 164–188.
4. Institute on Medicine. *The health of lesbian, gay, bisexual, and transgender people: building a foundation for better understanding*. Washington, DC: The National Academies Press, 2011.
5. Fredriksen-Goldsen KI, Kim HJ, Bryan AEB, *et al*. The cascading effects of marginalization and pathways of resilience in attaining good health among LGBT older adults. *Gerontologist* 2017; 57(Suppl. 1): S72–S83.
6. Yarns BC, Abrams JM, Meeks TW, *et al*. The mental health of older LGBT adults. *Curr Psychiatry Rep* 2016; 18: 60.
7. GLAAD. *Accelerating acceptance 2019: a survey of American acceptance and attitudes toward LGBTQ Americans*. New York: GLAAD, 2019.
8. https://www.glsen.org/sites/default/files/LGBTQ-History-Timeline-References.pdf (accessed 2 July 2021).
9. Nadal KL, Davidoff KC and Davis LS. A qualitative approach to intersectional microaggressions: understanding influences of race, ethnicity, gender, sexuality, and religion. *Qual Psychol* 2015; 2: 147–163.
10. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health* 2012; 102: 1267–1273.
11. Meyer IH. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol Bull* 2003; 129: 674–697.
12. Aldwin CM, Igarashi H, Gilmer DF, *et al*. *Health, illness, and optimal aging: biological and psychological perspectives*. 2nd ed. New York: Springer Publishing Company, 2013.
13. Witten TM. End of life, chronic illness, and trans-identities. *J Soc Work End Life Palliat Care* 2014; 10: 34–58.
14. Herek GM. A nuanced view of stigma for understanding and addressing sexual and gender minority health disparities. *LGBT Health* 2016; 3: 397–399.
15. Chidiac C and Connolly M. Considering the impact of stigma on lesbian, gay, and bisexual people receiving palliative and end of life care. *Int J Palliat Nurs* 2016; 22: 334–340.
16. Meyer IH. Resilience in the study of minority stress and health of sexual and gender minorities. *Psychol Sex Orient Gender Divers* 2015; 2: 209–213.
17. Smith MS and Gray SW. The courage to challenge: a new measure of hardiness in LGBT adults. *J Gay Lesbian Soc Serv* 2009; 21: 73–89.
18. Colpitts E and Gahagan J. The utility of resilience as a conceptual framework for understanding and measuring LGBTQ health. *Int J Equity Health* 2016; 15: 60.
19. McConnell EA, Janulis P, Phillips G 2nd, *et al*. Multiple minority stress and LGBT community resilience among sexual minority men. *Psychol Sex Orientat Gend Divers* 2018; 5: 1–12.
20. Singh AA and McKleroy VS. 'Just getting out of bed is a revolutionary act': the resilience of transgender people of color who have survived traumatic life events. *Eur Phys Educ Rev* 2011; 17: 34–44.
21. Bonanno GA, Westphal M and Mancini AD. Resilience to loss and potential trauma. *Annu Rev Clin Psychol* 2011; 7: 511–535.
22. Smith BW, Tooley EM, Christopher PJ, *et al*. Resilience as the ability to bounce back from stress: a neglected personal resource? *J Posit Psychol* 2010; 5: 166–176.
23. Witten TM. It's not all darkness: robustness, resilience, and successful transgender aging. *LGBT Health* 2014; 1: 24–33.
24. Meyer I. Identity, stress, and resilience in lesbians, gay men, and bisexuals of color. *Couns Psychol* 2010; 38: 1–7.
25. Grasso C, Goldhammer H, Brown RJ, *et al*. Using sexual orientation and gender identity data in electronic health records to assess for disparities in preventive health screening services. *Int J Med Inform* 2020; 142: 104245.
26. When health care isn't caring? Lambda Legal Survey on LGBT people and people living with HIV, https://www.lambdalegal.org/sites/default/files/publications/downloads/whcic-report_when-health-care-isnt-caring.pdf (2010, accessed 26 August 2021).
27. Sabin JA, Riskind RG and Nosek BA. Health care providers implicit and explicit attitudes toward lesbian women and gay men. *Am J Public Health* 2015; 105: 1831–1841.
28. James SE, Herman JL, Rankin S, *et al*. *The report of the 2015 US transgender survey* Washington, DC: National Center for Transgender Equality, 2016.
29. Carter PL and Reardon SF. *Inequality matters*. New York: William T. Grant Foundation,

https://ed.stanford.edu/sites/default/files/inequalitymatters.pdf (September 2014, accessed 19 March 2021).

30. MacCartney D and Fuwa M. *Intersecting inequality: the effects of race, class, gender, and sexual orientation*. Princeton, NJ: Princeton University, http://paa2006.princeton.edu/papers/61138 (2006, accessed 2 July 2021).
31. Veenstra G. Race, gender, class, and sexual orientation: intersecting axes of inequality and self-rated health in Canada. *Int J Equity Health* 2011; 10: 3.
32. Balsam KF, Molina Y, Beadnell B, *et al*. Measuring multiple minority stress: the LGBT People of Color Microaggressions Scale. *Cultur Divers Ethnic Minor Psychol* 2011; 17: 163–174.
33. Williams D and Mohammed S. Discrimination and racial disparities in health: evidence and needed research. *J Behav Med* 2009; 32: 20–47.
34. Dai H and Hao J. Sleep deprivation and chronic health conditions in sexual minority adults. *Behav Sleep Med* 2017; 17: 254–268.
35. Emlet CA. Social, economic, and health disparities among LGBT older adults. *Generations* 2016; 40: 16–22.
36. Espinoza R. *Out and visible: the experiences and attitudes of LGBT older adults, ages 45-75*. New York: Services and Advocacy for GLBT Elder, 2014.
37. Wallace S, Cochran S, Durazo E, *et al. The health of aging lesbian, gay, and bisexual adults in California*. Los Angeles, CA: UCLA Center for Health Policy Research, 2011.
38. Fredriksen-Goldsen KI, Kim HJ, Barkan SE, *et al*. Health disparities among lesbian, gay, and bisexual older adults: results from a population-based study. *Am J Public Health* 2013; 103: 1802–1809.
39. Fredriksen-Goldsen KI. Resilience and disparities among lesbian, gay, bisexual, and transgender older adults. *Public Policy Aging Rep* 2011; 21: 3–7.
40. Kenagy GP. Transgender health: findings from two needs assessment studies in Philadelphia. *Health Soc Work* 2005; 30: 19–26.
41. Lindstrom M and Rosvall M. Sexual identity and low leisure-time physical activity: a population based study. *Public Health* 2020; 182: 77–79.
42. Galloza J, Castillo B and Micheo W. Benefits of exercise in the older population. *Phys Med Rehabil Clin N Am* 2017; 28: 659–669.
43. Flenar DJ, Tucker CM and Williams JL. Sexual minority stress, coping, and physical health indicators. *J Clin Psychol Med Settings* 2017; 24: 223–233.
44. Fredriksen-Goldsen K, Kim HJ, Shiu C, *et al*. Successful aging among older adults: physical and mental health-related quality of life by age group. *Gerontologist* 2015; 55: 154–168.
45. Haider AH, Schneider EB, Kodalek LM, *et al*. Emergency departmental query for patient-centered approaches to sexual orientation and gender identity: the EQUALITY Study. *JAMA Intern Med* 2017; 177: 819–828.
46. Acquaviva K. *LGBTQ-inclusive hospice and palliative care: a practical guide to transforming professional practice*. New York: Harrington Park Press, 2017.
47. Cloyes KC, Hull W and Davis A. Palliative and end-of-life care for lesbian, gay, bisexual, transgender cancer patients and their caregivers. *Semin Oncol Nurs* 2018; 34: 60–71.
48. Witten TM. Graceful exits: intersection of aging, transgender identities, and the family/community. *J GLBT Fam Stud* 2009; 5: 35–61.
49. Stein GL and Bonuck KA. Attitudes on end-of-life care and advance care planning in the lesbian and gay community. *J Palliat Med* 2001; 4: 173–190.
50. Aging with dignity: five wishes, https://agingwithdignity.org/docs/default-source/default-document-library/product-samples/fwsample.pdf?sfvrsn=2 (accessed 13 March 2021).
51. POLST: advance care planning for the seriously ill, http://polst.org/wp-content/uploads/2018/01/2013.09.26_Final-POLST-Article.pdf (accessed 2 July 2021).
52. MOLST: medical orders for life sustaining treatment, https://www.health.ny.gov/forms/doh-5003.pdf (accessed 13 April 2021).
53. Cartwright C, Hughes M and Lienert T. End-of-life care for gay, lesbian, bisexual, and transgender people. *Cult Health Sex* 2012; 14: 537–548.
54. Hughes M and Cartwright C. LGBT people's knowledge of and preparedness to discuss end-of-life care planning options. *Health Soc Care Community* 2014; 22: 545–552.
55. Drescher J. Queer diagnoses: parallels and contrasts in the history of homosexuality, gender variance, and the diagnostic and statistical manual. *Arch Sex Behav* 2010; 39: 427–460.

56. Drescher J. Out of DSM: depathologizing homosexuality. *Behav Sci* 2015; 5: 565–575.

57. Pillard R. From disorder to dystonia: DSM-II and DSM-III. *J Gay Lesbian Ment Health* 2009; 13: 82–86.

58. American Psychiatric Association. *Gender dysphoria*. Washington, DC: American Psychiatric Association, https://www.psychiatry.org/patients-families/gender-dysphoria (2013, accessed 2 July 2021).

59. D'Augelli AR, Grossman AH, Hershberger SL, *et al*. Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging Ment Health* 2001; 5: 149–158.

60. Wight RG, LeBlanc AJ, Meyer IH, *et al*. Internalized gay ageism, mattering, and depressive symptoms among midlife and older gay-identified men. *Soc Sci Med* 2015; 147: 200–208.

61. Grant JM, Mottet LA, Tanis J, *et al*. *Injustice at every turn: a report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

62. Cochran SD, Grella CE and Mays VM. Do substance use norms and perceived drug availability mediate sexual orientation differences in patterns of substance use? Results from the California Quality Life Survey II. *J Stud Alcohol Drugs* 2012; 73: 675–685.

63. Pantalone DW, Bimbi DS and Parsons JT. Motivations for the recreational use of erectile enhancing medications in urban gay and bisexual men. *Sex Transm Infect* 2008; 84: 458–462.

64. McCabe SE, West BT, Hughes TL, *et al*. Sexual orientation and substance abuse treatment utilization in the United States: results from a national survey. *J Subst Abuse Treat* 2013; 44: 4–12.

65. Fredriksen-Goldsen KI, Emlet CA, Kim HJ, *et al*. The physical and mental health of lesbian, gay male, and bisexual (LGB) older adults: the role of key health indicators and risk and protective factors. *Gerontologist* 2013; 53: 664–675.

66. Monin JK, Mota N, Levy B, *et al*. Older age associated with mental health resiliency in sexual minority US Veterans. *Am J Geriatr Psychiatry* 2017; 25: 81–90.

67. Stein GL, Berkman C, O'Mahony S, *et al*. Experiences of lesbian, gay, bisexual, and transgender patients and families in hospice and palliative care: perspectives of the Palliative Care Team. *J Palliat Med* 2020; 23: 817–824.

68. Arthur DP. Social work practice with LGBT elders at end of life: developing practice and clinical skills through a cultural perspective. *J Soc Work End Life Palliat Care* 2015; 11: 178–291.

69. Gendron T, Maddux S, Krinsky L, *et al*. Cultural competence training for healthcare professionals working with LGBT older adults. *Educ Gerontol* 2013; 39: 454–463.

70. Durso LE. Data move us closer to full equality by speaking for those who cannot: advocating for LGBT older adults. *Am J Public Health* 2017; 107: 1219–1220.

71. Cahill SR. Research and policy change to improve healthcare and elder services for LGBT older adults. *LGBT Health* 2017; 4: 381–383.

72. https://www.washingtonpost.com/religion/2021/03/16/equality-act-fairness-for-all-religious-liberty-lgbtq-lgbt-biden/ (accessed 2 July 2021).

73. https://www.hrw.org/news/2020/06/15/us-supreme-court-ruling-victory-lgbt-workers# (accessed 2 July 2021).

74. Fredriksen-Goldsen K, Siu C, Kim HJ, *et al*. *At risk and underserved: LGBTQ older adults in Seattle/King County, Findings from aging with pride*. Seattle, WA: University of Washington, 2015.

75. Johnson L, Shipperd JC and Walton H. The psychologist's role in transgender specific care with US veterans. *Psychol Serv* 2016; 13: 69–76.

76. Daniel H and Butkus R. Lesbian, gay, bisexual, and transgender health disparities: executive summary of a policy position paper from the American College of Physicians. *Ann Intern Med* 2015; 163: 135–148.

77. Puckett JA, Cleary P, Kinton R, *et al*. Barriers to gender affirming care for transgender and gender non-conforming individuals. *Sex Res Soc Policy* 2018; 15: 48–59.

78. Maingi S, Bagabag AE and O'Mahony S. Current best practices for sexual and gender minorities in hospice and palliative care settings. *J Pain Symptom Manage* 2018; 55: 1420–1427.

79. Foronda G, Baptiste DL, Reinholdt MM, *et al*. Cultural humility: a concept analysis. *J Transcult Nurs* 2016; 27: 210–217.

80. Hatzenbuehler ML and Pachankis JE. Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth. *Pediatr Clin North Am* 2016; 63: 985–997.

81. Diewald M and Mayer KU. The sociology of the life course and life span psychology: integrated paradigm or complementing pathways? *Adv Life Course Res* 2009; 14: 5–14.

82. Borneman T, Ferrell B and Puchalski C. Evaluation of the FICA tool for spiritual assessment. *J Pain Symptom Manage* 2010; 40: 163–173.

83. Chochinov HM, McClement S, Hack T, *et al.* Eliciting personhood within clinical practice: effects on patients, families, and health care providers. *J Pain Symptom Manage* 2015; 49: 974–980.

84. Adams M and Tax AD. Assessing and meeting the needs of LGBT older adults via the Older Americans Act. *LGBT Health* 2017; 4: 389–393.

85. *LGBT older adults in long-term care facilities: stories from the field*. SAGE, Lambda Legal, and National Senior Citizens Law Center Collaboration, https://www.diverseelders.org/resource/lgbt-older-adults-in-long-term-care-facilities-stories-from-the-field/ (2011, accessed 13 March 2021).

86. Rawlings D. End-of-life care considerations for gay, lesbian, bisexual, and transgender individuals: case study. *Int J Palliat Nurs* 2012; 1: 29–34.

87. Metlife Mature Market Institute. Still out, still aging: the Metlife study of lesbian and gay baby boomers, https://www.tandfonline.com/doi/full/10.1080/15504280903472949?scroll=top&needAccess=true (2010, accessed 2 July 2021).

88. de Vries B, Gutman G, Humble A, *et al.* End-of-life preparations among LGBT older Canadians: the missing conversations. *Int J Aging Hum Dev* 2019; 88: 358–379.

89. Stinchcombe A, Smallbone J, Wilson K, *et al.* Healthcare and end-of-life needs of lesbian, gay, bisexual, and transgender (LGBT) older adults: a scoping review. *Geriatrics* 2017; 2: 1–13.

90. Van Wagenen A, Driskell J and Bradford J. 'I'm still raring to go': successful aging of lesbian, gay, bisexual, and transgender older adults. *J Aging Stud* 2013; 27: 1–14.

91. Biller R and Rice S. Experiencing multiple losses of persons with AIDS: grief and bereavement issues. *Health Soc Work* 1990; 15: 283–290.

92. Simms V, Higginson I and Harding R. Integration of palliative care throughout HIV disease. *Lancet Infect Dis* 2012; 12: 571–575.

93. Teno J, Fleishman J, Brock DW, *et al.* The use of formal prior directives among patients with HIV-infected diseases. *J Gen Intern Med* 1990; 5: 490–494.

94. Curtis JR, Patrick DL, Caldwell E, *et al.* The quality of patient-doctor communication about end-of-life care: a study of patients with advanced AIDS and their primary care clinicians. *AIDS* 1999; 13: 1123–1131.

95. Harding R, Epiphaniou E and Chidgey-Clark J. Needs, experiences, and preferences of sexual minorities for end-of-life care and palliative care: a systematic review. *J Palliat Med* 2012; 15: 602–611.

96. Porter KE, Oala CR and Witten TM. Transgender spirituality, religion, and successful aging: findings from the Trans Metlife Survey. *J Relig Spiritual Aging* 2012; 25: 112–138.

97. Shell JA. Sexual issues in the palliative care population. *Semin Oncol Nurs* 2008; 24: 131–134.

98. Griebling TL. Sexuality and aging: a focus on lesbian, gay, bisexual, and transgender (LGBT) needs in palliative and end of life care. *Curr Opin Support Palliat Care* 2016; 10: 95–101.

Seattle Rainbow Housing

Aging in Community:

Addressing LGBTQ Inequities in Housing and Senior Services

Karen Fredriksen Goldsen, PhD

Table of Contents

"I do worry about being elderly and ending up in a rest home and the staff not accepting me or my spouse or our relationship. Are we going to feel comfortable being able to kiss each other? Can we have our photos up on the wall? Will we feel safe? How will staff interact with us? Will we be treated differently or go back in the closet to protect ourselves?"

Acknowledgements

This report results from a community engaged effort to examine the housing and service-related needs of LGBTQ older adults in Seattle/King County. I want to acknowledge the many individuals and organizations that made this project possible. Without the active participation across so many diverse corners of the Seattle/King County LGBTQ community and the housing and service sectors, I could not have completed this work. I deeply appreciate Maureen Kostyack and the City of Seattle Office of Housing, who provided ongoing support and resources through all phases of the project. I want to thank Seattle Councilmember Lorena González for recognizing the need and making resources possible to complete this work. I deeply appreciate the efforts of Councilmember Lisa Herbold for working with Aging with Pride and Generations Aging with Pride to ensure that LGBTQ older adults were identified as a health disparate population in the City of Seattle Housing Levy. I also want to thank King County Council Chair Joe McDermott for his support of LGBTQ older adults and their communities. I deeply appreciate the following individuals and organizations that stepped up and gave their time so generously to serve on the Rainbow Housing Advisory Committee including Marsha Botzer, Ingersoll Gender Center; Alex Brennan, Capitol Hill Housing; Debbie Carlsen, LGBTQ Allyship; Maureen Kostyack, City of Seattle Office of Housing; Luis Fernando Ramírez, Hermanos; Cicily Nordness, Seattle Housing Authority; Ray Padilla, Bellwether Housing; Ruben Rivera-Jackman, Generations Aging with Pride and Senior Housing Assistance Group (SHAG); Steven Sawyer, POCAAN; and Jon Morrison Winters, City of Seattle Aging and Disability Services. These individuals gave their time and expertise to provide guidance and feedback on every aspect of the project including the review of existing LGBTQ housing materials, input on community-based listening sessions, survey development, outreach and recruitment, data collection and analysis, and the development of recommendations based on the information gathered through the project.

I want to acknowledge the City of Seattle LGBTQ Commission for their input and support of this project. I also want to thank Emily Skola, Alisa Strayer, Ian Johnston, Ian Kirkman, and Jayn Goldsen, and the many others who helped distribute surveys, and assisted with the review of literature and data analyses to ensure its success. I want to recognize and thank all the LGBTQ older adults and countless other community members who provided feedback and input across all phases of the project including outreach and recruitment, information gathering, the strengths and housing-related needs, analysis of findings as well as contributed their vision and ideas for the future. I hope this report and the recommendations identified will lead to improvements in housing as well as aging, health and human service-related programs for Seattle/King County's LGBTQ older adults, and their families and communities.

Karen I. Fredriksen Goldsen, PhD
National LGBTQ Health and Aging Specialist
September 2018

Executive Summary

Seattle/King County is vibrant, with a growth rate surpassing most large metropolitan areas, intensifying issues of housing affordability and accessibility. Given profound demographic shifts and the aging of the U.S. population overall, Seattle/King County is becoming increasingly older and more diverse by race, ethnicity, sexual orientation, and gender identity and expression. With one of the largest LGBTQ communities in the nation, 8% of older adults in Seattle/King County are LGBTQ accounting for more than 27,000 older adults. Housing and aging issues are at a critical crossroads - still today in Seattle/King County LGBTQ older adults remain largely invisible and underserved.

This project was commissioned by the City of Seattle Office of Housing, with the goals of examining the housing and senior service needs of LGBTQ older adults to create an action agenda. More than 500 surveys were returned, with 419 completed by LGBTQ older adults, reflecting unprecedented diversity including those age 70 and older (30%), people of color (32.5%), women (43.1%), and trans/non-binary (17.8%).

Based on the information gathered, several key housing and senior service challenges emerged:

- Inadequate services prevent LGBTQ seniors from remaining in their homes and aging in community.
- Lack of affordable, stable, safe, and accessible housing for LGBTQ seniors.
- Limited cultural capacity of providers to ensure LGBTQ affirming housing environments.
- High rates of discrimination and bias in housing, with most not obtaining legal recourse.
- LGBTQ racial inequities in access to affordable housing and senior services.
- Insufficient community engagement and advocacy for LGBTQ aging and senior housing.
- Lack of information necessary to proactively guide and monitor decision making to better support LGBTQ communities and eliminate inequities in the allocation of City resources.

Seattle/King County is falling behind other major metropolitan areas in addressing LGBTQ housing and senior needs. In 2013, the City of San Francisco commissioned a report to assess the needs of LGBTQ older adults. Based on the findings and advocacy efforts, San Francisco's Department of Aging and Adult Services now invests more than 6 million dollars to address the needs of LGBTQ seniors, with an LGBTQ Senior Center and two LGBTQ senior housing buildings – Seattle/King County has neither. This report is an important first step for Seattle/King County to have the information necessary to address the needs of LGBTQ older adults and their communities.

"We have the history and years of experience.
But our talents are being wasted. It is our turn. Count us in."

Key Findings

LGBTQ older adult participants were resilient yet at-risk. More than six out of ten wanted to stay in their current homes, yet many were vulnerable to losing their housing resulting from a convergence of risk factors within the context of rising rents and housing costs.

"We are being forced back into the closet. We don't have safe and affordable places to live or good services."

LGBTQ participants compared to older adults in Seattle/King County had significantly higher rates of renting, elevated rent cost burden, and were more likely to live alone in old age with no supports available.

Reporting higher than average housing cost burden and living in unaffordable housing and most were living on fixed incomes. Twenty percent experienced homelessness in the past five years.

In Seattle/King County
58% of renters aged 60+ were housing cost burdened
compared to
87% of the LGBTQ older adult participants

Three-quarters of the LGBTQ older adults barely had enough financial resources to make ends meet. One-quarter were well- resourced; many of them did not feel specialized housing or services were necessary.

Nearly 40% of the LGBTQ older adult participants wanted to move, which is significantly higher than older adults in general – yet most faced significant barriers to moving.

LGBTQ older adults had elevated disparities in disability and health. Yet many homes and neighborhoods are ill-equipped to accommodate mobility limitations, which drives heightened demand for accessibility and home modifications and supports.

LGBTQ older adults experienced high rates of discrimination, with trans older adults reporting nearly double the rates. More than four out of five LGBTQ older adults did not report, thus did not receive, any legal recourse.

In the general population
13% of adults aged 65+ want to move
compared to
39% of LGBTQ older adult participants

Those who moved within the past year experienced
Homelessness 48.5%
Eviction 33.3%
Foreclosure 15.2%
within the past five years

Most LGBTQ older adults were not accessing needed senior or housing services because the services were felt to be non-LGBTQ affirming, too costly, and/or not accessible.

LGBTQ older adults are active in housing and service advocacy. Over half raised money or donated food, clothing or supplies, or helped someone with a housing search and place to stay.

Racial and ethnic minority LGBTQ older adults reported higher levels of housing cost burden, lack of support, and lack of access to many housing and aging services than non-Hispanic Whites.

The consequences of losing housing late in life were severe for LGBTQ older adults, as they often could not secure new housing. Even after a short hospital or rehabilitation stay, many did not have a social or financial safety net necessary to retain their housing, which if lost often led to premature institutionalization for the remainder of their lives. Eviction often led to homelessness, which can result in premature mortality. Not addressing aging and housing needs directly within LGBTQ communities can result in much greater public cost.

Action Plan and Recommendations

1. **Promote aging in community via funding an LGBTQ Senior Center with LGBTQ affirming services and programs to support these resilient at-risk older adults.**

   Recommendations:
   - Fund an LGBTQ-affirming Senior Center with one-point entry (e.g., for senior services, referral, enrollment assistance, case management), built within the LGBTQ community so it is trusted and can reach those in greatest need and provide support and technical assistance to other providers.
   - Expand awareness of, and access to, home repair and housing modification programs to maintain and support accessible and safe housing.
   - Test the effectiveness of additional home-based mental health and substance abuse counseling services, especially for older adults who report difficulty accessing and maintaining such support services.

> *"Hey, I was arrested in the park. It is not safe. We need services that we build in our community."*

2. **Fund and provide affordable, stable, safe, and accessible LGBTQ senior housing.**

   Recommendations:
   - Prioritize and fund affordable LGBTQ senior housing developments incorporating best practices, such as formalized agreements with trusted community-based aging service providers early in the development process; provision of storefront visibility; and ample, dedicated space for the delivery of senior services for residents and the community. Incorporate LGBTQ affirming principles with equity and age-friendly universal design in housing developments for low-income and mixed-income levels.
   - Increase the supply of rental housing subsidies, and assistance with mortgage payments, property taxes, and utilities. Provide housing counseling, rental assistance, eviction prevention support, and legal services to decrease housing instability and homelessness of LGBTQ older adults.
   - Develop and test alternative housing models, such as home share programs, community-based housing via community land trusts, intergenerational housing programs, and models designed to allow professional and volunteer caregivers to live among those needing home-based services.

3. **Enhance cultural capacity and create LGBTQ affirming housing environments and services with attention to high-risk groups through trainings and resources.**

   Recommendations:
   - Fund, design and implement an LGBTQ equity housing training forum tailored toward housing providers, including intersectionality and culture, and race/ethnicity.
   - Develop and facilitate LGBTQ affirming trainings, specifically for shelters, transitional housing, and long-term care facilities, to reduce social isolation and end bullying by residents.
   - Create and disseminate an LGBTQ affirming housing and resource guide for community use and resident housing councils.

"I remember the early days of AIDS here in Seattle. We were dying. No one would help us. Now we are old and dying. Still today - no one is here to help us."

4. **Ensure the reporting of discrimination and legal recourse.**

   Recommendations:
   - Launch a community-wide awareness campaign on what constitutes discrimination and how to report it, including legal protections in public accommodations such as shelters, transitional housing, and long-term care facilities.
   - Ensure the handling of discrimination complaints is affirming for marginalized and underserved LGBTQ older adults, including the oldest, trans, bisexuals, and people of color. Pilot test the use of navigators to support vulnerable seniors and others through the reporting process and investigation of complaints.
   - Expand fair housing testing to assess violations of housing discrimination laws by sexual orientation and gender identity and expression, as well as intersectional forms of discrimination such as race/ethnicity, disability, and use of housing vouchers.

5. **Promote LGBTQ community support, engagement and advocacy.**

   Recommendations:
   - Work with nonprofit and for-profit agencies and communities to promote the understanding of LGBTQ aging and housing issues.
   - Prioritize addressing the needs of hard to reach and traditionally underserved LGBTQ older adults, including people of color, immigrants and linguistically diverse, those living in poverty, the oldest, trans, queer, bisexual older adults, those living with HIV/AIDS, and those with disabilities.
   - Include more diverse LGBTQ older adult voices in housing and senior advocacy efforts as well as planning processes, including land use, urban design, and housing and senior service advisory boards.

6. **Expand the collection and utilization of data to monitor LGBTQ housing and aging-related service needs, and to ensure equity in budgeting and the allocation of City and County resources**.

Recommendations:

- Expand the collection of data on sexual orientation and gender identity and expression using best practices when voluntary demographic data are collected via City and County agencies and contractors, such as client intake and other forms for services and contracts.
- Ensure training is available for City and County workers and contracted staff to attain skills and abilities needed to effectively collect such data. Assess and pilot test methods to make data publicly available.
- Analyze and eliminate LGBTQ inequities in the City's and County's allocation of resources, including housing initiatives, senior programs and services, and all other policy and regulatory mandates.

Conclusion

We urge the Mayor, City and County officials, and departments to implement these recommendations, with the community providing much needed advocacy. It is important to honor and utilize the many strengths and valuable contributions LGBTQ older adults have made and continue to make. We now have an opportunity to implement an action plan that is LGBTQ-affirming, age-friendly, and promotes racial equity - one that recognizes and caters to the strengths of LGBTQ older adults as they *age in community with pride*.

"As a trans activist of color I want to help my community – who will be there to help me with my needs."

Introduction

Seattle/King County is vibrant and growing, with a growth rate that surpasses most large metropolitan areas.[1] In 2015, the population in King County exceeded 2 million,[3] and between 2015 and 2017, the Puget Sound region gained over 80,000 new residents.[4] Since 2010, rental prices in King County have increased by 58.7%[5] and the cost of living has increased by 21.8%.[6] As Seattle/King County continues to increase in population size, housing in the region is of heightened demand and cost, creating many serious challenges for older adults in the area.[7] Within the context of growth in the overall population size, issues of housing affordability and accessibility intensify.

Given profound demographic shifts and the significant aging of the U.S. population overall, Seattle/King County is becoming increasingly older and more racially, ethnically, and culturally diverse. It is estimated that within two decades, older adults will constitute more than 20% of the U.S. population overall.[8] The population of Seattleites over 60 years of age has increased by 24%, with approximately 345,000 King County residents over the age of 60.[7] In King County, 23% of those over the age of 60 are racial or ethnic minorities.

We are also witnessing increasing diversity in the older adult population by both sexual orientation and gender identity and expression. Seattle has one of the largest LGBTQ populations in the country.[9] It is estimated that 2.4% of the U.S. population age 50 and older self-identifies on public health surveys as lesbian, gay, bisexual or transgender, which accounts for more than 2 million older adults nationally.[10] This number is expected to more than double by 2030, to 5 million LGBTQ older adults. When also taking into consideration the number of older adults who are in same-sex relationships, engage in same-sex sexual behavior, or who are sexual or gender diverse but who do not publicly identify as lesbian, gay, bisexual or transgender, the number of sexual and gender diverse older adults increases substantially, representing more than 8% of the older adult population. Currently, there are more than 27,000 LGBTQ adults over the age of 60 living in Seattle/King County.

LGBTQ older adults in the state of Washington, including Seattle/King County, experience systematic health disparities,[11] which are inequities in health resulting from social, economic, and environmental disadvantages.[12] As a result, LGBTQ older adults are at elevated risk of disability and poor physical and mental health compared to heterosexuals of similar age, even when accounting for differences in age, income and education.[11] Despite the alarming findings regarding health disparities in the LGBTQ older adult population, they remain largely invisible in aging and housing services and policies in Seattle/King County.

The report, *At-risk and Underserved: LGBTQ Older Adults in Seattle/King County* (2015)[13] first identified LGBTQ older adults as an at-risk, underserved and under-counted population in Seattle/King County. In 2015, the Seattle Mayoral LGBTQ Task Force Report stated, "The City should develop measures to evaluate the inclusivity of its policies, programs, and practices to ensure that they are inclusive of LGBTQ seniors".[14] In the 2016-2019 *Area Plan on Aging* in Seattle/King County, LGBTQ older adults were for the first time identified as an underserved population in need of outreach and services.[7] More recently, in 2017, Mayor Durkan released an updated draft of the Age Friendly Seattle Action Plan, which outlines goals to create and enhance services for community-dwelling seniors.[15] In addition, the King County Veterans, Seniors, and Human Services Levy was reapproved in November 2017, providing funds to address housing, veterans, and aging services.[16] Such efforts intersect with the City of Seattle's

Race and Social Justice Initiative, designed to address and eliminate racial inequities in the access and delivery of services and programs, contracting, workforce development, and outreach and public engagement, which all require attention to individual, institutional and structural racism.

Seattle now has one of the highest homelessness rates in the country. Recent research conducted in Seattle found that among LGBTQ adults of all ages 63% experienced increased rent, 27% moved due to rent or renovations, 5% had experienced homelessness, 5% reported "doubling-up" with friends or family rent-free, and 2% faced eviction or foreclosure over the previous two years.[17] In regional studies of the homeless population, 18% identified as LGBTQ compared to 4.8% of the general population living in Seattle.[18] Nationally, studies have found that approximately 30% of transgender adults have experienced homelessness during their lifetime.[19] While existing information points to critical challenges in housing for older adults in general and LGBTQ younger adults in Seattle, there is a dearth of research specifically examining the housing and senior service needs of LGBTQ older adults.

"Housing as a basic need provides not only shelter, but ideally serves as a place of refuge, respite, and safety. Aging in place connotes the ability to live at home independently and safely, regardless of age, income, or ability."[20] However, because of the extremely high rates of social isolation among LGBTQ older adults, aging in place, primarily in one's home, also can connote risk. Aging in community - connected, engaged and safe, is critical for LGBTQ older adults. Population aging itself will outgrow the supply of accessible and affordable housing not only locally, but nationally,[2] which has the potential for severe consequences among LGBTQ older adults given the many challenges they face.

Housing and aging issues in the LGBTQ community remain at a critical crossroads. LGBTQ older adults remain largely invisible in Seattle/King County, in the LGBTQ community, and in services. They continue to occupy the margins and are vastly underserved in housing, aging and health services. In a national survey, 78% of LGBTQ older adults reported interest in affordable LGBTQ-friendly housing.[21] Previous studies have consistently cited the need for further research of the housing-related needs of the local LGBTQ older adult population. As a result, the City of Seattle Office of Housing commissioned this study on the housing and senior service needs of LGBTQ older adults.

Comprehensive and up-to-date information is critically needed to understand the strengths and needs of LGBTQ older adults to take effective action. The goals of this report are to provide an overview of the housing and senior service experiences and needs of LGBTQ older adults living in the Seattle/King County, and to create an action agenda to equip community stakeholders and Seattle/King County policymakers with the information necessary to ensure local housing efforts and aging services are inclusive, relevant, and effective for LGBTQ older adults and their families, caregivers and communities.

"Parents are usually gone and there is often tension with our siblings because of our sexual orientation. Without children or parents - who will help us? I'm currently thinking about leaving Seattle because I can't afford to grow old here."

Community Engaged Approach

This project required a comprehensive community engaged approach to identify the needed information to assess the full range of housing and aging service needs of Seattle/King County's diverse LGBTQ older adults. The process started by reviewing available information on housing and service needs, as well as demographic trends within Seattle/King County. We examined numerous recent reports including: Washington State University's Metropolitan Center for Applied Research & Extension (2018)[22]; Seattle/King County's Point-in-Time Count (2017)[18]; King County Aging and Disability Services' *Area Plan*[7]; LGBTQ Allyship Housing report (2017)[17]; Housing Development Consortium of Seattle-King County 2017 Annual Report (2017)[23]; City of Seattle's *Age Friendly Seattle Action Plan 2018–2021* (2018)[15]; and *At-risk and Underserved: LGBTQ Older Adults in Seattle/King County*.[13] Next, we assessed available population-based and service-related data on LGBTQ older adults (e.g., the Behavioral Risk Factor Surveillance System survey).[24] We also reviewed the compilation of comments and recommendations from the University of Washington's Aging with Pride annual forums including Town Hall: Aging the LGBTQ Way (2015); LGBTQ Aging and Health (2016); and, Aging with Pride and City of Seattle: Aging the LGBTQ Way Forum (2017).

Our goal was to ensure inclusion of traditionally under-represented groups of the LGBTQ community including people of color, those living in poverty, the oldest LGBTQ adults, women, bisexuals, queer, and transgender and gender diverse older adults. An important aspect of the project was to promote racial equity and to gather information from racially, ethnically and culturally diverse LGBTQ older adults on the housing and service needs they experienced. The project also incorporated an intersectional lens assessing the intersections of race/ethnicity, sexual orientation, and gender identity and expression. We developed and implemented multiple outreach and recruitment techniques to ensure diverse participation including offering all our information gathering tools in English and Spanish. We worked with many diverse older adults, community agencies, and community-based outreach workers to reach those hardest to reach, and those living in assisted living and long-term care facilities, shelters, as well as older adults who were homeless. While the age of 50 is not typically considered "old age," because of health disparities and chronic stress, LGBTQ adults are more likely to experience early onset of disability,[11] more multiple chronic conditions[25] and premature death.[26] Thus, in this study we included participants aged 50 and older.

The Rainbow Housing Advisory Committee began meeting in November 2017; the survey was circulated from January 2018 to June 2018 (six-month data gathering period). As a result of this rigorous outreach process, 502 surveys were completed, with 419 completed by LGBTQ older adults (50 and older, residing in Seattle/King County, and LGBTQ or sexual/gender diverse), an unprecedented number of LGBTQ older adults from traditionally under-represented groups. The success of these outreach efforts would not have been possible without the help, engagement and participation of LGBTQ older adults, community groups, and advocates that work directly within these diverse communities. Because of the targeted nature of the outreach activities, it is important to recognize that this is one of the most diverse samples to date of LGBTQ older adults. Thus, the findings reported are based on the extensive outreach strategies and are not generalizable to all LGBTQ older adults living in Seattle/King County. We also included direct quotes from the participants, many of whom took the time to write comments on the surveys and share their experiences with us.

For more information about the survey, see *Methodology* section (Appendix I).

Who Participated in the Project?

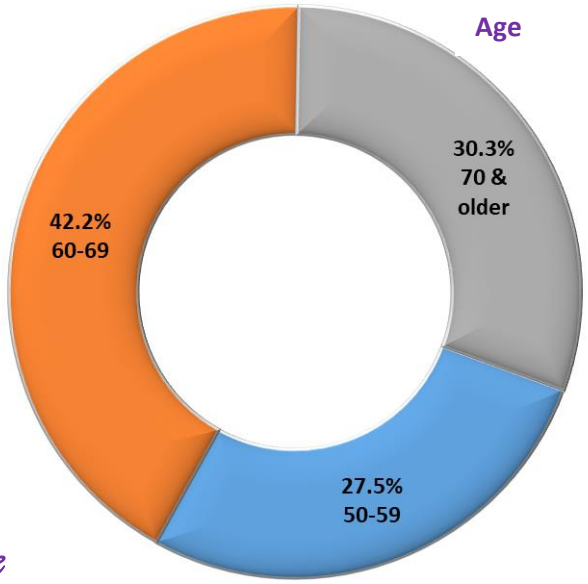
The Seattle/King County LGBTQ older adult community is tremendously diverse in many important ways including by sexual orientation, gender identity and expression, sex, age, race and ethnicity, income, education, and geographic location. This project secured the most demographically diverse sample to date of Seattle/King County's LGBTQ older adults including over 73% age 60 and older and more than 30% age 70 and older, and 32.5% adults of color. When comparing LGBTQ older adult participants to older adults in Seattle/King County's general population, several key findings emerge that deserve attention:

- Significantly more LGBTQ older adults had a disability (43.2%) compared to straight older adults in Washington State, including Seattle/King County (35.0%).[13]
- LGBTQ older adults compared to straight older adults in Washington State, including Seattle/King County, were a health disparate population, with elevated rates of multiple chronic conditions and adverse physical and mental health outcomes.[11]
- Six out of ten (62.5%) LGBTQ participants 65 and older had a bachelor's degree or higher compared to 38% of Seattle's general older population,[15] yet their incomes have not kept pace. Contrary to popular stereotypes, 35.7% of LGBTQ older adult participants' households had incomes below $20,000 and half had household assets (including real estate, cars, businesses, financial assets, retirement) less than $10,000.

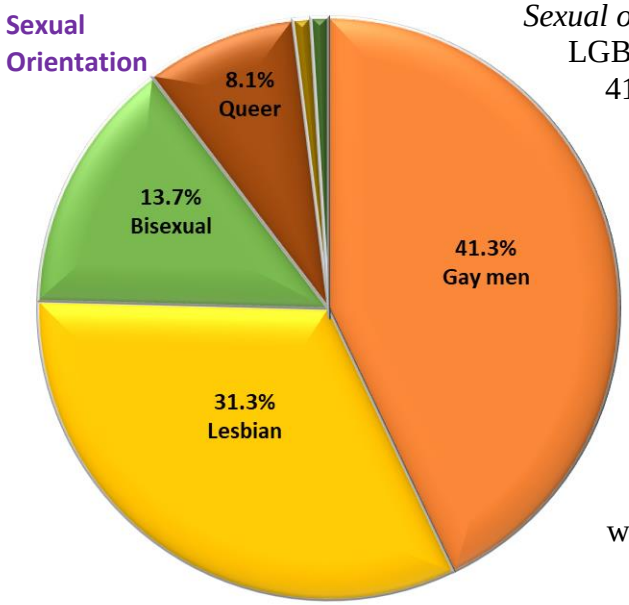
Findings

In Seattle/King County, 419 lesbian, gay, bisexual, trans (transgender and gender non-binary), and queer (LGBTQ) older adults participated in the Seattle Rainbow Housing Survey. Because a primary goal of the project was to ensure the representation of demographically hard to reach segments of the population, the background characteristics may not be reflective of all LGBTQ older adults living in Seattle/King County.

Age: Participants ranged from 50 to 87 years of age, with a median age of 65. Nearly one-third (30.3%) were 70 years of age and older and 42.2% were 60 to 69 years of age. We also included those 50 to 59 years of age (27.5%) because LGBTQ older adults compared to straight older adults often experience disability and are more likely to have more multiple chronic conditions at younger ages.[25]

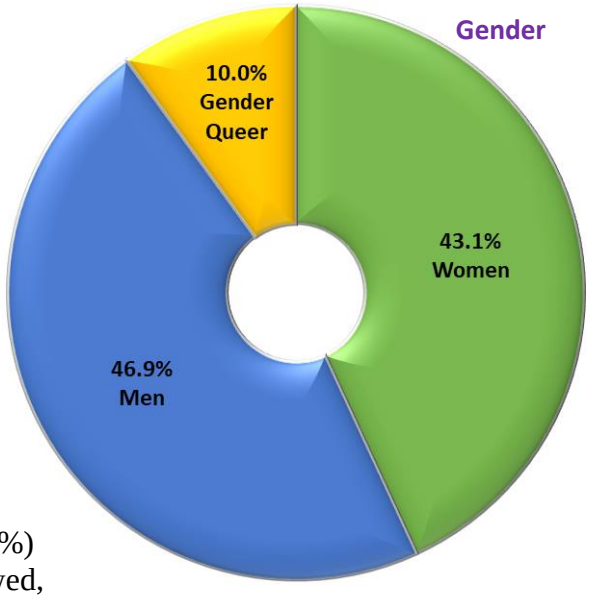


"Being trans and older, employment is very difficult for me to get, which limits my housing."



Sexual orientation: About one-third (31.3%) of the LGBTQ older adult participants identified as lesbians; 41.3% as gay men; 13.7 bisexual; 8.1% queer; 1.0% as straight; and 1% as other.

Gender identity and expression, gender: Nearly one-fifth (17.8%) of the participants identified as transgender or gender non-binary and diverse. For the purposes of this report we will use trans to connote transgender and gender non-binary and diverse. In terms of gender, 10.0% identified as gender queer or non-binary or gender diverse or expansive. The remaining participants identified about half women (43.1%) and half (46.9%) men.

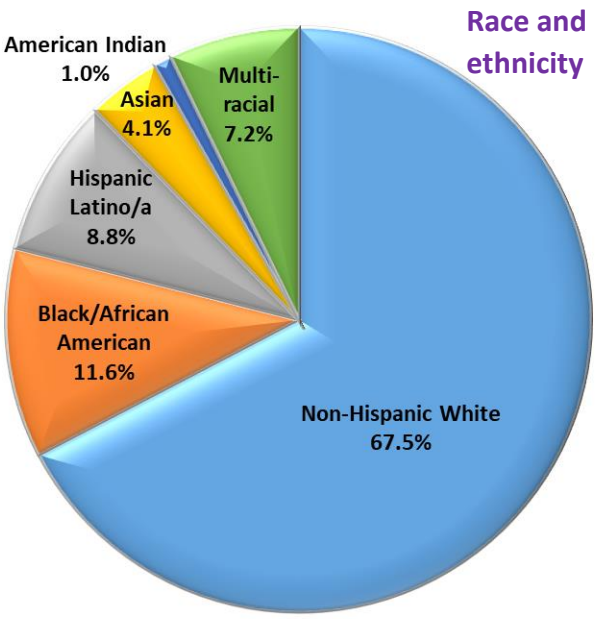


Race and ethnicity: The participants were significantly more diverse by race and ethnicity than previous projects, with 32.5% LGBTQ older adults of color and 67.5% non-Hispanic White. Of the people of color, 11.6% were Black/African American; 8.8% Hispanic/Latino(a); 4.1% Asian/Pacific Islander; and 1.0% Native American/Alaskan Native; 7.2% were multi-racial. Twelve percent (11.6%) of the participants were born outside of the United States or U.S. Territories.

Marital and partnership status: Nearly 70% (69.4%) were single including 5.9% divorced, 5.0% widowed, and 1.6% separated. Among the one-third (30.3%) married or partnered, 16.6% were legally married, 11.9% partnered but not married, and 1.9% in registered domestic partnership.

Income, poverty and financial status: When asked about their annual household income, more than one-third (35.7%) had an annual household income of $20,000 or less. When taking both household income and size into account, more than 25% had incomes at or below 200% of the federal poverty level. Half (49.5%) had household assets (including real estate, cars, businesses, financial assets, retirements, etc.) of less than $10,000.

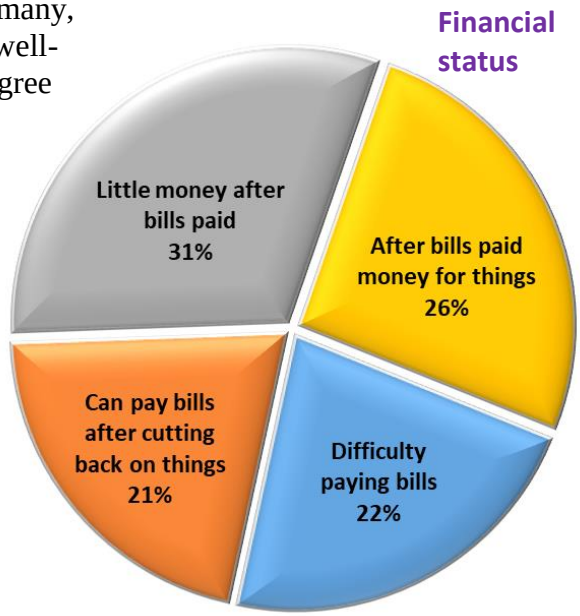
"Single, older lesbian women living alone can have challenges, both in living arrangements and in socializing. This is true of single people generally, but harder if you are trying to find a subset that's only 10% of the population."



In terms of financial status and resources and ability to meet their financial obligations, 22.3% have difficulty paying bills; 21.0% had to cut back on other expenses to make ends meet; and 31.0% could pay bills but had little spare money to buy extra things. After paying bills, one-quarter (25.8%) had money for extra things.

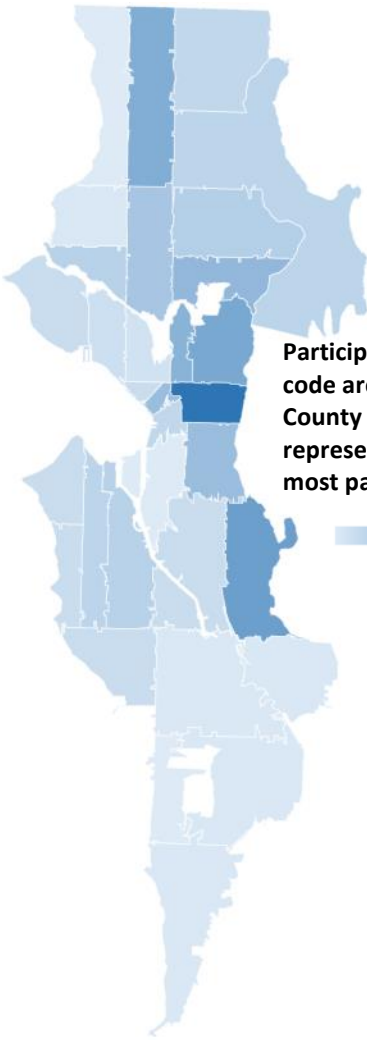
There were significant differences in financial status by race and ethnicity and gender identity and expression. For example, all of the American Indian/Alaskan Native LGBTQ older adults had difficulty paying bills or had to cut back on other experiences to make ends meet as did 95.0% of Black/African Americans, 91.2% of Hispanic/Latinos(a), and 76.9% Asian/Pacific Islanders compared to 69.1% of non-Hispanic Whites. In addition, trans and bisexual older adults had significantly fewer financial resources than cisgender or non-bisexual older adults, respectively.

Education: Despite severe economic challenges for many, the LGBTQ older adult participants were relatively well-educated. Over half (57.6%) had a 4-year college degree or more; 27.1% some college; 8.4% a high school degree or GED; and 6.9% less than a high school education.



Employment: Among the LGBTQ older adult participants 65 and older, 41.7% were working in paid employment, with 18% working full-time. Among those under 65, 36.1% were not employed. Twelve percent (12.4%) owned a business. Almost one fifth (17.9%) had served in the military including 24.3% men and 7.6% women. About one-third (31.5%) of trans participants had served in the military.

"Given that many LGBTQ have historically lower pay than "hets," as a group, we are not as financially secure. We have a hard time financially. Social security will be lower. Assets smaller. Having enough money to retire is more challenging."



Participants represented 55 zip code areas in the Seattle/King County area. Darker areas represent the areas with the most participants.

Geographic location: Participants from 55 different zip code areas participated in the project. The highest concentration of participants were from Capitol Hill (16.5%), Central District (8.0%), Rainier Valley (7.7%), and downtown (6.3%).

Disability and health: Nearly half (43.2%) reported a disability that substantially limited one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying. As a heath disparate population, 37.1% of the LGBTQ older adult participants reported poor physical health and 29.7% mental distress. Almost one in five (18.5%) had a HIV or AIDS diagnosis. Among men, 30.9% had HIV/AIDS, and among transgender women 36.4% had HIV/AIDS. Largely resulting from Medicare, nearly all (99%) had health insurance.

"Chronic health problems disproportionately affect those in the LQBTQ communities of color than others. Many of us are just one major illness away from the streets."

Summary

The LGBTQ older adult participants were diverse in terms of sexual orientation, gender identity and expression, age, race and ethnicity, employment status, education, and many more characteristics. They were demographically at-risk with limited financial resources, fewer family members, including family of choice, to assist them and many had accumulated disadvantages over the life course, such as higher rates of disability, regardless of their significantly higher rates of educational attainment. Racial and ethnic minority LGBTQ older adults, including Native American/Alaskan Natives, Black/African Americans, Hispanic/Latinos(a) and Asian/Pacific Islanders had significantly lower financial resources than non-Hispanic Whites, as did trans, gender diverse and bisexual older adults.

"Aging LGBTQ folks with limited income have a difficult time finding and keeping housing. This is especially true of those with HIV/AIDS because they've been ill a long time now with compromised immune systems, on top of aging in general. Ideally I'd like to see an LGBTQ-friendly assisted living place or a nursing home."

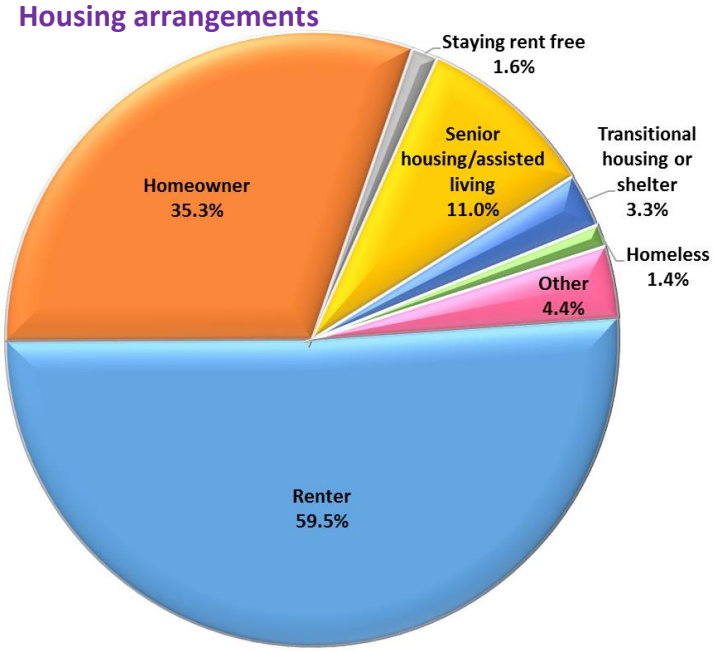
Current Housing and Housing Needs

Access to affordable and quality housing is considered an important indicator of community health.[28] When comparing LGBTQ older participants to the general population of older adults in Seattle/King County, LGBTQ older adults are at elevated risk relative to several key housing indicators:

- Approximately one-quarter (25.3%) of adults 60 and older in Seattle/King County rent their home[22] compared to 62.9% of the LGBTQ participants 60 and older.
- Over half (58.0%) of renters 60 and older in Seattle were housing cost burdened (spending 30% or more of their income on housing costs), which is considered unaffordable housing,[22] compared to 86.8% of the LGBTQ participants 60 and older.
- Nearly 90% (87.0%) of adults age 65 and older in the general population want to remain in their homes[30] compared to 61.2% of LGBTQ participants age 65 and older. LGBTQ older adult participants who want to move face significant barriers.

Findings

Household composition: Among the LGBTQ older adult participants 60.2% lived alone. Those living alone were at elevated risk of housing instability since they were less likely to have someone available to support them when needs arise. In terms of other household types, nearly one third (28.5%) lived with spouse or partner, 8.6% with friend(s) or roommate(s), 5.3% other family of choice or children, and 4.4% lived with others.



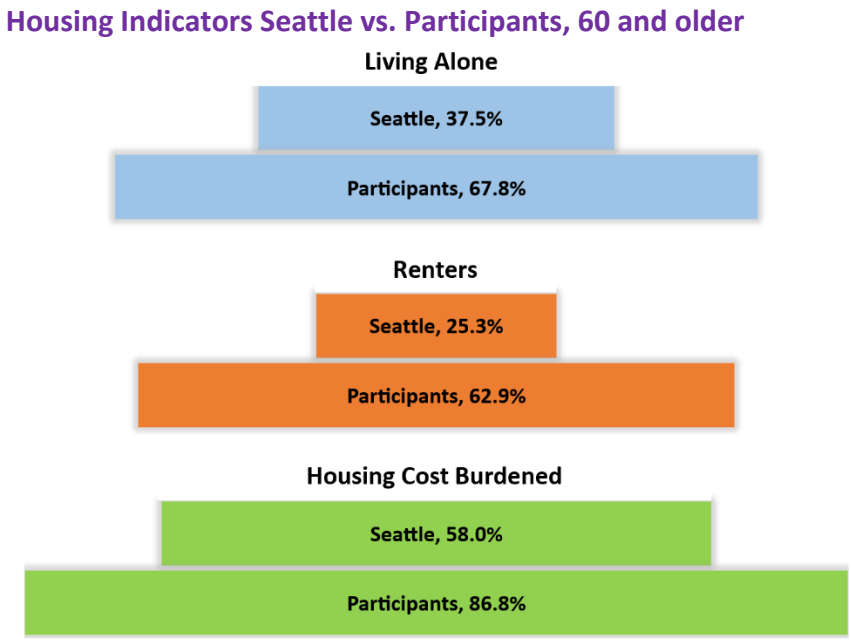
Housing arrangements: Among participants 59.5% were renters. One-third (35.3%) were homeowners and another two percent (1.6%) stayed with friends or family rent free.

Among renters, almost half (48.0%) lived in a private rental not subsidized. Forty-six percent (45.7%) lived in subsidized housing and/or received rental assistance, including 19.0% who lived in housing subsidized through the Seattle Housing Authority; 17.2% lived in another type of subsidized or affordable housing; and 9.5% lived in a private rental paid via a housing voucher or other rental assistance.

"I'd like to see section 8 vouchers be more realistic to the rents being asked in the 'New Seattle'."

One in ten (10.4%) lived in senior housing, assisted living or another age-restricted community. Less than one percent (0.5%) were living in a nursing home or other type of health care facility.

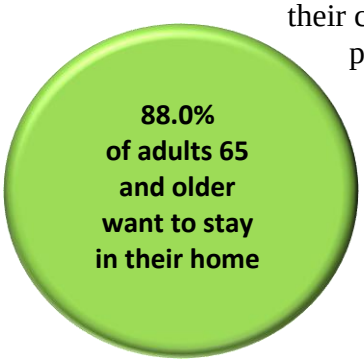
Homelessness: Homeless individuals are defined as those who are lacking "a fixed, regular, and adequate nighttime residence," including those living in shelters.[22] Seattle is one of four metropolitan areas in the U.S. with the largest homeless populations along with New York City, Los Angeles, and San Francisco—these cities are also high-cost housing markets.[29] About 5% of the LGBTQ older adult participants were homeless, including 3.3% living in shelters or transitional housing and 1.4% living on the streets. In the past five years, one in five (19.9%) had experienced at least one episode of homelessness.

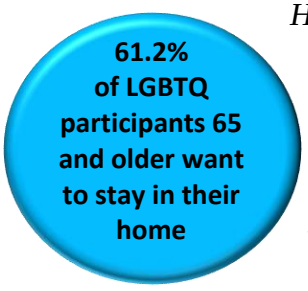


Housing cost burdened: The cost of housing consists of many items including rent or mortgage, utilities, property taxes, and other direct housing expenses. Households spending 30% or more of their income on housing costs are generally considered to be burdened by housing costs[29] and living in unaffordable housing.[22]

Among LGBTQ older adult renters age 60 and older, the housing cost-burdened share was high at 86.8%; among renters 50 and older 85.9% were housing cost-burdened. Although the share of cost-burdened LGBTQ older adults homeowners compared to renters was lower, six out of 10 (61.5%) homeowners were cost burdened and living in unaffordable housing.

Aging in Community: Although the majority of LGBTQ older adults (62.8%) want to remain in their current housing, this is significantly lower than the older adult population in general; nearly 40% (37.2%) want to move from their current housing.





Housing instability: Nearly 40% (38.4%) of the participants did not feel confident they could continue living in their current housing as long as needed. Four out of 10 (42.8%) had moved within the past four years, including 10.8% who had moved within the past year. Of those who moved

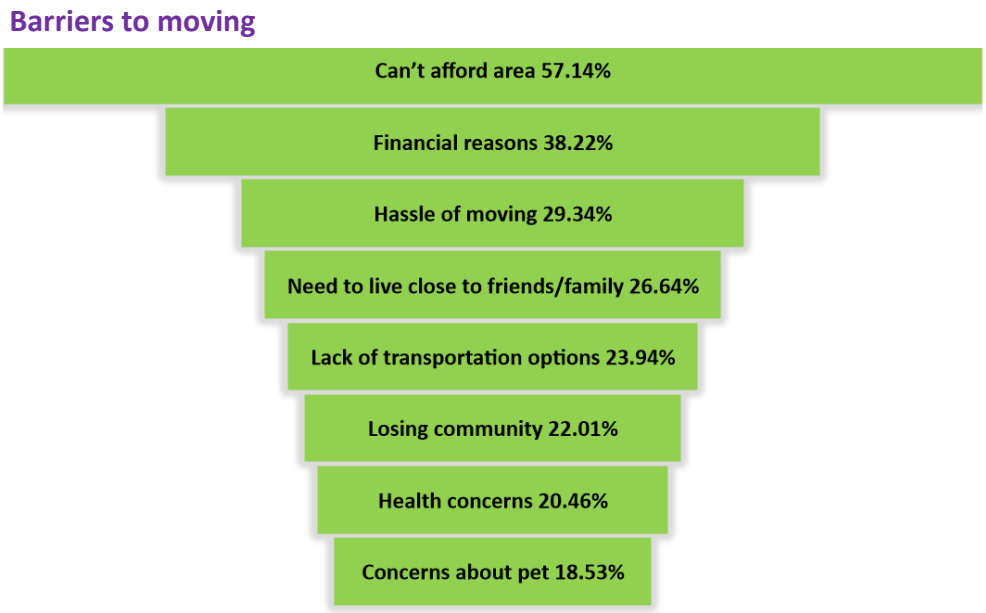
"I live in a nursing home. I don't have anyone to help. I want to move. Can't go out. I don't want to live like this."

within the past year, 48.5% experienced homelessness, 33.3% eviction, and 15.2% foreclosure within the past five years. Eviction was associated with homelessness.

Those who moved within the past year experienced
Homelessness 48.5%
Eviction 33.3%
Foreclosure 15.2%
within the past five years

Barriers to moving: Among the LGBTQ older adult participants, nearly 90% (86.9%) reported barriers to moving. The most frequently identified barriers included not being able to afford to live in a desired area (57.1%); financial reasons (e.g. unable to sell property, owe more than house is worth) (38.2%); the hassle or uncertainty about what to do with personal belongings (29.3%); the need to live close to current friends, family, and other informal supports (26.6%); lack of transportation (23.9%); fear of losing connection to the history, culture or community (22.0%); health concerns (20.5%); and difficulty relocating with pets (18.5%).

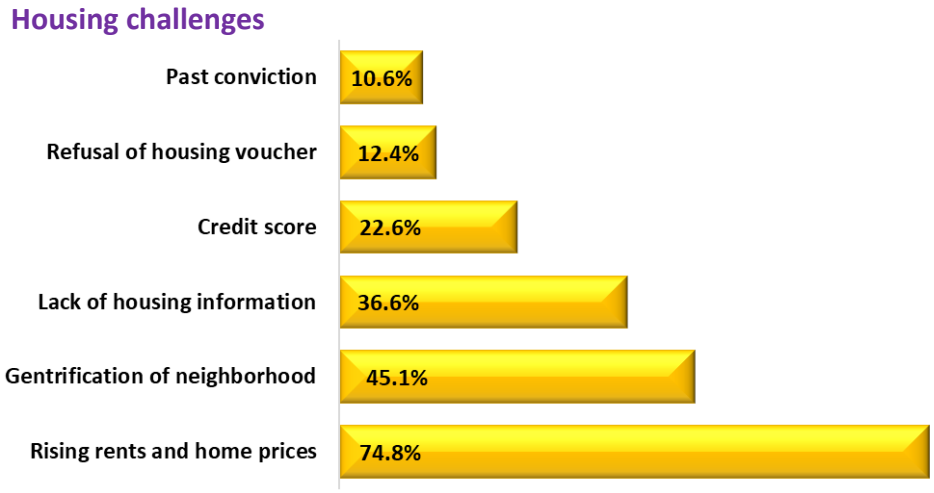
Housing challenges: Challenges LGBTQ older adult participants experienced in the past 5 years included rising rents and home prices (74.8%) and the gentrification of their neighborhood and feeling pushed out (45.1%). In addition, many reported difficulties finding housing because of the following: lack of information about available housing (36.6%); credit score (22.6%); housing voucher or other rental assistance (12.4%); or the result of a past conviction or arrest (10.6%).



Accommodations: Among participants with a disability, within the past five years 23.7% had difficulty finding housing with reasonable accommodations for a disability. More than two-thirds (67.5%) of those with a disability reported having difficulty finding affordable housing or housing in sufficiently good condition. More than three-quarters (76.4%) of the LGBTQ older adult participants overall reported that in the future they would need additional physical supports and home modifications, including grab bars, railing, ramps, good lighting, and elevators.

"The "gayborhood" is disappearing, and the newer generations aren't getting the benefit of experiences of an older generation."

Addressing housing challenges: More than 90% (93.1%) of the LGBTQ older adults indicated that expanding the availability of affordable housing was a priority for addressing the current housing issues facing their community. They also identified other important ways to respond to the current housing needs of LGBTQ older adults: expand the supply of rental housing subsidies (68.4%); increase renter protections (63.8%); provide more housing close to services and other supports in the community (59.4%); improve information and referrals for affordable housing and housing assistance programs (59.1%); develop more housing for mixed income levels (54.7%); develop more affordable housing in communities of color (53.4%); and provide assistance with mortgage payments, property taxes, or utilities (52.8%).



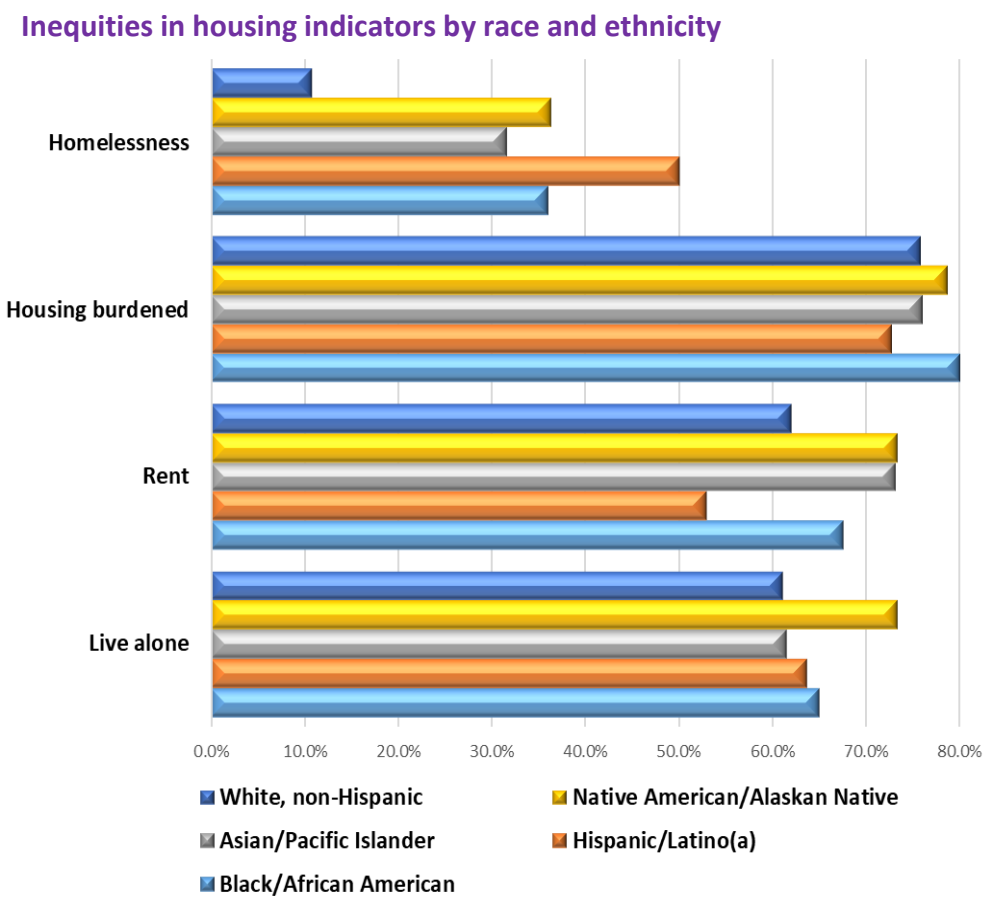
Future housing needs: Four out of ten (41.2%) of the LGBTQ older adult participants want to live in senior housing or to live in an age-restricted community; 40.0% low-income or subsidized housing; 36.28% want to live with other LGBTQ adults; 27.1% want shared housing or community-owned housing; 14.2% assisted living; and 3.1% a nursing home or other health care facility. Interestingly, only 13.4% would ideally live in intergenerational housing or housing for families with children or people all ages.

> "I had an issue with a lack of wheelchair access. It was promised that a ramp would be built and then deemed too costly."

There were several inequities in housing indicators by race and ethnicity. Those most likely to rent included Native American/Alaskan Natives (73.3%), Asian/Pacific Islanders (73.1%), and Black/African Americans (67.5%). The highest housing cost burden was reported by Black/African Americans (80.0%), Native American/Alaskan Natives (78.6%), and Asian/Pacific Islanders (76.0%). Those with the highest rates of living alone were Native American/Alaskan Natives (73.3%), followed by Black/African Americans (50.0%).

