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SHALOM
HOSPICE & PALLIATIVE CARE

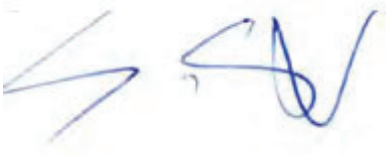
Shalom Hospice of Southwest Washington LLC
Certificate of Need Application
to
Establish a Medicare Medicare/Medicaid Hospice Agency in Clark County

December 2024

Certificate of Need Application
Hospice Agency

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

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

Signature and Title of Responsible Officer:  Samuel Stern Managing Member/Chief Executive Officer Email Address: sstern@affinityhealthmanagement.com	**Date:** December 28, 2024 **Telephone Number:** 510.499.9977
Legal Name of Applicant: Shalom Hospice of Southwest Washington, LLC **Address of Applicant:** 1000 SE Everett Mall Way Suite 402 Everett, WA 98208	**Provide a brief project description:** ☒ New Agency ☐ Expansion of Existing Agency ☐ Other: _____ **Estimated capital expenditure:** $118,000
Identify the county proposed to be served for this project: Clark County.	

Section 1
APPLICANT DESCRIPTION

1. **Provide the legal name(s) and address(es)of the applicant(s).**
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

The legal name of the applicant is Shalom Hospice of Southwest Washington LLC (Shalom). Shalom is registered with the Washington Secretary of State.

SYGS Management LLC (SYGS) is the sole owner of Shalom. SYGS is owned 95% by the SYGS 2023 Trust and 5% by Samuel Stern.

The address of Shalom is:

Mailing:
1000 SE Everett Mall Way
Suite 402
Everett, WA 98208

Physical:
Park Tower 4
222 NE Park Plaza Drive
Vancouver, WA 98684

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

Shalom is a Washington State limited liability company organized under chapter 25.15 RCW. Shalom's UBI number is 605-622-972.

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

Questions regarding this application should be sent to:

Samuel Stern
Managing Member/Chief Executive Officer
510.499.9977
sstern@affinityhealthmanagement.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).**

Jody Carona
Health Facilities Planning & Development
206-441-0971
Healthfac@healthfacilitiesplanning.com

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

An organizational chart will be provided with the screening response.

6. **Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:**
   - **Facility and Agency Name(s)**
   - **Facility and Agency Location(s)**
   - **Facility and Agency License Number(s)**
   - **Facility and Agency CMS Certification Number(s)**
   - **Facility and Agency Accreditation Status**

Shalom Hospice of Southwest Washington LLC is one of a number of hospice agencies owned by SYGS, Samuel Stern, and/or the Stern Family Trusts. These agencies are operated under the name of Continuum Care, Affinity Care, or Shalom Hospice.

A listing of agencies is included in Exhibit 1.

Section 2
PROJECT DESCRIPTION

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

This question is not applicable because there is no existing 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 question is not applicable.

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.**

Shalom Hospice of Southwest Washington LLC

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4. Provide a detailed description of the proposed project.

Shalom is requesting approval under the provisions of WAC 246-310-290 (12), which states:

> *The department may grant a certificate of need for a new hospice agency in a planning area where there is not numeric need.*
> *(a) The department will consider if the applicant meets the following criteria:*
> *(i) All applicable review criteria and standards with the exception of numeric need have been met;*
> *(ii) The applicant commits to serving Medicare and Medicaid patients; and*
> *(iii) A specific population is underserved; or*
> *(iv) 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.*

In the case of this application, all other review criteria, and standards, with the exception of numeric need are met, and Shalom commits to serving any Medicare and Medicaid patient that seeks or chooses our care.

This application outlines the extent of the underserved Jewish community in the Planning Area, and letters of support will provide more detail. Shalom will place an emphasis on serving terminally ill individuals of the Jewish faith in a manner that recognizes and honors Jewish heritage, history, rituals, and traditions. Shalom literally means "may you be full of well-being." It is used in Judaism as a blessing for coming and going, at any time, in any situation.

While Medicare does not collect data on use of hospice by religion, we know both nationally and in Washington, and in the adjacent Portland metro area, that few agencies have practices or staff that are trained in or aware of Jewish rituals and traditions. Few offer strong rabbinic support. Because no existing Clark or Portland metro agencies provide support that honors the faith, persons of the Jewish faith are too often electing to forego hospice.

The Washington State Department of Health's annual survey of hospice agencies shows a downward trend in both use rates and average length of stay statewide in the past few years. While Clark County residents' use of hospice is higher than the state, it is still down by 10% in the past two years. The Washington State and Clark County trends are contrary to national trends. Shalom will engage the community and providers to increase appropriate and timely use of hospice and assure that all that can benefit from hospice are provided the opportunity to timely enroll.

As discussed with the Program during our November 20, 2024, TA, we are also simultaneously submitting to the Oregon Health Authority (OHA) to be licensed in Oregon, to be able to serve the Portland metro area (Multnomah, Washington and Clackamas). Oregon does not require a CN to begin operations.

While we are well aware that the CN Program will not evaluate need in the Portland metro area. A study commissioned by the Jewish Federation of Greater Portland (which includes Clark County) entitled *2022-2023 Greater Portland Jewish Community Study* identified more than 75,500 people living in Jewish households in Greater Portland and Southwest Washington. While access to hospice care was not part of the 2022 Community Study, our engagement with Rabbis, Chabads, and local Jewish organizations confirms the lack of hospice options for persons and families seeking Jewish rituals and practices at end of life.

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

Shalom will be available and accessible to individuals regardless of where they reside in Clark County, and while not part of this CN process, Shalom is also in process of becoming licensed to serve the Portland metro area. The Portland metro area will be served through our agency located in Clark County. There are no prior CN review requirements in Oregon.

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:

Shalom's estimated timeline for project implementation is as follows:

Event	**Anticipated Month/Year**
CN Approval	August 2025
Design Complete (if applicable)	NA
Construction Commenced	NA
Construction Completed (if applicable)	NA
Agency Providing Medicare and Medicaid Hospice Services in the Proposed County	March 2026

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.

The following services will also be provided to Clark County residents:

X Skilled Nursing	X Durable Medical Equipment (contracted)
X Home Health/Care Aide	IV Services
X Physical Therapy (contracted)	X Nutritional Counseling
X Occupational Therapy (contracted)	X Bereavement Counseling
X Speech Therapy (contracted)	X Symptom and Pain Management
X Respiratory Therapy (contracted)	X Pharmacy Services (contracted)
X Medical Social Services	X Respite Care
X Palliative Care	X Spiritual Counseling
X Other (please describe): Music Therapy, Equine Therapy, Virtual Reality Therapy, homemaker services, volunteer services, massage therapy, and pet therapy.	

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).

While Shalom Clark will be new to Washington State, we do have related organizations, including Shalom Kitsap (CN approved in the fall of 2024, but not yet operational) and Continuum Snohomish and Continuum King that are providing services. Continuum Snohomish serves both Snohomish and Pierce Counties.

More detail on these agencies is included in Exhibit 1.

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 question is not applicable.

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

Shalom will place an emphasis on serving terminally ill individuals of the Jewish faith in a manner that recognizes and honors Jewish heritage, history, rituals, and traditions. Our staff and programming will also welcome any Clark County and adjacent Portland metro resident meeting Medicare or Medicaid requirements and choosing our service. Shalom will serve all individuals, regardless of religion, sexual orientation, handicap, race, ethnicity, or financial ability.

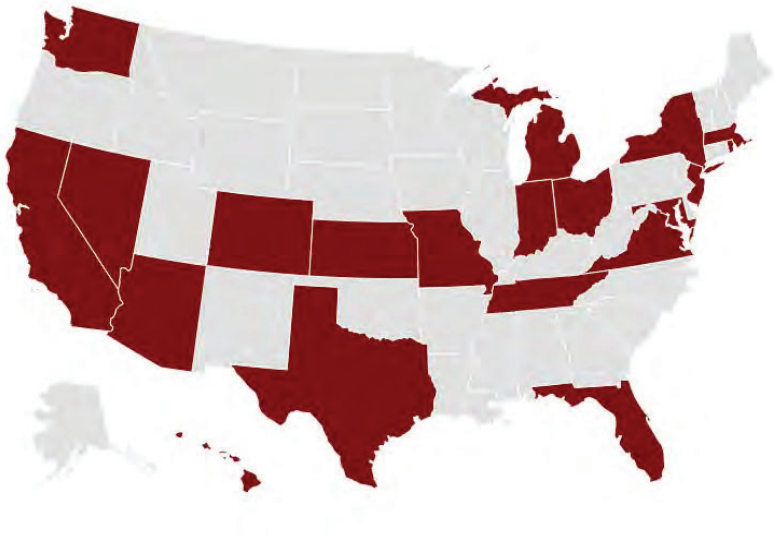
We will provide a full range of hospice services designed to meet the physiological, psychological, social, and spiritual needs of people and their families facing the end of life and bereavement in Clark County, as well as in the Portland metro area.

Shalom will predominantly serve adults, age 18 and over. That said, Shalom's members have both the interest in and proven expertise to provide care for pediatric patients and their families and will be equipped to provide care to pediatric patients if requested.

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

A copy of the letter of intent is included in Exhibit 2.

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.



Shalom will apply for an in-home services license and will seek and secure Medicare certification and a Medicaid contract. Shalom will also secure National *Institute for Jewish Hospice* (NIJH) accreditation. No hospice in Clark County (or the greater Portland area) currently holds this designation. A map of the States with accreditation as of the time of filing this application, are colored in the map. In Washington, the only agency is based in King County, though Shalom Kitsap will secure accreditation once operational.

Section 3
CERTIFICATE OF NEED REVIEW CRITERIA
NEED (WAC 246-310-210)

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

This 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.**

According to OFM, Clark County's 2025 population is estimated at nearly 521,000. It is projected to be over 583,000 by 2030. Those over 65+ are the primary users of hospice, and Clark County is aging rapidly. Its 65+ population grew nearly 69% between 2010 and 2020, while the total County population during the same time frame increased by just over 17% Countywide. Statewide, the 65+ age cohort grew 55% between 2010 and 2020. In 2025, it is estimated that the 65+ population will represent nearly 20% of the total population (compared to 19% statewide). Projected utilization is detailed in Table 1:

Table 1
Projected Patient Admissions and Days, 2026-2029
Note: This includes all admissions and days, including Oregon

	2026 Partial Year (10 months)	2027	2028	2029
Estimated number of Jewish admissions	20	30	35	40
Total number of admissions (includes Jewish)	107	177	214	244
Total number of patient days	6,398	10,583	12,795	14,589
Average daily census	21	29	35	40

Source: Applicant

The Jewish admissions are a conservative estimate. Available data suggests that the Jewish population accounts for less than 2% of the population in the Greater Portland area, and approximately 24% of that population is aged 65+ (9% of which are 75+). Further, it has been our experience that some Jewish families relocate end-of-life family members so that they can participate in a Jewish hospice program.

WAC does not require that the specific population be of particular size or a specific percentage of the total population. At end of life, the Jewish community deserves to be cared for in a manner that values their life customs, beliefs, and rituals, and by staff that are trained to embrace their unique care requirements. Today, the Jewish population of Clark County and Portland metro has no meaningful choice related to hospice care.

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

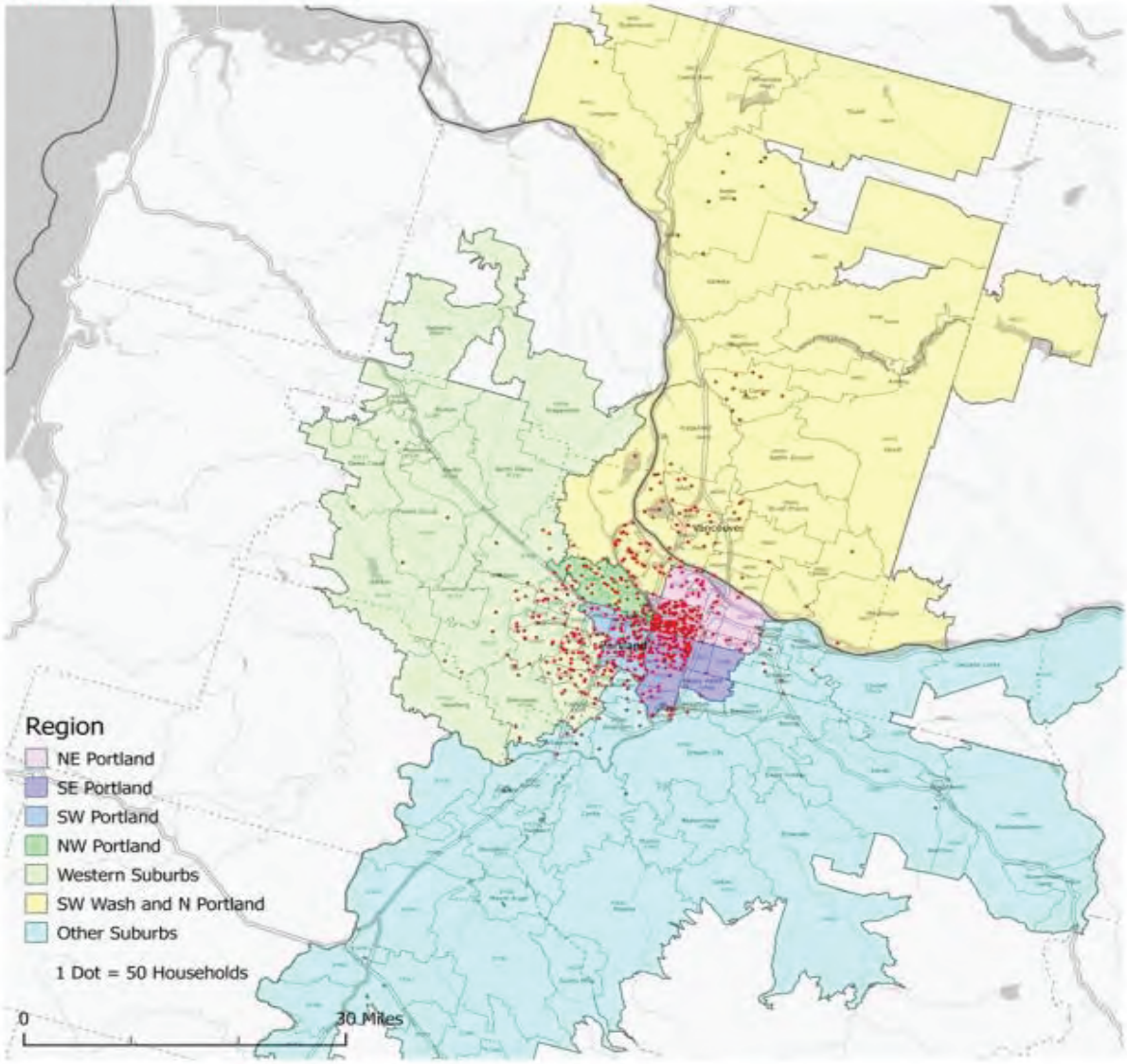
A Brandeis University Cohen Center for Modern Jewish Studies' American Jewish Population Project report entitled *American Jewish Population Estimates, Summary & Highlights* found that about 2% of the US population identify as Jewish, and less than 2% of the total populations of Washington and Oregon do so as well; with higher percentages in urban areas of the two States. The same study found that compared to all US adults, Jewish adults are disproportionately older. Specifically, the Report found that:

> *The gap between Jewish adults and all adults ages 65 or older is a difference of eight percentage points (30% of Jewish adults vs. 22% of all adults). This gap is partly explained by differences in longevity and increased life expectancy among higher educated white adults in the United States. The age distribution among Jewish adults highlights the Baby Boomer generation, those ages 55 to 74 years old, who represent more than one third (35%) of Jewish adults. Those in the Boomer generation straddle the typical retirement age (between 65 to 67 years old), which may have tremendous importance in the coming years. About half of Baby Boomers are entering retirement years (ages 65-74).*

Another Brandeis study, the *2022-2023 Greater Portland Jewish Community Study* included a comprehensive portrait of the 75,500 people living in Jewish households in Greater Portland and Southwest Washington and provides insight into their families; their Jewish attitudes, affiliations, and behaviors; their health and other measures of their engagement in Jewish life. Of the 75,500 residents living in Jewish households, 56,600 report being Jewish.

Per the study, 24% of Jewish households in Greater Portland reside in Northeast Portland. 19% percent live in the Western Suburbs, 17% in Southwest Washington and North Portland, 14% in Southeast Portland, 13% in Southwest Portland, 8% in Northwest Portland, and 5% in the Other Suburbs. A map of service area included in the Study is below:

Figure 2.2a. Geographic distribution of the Greater Portland Jewish community, full view of region (1 dot = 50 households)



Study highlights also confirm the diversity of the Jewish community:

- Fifty-two percent of Jewish adults in Greater Portland do not identify with any particular denomination of Judaism. Five percent identify as Orthodox, 8% as Conservative, 23% as Reform, and 12% identify with other denominations.

- Seven percent of Jewish adults in Greater Portland identify as LGBTQ+.

- Similarly, 7% of Jewish adults are Israeli citizens, and 7% grew up in Russian-speaking households.

- Seven percent of Jewish individuals in Greater Portland, including 16% of Jewish children, identify as People of Color. Thirteen percent of Jewish individuals, including 26% of Jewish children, identify as Hispanic or with any racial group other than white.

- Ninety-seven percent of Jewish adults in Greater Portland feel at least some sense of belonging to the Jewish people, including 46% who feel this connection a great deal.

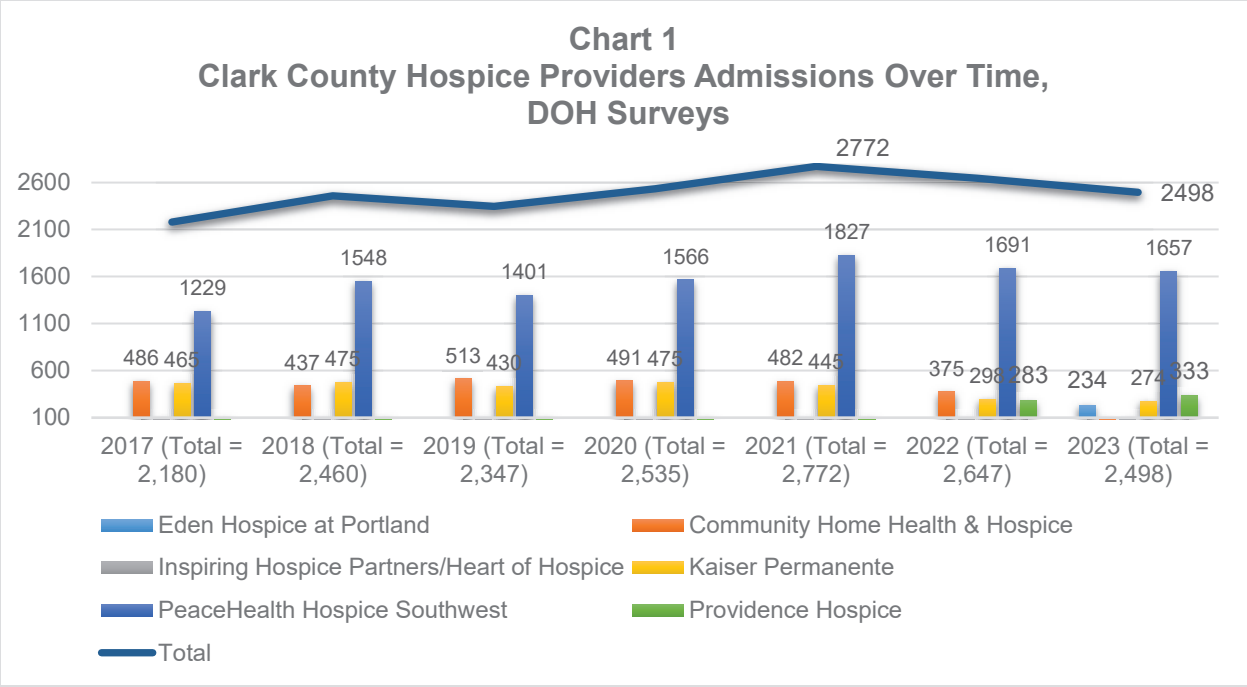
- Sixty-three percent of Jewish adults are very concerned about antisemitism around the world, and 60% are very concerned about antisemitism in the United States.

- Eighteen percent of Jewish adults personally experienced one or more antisemitic incidents in the past year. For 31% of Jewish adults, a fear of antisemitism and their concern for their safety or comfort as a Jew has caused them to change their behavior in the past year.

Shalom has programming to support Jewish end of life care and programming that will support the diversity of the population and allay concerns about safety.

The Department of Health's 2024 hospice need methodology (included in Exhibit 3) projects no need for an additional hospice agency in the County in 2026, the identified planning horizon. It also shows that in 2023, six agencies had CN approval to serve the County; however, we note that Community Home Health was acquired by Eden in early 2024, and Inspiring Hospice has demonstrated through its surveys that it is has no volume in Clark County. The remaining agencies in addition to Eden include: PeaceHealth Hospice Southwest, Providence Hospice in Oregon, and Kaiser which serves only enrolled members of its HMO.

Using data that the Department's annual survey has collected from the period of 2017-2023, Chart 1 below demonstrates that hospice admissions have declined nearly 10% since peaking in 2021. The downward trend is a direct result of the decreasing use rate and length of stay.



To determine the projected hospice admissions in each Planning Area, the Department calculates a statewide use rate and applies that use rate to each Planning Area's average total resident deaths by age cohort. As can be seen in Table 2, the Statewide 65+ use rate has been declining since the 2019 methodology (which used 2016-2018 data) was published.

Table 2: Department of Health Methodology
Statewide Hospice Use Rates Over Time

	2019 (2016-2018 Data)	2020 (2017-2019 Data)	2021 (2018-2020 Data)	2022 (2019-2021 Data)	2023 (2020-2022 Data)	2024 (2021-2023 Data)	Chg. 2019-2024
0-64	27.89%	27.41%	25.67%	23.16%	21.09%	20.44%	27%
65+	61.56%	60.52%	60.15%	58.07%	56.80%	54.75%	11%

Source: Department of Health Certificate of Need Hospice Methodologies; 2018-2024

Shalom's engagement with the Jewish community has demonstrated that neither Clark nor Portland metro Jewish residents have choice related to hospice care if they want Jewish death and dying rituals, beliefs, and customs. Choice is extremely important for individuals to feel they have options and some control over their healthcare decisions.

While our focus is on Jewish residents, we also have proven programming to address the needs of other traditionally underserved groups including Black people, Asians, dual eligible Medicare/Medicaid Enrollees, homeless, and LGBTQ+. Through our Shared Services Agreement, included as Exhibit 4, our Clark County team will have ready access to the expertise needed to support any other identified underserved in the County. That expertise includes training, programming, and proven tools that address specific concrete obstacles long identified by health policy makers and researchers but frequently not well addressed.

Examples include the insensitivity to cultural variations in attitudes towards death and dying, and the frequent difficulty clinicians have communicating about end-of-life issues or the lack of culturally appropriate sources of information and resources within communities. Shalom has learned that these barriers can be confronted and overcome with constant, concerted effort and with the application of common-sense techniques.

We also know that the development of a workforce that reflects the population served is a crucial element in overcoming barriers to unmet needs. This is a priority for us, and, in other communities in which our Managing Members established new agencies, they have been able to reflect the community in the Agency's workforce. It is important because it not only facilitates access to service but improves quality of care as well.

Shalom has already outreached to Jewish organizations, places of gathering and worship, trusted physicians and other health care entities in the County and the greater Portland area to listen to their current experiences. We have consistently heard that exiting agencies in Clark County and the greater Portland area provide competent and quality core hospice services but fail to meet the Jewish community's spiritual needs. Shalom is being welcomed because of the promise of having the option to select a Program that offers choice to residents who are of the Jewish faith and wish to be cared for in a Jewish hospice.

Listening is part and parcel of our program model and mission and will be employed in service to our Jewish patients. We will do the same to improve accessibility for any person that seeks our care. Our efforts will ensure that all people who would benefit from hospice care will have the knowledge and opportunity to choose that option if they so desire. In this way we expect to contribute toward the improvement of the broader system of care, while at the same time meeting the needs of specific individuals.

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.

This application is not an unnecessary duplication, as no existing Clark County provider offers programming specific to Jewish residents, and none holds NIJH accreditation. Shalom's presence in the County will not duplicate existing services but instead bring services focused on meeting the needs of the Jewish population. In our review of the websites of the existing providers, in our calls to these providers, and in our meeting with Jewish organizations serving Clark County and the greater Portland area, we have confirmed that the Jewish population is leery of hospice. They are concerned that the specific special needs of the Jewish people and personalized care within the framework of Jewish law and ritual will not be provided or respected. This creates a barrier to end-of-life hospice services for the Jewish population.

Mr. Samuel Stern, Shalom's Managing Governor, is an Orthodox Jew and schooled in associated teachings. Mr. Stern has a degree in Talmudic Law and is intimately familiar with the needs, rituals, practices, and traditions of the Jewish community. He will work alongside the Shalom team to effectively meet the needs of its patients.

Shalom's unique programming will focus on providing recognition and support for survivors of the Holocaust; addressing pain control measures; providing life-sustaining measures in accordance with religious observances; coordinating with and having available support from local Rabbis for spiritual care, guidance, and consultation; and coordinating with the various Chabads to ensure patient care plans include recognition of Kosher diet requirements.

Shalom will also address the end-of-life needs of Jewish patients by incorporating training and education by the NIJH in its regular activities and for all staff members. NIJH began in 1985 by Rabbi Maurice Lamm. He was the first Orthodox Rabbi on the board of the Jewish Federation in Los Angeles. He traveled to hospices around the country to train hospice team members to care for the dying Jewish population in their communities. Today, NIJH hosts conferences whereby staff members and health care providers attend comprehensive training to gain enhanced understanding of Jewish culture and religion, and their impact on death and dying. This understanding enables participants to then integrate Jewish medical ethics into hospice care and better recognize Jewish grief and mourning. NIJH training for staff members includes teaching of aspects of Jewish Heritage & Holidays; Jewish Medical Ethics; and the Final Journey, Death, Burial and Mourning. Further, NIJH training recipients are given video cards, Jewish living wills, explanation of the taharah process and an explanation of the custom to use a plain wooden coffin. Accredited agencies are given many materials like the book *Prayer and Hope* written by Rabbi Lamm with Rabbi Bulka. Shalom will also look to *Jewish Ritual, Reality and Response at the End of Life: A Guide for Caring for Jewish Patients and Their Family* as an additional valuable resource for end-of-life patient care, as well as its usefulness as an interesting exploration of Judaism's rich traditions.

Furthermore, Shalom will have a local Rabbi for spiritual and religious support of hospice patients and their families. In addition, Shalom's triage services will be provided by Affinity Hospice Management (see draft Shared Services Agreement provided in Attachment 4) and this team's on-call nurses and compliance team have all received NIJH training and accreditation.

Shalom ascribes to Chayim Aruchim, which helps the Jewish community make informed end-of life health care decisions in keeping with their religious beliefs. The Center for Culturally Sensitive Health Advocacy and Counseling has worked to increase cultural sensitivity and awareness around end-of-life situations for Jewish people and their health care providers. With a team of halachic authorities, legal experts, medical, patient, and pastoral care professionals, and high-level government policy advocates, Chayim Aruchim endeavors to serve as a vital resource in championing, promoting, and ensuring the implementation of preferences of Torah observant patients' care decisions in compliance with halacha (the body of Jewish religious laws that govern Jewish people's daily lives and religious practices).

We will also work with the Chabad organizations, local Rabbis, and other organizations to sponsor quarterly community education events and workshops at various religiously affiliated sites, including local congregations, regarding the benefits of hospice services. Presentations will include an explanation of the hospice benefit available under Medicare, the interdisciplinary team approach to care for patients in hospice, and the ways in which hospice can meet the physical, emotional, and spiritual needs of the Jewish patient and their family at the end of life.

Shalom will provide extra training to staff so that they are available to respectfully respond to the needs of Jewish patients. This includes being available to respond to any requests from Jewish community organizations for assistance and evaluation of patients, including but not limited to: 24/7 triage coverage; physical visits to assess hospice eligibility of patients and admission, regardless of ability to pay (charity patients); and availability of palliative care programs for Jewish patients who are in need of support but do not presently meet the requirements for admission to hospice care.

Our bereavement program will also include a track specifically designed to address the needs of Jewish patients, families, caregivers, and those who need grief support regardless of whether they are associated with hospice services.

Finally, Mr. Stern has already developed, in partnership with a Virtual Reality designer, modules that incorporate a virtual reality platform for the Jewish population that honors the history and plight of the Jewish experience and provides “travel” to religiously significant sites and experiences throughout the world.

Judaism prescribes rituals related to dying and mourning, some dating back thousands of years. That said, the Jewish community is diverse, and Shalom will not dictate what anyone should or should not do. Rather, we will help our Jewish patients and families secure the care they desire with the respect and dignity they deserve.

Related to hospice care, Judaism law generally requires that every effort be made to sustain and extend life, and mandates that a patient never be deprived of the most elemental forms of human sustenance — food, water, and oxygen — even if they are artificially provided. This means that, for hospice patients concerned about complying with Jewish law, it is necessary to ensure that hospice continues to provide intravenous fluids and hydration as religiously required.

Jewish tradition also raises concerns about fully disclosing to a patient the fact that a condition is terminal, lest the patient be deprived of a will to live. Medical professionals familiar with the requirements of Jewish law in this respect are often able to transition a patient to hospice without fully disclosing the particulars of their diagnosis. We will use a Rabbinic advisor to ensure that all decisions are made in accordance with the patient’s desires and beliefs.

Before death, Jews typically recite a prayer called V*iduy* where they acknowledge their imperfections and request forgiveness. Patients may recite *Viduy* themselves or request a Rabbi to perform this ritual on their behalf.

Shalom will continue our support after death. *Aninut* is the period from the moment of death until the burial. Death marks the beginning of the separation of the body and soul; however, the separation is not considered complete until burial. Because the soul is thought to attend to the body until that time, the deceased is never left unattended until burial (*shmirah* or watching). It is Jewish practice to bury the deceased as quickly as possible to provide comfort for their soul and expedite the person's journey to the Next World. It also allows the mourning process for the survivor to begin.

Jewish law prohibits cremation. As soon as practically possible, the body is washed and prepared for burial. Within 72 hours, families often bury the deceased in an unadorned wooden casket, emphasizing the equality of all people. These practices concretize the death and transform the family members into mourners, a religious status with specific obligations.

The first week after death is called *Shiva* (seven days), when the family stays home, receives visitors, and prays together with the community. During the first month, the mourners return to work and family roles with many restrictions, such as avoiding celebrations and listening to live music. Various mourning rituals, including the daily recitation of the *Kaddish* prayer (a declaration of God's majesty recited at every prayer service) for close relatives, continue for eleven months after the death.

Shalom Hospice is requesting approval under the provisions of WAC 246-310-290 (12), which state:

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> *(ii) The applicant commits to serving Medicare and Medicaid patients; and*
> *(iii) A specific population is underserved; or*
> *(iv) 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.*

As noted earlier, in the case of this application, all other review criteria and standards, with the exception of numeric need, are met. Shalom will place an emphasis on serving terminally ill individuals of the Jewish faith in a manner that recognizes and honors Jewish heritage, history, rituals, and traditions. Too many Clark County (and Portland metro) residents of the Jewish faith, are not choosing hospice if they desire Jewish rituals, traditions, and strong Rabbinic support.

To the benefit of the entire County, we will also bring our experience to bear in an effort to increase use rates and ALOS back to prior levels in the County.

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

Shalom Hospice will serve all residents of Clark County and Portland metro that meet Medicare and Medicaid requirements and choose to be cared for by our Agency.

6. Identify how this project will be available and accessible to underserved groups.

Please refer to the response to Q4 above, and to Exhibit 5 for information regarding Jewish death and dying customs and rituals. By embracing and supporting these customs and rituals, and by partnering with existing Jewish organizations, Shalom will quickly become an accepted and trusted County resource, and we fully expect to be the preferred hospice for the Jewish community in both Clark County and the Portland metro area.

Shalom will also serve Medicare and Medicaid patients and patients that cannot afford to pay for services. Shalom will seek both Medicare and Medicaid certification and has included a charity care allowance in our pro forma.

Our sister organizations in Washington, Continuum of Snohomish and Continuum of King, have been operational for a number of years and have experienced phenomenal success.

7. Provide a copy of the following policies:

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

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

The requested draft policies are included in Exhibit 6. These draft policies are the same as those used by our sister agency, Shalom Hospice of Puget Sound, LLC. These policies have already been found to comply with all CN requirements.

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 data and narrative provided throughout this application demonstrates that Shalom meets all applicable standards, with the exception of numeric need. We have further demonstrated our commitment to Medicare and Medicaid. WAC 246-310-290 (12) states:

> (12) The department may grant a certificate of need for a new hospice agency in a planning area where there is not numeric need.
> (a) The department will consider if the applicant meets the following criteria:
> (i) All applicable review criteria and standards with the exception of numeric need have been met;
> (ii) The applicant commits to serving Medicare and Medicaid patients; and
> ***(iii) A specific population is underserved.***

WAC does not require that the specific population be of particular size or a specific percentage of the total population. At end of life, the Jewish community deserves to be cared for in a manner that values their life customs, beliefs, and rituals related to dying and mourning and Jewish medical, and by staff that are trained to embrace their unique care requirements. Today, the Jewish population of Clark and the Portland metro area have no real choice related to hospice care.

Section 3
CERTIFICATE OF NEED REVIEW CRITERIA
FINANCIAL FEASIBILITY (WAC 246-310-220)

1. **Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:**
   - **Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.**
   - **Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.**
   - **Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.**
   - **For existing agencies proposing the 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.**

The requested information is included in Exhibit 7.

2. **Provide the following agreements/contracts:**

   - **Management agreement**
   - **Operating agreement**
   - **Medical director agreement**
   - **Joint Venture agreement**

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

Shalom will not have a management agreement, operating agreement, joint venture agreement, or medical director agreement (because the Medical Director will be an employee). Shalom will have a shared services agreement, a draft copy of which is included in Exhibit 4. A draft job description for the Medical Director is included as Exhibit 8.

These draft documents are the same as those used by our sister organization, Shalom Hospice of Puget Sound, LLC in its recent CN application. In the CN evaluation the Program specifically noted these complied with all CN requirements.

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

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

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

a. **An executed purchase agreement or deed for the site.**
b. **A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**
c. **An executed lease agreement for at least three years with options to renew for not less than a total of two years.**
d. **A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.**

Shalom is still finalizing the lease with the landlord. An executed lease will be provided with the screening response.

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

Details on the capital expenditure are included in Table 3.

Table 3: Proposed Capital Expenditure

Line Item	Cost
Office Equipment and Computers/ Communication Devices/ Furniture, including Sales Tax	$82,193.00
Leasehold Improvements/Signage/ Including sales Tax	$35,807.00
Total	**$118,000**

Source: Applicant, includes sales tax

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.

The LLC's Managing Member, or Governor, is responsible for the capital expenditure estimate. Mr. Stern has established several new hospice agencies in Washington State over the past four years, as well as others throughout the nation. Mr. Stern is also currently negotiating with the landlord for this project.

He has a strong working knowledge of the capital required to start a new hospice.

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.

Pre-certification costs totaling $378,112 are included in the pro forma.

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.

The LLC is responsible for funding the start up.

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

To the extent that the Jewish community and those that do not have timely access to hospice in Clark County are currently using higher-cost health care services (ED visits, extended hospitalizations) that are reduced if they enroll in a hospice program, overall total costs and charges for health care services will decrease. Studies demonstrate that patients enrolled in hospice are less likely to be hospitalized, admitted to intensive care, or undergo unnecessary invasive procedures.

Other studies have demonstrated that hospice admissions in the last six months of life are correlated with increased patient satisfaction ratings, better pain control, reductions in hospital days, fewer hospital deaths, and fewer deaths occurring with an ICU admission during hospitalization.

A 2022 Journal of the American Medical Association article demonstrated a reduction in total health care expenditures for hospice patients[1]. Per the article:

> ***Main Outcomes and Measures*** *Total health care expenditures were measured across payers (family out-of-pocket, Medicare, Medicare Advantage, Medicaid, private insurance, private health maintenance organizations, Veteran's Administration, and other) and by expenditure type (inpatient care, outpatient care, medical visits, skilled nursing, home health, hospice, durable medical equipment, and prescription drugs).*
> ***Results*** *The study population included 5464 decedents (mean age 78.7 years; 48% female) and 38% enrolled with hospice. Total health care expenditures were lower for those who used hospice compared with propensity score weighted non-hospice control participants for the last 3 days of life ($2813 lower; 95% CI, $2396-$3230); last week of life ($6806 lower; 95% CI, $6261-$7350); last 2 weeks of life ($8785 lower; 95% CI, $7971-$9600); last month of life ($11 747 lower; 95% CI, $10 072-$13 422); and last 3 months of life ($10 908 lower; 95% CI, $7283-$14 533). Family out-of-pocket expenditures were lower for hospice enrollees in the last 3 days of life ($71; 95% CI, $43-$100); last week of life ($216; 95% CI, $175-$256); last 2 weeks of life ($265; 95% CI, $149-$382); and last month of life ($670; 95% CI, $530-$811) compared with those who did not use hospice. Health care savings were associated with reductions in inpatient care.*
>
> ***Conclusions and Relevance*** *In this population-based cohort study of community-dwelling Medicare beneficiaries, hospice enrollment was associated with lower total health care costs for the last 3 days to 3 months of life. Importantly, we found no evidence of cost shifting from Medicare to families related to hospice enrollment. The magnitude of lower out-of-pocket spending to families who enrolled with hospice is meaningful to many Americans, particularly those with lower socioeconomic status.*

[1] *JAMA Health Forum.* 2022;3(2): e215104. doi:10.1001/jamahealthforum.2021.5104

Shalom will support our patients and families to access our music, equine, virtual reality, art, massage, aroma, and other therapies to manage pain and symptoms. All these programs will improve the quality of life of the patient and have supported the management of costs.

Further, while not in the pro forma, Shalom intends to establish a palliative care program in Clark County and will work with existing health care providers to identify patients appropriate for palliative care. Palliative care programs are designed to support patients that are not yet eligible for, or have not yet requested, hospice care, but have advanced chronic illnesses. Palliative care programs can support patients engaged in curative treatment. The goal of a palliative care program is to keep patients stable and out of the hospital by providing home-based services.

Shalom's palliative care service will provide pain and non-pain symptom management, education to promote patient and family awareness of illness trajectory and treatment choices, and psychosocial and spiritual support. The typical disease group of patients enrolled in palliative care include cancer, COPD, heart failure and dementia. The palliative care team typically provides in-home medical consultation, caregiver support and advance care planning.

Research has found that patients enrolled in palliative care cost less than similar patients who are not in a palliative care program, simply because they have fewer hospital visits[1]. Palliative care is also demonstrated to improve quality of life for both the patient and the family. Because of their success in reducing costs and improving patient and family satisfaction, they are increasingly sought out by insurers.

The establishment of a new hospice agency that will improve access and availability and target barriers is both the "right thing to do" and consistent with value-based care delivery and Washington's Medicaid transformation efforts. In addition to better access and enhanced equity,

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.

Shalom's charges for hospice services will not be determined by its capital expenditures nor its initial pre-opening and operating deficits. The project will not affect the charges for hospice, and, importantly, this project will have no effect on billed rates to patients, providers, or payers.

[1] "Effective of a Home-Based Palliative Care Program on Healthcare Use and Costs, Journal of American Geriatrics, J. Brian Cassel, PhD, et.al , November 2016, p. 2288-2295.

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

Table 4 provides the requested information for Shalom.

Table 4
Estimated Sources of Revenue by Payer

Payer	Percentage of Gross Revenue	Percentage of Patients
Medicare/Medicare Advantage	88.7%	88.5%
Medicaid	3.9%	4.0%
Commercial/VA/TriCare	5.8%	6.0%
Self-Pay/Other	1.6%	1.5%
Total	**100.0%**	**100.0%**

Source: Applicant

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.

This project does not assume the addition of a county by an existing agency.

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.

General costs are provided in the capital expenditure table, above. Equipment needs include office furnishings, communication equipment, and computers for staff. Details on the specific equipment are included in Table 5 below.

Table 5
Equipment List

Item	Quantity
Desktop Computers	5
Laptop Computers	5
Conference Table	1
Conference Table Chairs	15
Desks	6
Desk Chairs	6
Cell Phones	10
Tablets	10
Copy Machine	1
Staff Refrigerator, Microwave, and Coffee Machine	1

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

A contribution from the LLC will fund the initial costs.

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.

There is no debt financing for this project. 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.**

No audited financial statements exist. In the recent CN issued to Shalom Hospice of Puget Sound, LLC we provided documentation that the funds needed to cover these costs are available by submitting a bank letter. In its CN evaluation, the Program noted that "*this method is suitable, as documentation shows adequate assets to cover project costs*," and further included a condition requiring Shalom to finance the project consistent with the financing description in the application.

Shalom will provide a new bank letter with screening and also agrees to the condition.

Section 3
CERTIFICATE OF NEED REVIEW CRITERIA
Structure and Process (Quality) of Care (WAC 246-310-230)

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

Table 6 details the projected Clark County FTEs for the first three years of operation.

Table 6
Clark County Projected FTEs by Year

Staff	2026	2027	2028	2029	Salary/FTE
Administrator	1.08	1.00	1.00	1.00	$204,750
Medical Director	0.35	0.20	0.20	0.20	$420,000
Clinical Director	0.83	1.00	1.00	1.00	$162,750
Registered Nurse	1.90	2.90	3.50	4.00	$131,250
Hospice Aide	1.90	2.90	3.50	4.00	$57,750
MSW	0.74	1.16	1.40	1.60	$99,750
Chaplain	0.74	1.16	1.40	1.60	$89,250
Music Therapist	0.35	0.58	0.70	0.80	$78,750
Intake	0.83	1.00	1.00	1.00	$84,000
Office Manager	0.42	0.50	1.00	1.00	$94,500
Team Coordinator				0.25	$73,500
Marketing	0.42	0.50	0.75	1.00	$115,500
Volunteer Coordinator	0.83	1.00	1.00	1.00	$84,000
Bereavement Coordinator				0.25	$105,000
PT/OT/SP/RT	Contracted				
Dietitian	Contracted				
Nurse Practitioner	0.08	0.14	0.17	0.19	$183,750
Total	10.38	13.90	16.62	18.89	

Source: Applicant

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

This question is not applicable.

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

Table 7 depicts the projected staff to patient ratio. The ratios included in the table represent the average ratio across the three-year projection period.

Table 7
Proposed Staff to Patient ADC Ratio

Type of Staff	Staff / Patient Ratio
Skilled Nursing (RN)	1:10
Medical Social Worker	1:25
Hospice Aide	1:10
Chaplain	1:25

Source: Applicant

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

Shalom's staffing is based, primarily, on the experience of Shalom's sister agencies in Washington. It is also based on national staffing data from the National Hospice and Palliative Care Organization (NHPCO). NHPCO provides its members with many tools related to standards and practices for operating a community hospice agency. Shalom's direct patient staffing ratios (RN, HHA, chaplain and MSW) are consistent with, or in most cases better, than the NHPCO national averages.

Based on the performance of our sister organizations, we know that the staffing is adequate. We also know that it produces exceptionally high metrics on quality and patient and family satisfaction.

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.

Shalom's Medical Director will be Don Nguyen, MD. Dr. Nguyen's professional license number is MD60957806.

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

The Medical Director will be an employee. The job description is included in Exhibit 8. This job description was reviewed by the CN Program in the recent Shalom CN application in Kitsap and found to meet all requirements.

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.)

As shown in Table 8, Shalom will be supported by Patrick Shepard in the role as Interim Administrator during start-up until a qualified Clark County specific Administrator can be hired. Dr. Nguyen will be the Medical Director. Both Mr. Shepard and Dr. Nguyen are experienced hospice leaders and have been with Shalom sister organizations for a number of years. They will both be responsible for recruiting and hiring staff prior to opening.

Table 8
Key Staff

Name	Title	DOH Credential Number (if applicable)
Patrick Shepard	Administrator	NA
Don Nguyen	Medical Director	MD60957806

Source: Applicant

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

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.

Shalom's sister agencies operating in Washington (Continuum) have been successful in recruiting using multiple strategies and tools. The same is true of our other agencies. We will access this expertise to support our recruitment.

In summary, Shalom will employ daily searches for qualified candidates through the major employment sites and LinkedIn. We will host and partner job fairs with others to increase opportunities, and support and encourage staff interested in part-time only employment. For high demand positions, we will engage with recruiters that specialize in the positions they are hiring for and are familiar with the Clark County and Portland metro markets.

Shalom will additionally offer competitive compensation packages (including 401K plans with generous matches), paid time off, a wide selection of health insurance options, dental insurance, vision insurance, life insurance, and excellent work/life balance. Shalom will also offer comprehensive in-service training and professional development opportunities with the main objective to enable and incentivize staff to work together to benefit patients and their families.

If Shalom is unable to recruit staff with our current tools and normal strategies, we are prepared to use staffing agencies, temporarily borrow staff from other agencies, use traveling staff and/or rely on recruiters to cast a search nationally and relocate providers and staff to the area.

New staff are provided with training and orientation and work under direct supervision during their initial period of employment. The length of direct supervision is related to their existing level of experience and the judgment of their supervisors.

As a means of employing and supporting citizens of high character, Shalom will focus on employing members of our National Guard and Reserve. In the past, our members' agencies have been recognized by the Department of Defense and honored with a Patriotic Employer award for these efforts. The award recognizes sustained support (minimum 3 years) of the Guard and Reserve.

Volunteers will also be a critical part of the hospice team. Volunteer recruitment will commence immediately upon receipt of our state license and will include the following:

- We will post on Jewish websites, and websites like VolunteerMatch.org and Craigslist.org for volunteers interested in making friendly visits to patients to provide companionship and socialization, as well as volunteers who are able to provide art therapy, pet therapy, massage, hair cutting and styling, designing and delivery of flower bouquets, making lap blankets, teddy bears, etc. Presentations will be made to community service organizations regarding Shalom and the volunteer program.

- Depending on the community, we have worked with local colleges and university websites that connect students to volunteer opportunities, particularly for pre-med students, nursing programs, chaplaincy programs, and social work programs.
- In the larger assisted living facilities, volunteer opportunities will be provided to the independent-living residents.

All applicants that apply will be thoroughly screened, undergo a full background check, and will receive a personal interview. Once selected, volunteer orientation and training will occur as soon as the volunteer is able to schedule.

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

Shalom's business hours will be Monday through Friday from 8:30 a.m. to 5:00 p.m. In addition, a Hospice RN will be available 24 hours a day/7 days per week. Families are able to access the hospice nurse after hours by calling the 24/7/365 triage phone line. Response time is programmed to be 30 minutes or less. This RN will have access to the patient's record and will assist them with any concerns and help manage their symptoms and facilitate any needed additional care.

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

This question is not applicable.

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

This question is not applicable.

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

This question is not applicable.

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

Shalom will establish ancillary and support services including:

- Inpatient Care
- PT/OT/ST/RT/IV therapy
- X-Ray
- Pharmacy
- Durable Medical Equipment
- Medical Supplies
- Laboratory
- Dietary/Nutritionist
- Ambulance
- Biowaste removal
- Specialty therapies

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

This question is not applicable.

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

This question is not applicable.

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

Shalom will establish working relationships with at least:

- Jewish Organizations, Chabads, Congregations and Clergy
- Jewish Family and Child Services
- Discharging hospitals, physicians, and coordinators
- Home Health and home care agencies
- Nursing Homes, Assisted Living and Adult Family Homes
- VA
- HMOs and other payers
- State and County Veteran's Programs

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.

No member of the LLC nor the proposed medical director or interim administrator have any history with respect to the items noted in Q18.

