Received by Certificate of Need Program
January 31, 2024
-Jules Kolln

Shalom Hospice of Puget Sound LLC
Certificate of Need Application
to
Establish a Medicare Medicare/Medicaid Hospice Agency in Kitsap County

January 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:** January 28, 2024 **Telephone Number:** 510.499.9977
Legal Name of Applicant: Shalom Hospice of Puget Sound 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:** $115,000
Identify the county proposed to be served for this project: Kitsap 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 Puget Sound LLC (Shalom).
Shalom is registered with the Washington Secretary of State. The Governors of the LLC are the Stern Family (SYGS) 2023 Trust (90% ownership) and Samuel Stern (10% ownership).

The address of Shalom is:

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

Physical:
19352 Viking Avenue NW
Poulsbo, WA 98370

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 605-376-453. An organizational chart detailing the relationship between Shalom and its related parties will be provided with the screening response.

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).**

This question is not applicable.

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 Puget Sound LLC is one of a number of hospice agencies owned by Samuel Stern and/or the Stern Family Trust. Mr. Stern and his trust operate sister hospice programs under the name of Continuum Care, Affinity Care or Shalom Hospice in six states. These states include Florida, Washington, New Jersey, Virginia, Tennessee, and Ohio.
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 Puget Sound LLC

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

Physical:
19352 Viking Avenue NW
Poulsbo, WA 98370

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.*

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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 Medicare and Medicaid patients. We also will demonstrate that Jewish residents are underserved and will further demonstrate, that declining hospice use rates have resulted in a diminishment of services that has triggered a general underservice for all County residents at the end of life.

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, in any time frame, in any situation.

While Medicare does not collect data on use of hospice by religion, we know both nationally and in Washington that few agencies have policies or staffed that are trained in or aware of Jewish rituals and traditions. Few offer strong rabbinic support. None of the existing Kitsap agencies provide this support, and persons of the Jewish faith must decide on foregoing hospice or choosing one that does not honor their faith.

Shalom will also serve all residents of Kitsap County that meet Medicare requirements and choose to be cared for by our Agency. The Washington State Department of Health's most recent surveys of hospice agencies and hospice methodologies show some concerning trends statewide that have affected hospice access; and these trends are even more pronounced in Kitsap County. When the most recent three-year hospice admission data and the resultant use rate is compared over time, significant reductions in use rates, both for the 65+ and the under 65 populations are identified statewide and even more significantly in Kitsap County, making the County as a whole underserved. As described in more detail in the Need section, Shalom is well-equipped to also address this general hospice underutilization in the County.

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 Kitsap County.

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

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

Event	**Anticipated Month/Year**
CN Approval	September 2024
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 2025

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 Kitsap 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).

Shalom is new to Washington State. Related organizations, including Continuum Snohomish and Continuum King 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.

Shalom will serve all patients in need of hospice desiring to be cared for by our Agency. 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 Kitsap County.

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.

We will also see *National Institute for Jewish Hospice* accreditation. No hospice in Kitsap County currently holds this designation.

Section 3
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.**

The projected utilization is detailed in Table 1:

Table 1
Projected Patient Days and Admissions, 2022-2025 by County

Kitsap	2025 Partial Year	2026	2027	2028
Total number of admissions	68	121	185	245
Total number of patient days	2,185	7,394	11,305	14,972
Average daily census	12.0	20.3	31.0	41.0

Source: Applicant

Specific assumptions include:

ALOS: In all years except the start-up year, Shalom has assumed the ALOS would be 61.11. which is the Washington State average from the Department's methodology.

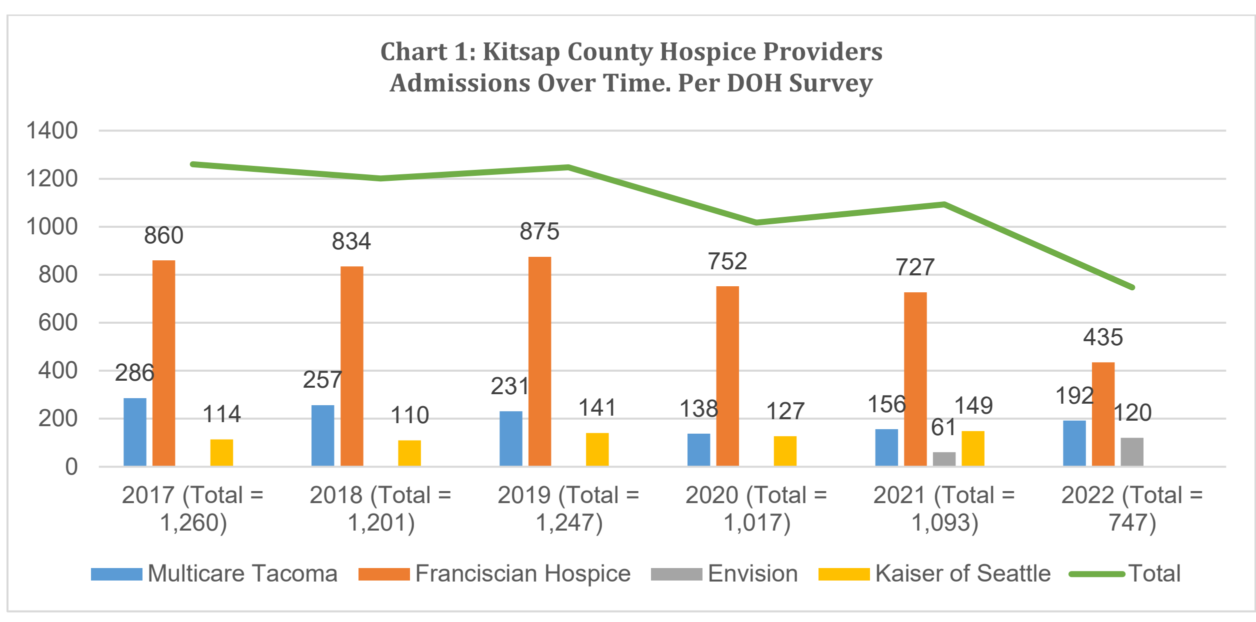
Admissions: While we will target Jewish residents, our staff and programming will welcome to any Kitsap County resident meeting Medicare requirements and choosing our service. The unmet ADC in Kitsap County, per the Department's 2023 published methodology is 24 in 2025. This estimated need applies the declining statewide hospice use rate to Kitsap County demographics. Assuming that the use rate returns to the even the State's three-year trend for the period of 2018-2020, the unmet ADC is 42.

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

According to Claritas, Kitsap County's 2024 population is estimated at 280,833. It is also projected to exceed 290,000 by 2028. In 2020, the 65+ cohort, represented 19% of the total population (compared to 16% statewide). Kitsap County's 65+ population grew 56.8% between 2010 and 2020, while the total population during the same time frame increased 10% Countywide. In 2024, it is estimated that the 65+ population will represent 24% of the total population. In an effort to compare population change to the Department's dataset for hospice, Shalom interpolated data for 2017 and 2022, and found that the total population grew by an estimated 6%, while the 65+ population grew by 20%.

The American Jewish Population Project, *2020 Jewish Population Estimates (Release Date: March 2021*), estimated the population of Kitsap/Island Counties at 4,300. No historical or estimated future data was provided.

The Department of Health's 2024 hospice need methodology (included in Exhibit 3) projects no need for any additional hospice agency in the County by 2025, the Department's identified planning horizon. It also shows that in 2023, three agencies served the County: Franciscan Hospice, MultiCare Hospice and Envision. In addition, Kaiser has a small presence in the County, serving enrolled members of its HMO. Using data that the Department's annual survey has collected from the period of 2017-2022, the following admissions of these providers in Kitsap is shown below and documents the decline in total admissions in the County.



To determine the projected hospice admissions in each Planning Area, the Department calculates a statewide use rate and applies that use rate to the 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 (using 2016-2018 data) was published.

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

	2018 Methodology (2015-2017 Data)	2019 Methodology (2016-2018 Data)	2020 Methodology (2017-2019 Data)	2021 Methodology (2018-2020 Data)	2022 Methodology (2019-2021 Data)	2023 Methodology (2020-2022 Data)
0-64	28.50%	27.89%	27.41%	25.67%	23.16%	21.39%
65+	60.91%	61.56%	60.52%	60.14%	58.07%	57.39%

Source: Department of Health Certificate of Need Hospice Methodologies; 2018-2023

As identified in Table 3, Department of Health hospice survey data by year also shows the Kitsap County use rates have experienced an even more significant decline than the state, and when compared to other counties, the Kitsap use rate shows the highest rate of decline Statewide. Shalom does note that Kaiser did not provide survey data for 2022. We are unclear as to whether this is because they are now contracting with another provider to provide hospice or if they failed to complete the survey. Even when adjusting the data to assume volume for Kaiser in 2022, using the Department of Health's historic approach (averaging the years of data that were available), Kitsap's use rate decline is still higher than the state and remains in the top five declines statewide.

**Table 3: Department of Health Methodology
65+ Hospice Use Rate By Year
Kitsap County vs. Statewide**

County	**2018**	**2019**	**2020**	**2021**	**2022**	**% change 2018-2022**
Kitsap	60%	59%	54%	38%	36%	**-38.91%**
State	**63%**	**61 %**	**60%**	**55%**	**52%**	**-18.11%**

Source: Department of Health survey data and methodologies; 2019-2023.

As shown in Chart 1 above, Kitsap county hospice admissions have also been declining over time.

In addition to the overall hospice use rate declining, as can be identified in Table 4, other Statewide access indicators collected and reported by CMS also show that statewide performance has been worsening over the last several years.

Table 4: Statewide Average Key Access Indicators			
	% of Patients on Services 7 Days or Less (lower is better)	**Total Visit-Hours in the Last Week Before Death (higher is better)**	**% Admitted from Hospital in 0-1 Days (higher is better)**
2015	27.1%	5.64	85.3%
2016	27.4%	5.97	85.5%
2017	27.9%	6.04	87.1%
2018	27.0%	6.21	85.4%
2019	26.7%	6.15	86.0%
2020	30.6%	5.66	86.2%
2021	31.7%	5.39	83.7%
2022	30.6%	5.44	82.4%

Importantly, as shown in Table 5 the Department can have confidence that Shalom will have a real and measurable impact on these access indicators and, hence, the declining use rate/underutilization in Kitsap County by evaluating the experience of our sister agency in Washington (Continuum Snohomish LLC). Continuum is outperforming the other providers in Kitsap County and is performing better than the state average on these access indicators. in comparison to both the Statewide average and to the other providers currently operating in Kitsap County.

Table 5: Hospice Access Indicators By Kitsap County Providers and Statewide						
	% of Patients on Service 7 days or Less (Lower is Better)		**Total Visit-Hours in the Last Week Before Death (Higher is better)**		**% Admitted from Hospital in 0-1 Days (Higher is Better)**	
	2019	**2022**	**2019**	**2022**	**2019**	**2022**
MultiCare Tacoma	24.6%	27.3%	5.02	4.77	82.6%	77.9%
Franciscan Hospice	23.4%	31.2%	4.22	5.10	83.3%	78.8%
Envision	NA	28.8%	NA	5.25	NA	75.9%
Continuum of Snohomish LLC	**NA**	**33.1%**	**NA**	**5.38**	**NA**	**89.8%**
State Average	26.7%	30.6%	6.15	5.44	86.0%	82.4%

Source: Berg Data Solutions, Medicare FFS beneficiary data, 2019 and 2022.