Other key demographic differences in housing needs: When comparing key housing indicators, by other demographic characteristics, several important differences also emerged. Those significantly most likely to live alone and experience high housing cost burden with diminished financial status were those 60 and older, trans, bisexual, single, veterans, those with limited education, and living with a disability.

Those at greatest risk of housing instability (e.g., not confident they can continue living in their current housing) or homelessness in the last five years included those age 70 or older, living in poverty, queer, trans and gender non-binary and diverse, renters with high housing cost burden, those with a disability, those living with HIV, and those with mental health or substance abuse histories.



"My mortgage payment is lower than rent at most apartments in Seattle, and I still have difficulty paying it. I live on the outskirts of town to afford this place, which makes getting to my Harborview appointments or taking part in most activities difficult and quite a long process."

Discrimination, Victimization and Bias in Housing

It is important to account for the experiences of discrimination, victimization, and bias in housing experienced by LGBTQ older adult participants. Discrimination, victimization, and bias are known to have harmful cumulative effects on the ability to access and retain housing in later-life. Those who experience abuse in later life are at increased risk of nursing home placement and increased mortality.[31] When assessing discrimination and bias in housing some important findings emerged:

- Nearly one-third (31.3%) of the LGBTQ participants reported experiencing discrimination based on sexual orientation in the sale or rental of a house, apartment, or condominium.
- Discrimination based on perceived gender identity and expression was nearly double across most types of discrimination, with 53.9% of trans older adult participants having experienced discrimination in the sale or rental of house, apartment, or condominium.
- Nearly half (48.15%) of trans older adult participants reported being physically hurt, pushed, punched, assaulted or physically threatened by someone in their housing.
- Of the LGBTQ older adult participants who experienced discrimination, only 14.9% reported it, due to lack of understanding of how to report or lack of trust of the reporting systems.

Findings

Housing discrimination by sexual orientation and gender identity and expression

In Seattle/King County it is illegal to discriminate in the rental or sale of housing based on sexual orientation, gender identity, sex, marital status, age, race, creed, disability, and alternative sources of income. When participants were asked about experiences of housing-related discrimination because of their perceived sexual orientation, nearly one-third (31.3%) reported experiencing discrimination in the sale or rental of a house, apartment, condominium, or lot. Among trans participants more than half reported discrimination in the sale or rental of a house, apartment, condominium, or lot (53.9%).

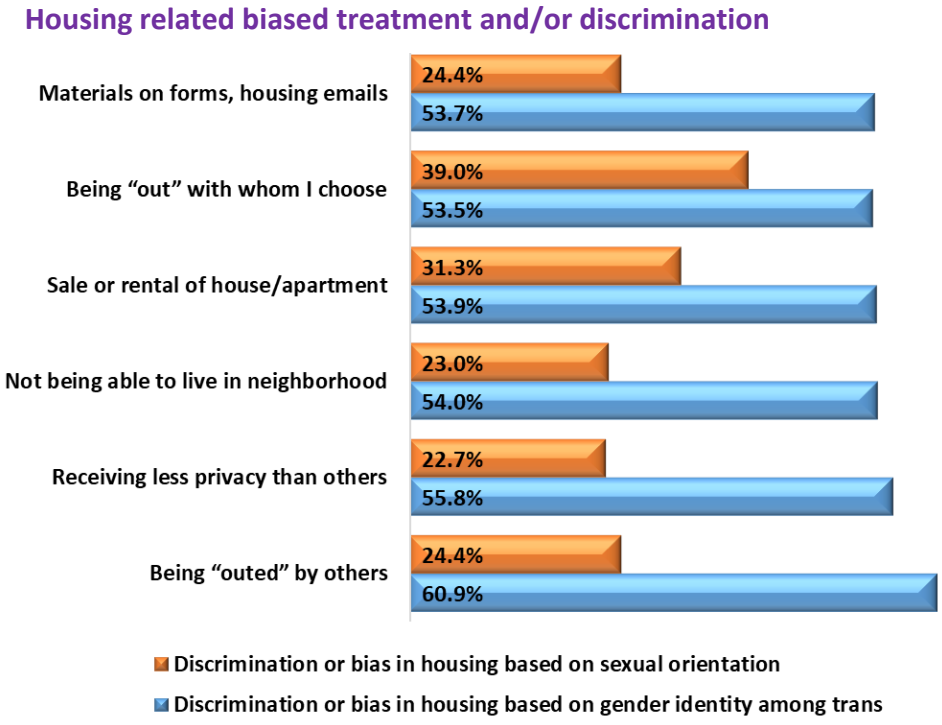
Biased treatment

Bias refers to attitudes and beliefs, either explicit or implicit, resulting in unequal treatment,[33] which in housing and services would likely result in the loss of one's sense of security and safety. Nearly one-quarter (23.0%) of the participants perceived biased treatment based on sexual orientation in not being able to live in the neighborhood in which they wanted; 16.9% experienced biased treatment in advertising and/or the evaluation of housing applications; and 14.2% in unequal rents, deposits, or fees. Among trans participants the most common types

"I think being a "woman of a certain age" is already a bias against me (so I'm very unopen about my orientations- sexual or otherwise.)"

of housing-related biased treatment experienced included not being able to live in the neighborhood in which they wanted (54.0%) followed by bias in the enforcement of housing rules or policies (48.8%); advertising or evaluation of housing applications (45.7%); and unequal rents, deposits, or fees (36.1%).

Previous research has found that acts of housing discrimination occur most often during rental transactions.[32] Types of biased treatment experienced by LGBTQ renters based on their sexual orientation included: enforcement of housing rules or policies (28.3%); materials on forms, housing bulletin boards, walls, and emails (24.7%); and lack of response to repair requests and other housing concerns (19.8%).



Among trans older adult renters, the most frequent types of biased treatment experienced included: material on forms, housing bulletin boards, walls, and/or emails (53.7%); enforcement of housing rules or policies (48.8%); and not having repair requests or other housing concerns addressed (41.2%).

There were also racial inequities in the rates of discrimination in housing because of perceived sexual orientation. For example, discrimination in the sale or rental of a house, apartment, condominium, or lot was experienced most frequently by Hispanic/Latinos(a) (61.5%), followed by Black/African Americans (52.9%), Native American/Alaskan Natives (41.7%), and Asian/Pacific Islanders (37.5%) compared to non-Hispanic Whites (24.4%).

Discrimination by gender identity and expression was also significantly higher for trans older adults of color. For example, among trans older adults, eighty percent of the Hispanic/Latinos(a) and Asian/Pacific Islanders, 60% of Black/African Americans and 57.1% of Native American/Alaskan Natives had experienced discrimination in the sale or rental of house, apartment, condominium, or lot compared to 35.0% of non-Hispanic Whites.

Four out of ten (40.0%) LGBTQ older adult renters with a disability experienced biased treatment in securing reasonable accommodations for a disability.

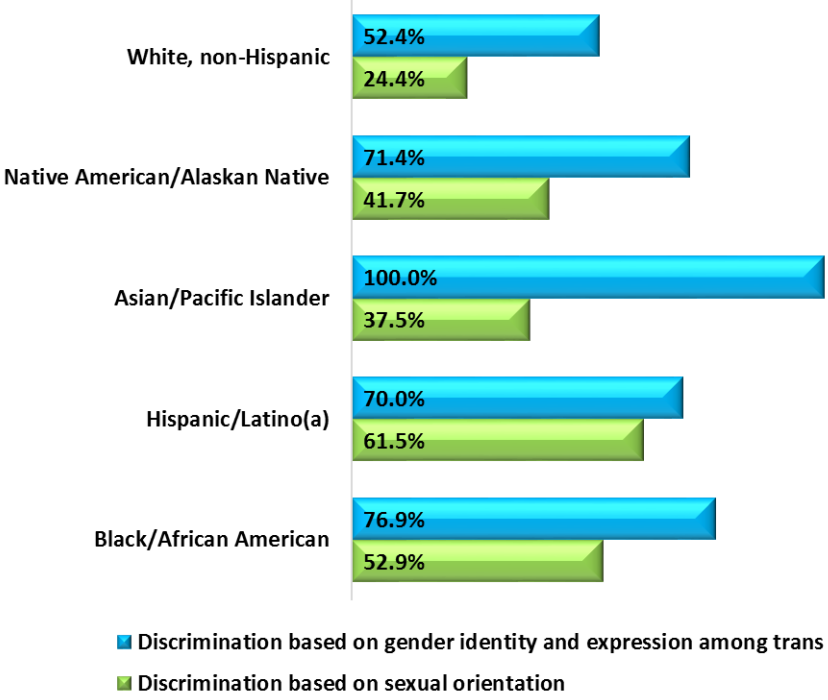
"Very few care about seniors, let alone LGBTQ seniors. Ageism is very, very real. And devastating."

The LGBTQ older adult participants also reported high rates of discrimination in the workplace as well as hate crimes due to their perceived sexual orientation or gender identity or expression, both of which have the potential for

long-term impact on their economic resources available for housing. For example, 41.2% of the LGBTQ older adults reported experiencing discrimination in employment hiring and 32.6% had been fired from a job due to their perceived sexual orientation. Four out of 10 (41.7%) experienced a hate crime and 17.9% have experienced a violent crime three or more times.

Trans older adult participants reported nearly double the rates of discrimination in the workplace due to their gender identity or expression, including discrimination in employment hiring (80.8%) and having been fired from a job (73.5%). Two-thirds (66.0%) experienced a hate crime and 37.7% a violent crime three or more times.

Discrimination sale or rental of house, apartment, condominium, or lot by race and ethnicity



Other biases in housing: Many LGBTQ older adult participants experienced additional types of biases in their housing based on their perceived sexual orientation and gender identity and expression. By sexual orientation, the other common types of biases encountered was not able to be "out" and live openly or with whom they chose (39.0%); having felt isolated or made to feel invisible in their housing (26.60%); bullied in their housing (25.3%); "outed" by others in their housing (24.4%); and received less privacy than others in their housing (22.7%).

Trans participants also experienced additional biases in their housing at almost double the rate based on their perceived gender identity or expression, including not having access to appropriate bathrooms (57.8%); isolated or made to feel invisible (57.4%); received less privacy than others in their housing (55.8%); being "outed" by others in their housing (53.5%); and bullied in their housing (46.3%).

"A secure safe environment is needed where LGBTQ tenants do not even need to think about being harassed, outed, assaulted."

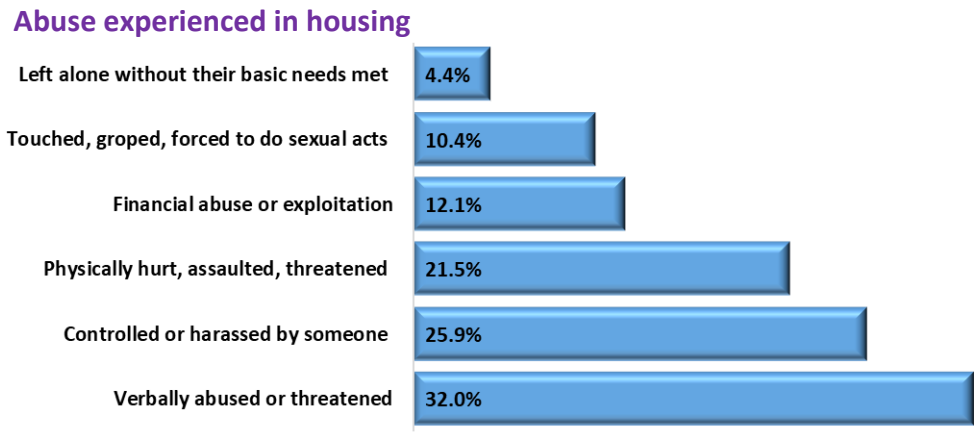
Biased treatment in shelters, transitional housing and long-term care facilities: Type of housing was associated with the rate of biased treatment experienced in housing. Compared to home owners and renters, those in shelters, transitional housing and long-term care facilities reported high rates of biased treatment. For example, based on their perceived sexual orientation, biased treatment included not able to be "out" and live openly or with whom they choose (50.0%); "outed" by others in their housing (48.8%); and in the enforcement of housing rules or policies (36.6%).

Trans participants living in shelters, transitional housing and long-term care facilities reported extremely high rates of biased treatment based on their perceived gender identity or expression, including receiving less privacy than others in housing (76.9%); enforcement of housing rules or policies (75.0%); in materials on forms, housing bulletin boards, walls, emails (75.0%); and in getting reasonable accommodations for a disability (72.7%).

Intersecting types of discrimination: Participants reported intersecting types of discrimination or harassment they experienced in housing. One-quarter (25.0%) experienced discrimination in housing based on their sex or gender; 21.7% age; 18.5% race or skin color; 12.0% poverty or alternate source of income, 11.7% disability or ability status, and 7.8% marital status.

"Shelters are not safe for us. I've lived on the streets off and on but now I'm getting older and I don't know what to do. I fear for my life like I never have before."

Abuse in housing: Many types of abuse can also occur in housing including physical, verbal, sexual, and/or economic abuse. Nearly half (48.5%) of the LGBTQ older adult participants reported experiencing abuse in their housing, including having been verbally abused or threatened by someone (32.0%); controlled or harassed by someone (25.9%); physically hurt, pushed, punched, assaulted, or physically threatened (21.5%); or touched, grabbed, or groped without their consent or forced to do sexual acts (10.4%). In addition, 12.1% experienced financial abuse or exploitation in housing (such as forced or tricked to give someone money or property), and 4.4% experienced neglect, having been left alone without their basic needs met (such as food, water, or medications). Among trans older adults nearly half (48.15%) reported being physically hurt, pushed, punched, assaulted or physically threatened by someone in their housing. Safety was a common concern for many LGBTQ older adults as noted in many comments.



"I am constantly concerned about my physical safety particularly at night because of being gay."

Reporting housing discrimination: Despite the alarming rate at which the LGBTQ older adult participants experienced discrimination in housing, only 14.9% reported it. Reasons for not reporting housing discrimination included not knowing where to go for help (38.0%); not

knowing about legal protections against housing discrimination (35.5%); and, not knowing where to get information on housing discrimination (28.1%). About 40% of the participants shared other reasons for not reporting housing discrimination, which most often stated a lack of trust in the reporting systems, such efforts would be futile, and nothing would change or be corrected, even if it was reported.

"I'm poor and living in a nursing home. I can't be who I am as a bisexual person. I have to hide. People stare at me. I would like to die. I would now."

For example, none of the Hispanic/Latino(a) older adult participants reported housing discrimination. Furthermore, 87.1% of Black/African Americans, 81.8% Asian/Pacific Islanders, and 80.0% of Native American/Alaskan Natives did not report housing-related discrimination.

Other key demographic differences in discrimination and biased treatment: When examining types and frequency of discrimination, renters were significantly more likely than homeowners to experience discrimination in the sale or rental of a house, apartment, or condominium. In addition, LGBTQ older adult renters compared to homeowners, experienced many other types of discrimination at nearly twice the rate, including discrimination by sex and gender, age, and race or skin color. Those experiencing housing cost burden, compared to those who did not, experienced higher rates on almost all indicators of discrimination. Renters compared to homeowners were also significantly more likely to have experienced biased treatment, e.g., being "outed" by others in their housing.

Queer and/or trans identified older adults experienced the highest rates of discrimination across nearly all types when compared to those who identified as lesbian, gay or bisexual and/or cisgender. Those partnered or married, compared to those single, and those living with others compared to those living alone, also experienced elevated rates of housing discrimination. Other demographic factors associated with elevated risk for discrimination included those oldest compared to those younger and those living in poverty. Those with a disability were almost twice as likely to experience discrimination in housing based on sexual orientation or gender identity or expression. Those with lowest level of educational attainment (high school or less) were significantly less likely to report housing-related discrimination compared to those with more than a high school education.

"While I don't identify as trans, I'm definitely gender queer and my presentation has always been "androgynous". This has caused so much discrimination and harassment that I can't even quantify it."

Community Resources, Support and Engagement

The LGBTQ community is engaged with many opportunities for social connection, yet it is often characterized as youth oriented. Social and community resources, including emotional and social support, instrumental assistance, and tangible resources, have been found to be important protective factors in enhancing housing stability and providing a safety net during times of need. The findings highlight several key factors related to social and community resources, supports and engagement associated with LGBTQ older adults' housing experiences, needs and vulnerabilities.

- As friends and chosen family members age, many experienced their own limitations, which reduced their ability to assist others. LGBTQ older adults are less likely to have children, relatives or other people to help them compared to the general older adult population in Seattle/King County. Thus, LGBTQ older adults are less likely to have a safety net when problems arise as they age.[13]
- The oldest LGBTQ older adults, the long-term survivors, are at greatest vulnerability of social isolation since they have generally outlived their peers and those available to help them. They are especially vulnerable to housing instability and are at heightened risk of premature institutionalization or death.
- LGBTQ older adults participate in their communities and have much to offer, yet few have access to meaningful employment or volunteer opportunities. Most of them have been directly involved in addressing the housing challenges facing Seattle/King County. LGBTQ older adults who feel a strong connection to their community are often hesitant to leave, underscoring a need for support to age in community.

Findings

Support available: Most LGBTQ older adults reported many strengths as they built strong communities and networks of support. Three-quarters (76.1%) of the LGBTQ older adult participants had someone they could turn to for instrumental or short-term support. Yet most were supported by peers of similar age, many of whom face their own aging and health challenges as they age, which limits their ability to provide intensive or on-going support. Significantly fewer Black/African American and Hispanic/Latino(a) LGBTQ older adults compared to non-Hispanic Whites had someone they could turn to for support.

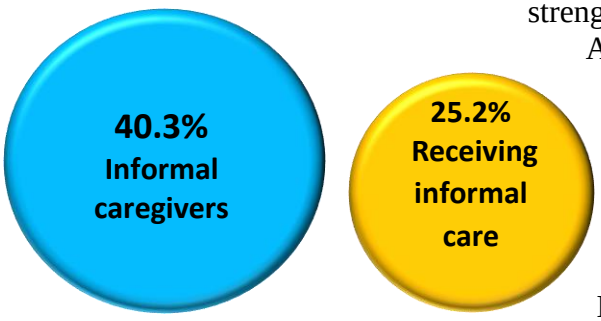
"Being older and LGBTQ can be a very isolating experience especially for those of us who are estranged from relatives and childless ourselves."

The LGBTQ older adult participants were less likely to be married or partnered or to have children or others to support them compared to most older adults in Seattle/King County. Only about one-quarter of LGBTQ older adults in Seattle/King County had children[13] and few had cross-generational ties, which may result in less support in old age. These factors can also place limits on housing options for LGBTQ older adults as they age.

Social isolation: Many LGBTQ older adults reported social isolation, which increases risk of adverse aging and health outcomes, including poor health, memory loss, and premature institutionalization or mortality.[34] More than 6 out of 10 participants (64.3%) reported they felt socially or emotionally unsupported in the past week. Half (50.9%) felt there was no or little support from others in their neighborhood. Many of the LGBTQ older adults expressed feeling discounted, ostracized and marginalized by the ageism in the LGBTQ community.

Faith, spiritual or religious support: Older adults often turn to places of faith or worship for support, community, and help in older age, which has been identified as a protective resource in aging.[35-37] However, many LGBTQ older adults have had adverse experiences and have become estranged from religious or spiritual institutions. More than half of the participants (56.4%) reported they did not have access to a supportive spiritual community or place of worship in their neighborhood. More than one-third (39.7%) attended spiritual or religious services or activities in the past month. Black/African American and Hispanic/Latino(a) LGBTQ older adults had higher levels of participation in spiritual and religious activities than non-Hispanic Whites.

Caregiving: In response to the larger cultural and historical context as well as the HIV/AIDS pandemic, LGBTQ communities have demonstrated strength in their ability to provide care for one another. Among the LGBTQ older adult participants, 2 out of 5 (40.3%) were caregivers, assisting a spouse, partner, friend, or other family member because of health-related need. There were racial and ethnic inequities in the provision of informal caregiving. For example, Black/African American (46.3%), Asian/Pacific Islander (44.0%) and Hispanic/Latino(a) (43.8%) LGBTQ older adults were significantly more likely to be providing informal, unpaid caregiving compared to non-Hispanic Whites (37.6%).



While more than 40% of LGBTQ older adults were providing informal care, only one-quarter (25.2%) were currently receiving care or help from a spouse, partner, friend, or family member because of a health limitation despite high levels of disability and impairment. There weren't significant racial or ethnic differences in receiving care despite higher levels of disability and impairment among LGBTQ older adults of color.

Disclosure: The extent to which LGBTQ older adults were willing and able to access support from others was found to be associated with the degree they disclosed or were "out" about their sexual orientation and/or gender identity or expression. Four out of ten participants (40.4%) openly disclosed and were out about their sexual orientation to others. One-third (33.8%) were out only under certain conditions, and more than one-quarter (25.8%) were never out.

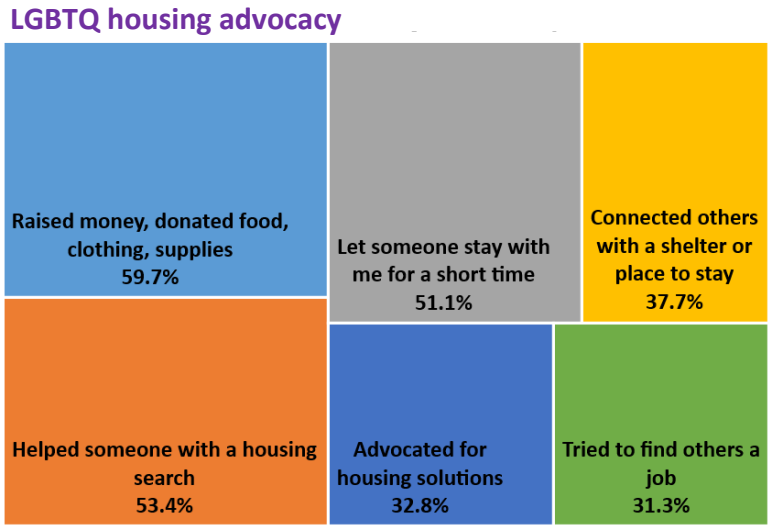
"LGBTQ older people are more isolated than many others. They are not often out. Many still feel a need to guard being out,"

As might be expected, we found significant differences in disclosure rates of sexual orientation by age. For example, of the youngest group, 50-59 years of age, about half (47.1%) were out; 40.2% were out only under certain conditions; and 12.7% were never out. Among those 70 and older, less than one-third (29.8%) were out, 32.9% out only under certain conditions, and 37.3% were never out. By race and ethnicity, Black/African American, Hispanic/Latino(a), and Asian/Pacific Islander LGBTQ older adults were less likely to openly disclose their identities compared to non-Hispanic Whites.

Less than one-third (30.9%) of trans older adult participants were out about their gender identity or expression to others;12.7% were only out under some conditions, and more than half (56.4%) were never out. Among those age 70 and older, only 6.7% of the trans participants were out, and 93.4% were never out.

"We need more community-based organizations, services that can fill in for the lack of immediate family in terms of care-giving help."

Giving back: LGBTQ older adult housing-related advocacy: Over half of LGBTQ older adults raised money or donated food, clothing or supplies (59.7%); helped someone with a housing search (53.4%); or let someone stay with them for 1 day to 3 weeks (51.1%). Approximately a third of participants connected someone with a place to stay (37.7%); advocated for housing solutions (32.8%); or tried to find others a job (31.3%).



Limited volunteer opportunities: Nearly half (47.7%) of the LGBTQ older adult participants did not have access to volunteer opportunities in their neighborhood.

Other key demographic differences in support and caregiving: Several demographic groups reported significantly lower levels of social support than other groups, including those who were single, lived alone, living in poverty, and experienced housing burden. Those who identified as queer, gender non-binary, bisexual, and had a disability reported significantly less social support than did other demographic groups.

Women reported significantly higher levels of support than men across some key indicators, such as social support and engagement in religious and spiritual activities. In terms of caregiving, the oldest age group was significantly more likely than the younger age groups to both provide caregiving and receive care. Women and those gender non-binary were significantly more likely to provide caregiving support, although men also provided relatively high levels of care. The demographic profile for those receiving care was more similar, although those with a disability and those living in poverty were significantly more likely to receive care.

Gaps in Services to Support Aging and Housing

LGBTQ older adults, compared to older adults in general, are less likely to access health, aging or human services, which has been found to be strongly associated with past experiences of discrimination and victimization in service settings.[38] A recent study found up to 60% of Seattle's LGBTQ older adults, especially among those hardest to reach and most vulnerable, would forego utilizing much needed aging-related services if it required them to access services in the general community.[42]

LGBTQ older adult participants in this project were surveyed about the housing and aging-related services and programs they *needed* but did not use in the past 12 months. Participants were also asked about *barriers* to services and programs that impacted their housing, and their recommendation for the future. Several key highlights emerged:

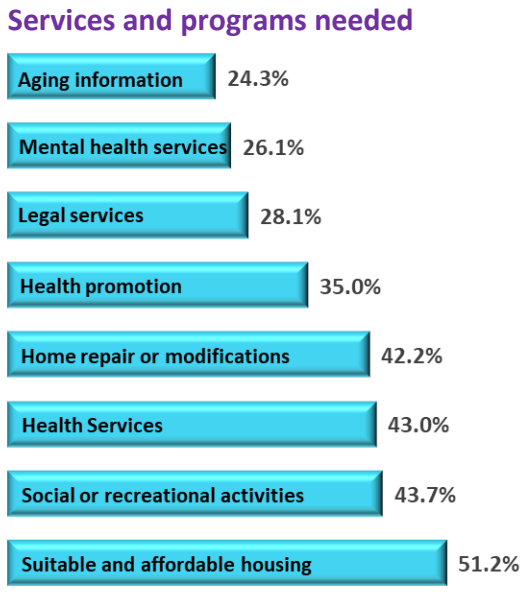
- Many LGBTQ older adults reported needing, but not accessing, a variety of housing and aging-related services and supports that could potentially help them remain in their own homes and communities, because they perceived them as not LGBTQ affirming.
- Some aging and housing support services were perceived to be too costly, even among LGBTQ older adult participants who would likely meet income eligibility requirements.
- Among those at risk of housing instability, nearly two-thirds (62.4%) did not have access to a welcoming senior center in their neighborhood.
- Top recommendations for safe and affirming housing for LGBTQ older adults included developing LGBTQ-specific friendly housing, ensuring housing programs/materials are LGBTQ inclusive, providing LGBTQ training for housing providers, developing an LGBTQ guide to housing, and providing training on intersecting identities (sex, gender, sexual orientation, race, ethnicity, culture, income) for housing providers.

Findings

Services and programs needed: Many aging-related services are designed to assist older adults so they can remain living independently in their own homes and communities. More than half (51.2%) indicated that in the past 12 months they needed access to suitable and affordable housing. Other housing and home-related support services identified as needed included home repair, maintenance, and/or modifications (42.2%); home delivered meals or free groceries (17.9%); and door-to-door transportation (17.7%). In-home health services and personal care or housekeeping (20.5%) or skilled nursing care (6.7%) were also identified as needed.

> "I was soliciting bids from plumbers/electricians/handymen/ roofers for various repairs/upgrades to home. When some of the prospective bidders realized that I'm a lesbian they suddenly became disinterested in bidding on the job with no explanation or became rude and did a vanishing act."

Several other aging related services were also needed to support their ability to remain in their housing including chronic disease education and management (42.9%); health promotion, wellness and exercise classes (35.0%); legal services (28.1%); mental health services (26.1%); support groups (26.1%); information, referral, and outreach (24.3%); case management and social worker support (16.6%); and caregiver support and respite (9.2%). Among those at-risk of housing instability, nearly two-thirds (62.4%) did not have access to a welcoming senior center. Black/African American, Hispanic/Latino(a), and Asian/Pacific Islander LGBTQ older adults were significantly less likely than other racial and ethnic groups to have access to an LGBTQ affirming senior center in their neighborhood. Several other types of services were ranked as likely needed in the future including: assistance with activities of daily living such as bathing, dressing, or eating (93.8%).



Barriers to services: Not LGBTQ affirming: The LGBTQ older adult participants were also asked what specific barriers they encountered in accessing needed services in the past 12 months. The most common reason they did not access needed services was because the services were perceived to be non-LGBTQ affirming, such as aging information and referral (50.0%); social and recreational activities (46.0%); suitable and affordable housing (29.3%); social work and case management services (27.1%); and health promotion, wellness, or exercise classes (25.3%). Among the nearly 30% of LGBTQ older adults that were well-resourced, many did not feel specialized services or housing were necessary.

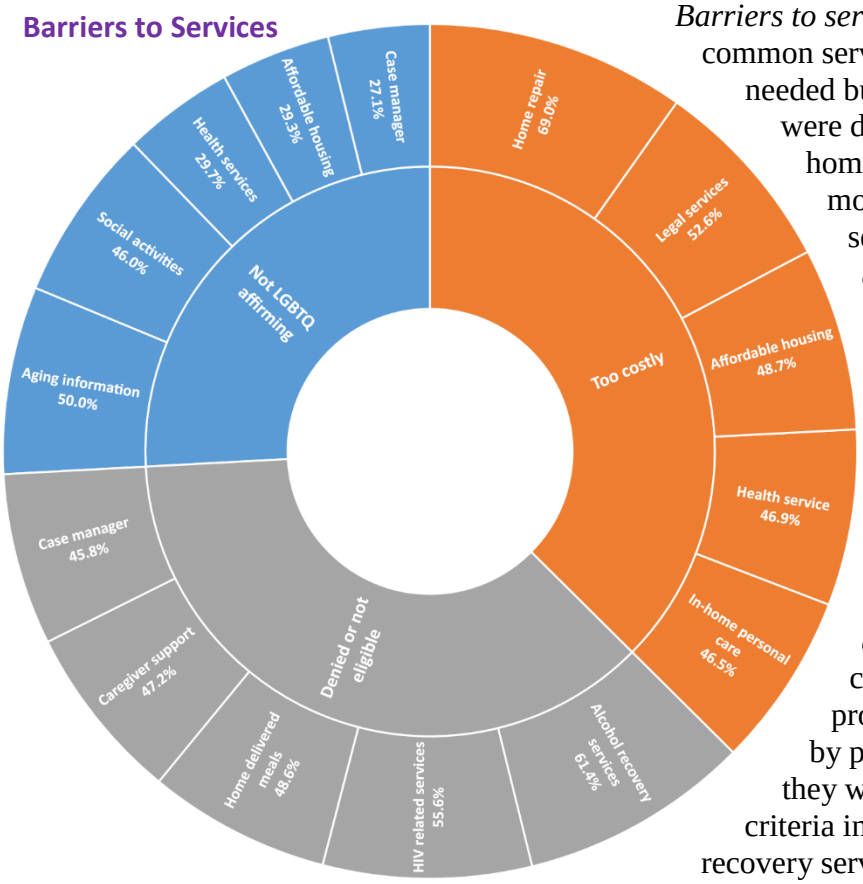
"Housing that is affordable and encourages people to be active and engaged and that helps people stay healthy, especially the aging population dealing with the health effects of HIV."

Racial and ethnic minority LGBTQ older adults across all groups (Hispanic/Latino(a), Black/African American, Asian/Pacific Islander, and American Indian/Alaskan Native) were significantly more likely than non-Hispanic Whites to report affordable and suitable housing as non-LGBTQ affirming. In addition, Black/African American, Hispanic/Latino(a) and American Indian/Alaska Native LGBTQ older adults were significantly more likely to identify lack of LGBTQ and trans affirming services as barriers.

Others who experienced services as not being LGBTQ affirming included 63.6% of those living with HIV/AIDS; and 78.9% of the trans participants when accessing trans affirming health

"Affordable housing is disappearing from Seattle at an alarming rate - create more units suitable for LGBTQ older adults."

services (e.g., health insurance coverage, legal documents, as well as specific gender-affirming interventions and needed adaptations to routine medical screenings and procedures).



Barriers to services: Too costly: The most common services LGBTQ participants needed but did not use because they were deemed too costly included home repair, maintenance, or modifications (69.0%); legal services (52.6%); suitable and affordable housing (48.7%); and in-home personal care or housekeeping (46.5%). Many of the participants who deemed these services to be too costly were living at or below the poverty level.

Barriers to services: Denied or not eligible: The most common services and programs needed but not used by participants because they felt they would not meet the eligibility criteria included alcohol or substance recovery services (61.4%); HIV related services (55.6%); home delivered meals or free groceries (48.6%); caregiver support or respite (47.2%); and social work and case management services (45.8%).

Recommendations for safe and welcoming housing for LGBTQ older adults: Participants ranked recommendations they thought would help make housing safe and affirming for LGBTQ older adults. They ranked the recommendations in the following order: Develop LGBTQ-specific friendly housing (82.8%); ensure housing programs, forms, and materials are LGBTQ inclusive (71.7%); provide LGBTQ training for housing providers (68.5%); develop an LGBTQ guide to housing (66.2%); and provide training on intersecting identities (sex, gender, sexual orientation, race, ethnicity, culture, income) for housing providers (55.5%). Among trans participants, 67.9% indicated a need for trans affirming training for housing providers.

"To help older LGBTQ adults there needs to be specially trained people who are sensitive to their life experiences and can assure them that there are safe places for them."

Other key demographic differences in accessing services and barriers encountered: There were several other significant demographic differences in terms of lack of access to specific services. The demographic groups most likely to identify the need for affordable and suitable housing included those living alone, single, renters, with high housing cost burden, living at or below the federal poverty level, and those living with a disability compared to the other demographic groups. Those who were significantly most likely to report the lack of LGBTQ and trans affirming services as a barrier included those living alone, renters, with high housing cost burden, living at or below the federal poverty level, and those living with a disability compared to the other demographic groups.

LGBTQ older adult demographic groups least likely to have access to an inclusive and affirming senior center in their neighborhood included those living alone, single, those at or below the federal poverty level, renters with high housing cost burden and living with a disability compared to other groups. In addition, those who were oldest, identified as bisexual, queer and trans non-binary, men, having a high school or less education, and having served in the military were the demographic groups significantly more likely than others to report not having access to an LGBTQ affirming senior center in their neighborhood.

"I'm a trans woman that is old. I need help.
I might lose my housing and my health is declining.
I don't feel safe in my neighborhood.
What am I to do. I don't have anyone to help me.
I'm alone, sick, and tired. Racism and poverty affect my every day.
How can we get more support for our community?
Who is there to help us when we need it most."

Action Plan and Recommendations

Within the context of growth in the overall population size, issues of housing affordability and accessibility are intensifying in Seattle/King County. Based on the information gathered, several key housing and senior service challenges emerged:

- Inadequate services prevent LGBTQ seniors from remaining in their homes and aging in community.
- Lack of affordable, stable, safe, and accessible housing for LGBTQ seniors.
- Limited cultural capacity of providers to ensure LGBTQ affirming housing environments.
- High rates of discrimination and bias in housing, with most not obtaining legal recourse.
- LGBTQ racial inequities in access to affordable housing and senior services.
- Insufficient community engagement and advocacy for LGBTQ aging and senior housing.
- Lack of information necessary to proactively guide and monitor decision making to better support LGBTQ communities and eliminate inequities in the allocation of City resources.

Seattle/King County is falling behind other major metropolitan areas in meeting LGBTQ housing and senior service needs. In 2013, the City of San Francisco commissioned a report to assess the needs of LGBTQ older adults. Based on the findings and advocacy efforts, San Francisco's Department of Aging and Adult Services now invests more than 6 million dollars to address the needs of LGBTQ seniors, with an LGBTQ Senior Center and two LGBTQ senior housing buildings – Seattle/King County has neither. This report is an important first step for Seattle/King County to have the information necessary to address the needs of LGBTQ older adults and their communities.

Key findings

LGBTQ older adult participants were resilient yet at-risk. More than six out of ten wanted to stay in their current homes, yet many were vulnerable to losing their housing resulting from a convergence of risk factors within the context of rising rents and housing costs.

Compared to older adults in Seattle/King County, LGBTQ older adults had significantly higher rates of renting, elevated rent cost burden, and were more likely to live alone in old age with no supports available.

Reporting higher than average housing cost burden and living in unaffordable housing and most were living on fixed incomes. Twenty percent experienced homelessness in the past five years.

Three-quarters of the LGBTQ older adults barely had enough financial resources to make ends meet. One-quarter were well- resourced; many of them did not feel specialized housing or services were necessary.

Nearly 40% of the LGBTQ older adult participants wanted to move, which is significantly higher than older adults in general – yet most faced significant barriers to moving.

Elevated disparities in disability and health have been documented among LGBTQ older adults. Yet many Seattle/King County homes and neighborhoods are ill-equipped to accommodate mobility limitations, which drives heightened demand for accessibility and home modifications and supports.

LGBTQ older adults experienced high rates of discrimination, with trans older adults reporting nearly double the rates. More than four out of five LGBTQ older adults did not report, thus did not receive, any legal recourse.

Most LGBTQ older adults were not accessing needed senior or housing services because the services were felt to be non-LGBTQ affirming, too costly, and/or not accessible.

LGBTQ older adults are active in housing and service advocacy. Over half raised money or donated food, clothing or supplies, or helped someone with a housing search and place to stay.

Racial and ethnic minority LGBTQ older adults reported higher levels of housing cost burden, lack of support, and lack of access to many housing and aging services than non-Hispanic Whites.

The consequences of losing housing late in life were severe for LGBTQ older adults, as they often could not secure new housing. Even after a short hospital or rehabilitation stay, many did not have a social or financial safety net necessary to retain their housing, which if lost often led to premature institutionalization for the remainder of their lives. Eviction often led to homelessness, which can result in premature mortality. Not addressing aging and housing needs directly within LGBTQ communities can result in much greater public cost.

Action Plan and Recommendations

1. **Promote aging in community via funding an LGBTQ Senior Center with LGBTQ affirming services and programs to support these resilient at-risk older adults.**

   Recommendations:
   - Fund an LGBTQ-affirming Senior Center with one-point entry (e.g., for senior services, referral, enrollment assistance, case management), built within the LGBTQ community so it is trusted and can reach those in greatest need and provide support and technical assistance to other providers.
   - Expand awareness of, and access to, home repair and housing modification programs to maintain and support accessible and safe housing.
   - Test the effectiveness of additional home-based mental health and substance abuse counseling services, especially for older adults who report difficulty accessing and maintaining such support services.

2. **Fund and provide affordable, stable, safe, and accessible LGBTQ senior housing.**

   Recommendations:
   - Prioritize and fund affordable LGBTQ senior housing developments incorporating best practices, such as formalized agreements with trusted community-based aging service providers early in the development process; provision of storefront visibility; and ample, dedicated space for the delivery of senior services for residents and the community.

Incorporate LGBTQ affirming principles with equity and age-friendly universal design in housing developments for low-income and mixed-income levels.

- Increase the supply of rental housing subsidies, and assistance with mortgage payments, property taxes, and utilities. Provide housing counseling, rental assistance, eviction prevention support, and legal services to decrease housing instability and homelessness of LGBTQ older adults.
- Develop and test alternative housing models, such as home share programs, community-based housing via community land trusts, intergenerational housing programs, and models designed to allow professional and volunteer caregivers to live among those needing home-based services.

3. **Enhance cultural capacity and create LGBTQ affirming housing environments and services with attention to high-risk groups through trainings and resources.**

   Recommendations:
   - Fund, design and implement an LGBTQ equity housing training forum tailored toward housing providers, including intersectionality and culture, and race/ethnicity.
   - Develop and facilitate LGBTQ affirming trainings, specifically for shelters, transitional housing, and long-term care facilities, to reduce social isolation and end bullying by residents.
   - Create and disseminate an LGBTQ affirming housing and resource guide for community use and resident housing councils.

4. **Ensure the reporting of discrimination and legal recourse.**

   Recommendations:
   - Launch a community-wide awareness campaign on what constitutes discrimination and how to report it, including legal protections in public accommodations such as shelters, transitional housing, and long-term care facilities.
   - Ensure the handling of discrimination complaints is affirming for marginalized and underserved LGBTQ older adults, including the oldest, trans, bisexuals, and people of color. Pilot test the use of navigators to support vulnerable seniors and others through the reporting process and investigation of complaints.
   - Expand fair housing testing to assess violations of housing discrimination laws by sexual orientation and gender identity and expression, as well as intersectional forms of discrimination such as race/ethnicity, disability, and use of housing vouchers.

5. **Promote LGBTQ community support, engagement and advocacy.**

   Recommendations:
   - Work with nonprofit and for-profit agencies and communities to promote the understanding of LGBTQ aging and housing issues.
   - Prioritize addressing the needs of hard to reach and traditionally underserved LGBTQ older adults, including people of color, immigrants and linguistically diverse, those living in poverty, the oldest, trans, queer, bisexual older adults, those living with HIV/AIDS, and those with disabilities.
   - Include more diverse LGBTQ older adult voices in housing and senior advocacy efforts as well as planning processes, including land use, urban design, and housing and senior service advisory boards.

6. **Expand the collection and utilization of data to monitor LGBTQ housing and aging-related service needs, and to ensure equity in budgeting and the allocation of City and County resources**.

Recommendations:

- Expand the collection of data on sexual orientation and gender identity and expression using best practices when voluntary demographic data are collected via City and County agencies and contractors, such as client intake and other forms for services and contracts.
- Ensure training is available for City and County workers and contracted staff to attain skills and abilities needed to effectively collect such data. Assess and pilot test methods to make data publicly available.
- Analyze and eliminate LGBTQ inequities in the City's and County's allocation of resources, including housing initiatives, senior programs and services, and all other policy and regulatory mandates.

Conclusion

We urge the Mayor, City and County officials, and departments to implement the recommendations outlined, with the community providing much needed advocacy on behalf of addressing the housing and service needs of LGBTQ older adults. While LGBTQ older adults are pioneers and have made important contributions to our City and County, they face significant risks in housing, which increase their vulnerability as they age. As we move forward, we have an important opportunity to articulate and implement an action plan that is LGBTQ-affirming, age-friendly and promotes racial equity, as it recognizes and caters to the strengths of our diverse community. The action plan is designed to facilitate the delivery of services and to expand options and choices in housing, so LGBTQ older adults can, rather than age in place, age within their communities, engaged and supported. Such a multipronged approach is needed now to address the growing aging, health, and housing inequities facing LGBTQ older adults, so they can *age in community with pride*.

"I would only prefer to move if I could live with people who are LGBTQ because I would be freer to be myself and be around neighbors who I share life experiences with. I would prefer to live in a rainbow community."

References

1. U.S. Census Bureau (2017a). *State and County QuickFacts: Seattle, Washington.* Retrieved fromhttps://www.census.gov/quickfacts/fact/table/seattlecitywashington,US/PST120217#viewtop
2. Joint Center for Housing Studies of Harvard University (2015). *Projections & implications for housing a growing population: Older households 2015-2035.* Retrieved from http://www.jchs.harvard.edu/sites/default/files/harvard_jchs_housing_growing_population_2016.pdf
3. King County Office of Economic and Financial Analysis (2016). *King County population: 1990 to 2015*. Retrieved from https://www.kingcounty.gov/independent/forecasting/King%20County%20Economic%20Indicators/KC%20Population.aspx
4. State of Washington Office of Financial Management (2018). *Strong population growth in Washington continues*. Retrieved from https://www.ofm.wa.gov/sites/default/files/public/dataresearch/pop/april1/ofm_april1_press_release.pdf
5. Zillow Research (2018). *Seattle Home Prices & Values, 2006-2018*. Retrieved from https://www.zillow.com/seattle-wa/home-values/
6. Seattle City Budget Office. *Inflation-Consumer Price Index-Historical Data*. 14 February 2018. Retrieved from https://www.seattle.gov/financedepartment/cpi/historical.htm
7. Aging and Disability Services. (2017). *Area Plan Update: Area Agency on Aging for Seattle/King County, Washington 2018-2019.* Seattle, WA: Department of Health and Human Services King County. Retrieved from http://www.agingkingcounty.org/wp-content/uploads/sites/185/2018/01/Area-Plan-Update_2018-2019_FINAL.pdf
8. Colby, S. L., & Ortman, J. M. (2015, March 3). *Projections of the size and composition of the U.S. population: 2014 to 2060* (Report No. P25-1143). U.S. Department of Commerce. Economics and Statistics Administration. U.S. Census Bureau. Retrieved from https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf
9. Newport, F., & Gates, G. J. (2015, March 20). San Francisco metro area ranks highest in LGBT percentage. *Gallup.* Retrieved from https://news.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx?utm_source=Social%20Issues&utm_medium=newsfeed&utm_campaign=tiles
10. Fredriksen-Goldsen, K. I., & Kim, H.-J. (2017). The science of conducting research with LGBT older adults - An introduction to Aging with Pride: National Health, Aging and Sexuality/Gender Study (NHAS). *The Gerontologist 57*(S1), S1-S14. doi:10.1093/geront/gnw212
11. Fredriksen-Goldsen K. I., Kim, H.-J., Barkan, S. E., Muraco, A., & Hoy-Ellis, C. P. (2013). Health disparities among lesbian, gay, and bisexual older adults: Results from a population-based study. *American Journal of Public Health, 103*(10), 1802-1809. doi:10.2105/AJPH.2012.301110
12. U. S. Department of Health and Human Services. (2010). *Foundation health measures: Disparities, Healthy People 2020.* Retrieved from http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx

13. Fredriksen-Goldsen, K., Shiu, C., Kim, H. J., Emlet, C. A., & Goldsen, J. (2015). *At-Risk and Underserved: LGBTQ Older Adults in Seattle/King County.* Retrieved from http://age-pride.org/wordpress/wp-content/uploads/2015/10/Seattle-King-County_Report_FINAL-with-tables.pdf
14. City of Seattle (2015). *Mayor Ed Murray's LGBTQ Task Force Report: Recommendations to the Mayor.* Retrieved from http://murray.seattle.gov/wp-content/uploads/2015/07/LGBTQ-Task-Force-Report1.pdf
15. City of Seattle. (2018). *Age Friendly Seattle Action Plan 2018–2021.* Retrieved from http://www.seattle.gov/Documents/Departments/AgeFriendly/AgeFriendlySeattleActionPlanWeb.pdf
16. King County Department of Community and Human Services. (2018). *Veterans, Seniors and Human Services Levy Implementation Plan.* Retrieved from https://www.kingcounty.gov/~/media/depts/community-human-services/VHS-Levy/VSHSL%20Planning/VSHSL_Implementation_Plan_-_Passed.ashx?la=en
17. LGBTQ Allyship. (2017). *2017 Housing survey of the LGBTQ+ community.* Retrieved from http://allyship.org/wp-content/uploads/2017_LGBTQ_Housing_Survey.pdf
18. All Home Applied Survey Research. (2017). *Seattle/King County Point-in-Time Count of persons experiencing homelessness, 2017*: Count Us In. Seattle, Washington: All Home. Retrieved from: http://allhomekc.org/wp-content/uploads/2016/11/2017-Count-Us-In-PIT-Comprehensive-Report.pdf
19. James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey.* Washington, DC: National Center for Transgender Equality.
20. Centers for Disease Control and Prevention. (2009). *Healthy places terminology.* Retrieved from https://www.cdc.gov/healthyplaces/terminology.htm
21. SAGE (Services and Advocacy for GLBT Elders). (2014). *Out & visible: The experiences and attitudes of lesbian, gay, bisexual and transgender older adults, age 47-75.* Retrieved from https://www.sageusa.org/wp-content/uploads/2018/05/sageusa-out-visible-lgbt-market-research-full-report.pdf
22. Washington State University Metropolitan Center for Applied Research & Extension. (2018). *Moving toward age-friendly housing in King County.* Retrieved from http://www.agingkingcounty.org/wp-content/uploads/sites/185/2018/02/MovingTowardAgeFriendlyHousingInKingCounty.pdf
23. Housing Development Consortium. Housing Development Consortium of Seattle-King County 2017 Annual Report (2017). Retrieved from https://www.housingconsortium.org/wp-content/uploads/2018/03/HDCAnnualReport2017.pdf
24. Centers for Disease Control and Prevention. (2012). *Behavioral Risk Factor Surveillance System Survey.* Retrieved from http://www.cdc.gov/brfss/
25. Fredriksen-Goldsen, K. I., Kim, H.-J., Shiu, C., & Bryan, A. E. B. (2017). Chronic health conditions and key health indicators among gay, lesbian, and bisexual older US adults, 2013-2014. *American Journal of Public Health, 107*(8), 1332-1338. doi:10.2105/AJPH.2017.303922
26. Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. *American Psychologist*, *71*(8), 742. doi:10.1037/amp0000068
27. Fredriksen-Goldsen, K. I., Kim, H. J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C.P., & Petry, H. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Institute for Multigenerational Health.

Retrieved from http://www.age-pride.org/wordpress/wp-content/uploads/2011/05/Full-Report-FINAL-11-16-11.pdf
28. Vega, W. A., & Wallace, S. P. (2016). Affordable housing: A key lever to community health for older Americans. *American Journal of Public Health*, *106*(4), 635. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4815997/
29. Joint Center for Housing Studies of Harvard University. (2018). *The state of the Nation's housing 2018.* Retrieved from http://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2018.pdf
30. Harrell, R., Lynott, J., Guzman, S., & Lampkin, C. (2014). *What is livable? Community preferences of older adults.* Washington, DC: AARP Public Policy Institute [Online]. Retrieved from https://www.aarp.org/content/dam/aarp/research/public_policy_institute/liv_com/2014/what-is-livable-report-AARP-ppi-liv-com.pdf
31. National Adult Protective Services Association. (n.d.). *Elder financial exploitation*. Retrieved from http://www.napsa-now.org/policy-advocacy/exploitation/
32. National Fair Housing Alliance. (2017). *2017 Fair housing trends report: The case for fair housing*. Retrieved from https://nationalfairhousing.org/2017-fair-housing-trends-report/
33. Fiske, S. T. (2018). Prejudice, discrimination, and stereotyping. In R. Biswas-Diener & E. Diener (Eds), *Noba Textbook Series: Psychology*. Champaign, IL: DEF publishers.
34. Cacioppo, J. T. & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine 46*(3 Suppl), S39-S52.
35. Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual Review of Clinical Psychology, 5*, 363-389. doi:10.1146/annurev.clinpsy.032408.153621
36. McCullough, M. E., & Laurenceau, J. P. (2005). Religiousness and the trajectory of self-rated health across adulthood. *Personality and Social Psychology Bulletin*, *31*(4), 560-573. doi:10.1177/0146167204271657
37. Solomon, R., Kirwin, P., Van Ness, P. H., O'Leary, J., & Fried, T. R. (2010). Trajectories of quality of life in older persons with advanced illness. *Journal of the American Geriatric Society, 58*(5), 837-843. doi:10.1111/j.1532-5415.2010.02817
38. Mirza, S. A., & Rooney, C. (2018, January 18). Discrimination prevents LGBTQ people from accessing health care. *Center for American Progress.* Retrieved from https://www.americanprogress.org/issues/lgbt/news/2018/01/18/445130/discrimination-prevents-lgbtq-people-accessing-health-care/
39. U.S. Department of Health and Human Services. (2017). *2017 Poverty guidelines*. Retrieved from https://aspe.hhs.gov/2017-poverty-guidelines
40. U.S. Census Bureau. (2017b). *How disability data are collected from The American Community Survey*. Retrieved from https://www.census.gov/topics/health/disability/guidance/data-collection-acs.html
41. Kim, J., Cannon, J., Cheh, V., Duda, N., & Hall, J. (2010). *Community Partnerships for Older Adults (CPFOA) Program Survey of Older Adults, 2008 [United States]*. Ann Arbor, MI: Inter-university Consortium for Political and Social Research.
42. Fredriksen-Goldsen, K.I. (2018, June). Aging with Pride and the Future of LGBTQ Health and Aging. *Seattle Townhall*. Seattle, WA.

Appendices

Methodology

We developed a targeted outreach strategy to better understand the health and aging needs of older diverse LGBTQ adults who reside in Seattle/King County. The project announcement and survey, available online and hardcopy, were distributed via community centers, housing facilities, mental health and wellness centers, health and aging resource fairs, agencies serving those with HIV, and community outreach workers. To reach a more racially and ethnically diverse sample, both online and hardcopy versions of survey were available in English and Spanish. In addition, community outreach workers also distributed surveys within diverse communities. Targeted recruitment was needed to improve the diversity of the sample and to increase sample sizes for statistical comparisons and was not intended to produce a representative sample. Because of its targeted nature, the sample is likely not reflective of LGBTQ older adults living in Seattle/King County.

The announcement described the purpose of the project and criteria for inclusion. A link to the survey was embedded in the emailed project announcement. Participants could also call or email to receive an online or hardcopy survey. We also offered gift card incentives and the opportunity to enter a raffle for a $200.00 gift card to QFC or Fred Meyer as a token of appreciation for their time.

To be eligible, participants were required to be 50 years of age or older, and residing in Seattle/King County. In addition, participants either identified as LGBTQ or were sexual/gender diverse, or attracted to or had an intimate or sexual relationship with someone of the same sex or gender.

The self-administered survey consisted of several sections including: Current housing; housing related discrimination and victimization; health and well-being; social support and engagement; housing related services and programs; and background characteristics.

Surveys were distributed and collected over a six-month period, from January 2018 through June 2018 and were completed by 502 participants, with 419 older adults meeting all the inclusion criteria, an unprecedented number of older adult participants across traditionally under-represented groups.

For data analysis, descriptive statistics were initially conducted. Next, in each report section, similarities and differences were examined by housing related indicators (living alone; at or below the federal poverty level; limited financial resources; renting; housing burden; homelessness in the past 5 years) and by background characteristics including age (70 and older; 60-69; 50-59); gender (women; men; gender queer or non-binary or gender expansive); sexual orientation (lesbians; gay men; bisexual women and men; and queer); gender identity (transgender and gender non-binary and diverse participants; cisgender); race and ethnicity (non-Hispanic White; Black/African American; Hispanic/Latino(a); Asian/Pacific Islander; Native American/Alaskan Native); partnership status (single; married/partnered); education (high school or less; some college or more); and ability status (living with a disability; no disability). In addition, we examined how current housing and housing instability, displacement, homelessness, discrimination and victimization, health disparities, community support and engagement, and gaps in services and programs were associated with housing related indicators and background characteristics. Statistical tests were applied, as appropriate. In this study, lesbians, gay men, bisexuals, and queers are treated as distinct groups (bisexual women and men were combined due to sample sizes).

Unavailable in most other studies, the sample of LGBTQ older adults in this study are age 50 and older and diverse in many respects. However, there are limitations that are important to consider. First, the design and sampling procedures used in this study do not allow for the generalizability of the findings. Thus, the findings cannot be generalized beyond those who participated in the study. Recruitment of underrepresented groups was a primary focus of the study, and while we achieved greater diversity than other previous studies, continued work is needed to find effective ways to reach diverse communities, including across diverse refugee communities. In addition, only self-report data were collected and likely based on participants' perceptions and interpretations rather than behaviors; such measures do not replace objective indicators.

Selected Key Terms and Measures

Background characteristics:
Sexual orientation: Participants were asked to select from one of the following categories: gay or lesbian; bisexual; straight or heterosexual; queer; or not listed above (please specify).

Gender: Participants were asked to select their current gender from one of the following categories: woman; man; gender queer or non-binary or gender diverse or expansive; or not listed above (please specify).

Gender identity and expression and trans: Participants were asked if they had ever considered themselves trans or transgender. In addition, they were asked which of the following best described their sex assigned at birth or listed on their first birth certificate: female or male. Participants were considered trans if they self-identified as trans or transgender or if their current gender was different than their sex assigned at birth, or if they identified as gender queer or non-binary or gender expansive, or not listed above.

Cisgender: Not transgender or trans.

Age: Calculated from participant’s year of birth. Participants were grouped into age 50-59, 60-69, 70 and older.

Race and ethnicity: Participants were asked to identify their race and ethnicity by selecting one or more of the following: Non-Hispanic White; Hispanic/Latino(a); Black/African American; Asian/Pacific Islander; Native American/Alaskan Native; or not listed above (please specify). Participants who marked more than one race were categorized as multiracial. For Native American/Alaska Native, those who were exclusively Native American/Alaska Native and those who were Native American/Alaska Native multi-racial were combined for analyses due to small size.

Income: Participants selected their annual household before taxes in 2017 from the following categories: less than $20,000; $20,000-$24,999; $25,000-$34,999; $35,000-$49,999; $50,000-$74,999; $75,000 or more. Income was dichotomized by factoring annual household income with household size to determine whether participants were at or below the 200% of the federal poverty level (FPL).[39]

Financial status: Participants were asked which of the following best described their current resources: I have difficulty paying bills no matter what I do; I have enough money to pay bills, but only because I cut back on things; I have enough money to pay bills, but little spare money to buy extra or special things; After paying bills, I have enough money for special things. Those with limited financial resources did not have money available to buy special things.

Education: Participants selected their highest level of education. Categories included: less than high school; high school or GED; less than 4 years of college; 4 years of college degree or more. Education was dichotomized into either high school or less, or some college or more.

Relationship status: Participants were asked to select their current relationship status from one of the following: single; married, legally recognized; registered domestic partnership, not married; partnered, not married, not registered domestic partnership; divorced; widowed; separated; other (please specify). Relationship status was categorized into married/partnered or single.

Physical disability: Participants were asked whether they had a condition that substantially limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting, or carrying.[40]

Military status: Participants were asked if they had served in the military.

Housing-related indicators:
Living arrangement: Participants were asked with whom they currently live: I live alone; partner or spouse; other family of choice or children; friend or roommate(s); other (please specify). Living arrangement was dichotomized into living alone or living with others.

Housing arrangement: Participants were asked about their current living arrangement: renter; homeowner; staying with friends or family rent free; living in senior housing or age-restricted community; living in an assisted living community; living in a nursing home or other health care facility; living in transitional housing or a shelter; homeless; other (please specify).

Housing burdened: Participants were asked what percent of their income they estimate to spend on their housing including rent or mortgage, utilities, property taxes, or other direct housing expenses. Categories included: 0% to 9%; 10% to 24%; 25% to 29%; 30% to 49%; 50% to 74%; 75% or more. Households spending 30% or more of their income on housing costs were considered housing burdened[29] and living in unaffordable housing.[22]

Housing instability: Participants were asked how confident they were that they would be able to continue living in their current housing for as long as they like.[41] Housing instability was dichotomized into confident and not confident.

Homelessness past 5 years: Participants were asked if in the past five years they had experienced specific challenges finding or maintaining safe, quality, or affordable housing, with homelessness as a discreet response category.

"Once gays and lesbians go into senior housing,
they go back into the closet.
That is so wrong.
There is safety in numbers.
So, designate some housing specifically for LGTBQ people."

ARTICLE

Hospice Use Lower Among African Americans

Geriatrics

By Tim Pittman

Published January 15, 2018

African Americans use hospice services at far lower rates than whites and are more likely to experience untreated pain at the end of their lives, according to Duke geriatric researchers.

The disparities experienced by African Americans across the health spectrum are also evident as those patients reach the end of their lives, says Kimberly S. Johnson, MD, a Duke researcher and specialist in both geriatric and palliative medicine.

African Americans are more likely to report dissatisfaction with care and problems in communicating with providers, Johnson says, although hospice use improves the care experience for patients and their caregivers.

The most commonly cited barriers to hospice use for African Americans include preferences for life-sustaining therapies, lack of knowledge about hospice, general mistrust of the health care system, and spiritual beliefs. The small number of African Americans working in hospices may also present a barrier.

"Understanding the barriers to hospice use for older African Americans and addressing those barriers is critical to increase the overall quality of life for this population," Johnson says.

Citing data from the National Hospice and Palliative Care Organization, Johnson says that African Americans make up only about 8% of hospice patients, while whites account for more than 80%. In the United States, the population of African Americans exceeds 12%. This statistic is particularly surprising, Johnson says, because African Americans are more likely to have many of the conditions common to hospice care such as cancer and heart disease.

Johnson notes, however, that as hospice use has increased over time, African American and white Medicare beneficiaries have benefitted, but African Americans continue to use hospice services less frequently. In 2014, about 50% of white Medicare patients were in hospice care at the time of death. Less than 40% of African American patients were enrolled.

The gap between white and African American proportional use of hospice should send a strong signal to hospice owners to improve outreach in their service areas.

Johnson's most recent project, published in the *Journal of Palliative Medicine* in February 2016, surveyed 118 eligible hospices in North and South Carolina as part of a cross-sectional survey to identify channels for more effective outreach to African Americans.

She encourages hospice owners to recruit more African American staff to help with outreach and to identify such community institutions as churches and primary care providers to recruit more patients.

Share:

Related Articles

INTERDISCIPLINARY

End-of-Life Planning: Making Difficult Conversations Easier

PRACTICE MANAGEMENT

By Katherine Kahn

INTERDISCIPLINARY

End-of-Life Planning Is Now Billable

ARTICLE

By Frank Celia

GENERAL MEDICINE

Early Geriatric Service Paved the Way for Fast-Growing Palliative Care

ARTICLE

By Tim Pittman

HHS Public Access

Author manuscript

Am J Nephrol. Author manuscript; available in PMC 2017 June 29.

Published in final edited form as:

Am J Nephrol. 2016 ; 44(1): 46–53. doi:10.1159/000447097.

Racial Disparities in End-of-Life Communication and Preferences among Chronic Kidney Disease Patients

Nwamaka D. Eneanya, MD, MPH[1], **Julia B. Wenger**[1], **Katherine Waite**[2], **Stanley Crittenden, MD**[3], **D. Bora Hazar, MD**[1], **Angelo Volandes, MD, MPH**[4], **Jennifer S. Temel, MD**[5], **Ravi Thadhani, MD, MPH**[1], and **Michael K. Paasche-Orlow, MD, MPH**[2]

[1] Division of Nephrology, Department of Internal Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA.

[2] Section of General Internal Medicine, Department of Internal Medicine, Boston Medical Center, Boston University School of Medicine, Boston, MA.

[3] Division of Nephrology, Department of Internal Medicine, Boston Medical Center, Boston University School of Medicine, Boston, MA.

[4] Division of General Medicine, Department of Internal Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA.

[5] Division of Hematology and Oncology, Department of Internal Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA.

Abstract

Background—Previous studies on end-of-life (EOL) care among patients with chronic kidney disease (CKD) have been largely limited to White hemodialysis patients. In this study we sought to explore racial variability in EOL communication, care preferences and advance care planning among patients with advanced CKD prior to decisions regarding initiation of dialysis.

Methods—We performed a cross-sectional study between 2013 and 2015 of Black and White patients with Stage IV or V CKD (per the Modified Diet in Renal Disease estimation of GFR < 30 ml/min/1.73m^2) from two academic centers in Boston. We assessed experiences with EOL communication, advance care planning, EOL care preferences, hospice knowledge, spiritual/religious and cultural beliefs, and distrust of providers.

Results—Among 152 participants, 41% were Black. Black patients were younger, had less education, and lower income than White patients (all $p < 0.01$). Black patients also had less knowledge of hospice compared to White patients (17% vs. 61%, $p < 0.01$). A small fraction of patients (8%) reported having EOL discussions with their nephrologists and the majority had no advance directives. In multivariable analyses, Blacks were more likely to have not communicated EOL preferences (adjusted Odds Ratio aOR, [95% Confidence Interval CI] 2.70 [1.08, 6.76]) and more likely to prefer life-extending treatments (aOR, 3.06 [1.23, 7.60]) versus Whites.

Corresponding Author Nwamaka Eneanya, MD, MPH, 165 Cambridge Street, Suite #302, Boston, MA 02114, Ph: 617-643-4540, Fax: 617-724-1122, Aeneanya@partners.org.

Conflict of interest: All authors have approved this manuscript for submission. To the best of our knowledge, no conflict of interest, financial or other, exists.

Conclusions—As Black and White patients with advanced CKD differ on EOL communication, preferences, and hospice knowledge, future efforts should aim to improve patient understanding and promote informed decision-making.

Keywords

Racial disparities; end-of-life; chronic kidney disease

Introduction

Although survival rates for patients with chronic kidney disease (CKD) and end-stage renal disease (ESRD) initiating hemodialysis (HD) have slightly improved, only 54% of people who start HD are alive within three years.[1] Furthermore, patients with ESRD typically experience intensive patterns of health care utilization at the end of life as opposed to comfort care.[2] For instance, many who choose dialysis also receive other life-sustaining treatments such as cardiopulmonary resuscitation and mechanical ventilation despite a poor likelihood of survival.[3-5] As communication about care desired at the end of life is one of the best ways for people to preserve their wishes, early goals of care discussions are especially salient in this population.[6-9]

Previous literature on end-of-life (EOL) conversations and preferences for care among patients with CKD has largely been limited to patients on maintenance HD.[6,10-12] Despite national guidelines and initiatives to improve EOL care for nephrology patients, recent studies have demonstrated that patients infrequently engage in prognostic and EOL discussions with their nephrologists.[6,7,13] Furthermore, studies of advance care planning (ACP), defined as the process where individuals plan ahead for care desired if they were to become incapacitated, and patients with kidney disease have been conducted almost exclusively among White patients.[6,14-16] Several disciplines of healthcare have demonstrated how minority racial-ethnic groups typically experience less access to palliative care services, receive more life-sustaining therapies and are less likely to use hospice during the final months of life compared to other racial-ethnic groups.[17-21] While poor education, spirituality, and trust of the healthcare system likely contribute to disparities in patterns of care at the end of life, such relationships have not been evaluated in CKD patients.[21,22] In this study we sought to explore whether racial variability exists with regards to EOL communication, care preferences, and ACP among patients with advanced CKD prior to initiation of dialysis.

Methods

Setting and study participants

We performed a cross-sectional study between August 2013 and February 2015 among patients with Stage IV or V CKD (as defined by the Modified Diet in Renal Diseases[23] estimation of GFR < 30 ml/min/1.73m^2). Patients were recruited from outpatient nephrology clinics associated with two academic centers in Boston, Massachusetts. Eligibility included age 45 years or older, English-speaking and self-report of Black or White race. Patients were excluded if they had a known history of dementia or were found to have severe cognitive

deficit (as determined by eight or more errors on the Short Portable Mental Status Questionnaire).[24] Patients were also excluded if they were listed for kidney transplantation as the illness trajectory and prognoses for such patients differs significantly from those without this treatment option. The Institutional Review Boards at Partner's Healthcare and Boston Medical Center approved this study.

Data collection

All study personnel underwent training in conducting structured patient interviews using study questionnaires. All interviews were performed in a quiet and private room in the outpatient clinic at a scheduled routine visit. Patient demographic information including age, gender, race, ethnicity, formal level of education, annual income, and health insurance status were ascertained through study questionnaires. We reviewed electronic medical records for comorbid conditions and the Charlson Comorbidity Index (CCI) score was calculated.[25]

Outcomes

The primary outcome was prior EOL communication with any providers (yes versus no). Additional outcomes included, EOL communication with nephrologists (yes versus no), EOL communication with family members or friends (yes versus no), ACP (possession of healthcare proxy [HCP] and Do-Not-Rescusitate [DNR] forms or living wills; yes versus no) and EOL preferences. As previously done in research investigating EOL care in seriously ill patients [26], we ascertained EOL preference for resuscitation (yes versus no) as well as life-extending care (comfort versus life-extending) and site of death (hospital versus home) at the end of life. Using the outpatient electronic medical record (EMR), we verified whether DNR orders, living wills, and HCP forms had been completed for all patients. For patients who had evidence of these forms in the EMR, they were given credit for having such documentation even if this had not been reported. For any missing information in the EMR, we deferred to the patient's response as confirmation.