In its October 2024 CN approval of Shalom of Puget Sound LLC, the Program found:

> *Shalom provided the name and professional license number for the individual who will be the Medical Director for the new hospice agency, Don Nguyen, MD. Using data from the Medical Quality Assurance Commission, the department found that Don Nguyen, MD is compliant with state licensure and has no enforcement actions on their license.*
>
> *For hospice services, the department reviews two different areas when evaluating this sub-criterion. One is a review of the Centers for Medicare and Medicaid Services (CMS) "Terminated Provider Counts Report" and the second is a review of the applicant's conformance with Medicare and Medicaid standards. The department uses the CMS 'Survey Activity Report' to identify facilities with a history of condition level findings. For CMS surveys, there are two levels of deficiencies: standard and condition.*[14]
>
> - *Standard Level*
>
> *A deficiency is at the Standard level when there is noncompliance with any single requirement (or several requirements) within a particular standard that is not of such character as to substantially limit a facility's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred.*
>
> - *Condition Level*
>
> *Deficiency at the Condition level may be due to noncompliance with requirements in a single standard that, collectively, represent a severe or critical health or safety breach, or it may be the result of noncompliance with several standards within the condition. Even a seemingly small breach in critical actions, or at critical times, can kill or severely injure a patient, and such breaches would represent a serious or severe health or safety threat.*

Regarding Terminated Provider Counts, the Program found that none of the hospice agencies owned or operated by the Stern Family Trusts were involuntarily terminated from participation in Medicare reimbursement. Using the Center for Medicare and Medicaid Services (CMS) Quality, Certification & Oversight Reports (QCOR) website, Of the 24 agencies operated by Affinity or Continuum at the time of the analysis, 14 were not surveyed during the period identified above. Of the remaining 10 agencies, 9 were surveyed as an initial or accreditation survey and no deficiencies were found. The 1 remaining agency had one or more surveys, occurring in 2022 and 2023, which resulted in no deficiencies and are noted to be in compliance. [source: iQIES Hospice Survey Reports October 2021 through August 2023.]

Of the two Washington State agencies which are currently Medicare and Medicaid-certified, for full year 2021 through partial year 2022 there was a total of one standard level survey conducted which resulted in no deficiencies.

Shalom believes that the Program will find the same high quality when it updates this analysis in 2025.

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

The *Need Section* of this CN application demonstrates the lack of services for the Jewish community and the decreasing use rate and ALOS for the entire County. While serving all, Shalom will focus on the Jewish community and on increasing use of hospice. We will do so by outreach, building trust and by assuring our staff is trained and respectful of culture, values, and beliefs.

Our efforts will ensure that all people who would benefit from hospice care will have the knowledge and opportunity to choose that option if they so desire. In this way we expect to contribute toward the improvement of the broader system of care in the County and Portland metro area and support collaboration and coordination and reduce fragmentation of services, particularly for the most underserved in our community.

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.

As detailed in Question 17, Shalom will work directly with the existing Clark and Portland metro Jewish organizations to ensure patients' comprehensive medical, social, and spiritual needs are met. We will also have resources to support any special population and the general public.

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.

Please refer to the response to Q18, above. None of the agencies currently owned and/or operated by Mr. Stern, SYGS Management LLC (SYGS), or the SYGS 2023 Trust have any history or pattern of condition level negative findings.

This is also true of any agencies of which Mr. Stern has divested.

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.

Section 3
CERTIFICATE OF NEED REVIEW CRITERIA
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.**

Shalom considered the following options:

- Do nothing,
- Provide service in Clark County only.
- Undertake the project described in this application (Clark and Portland Metro).

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.**

Table 9 provides a comparison of the options considered.

Table 9
Advantages and Disadvantages of Options Considered

	Option 1 No Action	Option 2 Provide service in Clark County Only	Option 3 Undertake the Project Described in this Application (Clark and Portland Metro)
Patient Access to Health Care Services	No ability to improve access, especially for the Jewish community.	Our analysis demonstrated that a large Jewish population exists contiguous to Clark County in the Portland metro area and there are no providers that are NIJH accredited in either community.	Ability to serve the Jewish community in both Clark County and the Portland Metro area is positive. Further, in conversation with the CN Program we found that inclusion of Portland metro would be perceived as a positive.
Capital Cost	No capital	Capital cost estimated at $105,000 (less equipment) than Option 2.	Capital cost is $118,000.
Legal Restrictions	None	Certificate of Need required	Certificate of Need required for Washington. No CN requirement in Oregon.
Staffing Impacts	None	Requires close to the same number of staff, at least administrative staff, as Option 3.	Requires the highest level of additional staff, but still a relatively small number.
Quality of Care	No improvement	Ability to provide a high-quality hospice option for Jewish residents and the County at large. Through the shared services agreement, Shalom will have access to data, metrics, policies, and QI initiatives.	Same as Option 2
Cost or Operation Efficiency	None	Will allow for the provision of services to Clark patients needing services. Improved access may reduce total costs of care for the County by reducing unnecessary ED visits, specialty provider visits and hospitalizations.	Same as Option 2, but expand benefit to Portland metro market and supports increase operational efficiency and financial viability.

Source: Applicant

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

This project involves only minor cosmetic changes and new signage. It does not involve any construction. 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.**

Hospice care has been demonstrated to be a cost-effective service. A study published in the March 2013 *Health Affairs* found that hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries. Researchers at the Department of Geriatrics and Palliative Medicine at the Icahn School of Medicine at Mt. Sinai looked at the most common hospice enrollment periods: 1 to 7 days, 8 to 14 days, 15 to 30 days, and 53 to 105 days. Within all enrollment periods studied, hospice patients had significantly lower rates of hospital and intensive care use, hospital readmissions, and in-hospital death when compared to the matched non-hospice patients. The study found savings to Medicare for both cancer patients and non-cancer patients. It also found that savings grow as the period of hospice enrollment lengthens.

In terms of staffing, hospice fosters efficiency by allocating scarce RN and other resources to those most in need. For example, instead of a patient requiring a 1:1 ratio in the ICU, the patient is at home with nursing resources to provide comfort care.

See also the response to Q8, in Cost Containment.

<u>Hospice Agency Superiority</u>
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.

A second provider submitted an LOI, but at this time Shalom is not aware of whether the provider will submit a CN or what its proposal is based on. We will provide more information for this section in screening and during public comment.

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.

Shalom, nor any entity with a qualifying ownership interest in Shalom, anticipates submitting any other applications in this year's concurrent review cycles.

Exhibit 1
Hospice Agency List

Affinity / Continuum / Shalom Hospice Entities

Entity	Address	Provider No.	License
Continuum Care of Snohomish LLC	19009 33rd Ave W Ste 305, Lynnwood WA 98036-4740	50-1545	IHS.FS.61010090
Continuum Care of King LLC	14240 Interurban Ave S Ste 212, Tukwila WA 98168-4660	50-1549	IHS.FS.61058934
Shalom Hospice of Puget Sound LLC	19352 Viking Way NW Ste A, Poulsbo WA 98370-7276	Pending	Pending
Continuum Care of Broward LLC	7771 W. Oakland Park Blvd., Suite 224, Sunrise FL 33351-6705	10-1562	50370985
Continuum Care of Sarasota LLC	8590 Potter Park Dr Ste B, Sarasota FL 34238-5440	10-1564	50370986
Continuum Care of Miami Dade LLC	1150 NW 72nd Ave, Ste 400, Miami FL 33126-1947	10-1565	50370988
Affinity Care of Manatee County LLC	209 6th Ave E Ste A, Bradenton FL 34208-1904	10-1571	50370992
Affinity Care of Charlotte and DeSoto LLC	18501 Murdock Cir Unit 103, Port Charlotte FL 33948-4002	Pending	50370995
Affinity Care of Hillsborough LLC	4510 Oak Fair Blvd Ste 130, Tampa FL 33610-7346	Pending	Pending
Affinity Care of the Treasure Coast		Pending	Pending
Affinity Care of NJ LLC	635 Duquesne Blvd, Ste 1, Brick NJ 08723-5073	31-1591	25234
Branch	140 Littleton Rd Ste 103, Parsippany NJ 07054		25309
Affinity Care of Ohio LLC	9349 Waterstone Blvd Ste 340, Cincinnati OH 45249-8320	36-1713	0264-HSP
Branch	2207 Olympic St, Springfield OH 45503-2736		0264-HSP
Affinity Care of Northern Ohio LLC	25 S Main St Ste 6, Munroe Falls OH 44262-1660	36-1725	0281-HSP
Branch	2001 Crocker Rd Ste 325, West Lake OH 44145-6978		0281-HSP
Affinity Care of Indiana LLC	3935 Eagle Creek Parkway Ste G. Indianapolis IN 46254-4690	15-1645	25-015559-1
Affinity Care of Pittsburgh LLC	2551 Washington Rd Ste 811, Pittsburgh PA 15241-2513	Pending	18261601
Affinity Care of Pennsylvania LLC	6 Interplex Ste 211, Trevose PA 19053-6964	73-1501	18071601
Branch	95 Highland Ave Ste 140, Bethlehem PA 18017-9432		
Affinity Care of Virginia LLC	714 Thimble Shoals Blvd, Suite C, Newport News, VA 23606-2574	49-1637	HSP-23422
Branch	3736 Winterfield Rd Ste 202, Midlothian VA 23113-9235		HSP-23425
Branch	3501 Colonial Green Circle, Roanoke VA 24018-3752		HSP-23430
Branch	450 Solomon Dr Ste 201, Fredericksburg VA 22405-1364		HSP-23443
Affinity Care of Missouri LLC d/b/a One Community Hospice	14700 E 42nd St S, Ste S, Independence MO 64055-4773	26-1609	283-3HO
Affinity Care of DC LLC	1140 Varnum St NE Ste 208B, Washington DC 20017-2153	09-1508	oes not issue Hospice Lic
Affinity Care of Maine LLC	600 Southborough Dr Ste 103, South Portland ME 04106-6915	20-1524	39707
Affinity Care of Oklahoma LLC	5627 North Classen Blvd Ste 100, Oklahoma OK 73118-4031	37-1733	HO4328
Shalom Hospice LLC	5409 Maryland Way Ste 212, Brentwood TN 37027-5068	44-1606	626
Shalom Hospice of Knoxville LLC	8351 E Walker Springs LN Ste 402, Knoxville TN 37923-3142	44-1609	629
Affinity Care of Georgia LLC	2751 Buford Hwy NE, Ste 285, Atlanta GA 30324-5499	85-1587	HSPC001493
Branch	1020 Barber Creek Dr Ste 322, Watkinsville GA 30677-5984		
Affinity Care of Connecticut	2751 Dixwell Ave Fl 3, Hamden CT 06518-3321	07-1547	9915775
Shalom Hospice of Hawai'I LLC	677 Ala Moana Blvd Ste 1600, Honolulu HI 96813-5419	Pending	Pending

Exhibit 2
Letter of Intent

RECEIVED
By Certificate of Need at 9:27 am, Nov 27, 2024

SHALOM
HOSPICE & PALLIATIVE CARE

November 27, 2024

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
Via email: eric.hernandez@doh.wa.gov>; FSLCON@DOH.WA.GOV

Dear Mr. Hernandez:

Shalom Hospice of Southwest Washington LLC submits this letter of intent to establish a Medicare certified/Medicaid eligible hospice agency in Clark County. In conformance with the requirements of WACs 246-310-080 and 246-310-290(3), the following information is provided:

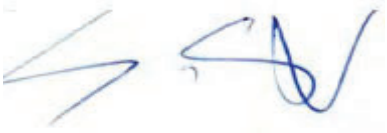
A Description of the Extent of Services Proposed:
Shalom Hospice of Southwest Washington LLC proposes to establish a Medicare certified/Medicaid eligible hospice agency in Clark County. In addition to serving all eligible patients and providing all Medicare required services as well as a number of specialty therapies, Shalom will place an emphasis on outreaching to and serving currently underserved, terminally ill individuals of the Jewish faith in a manner that recognizes and honors Jewish heritage, history, rituals, and traditions. .

1. Estimated Cost of the Proposed Project:
The capital required to establish the agency is estimated at $118,000.

2. Description of the Service Area:
Consistent with WAC, the service area is Clark County.

Please do not hesitate to contact me if you have any questions or require additional information.

Sincerely,



Samuel Stern,
Managing Member and Chief Executive Officer

Exhibit 3
CN Methodology

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
2021	3,883
2022	3,331
2023	3,399
	average: 3,538

Deaths ages 0-64	
Year	Deaths
2021	18,015
2022	17,201
2023	16,708
	average: 17,308

Use Rates	
0-64	20.44%
65+	54.75%

Hospice admissions ages 65+	
Year	Admissions
2021	27,885
2022	28,503
2023	26,755
	average: 27,714

Deaths ages 65+	
Year	Deaths
2021	50,717
2022	52,002
2023	49,130
	average: 50,616

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
Prepared by DOH Program Staff

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

0-64				
County	2021	2022	2023	2021-2023 Average Deaths
Adams	23	25	30	**26**
Asotin	43	45	74	**54**
Benton	536	566	414	**505**
Chelan	256	225	158	**213**
Clallam	185	179	190	**185**
Clark	1,078	1,002	1,058	**1,046**
Columbia	11	12	15	**13**
Cowlitz	401	311	310	**341**
Douglas	45	45	89	**60**
Ferry	21	22	26	**23**
Franklin	110	79	179	**123**
Garfield	4	2	5	**4**
Grant	208	190	243	**214**
Grays Harbor	236	223	309	**256**
Island	116	117	146	**126**
Jefferson	54	59	58	**57**
King	4,892	4,902	4,217	**4,670**
Kitsap	489	462	556	**502**
Kittitas	88	78	76	**81**
Klickitat	50	50	58	**53**
Lewis	186	191	248	**208**
Lincoln	24	24	35	**28**
Mason	168	152	202	**174**
Okanogan	92	106	112	**103**
Pacific	59	69	72	**67**
Pend Oreille	55	44	47	**49**
Pierce	2,574	2,518	2,320	**2,471**
San Juan	24	12	37	**24**
Skagit	334	258	282	**291**
Skamania	25	20	48	**31**
Snohomish	1,563	1,468	1,637	**1,556**
Spokane	1,842	1,603	1,340	**1,595**
Stevens	114	107	141	**121**
Thurston	763	709	626	**699**
Wahkiakum	7	9	8	**8**
Walla Walla	138	157	110	**135**
Whatcom	443	467	475	**462**
Whitman	59	65	63	**62**
Yakima	699	628	694	**674**

65+				
County	2021	2022	2023	2021-2023 Average Deaths
Adams	92	91	84	**89**
Asotin	188	227	236	**217**
Benton	1,610	1,739	1,332	**1,560**
Chelan	870	873	617	**787**
Clallam	906	935	1,019	**953**
Clark	3,705	3,709	3,399	**3,604**
Columbia	43	37	40	**40**
Cowlitz	1,100	989	1,033	**1,041**
Douglas	174	205	270	**216**
Ferry	63	60	105	**76**
Franklin	261	234	364	**286**
Garfield	24	24	20	**23**
Grant	523	533	616	**557**
Grays Harbor	590	683	762	**678**
Island	504	548	732	**595**
Jefferson	295	298	349	**314**
King	11,896	12,448	10,961	**11,768**
Kitsap	1,832	1,895	1,909	**1,879**
Kittitas	241	261	317	**273**
Klickitat	164	130	175	**156**
Lewis	723	753	811	**762**
Lincoln	76	67	120	**88**
Mason	461	414	646	**507**
Okanogan	324	341	407	**357**
Pacific	239	235	295	**256**
Pend Oreille	119	127	164	**137**
Pierce	6,264	6,412	5,695	**6,124**
San Juan	91	78	134	**101**
Skagit	1,190	1,215	1,168	**1,191**
Skamania	56	60	89	**68**
Snohomish	4,478	4,833	4,660	**4,657**
Spokane	4,810	4,603	3,990	**4,468**
Stevens	304	336	423	**354**
Thurston	2,285	2,419	2,175	**2,293**
Wahkiakum	25	24	54	**34**
Walla Walla	595	598	567	**587**
Whatcom	1,674	1,653	1,552	**1,626**
Whitman	278	233	237	**249**
Yakima	1,644	1,682	1,603	**1,643**

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
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	2021-2023 Average Deaths	Projected Patients: 20.44% of Deaths
Adams	26	5
Asotin	54	11
Benton	505	103
Chelan	213	44
Clallam	185	38
Clark	1,046	214
Columbia	13	3
Cowlitz	341	70
Douglas	60	12
Ferry	23	5
Franklin	123	25
Garfield	4	1
Grant	214	44
Grays Harbor	256	52
Island	126	26
Jefferson	57	12
King	4,670	955
Kitsap	502	103
Kittitas	81	16
Klickitat	53	11
Lewis	208	43
Lincoln	28	6
Mason	174	36
Okanogan	103	21
Pacific	67	14
Pend Oreille	49	10
Pierce	2,471	505
San Juan	24	5
Skagit	291	60
Skamania	31	6
Snohomish	1,556	318
Spokane	1,595	326
Stevens	121	25
Thurston	699	143
Wahkiakum	8	2
Walla Walla	135	28
Whatcom	462	94
Whitman	62	13
Yakima	674	138

65+		
County	2021-2023 Average Deaths	Projected Patients: 54.75% of Deaths
Adams	89	49
Asotin	217	119
Benton	1,560	854
Chelan	787	431
Clallam	953	522
Clark	3,604	1,974
Columbia	40	22
Cowlitz	1,041	570
Douglas	216	118
Ferry	76	42
Franklin	286	157
Garfield	23	12
Grant	557	305
Grays Harbor	678	371
Island	595	326
Jefferson	314	172
King	11,768	6,444
Kitsap	1,879	1,029
Kittitas	273	149
Klickitat	156	86
Lewis	762	417
Lincoln	88	48
Mason	507	278
Okanogan	357	196
Pacific	256	140
Pend Oreille	137	75
Pierce	6,124	3,353
San Juan	101	55
Skagit	1,191	652
Skamania	68	37
Snohomish	4,657	2,550
Spokane	4,468	2,446
Stevens	354	194
Thurston	2,293	1,256
Wahkiakum	34	19
Walla Walla	587	321
Whatcom	1,626	890
Whitman	249	137
Yakima	1,643	900

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
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.

0-64								
County	Projected Patients	2021-2023 Average Population	2024 projected population	2025 projected population	2026 projected population	2024 potential volume	2025 potential volume	2026 potential volume
Adams	5	18,382	18,748	18,931	19,076	5	5	6
Asotin	11	16,591	16,360	16,244	16,150	11	11	11
Benton	103	177,393	180,477	182,019	183,656	105	106	107
Chelan	44	62,984	63,139	63,217	63,358	44	44	44
Clallam	38	52,399	52,704	52,857	53,039	38	38	38
Clark	214	429,086	437,545	441,774	445,732	218	220	222
Columbia	3	2,713	2,615	2,566	2,534	2	2	2
Cowlitz	70	88,027	88,206	88,295	88,438	70	70	70
Douglas	12	35,501	35,746	35,869	36,040	12	12	12
Ferry	5	5,047	4,886	4,806	4,794	5	4	4
Franklin	25	90,044	92,587	93,859	95,174	26	26	27
Garfield	1	1,570	1,569	1,569	1,565	1	1	1
Grant	44	86,185	87,363	87,952	88,582	44	45	45
Grays Harbor	52	57,788	57,179	56,875	56,714	52	51	51
Island	26	64,048	64,464	64,672	64,972	26	26	26
Jefferson	12	20,192	20,040	19,964	20,079	12	12	12
King	955	1,984,180	2,003,368	2,012,962	2,022,512	964	968	973
Kitsap	103	222,634	222,729	222,776	223,024	103	103	103
Kittitas	16	38,910	39,653	40,024	40,367	17	17	17
Klickitat	11	17,103	16,874	16,759	16,746	11	11	11
Lewis	43	64,018	64,432	64,639	64,828	43	43	43
Lincoln	6	7,794	7,775	7,765	7,769	6	6	6
Mason	36	50,196	50,594	50,793	51,105	36	36	36
Okanogan	21	31,737	31,392	31,219	31,139	21	21	21
Pacific	14	15,464	15,346	15,287	15,287	14	13	13
Pend Oreille	10	9,602	9,485	9,427	9,408	10	10	10
Pierce	505	794,221	801,483	805,114	808,657	510	512	514
San Juan	5	11,668	11,640	11,626	11,711	5	5	5
Skagit	60	100,998	101,846	102,270	102,688	60	60	61
Skamania	6	9,121	8,875	8,752	8,728	6	6	6
Snohomish	318	717,100	725,839	730,209	734,203	322	324	326
Spokane	326	449,365	452,277	453,733	455,179	328	329	330
Stevens	25	35,550	35,071	34,832	34,983	24	24	24
Thurston	143	244,360	248,369	250,374	252,633	145	146	148
Wahkiakum	2	2,930	2,903	2,890	2,890	2	2	2
Walla Walla	28	50,370	50,382	50,388	50,438	28	28	28
Whatcom	94	186,794	189,395	190,696	192,079	96	96	97
Whitman	13	42,503	42,531	42,545	42,566	13	13	13
Yakima	138	219,982	220,690	221,044	221,446	138	138	139

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
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	2021-2023 Average Population	2024 projected population	2025 projected population	2026 projected population	2024 potential volume	2025 potential volume	2026 potential volume
Adams	49	2,613	2,629	2,637	2,692	49	49	50
Asotin	119	5,884	6,305	6,515	6,700	127	132	135
Benton	854	35,088	37,611	38,872	40,093	916	946	976
Chelan	431	17,494	18,677	19,268	19,807	460	474	488
Clallam	522	25,678	26,295	26,603	26,888	535	541	547
Clark	1,974	90,303	97,923	101,733	105,735	2,140	2,223	2,311
Columbia	22	1,200	1,259	1,289	1,312	23	24	24
Cowlitz	570	24,060	25,237	25,826	26,521	598	612	628
Douglas	118	8,396	9,109	9,465	9,777	129	134	138
Ferry	42	2,147	2,323	2,411	2,428	45	47	47
Franklin	157	10,341	11,433	11,979	12,478	173	182	189
Garfield	12	706	695	690	692	12	12	12
Grant	305	15,343	16,571	17,185	17,801	330	342	354
Grays Harbor	371	18,161	19,082	19,542	19,860	390	400	406
Island	326	24,127	25,030	25,482	25,885	338	344	349
Jefferson	172	13,427	14,221	14,618	14,832	182	187	190
King	6,444	328,719	352,755	364,773	377,152	6,915	7,150	7,393
Kitsap	1,029	57,228	61,385	63,464	65,489	1,103	1,141	1,177
Kittitas	149	8,664	9,028	9,210	9,439	156	159	163
Klickitat	86	5,987	6,572	6,864	7,054	94	98	101
Lewis	417	19,253	19,962	20,316	20,685	433	440	448
Lincoln	48	3,169	3,276	3,330	3,362	50	50	51
Mason	278	16,945	17,962	18,471	18,902	294	303	310
Okanogan	196	10,685	11,348	11,680	11,916	208	214	218
Pacific	140	8,159	8,534	8,722	8,815	147	150	152
Pend Oreille	75	4,007	4,332	4,494	4,618	81	84	86
Pierce	3,353	145,038	156,642	162,444	168,469	3,621	3,755	3,895
San Juan	55	6,561	7,030	7,265	7,399	59	61	62
Skagit	652	31,128	32,882	33,759	34,696	689	707	727
Skamania	37	2,673	3,108	3,326	3,440	44	47	48
Snohomish	2,550	132,107	144,618	150,874	157,737	2,791	2,912	3,045
Spokane	2,446	99,458	106,030	109,316	112,735	2,608	2,689	2,773
Stevens	194	11,642	12,868	13,481	13,710	214	225	228
Thurston	1,256	58,110	61,778	63,612	65,312	1,335	1,374	1,411
Wahkiakum	19	1,558	1,651	1,697	1,722	20	20	21
Walla Walla	321	12,666	13,106	13,326	13,528	332	338	343
Whatcom	890	45,443	48,232	49,627	51,012	945	972	1,000
Whitman	137	5,739	5,980	6,101	6,249	142	145	149
Yakima	900	39,479	41,504	42,516	43,626	946	969	994

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
Prepared by DOH Program Staff

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	2024 potential volume	2025 potential volume	2026 potential volume	Current Supply of Hospice Providers	2024 Unmet Need Admissions*	2025 Unmet Need Admissions*	2026 Unmet Need Admissions*
Adams	54	55	56	**37.67**	17	17	18
Asotin	138	142	146	**104.00**	34	38	42
Benton	1,021	1,052	1,083	**1,023.67**	(3)	29	59
Chelan	503	518	531	**761.70**	(258)	(244)	(230)
Clallam	572	579	585	**353.90**	219	225	231
Clark	2,358	2,443	2,533	**2,704.23**	(346)	(261)	(171)
Columbia	25	26	26	**24.33**	1	2	2
Cowlitz	667	681	698	**752.00**	(85)	(71)	(54)
Douglas	141	146	150	**508.70**	(368)	(363)	(358)
Ferry	50	51	52	**37.33**	12	14	14
Franklin	199	208	216	**187.33**	12	20	28
Garfield	13	13	13	**7.33**	6	6	6
Grant	374	386	399	**275.33**	99	111	124
Grays Harbor	442	451	458	**351.37**	91	100	106
Island	364	370	376	**477.33**	(114)	(107)	(102)
Jefferson	194	199	202	**129.00**	65	70	73
King	7,879	8,119	8,366	**8,516.53**	(638)	(398)	(151)
Kitsap	1,206	1,243	1,280	**1,200.17**	6	43	80
Kittitas	173	176	180	**144.33**	28	32	36
Klickitat	105	109	111	**86.33**	18	22	25
Lewis	476	483	492	**467.67**	8	16	24
Lincoln	55	56	57	**25.33**	30	31	31
Mason	330	339	346	**529.03**	(199)	(190)	(183)
Okanogan	229	235	239	**160.33**	68	74	79
Pacific	160	164	165	**73.33**	87	90	92
Pend Oreille	91	94	96	**70.33**	20	23	26
Pierce	4,131	4,267	4,409	**3,992.20**	139	275	417
San Juan	64	66	67	**102.67**	(38)	(36)	(35)
Skagit	749	768	787	**848.33**	(99)	(81)	(61)
Skamania	50	53	54	**36.33**	13	16	18
Snohomish	3,113	3,236	3,370	**4,129.43**	(1,016)	(893)	(759)
Spokane	2,936	3,018	3,103	**3,543.77**	(608)	(526)	(441)
Stevens	239	249	253	**140.67**	98	108	112
Thurston	1,480	1,521	1,559	**1,464.27**	16	57	95
Wahkiakum	22	22	22	**18.67**	3	3	4
Walla Walla	360	366	371	**272.67**	87	93	98
Whatcom	1,041	1,069	1,097	**1,727.80**	(687)	(659)	(631)
Whitman	155	158	161	**66.33**	89	92	95
Yakima	1,084	1,107	1,133	**935.33**	149	172	197

*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 2021-2023
Vital Statistics Death Data for Years 2021-2023
Prepared by DOH Program Staff

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

				Step 6 (Admits * ALOS) = Unmet Patient Days			
County	2024 Unmet Need Admissions*	2025 Unmet Need Admissions*	2026 Unmet Need Admissions*	Statewide ALOS	2024 Unmet Need Patient Days*	2025 Unmet Need Patient Days*	2026 Unmet Need Patient Days*
Adams	17	17	18	**59.79**	1,003	1,015	1,079
Asotin	34	38	42	**59.79**	2,045	2,294	2,514
Benton	(3)	29	59	**59.79**	(168)	1,722	3,556
Chelan	(258)	(244)	(230)	**59.79**	(15,438)	(14,565)	(13,766)
Clallam	219	225	231	**59.79**	13,070	13,451	13,805
Clark	(346)	(261)	(171)	**59.79**	(20,698)	(15,594)	(10,247)
Columbia	1	2	2	**59.79**	69	98	121
Cowlitz	(85)	(71)	(54)	**59.79**	(5,055)	(4,217)	(3,226)
Douglas	(368)	(363)	(358)	**59.79**	(21,997)	(21,694)	(21,427)
Ferry	12	14	14	**59.79**	732	830	850
Franklin	12	20	28	**59.79**	704	1,220	1,694
Garfield	6	6	6	**59.79**	337	332	333
Grant	99	111	124	**59.79**	5,890	6,638	7,390
Grays Harbor	91	100	106	**59.79**	5,420	5,967	6,347
Island	(114)	(107)	(102)	**59.79**	(6,789)	(6,420)	(6,088)
Jefferson	65	70	73	**59.79**	3,866	4,168	4,335
King	(638)	(398)	(151)	**59.79**	(38,143)	(23,782)	(8,999)
Kitsap	6	43	80	**59.79**	353	2,588	4,771
Kittitas	28	32	36	**59.79**	1,688	1,885	2,130
Klickitat	18	22	25	**59.79**	1,091	1,336	1,498
Lewis	8	16	24	**59.79**	476	943	1,429
Lincoln	30	31	31	**59.79**	1,790	1,838	1,867
Mason	(199)	(190)	(183)	**59.79**	(11,893)	(11,386)	(10,951)
Okanogan	68	74	79	**59.79**	4,087	4,443	4,698
Pacific	87	90	92	**59.79**	5,202	5,392	5,488
Pend Oreille	20	23	26	**59.79**	1,219	1,396	1,533
Pierce	139	275	417	**59.79**	8,287	16,445	24,907
San Juan	(38)	(36)	(35)	**59.79**	(2,299)	(2,181)	(2,111)
Skagit	(99)	(81)	(61)	**59.79**	(5,944)	(4,831)	(3,642)
Skamania	13	16	18	**59.79**	798	975	1,069
Snohomish	(1,016)	(893)	(759)	**59.79**	(60,756)	(53,421)	(45,394)
Spokane	(608)	(526)	(441)	**59.79**	(36,340)	(31,444)	(26,353)
Stevens	98	108	112	**59.79**	5,866	6,467	6,702
Thurston	16	57	95	**59.79**	943	3,382	5,658
Wahkiakum	3	3	4	**59.79**	172	205	223
Walla Walla	87	93	98	**59.79**	5,220	5,554	5,862
Whatcom	(687)	(659)	(631)	**59.79**	(41,075)	(39,402)	(37,738)
Whitman	89	92	95	**59.79**	5,301	5,473	5,685
Yakima	149	172	197	**59.79**	8,881	10,274	11,802

*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 2021-2023
Vital Statistics Death Data for Years 2021-2023
Prepared by DOH Program Staff

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

				Step 7 (Patient Days / 365) = Unmet ADC		
County	**2024 Unmet Need Patient Days***	**2025 Unmet Need Patient Days***	**2026 Unmet Need Patient Days***	**2024 Unmet Need ADC*†**	**2025 Unmet Need ADC***	**2026 Unmet Need ADC***
Adams	1,003	1,015	1,079	3	3	3
Asotin	2,045	2,294	2,514	6	6	7
Benton	(168)	1,722	3,556	(0)	5	10
Chelan	(15,438)	(14,565)	(13,766)	(42)	(40)	(38)
Clallam	13,070	13,451	13,805	36	37	38
Clark	(20,698)	(15,594)	(10,247)	(57)	(43)	(28)
Columbia	69	98	121	0	0	0
Cowlitz	(5,055)	(4,217)	(3,226)	(14)	(12)	(9)
Douglas	(21,997)	(21,694)	(21,427)	(60)	(59)	(59)
Ferry	732	830	850	2	2	2
Franklin	704	1,220	1,694	2	3	5
Garfield	337	332	333	1	1	1
Grant	5,890	6,638	7,390	16	18	20
Grays Harbor	5,420	5,967	6,347	15	16	17
Island	(6,789)	(6,420)	(6,088)	(19)	(18)	(17)
Jefferson	3,866	4,168	4,335	11	11	12
King	(38,143)	(23,782)	(8,999)	(104)	(65)	(25)
Kitsap	353	2,588	4,771	1	7	13
Kittitas	1,688	1,885	2,130	5	5	6
Klickitat	1,091	1,336	1,498	3	4	4
Lewis	476	943	1,429	1	3	4
Lincoln	1,790	1,838	1,867	5	5	5
Mason	(11,893)	(11,386)	(10,951)	(32)	(31)	(30)
Okanogan	4,087	4,443	4,698	11	12	13
Pacific	5,202	5,392	5,488	14	15	15
Pend Oreille	1,219	1,396	1,533	3	4	4
Pierce	8,287	16,445	24,907	23	45	68
San Juan	(2,299)	(2,181)	(2,111)	(6)	(6)	(6)
Skagit	(5,944)	(4,831)	(3,642)	(16)	(13)	(10)
Skamania	798	975	1,069	2	3	3
Snohomish	(60,756)	(53,421)	(45,394)	(166)	(146)	(124)
Spokane	(36,340)	(31,444)	(26,353)	(99)	(86)	(72)
Stevens	5,866	6,467	6,702	16	18	18
Thurston	943	3,382	5,658	3	9	16
Wahkiakum	172	205	223	0	1	1
Walla Walla	5,220	5,554	5,862	14	15	16
Whatcom	(41,075)	(39,402)	(37,738)	(112)	(108)	(103)
Whitman	5,301	5,473	5,685	14	15	16
Yakima	8,881	10,274	11,802	24	28	32

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.
†unmet need for 2024 is calculated by dividing by 366 days due to it being a leap year.

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
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	2024 Unmet Need ADC*†	2025 Unmet Need ADC*	2026 Unmet Need ADC*	Numeric Need?	Number of New Agencies Needed?**
Adams	3	3	3	FALSE	FALSE
Asotin	6	6	7	FALSE	FALSE
Benton	(0)	5	10	FALSE	FALSE
Chelan	(42)	(40)	(38)	FALSE	FALSE
Clallam	36	37	38	*TRUE*	*1*
Clark	(57)	(43)	(28)	FALSE	FALSE
Columbia	0	0	0	FALSE	FALSE
Cowlitz	(14)	(12)	(9)	FALSE	FALSE
Douglas	(60)	(59)	(59)	FALSE	FALSE
Ferry	2	2	2	FALSE	FALSE
Franklin	2	3	5	FALSE	FALSE
Garfield	1	1	1	FALSE	FALSE
Grant	16	18	20	FALSE	FALSE
Grays Harbor	15	16	17	FALSE	FALSE
Island	(19)	(18)	(17)	FALSE	FALSE
Jefferson	11	11	12	FALSE	FALSE
King	(104)	(65)	(25)	FALSE	FALSE
Kitsap	1	7	13	FALSE	FALSE
Kittitas	5	5	6	FALSE	FALSE
Klickitat	3	4	4	FALSE	FALSE
Lewis	1	3	4	FALSE	FALSE
Lincoln	5	5	5	FALSE	FALSE
Mason	(32)	(31)	(30)	FALSE	FALSE
Okanogan	11	12	13	FALSE	FALSE
Pacific	14	15	15	FALSE	FALSE
Pend Oreille	3	4	4	FALSE	FALSE
Pierce	23	45	68	*TRUE*	*1*
San Juan	(6)	(6)	(6)	FALSE	FALSE
Skagit	(16)	(13)	(10)	FALSE	FALSE
Skamania	2	3	3	FALSE	FALSE
Snohomish	(166)	(146)	(124)	FALSE	FALSE
Spokane	(99)	(86)	(72)	FALSE	FALSE
Stevens	16	18	18	FALSE	FALSE
Thurston	3	9	16	FALSE	FALSE
Wahkiakum	0	1	1	FALSE	FALSE
Walla Walla	14	15	16	FALSE	FALSE
Whatcom	(112)	(108)	(103)	FALSE	FALSE
Whitman	14	15	16	FALSE	FALSE
Yakima	24	28	32	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.

†unmet need for 2024 is calculated by dividing by 366 days due to it being a leap year.

Sources:
Self-Report Provider Utilization Surveys for Years 2021-2023
Vital Statistics Death Data for Years 2021-2023
Prepared by DOH Program Staff

Exhibit 4
DRAFT Shared Services Agreement

SUPPLEMENTAL STAFFING SERVICES AGREEMENT

THIS SUPPLEMENTAL STAFFING SERVICES AGREEMENT (the "Agreement") is made and entered into this 1st day of January, 20-- (the "Effective Date") by and between **SHALOM HOSPICE OF SOUTHWEST WASHINGTON LLC** ("Hospice") and AFFINITY HOSPICE MANAGEMENT LLC ("Provider").

RECITALS

A. WHEREAS, Hospice operates a licensed hospice program.

B. WHEREAS, Provider is a duly licensed provider of supplemental health care staffing services.

C. WHEREAS, Hospice desires to engage Provider, and Provider desires to be engaged, to provide Services (as the term is defined below) to Hospice patients in accordance with the terms and conditions of this Agreement.

AGREEMENTS

In consideration of the Recitals and mutual agreements that follow, the parties agree to the following terms and conditions:

1. Responsibilities of Provider.

(a) Provision of Services.

(i) Services. At the request of an authorized Hospice staff member, Provider shall provide Hospice with the staffing services of the qualified health professionals identified in Exhibit B ("Services"). Each staffing health professional shall be referred to as "Staff Member". Staff Members shall provide Services that are ordered by the Hospice interdisciplinary group, in accordance with the patient's plan of care and Hospice instructions, permitted to be performed under state law by such Staff Member, and consistent with the Staff Member's training.

(ii) Staff Member Assignments. Provider shall work with Hospice in establishing assignments of Staff Members to ensure continuity of care, and shall make every effort to fulfill the staffing requests with a Staff Member who has previously worked with that particular Hospice patient.

(iii) Availability. Provider shall be available to provide Services during regular business hours and, if necessary, on a 24-hour basis. Provider shall maintain sufficient personnel who have the requisite training, skills and experience to meet this obligation.

(b) Professional Standards and Credentials.

(i) Professional Standards. Provider shall ensure that all Services are provided in a safe and effective manner by qualified personnel. Services shall meet or exceed the current standards for providers of such Services and shall be in compliance with all applicable laws, rules, regulations, professional standards and licensure requirements, including those relating to patient health and safety.

(ii) Credentials.

[a] Licensure. Provider represents and warrants that it has and will maintain in good standing during the term of this Agreement all federal, state and local licenses, registrations and certifications required by law to provide Services. Upon Hospice's request, Provider shall provide Hospice with evidence of such licenses, registrations and certifications.

[b] Background Checks. Provider shall obtain criminal background checks on all Staff Members and other personnel who have direct contact with Hospice patients or access to Hospice patients' records. Unless state law specifies otherwise, Provider shall obtain the background check within three months of the date of employment for all states that the Staff Member has lived or worked in the past three years. If a Staff Member or other person must obtain a background check as

a condition of the individual's licensure, Provider is not obligated to obtain an additional background check as long as the individual's license is current.

[c] Qualifications of Personnel. Staff Members who provide Services shall be reasonably acceptable to Hospice. Provider represents and warrants that Staff Members providing Services: [i] are duly licensed, credentialed, certified and/or registered as required under applicable state laws; [ii] possess the education, skills, training and other qualifications necessary to provide Services; [iii] based on criminal background checks conducted by Provider, are eligible to provide Services and have not been found to have engaged in improper or illegal conduct relating to the elderly, children or vulnerable individuals; and [iv] meet the applicable qualifications and other requirements set forth in 42 C.F.R. § 418.76, including successful completion of a competency evaluation program for Staff Members providing hospice aide services. Provider shall ensure that Staff Members keep current with these qualifications and requirements.

[d] Disciplinary Action. Provider represents and warrants that neither Provider nor any of its personnel is under suspension or subject to any disciplinary proceedings by any agency having jurisdiction over professional activities of Provider or its personnel and is not under any formal or informal investigation or preliminary inquiry by such department or agency for possible disciplinary action.

[e] Exclusion from Medicare or Medicaid. Provider represents and warrants that neither Provider nor its personnel has been, at any time, excluded from participation in any federally funded health care program including, without limitation, Medicare or Medicaid; nor has been convicted or found to have violated any federal or state fraud and abuse law or illegal remuneration law.

(c) Records Regarding Qualifications of Staff Members. Provider shall maintain and provide to Hospice copies of the following information and documentation on each Staff Member prior to the Staff Member rendering Services:

(i) Qualifications Required by the Medicare Hospice Regulations. Proof of qualifications meeting the standards of 42 C.F.R. § 418.76.

(ii) Current Licensure and/or Certification. If applicable, proof of current licensure or certification from the appropriate licensing authority. Provider shall maintain records of investigations, sanctions, censures or licensure limitations, and shall provide this information to Hospice with proof of current licensure.

(iii) Compliance with Immigration Laws. Compliance with immigration laws including, without limitation, maintenance of a completed I-9.

(iv) Employment Application. A completed employment application listing Staff Member's education and work history.

(v) Proof of Competency. For Staff Members providing hospice aide services, proof of the successful completion of a competency evaluation program meeting the requirements of 42 C.F.R. § 418.76. Such documentation must include: [a] descriptions of the training/competency evaluation program, including the qualifications of the instructors; [b] a record that distinguishes between skills taught at a patient's bedside with supervision, and those taught in a laboratory using a real person (not a mannequin) and indicators of which skills each Staff Member was judged to be competent; and [c] how additional skills (beyond the basic skills listed in 42 C.F.R. § 418.76) are taught and tested. For all other Staff Members, proof of competency, skills and knowledge as demonstrated by a skills checklist and/or competency verification.

(vi) Physical Examination. Evidence of an initial hire physical examination, confirming a Hepatitis B inoculation or a signed declination form.

(vii) Tuberculosis Screening. Evidence of an initial hire tuberculosis screening and evidence of the results of a tuberculosis screening every twelve months thereafter.

(viii) Proof of Non-Excluded Status. Evidence that Provider has verified that Staff Member is not excluded by the U.S. Department of Health and Human Services Office of the Inspector General from participating in Medicare and Medicaid.

(ix) Proof of Experience. Proof of at least one (1) year, or equivalent, experience in a health care setting.

(x) Professional References. At least two (2) professional references, one (1) being from the most recent health care provider for whom Staff Member provided services.

(xi) Evaluations and Reports. Copies of any and all evaluations or reports concerning Staff Member, including, but not limited to, complaints made and/or disciplinary actions taken against Staff Member by Provider or by any organization that contracted or contracts with Provider or by another health care provider or another employer.

(xii) Criminal Background Check Results. Proof of a successful criminal background check. A new background check shall be conducted at intervals required by applicable laws, or at any time within such period that Provider or Hospice has reason to believe that a new background check should be obtained.

(d) Orientation and In-Service Training of Staff Members. Provider shall conduct an orientation program for each Staff Member upon hire and shall conduct or provide Staff Members with annual in-service training in the amount required by federal and/or state law for Staff Members to maintain all necessary certifications and licensures. Provider shall ensure that Staff Members providing hospice aide services receive at least 12 hours of in-service training during each 12-month period, and shall provide Hospice with documentation demonstrating that this requirement is met. For all other orientation and training activities, Provider shall maintain documentation of staff attendance and training content, and shall provide Hospice with such documentation upon request.

(e) Monitoring and Disciplinary Actions. Provider shall monitor the performance of each Staff Member. Provider shall provide a coordinator for screening, management and supervision of each Staff Member.

(f) Employment.

(i) Status of Staff Members. Each Staff Member is, and shall be for all purposes, the employee of Provider and shall not be considered an employee of Hospice.

(ii) Benefits. Provider shall be solely responsible for paying all compensation and benefits of each Staff Member. Provider retains the right to hire and fire Staff Members, to reassign Staff Members and to control the salary and benefits of Staff Members.

(iii) Withholdings. Provider shall be solely responsible for withholding payment of all federal, state and local income taxes for each Staff Member, as well as FICA and any other obligations imposed upon employers.

(g) Cancellations. Provider will provide Hospice with notification when Provider Staff Member cancels (and is unable to replace with a qualified and acceptable alternate Staff Member) or does not report to a case. If Hospice is not notified regarding the cancellation, Hospice will not reimburse Provider for a full visit or full hourly rate as set forth in Exhibit B.

(h) Authorization of Services. Provider shall provide Services to Hospice patients only with the authorization of designated personnel of Hospice. Provider is authorized to provide all Services identified in a patient's plan of care. Provider shall seek authorization from designated Hospice personnel prior to providing services not identified in the plan of care.

(i) Quality Assessment and Performance Improvement Activities. Provider shall cooperate with Hospice in its hospice-wide quality assessment and performance improvement activities. Components of the quality assessment and performance improvement program include: (i) data collection; (ii) reporting adverse patient events, analyzing their causes and implementing preventive actions and mechanisms; and (iii) taking actions to improve performance. Hospice shall also maintain a coordinated agency-wide program for the surveillance, identification, prevention, control and investigation of infectious and or communicable disease. Upon request, Hospice shall provide Provider with a description of its quality assessment and performance improvement program and information on relevant performance improvement projects. Third-party payors may also impose their own utilization management or quality assurance requirements which Provider must meet. Cooperating in such activities shall not constitute a waiver of any legal privileges or rights that may apply to the information that is shared. Hospice shall maintain the confidentiality of such information in whatever form it is provided.

(j) Coordination of Care. Provider shall participate in any meetings, when requested, for the coordination, supervision and evaluation by Hospice of the provision of Services. Hospice and Provider shall communicate with one another regularly

and as needed for each particular Hospice patient. Provider shall ensure that Staff Members report all concerns about the patient or family to the Hospice interdisciplinary group member who is coordinating the Services. Provider shall ensure that Staff Members report changes in the patient's medical, nursing, rehabilitative and social needs to Hospice's registered nurse.

(k) Policies and Procedures. In providing Services, Provider shall ensure that Staff Members abide by Hospice instructions, patient care protocols, patients' plans of care and applicable Hospice policies and procedures that are attached in Exhibit A.

(l) Complaints and Surveys. In the event of any complaint filed by, or with respect to, a Hospice patient receiving Services, or any investigation or survey initiated by any governmental agency, or any litigation commenced against Hospice, Provider shall fully cooperate with Hospice in an effort to respond to and resolve the same in a timely and effective manner. Provider shall also cooperate fully with any insurance company providing protection to Hospice in connection with investigations. In this connection, Provider shall notify Hospice promptly of any inquiries, claims and investigations, and cooperate fully with the directions of Hospice with respect thereto.

(m) Documentation. Provider shall provide all necessary documentation to Hospice for reimbursement activities.

2. Responsibilities of Hospice.

(a) Professional Management Responsibility.

(i) Compliance with Law. Hospice shall retain responsibility as the care provider to all Hospice patients and family units, pursuant to the Medicare Conditions of Participation for Hospice Care and state and local laws and regulations. This includes admission and/or discharge of patients, patient and family assessments, reassessments, establishment of Hospice plan of care, authorization of all services, and management of the care through interdisciplinary team meetings.

(ii) Coordination and Evaluation. Hospice shall retain responsibility for coordinating, evaluating and administering the hospice program, as well as ensuring the continuity of care of Hospice patients, which shall include coordination of Services. Methods used to evaluate the care may include: [a] periodic supervisory visits; [b] review of the qualifications of personnel providing Services; [c] review of documentation; [d] evaluation of the response of a Hospice patient to the plan of care; [e] discussion with patient and patient's caregivers; [f] patient evaluation surveys; and [g] quality improvement data.

(iii) Supervision. Hospice shall supervise Staff Members providing hospice aide and homemaker services in the manner specified in the Medicare Conditions of Participation for Hospice Care.

(b) Hospice Care Training. Hospice shall provide Staff Members with orientation about the hospice philosophy, as well as education regarding infection control.

(c) Designation of Hospice Representative. For each Hospice patient, Hospice shall designate a registered nurse, who will be responsible for coordinating and supervising services provided to a Hospice patient and available 24 hours per day, 7 days per week, for consultation with Provider concerning a Hospice patient's plan of care. The Hospice representative shall monitor Provider and be available to provide information to Provider regarding the provision of Services, and to coordinate the periodic evaluation of patient progress and outcomes of care upon request.

(d) Provision of Information. Hospice shall provide for the ongoing sharing of information with Provider and shall provide Provider with the information necessary to render Services in accordance with this Agreement, the Hospice patient's plan of care, assessments, treatment planning and care coordination.

(e) Policies and Procedures. Hospice shall provide Provider with copies of Hospice's policies and procedures applicable to the provision of Services, and shall meet with Provider to review such policies and procedures, as necessary.

(f) Complaints and Surveys. In the event of any complaint filed by or with respect to a Hospice patient receiving Services or any investigation or survey initiated by any governmental agency or any litigation commenced against Provider, Hospice shall fully cooperate with Provider in an effort to respond to and resolve the same in a timely and effective manner.

Hospice shall also cooperate fully with any insurance company providing protection to Provider in connection with investigations. In this connection, Hospice shall notify Provider promptly of any inquiries, claims and investigations.

3. Billing and Payment.

(a) Payment for Services. As compensation for Services, Hospice shall pay Provider a rate in accordance with the schedule set forth in Exhibit B. Within 10 calendar days of the end of the month and within at least 30 days of providing Services, Provider shall submit to Hospice an accurate and complete statement of Services provided to Hospice. The statement shall include information usually provided to third-party payors to verify services and charges including the name of Staff Member who provided Services, date(s) worked, shift worked, total hours worked, hourly rate, total charge and any additional information requested by Hospice. Hospice shall pay Provider within 30 days after receipt of a final and complete statement. Payment by Hospice, in respect to such bills, shall be considered final unless adjustments are requested in writing by Provider within 30 days of receipt of payment. Hospice shall have no obligation to pay Provider for any Services if Hospice does not receive a bill for such service within 60 days following the date on which the Services were rendered. Provider shall not bill any person other than Hospice for Services.

(i) Hospice shall not reimburse Provider for care until all necessary documentation has been submitted to Hospice. Reimbursement shall be limited to payment for time expended during the actually delivery of Services and shall exclude travel time.