Even using the Department's declining statewide use rate in its methodology, Kitsap County had the second highest unmet need in the state by 2025 (only Pierce County was higher at 55). While it did not meet the 35 ADC requirement by 2025 (required in the methodology to be classified as showing need) – if projected to 2028 (the third year of operation of Shalom's project), there is an unmet ADC of 42. In fact, it is above 35 in 2027; Shalom's proposed second full year of operation.

Applying an adjusted use rate from the 2021 methodology (which is even conservative since the use rate had already been declining prior to this year), results in an unmet need of 35 ADC in Kitsap by 2024, and 42 by 2025 (the Department's projection year).

Table 6: Estimated Kitsap County Unmet Need
Use Rate Comparison

	2023	2024	2025	2026	2027	2028
DOH Methodology Use Rate 0-64: 21.39% 65+: 57.39%	11	17	24	30	36	42
Adjusted Use Rate (Return to 2021 Methodology) 0-64: 25.67% 65+: 60.14%	28	35	42	49	56	63

As the Department can see, Shalom is not proposing an "everything but the kitchen sink" approach to our request for approval under WAC 246-310-290 (12); rather we are laser focused on the Jewish population and the overall declines in hospice use Countywide.

Today, the Jewish population of Kitsap County has no meaningful choice related to hospice care. When dealing with something as challenging as 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.

However, Shalom does note also that our sister organizations have proven programming that address the needs of other traditionally underserved groups including Blacks, Asians, dual eligible Medicare/Medicaid Enrollees, homeless, LGBTQ+, and that we will enjoy ready access to that expertise in order to meet any other identified underservice 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 with the application of common-sense techniques.

We also know that the development of a workforce that reflects our population 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 worship, trusted physicians and other health care entities in the County to listen to their current experiences. We have consistently heard that Kitsap's existing agencies provide 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 hospice and in offering 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 our mission and will be employed in service to our Jewish patients, but we will do the same to improve accessibility for any population 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 in the County, 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 Kitsap provider offers programming specific to Jewish residents, and none holds NIJH accreditation. In addition, the County's hospice access measures (days to admission, care hours in the last week of life, etc.) are generally lower than the State average, and definitely lower than that of our sister agency, Continuum of Snohomish. There is no question that Shalom's presence in the County will not duplicate existing services but instead bring services focused on meeting the needs of the Jewish population and bring the unique experience of our sister agencies in addressing the specific access issues resulting in general underservice in the County.

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

> *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.*

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. Shalom literally means "may you be full of well-being". It is used in Judaism as a blessing for coming and going, in any time frame, in any situation. Many Washington residents of the Jewish faith, including those in Kitsap County, are less likely to choose hospice if that hospice does not specifically honor Jewish rituals, traditions, while offering offer strong rabbinic support. None of the existing Kitsap agencies provide this support, and this religious group is underserved.

In addition, the overall declining use of hospice by individuals whose payer is Medicare, Medicaid or other, demonstrates that there has been a diminishment of services that has triggered underservice.

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

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

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

Please refer to Exhibit 4 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 accepted and trusted in Kitsap County and will likely be the preferred hospice for the Jewish community.

In addition, and as noted earlier in this application, Kitsap County providers in total have experienced a decline in resident hospice use. We were surprised to see that no agency is primarily based in the County.

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 its pro forma.

Our sister organization in Washington, Continuum, has been operational for about four years and as noted earlier, has experienced phenomenal success, measured in terms of number of patients admitted and the timeline for admitting the patient (within hours of discharge, not days) and in hours of care provided during the last days of life. In recognition of Continuum's availability and accessibility, in 2023 Continuum was awarded gold recognition in the Seattle Times' inaugural "Best in the PNW" list of top local businesses. The award is the culmination of months of regional nominations and voting to determine gold, silver, and bronze winners. The Times received nominations from over 11,100 businesses, and more than 116,000 people cast ballots.

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 5. These draft policies are the same as those used by our sister organization in prior CN applications. 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.

The Jewish community of Kitsap is underserved. We have also detailed that existing provider volumes have not kept pace with community growth, and the hospice and end of life needs of the general community are impacted as well. Assuming the current low statewide use rates, there is no numeric need. However, applying the statewide use rate achieved in the three-year period ending in 2020 to Kitsap County demonstrates need.

During the public comment period, letters of support from Kitsap County, as well as from providers and organizations in Washington that have experienced improvement as a result of our sister organization will be provided.

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 6. The pro forma includes the staffing, outreach and other costs associated with growing hospice use by the Jewish population, as well as increasing Kitsap County's low use of hospice.

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. There will be a shared services agreement, a draft copy of which is included in Exhibit 7.

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.**

The executed lease is included in Exhibit 8.

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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 7.

Table 7: Proposed Capital Expenditure

Line Item	Cost
Office Equipment/Computers/Communication Devices, Furniture (incl. sales tax)	$25,890
Software (incl. sales tax)	$17,469
Signage and Space Readiness (incl. sales tax)	$35,807
Legal/Consulting	$35,834
Total	**$115,000**

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. Mr. Sterns has established several new hospice agencies in Washington State over the past four years, as well as others throughout the nation. Mr. Stern was also responsible for 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 $43,923 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 Kitsap County are currently using higher-cost health care services (ED visits, extended hospitalizations) that are reduced when they are enrolled in a hospice program, overall total costs and charges for health care services will decrease.

The establishment of a new hospice agency that will improve access and availability and target disparities 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, studies demonstrate that patients enrolled in hospice are less likely to be hospitalized, admitted to intensive care, or undergo unnecessary invasive procedures.

Shalom will also work with the patient 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 the 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.

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[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.

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. As such, 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.

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 8 provides the requested information for Shalom.

Table 8 : Estimated Sources of Revenue by Payer

Payer	Percentage of Gross Revenue
Medicare/Medicare Advantage	88.6%
Medicaid	3.9%
Commercial/VA/TriCare	5.9%
Self-Pay/Other	1.6%
Total	**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. A listing of the actual equipment will be provided with screening.

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. Exhibit 6 identifies a contribution of $750,000. A letter documenting the contribution will be provided in screening.

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.**

Shalom is a new entity. No audited financial statements exist. If the Department requests further information, please advise in screening.

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 9 details the projected FTEs for the first three years of operation for Kitsap County.

Table 9: Kitsap County Projected FTEs by Year

Staff	2025	2026	2027	2028	Salary/FTE
Administrator	0.50	1.00	1.00	1.00	$ 195,000
Clinical Director	0.50	1.00	1.00	1.00	$ 155,000
Medical Director	0.30	0.20	0.20	0.20	$ 400,000
Registered Nurse	0.60	2.03	3.10	4.10	$ 125,000
Hospice Aide	0.60	2.03	3.10	4.10	$ 55,000
MSW	0.24	0.81	1.24	1.64	$ 95,000
Chaplain	0.24	0.81	1.24	1.64	$ 85,000
Music Therapist	0.12	0.41	0.62	0.82	$ 75,000
Intake	0.50	1.00	1.00	1.00	$ 80,000
Office Manager	0.25	0.50	1.00	1.00	$ 90,000
Team Coordinator	0.00	0.00	0.00	0.25	$ 70,000
Marketing	0.25	0.50	0.75	1.00	$ 110,000
Volunteer Coordinator	0.50	1.00	1.00	1.00	$ 80,000
Bereavement Coordinator	0.00	0.00	0.00	0.25	$ 100,000
PT/OT/SP/RT	Contracted				
Dietitian	Contracted				
Nurse Practitioner	0.03	0.10	0.15	0.20	$ 175,000
Total	**4.63**	**11.39**	**15.40**	**19.20**	

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

Table 10
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
Volunteer Coordinator	1:100

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 was based on a review of the literature, national staffing data, and the experience of Shalom's sister agencies in Washington. The National Hospice and Palliative Care Organization (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 both adequate, and 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 9.

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.)**

Shalom will be supported by Patrick Shepard in the role as Interim Administrator during start-up until a qualified Kitsap County specific Administrator can be hired. Dr. Nguyen will be the Medical Director. Mr. Shepard and Dr. Nguyen will be responsible for recruiting and hiring staff prior to opening.

Table 11
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 agency operating in Washington (Continuum) has historically been successful in recruiting using multiple strategies and tools. The same is true of the other Shalom agencies associated with Mr. Stern and/or the Stern Family Trust. We will access their 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 grow opportunities, and also 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 Kitsap County market.

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 excellent 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 Federation of Greater Seattle
- Discharging hospitals, physicians, and coordinators
- County Area Agency on Aging.
- Home Health and home care agencies
- Nursing Homes, Assisted Living and Adult Family Homes
- VA
- HMOs and other payers
- Washington 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.

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 underserved nature of 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 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 16, Shalom will work directly with the existing Kitsap County Jewish organizations to ensure patients' comprehensive medical, social, and spiritual needs are met. Our sister organization, Continuum, has developed exceptionally strong relationships with existing health care providers in Snohomish, King and now Pierce County. These relationships have served to benefit the patients we serve and their families; and we will utilize similar outreach to establish and develop the relationships.

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.

None of the agencies currently owned and/or operated by Mr. Stern and/or the Stern Family Trust have any pattern of condition level negative findings. This is also true of any agencies that Mr. Stern and/or the Stern Family Trust have divested. In other words, there were no patterns at the time of divesture.

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,
- Establish a licensed only agency,
- Undertake the project described in this application.

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 12 provides a comparison of the options considered.

Table 12
Advantages and Disadvantages of Options Considered

	No Action	Licensed Only Hospice Agency	Undertake the Project Described in this Application
Patient Access to Health Care Services	No ability to improve access, especially for the Jewish community.	Won't increase access to the majority of patients needing hospice services, and particularly the underserved, because won't be accessible to Medicare and Medicaid patients.	Ability to serve the Jewish community and to address the loss of access to hospice that has occurred throughout the County.
Capital Cost	No capital	Very low capital	Capital cost is $115,000.
Legal Restrictions	None	None	Certificate of Need required
Staffing Impacts	None	Requires additional staff, but fewer than a Medicare certified agency would.	Requires the highest level of additional staff, but still a relatively small number.
Quality of Care	No improvement	Not able to enhance access or quality to the majority of patient in need of services	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.
Cost or Operation Efficiency	None	Low volumes; cannot provide the same level of service as a Medicare/ Medicaid certified agency, so will have difficulty maintaining financial viability.	Will allow for the provision of services to all patients needing services. Improved access may reduce total costs of care for the County by reducing unnecessary ED visits, specialty provider visits and hospitalizations.

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.

<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.

Shalom is the only applicant. This question is not applicable.

<u>Multiple Applications in One Year</u>

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.