We collected secondary outcomes including spiritual/religious beliefs, cultural beliefs, and distrust of healthcare providers and their influence on EOL preferences using single item measures (yes versus no) during patient interviews. In addition, hospice knowledge was determined by content analysis of an open-ended follow-up item for participants who had heard of the term ‘hospice’ (“Since you have heard of hospice, what does this mean to you in your own words?”). Three members of the study staff subsequently and independently categorized responses into “poor knowledge”, “partial knowledge”, or “good knowledge”. [27] The third study staff member was also used to adjudicate any disagreements in categorization.

Statistical analyses

Descriptive participant characteristics are presented using proportions for categorical variables and means (standard deviations) for continuous variables. We tabulated the proportions of participants who had a history of EOL discussion with their healthcare providers/families, preference for resuscitation, EOL care and site of care, and possession of HCP form, DNR order or living will. We also ascertained whether culture, religion/spirituality and distrust of healthcare providers had an impact on preferences. Hospice

knowledge response categories were dichotomized into poor or partial knowledge versus good knowledge.

We used univariate logistic regression analysis to identify statistically significant racial differences in EOL preferences and communication. Models were examined for each of five outcomes where statistically significant racial differences existed in univariate analysis including: 1) No communication of EOL preferences with family; 2) No possession of a HCP form; 3) No possession of DNR order or living will; 4) Preference for EOL life-extending care; and 5) Preference for site of death. Collinearity for demographic variables, hospice knowledge, and study site with race were tested using the variance inflation factor. Multivariable logistic regression analyses were then performed to identify significant predictors of each of the five outcomes. As the distribution of elderly patients differed among racial groups, we stratified the final analyses by age (< 65 years versus ≥ 65 years). In addition, we stratified the final analysis of hospice knowledge by level of education. All analyses were performed using SAS version 9.2 (Cary, NC). Statistical significance was determined by p-values < 0.05.

Results

Patient characteristics

A total of 268 patients were approached for study enrollment. Fifty-four patients were ineligible, 61 patients declined participation, and one patient stopped the study early (Figure 1). Among 57% of patients who enrolled and completed the study, 41% were Black. Black patients were younger compared to White patients with a mean age (± SD) of 66 (± 11) years versus 70 (± 10) years ($p = 0.01$) (Table 1). A higher proportion of Black patients had an annual income < $30,000 and a lower level of education attainment (both $p < 0.01$). There was no significant difference in mean CCI score between the two racial groups.

Hospice knowledge

All White patients (n = 89) and 75% of Black patients (n = 47) reported that they had heard of “hospice” and responded to the query about the meaning of hospice. Examples of these patients’ verbatim descriptions of the meaning of hospice are listed in Table 2. We determined 17% (8/47) of Black patients’ and 61% (54/89) of White patients’ responses as exhibiting good knowledge of hospice ($p < 0.01$). In addition, when stratified by level of education, we observed that among those who graduated high school (n = 128), racial differences persisted (p < 0.01), but these differences were not significant among those who had not graduated high school (n = 24, p = 0.42).

Previous EOL communication

Overall, 77% percent of patients reported never having a prior EOL discussion with any healthcare provider (Table 1). Specifically, 92% of patients reported never having such conversations with a nephrologist. Significantly more Black patients reported not having discussions about EOL preferences with their family members or friends compared to White patients (54% versus 27%, $p = 0.01$, Table 1). After adjusting for age, education, income, study site, CCI score and hospice knowledge, Black patients were still more likely to not

communicate EOL preferences with family members and friends (adjusted Odds Ratio aOR, [95% Confidence Interval CI] 2.70 [1.08, 6.76], Table 3) compared to White patients.

Advance care planning

Two patients reported that they did not have a living will and 14 patients reported having no HCP despite record of these documents in the EMR. There were no differences in patient characteristics between those with and without EMR evidence of ACP documentation. A higher proportion of the Black patients reported that they had not completed DNR orders or living wills and had no evidence of such documentation in the EMR compared to White patients (78% versus 62%, $p = 0.04$, Table 1). More Black patients also had not completed HCP forms and had no evidence of such documentation in the EMR compared to White patients (50% versus 30%, $p = 0.01$). In adjusted analyses, there were no significant racial differences.

EOL care preferences

A total of 89% of patients preferred to be resuscitated and there was no difference between Blacks and Whites. At the same time, a higher proportion of Black patients preferred to extend life as opposed to focusing on comfort care compared to White patients (56% vs. 25%, $p < 0.01$, Table 1). Similarly, Blacks were more likely to prefer spending their final moments of life in a hospital versus Whites (41% vs. 19% $p < 0.01$). In adjusted analyses, Black patients were more likely to prefer to extend life if critically ill (3.06 [1.23, 7.60], Table 3); however, there was no difference in preference for site of death.

In the final models, additional significant predictors included: income (p= 0.03; for EOL communication), study site (p = 0.02; for completion of HCP form), Charlson comorbidity score (p < 0.01; for completion of HCP form) and education (p = 0.01; for site of death). In multivariable analyses stratified by age, younger (< 65 years) Black patients were more likely to prefer life-extending care (9.15 [1.48, 56.74], Table 3) than White patients. However, there were no racial differences in preference for EOL communication, ACP or EOL care preferences among patients ≥ 65 years of age (Table 3).

There were no significant racial differences with regards to the influence of religious/spiritual beliefs, cultural beliefs, and distrust of healthcare providers on preferences for care at the end of life (not displayed).

Discussion

Among patients with advanced CKD not yet on dialysis, few patients reported having discussions about EOL preferences and many had not completed any form of ACP. Black patients were less likely to understand the meaning of hospice compared to White patients. Furthermore, independent of age, education, income, comorbidities, study site and hospice knowledge, Black patients were less likely to communicate EOL preferences with family members and more likely to desire treatment intended to extend life if they were to become critically ill compared to White patients. In particular, younger Black patients were more likely to prefer life-extending care compared to younger White patients.

Our study confirms very low rates of ACP and EOL discussions for patients with CKD with their nephrologists and their other health care providers. Davison et al. showed that 44% of CKD patients had completed a health care proxy or enduring power of attorney and 38% reported having a personal directive; however, most of this cohort had already begun dialysis and was almost exclusively White.[7] Furthermore, despite patients feeling somewhat comfortable discussing EOL issues with family members and healthcare providers, only 33% had spoken with family member/health care proxies and 10% had spoken with nephrologists within the past year about EOL issues. Our findings build upon this knowledge by enrolling a mixed race cohort of patients who had not yet begun dialysis, and by identifying the fact that Black patients in our study were less likely to communicate EOL preferences with their families and more likely to prefer life-extending treatment at the end of life compared to White patients. Factors such as lack of awareness of illness trajectory and prognosis in addition to unrealistic expectations of health statuses likely contribute to poor communication between patients with kidney disease and their families.[28,29] For example, a recent randomized controlled trial of a communication intervention geared specifically toward Black patients with ESRD and their surrogates was particularly effective in improving patient-surrogate congruence and decisional confidence in goals of care.[30] This approach elucidated the complex relationships of health awareness and subsequent emotional burden that often occurs within families. As medical decision-making at the end of life for seriously ill patients can be difficult to predict and lead to traumatic experiences for patients' families and healthcare providers, the promotion of clear prognostic and ACP communication early in the course of CKD becomes a key strategy for improving delivery of EOL care while simultaneously reducing racial disparities.[31-33]

Differences in EOL treatment preferences and practice patterns between different racial and ethnic groups have been confirmed across several disciplines of healthcare.[34-37] Such differences are inherently a problem if they are driven by misinformation. Fewer Black patients understood the meaning of hospice compared to White patients. Our data also demonstrated the important interplay between hospice knowledge, racial differences, and EOL preferences – a notion that could contribute to subsequent discrepant hospice utilization at the end of life.[34,38] Through treatment of emotional and physical symptoms, hospice care has been proven to significantly improve the transition to death for patients and their families. Less understanding of the benefits of hospice has been associated with more aggressive care at end of life and a lower quality of death.[31] Educational programs for CKD patients and their families have the potential to promote more informed decision-making regarding treatment options at the end of life, better satisfaction with care, and decreased disparities.[15]

We did not find substantial racial differences with regards to all aspects of care desired at the end of life. In adjusted analyses, Blacks and Whites had similar likelihood of completing HCP forms, DNR forms or living wills, and preference for site of death. Differences in nephrology clinic practices as well as illness severity could impact completion of advance directives. For instance, despite national guidelines that recommend the incorporation of ACP into routine clinical practice,[13] none of the study sites had formal protocols for EOL communication or documentation. Factors such as education and income that remained significant predictors of certain EOL outcomes after adjustment may indeed represent social

determinants of health that are fixed and unequal between the two races within the CKD population.[39,40] Historically, similar socioeconomic factors have been linked to racial differences in CKD development and progression. Our findings reinforce the need for more awareness in this arena with regards to disparate EOL care. Black patients were also younger than White patients in this cohort and our analyses revealed that racial differences in the outcomes examined were isolated to the younger patients. These findings could reflect ACP efforts traditionally targeted towards frail and older patients and highlight the need for interventions that reach a broader patient population.[2,14,41]

Our study has some limitations. The study population was comprised of Black and White English-speaking patients from two academic centers in the Boston metro area which reduces generalizability. We did not verify documentation of EOL discussions in the EMR as all patients enrolled in the study were cognitively intact without dementia. While it is possible that patients may have misunderstood or not remembered previous EOL discussions, it is unlikely that this phenomenon explained the racial differences we observed. Also, previous work has cited strong religious/spiritual beliefs, culture, and healthcare distrust as catalysts for differences in preferences and between Black and White patients.[21] However, our findings showed no significant racial differences among these factors. We did not collect data on specific religion affiliation and therefore could not determine any overarching themes that would affect EOL preferences or communication relating to this factor. Also, due to the limited diversity of our cohort, we were unable to determine the effect of ethnicity on outcomes. Future research is needed to understand the divergence of our findings from prior work on racial disparities in religion/spiritual beliefs, culture, and healthcare distrust. While this may reflect limitations in the generalizability of our cohort, these observations may also reflect true changes that have transpired over time and/or the possibility that racial disparities in these factors may not be present among CKD patients or in general for patients who have had stable access to medical care (as has been the case in Massachusetts). Additionally, we explored the concept of hospice as a follow-up question only with patients who reported that they were familiar with the term. This could have potentially excluded patients who may have been knowledgeable about the concept despite unfamiliarity with the word hospice. Furthermore, sociocultural factors such as education level could have affected patients' likelihood of answering a question phrased as 'Have you heard of...?' with a 'yes' or 'no' response. Independent of actual understanding of the meaning of 'hospice,' it might be harder for people with a higher level of education to say that they have never heard of this word. Another limitation relates to the cross-sectional study design, which blocks our ability to make stronger causal inferences.

Despite these limitations, this study is the first to our knowledge to investigate and describe racial differences in EOL communication and preferences among pre-dialysis patients with chronic kidney disease. In conclusion, EOL discussions with providers and the rate of ACP are very low for patients with CKD. Black patients are less likely to have had any EOL communication with their families and prefer more aggressive care at the end of life than White patients. At the same time, Black patients in our study have lower hospice knowledge compared to White patients. This may have a large influence on the racial disparities in EOL preferences we observe. These differences have important implications in designing research

and clinical care interventions that improve patient understanding, promote better informed decision-making and reduce racial disparities for patients with advanced CKD.

Acknowledgments

We thank Sarah M. Doughtery for her assistance with patient recruitment and data entry. This study was supported by a grant from the American Society of Nephrology Foundation for Kidney Research Ben J. Lipps Research Fellowship Program (PI – Eneanya) and a mentorship grant from the National Institute of Diabetes and Digestive and Kidney Diseases K24-DK094872 (PI - Thadhani).

References

1. Saran R, Li Y, Robinson B, Ayanian J, Balkrishnan R, Bragg-Gresham J, Chen JT, Cope E, Gipson D, He K, Herman W, Heung M, Hirth RA, Jacobsen SS, Kalantar-Zadeh K, Kovesdy CP, Leichtman AB, Lu Y, Molnar MZ, Morgenstern H, Nallamothu B, O'Hare AM, Pisoni R, Plattner B, Port FK, Rao P, Rhee CM, Schaubel DE, Selewski DT, Shahinian V, Sim JJ, Song P, Streja E, Kurella Tamura M, Tentori F, Eggers PW, Agodoa LY, Abbott KC. Us renal data system 2014 annual data report: Epidemiology of kidney disease in the united states. American journal of kidney diseases : the official journal of the National Kidney Foundation. 2015; 65:A7.
2. Wong SP, Kreuter W, O'Hare AM. Treatment intensity at the end of life in older adults receiving long-term dialysis. Archives of internal medicine. 2012; 172:661–663. discussion 663-664. [PubMed: 22529233]
3. Moss AH, Holley JL, Upton MB. Outcomes of cardiopulmonary resuscitation in dialysis patients. Journal of the American Society of Nephrology : JASN. 1992; 3:1238–1243. [PubMed: 1477319]
4. Wong SP, Kreuter W, Curtis JR, Hall YN, O'Hare AM. Trends in in-hospital cardiopulmonary resuscitation and survival in adults receiving maintenance dialysis. JAMA internal medicine. 2015; 175:1028–1035. [PubMed: 25915762]
5. Saeed F, Adil MM, Malik AA, Schold JD, Holley JL. Outcomes of in-hospital cardiopulmonary resuscitation in maintenance dialysis patients. Journal of the American Society of Nephrology : JASN. 2015
6. Goff SL, Eneanya ND, Feinberg R, Germain MJ, Marr L, Berzoff J, Cohen LM, Unruh M. Advance care planning: A qualitative study of dialysis patients and families. Clinical journal of the American Society of Nephrology : CJASN. 2015
7. Davison SN. End-of-life care preferences and needs: Perceptions of patients with chronic kidney disease. Clinical journal of the American Society of Nephrology : CJASN. 2010; 5:195–204. [PubMed: 20089488]
8. Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. BMJ (Clinical research ed). 2010; 340:c1345.
9. Schonwetter RS, Walker RM, Solomon M, Indurkhya A, Robinson BE. Life values, resuscitation preferences, and the applicability of living wills in an older population. Journal of the American Geriatrics Society. 1996; 44:954–958. [PubMed: 8708307]
10. Song MK, Ward SE, Fine JP, Hanson LC, Lin FC, Hladik GA, Hamilton JB, Bridgman JC. Advance care planning and end-of-life decision making in dialysis: A randomized controlled trial targeting patients and their surrogates. American journal of kidney diseases : the official journal of the National Kidney Foundation. 2015
11. Bristowe K, Horsley HL, Shepherd K, Brown H, Carey I, Matthews B, O'Donoghue D, Vinen K, Murtagh FE. Thinking ahead--the need for early advance care planning for people on haemodialysis: A qualitative interview study. Palliative medicine. 2015; 29:443–450. [PubMed: 25527527]
12. Tong A, Cheung KL, Nair SS, Kurella Tamura M, Craig JC, Winkelmayer WC. Thematic synthesis of qualitative studies on patient and caregiver perspectives on end-of-life care in ckd. American journal of kidney diseases : the official journal of the National Kidney Foundation. 2014; 63:913–927. [PubMed: 24411716]

13. Davison SN, Levin A, Moss AH, Jha V, Brown EA, Brennan F, Murtagh FE, Naicker S, Germain MJ, O'Donoghue DJ, Morton RL, Obrador GT. Executive summary of the kdigo controversies conference on supportive care in chronic kidney disease: Developing a roadmap to improving quality care. Kidney international. 2015; 88:447–459. [PubMed: 25923985]
14. Kurella Tamura M, Goldstein MK, Perez-Stable EJ. Preferences for dialysis withdrawal and engagement in advance care planning within a diverse sample of dialysis patients. Nephrology, dialysis, transplantation : official publication of the European Dialysis and Transplant Association - European Renal Association. 2010; 25:237–242.
15. Davison SN, Jhangri GS, Koffman J. Knowledge of and attitudes towards palliative care and hospice services among patients with advanced chronic kidney disease. BMJ supportive & palliative care. 2014
16. Fried TR, Redding CA, Robbins ML, Paiva AL, O'Leary JR, Iannone L. Development of personalized health messages to promote engagement in advance care planning. Journal of the American Geriatrics Society. 2016
17. Thomas BA, Rodriguez RA, Boyko EJ, Robinson-Cohen C, Fitzpatrick AL, O'Hare AM. Geographic variation in black-white differences in end-of-life care for patients with esrd. Clinical journal of the American Society of Nephrology : CJASN. 2013; 8:1171–1178. [PubMed: 23580783]
18. Barnato AE, Chang CC, Saynina O, Garber AM. Influence of race on inpatient treatment intensity at the end of life. Journal of general internal medicine. 2007; 22:338–345. [PubMed: 17356965]
19. Jennings B, Ryndes T, D'Onofrio C, Baily MA. Access to hospice care. Expanding boundaries, overcoming barriers. The Hastings Center report. 2003; (Suppl:S3-7):S9–13. S15–21. passim.
20. Nhpco facts and figures: Hospice care in america. National hospice and palliative care organization; Alexandria, va: Oct. 2014
21. Crawley L, Payne R, Bolden J, Payne T, Washington P, Williams S. Palliative and end-of-life care in the african american community. JAMA : the journal of the American Medical Association. 2000; 284:2518–2521. [PubMed: 11074786]
22. Volandes AE, Paasche-Orlow M, Gillick MR, Cook EF, Shaykevich S, Abbo ED, Lehmann L. Health literacy not race predicts end-of-life care preferences. Journal of palliative medicine. 2008; 11:754–762. For Peer Review. [PubMed: 18588408]
23. Levey AS, Bosch JP, Lewis JB, Greene T, Rogers N, Roth D. A more accurate method to estimate glomerular filtration rate from serum creatinine: A new prediction equation. Modification of diet in renal disease study group. Annals of internal medicine. 1999; 130:461–470. [PubMed: 10075613]
24. Pfeiffer E. A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. Journal of the American Geriatrics Society. 1975; 23:433–441. [PubMed: 1159263]
25. Charlson ME, Pompei P, Ales KL, MacKenzie CR. A new method of classifying prognostic comorbidity in longitudinal studies: Development and validation. Journal of chronic diseases. 1987; 40:373–383. [PubMed: 3558716]
26. A controlled trial to improve care for seriously ill hospitalized patients. The study to understand prognoses and preferences for outcomes and risks of treatments (support). The support principal investigators. JAMA : the journal of the American Medical Association. 1995; 274:1591–1598. [PubMed: 7474243]
27. Shelkowitz E, Vessella SL, O'Reilly P, Tucker R, Lechner BE. Counseling for personal care options at neonatal end of life: A quantitative and qualitative parent survey. BMC palliative care. 2015; 14:70. [PubMed: 26626572]
28. Wachterman MW, Marcantonio ER, Davis RB, Cohen RA, Waikar SS, Phillips RS, McCarthy EP. Relationship between the prognostic expectations of seriously ill patients undergoing hemodialysis and their nephrologists. JAMA internal medicine. 2013; 173:1206–1214. [PubMed: 23712681]
29. Paterson BL. The shifting perspectives model of chronic illness. Journal of nursing scholarship : an official publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau. 2001; 33:21–26.

30. Song MK, Ward SE, Happ MB, Piraino B, Donovan HS, Shields AM, Connolly MC. Randomized controlled trial of spirit: An effective approach to preparing african-american dialysis patients and families for end of life. Research in nursing & health. 2009; 32:260–273. [PubMed: 19205027]
31. Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. JAMA : the journal of the American Medical Association. 2004; 291:88–93. [PubMed: 14709580]
32. Uhlmann RF, Pearlman RA, Cain KC. Physicians' and spouses' predictions of elderly patients' resuscitation preferences. Journal of gerontology. 1988; 43:M115–121. [PubMed: 3418031]
33. Mack JW, Paulk ME, Viswanath K, Prigerson HG. Racial disparities in the outcomes of communication on medical care received near death. Archives of internal medicine. 2010; 170:1533–1540. [PubMed: 20876403]
34. Zheng NT, Mukamel DB, Caprio T, Cai S, Temkin-Greener H. Racial disparities in in-hospital death and hospice use among nursing home residents at the end of life. Medical care. 2011; 49:992–998. [PubMed: 22002648]
35. Loggers ET, Maciejewski PK, Jimenez R, Nilsson M, Paulk E, Stieglitz H, Prigerson HG. Predictors of intensive end-of-life and hospice care in latino and white advanced cancer patients. Journal of palliative medicine. 2013; 16:1249–1254. [PubMed: 24053593]
36. Hernandez RA, Hevelone ND, Lopez L, Finlayson SR, Chittenden E, Cooper Z. Racial variation in the use of life-sustaining treatments among patients who die after major elective surgery. American journal of surgery. 2015; 210:52–58. [PubMed: 25465749]
37. Dillon PJ, Roscoe LA. African americans and hospice care: A narrative analysis. Narrative inquiry in bioethics. 2015; 5:151–165. [PubMed: 26300148]
38. Cagle JG, LaMantia MA, Williams SW, Pek J, Edwards LJ. Predictors of preference for hospice care among diverse older adults. The American journal of hospice & palliative care. 2015
39. Nicholas SB, Kalantar-Zadeh K, Norris KC. Socioeconomic disparities in chronic kidney disease. Advances in chronic kidney disease. 2015; 22:6–15. [PubMed: 25573507]
40. Bruce MA, Beech BM, Sims M, Brown TN, Wyatt SB, Taylor HA, Williams DR, Crook E. Social environmental stressors, psychological factors, and kidney disease. Journal of investigative medicine : the official publication of the American Federation for Clinical Research. 2009; 57:583–589. [PubMed: 19240646]
41. Kurella M, Covinsky KE, Collins AJ, Chertow GM. Octogenarians and nonagenarians starting dialysis in the united states. Annals of internal medicine. 2007; 146:177–183. [PubMed: 17283348]

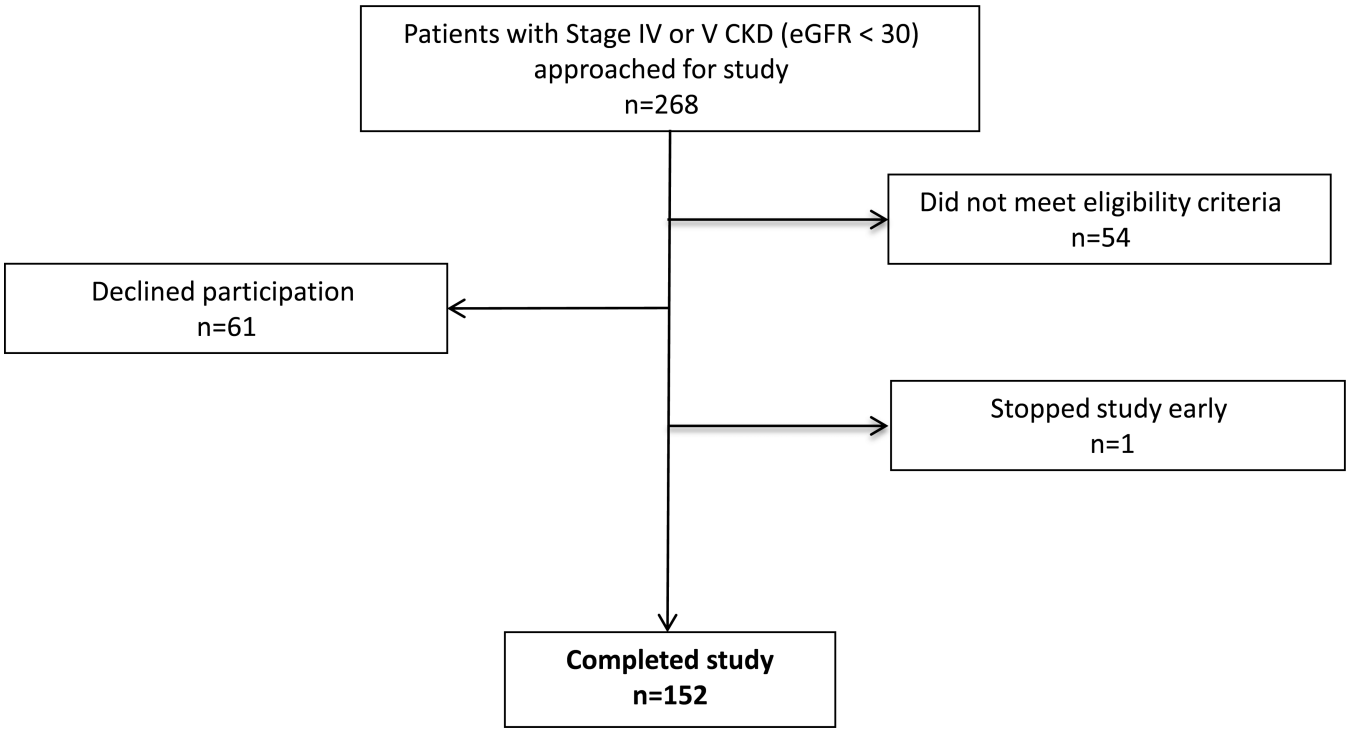


Figure 1.
Study Enrollment

Table 1

Patient characteristics

	Total (N=152)	Black (N=63)	White (N=89)	P-Value
Age, years[1]	69 (11)	66 (11)	70 (10)	0.01
Age ≥ 65, years (%)	68	56	78	< 0.01
Hispanic ethnicity (%)	2	3	1	0.16
Male (%)	61	52	66	0.08
Less than high school education (%)	16	32	4	< 0.01
Income less than $30,000 (%)	47	68	31	< 0.01
Health insured (%)	98	97	99	0.36
Charlson comorbidity index score[1]	7 (2)	7 (2)	7 (2)	0.96
EOL[2] Communication				
No communication of EOL preferences with any healthcare provider EOL (%)	77	76	78	0.85
No communication of EOL preferences with kidney doctor (%)	92	87	96	0.06
No communication of EOL preferences with family members or friends (%)	38	54	27	< 0.01
Advance Care Planning				
No completion of healthcare proxy form (%)	39	51	30	0.01
No completion of DNR[3] form or living will (%)	68	78	62	0.04
EOL Preferences				
Prefer to be resuscitated in current health state (%)	89	90	87	0.57
Prefer to extend life versus comfort care if critically ill (%)	38	56	25	< 0.01
Prefer to stay in the hospital versus go home if critically ill (%)	29	43	20	< 0.01

[1] **Presented as mean (± SD)**

[2] **EOL = End-of-Life**

[3] **DNR = Do Not Resuscitate**

Table 2

Examples of hospice responses[1,2]

Poor Knowledge	Partial Knowledge	Good Knowledge
“It's a place where people who can't take care of their activities of daily living are taken care of.”	“It means that you are seriously ill.”	“It's final care at home or in a suitable setting. It's palliative care.”
“The preface to hospital - a type of hospital.”	“You usually have a 6 month window of dying.”	“Hospice is care that people get when they are dying.”
“It's where people go to be taken care of after an operation.”	“I don't know what it means. Nothing can be done about the person's situation so they go home and die.”	“It means that its giving care to someone in the end stages of life. It's compassionate care among family that helps someone ease into death without pain. It can be at home if desired.”

[1] **Patient responses to “Since you have heard of hospice, what does this mean to you in your own words?”**

[2] **17% of Black patients had good knowledge versus 61% of White patients ($p < 0.01$)**

Table 3

End-of-life life communication, advance care planning, and preferences for Black versus White patients

End-of-life Preference	Unadjusted OR (95% CI)	Adjusted OR[1] (95% CI)	Adjusted OR[2] (95% CI) < 65 years	Adjusted OR[2] (95% CI) ≥ 65 years
No communication of end-of-life preferences with family members of friends	3.18 (1.61, 6.28)**	2.70 (1.08, 6.76)**	3.93 (0.72, 21.61)	1.91 (0.61, 5.95)
No completion of healthcare proxy form	2.16 (1.04, 4.50)**	1.03 (0.39, 2.71)	1.14 (0.22, 5.91)	0.81 (0.23, 2.79)
No completion of living will or DNR[3] form	2.37 (1.21, 4.63)**	2.13 (0.77, 5.90)	4.05 (0.27, 59.63)	1.68 (0.53, 5.33)
Prefer to extend life versus comfort care if critically ill	3.66 (1.85, 7.26)**	3.06 (1.23, 7.60)**	9.15 (1.48, 56.74)**	2.40 (0.74, 7.76)
Prefer to stay in the hospital versus go home if critically ill	2.66 (1.31, 5.40)**	1.87 (0.71, 4.75)	6.49 (0.78, 54.15)	1.45 (0.45, 4.74)

OR, odds ratio; CI, 95% confidence interval.

[1]**Multivariable analyses adjusted for age, education, income, study site, Charlson comorbidity index score, and hospice knowledge**

[2]**Multivariable analyses adjusted for education income, study site, Charlson comorbidity score, and hospice knowledge, stratified by age of 65**

[3]**DNR = Do Not Resuscitate**

Statistically significant, $p < 0.05$

Am J Hosp Palliat Care. 2015 Feb;32(1):84-9. doi: 10.1177/1049909113506782. Epub 2013 Oct 1.

The influence of race on end-of-life choices following a counselor-based palliative consultation

Kathleen Benton [1], James Stephens [2], Robert Vogel [2], Gerald Ledlow [2], Richard Ackermann [3], Carol Babcock [4], Georgia McCook [5]

Affiliations

PMID: 24085311 DOI: 10.1177/1049909113506782

Abstract

Black Americans are more likely than whites to choose aggressive medical care at the end of life. We present a retrospective cohort study of 2843 patients who received a counselor-based palliative care consultation at a large US southeastern hospital. Before the palliative consultation, 72.8% of the patients had no restrictions in care, and only 4.6% had chosen care and comfort only (CCO). After the consult, these choices dramatically changed, with only 17.5% remaining full code and 43.3% choosing CCO. Both before and after palliative consultation, blacks chose more aggressive medical care than whites, but racial differences diminished after the counselor-based consultation. Both African American and white patients and families receiving a counselor-based palliative consultation in the hospital make profound changes in their preferences for life-sustaining treatments.

Keywords: African Americans; hospice; mortality; palliative consultation; resuscitation; treatment preferences.

LinkOut - more resources

Virtual Mentor
American Medical Association Journal of Ethics
September 2006, Volume 8, Number 9: 613-616.

Op-ed
Racial disparities in hospice: moving from analysis to intervention
by Ramona L. Rhodes, MD, MPH

Hospice is a program designed to provide comfort—rather than curative—care to terminally ill patients and support to their families. Hospice services are provided by a multidisciplinary team of physicians, nurses, social workers, clergy and volunteers who work together to help patients and their families meet the challenges of end-of-life care. Hospice services can be provided in a variety of venues including the home, inpatient hospice facilities and long-term-care facilities. Several studies have documented the benefits of hospice to patients and their families. For example, in a randomized, controlled trial of terminally ill cancer patients and their primary care givers, Kane et al. found that patients enrolled in a hospice program experienced significantly less depression and expressed more satisfaction with care [1]. Furthermore, caregivers of hospice patients showed somewhat more satisfaction and less anxiety than did those of controls [1]. Bereaved family members told Teno and colleagues in a national study that loved ones who died at home with hospice services had reported fewer unmet needs and greater satisfaction with their experience [2]. Finally, Miller et al. observed that hospice enrollment improves pain assessment and management for nursing home residents [3]. The literature consistently finds that participation in a hospice program improves the quality of care patients receive at the end of life.

Since the inception of the Medicare hospice benefit, hospice services have been available to many patients. Despite these additional sources of funding and the evidence of improved quality of care at the end of life, African Americans and members of other ethnic minority groups consistently underutilize hospice. For example, in a secondary analysis of the 1993 National Mortality Followback Survey, Greiner et al. found that being African American was negatively associated with hospice use regardless of the patient's access to health care [4]. In a retrospective analysis of more than one million Medicare enrollees, Virnig and colleagues found that the rate of hospice use was significantly lower for blacks than for nonblacks [5]. Furthermore, even though blacks made up 12 percent of the population of the United States in 2004 they accounted for only 8.1 percent of hospice admissions for that year [6].

Several possible causes for racial disparity in hospice utilization have been proposed. Research has suggested, for instance, that lack of knowledge about hospice programs is a barrier to their use in the African American community [7]. Mistrust of the

health care system, conflicts between individuals' spiritual and cultural beliefs and the goals of hospice care, and preferences for aggressive life-sustaining therapies have also been suggested as causes [8-12]. Some believe that providers' conscious or unconscious stereotyping of their patients may also lead to disparities in health care [13]. Additionally, the prohibitive cost of health care, barriers to access and a culturally insensitive health care system have been thought to contribute [8]. Few of these reasons for underutilization of hospice services by African Americans and members of other minority and ethnic groups have been studied in depth.

When compared with use by Caucasian patients, not only do African Americans underutilize hospice, they also perceive the quality of end-of-life care differently. According to Welch et al. blacks were less likely to rate the care their family members received at the end of life as "excellent" or "very good." They were more likely to have concerns about being told what to expect when their loved one died and more likely to be distressed about the amount of emotional support they received from the health care team during their loved one's last days [14]. There were, however, marked decreases in the disparities noted in perceptions about the quality of care once patients enrolled in hospice, particularly with regard to overall satisfaction with services and attending to the needs of family members [15]. Hence, there is evidence that having hospice care leads to improvements in African Americans' perceptions of end-of-life care.

Though initiatives have been implemented in some areas, more culturally sensitive education is needed to increase awareness of hospice and its benefits. Some studies suggest that cultural diversity among hospice staff may influence diversity among hospice patients [11]. Consequently, hospice programs should strive to increase diversity not only among their patient populations but also among their employees and volunteers. Given that conflicts between cultural preferences and hospice goals are thought to inhibit its utilization, cultural sensitivity should be emphasized to all health care workers, particularly those who care for patients at the end of life. Interventions directed at these areas are sorely needed, as is evaluation of their effectiveness.

Access to hospice has been increasingly thought of as a public health matter. The right to quality care at the end of life is one that should be extended to everyone regardless of race, ethnic background or socioeconomic status. Barriers to hospice utilization should be researched and identified so that appropriate interventions can be conducted to overcome these obstacles. The evidence that hospice is underutilized by those of underserved communities is substantial, but few steps are being taken to understand and reverse this trend. The time has come for research to move from the analysis of disparities in end-of-life care and hospice utilization to identification of barriers and interventions to reverse the trend.

References

1. Kane RL, Wales J, Bernstein L, Leibowitz A, Kaplan S. A randomized

controlled trial of hospice care. *Lancet*. 1984;2:890-892.
2. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004;291:88-93.
3. Miller SC, Mor V, Teno J. Hospice enrollment and pain assessment and management in nursing homes. *J Pain Symptom Manage*. 2003;26:791-799.
4. Greiner KA, Perera S, Ahluwalia JS. Hospice usage by minorities in the last year of life: results from the National Mortality Followback Survey. *J Am Geriatr Soc.* 2003;51:970-978.
5. Virnig BA, Kind S, McBean M, Fisher E. Geographic variation in hospice use prior to death. *J Am Geriatr Soc.* 2000;48:1117-1125.
6. National Hospice and Palliative Care Organization. *NHPCO's 2004 Facts and Figures*. Available at: www.nhpco.org/files/public/Facts_Figures_for2004data.pdf. Accessed July 31, 2006.
7. Rhodes RL, Teno JM, Welch LC. Access to hospice for African Americans: are they informed about the option of hospice? *J Palliat Med.* 2006;9:268-272.
8. Born W, Greiner KA, Sylvia E, Butler J, Ahluwalia JS. Knowledge, attitudes, and beliefs about end-of-life care among inner-city African Americans and Latinos. *J Palliat Med*. 2004;7:247-256.
9. Jackson F, Schim SM, Seeley S, Grunow K, Baker J. Barriers to hospice care for African Americans: problems and solutions. *J Hosp Palliat Nursing.* 2000;2:65-72.
10. Reese DJ, Ahern RE, Nair S, O'Faire JD, Warren C. Hospice access and use by African Americans: addressing cultural and institutional barriers through participatory action research. *Soc Work*. 1999;44:549-559.
11. Reese DJ, Melton E, Ciaravino K. Programmatic barriers to providing culturally competent end-of-life care. *Am J Hosp Palliat Care*. 2004;21:357-364.
12. McKinley ED, Garrett JM, Evans AT, Danis M. Differences in end-of-life decision making among black and white ambulatory cancer patients. *J Gen Intern Med*. 1996;11:651-656.
13. Strothers HS III, Rust G, Minor P, Fresh E, Druss B, Satcher D. Disparities in antidepressant treatment in Medicaid elderly diagnosed with depression. *J Am Geriatr Soc*. 2005;53:456-461.
14. Welch LC, Teno JM, Mor V. End-of-life care in black and white: race matters for medical care of dying patients and their families. *J Am Geriatr Soc.* 2005;53:1145-1153.
15. Rhodes RL, Teno JM, Connor SR. Bereaved family members' perceptions of satisfaction with hospice services: do racial differences exist? *J Am Geriatr Soc.* 2006;54:S5.

Ramona L. Rhodes, MD, MPH, is an assistant professor in the Division of Geriatrics at Brown Medical School in Providence, R.I., and a researcher at Brown

University's Center for Gerontology and Health Care Research. Her research examines racial differences in long-term care and end-of-life care.

Related articles
Should cost be a consideration in offering palliative care? September 2006

Dying well in America: What is required of physicians? September 2006

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

CHARITY CARE
Policy No. 5-017

PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

Moments Hospice will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient must provide personal financial information upon which the determination of charity care will be made.

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

3. The Executive Director/Administrator, with the appropriate program director, will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding-fee schedule to be implemented.

6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the organization is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

FIVE WISHES®

MY WISH FOR:

1 The Person I Want to Make Care Decisions for Me When I Can't

2 The Kind of Medical Treatment I Want or Don't Want

3 How Comfortable I Want to Be

4 How I Want People to Treat Me

5 What I Want My Loved Ones to Know

print your name

birthdate

Five Wishes

There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important—how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed it is valid under the laws of most states.

What Is Five Wishes?

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association's Commission on Law and Aging, and the nation's leading experts in end-of-life care. It's also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won't have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants. You can be there for them when they need you most. You will understand what they really want.

How Five Wishes Began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC's Today Show and in the pages of *Time* and *Money* magazines. Newspapers have called Five Wishes the first "living will with a heart and soul." Today, Five Wishes is available in 28 languages.

Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 30 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States

If you live in the **District of Columbia** or one of the **42 states** listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law:

Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kentucky	Nevada	Tennessee
California	Louisiana	New Jersey	Vermont
Colorado	Maine	New Mexico	Virginia
Connecticut	Maryland	New York	Washington
Delaware	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wisconsin
Georgia	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Pennsylvania	
Idaho	Missouri	Rhode Island	

If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state's legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. *AND*
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

First Choice Name _____ Phone _____

Address _____ City/State/Zip _____

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Second Choice Name _____ Third Choice Name _____

Address _____ Address _____

City/State/Zip _____ City/State/Zip _____

Phone _____ Phone _____

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: **(Please cross out anything you don't want your Agent to do that is listed below.)**

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

_____

_____

_____

_____

_____

_____

_____

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

Close to death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location_____.
- The following person knows my funeral wishes: _____.

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

_____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

_____

_____

_____

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

_____

_____

_____

Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, _____, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature: _____

Address: _____

Phone: _____ Date: _____

Witness Statement • (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)

_____	_____
Signature of Witness #1	Signature of Witness #2
_____	_____
Printed Name of Witness	Printed Name of Witness
_____	_____
Address	Address
_____	_____
Phone	Phone

Notarization • Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF _____ COUNTY OF _____

On this _____ day of _____, 20_____, the said _____, _____, and _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: _____

Notary Public

What To Do After You Complete Five Wishes

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:

_____

_____

_____

Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, and Vermont Must Follow Special Witnessing Rules.

If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

_____
Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

_____
Name

_____
Address City/State/Zip

_____
Phone

My primary care physician is:

_____
Name

_____
Address City/State/Zip

_____
Phone

My document is located at:

_____

_____

_____

_____

Cut Out Card, Fold and Laminate for Safekeeping

Here's What People Are Saying About Five Wishes:

"It will be a year since my mother passed on. We knew what she wanted because she had the Five Wishes living will. When it came down to the end, my brother and I had no questions on what we needed to do. We had peace of mind."

Cheryl K.
Longwood, Florida

"I must say I love your Five Wishes. It's clear, easy to understand, and doesn't dwell on the concrete issues of medical care, but on the issues of real importance—human care. I used it for myself and my husband."

Susan W.
Flagstaff, Arizona

"I don't want my children to have to make the decisions I am having to make for my mother. I never knew that there were so many medical options to be considered. Thank you for such a sensitive and caring form. I can simply fill it out and have it on file for my children."

Diana W.
Hanover, Illinois

To Order:

Call (888) 5-WISHES to purchase more copies of Five Wishes, the Five Wishes DVD, or the Conversation Guide for Individuals and Families. Ask about the "Family Package" that includes 10 Five Wishes, 2 Conversation Guides, and 1 DVD at a savings of more than 50%. For more information visit Five Wishes' website, or call for details.

(888) 5-WISHES or (888) 594-7437

www.FiveWishes.org

Aging with Dignity

P.O. Box 1661
Tallahassee, Florida 32302-1661

Hospice Admission Booklet

Moments Hospice™

Moments are Forever

☐ **Brainerd Office:**
17021 Commercial Park Rd.
Suite 8
Brainerd, MN 56401
Phone: (218) 513-2370
Fax: (218) 513-2371

☐ **Golden Valley Office:**
820 Lilac Drive N.
Suite 210
Golden Valley, MN 55422
Phone: (763) 205-3600
Fax: (763) 205-9350

☐ **Hermantown Office:**
4897 Miller Trunk Hwy
Suite 220
Hermantown, MN 55811
Phone: (218) 520-0870
Fax: (218) 520-0875

☐ **Mankato Office:**
124 E Walnut Street
Suite 330
Mankato, MN 56001
Phone: (507) 609-8800
Fax: (507) 609-8810

☐ **Rochester Office:**
1816 2nd Street SW
Suite B
Rochester, MN 55902
Phone: (507) 888-9700
Fax: (507) 888-9780

☐ **St. Cloud Office:**
2229 Roosevelt Road
Suite #1
St. Cloud, MN 56301
Phone: (320) 372-4300
Fax: (320) 372-4380

CHAP
EST. 1965

STATEMENT OF CONFIDENTIALITY
This booklet may contain protected health information. Persons other than you and your health care providers must have your permission to view this booklet.

Office Hours and On-Call Guidelines

OFFICE HOURS

Our office hours are Monday through Friday from 8:30 a.m. to 5:00 p.m., except during holidays.

ON-CALL GUIDELINES

We are committed to being available to help you 24 hours a day, 7 days a week, 365 days a year. When our office is closed, there is an experienced hospice RN available to assist you with any needs you may have over the phone. There is an RN available to provide visits if phone assistance is not adequate at the time.

Do not call 911 before calling Moments Hospice.

We know that you may find yourself in a scary situation and want to get help fast. Calling Moments instead of 911 will give you the help you need while following the plan of care that was chosen at time of admission to hospice. *If you have called 911, please call Moments Hospice to inform us. We will help you to talk with the paramedics and/or staff in the emergency room to determine what you want to do for your loved one.*

EXAMPLES OF REASONS TO CALL

During office hours:

- Medication refills
- Messages for your primary nurse
- Supplies are needed
- Questions about visit schedule
- Messages for social worker, spiritual counselor or other hospice staff
- Questions about the hospice aide/homemaker

After hours or when office is closed:

- Pain that does not respond to pain medication on hand
- Difficulty breathing
- Patient is more agitated or restless than previously—cannot relax well
- If the patient has fallen (visits provided if injury has occurred)
- Uncontrolled symptoms: nausea, vomiting or diarrhea, bleeding
- Fever greater than 101°F (after Tylenol® given)
- Unable to awaken patient
- Patient was taken to the hospital
- Patient death

Moments Hospice is available to help you with whatever you need. Please do not hesitate to contact us.

Hospice Admission Booklet

Rev. 10/20

Moments Hospice™

Moments are Forever

Welcome, Mission and Philosophy

OUR MISSION STATEMENT: Changing the Hospice experience, one Moment at a time.

Moments Hospice seeks to positively change your hospice experience by following our vision of:

- Keeping patients at the center of all we do, Moments Hospice seeks to fulfill our promise of comfort and dignity from admission through bereavement.
- Utilizing "The Moments Way," we serve patients, families and referral partners with expertise and integrity.
- Investing in technology and resources to create an effective work environment to provide exceptional care.
- With humility, Moments Hospice utilizes each missed opportunity to create process improvement.
- Through educational empowerment, we create a better understanding and use of the Hospice benefit.

Moments Hospice is privately owned and operated. The hospice is accredited by Community Health Accreditation Partner (CHAP) and licensed in the state of Minnesota. We are committed to ensuring your rights and privileges as a hospice patient. We have written this booklet to help you better understand hospice care. If you have additional questions, please do not hesitate to ask us.

We are honored and thankful that you have chosen Moments as your hospice provider.

The Leadership and Staff of Moments Hospice.

SECTION I.

HOSPICE OVERVIEW

This booklet contains general information regarding your rights and responsibilities as a patient. As state and federal regulations change, there may be additions or changes to this booklet as necessary. Our complete policy and procedure manual regarding your care and treatment is available upon request for your viewing at the agency office at any time during normal office hours.

CRITERIA FOR ADMISSION

Admission to our hospice program is made upon the recommendation of your physician and is based upon your needs. Normally, appropriate candidates for hospice are patients:

- With a life expectancy of 6 months or less if the illness runs its normal course;
- Who desire palliative treatment;
- Who want to stay at home as long as possible; and
- Who have a primary care person.

On admission, our nurse will visit you or your family to discuss hospice services, assess your immediate needs and recommend a plan of care.

If we cannot meet your needs, either directly by our hospice or indirectly through service agreements with other providers, we will not admit you or will not continue to provide services to you.

HOSPICE CONCEPT

What is Hospice?

- Hospice care provides comfort and kindness to those persons nearing the end of life's journey.
- Hospice will help you make decisions about how and where you want to spend the rest of your life.
- Hospice is a special kind of caring.

Why Hospice?

- Hospice treats you, not the disease. The focus is on care, not cure. You and your family's medical, social, emotional and spiritual needs are addressed by a team of hospice professionals and volunteers.
- Hospice considers your entire family, not just you, as the "unit of care." You and your family are included in the decision making process. Hospice will help you and your family make choices about end-of-life issues and enable you to have greater control over these choices. Bereavement counseling is provided to your family for up to 13 months after your death.
- Hospice offers palliative, rather than curative treatment. Hospice will provide care and comfort when cure is no longer an option. Through ever advancing technology, pain and symptom control will enable you to live as fully and comfortably as possible.
- Hospice emphasizes quality, rather than length of life. Hospice neither hastens nor postpones your death. It affirms life and regards dying as a normal process.

SERVICES

Hospice services are provided by an interdisciplinary team including **Nursing, Physician, Medical Social Services, Spiritual Services, Hospice Aide, Volunteers and therapies** if determined to be necessary by the team. In addition to the team, hospice provides approved medications, medical supplies and equipment, as appropriate.

THE ROLES OF THE HOSPICE STAFF

Primary Care Nurse (Case Manager): You will be assigned a primary care nurse who will coordinate your care with the other members of the interdisciplinary group.

- Helping to keep symptoms under control
- Teaching caregivers the best way to provide care
- Ordering medical supplies and equipment
- Communicating with doctors
- Teaching progression of disease, helping you know what to expect
- Giving information needed to help with decisions needed

Your nurse/case manager will help develop your plan of care and include any other disciplines in your care that would be beneficial for the patient.

Physician Services: Both your attending physician and the hospice medical director will be a part of your team to manage symptoms and maintain as much comfort as possible.

Medical Social Worker: Due to the stressful nature of end-of-life care, social workers are required to help with multiple needs, from financial to emotional concerns. They may help with finding nursing home placement or funeral arrangements.

Hospice Aide: Trained aides to assist with bathing, dressing and other activities of daily living as directed by the case manager.

Spiritual Counselor (Chaplain): As people face death, they often have questions that are spiritual in nature. Our Spiritual Counselors or Chaplains can address any needs of any faith or religion or spiritual concerns that are not religious in nature.

Additional Therapies: Your case manager has the ability to utilize music, massage, volunteers, physical/occupational/speech therapy or dietary counseling as needed to address any symptoms that arise.

Bereavement: Bereavement services are offered to the families/friends who are left behind after the patient passes. These services are offered for 13 months following the death and include mailings, phone counseling and in-person counseling as needed to deal with the grief and loss of their loved one. For needs that exceed the scope of hospice bereavement services, referrals to other organizations and professionals within the community are available. These services are also made available to anyone in the community in which hospice services are provided.

LEVELS OF HOSPICE CARE

Routine Home Care: Care is provided intermittently by hospice team members in the patient's or family's home or in a nursing care facility.

General Inpatient Care: Care is provided at a contractual hospital, skilled nursing facility or inpatient hospice facility for patients who need pain control or acute/chronic symptom management which cannot be managed in other settings. The necessity for inpatient care and paid length of stay will be determined by the hospice interdisciplinary group. If a hospice patient needs hospitalization for any reason unrelated to the terminal diagnosis, traditional Medicare Part A will be utilized.

Inpatient Respite Care: Up to five (5) days of respite care at a contractual hospital, nursing care facility or inpatient hospice facility will be paid by hospice, if approved by the hospice interdisciplinary group. This benefit may be used to give the family/caregiver a rest and the patient does not need to meet acute care standards.

Continuous Home Care: A minimum of eight (8) hours of care per day may be provided during periods of crisis to maintain the patient at home. Criteria for continuous home care are the same as general inpatient care and consist predominantly of nursing care, however, hospice aides or homemakers may also supplement nursing care.

MEDICARE HOSPICE BENEFIT

If you are receiving care under the Medicare Hospice Benefit, Medicare requires that no more than 30 days prior to the beginning of the third benefit period (180 days) and prior to each subsequent benefit period, a hospice physician or nurse practitioner must conduct a face-to-face visit with you to determine continued eligibility for hospice care. If you refuse to allow the face-to-face visit, you will no longer be eligible to receive hospice care under the Medicare Hospice Benefit.

If you have Medicare Part D coverage, we will work with your physician and pharmacy to determine which medications we will cover under the Medicare Hospice Benefit, which medications will be covered under your Part D plan and which medications are determined to be no longer medically necessary and if continued, would become your financial responsibility. If you disagree with any drug coverage determination, you may appeal the decision through the Medicare fee-for-service appeals process, Part D appeals process or submit a complaint with a Medicare-contracted Quality Improvement Organization (QIO). Please ask your hospice representative if you need assistance with any of these steps.

Medicare will reimburse the cost of hospice care under your Medicare Hospital Insurance (Part A). When all requirements are met Medicare will cover the following:

Services Covered Under the Medicare Hospice Benefit (if included in the plan of care)	**Services Not Covered Under the Medicare Hospice Benefit**
• Physician services • Nursing care • Medical appliances and supplies • Medications for symptom management and pain relief of the terminal illness and related conditions (must be pre-approved by hospice) • Short-term inpatient care for pain and symptom control • Hospice aide/homemaker • Spiritual counseling • Bereavement counseling • Physical therapy, occupational therapy, speech therapy • Medical social services • Dietary counseling • Volunteer services • Short-term respite care	• Treatment for the terminal illness which is not for palliative symptom management and is not within the hospice plan of care • Care provided by another hospice that was not arranged by the patient's hospice • Ambulance transportation not included in the plan of care • Medications that are not related to the terminal illness • Visits to the emergency department without the prior approval or arrangements by hospice • Inpatient care at non-contracted facilities • Sitter services/hired caregivers • Admission to the hospital without the prior approval or arrangements by hospice • Lab studies, medical testing and/or any treatments not indicated

CHARGES

In most cases, your insurance company will pay hospice directly; however, not all insurance plans provide full coverage for hospice care and some hospice services may not be covered under your plan. We receive our reimbursement from Medicare, Medicaid and private health insurance for services. All third-party payers are billed for hospice services as appropriate.

All patients, who meet the requirements, are accepted regardless of ability to pay. Medicare or Medicaid patients will not be refused care or have their hospice care discontinued or reduced due to their inability to pay for that care. Our social worker will meet with the patient/family to determine concerns and needs.

If you are an Original Medicare (fee for service) beneficiary and we believe Medicare may not pay for an item or service that Medicare usually covers, you or your authorized representative will be issued and asked to sign and date an **Advance Beneficiary Notice (ABN)** prior to receiving the service.

Should any change be made in this policy regarding services or charges, you or your responsible party will be advised. Please call our office if you have questions about charges or insurance billing.

PLAN OF CARE

Our hospice involves key professionals and other staff members in developing your individual plan of care, which is based upon identified problems, needs and goals, physician orders for medications, treatments and care, your environment and your personal wishes whenever possible. Effective pain management is an important part of your treatment plan.

The plan includes five basic areas:

- Physical Care
- Psychosocial Needs
- Spiritual Needs
- Bereavement Care
- Personal Care and Comfort

The plan is reviewed and updated as needed, based on your changing needs. We encourage your participation and will provide necessary medical information to assist you. You have the right to refuse any medication or treatment procedure; however, such refusal may require us to obtain a written statement releasing the agency from all responsibility resulting from such action. Should this happen, we would encourage you to discuss the matter with your physician for advice and guidance.

On admission, you and an agency clinician will create a list of your current medications (including any over-the-counter medications, herbal remedies and vitamins). We will compare this list to the medications ordered by your physician. Our staff will continue to compare the list to the medications that are ordered, administered or dispensed to you while under our care. This will be done to resolve any discrepancies (such as omissions, duplications, contraindications, unclear information, potential interactions and changes).

We fully recognize your right to dignity and individuality, including privacy in treatment and in the care of your personal needs. We will always notify you if an additional individual needs to be present for your visit for reasons of safety, education or supervision. Prior to anyone visiting your home, we will ask your permission. You have the right to refuse any visitors and this will not compromise your care in any way.

We do not participate in any experimental research connected with patient care, except under the direction of your physician and with your written consent.

There must be a willing, able and available caregiver to be responsible for your care between hospice visits. This person can be you, a family member, a friend or a paid caregiver.

MEDICAL RECORDS

Your medical record is maintained by our staff to document physician orders, assessments, progress notes and treatments. Your records are kept strictly confidential by our staff and are protected against loss, destruction, tampering or unauthorized use. Our Notice of Privacy Practices describes how your protected health information may be used by us or disclosed to others, as well as how you may have access to this information.

DISCHARGE, TRANSFER AND REFERRAL POLICY

Discharge, transfer or referral from hospice may result from several types of situations including the following:

- The hospice determines that the patient is no longer terminally ill;
- The patient moves out of the hospice's service area;
- The patient is receiving treatment for a medical condition unrelated to the terminal illness or related conditions in a facility with which the hospice does not have a contract and is unable to access the patient to provide hospice services;
- The patient transfers to another hospice;
- The patient's behavior (or situation) is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired;
- Issues of patient or staff safety cannot be resolved; and/or
- Patient/family requests to end (revoke) the services of the hospice.

You will be given at least ten days' advance notice of the termination of a service, except in cases where:

- You engage in conduct that alters the conditions of employment between the hospice provider and the individual providing hospice services, or create an abusive or unsafe work environment for the individual providing hospice services;
- An emergency for the informal caregiver or a significant change in your condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the hospice provider; and/or
- You are no longer certified as terminally ill.

You will be given a timely advance notice of a transfer to another agency or discharge, except in case of emergency. If you are referred, transferred or discharged to another organization, we will provide them with a list of your current medications and information necessary for your continued care, including pain management.

If you are discharged because you are no longer considered to be terminally ill, we will provide any necessary family counseling, patient education or other services as indicated.

All transfers or discharges will be documented in the medical chart on a discharge summary. When a discharge occurs, an assessment will be completed and instructions will be provided for any needed ongoing care or treatment. We will coordinate your referral to available community resources as needed.

If you are a Medicare beneficiary, you or your authorized representative will receive and be asked to sign and date a **Notice of Medicare Non-Coverage (NOMNC)** at least two days before your covered Medicare services will end. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice. If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) at the phone number listed on the form no later than noon of the day before your services are to end and ask for an immediate appeal.

EXPERIENCE OF CARE/PATIENT SATISFACTION SURVEYS

Our hospice has contracted with Strategic Healthcare Programs (SHP), a vendor approved by the Centers for Medicare and Medicaid Services (CMS) to perform mandatory Consumer Assessment of HealthCare Providers and Systems (CAHPS) surveys. The survey considers you and your primary caregiver as a unit of care. SHP may contact your caregiver or family member by mail or telephone after your death to evaluate the experience of care and services you and your loved ones received from our hospice agency.

Our patients are very important to us. Please ask questions if something is unclear regarding our services or the care you receive or fail to receive. Our hospice agency may also contact you, your caregiver or family at intervals to assess your satisfaction with the care and services we are providing. We will not ask the same questions included in the CAHPS survey. Your answers will help us to improve our services and ensure that we meet your needs and expectations.

NOTICE OF NONDISCRIMINATION

Moments Hospice complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of social status, political belief, sexual preference, race, color, religion, national origin, age, sex or disability with regard to admission, access to treatment or employment.

Moments Hospice provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats); and free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Moments Hospice.

PROBLEM SOLVING PROCEDURE

1. You may contact a supervisor by phone 24 hours daily, 7 days a week at the number checked on the front or back cover of this booklet.
2. Written complaints and correspondence may be sent to the appropriate address checked on the front cover of this booklet.
3. You may also contact the state's toll-free home care hotline at **1-800-369-7994, TDD: (651) 201-5797**, which operates from 8:00 a.m. to 4:30 p.m., Monday through Friday (except holidays). If voicemail answers, please leave a message and your call will be returned. The purpose of the hotline is to receive complaints or questions about local home care/hospice agencies and to lodge complaints concerning the implementation of advance directive requirements. You may also submit your complaint in writing to P.O. Box 64970, St. Paul, MN 55164-0970.
4. You may also contact the Ombudsman for Long-Term Care by calling **1-800-657-3591** or in writing at Home Care Ombudsman, Ombudsman for Long-Term Care, P.O. Box 64971, St. Paul, MN 55164-0971.
5. You may also contact the Ombudsman for Mental Health and Developmental Disabilities by phone at **1-800-657-3506** or in writing at Ombudsman for Mental Health and Developmental Disabilities, 121 7th Place East, Suite 420, Metro Square Building, St. Paul, MN 55101-2117.
6. You may also contact the CHAP hotline 24 hours a day at **1-800-656-9656.** Customer service hours of operation are 8:00 a.m. to 6:00 p.m., Eastern Time, Monday through Friday (except holidays).

SECTION II.

COMBINED MINNESOTA AND FEDERAL HOSPICE BILL OF RIGHTS

Minnesota Hospice Bill of Rights Per Minnesota Statutes, Section 144a.751

The language in **bold** print represents additional consumer rights under federal law for patients of Medicare-certified hospices.

Subdivision 1. **Statement of rights.** An individual who receives hospice care has the right to:

Be informed of his or her rights and the hospice must protect and promote the exercise of these rights.

(1) **Exercise his or her rights as a patient of the hospice.** Receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated.

Notice of rights and responsibilities: (1) During the initial assessment visit in advance of furnishing care, the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands; (2) The hospice must comply with the requirements of subpart I of part Code of Federal Regulations (CFR) 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law; (3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

(2) Receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services. **Be involved in developing his or her hospice plan of care.**

(3) Be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequence of these choices, including the consequences of refusing these services.

(4) Be told in advance, whenever possible, of any change in the hospice plan of care and to take an active part in any change.

(5) Refuse **care**, services or treatment.

(6) Know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services.

Receive information about the scope of services that the hospice will provide and specific limitations on those services.

(7) Know in advance of receiving care whether the hospice services may be covered by health insurance, medical assistance, Medicare, or other health programs in which the individual is enrolled. **Receive information about the services covered under the hospice benefit.**

(8) Receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services.

(9) Know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services.

(10) Choose freely among available providers and change providers after services have begun, within the limits of health insurance, medical assistance, Medicare, or other health programs. **Choose his or her attending physician.**

(11) Have personal, financial, and medical information kept private and be advised of the provider's policies and procedures regarding disclosure of such information.

(12) Be allowed access to records and written information from records according to section 144.291 to 144.298. **Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.**

(13) Be served by people who are properly trained and competent to perform their duties.

(14) Be treated with courtesy and respect and to have the patient's property treated with respect. To have his or her property and person treated with respect.

(15) Voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property **by anyone who is furnishing services on behalf of the hospice. The patient has the right to not be subjected to discrimination or reprisal for exercising his or her rights.**

(16) Be free from physical and verbal abuse. **Be free from mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property.**

(17) Reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) The recipient of services engages in conduct that alters the conditions of employment between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing hospice services;

(ii) An emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the hospice provider; or

(iii) The recipient is no longer certified as terminally ill;

(18) A coordinated transfer when there will be a change in the provider of services.

(19) Know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint.

(20) Know the name and address of the state or county agency to contact for additional information or assistance.

(21) Assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation. **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. 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.**

(22) Have pain and symptoms managed to the patient's desired level of comfort. Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

The hospice must:

- **Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries or unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice, are reported immediately by hospice employees and contracted staff to the hospice administrator.**
- **Immediately investigate all alleged violations involving anyone furnishing services on behalf of the hospice and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures.**
- **Take appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency.**
- **Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation.**

If the hospice provider operates a residential hospice facility, the written notice to each residential hospice patient must include the number and qualifications of the personnel, including both staff persons and volunteers, employed by the provider to meet the requirements of MN Rule 4664.0390 on each shift at the residential hospice facility.

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOSPICE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR LONG-TERM CARE.

MINNESOTA DEPARTMENT OF HEALTH

OFFICE OF HEALTH FACILITY COMPLAINTS
85 East Seventh Place, Suite 300
P.O. Box 64970
St. Paul, MN 55164-0970
Phone: (651) 201-4201 or 1-800-369-7994
Fax: (651) 281-9796
health.ohfc-complaints@state.mn.us
https://www.health.state.mn.us/facilities/regulation/ohfc/index.html

OMBUDSMAN FOR LONG-TERM CARE
P.O. Box 64971
St. Paul, MN 55164-0971
Phone: (651) 431-2555 or 1-800-657-3591
Fax: (651) 431-7452
mba.ooltc@state.mn.us
http://www.mnaging.org/Advocate/OLTC.aspx

MEDICARE BENEFICIARY AND FAMILY CENTERED CARE QUALITY IMPROVEMENT ORGANIZATION LIVANTA, LLC
BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
Phone: 1-888-524-9900; TTY 1-888-985-8775
https://livantaqio.com/en/Beneficiary/Immediate_Advocacy

Licensee Name: Moments Hospice			
	Telephone Number:	**Address:**	**Title of Person to Whom Problems or Complaints May be directed:**
Brainerd	(218) 513-2370	17021 Commercial Park Rd. Suite 8 Brainerd, MN 56401	Administrator
Golden Valley	(763) 205-3600	820 Lilac Drive N. Suite 210 Golden Valley, MN 55422	Administrator
Hermantown	(218) 520-0870	4897 Miller Trunk Hwy Suite 220 Hermantown, MN 55811	Administrator
Mankato	(507) 609-8800	124 E Walnut Street Suite 330 Mankato, MN 56001	Administrator
Rochester	(507) 888-9700	1816 2nd Street SW Suite B Rochester, MN 55902	Administrator
St. Cloud	(320) 372-4300	2229 Roosevelt Road Suite 1 St. Cloud, MN 56301	Administrator

Subd. 2. **Interpretation and enforcement of rights.**
The rights under this section are established for the benefit of individuals who receive hospice care. A hospice provider may not require a person to surrender these rights as a condition of receiving hospice care. A guardian or conservator or, when there is no guardian or conservator, a designated person, may seek to enforce these rights. This statement of rights does not replace or diminish other rights and liberties that may exist relative to persons receiving hospice care, persons providing hospice care, or hospice providers licensed under section 144A.753.

Subd. 3. **Disclosure.** A copy of these rights must be provided to an individual at the time hospice care is initiated. The copy shall contain the address and telephone number of the Office of Health Facility Complaints and the Office of the Ombudsman for Older Minnesotans and a brief statement describing how to file a complaint with these offices. Information about how to contact the Office of the Ombudsman of the Ombudsman for Older Minnesotans shall be included in the notices of change in provider fees and in notices where hospice providers initiate transfer or discontinuation of services.

ADDITIONAL RIGHTS

YOU HAVE THE RIGHT TO:

- Have a relationship with our staff that is based on honesty and ethical standards of conduct and to have ethical issues addressed. You have the right to be informed of any financial benefit we receive if we refer you to another organization, service, individual or other reciprocal relationship.
- Have all mistreatment, abuse, neglect, injury and exploitation complaints by anyone furnishing service on behalf of hospice are reported immediately by our staff to the hospice administrator. All reports will be promptly investigated and immediate action taken to prevent potential violations during our investigation. Hospice will take appropriate corrective action in accordance with state law. All verified violations will be reported to the appropriate state/local authorities, including to the state survey and certification agency within five (5) working days of becoming aware of the violation, unless state regulations are more stringent. If our agency staff suspects abuse or mistreatment of any kind, we will report our suspicions in accordance with our policy and state law.
- Be free from physical and mental abuse, corporal punishment, restraint or seclusion of any form imposed as a means of coercion, discipline, convenience or retaliation by staff while receiving hospice care.
- Have cultural, psychosocial, spiritual and personal values, beliefs and preferences respected. You will not be discriminated against based on social status, political belief, sexual preference, race, color, religion, national origin, age, sex or disability. If you feel that you have been the victim of discrimination, you have the right to file a grievance without retaliation for doing so. Our staff is prohibited from accepting gifts or borrowing from you.
- Have an environment that preserves dignity and contributes to a positive self-image.
- Receive information in plain language to ensure accurate communication, in a manner that is accessible, timely and free of charge to:
    - Persons with disabilities. This includes access to websites, auxiliary aids and services in accordance with state and federal law and regulations.
    - Persons with limited English proficiency. This includes access to interpreters and written translation.

- Voice grievances without fear of coercion, or an unreasonable interruption in care, treatment or services for doing so. The organization must document both the existence of a complaint and the resolution of the complaint. Our complaint resolution process is explained in our Problem Solving Procedure.
- Have family involved in decision making as appropriate concerning your care, treatment and services, when approved by you or your representative, if any, and when allowed by law.
- Participate or refuse to participate in research, investigational or experimental studies or clinical trials. Your access to care, treatment and services will not be affected if you refuse or discontinue participation in research.
- Formulate advance directives. You will be informed if we cannot implement an advance directive on the basis of conscience.
- Have your wishes concerning end-of-life decisions addressed and to have health care providers comply with your advance directives in accordance with state laws. You have the right to receive care without conditions or discrimination based on the execution of advance directives.
- Accept, refuse or discontinue care, treatment and services without fear of reprisal. You may refuse part or all of care/services to the extent permitted by law; however, should you refuse to comply with the plan of care and your refusal threatens to compromise our commitment to quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care
- Personal privacy and security during home care.
- Request changes to and receive an accounting of disclosures regarding your own protected health information as permitted by law.
- Confidentiality of written, verbal and electronic information including your medical records, information about your health, social and financial circumstances or about what takes place in your home.
- Refuse filming or recording or revoke consent for filming or recording of care, treatment and services for purposes other than identification, diagnosis or treatment.
- Be advised of our policies and procedures regarding accessing and/or disclosure of clinical records. Our Notice of Privacy Practices describes your rights in detail.