(ii) Hospice shall not reimburse Provider for full visit or full hourly rate when the patient is not home at the time of the visit or if the patient refuses Services. Hospice agrees to provide Provider notification regarding a case that is cancelled because of death or the refusal of the patient to receive Service.

(b) Limitation on Hospice's Financial Responsibility. Hospice shall bear no financial responsibility, obligation or other liability to reimburse Provider for any charges, costs, expenses or other fees for services that are not in conformity with the plan of care for a given Hospice patient.

(c) Rates. Except as otherwise set forth in this Agreement, Provider shall accept the rates set forth in Exhibit B as payment in full for Services provided to Hospice patients. The rates represent fair market value and do not take into account the volume or value of referrals.

4. Insurance and Indemnification.

(a) Insurance. Each party shall obtain and maintain appropriate professional liability, commercial general liability, worker's compensation and employer's liability and comprehensive auto liability insurance coverage, in accordance with the minimum amounts required from time to time by applicable federal and state laws and regulations; but at no time shall the terms or coverage amounts of Provider's professional liability insurance be less than $1 million per claim and $3 million in the aggregate. Either party may request evidence of insurance from the other party and such other party shall provide such evidence to the requesting party in a timely manner. Provider shall ensure that Hospice receives at least 30 days' notice prior to the termination of any insurance policy required by this Agreement.

(b) Indemnification. Provider shall indemnify, defend and hold harmless Hospice and all of its employees, agents, principals and related entities (collectively, the "Indemnified Parties") from and against any and all claims, actions, investigations, survey citations, demands, liabilities or expenses, including reasonable attorneys' fees and costs (collectively, "Liabilities"), resulting from, or claimed to have resulted from, the acts or omissions of Provider, Staff Members or Provider's other employees, agents or servants. Provider shall also indemnify, defend and hold harmless the Indemnified Parties from against all Liabilities, resulting from, or claimed to have resulted from, Provider's contracting with or employing health care personnel including, but not limited to, claims relating to compensation and benefits, workers' compensation, unemployment compensation and any state or federal taxes arising out of such employment.

5. Records.

(a) Creation and Maintenance of Records. Provider shall ensure Staff Members prepare and promptly provide to Hospice complete and detailed records concerning each Hospice patient receiving Services under this Agreement, in

accordance with prudent recordkeeping procedures and Hospice policies and procedures and as required by applicable federal and state laws and regulations and Medicare and Medicaid program guidelines. Each record shall completely, promptly and accurately document all Services provided to, and events concerning, each Hospice patient.

(b) Access by Hospice. Provider shall permit Hospice or its authorized representative, upon reasonable notice, to review and make photocopies of records maintained by Provider relating to the provision of Services including, but not limited to, billing and payment records. This section shall survive the termination of this Agreement.

(c) Inspection by Government. In accordance with 42 U.S.C. § 1395x(v)(1)(I) and 42 C.F.R. § 420.300, et seq., Provider shall make available, until the expiration of five years from the termination of this Agreement, upon written request, to the Secretary of Health and Human Services of the United States, and upon request, to the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement and any of its books, documents and records that are necessary to certify the nature and costs of Medicare reimbursable services provided under this Agreement. If and to the extent Provider carries out any of its duties under this Agreement through a subcontract with a related organization having a value or cost of $10,000 or more over a 12month period, then Provider shall ensure that the subcontract contains a clause comparable to the clause in the preceding sentence. Nothing contained in this section shall be construed as a waiver by either party of any legal rights of confidentiality with respect to patient records and proprietary information.

(d) Destruction of Records. Provider shall take reasonable precautions to safeguard records against loss, destruction and unauthorized disclosure.

6. Confidentiality. Each party acknowledges that as part of its performance under this Agreement, it may be required to disclose to the other party certain information pertaining to Hospice patients (collectively, "Patient Information") and may also be required to disclose to the other party certain business or financial information (collectively, with the Patient Information, the "Confidential Information"). Each party agrees that it shall treat Confidential Information with the same degree of care it affords its own similarly confidential information and shall not, except as specifically authorized in writing by the other party or as otherwise required by law, reproduce any Confidential Information or disclose or provide any Confidential Information to any person. A party that discloses Confidential Information shall be entitled to injunctive relief to prevent a breach or threatened breach of this section, in addition to all other remedies that may be available. This section shall survive termination of this Agreement.

7. Term and Termination.

(a) Term. This Agreement shall have an initial term of one year beginning on the Effective Date ("Initial Term") and shall automatically renew for successive one year terms, unless sooner terminated as provided below.

(b) Termination.

(i) Without Cause. This Agreement may be terminated by either party for any reason after the Initial Term by providing at least 90 days' prior written notice to the other party.

(ii) Mutual Written Agreement. This Agreement may terminate at any time after the Initial Term upon written agreement of the parties.

(iii) For Cause. Either party may terminate this Agreement upon 30 days' prior written notice to the other party, if the other party breaches this Agreement and fails to cure such breach within such 30-day period.

(iv) Change in Law. In the event there are substantial changes or clarifications to any applicable laws, rules or regulations that materially affect, in the opinion of either party's legal counsel, any party's right to reimbursement from third-party payors or any other legal right of any party to this Agreement, the affected party may, by written notice to the other party, propose such modifications to this Agreement as may be necessary to comply with such change or clarification. Upon receipt of such notice, the parties shall engage in good faith negotiations regarding any appropriate modifications to this Agreement. If such notice is given and the parties are unable within 60 days thereafter to agree to appropriate modifications to this Agreement, either party may terminate this Agreement by providing at least 30 days' notice to the other party.

(v) Immediate Termination. Notwithstanding the above, Hospice may immediately terminate this Agreement if permissible by state law and if:

[a] Failure to Possess Qualifications. Provider or its personnel are excluded from any federal health program or no longer possess the necessary qualifications, certifications and/or licenses required by federal, state and/or local laws to provide Services.

[b] Liquidation. Provider commences or has commenced against it proceedings to liquidate, windup, reorganize or seek protection, relief or a consolidation of its debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

[c] Failure to Have Insurance. Provider ceases to have any of the insurance required under this Agreement.

[d] Threats to Health, Safety or Welfare. Provider or its personnel fails to perform its duties under this Agreement and Hospice determines in its full discretion that such failure threatens the health, safety or welfare of any patient.

[e] Commission of Misconduct. Provider commits an act of misconduct, fraud, dishonesty, misrepresentation or moral turpitude involving Hospice or its patients.

(c) Effect of Termination on Availability of Services. In the event this Agreement is terminated, Provider shall work with Hospice in coordinating the continuation of Services to existing Hospice patients and shall continue to provide Services to Hospice patients after this Agreement is terminated, if Hospice determines that removing Services would be detrimental to Hospice patients. In such case, Services shall continue to be provided in accordance with the terms set forth in this Agreement. This section shall survive termination of this Agreement.

8. Notification of Material Events. Provider shall immediately notify Hospice of:

(a) Ownership Change. Any change in 10% or more of its ownership.

(b) Business Address Change. Any change in business address.

(c) Licensure Actions. The commencement of any action on licenses, permits or other legal authorizations including, but not limited to, any sanctions, intermediate or otherwise, administrative or judicial fines, penalties, investigations or reports of action by federal or state officials against Provider or its personnel.

(d) Exclusion. Any threatened, proposed or actual exclusion of it or any of its subcontractors or personnel from any government program including, but not limited to, Medicare or Medicaid.

(e) Insurance. The cancellation or modification of any of the insurance coverage Provider is required to have under this Agreement.

(f) Liquidation. The commencement of any proceeding to liquidate, windup, reorganize or seek protection, relief or a consolidation of Provider's debts under any law relating to insolvency, reorganization or relief of debtors or seeking the appointment of a receiver or trustee.

(g) Violations Involving Mistreatment, Neglect or Abuse. All alleged violations involving mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of Hospice, to the extent that Provider or Provider's personnel has knowledge of such events.

(h) Patient Grievances. A Hospice patient's grievance regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of Hospice.

9. Nondiscrimination. The parties agree that in the performance of this Agreement they will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, sex, age, religion or national origin in any manner prohibited by federal or state laws.

10. Independent Contractor. In performance of the services discussed herein, Hospice and Provider shall each be, and at all times are, acting and performing as an independent contractor, and not as a partner, a co venturer, an employee, an agent or a representative of the other. No employee or agent of one party to this Agreement shall be considered an employee or agent of the other party.

11. Use of Name or Marks. Neither Hospice nor Provider shall have the right to use the name, symbols, trademarks or service marks of the other party in advertising or promotional materials or otherwise without receiving the prior written approval of such other party; provided, however, that one party may use the name, symbols or marks of the other party in written materials previously approved by the other party for the purpose of informing prospective Hospice patients and attending physicians of the availability of the services described in this Agreement.

12. Business Associate Requirements. Provider qualifies as a Business Associate when providing certain Services to Hospice, a Covered Entity, and shall comply with this section and the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as set forth in Title 45, Parts 160 and 164 of the Code of Federal Regulations (the "CFR") (Subparts A and E, the "Privacy Rule" and Subparts A and C, the "Security Rule").

(a) Definitions. Capitalized terms not otherwise defined in this Agreement shall have the meanings given to them in HIPAA and as amended, and are incorporated herein by reference; provided, however, that the term "Protected Health Information" and "PHI" shall include for purposes of this Agreement the term "Electronic Protected Health Information."

(b) Use and Disclosure of Protected Health Information. Provider shall Use and/or Disclose Protected Health Information created for or received from or on behalf of Hospice ("PHI") only to the extent necessary for Provider to provide the Services. Hospice shall not request Provider to Use or Disclose PHI in any manner that would not be permissible under HIPAA if done by Hospice.

(c) Provider's Operations. Provider may use PHI as necessary for Provider's proper management and administration or to carry out Provider's legal responsibilities. Provider may Disclose PHI for such purposes only if:

(i) Required by Law. The Disclosure is required by law; or

(ii) Obtain Reasonable Assurances. Provider obtains reasonable assurances from any person or organization to which Provider shall Disclose such PHI that such person or organization shall:

[a] Maintain in Confidence. Hold such PHI in confidence and Use or further Disclose it only for the purpose for which Provider disclosed it to the person or organization or as required by law; and

[b] Notification of Breach. Notify Provider of any instance in which the person or organization becomes aware that the confidentiality of such PHI was breached.

(d) Safeguards. Provider shall develop, implement, maintain and use appropriate administrative, technical and physical security safeguards to preserve the confidentiality, integrity and availability of all PHI. Provider shall document and keep these safeguards current.

(e) Providers and Agents. Provider shall require any and all subcontractors or agents to whom Provider provides PHI to agree to impose at least the same obligations to protect such PHI as are imposed on Provider by this Agreement.

(f) Access to Health Information by Individuals. Provider shall make available to Hospice, within five (5) days of receiving a request from Hospice, all PHI necessary for Hospice to respond to an Individual's request for access to PHI. Provider shall forward to Hospice any and all requests by an Individual to access such records.

(g) Correction of Health Information. Within five (5) days of receiving a request from Hospice, Provider shall amend or correct PHI in its possession or under its control.

(h) Accounting of Disclosures. Provider shall maintain sufficient documentation to provide Hospice with a list of those Disclosures of PHI made by Provider or its agents, for which Hospice is required to account, pursuant to 45 C.F.R. §164.528.

(i) Access to Books and Records. Provider shall make its internal practices, books and records relating to the Use and Disclosure of PHI, if such books and records are not otherwise protected by applicable legal privileges, available to Hospice, the Department of Health and Human Services ("HHS") or its designee for the purpose of determining Hospice's compliance with HIPAA.

(j) Reporting. Provider shall report to Hospice any Security Incident, Use or Disclosure of PHI not authorized by this Agreement or in writing by Hospice. Provider shall make the report to Hospice not less than 24 hours after Provider learns of such Security Incident, Use or Disclosure. Provider's report shall at least: (i) identify the nature of the Security Incident or unauthorized Use or Disclosure; (ii) identify the PHI that was the subject of the Security Incident or the improper Use or Disclosure; (iii) identify who was responsible for the Security Incident or the unauthorized Use or Disclosure; (iv) identify what Provider has done or shall do to mitigate any deleterious effect of the Security Incident or unauthorized Use or Disclosure; (v) identify what corrective action Provider has taken or shall take to prevent future Security Incidents or similar unauthorized Uses or Disclosures; and (vi) provide such other information, including a written report, as reasonably requested by Hospice.

(k) Mitigation. Provider agrees to mitigate, to the extent practicable, any harmful effect that is known by Provider to have been caused by a Security Incident or Use or Disclosure of PHI by Provider in violation of the requirements of this Agreement.

(l) Termination. Upon Hospice's knowledge of a material breach by Provider of a provision in this section, Hospice shall:

(i) Opportunity to Cure. Provide an opportunity for Provider to cure the breach or end the violation, and terminate if Provider does not cure the breach or end the violation within the time specified by Hospice.

(ii) Material Breach. Immediately terminate this Agreement if Provider has breached a material term of this Agreement and cure is not possible.

(m) Return or Destruction of Health Information.

(i) Return of PHI. Except as provided below, upon termination, cancellation, expiration or other conclusion of this Agreement, Provider shall return to Hospice or destroy all PHI received from Hospice, or created or received by Provider on behalf of Hospice. This provision shall apply to PHI that is in the possession of subcontractors or agents of Provider.

(ii) Maintain PHI. In the event that Provider determines that returning or destroying the PHI is not feasible, Provider shall provide to Hospice notification of the conditions that make return or destruction infeasible. Provider shall extend the protections of this Agreement to such PHI and limit further Uses and Disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as Provider maintains such PHI. This provision shall survive the termination of this Agreement.

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

13. Miscellaneous Provisions.

(a) Amendment. No amendment, modification or discharge of this Agreement, and no waiver hereunder, shall be valid or binding unless set forth in writing and duly executed by the parties hereto.

(b) Severability. This Agreement is severable, and in the event that any one or more of the provisions hereof shall be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not in any way be affected or impaired thereby.

(c) Headings. The descriptive headings in this Agreement are for convenience only and shall not affect the construction of this Agreement.

(d) Governing Law. This Agreement, the rights and obligations of the parties hereto, and any claims or disputes relating thereto, shall be governed by and construed in accordance with the laws of the State of Washington .

(e) Non-assign ability. Provider shall not assign or transfer, in whole or in part, this Agreement or any of Provider's rights, duties or obligations under this Agreement without the prior written consent of Hospice, and any assignment or transfer by Provider without such consent shall be null and void.

(f) Waiver. The waiver by either party of a breach or violation of any provision in this Agreement shall not operate or be construed as a waiver of any subsequent breach or default of a similar nature or as a waiver of any such provisions, rights or privileges hereunder.

(g) Binding Effect. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective successors and permitted assigns.

(h) No Third-party Beneficiaries. Except as expressly provided elsewhere herein, nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party.

(i) Force Majeure. In the event that either party's business or operations are substantially interrupted by acts of war, fire, labor strike, insurrection, riots, earthquakes or other acts of nature of any cause that is not that party's fault or is beyond that party's reasonable control, then that party shall be relieved of its obligations only as to those affected operations and only as to those affected portions of this Agreement for the duration of such interruption.

(j) No Requirement to Refer. This Agreement is not intended to influence the judgment of any physician or provider in choosing medical specialists or medical facilities appropriate for the proper care and treatment of residents. Neither Provider nor Hospice shall receive any compensation or remuneration for referrals.

(k) Nonexclusive Agreement. This Agreement is intended to be nonexclusive, and either party may use any provider for the same or similar services.

(l) Counterparts. This Agreement may be executed in any number of counterparts, all of which together shall constitute one and the same instrument.

(m) Notices. All notices or other communications which may be or are required to be given, served or sent by any party to the other party pursuant to this Agreement shall be in writing, addressed as set forth below, and shall be mailed by first-class, registered or certified mail, return receipt requested, postage prepaid or transmitted by hand delivery or facsimile. Such notice or other communication shall be deemed sufficiently given or received for all purposes at such time as it is delivered to the addressee (with the return receipt, the delivery receipt, the affidavit or messenger or the answer back being deemed conclusive evidence of such delivery) or at such time as delivery is refused by the addressee upon presentation. Each party may designate by notice in writing a new address to which any notice or communication may thereafter be so given, served or sent.

Entire Agreement. This instrument contains the entire agreement of the parties hereto and supersedes all prior oral or written agreements or understandings between them with respect to the matters provided for herein. This Agreement may not be modified or amended except by mutual consent of the parties, and any such modification or amendment must be in writing duly executed by the parties hereto, and shall be attached to, and become a part of, this Agreement.
The parties have executed this Agreement as of the day, month and year first written above.

HOSPICE:

By: _____

Name: _____

Title: _____

PROVIDER

By: _____

Name: _____

Title: _____

ATTACHMENT A: DESCRIPTION OF SERVICES

Includes but is not limited to the following Services Clinical

Compliance:

- Monitors and administering compliance standards for local, state, and federal regulators
- Perform risk assessments and determine the level of risk
- Obtain and/or establish policies and/or procedures for specific issues and areas
- Educate on the policies and procedures and communicate awareness
- Monitor compliance with the laws, regulations, and policies
- Audit the highest risk areas
- Re-educate staff on regulations and issues identified in the audit

Intake Support/Triage:

- Train and assist staff with intake duties and services. Provide intake support as needed
- Provide after hours, holiday & weekend nursing triage (call help line for patients, referral sources)
- Access and update medical records and provide reports on all calls received by triage
- Contact on-call staff as needed

Finance/Accounting:

- **Bookkeeping:** Daily management of all vendor invoices and posting of receivables to accounts. Setup general ledger accounts, setup vendors, pay on accounts per policy, manage paperwork, monthly financial reporting, tax and withholding filings, cost report preparation, audits, state and federal required filings, and other accounting related services as needed.
- **Payroll Support**: review payroll batches for completeness, filing of any taxes or withholdings, state and federal reporting, updates to software as needed, collaboration with payroll vendor and agency, produce manual checks as needed, managing payroll accounts, worker's comp filings, prepare cost report information related to payroll, and other payroll support related services a needed.
- **Banking:** reconciling bank statements, establishing accounts as needed, monitor activity and report to agency, deposit checks, obtaining bank letters, and other banking related services as needed.
- **Financial Reports including KPI**

Billing/Collections:

- Preparation, submission, collection, and completion of all claims for services billed including nursing home room and board.
- Submission of Notice of Election and support for insurance verification and authorization.

- Updates to software regarding new payor contracts, fee schedules and edits needed for billing. Assistance with software workflows impacting billing
- Payment posting, appeals, claim audits, and anything else related to billing and collection of claims.

Administration:

IT Support, Legal, Consulting, Key Performance Reporting and Monitoring, Insurance, Market research and analytics, Marketing/Advertising, Website administration, Education, Lobbying Activities, Association Representation, Contracting, and other shared support services as needed.

ATTACHMENT B: FEE SCHEDULE

Fee Schedule

Year	Rate
2025	
2026	
2027	
2028	
2029	
2030	

Payments will be made in monthly equal instalments, unless otherwise stated in the agreement.

Exhibit 5
Underserved Population Documentation

NIJH

Established in 1985 • 55,000 members
24 hour toll-free number
National Accredited Hospices
NIJH Jewish Hospice Manual
Publications and Tapes
Order at www.nijh.org

SUGGESTED READINGS

Publications of the National Institute for Jewish Hospice
Available at www.nijh.org

Caring for the Jewish Terminally Ill ✶ **At Bedside;** *Insights into Visiting the Sick* ✶ **Realities of the Dying;** *Understanding what a seriously ill person goes through* ✶ **Self-Healing and Hospice Care;** *Synthesizing self-healing and the acceptance of dying* ✶ **The Jewish Way in Death and Mourning** *Rabbi Maurice Lamm* ✶ **The Power of Hope** *Rabbi Maurice Lamm* ✶ **The Jewish Orphaned Adult;** *A philosophical reflection on the experience of losing a parent* ✶ **How To Console;** *A guide to visiting the mourner* ✶ **The NIJH Living Will with Durable Power of Attorney**

OTHER SUGGESTED READINGS

The Meaning of Death, *Herman Feifel Editor (1965)* ✶ **New Meanings of Death,** *Herman Feifel Editor (1977)* ✶ **Ethical Wills; A Modern Jewish Treasury** *Reamer, Jack and Nathaniel Stampfer, Editors*

The National Institute for Jewish Hospice
Direct Line **516-791-9888 • 800-446-4448 • www.nijh.org**

For Families of the Jewish Terminally Ill

The sap of life is draining
and our heads are bowed in sadness,
but the fragrance of the flower
remains
forever

By
Rabbi Dr. Maurice Lamm
President and Founder NIJH

The National Institute for Jewish Hospice
Direct Line 516-791-9888 • 800-446-4448 • www.nijh.org

In Appreciation

Funds for the original publication
were provided by the
Milken Families,
in memory of their beloved husband,
father and grandfather,
Bernard Milken.

In Gratitude

The National Institute for Jewish Hospice
is grateful to the
Jewish Federation Council of Greater Los Angeles
for permitting the reprinting of portions of this
publication originally written under the auspices of the
Council on Jewish Life
and it's
Jewish Hospice Commission
under the chairmanship of
Rabbi Maurice Lamm.

The masculine gender in this booklet is used in the generic sense.

Judaism is a faith that embraces all of life, and it regards death as a part of life. As this faith leads us through moments of joy so does it guide us through the anguish of grief, bidding us to turn our gaze from the night of death to the daylight of life.

The Confessional Prayer:

I acknowledge before You, Lord my God, and God of my ancestors, that both my healing and my death are in your hands.

May it be Your will to bring me complete healing.

But if I am to die from this illness, I accept it in love. May my death be atonement for all the sins, iniquities and transgressions, that I have committed before You.

Hide me in the shadow of your wings, and secure my reward in paradise, held in safekeeping for the righteous.

Make known to me the path of life. In your presence is fullness of joy; at your right hand is bliss for evermore.

Father of orphans and protector of widows, protect my dear family whose souls are bound with mine. Into your hand do I entrust my spirit. May You redeem me, Lord, God of Truth. Amen and Amen

Sh'ma Yisrael, Adonai Elohenu, Adonai Echad

Listen, O Israel:
the Lord, our God,
the Lord is One.

participation. **This includes a Hevra Kadisha society,** whose members devote themselves to preparing the dead body for burial, and a **Meal of Consolation provided by neighbors** for the immediate family on their return home from the burial ceremony. Note that it is the friends who are to provide for the needs of the bereaved, not the other way around.

These behaviors serve to reduce feelings of abandonment and loss on the part of the bereaved. They also afford a channel whereby the community can express feelings of shard loss. Additionally, they contribute to quickening the repair of the breach which has occurred in the social fabric.

The family may, in its turn, want to express part of its grief by some worthy act – perhaps a contribution to the synagogue, an educational foundation, United Jewish Appeal, an Israeli institution, or a medical research fund.

Visiting the cemetery after the funeral is a personal matter. It is recommended, however, that one should not go until after the period of Shiva. **Unveiling of a monument** usually takes place anytime after the Shiva period and before the end of the first year of death. No elaborate ceremony is required, but relatives and friends may be asked to come.

While Judaism strongly encourages people to express their grief openly and unabashedly during the mourning period, it also aims at enabling the mourners to accept their loss realistically and to return to a productive life. Consequently, it sets limits on the mourning process. It confines the essential mourning period to the first year after death for the father and mother. Despite this, there still is provision for further grief catharsis in an annual observance – *Yahrzeit* – each year on the anniversary of the person's death, as well as the saying of *yizkor*, a remembrance prayer, four times during the year on holy days.

Preface

We live in a culture that cherishes vitality and youth and we are mostly shielded from experiences of death as we grow up. Consequently, when a close relative dies, we confront feelings and situations which are new and uncomfortable. We are not quite sure how to handle the anger and guilt that often accompany this experience. We know even less about how to interact with a relative who is dying. Many fears concerning our own death inevitably rise at such a time, and we may not be certain how to deal with these either.

The Jewish tradition has a wealth of experience in dealing with all facets of life, including the aspects of sickness and dying. In this context, the National Institute for Jewish Hospice has generated materials in an effort to disseminate information about Jewish values and conduct to families who are facing the death of a relative and to members of the helping professions. We hope that the information included in this booklet will help to make the experience of dying more comprehensible for the family.

Hospice Care

The Nature of Hospice Care

The term "hospice" means "hospitality for travelers." In origin, it refers to resting places or wayside inns during the Middle Ages which grew up along certain routes where religious communities welcomed and refreshed pilgrims until they were able to continue on their journey. Today, hospice is a philosophy of medical and humanistic supportive care for terminally ill patients, when curative medical treatment is no longer effective.

Hospice care may take place in a free-standing or separate facility, a specialized unit within a hospital, a nursing home where the hospice team comes to the patient,

or at home if there is a care giver, or in a combination of these facilities.

Three major features characterize hospice care;

- Greater emphasis on personal care for the patient
- Concerted effort to prevent and relieve chronic pain associated with much of terminal illness
- Involvement of family members and close friends of the patient during the hospice stay.

The hospice orientation seeks to maximize the patient's quality of life; the emphasis is on living rather than dying. It recognizes that when cure is not possible, providing care and comfort can be just as significant a contribution to the patient. Hospice realizes the value of attending to the patient's emotional, social and spiritual needs, along with his medical requirements. The patient is viewed not just as another diagnosis or statistic but as a person with fears and hopes, expectations and desires, and as a part of a family.

The Hospice Team

Hospice care has two major formats. In one, the terminally ill person enters a facility specifically designed to provide palliative care. There, a team of professionals does everything to prevent and control the patient's physical pain. It also provides him with emotional support by making his surroundings feel familiar using items from his home that would comfort him. Family and friends may visit at any time of the day and night preventing loneliness. This also allows the family to become acclimated to the needs of the patient.

The second format is on an outpatient basis. Care takes place in the home, where the family assumes an even larger role, but is aided by home visits from the hospice team which is called upon as needed. Nether form is the "right" form. Which is right depends upon the patient and family. Sometime patients combine both forms of hospice care,

of ways for grief to be expressed through various laws, rites and time sequences/ these can be very supportive at a time when one feels adrift because of the loss of an important part of one's personal and social life. Among the more commonly practiced are:

- **Shiva**: a mourning period of seven days after burial by the bereaved.
- **Shloshim**: the observance of a period of thirty days after the funeral during which mourners resume normal activity but avoid places of entertainment and continue to recite certain prayers.
- **Kaddish**: the recitation of this prayer daily during the first eleven months after burial.

Formal mourning is obligatory for the direct relatives of the dead person – father, mother, husband, wife, son, daughter, brother and sister.

Loss of a loved one is difficult to accept, and it may take a while for one's physical and emotional systems to adjust to this new reality. **Effective mourning does not aim at erasing the memory of one's loved one**. Rather, it means remembering him tenderly, but going on with life and developing further relationships.

Consequently, during the mourning period one should recall memories of the dead person together with the friends and other members of the family. In that process one should not hesitate to cry or laugh. **Visitors should help mourners talk about their memories of the deceased** rather than try to get their minds off him, as many people mistakenly do. On the other hand, mourners should not feel guilty if they grow weary of speaking about the deceased during the mourning period.

A major orientation of the Jewish response to death is to provide emotional and social support for the survivors. Jewish rituals of mourning mandate strong communal

On Purim, arrangements can be made to have the Megillah, the story of Queen Esther, read by a visiting student or, if all else fails, by telephone. Children in Purim costumes visiting from schools will certainly bring a smile to a patient's heart.

A dying person should not fast on Tisha B'Av or any other traditional fast day.

Prayer books, head coverings and prayer shawl *(tallit)* should be available. Even if they are not used, it might be of solace to have them nearby.

The Torah declares, "And he shall live by them." The observances specified above enable people to live full, meaningful, God-oriented lives. But no life should be compromised, **no limb should be endangered and no person discomfited in order to fulfill these mitzvot.**

Treatment of the Dead Body

After death, the eyes and mouth of the dead person should be closed and a sheet drawn over the face. Calling a rabbi at this time will facilitate meaningful burial arrangements. From the moment of death until burial, the deceased should not be left alone. Jewish law permits autopsy when state law requires it. Customarily, burial takes place as soon as possible after death. **Cremation is forbidden by traditional religious law.**

Bereavement and Grief: The Jewish Way

The Jewish tradition recognizes that the ache and pain of death does not end with physical death. The Biblical book of Ecclesiastics says that there is "A time to weep... a time to mourn." **Judaism respects grief and provides for its emotional relief.** It views expression of grief, not as a sign of weakness or self-indulgence, but as a deep human

remaining at home as much as possible and using an in-patient facility only when there is an emergency situation. The patient, in this case may often return home once the crisis has passed.

The key to hospice care is **the integration of many people with different skills,** all of whom contribute to the patient's overall treatment plan. Hospices can vary as to which member of the team coordinates the work of others. The following people are commonly part of the hospice team:

Physician and Nurse. A distinctive element of hospice care is that the primary role of the physician and nurse is **to prevent or minimize distressing symptoms associated with much of terminal illness.** The hope for cure, however, is never completely abandoned.

Social Worker / Psychologist / Psychiatrist. These professionals work with the patient and family in helping them to respond to this traumatic life experience. They help identify and obtain psychological and social resources available to the patient and his family.

Rabbi. The Rabbi seeks to meet the pastoral and spiritual needs of the patient and family, understanding, as he does, the attitudes of Jewish people toward life and death, pain and suffering. Since medicine has made great leaps into areas of cancer and life-threatening illness there is no longer catastrophic death. Now a patient can "die" for six months, even longer, so the Rabbi also serves as a resource of information concerning the Jewish standpoint toward medical issues and Jewish concepts and practices concerning dying, death and mourning.

Hospice Volunteer. The hospice volunteer affords the patient and family the support they need during the dying process and bereavement. They provide emotional relief by listening to the patient and family in a

compassionate, non-judgmental way. The volunteer may also help with the simple tasks of reading, writing down memories, or telling stories to the patient, when the family needs to be refreshed.

Family and Friends. Crucial to the hospice team are members of the dying person's family and his friends. Jewish tradition is wise in emphasizing the mitzvah of visiting the sick, for it recognizes that one of the real problems of serious illness is the isolation and loneliness that the patient feels. The very presence of members of the family inevitably helps the patient die with dignity. Attending to the dying relative also helps alleviate feelings of guilt and fears on the part of family members. Beyond that, attending to the dying is a special mitzvah, described as *"hesed shel emet"* a loving act of true loyalty, because it is an act that the dying patient will never be able to pay back. It is consequently a mark of true humanity and love for members of the family and friends to be with a person during the time of dying. Members of the family should not expect to be with the dying patient every moment of every day, and they should feel free to call on members of the hospice team to assist. The family and friends of a dying person can be a major key to the effectiveness of hospice care.

The Dying Person and His Family: The Jewish Spirit

When you ask dying persons what they fear most, they often respond, **"having pain" and "being left alone, abandoned."** They communicate the wish for our care and concern, and to be treated as mature individuals even though they are dependent and dying. It is important to recognize these deep needs because too many of us in attending to the dying person's medical requirements tend to overlook his emotional and spiritual desires.

Here are some of the salient and meaningful traditions as they relate to the seriously ill:

- Lighting Sabbath candles is a beautiful, family – associated ceremony designed to bring peace into our lives.
- The wearing of Tefillin by men promotes the feeling of being embraced by God's commandments. If a dying person does not own a pair of Tefillin, they can be acquired from a nearby synagogue or Jewish book store.
- Most terminally ill people cannot eat very much, however, a bit of such characteristically Jewish foods as gefilte fish, blintzes, etc. can often bring satisfaction. The patient need not wait the traditional lapse of time to eat dairy after meat foods; he need only rinse his mouth.
- **For Passover** a physician should be consulted as to whether Matzah and wine are medically permitted. Diluted grape juice, or even tea, can be substituted for wine.
- Unless specifically required for medicinal purposes, breads, non-Passover cakes and cereals known as Chametz, should not be eaten. Prescribed drugs, may, of course, be taken but should be kept separate from the Passover food.
- **Rosh Hashanah** is a time for the blowing the Shofar. Have a local rabbi arrange this at bedside.
- **Yom Kippur.** If the patient is obstinate, a rabbi should contravene and medical advice should be called to assure him of the wisdom of the law of not fasting. Perhaps one meal can be delayed or skipped.
- **On Sukkot, the Lulav and etrog,** a citron and palm fronds, can be held for just a few moments. They can be obtained at a local synagogue.
- **On Chanukah,** the candles may be kindled by a member of the family in the hospital or at home, but great care should be exercised in the presence of flammable medical equipment. If necessary, an electric menorah can be used.

Almighty before whom one feels powerless. Even people who have not been able to pray or believe in God are often moved to do so in such conditions. "Pray for me" is a phrase often heard in hospital corridors. "Pray for yourself" is equally valid, and sometimes even more helpful.

As life nears its end, the last syllables uttered by many Jews have been the confessional prayer call ***vidduy***. It is an apology to God for the misdeeds of a lifetime. The sages considered it extremely valuable as an expiation for all sins. It is brief and moving. Great care should be taken in introducing this prayer, assuring the patient that many have recited this payer and survived. If one judges this might traumatize the patient, the confession should not be recited. Please see page 20 for a brief form of this confession.

Holiday Celebrations

Traditions of the Jewish people in celebrating holidays can provide significant support for a dying person, whether he has observed them in the past or not. Frequently, the practice recalls moments of early personal history which gives great satisfaction. It can also convey a sense of security in a time filled with fear of the unknown. Often, it yields unexpected benefits as one begins to feel closer to the Almighty, and indeed closer to one's people.

Judaism is an old and wise religion, and is superbly sensitive to needs of the dying as well as the living. Nevertheless, all these traditional practices can and should, be observed in the patient's medically debilitated state. They should not be carried out contrary to the physician's advice; their performance should be suggested, not urged; they should be practiced only to further the individual's needs, not as an obligation; they should conform to the patient's physical and psychological well-being and remain within his interest and attention span.

We can abandon a person not only by not being there physically but by neglecting his psychological and religious longings. The unhappy result is that the dying person is often left to die emotionally and spiritually alone.

Being in the presence of a dying person is a strain for most of us for a variety of reasons. We ourselves may feel depressed and helpless about the situation. The dying patient often looks peculiar, talks incoherently and may have an unpleasant odor; and, strangely, the dying person may remind us of our own mortality. Nevertheless, we should try to resist withdrawing support and love from the patient because of our own anxiety, frustration and pain.

Try to be sensitive to what the dying person is saying. Let the patient set the pace in discussing oncoming death and its related problems. Do not force him to talk about them unwillingly. But do not pull back and hide when the patient wants to talk. When a patient talks about suffering, hopelessness, anger, and death, it can make many of us feel uncomfortable, even threatened. Some of us may attempt to pay no attention, hoping that if we ignore it or pretend it was not said, the patient may go on to a more cheerful topic. This is unfortunate for both the patient and family for it suggests to the patient that the subject of death is forbidden, and prevents family members resolving their own feelings and fears.

It is not important to have answers to all the questions a dying person may ask. Some questions just do not have adequate answers. The dying person, however, should be afforded every opportunity to explore the relationship of his beliefs to his present illness with whomever he feels is a suitable spiritual companion, and to keep his usual religious practices.

Touching can convey feelings that go beyond words, and can frequently comfort people whose state of

consciousness or confusion has placed them beyond the reach of words. Patients feel as though they are pariahs and can't be touched. **You can't catch cancer.** Do not be embarrassed to hug, stroke, or touch the patient when appropriate, without overdoing it.

Being terminally ill **does not rob** a patient of his intelligence or sense of responsibility. What is of utmost support to a dying patient is respect for his integrity and consideration of his wishes and **not treating him as a child.** As there are numerous ways of living, there are many ways of dying. Individual differences and regard for the humanity of the patient should be our principal guides.

The family can expect to experience many mixed feelings. The love they have for their relative gives them the wish to do everything they can to make this time special. Sometimes and some days it can be very hard to do that, no matter how much they want to. The family has shared feelings of pain and joy together in life, and it can cause stress to hide the sadness and anger of approaching death.

At times, people may find themselves, in the privacy of their own minds, rehearsing the death of a dying person as a way of anticipating it. This is not unusual or inappropriate. It is an attempt to cope with the approaching death of the patient. This, nevertheless, should not inhibit encouragement and sustenance of the patient.

Despite the fact that death is not an act of will on the part of the patient, many patients need **permission and forgiveness** for leaving their families and causing pain. Conversely, family members may need the patient's "consent" to allow them to let him go.

In the Jewish tradition, being terminally ill does not

be handled forthrightly, but with a minimum of agitation and with great discretion.

Ethical Wills

In order to give further initiative to the terminal patient, he should be encouraged to write an ethical will. This is an ancient Jewish device. **People should leave their families not only an inheritance, but also a heritage.** A parent may not have been able to communicate effectively with a child or grandchild. The ethical will affords the opportunity to communicate to loved ones a sense of purpose in life, values and beliefs, in a format that will be treasured after death. An ethical will need not be in any specified form. It can be a letter or a recording, and it does not have to be especially articulate or complete. The key is that it be personal. Examples can be found in several contemporary books. (See Suggested Readings.)

Making Amends

Patients depressed by, or feeling guilty for hurting a friend or relative, should be encouraged to "make up" or engage in some form of restitution, if that will not disturb them. This suggestion is not easily made and requires great delicacy and preparation. Do not moralize or urge – only suggest in passing.

Prayer

Prayer is a gift to mankind. It can be of great comfort to many patients. There is formal prayer, recited from the prayer book. There is also informal prayer which can be recited in any language, posture and at any time. The patient's prayer may be for an extension of life, remission from pain or for the success of loved ones. It may also be used to vent anger and complaint, even to ask for a rapid death. Prayer is especially valuable at this period because it allows for articulating fears and hopes in an elevated manner and because it opens up communication to the

A visit to the sick is not complete until the visitor offers words of hope and prayer for him. These visits are designed by Jewish tradition to bring solace to the patient. They are not times for bearing bad news, for excessive indulgence and pity, for bewailing the monumental tragedy, for family quarrels, for anger or sadness. The comforting component should predominate – sometimes even at the expense of complete truth. There is a fine line in the art of comforting someone. Trying to look cheerful may make the patient fell that you don't understand how sick he is; looking sad sometime makes the patient morose resulting in his having to cheer you up. It is no simple matter to bring cheer into this situation, but it is necessary.

Hope

While it is obviously difficult to convey hope in a hopeless situation, **one can hope for less pain, for the future happiness of children, for the family's continuation of the values the patient has cherished.** There should be an intelligent awareness of hope's limitations, but sincere recognition, nonetheless, of it's potential comfort.

Charity

The Jewish sages said that "Charity rescues one from death." **The dying person is usually in a passive condition, with limited power to initiate meaningful actions or to make significant decisions.** Distributing charity, no matter who the recipient or what the amount, and deliberating on which institution or program should receive it, may give the dying person a feeling of some strength and a sense of being alive, empowering him during moments of greatest weakness.

Arrangements

If financial, insurance, last will, or cemetery pre-purchase arrangements have not been made and the patient is capable of decision-making, these subjects should

diminish respect for the sanctity and meaningfulness of life. Since time is now limited, life becomes even more precious. It is now an interval during which the relationship between family and dying person could grow in depth and quality. It should be a period when loved ones sustain and cherish the patient; when a patient sets his house in order, transmits any final messages he wishes, and makes peace with God.

Medical Issues Connected With Dying: The Jewish Perspective

The obligation to heal

Judaism affirms that the body we inhabit belongs to God. We demonstrate our responsibility through prevention, cure and care. The physician's efforts to cure are not perceived as a denial of God's prerogatives, but rather as a duty.

Telling the Truth

The following principles apply;

In general, the better informed a patient is, the easier it is for him to cope with reality. People tend to do better when they are oriented toward reality rather than to fantasy. Make sure the patient understands the terminology used.

The patient has a legal and ethical right to know the truth. Patients who want to know will usually ask direct questions. Such questions should be answered intelligently and honestly. When possible, answers should include hope for improvement, even if the improvement relates only to symptoms.

Respect Denial

We should be prudent in providing unrequested information. Some patients may deny the reality of their situation in order to protect their emotional integrity. This

must be respected. According to Jewish Law, it is permissible to withhold facts about a patient's condition (or that of a close friend or relative), if that will contribute to the welfare of the patient.

In some cases it is the patient that wants to hear the truth but the family is in denial and the patient agonizes over unfinished business.

Needs of the patient are primary. Decisions as to sharing information about the patient's condition should be determined in this context.

Extraordinary Life Support Measures

At some point in illness, death may become imminent. Even at this stage, certain Orthodox authorities strenuously oppose any relaxation of energies to extend life. Nevertheless, many Orthodox rabbis and most Conservative and Reform rabbis maintain that heroic measures are not required to prolong the life of such a patient. The sacred obligation of the physician is then to make the patient as comfortable as possible.

Organ Donation

Because Judaism views the body as God's property, people do not have the right to disfigure it without good reason. One such good reason is helping another patient to live, by donating a healthy organ to replace his deficient one. The donation can be either a living donation – such as when a parent donates one of his kidneys for his child – or a cadaveric donation, when someone is irreversibly terminally ill, and donates one or more of his organs to a needy recipient. This is not only not considered to be disfiguring or dishonorable to the integrity of the donor, but an example of extreme generosity. However, Jewish law requires that a dying person assuredly be brain stem dead, or the living donor not at risk for losing his life, that we know there is a needy recipient, and that the surgeon

approach the issue with reverence. Some Jewish authorities differ as to the exact moment of death.

The Traditional Jewish Support System

The art of loving can become strained when someone you love is approaching death. However, expression of love can rise to its most intense level at precisely this moment. At this time, expressions of love plumb our deepest personal resources. We should make use of every conceivable device to make these days meaningful. The rich Jewish heritage has designed various helping strategies for coping with problems of the severely ill and the dying.

Family

The company of family and friends is a therapeutic presence and considered a very great mitzvah. It reassures the patient of his continuing worth as an individual and reinforces his feelings of being an integral member of the family and community. Traditionally, a minyan of ten Jews are gathered to be present at the moments of life's expiration. Visits to the terminally ill should be frequent but usually of short duration, in keeping with the patients fatigue threshold. **The visitor should not stand over the bed, but sit near the bed.** The patient is constantly looking up at doctors, nurses, and visitors and made to feel powerless, like an object over whom people work. While visiting the sick is a mitzvah, patients may desire privacy at times, and this should be respected.

It is proper, and it will be comforting to many patients, to recite a prayer for the sick informally and in a language the patient understands. Also, a formal prayer should be recited in the synagogue at the open Torah scroll. This prayer is call the *"mi she'berach."* The synagogue should be informed of the Hebrew (preferably) or English names of the **sick person and his mother**, who is considered the natural source of compassion.

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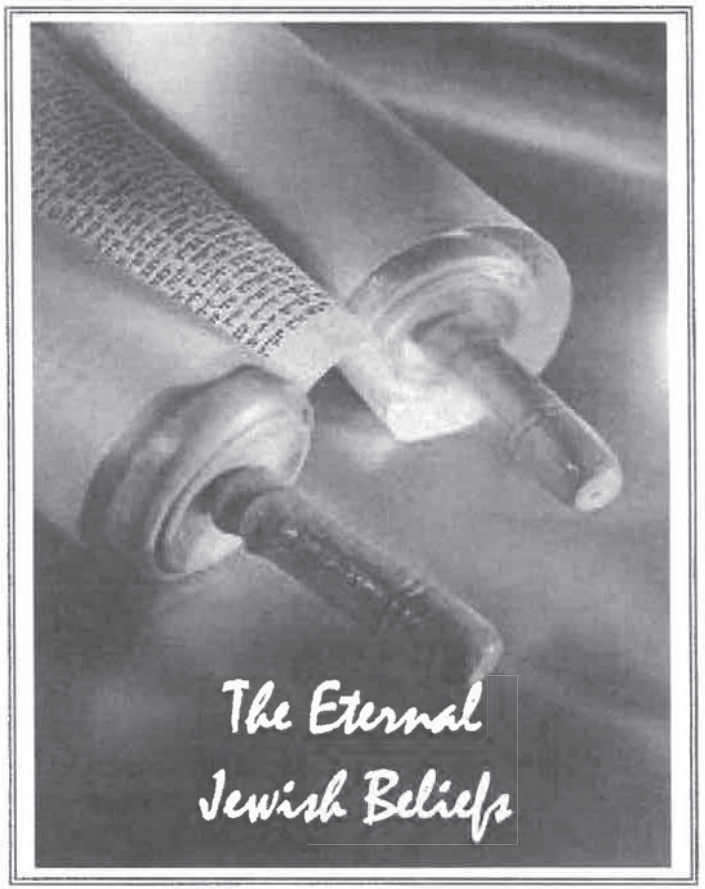

Reward and Punishment
The Messiah
Resurrection

Rabbi Dr. Maurice Lamm

#7

Introduction

As a person ages and grows closer to that time of passage from this world, it is a good time to be contemplative and think about spiritual matters. As a person reflects on his/her life and his/her accomplishments, there are three traditional Jewish beliefs that are particularly meaningful at this time. They are; Reward and Punishment, the Messiah, and the physical Resurrection of the body.

Jews for two-millennia held these beliefs to be incontrovertible, fundamental, even undeniable as articles of faith. Maimonides, in the thirteenth century, was the first to formalize and codify ancient Jewish beliefs. He held that these three concepts were among the thirteen basic beliefs of Judaism. In the fourteenth century, Hasdai Crescas revised Maimonides formulation of the basic truths but still kept reward and punishment, the Messiah and immortality as part of them. In the fifteenth century when Simon ben Zemah Duran reduced the basic number, and still later, when philosopher Joseph Albo revised the basic concepts again, they retained these three beliefs as fundamental to the faith.

In Nazi Germany, hundreds of thousands of Jews, packed in cattle-cars headed for the crematoria, sang the old hymn, "I Believe in the Coming of the Messiah." Philosopher Herman Cohen has observed that "If the Jewish religion had done nothing more for mankind than proclaim the Messianic idea of the Old Testament prophets, it could have claimed to be the bedrock of all the world's ethical culture" (cited by Levinthal, 1935).

Despite the unwavering stability of these ideas, the preponderance of Jews today do not understand these concepts, let alone appreciate their history. This may be a lingering effect of the efforts made by post emancipation rationalist Jewish philosophers in their rebellion against ancient and medieval thinking. They convinced many that the sole emphasis of Judaism is on this-worldliness, not sullied or compromised by metaphysical ruminations of a hereafter in any form.

Surveying the major thinkers, however, one can say with confidence that the vast majority of Jews in every age have believed in reward and punishment, in some form of life after death, the resurrection of the physical body, and the immortality of the soul.

Here is a brief overview of those beliefs;

Reward and Punishment

Judaism, as a moral code, has as its foundation that man has freedom of choice in his actions, and the responsibility for the consequences of his choices. When we choose the right moral choice and it brings goodness to others, there is a reward for that. And when we choose wrongly and bring pain and suffering to others, there is punishment for those choices as well. Reward and punishment can take place in this world, as well as in the next world after death.

Most of us have lived lives of goodness, and brought happiness and support, comfort and caring to our families, friends, communities and those in need. We can look back and be proud of our life

The afterlife has not been "thought up." It is not a rational construction of a religious philosophy that has been imposed on believers. It has sprung from within the hearts of masses of men and women, a sort of consensus genium, inside out, a hope beyond and above the rational, a longing for the warm sun of eternity. On this view, the afterlife is not a theory to be proven logically or demonstrated by rational analysis. It is axiomatic. It is to the soul what oxygen is to the lungs

As we come closer to the juncture of life and death, it is imperative to understand that according to these traditional Jewish beliefs, we are really at a juncture of life and life, and that we will be responsible and answerable for the choices we made in our life, and that our life is part of a larger mission of bringing perfection to the world, and we will be resurrected back into the perfect world. With these thoughts and beliefs in mind, we can approach this major life event of death with preparation and tranquility.

During the second commonwealth, the belief in the resurrection of the body, in contradistinction to the immortality of the soul, is documented as a fundamental of Jewish belief. By the time of its redaction, the Mishna records: "He who says there is no resurrection of the dead will have no share in the world to come" (Sanhedrin 10:1). Maimonides codified this as a never-to-be-denied-component of the faith.

A cluster of uniquely Jewish concepts emerge from this understanding of resurrection. A human being's ultimate destiny is not in his or her hands alone, by virtue of his or hers immortal soul. It is an act of God's mercy to revive humans after they have slept in the dust. Judaism does not address a disembodied soul, but a whole person; salvation is not a private enterprise, but a corporate redemption of all humans. The body has value as a creation of God, and not only as a housing for the spirit: life on earth has value.