Neither Shalom, nor any entity with a qualifying ownership interest in Shalom, is submitting any other applications in either of this year's concurrent review cycles.

Exhibit 1
Facility List

Affinity / Continuum Hospice Entities

Entity	Address	Provider No.	Incorp Date	CON Date	License	Ownership
Continuum Care of Snohomish LLC	1000 SE Everett Mall Way, Suite 402, Everett, WA 98208-2814	50-1545	10/17/2017	CN#18-06 | 08/05/2019	IHS.FS.61010090	90/10
Continuum Care of King LLC	14240 Interurban Ave S Ste 212, Tukwila WA 98168-4660	50-1549	12/6/2018	CN#19-49 | 03/02/2021	IHS.FS.61058934	90/10
Continuum Care of Broward LLC	7771 W. Oakland Park Blvd., Suite 224, Sunrise FL 33351-6705	10-1562	10/7/2019	#10609 | 03/13/2020	50370985	100
Continuum Care of Sarasota LLC	5589 Marquesas Circle, Suite 202, Sarasota, FL 34233-3337	10-1564	9/20/2019	#10607 | 03/09/2021	50370986	100
Continuum Care of Miami Dade LLC	1150 NW 72nd Ave, Ste 400, Miami FL 33126-1947	10-1565	5/25/2020	#10658 | 09/20/2021	50370988	100
Affinity Care of Manatee County LLC	209 6th Ave E Ste A, Bradenton FL 34208-1904	PENDING	2/3/2021	#10651 | 11/08/2022	50370992	95/5
Affinity Care of Charlotte and DeSoto LLC	18501 Murdock Cir Unit 103, Port Charlotte FL 33948-4002	PENDING	3/4/2022	#10714 | 11/09/2022	Pending	95/5
Affinity Care of NJ LLC	635 Duquesne Blvd, Ste 1, Brick NJ 08723-5073	31-1591	8/31/2020	N/A	25234	90/10
Branch Location	140 Littleton Rd, Ste 103, Parsippany NJ 07054-1867				25309	
Affinity Care of Ohio LLC	9349 Waterstone Blvd Ste 340, Cincinnati OH 45249-8320	36-1713	9/22/2020	N/A	0264-HSP	90/10
Branch Location						
Affinity Care of Northern Ohio LLC	25 South Main Street, Suite 6, Munroe Falls, OH 44262-1660	36-1725	11/29/2021	N/A	0281-HSP	95/5
Affinity Care of Missouri LLC	14700 E 42nd Street S Ste S, Independence MO 64055-4773	26-1609	9/3/2021	N/A	1124954	
Affinity Care of Indiana LLC	3935 Eagle Creek Parkway Ste G. Indianapolis IN 46254-4690	15-1645	10/5/2021	N/A	24-015559-1	90/10
Affinity Care of Pennsylvania LLC	6 Interplex Ste 211, Trevose PA 19053-6964	73-1501	10/5/2021	N/A	18071601	90/10
Branch Location	95 Highland Ave Ste 140, Bethlehem PA 18017-9432					
Affinity Care of DC LLC	1205 Brentwood Rd NE, Washington DC 20018-1019	09-1508	3/11/2021	#21-5-1 | 03/11/2022	DC doesn't issue license	90/10
Affinity Care of Virginia LLC	714 Thimble Shoals Blvd, Suite C, Newport News, VA 23606-2574	49-1637	10/13/2020	N/A	HSP-0000422	45/27.5/27.5
Branch Location	3736 Winterfield Rd., Suite 202, Midlothian, VA 23113-0000				HSP-0000425	
Branch Location	3501 Colonial Green Circle, Roanoke, VA 24018				HSP-0000430	
Branch Location	450 Solomon Dr, Suite 201, Fredericksburg VA 22405-1364				HSP-0000443	
Affinity Care of Oklahoma LLC	5627 North Classen Blvd Ste 100, Oklahoma OK 73118-4031	37-1733	6/27/2022	N/A	HO4328	90/10
Affinity Care of Maine LLC	600 Southborough Dr Ste 103, South Portland ME 04106-6915	20-1524	7/11/2022	N/A	39707	90/10
Shalom Hospice LLC	5409 Maryland Way, Ste 212, Brentwood TN 37027-5068	44-1606	1/21/2022	CN2203-014A | 06/22/2022	0000000626	90/10
Shalom Hospice of Greater Knoxville LLC	8351 E Walker Springs LN Ste 402, Knoxville TN 37923-3142	PENDING	1/12/2023	CN2305-013A | 08/23/2023	0000000629	95/5
Affinity Care of Georgia LLC	2751 Buford Hwy NE Ate 285, Atlanta GA 30324-5488	PENDING	11/11/2022	N/A	HSPC001493	60/40
Affinity Care of Connecticut LLC	2751 Dixwell Ave FL, Hamden CT 06518-3321	PENDING	5/12/2023	N/A	Pending	95/5

Ownership Legend

100 | 100% Samuel Stern

90/10 | 90% Stern Family 2019 Trust / 10% Samuel Stern

95/5 | 95% SYGS 2023 Trust / 5% Samuel Stern

60/40 | 60% Starco of Georgia / 40% Georgia Hospice

45/27.5/27.5 | 45% Starco of Virginia / 27.5% America Ave Holdings / 27.5% PPG Affinity LLC

Exhibit 2
Letter of Intent

Received by the
Certificate of Need Program on
December 29, 2023

December 28, 2023

Eric Hernandez, Program Manager
Certificate of Need Program
Department of Health
111 Israel Road Southeast
Tumwater, WA 98501
Via email: eric.hernandez@doh.wa.gov>; FSLCON@DOH.WA.GOV

Dear Mr. Hernandez:

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

1. A Description of the Extent of Services Proposed:
Shalom Hospice of Puget Sound LLC proposes to establish a Medicare certified/Medicaid eligible hospice agency to serve Kitsap County. The agency will provide all Medicare required services as well as a number of specialty therapies.

2. Estimated Cost of the Proposed Project:
The capital required to establish the agency is estimated at $115,000.

3. Description of the Service Area:
Consistent with WAC, the service area is Kitsap 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
DOH Methodology

Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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
2020	3,680
2021	3,883
2022	3,377
average:	**3,647**

Deaths ages 0-64	
Year	Deaths
2020	16,663
2021	18,015
2022	17,201
average:	**17,293**

Use Rates	
0-64	21.09%
65+	56.80%

Hospice admissions ages 65+	
Year	Admissions
2020	27,957
2021	27,885
2022	28,832
average:	**28,225**

Deaths ages 65+	
Year	Deaths
2020	46,367
2021	50,717
2022	52,002
average:	**49,695**

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2020	2021	2022	2020-2022 Average Deaths
Adams	20	23	25	23
Asotin	56	43	45	48
Benton	555	536	566	552
Chelan	224	256	225	235
Clallam	195	185	179	186
Clark	1,043	1,078	1,002	1,041
Columbia	7	11	12	10
Cowlitz	314	401	311	342
Douglas	42	45	45	44
Ferry	19	21	22	21
Franklin	100	110	79	96
Garfield	5	4	2	4
Grant	186	208	190	195
Grays Harbor	209	236	223	223
Island	110	116	117	114
Jefferson	68	54	59	60
King	4,456	4,892	4,902	4,750
Kitsap	454	489	462	468
Kittitas	78	88	78	81
Klickitat	42	50	50	47
Lewis	205	186	191	194
Lincoln	15	24	24	21
Mason	143	168	152	154
Okanogan	88	92	106	95
Pacific	55	59	69	61
Pend Oreille	41	55	44	47
Pierce	2,364	2,574	2,518	2,485
San Juan	18	24	12	18
Skagit	269	334	258	287
Skamania	26	25	20	24
Snohomish	1,587	1,563	1,468	1,539
Spokane	1,634	1,842	1,603	1,693
Stevens	86	114	107	102
Thurston	628	763	709	700
Wahkiakum	10	7	9	9
Walla Walla	150	138	157	148
Whatcom	457	443	467	456
Whitman	51	59	65	58
Yakima	653	699	628	660

65+				
County	2020	2021	2022	2020-2022 Average Deaths
Adams	59	92	91	81
Asotin	186	188	227	200
Benton	1,522	1,610	1,739	1,624
Chelan	785	870	873	843
Clallam	777	906	935	873
Clark	3,205	3,705	3,709	3,540
Columbia	43	43	37	41
Cowlitz	968	1,100	989	1,019
Douglas	160	174	205	180
Ferry	58	63	60	60
Franklin	263	261	234	253
Garfield	11	24	24	20
Grant	455	523	533	504
Grays Harbor	558	590	683	610
Island	505	504	548	519
Jefferson	273	295	298	289
King	11,186	11,896	12,448	11,843
Kitsap	1,714	1,832	1,895	1,814
Kittitas	241	241	261	248
Klickitat	113	164	130	136
Lewis	653	723	753	710
Lincoln	75	76	67	73
Mason	408	461	414	428
Okanogan	277	324	341	314
Pacific	177	239	235	217
Pend Oreille	101	119	127	116
Pierce	5,608	6,264	6,412	6,095
San Juan	94	91	78	88
Skagit	1,068	1,190	1,215	1,158
Skamania	47	56	60	54
Snohomish	4,278	4,478	4,833	4,530
Spokane	4,322	4,810	4,603	4,578
Stevens	248	304	336	296
Thurston	2,007	2,285	2,419	2,237
Wahkiakum	18	25	24	22
Walla Walla	522	595	598	572
Whatcom	1,481	1,674	1,653	1,603
Whitman	226	278	233	246
Yakima	1,675	1,644	1,682	1,667

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2020-2022 Average Deaths	Projected Patients: 21.09% of Deaths
Adams	23	5
Asotin	48	10
Benton	552	116
Chelan	235	50
Clallam	186	39
Clark	1,041	220
Columbia	10	2
Cowlitz	342	72
Douglas	44	9
Ferry	21	4
Franklin	96	20
Garfield	4	1
Grant	195	41
Grays Harbor	223	47
Island	114	24
Jefferson	60	13
King	4,750	1,002
Kitsap	468	99
Kittitas	81	17
Klickitat	47	10
Lewis	194	41
Lincoln	21	4
Mason	154	33
Okanogan	95	20
Pacific	61	13
Pend Oreille	47	10
Pierce	2,485	524
San Juan	18	4
Skagit	287	61
Skamania	24	5
Snohomish	1,539	325
Spokane	1,693	357
Stevens	102	22
Thurston	700	148
Wahkiakum	9	2
Walla Walla	148	31
Whatcom	456	96
Whitman	58	12
Yakima	660	139