- Be advised orally and in writing before care is initiated of our billing policies and payment procedures and the extent to which payment may be expected from Medicare, Medicaid, any other federally funded or aided program or other third-party sources known to us; charges for services that will not be covered by Medicare; and the charges that you may have to pay.
- Be advised orally and in writing of any changes in payment, charges and patient payment liability as soon as possible when they occur but no later than 30 calendar days from the date that we become aware of a change.
- Receive a Patient Notification of Hospice Non-Covered Items, Services and Drugs if there are conditions, items, services and drugs that the hospice determines to be unrelated to my terminal illness and related conditions and would not be covered by the Medicare hospice benefit.
- Receive information for my cost-sharing responsibilities for hospice services, if any.
- Have access to all bills, upon request, for the services you have received regardless of whether the bills are paid by you or another party.
- Receive information about organization ownership and control.
- Receive high-quality, appropriate care without discrimination, in accordance with physician orders.
- Receive education about your role and your family's role in managing pain when appropriate, as well as potential limitations and side effects of pain treatments.
- Receive pastoral and other spiritual services.
- Receive the name and contact information for the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO).
- Immediate advocacy from the BFCC-QIO if you disagree with any of the hospice's determinations of non-covered items, services or drugs.
- Be admitted only if we can provide the care you need. A qualified staff member will assess your needs. If you require care or services that we do not have the resources to provide, we will inform you, and refer you to alternative services, if available; or admit you, but only after explaining our care/service limitations and the lack of a suitable alternative.
- Receive emergency instructions and be told what to do in case of an emergency.
- Be informed how to contact CHAP to ask questions, report grievances or voice complaints. Contact information for CHAP is provided in our Problem Solving Procedure.

YOUR RESPONSIBILITIES

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information to the best of your knowledge about your present complaints and past illness(es), hospitalizations, medications, allergies and other matters relating to your health.
- Remain under a doctor's care while receiving hospice services.
- Notify us of perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status or change of physician).
- Follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment or service plan.
- Ask questions when you do not understand about your care, treatment and service or other instruction about what you are expected to do. If you have concerns about your care or cannot comply with the plan, let us know.
- Report and discuss pain, pain relief options and your questions, worries and concerns about pain medication with staff or appropriate medical personnel.
- Tell us if your visit schedule needs to be changed due to medical appointment, family emergencies, etc.
- Tell us if your Medicare or other insurance coverage changes or if you decide to enroll in a Medicare or private HMO (Health Maintenance Organization).
- Promptly meet your financial obligations and responsibilities agreed upon with the agency.
- Follow the organization's rules and regulations.
- Tell us if you have an advance directive or if you change your advance directive.
- Tell us of any problems or dissatisfaction with the services provided.
- Provide a safe and cooperative environment for care to be provided (such as keeping pets confined, putting away weapons or not smoking during your care).
- Show respect and consideration for agency staff and equipment.
- Carry out mutually agreed responsibilities.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

Our agency is required by law to maintain the privacy of protected health information, to provide you adequate notice of your rights and our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. *[45 CFR § 164.520]* We will use or disclose protected health information in a manner that is consistent with this notice.

The agency maintains a record (paper/electronic file) of the information we receive and collect about you and of the care we provide to you. This record includes physicians' orders, assessments, medication lists, clinical progress notes and billing information.

As required by law, the agency maintains policies and procedures about our work practices, including how we coordinate care and services provided to our patients. These policies and procedures include how we create, receive, access, transmit, maintain and protect the confidentiality of all health information in our workforce and with contracted business associates and/or subcontractors; security of the agency building and electronic files; and how we educate staff on privacy of patient information.

As our patient, information about you must be used and disclosed to other parties for purposes of **treatment, payment and health care operations**. Examples of information that must be disclosed:

- **Treatment:** Providing, coordinating or managing health care and related services, consultation between health care providers relating to a patient or referral of a patient for health care from one provider to another. For example, we meet on a regular basis to discuss how to coordinate care for patients and to schedule visits.
- **Payment:** Billing and collecting for services provided, determining plan eligibility and coverage, utilization review (UR), precertification, medical necessity review. For example, occasionally the insurance company requests a copy of the medical record be sent to them for a coverage review prior to paying the bill.
- **Health Care Operations:** General agency administrative and business functions, quality assurance/improvement activities; medical review; auditing functions; developing clinical guidelines; determining the competence or qualifications of health care professionals; evaluating agency performance; conducting training programs with students or new employees; licensing, survey, certification, accreditation and credentialing activities; internal auditing; and certain fundraising activities and with your authorization, marketing activities. For example, our agency periodically holds clinical record review meetings where the consulting professional of our record review committee will audit clinical records for meeting professional standards and utilization review.

The following uses and disclosures do not require your consent, and include, but are not limited to, a release of information contained in financial records and/or medical records, including information concerning communicable diseases such as Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS), drug/alcohol abuse, psychiatric diagnosis and treatment records and/or laboratory test results, medical history, treatment progress and/or any other related information as permitted by state law to:

1. Your insurance company, self-funded or third-party health plan, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of your bill for services;
2. Any person or entity affiliated with or representing us for purposes of administration, billing and quality and risk management;

3. Any hospital, nursing home or other health care facility to which you may be admitted;
4. Any assisted living or personal care facility of which you are a resident;
5. Any physician providing you care;
6. Law enforcement, paramedics, other first responders and public health authorities;
7. Licensing and accrediting bodies;
8. Contact you to raise funds for the agency; you will be given the right to opt out of receiving such communications;
9. Any business associate or institutionally related foundation for the purpose of raising funds for the agency (information may include: demographics – name, address, contact information, age, gender, date of birth; dates of health care provided; department of services; treating physician; outcome information; and health insurance status). You will be given the right to opt out;
10. Refill reminders for drugs, biologicals and/or drug delivery systems that have already been prescribed to you;
11. Marketing communications promoting health products, services and information if the communication is made face to face with you or the only financial gain consists of a promotional gift of nominal value provided by the agency; and
12. Other health care providers to initiate treatment.

We are permitted to use or disclose information about you without consent or authorization in the following circumstances:

1. In **emergency treatment situations**, if we attempt to obtain consent as soon as practicable after treatment;
2. Where **substantial barriers to communicating with you** exist and we determine that the consent is clearly inferred from the circumstances;
3. Where we are **required by law** to provide treatment and we are unable to obtain consent;
4. Where the use or disclosure of medical information about you **is required by federal, state or local law**;
5. To provide information **to state or federal public health authorities**, as required by law to: prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify persons of recalls of products they may be using; notify a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a communicable disease or condition; and notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence (if you agree or when required or authorized by law);
6. **Health care oversight activities**, such as audits, investigations, inspections and licensure by a government health oversight agency as authorized by law to monitor the health care system, government programs and compliance with civil rights laws;
7. **To business associates** regulated under HIPAA that work on our behalf under a contract that requires appropriate safeguards of protected health information;
8. **Certain judicial administrative proceedings** in response to a court or administrative order, a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order from the Court protecting the information requested;
9. **Certain law enforcement purposes**, such as helping to determine whether a crime has occurred, to alert law enforcement to a crime on our premises or of your death if we suspect it resulted from criminal conduct, identify or locate a suspect, fugitive, material witness or missing person, or to comply with a court order or subpoena and other law enforcement purposes;

10. **To coroners, medical examiners and funeral directors**, in certain circumstances, for example, to identify a deceased person, determine the cause of death or to assist in carrying out their duties;
11. **For cadaveric organ, eye or tissue donation purposes** to communicate to organizations involved in procuring, banking or transplanting organs and tissues (e.g., if you are an organ donor);
12. **For certain research purposes** under very select circumstances. We may use your health information for research. Before we disclose any of your health information for such research purposes, the project will be subject to an extensive approval process. We will usually request your written authorization before granting access to your individually identifiable health information;
13. **To avert a serious threat to health and safety**: To prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public, such as when a person admits to participation in a violent crime, causes serious harm to a victim, is an escaped convict or is diagnosed with a communicable disease considered by the Centers for Disease Control and Prevention (CDC) to be a serious threat to the general public. Any disclosure, however, would only be to someone able to help prevent the threat;
14. **For specialized government functions**, including military and veterans' activities, national security and intelligence activities, protective services for the President, foreign heads of state and others, medical suitability determinations, correctional institution and custodial situations; and
15. **For Workers' Compensation purposes**: Workers' compensation or similar programs provide benefits for work-related injuries or illness.

We are permitted to use or disclose protected health information about you provided you are informed in advance and given the opportunity to individually agree to, prohibit, opt out or restrict the disclosure in the following circumstances:

1. Use of a directory (includes name, location, condition described in general terms) of individuals served by our agency;
2. Share information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts for purposes of notifying your family, personal representatives or certain others of your location or general condition;
3. Provide proof of immunization to a school that is required by state or other law to have such proof with agreement to disclosure by parent, guardian or other person acting in loco parentis if record is of an unemancipated minor; and
4. Provide a family member, relative, friend or other identified person, prior to, or after your death, the information relevant to such person's involvement in your care or payment for care; to notify a family member, relative, friend or other identified person of your location, general condition or death.

Other uses and disclosures not covered in this notice will be made only with your authorization. Authorization may be revoked, in writing, at any time, except in limited situations for the following disclosures:

1. Marketing of products or services or treatment alternatives that may be of benefit to you when we receive direct payment from a third party for making such communications;
2. Psychotherapy notes under most circumstances, if applicable; and
3. Any sale of protected health information resulting in financial gain by the agency unless an exception is met.

YOUR RIGHTS - You have the right, subject to certain conditions, to:

- **Request restrictions on uses and disclosures of your protected health information** for treatment, payment or health care operations. However, we are not required to agree to any requested restriction. Restrictions to which we agree will be documented. Agreements for further restrictions may, however be terminated under applicable circumstances (e.g., emergency treatment).

  We must agree to your request to restrict disclosure of protected health information about you to a health plan if: 1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and 2) the protected health information pertains solely to a health care item or service for which you or someone on your behalf paid the covered entity in full. (164.522 Rights to request privacy protection for protected health information).
- **Confidential communication of protected health information.** We will arrange for you to receive protected health information by reasonable alternative means or at alternative locations. Your request must be in writing. We do not require an explanation for the request as a condition of providing communications on a confidential basis and will attempt to honor reasonable requests for confidential communications.

  If you request your protected health information to be transmitted directly to another person designated by you, your written request must be signed and clearly identify the designated person and where the copy of protected health information is to be sent.
- **Inspect and obtain copies of protected health information** that is maintained in a designated record set, except for psychotherapy notes, information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding, or protected health information that may not be disclosed under the Clinical Laboratory Improvements Amendments of 1988 *[42 USC § 263a and 45 CFR § 493 (a)(2)]*.

  If the requested protected health information is maintained electronically and you request an electronic copy, we will provide access in an electronic format you request, if readily producible, or if not, in a readable electronic form and format mutually agreed upon.

  If we deny access to protected health information, you will receive a timely, written denial in plain language that explains the basis for the denial, your review rights and an explanation of how to exercise those rights. If we do not maintain the medical record, we will tell you where to request the protected health information.
- **Request to amend protected health information** for as long as the protected health information is maintained in the designated record set. A request to amend your record must be in writing and must include a reason to support the requested amendment. We will act on your request within sixty (60) days of receipt of the request. We may extend the time for such action by up to 30 days, if we provide you with a written explanation of the reasons for the delay and the date by which we will complete action on the request.

  We may deny the request for amendment if the information contained in the record was not created by us, unless you provide a reasonable basis for believing the originator of the information is no longer available to act on the requested amendment; is not part of the designated medical record set; would not be available for inspection under applicable laws and regulations; or the record is accurate and complete. If we deny your request for amendment, you will receive a timely, written denial in plain language that explains the basis for the denial, your rights to submit a statement disagreeing with the denial and an explanation of how to submit that statement.

- **Receive an accounting of disclosures of protected health information** made by our agency for up to six (6) years prior to the date on which the accounting is requested for any reason other than for treatment, payment or health operations and other applicable exceptions. The written accounting includes the date of each disclosure, the name/address (if known) of the entity or person who received the protected health information, a brief description of the information disclosed and a brief statement of the purpose of the disclosure or a copy of the written request for disclosure. We will provide the accountings within 60 days of receipt of a written request. However, we may extend the time period for providing the accounting by 30 days if we provide you with a written statement of the reasons for the delay and the date by which you will receive the information. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.
- **Receive notification of any breach in the acquisition, access, use or disclosure** of unsecured protected health information by the agency, its business associates and/or subcontractors.
- **Obtain a paper copy of this notice,** even if you had agreed to receive this notice electronically, from us upon request.

COMPLAINTS - If you believe that your privacy rights have been violated, you may complain to the agency or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation against you for filing a complaint. The complaint should be filed in writing, and should state the specific incident(s) in terms of subject, date and other relevant matters. A complaint to the Secretary must be filed in writing within 180 days of when the act or omission complained of occurred, and must describe the acts or omissions believed to be in violation of applicable requirements. *[45 CFR § 160.306]*

EFFECTIVE DATE - This notice is effective August 8, 2017. We are required to abide by the terms of the notice currently in effect, but we reserve the right to change these terms as necessary for all protected health information that we maintain. If we change the terms of this notice (while you are receiving service), we will promptly revise and distribute a revised notice to you as soon as practicable by mail, email (if you have agreed to electronic notice), hand delivery or by posting on our website.

If you require further information about filing a complaint or other matters covered by this notice, please contact Eli Jaffa at the appropriate address listed below:

Brainerd Office
17021 Commercial Park Rd., Suite 8
Brainerd, MN 56401
Phone: (218) 513-2370
Fax: (218) 513- 2371

Golden Valley Office
820 Lilac Drive N., Suite 210
Golden Valley, MN 55422
Phone: (763) 205-3600
Fax: (763) 205-9350

Hermantown Office
4897 Miller Trunk Hwy, Ste 220
Hermantown, MN 55811
Phone: (218) 520-0870
Fax: (218) 520-0875

Mankato Office
124 E Walnut St., Ste. 330
Mankato, MN 56001
Phone: (507) 609-8800
Fax: (507) 609-8810

Rochester Office
1816 2nd Street SW, Suite B
Rochester, MN 55902
Phone: (507) 888-9700
Fax: (507) 888-9780

St. Cloud Office
2229 Roosevelt Road, Suite 1
St. Cloud, MN 56301
Phone: (320) 372-4300
Fax: (320) 372-4380

MINNESOTA ADVANCE DIRECTIVES

It is your right to decide about the medical care you will receive. You have the right to be informed of treatment options available before giving consent for medical treatment. You also have the right to accept, refuse or discontinue any treatment at any time.

All of us who provide you with health care services are responsible for following your wishes. However, there may be times when you may not be able to decide, or make your wishes known.

Many people want to decide ahead of time what kinds of treatment they want to keep them alive.

Minnesota Law: Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. The information that follows tells about health care directives and how to prepare them. It does not give every detail of the law.

What is a Health Care Directive? A health care directive is a written document that informs other of your wishes about your health care. It allows you to name a person ("agent") to decide for you if you are unable to decide. It also allows you to name an agent if you want someone else to decide for you. You must be at least 18 years old to make a health care directive.

Why Have a Health Care Directive? A health care directive is important if your attending physician determines you can't communicate your health care choices (because of physical or mental incapacity). It is also important if you wish to have someone else make your health care decisions. In some circumstances, your directive may state that you want someone other than an attending physician to decide when you cannot make your own decisions.

Must I Have a Health Care Directive? What Happens if I Don't Have One? You don't have to have a health care directive. But, writing one helps to make sure your wishes are followed.

You will still receive medical treatment if you don't have a written directive. Health care providers will listen to what people close to you say about your treatment preferences, but the best way to be sure your wishes are followed is to have a health care directive.

How Do I Make a Health Care Directive? There are forms for health care directives. You don't have to use a form, but your health care directive must meet the following **requirements** to be legal:

- Be in writing and dated.
- State your name.
- Be signed by you or someone you authorize to sign for you, when you can understand and communicate your health care wishes.
- Have your signature verified by a notary public or two witnesses.
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

Before you prepare or revise your directive, you should discuss your health care wishes with your doctor or other health care provider. Information about how to obtain forms for preparation of your health care directive can be found in the Resource Section of this information.

I Prepared My Directive in Another State. Is It Still Good? Health care directives prepared in other states are legal if they meet the requirements of the other state's laws or the Minnesota requirements. But requests for assisted suicide will not be followed.

What Can I Put in a Health Care Directive? You have many choices of what to put in your health care directive. For example, you may include:

- The person you trust as your agent to make health care decisions for you. You can name alternative agents in case the first agent is unavailable or joint agents.
- Your goals, values and preferences about health care.
- The types of medical treatment you would want (or not want).
- How you want your agent or agents to decide.
- Where you want to receive care.
- Instructions about artificial nutrition and hydration.
- Mental health treatments that use electroshock therapy or neuroleptic medications.
- Instructions if you are pregnant.
- Donation of organs, tissues and eyes.
- Funeral arrangements.
- Who you would like as your guardian or conservator if there is a court action.

You may be as specific or as general as you wish. You can choose which issues or treatments to deal with in your health care directive.

Are There Any Limits to What I Can Put in My Health Care Directive? There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

How Long Does a Health Care Directive Last? Can I Change It? Your health care directive lasts until you change or cancel it. As long as the changes meet the health care directive requirements listed above, you may cancel your directive by any of the following:

- A written statement saying you want to cancel it.
- Destroying it.
- Telling at least two other people you want to cancel it.
- Writing a new health care directive.

What If My Health Care Provider Refuses to Follow My Health Care Directive? Your health care provider generally will follow your health care directive or any instructions from your agent, as long as the health care follows reasonable medical practice.

But, you or your agent cannot request treatment that will not help you or which the provider cannot provide. If the provider cannot follow your agent's directions about life-sustaining treatment, the provider must inform the agent. The provider must also document the notice in your medical record. The provider must allow the agency to arrange to transfer you to another provider who will follow the agent's directions.

What If I've Already Prepared a Health Care Document? Is It Still Good? Before August 1, 1998, Minnesota law provided for several other types of directives, including living wills, durable health care powers of attorney and mental health declarations. The law changed so people can use one form for all their health care instructions.

Forms created before August 1, 1998, are still legal if they followed the law in effect when written. They are also legal if they meet the requirements of the new law (described above). You may want to review any existing documents to make sure they say what you want and meet all requirements.

What Should I Do With My Health Care Directive After I Have Signed It? You should inform others of your health care directive and give people copies of it. You may wish to inform family members, your health care agent or agents, and your health care providers that you have a health care directive. You should give them a copy.

It's a good idea to review and update your directive as your needs change. Keep it in a safe place where it is easily found.

How to Obtain Additional Information: If you want more information about health care directives, please contact your health care provider, your attorney or the Minnesota Board on Aging's Senior LinkAge Line® at 1-800-333-2433. A suggested health care directive form is available on the Internet at: http://www.mnaging.org/.

Request by Client for Discontinuation of Life-Sustaining Treatment: If you, your family member, or your caregiver requests our employee or agent acting on our behalf to discontinue a life-sustaining treatment, our employee or agent will not discontinue the treatment. Our staff will promptly notify their supervisor or other agency representative of your request. The agency will contact the physician who ordered your treatment and make the physician aware of your request to discontinue a life-sustaining treatment. The agency is not required to discontinue treatment, except as may be required by law or court order.

PROVIDER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

If you have a serious health condition and need to make decisions about life-sustaining treatment in advance of medical emergencies, you should talk with your physician about completing a Provider Orders for Life-Sustaining Treatment (POLST) form. This form is completed and signed by your physician, nurse practitioner or physician's assistant and turns your wishes for treatment measures at the end of life into medical orders. The POLST form is recognized by emergency medical service personnel and other health care providers and travels with you between care settings including your home, long-term care facility or hospital. Once the POLST form has been completed, it should be kept in a place where emergency responders can locate it easily (for example, on your refrigerator door). It should be reviewed each time you are transferred from one care setting to another and can be changed or revoked if your treatment preferences change.

AGENCY POLICY ON ADVANCE DIRECTIVES

PURPOSE

To support the implementation of the Patient Self-Determination Act within the framework of state and federal law and organization policies.

POLICY

Moments Hospice recognizes that all adult persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of Moments Hospice to encourage individuals and their family/caregivers to participate in decisions regarding care, treatment, and services. Valid Advance Directives, such as living wills, Durable Powers of Attorney, and DNR (Do Not Resuscitate) or DNI (Do Not Intubate) orders, will be followed to the extent permitted and required by law. In the absence of Advance Directives Moments Hospice will provide appropriate care according to the plan of care/service or as authorized by the attending physician. Moments Hospice will not determine the provision of care/service or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.

An Advance Directive will be implemented as follows:

- The Durable Power of Attorney for an Advance Directive is effective only when the patient is unable to participate in his/her own medical treatment decisions.
- The patient's designated advocate can then make medical treatment choices based on the Advance Directive. The patient advocate may make a decision to withhold or withdraw treatment that allows the patient to die. This is done only if the patient expressed, in a clear and convincing manner, that the advocate is authorized to make such a decision and acknowledges that such a decision would or could allow the patient's death.
- Executing and implementing an Advance Directive is a process, not a one-time event. On an ongoing basis, personnel will keep the patient, family/caregiver and patient's representative up to date concerning the patient's medical condition. They will discuss the patient's preferred course of treatment as his/her condition changes. The discussions will be documented in the clinical/service record.

Minnesota law allows you to inform others of your health care wishes. You have the right to state your wishes or appoint an agent in writing so that others will know what you want if you can't tell them because of illness or injury. There are forms for health care directives. You don't have to use a form, but your health care directive must meet the following requirements to be legal:

- Be in writing and dated.
- State your name.
- Be signed by you or someone you authorize to sign for you when you can understand and communicate your health care wishes.
- Have your signature verified by a notary public or two witnesses.
- Include the appointment of an agent to make health care decisions for you and/or instructions about the health care choices you wish to make.

There are some limits about what you can put in your health care directive. For instance:

- Your agent must be at least 18 years of age.
- Your agent cannot be your health care provider, unless the health care provider is a family member or you give reasons for the naming of the agent in your directive.
- You cannot request health care treatment that is outside of reasonable medical practice.
- You cannot request assisted suicide.

SECTION III.

HOME SAFETY

All patients need to take special precautions to ensure a safe living environment. Most accidents in the home can be prevented by eliminating hazards. This list will help you find potential hazards in your home. Note each statement that you need to work on to make your home a safer place. **Please speak with your nurse/therapist or call the agency at any time if you have any concerns or questions about patient safety.**

PREVENTING FALLS

At least half of all falls happen at home. Each year, thousands of older Americans experience falls that result in serious injuries, disability and even death. Falls are often due to hazards that are easily overlooked but easy to fix. Use the following **SELF ASSESSMENT**. Check all of the risk factors below that apply to you and your home. The more factors checked, the higher your risk for falling.

- ☐ **History of Falling** - two or more falls in last six months.
- ☐ **Vision Loss** - changes in ability to detect and discriminate objects; decline in depth perception; decreased ability to recover from a sudden bright light or glare.
- ☐ **Hearing Loss** - may not be as quickly aware of a potentially hazardous situation.
- ☐ **Foot Pain/Shoe Problems** - foot pain; decreased sensation/feeling; skin breakdown; ill-fitting or badly worn footwear.
- ☐ **Medications** - taking four or more medications; single or multiple medications that may cause drowsiness, dizziness or low blood pressure.
- ☐ **Balance and Gait Problems** - decline in balance; decline in speed of walking; weakness of lower extremities.
- ☐ **High or Low Blood Pressure** that causes unsteadiness.
- ☐ **Hazards Inside Your Home** - tripping and slipping hazards; poor lighting; bathroom safety; spills; stairs; reaching; pets that get under foot.
- ☐ **Hazards Outside Your Home** - uneven walkways; poor lighting; gravel or debris on sidewalks; no handrails; pets that get under foot; hazardous materials (snow, ice, water, oil) that need periodic removal and clean up.

Review each of the following safety tips and note the ones you need to work on:

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Wear shoes that give good support and have thin, non-slip soles. Avoid wearing slippers and athletic shoes with deep treads.
- Remove things you can trip over (such as, papers, books, clothes and shoes) from stairs and places where you walk.
- Keep outside walks and steps clear of snow and ice in the winter.
- Remove small throw rugs or use double-sided tape to keep them from slipping.
- Ask someone to move any furniture so your path around the house is clear.
- Clean up spills immediately.
- Be aware of where your pets are at all times.

- Keep items used often within easy reach (about waist high) in cabinets.
- Do not walk over or around cords or wires, e.g., cords from lamps, extension cords or telephone cords. Coil or tape cords and wires next to the wall so you can't trip over them. Have an electrician add more outlets, if needed.
- Use a steady step stool with a hand bar. Never use a chair as a step stool.
- Improve the lighting in your home. Replace bulbs as needed. Lamp shades or frosted bulbs can reduce glare.
- Make sure stairways, halls, entrances and outside steps are well lit. Have a light switch at the top and bottom of the stairs.
- Place a lamp, flashlight and extra batteries within easy reach of your bed.
- Place night lights in bathrooms, halls and passageways so you can see where you are walking at night.
- Make sure the carpet is firmly attached to every step. If not, remove the carpet and attach non-slip rubber treads on the stairs. Paint a contrasting color on the top front edge of all steps so you can see the stairs better.
- Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs. Fix loose or uneven steps.
- Install grab bars next to your toilet and in the tub or shower.
- Use non-slip mats in the bathtub and on shower floors.
- Use an elevated toilet seat and/or shower stool, if needed.
- Exercise regularly. Exercise makes you stronger and improves your balance and coordination. Talk to your doctor about what exercise is right for you.
- Have your nurse, doctor or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down
- Use a cane or assistive device for extra stability, if needed.
- Consider wearing a device that brings help in case you fall and can't get up.

FIRE SAFETY/BURN PRECAUTIONS

- Make sure the patient has easy access to a telephone, and post the fire department number on every telephone. All family members and caregivers should be familiar with emergency 911 procedures.
- Notify the fire department if a disabled person is in the home.
- **Do not smoke (including e-cigarettes) in bed or where oxygen is being used.** Never leave burning cigarettes unattended. Do not empty smoldering ashes in a trash can. Keep ashtrays away from upholstered furniture and curtains.
- Install smoke detectors on every floor of your home, including the basement. Place smoke detectors near rooms where people sleep. Test smoke detectors every month to make sure they are working properly.
- Install new smoke detector batteries twice a year or when you change your clocks in the spring and fall.
- Fire extinguishers should be checked frequently for stability.
- Make a family fire escape plan and practice it every six months. Plan at least two different escape routes from each room for each family member. If your exit is through a ground floor window, make sure it opens easily.
- If you live in an apartment building, know where the exit stairs are located. Do not use an elevator during a fire emergency.
- Designate a safe place in front of the house or apartment building for family members to meet after escaping a fire.
- If your fire escape is cut off, remain calm, close the door and seal cracks to hold back smoke. Signal for help at the window.
- Evacuate a bedbound patient to a safe area by placing him or her on a sturdy blanket and pulling or dragging the patient out of the home.
- Avoid excess clutter of newspapers, magazines, clothing, etc. These piles can become a fuel source for potential fires.
- Remember, life safety is first, but if the fire is contained and small, you may be able to use your fire extinguisher until the fire department arrives.
- Have your heating system checked and cleaned regularly by someone qualified to do maintenance.
- Wood-burning stoves should be properly installed. The chimney should be inspected and cleaned by a professional chimney sweep, and trash should not be burned in the stove because it could overheat. Gasoline or other flammable liquids should never be used to start wood stove fires.
- Keep portable electric or kerosene heaters out of high-traffic areas. Operate them on the floor at least three feet from upholstered furniture, drapes, bedding and other combustible materials, and turn them off when family members leave the house or go to sleep. Use kerosene heaters only in well-ventilated rooms. Store kerosene outside in a tightly sealed, labeled container.
- Make sure electrical appliances and cords are clean, dry and in good condition.
- Electrical outlets should be grounded and outlets with several plugs should not be used.
- Keep cooking areas free of flammable objects (potholders, towels, etc.).
- Keep storage area above the stove free of flammable/combustible items.

- Wear short or tight sleeves while cooking; do not reach over stove burner.
- Do not leave the stove unattended when cooking, especially when the burner is turned to a high setting.
- Turn pan handles away from burners and the edge of the stove.
- Avoid cooking on high heat with oils and fat.
- Puncture plastic wrap before heating foods in the microwave.
- Never place hot liquids/solids at edge of counter.
- Place layered protection between skin and heating pad.
- Keep electrical appliances away from the bathtub or shower area.
- Never leave patient alone in the shower/tub.
- Set water heater thermostat below 120°F to prevent accidental scalding.
- Store flammable liquids in properly labeled, tightly closed, non-glass containers. Store away from heaters, furnaces, water heaters, ranges and other gas appliances. Make sure the garage is adequately ventilated.

MEDICATION SAFETY

- Do not take medications that are prescribed for someone else.
- Create a complete list of current medications (including prescription and over-the-counter medications, herbal remedies and vitamins), and keep this list with you at all times in the event of emergency situations. Review the list for discrepancies and make changes immediately as they occur. Show the list to your doctor or pharmacist to keep from combining drugs inappropriately.
- Know the name of each of your medicines, why you take it, how to take it, potential side effects and what foods or other things to avoid while taking it.
- Report medication allergies or side effects to your health care provider.
- Take medications exactly as instructed. If the medication looks different than you expected, ask your health care provider or pharmacist about it.
- Drug names can look alike or sound alike. To avoid errors, check with your health care provider if you have questions.
- Do not use alcohol when you are taking medicine.
- Do not stop or change medicines without your doctor's approval, even if you are feeling better. If you miss a dose, do not double the next dose later.
- Use a chart or container system (washed egg carton or med-planner) to help you remember what kind, how much and when to take medicine.
- Take your medicine with a light on so you can read the label.
- Read medicine labels (including warnings) carefully and keep medicines in their original containers.
- Store medications safely in a cool, dry place according to instructions on the label of the medication.

- Keep medicines away from children and confused adults.
- **Federal disposal guidelines for medications:** Follow any specific disposal instructions on the prescription drug labeling or patient information insert. Do not flush medications down the sink or toilet unless this information specifically instructs you to do so. If your community has a pharmaceutical take-back program, take your unused drugs to them for proper disposal. If no such program is available, remove drugs from their original containers and mark out any identifying information on the original containers. Mix the drugs with an undesirable substance like coffee grounds or kitty litter. Place the mixture in a sealable bag, empty can or other container and place it and the empty, original containers in the trash.

DISPOSAL OF CONTROLLED DRUGS

PURPOSE

To promote the safe disposal of medications in the home in order to protect patients/families, reduce negative environmental impact and prevent illegal diversion of drugs.

POLICY

The hospice will utilize appropriate methods for the disposal of medications, including controlled substances, in accordance with applicable state and federal regulations and best practice guidelines.

Hospice personnel will be educated on drug disposal policy and techniques for safely disposing of drugs in the home setting.

PROCEDURE

1. The Case Manager will provide a copy of the written policies and procedures on drug disposal to the patient/representative and family. The Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe disposal medications, including controlled substances. Patient/family education will be documented in the clinical record.
2. Upon patient death or when a hospice patient otherwise no longer has a need for one or more medications, the hospice nurse or other appropriate hospice staff will assist the patient/family to dispose of them or will instruct the patient/family to dispose of them according to policy. The hospice will also provide information on take-back and mail-back programs.
3. Drugs will be disposed of on site. Hospice personnel will not remove a drug from the patient's home.
4. If the manufacturer's instructions or State or local guidelines specify how a drug should be destroyed, the hospice will follow specified guidelines and document accordingly. Otherwise, drugs will be disposed of using the following methods:
   A. Modify drugs as follows:
      1. Add cat litter, detergent, charcoal or non-toxic powder to liquid drugs and seal in a plastic bag or other sealable container, and place in the trash.

2. Add a small amount of water to capsules or pills to partially dissolve them in a slurry, then mix with cat litter or other dry ingredient (as above), and place in the trash.
3. Never mix drugs with toxic chemicals or other products harmful to humans if ingested.

B. Modify containers to protect protected health information (PHI). Use permanent markers to mark over the patient's name and any other protected information before throwing containers in the trash.

5. The nurse will document in the medical record:
   A. Disposal instructions given, the patient/family's verbal response as to their understanding of the disposal process and their responsibility to properly dispose of the unneeded medication(s).
   B. The drugs that were disposed of and the process used to dispose of them.
6. If the patient/family refuses the disposal/destruction of medications, this will be reported to the patient's physician and clinical supervisor and documented in the patient record.

HAZARDOUS ITEMS AND POISONS

- Know how to contact your poison control team.
- Carefully store hazardous items in their original containers.
- Do not mix products that contain chlorine or bleach with other chemicals.
- Purchase insecticides for immediate need only and store excess properly.
- Keep hazardous items, cleaners and chemicals out of reach of children and confused or impaired adults.
- Dispose of hazardous items and poisons only as directed.

MEDICAL EQUIPMENT SAFETY

- Keep manufacturer's instructions with or near specialized medical equipment. Perform routine and preventive maintenance according to the instructions.
- Keep phone numbers available in the home to obtain service in case of equipment problems or equipment failure.
- Have backup equipment available, if indicated.
- Provide adequate electrical power for medical equipment, such as ventilators, oxygen concentrators and other equipment.
- Test equipment alarms periodically to make sure that you can hear them.
- Have equipment batteries checked regularly by a qualified service person.
- Have bedside rails properly installed and use only when necessary. Do not use bed rails as a substitute for a physical protective restraint.
- If bed rails are split, remove or leave the foot-end down so the patient is not trapped between the rails.
- The mattress must fit the bed. Add stuffers in gaps between the rail and mattress or between the head and foot board and mattress to reduce gaps.
- Register with your local utility company if you have electrically powered equipment, such as oxygen or ventilator.

OXYGEN SAFETY

- Use oxygen only as directed.
- Oxygen creates a high risk for fire because it causes an acceleration of flame in the presence of flammable substances and open flames.
- **Do not smoke around oxygen.** Post **"No Smoking"** signs inside and outside the home.
- Store oxygen cylinders away from heat and direct sunlight. Do not allow oxygen to freeze or overheat.
- Keep oil/petroleum products (such as Vaseline®, oily lotions, face creams or hair dressings), grease and flammable material away from your oxygen system. Avoid using aerosols (such as room deodorizers) near oxygen.
- Dust the oxygen cylinder with a cotton cloth and avoid draping or covering the system with any material.
- Keep open flames (such as gas stoves and candles) at least 10 feet away from the oxygen source.
- Keep at least 6 inches of clearance around an oxygen concentrator at all times. Plug it directly into a wall outlet, and limit the use of extension cords.
- Have electrical equipment properly grounded and avoid operating electrical appliances, such as razors and hairdryers, while using oxygen. Keep any electrical equipment (including e-cigarettes) that may spark at least 10 feet from the oxygen system.
- Use 100% cotton linens/clothing to prevent sparks and static electricity.
- Place oxygen cylinders in appropriate stand to prevent tipping, or secured to the wall or placed on their side on the floor. Store in a well-ventilated area and not under outside porches or decks or in the trunk of a car.
- Have a backup portable oxygen cylinder in case of a power or oxygen concentrator failure.
- Alert property management of oxygen use when living in a multi-dwelling residence.

EMERGENCY/DISASTER PREPAREDNESS PLAN

We realize that natural or man-made disasters (severe weather conditions, floods and fires, including emergencies that result in a state-ordered call for evacuation) would impede the ability of Moments Hospice personnel to continue home care, residential and/or inpatient hospice visits to their patients as planned.

Likewise, public health crises such as epidemics or bio-terrorism may require that we share our resources and personnel with the community. So that we are always ready to implement our agency emergency/disaster plan, we keep track of the following: how urgently a patient needs hospice visits; how their services will be continued; if the patient is to be transported to a shelter; and their medication and equipment needs. All patients are assigned a priority code:

- Red/Acuity 1: Patients who cannot safely forego care and require health care intervention regardless of other conditions. Patients in this category include significant pain management issues; patients who may be transitioning; and highly unstable Dyspneic patients
- Yellow/Acuity 2: Patients with recent exacerbation of disease process. Patients who can be seen but can wait 24 hours without serious consequences. Patients with essential untrained families/caregivers who are not prepared to provide needed care.
- Green/Acuity 3: Patients who can safely forego care or a scheduled visit without a high probability of harm or deleterious effect.

If an emergency occurs, we will make every effort to contact you by phone and keep you informed and continue your hospice visits; however, the safety of our staff must be considered. Every possible effort will be made to ensure that your medical needs are met by the agency or through any previously agreed upon arrangements made with you or your family caregiver.

Should you decide to stay in your home during a state ordered evacuation, there may be a temporary disruption of services. You should tune in to your local radio or television station for information and instructions.

Please notify our office if you evacuate or relocate to another location, if possible.

Recommended items for a Home Disaster Supplies Kit include:

- First aid kit
- Bottled water - at least 3 gallons per person
- Flashlight and extra batteries
- Non-perishable food/snacks for at least 3 days
- Battery-powered radio and extra batteries
- List of family medications
- List of essential phone numbers
- County and city maps
- Wide tape and plastic garbage bags
- Bath-size towels
- Location on dial of radio station

Recommended items for to bring to a shelter during an evacuation:

- Two-week supply of medications
- Medical supplies and oxygen
- Wheelchair, walker, cane, etc.
- Special dietary foods/can opener
- Bedding
- Lightweight folding chair
- Air mattress, sleeping bag or cot
- Extra clothing, hygiene items, glasses
- Important papers
- Valid ID with current name and address
- Hospice folder
- Portable battery pack for cell phone

Most shelters have electric power from a generator. If you evacuate to a shelter, bring your electrical devices (such as an oxygen concentrator).

POWER OUTAGE

It is important to be prepared for a lack of electricity.

- Keep flashlights with extra batteries for every household member.
- Keep at least a one-week supply of nonperishable food and water.
- Have an alternate plan (such as a cooler and ice packs) if you rely on refrigerated medicines.
- Check the refrigerator temperature when the power is restored. Throw out food if the temperature is 40°F or higher.
- Determine whether your home phone will work in a power outage.
- Keep mobile phones and other battery-powered equipment charged.
- Keep gas tanks and cans full.

FLOOD

Be aware of flood hazards, especially if you live in a low-lying area, near water or downstream from a dam. Flooding can take days to happen, but flash floods produce raging waters in minutes. Six inches of moving water can knock you off your feet. Avoid moving water if you must walk in a flooded area. Use a stick to test if the ground is firm enough to walk on.

Be ready to evacuate if a flood watch is issued. Move important items upstairs. Fill a clean bathtub with water in case water becomes contaminated or is shut off. Turn off your utilities at the main valves if you are instructed to do so. Do not touch electrical equipment if you are wet or standing in water.

LANDSLIDE

If you live in a low-lying area or near a stream or channel, be alert for any sudden increase or decrease in water flow and notice whether the water changes from clear to muddy. Move away from the path of a landslide or debris flow as quickly as possible. Mudflows can move faster than you can walk or run. Look upstream before crossing a bridge and do not cross the bridge if a mudflow is approaching.

TORNADO

As soon as a tornado is sighted, go to the lowest floor and find an interior room. Good shelters are basements, rooms and halls with no outside walls, bathtubs and spaces under the stairs. Many public buildings have designated shelter areas. Stay away from windows, doors and outside walls. Get under a sturdy item, such as a table, and protect your head. Stay until the danger passes.

If the patient is bedbound, move the bed as far from windows as you can. Use heavy blankets or pillows to protect the head and face.

If you are in a vehicle, trailer or mobile home, get out immediately and go to a sturdy structure. If there is not one close by, lie flat in the nearest ditch and cover your head. Do not try to out-drive a tornado. They are erratic and move swiftly.

LIGHTNING

If you are inside:

- Avoid tubs, faucets and sinks because metal pipes conduct electricity.
- Stay away from windows.
- Avoid using phones with cords, except for emergencies.

If you are outside:

- Avoid natural lightning rods, such as tall trees in open areas.
- Get away from anything metal.

WINTER STORM

Heavy snowfall and extreme cold can immobilize a region, resulting in isolation. Icy and/or blocked roads and downed power lines can happen any time it is cold or snowy. Wear layers of loose, lightweight, warm clothes, rather than one heavy layer. Wear hats and outer layers that are tightly woven and water repellent. Mittens will keep your hands warmer than gloves.

EARTHQUAKE

Protect yourself from falls, falling objects and crumbling buildings. It is best to stay where you are. Stay away from the outside of buildings, walls, power lines, trees, street lights and signs.

If you are inside, stay there and:

- Get under a sturdy table and protect your head.
- If you are in a wheelchair, move to a doorway, lock the wheels and cover your head with your arms.
- If you are in bed, stay there. Cover your head with a pillow to protect it from falling objects and debris.

If you are outside, stay there. Stay away from the outside of buildings.

If you are in a car, stop, park away from dangerous items and stay there until the quaking stops.

After the earthquake, wait a few minutes before moving. Make any noise you can if you are trapped or shine a flashlight. Be prepared for aftershocks.

WILDFIRE

Wildfires often begin unnoticed and spread quickly. If a wildfire threatens your area, follow these simple steps to protect yourself. Please evacuate immediately when asked by firefighters and law enforcement officials.

- Wear only cotton or wool clothes.
- Proper attire includes long pants, long sleeved shirt or jacket and boots.
- Carry gloves, a handkerchief to cover your face, water to drink and goggles.
- Keep a flashlight, mobile phone and portable radio with you at all times.
- Take important documents with you (bank, IRS, trust, investment, insurance policy, birth certificates, passports, medical records).
- Make sure to designate a safe meeting place and contact person.
- Close all interior doors of your home.
- Remove lightweight, non-fire-resistant curtains and other combustible materials from around windows.
- Turn off all pilot lights.
- Move overstuffed furniture, such as couches and easy chairs, to the center of the room.
- Place vehicles in the garage, pointing out with keys in the ignition.

CIVIL DISTURBANCE

- Consider installing an electronic security system.
- Unless instructed to evacuate, the safest place to stay is your home.
- Do not go to observe the disturbance or unrest.
- Close all window blinds and curtains.
- Lock all doors and windows and secure your valuables and important records.
- Stay away from doors and windows.
- If you are confronted, remain calm and try to peacefully remove yourself from the situation.
- Call 911 if there is a threat to life or safety.

BIOLOGICAL THREAT

The first evidence of an attack may be when you notice symptoms of the disease caused by exposure to an agent. It may take time for public health officials to determine exactly what the illness is, how it should be treated and who is in danger. In the event of a biological threat or attack, follow these safety guidelines:

- Check local news websites, TV and radio stations for official news and information, including signs and symptoms of the disease, areas in danger, if medications or vaccinations are being distributed and where you should seek medical attention if you become ill.
- Get away quickly if you become aware of an unusual or suspicious substance.
- Cover your mouth and nose with layers of fabric that can filter the air but still allow breathing (e.g., two to three layers of cotton, such as a T-shirt, handkerchief or towel).
- Depending on the situation, wear a face mask to reduce inhaling or spreading germs.

- If you have been exposed to a biological agent, remove and bag your clothes and personal items. Follow official instructions for disposal of contaminated items.
- Wash yourself with soap and water and put on clean clothes.
- Do not assume that you should go to the emergency department or that any illness is the result of a biological attack. However, contact authorities and immediately seek emergency medical attention if your symptoms match those described and you are in the group considered at risk.
- Expect to receive a medical evaluation and treatment, and follow instructions of doctors and other public health officials.
- You may be advised to stay away from others or even quarantined if the illness caused by the biological agent is believed to be contagious.
- Avoid crowds in the event of a declared biological emergency or developing epidemic.
- Follow the practices listed in the Infection Prevention and Control section of this booklet.
- Follow the instructions provided by emergency response personnel and the Centers for Disease Control and Prevention (CDC). For more information visit www.ready.gov or www.emergency.cdc.gov.

CHEMICAL EXPOSURE

In the event of an exposure to a hazardous chemical, item or poison follow these safety steps:

- Seek medical attention for screening and professional treatment.
- Drink only stored water.
- **If you are outdoors**, get as far away as possible from the contaminant by moving upwind (and uphill if possible) from it.
- **If you are indoors**, close doors and windows tightly, shut off heating and air conditioning and close fireplace dampers. Tape plastic over any windows in the room and use duct tape around the windows and doors to make an unbroken seal. Also, tape over any vents into the room and seal any electrical outlets or other openings. Sink and toilet drain traps should have water in them so you can use the sink and toilet as usual.

Remove possible contamination from your person by:

- Removing any exposed clothing (avoid touching any contaminated areas) as quickly as possible. Clothing that has to be pulled over your head should be cut off instead of being pulled over your head.
- Washing contaminants from your skin with large amounts of soap and water as quickly as possible. If your eyes are burning or your vision is blurred, rinse your eyes with plain water for 10 to 15 minutes. If you wear contacts, remove them and put them with the contaminated clothing. Do not put the contacts back in your eyes. If you wear eyeglasses, decontaminate them with household bleach, then rinse and dry.

- Disposing of contaminated clothing. Avoid touching contaminated areas of the clothing by wearing gloves or using tongs, tool handles, etc., and place it and anything that touched the contaminated clothing inside a plastic bag. Seal the bag, and then seal that bag inside another plastic bag.
- Dressing in clothing that is not contaminated. Since clothing stored in a drawer or closet is unlikely to be contaminated, this will be your safest choice. When you leave your shelter-in-place location, follow instructions from local emergency coordinators to make your home safe again and to avoid any contaminants outside.

EXPLOSION

- Get under a sturdy table or desk if things are falling around you. When they stop falling, leave quickly, watching for falling debris.
- Stay low if there is smoke and check for fire or other hazards, such as damaged floors and stairs.
- Do not stop to retrieve personal possessions or make phone calls.
- Do not use elevators.
- Check for fire and other hazards.
- Once you are out, do not stand in front of windows, glass doors or other potentially hazardous areas.
- Move away from sidewalks or streets to be used by emergency officials or others still exiting the building.
- Make any noise you can if you are trapped or shine a flashlight. Shout only as a last resort. Shouting can cause you to inhale dangerous amounts of dust.
- Avoid unnecessary movement so you do not kick up dust.
- Cover your nose and mouth with anything you have on hand.

NUCLEAR EXPLOSION

Remember the three protective factors: distance, shielding and time. Radioactive fallout can be carried by the wind for hundreds of miles. Radiation levels are extremely dangerous after a nuclear detonation but the levels reduce rapidly. During the period with the highest radiation levels it is safest to stay inside.

If a nuclear attack warning is issued:

- Take cover as quickly as you can, below ground if possible, and stay there until instructed to do otherwise. Go as far below ground as possible or in the center of a tall building.
- Find the nearest building, preferably built of brick or concrete, and go inside to avoid any radioactive material outside. If better shelter, such as a multi-story building or basement, can be reached within a few minutes, go there immediately.
- Expect to stay inside for at least 24 hours, unless told otherwise by authorities.
- If you are downwind from the detonation, you may also be asked to take protective measures.

If you are caught outside and unable to get inside immediately:

- Do not look at the flash or fireball – it can blind you.
- Take cover behind anything that might offer protection.
- Lie flat on the ground and cover your head. If the explosion is some distance away, it could take 30 seconds or more for the blast wave to hit.
- Get clean as soon as possible, to remove radioactive material that may have settled on your body.
- Remove your clothing to keep radioactive material from spreading. Removing the outer layer of clothing can remove up to 90% of radioactive material.
- If practical, place your contaminated clothing in a plastic bag and seal or tie the bag. Place the bag as far away as possible from humans and animals so that the radiation it gives off does not affect others.
- When possible, take a shower with lots of soap and water to help remove radioactive contamination. Do not scrub or scratch your skin. If you cannot shower, use a wipe or clean wet cloth to wipe your skin that was not covered by clothing.
- Wash your hair with shampoo or soap and water. Do not use conditioner in your hair because it will bind radioactive material to your hair, keeping it from rinsing out easily.
- Gently blow your nose and wipe your eyelids, eyelashes and ears with a clean wet cloth.

NUCLEAR POWER PLANT EMERGENCY

- Follow Emergency Alert System (EAS) instructions carefully.
- Minimize your exposure by increasing the distance between you and the source of the radiation.
- If you are told to evacuate, keep car windows and vents closed; use re-circulating air
- If you are advised to remain indoors, turn off the air conditioner, ventilation fans, furnace and other air intakes; shield yourself by placing heavy, dense material between you and the radiation source; and go to a basement or other underground area, if possible.
- Do not use the telephone unless absolutely necessary.
- Stay out of the incident zone. Most radiation loses its strength fairly quickly.

EMERGENCY PREPAREDNESS AND PETS

When disaster strikes, if it is not safe for you, it is not safe for your pet. Plan ahead to help your pet survive a disaster.

- **ID your pet.** Make sure your pet is wearing a securely-fastened collar with up-to-date identification including your cell phone number. Consider having your pet micro-chipped. For caged pets, attach identification to the cage.
- **Put together a pet disaster kit.** Food and water for at least five days for each pet; bowls, manual can opener, medications, medical records and vaccination schedules; leashes, harnesses and carriers; waste collection and disposal supplies; current photos of you with your pets to help others identify them in case you and your pets become separated; and written information about feeding schedules and behavior issues.
- **Plan ahead to take your pet with you in an evacuation.** With the exception of service animals, pets usually are not allowed in public shelters. Identify the hotels that will accept you and your pets in an emergency, and prepare a list with phone numbers. Call ahead for reservations if you know you may need to evacuate. Ask if no-pet policies can be waived in an emergency. Identify friends, boarding facilities, animal shelters or veterinarians that can care for your pet in an emergency.

EMERGING INFECTIOUS DISEASES

An emerging infectious disease is a contagious infection whose incidence has increased in recent years and could continue to increase in the future. Some examples are measles, Ebola, Zika, COVID-19etc.

Preventing an emerging infectious disease:

- Ask your physician if your immunizations are up-to-date and if you need additional vaccinations.
- Wear a face mask to reduce spreading germs if you are sick, or to avoid coming in contact with contagious germs if others around you are sick.
- Follow the practices listed in the Infection Prevention and Control section of this booklet.

Preparing for an emerging infectious disease:

- Check local news websites, TV and radio stations for information, including symptoms of the disease, areas in danger, if medications or vaccinations are being distributed and where to seek medical attention if you become ill. The occurrence of a disease does not necessarily mean there is an epidemic or outbreak.
- Do not assume that any illness is the result of the emerging infectious disease; symptoms of many common illnesses may overlap. However, if you or a family member are in a high-risk group and the symptoms match those described, immediately seek emergency medical attention.
- Follow the instructions provided by emergency response personnel and the Centers for Disease Control and Prevention (CDC). For more information visit www.cdc.gov.

INFECTION PREVENTION AND CONTROL

To help prevent the spread of a widespread pandemic or isolated infection, follow the guidelines in this section. Stay clean and use good hygiene. Items used in health care, such as bandages or gloves, can spread infection, harm trash handlers, family members and others who touch them, and harm the environment if they are not disposed of properly. Some illnesses and treatments (such as chemotherapy, dialysis, AIDS, diabetes and burns) can make people more at risk for infection. Your nurse will tell you how to use protective clothing (such as gowns or gloves) if you need it.

Please tell your doctor or a hospice staff member if you notice any of the following signs and symptoms of infection: pain, tenderness, redness or swelling; inflamed skin, rash, sores or ulcers; fever or chills; pain when urinating; sore throat or cough; confusion; increased tiredness or weakness; nausea, vomiting or diarrhea; and/or green or yellow pus.

PRACTICE GOOD HEALTH HABITS

Cover your mouth and nose with a tissue when you cough or sneeze. If you do not have a tissue, cover your mouth with your upper sleeve, not your hands.

Avoid close contact with people who are sick. If you are sick, keep your distance from others.

Avoid touching your eyes, nose or mouth. Germs may spread if you touch something that is contaminated, and then touch your eyes, nose or mouth.

Get plenty of sleep, be physically active, manage your stress, drink plenty of fluids and eat nutritious food.

WASH YOUR HANDS

Wash your hands frequently and correctly, even if you wear gloves. It is the single most important step in controlling the spread of infection.

Always wash hands before tending to a sick person; touching or eating food; and treating a cut or wound.

Always wash hands after:

- Tending to a sick person
- Treating a cut or wound
- Using the bathroom
- Touching animals or their waste
- Touching soiled linens
- Touching garbage
- Changing diapers
- Coughing, sneezing or blowing your nose

If you have visibly dirty hands, or they are contaminated or soiled in any way, wash them with soap (liquid soap is best) and warm running water. Remove jewelry, apply soap, wet your hands and rub them together for at least 20 seconds. Wash all surfaces, including wrists, palms, back of hands, between fingers and under nails. Rinse off the soap and dry your hands with a clean towel that has not been shared. If one is not available, air-dry your hands. Use a towel to turn off the faucet. If you used paper towels, throw them in the trash. To avoid dry or chapped hands, pat them dry and use lotion after washing.

If you do not have visibly dirty hands, use an alcohol-based hand rub to clean them. Use a rub with 60 to 90% ethyl or isopropyl alcohol. Open the cap or spout and apply a dime-sized amount (or the amount recommended on the label) in one palm, then rub hands vigorously, covering all surfaces of hands and fingers, until they are dry.

DISPOSABLE ITEMS AND EQUIPMENT

Some items that are not sharp: *paper cups, tissues, dressings, bandages, plastic equipment, catheters, incontinence supplies, plastic tubing, gloves, etc.*

Store these in a clean, dry area. Throw away used items in waterproof (plastic) bags. Fasten the bags securely and throw them in the trash.

NON-DISPOSABLE ITEMS AND EQUIPMENT

Some items that are not thrown away: *dirty laundry, dishes, thermometers, toilets, walkers, wheelchairs, bath seats, suction machines, oxygen equipment, mattresses, etc.*

Wash dirty laundry separately in hot, soapy water. Handle it as little as possible so you do not spread germs. If the patient has a virus, add a mix of 1 part bleach and 10 parts water to the load.

Clean equipment as soon as you use it. Wash small items (not thermometers) in hot, soapy water, then rinse and dry them with clean towels. Wipe thermometers with alcohol before and after each use. Store them in a clean, dry place. Wipe off equipment with a normal disinfectant or bleach mix. Follow the cleaning instructions that came with the item and ask your nurse or therapist if you have questions.

Pour liquids in the toilet. Clean their containers with hot, soapy water, then rinse them with boiling water and let them dry.

SHARP OBJECTS

Some sharp items: *needles, syringes, lancets, scissors, knives, staples, glass tubes and bottles, IV catheters, razors, etc.*

Put used **sharps** in a clean, hard plastic or metal container with a screw-on or tight lid. Seal it with heavy-duty tape and dispose of it in the trash or according to area regulations. Do not overfill sharps containers or re-cap used needles. **DO NOT use glass** or clear plastic containers. **Never** put sharps in containers that will be recycled or returned to a store.

BODY FLUID SPILLS

Put on gloves and wipe the fluid with paper towels. Use a solution of 1 part bleach and 10 parts water to wipe the area again. Double bag used paper towels and throw them in the trash.

PAIN MANAGEMENT

Discuss with your physician or your hospice nurse any concerns or questions you have about your pain management. Following are a few of the common concerns or questions of hospice patients.

If I have lots of pain, does that mean I'm in bad shape? Pain is not a measurement of disease advancement. Some people have severe pain early in the disease process, others have no pain. Pain depends solely on the location and involvement of the disease, not on how far along it is.

How will my pain be controlled? Your physician and nurse will work with you so that you are as pain free and alert as possible. The nurse will ask you at each visit how your pain and comfort have been and will need honest answers from you about your pain.

Should I only take my pain medicine if it gets really bad? It is proven that the best way to control pain is to prevent pain. Your physician and nurse will encourage you to take your pain medicine at regular intervals rather than only when needed. For example: every 4, 6, 8 or 12 hours. You'll sleep better and generally feel better if you keep your pain under control.

What is the correct dose that I should be taking? The **correct dose** of pain medicine is the dose that relieves your pain and is within the orders prescribed by your doctor.

If I take pain medications, such as narcotics, will I sleep all the time? It is normal to experience mild drowsiness the first two to three days when narcotics are prescribed. This is due to your body getting much needed rest. Fighting pain is exhausting. After the first few days, you will feel and sleep better as your pain will be under control. Narcotic medication is often in a long-acting form, so you can have longer pain relief.

If I take pain medicine too often, will I get addicted? People fear addiction needlessly. You will not become addicted because there is a real need for the medication - pain relief. If you take medication to relieve pain, you are not an addict nor will you become tolerant to pain medications.

What if I can't swallow? There are many ways to deliver pain medication. If you have difficulty swallowing, other ways will be suggested. Other options are equally effective as oral, such as rectal, under the tongue, under the skin, patches or intravenous.

What if I don't want to take morphine because it's so strong and is used as the last resort? Morphine is no longer viewed as a last resort for pain control. It is easy to use, easy to change, offers the best relief for people who have pain and has a very wide window of safety. Studies have shown that many ideas about morphine are not correct.

I've heard there are side effects from taking narcotics. Is there anything that can prevent these side effects? To prevent the common side effects from narcotics, your physician and nurse will suggest such medications as laxatives, anti-nausea medications and anti-histamines.

PAIN CONTROL INVENTORY

It is imperative that you or your caregiver(s) keep a record of your pain medication use and its effect so that we may help you become as comfortable as possible. Remember to call your doctor or nurse if your pain becomes severe and is unrelieved with prescribed medication.

Pain Intensity Scale: 0 1 2 3 4 5 6 7 8 9 10

No pain — Moderate Pain — Worst Pain Possible

Date	Time	Pain Intensity Scale	Medications I took	Pain intensity one (1) hour after taking medication	What was I doing when I felt the pain?

NUTRITION

Nutrition is an important part of our lives, from the time we take our first breath as an infant. Our culture places much importance on meal planning and social interactions centered on food. Often feeding and preparing meals for a loved one is a non-verbal way of communicating love, concern and caring.

Whenever anyone is ill, it is common for his or her appetite to decrease, whether the illness is the flu or a cancer-related process. The body's need for calories and other nutrients is altered because of the change in activity and the change in metabolic rate, due to the disease process.

Many hospice patients experience one or more of the following problems that interfere with nutrient intake: decrease or loss in appetite, nausea, vomiting, chronic pain, diarrhea and constipation. This makes it difficult to find the right kind of foods that are well tolerated and accepted by the patient. Too often this challenge can turn into friction between the patient and the caregiver and interfere with open communication. To keep communication open it is best to allow the patient to eat what and when he/she desires. When a person is facing the end of their life their priorities change and eating is often not important to them. Furthermore, the disease process and medication can cause taste aversions and specific foods may taste bland, salty, sour or too sweet.

The following are some frequent eating problems and suggestions for overcoming them. Remember that these are just suggestions. Each person has individual needs and preferences. For increased nutritional needs such as added calories, protein, fluids, vitamins and/or minerals contact the hospice nurse.

When it is difficult to swallow liquids or solids:

- Thin liquids are usually the most difficult to swallow, softer blended foods are sometimes easier to swallow. There is also commercial thickener available.
- If mucus is a problem, then cranberry, pineapple or citrus juice may be helpful in cutting or thinning the mucus. If milk products increase mucus production, a dairy-free nutritional supplement can be used.
- For further information on swallowing difficulties or for special products, contact the hospice nurse.

When you are just not hungry:

- Keep snacks handy and in sight for nibbling.
- Drinks made with ice cream or frozen yogurt (such as milk shakes and smoothies) provide a large number of calories within a small volume. Also, supplemental drinks such as Carnation Breakfast Essentials® provide nutrients.
- Breakfast foods are often well tolerated. Do not feel that a particular food should be eaten at a particular time. Eat whatever you like, whenever you like.
- Try eating small meals with snacks in between. Small meals may even be just one item.

When you are nauseated:

- Eat frequent small meals.
- Choose bland foods that are not greasy or too sweet, such as chicken noodle soup with saltine crackers, gelatin with fruit and apple juice.
- Drink liquids between meals rather than at meal times. Clear, cool beverages are usually better tolerated. Popsicles® and flavored ice cubes are good choices.
- Dry foods, such as toast and crackers, are usually well tolerated.
- Do not lie down for at least two hours after eating. Sit up or recline with your head at least four inches above your feet.

When your mouth or throat is sore or dry:

- Take small bites of food and take a swallow of beverage with each bite.
- Try cold foods such as Popsicles®, sherbet, ice cream, fruit ices, milk shakes and ice chips. Sometimes eating ice-cold foods first may make eating other foods more tolerable.
- Sometimes using a straw can make swallowing more comfortable.
- Smooth foods, such as whipped cream, pudding cream pies, canned fruits or gelatins, are usually less irritating to the mouth or throat.
- Creamed soups and other creamed foods are often well tolerated. Keep temperatures warm rather than piping hot.
- Drink soothing beverages such as apple juice, peach or pear nectar and milk (if tolerated). Carbonated beverages, salty liquids (such as broth or vegetable juices), citrus juices (containing acid) and spicy foods may irritate a sore mouth or throat.

BOWEL MANAGEMENT

Most hospice patients have some difficulty with their bowel movements. There are several reasons why you may be constipated. Changes in your diet, decreased fluid intake or decreased activity may contribute to constipation; however, the use of pain medications (narcotic analgesics) is usually the major cause of constipation.

Untreated constipation can lead to a more serious condition (impaction or bowel obstruction) and a daily bowel program can help to prevent such problems. The overall goal is to have a bowel movement approximately every three (3) days. The following guidelines should help you maintain normal bowel function.

- Drink plenty of liquids, especially in combination with high-fiber foods. Tea, hot lemon water and juices, such as prune juice, may be effective.
- Try to have a bowel movement at the same time of the day. Be sure to allow adequate time on the toilet or bedpan.
- Keep a record of your bowel movements and note whether they are hard or soft.
- Take your stool softener/laxative pill *as prescribed*. The dose can range from two to eight (2-8) pills per day or more if needed. Examples of such preparations are Peri-Colace®, Senokot S® or Doxidan®.
- Other laxative preparations can be added if the stool softener/laxative pill alone does not work. Examples of these are Dulcolax®, milk of magnesia, Phillips' M-O or lactulose.
- Call the nurse if you do not have a bowel movement in three (3) days. It might be necessary for you to have a rectal suppository, an enema or be checked for a stool impaction.
- Call the nurse if you have any of the following symptoms:
  - Abdominal distention or bloating
  - Rectal pain with your bowel movement
  - The urge but inability to pass stool
  - Oozing of liquid stool after no bowel movement for several days
  - Rectal fullness and pressure

PRIMARY CAREGIVER GUIDELINES

We thank you for the privilege of assisting you with the care of your loved one. We salute you for all you have done to surround your loved one with understanding care, to provide your loved one with comfort and calm, and to enable your loved one to leave this world with a sense of peace and love. You have given your loved one the most wonderful, beautiful and sensitive gifts we humans are capable of, and, in giving that gift, have given yourself a wonderful gift as well.

Caring in the home for a loved one who has a limited life expectancy and who is undergoing many physical, emotional, mental and spiritual changes, can be a challenging and fulfilling experience. It can also be confusing and tiring.

Our hospice supports your willingness to undertake the role of primary caregiver for your loved one. In this way, you permit him or her to be maintained in comfortable and familiar surroundings at this vulnerable time in his or her life's journey. We will do everything possible to help you do this effectively and appropriately. We see ourselves as a team with each of us having differing roles and responsibilities which, taken together, achieve maximum benefit for your loved one and for you.

Primary care refers to the basic physical and emotional activities involved in meeting the ongoing daily living needs of your loved one at home. This may involve doing such things as maintaining the person's hygiene, nourishment and use of medications. It may involve such comfort measures as preventing constipation, nausea or other symptoms, turning, skin care, oral care, bathing and grooming. It may include learning such skills as ostomy care and utilizing special equipment. It may include filling prescriptions, communicating with the physician, communicating with community resources, utilizing printed materials and making final arrangements. Generally, it means being available to your loved one to listen, to touch, to share, to be present and to care.

Your individual hospice team is pledged to support you in every possible way as you undertake this role. It will help you deal with your limitations and frustrations. It will help you arrange for all supportive services that are needed in the home. It will help facilitate utilization of respite care and inpatient care as needed. It will help you deal with your own feelings and how this situation is affecting your life, your needs and your hopes. It will help you clarify your choices, your available alternatives and resources, and your values, priorities and beliefs, and implement them in the most helpful manner.

The team will explain the progression of the illness, how the needs of your loved one will change and how to respond as these changes take place. It will seek to help you anticipate these changes and implement procedures so that they do not become big problems or out-of-control situations.

In all that the team says, does and offers you, it is the team's deepest commitment to enable you to maximize your involvement of time, energy and love with your loved one.

TO BE ABLE TO TAKE CARE OF ANOTHER, YOU MUST FIRST TAKE CARE OF YOURSELF.

Tips on taking care of yourself:

- Love yourself at least as much as you love the one you are caring for.
- Get enough rest, perhaps naps during the day. Conserve your energy.
- Exercise. Even a short walk helps sleep and gives energy.
- Eat well. Choose a variety of foods from the five basic food groups. Drink plenty of water.
- Reduce stress. Think about what has helped in the past.
- Take breaks. Relax and think of other things.
- Pay attention to what your body is telling you. Is it tired, stressed, tense?
- Nurture your spiritual side. Pursue those things that are uplifting to you.
- Pamper yourself, especially on difficult days. Be patient and considerate of yourself.
- Avoid unrealistic expectations of yourself.
- Allow others to help you.
- Set limits. It's OK to say "no" sometimes.
- Recognize your needs and limitations.

Tips on helping loved ones:

- Allow them to talk. Listen without judgment and with only occasional comment.
- Acknowledge and validate their feelings and let them express their feelings in many ways.
- Avoid taking any negative feelings personally.
- Let them have control over their situation as much as possible.
- Include them in decision making and discussions.
- Let them do as much as they want to and have the energy for, no matter how slow, painful or difficult it seems to you.
- Don't underestimate their pains, symptoms and fear. These are real and valid.
- Avoid judging.
- Talk about subjects you used to discuss together, the times you shared. Laugh together.

Experience has shown that often the best patient care is provided by family and friends. Regardless of how capable and efficient a professional's care may be, the presence and touch of a person who has a close relationship with the patient will provide the greatest gift.

PREPARING FOR THE DYING PROCESS

When a person enters the final stage of the dying process, two different but interrelated dynamics are at work. On the physical plane, the body begins the final process that ends when all physical activities cease to function. Usually, this is an orderly and progressive series of physical changes that, rather than invasive medical intervention, are best responded to through comfort enhancing measures.

The second dynamic of the dying process occurs on the emotional, spiritual and mental plane. This dynamic may appear as a withdrawal from one's present surroundings and relationships or a letting go of all that keeps one attached to this life. This process also tends to follow its own path and schedule but it often includes activity or conversations to resolve whatever is unfinished in one's life. Examples of this work may be attempts to resolve misunderstandings or broken relationships, or to make preparations for the well-being of a loved one following one's own death. There is sometimes the need to receive family permission to die or to let go. For patient and for family, it is helpful to offer words of forgiveness, if needed, as well as words of appreciation and love. Acceptance and compassionate support assist both patient and family through this time of transition.

When a person's body is ready to stop but he/she still has important matters that are not resolved or a significant individual with whom he/she has not made peace, the patient may linger even though very debilitated. On the other hand, when a person is emotionally, spiritually and mentally ready to let go but his or her body has not completed its final physical process, he/she will continue to live. The person dying appears to have some control over the process, and sometimes staff, reading the signs, can offer estimates of when death is approaching. Ultimately, one's death is not under human control or prediction.

The goal of hospice care at this point is to help you and your family prepare for dying, death and for their continued living. Working with hospice staff to control symptoms that cause pain and discomfort, taking responsibility to complete unfinished business and understanding what the dying process looks like will give you active ways to interact with loved ones as caregivers.

The physical, emotional, spiritual and mental changes which indicate impending death are offered to you below to help you understand the natural circumstances which may happen and how you can respond appropriately. Not all of these changes will occur with every person, nor will they occur in this particular sequence. Each person is unique, and what has been most characteristic of the way your loved one has lived consistently, may affect the way this final death phase and release occurs. This is not the time to try to change your loved one, but the time to give full acceptance, support and comfort.

Coolness: The person's hands and then arms, and feet and then legs become increasingly cool to the touch and at the same time the color of the skin may change. This is a normal indication the circulation of blood is decreasing to the body's extremities and being reserved for the most vital organs. Keep the person warm with a blanket. Do not use an electric blanket.