Conclusion

Jews have long had an abiding faith in a world beyond the grave (Lamm, 1969). The conviction in a life after death – unprovable but unshakeable – has been cherished since the beginning of thinking humanity's life on earth. It makes its appearance in religious literature not as commanded irrevocably by an absolute god, but as though it has been growing and developing naturally in the soul. The belief then sprouts forth through prayer and hymn. Only later does it become extrapolated in complicated metaphysical speculation.

accomplishments. However, we were certainly human beings and made our share of mistakes. We can choose to fix those mistakes - but only when we are still alive. The words of love unspoken to a spouse, a parent estranged from a child, business partners we quarreled with – these are only some examples of situations that we can stretch out our hand to those people and correct now, but only now while we are still alive.

There are also things that we could have accomplished for the greater good, if we had been more focused on that as a goal. Our priorities in life should include; family, friends, Jews in need, Israel, and the needs of our community, both our local Jewish community and the broader community in which we live. Sometimes life is so complicated and busy that we can get caught up in the day-to-day of our own personal life, and we do not focus on how to help others – both individuals and community. This contribution to the greater good is also something that can be rectified now, through one's own efforts, through encouraging family members to become so involved or by naming organizations committed to the greater good as beneficiaries in your will.

All of these are the unfinished business of our lives and we should strive to conclude all our business before our time comes. Jewish tradition has two customs that are powerful tools in this regard. The first is the "Viduy" Prayer, the prayer traditionally said before the time of death. One of the things in this prayer is that their death should be an atonement for all their sins. Another ancient Jewish custom is an Ethical will, in which a person reviews the principles he built his

life upon, and his accomplishments based on those principles, and provides ethical directives for his children.

The Messiah

The generic term Messiah means "anointed one." Kings and priests were anointed in ancient times to set them apart from the common person. This specialness was also applied to the spiritual leadership of a descendant of the house of David. The anointed one will bring redemption to this world. It will then be a time of true bliss unparalleled in our own existence. It will not be a new world, a qualitatively different world – rather, it will be this world brought to perfection. Universal peace, tranquility, lawfulness, and goodness will prevail, and all will acknowledge the unity and lordship of God.

The traditional outlook of Judaism is that the Messiah will be the dominating figure of an age of universal peace and plenty. Through a restored Israel, he will bring about the spiritual regeneration of humanity, when all will blend into one brotherhood to perform righteousness with a perfect heart: "On that day, the Lord shall be One, and His name One" (Zechariah 14:9). Jewish prayers are replete with references to the messianic hopes and aspirations. There is hardly a prophet of note who does not mention Messiah and the messianic age.

Will the Messiah be a specific person, or will he only represent an era of perfection – "*yemot ha'Mashiach*", the "days of the Messiah? Traditional Judaism believes in the coming of a flesh-and-blood mortal sent expressly by God to complete the mission of His people. The traditional belief is that people must strive to better the world and by these efforts help bring the Messiah. The personal Messiah, supernaturally introduced to humanity, will not be a divine personality as in Christianity. He will herald a redemption granted by God, but the Messiah will have no ability to fabricate that redemption himself. He will have no miraculous powers; he will not be able to atone for the sins of others; he will have no superhuman relationship with God. Instead, he will be an exalted personality of incomparable spiritual ability who will begin the rehabilitation of the Jewish people and the subsequent regeneration of humanity.

Although some modern theologians have disputed the idea of a supernatural introduction of the Messiah and the idea of a personal Messiah, there is however, a two-millennia tradition that affirms that position – despite the rational analyses, let alone the metaphysical misgivings of sophisticated contemporary theologians.

Resurrection

The doctrine of Israel's messianic redemption is integrally entwined with that of resurrection. The belief that God " opens your graves and bring you out of your graves" (Ezekiel 37:12) is presumed throughout the Bible, expressing itself through figures of speech and metaphors that imply the power of God and even the power of the prophets to revive the dead. It is most eloquently expressed by Ezekiel in his vision of the Valley of the Dry Bones.

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CARING

FOR JEWISH HOSPICE PATIENTS

By

Rabbi Dr. Maurice Lamm

President and Founder NIJH

The National Institute for Jewish Hospice
Thanks

For their work on the draft version of this publication

What is NIJH?

NIJH is the National Institute for Jewish Hospice. It was established in 1985, with headquarters in New York and Los Angeles. It is a resource center for hospice care of Jewish patients. NIJH is directed by professional leadership of scholars, administrators and clinical experts.

Why Would A Hospice Become Accredited By NIJH?

1. To enhance the hospice's ability to respond to the needs of Jewish patients and their families.
2. To continue to educate staff and volunteers on cultural and religious diversity.
3. To develop human palliative strategies that are tailored to the needs of Jewish patients.

What Topics Are Available In Educational Material For Staff And Volunteers?

Customs and Culture
Ethics
Art of Hope
Suffering vs. Pain
Grief and mourning

What Are The Learning Goals of NIJH?

1. To gain enhanced understanding of Jewish culture and religion and their impact on death and dying.
2. To integrate understanding of Jewish medical ethics
3. To discover unique aspects of Jewish grief and mourning

Jewish Heritage and Background

The Jewish culture has a deep heritage tied to ancient Hebrew Scriptures. Traditionally all Jewish people are those who are descendants of Abraham, and they originated as a people in the Middle East. They live under the statutory law, called Halakha,

given by Moses and found in the Torah (Genesis, Exodus, Leviticus, Numbers and Deuteronomy). The Jewish people live by affirmation of the Jewish law.

Jewish Diversity

The Jewish people are as diverse as any sub-group of our population, with variations in religious and cultural identification. In general, there is a continuum ranging from Ultra Orthodox to secular Jews.

End of life customs and practices vary by the individual's belief system

Views in this booklet are representative of all streams of Judaism

Hasidic / Ultra Orthodox

Abide very strictly to Jewish law

Distinctive in dress;

- Men; black suits, long coats, hats
- Married Women; Cover hair with wig or scarf (may shave head)

Modesty is very important

- Men should not touch women other than their wife; a woman may not touch men other than her husband

Look to religious authority for decisions

Orthodox / Centrist Orthodox

Relatively strict on interpretation of law and ethics

Torah cannot be altered

Conservative and Reconstructionist

Conservative;

- View Judaism in historical context, refer to rabbinical rulings

Reconstructionist;

- View Judaism as evolving civilization
- Possess more individual autonomy for decisions

Grief and Mourning

Aninut

The time period between the death and burial of one of the seven close relatives (father, mother, brother, sister, wife or husband, son, daughter)

The prevailing emotion is despair

The need is to focus on burial and fiscal arrangements

The mourner refrains from most social, personal and religious activities

Shivah

The 7 Day mourning period after burial

Family and friends visit to comfort the mourners and remember the loved one

The Jewish community usually provides food for mourners

There are no Shivah visits on Sabbath and major Jewish Holy Days

Hospice caregivers should pay a Shivah (condolence) visit or make a condolence call

A candle is lit for the seven days of Shivah

Kaddish (mourner's prayer) recited daily during Shivah and Sheloshim

Sheloshim

The 30 day period following burial (Shivah time is included in the 30 day count)

The mourner is encouraged to leave home after Shivah

The mourner does not participate in parties or listen to music

The end of Sheloshim concludes the mourning period, except for the loss of parents. The mourning period for parents is one year.

Resources Available On The Internet

The National Institute for Jewish Hospice
www.nijh.org

Foundation for Jewish Culture
www2.jewishculture.org

Judaism 101
www.jewfaq.org/index.html

BBC Religion and Ethics – Judaism
www.bbc.co.uk/religion/religions/judaism

Obligations of The Jewish Family

The Jewish culture values the family's involvement in the care of their loved one. You should be aware of a number of obligations that you might find in a typical Jewish family;

1. It is often a priority of the family to keep the physical environment of the patient clean.
2. The family will work to relieve the patient of financial worries and take care of business issues.
3. The family will provide companionship to the patient, and they will work to cheer the patient, and "humanize" the environment of the patient.
4. It is part of the Jewish tradition that suffering has meaning. The patient and family may want to talk about what the suffering might mean. It is important to note that pain is a physical manifestation. Suffering is usually thought of as a psychological or spiritual manifestation.

It is the task of the hospice staff and volunteers to ensure support to the patient and family in all of these domains.

Support Through Jewish Cultural Traditions And Values

Prayer may be accompanied by a prayer shawl (tallit) and phylacteries (tefilin – small black boxes worn on an arm and head that contain Scriptural passages)

The Jewish people live by certain dietary laws; for example, they do not eat pork or shellfish, and they do not mix meat and dairy products or utensils.

There are specific rules for food preparation and utensils.

Assist the family in finding kosher meals if it is important to them

The Sabbath

The Jewish Sabbath begins at sunset on Friday night and continues to sundown of Saturday. The celebration of the Sabbath includes Sacramental wine, Challah (twisted bread) and candles.

Major Holidays

Rosh Hashana – Jewish New Year

Yom Kippur – Day of Atonement

Sukkot – Festival of Tabernacles

Passover – 8 day festival celebrating exodus

Shavuot – Pentecost - Giving of the Torah at Mount Sinai and harvest

Chanukah – Festival of Lights -lighting candles progressively over 8 days

Purim – highlighted by reading Scroll of Esther

Staff and volunteers may assist patient and family in celebrating the festivals

Understanding Jewish Medical Ethics From A Jewish Perspective

1. **Autonomy: It is the patient's right to choose among available alternatives**. In Jewish culture the patient's right is voluntarily limited to being consistent with Jewish law. Traditional Jews will look to their rabbi to ensure that their decision-making is consistent with Jewish law.
2. **Beneficence: Physicians provide health care that is beneficial to patient.** In Jewish culture physicians are obligated to heal and benefit patients, and patients are obligated to seek beneficial treatment.
3. **Non-Maleficence: Physicians avoid providing care that is harmful.** *(May contend with beneficence.)* In Jewish tradition, individuals have obligations to properly care for themselves and avoid exposing themselves to bodily harm.
4. **Justice: Providing care that is good for the society as a whole.** *(May contend with Autonomy and Beneficence.)* There is a fair allocation of limited health resources. In Jewish culture patient priority is first-come, first-served. In case of conflict, priority may be based on hierarchy related to social worth.

Advanced Directives and Wills

Ethical "Wills" – are personal communications to loved ones via writing, audio or video about what the patient has valued in life.

Ethical wills can help foster and highlight a patient's values and beliefs and transmit them to future generations.

Living Wills and Durable Power of Attorney (DOA). The Jewish faith generally is supportive of palliative care vs. heroic efforts, with the exception that Orthodox authorities may require a family to seek heroic measures. A Jewish Living Will and Power of Attorney form that reflects Jewish law (Halakha) is available for hospice patients from NIJH.

Care of the Body After Death

The Jewish way is to bury immediately and mourn gradually.

At Death;

1. Eyes and mouth should be shut closed
2. Limbs and fingers should be discreetly straightened
3. Body should not be moved (unless for the honor or safety of the body)

Preparing The Body

1. The body is washed and prepared by the Chevra Kadisha (Jewish Burial Society), if available, or by family members.
2. The body is dressed in white shroud
3. A sheet is drawn over the face of the deceased
4. The family should contact a rabbi and the funeral home
5. The body should not be left alone until buried
6. Bury promptly, preferably within 24 hours. No burials are scheduled on the Sabbath or major religious Holy Days.
7. No possessions are buried with the body
8. Autopsies are not permitted without express permission of a rabbi.

The Funeral

1. The casket should be closed during the funeral service
2. No flowers should adorn the casket
3. Secular fraternity "rituals" are discouraged, but permitted (such as Masons, Rotary, Kiwanis, Elks, etc.)

Reform

Broader interpretation of the law
More lenient re: beliefs and social conveniences
Mourning Practices:
- Home environment may not embrace strict rules of Orthodox (wear regular clothing, etc.,)
- May shorten mourning period

Secular Jews

Secular Jews have cultural connections but no religious observances

The Relationship Between A Jewish Patient And Health Care Workers

Judaism affirms that individuals inhabit a body that belongs to God. Healthcare professionals are expected to partner with the patient in ;

1. Prevention
2. Cure
3. Comfort
4. Palliation
5. Understanding and support

Responding To Questions From Patients And Families

When working with a Jewish family, honesty must always be laced with **HOPE**;

- That the patient may feel better / improve / be cured
- For quality days with family
- To be pain free
- To celebrate holidays with loved ones

Don't "dis-hope" the patient: bring live flowers rather than cut flowers that wither and die.

Respect denial;

- Denial may assist in maintaining emotional integrity
- Remember; need of patient are primary

HOPE is a major theme in the Jewish faith.

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At Bedside

Insights into Visiting the Sick For Family and Friends

By
Rabbi Dr. Maurice Lamm
President and Founder NIJH

In Memory Of

Tod Michael Zipnick

"My Beloved Is Mine,
And I Am My Beloved"
-Song of Songs, Chapter 2, Verse 16

The National Institute for Jewish Hospice

is indebted to

Laurie Zipnick

She chose to remember Tod in this meaningful way

NOTE:
The masculine gender in this booklet is used in the generic sense.

At Bedside

has drawn upon three sources that
we recommend reading;

1. Joseph Levine, *The Delicate Mitzvah, Visiting the Sick,* Moment Magazine, Vol. 4, #5, pp.50-55.

2. *The Healing Visit,* Shofnos and Zwebner, Targum Press, Southfield, Michigan 1989

3. *Color The Twilight,* a lecture delivered by Rabbi Dr. Maurice Lamm and published by the Council of Jewish Federations, New York, 1982

At Bedside

When a friend or close relative dies, we confront feelings and situations which are new and uncomfortable. We are not quite sure how to handle the anger and guilt that often accompany this experience. We know even less about how to interact with someone who is dying. Many fears concerning our own death inevitably arise at such a time, and we may no be certain how to deal with these either.

The Jewish tradition has a wealth of experience in dealing with all facets of life, including severe illness and dying. In this context, the national Institute for Jewish Hospice has generated materials in an effort to disseminate information about Jewish values and conduct to people facing the death of relatives or friends, and to members of the helping professions. We hope that the information in this booklet will help to make the experience of dying more comprehensible.

Visiting the Sick

Visiting the seriously ill is not a uniformly pleasant activity. There is a natural reluctance to experience sadness and to "intrude" on someone's privacy. We may be unsure of what to say; we may fear making a mistake in judgment; we might be upset by the patient's physical appearance; and, in general, we may feel uneasy surrounded by sick people in a hospital setting. Certainly some of these concerns are understandable and even appropriate. Sometime patients do prefer privacy; sometimes you may have an awkward relationship with the sick party. It is even true that we can expect, from time to time, that visiting the sick will make s aware of our own vulnerability. All these considerations, however, should be overcome in order to fulfill the religious obligation of

visiting the sick. It can even serve as a positive feeling in the way it alerts us to the universal human condition.

Visiting the sick is an obligation of caring and moral people. It is recognized universally as an important good that the community quite properly demands of its citizens. To Judaism, such visitation is not simply a courtesy call, or even solely a moral obligation. It is a religious mandate – a mitzvah – actually an act of imitating God, who "visited" the Patriarch Abraham during his illness.

The visit, especially to a person who is terminally ill, is a much-needed antidote to the hospital's sterile environment and to the feelings of being abandoned. Gone are the family pictures, one's favorite music, the pet, the familiar books. Because of its intense focus on physical cure, the hospital is concerned primarily with tubes and needles, pills and monitors – dealing with parts rather than the whole of a person. The patient in a modern hospital is often made to feel like an object, punctured and pulled, sometimes treated for physical wounds with disregard for personal sensitivities, handled as a "humanoid" rather than as a human being. Visiting the sick can provide a religious and humane attitude that conveys warmth, sensitivity and personal interest. Understanding eyes and helping hands can go a long way toward restoring a sense of connectedness, of self-worth and esteem.

The visit, in order to fulfill its moral and religious obligations, needs to have therapeutic value. The visitor can try to provide support beyond medical care, such as physical assistance, psychological support, and spiritual enhancement. The visit itself reassures patients of their continuing worth as individuals. It reinforces their feelings of being integral members of the family and of the community.

to be visited. No one is so unimportant as to be ignored, and no visitor too distinguished to make that visit.

But family or friends who cannot control their sadness, or who are themselves frail or sick and cannot tolerate the taxing of their senses, should be judicious about when to visit or even whether to visit. Sometimes, in fact, family or friends are too concerned about an adverse effect of the visit on themselves.

Should enemies of the patient visit him? The sage advice of Jewish tradition is that they should visit only after checking with the family to determine the kind of impression it would make.

A pre-modern custom has it that relatives should visit immediately while more distant acquaintances should wait for three days after the onset of the illness. This custom is not binding on us today, and the visit should be made when it is most appropriate, especially when the illness is catastrophic. In all matters – whether involving restraint or extensive personal involvement – friends and relatives should be guided by the needs of the person who is sick.

The manner in which we die may have changed compared to days gone by, but the needs of the seriously ill and the dying remain the same – the need for comfort and care, of hope just ahead, of keeping faith with the patient as a human being until the very end. This is our gift and contribution to the patient when we are present at bedside.

the patient's unique suffering and circumstance.

Don't offer platitudes. Chances are the sick person knows the prognosis and the odds. An off-hand assurance that everything is just fine, may be too offensive to bear lightly.

Don't give spiritual counsel, or speak as if you know God's plan. Patients should never be made too feel guilty for their deteriorated condition. Sometimes, however, a person who is recuperating must be encouraged to take responsibility for his own rehabilitation.

Rather than ask general, vacant questions, such as "How are you feeling?" ask questions that elicit a specific response, "How are you feeling today?" Sometimes you can tell or ask something related to the patient's interest.

Don't wear a depressed face. He knows you are unhappy to see him in this condition. Be bright, without being euphoric. Create a pleasant ambiance.

When To Visit?

Neither too early nor too late in the day; not during doctors' visits or tests; not when physical needs are being attended to; not when spouse and children have just come to visit; not when it interferes with hospital routine.

If possible, the visitor should give the patient the option of choosing the time for the visit. In a place without clocks and calendars, time is measured in events. A visit can be a very pleasant event to anticipate.

Who Should Not Visit?

Virtually everyone should visit, and every patient deserves

In earlier, more traditional times, when a person was in his last moments, no one, except for those who were overwrought, left his presence. Indeed, a minyan of Jews was brought in to be close by in case of death. (A minyan (ten Jews) is a religious quorum required for public prayer service.) Why bring a minyan to the dying patient? On the contrary, one could counter: "Don't clutter the atmosphere, let him die quietly." but the tradition counseled that a person should die surrounded by family and friends. This is most frequently not possible in a contemporary setting, but it remains an important tradition, and it keeps us mindful of an important principle of health care.

Understanding the Seriously Ill

The primary requirement for successfully performing the mitzvah (good deed) of visiting the sick is understanding the person who is now seriously ill, confined to a 6' x 3' rectangle of mattress, who is power-less and often hope-less, and bewildered. He is trying to sort out where he might have gone wrong and how to cope with the depletion of energies and loss of control which he now perceives to be his lot.

Understanding and empathy are needed to enable visitors to make the call therapeutic. Try to gain some insight into the patient's physical and psychological condition. This will be helpful in your conversations with him, and will prevent your making inappropriate suggestions.

Powerlessness

The patient is usually in a passive condition. He is powerless to initiate certain significant actions and limited in carrying out decisions. A formerly industrious person is

now dependent on others. This may generate feelings of inadequacy and impotence. He is tested and turned, injected and cried over, spoken about and prayed for. By being rendered passive he has been effectively removed from the world of activity.

In a hospital, strangers freely enter his room. They are authorized to touch him, to wake him in the middle of the night, to stick needles into his body, to take blood, to command urination, to grant or withhold food. How the pattern of his life has changed. It alternates between periods of solitude broken by sudden intrusions – volunteers, library book carts, dietitians with menus, housekeepers, TV salespersons, chaplains, nurses, and culminated with the doctor, often accompanied by what appears to be a platoon of investigators. Figures in white solemnly stand nosing around while questions about body functions are discussed; the chart is consulted; heads nod in knowing cadence. The room may change from full to empty in a moment, followed by sounds of a hallway consultation which can be partially heard but seldom understood by the patient, with a predictable rise in anxiety. "Are they talking about me? Is there something I was not told?"

Is it any wonder that loneliness, boredom, fear, shock, anger, guilt, and inadequacy now assault the patient? And this list doesn't even touch on the actual illness, the prognosis, or the person's physical pain.

The Jewish tradition provides specific activities which return an element of power to the individual. While it is true that just keeping up with one's day-to-day progress is a source of some anxiety, there are thought to be managed, or projects that should be undertaken' the writing of an ethical will and/or an oral history, giving

experiences with them.

Humor is on place, if it is done with sensitivity and within the limits imposed by the hospital environment, the neighboring patient, the sick person's tolerance, and good judgment. Try to relate such humor to the natural flow in your regular relationship with the patient.

You need not speak of the illness at all, except in fleeting reference, unless it is the desire of the patient. One who becomes sick does not lose interest or intelligence, although the illness does dominate his thoughts. Ignorance does not automatically accompany disability. "Invalid" is not "in-valid."

What Not To Say

Do not tire the patient. It is not proper, no matter what the motivation, to cause the patient to speak constantly. Reassure him that you can stay close, even without conversing at all.

Have compassion, but do not be over-solicitous or press for information the patient may be unwilling to give.

Do not offer your own advice on medicine or doctors, especially when it is unsolicited. Someone once said that 30% of advice is not useful, 60% is repetitious; and 5% is dangerous. If you believe you fall into the category of the remaining 5%, give the advice – but with sensitivity.

Accept the person's feelings as legitimate, and also as unique. It is unique, since feelings depend on details of experience and attitude, religion and the psyche – all forming a composite of different proportions. Don't talk of other people's reactions – it only serves to dilute the

little space he does have in a hospital setting; neither at the head of the bed nor at the foot.

Unless the patient desires otherwise, sit alongside the bed within reach, at about the middle, and at eye level, in order to be able to convey intimacy and chat amiably, and to hold hands or hug, or stroke – warmth flows from person-to-person and is comforting.

What To Say? What To Do?

These are some of the things visitors might do, depending upon their relationship with the patient and the frequency with which they are likely to visit.

They can help connect sick friends back to the community from which they came. Sometimes, after all, being sick causes people to worry about whether or not they are forgotten at home. Without making the person feel bad for what he or she is missing, a visitor can bring new of their mutual organizations, or some knowledge of community, cultural, or sports events that interest the friend. Surely current events in world affairs is appropriate.

Sometimes it is helpful to keep your eyes open for ways to assist without being asked. Without intruding into people's privacy, you may be able to learn about some situation that needs tending to. Is proper food being provided? Is the patient being provided for meaningfully? Long-term patients – especially elderly people – can benefit from running errands for them, reading stories to them, or handling small business or administrative items, such as insurance questions and family responsibilities.

Speak of the patient's strengths and abilities – and try to provide him with proof of these positive qualities from

charity – projects which may make the patient feel like a human being because he is giving, not only receiving. (These matters are addressed in fuller detail in the NIJH booklet, Caring For the Terminally Ill.)

Anger

It is not unusual for patient and visitor, most often relatives, to experience anger toward one another. A matter that would be a minor irritation in the outside world might be magnified in the hospital setting. Remember, we are no longer dealing with two psychologically equal individuals. The patient has been placed in a very dependent role for almost all his needs. In the best of circumstances, resentment builds up on the part of the patient. He has lost control over so much of his life. In spite of prearrangement, the visitor may arrive in the middle of, or shortly after, some incident that bring these pent-up emotions to the surface. It is far safer for the patient to vent anger at someone who does not have physical control over his body, rather than at health professionals.

Therefore, neither party should be surprised at an outburst. And since the visitor has his or her anxieties and possible unresolved antagonisms that existed prior to the hospitalization, the potential for a flare-up is always present. This too is acceptable, as long as both parties keep in mind who and where they are. This is another reason why working at one's awareness of what is going on is important. If you can identify hostility early, you have a better chance of dealing with it before it erupts into anger or tears. Remember that just below the surface of a seemingly innocuous conversation, a deep river of emotion is silently flowing, carrying memories, hopes and fears for both of you.

The visitor might find himself buffeted by surprising feelings and emotions, like anger. This is likely to result from new demands put on him by the sickness of the patient, a hidden feeling that he is being abandoned by the sick person, perhaps even a suppressed sense of relief at soon being liberated from having to attend to the dying person. The visitor needs to understand that these are not monstrous and unnatural sentiments, and many people react this way in the face of having to deal with the oncoming death of a loved one.

Loneliness

That the terminally ill person is lonely is understandable. He is thrown back on his own resources. He will travel the road to his ultimate destiny totally alone, without any company. But he is lonely for other reasons.

First, he has already begun to mourn himself, his own dying, the world will go on without his presence, without his direction. In Hebrew, the mourner is *avel*, which means "one who withdraws." Not only does the *family* withdraw, and become *avelim* after the death of their beloved, but the *patient* himself begins to withdraw.

Second, he is not alone just because of his own withdrawal, but because he is suffering from what some might call today the "Pariah Syndrome." If death is a terminus of relationships and dying is its prelude, relationships already now begin to alter and to become strained. It is a candlelight that is preparing to be extinguished, it first flickers and sputters before it dies. Among the flickerings in relationships are well-meaning friends and relatives who shy away from the terminally ill because they don't know what to say or because they are being reminded of their own vulnerability and mortality.

the visitor may make reference to this ultimate form of hope. Nobody, of course, formally knows what happens after we die, and therefore it is not surprising that Jewish people through the centuries have entertained a variety of views on the subject. Some believe that the soul is immortal; traditional Jews believe that ultimately there will be a bodily resurrection; and still others that, at the very least, we live on in the memory of close ones and in the influence we have had in their lives.0

However one thinks on these matters, the patient can be comforted in knowing, that for Judaism, life does not lose its significance with bodily death, that one's hope for a continued existence before God and for those who live after our death is well-founded.

Practical Suggestions

There are specific kernels of advice found sprinkled throughout Jewish literature.

Where Should You Position Yourself

Body language communicates powerful subliminal messages, especially to one who is sensitive to these matters and has the time to spend hours thinking about such details. The Jewish code of practice, the *Shulchan Arukh*, suggests;

Don't stand over the patient. Everyone who tends to him, including medical personnel and family, stands over him and thereby assumes a superior posture of looking down and forcing the patient to strain to look up.

Don't sit too far, in the corner of the room, because you might appear disinterested; nor too close, invading what

between family and the dying person should know be increased in depth and quality. It should be a period when loved ones sustain and cherish the patient, overriding previous instances of dissonance and bickering in the relationship.

Rabbi E. Dessler, one of this century's greatest Jewish ethicists, asks which comes first – giving or loving? The usual answer is that one gives to a person whom one already loves. But the reverse may be true. The more parents give to a child who is in need, the more love grows. The mutual giving to one another of patient and family can intensify their love.

Particularly at a time of terminal illness, the family must give and love demonstrably. They should hug and stroke and touch the patient when appropriate and acceptable to him or her. The consequences of such an attitude may be the achieving of an even deeper level of love.

Hope

As one should not leave the room of a sick patient without offering a prayer in his presence, so should one avoid leaving without some offer of hope to the patient.

In the midst of an apparently hopeless situation one is nonetheless mandated to give hope. But what can one hope for? One could hope for less pain – people may not be afraid to die; they are sorely afraid of pain. One could hope for the happiness of a surviving mate and children; for the family's continuation of the values that one taught; for the amelioration of whatever is his most fearful concern.

Jewish tradition affirms belief in a life after death, and

Forgiveness

The Jewish tradition understands that the patient, in order to achieve a peace within himself, has the need for the process of *mechillah*. *Mechillah* generally means asking forgiveness of people one has wronged, and many terminal ill need that opportunity.

Pertinent to the dying is a second form of *mechillah* – permission to die. Despite the fact that dying is not an act of the patients will, many patients require forgiveness for leaving their families – in a sense abandoning them – and forgiveness for the pain and trouble they caused through the agonizing process of dying and death. Conversely, family members might need the patient's consent for allowing them to say, "it's alright for you to let go." There is also a permission they require of God, that He is permitting to do what they are doing, although, of course, it is not an act of will.

These forgivenesses are often beyond simple rationality, and are most often not articulated explicitly. Only open discussion can explore their needs.

What The Visitor Should Strive For

Design a Healing Climate

A shared history binds patient and visitor to one another. In this context, there is a good chance that constructive dialogue will take place and the blessing of comfort and insight may emerge.

Just because you are visiting a seriously ill person does not mean you have to adopt a solemn demeanor. The

attitudes. For example, if part of your relationship with the patient has revolved around swapping jokes, bring one along. It is reassuring in an atmosphere of so much uncertainty to know that some of your patterns of relating remain the same.

Heart speaks to heart. Eyes communicate. In a short time, in spite of the visitor's apprehension, the patient will know, perhaps not during the first visit but soon thereafter, that the visitor has come to "be with," rather than to "carry out an obligation." *You do not fulfill the mitzvah only with the presence of your body. You fulfill the mitzvah with your inner self.* And the wisdom of silence can also be helpful. But listening to understand is a discipline, for in the daily world we are more often valued for our ability to provide information or answers. In the sickroom, we serve best when we look and listen creatively; we are really not expected to provide "answers." Our value lies more in helping the patient to clarify thoughts and feelings about the significance of what is happening.

"How long should a visit last?' is a question that people often ask. It depends on both parties. When in doubt leave early. We have found that patients soon devise little parting speeches that usually begin with the phrase "It is very nice that you have taken the time to come see me".... that translates as "Good-bye for today. Take the hint.

According to Jewish tradition, a visitor carries away a portion of the patient's burden by virtue of his visit. The visitor often leaves the hospital richer in mind and spirit if he or she has successfully fulfilled the *mitzvah* of visiting the sick, *bikur cholim*, with sensitivity, trust and love.

Applying Jewish Spiritual Values

Prayer

Jewish tradition believes in the practical efficacy of prayer. Of course, prayer is never a substitute for medical care, but done well it can be an important supplement to it. The sick, particularly, may find a great source of comfort in prayer, and so may members of the family who are in the room during the visitation. Sincere personal prayer can be voiced as a hope addressed to God. Maimonides and other sages state that it is incumbent upon visitors to personally pray for the patient's recovery, or for his ease and relief from pain. One should do that in the language the patient understands best. For example, "I pray to God that..."

Many people might like to pray personally but do not know how to pray. In such a case it is appropriate to use a prayer book with an English translation. Obviously, you can pray in any language that is familiar to you. If a patient doesn't wish to participate in prayer, his wishes should be respected. Jewish tradition obliges us to cheer the patient up – even at the expense of omitting this important religious act. Perhaps an initial statement on the values of asking for God's assistance, in addition to the medical staff's help, might serve as a good starter.

Moses prayed for his sister Miriam's recuperation by saying five words; "*El na, refa na la.*" "Please God; please heal her." (Numbers, XII, 13)

Love

Since time is limited for the dying, love becomes an even

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IMPORTANT CALENDAR NOTE

We have provided the dates of the holidays from Nov. 2014 and on for the coming year. Past the dates in this calendar, however, please note that the Jewish calendar is different from the regular calendar and so each year the Jewish holidays will come on different days of the regular calendar, and a Jewish calendar needs to be checked each year.

event. There are no particular rituals associated with this day, and most Jewish . have special celebrations and events. Jewish pride in the State of Israel is a source of encouragement and a reminder to patients that, despite all dismal predictions, the Jewish people continue to survive.

XI. SHAVU'OT (PENTECOST)

Major Holiday

This year the holiday is on May 24 and May 25, 2015.

This two-day biblical holiday, known in English as Pentecost, falls in May or June and celebrates the giving of the Ten Commandments and the Torah on Mount Sinai by God to the Jewish people, and the annual harvest in Israel. At synagogue services on Shavuot morning, we also read the biblical Book of Ruth. Ruth was a non-Jewish woman whose love for God and Torah led her to convert to Judaism.

On Shavuot, it is customary to decorate the synagogue with branches and flowers. This is because Mount Sinai blossomed with flowers on the day the Torah was given. It is also a custom to eat dairy foods, including blintzes, on this holiday.

Beyond the issues of use of electricity, etc. of all major holidays, there are no other restrictions or hospice concerns for this holiday.

Holidays and Commemorations

Judaism is an old and wise religion, and is superbly sensitive to the needs of the dying, as it is to the living. Holiday traditions can be a source of great comfort and solace to a dying person, evoking childhood memories and conveying a sense of continuity in a time filled with fear of the unknown. The observance of holiday traditions often yields unexpected benefits as one begins to feel closer to the Almighty, and indeed closer to one's people. Many Jewish holidays have special foods associated with them as well: a smell or a small taste may awaken pleasant associations for the patient.

The Torah declares, "And he shall live by them," meaning that Jews live by the mitzvot (observances) God has commanded them to perform. Holiday observances enable people to live meaningful, God-oriented lives. But no life should be compromised, no limb endangered, and no terminally ill patient even made uncomfortable in order to fulfill these mitzvot. In other words, no celebration should be carried out contrary to a physician's advice. Religious practice should be performed to further an individual's needs, no to fulfill a religious obligation, and they should conform to the patient's physical and psychological well-being, remaining within his or her interest and attention span.

General Notes

1. There is a wide variety of Jewish practices. This ranges from those that are very traditional and strictly follow all religious observances, to those who have mostly cultural connections and follow few religious observances, and includes a wide variety in between. We are presenting the traditional observances to give you the most information, which then need to be tailored to each individual family's Jewish lifestyle.

2. All Jewish holidays, including the Sabbath, start at sundown the night before, and continue until full darkness on the next day.

3. There are two categories of Jewish holidays, **Major** and **Minor**. On the Major holidays, more traditional Jews will refrain from business, and the use of most electric items. They will not turn lights on or off, and will not answer the phone. On Minor holidays, the day is a regular day with the addition of the holiday observances, business can take place and electricity is used. We will indicate into which category each holiday belongs.

I. The Sabbath

Status of a Major Holiday

I. HISTORICAL BACKGROUND

The seventh day of the week, Shabbat, is said to offer a taste of the world to come. Jews speak of the Sabbath Queen and liken Shabbat to the crown of the week, the crown of the Jewish holy days, the crown of the Jewish spirit, and the secret to Jewish survival.

II. OBSERVANCES

The observance begins before sundown on Friday night, ushered in by the lighting of candles 18 minutes before sunset, which symbolizes bringing peace, light and cheer into people's lives. The traditional meal on Friday night is preceded by the recitation of "Kiddush," the benediction over wine, and the "Motzi," the blessing over the thick braided bread called challah. The meal, characteristically, but not necessarily, includes the traditional chicken soup with matzah balls, all sitting atop a white linen tablecloth. Even those who are less observant often keep the tradition of a special family dinner on Friday night.

IX. YOM HA-SHOAH

Minor Holiday

This year the holiday is on April 28, 2014.

This contemporary commemoration, known in English as Holocaust Day, falls during April and memorializes the immense tragedy of the Holocaust and the annihilation of six million Jews, including one million children. There are ed with the day, but it is important especially to patients who are survivors of the Holocaust. Virtually all Jewish communities have special commemoration services and events. If possible, it is preferable not to remind patients of this day; it will only add to the sadness they already are experiencing because of their own condition.

X. YOM HA-ATZMA'UT

Minor Holiday

This year the holiday is on May 6, 2014.

Israel Independence Day, celebrated in April or May on the Jewish calendar, marks the founding of the modern State of Israel on May 14, 1948. All Jews, especially those who are deeply Zionistic (supporters of the land and the people of Israel) should be reminded of this wonderful

special gift. The afikoman, which means "dessert," is eaten at conclusion of the Seder.

Other customary foods at the Seder include "maror," the bitter herbs, usually ground horseradish or romaine lettuce – a reminder of the bitterness of servitude; "charoset," a mixture of fruit, wine, nuts, and spices, which symbolizes the mortar used by the Jewish slaves in building the pyramids of Egypt; and hard-boiled eggs in salt water. Four cups of wine are served to each guest during the course of the Seder. A fifth cup of wine, designated as the Cup of Elijah, is placed on the table and the door is opened to symbolically welcome the prophet Elijah, harbinger of the Messiah, who is said to visit every Seder table.

III. HOSPICE CONCERNS & ISSUES

A physician should be consulted as to whether Matzah and wine, and the other ritual foods, are medically permitted for the hospice patient. The Matzah can be soaked in water to soften it. Diluted grape juice, or even tea, can be substituted for wine, if need be.

Prescribed drugs should be taken, of course, but should be kept separate from Passover food. Anything containing "Chametz" (produced from grains) should not be used, unless specifically required for medicinal purposes.

If in a hospice unit, the patient's family may need special accommodations for observing the many specific food practices unique to Passover.

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Most Jews who attend services likely attend Saturday morning. Each week a different Torah (Bible) portion is read in the synagogue. The caregiver may provide a Jewish Bible (not a Gideon's edition or one that also contains the New Testament). Shabbat lunch is another festive occasion. Since the Sabbath is a day of rest, many Jews refrain from doing work or other weekday chores, gathering with family and friends to enjoy a day of Jewish learning or relaxation.

Shabbat ends after it is fully dark Saturday night with a brief ceremony called "Havdala." Blessings are said over wine, light and sweet smelling spices, and over the separation of "light and darkness, holy and profane, Shabbat and the weekday."

III. HOSPICE CONCERNS & ISSUES

The only hospice issues are concerning the patient's and the family's use of electricity and phones. In a more observant family that does not use them, it is important to know that they will leave on any lights that will be needed on the Shabbat. Consequently, a hospice professional should not turn off any lights they find on (such in a bathroom) as the family will not be able to turn them back on. If the hospice worker needs to turn on any light, or use any electricity, to perform their duties, they certainly can, but should make sure to turn it off when they finish.

Similarly, such a family will not answer their phones on Shabbat. Most of the times, as long as all of the hospice staff are aware of this, there usually in no problem. It does mean that sometimes things will need to be arranged before Shabbat.

Of course, in a life-threatening emergency, all restrictions fall away, and anything needed to be done to safeguard life is done promptly and without any restrictions.

II. Rosh Hashana

Major Holiday

This year the holiday is on Sept. 14 and Sept. 15, 2015.

I. HISTORICAL BACKGROUND

The phrase "High Holidays" encompasses Rosh Hashana, the Jewish New Year, and Yom Kippur, the Day of Atonement. Rosh Hashana is a two-day holiday, and usually falls in September and is a time of repentance and prayer.

It is said that, in the period between Rosh Hashanah and Yom Kippur, God weighs the deeds of each Jew and decides his or her fate for the coming year. This is reflected in the traditional High Holiday greeting, "May you be inscribed in the Book of Life." Through "Prayer, Repentance and Good Deeds," Jews believe they can tip the scale in their favor. Therefore, the Jewish New Year is a time of solemnity and not a day of partying, like the regular New Year on January 1. Many synagogues have long services with many added prayers on these solemn days.

II. OBSERVANCES

As on all major holidays, there are festive meals at night and during the day. It is customary on Rosh Hashanah to eat apples dipped in honey, as a form of prayer that the coming year will be a sweet one. There are also customs of eating different foods whose names symbolize blessing, as a physical payer for the year to be a good one.

The most important mitzvah (Commandment) on Rosh Hashanah is the blowing of the Shofar, a ram's horn, for which no other instrument can substitute. It is blown in a particular fashion and only an experienced Shofar-blower knows how to make the requisite sounds.

The "Haggadah" is read, which tells the entire story of how Moses, chosen by God, led the Jews out of slavery in Egypt; to the appearance of Moses, the ten Plagues, the Exodus and the splitting of the Red Sea.

Although Passover is one of the most important Jewish holidays, only the first two days and the last two days have Major status (see Notes in Introduction). The intermediate days, the days in between, have Minor status.

II. OBSERVANCES

1. FOOD: On all eight days of Passover, all grain products, including all bread, non-Passover cakes, pasta and cereals, are called "Chametz" and should not be eaten. Therefore, bread is replaced by Matzah. Matzah is a thin, cracker type of bread, made without any leavening agents, baked specially for Passover. All processed foods need to be Kosher for Passover. (Kosher for Passover indicates that not only is it kosher, but it has no grain ingredients and is therefore fit for Passover use.) All raw foods, such as fruits and vegetables may be eaten.

2. THE SEDER: There are more rituals associated with the Passover Seder than with any other ritual meal in Judaism.

The "Haggadah" is read. The youngest child traditionally sings the "Mah Nistana," the Four Questions, which begins, "Why is this night different from all other nights?"

At the beginning of the Seder, three pieces of Matzah are placed under a special cover. Later, the middle Matzah is broken into two and one piece, called the "Afikoman," is hidden. The children at the Seder search for the afikoman and barter it with the adults for a the

can provide satisfaction and joy.

3. Sending Mishloach Manot (the food package) might be beyond the patient's ability, but receiving them (often gaily decorated) would surely bring a smile, and renew the feeling of belonging.

4. Charity, thinking of others, is something that could be beneficial and brings self-worth and power to the patient.

5. Having children come in their costumes would add positive energy and a festive spirit to the patient.

6. Fasting on the Fast of Esther is not permitted for one who is even minimally sick.

VIII. PASSOVER, PESACH

Major Holiday

The holiday of Passover is this year from April 4, 2015, through April 11, 2015. The two Seder nights are Friday night April 3, and Saturday night April 4, 2015.

I. HISTORICAL BACKGROUND

Pesach, in English "Passover' or Festival of Freedom, which falls in March or April, commemorates the Exodus of the Jews from the slavery of ancient Egypt. It is celebrated with a festive meal, called the Seder, on the first two nights of the eight-day holiday.

Usually, the entire extended family and invited guests, celebrate the Seder together. It is common to have two, three or four generations join in the Seder. Many synagogues have a communal Seder. The Seder is one of the highlights of the year, with each family having their own traditions that they look forward to.

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III. HOSPICE CONCERNS & ISSUES

A local rabbi may well be able to arrange for the Shofar to be blown at the patient's bedside, but it is important to make sure that this will not disturb other patients or frighten them with its otherworldly sound.

III. Yom Kippur

Major Holiday

This year the holiday is on September 23, 2015.

I. HISTORICAL BACKGROUND

The ten days that began on Rosh Hashanah and culminate on Yom Kippur, are known as the Ten Days of Repentance. There are extra prayers, people do extra acts of kindness, and are introspective about their life. Yom Kippur, the Day of Atonement, is the most somber day of the Jewish calendar. This is the final day of judgment for the coming year.

II. OBSERVANCES

On Yom Kippur, starting from sundown the night before, Jews refrain from all food, drink and work, and the entire day is devoted to prayer. There is a special prayerbook, called a "machzor" that contains many special prayers reflecting the solemnity of the day.

III. HOSPICE CONCERNS & ISSUES

Jewish law, however, forbids fasting if it will, in any way, sicken a person or endanger his or her life or health. If a patient insists on fasting despite doctor's orders, caregivers should consult his or her family or a rabbi, who can assure the patient of the wisdom of the law of not fasting. If it does not contravene physician's orders, perhaps a single meal can be skipped or delayed.

IV. Sukkot and Simchat Torah

Major Holiday

This year the holiday is on Sept. 28 to Oct.6, 2015.
Simchat Torah is the last day Oct.6.

I. HISTORICAL BACKGROUND

Sukkot, a nine-day holiday known in English as Tabernacles, follows Yom Kippur by four days and usually falls in October. After leaving Egypt and slavery behind, the Jews traveled in the desert for forty years. During that time, they were protected and provided for by God in many miraculous ways. Sukkot celebrates the ongoing protection of God in our life.

II. OBSERVANCES

The main features of the holiday are building a temporary hut covered loosely by branches, bamboo or wooden slats, called a Sukkah. For eight days, all meals are taken in the Sukkah. The holiday prayers are marked by the waving of the "lulav" and "etrog." A lulav is a bouquet of a palm frond, two myrtle branches, and three willow branches. It is bundled together with an etrog, which is a citron (superficially it appears to be a large lemon, but it is not).

The eighth day of Sukkot is Shemini Azeret – a day on which Jews traditionally recite a memorial prayer for departed ones called "Yizkor." Yizkor is recited four times a year: on Yom Kippur, on the final days of Sukkot and Passover, and the second day of Shavuot, a spring holiday. The concluding day of Sukkot is called Simchat Torah, a joyous celebration marking the annual completion of the Torah-reading cycle and the beginning of the new cycle.

III. HOSPICE CONCERNS & ISSUES

For many hospice patients, eating in a Sukkah is not realistic or possible. However, the Lulav and etrog set, if desired, can be ordered or borrowed from a local synagogue. The patient can hold the Lulav and etrog and wave them for just a few minutes.

commemorates the prayers, supplications and fasting that Jews of that time did to be delivered from their enemies. The fast starts from the morning of the day and goes until dark.

II. OBSERVANCES

1. The Megillah, the Book of Esther handwritten on a scroll, is publicly read in a synagogue on the night of Purim and again in the morning. When Haman's name is mentioned, people spin "graggers"- noisemakers, to drown out the memory of this wicked person.

2. During the day of Purim, a festive meal is held to celebrate the holiday. It traditionally includes wine.

3. During the day of Purim, a package of food is sent to one's friends symbolizing the unity of the Jewish people. It usually includes "Hamantashen," triangular pastries filled with poppy seeds, prunes, or other sweets.

4. During the day of Purim, charity is given to poor people to enable them to celebrate the holiday.

5. Children often dress up in costumes to add fun and revelry to the day.

III. HOSPICE CONCERNS & ISSUES

1. There are many communities where volunteers are available to come to people's homes and give a private reading of the Megillah. A local rabbi or synagogue can often provide this service.

2. Of course, any food at the festive meal would have to be appropriate to the patient, but even joining such a meal

In life, we too go through cycles. A patient in hospice still has that sap of life in him, and still has great potential to contribute, especially to his own personal spiritual growth and especially to his immediate family.

III. HOSPICE CONCERNS & ISSUES

As this non-holiday holiday has no requirements except to eat fruit, the only hospice concern is the patient's diet. If a patient is unable to eat any, just talking and thinking about the messages of Tu B'Shevat is a beautiful way to fulfill this Jewish custom

VII. PURIM

Minor Holiday

The holiday of Purim comes this year on Thursday, March 5, 2015.
The Fast of Esther is on Wednesday, March 4, 2015.

I. HISTORICAL BACKGROUND

This frolicking holiday, also known as the Feast of Lots, commemorates the foiling of a plan by the evil Haman, the king's c r, to slay all the Jews of the Persian Empire. It is celebrated by reading the "Megillah," the biblical Book of Esther. The Megillah describes how Queen Esther, who was secretly Jewish and the unwilling consort to King Xerxes (Achashverosh), together with her uncle Mordecai, wrested victory from Haman, and sent him and his son's to the gallows, precisely reversing the intentions of Haman to hang Mordecai and kill the Jews.

The Fast of Esther, held before the Purim holiday,

V. Chanukah

Minor Holiday

This year the holiday is from Dec. 6 (night) to Dec.14, 2015.

I. HISTORICAL BACKGROUND

The two most widely observed Jewish festivals are Chanukah and Pesach (Passover). The eight-day festival of Chanukah, also known as the Festival of Lights, is celebrated in December. Chanukah celebrates the miraculous victory in 165 B.C.E. of the Jewish Maccabees against the Syrian-Greek regime of Antiochus, who tried to stop the practice of the Jewish religion. Antiochus outlawed Jewish observance — including circumcision, Shabbat, and Torah study — under penalty of death. When the victorious Jews re-entered the Holy Temple, they found only a single jug of ritually pure oil, which was enough to burn for only one day, but which miraculously lasted for eight days.

II. OBSERVANCES

Each night Jews light a special eight-branched candelabrum called a menorah. On the first night of Chanukah, one candle is lit, on the second two, and so on. The candles may be kindled for the patient by a family member or a friend.

Through a synagogue or Jewish community center it may be possible to arrange for children to come and sing Chanukah songs. Children also enjoy playing driedel (a driedel is a spinning top) on Chanukah. Potato pancakes, or "latkes" as they are called, traditionally are served on this holiday. Since Chanukah is traditionally a time for gift giving, a small gift may be given to the patient, or provided to the patient for him or her to give to children or grandchildren. In lieu of a gift, token money, called Chanukah gelt, also is appropriate.

III. HOSPICE CONCERNS & ISSUES

Of course, great care needs to be exercised with the candles around medical equipment; indeed, the medical equipment required by the patient might preclude candles. An electric menorah may then be used in such a situation. A menorah and other Chanukah decorations in a hospice unit lobby (or other public area) make a nice addition to other holiday decorations.

VI. Tu B'Shevat

This year the holiday is on Feb.4, 2015

1. The Non-Holiday Holiday

The 15th day of the Jewish month Shevat, Tu B'Shevat, (literally "the 15th of Shevat") is called the New Year for Trees. This year it falls out on January 16, 2014. It does not have the status of a holiday; it is a day that Jews celebrate by way of custom. A Jewish custom comes from the Jewish soul. The custom of Tu B'Shvat was particularly developed by the mystics.