65+		
County	2020-2022 Average Deaths	Projected Patients: 56.80% of Deaths
Adams	81	46
Asotin	200	114
Benton	1,624	922
Chelan	843	479
Clallam	873	496
Clark	3,540	2,010
Columbia	41	23
Cowlitz	1,019	579
Douglas	180	102
Ferry	60	34
Franklin	253	144
Garfield	20	11
Grant	504	286
Grays Harbor	610	347
Island	519	295
Jefferson	289	164
King	11,843	6,726
Kitsap	1,814	1,030
Kittitas	248	141
Klickitat	136	77
Lewis	710	403
Lincoln	73	41
Mason	428	243
Okanogan	314	178
Pacific	217	123
Pend Oreille	116	66
Pierce	6,095	3,461
San Juan	88	50
Skagit	1,158	658
Skamania	54	31
Snohomish	4,530	2,573
Spokane	4,578	2,600
Stevens	296	168
Thurston	2,237	1,271
Wahkiakum	22	13
Walla Walla	572	325
Whatcom	1,603	910
Whitman	246	140
Yakima	1,667	947

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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2020-2022 Average Population	2023 projected population	2024 projected population	2025 projected population	2023 potential volume	2024 potential volume	2025 potential volume
Adams	**5**	**18,199**	18,565	18,748	18,931	5	5	5
Asotin	**10**	**16,706**	16,475	16,360	16,244	10	10	10
Benton	**116**	**175,851**	178,935	180,477	182,019	119	120	121
Chelan	**50**	**62,907**	63,062	63,139	63,217	50	50	50
Clallam	**39**	**52,247**	52,552	52,704	52,857	40	40	40
Clark	**220**	**424,857**	433,316	437,545	441,774	224	226	228
Columbia	**2**	**2,763**	2,664	2,615	2,566	2	2	2
Cowlitz	**72**	**87,937**	88,116	88,206	88,295	72	72	72
Douglas	**9**	**35,378**	35,624	35,746	35,869	9	9	9
Ferry	**4**	**5,127**	4,967	4,886	4,806	4	4	4
Franklin	**20**	**88,772**	91,315	92,587	93,859	21	21	21
Garfield	**1**	**1,570**	1,569	1,569	1,569	1	1	1
Grant	**41**	**85,596**	86,774	87,363	87,952	42	42	42
Grays Harbor	**47**	**58,092**	57,484	57,179	56,875	46	46	46
Island	**24**	**63,840**	64,256	64,464	64,672	24	24	24
Jefferson	**13**	**20,269**	20,116	20,040	19,964	13	13	13
King	**1002**	**1,974,586**	1,993,774	2,003,368	2,012,962	1011	1016	1021
Kitsap	**99**	**222,587**	222,681	222,729	222,776	99	99	99
Kittitas	**17**	**38,539**	39,282	39,653	40,024	17	18	18
Klickitat	**10**	**17,217**	16,988	16,874	16,759	10	10	10
Lewis	**41**	**63,811**	64,225	64,432	64,639	41	41	41
Lincoln	**4**	**7,804**	7,785	7,775	7,765	4	4	4
Mason	**33**	**49,998**	50,395	50,594	50,793	33	33	33
Okanogan	**20**	**31,910**	31,564	31,392	31,219	20	20	20
Pacific	**13**	**15,523**	15,405	15,346	15,287	13	13	13
Pend Oreille	**10**	**9,660**	9,543	9,485	9,427	10	10	10
Pierce	**524**	**790,591**	797,852	801,483	805,114	529	531	534
San Juan	**4**	**11,682**	11,654	11,640	11,626	4	4	4
Skagit	**61**	**100,574**	101,422	101,846	102,270	61	61	62
Skamania	**5**	**9,243**	8,998	8,875	8,752	5	5	5
Snohomish	**325**	**712,731**	721,470	725,839	730,209	329	331	333
Spokane	**357**	**447,909**	450,821	452,277	453,733	359	360	362
Stevens	**22**	**35,790**	35,311	35,071	34,832	21	21	21
Thurston	**148**	**242,356**	246,365	248,369	250,374	150	151	152
Wahkiakum	**2**	**2,943**	2,917	2,903	2,890	2	2	2
Walla Walla	**31**	**50,364**	50,376	50,382	50,388	31	31	31
Whatcom	**96**	**185,493**	188,095	189,395	190,696	97	98	99
Whitman	**12**	**42,489**	42,517	42,531	42,545	12	12	12
Yakima	**139**	**219,628**	220,336	220,690	221,044	140	140	140

Sources:
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2020-2022 Average Population	2023 projected population	2024 projected population	2025 projected population	2023 potential volume	2024 potential volume	2025 potential volume
Adams	46	2,605	2,621	2,629	2,637	46	46	46
Asotin	114	5,673	6,094	6,305	6,515	122	126	131
Benton	922	33,826	36,349	37,611	38,872	991	1,025	1,060
Chelan	479	16,903	18,085	18,677	19,268	512	529	546
Clallam	496	25,369	25,986	26,295	26,603	508	514	520
Clark	2,010	86,493	94,113	97,923	101,733	2,187	2,276	2,365
Columbia	23	1,170	1,229	1,259	1,289	24	25	26
Cowlitz	579	23,471	24,649	25,237	25,826	608	622	637
Douglas	102	8,039	8,752	9,109	9,465	111	116	120
Ferry	34	2,058	2,235	2,323	2,411	37	39	40
Franklin	144	9,795	10,887	11,433	11,979	160	167	175
Garfield	11	711	700	695	690	11	11	11
Grant	286	14,729	15,957	16,571	17,185	310	322	334
Grays Harbor	347	17,700	18,621	19,082	19,542	365	374	383
Island	295	23,676	24,579	25,030	25,482	306	312	317
Jefferson	164	13,029	13,824	14,221	14,618	174	179	184
King	6,726	316,701	340,737	352,755	364,773	7,237	7,492	7,747
Kitsap	1,030	55,150	59,307	61,385	63,464	1,108	1,147	1,185
Kittitas	141	8,482	8,846	9,028	9,210	147	150	153
Klickitat	77	5,695	6,280	6,572	6,864	85	89	93
Lewis	403	18,899	19,608	19,962	20,316	418	426	433
Lincoln	41	3,116	3,223	3,276	3,330	43	43	44
Mason	243	16,436	17,453	17,962	18,471	258	265	273
Okanogan	178	10,353	11,017	11,348	11,680	190	195	201
Pacific	123	7,971	8,347	8,534	8,722	129	132	135
Pend Oreille	66	3,845	4,170	4,332	4,494	71	74	77
Pierce	3,461	139,235	150,840	156,642	162,444	3,750	3,894	4,038
San Juan	50	6,326	6,796	7,030	7,265	53	55	57
Skagit	658	30,250	32,005	32,882	33,759	696	715	734
Skamania	31	2,455	2,891	3,108	3,326	36	39	42
Snohomish	2,573	125,852	138,363	144,618	150,874	2,828	2,956	3,084
Spokane	2,600	96,172	102,744	106,030	109,316	2,778	2,867	2,956
Stevens	168	11,029	12,255	12,868	13,481	187	196	205
Thurston	1,271	56,276	59,944	61,778	63,612	1,353	1,395	1,436
Wahkiakum	13	1,512	1,604	1,651	1,697	13	14	14
Walla Walla	325	12,446	12,886	13,106	13,326	336	342	348
Whatcom	910	44,049	46,838	48,232	49,627	968	997	1,026
Whitman	140	5,619	5,860	5,980	6,101	146	149	151
Yakima	947	38,467	40,491	41,504	42,516	997	1,022	1,046

Sources:
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2023 potential volume	2024 potential volume	2025 potential volume	Current Supply of Hospice Providers	2023 Unmet Need Admissions*	2024 Unmet Need Admissions*	2025 Unmet Need Admissions*
Adams	51	51	51	**44.00**	7	7	7
Asotin	132	136	141	**100.33**	32	36	40
Benton	1,109	1,145	1,180	**1,057.33**	52	88	123
Chelan	562	579	595	**769.67**	(208)	(191)	(174)
Clallam	547	553	559	**429.67**	118	124	130
Clark	2,411	2,502	2,593	**2,909.67**	(498)	(408)	(317)
Columbia	27	27	28	**36.33**	(10)	(9)	(9)
Cowlitz	680	695	709	**813.33**	(133)	(119)	(104)
Douglas	120	125	130	**566.00**	(446)	(441)	(436)
Ferry	41	43	44	**36.00**	5	7	8
Franklin	180	189	197	**191.33**	(11)	(3)	6
Garfield	12	12	12	**9.33**	2	2	2
Grant	352	364	376	**270.33**	81	93	106
Grays Harbor	411	420	429	**352.00**	59	68	77
Island	330	336	342	**469.00**	(139)	(133)	(127)
Jefferson	187	192	196	**132.67**	54	59	64
King	8,248	8,508	8,769	**8,624.67**	(376)	(116)	144
Kitsap	1,207	1,245	1,284	**1,141.00**	66	104	143
Kittitas	164	167	171	**151.67**	13	16	19
Klickitat	95	99	103	**99.00**	(4)	(0)	4
Lewis	459	467	475	**453.67**	6	13	21
Lincoln	47	48	49	**21.00**	26	27	28
Mason	291	298	306	**524.67**	(234)	(226)	(219)
Okanogan	210	215	221	**183.00**	27	32	38
Pacific	142	145	148	**65.33**	76	79	82
Pend Oreille	81	84	86	**65.33**	16	18	21
Pierce	4,279	4,426	4,572	**4,244.33**	35	181	328
San Juan	57	59	61	**99.00**	(42)	(40)	(38)
Skagit	757	776	795	**791.33**	(35)	(15)	4
Skamania	41	44	47	**41.67**	(0)	2	5
Snohomish	3,157	3,287	3,417	**4,217.00**	(1,060)	(930)	(800)
Spokane	3,137	3,227	3,317	**3,195.67**	(58)	32	122
Stevens	208	217	226	**148.33**	60	69	78
Thurston	1,503	1,546	1,589	**1,766.33**	(263)	(220)	(178)
Wahkiakum	15	16	16	**14.33**	1	1	2
Walla Walla	367	373	379	**280.33**	87	93	99
Whatcom	1,065	1,095	1,124	**1,718.33**	(653)	(624)	(594)
Whitman	158	161	164	**112.67**	45	48	51
Yakima	1,136	1,161	1,187	**1,087.67**	49	74	99

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

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Distributed November 6, 2023