Sleeping: The person may spend an increasing amount of time sleeping and appear to be noncommunicative and unresponsive. This normal change is partly due to changes in body chemistry. Sit with your loved one, hold hands and speak softly and naturally. Do not talk about the person in the person's presence as the sense of hearing remains intact during the dying process. Speak to him or her directly as you normally would, even though there may be no response.

Disorientation: The person may seem confused about the time, place and identity of family and friends. This is also due in part to the body chemistry changes. Sometimes a paper or white board reminder of the day and time is helpful. Identify yourself by name before you speak rather than asking the person to guess who you are. For the patient's comfort, speak softly, clearly and truthfully when you have to communicate, such as, "it is time to take your medication…" and explain the reason for the communication, such as, "… so you won't begin to hurt."

Incontinence: The person may lose control of urine and/or bowel matter as the muscles in those areas begin to relax. Discuss with the hospice nurse what can be done to keep your loved one clean and comfortable as well as how to protect the bed.

Congestion: The person may have sounds of congestion coming from his or her throat or chest, as small amounts of fluids accumulate and cause a vibration noise. This normal change is due to the decrease of fluid intake and an inability to cough up normal secretions. Suctioning usually only increases the secretions and causes much discomfort. Gently turn the person's head to the side and allow gravity to drain the secretions. You may also gently wipe the mouth with a moist cloth. The sound of the congestion does not indicate the onset of severe or new pain and is normal for the physical decline.

Intake Decrease: The person may begin to want little or no food or liquid. This means the body is conserving energy for other functions and getting ready for the end phase. Do not try to force food or drink or use guilt to manipulate them into eating or drinking. To do this only makes the person uncomfortable. Small chips of ice, frozen juice or sports drink may be refreshing in the mouth. Glycerin swabs may help keep the mouth and lips moist. A cool, moist washcloth on the forehead may increase physical comfort.

Urine Decrease: The person's urine output normally decreases due to the decreased fluid intake as well as decrease in circulation through the kidneys. Consult with your hospice nurse to determine whether there may be a need to insert or irrigate a catheter.

Breathing Pattern Change: The person's regular characteristic breathing pattern may change with the onset of a different breathing pace which alternates with periods of no breathing. This pattern is called the "Cheyne-Stokes" syndrome. It is very common and indicates a decrease in circulation in the internal organs. Elevating the head, holding hands and speaking gently may help bring comfort.

EMOTIONAL, SPIRITUAL AND MENTAL CHANGES WITH SUGGESTED RESPONSES

Decreased Socialization: The person may only want to be with a very few or even just one person. This is a sign of preparation for release and affirms from whom the support is most needed in order to make the approaching transition. If you are not a part of this inner circle at the end, it does not mean you are not cared about or are unimportant. It means you have already fulfilled your task with him or her, and it is the time for you to say goodbye. If you are part of the final inner circle of support, the person needs your affirmation, support and permission.

Withdrawal: The person may seem unresponsive, withdrawn or in a comatose-like state. This indicates preparation for release, a detaching from surroundings and relationships and a beginning of letting go. Hearing is believed to remain until the end, so speak to your loved one in your normal tone of voice, identify yourself by name when you speak, hold his or her hand and say whatever you need to say that will help the person let go.

Sensory Experiences: The person may speak or claim to have spoken to those who have already died, or to see or have seen places not presently accessible or visible to you. This does not indicate a drug reaction or hallucination. The person is beginning to detach from this life and is being prepared for the transition so it will not be frightening. Do not contradict, explain away, belittle or argue about what the person claims to have seen or heard. Just because you cannot see or hear it does not mean it's not real to your loved one. Affirm the experiences. They are normal and common. If they frighten your loved one, explain to him or her that they are normal.

Restlessness: The person may perform repetitive and restless tasks. This may be caused by decreased oxygen circulation to the brain and body chemistry changes. The restlessness may in part indicate that something is unresolved or unfinished that is disturbing and prevents him or her from letting go. Do not interfere or try to restrain such motions. Your hospice team member will assist you in identifying what may be happening and help you find ways to help the person find release from the tension or fear. Other things which may be helpful in calming the person are to speak in a quiet natural way, recall a favorite place, lightly massage the forehead, read to the person or play music. Give assurance that it is OK to let go.

Unusual Communication: The person may make statements, gestures or requests that are seemingly out of character. This may indicate the time is ready for the person to say goodbye and is testing to see if you are ready to let him/her go. Accept this moment as a beautiful gift when it is offered. Kiss, hug, hold, cry and say whatever you need to.

Giving Permission: Giving your loved one permission to let go without making him or her feel guilty for leaving or trying to keep him or her with you to meet your own needs can be difficult. A dying person will normally try to hold on, even though it brings prolonged discomfort, in order to be sure that those who are going to be left behind will be all right. Therefore, your ability to release the dying person from this concern and give him or her assurance that it's all right to let go whenever he or she is ready is one of the greatest gifts you have to give your loved one at this time.

Saying Goodbye: When the person is ready to die and you are able to let go, then is the time to say goodbye. Saying goodbye is your final gift of love to the loved one, for it achieves closure and makes the final release possible. It may be helpful to lie in bed with the person and hold him or her. It may also be helpful to take your loved one's hand and say everything that you need to, so that afterward you do not have regrets for not saying certain things. It may be as simple as saying, "I love you." It may include recounting favorite memories, places and activities you shared. It may include saying, "I'm sorry for whatever I contributed to add tensions or difficulties in our relationship." It may also include saying, "Thank you for…"

Tears are a normal and natural part of saying goodbye. Tears do not need to be hidden from your loved one and you do not need to apologize for them. Tears express your love and help you to let go.

HOW TO KNOW WHEN DEATH HAS OCCURRED

The death of a hospice patient is not a medical emergency. Nothing must be done immediately. The signs of death include such things as:

- No breathing
- Loss of control of bowel and bladder
- Eyelids slightly open
- No blinking
- No heartbeat
- No response
- Eyes fixed on a certain spot
- Jaw relaxed and mouth slightly open

FAMILY GUIDELINES WHEN DEATH OCCURS

We have a hospice nurse on call 24 hours a day, seven days a week.

- Call the hospice nurse at the number checked on the front or back cover.
- The hospice nurse will call the funeral home when he/she arrives.

Moments Hospice™
Moments are Forever

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT TO PROVIDER

PATIENT NAME: _____ **PATIENT ID:** _____ **ADM. DATE:** _____

Consent for Treatment and Authorization for Payment to Provider:
I have been fully informed of Moments Hospice's assessment and evaluation of my hospice needs. I hereby give my permission for authorized personnel of Moments Hospice to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care. I understand the following hospice care and services may be provided to me during the course of illness: physician, nursing, social work, therapy services, counseling services (bereavement, spiritual, dietary), hospice aide/homemaker, volunteers, durable medical equipment, pharmaceuticals, medical supplies, respite care, short-term inpatient care and continuous care. I understand that I may refuse treatment or terminate services at any time and the hospice agency may terminate their services to me as explained in my orientation. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payers be made in my behalf to Moments Hospice. I understand I am responsible for all the amounts not paid by my commercial insurance. If I am a Private Pay patient, I agree to pay for all services rendered by hospice. I have been provided a full understanding of hospice care and understand that certain benefits are waived by election of the Medicare hospice benefit if applicable. I hereby elect to participate in hospice care. If I have Medicare Part A, benefits I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or services. If I have other insurance, I may be responsible for the co-payment, deductible and any charges that my coinsurance will not cover. I authorize Moments Hospice to release to Medicare or intermediaries, or other health plan any information needed for this or other related claims. This authorization and request shall apply to the period starting the above admission date and until ordered to be discontinued by my physician. I have been informed of my right to an itemized accounting of my billing information, and that Moments Hospice will comply with written requests for the information within 30 days.

Release of Information for Disaster Situations:
I agree that the agency may share my protected health information with emergency officials or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

Declaration of Advance Directives:
I have received state specific information regarding Advance Directives and a copy of the agency policies concerning Advance Directives. I understand my right to make decisions about my medical care, and the agency will make every attempt to comply with any Advance Directives I have executed. It will be my responsibility to notify my physician and the agency if such directives are changed or withdrawn. I understand that it is the policy of the agency to provide services without discrimination, including whether or not they have executed any Advance Directives.

1. Advance Directives **have been executed**. *(Mark all that apply.)*
   - ☐ **Living Will** Date on Document: _____
     Physician who has a copy: _____ Phone: _____
   - ☐ **Health Care Directive** Date on Document: _____
     Health Care Agent: _____ Phone: _____
   - ☐ **Copy requested** ☐ **Patient declines to furnish copy**
   - ☐ **Do Not Resuscitate (DNR) Order** *(See physician orders.)*
   - ☐ **Provider Orders for Life Sustaining Treatment (POLST)**
2. Advance Directives **have not been executed**.

   Patient/Caregiver Action
   - ☐ Patient does not wish to execute an Advance Directive at this time.
   - ☐ Patient is considering the execution of an Advance Directive and will notify Moments Hospice when prepared to execute Advance Directive.

   Patient Education *(Check one.)*
   - ☐ Patient has been found to be incapacitated, at this time.
   - ☐ Patient is able to receive oral and written information concerning Advance Directives.

Patient Signature: _____ **Date:** _____
Reason patient is unable to sign: _____
Patient Representative Signature: _____ **Date:** _____
(Relationship to Patient): _____
Moments Hospice Representative Signature: _____ **Date:** _____

Moments Hospice™
Moments are Forever

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT TO PROVIDER

(CONTINUED)

PATIENT NAME: _____ PATIENT ID: _____ ADM. DATE: _____

Confidentiality:
It is the policy of the agency to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home, other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies; and other health care providers in order to initiate treatment.

I have been informed of the type and planned frequency of services to be provided to me by Moments Hospice. I have participated in and agree to the established plan of care. I acknowledge receiving information about my Rights and Responsibilities as a patient; home safety; emergency measures; management of medical waste in the home; complaint procedure; confidentiality policies; HIV Notice; HIPAA Privacy Notice; Advance Directives policies and information about my right to make health care decisions; and state home care/hospice hotline.

Consent to Film or Record:
I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

Patient Rights/Emergency Plan/Complaint Procedure:
Prior to receiving care, I have been provided with a written copy of my rights and responsibilities as a patient. A hospice representative has discussed them with me and I understand them. The Moments Hospice Emergency/Disaster Preparedness Plan and the Problem Solving Procedure was provided with an opportunity to ask questions. I understand that if I have any complaints or problems concerning my care I can call the Moments Hospice's Administrator at the appropriate number checked on the front or back cover. I have been informed that the State of Minnesota has a toll-free home care/hospice hotline number.

I acknowledge receipt of the above information. My signature on page one of this form verifies that the above information has been verbally explained to my understanding and agreement. I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

Moments Hospice™
Moments are Forever

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT TO PROVIDER

PATIENT NAME: _____ **PATIENT ID:** _____ **ADM. DATE:** _____

Consent for Treatment and Authorization for Payment to Provider:
I have been fully informed of Moments Hospice's assessment and evaluation of my hospice needs. I hereby give my permission for authorized personnel of Moments Hospice to perform all necessary procedures and treatments as prescribed by my physician for the delivery of hospice care. I understand the following hospice care and services may be provided to me during the course of illness: physician, nursing, social work, therapy services, counseling services (bereavement, spiritual, dietary), hospice aide/homemaker, volunteers, durable medical equipment, pharmaceuticals, medical supplies, respite care, short-term inpatient care and continuous care. I understand that I may refuse treatment or terminate services at any time and the hospice agency may terminate their services to me as explained in my orientation. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payers be made in my behalf to Moments Hospice. I understand I am responsible for all the amounts not paid by my commercial insurance. If I am a Private Pay patient, I agree to pay for all services rendered by hospice. I have been provided a full understanding of hospice care and understand that certain benefits are waived by election of the Medicare hospice benefit if applicable. I hereby elect to participate in hospice care. If I have Medicare Part A, benefits I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or services. If I have other insurance, I may be responsible for the co-payment, deductible and any charges that my coinsurance will not cover. I authorize Moments Hospice to release to Medicare or intermediaries, or other health plan any information needed for this or other related claims. This authorization and request shall apply to the period starting the above admission date and until ordered to be discontinued by my physician. I have been informed of my right to an itemized accounting of my billing information, and that Moments Hospice will comply with written requests for the information within 30 days.

Release of Information for Disaster Situations:
I agree that the agency may share my protected health information with emergency officials or others involved in my care to assist in disaster relief efforts. ☐ Yes ☐ No

Declaration of Advance Directives:
I have received state specific information regarding Advance Directives and a copy of the agency policies concerning Advance Directives. I understand my right to make decisions about my medical care, and the agency will make every attempt to comply with any Advance Directives I have executed. It will be my responsibility to notify my physician and the agency if such directives are changed or withdrawn. I understand that it is the policy of the agency to provide services without discrimination, including whether or not they have executed any Advance Directives.

1. Advance Directives **have been executed**. *(Mark all that apply.)*
   - ☐ **Living Will** Date on Document: _____
     Physician who has a copy: _____ Phone: _____
   - ☐ **Health Care Directive** Date on Document: _____
     Health Care Agent: _____ Phone: _____
   - ☐ **Copy requested** ☐ **Patient declines to furnish copy**
   - ☐ **Do Not Resuscitate (DNR) Order** *(See physician orders.)*
   - ☐ **Provider Orders for Life Sustaining Treatment (POLST)**
2. Advance Directives **have not been executed**.

   Patient/Caregiver Action
   - ☐ Patient does not wish to execute an Advance Directive at this time.
   - ☐ Patient is considering the execution of an Advance Directive and will notify Moments Hospice when prepared to execute Advance Directive.

   Patient Education *(Check one.)*
   - ☐ Patient has been found to be incapacitated, at this time.
   - ☐ Patient is able to receive oral and written information concerning Advance Directives.

Patient Signature: _____ **Date:** _____
Reason patient is unable to sign: _____
Patient Representative Signature: _____ **Date:** _____
(Relationship to Patient): _____
Moments Hospice Representative Signature: _____ **Date:** _____

Moments Hospice™
Moments are Forever

CONSENT FOR TREATMENT AND AUTHORIZATION FOR PAYMENT TO PROVIDER

(CONTINUED)

PATIENT NAME: _____ PATIENT ID: _____ ADM. DATE: _____

Confidentiality:
It is the policy of the agency to protect all clinical records against loss, defacement, tampering, and use by unauthorized persons. I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that may be responsible for paying or processing for payment any portion of my bill for services; any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management; any hospital, nursing home, other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident; any physician providing my care; family members and other caregivers who are part of my plan of care; licensing and accrediting bodies; and other health care providers in order to initiate treatment.

I have been informed of the type and planned frequency of services to be provided to me by Moments Hospice. I have participated in and agree to the established plan of care. I acknowledge receiving information about my Rights and Responsibilities as a patient; home safety; emergency measures; management of medical waste in the home; complaint procedure; confidentiality policies; HIV Notice; HIPAA Privacy Notice; Advance Directives policies and information about my right to make health care decisions; and state home care/hospice hotline.

Consent to Film or Record:
I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

Patient Rights/Emergency Plan/Complaint Procedure:
Prior to receiving care, I have been provided with a written copy of my rights and responsibilities as a patient. A hospice representative has discussed them with me and I understand them. The Moments Hospice Emergency/Disaster Preparedness Plan and the Problem Solving Procedure was provided with an opportunity to ask questions. I understand that if I have any complaints or problems concerning my care I can call the Moments Hospice's Administrator at the appropriate number checked on the front or back cover. I have been informed that the State of Minnesota has a toll-free home care/hospice hotline number.

I acknowledge receipt of the above information. My signature on page one of this form verifies that the above information has been verbally explained to my understanding and agreement. I understand a copy of this consent form shall be as valid as the original and shall remain in effect until I am discharged from the agency. I also understand that I may revoke this consent in writing at any time.

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE *(WITH AREA CODE)*

A CARDIOPULMONARY RESUSCITATION (CPR) *Patient has no pulse and is not breathing.*

CHECK ONE

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).

☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B MEDICAL TREATMENTS *Patient has pulse and/or is breathing.*

CHECK ONE

(NOTE REQUIREMENTS)

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.

TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.

TREATMENT PLAN: Maximize comfort through symptom management.

C DOCUMENTATION OF DISCUSSION

CHECK ALL THAT APPLY

☐ **Patient** *(Patient has capacity)* ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**

☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE ***(STRONGLY RECOMMENDED)*** | NAME *(PRINT)*

RELATIONSHIP *(IF YOU ARE THE PATIENT, WRITE "SELF")* | PHONE *(WITH AREA CODE)*

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D SIGNATURE OF PHYSICIAN / APRN / PA

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME *(PRINT)* ***(REQUIRED)*** | LICENSE TYPE ***(REQUIRED)*** | PHONE *(WITH AREA CODE)*

SIGNATURE ***(REQUIRED)*** | DATE ***(REQUIRED)***

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

INFORMATION FOR

PATIENT NAMED ON THIS FORM

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT

E ADDITIONAL PATIENT PREFERENCES *(OPTIONAL)*

CHECK ONE FROM EACH SECTION

ARTIFICIALLY ADMINISTERED NUTRITION *Offer food by mouth if feasible.*

- ☐ **Long-term artificial nutrition by tube.**
- ☐ **Defined trial period of artificial nutrition by tube.**
- ☐ **No artificial nutrition by tube.**

ANTIBIOTICS

- ☐ **Use IV/IM antibiotic treatment.**
- ☐ **Oral antibiotics only (no IV/IM).**
- ☐ **No antibiotics. Use other methods to relieve symptoms when possible.**

ADDITIONAL PATIENT PREFERENCES *(e.g. dialysis, duration of intubation).*

HEALTH CARE PROVIDER WHO PREPARED DOCUMENT

PREPARER NAME ***(REQUIRED)*** PREPARER TITLE ***(REQUIRED)***

PREPARER PHONE *(WITH AREA CODE)* ***(REQUIRED)*** DATE PREPARED ***(REQUIRED)***

NOTE TO PATIENTS AND SURROGATES

The POLST form is always voluntary and is for persons with advanced illness or frailty. POLST records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. A Health Care Directive is recommended for all capable adults, regardless of their health status. A Health Care Directive allows you to document in detail your future health care instructions and/or name a Health Care Agent to speak for you if you are unable to speak for yourself.

DIRECTIONS FOR HEALTH CARE PROVIDERS

Completing POLST

- Completing a POLST is always voluntary and cannot be mandated for a patient.
- POLST should reflect current preferences of persons with advanced illness or frailty. Also, encourage completion of a Health Care Directive.
- Verbal / phone orders are acceptable with follow-up signature by physician/APRN/PA in accordance with facility/community policy.
- A surrogate may include a court appointed guardian, Health Care Agent designated in a Health Care Directive, or a person whom the patient's health care provider believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known, such as a verbally designated surrogate, spouse, registered domestic partner, parent of a minor, or closest available relative.

Reviewing POLST

This POLST should be reviewed periodically, and if:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change, or
- The patient's Primary Medical Care Provider changes.

Voiding POLST

- A person with capacity, or the valid surrogate of a person without capacity, can void the form and request alternative treatment.
- Draw line through sections A through E and write "VOID" in large letters if POLST is replaced or becomes invalid.
- If included in an electronic medical record, follow voiding procedures of facility/community.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

Moments Hospice™
Moments are Forever

CONSENT FOR ELECTION OF MEDICARE HOSPICE BENEFIT

PATIENT NAME: _____ **PATIENT ID:** _____

PHILOSOPHY AND COVERAGE OF HOSPICE CARE: I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand and have been given an explanation of the purpose and nature of the hospice care available through the Medicare Hospice Benefit and am aware that all treatment will focus on comfort (palliative) rather than cure (curative) or life prolonging. Treatment will be for management of symptoms and to provide comfort for my terminal illness and related conditions. The focus of my care is to provide comfort and support to both me and my family/caregivers and to maintain me in my home rather than in a hospital. I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor, volunteer and other disciplines that may be necessary. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to Moments Hospice and my attending physician. I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (i.e., cost-sharing, if applicable, for drug co-payments, inpatient respite care, etc.). I have been provided information on the items, services and drugs that Moments Hospice will cover and furnish upon election of hospice.

I understand that I can use standard Medicare in the usual manner to pay the bill for:

1. My doctor, if not an employee of this hospice.
2. Items, services and drugs unrelated to my terminal illness and related conditions. (**Note:** I understand that items, drugs and services unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, Moments Hospice will be providing virtually all of my care related to my terminal illness and related conditions needed under the hospice election.)

RIGHT TO CHOOSE MY ATTENDING PHYSICIAN: I understand that I or my representative have the right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician. ☐ My choice for my attending physician is:

Physician Full Name: _____ NPI #: _____

Office Address: _____

MEDICARE HOSPICE BENEFIT PERIODS: Medicare will make payment for unlimited hospice days; however, the days are broken into three benefit periods to be used in this order. These periods are as follows: 1) First Benefit Period - 90 days; 2) Second Benefit Period - 90 days; 3) Subsequent 60 day Period - Unlimited as long as beneficiary meets requirement for benefit.

Prior to the beginning of each benefit period my medical condition will be evaluated for continued hospice appropriateness by my physician and the hospice interdisciplinary group.

I understand that I can revoke this benefit at any time and resume regular Medicare coverage. I know I will lose any hospice days remaining in the benefit period in which I revoke.

I understand that I may transfer my hospice care to another Hospice Program once during each election period.

RIGHT TO REQUEST PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES, AND DRUGS: I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services and Drugs" addendum that lists the items, services and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. Moments Hospice must furnish this Notification to me within five (5) days, if I request this Notification on the start of care date. Moments Hospice must furnish this Notification to me within 72 hours or three (3) days if I request this Notification during the course of hospice care.

BENEFICIARY AND FAMILY CENTERED CARE-QUALITY IMPROVEMENT ORGANIZATION (BFCC-QIO): I acknowledge that I have been provided information regarding my right to and the provision of Immediate Advocacy through the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if I disagree with any of the hospice's determinations. I have been provided with the contact information for the BFCC-QIO that serves my area: Livanta, LLC (1-888-524-9900; TTY: 1-888-985-8775).

Acknowledging/understanding the above, I choose to elect the Medicare hospice benefit and receive services from Moments Hospice to begin on: _____ (start of care date).

Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Patient Signature	Date	Responsible Person, Representative or Legal Guardian Signature
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Moments Hospice™
Moments are Forever

CONSENT FOR ELECTION OF MEDICARE HOSPICE BENEFIT

PATIENT NAME: _____ **PATIENT ID:** _____

PHILOSOPHY AND COVERAGE OF HOSPICE CARE: I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand and have been given an explanation of the purpose and nature of the hospice care available through the Medicare Hospice Benefit and am aware that all treatment will focus on comfort (palliative) rather than cure (curative) or life prolonging. Treatment will be for management of symptoms and to provide comfort for my terminal illness and related conditions. The focus of my care is to provide comfort and support to both me and my family/caregivers and to maintain me in my home rather than in a hospital. I understand that I and/or my caregiver will participate in developing the plan of care along with the hospice team composed of a physician, nurse, medical social worker, spiritual counselor, volunteer and other disciplines that may be necessary. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to Moments Hospice and my attending physician. I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (i.e., cost-sharing, if applicable, for drug co-payments, inpatient respite care, etc.). I have been provided information on the items, services and drugs that Moments Hospice will cover and furnish upon election of hospice.

I understand that I can use standard Medicare in the usual manner to pay the bill for:

1. My doctor, if not an employee of this hospice.
2. Items, services and drugs unrelated to my terminal illness and related conditions. (**Note:** I understand that items, drugs and services unrelated to my terminal illness and related conditions are exceptional and unusual and, in general, Moments Hospice will be providing virtually all of my care related to my terminal illness and related conditions needed under the hospice election.)

RIGHT TO CHOOSE MY ATTENDING PHYSICIAN: I understand that I or my representative have the right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

☐ I do not wish to choose an attending physician. ☐ My choice for my attending physician is:

Physician Full Name: _____ NPI #: _____

Office Address: _____

MEDICARE HOSPICE BENEFIT PERIODS: Medicare will make payment for unlimited hospice days; however, the days are broken into three benefit periods to be used in this order. These periods are as follows: 1) First Benefit Period - 90 days; 2) Second Benefit Period - 90 days; 3) Subsequent 60 day Period - Unlimited as long as beneficiary meets requirement for benefit.

Prior to the beginning of each benefit period my medical condition will be evaluated for continued hospice appropriateness by my physician and the hospice interdisciplinary group.

I understand that I can revoke this benefit at any time and resume regular Medicare coverage. I know I will lose any hospice days remaining in the benefit period in which I revoke.

I understand that I may transfer my hospice care to another Hospice Program once during each election period.

RIGHT TO REQUEST PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES, AND DRUGS: I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services and Drugs" addendum that lists the items, services and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. Moments Hospice must furnish this Notification to me within five (5) days, if I request this Notification on the start of care date. Moments Hospice must furnish this Notification to me within 72 hours or three (3) days if I request this Notification during the course of hospice care.

BENEFICIARY AND FAMILY CENTERED CARE-QUALITY IMPROVEMENT ORGANIZATION (BFCC-QIO): I acknowledge that I have been provided information regarding my right to and the provision of Immediate Advocacy through the Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) if I disagree with any of the hospice's determinations. I have been provided with the contact information for the BFCC-QIO that serves my area: Livanta, LLC (1-888-524-9900; TTY: 1-888-985-8775).

Acknowledging/understanding the above, I choose to elect the Medicare hospice benefit and receive services from Moments Hospice to begin on: _____ (start of care date).

Note: The start of care date, also known as the effective date of the election, may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Patient Signature	Date	Responsible Person, Representative or Legal Guardian Signature
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Moments Hospice™
Moments are Forever

PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES AND DRUGS

PATIENT NAME: _____ **PATIENT ID:** _____ **DATE OF REQUEST:** _____

PURPOSE OF ISSUING THIS NOTIFICATION: I acknowledge that the purpose of this Notification is to notify me and/or my representative, in writing, of those conditions, items, services and drugs the hospice will not be covering because Moments Hospice has determined they are unrelated to my terminal illness and related conditions. I understand that if I request this Notification on the effective date of the hospice election (that is, on the start date of hospice care), Moments Hospice must furnish this Notification to me within five (5) days. Moments Hospice must furnish this Notification to me within 72 hours or three (3) days if I request this Notification during the course of hospice care.

DIAGNOSIS(ES) RELATED TO TERMINAL ILLNESS AND RELATED CONDITIONS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

DIAGNOSIS(ES) UNRELATED TO TERMINAL ILLNESS AND RELATED CONDITIONS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

NON-COVERED ITEMS, SERVICES AND DRUGS DETERMINED BY HOSPICE AS NOT RELATED TO MY TERMINAL ILLNESS AND RELATED CONDITIONS:

Items/Services/Drugs:	**Reason for Non-Coverage:**

Note: The hospice makes individual patient-specific decisions as to whether or not conditions, items, services and drugs are related to your terminal illness and related conditions. You or your representative should share this list and clinical explanation with other health care providers from which you seek items, services or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions. Moments Hospice will provide its reasons for non-coverage in language that you or your representative understand.

RIGHT TO IMMEDIATE ADVOCACY: You have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for Immediate Advocacy if you or your representative disagree with the decision of Moments Hospice regarding items, services or drugs not covered because Moments Hospice has determined they are unrelated to your terminal illness and related conditions. The following is the contact information for the BFCC-QIO that serves your area: Livanta, LLC (1-888-524-9900; TTY: 1-888-985-8775).

ACKNOWLEDGMENT OF NON-COVERED ITEMS, SERVICES AND DRUGS NOT RELATED TO MY TERMINAL ILLNESS AND RELATED CONDITIONS: I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by Moments Hospice. Signing this Notification (or its updates) is only acknowledgment of receipt of this Notification (or its updates) and not necessarily agreement with the determinations of Moments Hospice.

_____	_____	_____
Patient Signature	Date	Responsible Person, Representative or Legal Guardian Signature
_____	_____	_____
Hospice Representative Signature	Date	Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Moments Hospice™
Moments are Forever

PATIENT NOTIFICATION OF HOSPICE NON-COVERED ITEMS, SERVICES AND DRUGS

PATIENT NAME: _____ **PATIENT ID:** _____ **DATE OF REQUEST:** _____

PURPOSE OF ISSUING THIS NOTIFICATION: I acknowledge that the purpose of this Notification is to notify me and/or my representative, in writing, of those conditions, items, services and drugs the hospice will not be covering because Moments Hospice has determined they are unrelated to my terminal illness and related conditions. I understand that if I request this Notification on the effective date of the hospice election (that is, on the start date of hospice care), Moments Hospice must furnish this Notification to me within five (5) days. Moments Hospice must furnish this Notification to me within 72 hours or three (3) days if I request this Notification during the course of hospice care.

DIAGNOSIS(ES) RELATED TO TERMINAL ILLNESS AND RELATED CONDITIONS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

DIAGNOSIS(ES) UNRELATED TO TERMINAL ILLNESS AND RELATED CONDITIONS:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

NON-COVERED ITEMS, SERVICES AND DRUGS DETERMINED BY HOSPICE AS NOT RELATED TO MY TERMINAL ILLNESS AND RELATED CONDITIONS:

Items/Services/Drugs:	**Reason for Non-Coverage:**

Note: The hospice makes individual patient-specific decisions as to whether or not conditions, items, services and drugs are related to your terminal illness and related conditions. You or your representative should share this list and clinical explanation with other health care providers from which you seek items, services or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions. Moments Hospice will provide its reasons for non-coverage in language that you or your representative understand.

RIGHT TO IMMEDIATE ADVOCACY: You have the right to contact the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO) for Immediate Advocacy if you or your representative disagree with the decision of Moments Hospice regarding items, services or drugs not covered because Moments Hospice has determined they are unrelated to your terminal illness and related conditions. The following is the contact information for the BFCC-QIO that serves your area: Livanta, LLC (1-888-524-9900; TTY: 1-888-985-8775).

ACKNOWLEDGMENT OF NON-COVERED ITEMS, SERVICES AND DRUGS NOT RELATED TO MY TERMINAL ILLNESS AND RELATED CONDITIONS: I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by Moments Hospice. Signing this Notification (or its updates) is only acknowledgment of receipt of this Notification (or its updates) and not necessarily agreement with the determinations of Moments Hospice.

_____ _____ _____
Patient Signature Date Responsible Person, Representative or Legal Guardian Signature

_____ _____ _____
Hospice Representative Signature Date Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Minnesota Department of **Human Services**

DHS-2868-ENG 8-15

Minnesota Health Care Programs (MHCP)

Hospice Transaction Form

Hospice providers: Use this form to report hospice election, certification, revocation of hospice services, change of hospice provider, and death of the MHCP member. Review the information in the Hospice Services section of the MHCP Provider Manual for more information and detailed instructions about this form.

Before the hospice provider initiates services they must develop a hospice plan of care and coordinate services with other providers, including county case managers, to assure services are not duplicated.

MHCP Member Information

Election of Hospice Services - age 22 and older

I choose to receive hospice services beginning _____ (MM/DD/YYYY) under Medical Assistance or MinnesotaCare. The hospice provider informed me about the nature and extent of hospice services, and my right to stop getting hospice services at any time. I understand this means I waive my right to any other medical services related to treating the terminal condition for which I elected hospice services. [Complete all appropriate boxes below.]

Election of Hospice Services - age 21 and under

I choose to receive hospice services beginning _____ (MM/DD/YYYY) under Medical Assistance or MinnesotaCare. The hospice provider informed me about the nature and extent of hospice services as a person age 21 or under. I understand my right to stop getting hospice services at any time. [Complete all appropriate boxes below.]

SIGNATURE OF MHCP MEMBER OR LEGAL REPRESENTATIVE			DATE
WITNESS SIGNATURE – required when recipient of the hospice care is not able to sign			DATE
MHCP MEMBER NAME	MEMBER ID NUMBER		DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP CODE

Medicare Hospice Election

☐ Yes A member who is dually eligible for both Medicare and Medical Assistance must elect hospice under Medicare, as well as Medical Assistance. Check Yes if the person is eligible for and has elected hospice under Medicare.

Elected Hospice Provider

NAME OF HOSPICE		NPI	
ADDRESS OF HOSPICE	CITY	STATE	ZIP CODE
HOSPICE PHONE NUMBER (include area code)	HOSPICE FAX NUMBER (include area code)		

The elected hospice provider must complete all applicable sections of this form and fax it to DHS at 651-431-7554 within two calendar days of initiating or changing services to be paid for the hospice services provided. If this form is incomplete or not submitted timely, it may be returned or claims may deny.

Send a copy of this form to the county worker to assure that correct spenddown data and other changes are in the DHS computer system. Do not send a copy to the MinnesotaCare worker if the person is in MinnesotaCare.

Certification of Terminal Illness

We (or I) certify that the MHCP member named on this form has a terminal illness with a life expectancy of six months or less. [Attending physician or nurse practitioner must complete the following fields.]

TERMINAL ILLNESS DIAGNOSIS OR DIAGNOSES	ICD DIAGNOSIS CODE(S)

HOSPICE MEDICAL DIRECTOR/DESIGNEE NAME	NPI

SIGNATURE	DATE

ATTENDING PHYSICIAN OR NURSE PRACTITIONER NAME	NPI

SIGNATURE	DATE

If the hospice service cannot get written certification within two calendar days of when they initiate service, they may get oral certification. They must obtain and submit written certification no later than eight calendar days after they initiate service. The person getting oral certification must acknowledge receiving it by signing below.

AUTHORIZED NAME	AUTHORIZED SIGNATURE	DATE

Check when appropriate

☐ The member named on this form has no attending physician and is relying on the hospice to fulfill the main role of determining and delivering care.

Discharge Statement

The member named on this form is discharged from the hospice program effective _____ (DATE)

HOSPICE MEDICAL DIRECTOR OR DESIGNEE	SIGNATURE

Revocation of Hospice Services

Effective _____ (DATE OF REVOCATION) I no longer want to receive hospice services. The hospice provider has informed me that hospice will no longer pay for my medications and services and that Medical Assistance or MinnesotaCare will resume paying for any medications or other services that are covered under my benefits.

SIGNATURE OF MHCP MEMBER OR LEGAL REPRESENTATIVE	DATE	WITNESS SIGNATURE	DATE

Change of Designated Hospice Provider

Effective _____ (DATE) the MHCP member named on this form chose the following hospice provider. The current hospice provider must complete this form and submit it to DHS and the newly elected hospice provider.

HOSPICE NAME	SIGNATURE OF MHCP MEMBER OR LEGAL REPRESENTATIVE

Death of Person Who Was Receiving Hospice Services

The hospice provider must complete and fax this to DHS at 651-431-7554 if the MHCP member dies while in hospice care.

DATE OF DEATH	HOSPICE MEDICAL DIRECTOR OR DESIGNEE NAME
NPI	SIGNATURE OF MEDICAL DIRECTOR OR DESIGNEE

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកការ់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກໍາກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA5 (3-12)

This information is available in alternative formats to individuals with disabilities by calling your county worker. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Moments Hospice™
Moments are Forever

PATIENT EVACUATION PLAN

Patient Name: _____ **Patient ID:** _____

DOB: ____/____/_____ ☐ **Male** ☐ **Female** **Home Phone:** _____ **Cell Phone:** _____

Address: _____

Emergency Contact Name *(out of home)*: _____

Relationship: _____ **Phone:** _____ **Alt. Phone:** _____

Address: _____

In the event of an emergency or natural or man-made disaster, and to facilitate appropriate evacuation, transportation and care, the patient plans to:

☐ Remain in the home

☐ Evacuate to home of family member or friend with assistance of family and/or caregiver.
Name: _____ Address: _____ Phone: _____

☐ Evacuate with assistance of Moments Hospice to arrange for non-emergency transportation, contact the patient's out-of-home emergency contact and help to locate an available:
☐ Motel/hotel ☐ Shelter ☐ Special needs shelter ☐ Non-emergency inpatient admission

☐ Evacuate with assistance of emergency officials. **Call 911 for emergency transportation.**

If evacuation is needed, notify Moments Hospice.

Select all special needs:

☐ **Patient has restricted mobility:** *(Select level of mobility)*
☐ Bedbound ☐ Chair/wheelchair bound ☐ Ambulatory with assistance: ☐ Maximum ☐ Moderate ☐ Minimum

☐ **Patient requires lifesaving equipment:** *(Select all that apply)*
☐ ***Insulin*** requiring diabetic. Insulin administered by: ☐ Injection ☐ Pump *(type: _____)*
Insulin type, dose and frequency: _____
☐ ***Oxygen*** at ____ liters/minute via: ☐ Nasal cannula ☐ Mask ☐ Tracheal ☐ Liquid ☐ Concentrator ☐ Cylinder
☐ Requires oxygen continuously ☐ Requires oxygen intermittently: hours per day: _____
☐ Portable oxygen cylinder available ☐ Portable battery-operated oxygen concentrator available ☐ **No** portable oxygen available
☐ ***Ventilator*** dependent: *(type: _____)*
Ventilator settings: Respiratory rate: _____ Tidal volume: _____ FiO_2: _____ PEEP: _____
☐ Ventilator **is** portable with back-up battery ☐ Ventilator **is not** portable
☐ ***CPAP:*** _____ cm H_2O
☐ ***BiPAP:*** IPAP: _____ cm H_2O EPAP: _____ cm H_2O
☐ ***BiPAP ST:*** IPAP: _____ cm H_2O EPAP: _____ cm H_2O Respiratory rate: _____
☐ ***Suction machine:*** ☐ Suction machine **is** portable with back-up battery ☐ Suction machine **is not** portable
☐ ***Infusion pump:*** ☐ Infusion pump **is** portable with back-up battery ☐ Infusion pump **is not** portable
☐ ***Enteral pump:*** ☐ Enteral pump **is** portable with back-up battery ☐ Enteral pump **is not** portable
☐ ***Apnea monitor:*** ☐ Apnea monitor **is** portable with back-up battery ☐ Apnea monitor **is not** portable

☐ **Other medical needs:**
☐ Wound care: _____
☐ Intravenous medications: _____
☐ Tube feeding: _____
☐ Other: _____

☐ **Other special needs:**
☐ Communication barriers: _____ ☐ Language barrier: _____
☐ Intellectual disability: _____ ☐ Special diet: _____
☐ Other: _____

MOMENTS HOSPICE REPRESENTATIVE SIGNATURE/TITLE: _____ **DATE:** _____

MOMENTS HOSPICE REPRESENTATIVE SIGNATURE/TITLE: _____ **DATE:** _____

Moments Hospice™
Moments are Forever

PATIENT EVACUATION PLAN

Patient Name: _____ **Patient ID:** _____

DOB: ____/____/_____ ☐ **Male** ☐ **Female** **Home Phone:** _____ **Cell Phone:** _____

Address: _____

Emergency Contact Name *(out of home)*: _____

Relationship: _____ **Phone:** _____ **Alt. Phone:** _____

Address: _____

In the event of an emergency or natural or man-made disaster, and to facilitate appropriate evacuation, transportation and care, the patient plans to:

☐ Remain in the home

☐ Evacuate to home of family member or friend with assistance of family and/or caregiver.
Name: _____ Address: _____ Phone: _____

☐ Evacuate with assistance of Moments Hospice to arrange for non-emergency transportation, contact the patient's out-of-home emergency contact and help to locate an available:
☐ Motel/hotel ☐ Shelter ☐ Special needs shelter ☐ Non-emergency inpatient admission

☐ Evacuate with assistance of emergency officials. **Call 911 for emergency transportation.**

If evacuation is needed, notify Moments Hospice.

Select all special needs:

☐ **Patient has restricted mobility:** *(Select level of mobility)*
☐ Bedbound ☐ Chair/wheelchair bound ☐ Ambulatory with assistance: ☐ Maximum ☐ Moderate ☐ Minimum

☐ **Patient requires lifesaving equipment:** *(Select all that apply)*
☐ ***Insulin*** requiring diabetic. Insulin administered by: ☐ Injection ☐ Pump *(type: _____)*
Insulin type, dose and frequency: _____
☐ ***Oxygen*** at ____ liters/minute via: ☐ Nasal cannula ☐ Mask ☐ Tracheal ☐ Liquid ☐ Concentrator ☐ Cylinder
☐ Requires oxygen continuously ☐ Requires oxygen intermittently: hours per day: _____
☐ Portable oxygen cylinder available ☐ Portable battery-operated oxygen concentrator available ☐ **No** portable oxygen available
☐ ***Ventilator*** dependent: *(type: _____)*
Ventilator settings: Respiratory rate: _____ Tidal volume: _____ FiO_2: _____ PEEP: _____
☐ Ventilator **is** portable with back-up battery ☐ Ventilator **is not** portable
☐ ***CPAP:*** _____ cm H_2O
☐ ***BiPAP:*** IPAP: _____ cm H_2O EPAP: _____ cm H_2O
☐ ***BiPAP ST:*** IPAP: _____ cm H_2O EPAP: _____ cm H_2O Respiratory rate: _____
☐ ***Suction machine:*** ☐ Suction machine **is** portable with back-up battery ☐ Suction machine **is not** portable
☐ ***Infusion pump:*** ☐ Infusion pump **is** portable with back-up battery ☐ Infusion pump **is not** portable
☐ ***Enteral pump:*** ☐ Enteral pump **is** portable with back-up battery ☐ Enteral pump **is not** portable
☐ ***Apnea monitor:*** ☐ Apnea monitor **is** portable with back-up battery ☐ Apnea monitor **is not** portable

☐ **Other medical needs:**
☐ Wound care: _____
☐ Intravenous medications: _____
☐ Tube feeding: _____
☐ Other: _____

☐ **Other special needs:**
☐ Communication barriers: _____ ☐ Language barrier: _____
☐ Intellectual disability: _____ ☐ Special diet: _____
☐ Other: _____

MOMENTS HOSPICE REPRESENTATIVE SIGNATURE/TITLE: _____ **DATE:** _____

MOMENTS HOSPICE REPRESENTATIVE SIGNATURE/TITLE: _____ **DATE:** _____

Moments Hospice™
Moments are Forever

SERVICE PLAN

PATIENT NAME: _____ PATIENT ID: _____

SERVICE FREQUENCY/DURATION/SUPERVISION AND FINANCIAL AGREEMENT

Discipline	Frequency of Services	Anticipated Source of Payment	Level of Care	Patient Financial Responsibility	Re-assess at least every 60 days
SN			RHC: GIP: Respite: Cont. Care:		
PT/OT/ST					
MSW					
HHA					
CHAP					
RD					

AUTHORIZED PERSONS TO RECEIVE HEALTH INFORMATION

I give permission for my care to be discussed with the following people:

_____ _____

CONTINGENCY PLANNING

Essential Services: If services are needed for medical or safety reasons and our staff is unable to keep the appointment, Moments Hospice will make arrangements through with another provider or other reasonable means.

Nonessential Services: If staff is unable to keep a scheduled appointment that is not essential for medical or safety reasons, Moments Hospice will provide a replacement person or notify me and reschedule the appointment.

Action to be taken by Moments Hospice and me and my representative if services cannot be provided:

_____

_____

Emergency: In case of an emergency or change in condition, the Agency staff shall call the following person(s): _____

_____ by *(method of contact):* _____.

The person authorized to sign for me in case of an emergency *(name and relationship)*: _____

I understand that emergency service will be summoned during an emergency unless there is a written physician's orders in my record that reflects my wishes regarding "Do Not Resuscitate" or "Do Not Intubate" (DNR/DNI). If no DNR/DNI, the agency will call 911.

By signing this form, I acknowledge receipt of the admission booklet and confirm my understanding and agreement with its contents. My signature below indicates my approval.

_____ _____ _____
Patient Signature | Date | Responsible Person or Legal Guardian Signature

_____ _____ _____
Moments Hospice Representative Signature | Date | Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Moments Hospice™
Moments are Forever

MILITARY HISTORY CHECKLIST

PATIENT DATA

Completed by: _____

Patient's Name: _____ Date: _____

Address: _____

Hospice Medical Record #: _____ Last 4 SSN: _____

VETERAN STATUS INFORMATION

1. Did you (or your spouse or family member) serve in the military?

1a. Patient ☐ Yes ☐ No

Did you serve on active duty? ☐ Yes ☐ No

Did your service include combat, dangerous or traumatic assignments? ☐ Yes ☐ No

Do you have a copy of your DD214 discharge papers? ☐ Yes ☐ No

1b. Did your spouse serve on active duty? ☐ Yes ☐ No

Comments: _____

1c. Do you have any immediate family members that served or are serving in the military? ☐ Yes ☐ No

Comments: _____

MILITARY BACKGROUND

2. In which branch of the military did you serve?

☐ Army ☐ Marines ☐ Merchant Marines during WWII

☐ Navy ☐ Coast Guard ☐ Other: _____

☐ Air Force ☐ Reservist or National Guard member _____

3. In which war era or period of service did you serve?

☐ WWI (4/6/17 to 11/11/18)

☐ WWII (12/7/41 to 12/31/46)

☐ Korea (6/27/50 to 1/31/55)

☐ Cold War

☐ Peace Time

☐ Other: _____

☐ Vietnam (8/5/64 to 5/7/75 and 2/28/61 for veterans who served "in country" (in Vietnam) before 8/5/64)

☐ Gulf War (8/2/90 through a date to be set by law or presidential proclamation)

☐ Afghanistan/Iraq (OEF/OIF)

Note: after 9/7/80, must have completed 24 months continuous active service, or the full period for which they were called or ordered to active duty.

4. Overall, how do you view your experience in the military?

_____

_____

5. If available would you like your hospice staff/volunteer to have military experience? ☐ Yes ☐ No

VA BENEFITS INFORMATION

6. Are you enrolled in VA? ☐ Yes ☐ No

6a. Do you receive any VA benefits? ☐ Yes ☐ No

6b. Do you have a service-connected condition? ☐ Yes ☐ No

6c. Do you get your medications from VA? ☐ Yes ☐ No

6d. What is the name of your VA hospital or clinic? _____

6e. What is the name and contact information of your VA physician or Primary Care Provider?

_____

6f. Would you like to talk with someone about benefits you or your family might be eligible to receive? ☐ Yes ☐ No

Moments Hospice™
Moments are Forever

SERVICE PLAN

PATIENT NAME: _____ PATIENT ID: _____

SERVICE FREQUENCY/DURATION/SUPERVISION AND FINANCIAL AGREEMENT

Discipline	Frequency of Services	Anticipated Source of Payment	Level of Care	Patient Financial Responsibility	Re-assess at least every 60 days
SN			RHC: GIP: Respite: Cont. Care:		
PT/OT/ST					
MSW					
HHA					
CHAP					
RD					

AUTHORIZED PERSONS TO RECEIVE HEALTH INFORMATION

I give permission for my care to be discussed with the following people:

_____ _____

CONTINGENCY PLANNING

Essential Services: If services are needed for medical or safety reasons and our staff is unable to keep the appointment, Moments Hospice will make arrangements through with another provider or other reasonable means.

Nonessential Services: If staff is unable to keep a scheduled appointment that is not essential for medical or safety reasons, Moments Hospice will provide a replacement person or notify me and reschedule the appointment.

Action to be taken by Moments Hospice and me and my representative if services cannot be provided:

_____

_____

Emergency: In case of an emergency or change in condition, the Agency staff shall call the following person(s): _____

_____ by *(method of contact):* _____.

The person authorized to sign for me in case of an emergency *(name and relationship)*: _____

I understand that emergency service will be summoned during an emergency unless there is a written physician's orders in my record that reflects my wishes regarding "Do Not Resuscitate" or "Do Not Intubate" (DNR/DNI). If no DNR/DNI, the agency will call 911.

By signing this form, I acknowledge receipt of the admission booklet and confirm my understanding and agreement with its contents. My signature below indicates my approval.

_____ _____ _____
Patient Signature | Date | Responsible Person or Legal Guardian Signature

_____ _____ _____
Moments Hospice Representative Signature | Date | Printed Name and Relationship of Person Above

☐ *Patient unable to sign due to:* _____

Moments Hospice™
Moments are Forever

VOLUNTEER REQUEST FORM

PATIENT NAME: _____ **MR#:** _____ **DATE:** _____

Volunteer coordinator: _____
Phone no.: _____
Care coordinator (RN): _____
Phone no.: _____
Patient problem: _____
_____
Patient address: _____
_____
Patient's telephone no.: _____
Patient's DOB: _____
Primary caregiver's relationship to patient: _____

Volunteer needed: ☐ Weekday ☐ Weekend ☐ Morning ☐ Afternoon ☐ Evening ☐ No preference
Time(s) requested: _____
Characteristics of volunteer requested: Race____ Gender____
Special skills/interests: _____
Volunteer activity: Frequency _____
Duration _____
Caregiver name: _____
Address: _____
_____
Telephone no.: _____ DOB: _____

PERTINENT AND OTHER PRECAUTIONARY INFORMATION. Check all that apply. Circle appropriate item if separated by slash.

Description of the Patient

☐ Lives alone ☐ Lives with other ☐ Alone during day
☐ Bed bound ☐ Bed rest /BRPs ☐ Up as tolerated
☐ Amputee (specify) _____
☐ Partial weight bearing ☐ Right ☐ Left
☐ Non-weight bearing ☐ Right ☐ Left
☐ Hip precautions ☐ Special equipment _____
☐ Speech/communication deficit ☐ Alert ☐ Oriented
☐ Closed to communication ☐ Lethargic ☐ Confused
☐ Open to communication ☐ Hostile ☐ Denying
☐ Frightened ☐ Accepting ☐ Withdrawn ☐ Angry
☐ Vision deficit ☐ Glasses ☐ Contacts ☐ Other _____
☐ Hearing deficit ☐ Hearing aid
☐ Dentures ☐ Upper ☐ Lower ☐ Partial
☐ Urinary catheter ☐ Prone to fractures
☐ Prosthesis (specify) _____
☐ Allergies (specify) _____
_____
☐ Bleeding precautions ☐ Seizure precaution
☐ Diabetic ☐ Do not cut nails
☐ Watch for hyper/hypoglycemia
☐ Diet _____
☐ DNR (Do Not Resuscitate)

Description of the Primary Caregiver

☐ Friendly ☐ Not friendly
☐ Angry ☐ Passive
☐ Frightened ☐ Resigned
☐ Controlling ☐ Relinquishing control
☐ Anxious ☐ Stressed
☐ Isolated ☐ Open to communication
☐ Independent ☐ Dependent
☐ Denying ☐ Exhausted
☐ Hostile ☐ Closed to communication
☐ Confident ☐ Accepting
☐ Withdrawn ☐ Self-reliant
☐ Lacks confidence
☐ Well supported
Tobacco use in home: ☐ None ☐ Mod. ☐ Heavy
Special needs/concerns: _____

ASSIGNMENT - Check all applicable tasks. Write additional instructions as needed beside appropriate item.

☐	Companionship - patient
☐	Respite-caregiver
☐	Emotional support - Patient
☐	Caregiver
☐	Bereavement: telephone call
☐	Support
☐	Attend funeral
☐	Answer phone
☐	Volunteer:
☐	Volunteer:

☐	Activities: Shopping
☐	Light housekeeping
☐	Yard Work
☐	Laundry
☐	Meal preparation
☐	Other (specify)
☐	Clerical work (hospice agency)
☐	Other (specify)
☐	Volunteer:
☐	Volunteer:

Moments Hospice™
Moments are Forever

MEDICATION LIST FOR PATIENTS AND FAMILIES

ALLERGIES: _____

SENSITIVITIES: _____

DATE STARTED /STOPPED	TRADE NAME	GENERIC NAME	PURPOSE	DOSE/ROUTE	FREQUENCY

Moments Hospice™

Moments are Forever

☐ **Brainerd:** Phone: (218) 513-2370; Fax: (218) 513-2371
☐ **Golden Valley:** Phone: (763) 205-3600; Fax: (763) 205-9350
☐ **Hermantown:** Phone: (218) 520-0870; Fax: (218) 520-0875
☐ **Mankato:** Phone: (507) 609-8800; Fax: (507) 609-8810
☐ **Rochester:** Phone: (507) 888-9700; Fax: (507) 888-9780
☐ **St. Cloud:** Phone: (320) 372-4300; Fax: (320) 372-4380

Your Professional Hospice Staff

Nurse: _____

Medical Director: _____

Hospice Aide: _____

Social Worker: _____

Spiritual Counselor: _____

Volunteer(s): _____

Important Phone Numbers *(Patient to complete)*

Ambulance/Police/Fire
911 or _____

Poison Control
1-800-222-1222 or 911

Hospital
_____

Medical Equipment (Oxygen)
_____

Doctor
_____

Electric Company
_____

Funeral Home
_____

Phone Company
_____

Non-Emergency Transportation
_____

Water Company
_____

Pharmacy
_____

Family
_____

MEDFORMS®
Medical Forms Management, Inc.
Custom Publishing for Home Care
P.O. Box 40333 | Nashville, TN 37204
800-843-9178 | medforms.com

What is Music Therapy?

Music Therapy is an established health profession in which music is used within a therapeutic relationship to address physical, emotional, cognitive, and social needs of individuals. After assessing the strengths and needs of each client, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music. Through musical involvement in the therapeutic context, clients' abilities are strengthened and transferred to other areas of their lives. Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words. Research in music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings.

Taken from the American Music Therapy Association website www.musictherapy.org

About Moments Hospice

Moments Hospice™
Moments are Forever

Moments Hospice is a Medicare Certified Hospice Agency serving the entire Twin Cities Metropolitan area. We are focused on creating individual plans of care, because every patient and family is unique. Moments Hospice is committed to honoring patient's and family's wishes during the end of life process. We take great pride in creating long lasting partnerships with our Hospitals, Facilities and Community partners by recognizing that we are guests in their facilities and that collaborating on a joint plan of care always results in the best outcome for the patient. It is our mission to help increase the communities awareness of the Hospice Benefit as we believe that everyone deserves to be comfortable with an optimal quality of life during the end of life process.

MUSIC THERAPY AND HOSPICE CARE

MOMENTS HOSPICE
820 Lilac Dr. N, Suite 210
Golden Valley, MN 55422
(763)-205-3600
www.momentshospice.com

How is Music Therapy unique to hospice care?

Music therapy is unique to hospice care in that it benefits the whole person, their families, and their caregivers. This means embracing the patient's culture, religious beliefs, and memories to create a meaningful experience. It aims to promote an environment of healing and emotional restoration while alleviating physical, emotional, social, and spiritual distress. While many of the same techniques and interventions are used, now two patient experiences look the same. By using the restorative power of music, music therapy allows hospice patients to engage in total well-being.

Music Therapy can be used for:

- Pain management
- Anxiety/Stress
- Agitation
- Spiritual concerns
- Socialization
- Reminiscing/Life review
- Coping skills
- Mood management
- Control/independence at the end of life
- Grief
- Maintain/improve comfort

Techniques and Interventions Used:

- Singing
- Instruments work
- Lyric analysis/discussion
- Relaxation to music
- Guided imagery
- Song writing
- Making musical choices
- Rhythmic movements/ dancing

Namaste Care Program Education Session

This Event is open to the Public

About this Event:

- Namaste Care program is for maintaining quality of life in advanced dementia.
- Learn tools on how agitation can be managed by providing meaningful activities on a daily basis.
- This program was originally designed for people with advanced dementia, who cannot participate in traditional activities.
- Learn how creating a calm environment and loving touch can improve communication, decrease agitation and symptoms of depression.
- Namaste Care decreases psychotropic medications and increases job satisfaction of caregivers.
- Caregivers will learn ways to engage with their patients ,or loved ones when Communication seems impossible.
- Namaste Care is now offered in 10 countries.
- Moments Hospice has engaged Ms. Simard to assist them to be the first Hospice in Minnesota to offer Namaste Care to all of their patients by all disciplines especially those with memory loss.

Please RSVP by June 7th. To reserve your seat(s), please go to:
http://evite.me/434X2ENgd8

Or Call: (952) 758-2511

1.0 CEU for Social Workers and Nurses (transferable to Board of Nursing CEP-947)

Tuesday, June 11th from 3:00pm-4:00pm

Mala Strana Assisted Living And Rehabilitation Center

999 Columbus Ave N, New Prague, MN 56071

Joyce Simard, MSW is an Adjunct Associate Professor School of Nursing, University of Western Sydney Australia and a private geriatric consultant residing in Land O Lakes, Florida. She received her MSW from the University of Minnesota and was employed as a social worker in St Louis Park, MN. She has been involved in long-term care for over 40 years serving as an Alzheimer's specialist for many healthcare companies providing services in skilled nursing homes, assisted living communities and hospice organizations. Ms. Simard has written numerous articles and chapters in healthcare books and has authored "The End-of-Life Namaste Care Program for People with Dementia" now in its second edition.

Moments Hospice™
Moments are Forever

MONARCH
HEALTHCARE MANAGEMENT

WellnessVR™

VR-Based Programming for Seniors

WellnessVR is an affordable, subscription-based platform developed with partners in health care & designed to enhance wellbeing in seniors.

WellnessVR programming includes:

Virtual Travel

Bring the world to your community.

Arts & Culture

Enrich and engage with creative therapy.

Relaxing Nature Scenes

Reduce anxiety and promote wellbeing.

and more, with new content added every month.

Sign up for a Free 2-hour Demo

To try VR-Programming in your community.
visit wellnessvr.io/demo

Quotes about WellnessVR from Seniors

“I feel like I'm right in the middle of it. Wow!”

“This is just what I needed today. I was feeling stressed.”

“If anybody doesn't do this they're nuts.”

“Feels so realistic.”

“Very relaxing with all the waves.”

“Oh this is wonderful!”

”Oh you're gonna love it!”

“I felt like I was there. The actual feeling of being there.”

WellnessVR™

www.wellnessvr.io

WEST METRO

Virtual reality lets seniors travel without leaving home

VR technology engages memory-care patients as entertainment and therapy.

By Katy Read (https://www.startribune.com/katy-read/6134696/) Star Tribune

JULY 23, 2019 — 11:22PM

A stream wound through a forest with snowy mountains beckoning in the background. The water looked so refreshing that Kathy Boone wanted to dip a toe in, so she kicked off a shoe.

"Whoo, I love it!" said Boone, 68. "Anybody else want to go barefoot?"

Shorewood Landing, a senior-housing center in Shorewood, is far from the nearest snow-capped peaks. But on Tuesday, half a dozen residents visited Rocky Mountain National Park via virtual reality (VR), a technology that presents realistic sounds and three-dimensional scenes.

The residents — most of them in memory care — donned headsets and could hear the stream flowing, gaze 360 degrees around the forest, and look up and see blue sky.

Bill Hurrell, 92, spotted a group of anglers by the stream. "I like her fishing outfit!" said Hurrell, 92. "I just wish they had better focus on it — it looks pretty good."

WellnessVR is produced by a Minneapolis-based company called Visual. Its VR programming for senior residences is a blend of entertainment and therapy, said Chuck Olsen, founder and CEO.

After leaving the mountain stream, residents virtually visited the Ordway Center in St. Paul to watch part of an opera. One woman in the group, a former professional opera singer, sang along. From there it was off to a beach in the Florida Keys where, hearing the waves, some residents said they felt like jumping in.

VR can capture memory-care patients' attention longer than traditional senior-living programming such as music or bingo. Afterward, the lunchroom is abuzz with residents describing what they'd seen. On Tuesday, a particularly active woman remained seated about twice as long as she usually does. "I have never seen her this engaged in anything before," said Nadia Smith, activities director.

Grandparents can brag to their grandkids, Olsen said, about having an adventure even many millennials haven't experienced.

WellnessVR is one of several programs around the country providing such therapy, Olsen said. In 2017, it partnered with Minneapolis-based Ebenezer Senior Living to study therapeutic benefits. In questionnaires before and after the experience, 96% of participants reported feeling happier, 97% more relaxed and 94% less worried.

"The mood changes carried over after the session," said Joel Prevost, director of outreach and engagement with Visual.

University of Washington researchers found that, for burn victims, VR visits to snowy landscapes were more effective than morphine in relieving excruciating pain. Other potential uses include virtual field trips for young students and academic researchers,

ELIZABETH FLORES - STAR TRIBUNE

Shorewood Landing Activities Director Nadia Smith placed a virtual reality system onto memory-care resident Cleone Foste for a

ELIZABETH FLORES • STAR TRIBUNE

Shorewood Landing memory-care resident Kathy Boone described on Tuesday what it was like to be in Montana — via a virtual reality

Olsen said.

Tim Knopik, 74, of Shorewood Landing, said he'd like to take a virtual trip to Las Vegas — specifically to the first floor of Binion's Gambling Hall on a Saturday night.

That particular scene might not be on the agenda but Olsen said "we do take requests" and keep a record of them.

Although WellnessVR's programs aren't currently tailored to residents' specific needs, its library of 63 experiences includes scenes such as Minnehaha Falls and close-up farm animals, designed to appeal to aging Minnesotans. A program called "Grandmother's Porch" involves an old-fashioned (computer generated) porch. But someday VR could feature people's actual grandmothers' actual porches. Individualized VR programs could take people to their hometowns or to visit their grandchildren — someday even providing two-way live interaction among family members.

"Virtual reality can be both a travel machine and a time machine," Olsen said.

Anita Cornelius, regional assisted living director at Ebenezer, said memory care residents don't always recall their VR experiences afterward.

But that's OK, she said, because for people with memory loss, recalling the past isn't as important as enjoying the present. "Their experiences are moment to moment. That's where their life is."

Correction: Previous versions of this article misstated the age for Kathy Boone, the title for Joel Prevost, the title for Anita Cornelius and one reference to the name of the virtual reality technology.

Katy Read is a reporter covering Carver County and western Hennepin County. She has also covered aging, workplace issues and other topics for the Star Tribune. She was previously a reporter at the Times-Picayune in New Orleans, La., and the Duluth News-Tribune.

katy.read@startribune.com 612-673-4583

DEATH WITH DIGNITY

Policy No. 9-033
WA

PURPOSE

To provide guidelines for circumstance where patients are selecting to choose Death with Dignity as outlined in the Washington Death with Dignity Act 70.245

POLICY

The patients of Moments Hospice will have the right to choose Death with Dignity, per the RCW Chapter 70.245 and Chapter 246-978 WAC.

PROCEDURE

1. Moments Hospice will respect Patients' rights to choose Death with Dignity.
2. Death with Dignity may only be chosen by patients 18 years of age and older who are deemed competent and who have voluntarily expressed their wish to die.
3. Moments Hospice staff will not witness form for request of Death with Dignity medications as described in RCW 70.245.220.
4. Moments Hospice Physician or staff will not order or administer Death with Dignity medications.
5. The attending physician shall:

    A. Make the initial determination of whether a patient has a terminal disease, is competent, and has made the request voluntarily;

    B. Request that the patient demonstrate Washington state residency under RCW 70.245.130;

    C. To ensure that the patient is making an informed decision, the primary physician will inform the patient of:

        a. His or her medical diagnosis;

        b. His or her prognosis;

        c. The potential risks associated with taking the medication to be prescribed;

        d. The probable result of taking the medication to be prescribed; and

        e. The feasible alternatives including, but not limited to, comfort care, hospice care, and pain control;

D. Refer the patient to a consulting physician for medical confirmation of the diagnosis, and for a determination that the patient is competent and acting voluntarily;

E. Refer the patient for counseling if appropriate under RCW 70.245.060;

F. Recommend that the patient notify next of kin;

G. Counsel the patient about the importance of having another person present when the patient takes the medication prescribed under this chapter and of not taking the medication in a public place;

H. Inform the patient that he or she has an opportunity to rescind the request at any time and in any manner, and offer the patient an opportunity to rescind at the end of the fifteen-day waiting period under RCW

I. Verify, immediately before writing the prescription for medication under this chapter, that the patient is making an informed decision;

J. Fulfill the medical record documentation requirements of RCW 70.245.120;

K. Ensure that all appropriate steps are carried out in accordance with this chapter before writing a prescription for medication to enable a qualified patient to end his or her life in a humane and dignified manner; and

L. Dispense medications directly, including ancillary medications intended to facilitate the desired effect to minimize the patient's discomfort, if the attending physician is authorized under statute and rule to dispense and has a current drug enforcement administration certificate; or

    a. With the patient's written consent:

        i. Contact a pharmacist and inform the pharmacist of the prescription; and

        ii. Deliver the written prescription personally, by mail or facsimile to the pharmacist, who will dispense the medications directly to either the patient, the attending physician, or an expressly identified agent of the patient.

M. The attending physician may sign the patient's death certificate which shall list the underlying terminal disease as the cause of death.

6. The patient will need to also see a consulting physician for examination and their have relevant medical records and confirm, in writing, the attending physician's diagnosis that the patient is suffering from a terminal disease, and verify that the patient is competent, is acting voluntarily, and has made an informed decision.

7. The attending physician shall recommend that the patient notify the next of kin of his or her request for medication under this chapter. A patient who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

8. If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a

patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

9. A patient may rescind his or her request at any time and in any manner without regard to his or her mental state. No prescription for medication Death with Dignity may be written without the attending physician offering the qualified patient an opportunity to rescind the request.

10. Death with Dignity medications must be administered independently by the patient.

11. At least fifteen days shall elapse between the patient's initial oral request and the writing of a prescription to end their life in a humane and dignified manner.

12. At least forty-eight hours shall elapse between the date the patient signs the written request and the writing of a prescription to end their life in a humane and dignified manner.

13. Any unused portion of medication that was dispensed for this purpose shall be disposed of as per lawful means and per medication destruction policy 2-008 Home Medication Management and Destruction.

14. Moments Hospice staff may be present during Death with Dignity act in order to provide support to the patients and/or family.

15. Moments Hospice staff who have an ethical dilemma with Death with Dignity will be allowed to request to not work with patients who are choosing Death with Dignity option.

16. Any applicable state regulations will be followed.

Moments Hospice™

MOMENTS ARE FOREVER

Moments Heart Program

1

MOMENTS HEART PROGRAM

And now here is my secret, a very simple secret: It is only with the heart that one can see rightly; what is essential is invisible to the eye.

~ Antoine de Saint-Exupery, *The Little Prince*

2

TABLE OF CONTENTS

Moments Hospice℠
Moments are Forever

3

WHO IS THE PROGRAM FOR?

- Moments Hospice patients admitted with a cardiac diagnosis as primary
- Moments Hospice patients, who although cardiac is not the primary diagnosis, do have significant cardiac disease
- Patients with or without a DNR
- Patients with or without an implanted pacemaker
- Patients with or without an implanted defibrillator

Moments Hospice℠
Moments are Forever

4

ELIGIBILITY

HEART DISEASE

CLINICAL INDICATORS:

- Patient is already optimally treated with diuretics and vasodilators (ACE inhibitors), not a candidate or declines invasive procedures, and
- Class IV of NYHA (physical activity causes discomfort, symptoms of recurrent heart failure or angina at rest)

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- » Treatment-resistant symptomatic arrhythmias
- » Ejection fraction ≤ 20 percent
- » History of cardiac arrest and CPR
- » Unexplained syncope
- » Brain embolism or cardiac origin
- » Concomitant HIV disease

- » Resistant to Nitrate Therapy
- » Decline in Palliative Performance scale to 50 percent or less
- » BMI less than 22
- » CHR or Cardiomyopathy with documented cardiomegaly
- » Ischemic Heart Disease, ASHD/ASCVD/CAD
- » Increase frequency of hospitalization or ER visits for symptom control
- » Current inotropic therapy dose unable to be reduced
- » Oxygen dependent

Moments Hospice
Moments are Forever

5

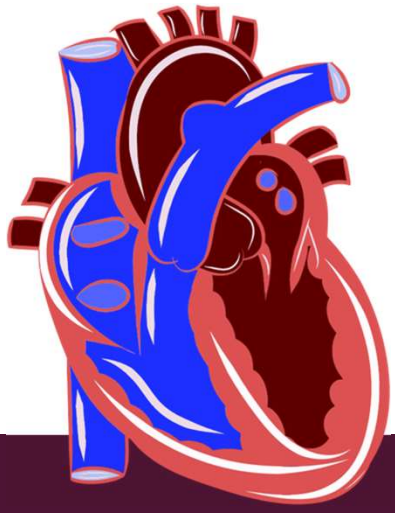
NEW YORK HEART ASSOCIATION CLASSIFICATIONS

Class I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation or dyspnoea.
Class II	Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in fatigue, palpitation or dyspnoea.
Class III	Marked limitation of physical activity. Comfortable at rest but less than ordinary activity results in fatigue, palpitation or dyspnoea.
Class IV	Unable to carry out any physical activity without discomfort. Symptoms at rest. If any physical activity is undertaken, discomfort is increased.