Dates

Tradition teaches that the New Year for fruit begins on the fifteenth of Shevat because most of the winter rains will have passed and the sap of the new growth has begun to flow inside the tree: the dormant tree is waking from its winter sleep. The almond tree is the first to bloom, actually blooming around Tu B'Shevat

How do we celebrate Tu B'Shevat and what does the celebration tell us about ourselves?

The observance of the day is just eating fruit. If at all possible, the fruits should include the seven species for which the Land of Israel is praised: wheat, barely, figs, pomegranates, grapes, olives and date-honey. Some have the custom to add as many other fruits as you can (using dry fruits to make eating more varieties possible) with the aim of reaching a total of 15 fruits in all.


Pomegranates

Many commentaries see in this a moral lesson, because Torah/Bible compares the human being to a tree (Deuteronomy20:19) to teach us many lessons for our personal growth.

Man and the earth both share great potential. A patch of untilled earth appears to be lifeless. One can dig in the ground and find nothing more than soil. But if you wait and watch you will witness its incredible potential develop. Plants and flowers will grow; huge trees and vast forests can develop.

Man too has the same tremendous, unlimited, continuous, hidden potential within him. Man, created in the image of G-d, can be like G-d and create and build. He can build his business and career, he can build his family, he can build his community. He can build himself into a morally sensitive, spiritual person and develop an altruistic nature. He can use his creativity to enhance the worlds he lives in. And he can continuously generate new ideas, new solutions and create new relationships.

The tree also goes through cycles in its life. The heavy-laden tree of summer empties itself of fruit in the autumn, and then slowly loses its leaves. By winter, the tree is bare, shorn of its previous glory.


Grapes

But then comes Tu B'Shvat. In the midst of the cold winter days, when all vegetation seems frozen or dead, the sap of the tree starts to flow beneath the surface bark. Rising slowly from roots buried in the hardened soil, the sap pushes its way up, pumping new life into outstretched branches that reach towards the heavens.

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While you are discussing final arrangements with both sons, the older son states: "My rabbi told me that Jews are not allowed to be cremated. We made this mistake with mom because I did not know any better, but I will not allow us to make the same mistake with dad. He has to have a proper Jewish burial and we have to sit shiva."

The younger son wants to honor his father's wishes and have him cremated and is not interested in sitting shiva.

How could this conflict be managed?

It is important to recognize that according to traditional Jewish law cremation is never allowed (although some rabbis in the Reform movement now allow cremation). From the older sons perspective his father's decision to choose cremation was wrong and should not be implemented. While Jewish law demands that one maintain respect for one's father, this respect does not allow a child to violate Jewish law, even if the father requests it. Just as a son could not get his father a ham sandwich (which violates the Jewish dietary laws) even if he asked for it, he cannot follows his wishes and cremate him because it is against Jewish law.

Having recognized the older son's objection, it is necessary to find out from the sons what each of their issues are and attempt to reach a solution that they both can accept, if possible. Sometimes, these disputes are insoluble, and then secular law, which will honor the wishes of the patient, will prevail. However, it is critical that when facilitating these types of discussions between family members, that all sides of the issue, including the thought processes beliefs of the involved family members and/or other interested parties, are understood.

We hope this booklet enlightens you to the Jewish issues in end of life care. A rabbi must always be consulted as each case is unique, but the principles and applications give us a broad understanding of Jewish Medical Ethics and end of life care.

Jewish Medical Ethics: A Review

In order to create a common language with secular medical ethics, Jewish medical ethics redefines the four main Georgetown ethical principles: Autonomy, Beneficence, Non-Maleficence, and Justice, in a fashion that is compatible with Jewish law and Jewish values.

1. Autonomy: Autonomy is commonly defined as the right of an individual to choose from any all alternatives offered based on his or her personal values or beliefs. While Judaism certainly respects an individual's right to choose, the major difference between the Jewish and secular definitions of autonomy is that the Jewish definition, in some sense, "voluntary" limits one's choices to those that are consistent with G-d's law, as defined in the Torah and other Jewish sources.

2. Beneficence: Beneficence is commonly defined as the obligation of healthcare providers to provide patients with care that is beneficial. Judaism agrees with this but adds that patients are also obligated to seek beneficial treatment.

3. Non-maleficence: Non-maleficence is the avoidance of harm, and since most medical treatments have some risk of side effects than can be harmful to some, one generally considers the potential for harm against the potential benefit that can be gained. Judaism sees this value in much the same fashion.

4. Justice: Justice can be divided into two types:
   a. Social Justice: This can be defined as determining what is good for the society as a whole.
   b. Distributive Justice: In the face of limited resources, distributive justice allows for the allocating or rationing of the available resources based on where they will do the greatest good for the society. Jewish law is compatible with this idea, and this principle is the basis for the Israeli national health care system, which is a national managed health care model.

End of Life Care Decision Making

When applying these principles to various issues related to end of life care, it must be remembered that the patients must be considered terminally ill according to Jewish definitions (which will be reviewed below). While, under Jewish law, there are general rules that apply to end of life care decision making, decisions that affect specific patients should be made, as done in hospice care in general, on a case-by-case basis, as there is some degree of flexibility and the ability to make exceptions within the framework of Jewish law. Therefore, a rabbi who is an expert in Jewish medical ethics must be involved in the decision making process in order to be able to apply the general law to the specific circumstances of the patient being cared for. Not all community rabbis are experts in this area, and while patients are encouraged to seek out their own rabbis, if the rabbi is not knowledgeable he has an obligation to consult a rabbi who has the necessary expertise.

It is also important that the rabbi who is being asked to make a specific recommendation about a patient speak directly with the patient's physician. More often than not, the doctor speaks with the family, and the family then speaks with the rabbi. The challenge in this situation is that the family may not relate all of the relevant information about the patient to the rabbi, in which case, if the rabbi renders a ruling without consulting with the physician, the ruling will be based on incomplete information. Only by speaking directly with the physician can the rabbi be assured of having all the necessary information necessary to make a recommendation to the patient and family that is compatible with Jewish law and takes into account the patient's specific circumstances.

Terminal Illness Defined by Jewish Law

There are two basic definitions of terminal illness under Jewish law. The first is a patient who has a prognosis of one-year or less, which is some sense, is more "liberal" than the Hospice Medicare Benefit requirement of six months or less. However, it must be noted that in most states in the US, the definition of

and that patients would never be abandoned. Sometimes, despite understanding these explanations, the patients, families, and/or rabbis will say "but that is not what happens in the hospitals in my town." If that is the case, it is important to ensure that this is not true, or if true, to correct the problem, and then provide additional reassurance that this will not happen going forward.

Returning to Case # 3, is the wife's statement that she does not want CPR and your response that you will write a DNR order sufficient to truly know what the patient wants?

It is possible, for example, that as the patient is currently symptom-free, if she suffered a cardiac event that she would, in fact, want CPR. This needs to be asked of the patient. If she states "No" then we could proceed with addressing the objections of her husband. If she said "Yes" then you would need to clarify at what point in her illness she would no longer want CPR and document this, so that you can revisit this issue at the appropriate time.

Assuming the patient still does not want CPR, and you have explained to the patient and her husband what a DNR order represents, what would you do if the wife and husband continue to disagree?

If there is a true disagreement, one option might be to have her consider, in addition to a living will stating her wishes, designating a health care surrogate other than her husband to ensure her wishes are carried out. However, this would seem to be a somewhat drastic approach that will place the patient and her husband in continued conflict. So what should we do? There are no easy answers. One approach to consider would be, with the patient's permission, to have a meeting with their rabbi in order to fully apprise him of medical situation and explain a DNR order really means.

CASE # 4

Returning to Case # 1: The patient has deteriorated to the point where death is imminent. When he was alert and aware, the patient stated that he wanted to be cremated and his ashes mingled with those of his wife, who had been cremated when she passed away.

CASE # 3

You are meeting with a 75year old female with advanced breast cancer to lung and bone. Her disease is progressive despite multiple successive programs of hormonal therapy and chemotherapy, and she has decided not to continue the treatments since they are no longer helping her. She is still functional and relatively symptom free. With her at the meeting are her husband, her son, and her daughter.

The goal of the meeting is to discuss various care options going forward, her goals of care, and to have her create an advance medical directive. As you discuss various issues, you raise the question of whether or not she would want CPR should she suffer a cardiac or respiratory arrest. She states that she would not want CPR, at which point you state "OK, then I will place a DNR order on your chart." Her husband immediately states: "Wait a minute! The Rabbi said that you should never agree to a DNR order, because then they will not treat you at all.

Although to hospice professionals, the idea that DNR means "Do Not Treat" is incorrect, the perception that it does is out in various communities including the many facets of the traditional Jewish community. Rabbis in many communities will caution their congregants against agreeing to sign a DNR because then they won't be treated, rather, the healthcare system will just "put them in the corner and wait for them to die." Many patients and families feel this way even without the input from a rabbi. Therefore, as this is an issue that hospice professionals will encounter, how should it be addressed?

When this issue is being raised with patients and families or with rabbis, it is important to educate them regarding what a DNR actually means. It is important to explain that the only interventions that would be withheld would be cardiac compressions, electric shock therapy to the heart, and endotracheal intubation and mechanical ventilation. Reassurance needs to be provided that interventions that are appropriate for treatment and control of various symptoms that the patient may experience would continue

terminal illness that is utilized in advance directives is much more flexible, and often includes various forms of irreversible neurological conditions (i.e. dementia, vegetative state, coma) that, with proper supportive care may have a prognosis of greater than one year. While in our secular society, these patients may sometimes be considered terminally ill if they choose to forgo certain types of supportive care (i.e. tube feedings), according to Jewish law, patients with these types of irreversible neurological conditions would not be considered terminally ill as they might live for several years with good basic supportive care, and a decision to forgo basic supportive care (i.e. tube feedings) would generally not be consistent with Jewish law.

An illustrative example of this would be the case of Terri Schiavo, who was an unfortunate young woman who ended up in a permanent vegetative state for many years. When it became clear to her husband that she was not going to recover neurologically, he believed that she would not want to continue to live the way she was, and decided to have her feeding tubes discontinued. Her parents objected, and this led to a very unfortunate public dispute over the correct course of action. While Terri Schiavo was not Jewish, a Jewish patient in her position who was committed to following Jewish law would not be allowed to have the feeding tube removed for two reasons:

1. Food and fluid are considered basic care by most rabbis even when provided artificially (see discussion below).
2. Since she had no major intercurrent illnesses or other comorbid illness to adversely affect her prognosis, she had a prognosis greater than one year and would not be considered terminally ill under Jewish law.

Discontinuing feedings in such a patient would result in death due to lack of nutritional support, which would be against Jewish law.

The second definition of terminal illness under Jewish law is called *"Goses,"* which could be best defined today as "actively dying." In the Talmud, an ancient Jewish source, a *goses* is generally defined as someone in the last 3 days of life. However, with the increase in medical knowledge and technology, limiting the *goses* to the last 3 days of life is not precise enough for our times.

Additionally, one cannot know when the last 3 days of life begins until after the patient has died. Hence, it seems prudent to equate *goses* with a patient who is "actively dying." Of interest is that in classic Jewish literature, one of the signs of the associated with a *goses* is the presence of upper airway secretions, often called the "death rattle" by hospice professionals. Knowing a patient is a *goses* can be important, as Jewish law teaches that one should only provide basic care to a patient in this state. Rabbi M. Feinstein, one of the most famous twentieth century rabbis and who made many of the rules of modern Jewish medical ethics, ruled that a patient in this condition should receive basic care should be kept clean and comfortable. However, interventions that will not benefit the patient, including such routine tasks as checking the patient's blood pressure, should not be done as it can cause the patient unnecessary distress.

Interventions in Terminally Ill Patients Defined by Jewish Law

Assisted suicide and euthanasia are not allowed under any circumstances according to Jewish law. While in the US, physician assisted suicide is allowed in 3 states, and being considered in others, the active taking of a human life, even if the person is a *goses*, is absolutely prohibited by Jewish law. Judaism believes that life is given and taken by G-d. It is not up to us to decide when a person's life should end.

The decision of a medically competent terminally ill person to refuse care is permitted if the care being offered if proven to be ineffective or futile, if it will only serve to delay the dying process, and/or if the terminally ill person is experiencing pain and suffering that will not be relieved by the intervention. These same conditions would allow care to be withheld from a terminally ill patient who is not medically competent.

Withdrawing of care from a terminally ill patient, however, is generally not permissible unless the intervention can clearly be viewed as an "impediment to death." For example, if a patient is a *goses*, actively dying, and someone is playing loud music that is agitating the patient and delaying the dying process, the person can

Again, there are basically two options:

1. Continue to maintain her on the ventilator and let nature take its course, as without brain stem activity she will soon die.
2. Remove her from the ventilator at this time as she is legally dead according to secular law.

Given the husband's prior position it is most likely that he would opt for immediate ventilator removal with coordination with the transplant team.

For the parents who are Orthodox Jews, their position may very well hinge on which Jewish definition of death they accept. If they believe that total brain including brain stem death is the Jewish definition of death, then the parents might agree to the son- in-law's wishes. However, if they believe that death under Jewish law is only established when the heart stops, then the parents would still consider her to be alive and would object to having the patient removed from the ventilator. Since they may understand that the patient's condition is terminal even if she remains on the ventilator, they might agree to option one above. While Jewish law would not allow the ventilator to be withdrawn, Jewish law does allow new interventions to be withheld. How taking this approach might affect the ability of the transplant team to remove various organs (other than the heart) for donation is unclear, and if her organs cannot be donated this might create more anguish for the patient's husband.

One final point is that legally the husband has the final say (unless the patient had a durable health care power of attorney appointing her parent(s) as healthcare surrogate), although it is hoped the family will work out their differences peacefully. However, it is often very difficult to satisfy all concerned parties in these situations.

A neurology consultant evaluates the patient and makes a diagnosis of persistent vegetative state. You arrange a meeting with the husband and the parents, all of whom have been actively involved in the care of the patient, to discuss further care options.

What are the possible options for care that are available?

At this point, there are two possible options for care:

1. Continue to provide mechanical ventilation and after a tracheostomy (which is necessary for chronic ventilator care) is done, transfer the patient to a chronic care facility.
2. Remove the patient from the mechanical ventilator which will likely result in the patient's death as she is ventilator dependent.

The husband believes his wife would not want to live this way, and therefore wants her removed from the ventilator. Since she is ventilator dependent, and it is anticipated she will die following extubation, he also wants to donate her organs for transplantation.

The parents vehemently disagree and want their daughter to have a tracheostomy and remain on the ventilator as long as necessary

The husband, trying to be respectful to his in-law' s wishes, agrees to allow her to have a tracheostomy and remain on the ventilator for several months to see if there is any neurological improvement and then have her re-evaluated.

About 2 weeks later, the patient's condition deteriorates. Repeat neurological evaluation determines that she is now clinically "brain dead" with no spontaneous respirations at all.

You again meet with the husband and parents to discuss options.

What are the options and issues now?

be asked to lower the volume or stop playing the music in order to reduce the patient's agitation and allow the natural dying process to continue. On the other hand, a mechanical ventilator, which may be seen by some as an "impediment to dying," is considered by Jewish law to be "life sustaining" and hence, it cannot be actively withdrawn.

Armed with these general rules regarding refusal, withholding, and withdrawing care, several key end of life issues can be examined:

1. Pain: The treatment of pain is mandatory as Judaism does not support the idea that one has to experience pain and/or suffering. Pain should be treated with appropriate amounts of analgesics, including opioid analgesics. While some are concerned that there is a significant risk of shortening life if opioid analgesics are used, this is pharmacologically incorrect as patients become tolerant to the respiratory depressant effects of the medications with chronic use. Patients should also receive appropriate psychosocial and spiritual counseling to address the non-physical causes of pain and suffering.

2. CPR: CPR may be refused or withheld since the medical literature demonstrates that in elderly patients with advanced chronic illness, CPR is ineffective and has significant complications. It is important to stress that agreeing to a DNR order (which indicates that one is declining CPR) does not mean "Do Not Treat."

3. Nutrition and Hydration: Unlike most interventions, all orthodox and some conservative rabbis consider the provision of nutrition and hydration to be "basic care" even when it is provided artificially (i.e. PEG tube, hypodermoclysis). Therefore, traditional Jewish patients should be provided with food and/or fluid in appropriate amounts that will allow them to maintain dignity and comfort while the harmful effects of overfeeding (aspiration pneumonia) and overhydration (edema, pulmonary congestion, and other signs of fluid overload). Most conservative rabbis and other rabbis from less traditional Jewish movements consider the provision of food and fluid by artificial means to be consistent with

medical interventions, which they are comfortable withholding or withdrawing if they believe it is not beneficial to the patient.

Regarding the legal requirement of informed consent and truth telling, one should be careful to provide information in a thoughtful way, leaving room for hope, as often talked about by Rabbi Lamm. However, Jewish law does allow one to withhold information if it is believed that the information will be harmful to the patient and this clearly conflicts with the legal concept of informed consent. The way this can be resolved is by being sensitive to how much information the patient wants or needs to know, and by giving the patient the necessary information in a fashion that keeps them positive and hopeful.

Advance directives are permitted by Jewish law. A "Health Care Power of Attorney" is permissible in all streams of Judaism including traditional Judaism. This is because the patient who wants decisions made according to Jewish law will designates a rabbi who is expert in Jewish medical ethics as a surrogate decision maker. As discussed above, it is the rabbi who, as the expert in Jewish law, will know what Jewish law would say to do in the specific situation that the patient is in at any particular time. A "Living Will" is somewhat more challenging, especially in the traditional Jewish world, as the document states what the patient does or does not want if s/he is terminally ill. Traditional Jews would include in the "living will" a provision that the instructions regarding what interventions they or do not wish should be based on their current condition after consultation with a designated rabbi.

Organ donation is permissible by Jewish law. However, among Orthodox rabbis, there is a major disagreement over how death is defined, which creates significant challenges regarding the donation of hearts, since potential donors have to be declared dead prior to donation. Some rabbis define death as the irreversible cessation of spontaneous respirations which can occur when the entire brain, including the brain stem, has ceased to function. Since patients in this situation can be declared deceased while still being

patient would have done if he could have decided for himself.

c. The patient may not have an advance directive. In this situation, state surrogacy laws would come into play. In most states, multiple children have equal say, and therefore the sons would have to reach some kind of consensus regarding their father's care.

It would seem prudent therefore, that whether or not the patient improves following the adjustment in analgesia, that a family meeting be held with the two sons, and if possible and agreed to by all parties, including the religious son's rabbi. The treatment plan regarding adjustments in analgesics and other possible causes of the changes in the patient's condition can be discusses. Issues regarding the mother's death and how her care might be affecting decisions around the father's care can also be addressed. The inclusion of the rabbi, if agreed to, is important, to ensure that the rabbi has an accurate picture of the patient's medical condition and prognosis, since up to this point he has only spoken with the son. Whether the situation will be resolved with this meeting is unknown and ongoing conversations based on changes in the patient's condition will likely be needed.

CASE # 2

The patient is a 23 year old female, married for one year, who was in a severe auto accident. She suffered major head trauma, and has been cared for in the ICU for a little over 1 month. She remains unresponsive with no signs of any cognitive activity, and she remains ventilator dependent despite several attempts at medical weaning.

She is the daughter of the local orthodox rabbi in the community. It is well known that while she was in college she became less observant in her faith. She and her husband of one year, who is also Jewish, belong to the local reform temple. While her parents have not been happy with her religious choices, they have accepted them and they had a good relationship prior to the auto accident.

possible options:

a. Enteral tube feeding: Enteral feeding via a PEG tube would be an appropriate consideration if the patient had a prognosis measured in months and if he was stable enough medical condition to tolerate the medical procedure. If his prognosis is weeks to only a couple of months, and/or his medical condition is less stable, NG tube feedings could be considered, although the family must be made aware of the potential significant discomfort that the patient might experience from the tube. In either case, the amount of feedings should be monitored carefully as patients remain at risk for aspiration pneumonia, especially if they are being overfed.
b. Hypodermoclysis: If the patient has a prognosis of days to 1-2 weeks, subcutaneous hydration via hypodermoclysis is a reasonable alternative to tube feeding. Generally, patients receive 500-1000 cc of fluid per day through a small silastic catheter. This is enough fluid to sustain the patient without risking complications of fluid overload.

4. Advance directive and responsibility for medical decision making: It is not known whether the patient has an advance directive.

a. If he has a "living will" which gives specific instructions on his wishes regarding food and fluid then on a legal level this would have to be followed, despite the fact that, if the patient opted to forgo artificial nutrition and hydration, the religious son would object.
b. If he has a durable health care power of attorney that specifically names one or both of his sons as surrogate(s), then the individual(s) named would be able to make medical decisions for the patient. Keep in mind, however, that the decision of the surrogate(s) has to be consistent with what the

supported by mechanical ventilation and can still have a beating heart, these individuals can donate their hearts. Some rabbis define death as the irreversible cessation of cardiac function. Since the heart has to stop beating for these individuals to be declared deceased, they cannot be heart donors.

CASE PRESENTATIONS

The goal of these case presentations is not to give answers but to raise the issues that come forth in these cases.

(The following are cases that were presented and discussed with the audience, as examples of applying these principles. There are comments from Dr. Kinzbrunner as he interacted with the audience.)

CASE #1

The patient is a 79 year old male with end stage cerebrovascular disease and mild multi-infarct dementia. He has been somewhat responsive to verbal stimuli and he has been taking food and fluids by mouth.

The patient is being cared for in a long-term care facility and has a Stage IV sacral decubitus as a complication of his illness. He was married for 47 years until his wife died two years ago. Prior to death, she had suffered from advanced dementia, had been fed with a PEG tube for about 18 months, and ultimately succumbed to severe aspiration pneumonia.
He has two sons. He and his family are of the Jewish faith. He and his younger son are not observant, while the older son has recently become observant.

The patient has been experiencing significant pain in the area of the decubitus ulcer throughout the day as well as with the dressing changes. He has been medicated with one tablet of Vicodin every 4 hours round the clock, with an additional prn dose one half hour before dressing changes. Recently due to an increase in his discomfort despite the analgesia, his medication was changed to morphine, immediate release 10 mgs every 4 hours around the clock with an additional prn dose prior to dressing changes.

After several days on this regimen, the patient is more comfortable, but he has also become increasingly somnolent and is no longer eating or drinking. The younger son is comfortable with the situation as he is primarily concerned with the patient's level of comfort. He also believes that his father would not want to suffer like his mother had.

However, the older son, upon learning of the change in his father's condition, comes to the nursing home demanding to speak with you. When you arrive, he demands that the patient's pain medicine be stopped and that he have a feeding tube placed for the purpose of providing artificial nutritional support since this is what his rabbi told him that he had to do. The younger son, who is also present, begins to argue with his brother.

What are the issues the need to be addressed in this case? What would you recommend?

Identified issues include pain management, the increasing somnolence, the provision of hydration and nutrition to the patient, whether or not there is an advance directive, and who is responsible for making medical decisions for this patient. Although all of these issues are interrelated, they will be addressed individually.

1. Pain management: The patient had persistent pain on Vicodin, and while his pain improved with the change in analgesia to morphine, he developed increasing somnolence. Assuming that the somnolence is due to the increase in analgesia, it would be prudent to make some adjustments in the patient's analgesia to see if the somnolence resolves. Measures that could be taken would include:
    a. Reduce the analgesia by stopping the morphine and resuming the Vicodin. Since the Vicodin was insufficient to control the patient's pain, however, ensuring that there is additional analgesia available for breakthrough pain would be important.
    b. Ensuring that the patient is medicated with an additional dose of Vicodin (or 50% of the bioequivalent amount of morphine) 20-30 minutes prior to dressing changes.
    c. Another alternative to treat the painful decubiti would be to consider topical morphine. While morphine is not absorbed through normal skin surfaces, it has been shown to be effective when applied topically to damaged skin. This is likely due to opioid receptors in local tissue since the morphine is not absorbed systemically.
    d. If one felt that the patient's pain was clearly improved on the new dose, one could also consider adding a psychostimulant, such as methylphenidate or an amphetamine, both of which have been shown to have positive effects on opioid induced somnolence.

    If one or more of these measures is tried and the patient's somnolence improves to the point that the patient to start eating again, the issue regarding feeding the patient is resolved for the moment.

2. Somnolence: While it most likely that the somnolence is due to the increased analgesia, it is also possible that the two are not related. Possibilities that would need to be considered if his mental status does not improve after the analgesia is adjusted could include infection, metabolic or electrolyte disturbances, or the beginning of the dying process. The question of how aggressively to pursue these possibilities would depend on the patient's response to the change in analgesia and the potential chances of being able to reverse one of these other conditions if the patient's mental status does not improve.
3. Provision of artificial nutrition and/or hydration: Assuming the patient's mental status does not improve, then, based on whether the patient does or does not have an advance directive (see # 4), a decision as to whether to provide the patient with food and/or fluid will be made. If it is decided that the patient requires food and/or fluid, there are several

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Realities of the Dying

Rabbi Dr. Maurice Lamm

#6

The National Institute for Jewish Hospice
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NIJH In Your Will

After providing for your family and loved ones, you may want to put the National Institute for Jewish Hospice in your will, thus helping to assure the long-term future of this sacred work. Bequests are free of estate tax, and can substantially reduce the amount of your assets claimed by the government. You can give needed support to NIJH by simply including the following words in your will;

I give, devise, and bequeath to the National Institute for Jewish Hospice (insert amount being given here) to be used to support the help for Jewish terminally ill patients.

A bequest can be a specific dollar amount, a percentage of an estate, or all or part of the residue of an estate. You can also name NIJH as a contingency beneficiary, in the event someone named in your will is no longer living.

We recommend that a lawyer help you in drafting or amending a will.

Realities of the Dying

Rabbi Dr. Maurice Lamm

Funds for this publication were provided by the

Mount Sinai Memorial Park Mortuary

The
National Institute
for Jewish Hospice
Is grateful for its support

Realities of the Dying

For Caregivers

Family, Friends, Volunteers, Professionals

This booklet is addressed to you –
whether Jewish or non-Jewish –
who seek to provide care for
the terminally ill Jewish patient.

We hope this booklet will better equip those whose goal it is to get into the mind of the terminally ill patient. It is meant to help you understand what the realities are for those who are lying in bed day after day, waiting for the inevitable, and to help them live through this time.

The masculine gender in this booklet is used in its generic sense.

The National Institute for Jewish Hospice
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NIJH was established in 1985 to help alleviate suffering in serious and terminal illness. It's 55,000 members comprise business and professional leaders, and a consortium of endowing foundations. It communicates with hospices, hospitals, family services, medical organizations, and all health-care agencies, alerting them to the plight of the Jewish terminally ill.

The NIJH accreditation program provides training to hospices, geriatric centers or hospitals in the United States. NIJH has accredited hundreds of hospices

NIJH provides booklets, books, CDs and monographs confronting issues such as truth telling and euthanasia; providing insights into the art of hoping, the techniques of caring, and the understanding of pain. The NIJH Jewish Living Will and Durable Power of Attorney is also available.

24 hour toll-free number

A toll-free 800 number is functioning at all times. Information and guidance are provided about the availability and locations of hospices, hospitals, health professionals, home-care services, clergymen, psychologists, physicians, nurses and social workers especially pertinent to helping the terminally ill. Professionals will listen with understanding and provide relevant advice and direction.

Information

Over three and a half million letters have been sent out to virtually all Jewish families in the United States to elevate their consciousness concerning the plight of the seriously ill.

These letters, authored by the late Norman Cousins, Jack Klugman, Beatrice Arthur, Alan Alda, Judge Wapner, the late Jessica Tandy and Rabbi Maurice Lamm, have elicited numerous queries and much support and encouragement. NIJH responds to an average of over 500 letters a month.

NIJH's Board of Governors, headed by Rabbi Dr. Maurice Lamm, NIJH President, and Shirley Lamm, NIJH Executive Director, includes nationally known leaders in business, academia, government, and religion, who have given their names to support the cause of the Jewish terminally ill.

- ◈ fear of becoming dependent on others, of losing control over physical function, of being a nuisance;
- ◈ fear of what will become of the surviving spouse and children or others who had formerly been dependent of the patient;
- ◈ fear of failing to complete some life task or fulfill some obligation;
- ◈ fear of illness or death as a divine punishment;
- ◈ fear reflecting what the patient sees in the eyes of those around him;
- ◈ fear of the non-existence, of the unknown or of what happens after death.

Obviously, some of these fears may be misplaced and easily dispelled. If the patient's fear is of abandonment, assurances that his friends have no intention of leaving him may provide some comfort. If the patient fears becoming a nuisance, loved ones can make it clear that they welcome the opportunity and honor of caring for him. Other fears may not be so easily dispelled, but cry out for an opportunity for expression by the patient. It is interesting to note that for many dying patients the unknown and death itself may be the least of their fears and concerns.

Another personal emotional issue which you may uncover by listening to the patient is the need to be forgiven or to forgive another – and the need for permission to die from loved ones. Some patients may also regress to infantile behavior as a reaction to their loss of independence. But care-givers need to be very careful in providing adults with adult care and to avoid infantilizing patients, even though they may exhibit the mental behavior of infants.

Remaining open to what the patient is really saying – in words and gestures – will go a long way toward better understanding of what he is experiencing and how we can respond.

The realities of dying vary with each person. The common thread in all dying patients is that this condition is unique in every individual's life. To know in advance what this experience may be like is to prepare oneself to better manage this crucial moment. This foreknowledge facilitates love, and at this stage of life there is no more effective medicine than love.

Realities of the Dying

Rabbi Dr. Maurice Lamm

"Basic to understanding the problems of caring for the dying is an awareness that with all it's mysteries and ultimate questions, death is a concrete event, mostly smelly and mean, preceded and followed by pain"
Eric J. Casseell ("Being and Becoming Dead")

At the National Institute for Jewish Hospice we are concerned with the actual experience of people with serious and/or terminal illness such as cancer. The reason for exploring these realities is to enable us to gain a better understanding of what a serious ill loved one is likely to be going through on a daily basis. This understanding should also better equip those we guide to face such a person, and to encourage, support and just be with him through whatever he needs to be doing at this point of his life – whether that is recovering or dying.

We explore issues of hope, healing and truth-telling, the concept of the whole person, and the nature of pain and suffering for the ill person, as well as how hospice programs attempt to address some of these concerns for the terminally ill patients. We discuss how the dying individual must be seen as a whole person with interrelated physical, spiritual, psychological, emotional, and social facets, all of which are effected by the illness.

We have described in a series of booklets already published how hospice care arose in response to a tendency in the modern health care system to dehumanize dying patients by failing to treat them as people. For modern medicine, the seriously ill patient had become a biomedical "thing" which had to be kept alive as long as possible by heroic high-tech interventions, with little consideration for the experience and meaning of the illness to the real person inhabiting the body.

Here we try to focus more specifically on what dying patients commonly experience. However, in considering this actual experience, it is worth keeping in mind what Elisabeth Kubler-Ross said about her original pioneering worth with dying patients. She called these patients her "teachers," because they taught her something of what it means to be dying.

It is presumptuous for a healthy person to say to someone who is dying: " I know just exactly how you feel," because we don't. However, if we listen to them, they may tell us everything we need to know for the time we shall spend with them. What follows must be a gross generalization, because each person's dying is truly unique. But the alternative is to be silent and that is not acceptable. However, the experiences of hospice programs at least provide us with a starting place for considering the experience of the dying.

It is also important to remember, as Dr. Avery Weisman puts it, that "everyone has misgivings and qualms about death, including the professionals who preside at different stages of dying." Our personal dreads and fears about dying and our own mortality may well stand I our way of listening to the dying person who is now in front of us. So, for security, we fall back on our generalizations, truisms and misconceptions about dying. You may not fully resolve your own feelings about death and mortality until your own final days – if then. However, being of personal service and support to someone who is confronting death at least requires that you be aware of your own fears, and try to not let them get in the way of your interaction with the dying person you are visiting.

1. For someone who is terminally ill with a disease such as cancer, for example, two parallel sets of phenomena are happening. First of all, there is the physical deterioration and wasting from illness, leading to a host of symptoms and manifestations that most often fill the sick person's entire consciousness. There is literally no escaping from the pain, discomfort, restlessness and exhaustion, and also from the frustration with a body that has betrayed his cherished expectations of health and longevity. Sleep is an escape, but even sleep often becomes problematic.
2. At the same time, dying raises a host of emotional and psychological questions about meaning – the meaning of the illness, of the future, and of life itself.

Dying challenges us to face the ultimate reality of our

1 This pamphlet makes no suggestions for physical treatment. This falls totally in the domain of medical practitioners. Please do not construe a popular description of physical conditions as authoritative medicine.

It is essential to take our cues from the patient, rather that try to move him beyond the denial or anger or depression that he needs to be feeling at this time. All dying patients – even those who have reached a state of acceptance – will feel some kind of hope for continued existence. It may be better to see these five stages as "states" in which dying patients may find themselves, and to use these states as imperfect models for understanding the patient's behavior and feelings.

Other Losses

The main reason for considering Kubler-Ross's stages of dying is to provide us with some understanding of the dying patient's circumstances and thereby to better offer empathy, compassion, and support. It may also be helpful to consider the specific losses and limitations which the patient is experiencing as he progresses through his illness, or the specific fears raised by the illness, and to gently draw out these losses or fears in conversations with the patient.

There are other losses, of course that need to be factored into the equation – the loss of job, of the ability to be the breadwinner, of social status, of personal mobility, of role in family, of relationships with friends, of the ability to take care of personal grooming, of control over bodily functions, etc. How these losses are experienced will depend on the patient's personality interests and desires, and his family and social role.

If you understand which losses are most bitter to the patient, you may be able to suggest ways to compensate and return to him a measure of control and independence. For instance, letting the patient decide when to receive his bed bath and what to eat, or offering to take him on an outing of his choosing, can go a long way to restoring a sense of participating in his own destiny.

Some of the most common fears that a dying person may experience include:

- fear of abandonment;
- fear of pain or mutilation;
- fear of separation from loved ones, from home, from job, etc.

This way, rather than taking these outbursts personally.

3. The third case, ***bargaining***, is an almost childlike gesture in which the patient tries to negotiate with God or fate to obtain an extension on his "death sentence." This bargaining is an attempt to postpone the bad news that can no longer be denied or willed away through anger.

4. Bargaining is followed by ***depression***, "when the patient can no longer deny his illness. His numbness or stoicism, his anger and rage will soon be replaced with a sense of great loss." There is a distinction, also, between the depression that is a reaction to all of the immediate difficulties and losses imposed by the illness, and the depression that comes from "preparatory grief that the terminally ill patient has to undergo in order to prepare himself for his final separation from this world." For this latter type of depression, our customary offerings of encouragement and reassurance will not be very meaningful and may distract the patient from the emotional work that he has to do.

5. A final stage is ***acceptance***, accompanied by an emotional separation or decathexis from life. "if a patient has had enough time.... and has been given some help in working through the previously described stages, he will reach a stage during which he is neither depressed nor angry about his "fate"," she writes.

It would be easy to misconstrue these five stages of dying as a roadmap to the path all dying patients follow. However, Kubler-Ross's book implies – and later studies have clarified – that these stages are not so clear-cut. Dying patients will frequently move from one stage to another, depending on their mood on any given day. And some may never experience one or more of these identified stages. We may feel that acceptance is the desired end stage, but some patients may not choose to become accepting, and they should not be forced to.

mortality and the possibility of non-being – a reality which some psychologists tell us the unconscious psyche can never fully integrate. Is this the end for me? Is my life on this earth really drawing to a close? What will happen after I die? Emotional reactions to this circumstance – shock, depression, despair, denial, hope resignation, acceptance – are experienced I constantly shifting mixtures.

And these two realms of experience – the physical and the emotional – interact and interrelate on many levels, for instance, how the experience of physical pain leads to strange and surprising emotional reactions. In turn, this physical experience is itself shaped by many emotional variables long cherished but hidden under our surface. Attitudes about life and healing also greatly influence the experience of terminal illness. And mental states such as confusion, anxiety and depression – while reflecting the emotional life of the individual – may have direct physical causes and manifestations related to the illness and its symptoms.

Terminal illness is also a time of many losses: the loss of independence and control over one's life; of the ability to care for oneself; of personal dignity; of control over medical routines and over physical functions such as bowel and bladder; of trust in the relationship with one's body; of job, friends, activities and interests; and finally, of closest loved one and life itself. With loss comes grief and we should never forget that the dying patient may feel many of the same grief reactions as the loved ones he will leave behind. Because dying raises so many questions that cannot be answered, it is also a time of intense fears.

However, dying can also be a reflective twilight time, a time of transition between life and death in the same way that the real twilight is a beautiful transition between day and night. Although it is a time of suffering, it can also be – and often is – an occasion of great peace, serenity, personal growth, renewed faith, intimacy with loved ones, as well as an opportunity for reflection, review and new insights into one's life. And for some people it can be some or all of these things simultaneously – a tragic, sad, chaotic, rich and full time unlike any other in life.

Terminal Illness

Obviously, the physical experience of serious or terminal illness depends largely on the disease. In past generations people were more likely to die of accidents or catastrophic diseases or epidemics that struck suddenly and quickly led to death. However, advances in medical research and technology have resulted in a gradually aging population, which is more prone to chronic degenerative illnesses such as cancer and heart diseases.

The vast majority of patients in hospice programs are diagnosed with cancer – a disease that lends itself to relatively predictable progressions. Therefore, hospice experience in symptom management applies most directly to advanced cancer. However, other illnesses also result in definable and stratifiable terminal stages. These include advanced or end-stage pulmonary diseases (emphysema and chronic obstructive pulmonary disease); heart disease (e.g., ischemic heart disease secondary to coronary atherosclerosis, cardiomyopathy, congestive heart failure and CVAs – heart attacks); renal diseases, such as end-stage diabetes and liver diseases such as cirrhosis. Another life-threatening disease included in many hospices is amyotrophic lateral sclerosis – ALS or Lou Gehrig's disease – a progressive wasting of the muscles. In the late 1980s hospices were increasingly dominated by AIDS (the acquired immune deficiency syndrome), which resembles the wasting of end-stage cancer, but with even more troubling physical complaints.

Pain as a Symptom of Terminal Illness

Any discussion of the physical realities of the life-threatening or terminal illnesses such as cancer begins with the issue of pain. Many professionals consider the relief of pain to be their first and most important responsibility – because emotional and spiritual needs or family conflicts are difficult to address when the patient's immediate experience is dominated by pain.

There is, of course, a qualitative emotional difference between acute pain – which can give us important information about threats to the body – and chronic pain, which seems to the patient to have no time limit or hope of resolution, and which leads to feelings of hopelessness and despair. Such chronic pain can truly dominate the

hospital by Dr. Elisabeth Kubler-Ross in the mid 1960s, culminating in the publication of her book *On Death and Dying* in 1969. She and her students took the then unprecedented step of interviewing dying patients about their true feelings and perceptions of their illness.

"We decided that the best possible way we could study death and dying was by asking terminally ill patients to be our teachers," she writes. Although medical and nursing staff displayed considerable reluctance and even hostility for the idea, almost all patients who were asked to participate did so eagerly, glad to have someone who would listen to their feelings. Kubler-Ross also emphasizes that the patients were not informed of their terminal condition during her interviews. However, they knew it anyway, whether or not they were told directly from physicians.

Based on interviews with two hundred terminally ill patients, Kubler-Ross identified five stages of dying which patients with a slowly advancing degenerative disease might go through. These stages are not fixed and universally true, according to empirical data in 1991. But they serve to identify and outline commonly experienced reactions.

1. The first reaction is ***denial and isolation***, in which the patient says 'no, not me, it cannot be true." There is a distinction between the initial denial which is one of shock, and the ongoing partial denial which almost all patients use throughout their illness. The ongoing denial allows them to gradually assimilate the full meaning of their predicament, and "is a healthy way of dealing with the uncomfortable and painful situation," she explains. It "allows the patient to collect himself and, with time, mobilize other, less radical defenses."

2. The initial shock and denial may be followed by ***anger***, as it dawns on the patient that "oh yes, it is me, it was not a mistake." Denial is replaced by feelings of anger, rage, envy and resentment, displaced in all directions – even to medical staff and loved ones. Although this anger may seem highly irrational, it is important for loved ones to try to understand the patient's position and why he is acting

When a patient nears death from a degenerative disease such as cancer, there is both a physical and psychological withdrawal on many levels. Willing intake of food and water may cease and the patient's sensation of pain may be lessened. The patient may be sleeping most of the day or in a comatose state, and even if awake, may seem emotionally withdrawn. Many treatments, such as for infections or inadequate hydration or nutrition, are usually no longer needed at this point.

It is almost as if the patient and his body have come to a tacit understanding – regardless of previous attitudes held by the patient – that the physical deterioration, discomfort, pain and weariness have made it no longer viable to continue living. The body has worn out and the patient is tired of running the treadmill of painful and uncomfortable symptoms. Nature slowly administers a general anesthesia before she permits time's scythe to complete the most major of operations. The desire for life gives way to indifference and waiting; the sensations diminish; vitality fades; the fear of death mingles with the longing for rest. At this point many patients will say that they are "ready to die," and, as the inhabitant of the ravaged body, they are in the best position to recognize this changed status.

Any seriously ill person who is at home should be receiving visits from a hospice team or from a physician or a visiting nurse, whose job includes providing clear and simple instructions and explanations to family members. If an ill friend of yours is suffering from distressing symptoms that the family seems unable to handle or understand, you may encourage them to call the physician or visiting nurse for better directions – or offer to make the call for them.

If a patient's death at home is expected, the physician or visiting nurse can give the family reassurance and coaching about what to expect when the patient does die and how to handle the final arrangements with minimal distress and trauma. Ideally, such planning and support at the time of death may help mute the suddenness of the sting and prevent the spectacle of ambulances, paramedics and resuscitation efforts.

Stages of Dying

One of the landmarks in the modern movement of attention to the needs of the dying was the study of dying patients in a Chicago

patient's entire consciousness and his psychological, emotional, social and spiritual experience of illness. Chronic pain can also contribute to physical deterioration because of sleeplessness, loss of appetite and the anxiety it provokes.

Various studies indicate that patients with advanced cancer report moderate to severe pain forty to ninety percent of the time. The pain can be caused by:

1. the malignancy and it's growth and attack on body tissues
2. medical treatment for the cancer, or
3. a host of coincidental factors or byproducts of the disease.

Derek Doyle has identified eight principal types of pain with advanced cancer: Bone pain, visceral pain (especially the liver, kidneys and bladder), headache, colic, nerve entrapment, joint pain, muscular pain, and skin pain.

By concentrating on the relief of pain, that hospice movement has given us many insights on how to relieve even the most severe pain of advanced cancer. The hospice approach, first of all, is to recognize that pain has many components – psychological, emotional, social and spiritual as well as physical. This is not meant in the slightest way to suggest that pain is, "all in a person's mind" In fact, it is all too cruel and real for the person. But we do know that attitude, diversion, resolution of personal issues, even just a sympathetic listener can help moderate the patient's experience of pain.

Hospice's second contribution to pain management is to insist that pain in dying patients never be treated "P.R.N." (i.e., as needed). Although aspirin and similar medications may be adequate for some pain, morphine or other opiates are usually indicated if the pain is severe. Hospice-oriented physicians will give the patient enough morphine to bring the pain under control – no matter how much it takes – and will carefully monitor results until they discover the correct dosage. They realize that fears of addiction are not appropriate to the dying patient and that severely ill cancer patients can often tolerate quantities of morphine that would be fatal for the healthy person.

Caring physicians also understand that it is much easier to keep the patient pain-free with medication that it is to try to bring severe pain under control. Therefore the pain medication is given around

the clock, often at four or six hour intervals, rather than waiting for the patient to re-experience pain and then request medication.

In practice this means that the large doses required to bring the pain under control can be greatly reduced to a maintenance level once the pain is controlled, keeping the patient alert and relatively pain-free. By removing the formerly chromic pain from the patient's experience, the vicious cycle of despair and hopelessness caused by the pain and contributing to its severity is curtailed. The memory of that past pain and anticipation of future pain also ceases to be the dominant feature of the patient's constant experience.

Although this simple approach has demonstrated its effectiveness in countless terminal cases – making possible Dr. Cicely Saunders' promise to newly admitted patients at St. Christopher's Hospice that she would cure their pain – physicians, family members and patients themselves do not always permit this approach to be implemented, because of lack of understanding or misplaced fears about addiction. At the same time the physician must be sensitive to some of the side effects of morphine – particularly frowziness and constipation. The drowsiness may be a temporary reaction, requiring reassurance for family members that the patient will return to his former alertness within a few days.

Other Physical Symptoms

Among the other physical complaints (which may never effect you or the patient) with advanced cancer are;

◈ **Loss of appetite and unwillingness to eat**, sometimes accompanied by altered sense of taste, difficulty in swallowing, mouth infections or a very dry mouth. For the moderately ill cancer patient, special planning with the consultation of a dietician may encourage the patient to eat more. Small, frequent, attractive meals, a glass of wine before eating and liquid food supplements may also help the patient to take in adequate nutrition. However, as the disease enters the final stage, it is common for patients to stop eating altogether, and families may need gentle encouragement that they should no longer try to force food onto the patient;

◈ **Nausea and vomiting** caused by morphine and other medications or by the tumor;

◈ **Dehydration**, sometimes accompanied by thirst and dry mouth. Often seriously ill patients may be hydrated intravenously, although at the very end this may make the patients passing less comfortable;

◈ **Constipation and diarrhea**, both often related to medications or to inadequate diet. Sometimes an immobile patient will develop a total intestinal blockage which can be terribly painful and distressing, requiring active intervention by the physician;

◈ **Decubitus ulcers** – painful pressure sores on the skin caused by lack of circulation – which can develop if bedbound patients are not turned frequently;

◈ **Edema**, which is fluid build-up and swelling in the extremities, particularly around the ankles;

◈ **Pruritus** or skin itching; and

◈ **Seizures and Convulsions**

In addition, many changes in mental status may have an origin in the physical effects of the tumor or medications, exacerbated by an unfamiliar environment of the different daily routines of a hospital. Depressions, insomnia, drowsiness, confusion – even dementia and hallucinations – are not uncommon reactions, and both the patient and family need reassurance that these are normal side effects of the diseases or treatment.

Dr. Lamerton explains that, "physical death from disease proceeds by degrees. Organs fail at different rates. When a body begins to die, it does so from below upwards." If attentive symptom control has been practiced by the physician or hospice team, the pain and discomfort can be ameliorated.

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Singing

Breaks The Spiritual Deadlock

By
Rabbi Dr. Maurice Lamm
President and Founder NIJH

If we are going to heal from illness we need to break two kinds of spiritual illness. One paralyzes us so that we become passive and resigned; the other steals the very song from our throats, leaving us only with a groan. The spirit evaporates from our souls and we become submissive and flat. Psalm 105 teaches two positive ways to heal, and healing is the essence of health.

First, when illness de-activates us, we follow a prepared script and act like victims – we become couch potatoes, helplessly watching ourselves get weaker. We are fed and injected and analyzed and tested and predicted and watched over and prayed for and spoken of behind our backs. It is a gridlock that paralyzes us and makes us feel worse. Psalm 105 tells us: "Don't act like a victim."

Notice how the Psalmist erupts and fires off ten staccato charges in five sentences (1-5) give thanks; declare His name; make known His acts; sing to Him; make music to Him; tell of Him; glory in Him; search for His presence; seek Him; remember Him! To heal, to become whole, we must respond even ten times; energize our minds; and not allow ourselves to sink into victimhood.

Pain focuses our mind marvelously, a thinker once said. It will require heroism to take our mind off our condition, to take control of our souls, to be courageous, to feel empowered again.

32. He turned their rains into hail,
with flaming fire in their land.
33. It struck their vines and fig trees,
and shattered the trees in their borders.
34. God spoke and locusts came,
beetles beyond number.
35. They ate every herb in their land,
they ate up the fruit of their soil.
36. He struck all the firstborn in their land,
the prime of their strength.

37. He brought them out, carrying silver and gold,
and none among His tribes stumbled.
38. Egypt rejoiced when they departed,
for their terror had fallen upon them.
39. He spread out a cloud as a sheltering cover,
and a fire to illuminate the night.
40. They asked and He provided quail,
and satisfied them with bread from Heaven.
41. He opened a rock and waters gushed out,
they ran through dry places like a river.

42. For He remembered His holy word,
to Abraham, His servant.
43. And He led out his people with gladness,
His chosen ones with joyful singing.
44. He gave the lands of nations,
they inherited the toil of the nations.
45. So that they might keep His statutes,
and treasure His teachings,
Halelu-yah!