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	**2023 Unmet Need Admissions***	**2024 Unmet Need Admissions***	**2025 Unmet Need Admissions***	**Statewide ALOS**	**2023 Unmet Need Patient Days***	**2024 Unmet Need Patient Days***	**2025 Unmet Need Patient Days***
Adams	7	7	7	**61.11**	426	437	449
Asotin	32	36	40	**61.11**	1,947	2,201	2,455
Benton	52	88	123	**61.11**	3,186	5,350	7,514
Chelan	(208)	(191)	(174)	**61.11**	(12,705)	(11,678)	(10,652)
Clallam	118	124	130	**61.11**	7,183	7,558	7,934
Clark	(498)	(408)	(317)	**61.11**	(30,451)	(24,906)	(19,360)
Columbia	(10)	(9)	(9)	**61.11**	(601)	(567)	(533)
Cowlitz	(133)	(119)	(104)	**61.11**	(8,145)	(7,254)	(6,362)
Douglas	(446)	(441)	(436)	**61.11**	(27,229)	(26,950)	(26,672)
Ferry	5	7	8	**61.11**	331	417	502
Franklin	(11)	(3)	6	**61.11**	(668)	(162)	345
Garfield	2	2	2	**61.11**	149	144	139
Grant	81	93	106	**61.11**	4,961	5,707	6,453
Grays Harbor	59	68	77	**61.11**	3,614	4,150	4,686
Island	(139)	(133)	(127)	**61.11**	(8,477)	(8,129)	(7,781)
Jefferson	54	59	64	**61.11**	3,294	3,597	3,899
King	(376)	(116)	144	**61.11**	(22,996)	(7,100)	8,796
Kitsap	66	104	143	**61.11**	4,004	6,378	8,752
Kittitas	13	16	19	**61.11**	765	959	1,154
Klickitat	(4)	(0)	4	**61.11**	(256)	(19)	219
Lewis	6	13	21	**61.11**	347	817	1,286
Lincoln	26	27	28	**61.11**	1,595	1,639	1,682
Mason	(234)	(226)	(219)	**61.11**	(14,296)	(13,828)	(13,361)
Okanogan	27	32	38	**61.11**	1,629	1,971	2,313
Pacific	76	79	82	**61.11**	4,674	4,848	5,023
Pend Oreille	16	18	21	**61.11**	955	1,121	1,286
Pierce	35	181	328	**61.11**	2,112	11,074	20,036
San Juan	(42)	(40)	(38)	**61.11**	(2,550)	(2,437)	(2,325)
Skagit	(35)	(15)	4	**61.11**	(2,119)	(938)	243
Skamania	(0)	2	5	**61.11**	(29)	134	297
Snohomish	(1,060)	(930)	(800)	**61.11**	(64,778)	(56,842)	(48,905)
Spokane	(58)	32	122	**61.11**	(3,566)	1,934	7,435
Stevens	60	69	78	**61.11**	3,652	4,214	4,777
Thurston	(263)	(220)	(178)	**61.11**	(16,069)	(13,464)	(10,859)
Wahkiakum	1	1	2	**61.11**	57	81	104
Walla Walla	87	93	99	**61.11**	5,323	5,674	6,025
Whatcom	(653)	(624)	(594)	**61.11**	(39,906)	(38,104)	(36,302)
Whitman	45	48	51	**61.11**	2,759	2,943	3,126
Yakima	49	74	99	**61.11**	2,968	4,505	6,041

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

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

				Step 7 (Patient Days / 365) = Unmet ADC		
County	2023 Unmet Need Patient Days*	2024 Unmet Need Patient Days*	2025 Unmet Need Patient Days*	2023 Unmet Need ADC*	2024 Unmet Need ADC*†	2025 Unmet Need ADC*
Adams	426	437	449	1	1	1
Asotin	1,947	2,201	2,455	5	6	7
Benton	3,186	5,350	7,514	9	15	21
Chelan	(12,705)	(11,678)	(10,652)	(35)	(32)	(29)
Clallam	7,183	7,558	7,934	20	21	22
Clark	(30,451)	(24,906)	(19,360)	(83)	(68)	(53)
Columbia	(601)	(567)	(533)	(2)	(2)	(1)
Cowlitz	(8,145)	(7,254)	(6,362)	(22)	(20)	(17)
Douglas	(27,229)	(26,950)	(26,672)	(75)	(74)	(73)
Ferry	331	417	502	1	1	1
Franklin	(668)	(162)	345	(2)	(0)	1
Garfield	149	144	139	0	0	0
Grant	4,961	5,707	6,453	14	16	18
Grays Harbor	3,614	4,150	4,686	10	11	13
Island	(8,477)	(8,129)	(7,781)	(23)	(22)	(21)
Jefferson	3,294	3,597	3,899	9	10	11
King	(22,996)	(7,100)	8,796	(63)	(19)	24
Kitsap	4,004	6,378	8,752	11	17	24
Kittitas	765	959	1,154	2	3	3
Klickitat	(256)	(19)	219	(1)	(0)	1
Lewis	347	817	1,286	1	2	4
Lincoln	1,595	1,639	1,682	4	4	5
Mason	(14,296)	(13,828)	(13,361)	(39)	(38)	(37)
Okanogan	1,629	1,971	2,313	4	5	6
Pacific	4,674	4,848	5,023	13	13	14
Pend Oreille	955	1,121	1,286	3	3	4
Pierce	2,112	11,074	20,036	6	30	55
San Juan	(2,550)	(2,437)	(2,325)	(7)	(7)	(6)
Skagit	(2,119)	(938)	243	(6)	(3)	1
Skamania	(29)	134	297	(0)	0	1
Snohomish	(64,778)	(56,842)	(48,905)	(177)	(155)	(134)
Spokane	(3,566)	1,934	7,435	(10)	5	20
Stevens	3,652	4,214	4,777	10	12	13
Thurston	(16,069)	(13,464)	(10,859)	(44)	(37)	(30)
Wahkiakum	57	81	104	0	0	0
Walla Walla	5,323	5,674	6,025	15	16	17
Whatcom	(39,906)	(38,104)	(36,302)	(109)	(104)	(99)
Whitman	2,759	2,943	3,126	8	8	9
Yakima	2,968	4,505	6,041	8	12	17

*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 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Distributed November 6, 2023

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	2023 Unmet Need ADC*	2024 Unmet Need ADC*†	2025 Unmet Need ADC*	Numeric Need?	Number of New Agencies Needed?**
Adams	1	1	1	FALSE	FALSE
Asotin	5	6	7	FALSE	FALSE
Benton	9	15	21	FALSE	FALSE
Chelan	(35)	(32)	(29)	FALSE	FALSE
Clallam	20	21	22	FALSE	FALSE
Clark	(83)	(68)	(53)	FALSE	FALSE
Columbia	(2)	(2)	(1)	FALSE	FALSE
Cowlitz	(22)	(20)	(17)	FALSE	FALSE
Douglas	(75)	(74)	(73)	FALSE	FALSE
Ferry	1	1	1	FALSE	FALSE
Franklin	(2)	(0)	1	FALSE	FALSE
Garfield	0	0	0	FALSE	FALSE
Grant	14	16	18	FALSE	FALSE
Grays Harbor	10	11	13	FALSE	FALSE
Island	(23)	(22)	(21)	FALSE	FALSE
Jefferson	9	10	11	FALSE	FALSE
King	(63)	(19)	24	FALSE	FALSE
Kitsap	11	17	24	FALSE	FALSE
Kittitas	2	3	3	FALSE	FALSE
Klickitat	(1)	(0)	1	FALSE	FALSE
Lewis	1	2	4	FALSE	FALSE
Lincoln	4	4	5	FALSE	FALSE
Mason	(39)	(38)	(37)	FALSE	FALSE
Okanogan	4	5	6	FALSE	FALSE
Pacific	13	13	14	FALSE	FALSE
Pend Oreille	3	3	4	FALSE	FALSE
Pierce	6	30	55	***TRUE***	***1***
San Juan	(7)	(7)	(6)	FALSE	FALSE
Skagit	(6)	(3)	1	FALSE	FALSE
Skamania	(0)	0	1	FALSE	FALSE
Snohomish	(177)	(155)	(134)	FALSE	FALSE
Spokane	(10)	5	20	FALSE	FALSE
Stevens	10	12	13	FALSE	FALSE
Thurston	(44)	(37)	(30)	FALSE	FALSE
Wahkiakum	0	0	0	FALSE	FALSE
Walla Walla	15	16	17	FALSE	FALSE
Whatcom	(109)	(104)	(99)	FALSE	FALSE
Whitman	8	8	9	FALSE	FALSE
Yakima	8	12	17	FALSE	FALSE

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

**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:
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Department of Health
2023-2024 Hospice Numeric Need Methodology
290(7)(b) Agencies

Release Year	2023
Supply year 1	2020
Supply year 3	2022
Statewide ALOS	61.11
Default Admits = 35 ADC	209.0

			Supply Years									
			2020			2021			2022			
Provider	County	Certificate Year	Survey	CN Yet?	# Used	Survey	CN Yet?	# Used	Survey	CN Yet?	# Used	Notes
Stride Health Care	Chelan	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Olympic Medical Center	Clallam	2019	none	209.0	209.0	none	209.0	209.0				Third year 2021
Providence Health & Services	Clark	2019	none	209.0	209.0	18	209.0	209.0				Third year 2021
Stride Health Care	Douglas	2023	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
The Pennant Group (Puget Sound Hospice)	Grays Harbor	2021	none	no CN yet	0.0	6	209.0	209.0	31	209.0	209.0	Third year 2023
Envision Hospice	King	2019	77	209.0	209.0	74	209.0	209.0				Third year 2021
Continuum Care of King	King	2020	none	209.0	209.0	none	209.0	209.0	none	209.0	209.0	Third year 2022
EmpRes Healthcare Group	King	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Seasons	King	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
The Pennant Group	King	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Y.B.G. Healthcare	King	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Envision Hospice	Kitsap	2020	none	209.0	209.0	61	209.0	209.0	120	209.0	209.0	Third year 2022
The Pennant Group (Puget Sound Hospice)	Mason	2021	none	no CN yet	0.0	none	209.0	209.0	100	209.0	209.0	Third year 2023
Providence Health & Services	Pierce	2021	none	no CN yet	0.0	2	209.0	209.0	98	209.0	209.0	Third year 2023
Envision Hospice	Pierce	2021	21	no CN yet	21.0	121	209.0	209.0	85	209.0	209.0	Third year 2023
Continuum Care of Snohomish	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
The Pennant Group	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Seasons	Pierce	2022	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2024
Wesley Homes Hospice	Pierce	2023	17	no CN yet	17.0	50	no CN yet	50.0	41	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
Continuum Care of Snohomish	Snohomish	2019	143	209.0	209.0	342	209.0	342.0				Third year 2021
Envision Hospice	Snohomish	2019	none	209.0	209.0	1	209.0	209.0				Third year 2021
Glacier Peak Healthcare (Alpha)	Snohomish	2019	31	209.0	209.0	117	209.0	209.0				Third year 2021
Heart of Hospice	Snohomish	2019	none	209.0	209.0	none	209.0	209.0				Third year 2021
EmpRes Healthcare Group	Snohomish	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Seasons	Snohomish	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Providence Health & Services	Spokane	2023	none	no CN yet	0.0	none	no CN yet	0.0	none	209.0	209.0	Third year 2025 adjustment in 2022 as proxy
Envision Hospice	Thurston	2018	25	209.0	209.0							Third year 2020
Symbol Healthcare (Puget Sound Hospice)	Thurston	2019	6	209.0	209.0	19	209.0	209.0				Third year 2021
MultiCare Health	Thurston	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
Bristol Hospice	Thurston	2021	none	no CN yet	0.0	none	209.0	209.0	none	209.0	209.0	Third year 2023
EmpRes Healthcare Group	Whatcom	2020	none	209.0	209.0	26	209.0	209.0	65	209.0	209.0	Third year 2022

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Hospice Capacity Admission Calculations