NYHA: New York Heart Association.

Moments Hospice
Moments are Forever

6



THE HEART

7

THE HEART

- At the Center of a person's being
- Connected to connotations of emotions and love
- Pumps unoxygenated blood from the right side of the heart to the lungs and oxygenated blood from the left side to the rest of the body
- Comprised of cardiac cells – when working correctly these cells fire together to contract the muscle of the heart
- It has four chamber that the blood moves through on its journey through the heart
- Coronary arteries on the outside of the heart provide oxygenated blood to the heart muscle

Moments Hospice℠
Moments are Forever

8

THE HEART ~ FUN FACTS

- Heart Valve is about the size of a half dollar
- Stethoscope was invented as a result of doctors needing to place ear against the chest wall to hear the heart
- On average a heart beats 115,000 times a day
- Healthy heart pumps 1.3 gallons of blood per minute
- 60 Milliliters of blood is pumped with each beat by a healthy heart
- Blood moves through the aorta at about 1 mile/hour
- The blood vessels are approximately 60,000 miles long

Moments Hospice
Moments are Forever

9

THE HEART

- Heart disease is the #1 cause of death in the US
- Congestive heart failure
  - Fluid backs up into the lungs and tissues
- Left sided heart failure
  - Activity intolerance
  - Poor peripheral perfusion
  - Pulmonary congestion
- Right sided heart failure
  - Edema
  - Liver congestion with impaired function
  - Weight loss and Gi distress

10

SYMPTOM MANAGEMENT

11

MEDICATIONS

- Aggressive approach to symptom management
- Oral drug therapy: Management of oral cardiac medications including antihypertensives and diuretics with the Attending Physician and Hospice Medical Director to optimally treat symptoms. Morphine for relief of pain and dyspnea.
- IM/IV Diuretics: When oral medications alone may not be enough to manage a patient in fluid overload effectively and efficiently, IV/IM medications are provided when oral is not enough to maintain quality of life. Vials can be kept in the home for acute exacerbations to quickly control symptoms as part of the standing orders of a patient's care.
- Inotropic drips: Although costly, medications like Dobutamine and Milrinone can significantly increase patients' quality of life by improving cardiac contractility and vasodilation, providing more energy and less malaise. Admitting patients on these medications will allow them to pick a day to discontinue the medication once their affairs are in order, assist them to see a special person, or live to an important birthday or anniversary.

Moments Hospice℠
Moments are Forever

12

MANAGEMENT OF LVAD

- Left Ventricular Assist Device
  - Patients often die in hospitals without the benefits of hospice
  - Used for short term destination therapy
  - Partnership with local cardiac clinics
    - Peaceful end of life transitions
    - Patients can choose where they would like to be when their heart beats for the last time
    - Supplies delivered to have everything in the home when rapid changes occur

Moments Hospice℠
Moments are Forever

13

PATIENT AND CAREGIVER EDUCATION

14

EDUCATION

- Education on end-stage disease management
  - Weight tracking
  - Vital sign tracking
  - Monitoring for Exacerbations
  - Which medications to use when
  - Low Sodium Diet (as an option for symptom management)
- Education to call Moments Hospice
  - With ANY changes – call
  - When in doubt – call
  - New or worsening symptoms - call
- Education on nonpharmacological interventions
  - Positioning
  - Meditation or Progressive relaxation
  - Energy Conservation

Moments Hospice℠
Moments are Forever

15

NONPHARMACOLOGICAL INTERVENTIONS

16

SUPPLIES AND TREATMENTS

- Unna Boots,
- Tubigrips,
- Venous or arterial stasis ulcer treatments,
- Positioning devices
- Oxygen

Moments Hospice
Moments are Forever

17

COMPLIMENTARY AND ALTERNATIVE MEDICINE

- Music Therapy
- Massage Therapy
- Feeling Heard
- Progressive Relaxation
- Meditation
- Pet Therapy

Moments Hospice
Moments are Forever

18

PROGRESSIVE RELAXATION SCRIPT

If possible, you may want to dim the lights

Get into a comfortable position and if you are comfortable doing so, close your eyes

Take some nice slow deep breaths, in and out, there is no hurry [Pause to let them breathe]

Now let the breath find its own rhythm

~[Go from head to toe guiding the patient to relax each part of the body]~

Notice if there are any parts of your body that are not relaxed

Relax that part and any other parts that are not relaxed

Enjoy how it feels to be completely relaxed

[allow time for them to enjoy just being]

Now start to notice your breathing

Begin to wiggle your fingers and toes

Notice the sounds in the room around you

When you are ready open your eyes.

Know that you can give yourself this little gift of relaxation throughout your day.

Moments Hospice℠
Moments are Forever

19

GUIDED MEDITATION SCRIPT

Get into a comfortable position.

If you are comfortable closing your eyes, please do so.

Notice your breath, feel the rise and fall of your chest as you breath. If at anytime during your this experience you notice that you are "thinking" come back to noticing your breath. The mind will continue to think because that is what it does, but we can just let those thoughts pass like cars on the street. Notice them but do not hold on to them.

Now I want you to imagine a soft blue light. As you breathe in see this light filling every part of your body. As you breathe out, let go of anything that is causing you stress of heartache.

As the soft blue light fills your body it is providing comfort and peace to you. As you breathe out release any worry or concern.

Breathe in feeling safe

Breathe out stress and anxiety

Breathe in rest and relaxation

Breathe out feeling overwhelmed

Breathe in feeling loved

Breathe out worry and sorrow

Breathe in comfort

Breathe out

Take a couple deeper breaths bring in what you want and taking away what you want to get rid of.

Remember that this is aviable to you anytime during your day.

When you are ready, open your eyes and return to the room around you.

Moments Hospice℠
Moments are Forever

20

THE POWER OF FEELING HEARD

- The cardiac organ is associated with feelings of love, tenderness and care.
- Having a damaged heart can bring up a number of emotions for a patient.
- Feeling fully heard when the patient first begins to express some of these emotions can encourage them to continue to verbalize these deep feelings.
- Providing a safe space ensures the beneficial effects of feeling heard for the patient.

Moments Hospice℠
Moments are Forever

21

INTERDISCIPLINARY TEAM

22

INTERDISCIPLINARY TEAM

All Disciplines will have Individualized POC, increased visit frequency with Initial Moments and Final Moments and when needed for symptom control.

- Nurse – providing education, Managing Symptoms
- Social Worker –to assist with emotional aspect of Cardiac Disease, Looking for life meaning, Life review, Finding hope
- Chaplain – Spiritual aspect of Cardiac Disease, Exploring end-of life beliefs
- Medical Director – Medical Palliation of the disease conjunction with attending physician and the IDG
- Aide – hand on care, socialization, and light house keeping
- Volunteers – Additional supportive services
- Bereavement – Assist patient and family with anticipatory grief
- Other – Music Therapist, Massage Therapist, Death Doula, PT, OT, SLP

Moments Hospice
Moments are Forever

23

STAFF TRAINING

24

STAFF TRAINING

- Relias Courses:
  - Nurses:
    - Components of a Cardiac Assessment
    - Assessing Heart Sounds
    - Myocardial Infarction Management
    - Rapid Review: Assessing Fluid Volume Status
    - Reducing Readmissions and Unnecessary Hospitalization
    - Preventing hospitalizations for heart failure: Getting to the heart of the matter
  - Aides:
    - The Cardiovascular System

Moments Hospice℠
Moments are Forever

25

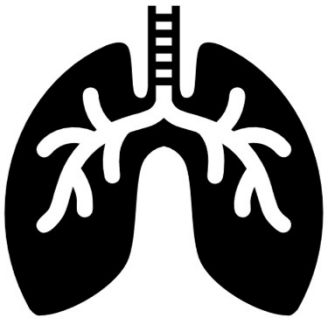
Moments Hospice™

MOMENTS ARE FOREVER

Breathe Program

1

MOMENTS BREATHE PROGRAM



To know even one life has breathed easier because you have lived.
This is to have succeeded.

~Ralph Waldo Emerson

2

TABLE OF CONTENTS

Moments Hospice℠
Moments are Forever

3

WHO IS THE PROGRAM FOR?

- Moments Hospice patients admitted with a pulmonary diagnosis as primary
- Moments Hospice patients, who although pulmonary is not the primary diagnosis, do have significant pulmonary disease
- Patients with or without a DNR

Moments Hospice℠
Moments are Forever

4

ELIGIBILITY

PULMONARY DISEASE

CLINICAL INDICATORS:

- Disabling dyspnea at rest
- Increasing visits to ER or current or prior hospitalizations over previous six months and/or respiratory failure

SUPPORTIVE FACTORS FOR ELIGIBILITY:

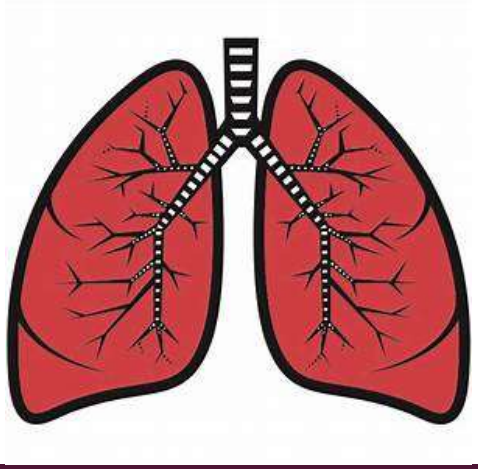
- Cor pulmonale/right heart failure secondary to pulmonary disease
- Resting tachycardia > 100/min
- Unintentional weight loss of 10 percent in previous six months
- Poor response or unresponsive to bronchodilators resulting in decreased functional capacity (bed to chair existence, fatigue, cough)

- Documentation of Forced Expiratory Volume (FEV1) after bronchodilator < 30 percent of predicted
- Hypoxemia at rest, p02 ≤ 55 mm Hg or
- Oxygen saturation of 88 percent or less on room air or
- Hypercapnia with pC02 ≥ 50 mm Hg

Moments Hospice℠
Moments are Forever

5

THE LUNGS



6

THE LUNGS

- The Breath of Life
- Related to relaxing (breathe easy, like a breath of fresh air)
- Brings oxygen into the body to infuse the blood to provide to the body's cells
- Comprised of little sacs called alveoli – which when working correctly air travels into on inhalation and then is expelled from on exhalation
- The human body has 2 lungs, but a person can survive with only 1
- Capillaries in the lungs carry the blood to the alveoli to pick up oxygen before traveling back to the heart
- Carbon Dioxide is expelled from the body via the lungs

Moments Hospice℠
Moments are Forever

7

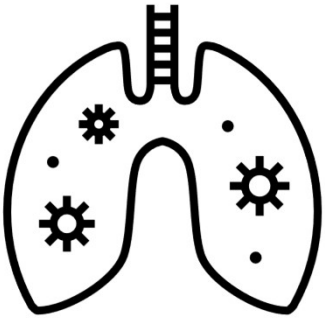
THE LUNGS ~ FUN FACTS

- The lungs create mucous which is the first defense against infections. Cilia (tiny hair like structures) push the mucous up and out of the lungs
- The brain is responsible for controlling breathing
- There is approximately 1,500 miles of airways in the lungs combined
- The left lung is smaller than the right allowing room for the heart inside the ribcage
- Deep breathing has a calming effect
- The origin of the word Lung comes from an Old English word "Lunge" which means "light"
- The Diaphragm is a dome shaped muscle the causes the lungs to inflate and deflate.
- Lungs weigh just under 3lbs together
- Wind instrument players need to regularly clean their instruments to prevent bacteria which can causes "Trombone Players' Lung"

Moments Hospice℠
Moments are Forever

8

THE LUNGS



- Lower respiratory infections are the #4 cause of death in the US
- Chronic Obstructive Pulmonary Disease (COPD)
  - Air sacs in lungs (alveoli) deteriorate and loose their elasticity.
  - Chronic Bronchitis (Infection of a part of the respiratory track) is common in COPD
- Emphysema
  - Alveoli break as a result or smoking or breathing in irritants
  - Decrease the area in the lungs available to oxygenate the blood
- Asthma
  - Swelling in the airways restrict air movement to and from the lungs
- Pulmonary Fibrosis
  - Damaged Lung tissues related to scaring and thickening of tissue
- Pulmonary Hypertension
  - The arteries and capillaries that carry blood to the lungs become constricted or destroyed

9

SYMPTOM MANAGEMENT

10

MEDICATIONS

- Aggressive approach to symptom management
- Oral drug therapy: Management of oral medications including expectorants, corticosteroids and antibiotics with the Attending Physician and Hospice Medical Director to optimally treat symptoms. Morphine for relief of pain and dyspnea. Antianxiety medications to help with fear related to dyspnea.
- Nebulized or inhaled medications: Bronchodilators and steroids
- Oxygen: High liter flow options available through Airvo units that can provide up to 60L of continuous, humidified oxygen when concentrator or liquid oxygen is not enough.

Moments Hospice
Moments are Forever

11

PATIENT AND CAREGIVER EDUCATION

12

EDUCATION

- Education on end-stage disease management
  - Breathing techniques
  - Vital sign tracking
  - Monitoring for Exacerbations
  - Which medications to use when
  - Oxygen use
- Education to call Moments Hospice
  - With ANY changes – call
  - When in doubt – call
  - New or worsening symptoms - call
- Education on nonpharmacological interventions
  - Positioning
  - Meditation or Progressive relaxation
  - Energy Conservation

Moments Hospice℠
Moments are Forever

13

NONPHARMACOLOGICAL INTERVENTIONS

14

SUPPLIES AND TREATMENTS

- Oxygen Masks including nonrebreather mask
- Different types of nasal cannulas
- Nebulizer equipment
- BiPAPs and CPAPs
- Positioning devices
- Oxygen equipment to allow for quality of life and mobility (as indicated)

Moments Hospice℠
Moments are Forever

15

COMPLIMENTARY AND ALTERNATIVE MEDICINE

- Music Therapy
- Massage Therapy
- Feeling Heard
- Progressive Relaxation
- Meditation
- Pet Therapy
- Breathing exersices

Moments Hospice℠
Moments are Forever

16

PROGRESSIVE RELAXATION SCRIPT

If possible, you may want to dim the lights
Get into a comfortable position and if you are comfortable doing so, close your eyes
Take some nice slow deep breaths, in and out, there is no hurry [Pause to let them breathe]
Now let the breath find its own rhythm
~[Go from head to toe guiding the patient to relax each part of the body]~
Notice if there are any parts of your body that are not relaxed
Relax that part and any other parts that are not relaxed
Enjoy how it feels to be completely relaxed
[allow time for them to enjoy just being]
Now start to notice your breathing
Begin to wiggle your fingers and toes
Notice the sounds in the room around you
When you are ready open your eyes.
Know that you can give yourself this little gift of relaxation throughout your day.

Moments Hospice℠
Moments are Forever

17

GUIDED MEDITATION SCRIPT

Get into a comfortable position.
If you are comfortable closing your eyes, please do so.
Notice the way the air feels as it passes through your nostrils. Just take a moment to notice how it feels. Does it tickle? Is it warm or cool? What else do you notice about it?
Now I want you to imagine you are on a boat gliding gently through the water. As you float gently along you notice that your breathing eases. You feel calm and relaxed.
The sun is setting. The sky is turning orange. It is very peaceful in this boat.
Take time to notice what you see around you.
Are there mountains in the distance? Are you on a lake, stream, wide river, or quiet pond?
Are there trees, meadows, or sand along the shore? Just take a moment to notice.
There is a slight breeze, and the temperature is just perfect. It feels so good and relaxing here.
As this breeze blows across you, it takes away any pain or stress you may be experiencing. Go ahead and release that.
Notice if you have any more pain or anxiety you are holding onto. Release that into the breeze.
As you float along peacefully in this calming place continue to release stress, pain, regrets, anxiety. Just let it go. It is safe to do so.
We are nearing the end of our journey. Know that you can always come back to this place.
Take a couple deeper breathes to bring the peace and tranquility into yourself. When you exhale release any remaining fear, pain, or stress.
Remember that this is aviable to you anytime during your day.
Start to notice the sounds in the room around you. Wiggle your fingers and your toes.
When you are ready, open your eyes and return to the room around you.

Moments Hospice℠
Moments are Forever

18

BREATHING EXERCISES

Pursed lip breathing

Start by relaxing your shoulders. Feel your shoulder blades drop down your back.
Purse your lips together. When you breath out imagine you are blowing out a candle.
Breathe in through your nose. Imagine you are smalling a flower.
You exhale should be twice as long as you inhale.
Closing your eyes while doing this can help you stay more present with your breath.
Practice this breathing nice and slowly.

Diaphragmatic or Belly Breathing

Start by relaxing your shoulders. Feel you shoulder blades move down you back.
Close your eyes to be present with the breath (if you are comfortable doing so).
Laying back may make it easier to feel the motion of your breath.
Put on hand on your chest and one on your abdomen.
You want to feel the hand on your belly moving up and down as you breathe.
When we breathe into our shoulders, we feel more anxious. This type of breathing will have a calming affect.
It can also help to reduce shortness of breath during activities.
Work to incorporate pursed lip breathing into belly breathing.
Practice this several times a day.

Moments Hospice℠
Moments are Forever

19

THE POWER OF FEELING HEARD

- Patients with diseases of the lungs experience much lose of control in their lives.
- Mobility limitations = relying on others more
- Effect self worth and self esteem
- May cause feelings of guilt (i.e. a smoker who has COPD causing hardship for the family)
- Having a safe space to express these frustrations
- Free to talk about the impact on their self esteem
- Safe space to share their deepest feelings will allow them to continue to express.

Moments Hospice℠
Moments are Forever

20

VENTILATOR PATIENTS

21

VENTILATOR MANAGEMENT AND DISCONTINUATION

- Ventilator management
  - Until the date of discontinuation of the ventilator
  - Allows for out-of-town family to be present
  - Allows for choosing the day for discontinuation
- Assistance in planning for ventilator removal
  - Family and patient(if able) are guided through the decision-making process
  - An interdisciplinary approach is utilized to ensure a peaceful experience

Moments Hospice℠
Moments are Forever

22

INTERDISCIPLINARY TEAM

23

INTERDISCIPLINARY TEAM

All Disciplines will have Individualized POC, increased visit frequency with Initial Moments and Final Moments and when needed for symptom control.

- Hospice Medical Director: Provide medication management to mitigate symptoms in line with the patient's wishes.
- Nursing: Provides medication management, teaching, regular assessment and support.
- Music Therapy: Provides music of patients' choice to aid in reducing anxiety and easing breathing.
- Massage Therapy: Provides gentle massage to ease anxiety.
- Social Work: Provide supportive presence and intervention to family and patient.
- Chaplain: Provides prayer and supportive presence to family and patient.
- Aide – hand on care, socialization, and light house keeping
- Volunteers – Additional supportive services
- Bereavement – Assist patient and family with anticipatory grief
- Other –Death Doula, PT, OT, SLP, RD

Moments Hospice℠
Moments are Forever

24

STAFF TRAINING

25

STAFF TRAINING

- Relias Courses:
  - Nurses:
    - Chronic Obstructive Pulmonary Disease and Common Treatments
    - Meeting the Oxygen Needs of Your Patients
    - Obstructive Lung Disease Versus Restrictive Lung Disease
    - Pneumonia and Bronchitis Management
    - Assessing Breath Sounds
    - Components of a Respiratory Assessment
    - Preventing hospitalizations for COPD: Just remember to breathe
  - Aides:
    - Oxygen Care
    - The Respiratory System

Moments Hospice℠
Moments are Forever

26

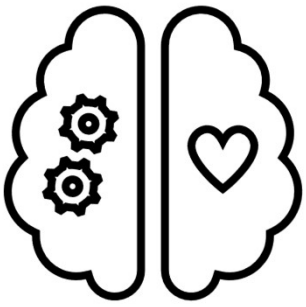
Moments Hospice™

MOMENTS ARE FOREVER

Respect Program

1

RESPECT PROGRAM



"The pleasure of remembering had been taken from me, because there was no longer anyone to remember with. It felt like losing your co-rememberer meant losing the memory itself, as if the things we'd done were less real and important than they had been hours before.".

~ John Green, *The Fault in Our Stars*

2

TABLE OF CONTENTS

Moments Hospice℠
Moments are Forever

3

WHY RESPECT?

- People with Dementia have faced a lot of losses
  - Memories
  - Ability to care for themselves
  - Ability to expresses their thoughts
  - Hobbies
  - judgement
- Respect does not have to be one of them
- We always want to remember who they are
  - Mothers
  - Lawyers
  - Teachers
  - Humanitarians
  - Sportsman
  - Travelers
  - Farmers
  - Nurses
  - Etc.

I speak to everyone in the same way, whether he is the garbage man or the president of the university.

~ Albert Einstein

Moments Hospice℠
Moments are Forever

4

RESPECT

- Using the patient's preferred name
- Cultural and religious preferences - dress, food, religious occasions, appropriate touch and gestures, etc.
- Kind and reassuring communication – do not patronize
- Include them in the conversation – do not talk about them as if they are not there
- No scolding and criticizing
- Honor Privacy
- Sensitivity to private tasks that need assistance such as showering and toileting
- Treat them like the adult that they are
- Allow simple decision making to maintain dignity
- Assisting with maintain a nice appearance

Moments Hospice℠
Moments are Forever

5

WHO IS THE PROGRAM FOR?

- Moments Hospice patients admitted with a dementia diagnosis as primary
- Moments Hospice patients, who although dementia is not the primary diagnosis, do have significant cognitive impairment
- Patients with or without a DNR

Moments Hospice℠
Moments are Forever

6

ELIGIBILITY

ALZHEIMER'S DISEASE AND RELATED DISORDERS

CLINICAL INDICATORS:

Patients are considered to be terminal stage of Alzheimer's disease if they meet indicators 1 and 2.

1. Stage 7 on the FAST Scale
   - » Unable to speak more than six intelligible words in the course of a day
   - » Speech ability is limited to the use of a single intelligible word in the course of a day
   - » Cannot walk without assistance
   - » Cannot sit up without assistance
   - » Loss of ability to smile

AND » Loss of ability to hold head up independently

2. One of the following in the last 12 months
   - » Aspiration pneumonia
   - » Recurrent or intractable infections (such as pneumonia or other URI)
   - » Pyelonephritis (or other upper UTI)
   - » Septicemia
   - » Multiple, progressive Stage 3 or 4 decubiti
   - » Fever after antibiotics
   - » Delirium
   - » 10 percent weight loss in last six months/albumin < 2.5 gm/dl

CO-MORBID CONDITIONS OR SUPPORTIVE FACTORS FOR ELIGIBILITY:

- » Malignancies
- » COPD
- » Renal Failure
- » Liver Disease
- » CHR
- » Cancer

Moments Hospice℠
Moments are Forever

7

THE BRAIN

8

THE BRAIN

- House of consciousness
- Holds memories and stories
- Frontal lobe = reasoning, problem solving, creativity, and motor skills
- Occipital lobe = input from eyes and assists with language
- Temporal lobe = memories, input from the ears, managing behaviors, understanding speech
- Parietal lobe = process sensory experiences, assist with controlling movement
- Cerebellum = balance

Moments Hospice℠
Moments are Forever

9

THE BRAIN CONTINUED

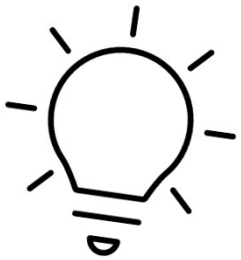
- Thalamus = processes sensory data
- Hypothalamus= hunger, thirst, and temperature
- Amygdala = reactions to fear and memories
- Hippocampus = learning process
- Brainstem = sleep, essential body functions such as breathing and heart rate

Moments Hospice℠
Moments are Forever

10

THE BRAIN ~ FUN FACTS

- Weighs 3 pounds
- Full brain development does not occur until age 26
- You use all of your brain. 10% is a myth
- There are 100,000,000,000 neurons in the brain
- It does not feel pain
- It uses 20% of the oxygen in the body
- The brain contains enough power to light a lightbulb



Moments Hospice℠
Moments are Forever

11

DEMENTIAS

- 50 million people worldwide
- Alzheimer's Disease
- Vascular Dementia
- Lewy Bodies
- Frontotemperal Dementia
- Other diseases that cause cognitive impairment
  - Parkinson's Disease
  - Huntington's Disease
  - Creutzfeldt-Jakob Disease
  - Normal Pressure Hydrocephalus
  - Wernicke-Korsakoff Syndrome

12

SYMPTOM MANAGEMENT

13

MEDICATIONS

- Medication can help control some behaviors, nonpharmacological interventions may, also be effective for behaviors
- Antianxiety medication may be used to assist with fear related to confusion
- Pain may no longer be interpreted correctly by the brain so pain medications may be beneficial even when the patient denies pain

Moments Hospice℠
Moments are Forever

14

PATIENT AND CAREGIVER EDUCATION

15

EDUCATION

- Education about the disease for family and caregivers
  - What to expect
  - How to manage behaviors
- Education on end-stage disease management
  - Behavior tracking
  - Monitoring for Exacerbations
  - Which medications to use when
  - High calorie diet (as indicated)
- Education to call Moments Hospice
  - With ANY changes – call
  - When in doubt – call
  - New or worsening symptoms - call
- Education on nonpharmacological interventions
  - Toileting schedule
  - Calming activities
  - Things to provide sense of purpose
- Support groups
  - How to find them
  - Benefits of attending

Moments Hospice℠
Moments are Forever

16

NONPHARMACOLOGICAL INTERVENTIONS

17

ROUTINE AND CONSISTENCY

- Some familiarity in the day
- Reduces anxiety
- Patients and care givers know what to expect
- Helps maintain function
- Allows for more independence
- Organization reduced stress for caregiver
- IDG members remain consistent (as much as possible)
  - They know the patient and their routine

Moments Hospice℠
Moments are Forever

18

ALZHEIMER'S PETS (ROBOTIC)

- Helps the whole person physically, psychologically, and socially.
- Benefits include:
  - Companionship
  - Excuse to get exercise
  - Improving interactions and socialization.
- Reduce:
  - Anxiety
  - Agitation
  - Irritability
  - Depression
  - Loneliness
- Interactive
- Sense of purpose
- Increase serotonin, a feel-good hormone

Moments Hospice℠
Moments are Forever

19

NAMASTE CARE

- 2 basic principles of Namaste Care Program:
  - Creating a calm environment
  - Providing all activities and interactions with an unhurried, loving touch approach
- Ponds cold cream and Old Spice aftershave to trigger memories
- Lavender spray for improved sleep and calming affect
- Bubbles, Dum Dum suckers, and things from outdoors for stimulation and memory such as grass clipping or flowers
- Setting the atmosphere such as dimming the lights and playing soft calming music
- Using gentle touch with hand massage and facial massages

Moments Hospice℠
Moments are Forever

20

WEIGHTED BLANKETS

- Dementia causes confusion, agitation, stress, mood swings and insomnia.
- The use of a weighted blanket can give the dementia patient a feeling of being warmly embraced.
- Creates a sense of:
  - Security
  - Calmness
  - Being grounded

21

FIDGET BLANKETS

- Help to decrease agitation/anxiety
- Gives patients sense of purpose
- Helps to keep their hands busy

Moments Hospice℠
Moments are Forever

22

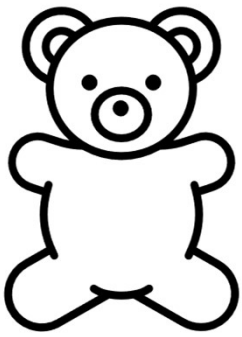
MEAL TIME

- Encourage Finger Foods
- Adaptive Cups, Plates, and Silverware
  - Assist patients to eat independently for longer periods of time

Moments Hospice
Moments are Forever

23

LAVENDER SCENTED TEDDY BEARS

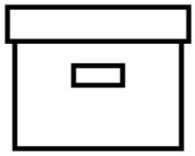


- Calming effects of the lavender
- Provide:
  - Something to care for
  - Tactile stimulation
  - Sense of security and distraction during personal cares

24

BUSY BOXES

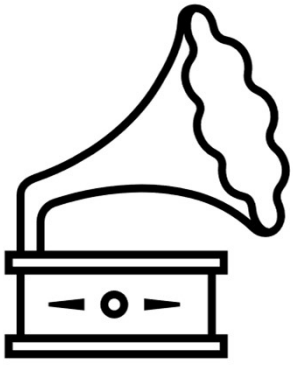
- Meaningful dementia activities bring back old memories
- Individualized to patient based on family history obtained
- Picture books with picture of:
  - Places they traveled
  - Pertaining to their field of work
  - Hobbies they enjoyed
  - Relatives
- Items to do things with:
  - PVC PIPE
  - Nuts/Bolts/Washers
  - Unfolded laundry
  - Office supplies



Moments Hospice
Moments are Forever

25

COMPLIMENTARY AND ALTERNATIVE MEDICINE



- Music Therapy
- Massage Therapy
- Feeling Heard
- Pet Therapy

26

THE POWER OF FEELING HEARD

- Time to express what they are wanting to say
- Ability to share stories from the past
- Allows for families to express what they need to be heard while they witness the changes in their loved ones
- Provides a calming affect

Moments Hospice℠
Moments are Forever

27

FAMILY SUPPORT

- Families of patients with dementia need special support and assistance
- Psychosocial support
  - Social Workers
  - Chaplains
  - Music Therapist
- They may need breaks
  - Planning back-to-back staff visits
  - Arrange for volunteer
  - Respite stays

Moments Hospice℠
Moments are Forever

28

FAMILY SUPPORT – CONTINUED

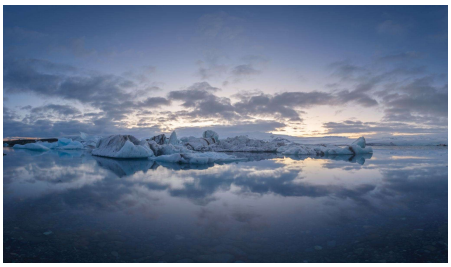
- Teaching healthy coping methods
- Encouraging good self-care
  - Taking breaks (allowing others to help)
  - Meditation
  - Good nutrition
  - Getting exercise
  - Encourage regular sleep
- Financial Assistance
  - Social Worker to assist with Resources
  - FMLA

Moments Hospice℠
Moments are Forever

29

PROGRESSIVE RELAXATION SCRIPT FOR THE FAMILY TO RELAX

If possible, you may want to dim the lights
Get into a comfortable position and if you are comfortable doing so, close your eyes
Take some nice slow deep breaths, in and out, there is no hurry [Pause to let them breathe]
Now let the breath find its own rhythm
~[Go from head to toe guiding the patient to relax each part of the body]~
Notice if there are any parts of your body that are not relaxed
Relax that part and any other parts that are not relaxed
Enjoy how it feels to be completely relaxed
[allow time for them to enjoy just being]
Now start to notice your breathing
Begin to wiggle your fingers and toes
Notice the sounds in the room around you
When you are ready open your eyes.
Know that you can give yourself this little gift of relaxation throughout your day.



Moments Hospice℠
Moments are Forever

30

INTERDISCIPLINARY TEAM

31

INTERDISCIPLINARY TEAM

All Disciplines will have Individualized POC, increased visit frequency with Initial Moments and Final Moments and when needed for symptom control.

- Nurse – Providing Education, Managing Symptoms
- Social Worker –Assist with emotional aspect of Dementia, Looking for life meaning, Life review, Finding hope, Providing Calming Prescence
- Chaplain – Spiritual aspect of, Exploring end-of life beliefs, Calming Presence
- Medical Director – Medical Palliation of the disease conjunction with attending physician and the IDG
- Aide – Hand on care, Socialization, Light house keeping, Namaste care
- Volunteers – Additional supportive services
- Bereavement – Assist patient and family with anticipatory grief
- Other – Music Therapist, Massage Therapist, Death Doula, PT, OT, SLP

Moments Hospice℠
Moments are Forever

32

STAFF TRAINING

33

STAFF TRAINING

- Relias Courses:
  - All IDG Members:
    - A Day in the Life of Henry: A Dementia Experience
    - Alternatives to Restraints in Elder Care
    - Person Centered Care Planning for People Living with Dementia
    - Stress Management for the Care Giver
    - Challenging Behaviors in Dementia Care
    - Considerations of Care - Families & Environment
    - Creating Moments of Joy
    - Creating Quality of Life in Dementia Care
    - Its All in Your Approach
  - Nurses:
    - Advanced Care Skills in Late-Stage Dementia
  - Aides:
    - Dental Care for People with Dementia

*Additional courses are available and will be assigned based on need and/or state regulations

Moments Hospice℠
Moments are Forever

34

2020 Point in Time Count | State Totals

		Emergency Shelter	Transitional Housing	Safe Haven	Total Sheltered	Unsheltered	TOTAL
Households with at least one adult and one child	**Households**	781	767	-	**1,548**	**570**	**2,118**
	Persons	2,505	2,336	-	**4,841**	**1,891**	**6,732**
Households with only children	**Households**	68	26	-	**94**	**224**	**318**
	Persons	95	47	-	**142**	**308**	**450**
Households without children	**Households**	5,813	1,048	81	**6,942**	**7,888**	**14,830**
	Persons	5,933	1,112	81	**7,126**	**8,615**	**15,741**
TOTAL	**Households**	6,662	1,841	81	**8,584**	**10,506**	**17,266**
	Persons	8,533	3,495	81	**12,109**	**10,814**	**22,923**
Subpopulations	**Chronically Homeless Individuals**	2,268	-	67	**2,335**	**4,472**	**6,807**
	Chronically Homeless Families	66	-	-	**66**	**164**	**230**
	Persons in Chronically Homeless Families	258	-	-	**258**	**610**	**868**
	Chronically Homeless Veteran Individuals	196	-	25	**221**	**379**	**600**
	Adults with a Serious Mental Illness	1,478	344	44	**1,866**	**4,743**	**6,609**
	Adults with a Substance Use Disorder	1,146	252	27	**1,425**	**3,873**	**5,298**
	Adults with HIV/AIDS	15	18	-	**33**	**196**	**229**
	Adult Victims of Domestic Violence	829	338	< 10	**1,189**	**2,356**	**3,545**
Veterans	**Veteran Households**	554	269	39	862	**673**	**1,535**
	Veterans	558	269	39	866	**741**	**1,607**
Youth Households (under 25)							
Households	**Total numbers of households**	500	375	-	875	**772**	**1,647**
	Unaccompanied Youth households	457	286	-	743	**720**	**1,463**
	Parenting Youth Households	43	89	-	132	**52**	**184**
Persons	**Total number of persons**	620	520	-	1,140	**1,080**	**2,220**
	Persons in parenting youth household	129	219	-	348	**129**	**477**
	Persons in unaccompanied youth household	491	301	-	792	**951**	**1,743**

2020 Point in Time Count | County Totals

County	TOTAL Homeless (sheltered and unsheltered)							
	Households w/out minors		Households with minors		Households with only minors		TOTAL	
	Persons	Households	Persons	Households	Persons	Households	Persons	Households
Adams County	0	0	0	0	0	0	0	0
Asotin County	13	13	<10	<10	0	0	15	14
Benton County	50	50	81	23	<10	<10	138	79
Chelan County	229	215	92	30	16	<10	337	248
Clallam County	151	147	46	16	<10	<10	198	164
Clark County	536	491	372	120	<10	<10	916	619
Columbia County	<10	<10	10	<10	0	0	11	<10
Cowlitz County	244	223	81	28	<10	<10	328	252
Douglas County	12	12	<10	<10	0	0	21	15
Ferry County	<10	<10	0	0	0	0	<10	<10
Franklin County	44	44	<10	<10	<10	<10	52	48
Garfield County	<10	<10	<10	<10	0	0	<10	<10
Grant County	104	97	75	19	<10	<10	180	117
Grays Harbor County	92	91	15	<10	<10	0	108	95
Island County	105	94	24	<10	0	0	129	103
Jefferson County	119	112	20	<10	0	0	139	118
King County	7707	7222	3743	1190	301	210	11751	8622
Kitsap County	390	366	133	42	<10	<10	524	409
Kittitas County	<10	<10	<10	<10	<10	<10	15	14
Klickitat County	28	27	<10	<10	<10	<10	33	30
Lewis County	97	89	45	16	0	0	142	105
Lincoln County	0	0	0	0	0	0	0	0
Mason County	90	86	83	25	<10	<10	178	113
Okanogan County	55	49	11	<10	<10	<10	67	56
Pacific County	48	44	11	<10	<10	<10	60	48
Pend Oreille County	11	10	29	<10	<10	<10	42	20
Pierce County	1527	1445	358	113	12	12	1897	1570
San Juan County	55	55	10	<10	0	0	65	59
Skagit County	181	162	130	36	<10	0	314	198
Skamania County	36	35	<10	<10	0	0	43	37
Snohomish County	818	776	284	92	30	29	1132	897
Spokane County	1171	1118	363	104	25	22	1559	1244
Stevens County	35	33	<10	<10	0	0	42	34
Thurston County	672	645	310	95	13	<10	995	747
Wahkiakum County	<10	<10	0	0	0	0	<10	<10
Walla Walla County	123	122	<10	<10	<10	<10	140	128
Whatcom County	521	496	165	55	<10	<10	687	552
Whitman County	<10	<10	14	<10	<10	0	22	10
Yakima County	457	442	176	49	0	0	633	491
TOTAL	**15741**	**14830**	**6732**	**2118**	**450**	**318**	**22923**	**17266**

Moments Hospice
Moments are Forever

November 30, 2021

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

Via email: eric.hernandez@doh.wa.gov; FSLCON@DOH.WA.GOV

Dear Mr. Hernandez:

Moments Hospice of King, LLC here within submits a letter of intent to establish a Medicare certified/Medicaid eligible hospice agency in King County. Consistent with WAC, the following information is provided:

1. A Description of the Extent of Services Proposed:

Moments Hospice of King, LLC intends to establish a Medicare certified/Medicaid eligible hospice agency to serve the entirety of King County.

2. Estimated Cost of the Proposed Project:

The capital required to establish the agency is estimated at $52,500.

3. Description of the Service Area:

The service area for the hospice agency will be King County.

Please feel free to contact me with any questions.

Sincerely,

DocuSigned by:
6DD558A256A14AB...

11/30/2021

Sol Miller
Chief Executive Officer
(612) 655-5242

Seattle's Immigrants and Refugees

a Snapshot

Between 2000 and 2014, Seattle's immigrant population grew 20% compared to 14% for the overall population.

18%

18% of Seattle residents are foreign-born. In King County, 20% of residents are foreign-born.

ACS 2014

NO. 8

Washington is the 8th largest refugee-receiving state.

Migration Policy Institute 2015

20%

Between 2000 and 2014, Seattle's immigrant population grew 20%.

ACS 2014

113,000

Seattle residents are foreign-born.

ACS 2014

Top 10 Countries of Origin

ACS 2014

1.	China	11.76%
2.	Vietnam	11.50%
3.	Philippines	8.01%
4.	Mexico	6.69%
5.	Ethiopia	5.43%
6.	Canada	5.15%
7.	South Korea	4.31%
8.	India	3.38%
9.	Somalia	2.69%
10.	Japan	2.62%

Language

Seattle School District & ACS 2014

43%
Speak English less than "very well"

129
languages spoken in Seattle schools

28%
live in households that are linguistically isolated

Education

ACS 2014

20%
of foreign-born have less than a high school degree.

43%
of foreign-born have a college or graduate degree.

Naturalization
ACS 2014

Number of foreign born eligible to be naturalized:

22,648
in Seattle

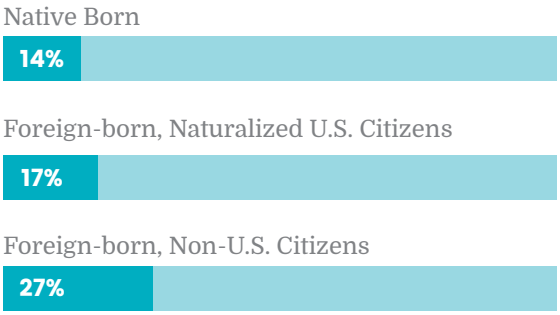
182,684
in Washington State

74,982
in King County

Median Income of Foreign-born
ACS 2014

$31,580

Comparing Federal Poverty Rates of Seattle Residents
ACS 2014



34%
of households headed by foreign-born women are at poverty level

37%
of foreign-born own homes

Foreign-born Spending Power
ACS 2014

$4.4 Billion

Entrepreneurship and Small Business
ACS 2014

45,696 new immigrant businesses opened in Washington State between 2006–2010.

$2.4 Billion

Net business income from new immigrant businesses or 13.1% of all net business income

Labor Market
ACS 2014

Foreign-born percentage of workers by occupation in the Seattle Metropolitan area

Building and Grounds Cleaning and Maintenance Occupations	40.2%
Computer and Mathematical Occupations	34.9%
Farming, Fishing, and Forestry Occupations	34.1%
Production Occupations	29.9%
Food Preparation and Serving Related Occupations	29%
Personal Care and Service Occupations	28.1%
Construction and Extraction Occupations	21.9%
Healthcare Support Occupations	22.8%

sage | Advocacy & Services for LGBT Elders

We refuse to be invisible®

Mr. James McLemore
Manager, Certificate of Need
Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, Fl 32399

4/19/2021

RE: Moments Hospice of Miami, LLC; CON Support Letter

Dear Mr. McLemore,

My name is Tim Johnston, and I am the Senior Director of National Projects at SAGE, a national advocacy and services organization that's been looking out for LGBT elders since 1978. In that capacity I run the SAGECare LGBT aging cultural competency training and education program.

LGBT older adults face a variety of challenges to aging well. A long history of discrimination, abuse, and bias makes them less likely to reach out for supportive services. That is why it is so important that providers do outreach directly to members of the LGBT community and provide safe and affirming services. We are in initial discussions with Moments Hospice to partner in a training project to ensure that their team has the skills they need to work with LGBT older people, and we applaud their commitment to investing time and energy into our community. There are too few providers that are committed to doing LGBT-specific outreach and we are hopeful that Moments Hospice can help increase the services available to our community.

We look forward to building our partnership to ensure that our community members are comfortable and treated well under their care.

Thank you for your attention to the matter.

Sincerely,

Tim R. Johnston
Senior Director of National Projects
SAGE

Physicians Guide to Hospice Eligibility

A REFERENCE FOR HOSPICE ADMISSION

Moments Hospice℠

Moments are Forever

TO OUR PARTNERS IN CARE:

As a local provider of hospice services, Moments Hospice supports you in your practice by helping to identify hospice eligibility with your patients so that the hospice conversation may begin as soon as possible.

This guide is designed to assist you in determining the earliest ime your patient is eligible for hospice. It will also help estimate a six-month terminal prognosis through disease-specific criteria and several staging tools including the Palliative Performance Scale, Functional Assessment Scale (FAST) and the NYHA Functional Classification for Congestive Heart Failure. While these criteria and tools are helpful, they do not replace your clinical judgment, Medicare requirements or any local coverage determinations.

In the absence of one or more criteria, co-morbidities or rapid functional decline may also support eligibility for hospice referral. Call Moments Hospice for additional information or to arrange an assessment.

Estimating a Six-Month Terminal Prognosis:

In general, a patient is eligible for hospice care when life expectancy is six months or less, and aggressive curative treatment is no longer an option or desired.

HOSPICE ELIGIBILITY MAY BE MET WITH THE FOLLOWING:

a. One significant terminal diagnosis as your patient meets Medicare Disease Specific Criteria, or

b. Multiple co-morbidities contribute to the terminal decline. Your patient exhibits multiple signs and symptoms that suggest a terminal progression but do not add up to a single terminal diagnosis. Often a combination of diagnoses is accelerating decline yet a patient does not have to meet all the criteria listed. Documenting your patient's terminal trajectory, in this case, should include several areas of decline so that a clear picture of poor prognosis is evident.

END-STAGE RENAL DISEASE

CLINICAL INDICATORS:

- Not seeking dialysis or renal transplant
- Creatinine clearance <10ml/min (<15ml for diabetics/CHF)
- Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
- Acute/Chronic renal failure

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Advanced disease of heart, liver or lung
- Malignancy (other organ system)
- Sepsis
- Oliguria: output<400 cc/24 hrs
- Cachexia or albumin <3.5 gm/dl

- Immunosuppression/AIDS
- Disseminated intravascular coagulation
- Platelet count <25,000
- GI bleeding
- Estimated GFR <10ml/min
- Hepatorenal syndrome
- Intractable fluid overload, unresponsive to treatment
- Intractable hyperkalemia >7.0 mmol/l
- Uremia
- Uremic pericarditis

STROKE / CVA / COMA

CLINICAL INDICATORS:

Palliative Performance Scale ≤ 40 percent (mainly in bed, unable to work, requires maximal assistance to perform self-care, normal or reduced food/fluid intake, either conscious, drowsy or confused)

- Inability to maintain hydration and caloric intake with one of the following:
  - Weight loss >10 percent during previous six months, or
  - Weight loss >7.5 percent during last three months or
  - Serum albumin <2.5gm/dl or
  - Current history of pulmonary aspiration not responsive to speech/language pathology intervention, or
  - Dysphagia severe enough to prevent the patient from receiving food/fluids necessary to sustain life in a patient who does not receive artificial nutrition/hydration, or
  - Calorie counts documenting inadequate caloric/fluid intake

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Aspiration pneumonia
- Upper UTI (ex. Pyelonephritis)
- Sepsis
- Refractory stage 3 to 4 decubitus ulcers
- Recurrent fever after antibiotic

CANCER

CLINICAL INDICATORS:

- Palliative Performance Scale score of ≤70 percent and
- Dependency with two or more Activities of Daily Living and
- Evidence of malignancy or metastases confirmed by pathology reports or
- Progression from earlier stage of disease to metastatic disease with either continued decline in spite of therapy or patient declines further disease-directed therapy
- No further treatment available or desired

CO-MORBIDITIES OR SUPPORTIVE FACTORS FOR ELIGIBILITY:

- COPD
- CHF

- Ischemic heart disease
- Diabetes
- Liver disease
- Renal failure
- Dementia
- Neurological disease
- Hypercalcemia >12
- Cachexia or weight loss of 5 percent in previous three months
- Requirement for transfusions
- Malignant ascites or pleural effusion

HEART DISEASE

CLINICAL INDICATORS:

- Patient is already optimally treated with diuretics and vasodilators (ACE inhibitors), not a candidate or declines invasive procedures, and
- Class IV of NYHA (physical activity causes discomfort, symptoms of recurrent heart failure or angina at rest)

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Treatment-resistant symptomatic arrhythmias
- Ejection fraction ≤ 20 percent
- History of cardiac arrest and CPR
- Unexplained syncope
- Brain embolism or cardiac origin
- Concomitant HIV disease

- Resistant to Nitrate Therapy
- Decline in Palliative Performance scale to 50 percent or less
- BMI less than 22
- CHR or Cardiomyopathy with documented cardiomegaly
- Ischemic Heart Disease, ASHD/ASCVD/CAD
- Increase frequency of hospitalization or ER visits for symptom control
- Current inotropic therapy dose unable to be reduced
- Oxygen dependent

PULMONARY DISEASE

CLINICAL INDICATORS:

- Disabling dyspnea at rest
- Increasing visits to ER or current or prior hospitalizations over previous six months and/or respiratory failure

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Cor pulmonale/right heart failure secondary to pulmonary disease
- Resting tachycardia > 100/min
- Unintentional weight loss of 10 percent in previous six months
- Poor response or unresponsive to bronchodilators resulting in decreased functional capacity (bed to chair existence, fatigue, cough)

- Documentation of Forced Expiratory Volume (FEV1) after bronchodilator < 30 percent of predicted
- Hypoxemia at rest, p02 ≤ 55 mm Hg or
- Oxygen saturation of 88 percent or less on room air or
- Hypercapnia with pC02 ≥ 50 mm Hg

LIVER DISEASE

CLINICAL INDICATORS:

- End-stage cirrhosis and not a candidate for transplant, and PT > 5 sec over control, and INR > 1.5, and serum albumin < 2.5 gm/dl

- At least one of the following:
  - Ascites, refractory to treatment or patient non-compliant
  - Hepatorenal syndrome
  - Spontaneous bacterial peritonitis
  - Hepatic encephalopathy despite treatment
  - Recurrent variceal bleed

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Progressive malnutrition
- Muscle wasting/loss of strength
- Continued alcohol consumption
- Hepatocellular carcinoma
- Positive HBsAg
- Hepatitis C refractory to Interferon

AMYOTROPHIC LATERAL SCLEROSIS (ALS)

CLINICAL INDICATORS:

Patients are considered end-stage ALS when meeting criteria in one or two.

1. Critically impaired breathing in the last 12 months as evidenced by
   - » Vital capacity < 30 percent of normal
   - » Dyspnea at rest
   - » Declines artificial ventilation
   - » External ventilation used for comfort measures only

OR

2. Rapid disease progression (as demonstrated by all of the following in the last 12 months) **with either a. or b.**
   - » Bed-bound status
   - » Barely intelligible or unintelligible speech
   - » Pureed diet
   - » Needing major assistance in all ADLs, and

a. Critical nutrition impairment in the last 12 months as demonstrated by
   - » Oral intake of nutrients and fluids insufficient to sustain life
   - » Continued weight loss
   - » Dehydration or hypovolemia
   - » Absence artificial feeding methods

OR

b. Life-threatening complications in the last 12 months as evidenced by ONE of the following:
   - » Recurrent aspiration pneumonia (with or without tube feedings)
   - » Upper UTI
   - » Sepsis
   - » Recurrent fever after antibiotic therapy
   - » Decubitus ulcers, multiple, Stage 3 to 4

The two crucial factors to consider in determining end-stage ALS are the patient's ability to breathe and, to a lesser extent, the patient's ability to swallow.

ALZHEIMER'S DISEASE AND RELATED DISORDERS

CLINICAL INDICATORS:

Patients are considered to be terminal stage of Alzheimer's disease if they meet indicators 1 and 2.

1. Stage 7 on the FAST Scale
   - » Unable to speak more than six intelligible words in the course of a day
   - » Speech ability is limited to the use of a single intelligible word in the course of a day
   - » Cannot walk without assistance
   - » Cannot sit up without assistance
   - » Loss of ability to smile

AND » Loss of ability to hold head up independently

2. One of the following in the last 12 months
   - » Aspiration pneumonia
   - » Recurrent or intractable infections (such as pneumonia or other URI)

- Pyelonephritis (or other upper UTI)
- Septicemia
- Multiple, progressive Stage 3 or 4 decubiti
- Fever after antibiotics
- Delirium
- 10 percent weight loss in last six months/albumin < 2.5 gm/dl

CO-MORBID CONDITIONS OR SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Malignancies
- COPD
- Renal Failure
- Liver Disease
- CHR
- Cancer

AUTOIMMUNE DISEASES

CLINICAL INDICATORS:

- Specific organ system involved: CHR/Ischemic heart disease, advanced kidney disease, and/or advanced liver disease
- Recurrent infections, pneumonia, sepsis, pyelonephritis, urinary tract infections
- Symptoms poorly responsive to treatment: pain, dyspnea, cough, nausea, vomiting, diarrhea, agitation
- Progressive weight loss > 10 percent in prior six months not attributable to reversible cause
- Multiple hospital or ER visits, increasing MD visits
- Palliative Performance Score < 70 percent

SUPPORTIVE FACTORS FOR ELIGIBILITY:

- Significantly decreased intake, artificial nutrition/hydration declined, dysphagia

- Dependence or assistance required in two or more of the following ADLs (continence, transfers, dressing, bathing, feeding, chair bound/bed bound status)
- Non-healing pressure ulcers (Stage III or IV) despite wound care
- HGB<10; Albumin <2.5 when available
- Ascites or edem
- Systolic BP below 90 or progressive postural hypotension
- Unexplained or refractory fevers
- Changes in level of consciousness
- Labs (when available): increasing pC02 or decreasing p02 or decreasing Sa02, increasing calcium, creatinine or liver function studies, increasing tumor markers (CEA, PSA), progressively decreasing/increasing serum sodium or increasing potassium
- Co-morbid conditions such as dementia, COPD, diabetes, neurological disease, malignancy

PARKINSON'S DISEASE

CLINICAL INDICATORS:

Patients are considered end-stage Parkinson's when meeting criteria in 1 or 2:

1. Critically impaired breathing in the last 12 months as evidenced by
   - Vital capacity < 30 percent of normal
   - Dyspnea at rest
   - Declines artificial ventilation
   - External ventilation used for comfort measures only

OR

2. Rapid disease progression (as demonstrated by all of the following in the last 12 months) **with either a. or b.**
3. Wheelchair or bed-bound status
   - Barely intelligible or unintelligible speech
   - Pureed diet

» Needing major assistance in all ADLs and

a. Critical nutrition impairment in the last 12 months as demonstrated by:

» Oral intake of nutrients and fluids insufficient to sustain life

» Continued weight loss

» Dehydration or hypovolemia

» Absence artificial feeding methods

OR

b. Life-threatening complications in the last 12 months as evidenced by **oNe** of the following:

» Recurrent aspiration pneumonia (with or without tube feedings)

» Upper UTI

» Sepsis

» Recurrent fever after antibiotic therapy

» Decubitus ulcers, multiple, Stage 3 to 4

NEW YORK HEART ASSOCIATION (NYHA)

STAGES OF HEART FAILURE:

CLASS I

- (Mild) No limitation of physical activity; ordinary physical activity does not cause undue fatigue, palpitation or dyspnea.
- No evidence of disease

CLASS II

- (Mild) Slight limitation of physical activity; comfortable at rest, but ordinary physical activity results in fatigue, palpitations or dyspnea.
- Evidence of minimal disease

CLASS III

- (Moderate) Marked limitations of physical activity; comfortable at rest, but less than ordinary activity causes fatigue, palpitations or dyspnea
- Evidence of moderately severe disease

CLASS IV

- (Severe) Unable to carry out any physical activity without discomfort; symptoms of cardiac insufficiency at rest; if any physical activity is undertaken, discomfort is increased
- Evidence of severe Cardiovascular disease

PALLIATIVE PERFORMANCE SCALE

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity and work; No evidence of disease	Full	Normal	Full
90%	Full	Normal activity and work; No evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort; Some evidence of disease	Full	Normal or Reduced	Full
70%	Reduced	Unable to do normal job/work; Significant disease	Full	Normal or Reduced	Full
60%	Reduced	Unalbe to do hobby/housework; Significant disease	Occasional Assistance necessary	Normal or Reduced	Full or Confusion
50%	Mainly sit/lie	Unable to do any work; Extensive disease	Considerable Assistance required	Normal or Reduced	Full or Confusion

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
40%	Mainly in bed	Unable to do most activity; Extensive disease	Mainly Assistance	Normal or Reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity; Extensive disease	Total Care	Normal or Reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity; Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity; Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion

FUNCTIONAL ASSESSMENT STAGE SCALE (FAST)

1. No difficulty either subjectively or objectively
2. Complains of forgetting location of objects; subjective work difficulties
3. Decreased job functioning evident to coworkers; difficulty in traveling to new locations; decreased organizational capacity*
4. Decreased ability to perform complex tasks (e.g., planning dinner for guests, forgetting to pay bills, etc.)
5. Requires assistance in choosing proper clothing to wear for the day, season or occasion (e.g., patient may wear the same clothing repeatedly, unless supervised)*
6. Occasionally or more frequently over the past weeks* for the following:
   a. Improperly putting on clothes without assistance or cueing
   b. Unable to bathe properly (not able to choose proper water temperature)
   c. In ability to handle mechanics of toileting (e.g., forget to flush toilet, does not properly wipe or dispose of toilet paper)

d. Urinary incontinence

e. Fecal incontinence

7. Changes in speech and expression, such as:

a. Ability to speak limited to approximately a half-dozen intelligible different words in the course of an average day or in the course of an intensive interview

b. Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview

c. Ambulatory ability is lost (cannot walk without personal assistance)

d. Cannot sit up without assistance [e.g., the individual will fall over if there are not lateral rests (arms) on the chair]

e. Loss of ability to smile

f. Loss of ability to hold up head independently

*Scored primarily on the basis of information obtained from knowledgeable informant.

BODY MASS INDEX (BMI)

UNDERWEIGHT (<18.5) IDEAL (19-24) OVERWEIGHT (25-29) OBESE (>30)

Height	Inches	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
4'10"	58"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4'11"	59"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5'0"	60"	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
5'1"	61"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5'2"	62"	104	109	115	120	126	131	136	142	147	153	158	163	169	175	180	186	191
5'3"	63"	107	113	118	124	130	135	141	146	152	158	164	169	175	180	186	191	197
5'4"	64"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5'5"	65"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5'6"	66"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5'7"	67"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5'8"	68"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5'9"	69"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5'10"	70"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	242

UNDERWEIGHT (<18.5) IDEAL (19-24) OVERWEIGHT (25-29) OBESE (>30)

Height	Inches	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
5'11"	**71"**	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6'0"	**72"**	140	147	154	162	169	177	184	191	199	206	213	221	228	236	242	250	258
6'1"	**73"**	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6'2"	**74"**	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6'3"	**75"**	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
6'4"	**76"**	156	164	172	180	189	197	205	213	221	230	238	245	254	263	271	279	287

HOSPICE IS AT ITS BEST WHEN SERVICES TO ADDRESS PAIN, SYMPTOMS, EMOTIONS AND PRACTICAL ISSUES ARE PROVIDED OVER MONTHS RATHER THAN WEEKS OR DAYS.

This ensures the patient and family receive the maximum benefit from the program and that all their care wishes and needs are fully addressed.

Studies published by the New England Journal of Medicine (2010) have shown that patients who received hospice care lived an average of two additional months longer and reported a higher quality of life than those who received standard care. When a referral is made in the latter stages of illness, the patient and family do not receive the full benefit of a coordinated set of services, medications, equipment and support.

Referring eligible patients to Moments Hospice sooner enables us to continue and augment the care you have been providing.

As always, we stand ready to assist you at a moment's notice, and we are available by phone for a consultation or patient assessment.

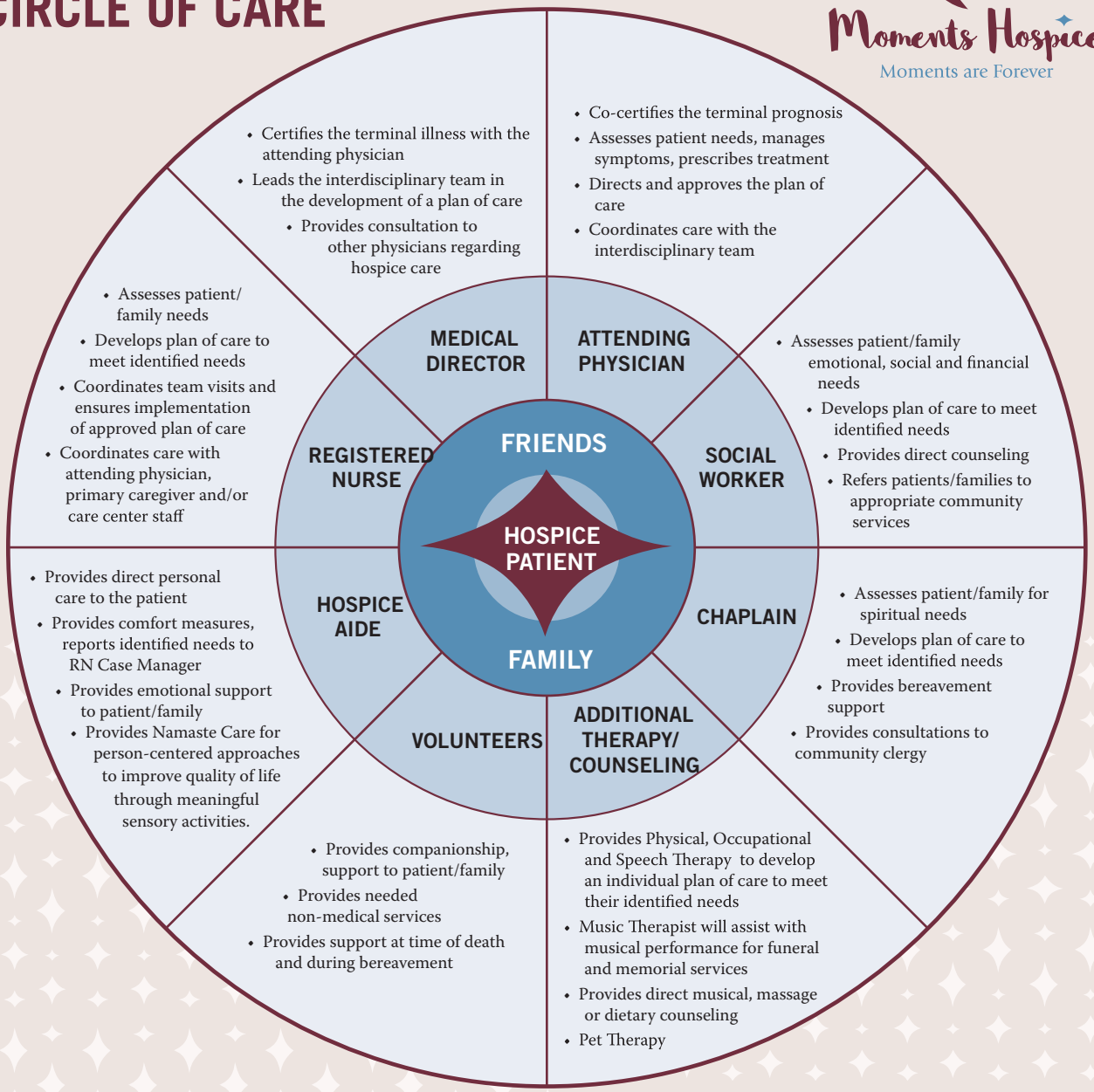
We look forward to supporting your work with your patients.

The Moments Hospice Team

Moments Hospice™

Moments Hospice
CIRCLE OF CARE

Moments Hospice™
Moments are Forever



The Circle of Care depicts the holistic continuum of care rendered by our team 24 hours a day, seven days a week to assess and meet the needs of the patient and family during the last moments of life.

ADMISSION CRITERIA AND PROCESS

Policy No. 1-009
DHS 131.17
DHS 131. 13(24)

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Moments Hospice will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

Patients are accepted for services based on their hospice care needs.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Moments Hospice reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Moments Hospice cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.

4. The patient must desire hospice services, and be aware of the diagnosis and prognosis.

5. The focus of care desired must be palliative versus curative.

6. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.

7. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

8. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

9. The patient must reside within the geographical area that the Moments Hospice services.

10. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

11. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

12. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.

2. The Clinical Supervisor will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

   A. Patient's geographical location

   B. Complexity of patient's hospice care needs/level of care required

   C. Hospice personnel's education and experience

D. Hospice personnel's special training and/or competence to meet patient's needs

E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

   A. Such notification and approval will be documented.

   B. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

   B. Explain the patient's rights and responsibilities and grievance procedure. (See "Bill of Rights" Policy No. 9-005.)

   C. Provide the patient with a copy of Moments Hospice notice of privacy practices.

   D. Wisconsin: Hospice employee shall inform the person and his or her representative, if any, of admission policies.

   E. Assess the family/caregiver's ability to provide care.

   F. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

   G. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

   H. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

   I. Provide services as needed and ordered by physician (or other authorized independent practitioner) and incorporate additional needs into the hospice plan of care.

   J. Give patient information about durable power of attorney for health care, if the patient has not already done so.

   K. Wisconsin: A written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that includes all of the following:

      a.) Clearly define the philosophy of the program.

b.) Limit admission to individuals with terminal illness as defined under s. DHS 131.13 (24).

1. Any person determined not to have a terminal illness as defined under s. DHS 131.13 (24) may not be admitted to the hospice.

2. Wisconsin DHS 131.13 (24) defines Terminal illness as a medical prognosis by a doctor of medicine or osteopathy that an individual's life expectancy is less than 12 months. Moments hospice only admits people with a life expectancy of 6 months or less.

c.) Clearly define the hospice's limits in providing services and the settings for service provision.

d.) Ensure protection of patient rights.

e.) Provide clear information about services available for the prospective patient and his or her representative, if any.

f.) Allow an individual to receive hospice services whether or not the individual has executed an advance directive.

L. Wisconsin: Initial determination.

a.) The hospice employee shall, based on the needs described by the person seeking admission or that person's representative, if any, or both, make an initial determination as to whether or not the hospice is generally able to meet those needs.

b.) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to the referring source alternative programs that may meet the described needs.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

   C. Access to care after hours

D. Costs to be borne by the patient, if any, for care

E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

F. Safety information

G. Infection control information

H. Emergency preparedness plans

I. Available community resources

J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 1-013)

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two

(2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No.1-014)

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services.

20. Wisconsin: The person seeking admission to the hospice shall be recognized as being admitted after:

    a.) Completion of the assessment.

    b.) Completion of a service agreement in which:

        1. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.

        2. The hospice agrees to provide care for the person.

        3. The person or the person's representative, if any, authorizes services in writing.

21. If a patient does not meet the admission criteria or cannot be cared for by Hospice Moments, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

22. The following individuals should be notified of non-admits:

    A. Patient

    B. Physician

    C. Referral source (if not physician)

22. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

23. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator in consultation with the Medical Director, upon request of the referring party and/or the patient.

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal

organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

25. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

26. Washington: Once a patient is admitted for care as evidenced by a signed admission form and plan of care, Moments Hospice will not end care without referring to an appropriate alternative agency or caregiver. Moments hospice will follow applicable discharge requirements of WAC 246-335-420, 246-335-520, and 246-335-620 as per policy 1-025 Discharge From Hospice Program.

27. Washington: Service will be started within seven calendar days of receiving and accepting a referral except in the following circumstances:

    A. Longer time frame for the start of services is requested by the client, designated family member, or legal representative, or referral source;

    B. Longer time frame for the start of services is agreed upon by the client, designated family member, or legal representative, or referral source in order for Moments Hospice to select and hire an appropriate caregiver to meet the needs of the client;

    C. Start of services was delayed due to Moments Hospice having challenges contacting client, designated family member, or legal representative;

    D. Different time frame is outline in a contract with DSHS or AAA.

CARE OF HOMELESS
Policy No. 9-034

PURPOSE

To ensure patient centered care is provided to patients who are homeless.

POLICY

Patients without a home will be accepted to Moments Hospice services, as appropriate.

A patient centered care plan will be developed in order to attempt to assist the patient to find safe living environment and to ensure hospice services are provided as appropriate.

Definitions

"Homeless person" means an individual living outside or in a building not meant for human habitation or which they have no legal right to occupy, in an emergency shelter, or in a temporary housing program which may include a transitional and supportive housing program if habitation time limits exist. This definition includes substance abusers, people with mental illness, and sex offenders who are homeless.

PROCEDURE

1. When it is identified that the patient has no home the IDG will work with community partners, temporary housing solutions, charitable organizations, and other resources to attempt to find a safe living environment for the patient.

2. The hospice plan of care will include interventions appropriate to the patients' unique circumstances and will be individualized for the palliation and care of the individual.

3. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources, programs, or grants.

4. Patients will not be discriminated against on the basis of race, color, religion, age, sex (an individual's sex, gender identity, cost of therapy, ability to pay, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, national origin, life circumstances (to include homelessness).