"When life is not a song, sing."
King David

"He who sings, frightens away his ills."
Cervantes

"To groan when we are ill is common,
to sing is courageous."
Rabbi M. Lamm

Even if all we do is chant "Oy vay," over and over, to a tune we improvise - "Sing to Him." Even a melancholy song somehow takes us out of ourselves and gives expression to our inner being. Sometimes I break out in a tune – a melody that uses sounds shaped only by my emotions. It articulates a groan that forces its way out of my interior; sometimes, it expresses an indescribable joy inside me that's in search of an audience.

Sometimes we sing a familiar tune with friends with whom we sway in closeness. It crystallizes our common despair, and the sadness gets dissipated in fellowship. It harmonizes our own souls with the souls of those who empathize with us. The harmony, in magical ways, transfers the energy of the group to us fragile individuals as we lift up our voices and keep time together.

Sing what you like; help others by offering to sing with them. Especially effective may be a mother's lullaby, one that she sang for us at bedtime or when we were sick. We can sing from religious songs; old nursery rhymes; oldies but goodies; college songs – if they make us smile or help us to express our anxiety. If you feel the onset of despair, sing out your despair with a melody.

To groan when we are ill is common; to sing is courageous. Think actively, sing passionately. It will break the most common gridlocks of illness, and let our souls soar to new heights.

Psalm 105

1. Give thanks to the Lord, declare His name;
make His acts known among the peoples.
2. Sing to Him, make music to Him;
tell all about His wonders!
3. Glory in His Holy name;
be glad of heart, be glad of heart, you who seek God.
4. Search for God and His might,
seek His presence always!
5. Remember the wonders He has wrought
His miracles, and the judgments of His mouth.

6. Seed of Abraham, His servant,
Children of Jacob, His chosen ones.
7. He is the Lord, our God;
His judgments are over the whole earth.
8. He remembered His covenant forever,
The word He commanded to a thousand generations
9. That covenant which He made with Abraham,
and His oath to Isaac.
10. He established it as a statute for Jacob,
For Israel as an everlasting covenant.
11. Saying,
"To you I will give the land of Canaan,
The portion of your inheritance."

12. When they were only a few in number,
and had hardly dwelled there;
13. They wandered from nation to nation,
from one kingdom to another people –
14. He permitted no one to wrong them;
He admonished kings on their behalf:
15. "Do not touch my anointed ones,
And to my prophets do no harm."

You may say, "I can't think of anything else." Perhaps you can't, but try it. I urge you to keep your mind active on other subjects. Your brain does have a mind of its own – but you can control it. Times like these call for combat, not resignation.

Now break the second gridlock. In the ten charges of the psalmist, one appears not to fit – "Sing to Him!" What's the value of a song? In our sophistication, we think of singing as an art form; but the Torah teaches that to sing is a blessing. In terms of the spirit, singing is on a higher level than speaking – it is why the Levites sang in the Temple. When we sing we raise our souls to God, and we gain insight into Him. Through song we address God.

And through song we learn to better endure our hardships. When life is not a song, sing! When King David was ill, he sang; when Cervantes, the great writer was ill, he said: "He who sings frightens away his ills." Ask yourself: Why do people always smile when they sing? Singing is an antidote to panic. The pious elders taught us that. It lightens the burden, lessens the fear, steadies the nerves. Singing gives voice to our deepest feelings; it enables us to express ourselves even if we are the only ones who hear it. And we will have made ourselves heard. Singing lifts the heart.

16. He called a famine in the land,
and broke every staff of bread.
17. Before them He sent a man –
Joseph was sold as a slave.
18. They tortured his feet with fetters,
his soul was laid in irons.
19. until the time that His word came to pass,
the word of God purified him.
20. The king sent messengers and released him,
a ruler of many peoples who set him free.
21. He appointed him master over his house,
and ruler over all his possessions,
22. to bind his ministers to his soul,
to make his elders wise.

23. Thus Israel came to Egypt,
and Jacob sojourned in the land of Ham.
24. And he caused His people to be extremely fruitful,
He made them stronger than their oppressors,
25. whose hearts He turned to hate His people,
to conspire against His servants.
6. He sent Moses, His servant,
Aaron, whom He has chosen.
7. They brought the words of His signs among them,
and wonders in the land of Ham.

28. He sent darkness and it was dark;
they did not rebel against His word.
29. He turned their waters into blood,
and He killed their fish.
30. Their land swarmed with frogs,
in the very chamber of the kings.
31. He spoke, and wild beasts came,
lice throughout their borders.

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Implementing Empathy

at the End-of-Life

by

Rabbi Dr. Maurice Lamm

Reprinted from
Jewish Ethics
and the
Care of End-of-Life Patients
A Collection of Rabbinical, Bioethical, Philosophical & Juristic Opinions
Edited by; Peter J. Hurwitz, Jacques Picard, and Avraham Steinberg

The National Institute for Jewish Hospice

Implementing Empathy at the End of Life

by Rabbi Dr. Maurice Lamm

Relieving the Suffering

There are two sentences freighted with the most tragic overtones known to man: "We have done everything we can. Now you're in God's hands." There words trigger a hail of emotion, from anger to fear to jealousy to guilt, that rip open the innards of those who care but are helpless. From this moment until the advent of death, the terminal patient and his family experience the most painful and critical hours of their lives.

What follows are the bases for managing the terminally ill Jew, and then a number of real-life strategies of care, emanating from the Jewish understanding of regesh, feeling, which caregivers could use.

Dying is the juncture between time and eternity. It is twilight, not day, not night, when the sun sinks beyond the horizon. Curiously, it is precisely at the end of the day when the deep colors of day and night blend and swirl in broad strokes on the brush-painted sky. It is like the twilight of the trees in the fall, when the leaves burst with a palette of colors, bringing together the greens and yellows of summer and winter. In physical nature, twilight squeezes out the most brilliant and memorable of scenes, but in human nature, twilight is most often a gray, bleak mist that is swallowed up by the onrushing blackness.

Ideally, this should not be so. After the initial trauma, the dying should experience a stillness, a serenity, a coming-together of all of the events of life, a bottom line that makes everything add up, peace that until now they never knew. No longer the relentless pressure to "make it," the drive to posses more and more. No more reputation to earn; no impossible goals to reach; no petty power to be acquired; no glorious models to imitate; nobody to impress; no more games to play. Terminal patients know at last that the

bitch-goddess of success makes a mockery of sincere striving. Finally, too finally, they can become detached from everything that is not truly an extension of their own self. They can love whoever they wish to love; no more ulterior motives. They are left with their mind and their soul and their memories and their faith and their values; and only with real friends and family. It may be the first time they can afford to live in purity, and in total honesty with their private self.

Yet these times may become intolerable – when the ticking of the clock is too loud, when family members are confused, erupting in anger at no one, blabbering incessantly but to no point, pouring sweetness-without-substance over a sick relative; when the patient does not know what to think, what to say, what to do, what is proper, mentally transfixed by questions without answers: "Why me? What now? Who will take care?"

The individual has no experience in dealing with such matters. Until a generation ago, death usually came too quickly for the victim to ruminate, and that is why, according to Jewish law, the definition of dying is a process that takes at the most three days. Today, when people die from degenerative diseases, the process of dying is often extended for six months or more. Because people spend more time with the dying, they have more time to be frightened; the mystery becomes greater, the emotional complexities overwhelming. The dying person, like most people, is used to being in the company of family or friends at every major step of life. Now death will terminate all relationships with everyone. This is the great fear. The end-of-life patient will let go of the offering hands all around, and will proceed to the precipice of life slowly and alone.

It is not only that individuals have not dealt with this matter in any creative, significant way. The community has not even put the management of dying on its agenda.

patient. The giving may exalt love to a level that was hitherto unimaginable.

The art of loving is most strained when you love someone who is approaching death. Done properly, love can rise to its most intense level at precisely this moment; feelings can become more authentic that at any other time in life; the capacity of giving and for sheer goodness can be unimaginable, and their effect can physically lengthen a person's life and make the last moments beautiful. These last expressions of love plumb our deepest personal resources.

A friend of mine, Jack Goldberg, was trying to impel his wife, Mary, to take more medicine in her dying days. He said to her, "Mary, I'm not giving you poison." Mary looked at him and said, "Jack, I never thought you were capable of caring for me so much. Even if you gave me poison, from you I would take it as medicine."

It is twilight. As the sun falls behind the horizon, human life, like nature, can produce a burst of color – the color of meaningfulness, of hope and love.

The Jewish community, which deals successfully with the daytime concerns of youth movements and old-age homes and family services and hospitals, and also with the night-time concerns of cemetery and free burial and conferences on grief, has never dealt with twilight. But dying is the crisis of life. One can die in fulfillment and with meaning; or in misery – filled with hate and jealousy. The confrontation with death is the greatest test of personality and of culture. May we abandon our people at this crossroads?

Just as a Torah scroll, used for holy purposes, retains its holiness even when it becomes religiously unqualified, so we humans, having been created with the sanctity of Gods image, retain our dignity even in death when the image disintegrates. Human remains possess the same holiness that characterizes a disqualified Torah scroll. Thus one may not dishonor a corpse, just as one may not dishonor the scroll. In dying, as even in death, man retains the integrity of having been created in Gods image.

In fact, this Torah view of human worth is the basis of social work. The Western religions, derived philosophically from a Jewish base, hold that all people – especially those who are sick and infirm, or to young to take care of themselves – are the objects of social work practice.

This idea translates itself onto practical behavioral application in Jewish law. For example, the Torah mandates speedy burial because it compares a dead human being to a king's wayward twin brother who is being hanged. When people pass by, they say: "There hangs the king." the brother's hanging reflects upon the dignity of the king. In much the same way, the rabbis reasoned, if we unnecessarily leave a human corpse to lie unburied, shame accrues to the King of Kings; man's image is Gods "twin." So too the performing of a routine

autopsy, except when needed to save life, runs counter to Jewish law, which says that not only the soul but the body of the person that contained the image of God is not to be unnecessarily disturbed.

Moreover, dying must be confronted as a new reality. Franz Borkenau classified cultures as death-defying, death-escaping, or death-denying.

The Egyptian culture, against which the Israelites rebelled, built society around the glorification of death, symbolized for ages by the pyramids.

America has a death-denying culture. In an era of possible nuclear holocaust and of the graphic nightly portrayal of bloodshed on television, this is comically absurd. We deny death by diversion, stupefaction, a closing of the eyes, wishful thinking. We repress our fear of death by developing the art of embalming – beroughing the dead to make them look alive; by having family sit separate from friends in the mortuary, by masking graves with green mates and consigning the burial to hired diggers. Indeed, we gladly consign the dying to specialists: the physician, the charge nurse, the private nurse, the rabbi, the convalescent home operator, and finally, the mortician. Someone else is always there to handle the terrible reality. "We can't bear to see it," we say in self-indulging compassion.

But by history and by theology, Judaism is death-defying. Of all the forms of ritual impurity, the most severe defilement is caused by contact with a dead body. Contrarily, holiness is identified with life. We refer to a "God of life," and we are unable to accept a "dead god," whether it be Adonis or Jesus. Through the centuries the Jew has followed Dylan Thomas's prescription, "Rage, rage against the dying of the light," and our survival relates directly to this.

Not only does Judaism defy death, but, as a

scenes fly by as we focus on another era. The content of this episodic recall is triggered by soft words from sympathetic eager-to-listen relatives and friends., It is a vacation from the constant bad news of the current situation – vacations, celebrations, heroic achievements, incidents that stirred pride, weddings and births and grandchildren, a Bar or Bat Mitzva, long-dead relatives, another country, a happier time. One of the qualities of the human brain is that, even though the senses are fading, it has the ability to soar back to old scenes for instantaneous recall.

This iconic replay of life's repertoire can transform a patient's mood more humanely than mind-altering drugs. The God-given capacity to forget events too horrific to deal with can now be abetted by the God-given function of remembering.

Love

Since time is now limited, life becomes ever more precious, and the relationship between the family and the dying person should be intensified in depth and quality. This should be a period when loved ones sustain and cherish the patient. Perhaps the relationship has been strained for many years, that there were dissonances and bickering, and therefore that the expression of love now suddenly demonstrated is felt to be hypocrisy. But now life is new and love can begin anew. Rabbi Eliyahu Dessler, the twentieth century's greatest Jewish ethicist, asks: Which come first – giving or loving? The common answer is that one gives to a person whom one already loves. But the reverse is also true. One loves the person to whom one has given. The more parents give to a child in need, the more the love grows.

At a time of terminal illness, that family should give of themselves. They should hug and stroke and touch the

Setting one's house in order. The time of dying is a time to make arrangements for one's family, and for dealing with one's own personal attitudes and status and relationships. The patriarch Jacob was blessed with illness, the rabbis say, in order that he might prepare for death. The prophet Isaiah tells King Hezekiah: "Set thy house in order, for thou shalt die, not live."

Reminiscence

Virtually all terminally ill people prefer to doe at home rather then in an institutional setting, even a caring, free-standing hospice. This is not only because of the personal care and the presence of family members, but also because the home surroundings are familiar and is a source of security at a time of fearful uncertainty.

This universal sentiment is the origin of a number of traditions. Among them is that in the last hours of life the dying should be surrounded by a minyan of people, akin to the quorum required for public prayer. Death is a moment of sanctity, as is a prayer service. But it also an awareness that the ambience of friends and relatives makes for warmth and a great relief from the fear of loneliness.

The terminally ill desperately desire what they know they cannot achieve, life, getting out of bed, back to the old days. Reminiscence is really episodic recall. We change the ambience of those who are sick and enable their minds, even if only for a short time, to fly away from their troubles to an earlier, healthier time.

Neuroscientists hold that the human mind is like a tape-recorder, stacked with an infinite number of dormant memories. Recalling these long-forgotten memories is like digging up subcortical imprints of remote events. With the collaboration of the patient, we rewind the tape, and the

consequence of the sin of Adam, it literally refuses to consider death a natural phenomenon. It is, as Adin Steinsaltz terms it, "the disease of death." Man is to do battle against the "spirit of defilement," which, in fact, is a lifelong battle against death, considered to be the worst defect of this world. The climactic last phrase of the traditional funeral service is *bila hamavet la-netzach*, "May God swallow death forever." In the end of time, man will be victorious; death will be defeated. *Herpat amo*, "the shame of His people will He remove from this earth." This is not only a fond wish, it has become a mandate to Jews to struggle, when feasible, against the end which inevitably will engulf us all. This philosophy informs the obstinate Jewish refusal to give up on life even against the most insurmountable medical odds. It explains the profound reluctance to pull plugs and stop treatments.

But we must live our daily lives before the realization of that ideality for which we strive. The reality that in the end we will face death mandates our confrontation with the process of dying. The traditional Jew is expected to prepare for death. He often sewed his own shrouds, purchased a burial plot while he was in the blossom of life, wrote a will, arranged his funeral, and handled his own death as the necessary though ever-present evil that it is. Man must accept death after defying it to the last. But repressing the reality of death is an un-Jewish attitude, and our elaborate attempts to deny it are a religious absurdity.

In this sense, we are called upon to confront the reality of dying. In Jewish law, even such mundane matters as concluding a business contract and formulating a last will were guided by different, more binding and efficacious standards during these fateful days. This is a new reality, requiring new attitudes. It is not life as usual, and it is not the resignation of death. Hospice is effective to the degree

that it looks upon the process of dying as a new stage of existence and uses different norms with which to realize our humanity.

Dying is not primarily a scientific event. Judaism makes a clear distinction between *bios* and *humanum*: physicality and humanity. It is important to determine at what point before birth the fetus goes from *bios* to *humanum*, from a simple physical organism to a fully developed human being; and at dying, at what point the *humanum* returns to *bios*, when one loses one's distinctive sanctity as a human being and becomes a vegetating organism. Jewish law, for this reason, extends a person's *humanum* well beyond the conscious state until the last breath of existence as a person.

Judaism forcefully and legally affirms that a human being may never be treated solely as *bios*, even during the terminal process of dying. Man is not primarily a fact. Dying is not primarily a scientific event, it is a human one. During this period, the person has to be treated more humanely, more sensitively, not less.

The care given a dying person is a demonstration of whether the caregiver's emphasis is on *bios* or on *humanum*, Jewish law or feeling. Judaism long ago established that it is concerned not primarily with sickness, but with the sick person. The Midrash says that even when there are only a few minutes left to life, we should advise the dying person, "Eat this, drink that," notwithstanding that it cannot possibly make any difference. A deep concern for the prevention of human pain and suffering was uppermost in the rabbis' minds. Even when dealing with the angst of ordinary healthy people, all religious requirements are exempted in the face of pain. The Hebrew word for "doctor," *rofeh*, derives from the Hebrew word *rapeh*, which means "to ease" or "to assuage."

tested and turned and injected; they are cried over and spoken behind and prayed for. The Jewish tradition provides form specific activities which give them a sense of power - thought to be managed, projects to be executed which can excite the mind and spark one's imagination to think creatively, even during this time of smallness.

Ethical wills. In order to give them some initiative, terminal patients should be encouraged to write an ethical will. This is an ancient Jewish device. People should leave their families not only an estate but also a heritage. Sometimes parents have not been able to communicate effectively with a child or grandchild. This affords them the opportunity to leave their loved ones a sense of their purpose of life, their values and beliefs, in a format that will be treasured after death.

Oral history. Another application of empathy which is of clear value at this time is leaving behind the legacy of an oral history. By speaking into a tape-recorder to be transcribed later, they can give an account of their youth and education, of their beliefs and dreams. A mate, child, or nurse can assist by asking pertinent questions and guiding the conversation. Describing one's life in this way invokes good feelings, both in recalling pleasant memories during the days of recording the personal history, and then in giving children a gift volume describing their family roots. It is little short of an intimation of immortality.

Charity. The Jewish sages said that "Charity rescues from death." Obviously the sages were not speaking of magic. They meant that it saves the dying from the feeling of death. Distributing charity, no matter who the recipient or what the amount, and deliberating on who should receive it, may give a person a feeling of strength and a sense of being alive.

a. He should not have brought a squad of interns when he was to tell a person that she is going to die. Does anything more critically deserve privacy than this event?

b. He should not have stood next to her bed, he should have sat down. First, because a person lying down feels more vulnerable when somebody stands over her. Second, because he looks like he has to get out of there fast, and can't afford time to stay.

c. He de-hoped her by saying nothing could be done.

She had the pain and the scar and nothing was done? He never mentioned that other treatments could be tried.

2. How could the resident have en-hoped her?

a. Without lying, he could have said that some of the tumor was removed, though not all of it.

b. That further therapy would be required to attempt to deal with the remainder.

c. He could have said that miracles happen every day and that she might be one of them.

d. He could have told her that researchers are coming up with new medications, and who could tell whether she would she could be lucky enough to get a working remedy.

e. Also he could have used the old medical escape, "It's in God's hands. I pray that He will help you."

Would he have saved her life? Ultimately no. Would she have lived longer? The lady died too soon of evident heartbreak. Hope might have enabled her to live while she was dying.

Power

Dying patients find themselves in a passive condition. They are powerless to initiate significant actions or make significant decisions. They are

Hospitals, which treat *bios* exclusively, characteristically do not relate to a sense of shame on the part of the patient, to the need for privacy, personal delicacy, the need for warmth. The hospice, which emphasizes the ***humanum*** component and treats not only the illness but the patient, provides a team of psychologists, clergy, social workers, doctors and nurses, but mainly family and volunteers, because it has a primary concern for human comfort and for the prevention and control of suffering.

The difference between an emphasis on bios and humanum is tellingly illustrated in the style of informing patients of their terminality. One can announce it in a direct and accurate clinical diagnosis. But with an emphasis on the ***humanum***, the telling can be a gradual self-revelation, a sort of Socratic self-understanding. After all, the shortest distance between two points is not necessarily a straight line when the straight line deals with a personal cataclysm, the upsetting of the whole natural order. If the patient chooses to deny the validity of the medical conclusion, Judaism tells us to respect his denial. Helmut Thielicke quotes a Japanese doctor who said, "There are lies that express profound human love." Truth we should tell, but the superior value is not truth but humanity. In all cases the old-folk wisdom obtains: "Be a mentsch" (Yiddish for "humane").

The care of the terminally ill, then, must embody certain fundamental principles: that we are created in the image of God and retain our integrity no matter who or in what condition we are; that a person's humanity should elicit from us sensitivity and delicacy; that defying death is an ideality and a hope, but the reality of our situation requires that we struggle to preserve life and, failing that, we struggle to preserve humanity, so long as we live. We

were created as human beings; we must nurture that creation by being human.

Strategies for Implementing Empathy

These underlying attitudes of the Jewish religion are expressed in specific strategies that ameliorate the agony attendant on a dying situation. If it is the true religion we believe it to be, Judaism must translate its moral axioms into policies of healthy behavior; virtually into a medicine-bag of attitudes which can make the twilight meaningful. These attitudes inform the Jewish component in hospice care. The Jewish part deals not only with Jewish law of medical-cure ethics, but with the Jewish law of care ethics. As there is a Jewish way of living, so too there is a Jewish way of dying – and of caring for the dying. The rich Jewish heritage, which thorough the centuries has experienced man in the zenith of his growth and the nadir of his decline, has designed helping strategies for coping with the problems of the severely ill.

Loneliness

That the dying are lonely is of course understandable. The shock has thrown them back on their own resources. They will travel the road to their ultimate destiny wholly alone, without any company.

But they are lonely for two other reasons as well. The dying have already begun mourning themselves, their own death, the world that will go on without their presence, without their direction. In Hebrew, the word for "mourner" is avel, which means "one who withdraws." The family withdraw and become mourners (*aveilim*), after the dying patient's death, but the patient begins now to withdraw in mourning for himself.

The dying are alone not only because of their own psychological state, but because others cause them to suffer a pariah syndrome; they are figuratively placed

was admitted to the hospital with a lesion in the right lung. She was not in pain, and was affable and very cheerful and helpful to the health personnel on the floor. She was transferred to surgery for an open thoracotomy, and was found to have squamous cell carcinoma that had metastasized and was inoperable. Then a section was removed for biopsy and the incision was closed.

She had to be informed of the terrible news. The resident entered the room with a gaggle of interns behind him, stood at the bed, looked down at her and had this conversation with her.

> *Resident:* Well, it's cancer and we really couldn't resect it, so we just opened and closed.
> *Patient:* Opened and closed?
> Resident: Yes, well, it couldn't be removed, so we just closed. It was useless.
> *Patient:* Opened and closed?
> Resident nodded.
> *Patient:* Opened and closed?
> Resident nodded again.
> *Patient:* You mean you just left the cancer there?
> *Resident:* Yes.

The patient died that night. The autopsy showed no actual cause of death, just the cancer, which had been there for many months. Dr. Levine writes in the *Western Journal of Medicine* that she believes the patient simply died of despair, the removal of Esperanto, HOPE, all hope had been squeezed out of her.

Comment:

1. The resident de-hoped the patient. He did it with body language, with unthinking and callous disregard.

conversation. But what can one hope for? Pessimists are fond of saying that from the moment of birth one proceeds every day closer to death. Helmut Thielicke observes that this is not quite true. He makes an analogy with walking. Every step we take seems to be a falling, and yet at the very last moment, before we really fall, we stretch forth our other leg and straighten up again. After a series of fallings and risings, we find that we have progress through these ups and downs. But dying is, after all, the time of the final falling. What straightening up can come?

What rising sun can be expected from the twilight? Yet hope we must. One can hope for less pain, for the future happiness of children, for the family's continuation of the values one has spent a lifetime instilling. While there should be an intelligent awareness of hope's limitations in this situation, a sincere expression of hope is required by the tradition. In fact, Jews believe that death may be the beginning of exaltation. a reunion of the divine image with the divine source of being, as Abraham J. Heschel says:

> Death is not sensed as a defeat but as a summation, an arrival, a conclusion. Our ultimate hope has no specific content, our hope is God. We trust that He will not desert those that trust in Him. The meaning as well as mode of being which man hopes to attain beyond the threshold of dying, remains an impenetrable mystery, yet it is the thought of being in God's knowing that may be both at the root and the symbol of the ultimate hope.

Here follows an illustrative case history:

> Dr. Alexandra Levine at the University of Southern California (USC) Medical School reports on an experience as a medical student. A 55-year-old-woman

outside the social pale. If death is a terminus of relationships, then dying is its prelude, and relationships now begin to be strained and to alter. It is like a candle flame about to be extinguished that flickers and sputters before it dies. Among the flickerings in personal relationships are the friends and relatives who shy away from the severely ill because they do not know what to say, how to express their genuine feelings of remorse. The patient, amputated from the living body politic, becomes passive, abandoned, and disconnected precisely when what is needed is connectedness to overcome the forbidding loneliness of dying.

Judaism addresses itself to this problem through the religious requirement of bikkur holim, "visiting the sick." The sick visitation is not merely a practice of social etiquette, but the fulfillment of a religious obligation.

Unfortunately, the structure and content of this important function is very often not properly focused. It is simply an exercise in undiscerning sweetness – important, but not crucially helpful. We pay scant attention to what the tradition demands from this religious institution and how psychological findings can enrich it.

Visits should be frequent but of short duration, in keeping with the patient's fatigue threshold. We are not to hover over the bed, not to stand, bit to sit on the patient's level. The patient is constantly looking up at doctors and nurses and visitors and made to feel like an object "over" whom people work. We must never leave without praying on the patient's presence. We must never leave without expressing hope (as described below).

The very presence of people is a therapeutic process and considered a very great mitzvah ("obligation"). It reassures the patient of his continuing worth as an individual and reinforces the feeling of being an integral member of the family and community. Traditionally, in

fact, a minyan of ten Jews (the minimum number for a public service) was gathered to be present at the expected moment of life's expiration.

Apology

Jewish tradition understands that, in order to achieve a degree of inner peace, end-of-life patients need the process of *mehillah*, the asking of forgiveness from those they may have wronged. It is wiping the slate clean, an unburdening of the accumulated baggage of a lifetime. Indeed, they also need a *mehillah* of another kind. Even though death is not an act of will on their part, many patients feel a need to apologize, and seek "permission," for leaving their families and for the pain they cause by dying. The need may not be expressed openly, and in response it may require only a look of recognition, a holding of hands; but it should not be mocked or ignored.

Prayer

Maimonides rules that no *bikkur holim* visit is complete without prayer for the sick person. Prayer is considered a gift, not an obligation, and it can be a great comfort to many patients. There is a formal prayer, recited from the prayerbook three times daily in the traditional manner.

There is also informal prayer, which can be recited in any language, in any posture, at any time. This prayer may ask for an extension of life or for remission from pain. It also may be used to vent anger and complaint, even to ask for a rapid death. Prayer is especially valuable at this time because it allows for the articulation of hopes and fears in an accepted and elevated manner, and because it is offered as a communication from one who is powerless to the Almighty. Even those who do not customarily pray or even believe in God are often moved to do so in such conditions. "Pray for me" is a phrase often heard in hospital corridors. "Pray for yourself" is equally valid and even more helpful.

Curiously, the Code of Jewish Law suggest that whereas prayers recited in the synagogue or outside the room should be in Hebrew, the prayer in the patient's room may be recited in any language the patient understands. Prayer, in this sense, serves the twofold purpose of petitioning God and comforting the sick. It is also entirely proper to recite a prayer for the sick in the synagogue before an open Torah scroll. The prayer is called Mi she-Berakh ("He who Blesses).

Traditionally, over the centuries, the last syllables uttered by Jews as life nears its end are the words of a confessional prayer called Viddui ("Confession"). It is a cumulative apology to God for the misdeeds of a lifetime. The Sages considered it extremely valuable as an expiation for all sins. It is brief and moving. Great care should be taken to introduce this prayer delicately, assuring the patient that many have recited this prayer and survived. If it might traumatize the patient, it should not be recited.

An abbreviated form of the confession is as follows: *Teheyai mitati kapparah al kol avonotai* ("May my death be an atonement for all my sins"):

> I acknowledge unto Thee, O Lord my God and God of my fathers, that both my cure and my death are in Thy hand. May it be Thy will to grant me a perfect healing. Yet, if Thou has decreed that I should die, may my death expiate all the sins which I have committed before Thee, and grant me a portion in the Garden of Eden and cause me to merit the life of the World to Come, which is reserved for the righteous. Hear, O Israel, the Lord our God, the Lord is One.

Hope

What hope is possible for the dying? Yet, in the midst of this apparently hopeless situation, one is mandated by the Jewish tradition to inject hope into every visit, every

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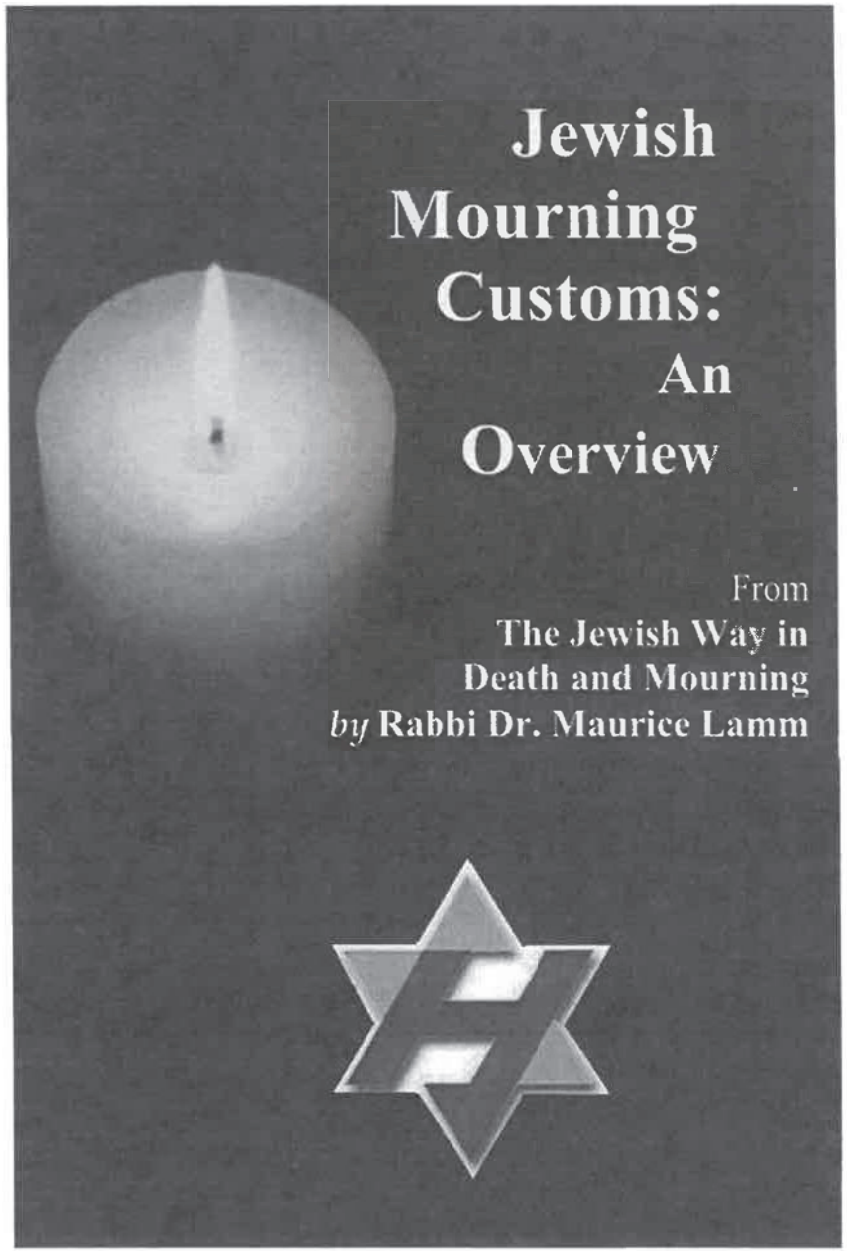

Jewish Mourning Customs: An Overview

From
The Jewish Way in Death and Mourning
by Rabbi Dr. Maurice Lamm

The National Institute for Jewish Hospice
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#9

Rabbi Maurice Lamm is the author of six major books, President of The National Institute for Jewish Hospice, and professor at the Yeshiva University rabbinical seminary in New York, where he holds the Chair in Professional Rabbinics. He was the Rabbi of one of the largest synagogues in the United States, Beth Jacob of Beverly Hills.

MAURICE LAMM

Rabbi Maurice Lamm was awarded an honorary doctorate by Yeshiva University, from which he holds a BA, MA and Rabbinic Ordination. He is most popularly known for his book "The Jewish Way in Death and Mourning", considered one of the seven best Jewish books by the New York Times, selling over 260,000 copies.

parents. This merit is achieved, primarily, by living on a high ethical and moral plane, by being responsive to the demands of God and sensitive to the needs of one's fellow man. The formal expression of this merit is accomplished by prayer to God and by contributions to charity.

The Yizkor prayer is recited in the synagogue on the following four major Jewish Holidays; Yom Kippur, and the last day of Passover, Sukkot/Festivals of Booths and Shavuot/ Pentecost.

YAHRZEIT: MEMORIAL ANNIVERSARY

Despite the Germanic origin of the word yahrzeit, the designation of a special day and special observances to commemorate the anniversary of the death of parents was already discussed in the Talmud. This religious commemoration is recorded not as a fiat, but as a description of an instinctive sentiment of sadness, an annual rehearsing of tragedy, which impels one to avoid eating meat and drinking wine – symbols of festivity and joy, the very stuff of life.

Yahrzeit may be observed for any relative or friend, but it is meant primarily for parents. It is customary to light a 24-hour candle on the day of the yahrzeit.

JOYOUS OCASIONS DURING MOURNING

The observance that most affects the daily life of the mourner during the twelve-month period is the complete abstention from parties and festivities, both public and private. Participation in these gatherings is simple not consonant with the depression and contrition that the mourner experiences. It borders on the absurd for the mourner to dance gleefully while his parent lies dead in a fresh grave. Thus, the Sages decreed that, while complete physical withdrawal from normal activities of society lasts only one week, withdrawal from joyous, social occasion lasts thirty days in mourning for other relatives, and one year (twelve Hebrew months) in mourning for one's parents. Joy, in terms of the mourning tradition, is associated largely with public, social events rather than with personal satisfactions.

THE UNVEILING; WHAT IS IT?

The service of commemoration, or unveiling, is a formal dedication of the cemetery monument. It is customary to hold the unveiling within the first year after death. It should be held at anytime between the end of shivah and the first yahrzeit.

YIZKOR: RECALLING THE DEAD

Recalling the deceased during a synagogue service is not merely a convenient form of emotional release, but an act of solemn piety and an expression of profound respect. The yizkor memorial service was instituted so that the Jew may pay homage to his forebears and recall the good life and traditional goals.

This memorial service is founded on a vital principle of Jewish life, one that motivates and animates the Kaddish recitation. It is based on the firm belief that the living, by acts of piety and goodness, can redeem the dead. The son can bring honor to the father. The "merit of the children" can reflect the value of the

THE JEWISH WAY OF DEATH

Death is the crisis of life. How a man handles death indicates a great deal about how he approaches life. As there is a Jewish way of life, there is a Jewish way of death.

As the Jewish way of life implies a distinctive outlook and a unique life-style based on very specific views of God and the place of man in society and the universe, so does the Jewish way of death imply singular attitudes toward God and nature, and toward the problem of good and evil; and it proffers a distinctive way of demonstrating specific Jewish qualities of reverence for man and respect for the dead.

For example, the prohibition of both cremation (the unnaturally speedy disposal of the dead) and embalming (the unnatural preservation of the dead), bespeaks a philosophy of man and his relationship to God and nature. Repugnance for the mutilation of a body expresses a reverence for man, because he was created in God's image. The ban on necromancy is founded on very precise theological concepts of creature and Creator. Likewise, the commandment to bury the dead without delay draws a very fine, but clear line between reverence for the dead and worship of the dead. The profound psychological insights implicit in the highly structured Jewish mourning observances speak eloquently of Judaism's concern for the psychological integrity of the human personality.

PREPARATION OF THE REMAINS: TAHARAH

"As he came, so shall he go," says Ecclesiastes. Just as a newborn child is immediately washed and enters this world clean and pure, so he who departs this world must be cleansed and made pure through the religious ritual called *taharah*, purification.

The *taharah* is performed by the *Chevra Kadisha* (the Holy Society, i.e. the Burial Society), consisting of Jews who are knowledgeable in the area of traditional duties, and can display proper respect for the deceased. Men perform the *tahara* for a man and women for a woman. In addition to the physical cleansing and preparation of the body for burial, the also recite the required prayers asking Almighty God for forgiveness for any sins

the deceased may have committed, and praying that the All-merciful may guard him and grant him eternal peace.

Jewish tradition recognizes the democracy of death. It therefore demands that all Jews, be buried in the same type of garment, shrouds that are called *tachrichim*. Wealthy or poor, all are equal before God, and that which determines their reward is not what they wear, but what they are. Nineteen hundred years ago, Rabbi Gamliel instituted this practice so that the poor would not be shamed and the wealthy would not vie with each other in displaying the costliness of their burial clothes.

The clothes to be worn should be appropriate for one who is shortly to stand in judgment before God Almighty, Master of the universe and creator of man. Therefore, they should be simple, handmade, perfectly clean, and white. These shrouds symbolize purity, simplicity, and dignity.

THE CASKET

"For dust thou art, and unto dust shalt thou return" (genesis3:19) is the guiding principle in regard to the selection of caskets.

...The coffin must be made completely of wood. The Bible tells us that Adam and Eve hid among the trees in the garden of Eden when they heard the Divine judgment for committing the first sin. "Said Rabbi Levi: "This was a sign for their descendants that, when they die and are prepared to receive their reward, they should be placed in coffins made of wood."

FLOWERS

In ancient days, the Talmud informs us, fragrant flowers and spices were used at funerals to offset the odor of the decaying body. Today, this is no longer essential and they should not be used at Jewish funerals at all. In our days, they are used primarily at Christian funerals, and are considered to be a non-Jewish ritual custom which should be discouraged. It is much better to honor the deceased by making a contribution to a synagogue, hospital, hospice or to a medical research association for the disease which

COMFORTING THE BEREAVED

A sacred obligation devolves upon every Jew to comfort the mourners, whether he is related to them or not, and whether he was a close friend or a passing acquaintance. In Judaism, exercising compassion by paying a condolence call is a mitzvah, considered by some of our greatest scholars to be biblically ordained... It is a person's duty to imitate God: as God comforts the bereaved, so man must do likewise....

The fundamental purpose of the condolence call during shivah is to relieve the mourner of the intolerable burden of intense loneliness. At no other time is a human being more in need of such comradeship. Avelut means withdrawal, the personal and physical retreat from social commerce and concern for others. It is the loss that he alone has suffered.

KADDISH; WHEN IS IT SAID?

The Kaddish is recited at every service, morning and evening, Shabbat and holiday, on days of fasting and rejoicing.

The period that mourners recite the Kaddish for parents is, theoretically, a full calendar year. The deceased is considered to be under Divine judgment for that period. Some communities, therefore, adhere to the custom that Kaddish be recited for twelve months in all cases. However, because the full year is considered to be the duration of Judgment for the wicked, and we presume that our parents do not fall into that category, the practice in most communities is to recite Kaddish for only eleven months – even on leap years, which last thirteen months, the Kaddish is recited for only eleven months. We subtract one day, so that we terminate the Kaddish in time to allow a full thirty days before the end of the twelve-month period.

The Kaddish is to be recited only in the presence of a duly-constituted quorum which consists of ten males (including mourners) above the age of Bar Mitzvah. If there are only nine adults and one minor present, it is still not considered a quorum for a minyan.

leave the house after shivah and to slowly rejoin society, always recognizing that enough time has not yet elapsed to assume full, normal social relations. Shaving and haircutting for mourners are still generally prohibited, as is cutting the nails, and washing the body all at once for delight (as opposed to washing for cleanliness that is required).

The fifth and last stage is the twelve-month period (which includes the sheloshim) during which time things return to normal, and business once again becomes routine, but the inner feelings of the mourner are still wounded by the rupture of his relationship with a parent. The pursuit of entertainment and amusement are curtailed. At the close of this stage, the twelve-month period, the bereaved is not expected to continue his mourning, except for brief moments when *yizkor* and *yahrzeit* is observed. In fact, our tradition rebukes a man for mourning more than this prescribed period.

The effect of shivah and sheloshim is on a biological, pre-rational level. The mourner generally has not yet physically disassociated from the deceased; mourning is all sentiment and therefore the religious practices deal with skin and water, nails and hair. Emerging from the sheloshim, properly observed, is to emerge from the maelstrom of emotions brought on by the death.

The year-long observances, however, are on a strictly rational plane – the avoidance of joyous situations is a formal rejection of fun for fun's sake in recognition of the loss, and the recitation of Kaddish is a strictly community-oriented declaration in the form of a prose-poem, mystically-based, but intellectually articulated.

In this magnificently conceived, graduated process of mourning, an ancient faith raises up the mourner from the abyss of despair to the undulating hills and valleys of normal daily life.

WHO IS THE MOURNER & WHO IS THE MOURNED?

Who is the mourner? Jewish law formally considers the bereaved to be those who have lost any one of the seven close relatives listed in Leviticus 21:1:3: father, mother, wife (or husband), son, daughter, (married or unmarried), brother, and sister (or half-brother or half-sister).

afflicted the deceased. This method of tribute is more lasting and meaningful.

TIMING THE FUNERAL SERVICE

The Bible, in its mature wisdom, required burial to take place as soon as possible following death.

The religious concept underlying this law is that man, made in the image of God, should be accorded the deepest respect. It is considered a matter of great shame and discourtesy to leave the deceased unburied – hi soul has returned to God, but his body is left to linger in the land of the living.

THE NIGHT BEFORE THE FUNERAL SERVICE

The "wake" is definitely alien to Jewish custom, and its spirit does violence to Jewish sensitivity and tradition. The custom of visiting the funeral parlor on the night before internment to comfort the mourners and to view the remains is clearly a Christian religious practice, and not merely an American folkway. If the convert finds that not visiting the night before will be an affront, he or she should make a token appearance. Nonetheless, the convert should understand that, in Judaism, the place for offering condolences is at home, during the seven special days of mourning called *shivah*.

RENDING THE GARMENT: KERIAH

The most striking Jewish expression of grief is the rending of the outer garments by the mourner prior to the funeral service

WHO MUST REND THEIR CLOTHING?

1. Seven relatives are obligated to perform this command: son, daughter; father, mother; brother, sister; and spouse.
2. They must be adults, above the age of thirteen. Minors who are in fact capable of understanding the situation, and appreciating the loss, should have other relatives or friends make the tear for them.
3. Divorced mates may cut their clothing, but they are not obligated to do so.

THE FUNERAL SERVICE

The funeral service is a brief and simple service designed primarily... for the honor and dignity of the deceased.

The service consists of a selection from the Psalms appropriate to the life of the deceased, a panegyric of his finer qualities which his survivors should seek to implant in their own lives, and a memorial Prayer asking that God shelter his soul "on the wings of His Divine presence."

THE INTERMENT

Jewish law is unequivocal in establishing absolutely, and uncompromisingly, that the dead must be buried in the earth. Man's body returns to the earth as it was. The soul rises to God, but the physical shelter, the chemical elements that clothed the soul, sink into the vast reservoir of nature.

CREMATION

Cremation is never permitted. The deceased must be interred, bodily, into the earth. It is forbidden - in every and any circumstance – to reduce the dead to ash in a crematorium. It is an offensive act, for it does violence to the spirit and letter of Jewish law, which never, in the long past, sanctioned the ancient pagan practice of burning on the pyre. The Jewish abhorrence of cremation has already been noticed by Tacticus, the ancient historian, who remarked upon what appeared to be a distinguishing characteristic that Jews buried, rather than burned, their dead.

THE MOURNING PATTERN

There is no legal obligation upon a person who had converted to Judaism to mourn his non-Jewish parents in the prescribed Jewish manner, but it is expected that the convert will show utmost respect for his natural parents. The grief that the convert expresses, although technically not required by Jewish law, should possess a markedly Jewish character. Therefore, it is important to know about these laws.

Judaism, with its long history of dealing with the soul of man, its intimate knowledge of man's achievements and foibles, his grandeur and his weaknesses, has wisely devised graduated periods during which the mourner may express his grief, and release with calculated regularity the built-up tensions caused by bereavement. The Jewish religion provides a beautifully structured approach to mourning.

FIVE STAGES OF MOURNING

The first period is that between death and burial (*anninut*), at which time despair is most intense. Not only the social amenities, but even major positive religious requirements, were canceled in recognition of the mourner's troubled mind.

The second stage consists of the first three days following burial, days devoted to weeping and lamentation. During this time, the mourner does not even respond to greetings, and remains in his home (except under certain special circumstances). It is a time when even visiting the mourner is usually somewhat discouraged, for it is too early to comfort the mourners when the wound is so fresh.

Third, is the period of *shivah*, the seven days following burial. (This longer period includes the first three days.) During this time, the mourner emerges from the state of intense grief to a new state of mind in which he is prepared to talk about his loss and to accept comfort from friends and neighbors. The world now enlarges for the mourner. While he remains in the house, expressing his grief through the observances of avelut – the wearing of the rent garment, the sitting on the low stool, the wearing of slippers, the refraining from shaving and grooming, the recital of the Kaddish – his acquaintances come to his home to express sympathy in his distress. The inner freezing that came with the death of his relative now begins to thaw. The isolation from the world of people and the retreat inward now relaxes somewhat, and normalcy begins to return.

Fourth is the stage of *sheloshim*, the thirty days following burial (which includes the shivah). The mourner is encouraged to

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COMFORTING

THE BEREAVED

Rabbi Dr. Maurice Lamm

AFTER SHIVA

Excerpts from Rabbi Earl Grollman's Book
"Living With Loss, Healing With Hope"

#10

COMFORTING THE BEREAVED

Rabbi Dr. Maurice Lamm

What About the Children

One person's death touches the lives of many.

Your children may have lost a parent, a sibling,
a grandparent,
or a treasured friend.

in the midst of your grief,
it is important that you reach out to them,
make time for them,
talk with them,
listen to them.

Until my father told me how angry he felt
about my mother's death
I thought he was mad at me.
- A ten-year-old child

Comforting the Bereaved
Rabbi Dr. Maurice Lamm

A sacred obligation devolves upon every Jew to comfort mourners, whether related to them or not, and whether the mourner was a close friend or only a passing acquaintance. In Judaism, exercising compassion by paying a condolence call is a mitzvah, considered by some of our greatest scholars to be Biblically ordained. The Bible records that God visited Isaac; "And it came to pass after the death of Abraham, that God blessed Isaac, his son" (Genesis 25:11). The sages infer from this verse that God Himself comforted the bereaved Isaac.

It is a man's duty to imitate God: as God comforts the bereaved, so man must do likewise. Consolation is considered a Godlike action that the children of Israel must perform. When, following the destruction of Jerusalem and the decimation of the Jewish people, Isaiah proclaimed God's message, "Comfort ye, comfort ye, my people" (Isaiah 40:1), it was not merely a recommendation from on high but a specific mandate obligating the prophet to bring consolation to his people.

The fundamental purpose of the condolence call during *shiva* is to relieve the mourner of the intolerable burden of intense loneliness. At no other time is a person in need of such comradeship. *Avelut* means withdrawal, a personal and physical retreat from social commerce and the concern for others. It is a loss that the mourner alone has suffered. All the traditions of mourning express this troubled loneliness in diverse ways, covering the spectrum of social life -- from the excessive growing of hair in indifference to social custom, to the avoidance of greetings, the minimum social courtesy.

Recognizing this state of mind, the visitor comes to the house of mourning, silently, to join the bereaved in his loneliness, to sit alongside him sorrowfully, to think his

thoughts and to linger on his loss. The warmth of such human presence is inestimable. Practiced as the tradition prescribes it, true consolation is a distillation of empathy. the effect of such visits by friends and relatives – some long forgotten, others who may have rarely paid the mourner any attention at all – is the softening of loneliness and the relief of the heavy burden of despair. It is an affirmation that the world at large is not a hateful and angry place, but a warm and friendly one. It is beckoning with open arms for the mourner to return to society. Comforting the mourners, says Maimonides, is *gemilut chasadim*, a genuine kindness – to both the dead and the living.

The purpose of the condolence call is not to convince the mourner of anything at all. This is the time for accompanying him on his very own path, not for argumentation or debate. It is a time for contemplating disaster. While the mourner himself may want to discuss it, it is not the prime purpose of the visit to relieve his fears for the future or his guilt for the past. Nor is it proper (indeed it borders on sacrilege, say the Sages) to impress upon the mourner the inevitability of death, as though to doubt the true purpose and justice of a decree that God issued, but that He would change if only He were free to do so. It is not seemly, perhaps it is entirely useless, to assure the mourner that others have suffered similar tragedies or worse fates, as though by right he should be less despairing. "It could have been worse," is cold consolation. This is a time for subjectivity, for an intensely personal evaluation of life, and the mourners should not be deprived of this indulgence. Some of the importuning of visitors that "life must go on," and that the mourner should be "thankful that worse did not occur," are well meaning, but hollow and sometimes annoying expressions.