0-64 Total Admissions by County Sum of 0-64			
County	2020	2021	2022
Adams	4	4	4
Asotin	24	9	6
Benton	132	107	137
Chelan	32	53	0
Clallam	24	24	18
Clark	297	308	313
Columbia	3	3	4
Cowlitz	94	116	75
Douglas	17	23	1
Ferry	3	6	4
Franklin	34	17	38
Garfield	3	0	1
Grant	40	27	30
Grays Harbor	27	2	40
Island	54	68	41
Jefferson	17	15	0
King	889	812	796
Kitsap	96	389	57
Kittitas	12	15	8
Klickitat	12	13	13
Lewis	47	38	52
Lincoln	6	5	1
Mason	43	37	28
Okanogan	31	19	20
Pacific	12	2	12
Pend Oreille	17	12	8
Pierce	425	322	325
San Juan	8	5	9
Skagit	70	85	67
Skamania	3	4	1
Snohomish	361	514	341
Spokane	362	368	388
Stevens	21	31	16
Thurston	129	107	102
Wahkiakum	3	3	1
Walla Walla	41	31	28
Whatcom	80	113	276
Whitman	12	15	0
Yakima	195	161	116

65+ Total Admissions by County Sum of 65+			
County	2020	2021	2022
Adams	48	36	36
Asotin	84	92	86
Benton	973	830	993
Chelan	421	686	490
Clallam	283	271	251
Clark	2238	2464	2709
Columbia	50	31	18
Cowlitz	707	793	655
Douglas	170	227	633
Ferry	28	32	35
Franklin	194	134	157
Garfield	7	6	11
Grant	254	230	230
Grays Harbor	186	8	203
Island	375	450	419
Jefferson	194	171	1
King	7131	6592	6252
Kitsap	921	704	690
Kittitas	157	115	148
Klickitat	87	82	90
Lewis	401	421	402
Lincoln	22	12	17
Mason	263	347	329
Okanogan	167	183	129
Pacific	69	2	99
Pend Oreille	49	55	55
Pierce	2714	2310	3127
San Juan	89	95	91
Skagit	607	750	795
Skamania	37	38	42
Snohomish	2636	3580	2794
Spokane	2648	2690	2504
Stevens	128	111	138
Thurston	1070	923	1137
Wahkiakum	11	17	8
Walla Walla	242	243	256
Whatcom	978	1054	2118
Whitman	128	175	8
Yakima	1190	925	676

Actual Survey Admits Not Adjusted For Newly Approved All Agencies			
County	2020	2021	2022
Adams	52	40	40
Asotin	108	101	92
Benton	1105	937	1130
Chelan	453	739	490
Clallam	307	295	269
Clark	2535	2772	3022
Columbia	53	34	22
Cowlitz	801	909	730
Douglas	187	250	634
Ferry	31	38	39
Franklin	228	151	195
Garfield	10	6	12
Grant	294	257	260
Grays Harbor	213	10	243
Island	429	518	460
Jefferson	211	186	1
King	8020	7404	7048
Kitsap	1017	1093	747
Kittitas	169	130	156
Klickitat	99	95	103
Lewis	448	459	454
Lincoln	28	17	18
Mason	306	384	357
Okanogan	198	202	149
Pacific	81	4	111
Pend Oreille	66	67	63
Pierce	3139	2632	3452
San Juan	97	100	100
Skagit	677	835	862
Skamania	40	42	43
Snohomish	2997	4094	3135
Spokane	3010	3058	2892
Stevens	149	142	154
Thurston	1199	1030	1239
Wahkiakum	14	20	9
Walla Walla	283	274	284
Whatcom	1058	1167	2394
Whitman	140	190	8
Yakima	1385	1086	792

Actual Survey Admits Only Under Default 290(7)(b) Newly Approved Only				Count of Newly Approved Agencies Only Under Default 290(7)(b) Newly Approved Only			Default Adjustments Only Under Default 290(7)(b) Newly Approved Only		
County	2020	2021	2022	2020	2021	2022	2020	2021	2022
Adams							-	-	-
Asotin							-	-	-
Benton							-	-	-
Chelan	0	0	0	1	1	1	209.0	209.0	209.0
Clallam	0	0	0	1	1	-	209.0	209.0	-
Clark	0	18	0	1	1	-	209.0	209.0	-
Columbia							-	-	-
Cowlitz							-	-	-
Douglas	0	0	0	1	1	1	209.0	209.0	209.0
Ferry							-	-	-
Franklin							-	-	-
Garfield							-	-	-
Grant							-	-	-
Grays Harbor	0	6	31	1	1	1	209.0	209.0	209.0
Island							-	-	-
Jefferson							-	-	-
King	77	74	0	6	6	5	1,254.0	1,254.0	1,045.0
Kitsap	0	61	0	1	1	1	209.0	209.0	209.0
Kittitas							-	-	-
Klickitat							-	-	-
Lewis							-	-	-
Lincoln							-	-	-
Mason	0	0	100	1	1	1	209.0	209.0	209.0
Okanogan							-	-	-
Pacific							-	-	-
Pend Oreille							-	-	-
Pierce	38	173	41	6	6	6	1,254.0	1,254.0	1,254.0
San Juan							-	-	-
Skagit							-	-	-
Skamania							-	-	-
Snohomish	174	118	0	6	5	2	1,254.0	1,045.0	418.0
Spokane	0	0	0	1	1	1	209.0	209.0	209.0
Stevens							-	-	-
Thurston	31	19	0	4	3	2	836.0	627.0	418.0
Wahkiakum							-	-	-
Walla Walla							-	-	-
Whatcom	0	26	65	1	1	1	209.0	209.0	209.0
Whitman							-	-	-
Yakima							-	-	-

Adjusted Admits Includes Adjustment for 290(7)(b) Agencies All Agencies				
County	2020	2021	2022	Average
Adams	52.00	40.00	40.00	**44.00**
Asotin	108.00	101.00	92.00	**100.33**
Benton	1,105.00	937.00	1,130.00	**1057.33**
Chelan	662.00	948.00	699.00	**769.67**
Clallam	516.00	504.00	269.00	**429.67**
Clark	2,744.00	2,963.00	3,022.00	**2909.67**
Columbia	53.00	34.00	22.00	**36.33**
Cowlitz	801.00	909.00	730.00	**813.33**
Douglas	396.00	459.00	843.00	**566.00**
Ferry	31.00	38.00	39.00	**36.00**
Franklin	228.00	151.00	195.00	**191.33**
Garfield	10.00	6.00	12.00	**9.33**
Grant	294.00	257.00	260.00	**270.33**
Grays Harbor	422.00	213.00	421.00	**352.00**
Island	429.00	518.00	460.00	**469.00**
Jefferson	211.00	186.00	1.00	**132.67**
King	9,197.00	8,584.00	8,093.00	**8624.67**
Kitsap	1,226.00	1,241.00	956.00	**1141.00**
Kittitas	169.00	130.00	156.00	**151.67**
Klickitat	99.00	95.00	103.00	**99.00**
Lewis	448.00	459.00	454.00	**453.67**
Lincoln	28.00	17.00	18.00	**21.00**
Mason	515.00	593.00	466.00	**524.67**
Okanogan	198.00	202.00	149.00	**183.00**
Pacific	81.00	4.00	111.00	**65.33**
Pend Oreille	66.00	67.00	63.00	**65.33**
Pierce	4,355.00	3,713.00	4,665.00	**4244.33**
San Juan	97.00	100.00	100.00	**99.00**
Skagit	677.00	835.00	862.00	**791.33**
Skamania	40.00	42.00	43.00	**41.67**
Snohomish	4,077.00	5,021.00	3,553.00	**4217.00**
Spokane	3,219.00	3,267.00	3,101.00	**3195.67**
Stevens	149.00	142.00	154.00	**148.33**
Thurston	2,004.00	1,638.00	1,657.00	**1766.33**
Wahkiakum	14.00	20.00	9.00	**14.33**
Walla Walla	283.00	274.00	284.00	**280.33**
Whatcom	1,267.00	1,350.00	2,538.00	**1718.33**
Whitman	140.00	190.00	8.00	**112.67**
Yakima	1,385.00	1,086.00	792.00	**1087.67**

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/61.11 ALOS = 209.0 default admissions
209.0 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

blue = proxy for new agencies issued a CN in 2022, since no 2022 for historical

Sources:
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Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Adams	2022	4	36
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2020	4	48
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Adams	2021	4	36
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Asotin	2022	6	86
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2020	24	84
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Asotin	2021	9	92
Chaplaincy Health Care	IHS.FS.00000456	Benton	2020	118	821
Heartlinks	IHS.FS.00000369	Benton	2020	14	152
Heartlinks	IHS.FS.00000369	Benton	2021	17	205
Heartlinks	IHS.FS.00000369	Benton	2022	14	198
Tri Cities Chaplaincy	IHS.FS.00000456	Benton	2021	90	625
Tri Cities Chaplaincy	IHS.FS.00000456	Benton	2022	123	795
Central Washington Home Care Service	IHS.FS.00000250	Chelan	2020	32	421
Central Washington Home Care Services	IHS.FS.00000250	Chelan	2021	53	686
Central Washington Home Care Services	IHS.FS.00000250	Chelan	2022	0	490
Enhabit Hospice	IHS.FS.61165576	Chelan	2021	0	0
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Clallam	2022	18	251
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2020	24	283
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Clallam	2021	24	271
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2020	0	0
Olympic Medical Hospice	IHS.FS.00000393	Clallam	2021	0	0
Community Health & Hospice	IHS.FS.60547198	Clark	2022	46	329
Community Home Health & Hospice	IHS.FS.00000262	Clark	2022	46	329
Community Home Health/Hospice	IHS.FS.60547198	Clark	2020	61	430
Community Home Health/Hospice	IHS.FS.60547198	Clark	2021	57	425
HEART OF HOSPICE	IHS.FS.60741443	Clark	2020	0	3
HEART OF HOSPICE	IHS.FS.60741443	Clark	2021	0	0
Kaiser Permanente	IHS.FS.00000353	Clark	2021	37	408
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2020	42	433
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Clark	2022	27	271
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2020	194	1372
PeaceHealth Hospice Southwest	IHS.FS.60331226	Clark	2022	167	1524
PeaceHealth Southwest Hospice	IHS.FS.60331226	Clark	2021	213	1614
Providence Hospice	IHS.FS.60201476	Clark	2020	0	0
Providence Hospice	IHS.FS.60201476	Clark	2021	1	17
Providence Hospice	IHS.FS.60201476	Clark	2022	27	256
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2020	3	50
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2021	3	31
Walla Walla Community Hospice	IHS.FS.60480441	Columbia	2022	4	18
Community Home Health & Hospice	IHS.FS.00000262	Cowlitz	2022	42	411
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2020	78	616
Community Home Health/Hospice	IHS.FS.00000262	Cowlitz	2021	73	558
Kaiser Permanente	IHS.FS.00000353	Cowlitz	2021	4	7
Kaiser Permanente Continuing Care Services	IHS.FS.00000353	Cowlitz	2022	2	17
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2020	16	91
PeaceHealth Hospice Southwest	IHS.FS.60331226	Cowlitz	2022	31	227
PeaceHealth Southwest Hospice	IHS.FS.60331226	Cowlitz	2021	39	228
Central Washington Home Care Service	IHS.FS.00000250	Douglas	2020	13	159
Central Washington Home Care Services	IHS.FS.00000250	Douglas	2021	19	209
Central Washington Home Care Services	IHS.FS.00000250	Douglas	2022	0	630
Enhabit Hospice	IHS.FS.61165576	Douglas	2021	4	18
Enhabit Hospice	IHS.FS.61165576	Douglas	2022	1	3
Frontier Home Health & Hospice	IHS.FS.60379608	Douglas	2020	4	11
Enhabit Hospice	IHS.FS.61165576	Ferry	2021	0	0
Hospice of Spokane	IHS.FS.00000337	Ferry	2020	3	28
Hospice of Spokane	IHS.FS.00000337	Ferry	2021	6	32
Hospice of Spokane	IHS.FS.00000337	Ferry	2022	4	35
Chaplaincy Health Care	IHS.FS.00000456	Franklin	2020	30	192
Heartlinks	IHS.FS.00000369	Franklin	2020	4	2
Heartlinks	IHS.FS.00000369	Franklin	2021	1	9
Heartlinks	IHS.FS.00000369	Franklin	2022	0	6
Tri Cities Chaplaincy	IHS.FS.00000456	Franklin	2021	16	125
Tri Cities Chaplaincy	IHS.FS.00000456	Franklin	2022	38	151
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Garfield	2022	1	11
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2020	3	7
Alpowa Healthcare, Inc. d/b/a Elite Home Health & Hospice	IHS.FS.60384078	Garfield	2021	0	6
Enhabit Hospice	IHS.FS.61165576	Grant	2021	2	5
Enhabit Hospice	IHS.FS.61165576	Grant	2022	1	10
Frontier Home Health & Hospice	IHS.FS.60379608	Grant	2020	0	3
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Grant	2022	29	220
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2020	40	251