5. When appropriate the Hospice IDG will attempt to assist the homeless patient to find placement in a skilled nursing facility.

6. Patients' rights and wishes will be respected.

7. When patient life choices may risk Hospice team member safety discharge for cause may be conserved and policy number 1-025 Discharge From Hospice Program will be followed.

BILL OF RIGHTS
Policy No. 9-005
DHS 131.19

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. A patient, who has not been judged to lack legal capacity, may designate someone (surrogate decision maker), to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

If the patient has been judged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction:

1. The rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf, OR

2. The patient may exercise his or her rights, or designate a legal representative to exercise his or her rights to the extent allowed by court order.

To assist with fully understanding patient rights, all policies will be available to the organization personnel, patients, and his/her representatives as well as other organizations and the interested public.

PROCEDURE

1. The Bill of Rights statement defines the right of the patient to:

   A. Have his or her property and person treated with respect.

   B. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

   C. Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.

D. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service; hospice patients have the right to refuse care or treatment.

E. Be involved in developing his or her hospice plan of care.

F. Refuse care or treatment.

G. Choose his or her attending physician.

H. Have a confidential clinical record maintained by the organization. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. (Wisconsin - to approve or refuse release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third-party payment contract.)

I. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries from unknown source, and misappropriation of patient property.

J. Access to care/service is based upon nondiscrimination.

K. Have communication needs met.

L. Receive information about the services covered under the hospice benefit.

M. Receive information about the scope of services that the hospice will provide and specific limitations on those services.

N. Be advised that the Hospice Organization complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the organization. (Washington: to include POLST and Moments Hospice scope of responsibility)

O. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

P. Receive written information describing the organization's grievance procedure which includes the contact information, contact phone number, hours of operation, and mechanism(s) for communication problems. The program shall describe in writing patient and family responsibilities and the mechanism to file a grievance and obtain a receipt that the information has been received by the patient or family. (Washington: Be informed of the Washington Department of Health complaint hotline number to report complaints about the Moments Hospice or credentialed health care professionals and be informed of the DSHS end harm hotline number to report suspected abuse of children or vulnerable adults.) All complaints will be addressed without retaliation.

Q. Receive an investigation by the organization of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, regarding the lack of respect for the patient's property by anyone furnishing

services on behalf of the organization; and that the organization will document the existence of the complaint and the resolution of the complaint.

R. Receive information addressing any beneficial relationship between the organization and referring entities.

S. Be informed verbally and in writing of any changes in payment information as soon as possible, but no later than 30 days from the date that the organization becomes aware of the change.

T. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, including fees for services/products provided, direct pay responsibilities, and notification of insurance coverage.

U. Receive in writing, prior to the start of care, the telephone numbers for the State Hotline and the CHAP Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization.

V. Be assured that the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.

W. Wisconsin - To request and receive an exact copy of one's clinical record.

X. Wisconsin - To be free from restraints and seclusion except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care.

Y. Wisconsin - To be treated with courtesy, respect and full recognition of the patient's dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements and the care of personal needs.

Z. Wisconsin - To privately communicate with others without restrictions.

AA. Wisconsin - To receive visitors at any hour, including small children, and to refuse visitors.

BB. Wisconsin - To be informed prior to admission of the types of services available from the hospice, including contracted services and specialized services for unique patient groups such as children.

CC. Wisconsin - To be informed of those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services.

DD. Washington: Receive quality services from the home care agency for services identified in the plan of care

EE. Washington: A statement advising of the right to ongoing participation in the development of the plan of care

FF. Washington: A statement advising of the right to have access to the Washington Department of Health’s listing of licensed home care agencies and to select any licensee to provide care, subject to the individual's reimbursement mechanism or other relevant contractual obligations

GG. Washington: A listing of the total services offered by the Moments Hospice and those being provided to the client

HH. Washington: The name of the individual within Moments Hospice responsible for supervising the client's care and the manner in which that individual may be contacted

II. Washington: Be treated with courtesy, respect, and privacy

JJ. Washington: Be free from Exploitation and discrimination

KK. Washington: Be informed of what Moments Hospice charges for services, to what extent payment may be expected from care insurance, public programs, or other sources, and what charges the client may be responsible for paying

LL. Washington: A fully itemized billing statement upon request, including the date of each service and the charge except if Moments Hospice is providing services through a managed care plan are not required to provide itemized billing statements

MM. Washington: Be informed of Moments Hospice policies and procedures for providing back-up care when services cannot be provided as scheduled

NN. Washington: Be informed of the Moments Hospice policies and procedures regarding the circumstances that may cause Moments Hospice to discharge a client

OO. Washington: Moments Hospice will ensure the rights addressed in this policy are implements and updated as appropriate.

2. The patient and family/caregiver responsibilities will be explained upon admission and as needed. The patient and family/caregiver are responsible for:

   A. Being fully informed by a physician of his or her medical condition, unless medically contraindicated and to be afforded the opportunity to participate in the planning of his or her medical treatment, including pain and symptom management and to refuse to participate in experimental research.

   B. Cooperating with the primary doctor, program staff and other caregivers.

   C. Advising the program of any problems or dissatisfaction with patient care.

   D. Notifying the program of address or telephone changes or when unable to keep appointments.

   E. Providing a safe environment in which care can be given. In the event that conduct occurs such that the patient’s or staff’s welfare or safety is threatened, service may be terminated.

   F. Obtaining medications, supplies and equipment ordered by the patient’s physician if they cannot be obtained or supplied by the program.

   G. Reporting unexpected changes in the patient’s condition.

   H. Understanding and accepting the consequences for outcomes if the care, services and/or treatment plan are not followed.

3. Wisconsin - Patient complaint procedure. Each patient shall have the right, on his or her own behalf or through others, to do all of the following:

    A. Express a complaint to hospice employees, without fear of reprisal, about the care and services provided and to have the hospice investigate the complaint in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint.

    B. Express complaints to the department, and to receive a statement provided by the department setting forth the right to and procedure for filing verbal or written complaints with the department.

    C. Be advised of the availability of a toll-free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long term care ombudsman to provide patient advocacy and other services under s. 16.009, Stats.

4. Upon admission, the admitting clinician will provide each patient or his/her representative with a written copy of the Bill of Rights.

5. Wisconsin - Fully inform each patient and patient's representative, if any, of all of the following:

    A. Those patient rights and all hospice rules and regulations governing patient responsibilities, which shall be evidenced by written acknowledgement provided by the patient, if possible, or the patient's representative, if any, prior to receipt of services.

    B. The right to prepare an advance directive.

    C. The right to be informed of any significant change in the patient's needs or status.

    D. The hospice's criteria for discharging the individual from the program.

E. The Bill of Rights statement will be explained and distributed to the patient prior to the initiation of organization services. This explanation will be in a language or communication method he/she can reasonably be expected to understand.

F. The patient will be requested to sign the Bill of Rights form. The original form will be kept in the patient’s clinical record. A copy will be maintained by the patient. The patient’s refusal to sign will be documented in the clinical record, including the reason for refusal.

G. The admitting clinician will document that the patient has received a copy of the Bill of Rights.

    A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

    B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

C. Written information will be provided to patients in English and predominant non-English languages of the population served.

7. When the patient's representative signs the Bill of Rights form, an explanation of that relationship must be documented and kept on file in the clinical record.

8. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.

9. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually.

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS

Policy No. 8-013

PURPOSE

To prevent organization personnel from discriminating against other personnel, patients, or other organizations on the basis of race, color, religion, age, sex (an individual's sex, gender identity, cost of therapy, ability to pay, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, national origin, life circumstances.

POLICY

In accordance with Title VI of the Civil Rights Act of 1964, Section 1157 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Moments Hospice will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

In accordance with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulations, Moments Hospice will not, directly or through contractual or other arrangements, discriminate on the basis of disability (mental or physical) in admissions, access, treatment or employment.

In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Moments Hospice will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with Title II of the Americans with Disabilities Act of 1990, Moments Hospice will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.

In accordance with other regulations, the organization will not discriminate in admissions, access, treatment, or employment on the basis of gender, sexual orientation, religion, or communicable disease.

PROCEDURE

1. The Section 504/ADA Compliance Coordinator designated to coordinate the efforts of Moments Hospice to comply with the regulations will be the Executive Director/Administrator. Contact the Executive Director/Administrator at 763-205-3600.

2. Moments Hospice will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate

information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See "Facilitating Communication" Policy No. 9-006.)

3. A copy of this policy will be posted in the reception area of Hospice Moments, given to each organization staff member, and sent to each referral source.

4. The following statement will be posted in the reception of the organization in English and at least the top 15 non-English languages spoken in the state: "Patient services are provided without regard to race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin."

5. The following statement will be printed in English and other non-English languages spoken in the state on brochures, other printed public materials and in a conspicuous location on the organization's web site accessible from the home page: "Patient services are provided without regard to race, color, religion, age, sex (an individual's sex, gender identity, sex stereotyping, pregnancy, childbirth and related conditions) , sexual orientation, disability (mental or physical), communicable disease, or national origin."

6. Any person who believes she or he has been subjected to discrimination or who believes he or she has witnessed discrimination, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for Moments Hospice to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

7. Grievances must be submitted to the Section 504 Coordinator within 30 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

8. A complaint may be filed in writing, or verbally, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought by the grievant.

9. The Section 504 Coordinator (or her/his representative) will conduct an investigation of the complaint to determine its validity. This investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.

10. The Section 504 Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

11. The grievant may appeal the decision of the Section 504 Coordinator by filing an appeal in writing to Moments Hospice within 15 days of receiving the Section 504 Coordinator's decision.

12. Moments Hospice will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504 Coordinator will maintain the files and records of Moments Hospice relating to such grievances.

14. The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of handicap with the regional office for Civil Rights of the U.S. Department of Health and Human Services.

15. All organization personnel will be informed of this process during their orientation process.

16. Moments Hospice will make appropriate arrangements to assure that persons with disabilities can participate in or make use of this grievance process on the same basis as the nondisabled. Such arrangements may include, but will not be limited to, the providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for providing such arrangements.

DISCHARGE FROM HOSPICE PROGRAM

Policy No. 1-025
DHS 131.18

PURPOSE

To establish standards and a process by which patients are discharged from the hospice program.

POLICY

Moments Hospice will provide service to a patient and family/caregiver as long as the patient remains terminally ill and lives in the designated service area. The organization will not discontinue or reduce care because of the inability to pay.

Moments Hospice policy that details the manner in which the hospice is able to end its obligation to a patient shall be provided to the patient or patient's representative, if any, as part of the acknowledgement and authorization process at the time of the patient's admission.

Wisconsin: Once a hospice has admitted a patient to the program, and the patient or the patient's representative, if any, has signed the acknowledgement and authorization for services under s. DHS 131.17 (4) (b), the hospice is obligated to provide care to that patient. Policy shall detail the manner in which Moments Hospice is able to end its obligations to a patient.

Washington: Once hospice services are established as evidenced by signed admission forms and plan of care Moments Hospice will not end the care relationship without referring to an appropriate alternative agency or caregiver, and follow all applicable discharge requirements in WAC 246-335-420, 246-335-520, and 246-335-620.

Discharge Criteria

The hospice may discharge a patient:

1. Upon the request or with the informed consent of the patient or the patient's representative.
2. If the patient elects care other than hospice care at any time.
3. If the patient elects active treatment, inconsistent with the role of palliative hospice care.
4. If the patient moves out of the geographical area served by the hospice or into a facility that does not have a contract with the hospice.
5. If the patient requests services in a setting that exceeds the limitations of the hospice's authority.
6. Wisconsin: For nonpayment of charges, following reasonable opportunity to pay any deficiency.
7. For the patient's safety and welfare or the safety and welfare of others.

A. If the hospice determines that the behavior of the patient or other persons in the patient's home is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

8. If the hospice determines that the patient is no longer terminally ill.

9. The Medical Director and/or attending physician will determine the patient is not hospice-appropriate according to standard clinical criteria for determining disease prognosis of six (6) months or less.

10. Patient leaves service area of Moments Hospice or transfers to another hospice.

11. Environment is determined to be unsafe for the patient and/or staff.

12. The patient or family/caregiver refuses to allow the hospice physician or nurse practitioner to have the required face-to-face encounter (prior to third and subsequent benefit periods).

PROCEDURE

1. The hospice interdisciplinary group will develop a discharge plan.

2. For Wisconsin patients: The hospice shall conduct the pre−discharge planning conference with the patient or the patient's representative and review the need for discharge, assess the effect of discharge on the patient, discuss alternative placements and develop a comprehensive discharge plan.

3. Washington: Patients will be given at least a forty-eight-hour written or verbal notice prior to discharge the will be documented in the client record. Unless:

   A. Moments Hospice worker safety,

   B. significant client noncompliance, or

   C. Client's failure to pay for services rendered are the reason(s) for the discharge

   D. if contract with DSHS or the AAA may follow different time frames for notice of discharge as established in the terms of the contract.

4. The Case Manager will ensure that necessary paperwork is completed at the time of discharge. This will include a signed revocation form, if necessary, and a written physician order to discharge, if appropriate.

5. Washington: When Moments Hospice is discharging a patient and is concerned about their ongoing care and safety may submit a self-report to appropriate state agencies which identifies the reasons for discharge and the steps taken to mitigate safety concerns;

6. When a patient is discharged, transferred, or referred to another organization, relevant information will include:

   A. Reason for transfer or discharge

B. Physical and psychosocial status at time of transfer or discharge, including specific medical, psychosocial, or other problems requiring interventions or follow-up

C. Summary of the care provided and progress toward achieving goals, including both positive and adverse patient responses to treatment or services

D. A copy of the current plan of care

E. A copy of the medication profile, including discontinued medications

F. The latest physician orders

G. Continuing symptom management needs, e.g., pain, nausea, dyspnea

H. Follow-up to be provided by an interdisciplinary team member from the service transferring the patient

I. All pertinent laboratory data

J. Summary of patient education provided to the patient and his/her comprehension of that information.

K. Instruction and referrals provided to the patient

L. Recommendations for resources, such as access to durable medical equipment, drugs, and biologicals still needed in self-care post-discharge.

M. Existence of any Advance Directives, if applicable

N. The date of discharge, which is the date of the last visit made

4. The hospice discharge summary provided to a facility receiving a hospice patient for care—or to the patient's community attending physician upon hospice discharge—includes at least the following:

   A. Summary of the patient's hospice stay, including treatments, symptoms, and pain management;

   B. The patient's current plan of care;

   C. The patient's latest physician orders;

   D. Any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician.

5. Documentation will be filed in the clinical record. Information will be documented on a discharge/transfer form, which is to be completed within 72 hours.

6. If the patient is discharged to the community, the organization will inform the family both verbally and in writing, including a timeline for discontinuation of services.

7. If the environment is determined unsafe for the patient and/or staff, the following steps will be taken:

A. Provide written recommendations to patient and family/caregiver and physician to resolve unsafe situation.

B. Refer to social worker for assistance with placement planning.

C. Consult with adult/child protective services and document.

D. Consider referrals to other agencies.

E. A formal letter will be provided to the patient and/or his/her representative that includes the organization's concern, recommendations, consequences if concerns are not resolved, and potential discharge date. A copy will be provided to the attending physician.

F. A 14-day notice is required prior to discharge.

G. Wisconsin: the organizations shall give written notice to the patient or patient's representative, if any, family representative and attending physician at least 14 days prior to the date of discharge, with a proposed date for a pre−discharge planning conference.

8. If the hospice determines the patient should be discharged for the cause of face-to-face encounter refusal, the following steps will be taken:

A. Advise the patient and/or caregiver that a discharge for cause is being considered.

B. Make a serious effort to resolve the problem and document efforts in the clinical record.

C. Obtain a written discharge order from the hospice medical director.

9. If the hospice determines the patient should be discharged for the cause of disruptive, abusive or uncooperative behavior, the following steps will be taken:

A. Advise the patient and/or caregiver that a discharge for cause is being considered.

B. Make a serious effort to resolve the problem(s) caused by the behavior or situation of a patient or other persons in the patient's home and document problems and efforts made to resolve it in the clinical record.

C. Determine that the patient's proposed discharge is not due to the patient's use of necessary hospice services.

D. Prior to discharging a patient for cause, the hospice IDG must obtain a written discharge order from the hospice medical director. If the patient has an attending physician involved in the care, this physician should be consulted before discharge and his/her review and decision should be included in the discharge note.

E. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (e.g. Adult Protective Services) or health care facilities prior to discharge.

F. The hospice notifies its Medicare Administrative Contractor (MAC) and the state licensure agency of the circumstances surrounding the impending discharge for cause.

10. A copy of the discharge summary will be sent to the attending physician. If requested, the patient's clinical record will be provided.

11. Document the matter and enter this documentation into the patient's clinical record.

Revocation

1. If patients revoke hospice care, they sign and date a form revoking hospice which is the final date of care. The revocation is effective immediately and cannot be signed on a date other than the date of revocation.

The live discharge planning process for extended prognosis:

1. When the IDT determines that a patient's condition has stabilized for a period of time or otherwise changed such that the patient cannot continue to be certified as terminally ill, the IDT members:

    a. Discuss the potential discharge with the Clinical Manager

    b. Discusses the potential discharge as a team

    c. If there is any question regarding the potential discharge, the DPS, Nurse Practitioner or Medical Director will make a home visit to see the patient

    d. Contact the attending physician, the patient and the family

    e. Receive a physician order for live discharge other than for death, revocation or transfer

    f. Plan for any necessary family counseling, patient education, or other additional services before the patient is discharged

Appeal rights in discharge situations:

1. Medicare hospice beneficiaries are entitled to appeal rights when they are at risk of discharge or termination of services from a hospice. The regulations require that for any termination of service, the provider of the service must deliver valid written notice to the beneficiary of the provider's decision to terminate services. This notice triggers the Medicare beneficiary's right to request an expedited determination.

Washington State Health Care Authority (HCA)
Hospice Rates
Effective October 1, 2021

Rev Code 0651		CBSA	Days 1-60 Rate	Days 61+ Rate
Routine Home Care (Capitated Daily Rate)	All Other Areas*	50	$ 212.34	$ 167.81
	Asotin	30300	$ 185.08	$ 146.26
	Benton	28420	$ 202.02	$ 159.65
	Chelan	48300	$ 196.62	$ 155.38
	Clark	38900	$ 234.70	$ 185.48
	Cowlitz	31020	$ 216.21	$ 170.86
	Douglas	48300	$ 196.62	$ 155.38
	Franklin	28420	$ 202.02	$ 159.65
	King	42644	$ 228.25	$ 180.38
	Kitsap	14740	$ 222.93	$ 176.18
	Pierce	45104	$ 224.38	$ 177.32
	Skagit	34580	$ 202.30	$ 159.87
	Skamania	38900	$ 234.70	$ 185.48
	Snohomish	42644	$ 228.25	$ 180.38
	Spokane	44060	$ 216.50	$ 171.09
	Thurston	36500	$ 223.40	$ 176.55
	Whatcom	13380	$ 234.22	$ 185.10
	Yakima	49420	$ 192.55	$ 152.17

Rev Code 0655		CBSA	Rate
Inpatient Respite Care (Daily Rate)	All Other Areas*	50	$ 493.00
	Asotin	30300	$ 434.30
	Benton	28420	$ 470.77
	Chelan	48300	$ 459.16
	Clark	38900	$ 541.14
	Cowlitz	31020	$ 501.32
	Douglas	48300	$ 459.16
	Franklin	28420	$ 470.77
	King	42644	$ 527.24
	Kitsap	14740	$ 515.80
	Pierce	45104	$ 518.92
	Skagit	34580	$ 471.38
	Skamania	38900	$ 541.14
	Snohomish	42644	$ 527.24
	Spokane	44060	$ 501.96
	Thurston	36500	$ 516.81
	Whatcom	13380	$ 540.10
	Yakima	49420	$ 450.40

Rev Code 0652		CBSA	Rate
Continuous Home Care (Hourly Rate)	All Other Areas*	50	$ 63.99
	Asotin	30300	$ 54.68
	Benton	28420	$ 60.47
	Chelan	48300	$ 58.62
	Clark	38900	$ 71.63
	Cowlitz	31020	$ 65.31
	Douglas	48300	$ 58.62
	Franklin	28420	$ 60.47
	King	42644	$ 69.42
	Kitsap	14740	$ 67.61
	Pierce	45104	$ 68.10
	Skagit	34580	$ 60.56
	Skamania	38900	$ 71.63
	Snohomish	42644	$ 69.42
	Spokane	44060	$ 65.41
	Thurston	36500	$ 67.77
	Whatcom	13380	$ 71.46
	Yakima	49420	$ 57.24

Rev Code 0656		CBSA	Rate
General Inpatient Care	All Other Areas*	50	$ 1,113.46
	Asotin	30300	$ 975.68
	Benton	28420	$ 1,061.29
	Chelan	48300	$ 1,034.02
	Clark	38900	$ 1,226.47
	Cowlitz	31020	$ 1,133.00
	Douglas	48300	$ 1,034.02
	Franklin	28420	$ 1,061.29
	King	42644	$ 1,193.84
	Kitsap	14740	$ 1,166.98
	Pierce	45104	$ 1,174.31
	Skagit	34580	$ 1,062.72
	Skamania	38900	$ 1,226.47
	Snohomish	42644	$ 1,193.84
	Spokane	44060	$ 1,134.49
	Thurston	36500	$ 1,169.36
	Whatcom	13380	$ 1,224.03
	Yakima	49420	$ 1,013.47

Pediatric Palliative Care (PPC)			
Rev Code 0659		CBSA	Rate

Service Intensity Add-on		
	CBSA	Per unit

Hospice Rates
Effective October 1, 2021

Pediatric Palliative Care (PPC)			
	All Other Areas*	50	$ 88.95
	Asotin	30300	$ 88.95
	Benton	28420	$ 80.67
	Chelan	48300	$ 88.95
	Clark	38900	$ 83.99
	Cowlitz	31020	$ 88.95
	Douglas	48300	$ 88.95
	Franklin	28420	$ 80.67
	King	42644	$ 88.95
	Kitsap	14740	$ 77.91
	Pierce	45104	$ 77.91
	Skagit	34580	$ 88.95
	Skamania	38900	$ 88.95
	Snohomish	42644	$ 88.95
	Spokane	44060	$ 88.27
	Thurston	36500	$ 83.99
	Whatcom	13380	$ 88.27
	Yakima	49420	$ 80.67

Service Intensity Add-on			
	All Other Areas*	50	$ 16.00
	Asotin	30300	$ 13.67
	Benton	28420	$ 15.12
	Chelan	48300	$ 14.66
	Clark	38900	$ 17.91
	Cowlitz	31020	$ 16.33
	Douglas	48300	$ 14.66
	Franklin	28420	$ 15.12
	King	42644	$ 17.36
	Kitsap	14740	$ 16.90
	Pierce	45104	$ 17.03
	Skagit	34580	$ 15.14
	Skamania	38900	$ 17.91
	Snohomish	42644	$ 17.36
	Spokane	44060	$ 16.35
	Thurston	36500	$ 16.94
	Whatcom	13380	$ 17.87
	Yakima	49420	$ 14.31

Hospice Care Center	
Rev Code 0145	**Rate**
All Hospice Care Centers	$269.00

* All Other Areas: These are the rates for all other areas of the state that are not a Core-Based Statistical Area (CBSA).

PROFESSIONAL SERVICES AGREEMENT FOR MEDICAL DIRECTOR

This PROFESSIONAL SERVICES AGREEMENT (the "Agreement") is executed on the 10th day of December, 2021 (the "Effective Date") by and between Moments Hospice of King, LLC, ("Hospice") and Dr. John H. Addison having its principal place of business at 9725 SE 36th St. STE 214 Mercer Island, WA 98040 ("Provider") each a "Party" and collectively the "Parties".

RECITALS

WHEREAS, Hospice is engaged in the provision of interdisciplinary services for the palliation and management of patients with terminal illnesses; and

WHEREAS, Provider is licensed to practice medicine by the State of Washington and is qualified by proper education, training and experience to provide Services to Hospice Patients under this Agreement;

WHEREAS, Hospice desires to engage Provider as an independent contractor to provide Services to Hospice Patients;

WHEREAS, Hospice and Provider desire to enter into an agreement to set forth their mutual rights and responsibilities with respect to the provision of Services to Hospice Patients,

NOW THEREFORE, in consideration of the promises and mutual covenants contained herein, the parties agree as follows.

ARTICLE I
STATEMENT OF PRINCIPLES

Hospice is engaged in providing interdisciplinary care and treatment to patients with a terminal illness in order to allow these patients to receive end-of-life care with minimal disruption, primarily in a home environment. The goals of Hospice are to provide consistent and comprehensive care for each of its patients from the home to the inpatient setting, if necessary, and back to the home setting again. The Parties agree to cooperate and coordinate their efforts to achieve these objectives. Hospice shall retain professional, administrative, and financial management responsibility for services provided to patients who elect to receive a hospice benefit and shall require that such services are rendered in a safe and effective manner by qualified personnel and in accordance with each patient's hospice plan of care.

ARTICLE II
DEFINITIONS

2.1. "**Affiliate**" shall mean any person, corporation, firm, partnership or other entity which directly controls, is controlled by or is under common control with a party to this Agreement.

2.2. "**Attending Provider**" means a doctor of medicine or osteopathy, duly licensed under applicable state and local laws and regulations, or an advanced practice nurse who serves the primary role in delivery of medical care to a Hospice Patient.

23 . "**Effective Date**" shall mean December 10th, 2021.

24 . "**Hospice Patient**" means a terminally ill individual who elects to receive hospice care and who is admitted to the Hospice program, including, without limitation, a Medicare or Medicaid Eligible Hospice Patient.

25 . "**Hospice Services**" shall mean all services provided by Hospice designed to provide palliative care and alleviate the physical, emotional, social and spiritual discomforts of patients with terminal illness, and to provide supportive care to the patient's primary care giver and/or family.

26 . "**Interdisciplinary Team**" means a group of persons consisting of Hospice Patient's Attending Provider and Hospice personnel who participate in the establishment of a Hospice Plan of Care, periodically review and update such plan, provide or supervise the care and services offered by Hospice and Provider, and establish policies and protocols governing the day- to-day provision of such care, including at least the following individuals: a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor.

27 . "**Medicare and/or Medicaid Eligible Hospice Patient**" means a terminally ill individual who is eligible for and does elect to receive hospice care under Medicare and/or Medicaid and who duly files with Hospice a statement electing to receive such care.

28 . "**Plan of Care**" means a written care plan established, maintained and reviewed at specific intervals by Hospice for each Hospice Patient, which care plan includes: (i) an assessment of the Hospice Patient's needs; (ii) an identification of the Hospice Services to be provided to Hospice Patients under this Agreement as needed to meet such Hospice Patient's needs (including management of discomfort and symptom relief) and the needs of the Hospice Patient's family and/or caretaker; (iii) details concerning the scope and frequency of such services, and (iv) the Services to be furnished by Provider hereunder.

29 . "**Quality Assurance and Performance Improvement Programs**" or "QAPI **Programs**" shall mean Hospice programs designed to monitor the effectiveness and safety of Hospice Services and quality of care; identify opportunities and priorities for improvement; track adverse patient events and analyze their causes; and implement preventive actions and mechanisms.

30 . "**Services**" shall mean any hands-on professional services or diagnostic interpretations within the scope of the license/certification of Provider, that may be rendered by Provider to a Hospice Patient and, for an advanced practice nurse (APN), is limited to professional services rendered as the Hospice Patient's Attending Provider.

ARTICLE III RESPONSIBILITIES OF PROVIDER

31 The Medical Director is Board Certified in a related specialty and:

a) Has expertise in the medical care of terminally ill individuals

b) Is employed full-time or part-time by the Hospice or has a contractual arrangement that provides for comprehensive medical direction of hospice

32 The Hospice Medical Director provides oversight of physician services.

a) Complements attending physician care

b) Supervises all hospice physician employees and contract hospice physicians

c) Acts as a medical resource person to the IDT/IDG

d) Assures overall continuity of the hospice medical services

e) Assures that the patient receives appropriate measures to control uncomfortable symptoms

- The Medical Director or physician designee is responsible for:

a) Collaborating with the IDT/IDG to ensure that the medical needs of the patient are met and providing oversight of the plan of care

b) Certifying that the patient meets the medical criteria for hospice admission based upon available diagnostic and prognostic indicators, 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.

c) Collaborating with the patient's attending physician to develop and update the patient's plan of care, to identify needs not met by the attending physician, and to ensure pain and symptom management and control

d) Re-certifying patients, as appropriate, for continuation of Medicare Hospice Benefit at appropriate levels of care

e) Serving as a medical resource to hospice staff, patients, families, and attending physicians regarding pain and symptom control management

f) Insuring the provision of direct medical services to patients either directly or through arrangements, as appropriate, in the absence of the patient's attending physician

g) Attending IDT/IDG conferences

h) Participating in plan of care development and managing oversight of medications and treatment

i) Documenting care provided in the patient's clinical record providing evidence of progression of the end-stage-disease process

j) Maintaining current knowledge of the latest research and trends in hospice care and pain/symptom management

k) Working in a team approach with the IDT/IDG

l) Participating in performance improvement programs, as indicated

m) Providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care

n) Reviewing and developing protocols for treatment and proposing the most current options for interventions

o) dealing with end-of-life issues

p) Participating in resolution of interpersonal conflict and issues of clinical and ethical concern

q) Participating in the development and updating of patient care policies and emergency procedures

r) Acting as a liaison to physicians in the community

4. Availability of Services. Provider shall be available for on-call consultations, assistance, decisions regarding patient care, and to provide related services to Hospice on a schedule and at times as agreed upon by Hospice and Physician.

5. Manner of Providing Services. Provider shall provide Services under this Agreement only: (i) as specifically authorized by Hospice; (ii) in a safe, effective and professional manner; (iii) in accordance with recognized standards of practice; (iv) in accordance with the Hospice Plan of Care for a given Hospice patient; and (v) as ordered and prescribed by the Attending Provider.

6. Coordination of Care and Communication. Provider shall (i) actively participate in the coordination of the Hospice Patients' care in accordance with current professional standards and practice, including participating in Hospice's ongoing interdisciplinary comprehensive assessments, developing and evaluating the Plan of Care, and contributing to patient and family counseling and education; and (ii) participate in meetings with Hospice under Section 4.6.

7. Representations and Warranties. Provider represents and warrants that at all times during the term of this Agreement, Provider shall meet the following requirements:

a) Hold a valid and unrestricted license/registration to practice medicine or advanced practice nursing in the State, as applicable and have no reprimands or censures on record from the applicable licensing Board in the State;

b) Hold a current DEA license;

c) Hold Board certification or be eligible for Board certification, if applicable;

d) Be currently qualified to participate in Medicare and Medicaid and not be listed at any time by any federal agency as debarred, suspended or excluded from participation in any federally funded program;

e) Not be under supervision or subject to any disciplinary proceedings by any hospital, health care facility, peer review organization or third party payer concerning quality of care, or by any state or federal department or agency having jurisdiction over the professional activities of the Provider;

f) Maintain the professional liability insurance required by Section 7.12 of this Agreement;

g) Disclose to Hospice, in writing, if Provider or any of Provider's family members has any financial relationship with Hospice.

18. Exclusion of Private Practice. This Agreement does not cover Provider's care and treatment rendered to individual patients outside the scope of this Agreement. Hospice is not responsible for supervising, managing or directing Provider in the provision of care, treatment or diagnosis of individual patients outside of the activities covered by this Agreement.

19. Basic Philosophy; Governing Authority. Provider shall perform the Services required hereunder in a manner consistent with the best interests of the Hospice Patient. Provider will be solely responsible for all medical and professional judgments related to Provider's Services under this agreement; provided, however, any matters related to the quality of care rendered by Hospice to Hospice patients are subject to the ultimate authority of Hospice's Board of Directors. All matters relating to administrative operation of Hospice are the sole responsibility of Hospice, and Provider shall report to a designated Hospice representative with respect to Hospice administrative matters.

20. Notice of Investigation or Adverse Action. Provider will notify Hospice in writing within seventy-two (72) hours of receiving notice by any means of any change made, proposed in, or investigation relating to, or any adverse action taken with respect to: (i) Provider's continued maintenance of the qualifications required in Section 3.4 hereof or (ii) the filing of any claim against or involving Provider alleging professional liability for services rendered to a Hospice Patient.

21. Compliance with Rules and Regulations/Non-discrimination.

a) Compliance. Provider shall perform the Services required hereunder in accordance with (i) recognized standards of Provider's profession and specialty; (ii) all applicable federal, state and local laws and regulations, (iii) the applicable regulations and standards of all applicable regulatory and accrediting agencies applicable to Hospice, (iv) the applicable standards of all governmental health programs and commercial managed care programs applicable to Hospice and (v) the rules, regulations, procedures and policies of Hospice to the extent they apply to its independent contractors.

b) Non-discrimination. Provider shall not discriminate against any patients seeking care from Hospice on the basis of race, color, religion, national origin, sexual orientation, handicap, age, sex, ability to pay or source of payment or any other unlawful or impermissible criteria under federal or State law or any other governmental authority with jurisdiction over Provider's conduct.

22. Provider Time Records. For purposes of supporting the compensation paid hereunder, Provider shall complete, sign and submit to Hospice a time record in the form attached hereto as Exhibit A for each calendar month during the Term of this Agreement (the "Time Record"). Provider shall certify each Time Record as to the actual Services rendered by Provider during the month. Each such record shall be due to Hospice within thirty (30) days after the end of the month during which the Services were rendered. Payment will be contingent upon receipt of such Time Record.

23. Health Requirements. Providers having direct contact with Hospice Patients must receive appropriate immunizations at Provider's expense prior to commencing to provide Services within a scope and time period reasonably acceptable to Hospice. Specifically, Provider shall (i) receive a Hepatitis B vaccination pursuant to the OSHA Blood Borne Pathogens standard at 29 C.F.R. § 1910.1030; and (ii) take a tuberculosis screening test each year and document that such

Provider is free from tuberculosis infection.

3.14. Criminal Background Check. Provider shall undergo a criminal background check at Provider's expense prior to performing Services to Hospice Patients under this Agreement in accordance with the Medicare Conditions of Participation at 42 C.F.R. § 418.114. Criminal background checks must be obtained in accordance with State requirements. In the absence of State requirements, criminal background checks must be obtained within three (3) months of the date of employment for all states where the Provider has lived or worked in the past three (3) years.

3.15. Infection Control. Provider shall follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. Provider shall participate in training regarding infection control as provided by Hospice and shall follow Hospice's infection control policies and procedures at all times while providing Services to Hospice Patients.

3.16. Quality Assurance/Performance Improvement. Provider shall participate in Hospice's QAPI program as directed by Hospice. Provider shall also participate in performance improvement projects as designed and implemented by Hospice.

3.17. Orientation and Training. Provider shall participate in the orientation and training provided by Hospice, as requested by Hospice, from time to time. Provider may not provide Services to a Hospice Patient until he/she has completed the orientation provided by Hospice under Section 4.4.

3.18. Evaluation. Provider shall participate in periodic evaluations of Provider's services by Hospice.

3.19. Excluded Provider and Indemnification. Provider represents and warrants that he/she is not and at no time has been excluded from participation in any federally funded health care program, including Medicare and Medicaid. Provider shall immediately notify Hospice of any threatened, proposed, or actual exclusion of Provider from any federally funded health care program, including Medicare and Medicaid. In the event that Provider is excluded from participation in any federally funded health care program during the term of the Agreement, or if at any time after the Effective Date of the Agreement it is determined that Provider is in breach of this paragraph, the Agreement shall, as of the effective date of such exclusion or breach, automatically terminate.

3.20. Compliance with Conditions of Participation. Provider shall comply with, and shall assist Hospice with complying with, the Medicare Conditions of Participation for Hospice at 42 C.F.R. Part 418, as they apply to the Services provided by Provider hereunder.

ARTICLE IV RESPONSIBILITIES OF HOSPICE

4.1. Space and Equipment. All equipment, facilities, and supplies used by Provider to provide Services pursuant to this Agreement shall be provided by Hospice to Provider, as determined to be necessary and appropriate by Hospice and at Hospice's cost,

4.2. Availability of Services. Hospice will coordinate Hospice Services to those Hospice Patients who require Services. Hospice will be the primary communicator between

Provider, the Attending Provider, the Hospice Patient, the Hospice Patient's family and/or caregiver, and other health care providers.

4.3. Patient Management. All Hospice patients receiving Services shall be patients of Hospice, and Hospice and its governing board shall retain ultimate authority for all Services provided to such Hospice Patients. Hospice shall perform continuous quality assessment and performance improvement activities related to such Services rendered to Hospice Patients, so that all care is furnished in a safe and effective manner by qualified personnel meeting or exceeding the applicable standards of care.

4.4. Orientation and Training. Hospice shall furnish an initial orientation to Provider. Such orientation shall include, but shall not be limited to, Hospice's philosophy, policies and procedures regarding methods of comfort, pain control, and symptom management; general principles about death and dying; individual responses to death; patient rights; appropriate forms; and record keeping requirements. In addition, Hospice shall determine and provide in-service training and education programs to Provider as Hospice deems necessary. Hospice shall maintain a written description of all training provided to Provider (including identification of instructors) during the preceding twelve (12) month period.

4.5. Professional Management Responsibility. Hospice shall assume, retain and maintain responsibility for administrative, financial management and oversight for all care provided to Hospice Patients (including Services provided by Provider), to ensure that the care is high quality and consistent with the professional standard of care.

4.6. Communication. In accordance with 42 C.F.R § 418.56, Hospice shall meet with Provider on a regular basis, at mutually agreeable times, to share information related to the care and treatment of Hospice Patients receiving Services from Provider and to review policies, procedures, and quality issues, and to discuss any other issues pertaining to the Services provided under this Agreement.

4.7. Performance Evaluation. Hospice will be responsible for assessing the skills and competence of Provider performing Services under this Agreement. Hospice shall maintain written policies and procedures describing its methods of assessing the competency of Provider.

4.8. Insurance. Hospice shall procure and maintain customary, appropriate and, if necessary, by law, required levels of insurance covering its activities and obligations hereunder during the Term of the Agreement.

ARTICLE V COMPENSATION

5.1. Hospice Services. As sole compensation to Provider for the Services provided to Hospice Patients under this Agreement, Hospice shall pay to Provider the amounts and under the payment terms set forth on Exhibit A attached hereto and incorporated herein by reference. Notwithstanding anything in the foregoing to the contrary, Hospice's obligation to pay the compensation described in this Section 5.1 is conditioned upon Hospice's receipt of the Time Records required pursuant to Section 3.9 and clinical records as required by Section 7.2. Payment to Group will be made within thirty (30) days of submission of the Time Records.

5.2. Non-Hospice Services. Provider shall be solely responsible to determine if he/she may bill and collect for professional services rendered to Hospice Patients that are outside the scope of the Services rendered under this Agreement or unrelated to the Hospice Patient's terminal illness, and any such billings are the sole responsibility of Provider. Hospice shall have no responsibility to compensate Provider for services rendered to Hospice Patients that are outside of the scope of this Agreement.

ARTICLE VI TERM AND TERMINATION

6.1. Term and Renewal. The initial term of this Agreement shall be for one (1) year (the "Initial Term") commencing on the Effective Date, unless otherwise terminated in accordance with this Agreement. This Agreement shall thereafter automatically renew for successive one (1) year renewal terms (each, a "Renewal Term"). The Initial Term and any Renewal Terms shall be collectively defined herein as the "Term."

6.2. Immediate Termination for Cause. Hospice may terminate this Agreement immediately upon written notice to Provider upon the occurrence of any of the following:

a) Provider dies or becomes disabled and is unable to fulfill the terms and obligations of this Agreement hereunder. The term "disabled" shall mean the inability of Provider to perform the duties under this Agreement for a period of 180 consecutive days due to injury or illness, as determined by Hospice in its sole discretion.

b) Provider is convicted of any offense punishable as a felony or is convicted of a misdemeanor involving moral turpitude or immoral conduct or commits any act for which civil monetary penalties may be imposed.

c) Provider commits fraud, embezzlement, misappropriation or the like with respect to any Hospice assets or the property of any Hospice Patient or otherwise violates any state or federal law.

d) Provider is sanctioned by the State Licensing Board, any state or local peer review or quality assurance organization, or by Medicare, Medicaid or any third-party payor or reimbursement sources.

e) Provider materially breaches any obligation pertaining to the confidentiality of Confidential information, PHI or any HIPAA requirements.

f) Provider fails to maintain the requirements in Section 3.4.

g) Provider violates Hospice rules and/or policies that would subject a Hospice employee to immediate termination.

6.3. Termination for Cause Following Cure Period. This Agreement shall terminate upon the breach of any other material provision of this Agreement, provided that written notice of the breach has been given and cure has not been made within thirty (30) days following such notice.

6.4. Termination Without Cause. Either Party may terminate this Agreement without cause by furnishing the other Party written notice of such termination "sixty days (60)" prior to the effective date of such termination, or upon mutual agreement of the Parties.

6.5. Effect of Termination. In the event that this Agreement is terminated for any reason, as set forth herein, all obligations of either Party shall cease on the date of such termination; provided, however, that nothing contained herein shall relieve Hospice of the obligation to pay for Services rendered prior to the date of termination or shall relieve the Parties of the obligations expressly made to extend beyond the term of this Agreement. Upon termination of this Agreement, Provider will continue to provide Services to those Hospice Patients to which Provider was providing Services as of the termination date until Hospice makes reasonable and medically appropriate arrangements to have another Provider provide the Services to such patients.

ARTICLE VII GENERAL PROVISIONS

7.1. Notice. Any notice, demand, or communication required, permitted, or desired to be given hereunder, shall be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, or overnight carrier addressed as follows:

To Provider: Dr. John H. Addison
9725 SE 36th St STE 214
Mercer Island, WA 98040

To Hospice: Moments Hospice of King, LLC
Attn: Eli Jaffa, President
820 Lilac Dr. N, Suite 210
Golden Valley, MN 55422

or to such other address, and to the attention of such other persons or officers as either Party may designate by advance written notice. Notice will be deemed given upon receipt.

7.2. Records. Provider shall prepare, maintain and deliver to Hospice all records, forms and documents related to Services provided by Provider under the terms and conditions of this Agreement, including, without limitation, patient records, in a form and containing such information as Hospice reasonably requests; provided, however, Provider may retain a copy of such records. Hospice shall have custody of and shall be the sole owner of all records, including patient records, related to Services rendered pursuant to this Agreement. Upon the expiration or termination of this Agreement, subject to the requirements of applicable law, Provider shall be entitled to obtain at Provider's sole cost and expense copies of the following:

a) Records of patients who have executed an appropriate authorization for Provider to assume responsibility for their continuing medical care; and

b) Records necessary or desirable to enable Provider to defend any malpractice action or other claim against Provider related to the Services rendered hereunder.

73. Non-solicitation

a) Non-Solicitation of Patients. During the term of this Agreement and for one year thereafter, Provider shall not, individually or collectively, as a participant in a partnership, sole proprietorship, corporation, limited liability company, or other entity, or as an operator, investor, shareholder, partner, director, employee, consultant, independent contractor or advisor of any such entity, or in any other capacity whatsoever, either directly or indirectly (1) offer hospice services as offered by Hospice to any past, present, or future patient who received services from Hospice; or (2) request any patient who received services from Hospice to terminate his or her relationship with Hospice; *provided, however,* Provider may treat former patients of Hospice who seek to receive services from provider

b) Non-Solicitation of Hospice Personnel. During the term of this Agreement and for 2 years thereafter, Provider shall not (i) participate, directly or indirectly, in or be materially involved in any manner in the hiring or any attempt to hire as an employee, officer, director, consultant, advisor or any person who is at the time of such hiring or attempted hiring an employee of Hospice; or (ii) otherwise, directly or indirectly, induce or attempt to induce any employee of Hospice to leave the employ of Hospice.

c) Modification of Restrictions. The Parties agree that if the covenants of this Section are deemed too restrictive by any court of competent jurisdiction in any proceeding involving the validity of said covenants, the court may reduce the offending restriction to the maximum restriction it deems reasonable under the circumstances.

d) Remedies. Provider's threatened or actual breach of any of the terms hereof will result in immediate, irreparable harm and injury to Hospice, not adequately compensable by monetary relief. As a result, Hospice shall have the right to enforce the provisions hereof by injunction, specific performance or other equitable relief, as well as through all other equitable and/or legal remedies to which Hospice may be entitled.

e) Survival. This section shall survive termination of this Agreement.

74. Entire Agreement. This Agreement, together with the attached Exhibits, constitutes the entire understanding of the Parties with respect to its subject matter and supersedes any previous contracts or understanding between the Parties.

75. Jeopardy. Notwithstanding anything to the contrary herein contained, in the event the performance of either Party of any term, covenant, condition or provision of the Agreement jeopardizes the licensure of Hospice or Provider, as applicable, any payment or reimbursement from Medicare, Medicaid, Blue Cross or other reimbursement or payment programs, or, if applicable, the tax-exempt status of Hospice or any of its Affiliates, or will prevent or prohibit any physician or any other health care professionals or their patients from utilizing Hospice or Provider or any of their services, or if for any other reason, performance violates any statute, ordinance, regulation or accreditation standard governing a Party, either Party may, at its option, initiate negotiations to resolve the matter through amendments to the Agreement and, if the Parties are unable to resolve the matter within thirty (30) days thereafter, either Party may, at its option, terminate the Agreement immediately.

7.6 . Non-Disclosure of Information. Provider agrees, with respect to all proprietary information that is or has been furnished or disclosed by Hospice or that is or has been developed by Provider for Hospice, including, but not limited to, information regarding Hospice's organization, personnel, programs, business activities, policies, procedures, patients, rights, obligations, liabilities and strategies ("Information"), that, (i) such Information is confidential and/or proprietary to Hospice and is entitled to and shall receive treatment as such by Provider; (ii) Provider will hold in confidence and will not disclose nor use any such Information, treating such Information with the same degree of care and confidentiality as it affords its own confidential and proprietary information; and (iii) all such Information furnished to Provider by Hospice, unless otherwise specified in writing, shall remain the property of Hospice and, in the event this Agreement is terminated, shall be returned to Hospice, together with any and all copies made thereof, and together with oral Information furnished to Provider which shall have been reduced to writing. In the event of Provider's actual or threatened breach of this paragraph, Hospice shall be entitled to a preliminary restraining order and injunction restraining Provider from violating its provisions. Nothing in the Agreement shall be construed to prohibit Hospice from pursuing any other available remedies for such breach or threatened breach, including the recovery of damages from Provider.

7.7 . Access to Records. To the extent required by 42 U.S.C. § 1395x(v)(1)(i) until the expiration of four (4) years after the termination or expiration of the Agreement, Provider shall make available, upon written request to the Secretary of the Department of Health and Human Services, or the Comptroller General of the United States General Accounting Office, or any of their duly authorized representatives, a copy of the Agreement and such books, documents and records as are necessary to certify the nature and extent of the costs of the goods or services provided by Provider under the Agreement. Provider further agrees that, in the event Provider carries out any of his/her duties under the Agreement through a subcontract with a related organization with a value or cost of Ten Thousand Dollars ($10,000.00) or more over a twelve (12) month period, such subcontract shall contain a provision requiring the related organization to comply with the with the requirements of this Section.

7.8 . Compliance Anti-Kickback and Physician Self-Referral Statutes. Neither Party shall engage in any activity prohibited by 42 U.S.C. § 1395nn (42 Code of Federal Regulations, Part 411 (411.1 to 411.361)), 42 U.S.C. § 1320a-7a and 42 U.S.C. § 1320a-7b (42 Code of Federal Regulations, Part 1001 (1001.952(a) to 1001.1001)) or any other federal state or local law or regulation relating to the referral of patients, including, without limitation, anti-kickback and self-referral prohibitions and limitations, as those laws or regulations now exist or as subsequently revised.

7.9 . HIPAA. Each Party acknowledges that it is a Covered Entity under the Health Insurance Portability and Accountability Act of 1996 and it's implementing regulations, as amended from time to time, including 45 C.F.R. Parts 160, 162 and 164 and the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations, as amended from time to time ("HIPAA"). Each Party shall comply, and shall require that their respective agents, employees and contractors shall comply, with HIPAA.

7.10 . Independent Contractor Status. It is expressly acknowledged by the Parties hereto that the Provider is an independent contractor with respect to Hospice, and nothing in the Agreement is intended, nor shall be construed, to create between Hospice and Provider an employer/employee relationship, a joint venture relationship, or a lease or landlord/tenant relationship, or to allow Hospice to exercise control or direction over the manner or method by which Provider provides the Services which are the subject matter of this Agreement. Provider

understands and agrees that (i) Hospice will not withhold on behalf of Provider any sums for income tax, unemployment insurance, social security, or any other withholding pursuant to any law or requirement of any governmental body relating to Hospice or its employees, and (ii) all such payments and withholdings are the sole responsibility of Provider. Provider agrees to indemnify and hold Hospice harmless for any and all liability or damages, including fines, assessments, penalties, interest, costs and/or attorney fees, Hospice may incur resulting from Provider's obligations to make all such payments and withholdings.

7.11 . No Referral Obligation. Nothing contained in this Agreement shall be construed as a promise or inducement for either Party to make a referral to the other. The Parties agree that the financial terms of this Agreement are fair market value for the Services provided by Provider under this Agreement, are a result of bona fide and arms-length negotiations and are not based in any manner upon the volume or value of referrals or other business between the Parties.

7.12 Insurance. Provider shall, at Provider's sole cost and expense, procure, keep and maintain throughout the term of the Agreement, insurance coverage in the minimum amounts not less than $500,000 for a single claim, and not less than $1,500,000 for aggregate claims during a twelve-month period.

In addition to the coverages specifically listed herein, Provider shall maintain any other usual and customary policies of insurance applicable to the Services being performed pursuant to the Agreement. Such policy(ies) shall cover all of Provider's Services provided hereunder. By requiring insurance herein, Hospice does not represent that coverage and limits will necessarily be adequate to protect Provider, and such coverage and limits shall not be deemed as a limitation on Provider's liability under the indemnities granted to Hospice in the Agreement. In the event Provider procures a "claims-made" policy to meet the insurance requirements herein, Provider agrees to purchase "tail" coverage upon the termination of any such policy or upon termination of the Agreement with an indefinite reporting period. Provider will furnish to Hospice at least annually a certificate of insurance evidencing all of the policies of insurance required herein.

7.13 . Indemnification. In performance of the duties and obligations of this Agreement:

a) Provider shall defend, indemnify and hold harmless Hospice, its officers, directors, employees and agents from and against all claims, liabilities, losses, damages, costs or expenses of any kind (including reasonable attorneys' fees) arising directly or indirectly out of the (i) breach of any material term of this Agreement or (ii) acts or omissions of Provider, his/her employees and agents.

b) Hospice shall defend, indemnify and hold harmless Provider, his/her employees and agents from and against all claims, liabilities, losses, damages, costs or expenses of any kind (including reasonable attorneys' fees) arising directly or indirectly out of the (i) breach of any material term of this Agreement or (ii) acts or omissions of Hospice, its employees and agents.

c) An indemnitee entitled to indemnification under this Section shall give prompt notice to the indemnitor once it learns of a claim or other circumstances likely to give rise to a request for indemnification.

7.14 . Assignment. Except as otherwise expressly provided herein, neither Party may assign any of its rights or obligations under the Agreement without the prior written consent of the other Party; provided, however, that Hospice may assign its rights and duties to an Affiliate.

7.15 . Amendments. The Agreement may be amended at any time by mutual agreement of the Parties, provided that, before any amendment shall become effective, it shall be reduced to writing and signed by each of the Parties.

7.16 . No Third-Party Beneficiaries. There are no third-party beneficiaries to the Agreement.

7.17 . Compliance. Provider acknowledges that he/she agrees to be bound by and comply with all policies and procedures set forth in Hospice's Compliance Program. In furtherance of the foregoing, Provider shall immediately notify Hospice of: (i) any and all possible instances of non-compliance on the part of Hospice or any of its employees or agents of which Provider is aware; (i) any subpoena or other request for information or other documents relative to the Services rendered hereunder; or (iii) any action taken to exclude Physician from participation in Medicare, Medicaid or other governmental payment programs. Further, if required under the Deficit Reduction Act of 2005, Hospice shall inform Group federal and State false claims acts and the Hospice's policies to prevent fraud and abuse.

7.18 . Binding Effect. This Agreement shall be binding upon and inure to the benefit of Hospice and Provider, and their respective successors and assigns.

7.19 . Governing Law. The Agreement shall be governed by and construed in accordance with the laws of the State irrespective of such state's choice-of-law principles.

7.20 . Partial Invalidity. If any provision of the Agreement is found to be invalid or unenforceable by any court or other lawful forum, such provision shall be ineffective only to the extent that it is in contravention of applicable laws without invalidating the remaining provision of the Agreement, unless such invalidity or unenforceability would defeat an essential business purpose of the Agreement.

7.21 . Cumulation of Remedies. The various rights, options, elections, powers and remedies of the Parties contained in, granted or reserved by the Agreement, are in addition to any others that the Parties may be entitled to by law, shall be construed as cumulative, and no one of them is exclusive of any of the others, or of any right or priority allowed by law.

7.22 . Waiver. No waiver or failure by any Party to enforce any of the terms, conditions, provisions, or obligations herein shall be construed as a waiver of any subsequent breach of such provision, term, condition or obligation, or obligation hereunder, whether the same or different in nature. No extension of time for performance of any of the obligations or acts shall be deemed an extension of time for performance of any other obligations or acts.

23. Counterparts. This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the Parties have executed and delivered this Agreement on the date first above written.

MOMENTS HOSPICE:

By: Eli Jaffa

Signature: _____

Date: 12/10/2021

PROVIDER:

By: John H. Addison, MD

Signature: Dr. John Addison

Date: 12/14/2021

EXHIBIT A
FORM OF TIME RECORD

A-1
Exhibit A

I. Medicare, Medicaid and Commercial Third-Party Insurance Patients

Hospice shall pay Provider for Services rendered to Hospice Patients under this Agreement at a rate of $250 dollars per hour, Payments shall be made within thirty (30) days of receipt of an invoice from Provider in a form and containing such information reasonably requested by Hospice and shall include the applicable Time Record required under Section 3.9 and clinical records as required by Section 7.2. Provider shall invoice Hospice directly for Services, and shall not seek payment from any Hospice Patient or other party. Provider shall submit such invoices to Hospice no later than the last day of the month following the month in which the Services were provided. Hospice shall have the sole right to bill and collect from Medicare for Services provided by Provider under the Agreement. Hospice's obligation to pay the compensation described herein is conditioned upon Hospice's receipt of the Time Records required pursuant to Section 3.9.

Compensation: In consideration for the Medical Director Services provided by Provider hereunder, Moments will pay Provider the hourly rate agreed upon by the Parties. Provider will maintain a time sheet detailing the hours worked and Compensation will be based on Provider's reported time sheet. The total amount of hours necessary for Provider to adequately fulfill the Services of this Agreement is expected to be an average of 52 hours per month, varying from month to month.

Payment in Full: Provider shall accept such compensation as payment in full for all Services provided by Provider hereunder, and shall not seek or accept additional compensation from Patients or their families or representatives, Medicare, Medicaid, or any other or third-party payers.

MOMENTS HOSPICE OF KING, LLC OPERATING AGREEMENT

THIS OPERATING AGREEMENT, made as of this 1st day of December, 2021 ("Effective Date") by and between **Eliyahu Jaffa and Shlomo Miller** whom may hereafter sometimes be referred to collectively as the "Parties" or the "Members" and individually as "party" or "Member".

RECITATIONS

WHEREAS the parties desire to operate a limited liability company to be known as Moments Hospice of King, LLC (the "Company") under and pursuant to the Washington Limited Liability Company Act, (currently WA Statutes Chapter 25.15 RWC et.seq.) (the "Act").

WHEREAS the parties desire to set forth in this Operating Agreement their respective rights, obligations and interests with respect to the Company and the Property.

AGREEMENT

NOW THEREFORE, in consideration of the mutual covenants and conditions set forth herein and for other good and valuable considerations, the sufficiency of which is hereby acknowledge the parties hereby mutually agree as follows:

1. RECITATIONS. The recitations hereinabove set forth are true and correct and are incorporated into this Agreement as if repeated verbatim.

2. OPERATION AND NAME. The parties hereby agree to operate a limited liability Company to be known as Moments Hospice of King, LLC Except as expressly provided in this Agreement to the contrary the rights and obligations of the parties and the administration and termination of the Company shall be governed by the Washington Limited Liability Company Act. The Company shall have all the powers of a limited liability Company under the laws of the United States and the State of Washington.

3. PRINCIPAL OFFICE. The location of the principal place of business of the Company shall be as stated in the Articles of Organization or at a location as the Managers select.

4. TERM. The Company shall continue for a perpetual period, unless;

(a) Members whose capital interest as defined in Article 5 exceeds 50 percent vote for dissolution; or

(b) Any event which makes it unlawful for the business of the Company to be carried on by the Members; or

(c) Any other event causing dissolution of this Limited Liability Company under applicable state laws.

5. INTEREST. The classification and interest of each Member in the Company and in the equity based voting rights, and in the share of the profits and losses thereof are as follows except as otherwise may be provided in this Agreement:

Member	Interest
Eliyahu Jaffa	50%
Shlomo Miller	50%
Total:	100%

6. MANAGEMENT. The Company shall be managed by its Chief Manager, Eliyahu Jaffa. The Chief Manager shall be responsible for all of the daily operations of the Company as provided in this Agreement. The other additional members of Miller shall further act as a Manager of the company as that term is generally accepted.

7. POWERS & RESTRICTIONS OF MEMBERS. The Company shall have authority and power to:

(a) Commence and/or continue to operate it business within the healthcare industry as further described herein;

(b) Borrow money; acquire assign, and/or distribute real property, tangible and/or intangible property; acquire assign, and/or distribute intellectual property rights; engage and/or procure licensing arrangements, and any additional transactions that are deemed to be in the best interest of the Company;

(c) Lend its funds or make guarantees of obligations of others upon such terms as reasonably prudent;

(d) Employ such person, firms or companies for the operation and management of all or any part of the Company business, on such terms and for such compensation as the members shall determine;

(e) Retain counsel, accountants, financial advisers and other professional personnel; and

(f) Engage in such other activities and incur such other expenses as may be necessary or appropriate for the furtherance of the Company's purposes, and execute, acknowledge and deliver any and all instruments necessary to the foregoing.

Notwithstanding the foregoing and in addition to other acts expressly prohibited or restricted by this Agreement or by law, each Member, without prior written approval of the majority of the Members, is expressly prohibited from the following:

(a) Doing any act in contravention of this Agreement;

(b) Doing any act which would make it impossible or unduly burdensome to carry on the ordinary business of the Company;

(c) Confessing a judgment against the Company in connection with any threatened or pending legal action;

(d) Processing any Company property or selling, exchanging, transferring, assigning or leasing the rights of the Company in specific Company property for other than a Company purpose;

(e) Admitting any other person as a member, except as provided in this Agreement.

(f) Executing or delivering any assignment for the benefit of creditors of the Company.

8. SALARIES. Members will not receive any salaries.

9. COMPANY BOOKS AND RECORDS. All books, records and accounts of the Company shall be held and maintained at the office of the Company, or at any other location in the State of Washington or the State of Minnesota, as agreed to by the Members and shall be open to inspection during business hours by all Members and their authorized representatives. For the purpose of the Company accounting, and for income tax reporting, the Company's fiscal year shall end on the last day of December, or such other lawful date agreed upon by the Members. Monthly financials will be provided to all Members including P&L statements and balance sheets.

10. DISTRIBUTIONS.

(a) The term "Cash Available for Distribution" means the excess, if any, of all gross cash receipts of the Company from all sources as of the date of determination, less the following items:

(i) All cash disbursements of the Company in connection with the business of the Company as of that date which include, without limitations: (a) direct operating obligations (b) interest on secured and unsecured loans; and (c) principal payments on secured and unsecured loans; and less.

(ii) An amount mutually determined by the Members for a reasonable allowance for anticipated cash disbursements and the reasonable capital requirements of the Company and any reserve for taxes, insurance and carrying costs which are estimated or determined to be made before additional cash receipts of. the Company from third parties will provide the funds therefore.

(b) Cash Available for Distribution shall be determined at the close of the fiscal year by the Chief Member. Unless the Chief Member determines otherwise, there shall be no distributions of Cash Available for Distribution until unpaid obligations and debts of the Company secured and unsecured, together with all interest thereon, are paid in full and satisfied. Cash Available for Distribution shall be distributed at such time as the Chief Member determines that the funds are available therefore and paid to each of the Members in accordance with their current membership interests.

11. TRANSFERS.

(a) ASSIGNMENT. If at any time a Member proposes to sell, assign or otherwise dispose of all or any part of its interest in the Company, Member shall comply with the following procedures:

(i) First make a written offer to sell such interest to the other Member(s) at a price determined in writing. At this point exiting member may not make this intention publicly known. If such other Members decline or fail to elect such interest within sixty (60) days, the exiting member may advertise its membership interest for sale as it sees fit.

(ii) If a member has a buyer of members interest, the other current member(s) have first right of refusal to purchase the exiting members interest for the agreed purchase price. If there are more than one current remaining members, remaining members may combine funds to purchase the exiting members interest. Exiting member must show that potential purchaser has full certified funds, or the ability to get full certified funds before the first right of refusal period starts. Current members have 60 days to buy exiting members interest if they so desire.

(iii) Pursuant to the applicable law, current members may unanimously approve the sale of exiting members' interests to grant full membership benefits and functionality to the new member. The current remaining members must unanimously approve the sale, or the purchaser or assignee will have no right to participate in the management of the business, affairs of the Company, or member voting rights. The purchaser or assignee shall only be entitled to receive the share of the profits or other compensation by way of income and the return of contributions to which that Member would otherwise be entitled. Exiting member must disclose to buyer or assignee if current members will not approve the sale.

(b) VALUATION OF EXITING MEMBERS INTEREST. If a member wants to exit the Company, and does not have a buyer of its membership interest, exiting member will assign its interest to current members according to the following set forth procedures:

(i) A value must be placed upon this membership interest before assigned.

(ii) If exiting member and current members do not agree on the value of this membership interest, exiting member must pay for a certified appraiser to appraise the Company value, and the exiting members' value will be assigned a value according to the exiting members' interest percentage.

(iii) The current members must approve the certified appraiser used by exiting member. Current members have 30 days to approve the exiting members certified appraiser. If current members disapprove the certified appraiser, they must show evidence to support their disapproval of the certified appraiser as a vendor qualified to make the Company business appraisal. Current members may not stall the process by disapproving all certified appraisers.

(iv) Upon completion of a certified appraiser placing a value on the Company, a value will be placed on exiting members' interest according to exiting members' percentage of membership interest.

(v) If current members disagree with the value placed on exiting members' interest, current members must pay for a certified appraiser to value the Company and exiting members' interest according to the same terms.

(vi) Current members' appraiser must be completed within 60 days or right of current members to dispute the value of exiting members interest expires.

(vii) Upon completion of current members certified appraiser, the exiting member must approve the value placed on exiting members' interest. Exiting member has 30 days to approve this value.

(viii) If exiting member does not approve current members' appraiser value, the value of the Company will be determined by adding both parties' values, then dividing that value in half, then creating the value of the exiting members' interest according to the exiting members' percentage of membership interest.

(c) DISTRIBUTION OF EXITING MEMBERS INTEREST. Upon determination of exiting members' interest value, the value will be a debt of the Company. The exiting member will only be able to demand payment of this debt at dissolution of the Company or the following method:

(i) The Company will make timely payments.

(ii) The Company will only be required to make payments towards exiting members' debt if the Company is profitable and passed income to current members.

(iii) The Company must make a debt payment to exiting member if the Company passed income of 50% of the total determined value of the exiting members' interest in one taxable year. (Example: If exiting members' value was $100,000 and current member(s) received $50,000 taxable income in the taxable year, the Company would owe a debt payment to exiting member. If current member(s) only received $90,000 in passed income, there would be no payment due.)

(iv) Debt payment must be at least 10% of the value of the passed income to current the Company members.

(v) The Company must make payment to exiting member within 60 days of the end of the taxable year for the Company.

(vi) Payment schedule will continue until exiting members debt is paid by the Company.

(vii) If the Company dissolves, exiting member will be a regular debtor and payment will follow normal Company dissolution payment statutes.

(viii) Exiting members' value of membership interest it assigned current members may NOT accrue interest.

(ix) The Company can pay off amount owed to exiting member at any time if it so desires.

11. TERMINATION.

(a) The Company may be terminated by the non-bankruptcy or solvent Member if: (I) any Member shall seek relief under any federal or state law relating to bankruptcy, receivership, insolvency or reorganization subject to provision (b) below; or (ii) if any Member shall make an assignment for the benefit of creditors or take any other similar action for the protection or benefit of creditors; or (iii) if any Member shall have instituted against it any proceedings under federal or state law for the relief of debtors which proceedings re not discharged within 60 days of the date of filing; or subject to provisions (b) below (iv) if the Members mutually agree to terminate the Company; or (v) in accordance with law. If the Company is terminated because of items (i), (ii) or (iii) above, the Member who has caused the termination shall no longer have a voice in the decisions, management and operation of the Company, and the other Member(s) shall thereupon have the right to manage the Company, without such other Member's participation.

(b) If cause for termination occurs due to items (a) (i) (ii) or (iii) in this Paragraph 13 then the Member not causing the termination event shall have the option to Buy-Out the other Member's interest as otherwise set forth in this Agreement in lieu of termination.

(c) Upon termination of the Company, assets of the Company shall be liquidated, sold and converted into cash within a reasonable period of time.

(d) If the Company is terminated for any reason while there is work in progress or outstanding contractual obligations of the Company, winding up the affairs and termination of the business of the Company may include completion of the work in progress as may be necessary to bring the matters to a state of completion on that stage or phase then in progress convenient for the cessation of work or performance of the outstanding contractual obligations of the Company.

(e) The assets of the Company shall be applied or distributed in liquidation in the following order of priority:

(i) To the creditors of the Company, other than any Member or their affiliates, in payment of debts and obligations of the Company and to the expenses of liquidation;

(ii) To the setting up of any reserves which the Parties may determine are reasonably necessary for any contingencies, unforeseen liabilities or obligations of the Company; '

(iii) To the Members in liquidation of other loans and advances to the Company made by the Members, if any, first by paying any Member whose other loans and advances to the Member are in excess of those made to the Company by other

Members until loans or advances are equal, and then to all Members, until all such other loans and advances made to the Company by the Members have been paid in full;

(iv) To the Members in accordance with their respective percentage interests in the Company

(f) Every effort shall be made to dispose of the assets of the Company, so that the distribution may be made to the Members in cash.

12. PRE-EMPTIVE INVESTMENT RIGHT. In the event that future investment is required to enable the Company to achieve its business objective, the current investors in have the right to invest at a level that maintains their current percentage of ownership.

13. VENTURE LIABILITIES AND INDEMNIFICATION

(a) The Members shall have no liability for the obligations or liabilities of the Company except to the extent required by the Washington Limited Liability Company Act.

(b) Each Member hereby indemnifies and holds harmless the other Member(s) against and from all claims, demands, losses, liens, liabilities, penalties, actions and rights of action including reasonable attorneys' fees and other expenses of prosecuting or defending claims or in controversies, litigated or not, such may arise by virtue of anything or omitted to be done by the other Member (directly or through or by agents, employees, or other representatives) outside the scope of or in breach of the terms of this Agreement, provided the other Member shall be promptly notified of the existence of the claim, demand, action or right of action and shall be given reasonable opportunity to participate in the defense thereof. Notwithstanding the foregoing, failure to give such notice shall not affect the other Member's obligations hereunder, except to the extent of any actual prejudice to it resulting therefrom. The interest of each Member shall be subordinate to the right of the other Member to be indemnified or held harmless.