The strategy of true compassion is a blend of presence and silence, the eloquence of human closeness. Sad, muttered

Community and Support

We all need the support of others,
particularly when we are devastated
by agonizing loss.

A good friend can be a lifeline,
someone you can talk to honestly,
someone who will not judge you,
but accept you as you are.

Rabbi Moshe Leib Sassover recounted a conversation he overheard between two villagers.

"Tell me, friend Ivan, do you love me?"
"I love you deeply."
"Do you know, my friend, what gives me pain?"
"How can I know that?"
If you don't know what gives me pain,
how can you say you love me?"

Yes, Rabbi Sasover concluded, to love, to truly love, means to know what gives pain to your friend.

Choosing Life

Grief ebbs, but it never ends

The path you walk
is long and arduous.

Trust yourself and respect your feelings.
In time you will gradually
make peace with your loss.

Then, turn toward the future
with courage and resolve.

To everything there is a season, and a time
to every purpose under heaven

A time to be born, and a time to die;
A time to pant, and a time to pick that which is planted;
A time to kill, and a time to heal;
A time to break down, and a time to build up;
A time to weep, and a time to laugh;
A time to mourn, and a time to dance.
-Ecclesiastes 3

words are clumsy openers of the heart compared with the whisper of soft eyes. The comradeship demonstrated by a facial expression speaks volumes that ancient bards could not match with mere words, no matter how beautiful. It fulfils at once the mourner's desperate need for both companionship and privacy. It was, therefore, and old custom, unfortunately lost to our generation, for visitors to sit silently on the earth with, and like, the mourner who sat there. How magnificent is this expression of compassion.

Therefore, the first principle of comforting the mourner, found in the major codes of Jewish law, is that one should be silent and allow the mourner to speak first. In many Jewish communities in ancient days, congregants accompanied the mourner as he walked home from synagogue on the Sabbath or holiday, and there they sat with him. How warm the physical presence of other human beings is. How it relieves that sharp sting of tragedy. The classic mourner, Job, visited by three friends, sat with them for seven days and no one uttered a sound. Ecclesiastes (3:7) notes that there "a time to keep silent and a time to speak." The Midrash (*Kohelet Rabbah* 3:9) records that the wife of Rabbi Mana died. His colleague, Rabbi Avin, came to pay a condolence call. Asked Rabbi Mana, "Are there any words of Torah that you would want to offer us in our time of grief?" Rabbi Avin replied, "At times like this, the Torah itself takes refuge in silence!" indeed, the Talmud codifies this emphasis on silence by the mourner in unusually forceful terms (*Mo'ed Katan* 15a). It categorically prohibits the mourner from studying Torah – remarkable for these expounders of the Torah – because Ezekiel, the prophet (24:17), says: "Sigh in silence." Speech leads to enjoyment, and certainly Torah study.

It is in this spirit that Maimonides cautions visitors not to speak too much. Somehow, words have a tendency to generate frivolity, so contrary to the spirit of *shiva*. Jewish

folk wisdom notes: True reward comes to one who is silent in the house of mourning and voluble in the wedding hall.

It is true, of course, that it is exceedingly difficult to comfort with warmth and hope and compassion while sitting relatively silent. Perhaps that is the reason for the parting phrase of consolation, "May God comfort you among the other mourners of Zion and Jerusalem." For only God can thoroughly comfort, as He consoled Isaac after his father Abraham's death, as He comforted the other mourners of Zion after the tragic destruction of the ancient Temple, and as he has comforted those who suffered in Crusades and pogroms and the Jewish exiled of every age. If the visitor feels uncomfortable in the tension of silence, he should of course talk to the mourner – but little and wisely.

When to Pay a Shivah Call

Making a *shivah* call to console mourners is a sensitive matter that requires forethought. When and how to do this is very important.

1. One may visit the mourner by day and by night.

2. Some rabbis held that the visit should be delayed until the third day after the interment. The mourner's wound is fresh, the deceased is constantly in his mind, and most prefer to agonize in private. However, if for some reason this delay cannot be arranged, the visit may be made even on the very first day. Other rabbis held that consolation visits could begin as soon as mourners begin *shivah*. Actually, comforting the bereaved begins at the cemetery when the mourners leave the grave passing through parallel rows of friends and relatives.

3. Visitors do not customarily pay condolence calls on the Sabbath or holidays, because these are days when one does

Accepting Your Pain

"Why?'
"Why me?"
"Why did my loved one have to die?"

There are questions that have no answers.

Unanswered *whys* are part of life.

Life and death
are brothers/sisters who dwell together
They cling to each other
and cannot be separated.
-Bahya Ibn Pakuda, Duties of the Heart

Shock

You may be numb

You may feel like a victim
of a violent windstorm –
swept away by forces
you didn't expect and
can't control

Nothing seems real.

You're not ready for this.

Denial

"I don't believe it. It can't be true.'
"How could this have happened to my loved one?"
"How could this happen to me?"
"It must be a horrible mistake, a nightmare."

Denial is a coping mechanism,
a part of grief.

When life seems unbearable, denial intervenes
and allows a temporary breathing spell.

not mourn publicly. However, the mourner may receive company and condolences on these days. There may be *shivah* visitation on *chol ha-mo'ed*, Rosh Chodesh, Purim and Chanukah.

4. If one did not visit during the *shivah*, one can express condolences anytime during the twelve months upon meeting those bereft of parents and during the thirty days for those bereft of other relatives.

5. Condolence calls may be paid by mourners who needed to return to business during *shivah* (if it was proper to do so) the same as to other mourners. If the mourner returned to work in violation of the tradition, he need not be visited, as he has denied himself the comfort of religious consolation.

Etiquette at the House of Mourning

The purpose of the visitor's presence and speech during the *shivah* should not be designed to distract the bereaved. It is altogether fitting, and entirely proper, to speak of the deceased, his qualities, his hopes, and his loved ones.

1. There should be no greeting, either of welcome or farewell. Details of this law are found above.

2. It is customary not to speak until the mourner does.

One should not speak too much and monopolize the discussion. Conversation in the house of *shivah* should be in the nature of a response to the mourner.

One should address the mourner's anguish, not distract his attention from it. Far from recalling the anguish that surely has not been forgotten, it gives the bereaved person the opportunity to reminisce and express his grief aloud. Psychologists assure us that the mourner very often desires

to speak of his loss. Dr. Eric Lindemann, in his *Symptomatology and Management of Acute Grief*, says: "there is no retardation of action and speech; quite to the contrary there is a push to speech, especially when talking of the deceased." Both the mourner's words and his tears should not be avoided or suppressed. it is analogous to the world of nature, where animals heal themselves by the licking of wounds.

There is really no need in these pages to chastise those that believe that joking and humorous remarks or frivolous tales will relieve the bitterness of the mourner's feelings. This all too prevalent type of "socializing" in the house of mourning is a constant reminder that coarse souls know no bounds.

3. One should not urge the mourner to "sit" on the *shivah* stool, as this innocent remark may imply to the mourner that he "remain" in grief. It may possible cause resentment.

4. The visitor should, by all means, be sensitive to the mourner's feelings, even if this means leaving early so that the mourner can have a rest from the baggage of good advice and well-meaning instructions. There is a time for all things, the Bible tells us, and surely there is a time for leaving the house of the bereaved. Visits should never be unduly prolonged, in the mistaken belief that one's presence brings an unusual degree of relief.

5. Upon leaving, the visitor should recite the phrase in Hebrew or in English or both: *Ha-makom yenachem etchem betokh she'ar avelei Tziyyon vi-Yershalayim*, "May God comfort you among the other mourners of Zion and Jerusalem."

Behavior During the Condolence Call

It sometimes is awkward to respond to condolence. The law provides some guidelines.

Expressing Your Feelings

Respect your feelings

Sorrow, like the river, must be given vent
leat it erode its bank.

Allow yourself to mourn and grieve
for what was and
what could have been

Tears

Crying is one means of working your way
out of despair

Crying is an honest expression of a grief
that transcends words.

When Sarah, our aged matriarch, died,
her husband, Abraham,
"came to mourn and weep for her." (Genesis 23:2)

Anger

With time, your anger may diminish

Find ways to let it go.

- ☐ Consider a long walk
- ☐ Work out at the gym
- ☐ Scream out loud in a private place, for example, car or shower
- ☐ Beat on a pillow with a tennis racket
- ☐ Listen to music
- ☐ Meditate.

Do whatever brings relief.

All garments must be rent
opposite the heart...
for the mourner has to
expose the heart
-Kitzur Shulkhan Arukh 195:3-4

1. The mourner should not respond to even well-meant greetings during the first three days.

2. The mourner does not need to rise to greet any guest, no matter his stature, and the mourner should not feel compelled to obey the little niceties of good form at this dreadful time. Visitors will understand.

3. The mourner should sit when people comfort him as they are about to leave. However, especially during prolonged visits he need not sit all the time but may stand and walk as he desires.

4. At mealtime, in the company of guests, the mourner can sit at the head of the table on a lower stool.

AFTER SHIVA

Excerpts from Rabbi Earl Grollman's Book
"Living With Loss, Healing With Hope"

Grief

Grandfather, you were the pillar of fire in front of the camp,
and now we are left in the camp alone, in the dark;
we are so cold and so sad

-Noa Ben-Artzi Philosof, age seventeen, spoken at the funeral of her grandfather, Israeli prime minister Yitzhak Rabin

I am racked with grief
Sustain me in accordance with Your word
-Psalm 119:28

Your grief is your own

None can know how you feel
No one can shoulder the pain for you

But there can be solace in the presence of others-
people who love you and want to help
people who also mourn the loss of your beloved.

And there can be solace in the rich sources
of our Jewish faith

That is why, during the *shiva,*
friends and family
come together
to offer condolences,
to offer help,
to recall the life they shared with your loved one.

Comforting the mourner is an act
of loving kindness toward both
the living and the dead
-Kitzur Shulkhan Arukh 193:11

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Death is a Night That Lies Between Two Days

By
Rabbi Dr. Maurice Lamm
President and Founder NIJH

Excerpted from
The Jewish Way in Death and Mourning
Jonathan David Publishing Co.

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In immortality man finds fulfillment of all his dreams. In this religious framework, the sages equated this world with an ante-room to a great palace, the glorious realm of the future. For a truly religious personality, death has profound meaning, because for him life is a tale told by a saint. It is, indeed, full of sound and fury which sometimes signifies nothing, but often bears eloquent testimony to the Divine power that created and sustained him.

The rabbis say this world can be compared to a wedding. At a wedding two souls are united. In that relationship they bear the seed of the future. Ultimately, the partners to the wedding die – but the seed of life grows on, and death is conquered, for the seed of the future carries the germ of the past. The world is like unto a wedding.

Death has meaning if life had no meaning. If one is not able to live, will one be able to die?

Is There Life After Life?

This section covers the concept of Immortality, the coming of a Messiah, the Resurrection of the Dead, and also the meaning of death in Jewish terms. Terminally ill patients, especially, may gain strength and confidence from the realization that Judaism has never considered death to be the final act of life. "Death is a night that lies between two days." "As we separate and die from the womb, only to be born to life, so we separate and die from our world, only to be re-born to life eternal."

7

The World Beyond the Grave

Life After Death

Man has had an abiding faith in a world beyond the grave. The conviction in a life after death, unprovable and unshakeable, has been cherished since the beginning of thinking man's life on earth. It makes its appearance in religious literature not as a fiat, commanded irrevocably by an absolute God, but rather arises plant-like, growing and developing naturally in the soul. It then sprouts forth through sublime prayer and sacred hymn. Only later does it become extrapolated in complicated metaphysical speculation. The after-life has not been "thought-up"; it is not a rational construction of a religious philosophy imposed on a believing man. It has sprung from within the hearts of masses of men, a sort of *consensus gentium*, inside out, a hope beyond and above the rational, a longing for the warm sun of eternity. The after-life is not a theory to be proven logically or demonstrated by rational analysis. It is axiomatic. It is to the soul what oxygen is to the lungs. There is little meaning to life, to God, to man's constant strivings, to all of his great achievements, unless there is a world beyond the grave.

The Bible, so vitally concerned with the actions of man in this world, and agonizing of his day-to-day morals, is relatively silent about the world-to-come. But, precisely, this very silence is a tribute to this awesome concept, taken for granted like the oxygen in the atmosphere. No elaborate apologia, no complex abstractions are necessary.

beast, and the world – in Shopenhauer's phrase – *eine grosse schlachtfeld*, a great battlefield, and if values are only those of the jungle, aimed only at the satisfaction of animal appetites – than death is simply a further reduction to the basic elements, progress an adventure into nothingness, and our existence on this earth only a cosmic trap. In this scheme, life is surrounded by parentheses, dropped or substituted without loss of meaning to nature. Death, in this sense, is the end of a cruel match that pits man against beat, and man against man. It is the last slaughter. Furtively, irrevocably, despairingly, man sinks into the soil of a cold and personal nature, his life without purpose, his death without significance. His grave need not be marked. As his days were as a passing shadow, without substance and shape, so his final repose.

If life is altogether absurd, with man bound and chained by impersonal fate or ironbound circumstances, where he is never able to achieve real freedom and only dread and anguish prevail – then death is the welcome release from the chains of despair. The puppet is returned to the box, a string is severed, the strain is no more. But if life is the creation of a benevolent God, the infusion of the Divine breath; if man is not only higher than the animal, but also "a little lower then the angels"; if he has a soul, as well as a body; if his relationship is not only the "I-it" of man and nature, but the "I-Thou" of creature with Creator; and if he tempers his passions with the moral demands of an eternal, transcendent God – then death is a return to the Creator at a time of death set by the Creator, and life-after-death the only way of a just and merciful and ethical God. If life has any significance, if it is not mere happenstance, then man knows that someday his body will be replaced, even as his soul unites with eternal God.

With all of modern man's sophistication, his brilliant technological achievements, the immense progress of his science, his discovery of new worlds of thought, he has not come one iota closer to grasping the meaning of death than did his ancient ancestors. Philosophers and poets have probed the idea of immortality, but stubbornly it remains, as always, the greatest paradox in life.

In practice, however, we must realize that what death means to the individual depends very much on what life means to him.

If life is a stage, and we are the poor players who strut and fret our hour upon the stage and then are heard no more; if life is a tale told by an idiot, full of sound and fury, signifying nothing; if life is an inconsequential drama , a purposeless amusement – then death is only the heavy curtain that falls on the final act. It sounds its hollow thud: *Finita la comedia*, and we are no more. Death has no significance, because life itself has no lasting meaning.

If life is only the arithmetic of coincidence, man a chance composite of molecules, the world a haphazard conglomeration without design and purpose, where everything is temporal and nothing eternal – with values dictated only by consensus – then death is merely the check-mate to an interesting, thoughtful, but useless game of chance. Death has no transcendent significance, since nothing in life has transcendent significance. If such is the philosophy of life, death is meaningless, and the deceased need merely be disposed of unceremoniously, and as efficiently as possible.

If life is only nature mindlessly and compulsively spinning its complicated web, and man only a high-level

The Bible, which records the sacred dialogue between God and man, surely must be founded on the soul's eternal existence. It was not a matter of debate, as it became later in history. When whole movements interpreted scripture with slavish literalism and could not find the after-life crystallized in letters or words, or later, when philosophers began to apply the yardstick of rationalism to man's every hope and idea and sought empirical proof for this conviction of the soul. It was a fundamental creed, always present, though rarely articulated.

If the soul is immortal then death cannot be considered a final act. If the life of the soul is to be continued, then death, however bitter, is deprived of its treacherous power of casting mourners into a lifetime of agonizing hopelessness over an irretrievable loss. Terrible though it is, death is a threshold to a new world – the "world-to-come."

A Parable

An imaginative and telling analogy that conveys the hope and confidence in the after-life, even though this hope must be refracted through the prism of death, is the tale of twins awaiting birth in the mother's womb. It was created by a contemporary Israeli rabbi, the late Y. M. Tuckachinsky.

Imagine twins growing peacefully in the warmth of the womb. Their mouths are closed, and they are being fed via the navel. Their lives are serene. The whole world, to these brothers, is the interior of the womb. Who could conceive anything larger, better, more comfortable? They begin to wonder; "We are getting lower and lower. Surely if it continues, we will exit one day. What will happen after we exit?"

Now the first infant is a believer. He is heir to a religious tradition which tells him that there will be a "new life" after this wet and warm existence of the womb. A strange belief, seemingly without foundation, but one to which he holds fast. The second infant is a thorough-going skeptic. Mere stories do not deceive him. He believes only in that which can be demonstrated. He is enlightened, and tolerates no idle conjecture. What is not within one's experience can have no basis in one's imagination.

Says the faithful brother: "After our 'death' here, there will be a new great world. We will eat through the mouth! We will see great distances, and we will hear through the ears on the sides of our heads. Why, our feet will be straightened! And our heads – up and free, rather than down and boxed in."

Replies the skeptic: Nonsense. You're straining your imagination again. There is no foundation for this belief. It is only your survival instinct, an elaborate defense mechanism, a historically-conditioned subterfuge. You are looking for something to calm your fear of 'death.' There is only *this world*. There is no world-to-come!"

"Well then," asks the first, "what do you say it will be like?"

The second brother snappily replies with all the assurance of the slightly knowledgeable: "We will go with a bang. Our world will collapse and we will sink into oblivion. No more. Nothing. Black void. An end to consciousness. Forgotten. This may not be a comforting thought, but it is the logical one."

in God as the God of goodness. A great teacher of our generation supports this by citing from the central prayer in the daily prayerbook, "You support the *falling*, and heal the *sick*, and free those who are *bound up*, and keep your faith with those who *sleep in the dust*." The prayerbook lists a series of evils that befall man, and asserts that God will save man from them. Those who "fall" suffer financial failure, a defect in the structure of society. We believe that God who is good will overcome that defect. He will "support the falling." Worse than that is sickness, which is a flaw in the physical nature of man. We believe that God is good and will not tolerate such an evil forever. He will heal the sick. Worse yet is the disease of slavery, the sickness which man wishes on his fellowman. God will overcome this, too, for He not only supports the falling and heals the sick, He is the great emancipator of man. The worst evil of all, however, the meanest scandal, the vilest disgrace to that being created in the image of God, is death, the end to all hope and all striving. But we believe in an ethical and good God. As He prevailed over the evils of lifetime, so will He prevail over the final evil, that of death. Thus, we conclude, you who support and heal, and free, will also keep your faith to those who are dead.

The Meaning of Death

What is death? Is it merely the cessation of the biological function of living? Is it but the tragedy to end all other tragedies? Is it simply the disappearance of the soul, the end of consciousness, the evaporation of personality, the disintegration of the body into its elemental components? Or, is there a significance, some deep and abiding meaning to death – one that transcends our puny ability to understand?

the just God balances the scales and rewards or punishes those who truly deserve it. This doctrine of a resurrection is, thus, a necessary corollary of our belief in a just God.

God is Merciful

But if we ask of God only that He can be just, can we expect that we ourselves will be resurrected? Who is so righteous as to be assured of that glorious reward? Hence we call upon God's mercy that he revive us. Thus, Joseph Albo, a fifteenth-century philosopher, notes that in the prayerbook the concept of resurrection is associated with "*great* mercy," whereas God's gift of life and sustenance are considered only "grace, kindness and mercy." Says Rabbi Albo: "The life of man is divided into three portions: the years of rise and growth, the middle years or the plateau, and the years of decline." These are described by the three adjectives – grace, kindness and mercy. While one is vigorous one does not require an *extra* measure of assistance from God in being nourished. All that he needs is Divine grace. In the second portion of life, man grows older, but he is still able and strong. He needs more than just Divine grace, he needs God's kindness. In the declining years, he is weak, dependent on others, and in desperate need of more than grace and kindness. He now needs God's mercy. But there is also a fourth portion of life: life after death. For this man requires more than grace, kindness and mercy. He needs "great mercy!" Thus in Albo's scheme, resurrection is only a natural, further development of God's providence. In the words of the prayerbook: "He sustains the living with kindness and revives the dead with *great* mercy."

God as an Ethical Personality

The concept of life-after-death also follows from a belief

Suddenly the water inside the womb bursts. The womb convulses. Upheaval. Turmoil. Writhing. Everything lets loose. Then a mysterious pounding- a crushing, staccato pounding. Faster, faster, lower, lower.

The believing brother exits. Tearing himself from the womb, he falls outward. The second brother shrieks – startled by the "accident" befallen his brother. He bewails and bemoans the tragedy – the death of a perfectly fine fellow. Why? Why? Why didn't he take better care? Why did he fall into that terrible abyss?

As he thus laments, he hears a head-splitting cry, and a great tumult from the black abyss, and he trembles: "Oh my! What a horrible end! As I predicted!"

Meanwhile as the skeptic brother mourns, his "dead" brother has been born into a "new" world. The head-splitting cry is a sign of health and vigor, and the tumult is really a chorus of *mazal tovs* sounded by the waiting family thanking God for the birth of a healthy son.

Indeed, in the words of a contemporary thinker, man comes from the darkness of the "not yet," and proceeds to the darkness of the "no more." While it is difficult to imagine the "not yet" it is more difficult to picture the "no more."

As we separate and "die" from the womb, only to be born to life, so we separate and die from our world, only to be re-born to life eternal. The exit from the womb is the birth of the body. The exit from the body is the birth of the soul. As the womb requires a gestation period of nine months, the world requires a residence of 70 or 80 years. As the womb is a *prozdor*, an anteroom prefatory to life, so our present existence is a *prozdor* to the world beyond.

The Concept of Immortality

The conception of an after-life is fundamental to the Jewish religion; it is an article of faith in the Jews' creed. The denial of the after-life constitutes a denial of the cornerstone of the faith. This concept is not merely an added detail that may lose its significance in some advanced age. It is an essential and enduring principle. Indeed, the Mishnah (*Sanhedrin* X, 1) expressly excludes from the reward of the "world beyond" he who holds that the resurrection of the dead is without Biblical warrant. Maimonides considers this belief one of the 13 basic truths which every Jew is commanded to hold.

The concept of the after-life entered the prayerbook in the philosophic hymns of *Yigdal* and *Ani Ma'amin*. Centuries later, hundreds of thousands of Jews, packed in cattle cars, enroute to the crematoria, sang the *Ani Ma'amin*, the affirmation of the coming of the Messiah. Philosophers, such as Hasdai Crescas in the fourteenth century, changed the formulation of the basic truths, but still kept immortality as a fundamental principle without which the Jewish religion is inconceivable. Simon Ben Zemah Duran, in the early fifteenth century, reduced the fundamentals to three, but resurrection was included. Joseph Albo, in the same era, revised the structure of dogmas, and still immortality remained a universally binding belief. No matter how the basic principles were reduced or revised, immortality remained a major tenet of Judaism. Indeed, we may say of immortality what Hermann Cohen says of the Messiah, "If the Jewish religion had done nothing more for mankind than proclaim the messianic idea of the Old Testament prophets, it could have claimed to be the bedrock of all of

useless, but are to be brought to fulfillment at the end of days.

The concept of resurrection thus serves to keep God ever in man's consciousness, to unify contemporary and historic Jewry, to affirm the value of god's world, and to heighten, rather than to depress, the values of man's worthy strivings in this world.

Which specific virtues might guarantee a person's resurrection is a subject of much debate. The method of resurrection is, of course, an open question that invites conjecture, but which can offer no definite answer.

While the details of the after-life are thus very much a matter of speculation, the traditional consensus must serve to illuminate the dark path. In the words of rabbi Joshua ben Chanania (*Niddah* 70b): "When they come to life again, we will consult about the matter."

Life After Death: A Corollary of Jewish Belief

The existence of a life after death is a necessary corollary of the Jewish belief in a just and merciful and ethical God.

God Is Just

The Jew is caught in a dilemma: he believes that God is righteous and just – He rewards the good and punishes the wicked. Yet, for all the strength of his belief, he lives in a world where he sees that life is unfair. he sees all too often the spiritual anomaly of the righteous who suffer and the wicked who prosper. The sages answer by saying that there is *spiritual* reward and *spiritual* punishment. the answer that religion gives is that the good, just, and eternal God revives the righteous dead, while the wicked remain in the dust. It is in life-after-death at which time

character. It will live again as a whole people. The individual, even in death, is not separated from the society in which he lived Third, physical resurrection affirms unequivocally that man's soul *and* his body are the creations of a holy God. There is a tendency to assume that the affirmation of a spiritual dimension in man must bring with it the corollary that his physical being is depreciated. Indeed, such has been the development of the body-soul duality in both the Christian tradition and in Oriental religions, and account for their glorification of asceticism. Further, even the Greek philosophers who were enamored at the beauty of the body, came to denigrate the physical side of man. They crowned reason as man's noblest virtue. For them the spiritual-intellectual endeavor to perceive the unchanging truth was the highest function of man. Man's material existence, on the other hand, was always in flux, subject to chance and, therefore inferior. Thus, they accepted immortality of the soul – which to the Greeks was what we call mind – which survives the extinction of his physical being. But they could not understand physical resurrection because they did not, by any means, consider the body worthy of being reborn.

To the contrary, Judaism has always stressed that the body, as the soul, is a gift of God – indeed, that it belongs to God." The soul is yours, and the body is your handiwork," the Jew declared. To care for the body is a religious command of the Bible. The practice of asceticism for religious purposes was tolerated, but the ascetic had to bring a sacrifice of atonement for his action. Resurrection affirms that the body is of value because it came from God, and it will be revived by God. Resurrection affirms that man's empirical existence is valuable in God's eyes.
His activities in this world are significant in the scheme of eternity. His strivings are not to be deprecated as vain and

the world's ethical culture."

Strange as it may appear, despite the historic unanimity has never been pierced, and only shadowy structures can be discerned. But, as a renowned artist remarked, the true genius of a painting can be determined at dusk when the light fades, when one can only see the outline, the broad strokes of the brush, while the details are submerged in darkness. The beauty of the concept of immortality and its enormous religious significance does not lie in the details. Maimonides denies that man can have a clear picture of the after-life and compares earth-bound creatures with the blind man who cannot learn to appreciate colors merely by being given a verbal description. Flesh-and-blood man cannot have any precise conception of the pure, spiritual bliss of the world beyond. Thus, says Maimonides, the precise sequence in which the after-life will unravel is not a cardinal article of the faith, and the faithful should not concern themselves with the details. So it is often in Judaism that abstract principles must be held in the larger, conceptual sense, while the formal philosophic details are blurred. Contrariwise, pragmatic religious ideals – the observance of the faith – are worked out to their minutest details, although the basic concept behind them may remain unknown forever.

For all that, there is a consensus of belief based on Talmudic derivations from the Torah and philosophic analyses of statements uttered by the sages. The concept is usually discussed under the headings of "Messiah" and "Resurrection of the Dead." (Concepts such as *Ge-hinnom* and *Gan Eden* are too complicated for discussion in this work.) The term *olam ha'ba*, the "world beyond," while relatively unclear, seems to have encompassed the two basic concepts of Messiah and resurrection. Maimonides lists these two as cardinal principles of the Jewish creed.

Messiah

The generic term, Messiah, means "anointed one." Kings and priests were anointed in ancient times to set them apart as specially designated leaders of society. The anointed one will bring redemption to the world. It will be a time of true bliss, unparalleled in our own existence. It will not be a new world, a qualitatively *different* world, rather will it be this world brought to perfection. Universal peace, tranquility, lawfulness and goodness will prevail, and all will acknowledge the unity and lordship of God.

Will the Messiah be a specific person, or will he only represent an era of perfection – "the days of Messiah?" Traditional Judaism believes, without equivocation, in the coming of an inconceivably great hero, anointed for leadership – a descendant of the house of David, who will lead the world out of chaos. He will be of flesh and blood, a mortal sent expressly by God to fulfill the glory of His people. The traditional belief is that man must work to better the world and help bring on the Messiah. It believes the idea that mankind *by itself* will inevitably progress to such an era to be unfounded optimism. A supernatural gift to mankind, in the person of the Messiah, will be required to bring the world to this pinnacle of glory. God will directly intervene to prevent the world from rushing headlong into darkness, and will bring the redemption through a human personality. The personal Messiah, supernaturally introduced to mankind, will not, however, be a Divine personality. He will only bring about the redemption that is granted by God. The Messiah will have no ability to bring the redemption himself. He will have no miraculous powers. He, himself, will not be able to atone for the sins of others. He will have no superhuman

the latter is even more significant – for resurrection serves only the righteous while the rain falls indiscriminately on all men.

This is one, supplementary reason why the body and all its limbs require to ne interred in the earth and not cremated, for it expresses our faith in the future resurrection. Naturally, the all-powerful God can recreate the body whether it was buried or drowned or burned. Yet, willful cremation signifies an arrogant denial of the possibility of resurrection, and those who deny this cardinal principle should not share in the reward for its observance. The body and its limbs – whether amputated before death, or during a permissible post-mortem examination – have to be allowed to decompose as one complete organism by the process of nature, not by man's mechanical act.

Resurrection: A Symbolic Idea

Some contemporary thinkers have noted that the physical revival of the dead is symbolic of a cluster of basic Jewish ideas:

First, man does not achieve the ultimate redemption by virtue of his own inherent nature. It is not because he, uniquely, possesses an immortal soul that he, inevitably, will be resurrected. The concept of resurrection underscores man's reliance on God who, in the words of the prayerbook, "Wakes the dead in great mercy." It is His grace and His mercy that rewards the deserving, and revives those who sleep in the dust.

Second, resurrection is not only a private matter, a bonus for the righteous individual. It is a corporate reward. *All* of the righteous of *all* ages, those who stood at Sinai, and those of our generation, will be revived. The *community* of the righteous has a corporate and historic

culminating in the birth of the astoundingly complex network of tubes and glands, bones and organs, their incredibly precise functioning and the unbelievably intricate human brain that guides them, is surely a miracle of the first magnitude. Curiously, the miraculous object, man himself, takes this for granted. In his preoccupation with daily trivia, he ignores the miracle of his own existence. The idea of rebirth may appear strange because we have never experienced a similar occurrence, for which reason we cannot put together the stuff of imagination. Perhaps it is because we can be active in creating life, but cannot participate with God in the recreation of life. Perhaps it is because, scientifically, recreation flies against any biological theory, while we are slowly coming to know how life is developed, and our researchers are about to create life in the laboratory test tube. But, who has created the researching biologist? And, can we not postulate an omnipotent Divine Biologist who created all men? Surely resurrection is not beyond the capacity of an Omnipotent God.

The sages simplified the concept of a bodily resurrection by posing an analogy which brings it into the experience of man. A tree, once alive with blossoms and fruit, full of the sap of life, stands cold and still in the winter. Its leaves have browned and fallen, its fruit rots on the ground. But the warm rains come and the sun shines. Buds sprout. Green leaves appear. Colorful fruits burst from their seed. With the coming of spring, God resurrects nature. For this reason the blessing of God for reviving the dead, which is recited in every daily prayer, incorporates also the seasonal request for rain. When praying for the redemption of man, the prayerbook uses the phrase "planting salvation." Indeed, the Talmud compares the day of resurrection with the rainy season, and notes that

relationship with God. He will be an exalted personality, of incomparable ability, who will usher in the rehabilitation of the Jewish people and the subsequent regeneration of mankind.

How the Messiah will come, and how we will be able to identify him has aroused the magnificent imaginative inventiveness and poetic fancy of masses of Jews in every age. Many of these ruminations are contradictory. Some are founded in Biblical interpretation, some on traditional beliefs handed down from father to son, while others are flights of folkloristic fancy. The time of the coming of the Messiah has aroused such fantastic conjecture by so many who confidently predicted specific dates and signs, causing so much anxiety and unreasonable anticipation, and culminating in such heartbreaking and spiritually-shattering frustration, that the sages have had to chastise severely those who "count the days" to "bring near the end" of redemption.

While some theologians have sought to dispute the supernatural introduction of the Messiah, or to denigrate the idea of a personal Messiah, there is no *a priori* reason to deny either. On the other hand, however, there does stand a millennium of unwavering conviction on the part of our most profound scholars and the great masses of Jews to affirm it. The authority of hundreds of generations will withstand superficial rational analysis, let alone the meta-physical misgivings and begrudging consent of contemporary, sophisticated theologians.

The Resurrection of the Dead

The body returns to the earth, dust to dust, but the soul returns to God who gave it. This doctrine of the immortality of the soul is affirmed not only by Judaism

and other religions, but by many secular philosophers as well. Judaism, however, also believes in the eventual resurrection of the body, which will be reunited with the soul at a later time on a "great and awesome day of the Lord." The human form of the righteous men of all ages, buried and long since decomposed, will be resurrected at God's will.

The most dramatic portrayal of this bodily resurrection is to be found in the "Valley of Dry Bones' prophecy in Ezekiel 37, read as the *haftorah* on the Intermediate Sabbath of Passover. It recalls past deliverances and envisions the future redemption of Israel and the eventual quickening of the dead.

"The hand of the Lord was upon me, and the Lord carried me out in a spirit, and set me down in the midst of the valley, and it was full of bones; and He caused me to pass by them round about, and , behold there was very many in the open valley; and, lo, they were very dry. And He said unto me: "Son of man, can these bones live?" And I answered: "O Lord, God, Thou knowest." Then He said unto me; "Prophesy over these bones, and say unto them: "O ye dry bones, hear the word of the Lord; Thus saith the Lord God unto these bones: Behold, I will cause breath to enter into you, and ye shall live. And I will lay sinews and cover you with skin, and put breath in you, and ye shall live; and ye shall know that I am the Lord." So I prophesied as I was commanded; and as I prophesized, there was a noise, and behold a commotion, and the bones came together, bone to its bone. And I beheld, and, lo, there were sinews upon them and flesh came up, and skin covered them above; but there was no breath in them. Then said He unto me: "Prophesy unto the breath, prophesy, son of man, and say to the breath: "Thus saith

the Lord God: Come from the four winds, O breath, and breathe upon these slain, that they may live.'" So I prophesized as He commanded me, and the breath came upon them, and they lived, and stood on their feet, an exceeding great host. Then He said unto me: "Son of man, these bones are the whole house of Israel; behold, they say: "Our bones are dried up, and our hope is lost; we can clean cut off.' Therefore, prophesy, and say unto them: 'Thus saith the Lord God: behold, I will open your graves, and cause you to come out of your graves, O my people; and I will bring you into the land of Israel. And ye shall know that I am the Lord, when I have opened your graves, O my people. And I will put my spirit in you, and ye shall live. And I will place you in your own land; and ye shall know that I the Lord have spoken, and performed it, saith the Lord.'"

The power of this conviction can be gauged not only by the quality of the lives of the Jews, their tenacity and gallantry in the face of death, but in the very real fear instilled in their enemies. After destroying Jerusalem and callously decimating its Jewish population, Titus, the Roman general, returned home with only a portion of his Tenth Legion. When asked whether he had lost all his other men on the battlefield, Titus gave assurance that his men were alive, but they were still on combat duty. he had left them to stand guard over Jewish corpses in the fields of Jerusalem because he was sincerely afraid that that their bodies would be resurrected and they would reconquer the Holy Land as they had promised.

The belief in a bodily resurrection appears, at first sight, to be incredible to the contemporary mind. But when approached from the God's-eye view, why is rebirth more miraculous than birth? The adhesion of sperm and egg, the subsequent fertilization and development in the womb

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Consolation
The Spiritual Journey Beyond Grief
cloth, 6" x 9", 360 pages
ISBN 0-8276-0764-4, $30
Publication Date: March 2004

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Chapter 4 ☙ Shiva; The Habitat of Healing

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and apply it to the management of our grief. Habitat Shiva includes the contrasting moods of many "rooms," each room calling forth its own spirit and style.

But the Habitat Is a Sukkah, It Is Only Temporary

Most people who have gone through the mourning experience can testify that Habitat Shiva, despite its magnificence, is notoriously unstable. The sukkah was a temporary dwelling or hut built by the Israelites and used by them during their wanderings in the desert before they reached Canaan. The ritual sukkah that we Jews build today is a hut, specifically built to be fragile by using see-through reeds or slats that enable rain to fall through, reminding us that our fate is in the hands of God.

Similarly, Habitat Shiva is a temporary shelter that stands for seven days, affording us limited protection until our strength begins to return. It is exactly what the Psalmist sought: "[God] will hide me in [His] Sukkah in the day of trouble" (Ps. 27:25).

In the day of our bitterness, we take refuge in this spiritual sukkah of healing, shielding us for the short trek

and imperceptibly when we face terrifying small griefs in personal ways, especially when we finally accept our griefs and integrate them into our future.

There are gender differences in how such grief is expressed. Men are less comfortable than women with a dramatic release, preferring slowly and deliberately to chip away at grief. Male mourners often intentionally suppress their sadness during certain times and then consciously bring it up later. Some psychologists call this practice "sampling": other psychologists have referred to this as "dosing." Men are likely to heal through silence and solitude, with little of the therapy or group support that women favor.

Traditionally, the female style of grieving focuses on crying, hugging, talking it out, and using therapy and support groups. In our times and culture, this is often viewed as "the right way" to mourn. And yet, scholars on the cutting edge of grief research are finding that the masculine style has its own benefits, too, and is no less effective. It emphasizes thinking it through, acting soberly, and exercising emotional control. the two modes appear to be contradictory, but on a profound level they likely compliment one another. In fact, the expression of mourning – male or female – may be more effected by other matters, such as a complex mélange of each mourner's background, fears, closeness to the deceased, and experience with previous death events.

Mindful of the elasticity built into shiva, the Halakhah, Jewish law, empowered people to respond to the life-shattering experience of loss in keeping with their own personality. One simply could not mandate talkativeness to a normally quiet person or silence to a verbose one. The style of each person's coping with grief must emerge from inside out - within the general framework established by the tradition. This ingenious arrangement, in synergy with the elasticity of the shiva laws and customs, and the strivings of each person's soul, provides the best possibility for restoring the mourner's health. It is sound, therefore, to take the advice of the Talmud – "make yourself a heart of many rooms" –

Chapter 4

Shiva; The Habitat of Healing

Mourning is like reentering the womb. We find a dark place where we can weep unheeded and become whole in our own time. Emptiness turns to hope in this safe refuge, this comforting cavern echoing endings and beginnings, slowly transformed again into a passageway into our older, other life.

- M. Fumia

Shiva is a sanctuary for grieving. It follows the course of suffering: It does not dismiss suffering with preachments of God's goodness nor cite easy assurances of desirable outcomes; it confronts rather than evades the pain of separation. In addition, it provides a profound though indirect healing regimen that leads us out of the entanglement of grief to a full acceptance of our loss and takes us even further, empowering us to growth and self-realization.

How does it accomplish such enormous tasks?

Carving Time Out of Eternity

Shiva responds to deep, rudimentary needs that are common to us all. It is Torah meeting us deep in our sub-conscious, in moments of profound despair.

We live in the infinite. We look up into a vast incomprehensible dome of billions of stars that are billions of years old – knowing that even with our marvelous brains, we cannot comprehend the idea of a "billion." We stand at the edge of oceans, whose depths we cannot truly fathom, which stretch beyond the farthest horizon to the point where endless sea touches endless sea. We stand beneath wild mountain ranges that pierce the skies while they dwarf our souls, shrinking us to feeble Lilliputians. And we peer down into deep caverns.

Time and space both seem infinite. But we are mortal and finite, blips in the endless stretches of the cosmos. To function in our world we need finite boundaries. To do that we must mark time and space. Boundaries enable us to orient ourselves; to navigate; to measure progress; to find meaning; to associate with ideas, with things, and with one another.

Because our lives, as we know them, are finite, we nail down special times – celebrations and commemorations – creating a grid that enables us to locate ourselves among the immensities and the eternities. How far are we from this boundary, that end, this precipice? Though we are each created unique, we are not alone. How close are we to this relative that neighbor this friend? We base our relationships on intuition, voice quality, senses, logic, and a bewildering network of criss-crossing communications. Our personal distinctiveness is replicable in every person. But it is the fences and separations that enable us to identify and associate with others. This grid, with its limits, its exclusivities, and its foci, enable us to navigate. We have set boundaries in time and space that become our directional signposts.

Sigmund Freud noted that "there is no innate grid of time and space in the unconsciousness; but as soon as we become

swerved? Where did he or she get lost? Shiva is a time for sharing information – to relate how our loved one managed to make a living and care for family or to hear stories of his early school years. What were her favorite movies, art style or music? What effect did he have on the lives of others? This is the stuff of earthly immortality; these are the fragments we mourn.

Instinctively, as we reconstruct the biography, we make judgments; and as we smile or cry over foibles and stories never before heard, we begin to form a picture of a real person. Comforters often exaggerate when they speak of the dead, as though hyperbole and false estimates were solace to mourners. Yet it is possible that we can re-evaluates some of our original impressions, separating truths from glorifications, fables, and exaltations. The opposite is also possible. We may realize areas in which we perhaps underestimated or misjudged the deceased – and we may now feel free to recant some of the offhand criticisms made during a lifetime of achievements.

Ma'ase avot siman le'banim. (The actions of parents are signs for their children.) On its face, this means that children replicate the behavior and destiny of their parents. But profound phrases yield layers of interpretation, and this aphorism takes on an additional meaning in mourning: that the actions of the parents can be signposts for children to use – or perhaps disagree with – so that some of the pain that befell their elders need not befall them.

Habitat Shiva is a "Heart of Many Rooms"

No two people mourn in the same way. There is a masculine way, a feminine way, a children's way, a parent's way, a grandparent's way, a sibling's way, and a host of ways for friends. Also, especially at death events, we express ourselves in a way that resonates from our unique psychological makeup. There is no one way that is the

and mementos, objects and odors – or the footprints of our activities, our life's journey.

Shiva is the habitat in which we mourners confront those pieces of the past. We bump into the remnants of life, such as the clothes and pictures; we listen to the stories of others; we have set aside seven days to contemplate the past; we touch things from the past that have unique aromas and textures. We begin to embrace the soul of the deceased, read cherished and dog-eared books, discover treasures in the picture albums, and listen to friends reminisce. In doing so, we take an unconscious inventory of the life of the deceased and tally the results – opening subjects and shutting them, finding closure by setting some aside and enshrining others in memory.

The healing of our angst is facilitated not by allusion to abstract principles and sage advice or by pills and needles, but by small, specific actions – the piecemeal disengaging from each association, the handling of each item that belonged to the departed. This is a powerful and beneficial aspect of mourning in Habitat Shiva.

Tracking the Tread Marks of Life's Journey

Just as we are surrounded by physical remnants of the past when we open closets, so we are soon surrounded by the deceased's outlook on life. if we go beyond chitchat with comforters and draw them out, they can help us reconstruct the biography of a person we thought we knew well. Why did the one we mourn take a particular direction? What were the achievements, the loves, and the angers our loved one prized? It is exceedingly rare to find no skid marks in a person's journey, to find that our loved one's life was smooth and that he or she just cruised the years.

To track our beloved's travels on life's rough road, we can ask relatives and friends (who find comfort in helping): Where were the incidental stops and reverses, the sudden detours of the main road, and the times our loved one

conscious, we seek patterns in the continuum of time." William James explained that when we look at wilderness, we discern patterns that are not embedded in nature; our minds instinctively impose such a grid on the natural world. In fact, military map-reading courses teach this early on: If a geometric structure is detected in the wild, it is evidence that human beings have intruded on nature. The need for patterns, shapes and boundaries is encoded in the human mind.

Not only do we need to measure time, we also need to invest it with meaning, purpose and will. That is why holy days, memorials, fast days and feasts, punctuate the calendars of all peoples – to commemorate historical events and to make sense of the morass of days. Professor Harvey Cox, author of The Secular City, called human beings "Homo festivus" for our built-in drive to mark significance through celebration. It is a spiritual counterpoint to our ever-present, ever changing secular landscape.

When we apply these ideas to mourning, we discover that shiva is not simply carved from the calendar to sharpen our focus on what we have lost. It also enables us as mourners to locate ourselves and orient ourselves in an environment distorted by the disappearance of a signpost. Shiva anchors us firmly in a nucleus of stability, calm and caring. Without the specific mourning periods – shiva, the thirty day sheloshim period, the year of saying Kaddish – we would be lost in a morass of days; and in the end, we would free-fall into Shakespeare's "dark backward abysm of time."

Mindfulness

To appreciate the Jewish tradition of mourning, we need to understand the subtlety of mindfulness. To focus on a single event at a precise moment, we set our "acute awareness." We bring the event to the front of our minds, giving it our special attention. Other matters, peripheral to our immediate concern, reside in "latent awareness." For instance, when we feed our children breakfast and get them ready to go off to school, we hold them in acute awareness. When they are

safely on the school bus, we may still retain them in acute awareness, but generally, when we focus on work and other concerns, we move them into our latent awareness.

Grieving is so powerful and so mind altering that it demands acute awareness. When, too soon, we resume our workaday lives and marginalize mourning to our latent awareness, we also marginalize our feelings of loss.

Judaism is keenly sensitive even to our unarticulated needs. Ears do not hear the cries of the soul. Mourners may be convinced that they can just go on living; their upbringing may convince them that they can handle anything that comes and maintain their composure – but one day mourning will face them in their acute awareness. It is human. Grieving refuses to remain latent; it tugs at the human mind, demanding attention, even if it takes a lifetime. Diversion does not dissolve this difficulty. in this and other subliminal ways, the seven-day space of shiva synchronizes with mindfulness.

Reorienting

The Rabbis held that while shiva may be observed in a home that is most comfortable for the mourners and their visitors, ideally it should be observed in the house of the deceased, with the family sitting together. Where a person has lived, say the Sages, the spirit of that person continues to dwell for some time:

> It is, after all, in that home that one is surrounded by all the tangible remains of a person's lifework, and it is only right that evidence of his life should be evident during shiva. It is therefore permitted to travel even long distances after the funeral in order to accomplish this. This is true even if no one has lived but the deceased, and even if there are no mourners present; his spirit is there.

If this cannot be accomplished or is not suitable in present circumstances, the first alternative is to hold shiva in the

Healing Bit by Bit

The natural antidote to suffering piecemeal is healing piecemeal. The strategy of healing during shiva is not to reduce the severity of sadness but to confront the source of sadness: the death. By confronting the fact of death and our specific loss – frontally, shorn of the typical niceties of social life – we mourners ultimately find comfort through suffering. Only by exposing our wounds to the open air and the light of day can we achieve timely closure. We get to the other side of the life cycle not by going under or by going over, but by going through.

The life now extinguished is examined in these days of fresh mourning, fragment by fragment. Bumping into the odds and ends of memory is not an annoyance, not an aggravation of an already painful situation, but a necessary step in reorientation. This is plainly observable and good theory, too. Freud, in his classic essay "Mourning and Melancholia," empathized and reemphasized that the "work" of grief is in fact the slow resolution of the bits of grief the mourner suffers – the meticulous process that must be performed piecemeal.

Rummaging in the Closets of Yesterday

Facing our grief acknowledges the value of certain practices, not directly taught by Jewish law but implicit in its style. During shiva, especially in the home of the deceased, mourners may examine the drawers and closets that hold the treasures and the trivia of the departed's life. Some find that it is too soon after death to do this. Some can never do it by themselves but ask others to dispose of everything. There is no mandate either way; grievers should function on their own level of comfort in such matters.

We go through life leaving clues from room to room, whether what we do is noble or trivial, foolish or wise. The clues are always there if we look hard enough; they are either the inanimate evidence of physical left behinds – the letters

by religious fiat. Therefore, the final halakhic decision in a dispute over mourning practices follows the lenient position. Also, for example, in the laws of mourning, the principle inheres that "a partial day is equivalent to a full day." This means that a full "day" of shiva is downsized to a partial day – an hour or two. That is why the first day of shiva, which begins directly after the cemetery service, is nonetheless considered a full day of mourning, even though only a few minutes of daylight may be left. That is why shiva ends early in the morning on the seventh day, and this, too, is considered a full day.

This concept allows mourners to expand or compress the seven-day period to fit their inner need. Because the law is flexible in dealing with the grieving heart, it wondrously facilitates mourners in adapting to a rearranged universe, especially mourners at the two extremes – those believing themselves strong enough to dispense with grief and those that are to weak to manage the rigors of the grief period. It can accommodate mourners who have conflicting emotions and behaviors, seeking both solitude and sharing with others at one and the same time.

Grief Breaks into a Thousand Pieces

We tend to view mourning as a single unwieldy burden, a heavy load that we struggle under and are sure will finally wear us down. We just want to unload the heaviness from our hearts. But grief is likely to be triggered more by small details than by a solitary emotional upheaval.

During shiva, we stumble over seemingly insignificant things that stop us cold: an article of clothing, a familiar gesture, a sensitive touch, a giggle, a tone of speech, an article of faith, a preposterous mispronunciation. These trifles unexpectedly detonate explosions of memories, forcefully transporting us back to roads we thought we had already trekked.

home of the family member recognized as the head of the family (*g'dol ha'bayit*), who stand in place of the deceased parent. This replicates a traditional family structure into which we can reinsert ourselves as we did in our youth, learning – in that environment – to be empowered to leave that haven and proceed courageously to the next step of life.