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Grant	2021	25	225
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Grays Harbor	2022	40	172
Harbors Home Health and Hospice	IHS.FS.00000306	Grays Harbor	2020	27	186
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2021	0	6
Puget Sound Hospice	IHS.FS.61032138	Grays Harbor	2022	0	31
EvergreenHealth	IHS.FS.00000278	Island	2020	0	6
EvergreenHealth	IHS.FS.00000278	Island	2021	0	4
EvergreenHealth	IHS.FS.00000278	Island	2022	0	4
Providence Hospice & Homecare of Snohomish County	IHS.FS.00000418	Island	2022	3	29
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Island	2020	5	36
Providence Hospice Snohomish	IHS.FS.00000418	Island	2021	7	36
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2020	20	81
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2021	22	111
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Island	2022	16	132
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2020	29	252
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2021	39	299
WhidbeyHealth Hospice	IHS.FS.00000323	Island	2022	22	254
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2020	17	178
Hospice of Jefferson County	IHS.FS.00000349	Jefferson	2021	14	162
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Jefferson	2022	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2020	0	16
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Jefferson	2021	1	9
Caroline Kline Galland	IHS.FS.60103742	King	2022	39	472
Continuum Care of King LLC	IHS.FS.61058934	King	2020	0	0
Continuum Care of King LLC	IHS.FS.61058934	King	2021	0	0
Continuum Care of Snohomish	IHS.FS.61010090	King	2020	2	40
Continuum Care of Snohomish	IHS.FS.61010090	King	2022	17	452
Continuum Care of Snohomish, LLC	IHS.FS.61010090	King	2021	9	309
Envision Hospice of Washington LLC	IHS.FS.60952486	King	2020	1	76
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2021	1	73
Envision Hospice of Washington, LLC	IHS.FS.60952486	King	2022	3	69
EvergreenHealth	IHS.FS.00000278	King	2020	316	2451
EvergreenHealth	IHS.FS.00000278	King	2021	259	2082
EvergreenHealth	IHS.FS.00000278	King	2022	320	2379
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2021	31	387
Franciscan Hospice and Palliative Care	IHS.FS.00000287	King	2022	30	405
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2020	49	446
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	King	2021	42	281
Kindred Hospice	IHS.FS.60330209	King	2020	9	200
Kline Galland Hospice	IHS.FS.60103742	King	2020	83	896
Kline Galland Hospice	IHS.FS.60103742	King	2021	42	410
Multicare Home Health, Hospice	IHS.FS.60639376	King	2020	36	137
Multicare Hospice	IHS.FS.60639376	King	2021	21	141
Multicare Hospice	IHS.FS.60639376	King	2022	23	100
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2021	1	116
Odyssey HealthCare Operating B, LP	IHS.FS.60330209	King	2022	1	67
Providence Hospice of Seattle	IHS.FS.00000336	King	2020	338	2059
Providence Hospice of Seattle	IHS.FS.00000336	King	2021	402	2664
Providence Hospice of Seattle	IHS.FS.00000336	King	2022	361	2215
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	King	2020	52	716
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2020	3	110
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2021	4	129
Wesley Homes Hospice, LLC	IHS.FS.60276500	King	2022	2	93
Y.B.G. Healthcare LLC DBA Heart and Soul Hospice	IHS.FS.61379202	King	2022	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Kitsap	2020	0	0
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2021	6	55
Envision Hospice of Washington, LLC	IHS.FS.60952486	Kitsap	2022	3	117
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2021	356	371
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Kitsap	2022	30	405
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2020	13	114
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Kitsap	2021	11	138
Multicare Home Health, Hospice	IHS.FS.60639376	Kitsap	2020	12	126
Multicare Hospice	IHS.FS.60639376	Kitsap	2021	16	140
Multicare Hospice	IHS.FS.60639376	Kitsap	2022	24	168
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Kitsap	2020	71	681
Kittitas Valley Healthcare Hospice	IHS.FS.00000320	Kittitas	2021	15	115
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2020	12	157
Kittitas Valley Home Health and Hospice	IHS.FS.00000320	Kittitas	2022	8	148
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2020	2	21
HEART OF HOSPICE	IHS.FS.60741443	Klickitat	2021	3	20
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Klickitat	2022	5	20

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Klickitat Valley Health - Hospice	IHS.FS.00000361	Klickitat	2021	3	28
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2020	4	38
Klickitat Valley Health Home Health & Hospice	IHS.FS.00000361	Klickitat	2022	5	44
Providence Hospice	IHS.FS.60201476	Klickitat	2020	6	28
Providence Hospice	IHS.FS.60201476	Klickitat	2021	7	34
Providence Hospice	IHS.FS.60201476	Klickitat	2022	3	26
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Lewis	2022	21	247
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2020	15	226
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Lewis	2021	19	221
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2020	32	175
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2021	19	200
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Lewis	2022	31	155
Enhabit Hospice	IHS.FS.61165576	Lincoln	2021	0	0
Hospice of Spokane	IHS.FS.00000337	Lincoln	2020	1	1
Hospice of Spokane	IHS.FS.00000337	Lincoln	2021	1	2
Hospice of Spokane	IHS.FS.00000337	Lincoln	2022	0	1
Washington HomeCare and Hospice of Central Basin, LLC	IHS.FS.60092413	Lincoln	2022	1	16
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2020	5	21
Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice	IHS.FS.60092413	Lincoln	2021	4	10
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Mason	2022	5	53
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2020	8	70
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Mason	2021	12	47
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2020	35	193
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2021	25	300
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Mason	2022	23	176
Puget Sound Hospice	IHS.FS.61032138	Mason	2021	0	0
Puget Sound Hospice	IHS.FS.61032138	Mason	2022	0	100
Enhabit Hospice	IHS.FS.61165576	Okanogan	2021	19	183
Enhabit Hospice	IHS.FS.61165576	Okanogan	2022	20	129
Frontier Home Health & Hospice	IHS.FS.60379608	Okanogan	2020	30	167
Hospice of Spokane	IHS.FS.00000337	Okanogan	2020	1	0
Community Home Health/Hospice	IHS.FS.00000262	Pacific	2020	1	3
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2021	2	2
Harbors Home Health & Hospice	IHS.FS.00000306	Pacific	2022	12	99
Harbors Home Health and Hospice	IHS.FS.00000306	Pacific	2020	11	66
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2022	8	55
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2020	17	49
Hospice of Spokane	IHS.FS.00000337	Pend Oreille	2021	12	55
Continuum Care of Snohomish	IHS.FS.61010090	Pierce	2022	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Pierce	2020	1	20
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2021	8	113
Envision Hospice of Washington, LLC	IHS.FS.60952486	Pierce	2022	1	84
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2021	141	1081
Franciscan Hospice and Palliative Care	IHS.FS.00000287	Pierce	2022	136	2118
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2020	30	181
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Pierce	2021	21	156
Multicare Home Health, Hospice	IHS.FS.60639376	Pierce	2020	161	866
Multicare Hospice	IHS.FS.60639376	Pierce	2021	145	914
Multicare Hospice	IHS.FS.60639376	Pierce	2022	156	818
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2020	0	1
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Pierce	2021	0	1
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2021	1	1
Providence Hospice of Seattle	IHS.FS.00000336	Pierce	2022	31	67
Puget Sound Hospice	IHS.FS.61032138	Pierce	2021	0	0
Virginia Mason Franciscan Hospice & Palliative Care	IHS.FS.00000287	Pierce	2020	232	1630
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2020	1	16
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2021	6	44
Wesley Homes Hospice, LLC	IHS.FS.60276500	Pierce	2022	1	40
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2020	8	89
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2021	5	95
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	San Juan	2022	9	91
Eden Hospice at Whatcom County	IHS.FS.61117985	Skagit	2021	0	1
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Skagit	2022	1	42
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2020	70	607
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2021	85	749
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Skagit	2022	66	753
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2020	2	18
HEART OF HOSPICE	IHS.FS.60741443	Skamania	2021	2	22
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Skamania	2022	0	21
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2020	0	3
PeaceHealth Hospice Southwest	IHS.FS.60331226	Skamania	2022	0	3
PeaceHealth Southwest Hospice	IHS.FS.60331226	Skamania	2021	0	1