(c) The Company shall indemnify, defend and hold harmless each Covered Person (as hereinafter defined) from and against any and all claims, demands, losses, liens, liabilities, penalties, actions and rights of action including reasonable attorneys' fees and other expenses of prosecuting or defending claims or controversies, litigated or net, which may arise by virtue of such Covered Person's activities taken primarily on behalf of the Company, or at the request or with the approval of the Company, or primarily in furtherance of the interest of the Company, provided however, that the acts, omissions or alleged acts or omissions upon which such actual or threatened claims or controversies are based did not constitute willful misconduct or gross negligence. For purposes of this Paragraph 14 (c), "Covered Person" means a Member, any affiliate of a Member, any officer, director, shareholder, partner, employee, representative of

agent of a Member or their respective affiliates, or any officer, employee or agent of the Company.

14. ENTIRE AGREEMENT. This Agreement is the entire agreement between the Members and no alteration or modification shall be binding unless in writing and signed by each Member.

15. NOTICES. All notices required or permitted by this Agreement shall be in writing addressed to the known addresses on file with the company or such other addresses as shall from time to time be supplied in writing to any Party from the other. Notice shall be deemed given when deposited in the United States Mails, addressed to the party to receive the same, postage prepaid, by certified or registered mail, return receipt requested, or telefax or by personal delivery to the Party to receive the same, provided that in the, case of personal delivery the courtesy copy shall also be personally delivered to the addressee thereof or mailed that business day in accordance with the requirements set forth above for the giving of notice by mail.

16. CONFIDENTIALITY. The Members agree that all information obtained concerning this Operating Agreement and the Company and its Members shall remain privileged and confidential. Members shall not divulge or disclose to any other person outside this Agreement, any information relating to the negotiations of this Agreement or proprietary Company Operations In addition, the software and all other company materials shall remain proprietary information and/or trade secrets and shall not be disclosed to any third party without written consent of a majority of the membership herein. In the event of a Buy Out or Termination, no Member shall divulge or disclose to any other person any information regarding the financial status of the Company, any financial matters regarding the Company, the ownership of the Company the management of the Company, any policies of the Company and/or Company correspondence or communications regarding the operations and/or ownership of the Company except as may be otherwise required by law or in the course of any litigation to resolve a legal matter between the Parties.

17. PARAGRAPH HEADINGS. All paragraph headings inserted in the Agreement are for informational purposes only and not to modify or limit the provisions of this Agreement.

18. APPLICABLE LAW. This Agreement shall be governed by Washington law. The Members shall execute all certificates required by law to be tiled in connection with the Company, including, without limitation, Fictitious Name certificates if applicable. Venue for all disputes hereunder shall be in the District of Minnesota, in Minneapolis, Minnesota.

19. BENEFIT AND OBLIGATIONS. This Agreement shall inure to the benefit of and be binding upon the Members and their respective permitted successor and assigns. Any person or entity succeeding to the interest of a Member shall succeed to all of such Member's rights, interests, and obligations hereunder, subject to and with the benefit of all terms and conditions of this Agreement, including the restrictive conditions contained herein.

20. FURTHER ASSURANCES. The Members agree to make, execute and deliver all further instruments and documents necessary or proper to comply with or carry out the purposes of this Agreement. Time shall be of the essence in the performance of all obligations under this Agreement.

21. SURVIVAL. All provisions hereof governing the rights of the Members after a termination and dissolution shall survive such termination and dissolution.

22. THIRD PARTY CLAIMS. In the event any third party unaffiliated with any Member claims any right upon or against the interest of another Member, directly or indirectly, the Company shall, upon receipt of notice of the existence of any such claims, have the light to satisfy any claim which is a lawful encumbrance upon the Company and charge the interest of the liened Member for the amount paid, plus reasonable costs incurred by the Company in connection therewith. No Party claiming any right upon or against the interest of any Member shall have any rights against the other Member by virtue of this Agreement or this provision. No person, firm or corporation not a Member shall have any rights hereunder or by virtue hereof, and no such person, firm or corporation shall be deemed to be a third-party beneficiary hereof.

23. SEVERABILITY. This Agreement is intended to be performed in accordance with, and only to the extent permitted by, all applicable laws, ordinances, rules and regulations. If any provision of this Agreement or any application thereof to any person or circumstances shall, for any reason and to any extent, be invalid or unenforceable, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be effective thereby but rather shall be enforced to the greatest extent permitted by law.

24. ATTORNEY'S FEES. In the event of any dispute hereunder or any action to interpret or enforce this Agreement, any' provision hereof or any matter rising here from, the prevailing party shall be entitled to recover its reasonable costs, fees and expenses, including, but not limited to, witness fees, expert fees, consultant fees, attorney, paralegal and legal assistant fees, costs and expenses and other professional fees, whether or any suit be brought or not, and whether in settlement., in any declaratory action, at trial and on appeal.

25. INTEGRATION. This Agreement contains the entire agreement of the Parties hereto as it relates to the Company and the Project, and no representations, inducements, promises or agreements, oral or otherwise, between the parties not embodied herein shall be of any force or effect. No amendment to this Agreement shall be binding upon any of the parties hereto unless such amendment is in writing and executed by all parties.

26. CONSTRUCTION. The Members agree that each Member and its counsel have reviewed and revised this Agreement and that any rule of construction to the effect that ambiguities are to resolved against the drafting party may not apply in the interpretation this Agreement or any amendments or exhibits thereto. Time shall be deemed to be of the essence in the performance by Members of all duties and obligations set forth in this Agreement.

IN WITNESS WHEREOF, the parties hereto have caused these presents to be executed the day and year first above written.

By:_____

Eliyahu Jaffa, Chief Member

By:_____

Shlomo Miller, Member

Affiliate Note - Term Sheet

Lender:	Guardian Hospice MN, LLC dba Moments Hospice, a Minnesota state limited liability corporation.
Borrower:	Moments Hospice of King, LLC, a Washington state limited liability corporation.
Loan Amount:	$400,000 USD
Loan Term:	Five (5) years.
Maturity:	December 31, 2027
Interest Rate:	0% APR
Fees:	None
Security:	Unsecured
Governing Law:	State of Minnesota
Binding Nature:	The provisions of this term sheet are binding on the parties hereto.

ACKNOLEDGED AND AGREED
December 23rd, 2021:

Guardian Hospice, MN LLC

By: _____
Name: Eli Jaffa
Title: Authorized member

Moments Hospice of King, LLC

By: _____
Name: Eli Jaffa
Title: Authorized member

December 27, 2021

Mr. Eric Hernandez, Program Manager
Certificate of Need Program
Washington State Department of Health
111 Israel Rd. SE
Tumwater, WA 98501

RE: Funding Commitment for Moments Hospice of King, LLC

Dear Mr. Hernandez,

Moments Hospice of King, LLC is applying for a hospice Certificate of Need to expand its services to King County. As such, the Program's application for the hospice CN requests a letter of funding commitment to be signed by the Applicant's financing source.

I, Eli Jaffa, as Member and President of Moments Hospice of King, have committed the necessary funds to execute the formation and growth of our proposed de novo Medicare-certified hospice agency in King County.

As shown on the Audited Financial Statements for Moments Hospice of King, LLC, we have funded the new entity with $400,000 which covers the start up cost as proposed with an additional cushion for any unforeseen expenses.

Sincerely Yours,

ELI JAFFA

Eli Jaffa
President, Moments Hospice

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Washington POLST
Portable Orders for Life-Sustaining Treatment
A Participating Program of National POLST

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL		
DATE OF BIRTH / /	GENDER (optional)	PRONOUNS (optional)

This is a medical order. It must be completed with a medical professional. Completing a POLST is always voluntary.
IMPORTANT: *See page 2 for complete instructions.*

MEDICAL CONDITIONS / INDIVIDUAL GOALS:	AGENCY INFO / PHONE (if applicable)

A

CHECK ONE

Use of Cardiopulmonary Resuscitation (CPR): **When the individual has NO pulse and is not breathing.**

☐ **YES – Attempt Resuscitation / CPR** *(choose FULL TREATMENT in Section B)*

☐ **NO – Do Not Attempt Resuscitation (DNAR) / Allow Natural Death**

When not in cardiopulmonary arrest, go to Section B.

B

CHECK ONE

Level of Medical Interventions: **When the individual has a pulse and/or is breathing.**

Any of these treatment levels may be paired with DNAR / Allow Natural Death above.

☐ **FULL TREATMENT – Primary goal is prolonging life by all medically effective means.** Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Includes care described below.
Transfer to hospital if indicated. Includes intensive care.

☐ **SELECTIVE TREATMENT – Primary goal is treating medical conditions while avoiding invasive measures whenever possible.** Use medical treatment, IV fluids and medications, and cardiac monitor as indicated. ***Do not intubate.*** May use less invasive airway support (e.g., CPAP, BiPAP, high-flow oxygen). Includes care described below.
Transfer to hospital if indicated. Avoid intensive care if possible.

☐ **COMFORT-FOCUSED TREATMENT – Primary goal is maximizing comfort.** Relieve pain and suffering with medication by any route as needed. Use oxygen, oral suction, and manual treatment of airway obstruction as needed for comfort.
Individual prefers no transfer to hospital. EMS: consider contacting medical control to determine if transport is indicated to provide adequate comfort.

Additional orders (e.g., blood products, dialysis): _____

C

Signatures: A legal medical decision maker *(see page 2)* may sign on behalf of an adult who is not able to make a choice. An individual who makes their own choice can ask a trusted adult to sign on their behalf, or clinician signature(s) can suffice as witnesses to verbal consent. A guardian or parent must sign for a person under the age of 18. Multiple parent/decision maker signatures are allowed but not required. Virtual, remote, and verbal consents and orders are addressed on page 2.

Discussed with: ☐ Individual ☐ Parent(s) of minor ☐ Guardian with health care authority ☐ Legal health care agent(s) by DPOA-HC ☐ Other medical decision maker by 7.70.065 RCW	X **SIGNATURE** – MD/DO/ARNP/PA-C **(mandatory)**	DATE **(mandatory)**
	PRINT – NAME OF MD/DO/ARNP/PA-C **(mandatory)**	PHONE

X **SIGNATURE(S)** – INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**	RELATIONSHIP	DATE **(mandatory)**
PRINT – NAME OF INDIVIDUAL OR LEGAL MEDICAL DECISION MAKER(S) **(mandatory)**		PHONE

Individual has: ☐ Durable Power of Attorney for Health Care ☐ Health Care Directive (Living Will)
Encourage all advance care planning documents to accompany POLST.

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

WSMA Washington State Medical Association
Physician Driven, Patient Focused

Washington State Department of Health

Exhibit 45

All copies, digital images, faxes of signed POLST forms are valid.
See page 2 for preferences regarding medically assisted nutrition.
For more information on POLST, visit **www.wsma.org/POLST**.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

LAST NAME / FIRST NAME / MIDDLE NAME/INITIAL	DATE OF BIRTH / /

Additional Contact Information (if any)

LEGAL MEDICAL DECISION MAKER(S) (by DPOA-HC or 7.70.065 RCW)	RELATIONSHIP	PHONE
OTHER CONTACT PERSON	RELATIONSHIP	PHONE
HEALTH CARE PROFESSIONAL COMPLETING FORM	ROLE / CREDENTIALS	PHONE

Preference: Medically Assisted Nutrition (i.e., Artificial Nutrition)

☐ **Check here if not discussed**

This section is NOT required. This section, whether completed or not, does not affect orders on page 1 of form.
Preferences for medically assisted nutrition, and other health care decisions, can also be indicated in advance directives which are advised for all adults. The POLST does not replace an advance directive. When an individual is no longer able to make their own decisions, consult with the legal medical decision maker(s) regarding their plan of care, including medically assisted nutrition. Base decisions on prior known wishes, best interests of the individual, preferences noted here or elsewhere, and current medical condition. Document specific decisions and/or orders in the medical record.

Food and liquids to be offered by mouth if feasible and consistent with the individual's known preferences.

☐ Preference is to avoid medically assisted nutrition.
☐ Preference is to discuss medically assisted nutrition options, as indicated.*
Discuss short- versus long-term medically assisted nutrition (long-term requires surgical placement of tube).

* Medically assisted nutrition is proven to have no effect on length of life in moderate- to late-stage dementia, and it is associated with complications. People may have documents or known wishes to not have oral feeding continued; the directions for oral feeding may be subject to these known wishes.

Discussed with: ____ Individual ____ Health Care Professional ____ Legal Medical Decision Maker

Directions for Health Care Professionals

NOTE: An individual with capacity may always consent to or refuse medical care or interventions, regardless of information represented on any document, including this one.

Any incomplete section of POLST implies full treatment for that section. This POLST is valid in all care settings. It is primarily intended for out of hospital care, but valid within health care facilities per specific policy. The POLST is a set of medical orders. The most recent POLST replaces all previous orders.

Completing POLST
- Completing POLST is voluntary for the individual; it should be offered as appropriate but not required.
- Treatment choices documented on this form should be the result of shared decision making by an individual or their health care agent and health care professional based on the individual's preferences and medical condition.
- POLST must be signed by an MD/DO/ARNP/PA-C and the individual or their legal medical decision maker as determined by guardianship, DPOA-HC, or other relationship per 7.70.065 RCW, to be valid. Multiple decision maker signatures are allowed, but not required.
- Virtual, remote, and verbal orders and consents are acceptable in accordance with the policies of the health care facility. For examples, see FAQ at www.wsma.org/POLST.
- POLST may be used to indicate orders regarding medical care for children under the age of 18 with serious illness. Guardian(s)/parent(s) sign the form along with the health care professionals. See FAQ at www.wsma.org/POLST.

NOTE: This form is not adequate to designate someone as a health care agent. A separate DPOA-HC is required to designate a health care agent.

Honoring POLST
Everyone shall be treated with dignity and respect.
SECTIONS A AND B:
- No defibrillator should be used on an individual who has chosen "Do Not Attempt Resuscitation."
- When comfort cannot be achieved in the current setting, the individual should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). This may include medication by IV route for comfort.
- Treatment of dehydration is a measure which may prolong life. An individual who desires IV fluids should indicate "Selective" or "Full Treatment."

Reviewing POLST
This POLST should be reviewed whenever:
- The individual is transferred from one care setting or care level to another.
- There is a substantial change in the individual's health status.
- The individual's treatment preferences change.

To void this form, draw a line across the page and write "VOID" in large letters. Notify all care facilities, clinical settings, and anyone who has a copy of the current POLST. Any changes require a new POLST.

Review of this POLST form: <u>Use this section to update and confirm order and preferences.</u>

This meets the requirement of establishing code status and basic medical guidance for admission to nursing and other facilities.

REVIEW DATE	REVIEWER	LOCATION OF REVIEW	REVIEW OUTCOME
			☐ No Change ☐ Form Voided ☐ New Form Completed

SEND ORIGINAL FORM WITH INDIVIDUAL WHENEVER TRANSFERRED OR DISCHARGED

Copies, digital images, and faxes of signed POLST forms are legal and valid. May make copies for records.
For more information on POLST, visit **www.wsma.org/POLST**.

Assisted Living Facility Search Results

Facilities Matching These Search Criteria:

Located in these counties: King
Specialities: All
Contracts: Assisted Living, Adult Residential Care, Enhanced Adult Residential Care, Expanded Community Services, Dementia Care, No Contract

Facility Info	Contracts & Specialties	Beds	Reports
King			
***Welcome Home Assisted Living LLC** License#: 2505 **Contact:** Singh, Amarpreet Region/Unit: 2J 738 N 200th St. Shoreline , WA 98133 (206) 546-1679 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=738+N+200TH+ST.%2c+SHORELINE%2c+WA+98133)	**Contract(s):** No Contract *Can NOT accept Medicaid*	8	View Reports (BHForms.aspx?Lic=2505)
Aegis Gardens at Newcastle License#: 2435 **Contact:** Stiff, Lori Region/Unit: 2D 13056 Se 76th St Newcastle , WA 98056 (425) 970-6708 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=13056+SE+76th+St%2c+Newcastle%2c+WA+98056)	**Contract(s):** No Contract *Can NOT accept Medicaid*	140	View Reports (BHForms.aspx?Lic=2435)
Aegis Living at Ravenna License#: 2455 **Contact:** Hing, Kerrington Region/Unit: 2J 8511 15th Ave Ne Seattle , WA 98115 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=8511+15th+Ave+NE%2c+Seattle%2c+WA+98115)	**Contract(s):** No Contract *Can NOT accept Medicaid*	104	View Reports (BHForms.aspx?Lic=2455)
Aegis Living Bellevue Overlake License#: 2567 **Contact:** Bouman, Alice Region/Unit: 2D 1845 116th Ave Ne Bellevue , WA 98004 (425) 233-6030 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1845+116th+Ave+NE%2c+Bellevue%2c+WA+98004)	**Contract(s):** No Contract *Can NOT accept Medicaid*	160	No Reports
Aegis Living Callahan House	**Contract(s):**	59	No Reports

License#: 2589
Contact: Sorensen, Brent
Region/Unit: 2J
15100 1st Ave Ne
Shoreline , WA 98155
(206) 417-9747
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15100+1st+Ave+NE%2c+Shoreline%2c+WA+98155)

No Contract

Can NOT accept Medicaid

Aegis Living Kirkland
License#: 2596
Contact: Sheron, Shannon J.
Region/Unit: 2D
13000 Totem Lake Blvd Ne
Kirkland , WA 98034
(425) 823-7272
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=13000+Totem+Lake+Blvd+NE%2c+Kirkland%2c+WA+98034)

Contract(s): 60
No Contract

Can NOT accept Medicaid

No Reports

Aegis Living Kirkland Waterfront
License#: 2586
Contact: Watkins, David
Region/Unit: 2D
1002 Lake Street S
Kirkland , WA 98033
(425) 250-1500
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1002+Lake+Street+S%2c+Kirkland%2c+WA+98033)

Contract(s): 126
No Contract

Can NOT accept Medicaid

No Reports

Aegis Living of West Seattle
License#: 2454
Contact: Chappelle, Kent
Region/Unit: 2J
4700 Sw Admiral Way
Seattle , WA 98116
(206) 436-0500
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4700+SW+Admiral+Way%2c+Seattle%2c+WA+98116)

Contract(s): 100
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2454)

Aegis Living Shoreline
License#: 2592
Contact: Moore, Kaylan
Region/Unit: 2J
14900 1st Avenue Ne
Shoreline , WA 98155
(206) 367-6700
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=14900+1ST+AVENUE+NE%2c+SHORELINE%2c+WA+98155)

Contract(s): 130
No Contract

Can NOT accept Medicaid

No Reports

Aegis Lodge of Kirkland
License#: 2492
Contact: Neal, Melissa
Region/Unit: 2D
12629 116th Ave Ne
Kirkland , WA 98034

Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=12629+116TH+AVE+NE%2c+KIRKLAND%2c+WA+98034)

Contract(s): 96
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2492)

Aegis of Bellevue
License#: 2491
Contact: Domann, Maria
Region/Unit: 2D
148 102nd Ave Se

Contract(s): 101
No Contract

Can NOT

View Reports (BHForms.aspx?Lic=2491)

Bellevue , WA 98004

Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=148+102nd+Ave+SE%2c+Bellevue%2c+WA+98004)

accept Medicaid

AEGIS OF ISSAQUAH
License#: 1997
Contact: Dupree, Sunni
Region/Unit: 2D
780 Nw Juniper Street
Issaquah , WA 98027
(425) 392-8100
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=780+NW+JUNIPER+STREET%2c+ISSAQUAH%2c+WA+98027)

Contract(s): 100
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1997)

AEGIS OF MADISON
License#: 2241
Contact: Bourgeois, Bryan
Region/Unit: 2J
2200 E Madison St
Seattle , WA 98112
(206) 325-1600
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2200+E+Madison+St%2c+Seattle%2c+WA+98112)

Contract(s): 125
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2241)

AEGIS OF MARYMOOR
License#: 2209
Contact: Young, Roger
Region/Unit: 2D
4585 West Lake Sammamish Parkway Ne
Redmond , WA 98052
(425) 497-0900
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4585+WEST+LAKE+SAMMAMISH+PARKWAY+NE%2c+REDMOND%2c+WA+98052)

Contract(s): 72
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2209)

Aegis of Mercer Island
License#: 2509
Contact: Clough, Phil
Region/Unit: 2D
7445 Se 24th Street
Mercer Island , WA 98040
(206) 602-1365
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7445+SE+24th+Street%2c+Mercer+Island%2c+WA+98040)

Contract(s): 128
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2509)

Aegis of Queen Anne at Rodgers Park
License#: 2381
Contact: Sponaugle, Nick
Region/Unit: 2J
2900 3rd Ave W
Seattle , WA 98119
(206) 858-9989
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2900+3rd+Ave+W%2c+Seattle%2c+WA+98119)

Contract(s): 150
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2381)

Aegis of Queen Anne on Galer
License#: 2339
Contact: Gomez, Ebrima
Region/Unit: 2J
223 W Galer St
Seattle , WA 98119
(206) 285-1106
Directions (http://maps.google.com/maps?

Contract(s): 68
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2339)

f=q&source=s_q&hl=en&geocode=&q=223+W+Galer+St%2c+Seattle%2c+WA+98119)

AEGIS SENIOR INN OF KENT
License#: 1944
Contact: White, Mina
Region/Unit: 2D
10421 Se 248th St
Kent , WA 98030
(253) 520-8400
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=10421+SE+248th+St%2c+Kent%2c+WA+98030)

Contract(s): 48
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1944)

AEGIS SENIOR INN OF REDMOND
License#: 1804
Contact: Cebull, Amanda
Region/Unit: 2D
7480 W Lake Sammamish Pkwy Ne
Redmond , WA 98052
(425) 883-4000
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7480+W+LAKE+SAMMAMISH+PKWY+NE%2c+REDMOND%2c+WA+98052)

Contract(s): 52
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1804)

ALJOYA MERCER ISLAND
License#: 2019
Contact: Becker, Marla A.
Region/Unit: 2D
2430 76th Avenue Se
Mercer Island , WA 98040
(206) 230-0150
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2430+76TH+AVENUE+SE%2c+MERCER+ISLAND%2c+WA+98040+++++)

Contract(s): 35
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2019)

ALJOYA THORNTON PLACE
License#: 2040
Contact: Parkins, Danielle
Region/Unit: 2J
450 Ne 100th Street
Seattle , WA 98125
(206) 470-8000
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=450+NE+100TH+STREET%2c+SEATTLE%2c+WA+98125+++++)

Contract(s): 35
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2040)

ARBOR VILLAGE RETIREMENT & ASSISTED LIVING COMMUNITY
License#: 1993
Contact: Frere, Christopher
Region/Unit: 2D
24121 116th Ave Se
Kent , WA 98030
(253) 856-1600
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=24121+116TH+AVE+SE%2c+KENT%2c+WA+98030)

Contract(s): 100
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1993)

BALLARD LANDMARK
License#: 2055
Contact: Glandon, Betty
Region/Unit: 2J
5433 Leary Avenue Nw
Seattle , WA 98107
(206) 782-4000
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=5433+LEARY+AVENUE+NW%2c+SEATTLE%2c+WA+98107+++++)

Contract(s): 60
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2055)

BAYVIEW MANOR HOMES

Contract(s): 21

View Reports

License#: 162 **Contact:** Smith, Joel G. Region/Unit: 2J 11 W Aloha St Seattle , WA 981199963 (206) 284-7330 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11+W+Aloha+St%2c+Seattle%2c+WA+981199963)	No Contract *Can NOT accept Medicaid*	(BHForms.aspx?Lic=162)
BEVERLY PARK GROUP HOME License#: 606 **Contact:** Massey, Richard Region/Unit: 2J 150 Sw 114th St Seattle , WA 98146 (206) 241-2049 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=150+SW+114TH+ST%2c+SEATTLE%2c+WA+98146)	**Contract(s):** 8 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=606)
Brannan Park Assisted Living and Memory Care Community License#: 2390 **Contact:** Bessette, Sherlyn Region/Unit: 2D 2901 I Street Ne Auburn , WA 98002 (253) 736-2800 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2901+I+Street+NE%2c+Auburn%2c+WA+98002)	**Contract(s):** 90 Specialized Dementia Care, Enhanced Adult Residential Care, Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2390)
Briarwood at Timber Ridge License#: 2544 **Contact:** Humphrey, Errin D. Region/Unit: 2D 100 Timber Ridge Way Nw Issaquah , WA 98027 (425) 427-5200 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=100+Timber+Ridge+Way+NW%2c+Issaquah%2c+WA+98027)	**Contract(s):** 35 No Contract *Can NOT accept Medicaid*	No Reports
Brookdale Admiral Heights License#: 2306 **Contact:** Schaper, Dawn Region/Unit: 2J 2326 California Ave Sw Seattle , WA 98116 (206) 866-1711 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2326+CALIFORNIA+AVE+SW%2c+SEATTLE%2c+WA+98116)	**Contract(s):** 55 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=2306)
Brookdale Federal Way License#: 2526 **Contact:** Santos, Patricia Region/Unit: 2D 31002 14th Ave S Federal Way , WA 98003 (253) 941-0156 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=31002+14th+Ave+S%2c+Federal+Way%2c+WA+98003)	**Contract(s):** 110 Enhanced Adult Residential Care, Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2526)
Brookdale Foundation House License#: 1917	**Contract(s):** 129 No Contract	View Reports (BHForms.aspx?

Contact: Mueller, Elizabeth Region/Unit: 2D 32290 1st Ave S Federal Way , WA 98003 (253) 838-8823 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=32290+1st+Ave+S%2c+Federal+Way%2c+WA+98003)	*Can NOT accept Medicaid*	Lic=1917)
Brookdale Renton License#: 2296 **Contact:** Holm, Kelly Region/Unit: 2D 71 Sw Victoria St Renton , WA 98057 (425) 226-8977 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=71+SW+VICTORIA+ST%2c+RENTON%2c+WA+98057)	**Contract(s):** 105 Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2296)
Brookdale West Seattle License#: 2319 **Contact:** Schaper, Dawn Region/Unit: 2J 4611 35th Ave Sw Seattle , WA 98126 (206) 932-5480 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4611+35TH+AVE+SW%2c+SEATTLE%2c+WA+98126)	**Contract(s):** 60 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=2319)
Cascade Place License#: 2541 **Contact:** Dravis, Brandon J. Region/Unit: 2D 2000 Mountain View Dr Enumclaw , WA 98022 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2000+Mountain+View+Dr%2c+Enumclaw%2c+WA+98022)	**Contract(s):** 40 Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2541)
CHATEAU AT BOTHELL LANDING RETIREMENT COMMUNITY License#: 2228 **Contact:** Ziomas, Alexander Region/Unit: 2J 17543 102nd Avenue Ne Bothell , WA 98011 (425) 485-1155 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17543+102ND+AVENUE+NE%2c+BOTHELL%2c+WA+98011)	**Contract(s):** 142 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=2228)
CHATEAU AT VALLEY CENTER RETIREMENT COMMUNITY License#: 2230 **Contact:** Kore, Muna Region/Unit: 2D 4450 Davis Ave S Renton , WA 98055 (425) 251-6677 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4450+Davis+Ave+S%2c+Renton%2c+WA+98055)	**Contract(s):** 120 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=2230)
Cogir Northgate License#: 2474 **Contact:** Dalke, Brandon	**Contract(s):** 85 No Contract	View Reports (BHForms.aspx?Lic=2474)

Region/Unit: 2J
11501 15th Ave Ne
Seattle , WA 98125
(206) 362-7250
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11501+15th+Ave+NE%2c+Seattle%2c+WA+98125)

Can NOT accept Medicaid

Cogir of Bothell
License#: 2342
Contact: Cline, Laurel
Region/Unit: 2J
10605 Ne 185th St
Bothell , WA 98011
(425) 487-3245
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=10605+NE+185th+St%2c+Bothell%2c+WA+98011)

Contract(s): 64
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2342)

Cogir of Northgate Memory Care
License#: 2344
Contact: Dalke, Brandon
Region/Unit: 2J
11039 17th Ave Ne
Seattle , WA 98125
(425) 487-3245
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11039+17th+Ave+NE%2c+Seattle%2c+WA+98125)

Contract(s): 49
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2344)

Cogir Queen Anne
License#: 2473
Contact: Klotz, Ken
Region/Unit: 2J
805 4th Ave N
Seattle , WA 98109

Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=805+4th+Ave+N%2c+Seattle%2c+WA+98109)

Contract(s): 100
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2473)

Covenant Living West
License#: 958
Contact: Gillaspie, Debra
Region/Unit: 2J
9115 Fortuna Drive
Mercer Island , WA 98040
(206) 316-8042
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=9115+FORTUNA+DRIVE%2c+MERCER+ISLAND%2c+WA+98040)

Contract(s): 55
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=958)

CRISTWOOD RETIREMENT COMMUNITY
License#: 770
Contact: Kulisewa, Kondi
Region/Unit: 2J
19303 Fremont Ave N
Shoreline , WA 98133
(206) 546-7573
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=19303+Fremont+Ave+N%2c+Shoreline%2c+WA+98133)

Contract(s): 90
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=770)

CROWN HILL GROUP HOME
License#: 516
Contact: Massey, Richard
Region/Unit: 2J
9523 15th Ave Nw
Seattle , WA 98117
(206) 782-4293

Contract(s): 6
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=516)

Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=9523+15TH+AVE+NW%2c+SEATTLE%2c+WA+98117)

DAYSTAR AT WESTWOOD
License#: 924
Contact: Thomas, Eva M.
Region/Unit: 2J
2615 Sw Barton Street
Seattle , WA 98126
(206) 937-6122
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2615+SW+BARTON+STREET%2c+SEATTLE%2c+WA+98126)

Contract(s): 60
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=924)

ELDORADO WEST RETIREMENT COMMUNITY
License#: 2140
Contact: Gregory, Shameka
Region/Unit: 2D
1010 Sw 134th St
Burien , WA 98146
(206) 248-1975
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1010+SW+134th+St%2c+Burien%2c+WA+98146)

Contract(s): 80
Specialized Dementia Care, Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2140)

Emerald City Senior Living
License#: 2364
Contact: Jacobi, Vince
Region/Unit: 2J
9001 Lake City Way Ne
Seattle , WA 98115
(206) 729-1200
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=9001+LAKE+CITY+WAY+NE%2c+SEATTLE%2c+WA+98115)

Contract(s): 119
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2364)

EMERALD HEIGHTS
License#: 994
Contact: Zell, Ann
Region/Unit: 2D
10901 176th Circle Ne
Redmond , WA 98052
(425) 556-8100
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=10901+176TH+CIRCLE+NE%2c+REDMOND%2c+WA+98052)

Contract(s): 60
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=994)

EVERGREEN COURT
License#: 1502
Contact: Kleppe, Wendy
Region/Unit: 2D
900 124th Avenue Ne
Bellevue , WA 98005
(425) 455-4333
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=900+124TH+AVENUE+NE%2c+BELLEVUE%2c+WA+98005)

Contract(s): 45
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1502)

EXPRESSIONS AT ENUMCLAW
License#: 1603
Contact: Mccoy, Theresa (becky)
Region/Unit: 2D
2454 Cole Street

Contract(s): 52
No Contract

Can NOT

View Reports (BHForms.aspx?Lic=1603)

Enumclaw , WA 98022
(360) 825-4565
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2454+COLE+STREET%2c+ENUMCLAW%2c+WA+98022)

accept
Medicaid

FAIRWINDS BRITTANY PARK
License#: 1172
Contact: Harrison, Kate
Region/Unit: 2A
17143 133rd Ave Ne
Woodinville , WA 98072
(425) 402-7100
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17143+133RD+AVE+NE%2c+WOODINVILLE%2c+WA+98072)

Contract(s): 45
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1172)

FAIRWINDS REDMOND
License#: 1814
Contact: Harrison, Kate
Region/Unit: 2D
9988 Avondale Road Ne
Redmond , WA 98052
(425) 558-4700
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=9988+AVONDALE+ROAD+NE%2c+REDMOND%2c+WA+98052)

Contract(s): 50
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1814)

FAMILY TO FAMILY SENIOR CARE INC
License#: 2347
Contact: Paul, Manuela
Region/Unit: 2D
25633 Se 30th St
Sammamish , WA 98075
(425) 644-7321
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=25633+SE+30th+St%2c+Sammamish%2c+WA+98075)

Contract(s): 15
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2347)

FARRINGTON COURT RETIREMENT COMMUNITY
License#: 2145
Contact: Byrd, Marcia
Region/Unit: 2D
516 Kenosia Ave S
Kent , WA 98030
(253) 852-2737
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=516+Kenosia+Ave+S%2c+Kent%2c+WA+98030)

Contract(s): 70
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2145)

Fieldstone Memory Care Issaquah
License#: 2471
Contact: Lattimer, Sara
Region/Unit: 2D
23845 Se Issaquah Fall City Rd
Issaquah , WA 980297514
(425) 654-4005
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=23845+SE+Issaquah+Fall+City+Rd%2c+Issaquah%2c+WA+980297514)

Contract(s): 68
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2471)

FIRWOOD
License#: 1795
Contact: Buchanan, Shelby
Region/Unit: 2J
10751 2nd Ave Nw
Seattle , WA 98177
(206) 362-0560
Directions (http://maps.google.com/maps?

Contract(s): 20
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1795)

f=q&source=s_q&hl=en&geocode=&q=10751+2ND+AVE+NW%2c+SEATTLE%2c+WA+98177)

FLORENCE OF SEATTLE ARBOR HEIGHTS
License#: 2009
Contact: Yamashita, Laurie
Region/Unit: 2J
9850 California Ave Sw
Seattle , WA 98136
(206) 714-3324
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=9850+CALIFORNIA+AVE+SW%2c+SEATTLE%2c+WA+98136)

Contract(s): 12
Enhanced Adult Residential Care, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2009)

FLORENCE OF SEATTLE LLC
License#: 2011
Contact: Yamashita, Laurie
Region/Unit: 2J
8424 16th Ave Sw
Seattle , WA 98106
(206) 767-3137
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=8424+16TH+AVE+SW%2c+SEATTLE%2c+WA+98106)

Contract(s): 21
Enhanced Adult Residential Care, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2011)

FOSS HOME AND VILLAGE
License#: 1065
Contact: Mohrman, Nancy
Region/Unit: 2J
13023 Greenwood Ave N
Seattle , WA 98133
(206) 364-1300
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=13023+Greenwood+Ave+N%2c+Seattle%2c+WA+98133)

Contract(s): 60
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1065)

FOUNTAIN COURT ASSISTED LIVING
License#: 1568
Contact: Kemp, Katie
Region/Unit: 2D
24200 224th Avenue Se
Maple Valley , WA 98038
(425) 432-3352
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=24200+224TH+AVENUE+SE%2c+MAPLE+VALLEY%2c+WA+98038)

Contract(s): 65
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1568)

FRED LIND MANOR
License#: 864
Contact: Foltz, Dave
Region/Unit: 2J
1802 17th Ave
Seattle , WA 98122
(206) 324-1632
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1802+17TH+AVE%2c+SEATTLE%2c+WA+98122)

Contract(s): 90
Assisted Living SOW, Adult Residential Care

Not accepting new Medicaid clients

View Reports (BHForms.aspx?Lic=864)

Garden Terrace Healthcare Center of Federal Way
License#: 1631
Contact: Butner, Nancy R.
Region/Unit: 2D
491 S 338th Street
Federal Way , WA 98003
(253) 661-2226
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=491+S+338TH+STREET%2c+FEDERAL+WAY%2c+WA+98003)

Contract(s): 34
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1631)

Gencare Lifestyle Federal Way at Steel Lake
License#: 2484
Contact: Sam, Brianna
Region/Unit: 2D
31200 23rd Avenue South
Federal Way , WA 98003

Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=31200+23rd+Avenue+South%2c+Federal+Way%2c+WA+98003)

Contract(s): 60
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2484)

GOLDEN HEARTH RESIDENT
License#: 1559
Contact: Kenney, Priscilla E.
Region/Unit: 2A
15934 Ne 139th Place
Woodinville , WA 98072
(425) 298-0407
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15934+NE+139TH+PLACE%2c+WOODINVILLE%2c+WA+98072)

Contract(s): 8
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1559)

HEARTHSTONE
License#: 193
Contact: Velasco, Rosie
Region/Unit: 2J
6720 E Green Lake Way N
Seattle , WA 98103
(206) 525-9666
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=6720+E+Green+Lake+Way+N%2c+Seattle%2c+WA+98103)

Contract(s): 62
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=193)

HERITAGE HOUSE AT THE MARKET
License#: 919
Contact: Herrmann, Jennifer
Region/Unit: 2J
1533 Western Avenue
Seattle , WA 98101
(206) 382-4119
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1533+WESTERN+AVENUE%2c+SEATTLE%2c+WA+98101)

Contract(s): 64
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=919)

High Point Village
License#: 2432
Contact: Howells, Angie
Region/Unit: 2D
1777 Highpoint St
Enumclaw , WA 98022
(360) 825-7780
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1777+Highpoint+St%2c+Enumclaw%2c+WA+98022)

Contract(s): 70
Specialized Dementia Care, Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2432)

HIGH WEST RESIDENCE
License#: 978
Contact: Liechty, Larry
Region/Unit: 2J
15035 8th Ave S
Burien , WA 98148
(206) 241-3119
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15035+8th+Ave+S%2c+Burien%2c+WA+98148)

Contract(s): 16
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=978)

HILLTOP MANOR BOARDING HOME
License#: 1278
Contact: Wager, Amanda
Region/Unit: 2J

Contract(s): 35
Adult Residential Care

View Reports (BHForms.aspx?Lic=1278)

1732 16th Ave
Seattle , WA 98122
(206) 329-5775
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1732+16TH+AVE%2c+SEATTLE%2c+WA+98122)

Can accept Medicaid

Holden at Southcenter
License#: 2584
Contact: Fowler, Shane
Region/Unit: 2D
112 Andover Park East
Tukwila , WA 98188
(253) 880-6674
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=112+Andover+Park+East%2c+Tukwila%2c+WA+98188)

Contract(s): 141
No Contract

Can NOT accept Medicaid

No Reports

HORIZON HOUSE
License#: 212
Contact: Warfield-larson, Lauri D.
Region/Unit: 2J
900 University St
Seattle , WA 98101
(206) 624-3700
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=900++UNIVERSITY+ST%2c+SEATTLE%2c+WA+98101)

Contract(s): 90
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=212)

IDA CULVER HOUSE BROADVIEW
License#: 945
Contact: Nordby, Karen
Region/Unit: 2J
12505 Greenwood Ave N
Seattle , WA 98133
(206) 361-1989
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=12505+GREENWOOD+AVE+N%2c+SEATTLE%2c+WA+98133)

Contract(s): 120
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=945)

Ida Culver House Ravenna
License#: 858
Contact: Gerhard, Sarah
Region/Unit: 2J
2315 Ne 65th St
Seattle , WA 98115
(206) 523-7315
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2315+NE+65th+St%2c+Seattle%2c+WA+98115)

Contract(s): 38
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=858)

ISLAND HOUSE
License#: 2375
Contact: Ondracek, Katrina
Region/Unit: 2J
7810 Se 30th St
Mercer Island , WA 98040
(206) 236-0502
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7810+SE+30th+St%2c+Mercer+Island%2c+WA+98040)

Contract(s): 40
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2375)

Jefferson House Memory Care Community
License#: 2548
Contact: Green, Chehara R.
Region/Unit: 2D
12217 Ne 128th Street
Kirkland , WA 98034
(425) 202-7254
Directions (http://maps.google.com/maps?

Contract(s): 80
Enhanced Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2548)

f=q&source=s_q&hl=en&geocode=&q=12217+NE+128th+Street%2c+Kirkland%2c+WA+98034)

JUDSON PARK RETIREMENT COMMUNITY
License#: 681
Contact: Boyar, Jonathan
Region/Unit: 2D
23600 Marine View Dr S
Des Moines , WA 98198
(206) 824-4000
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=23600+MARINE+VIEW+DR+S%2c+DES+MOINES%2c+WA+98198)

Contract(s): 52
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=681)

Kenmore Senior Living
License#: 2566
Contact: Hineline, Ashley
Region/Unit: 2J
7221 Ne 182nd St
Kenmore , WA 98028
(425) 481-4200
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7221+NE+182nd+St%2c+Kenmore%2c+WA+98028)

Contract(s): 100
Specialized Dementia Care, Enhanced Adult Residential Care, Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2566)

Keystone
License#: 2599
Contact: Parks, Deborah
Region/Unit: 2J
3515 Woodland Park Ave N
Seattle , WA 98103
(206) 461-6990
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=3515+Woodland+Park+Ave+N%2c+Seattle%2c+WA+98103)

Contract(s): 64
No Contract

Can NOT accept Medicaid

No Reports

Kin On Assisted Living
License#: 2519
Contact: Myers, Teresa
Region/Unit: 2J
5214 42nd Ave S
Seattle , WA 98118
(206) 721-0954
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=5214+42nd+Ave+S%2c+Seattle+%2c+WA+98118)

Contract(s): 25
Enhanced Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2519)

LAKESHORE
License#: 1052
Contact: Pelland, Lindsey
Region/Unit: 2J
11448 Rainier Ave S
Seattle , WA 98178
(206) 772-1200
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11448+RAINIER+AVE+S%2c+SEATTLE%2c+WA+98178)

Contract(s): 50
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1052)

Lakeview of Kirkland, Assisted Living
License#: 2482
Contact: Wallen, Olivia
Region/Unit: 2D
6505 Lakeview Dr Ne
Kirkland , WA 98033
(425) 803-6911
Directions (http://maps.google.com/maps?

Contract(s): 85
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2482)

f=q&source=s_q&hl=en&geocode=&q=6505+Lakeview+Dr+NE%2c+Kirkland%2c+WA+98033)

Laurel Cove Community
License#: 2389
Contact: Walker, Mykael
Region/Unit: 2J
17201 15th Ave Ne
Shoreline , WA 98155
(206) 364-9336
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17201+15th+Ave+NE%2c+Shoreline%2c+WA+98155)

Contract(s): 98
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2389)

Legacy House
License#: 2493
Contact: Huang, Min
Region/Unit: 2J
803 South Lane Street
Seattle , WA 98104
(206) 292-5187
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=803+South+Lane+Street%2c+SEATTLE%2c+WA+98104)

Contract(s): 68
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2493)

Lincoln Park Group Home
License#: 2437
Contact: Massey, Richard
Region/Unit: 2J
6935 Fauntleroy Way Sw
Seattle , WA 98136
(206) 829-2011
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=6935+Fauntleroy+Way+SW%2c+Seattle%2c+WA+98136)

Contract(s): 8
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2437)

LIVING COURT ASSISTED LIVING COMMUNITY
License#: 2153
Contact: Wood, Inta
Region/Unit: 2D
2229 Jensen St
Enumclaw , WA 98022
(360) 825-0280
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2229+JENSEN+ST%2c+ENUMCLAW%2c+WA+98022)

Contract(s): 65
Assisted Living SOW, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2153)

Longhouse Bothell
License#: 2547
Contact: Orr, Amy
Region/Unit: 2J
16605 122nd Place Ne
Bothell , WA 98011
(206) 453-6748
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=16605+122nd+Place+NE%2c+Bothell%2c+WA+98011)

Contract(s): 15
No Contract

Can NOT accept Medicaid

No Reports

Madison House
License#: 2436
Contact: Wiley, Smitty
Region/Unit: 2D
12215 Ne 128th St
Kirkland , WA 98034
(425) 821-8210
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=12215+NE+128th+St%2c+Kirkland%2c+WA+98034)

Contract(s): 84
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2436)

Merrill Gardens at Auburn

Contract(s): 65

View Reports

License#: 2506
Contact: Baharmast, Reza
Region/Unit: 2D
18 1st St Se
Auburn , WA 98002
(253) 258-3263
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=18+1st+St+SE%2c+Auburn%2c+WA+98002)

No Contract

Can NOT accept Medicaid

(BHForms.aspx?Lic=2506)

Merrill Gardens at Ballard
License#: 2507
Contact: Palm, Lisa
Region/Unit: 2J
2418 Nw 56th St
Seattle , WA 98107
(206) 838-8555
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2418+NW+56th+St%2c+Seattle%2c+WA+98107)

Contract(s): 50
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2507)

Merrill Gardens at Burien
License#: 2406
Contact: Reiter, Kyle
Region/Unit: 2D
15020 5th Ave Sw
Burien , WA 98166
(206) 539-4995
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15020+5th+Ave+SW%2c+Burien%2c+WA+98166)

Contract(s): 55
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2406)

Merrill Gardens at Kirkland
License#: 2587
Contact: Shackleton, Sarah
Region/Unit: 2D
14 Main St S
Kirkland , WA 98033
(425) 828-2570
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=14+Main+St+S%2c+Kirkland%2c+WA+98033)

Contract(s): 40
No Contract

Can NOT accept Medicaid

No Reports

Merrill Gardens at Renton Centre
License#: 2598
Contact: Thompson, Shelley M.
Region/Unit: 2D
104 Burnett Ave S
Renton , WA 98057
(425) 235-6400
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=104+Burnett+Ave+S%2c+Renton%2c+WA+98057)

Contract(s): 110
No Contract

Can NOT accept Medicaid

No Reports

Merrill Gardens at The University
License#: 2588
Contact: Schaedig, Michael
Region/Unit: 2J
5300 24th Ave Ne
Seattle , WA 98105
(206) 523-8400
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=5300+24th+Ave+NE%2c+Seattle%2c+WA+98105)

Contract(s): 45
No Contract

Can NOT accept Medicaid

No Reports

MIRABELLA
License#: 2034
Contact: Castillo, Kenneth
Region/Unit: 2J
116 Fairview Avenue North

Contract(s): 63
No Contract

Can NOT

View Reports (BHForms.aspx?Lic=2034)

Seattle , WA 98109 (206) 254-1447 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=116+FAIRVIEW+AVENUE+NORTH%2c+SEATTLE%2c+WA+98109+++++)		*accept Medicaid*	
Mirror Lake Village License#: 2564 **Contact:** Flores, Shannon Region/Unit: 2D 31000 9th Pl Sw Federal Way , WA 98023 (206) 212-4208 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=31000+9th+Pl+SW%2c+Federal+Way%2c+WA+98023)	**Contract(s):** 120 No Contract *Can NOT accept Medicaid*		No Reports
Murano Senior Living License#: 2521 **Contact:** Pickarz, Eric Region/Unit: 2J 620 Terry Ave Seattle , WA 98104 (206) 202-4620 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=620+Terry+Ave%2c+Seattle%2c+WA+98104)	**Contract(s):** 117 No Contract *Can NOT accept Medicaid*		No Reports
NIKKEI MANOR License#: 1186 **Contact:** Mclaughlin, Theresa Region/Unit: 2J 700 6th Ave S Seattle , WA 98104 (206) 726-6460 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=700+6TH+AVE+S%2c+SEATTLE%2c+WA+98104)	**Contract(s):** 56 Assisted Living SOW *Can accept Medicaid*		View Reports (BHForms.aspx?Lic=1186)
NORMANDY PARK ASSISTED LIVING License#: 1688 **Contact:** Dickerson, Antonette Region/Unit: 2D 16625 1st Ave S Burien , WA 98148 (206) 241-0821 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=16625+1st+Ave+S%2c+Burien%2c+WA+98148)	**Contract(s):** 120 Assisted Living SOW *Can accept Medicaid*		View Reports (BHForms.aspx?Lic=1688)
NORSE HOME License#: 145 **Contact:** Martin, Mike Region/Unit: 2J 5311 Phinney Ave N Seattle , WA 98103 (206) 781-7400 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=5311+PHINNEY+AVE+N%2c+SEATTLE%2c+WA+98103)	**Contract(s):** 86 Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care *Can accept Medicaid*		View Reports (BHForms.aspx?Lic=145)
NORTHAVEN II ASSISTED LIVING License#: 980 **Contact:** Storti, Darlene S. Region/Unit: 2J 531 Ne 112th St Seattle , WA 98125	**Contract(s):** 40 Assisted Living SOW *Can accept Medicaid*		View Reports (BHForms.aspx?Lic=980)

(206) 362-8077
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=531+NE+112TH+ST%2c+SEATTLE%2c+WA+98125)

NORTHGATE PLAZA
License#: 2374
Contact: Levingston, Angela
Region/Unit: 2J
11030 Ne 5th Ave
Seattle , WA 98125
(206) 363-6740
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11030+NE+5TH+AVE%2c+SEATTLE%2c+WA+98125)

Contract(s): 80
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2374)

Olympic View Assisted Living
License#: 2130
Contact: Snider, Leanna
Region/Unit: 2D
21202 International Blvd
Seatac , WA 98198
(206) 878-0900
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=21202+INTERNATIONAL+BLVD%2c+SEATAC%2c+WA+98198)

Contract(s): 60
Expanded Community Services, Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2130)

Overlake Terrace
License#: 2551
Contact: Huskinson, Joseph
Region/Unit: 2D
2956 152nd Ave Ne
Redmond , WA 98052
(425) 883-0495
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2956+152nd+Ave+NE%2c+Redmond%2c+WA+98052)

Contract(s): 150
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2551)

PARK PLACE
License#: 1532
Contact: Wahlgren, Fred
Region/Unit: 2J
6900 37th Avenue South
Seattle , WA 98118
(206) 722-7275
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=6900+37TH+AVENUE+SOUTH%2c+SEATTLE%2c+WA+98118)

Contract(s): 156
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1532)

PARK SHORE
License#: 183
Contact: Moore, Roger E.
Region/Unit: 2J
1630 43rd Ave E
Seattle , WA 98112
(206) 329-0770
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1630+43RD+AVE+E%2c+SEATTLE%2c+WA+98112)

Contract(s): 36
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=183)

Parkside Retirement Community
License#: 2550
Contact: Wester, Zachary
Region/Unit: 2D

Contract(s): 94
Expanded Community Services,

View Reports (BHForms.aspx?Lic=2550)

2902 I St Ne Auburn , WA 98002 (253) 939-1332 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2902+I+St+NE%2c+Auburn%2c+WA+98002)		Enhanced Adult Residential Care, Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care *Can accept Medicaid*	
PARKVIEW GROUP HOME License#: 1117 **Contact:** Cote, Marc G. Region/Unit: 2J 1114 15th Ave E Seattle , WA 98112 (206) 324-4113 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1114+15TH+AVE+E%2c+SEATTLE%2c+WA+98112)	**Contract(s):** 6 No Contract *Can NOT accept Medicaid*		View Reports (BHForms.aspx?Lic=1117)
PATRIOTS GLEN License#: 2121 **Contact:** Drew, Jordan Region/Unit: 2D 1640 148th Ave Se Bellevue , WA 98007 (425) 373-1161 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1640+148TH+AVE+SE%2c+BELLEVUE%2c+WA+98007)	**Contract(s):** 82 No Contract *Can NOT accept Medicaid*		View Reports (BHForms.aspx?Lic=2121)
PETERS CREEK RETIREMENT COMMUNITY License#: 2245 **Contact:** Hendricks, Brandie Region/Unit: 2D 14431 Redmond Way Redmond , WA 98052 (425) 869-2273 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=14431+REDMOND+WAY%2c+REDMOND%2c+WA+98052)	**Contract(s):** 70 Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care *Not accepting new Medicaid clients*		View Reports (BHForms.aspx?Lic=2245)
Prestige Senior Living Auburn Meadows License#: 2239 **Contact:** Muenzhuber, Tonee Region/Unit: 2D 945 22nd St Ne Auburn , WA 98002 (253) 333-0171 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=945+22nd+St+NE%2c+Auburn%2c+WA+98002)	**Contract(s):** 110 Assisted Living SOW *Can accept Medicaid*		View Reports (BHForms.aspx?Lic=2239)
Provail License#: 2401 **Contact:** Grabinski, Amal	**Contract(s):** 12 Expanded Community		View Reports (BHForms.aspx?Lic=2401)

Region/Unit: 2J 1548 Ne 175th St Shoreline , WA 98155 (206) 420-8838 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1548+NE+175th+St%2c+Shoreline+%2c+WA+98155)	Services, Enhanced Adult Residential Care, Enhanced Adult Residential Care *Can accept Medicaid*		
Providence Mount St. Vincent License#: 198 **Contact:** Byod, Charlene K. Region/Unit: 2J 4831 35th Ave Sw Seattle , WA 98126 (206) 937-3700 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4831+35th+Ave+SW%2c+Seattle%2c+WA+98126)	**Contract(s):** Assisted Living SOW, Adult Residential Care *Can accept Medicaid*	122	View Reports (BHForms.aspx?Lic=198)
Quail Park Memory Care Residences of West Seattle License#: 2458 **Contact:** Anderson, Brian T. Region/Unit: 2J 4515 41st Ave Sw Seattle , WA 98116 (206) 633-2273 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4515+41st+Ave+SW%2c+Seattle%2c+WA+98116)	**Contract(s):** No Contract *Can NOT accept Medicaid*	70	View Reports (BHForms.aspx?Lic=2458)
Queen Anne Manor License#: 2367 **Contact:** Mcfadden, Kristine Region/Unit: 2J 100 Crockett St Seattle , WA 98109 (206) 282-5001 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=100+Crockett+St%2c+Seattle%2c+WA+98109)	**Contract(s):** Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care *Can accept Medicaid*	103	View Reports (BHForms.aspx?Lic=2367)
RED OAK RESIDENCE OF NORTH BEND License#: 1158 **Contact:** Jarboe, Amy Region/Unit: 2D 650 E North Bend Way North Bend , WA 98045 (425) 888-7108 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=650+E+NORTH+BEND+WAY%2c+NORTH+BEND%2c+WA+98045)	**Contract(s):** No Contract *Can NOT accept Medicaid*	38	View Reports (BHForms.aspx?Lic=1158)
Redmond Heights Senior Living License#: 2522 **Contact:** Tuchman, Elizabeth Region/Unit: 2D 7950 Willows Rd Ne Redmond , WA 98052 (425) 885-4157 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7950+Willows+Rd+NE%2c+Redmond%2c+WA+98052)	**Contract(s):** No Contract *Can NOT accept Medicaid*	85	View Reports (BHForms.aspx?Lic=2522)

REGENCY NEWCASTLE License#: 2018 **Contact:** Ashton, Justin Region/Unit: 2D 7454 Newcastle Golf Club Road Newcastle , WA 98059 (425) 453-1508 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7454+NEWCASTLE+GOLF+CLUB+ROAD%2c+NEWCASTLE%2c+WA+98059+++++)	**Contract(s):** 85 Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2018)
RIVERSIDE EAST License#: 1413 **Contact:** Frankie, Elizabeth Region/Unit: 2J 10315 East Riverside Dr Bothell , WA 98011 (425) 481-1976 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=10315+EAST+RIVERSIDE+DR%2c+BOTHELL%2c+WA+98011)	**Contract(s):** 44 Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=1413)
Ruthaven ALF LLC License#: 2539 **Contact:** Jawara, Abdoulie Region/Unit: 2D 15843 Se 256th St Covington , WA 98042 (253) 631-5600 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15843+SE+256TH+ST%2c+COVINGTON%2c+WA+98042)	**Contract(s):** 14 Enhanced Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2539)
Sagebrook Senior Living at Bellevue License#: 2467 **Contact:** Carlos, Cash Region/Unit: 2D 15750 Ne 15th St Bellevue , WA 98008 (425) 641-4900 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15750+NE+15TH+ST%2c+BELLEVUE%2c+WA+98008)	**Contract(s):** 108 Assisted Living SOW, Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2467)
Silverado - Bellevue License#: 2573 **Contact:** Keith, Rebecca Region/Unit: 2D 14428 Ne 8th St Bellevue , WA 98007 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=14428+NE+8th+St%2c+Bellevue%2c+WA+98007)	**Contract(s):** 56 No Contract *Can NOT accept Medicaid*	No Reports
SPIRITWOOD AT PINE LAKE License#: 2137 **Contact:** Fahnestock, Taylor Region/Unit: 2D 3607 228th Ave Se Issaquah , WA 98029 (425) 313-9100 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=3607+228TH+AVE+SE%2c+ISSAQUAH%2c+WA+98029)	**Contract(s):** 80 Specialized Dementia Care, Enhanced Adult Residential Care, Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2137)
SPRING MANOR	**Contract(s):** 57	View Reports

License#: 1150
Contact: Ross, Amanda
Region/Unit: 2J
1103 16th Ave
Seattle , WA 98122
(206) 324-9021
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1103+16TH+AVE%2c+SEATTLE%2c+WA+98122)

No Contract

Can NOT accept Medicaid

(BHForms.aspx?Lic=1150)

STAFFORD SUITES
License#: 1157
Contact: Burgess, Marni
Region/Unit: 2D
112 Kennebeck Ave N
Kent , WA 98030
(253) 850-0333
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=112+KENNEBECK+AVE+N%2c+KENT%2c+WA+98030)

Contract(s): 75
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1157)

STILLWATER HOUSE
License#: 1519
Contact: Parks, Deborah
Region/Unit: 2D
8705 166th Ave Ne
Redmond , WA 98052
(425) 653-5080
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=8705+166th+Ave+NE%2c+Redmond%2c+WA+98052)

Contract(s): 16
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1519)

SUNRISE OF BELLEVUE
License#: 2163
Contact: Clark, Molly
Region/Unit: 2D
15928 Ne 8th St
Bellevue , WA 98008
(425) 401-5152
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15928+NE+8TH+ST%2c+BELLEVUE%2c+WA+98008)

Contract(s): 90
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2163)

Sunrise of Issaquah
License#: 2543
Contact: Fischer, Phyllis
Region/Unit: 2D
23599 Se Issaquah Fall City Rd
Issaquah , WA 98029
(425) 945-0006
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=23599+SE+Issaquah+Fall+City+Rd%2c+Issaquah%2c+WA+98029)

Contract(s): 107
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2543)

SUNRISE OF MERCER ISLAND
License#: 2164
Contact: Macdonald, Kim
Region/Unit: 2D
2959 76th Avenue Se
Mercer Island , WA 98040
(206) 232-6565
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2959+76TH+AVENUE+SE%2c+MERCER+ISLAND%2c+WA+98040)

Contract(s): 64
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2164)

Sunrise of Redmond
License#: 2464
Contact: Fenner, William R.
Region/Unit: 2D
15241 Ne 20th St

Contract(s): 10
No Contract

Can NOT

View Reports (BHForms.aspx?Lic=2464)

Bellevue , WA 98007 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15241+NE+20TH+ST%2c+BELLEVUE%2c+WA+98007)	*accept Medicaid*	
TERRY HOME License#: 1089 **Contact:** Norman, Joanne Region/Unit: 2D 138 3rd Ave Sw Pacific , WA 98047 (253) 288-0135 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=138+3RD+AVE+SW%2c+PACIFIC%2c+WA+98047)	**Contract(s):** 10 Expanded Community Services, Enhanced Adult Residential Care, Enhanced Adult Residential Care, Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=1089)
TERRY HOME AUBURN License#: 2205 **Contact:** Norman, Joanne Region/Unit: 2D 727 A Street Ne Auburn , WA 98002 (253) 737-4546 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=727+A+STREET+NE%2c+AUBURN%2c+WA+98002)	**Contract(s):** 16 Expanded Community Services, Enhanced Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2205)
The Bellettini License#: 2457 **Contact:** Bates, Frances Region/Unit: 2D 1115 108th Ave Ne Bellevue , WA 98004 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1115+108th+Ave+NE%2c+Bellevue%2c+WA+98004+++++)	**Contract(s):** 50 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=2457)
THE CANNON HOUSE License#: 2056 **Contact:** Weber, Vivian Region/Unit: 2J 113 23rd Avenue South Seattle , WA 98144 (206) 709-1777 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=113+23rd+AVENUE+SOUTH%2c+SEATTLE%2c+WA+98144)	**Contract(s):** 91 Assisted Living SOW *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=2056)
The Cottages of Covington License#: 2594 **Contact:** Jeppesen, Greg Region/Unit: 2D 17012 Se Wax Road Covington , WA 98042 (206) 232-9680 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17012+SE+Wax+Road%2c+Covington%2c+WA+98042)	**Contract(s):** 30 Specialized Dementia Care, Enhanced Adult Residential Care *Can accept Medicaid*	No Reports

The Cottages of Renton
License#: 2496
Contact: Liechty, Larry
Region/Unit: 2D
17033 108th Ave Se
Renton , WA 98055
(425) 528-7070
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17033+108th+Ave+SE%2c+Renton%2c+WA+98055)

Contract(s): 60
Specialized Dementia Care, Enhanced Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=2496)

THE GARDENS AT JUANITA BAY
License#: 456
Contact: Dinovi, Annika
Region/Unit: 2J
11853 97th Ave Ne
Kirkland , WA 98034
(425) 823-0410
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=11853+97th+Ave+NE%2c+Kirkland%2c+WA+98034)

Contract(s): 48
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=456)

THE GARDENS AT TOWN SQUARE
License#: 1604
Contact: Tolstoy, April
Region/Unit: 2D
933 111th Ave Ne
Bellevue , WA 98004
(425) 688-1900
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=933+111TH+AVE+NE%2c+BELLEVUE%2c+WA+98004)

Contract(s): 80
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1604)

THE INN AT ARBOR VILLAGE
License#: 1994
Contact: Frere, Christopher
Region/Unit: 2D
24205 116th Ave Se
Kent , WA 98030
(253) 893-0340
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=24205+116TH+AVE+SE%2c+KENT%2c+WA+98030)

Contract(s): 14
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1994)

THE KENNEY
License#: 128
Contact: Davis, Cynthia
Region/Unit: 2J
7125 Fauntleroy Way Sw
Seattle , WA 98136
(206) 937-2800
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=7125+Fauntleroy+Way+SW%2c+Seattle%2c+WA+98136)

Contract(s): 98
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=128)

THE LODGE AT ARBOR VILLAGE
License#: 2037
Contact: Frere, Christopher
Region/Unit: 2D
24004 114th Place Se
Kent , WA 98030
(253) 856-1600
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=24004+114TH+PLACE+SE%2c+KENT%2c+WA+98030+++++)

Contract(s): 60
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2037)

THE LODGE AT EAGLE RIDGE
License#: 1798
Contact: Wammock, Justin

Contract(s): 75
No Contract

View Reports (BHForms.aspx?Lic=1798)

Region/Unit: 2D
1600 S Eagle Ridge Dr S
Renton , WA 98055
(425) 793-8080
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1600+S+EAGLE+RIDGE+Dr+S%2c+Renton%2c+WA+98055)

Can NOT accept Medicaid

The Meridian at Stone Creek
License#: 2365
Contact: Schafer, Cindy
Region/Unit: 3D
1111 S 376th St
Milton , WA 98354
(253) 661-3651
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1111+S+376th+St%2c+Milton%2c+WA+98354)

Contract(s): 188
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2365)

THE SUMMIT AT FIRST HILL
License#: 1435
Contact: Powandra, Matthew
Region/Unit: 2J
1200 University St Suite 100
Seattle , WA 98101
(206) 652-4444
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1200+UNIVERSITY+ST+SUITE+100%2c+SEATTLE%2c+WA+98101)

Contract(s): 60
Enhanced Adult Residential Care, Assisted Living SOW, Adult Residential Care

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1435)

THE TERRACES AT SKYLINE
License#: 2054
Contact: Foltz, Carol
Region/Unit: 2J
715 9th Ave
Seattle , WA 98104
(206) 682-3200
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=715+9TH+AVE%2c+SEATTLE%2c+WA+98104+++++)

Contract(s): 86
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2054)

TRANSITIONAL RESOURCES
License#: 523
Contact: Slovek-walker, Darcell A.
Region/Unit: 2J
2970 Sw Avalon Way
Seattle , WA 98126
(206) 883-2050
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=2970+SW+AVALON+WAY%2c+SEATTLE%2c+WA+98126)

Contract(s): 16
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=523)

Truewood by Merrill, First Hill
License#: 2420
Contact: Reiter, Kyle
Region/Unit: 2J
1421 Minor Ave
Seattle , WA 98101
(206) 624-7637
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=1421+MINOR+AVE%2c+SEATTLE%2c+WA+98101)

Contract(s): 75
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2420)

UNIVERSITY HOUSE AT ISSAQUAH
License#: 1565
Contact: Vahlkamp, Susan
Region/Unit: 2D

Contract(s): 55
No Contract

Can NOT

View Reports (BHForms.aspx?Lic=1565)

22975 Se Black Nugget Road
Issaquah , WA 98029
(425) 557-4200
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=22975+SE+BLACK+NUGGET+ROAD%2c+ISSAQUAH%2c+WA+98029)

accept Medicaid

UNIVERSITY HOUSE AT WALLINGFORD
License#: 1170
Contact: Montelaro, Deborah
Region/Unit: 2J
4400 Stone Way N
Seattle , WA 98103
(206) 545-8400
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=4400+STONE+WAY+N%2c+SEATTLE%2c+WA+98103)

Contract(s): 25
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1170)

VASHON COMMUNITY CARE CENTER
License#: 1561
Contact: Kleppe, Wendy
Region/Unit: 2D
15333 Vashon Hwy Sw
Vashon , WA 98070
(206) 567-4421
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15333+VASHON+HWY+SW%2c+VASHON%2c+WA+98070)

Contract(s): 61
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1561)

Village Concepts of Fairwood
License#: 2554
Contact: Krill, Lynda M.
Region/Unit: 2D
17010 140th Ave Se
Renton , WA 98058
(888) 548-6609
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=17010+140th+Ave+SE%2c+Renton%2c+WA+98058)

Contract(s): 70
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=2554)

VILLAGE GREEN RETIREMENT CAMPUS
License#: 1159
Contact: Salas, Kim
Region/Unit: 2D
35419 1st Ave S
Federal Way , WA 98003
(253) 838-3700
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=35419+1ST+AVE+S%2c+FEDERAL+WAY%2c+WA+98003)

Contract(s): 65
No Contract

Can NOT accept Medicaid

View Reports (BHForms.aspx?Lic=1159)

VINEYARD PARK AT BOTHELL LANDING
License#: 1734
Contact: Bah, Gavina
Region/Unit: 2J
10519 East Riverside Drive
Bothell , WA 98011
(425) 485-8900
Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=10519+EAST+RIVERSIDE+DRIVE%2c+BOTHELL%2c+WA+98011)

Contract(s): 75
Assisted Living SOW

Can accept Medicaid

View Reports (BHForms.aspx?Lic=1734)

Vineyard Park of Covington
License#: 2593
Contact: Jeppesen, Greg
Region/Unit: 2D
17016 Se Wax Rd
Covington , WA 98042
(206) 232-9680
Directions (http://maps.google.com/maps?

Contract(s): 30
Enhanced Adult Residential Care

Can accept Medicaid

No Reports

f=q&source=s_q&hl=en&geocode=&q=17016+SE+Wax+Rd%2c+Covington%2c+WA+98042)

WEATHERLY INN AT LAKE MERIDIAN, THE License#: 1356 **Contact:** See-tower, Sherry Region/Unit: 2D 15101 Se 272nd St Kent , WA 98042 (253) 630-7496 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=15101+SE+272ND+ST%2c+KENT%2c+WA+98042)	**Contract(s):** 69 Specialized Dementia Care, Enhanced Adult Residential Care *Can accept Medicaid*	View Reports (BHForms.aspx?Lic=1356)
WESLEY HOMES DES MOINES ASSISTED LIVING License#: 1824 **Contact:** Meinecke, Lisa L. Region/Unit: 2D 816 S 216th St Des Moines , WA 981980000 (206) 870-8743 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=816+S+216TH+ST%2c+DES+MOINES%2c+WA+981980000)	**Contract(s):** 43 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=1824)
Wesley Homes Lea Hill LLC License#: 1964 **Contact:** Byrge, James G. Region/Unit: 2D 32049 109th Place Se Auburn , WA 98092 (253) 804-5644 Directions (http://maps.google.com/maps?f=q&source=s_q&hl=en&geocode=&q=32049+109th+Place+SE%2c+Auburn%2c+WA+98092+++++)	**Contract(s):** 20 No Contract *Can NOT accept Medicaid*	View Reports (BHForms.aspx?Lic=1964)