In some cases, mourners come to sit elsewhere with other family members, helping those beyond the immediate family rescript the future. On this level, the halakhah, Jewish law, provides boundaries, a space, to enable mourners to reorient themselves, even as we act out our disorientation.

During shiva mourners collide with clusters of the deceased's life: clothes, favorite pictures, furniture, hobbies, the accumulated stuff of life. In this collision, we are pressured to make an accurate measure of our distance from the departed, to locate our own life by reorganizing the very place we always met. In this way, we connect with reference points for reorientation, for learning where we are now and the direction we will be taking.

The deceased's soul is "present" in the deceased's home, hovering over the sadness and kindness. Jews of every kind, over a wide span of centuries, in a variety of Jewish communities, have found this idea comforting. In a contemporary sense, however, we can also see that the deceased's home – or the mourner's home – is the most natural place for us to reset our inner compass. Within the compressed experience of shiva, and within the invulnerable shield of our homes, we can recover our bearings and reformulate our lives. Call it "Habitat Shiva."

Adjusting the Focus

There is yet another way of appreciating the many-sided brilliance of "Habitat Shiva." It is illuminated by our understanding of people, such as mourners, in transition. The anthropologist Victor Turner calls the transitional stage

"liminality," meaning "threshold" – as "subliminal" means "below the level of consciousness."

Using Turner's concept, the mourner is a liminal person, literally on the threshold between one phase of life and the next. For example, in ancient tribal custom and often in modern practice, a person in transition from puberty to adolescence is in a state of liminality – living neither in the past nor yet in the future – and he or she exhibits strange characteristics common to all beings in a state of transition. In many cultures, liminal people may wear no distinctive dress that might reveal class or social standing, may not speak at all, may have no conjugal relations, may be mandated into total inaction, may allow their hair and nails to grow, and may exhibit no concern for social etiquette. the syndrome of liminality is characteristic of people in deep a transitional stage.

As mourners observing shiva, we are demonstrating a similar state of transition. We are no longer individuals belonging to a special class - we tear the fabric of our clothing to testify to that. We do not shave, we allow hair and nails to grow, we are bidden to be unconcerned with the niceties of etiquette – to not say hello or good-bye, but to grunt instead. We are forsworn from conjugal relations, and our posture guarantees passivity – we "sit" shiva. It is as though we were caught in a long, dark serpentine hallway between two well lit rooms. Before we emerge, we must brush aside the externals and everyday routines so that we can focus our acute awareness on surviving this transition and reaching the future. In a liminal sense, this hallway is a birth canal, a passage between one world and the next.

In this intermediate "no place," housed in the habitat for healing, mourners begin to acclimate to a future without the deceased and adjust their focus to the new environment they expect to find when finally they emerge from shiva.

Maneuvering for Stability

There are strange hidden remedies crouching shyly in the

Suddenly, from the moment we return from the internment, we are channeled. To the grid of normal religious acts are added a cluster of customs specifically designed to express bereavement. The anonymous medieval author of *Sefer ha'Chinuch* says that the human purpose of these observances is that as mourners we act out our grief – not merely by expressing it through persuasion or right thinking but also by performing symbols and acting out the mood of grief, thereby weaning ourselves away from anguish. We go from the undisciplined savagery of death to the highly disciplined laws of mourning, and that is how we orient ourselves and return to family and society.

The Elastic Soul of Mourners

The elegant ritual of shiva is ingeniously designed to embrace not only the despair of mourners but the emotional and rational contradictions that are endemic to bereavement as well: denial and acceptance; solitude and shared grieving; silence and talkativeness; crying out against fate yet justifying God; and swinging wildly from spiritual negation on the first day to slowly realized spiritual affirmation on the days and weeks that follow. Shiva is superbly flexible, elastic enough to accommodate the wide variety of passionate responses to death, and halakhically tolerant of conflicting emotions and ideas.

This appreciation of the sometimes volatile nature of morning is expressed by the halakhah's form code, which, in circumstances such as death, is intentionally made malleable. The rabbis, it could be said, were strict in enforcing the leniency of bereavement. The otherwise firm religious laws of living had to be tailored for the comfort of mourners. Life could not simply continue to be business as usual. When reality became taut, the Sages taught the wisdom of relaxing the strictures.

The Rabbis realized that a person's fiery emotions, passions, and hysteria could not be rigidly bound by

shadows of Habitat Shiva that promote the healing of grief in curious ways. These remedies are implicit in the observances of shiva, though we may be unaware of them.

I was once trekking up the base of a mountain in Vail, Colorado, when I came upon a long creek and could not get around it. The water was frantic but shallow. I found a path of stones balanced on other stones by which to cross the creek. As I stepped on the stones, I found they were shaky and would tip from side to side. With every stone, I had to switch from one foot to the other, back and forth, until I found my equilibrium. I could never have maintained my balance standing still; I had to move in rapid tilts to get from one side to the other.

For me, this was a graphic illustration of how we must keep our balance in life as we cross troubled waters. While we need to hold our heads high, experience teaches that to restore our equilibrium and get through tumultuous days, we may need to tilt and adjust, tilt and adjust, until we get to firm ground. Jewish law uses this very paradigm for overcoming the tumult and disorientation of grief. Imperceptibly, it insinuated into the mourning process a surprising, even radical tilting of roles, of time, and of space.

Role Reversal

The medical breakthroughs of our age have altered the nature of dying, transforming it from catastrophic death to degenerative death. Lingering illness increasingly burdens relatives for longer periods of time – caring, worrying, calling, preparing, managing doctors and nurses, and transmitting daily bad news to other relatives. Even those mourners not directly involved in end-of-life matters carry the anticipation of this doomsday as a burden in their hearts for many months. At death, the busyness turns to frenzy, and survivors must make major decisions, arrange the funeral, notify family and friends, and deal with myriad details: with hospitals, mortuaries, synagogues and cemeteries.

Suddenly, the funeral and burial are over, the mourners

mourning. In truth, it is liberating because being home enables us to go back into our selves, to surround ourselves with people with whom we have affinity; and, what is more, much more, in this Habitat Shiva that encloses the start of our new life we begin to receive intimate guidance on every detail of mourning observance, an ancient tradition. Mourners are often at a loss over what is proper and appropriate, but Jewish law and tradition provide a strong hand that limits and guides, bringing enormous comfort.

Essayist G. K. Chesterton illustrates this beautifully. Picture a plateau the size of a small house ten thousand feet above sea level. There are five children and a ball in this space. Where on this plateau are the children? They are huddles in the center, and the ball is not in play because the children are afraid that as they chase the ball they might fall off the mountaintop. Out of nowhere a helicopter lowers a fence that encircles the plateau. Where are the children now? Playing ball from one ledge to the other. The fence protects them from possible catastrophe.

Limitations keep us on a straight path, guide us, and require of us no effort. As Ralph Waldo Emerson observed, society's taboos are the guardrails on the bridge that spans the dangerous seas and prevent our drowning in our own excesses. So the mourners, limited to the confines of walls, family and friends, and constricted from the broad space of work and travel – the playing fields of society – are held firm, convalescing in familiar arms.

The second level is the "space switch" that we as mourners experience in the sudden change in the texture of religious observances from one day to the next. During the brief time between death and burial, all rituals are lifted from our shoulders. No prayers are required, no time-oriented, positive, religious practices need be observed, and even simple blessings are not permitted. We are encouraged to roam free over the day, possessed by our wild imaginings, suffused with gloom, and frenetic with the busyness of preparations.

recede from the fresh grave. And, just as suddenly, the tables are turned – they become death's victims and are at the center of concern, receiving all the compassion that until now was showered on the deceased. The transformation ritual is graphic and precise: Those at the gravesite form parallel rows leading out of the cemetery, and the mourners wend their way through the line, receiving the muttered greetings of consolation. Halakhah, Jewish law, made this specific moment a formal boundary in the burial ritual. Until the grave is covered and the interment is completed, every aspect, including the eulogy, must be directed to the deceased, the center of concern. But after the interment, everything undertaken must be supportive of the living.

The role of the survivors has dramatically reversed. The dying patient was the victim; now the mourners are the victims. The patient may have withdrawn gradually before death; now the mourners withdraw to the place of shiva. The patient may have been visited by the mourners; now the mourners are visited by others. the comforters become the comforted; the active turn passive; the ones who gave find themselves given to; those who fed the sick now find themselves being fed. In Biblical language, we go from *yekara d'shichva* to *yekara d'hayye* – shifting in a split second from "concern for the dead" to "concern for the living."

This silent turnaround tilts mourners dramatically, forcing them to seek the equilibrium that will enable them to navigate through the turbulence and eventually stand again on firm ground.

Time Warp

Between death and burial, mourners experience compressed time – there is a breathless rush to do everything to perform burial the very same day, or the next. This time is compacted by no less than three biblical commands to avoid leaving the deceased unburied. The consequences of failure, according to

Torah, could turn into one of the most shameful moments of life, an infringement of the respect for the dead. Clearly, this is a time that is expected to be out of joint.

After burial, the velocity of mourning suddenly brakes. With purposeful suddenness, Judaism expands time and forces the clock to run slower. Shiva is slow paced, full of the listening, sitting, and chatting that requires much patience and much endurance. If the process of burial seemed fast, mourning seems too slow. Physically, we dispose of the dead in double time; psychologically we heal slowly. This time warp, built into Jewish mourning, allows grievers to heal at an emotionally healthy pace.

We are accustomed to the effect of jet lag on our internal clocks. It may both fatigue and energize in a crazy-quilt pattern. Similarly, mourning is a lag on our minds. Death is the cost of life; suffering the death of close friends and relatives is the cost of having them. At the moment of loss, everything seems out of joint, feelings seem unexplainable, weeping seems inopportune, and our internal clocks seem thrown into frenzy. We cannot, and should not, combat the strange surges of our emotions, nor do we gain much by trying to explain ourselves to others or to ourselves. Let grief run its course, as it must. It will win, and – if we let it do so – we will win.

Space Switch

For mourners, space, like time, also changes. It may be altered on two levels.

The first is physical. In the case of prolonged illness, there is the dramatic switch from the broad landscape of hospital and cemetery to the narrow confines of a private home. As soon as the parallel lines are formed by family and friends leading mourners away from the grave to the house of shiva, diffused space becomes organized space. We are warmly tucked into home with those dear to us. On the surface this narrowing would seem to be a limiting factor, restricting our

Exhibit 6
Policies & Procedures

ADMISSION CRITERIA AND PROCESS	Effective: 3/1/2019
Patient Services	Policy No.:

PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Shalom will admit any patient with a life-limiting illness that meets the admission criteria.

> **MA State specific**: Limited life expectancy is defined as a prognosis of six (6) months or less life expectancy if the disease runs its normal course and is determined by the Hospice Medical Director and the patient's Attending Physician, if they have chosen one.

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.

> **FL State specific**: In no case shall a hospice patient be refused for admission or hospice services discontinued based on the inability of the patient to pay for such services.

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.

Shalom's admission policy includes the review of the patient's primary insurance plan, such as Medicare, Medicaid, Managed Care, Private Insurance, Worker's Comp or other payment sources including private pay. Shalom's review process includes, but is not limited to, insurance verification of coverage, in-network vs. out-of-network requirements, authorization requirements, deductible amount met and unmet, co-pay, patient liability, and patient's ability to pay as determined by Shalom's Charity Care policy. See Fiscal Management Policy: Charity Care.

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 Medicare Contractor's Local Coverage Determinations (LCDs).

Shalom reserves the right not to accept any patient who does not meet the admission criteria, within the limitations of applicable law and regulations.

A patient will be referred to other resources if Shalom 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 (See Patient Services Policy: Intake and Referral Process)

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, if one has been chosen by the patient/legal representative, and hospice Medical Director, utilizing the standard clinical prognosis criteria found in the Local Coverage Determination guidelines approved by the Medicare Contractor in the region. Medicare-Administrative-Contractors/Who-are-the-MACs

4. The patient/legal representative must desire hospice services, and the focus of care desired must be palliative versus curative.

5. The patient and family/caregiver agree to the hospice plan of care, understand their right to participate in developing the plan of care and sign the consent form for hospice care.

6. 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.

7. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

8. The patient must reside within the geographical area that the organization services.

9. 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.

10. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

11. 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, healthcare 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 Manager / designee 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).

WA State Specific:

The Initial patient assessment will be completed by a registered nurse within seven calendar days of receiving and accepting a physician or practitioner referral for hospice services. Longer time frames are permitted when one or more of the following is documented:

A. Longer time frame for completing the initial patient assessment is requested by physician or practitioner.

B. Longer time frame for completing the initial patient assessment is requested by the patient, designated family member, or legal representative; or

C. Initial patient assessment was delayed due to agency having challenges contacting the patient, designated family member, or legal representative.

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).

   FL State Specific: The assessment process will be initiated within two hours and the admission to hospice expedited subject to having a physician order on hand and the patient/family selecting the hospice option.

   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 "Patient Rights".)

   C. Provide the patient with a copy of the organization’s notice of privacy practices.

"Patient/Family Orientation for Hospice Care" handbook.\

D. Assess the family/caregiver's ability to provide care.

E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

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 provide training to the family or caregiver(s) 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")

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 Interdisciplinary Group, including the Medical Director / Physician designee and Attending physician, if any, and 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 Patient Service Policies: Initial Assessment; Comprehensive Assessment)

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 in the electronic record system.

20. If a patient does not meet the admission criteria or cannot be cared for by Shalom, the Intake/Referral Manager and Clinical Director should be notified and appropriate referrals to other sources of care made on behalf of the patient. In addition, a timeframe for follow up will be established, as needed.

21. 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. Exceptions will not be granted for admission when the patient does not meet LCD guidelines or does not have a life limiting illness. In other instances, if the patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator after consulting with the Compliance Officer, as well as the Clinical Director and/or 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, in compliance with regulations, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, attending physician and Medical Director 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.

ADMISSION CRITERIA AND PROCESS	**Policy Number:**
CHAP Standard(s): HPFC 9.D	
Federal Regulatory Citation:	
State/Local Regulatory Citation: MA 105 CMR 141.208 (C); WAC 246-335-620; FAC 59A-38.004(3)(a)11	
Dates Reviewed/Revised: 3/1/2019; 5/29/2019; 9/1/2019; 10/1/2019; 4/30/2020; 5/1/2020	

CHARITY CARE	Effective: 3/1/2019
Fiscal Management	Policy No.:

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.

Shalom will establish objective criteria and financial screening procedures for determining eligibility for charity care.

The organization will consistently apply the charity care policy.

PROCEDURE

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.

A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

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.

All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

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.

The revised sliding-fee schedule will be presented to the patient for agreement and signature.

After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

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.
The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

CHARITY CARE	Policy Number:
CHAP Standards: CIII.3a	
Federal Regulatory Citation: 418.100(e)	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019	

CHARITY CARE CRITERIA

Shalom is committed to the provision of medically necessary health care services to all persons in need of such services regardless of ability to pay. To protect the integrity of operations and fulfill this commitment, the following criteria for the provision of Charity Care/Financial assistance. Shalom also recognizes there are state legislation which establishes guidance for hospitals to develop sliding fee schedules; however, this same guidance is not applicable to hospices. When state specific legislation exists for hospices in regard to indigent policies, Shalom conforms to state standards. In absence of such legislation, Shalom follows the following set of criteria for Charity Care:

Eligibility Criteria

Charity Care/Financial Assistance is secondary to all other financial resources available to the patient, including but not limited to group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services. The medically indigent patient will be granted Charity Care/Financial Assistance regardless of race, national origin, or immigration status.

In those situations where appropriate primary payment sources are not available or for balances after payments from other sources, patients shall be considered for Charity Care/Financial Assistance under Shalom's policy based on the following criteria:

1. The full amount of Shalom's charges will be determined to be Charity Care/Financial Assistance for patients where their gross family income is at or below 200% of the current federal poverty level.

2. The following sliding fee schedule shall be used to determine the amount that shall be written off for patients with incomes between 201% and 400% of the current federal poverty level. Family is defined as a group of two or more persons related by birth, marriage, or adoption that live together; all such related persons are considered as members of one family.

3. The amount an individual is personally responsible for paying after all discounts, deductions, and reimbursements are applied (including those from insurance and the hospital facility's financial assistance policy shall not be more than the amounts generally billed to individuals who have insurance covering such care ("AGB"). Shalom has elected to use the Medicare Rate in effect for the dates of services to determine the AGB.

4. The responsible party's financial obligation remaining after the application of any sliding fee schedule shall be payable in monthly installments over a reasonable period of time, which Shalom considers no more than two (2) years. The responsible party's account shall not be turned over to a collection agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.

5. Income is defined as total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities.

Charity/Financial Assistance Percentage Discount

% of Federal Poverty Level	Patient Discount %
0-200%	100%
201-300%	75%
301-350%	50%
351-400%	25%

6. For accounts where we have enough information to accurately assess income levels, Shalom will determine if a patient falls below 200% of the federal poverty limits. If so, we will have the accounts scanned for possible DSHS coverage and will presumptively write off the outstanding balances to Financial Assistance for those accounts that do not meet DSHS requirements.

7. Shalom may offer Catastrophic Charity, which means Shalom may write off as Charity Care/Financial Assistance amounts for patients with family income more than 200% of the federal poverty level when circumstances indicate severe financial hardship or personal loss that goes beyond the Charity Care/Financial Assistance discount as outlined above. In these cases, patients should submit a written request for a further review along with the details of the catastrophic situation. The decision to grant Catastrophic Charity and the amount to be written off shall lie with a member of Shalom's Governing Body.

8. All requests for financial assistance will be made on the Charity Care/Financial Assistance forms with instructions, and written applications shall be furnished to patients when Charity Care/Financial Assistance is requested, when need is indicates, or when financial screening indicates potential need. All applicants for financial assistance must file with DHHS (if they meet Medicaid eligibility requirements) and be cooperative with DHHS.

Process for Eligibility Determination

A. Initial Determination:

1. Shalom shall use an application process for determining eligibility for Charity Care/Financial Assistance. Requests to provide Charity Care/Financial Assistance will be accepted from sources such as physicians, community/religious groups, social services, financial services staff, patient's family, and the patient.

2. During the patient registration process, or at any time after the patient has been notified of the existence and availability of Charity Care/Financial Assistance, Shalom will make an initial determination of eligibility based on verbal or written application for Charity Care/Financial Assistance.

3. If Shalom becomes aware of factors which might qualify the patient for Charity Care/Financial Assistance under this policy, it shall advise the patient of this potential and make an initial determination that such account is to be treated as Charity Care/Financial Assistance.

4. Determination of coverage will be dependent upon financial need at the time services were rendered.

5. Shalom will allow a patient to apply for Charity Care/Financial Assistance at any point from pre- admission through discharge recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in the need for charity services. If the change in financial status is temporary, Shalom may choose to suspend payments temporarily rather than initiate Charity Care/Financial Assistance.

6. Patient will receive a letter indicating final determination of Charity Care/Financial Assistance. If the patient is denied assistance, the letter will detail the reason for the denial, the date of decision and instructions to appeal or reconsider decision. Governing body shall review all second level appeals.

Financial Assistance Application

Section 1: Patient/Guarantor Information

Patient's Name: _____ Patient ID#_____

Patient's Date of Birth ___/___/_____ Patient's Marital Status: __Single ___Married

Guarantor Name: _____

Guarantor Address: _____

City_____ State _____ Zip _____

Note: If you are married, then your spouse's financial information and signature is required in order to process your application.

Section 2: Spouse Information:

Spouse's Name: _____

Spouse's Address: _____

City_____ State _____ Zip _____

Spouse's Date of Birth ____/____/_____ (MM/DD/YYYY)

Section 3: Household Information

Number of Dependents (see instructions) _____

Total Monthly Household Income: $_____

Section 4: Acknowledgement

I hereby acknowledge that the above information is true and accurate to the best of my knowledge.

I further grant Continuum authorization to verify any or all information given and authorize a consumer credit report, if necessary.

Patient/Guarantor's Signature: _____ Date: ___/___/_____

Spouse's Signature: _____ Date: ___/___/_____

Section 5: Determination – Office Use Only

_____% Approved Financial Assistance _____ Denied (Include Reason in Notes)

Notes: _____

_____

Authorized Person's Signature: _____ Date: ___/___/_____

Authorized Signer's Title _____

Instructions for Completing the Financial Assistance Form

Section 1. Patient/Guarantor Information

- Patient's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient or guarantor.
- Patient's Date of Birth: Clearly print on the blank line your date of birth.
- Patient's Marital Status: Clearly print single or married.
- Guarantor's Address: Clearly print on the blank line the address where you live including the city, state and zip.

Section 2: Spouse Information (may be skipped if you are single)

- Spouse's Name: Clearly print on the blank line the first name, middle initial, and last name of the patient or guarantor's spouse.
- Spouse's Address: Either clearly print on the blank line the address where your spouse resides or indicate "Same" if you and your spouse reside at the same address;
- Spouse's Date of Birth: Clearly print on the blank line your spouse's date of birth;

Section 3. Household Information

- Number of Dependents: Clearly print the number of dependents in your household you can claim on your taxes (children or adults who you financially provide more than 50% of their living expenses).
- Total Monthly Household Income: Clearly print the amount of income from all sources your household (yourself, your spouse, and dependents) receives monthly (including but not limited to wages, profits from business, rental income from rental properties, social security income (SSI/SSDI), income from investments, estates, trusts, alimony, child support, aid to dependent children, etc.)

Section 4. Acknowledgement

- Form must be signed by Patient/Guarantor, and if married then Spouse must sign.

Patient Rights and Responsibilities

As a hospice provider, we have an obligation to protect your rights and to provide these rights to you or your representative verbally and in writing in a language and manner you can understand, during the initial assessment visit before care is provided and on an ongoing basis, as needed.

YOUR RIGHTS

YOU HAVE THE RIGHT TO:

- Exercise your rights as a hospice patient without discrimination or reprisal for doing so. Your court- appointed representative or the legal representative you have selected in accordance with state law may exercise these rights for you in the event that you are not competent or able to exercise them for yourself.
- Receive information about organization ownership and control.
- 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.
- Be free from mistreatment, neglect, verbal, mental, sexual and physical abuse, corporal punishment, injuries of unknown source and misappropriation of your property. All mistreatment, abuse, neglect, injury and exploitation complaints by anyone furnishing service on behalf of hospice are reported immediately by our staff to the hospice administrator. All reports will be promptly investigated and immediate action taken to prevent potential violations during our investigation. Hospice will take appropriate corrective action in accordance with state law. All verified violations will be reported to the appropriate state/local authorities (e.g., state survey and certification agency) within five (5) working days of becoming aware of the violation.
- Be free from physical and mental abuse, corporal punishment, restraint or seclusion of any form imposed as a means of coercion, discipline, convenience or retaliation by staff while receiving care in a hospice-operated inpatient facility.
- Be treated with respect and consideration; recognition of your individuality and dignity; to 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 handicap. Our staff is prohibited from accepting gifts or borrowing from you.
- Have access to interpreters as indicated and necessary to ensure accurate communication.
- Voice grievances/complaints or recommend changes in policy, staff or service/care regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice without fear of coercion, discrimination, restraint, interference, reprisal or an unreasonable interruption in care, treatment or services for doing so.

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.

- Be advised when you are accepted for treatment or care, of the availability of the state's toll-free home care/hospice hotline number, its purpose and hours of operation. The hotline receives complaints or questions about local home care/hospice agencies and is also used to lodge complaints concerning the implementation of the advance directives requirements. The hotline operates 24 hours per day, 7 days per week. If voicemail answers, please leave a message and your call will be returned. The hotline may be reached at 1-866-247-9100. You may also submit your complaint to Washington State Department of Health, Phone 360.236.4700 or online to www.doh.wa.gov and locate the Contact US for Health System Quality Assurance.

DECISION MAKING – YOU HAVE THE RIGHT TO:

Choose your attending physician and other health care providers and communicate with those providers.

- Be fully informed in advance about the services/care covered under the Medicare or other hospice benefit, the scope of services hospice will provide, service limitations, name(s), discipline and responsibilities of staff members who are providing and responsible for your care, treatment or services, the planned frequency of visits proposed to be furnished, expected and unexpected outcomes, potential risks or problems and barriers to treatment.

- Be fully informed of your responsibilities.

- Be involved in developing your hospice plan of care; and to participate in changing the plan whenever possible and to the extent that you are competent to do so.

- Be advised of any change in your services or plan of care before the change is made.

- Have family involved in decision making as appropriate concerning your care, treatment and services, when approved by you or your surrogate decision maker 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.

- Be fully informed by a physician of your medical condition, unless medically contraindicated.

- Formulate advance directives and receive written information about the agency's policies and procedures on advance directives; a description of applicable state law, including the withdrawal or withholding of treatment and/or life support, before care is provided. 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 or

discrimination after being informed of the consequences for doing so. You may refuse part or all of care/services to the extent permitted by law; however, should you refuse to comply with the plan of care and your refusal threatens to compromise our commitment to quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care.

PRIVACY AND SECURITY - YOU HAVE THE RIGHT TO:

- Personal privacy and security during home care visits and to have your property and person treated with respect. Our visiting staff will wear proper identification so you can identify them.
- Restrict visitors or have unlimited contact with visitors and others and to communicate privately with these persons if you are residing in an inpatient hospice facility.
- Confidentiality of written, verbal and electronic protected health information including your medical records, information about your health, social and financial circumstances or about what takes place in your home.
- Refuse filming or recording or revoke consent for filming or recording of care, treatment and services for purposes other than identification, diagnosis or treatment.
- Access, request changes to and receive an accounting of disclosures regarding your own protected health information as permitted by law.
- Request us to release information written about you only as required by law or with your written authorization and to be advised of our policies and procedures regarding accessing and/or disclosure of clinical records. Our Notice of Privacy Practices describes your rights in detail.

FINANCIAL INFORMATION - YOU HAVE THE RIGHT TO:

- 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.
- 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.

QUALITY OF CARE - YOU HAVE THE RIGHT TO:

- Receive high quality, appropriate care by personnel who are qualified through education and experience to carry out the services for which they are responsible, without discrimination and in accordance with physician orders.
- Receive effective pain management and symptom control from the hospice for conditions

related to your terminal illness(es). You also have the right to receive education about your role and your family's role in managing pain when appropriate, as well as potential limitations and side effects of pain treatments.

- Receive pastoral and other spiritual services.
- Have an environment that preserves dignity and contributes to a positive self-image.
- 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.

YOUR RESPONSIBILITIES

YOU HAVE THE RESPONSIBILITY TO:

- To cooperate with your primary doctor, program staff and other caregivers.
- Obtain medications, supplies and equipment ordered by your physician if they cannot be obtained or supplied by the hospice program.
- Sign the required consents and releases for insurance billing and provide insurance and financial records as requested.
- 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.

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS	Effective: 3/1/2019
Governance and Leadership	

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, sex stereotyping, pregnancy, childbirth and related conditions), sexual orientation, disability (mental or physical), communicable disease, or national origin.

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, Shalom 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, Shalom 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, Shalom 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, Shalom 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 Shalom Care Hospice to comply with the regulations will be the Compliance Officer.

2. Shalom 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. The Clinical Director will maintain the list at each site and ensure its availability to personnel and volunteers. (See "Facilitating Communication" Policy and Organization List of Interpreters Form)

3. A copy of this policy will be posted in the reception area, 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 Shalom 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 60 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 Shalom within 15 days of receiving the Section 504 Coordinator's decision.

12. Shalom 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 Shalom 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. Shalom 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.

NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS	**Policy Number:**
CHAP Standard(s): CI.7	
Federal Regulatory Citation: Section 1157 of the Affordable Care Act (ACA) of 2010	
State/Local Regulatory Citation:	
Dates Reviewed/Revised: 3/1/2019, 2/28/2020	

	Medical Aid in Dying	Effective: 3/1/2019
		Policy No. H:2-074-1.1

PURPOSE

To provide general guidelines for supporting hospice patients who live in a state with legal medical aid in dying regulations and who express interest in this option or who acquire life-ending medication per their state regulations.

POLICY

Shalom Care Hospice recognizes the patient's right to make choices that fit his/her personal goals of care, values and beliefs. That right extends to the legal right under various state laws such as California's End of Life Option Act and Washington State's Death with Dignity Act to end their lives with prescribed medication. No patient will be denied Shalom Care Hospice services based on interest or active participation in these Acts.

Current hospice patients who express interest in these Acts will be given the opportunity to explore their reasons further with the interdisciplinary team. Hospice staff members and volunteers will be helped to explore their own beliefs and values and will be educated in responding respectfully to patients.

Staff members or volunteers who prefer for their own personal reasons not to work with patients who intend to pursue or participate in a state's medical aid in dying act will be allowed to opt out of providing care.

PROCEDURE

All staff will be provided education on their state's respective medical aid in dying act and the agency's policy. The following will be reviewed with all staff:

- Patients Rights as relates to their state's respective medical aid in dying act
- Agency position
- Shalom Care Hospice physician involvement
- Employee/Volunteer rights

Shalom Care Hospice's management team recognizes that each individual employee/volunteer will need to thoughtfully consider whether it is within their personal ability, values and beliefs to provide care for patients who are requesting medication to hasten death. It is not the intent of Shalom Care to assume staff/volunteer involvement. It is the employees' or volunteers' responsibility to inform their manager of concerns or reluctance around caring for patients who are requesting to participate in their state's respective medical aid in dying act.
Employees/volunteers who choose to opt out of providing care will request a reassignment from

their supervisor. These employees/volunteers will work to ensure patients do not feel devalued or abandoned.

No employee or volunteer shall attempt to influence in any way another employee or volunteer in his/her beliefs or opinions regarding their state's respective medical aid in dying act. The agency will fully respect the personal beliefs of all employees and volunteers without question or discrimination.

ADDENDUM WASHINGTON DEATH WITH DIGNITY ACT SHALOM CARE HOSPICE PROTOCOL

General Statement

Shalom Care Hospice (Shalom) continues to recognize its mission to support patients and families through the end of life, allowing patients to control their own journey as long as physically/mentally able. Shalom elects to follow a "partial participation stance" with the Washington Death with Dignity Act.

Partial participation stance is defined as:
The agency's medical staff may not serve as attending physicians under the Act, but may serve as consulting physicians. Agency staff will refer patients to an outside resource, such as Death with Dignity.org or Compassion & Choices.org, for guidance throughout the process.

Provision

No Shalom Care employee, volunteer or physician under contract will provide, deliver, administer, or assist with the administration of any medication to a Shalom patient that is intended as life-ending medication. No Shalom employee, volunteer or physician under contract may serve as a witness on the written request for life-ending medication.

Patients

Shalom will not refuse to admit or continue to care for patients who openly declare their interest in the Death with Dignity option.

Patients will be encouraged to share with their family members their interest and feelings in regards to the Death with Dignity medication.

Shalom employees will continue to honor and not violate a patient's right to confidentiality by informing the patient's family against the wishes of the patient.

Shalom Care Physicians

Physicians under contract with Shalom will not prescribe life-ending medication for patients receiving hospice services through Shalom Care Hospice.

A Shalom contracted physician may serve as a "consulting physician" for patients as defined in the Act.

- "Consulting physician" means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and

prognosis regarding an individual's terminal disease.

Employees/Volunteers

No employee of Shalom will encourage or discourage a patient's request nor communicate a value judgment about the patient's choices as related to the Death with Dignity Act.

Hospice team members may offer general information and education about the Death with Dignity Act upon patient or family request.

Upon patient or family request, hospice team members may choose to be present at time of the self-administration of the medication and remain to support the patient and family through the death. If the team member chooses not to be present, Shalom will offer the patient and family other team members to be present so there will always be support as the patient and family desire.

Exhibit 7
Financial Pro Forma and Assumptions

Hospice ProForma Profit and Loss
Shalom Hospice of Southwest Washington LLC

	2026	2027	2028	2029
Admissions	107	177	214	244
ALOS	59.79	59.79	59.79	59.79
Average Daily Census	21.0	29.0	35.0	40.0
Total Days (rounded)	6,398	10,583	12,795	14,589
General Inpatient Care	23	38	46	53
Inpatient Respite Care	1	2	3	3
Routine Home Care	6,374	10,543	12,746	14,534
Continuous Home Care	-	-	-	-
Total Days by LOC	6,398	10,583	12,795	14,590
Revenue				
	65% at 1-60 days/35% ALOS > 60 Days	65% at 1-60 days/35% ALOS > 60 Days	65% at 1-60 days/35% ALOS > 60 Days	65% at 1-60 days/35% ALOS > 60 Days
Medicare	1,405,990	2,325,742	2,812,133	3,207,089
Medicaid	61,676	102,018	123,339	140,646
Commercial	92,589	153,149	185,155	211,139
Self Pay & Other	24,858	41,116	49,707	56,680
Gross Revenue	1,585,113	2,622,025	3,170,334	3,615,554
Contractual Adjustments	(55,479)	(91,771)	(110,962)	(126,544)
Operating Revenue	1,529,634	2,530,254	3,059,372	3,489,010
Avg. Daily Rate	$ 239.08	$ 239.09	$ 239.11	$ 239.15
Deductions from Revenue				
Charity Care	(24,858)	(41,116)	(49,707)	(56,680)
Provision for Bad Debts	(30,096)	(49,783)	(60,193)	(68,647)
Deductions from Revenue	(54,954)	(90,899)	(109,900)	(125,327)
TOTAL REVENUE	**1,474,680**	**2,439,355**	**2,949,472**	**3,363,683**
Patient Care Costs				
Salaries and Benefits				
Hospice Employees	541,835	839,151	1,013,715	1,159,645
Payroll Taxes and Benefits	113,785	176,222	212,880	243,525
Total Salaries and Benefits	655,620	1,015,373	1,226,595	1,403,170
Contracted Services	384	635	768	875
Pharmacy - Medications & IV Supplies & Lab	42,867	70,906	85,727	97,753
DME Costs (Equipment, oxygen)	56,942	94,189	113,876	129,851
Medical Supplies	28,919	47,835	57,833	65,947
Other Direct Costs	1,069	1,771	2,138	2,443
General Inpatient Costs	24,815	40,998	49,630	57,182
Inpatient Respite Costs	595	1,191	1,786	1,786
5% R&B Expense	3,836	10,576	12,786	20,411
Mileage	17,109	28,352	34,217	39,106
Total Patient Care Costs	832,156	1,311,826	1,585,356	1,818,524

** Please note that there is rounding to the nearest whole number which may impact summaries though are immaterial for accounting purposes

Hospice ProForma Profit and Loss
Shalom Hospice of Southwest Washington LLC

	2026	2027	2028	2029
Administrative and Facility Costs				
Salaries				
Administrative Employees	729,803	724,500	800,625	874,125
Payroll Taxes and Benefits	153,259	152,145	168,131	183,566
Total Salaries and Benefits	883,062	876,645	968,756	1,057,691
Advertising	4,557	7,552	9,114	10,416
Auto (cars, gas, parking, tolls) + Admin Mileage	4,431	7,343	8,862	10,128
Amortization	6,556	7,867	7,867	7,867
Bank svc charges	19	31	38	43
Payroll svcs & Recruiting	20,286	33,617	40,572	46,368
Background Screening/Pre Emp Health	4,895	8,112	9,790	11,189
Business Licenses and Permits	1,390	2,304	2,780	3,178
Computer and internet	800	1,326	1,600	1,829
Dues & Subs	1,019	1,688	2,037	2,328
Insurance	15,408	25,533	30,815	35,218
Legal & Prof fees	38,434	4,308	5,200	5,942
Meals and Entertainment	1,323	2,192	2,646	3,024
Office exp and supplies	13,178	21,837	26,355	30,120
Other Cost				
Rent & Operating Costs	33,300	34,512	35,724	36,936
Repairs/Maintenance/Janitorial	2,173	2,638	2,646	2,653
Software	3,921	6,498	7,842	8,963
Taxes (Includes B&O and Permits)	28,532	47,196	57,066	65,080
Phone	10,889	18,044	21,777	24,888
Travel	1,541	2,554	3,083	3,523
Uniforms	483	800	966	1,104
Contracted administrative services	111,500	68,840	68,840	68,840
Miscellaneous	1,931	2,360	2,768	3,108
Total Other Admin Costs	306,566	307,152	348,388	382,745
Total Administrative Costs	1,189,628	1,183,797	1,317,144	1,440,436
Total Costs	2,021,784	2,495,623	2,902,500	3,258,960
Income (Loss) from Operations.	(547,104)	(56,268)	46,972	104,723

** Please note that there is rounding to the nearest whole number which may impact summaries though are immaterial for accounting purposes

Hospice Balance Sheet
Shalom Hospice of Southwest Washington LLC

	2026	2027	2028	2029
Assets				
Current Assets				
Cash	119,531	10,393	42,706	138,891
Accounts Receivable	182,123	251,050	303,550	346,179
Allowance for Doubtful Accounts	(3,642)	(5,021)	(6,071)	(6,924)
Prepaid Rent				
Total Current Assets	298,012	256,422	340,185	478,146
Leasehold Improvements	35,807	35,807	35,807	35,807
Furniture & Equipment	82,193	82,193	82,193	82,193
Accumulated Depreciation/Amortization	(6,556)	(14,423)	(22,290)	(30,157)
Total Property & Equipment	111,444	103,577	95,710	87,843
Other Assets				
Security Deposit	5,000	5,000	5,000	5,000
TOTAL ASSETS	414,456	364,999	440,895	570,989
Liabilities				
Current Liabilities				
Accounts Payable	96,620	100,601	117,858	133,017
Payroll Liabilites	69,940	72,770	84,437	94,649
Credit Cards Payable	45,000	45,000	45,000	45,000
Total Current Liabilities	211,560	218,371	247,295	272,666
TOTAL LIABILITIES	211,560	218,371	247,295	272,666
Equity				
Members' Contributions	750,000	750,000	750,000	750,000
Members' Distributions				
Net Income	(547,104)	(56,268)	46,972	104,723
Retained Earnings	(547,104)	(603,372)	(556,400)	(451,677)
TOTAL EQUITY	202,896	146,628	193,600	298,323
TOTAL LIABILITIES & EQUITY	414,456	364,999	440,895	570,989

** Please note that there is rounding to the nearest whole number which may impact summaries though are immaterial for accounting purposes

Shalom Hospice of Southwest Washington LLC

Financial Assumptions

Revenue Rates:

Level of Care	2026 Estimated Medicare Rates	2026 Estimated Medicaid Rates
1-60 days	$259.99	$259.99
61+	$204.78	$204.78
Cont HC (per hour)	$79.26	$79.26
Respite	$595.46	$595.46
GIP	$1,348.63	$1,348.63
R&B Rate	$401.24	
Service Intensity Add On	$79.26	

*** R&B Rate is based on the Average Medicaid Rate for Clark County SNF Rates**
*** SIA Amounts in Financials are assumed to be .013% of Routine Medicare Revenue Only**
*** Estimates used 2025 actual rates plus 3% increase based on average annual increase in rates in recent years**

Level of Care

Level of Care	Percent of Total Days
General Inpatient Care	0.36%
Inpatient Respite Care	0.02%
Routine Home Care	99.62%
Continuous Home Care	0.00%

Please note that Medicare and other insurances pay per diem (daily rate or based on 1 calendar day) for the levels of care. Shalom used Excel to round the level of care days to full days, which may vary slightly from the Total Days when calculated from Average Length of Stay times the Average Daily Census due to that full-day rounding.

Line Item	Assumption
Rounding	For reporting of numbers, Shalom rounded to the nearest dollar using Excel. So when manually calculating, there may be immaterial differences in the results due to this rounding. The pro forma financials have been hand-keyed. As such, there are some rounding in both census (patient days and ADC) as well as the estimated dollars.
Contractual Adjustments	Approximately 3.5% of total gross revenue.
Charity Care	Assume 100% Self Pay
Bad Debt	2% of total operating revenue reduced by charity care.

Line Item	Assumption
Salaries and Benefits	Based on FTE and staffing, benefits are assumed to be 21% of salaries.
Contracted Services	For PT/OT/SP/RT/Nurse/dietician/IV services; assumed to be $0.06/per patient day (PPD). Shalom has not previously experienced contracting for Nurse services as we utilize part time staff; however, we have contracts in place for contingency.
Pharmacy	Assumed to be $6.70/PPD
DME	Assumed to be $8.90/PPD
Medical Supplies	Assumed to be $4.52/PPD
Other Direct Expenses	Assumed to be $5.09 per patient per month (includes ambulance, chemotherapy, imaging, lab, radiation, transport)
General Inpatient Costs	Assumed GIP expense at 80% of the GIP rate, or $1,078.90 PPD. Due to the census rounding, even a 0.5 patient day difference equates to about $539 difference in the total costs.
Inpatient Respite Costs	Pass thru cost.
5% room and board expense for Medicaid patients in nursing homes receiving routine care	3% of routine patient days are assumed for room and board pass through for 2026, 5% for 2027 & 2028, and 7% for 2029. Room and Board rate assumed to be $401.24 and is based on the State of Washington, DSHS/Aging and Disability Services Administration Current Rate Report Run Date: November 1, 2024 using Clark County average nursing home Medicaid rate. Assumes Medicaid reimburses 95% of the rate. Assume no increase in the rate.
Mileage	Assumed $81.47 X ADC X 12 Months

Line Item	Assumption
Administrative & Facility Costs	Non direct clinical staff including but not limited to Medical Director, Bereavement Coordinator, Volunteer Coordinator, Clinical Director, Office Manager, Administrator/Executive Director, Intake, Team Coordinator, and Marketing. Benefits are estimated at 21% of salary.
Advertising	Assumed to be $21.70 per patient per month.
Auto (cars, gas, parking, tolls) + Admin Mileage	Assumed to be $21.10 per patient per month
Amortization	Amortization of capitalized office equipment, software, and leasehold improvements over 15 years estimated useful life
Bank Service Charges	Assumed to be $0.09 per patient per month.
Payroll Services & Recruiting	Assumed to be $96.60 per patient per month. This includes all Payroll Processing fees, recruiting such as job boards, recruiting services, and recruiting incentives.
Background Screening	Assumed to be $23.31 per patient per month
Business licenses and permits	Assumed to be $6.62 per patient per month
Computer / Internet	Assumed to be $3.81 per patient per month
Dues/Subscriptions	Assumed to be $4.85 per patient per month
Insurance	Assumed to be $73.37 per patient per month based upon current experiences in Snohomish County with State Workers Compensation and other insurance policies (such as General & Professional, E&O, etc). Please note that Professional Liability coverage includes Medical Director. The Worker's Comp rates are based on Employee Hours by Job Classification.

Line Item	Assumption
Legal, Professional Services	Assumed to be $12.38 per patient per month. In 2026, an additional $35,834 has been assumed for certificate of need related expenses and other startup costs
Meals and entertainment	Assumed to be $6.30 per patient per month.
Office Expenses & Supplies	Assumed to be $62.75 per patient per month.
Rent & Operating Costs	Rent and operating costs are based on the lease agreement in Attachment 6.
Repairs, Maintenance, Janitorial	Assumed costs are janitorial at ($50 per week/52 weeks) and Repairs/Maintenance of (.11 per patient per month)
Software	Assumed licensure fees of $45/month per user (user determined by ADC/2.4)
Taxes (Includes B&O and Permits)	Assumed to be .018 X Total Revenue
Phone	Assumed to be $51.85 per patient per month
Travel	Assumed to be $7.34 per patient per month
Uniforms	Assumed to be $2.30 per patient per month
Shared Services Agreement	Includes .1 FTE allocation for each of several key administrative staff (COO, Chief Compliance Officer, CFO, Triage) for 2026. In years 2027 - 2029, this is reduced to .056 FTE each. In addition, $12,000 annually has been allocated for billing, accounting, and other overhead, except in the first half year, which is assumed to be $10,000.

Line Item	Assumption
Miscellaneous	Estimated 1% of indirect costs (Advertising, Auto and mileage, amortization, Bank charges, Payroll Services & recruiting, Background Screening, Business Licenses and Permits, Computer & Internet, Dues & Subscriptions, Insurance, contracted admin services, Legal & Professional, meals and entertainment, office Expenses & Supplies, Rent & Operating Costs Allocation, Repairs/Maintenance/Janitorial, software, Taxes, Phone, and Travel) to cover unplanned expenses, and atypical expenses, such as but not limited to After Hours maintenance fees, additional fees and expenses related to COVID, overages on utilities, increases in or new taxes and licensing fees, Meals/Snacks, seminar, etc.

Exhibit 8
Medical Director Job Description

Job Title/Position: *Hospice Medical Director*

Reports To: *CEO/Executive Director/Administrator or Chief Clinical Officer (CCO)*

JOB DESCRIPTION SUMMARY

The hospice Medical Director will have overall responsibility for the medical component of the hospice program.

The hospice Medical Director will provide oversight of physician services by complementing attending physician care, acting as a medical resource to the interdisciplinary group, assuring continuity of hospice medical services, and assuring appropriate measures to control patient symptoms. The Medical director will serve as a hospice champion – promoting and representing the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.

ESSENTIAL JOB FUNCTIONS/RESPONSIBILITIES

The duties and responsibilities of the Medical Director will include, but not be limited to, the following:

1. Devoting his/her best ability to the proper management of the program

2. Providing overall medical direction to the program

3. Assuring that the established policies, bylaws, rules, and regulations of the organization are followed in the program

4. Adhering to requirements, terms, and conditions required by Medicare Conditions of Participation, accrediting body, and federal and state statutes governing the provision of services

5. Establishing and continually reviewing policies and procedures related to patient care, medical education, and emergency procedures

6. Developing and continually reviewing, in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director, criteria to monitor the quality of the education programs provided to physicians, personnel, and volunteers

7. Evaluating quality assessment performance improvement (QAPI) plans and monitoring to identify medical education needs in cooperation with the CEO/Executive Director/Administrator and/or Chief Clinical Officer/Clinical Director. Participates in QAPI teams and activities, as needed

8. Proposing organizational programs to address the needs identified (with the assistance and input of consultants of the specialties where medical education needs were identified)

9. Working with the CEO/Executive Director/Administrator and/or CCO/Clinical Director, after implementation of the programs, to determine the impact of said programs on the quality of care

10. Serving as a hospice champion in the community

11. Acting as a liaison to community physicians by providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care

12. Acting as medical liaison with other physicians at CONTINUUM CARE HOSPICE, LLC

13. Providing training regarding the medical aspects of caring for terminally ill patients to physicians, personnel, and volunteers

14. Reviewing patients' medical eligibility for hospice services, in accordance with hospice program policies and procedures, and establishing the plan of care in conjunctions with attending physician and interdisciplinary group prior to providing care written certification of terminal illness

15. Reviewing the clinical record and/or perform a medical examination to confirm the appropriateness of services

16. Reviewing necessary data from the referral source in order to validate the diagnosis and life-limiting prognosis established by the attending physician

17. Reviewing the clinical record and/or performing a medical examination to confirm the appropriateness of services

18. Providing written certification of the terminal illness for all subsequent benefit periods

19. Performing face-to-face encounters within thirty (30) days of the third and subsequent hospice benefit certification periods and attest to the encounter. (NP may complete the encounter and report findings to the hospice physician.)

20. Consulting with attending physicians regarding pain and symptoms management for hospice patients

21. Managing oversight of the patient's medications and treatments

22. Acting as medical resource to the hospice interdisciplinary group

23. Attending interdisciplinary group meetings and working in a team approach with the group

24. In conjunction with the attending physician and interdisciplinary group, reviewing and updating the plan of care at least every 15 days, or more frequently as needed

25. Assisting in the development and implementation of the plan of care that is coordinated with the attending physician

26. Documenting care provided in the patient's clinical record, providing evidence of progression of the end-stage disease process.

27. Insuring the availability of physician services and providing a substitute in the absence of the attending physician.

28. Maintaining current knowledge of the latest research and trends in hospice care and pain/ symptom management

29. Reviewing and developing protocols for treatment, and proposing the most current options for interventions

30. Demonstrating knowledge in communications, and counseling patients and family/caregivers dealing with end-of-life issues

31. Participating in resolution of interpersonal conflict and issues of clinical and ethical concern

32. Ensuring that competent physician services are routinely available on a 24-hour basis to meet the general medical needs of the hospice patient to the extent the needs are not met by the attending physician

33. Assisting with evaluation of protocols and procedures with respect to quality and cost outcomes

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

POSITION QUALIFICATIONS

1. Licensed as a Doctor of Medicine or Osteopathy in the state without restriction or subject to any disciplinary or corrective action.

2. Maintains controlled substances registration with state and federal authorities.

3. Have experience in hospice or palliative care and/or training in end of life care.

4. Participates in ongoing medical education activities related to the medical care of hospice and palliative care patients.

5. Not excluded from participating in the Medicare program

_____ _____

Employee Signature Date