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Providence Hospice	IHS.FS.60201476	Skamania	2020	1	16
Providence Hospice	IHS.FS.60201476	Skamania	2021	2	15
Providence Hospice	IHS.FS.60201476	Skamania	2022	1	18
Alpha Hospice	IHS.FS.61032013	Snohomish	2020	1	30
Alpha Hospice	IHS.FS.61032013	Snohomish	2021	6	111
Alpha Hospice	IHS.FS.61032013	Snohomish	2022	7	162
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2020	12	131
Continuum Care of Snohomish	IHS.FS.61010090	Snohomish	2022	30	406
Continuum Care of Snohomish, LLC	IHS.FS.61010090	Snohomish	2021	36	306
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2020	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Snohomish	2021	0	1
EvergreenHealth	IHS.FS.00000278	Snohomish	2020	70	672
EvergreenHealth	IHS.FS.00000278	Snohomish	2021	67	627
EvergreenHealth	IHS.FS.00000278	Snohomish	2022	68	642
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2020	0	0
HEART OF HOSPICE	IHS.FS.60741443	Snohomish	2021	0	0
Inspiring Hospice Partners of Oregon, LLC	IHS.FS.60741443	Snohomish	2022	1	42
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2020	3	84
Kaiser Permanente Home Health & Hospice	IHS.FS.00000305	Snohomish	2021	5	63
Providence Hospice & Homecare of Snohomish County	IHS.FS.00000418	Snohomish	2022	220	1396
Providence Hospice and Home Care of Snohomish County	IHS.FS.00000418	Snohomish	2020	267	1645
Providence Hospice of Seattle	IHS.FS.00000336	Snohomish	2020	0	0
Providence Hospice Snohomish	IHS.FS.00000418	Snohomish	2021	387	2378
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2020	8	74
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2021	13	94
Skagit Hospice Services dba Hospice of the Northwest	IHS.FS.00000437	Snohomish	2022	15	146
Gentiva Hospice	IHS.FS.60308060	Spokane	2022	106	198
Horizon Hospice	IHS.FS.00000332	Spokane	2021	36	520
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2020	28	456
Horizon Hospice & Palliative Care	IHS.FS.00000332	Spokane	2022	46	633
Hospice of Spokane	IHS.FS.00000337	Spokane	2020	302	1895
Hospice of Spokane	IHS.FS.00000337	Spokane	2021	317	1899
Hospice of Spokane	IHS.FS.00000337	Spokane	2022	236	1673
Kindred Hospice	IHS.FS.60308060	Spokane	2020	32	297
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Spokane	2021	15	271
Hospice of Spokane	IHS.FS.00000337	Stevens	2020	21	128
Hospice of Spokane	IHS.FS.00000337	Stevens	2021	31	111
Hospice of Spokane	IHS.FS.00000337	Stevens	2022	16	138
Bristol Hospice - Thurston, LLC	IHS.FS.61211200	Thurston	2021	0	0
Envision Hospice of Washington LLC	IHS.FS.60952486	Thurston	2020	1	24
Envision Hospice of Washington, LLC	IHS.FS.60952486	Thurston	2021	1	22
Envision Hospice of Washington, LLC	IHS.FS.60952486	Thurston	2022	2	39
Northwest Healthcare Alliance, Inc	IHS.FS.00000229	Thurston	2022	24	363
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2020	22	268
Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice	IHS.FS.00000229	Thurston	2021	31	282
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2020	106	772
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2021	75	600
Providence Sound HomeCare and Hospice	IHS.FS.00000420	Thurston	2022	76	725
Puget Sound Hospice	IHS.FS.61032138	Thurston	2020	0	6
Puget Sound Hospice	IHS.FS.61032138	Thurston	2021	0	19
Puget Sound Hospice	IHS.FS.61032138	Thurston	2022	0	10
Community Home Health & Hospice	IHS.FS.00000262	Wahkiakum	2022	1	2
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2020	3	11
Community Home Health/Hospice	IHS.FS.00000262	Wahkiakum	2021	1	14
PeaceHealth Hospice Southwest	IHS.FS.60331226	Wahkiakum	2022	0	6
PeaceHealth Southwest Hospice	IHS.FS.60331226	Wahkiakum	2021	2	3
Tri Cities Chaplaincy	IHS.FS.00000456	Walla Walla	2022	0	8
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2020	41	242
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2021	31	243
Walla Walla Community Hospice	IHS.FS.60480441	Walla Walla	2022	28	248
Eden Hospice at Whatcom County	IHS.FS.61117985	Whatcom	2021	2	24
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2020	0	0
Whatcom Hospice	IHS.FS.00000471	Whatcom	2021	111	1030
Whatcom Hospice	IHS.FS.00000471	Whatcom	2022	139	1025
Whatcom Hospice	IHS.FS.00000471	Whatcom	2020	80	978
Eden Hospice at Whatcom County, LLC	IHS.FS.61117985	Whatcom	2022	3	62
PeaceHealth Whatcom Hospice	IHS.FS.61214897	Whatcom	2022	134	1031
Alpowa Healthcare Inc dba Elite Home Health and Hospice	IHS.FS.60384078	Whitman	2022	0	8
Hospice of Spokane	IHS.FS.00000337	Whitman	2020	0	1
Kindred Hospice	IHS.FS.60308060	Whitman	2020	12	127
Odyssey HealthCare Operating B, LP	IHS.FS.60308060	Whitman	2021	15	175
Astria Hospice	IHS.FS.60097245	Yakima	2021	3	52

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Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Survey Data

Agency Name	License Number	County	Year	0-64	65+
Astria Hospice	IHS.FS.60097245	Yakima	2020	0	56
Heartlinks	IHS.FS.00000369	Yakima	2020	20	181
Heartlinks	IHS.FS.00000369	Yakima	2021	15	224
Heartlinks	IHS.FS.00000369	Yakima	2022	25	204
Memorial Home Care Services	IHS.FS.00000376	Yakima	2020	175	953
Memorial Home Care Services	IHS.FS.00000376	Yakima	2021	143	649

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Preliminary Death Data Updated September 22, 2023

County	0-64			65+	
	2020	2021	2022	2020	2021
ADAMS	20	23	25	59	92
ASOTIN	56	43	45	186	188
BENTON	555	536	566	1522	1610
CHELAN	224	256	225	785	870
CLALLAM	195	185	179	777	906
CLARK	1043	1078	1002	3205	3705
COLUMBIA	7	11	12	43	43
COWLITZ	314	401	311	968	1100
DOUGLAS	42	45	45	160	174
FERRY	19	21	22	58	63
FRANKLIN	100	110	79	263	261
GARFIELD	5	4	2	11	24
GRANT	186	208	190	455	523
GRAYS HARBOR	209	236	223	558	590
ISLAND	110	116	117	505	504
JEFFERSON	68	54	59	273	295
KING	4456	4892	4902	11186	11896
KITSAP	454	489	462	1714	1832
KITTITAS	78	88	78	241	241
KLICKITAT	42	50	50	113	164
LEWIS	205	186	191	653	723
LINCOLN	15	24	24	75	76
MASON	143	168	152	408	461
OKANOGAN	88	92	106	277	324
PACIFIC	55	59	69	177	239
PEND OREILLE	41	55	44	101	119
PIERCE	2364	2574	2518	5608	6264
SAN JUAN	18	24	12	94	91
SKAGIT	269	334	258	1068	1190
SKAMANIA	26	25	20	47	56
SNOHOMISH	1587	1563	1468	4278	4478
SPOKANE	1634	1842	1603	4322	4810
STEVENS	86	114	107	248	304
THURSTON	628	763	709	2007	2285
WAHKIAKUM	10	7	9	18	25
WALLA WALLA	150	138	157	522	595
WHATCOM	457	443	467	1481	1674
WHITMAN	51	59	65	226	278
YAKIMA	653	699	628	1675	1644

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Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
0-64 Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020-2022 Average Population
Adams	17,637	17,768	17,899	18,029	18,160	18,015	18,199	18,382	18,565	18,748	18,931	18,199
Asotin	16,969	16,906	16,842	16,779	16,715	16,822	16,706	16,591	16,475	16,360	16,244	16,706
Benton	162,262	163,693	165,123	166,554	167,984	174,308	175,851	177,393	178,935	180,477	182,019	175,851
Chelan	61,284	61,520	61,755	61,991	62,227	62,829	62,907	62,984	63,062	63,139	63,217	62,907
Clallam	52,716	52,661	52,605	52,550	52,494	52,094	52,247	52,399	52,552	52,704	52,857	52,247
Clark	387,296	393,291	399,287	405,282	411,278	420,628	424,857	429,086	433,316	437,545	441,774	424,857
Columbia	2,988	2,947	2,905	2,863	2,822	2,812	2,763	2,713	2,664	2,615	2,566	2,763
Cowlitz	85,417	85,517	85,617	85,717	85,817	87,848	87,937	88,027	88,116	88,206	88,295	87,937
Douglas	33,540	33,938	34,335	34,732	35,130	35,255	35,378	35,501	35,624	35,746	35,869	35,378
Ferry	5,834	5,782	5,731	5,680	5,628	5,208	5,127	5,047	4,967	4,886	4,806	5,127
Franklin	79,651	81,742	83,832	85,922	88,012	87,500	88,772	90,044	91,315	92,587	93,859	88,772
Garfield	1,665	1,644	1,623	1,602	1,581	1,570	1,570	1,570	1,569	1,569	1,569	1,570
Grant	81,535	82,660	83,784	84,909	86,033	85,007	85,596	86,185	86,774	87,363	87,952	85,596
Grays Harb	59,105	58,675	58,246	57,817	57,387	58,396	58,092	57,788	57,484	57,179	56,875	58,092
Island	62,514	62,664	62,814	62,964	63,114	63,633	63,840	64,048	64,256	64,464	64,672	63,840
Jefferson	20,636	20,653	20,670	20,688	20,705	20,345	20,269	20,192	20,116	20,040	19,964	20,269
King	1,798,581	1,820,215	1,841,848	1,863,482	1,885,115	1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962	1,974,586
Kitsap	212,548	214,045	215,543	217,040	218,538	222,540	222,587	222,634	222,681	222,729	222,776	222,587
Kittitas	36,206	36,768	37,330	37,892	38,453	38,168	38,539	38,910	39,282	39,653	40,024	38,539
Klickitat	16,208	16,082	15,955	15,828	15,702	17,332	17,217	17,103	16,988	16,874	16,759	17,217
Lewis	61,494	61,796	62,097	62,398	62,700	63,604	63,811	64,018	64,225	64,432	64,639	63,811
Lincoln	8,101	8,042	7,982	7,923	7,864	7,814	7,804	7,794	7,785	7,775	7,765	7,804
Mason	48,672	49,162	49,652	50,142	50,632	49,799	49,998	50,196	50,395	50,594	50,793	49,998
Okanogan	33,087	32,906	32,726	32,545	32,364	32,082	31,910	31,737	31,564	31,392	31,219	31,910
Pacific	15,115	14,972	14,830	14,688	14,545	15,581	15,523	15,464	15,405	15,346	15,287	15,523
Pend Oreill	10,045	9,998	9,952	9,905	9,859	9,718	9,660	9,602	9,543	9,485	9,427	9,660
Pierce	721,137	729,937	738,738	747,538	756,339	786,960	790,591	794,221	797,852	801,483	805,114	790,591
San Juan	11,305	11,194	11,084	10,974	10,863	11,697	11,682	11,668	11,654	11,640	11,626	11,682
Skagit	97,885	98,616	99,346	100,076	100,807	100,150	100,574	100,998	101,422	101,846	102,270	100,574
Skamania	9,272	9,266	9,260	9,254	9,248	9,366	9,243	9,121	8,998	8,875	8,752	9,243
Snohomish	661,812	672,806	683,800	694,793	705,787	708,361	712,731	717,100	721,470	725,839	730,209	712,731
Spokane	414,493	416,684	418,875	421,066	423,256	446,453	447,909	449,365	450,821	452,277	453,733	447,909
Stevens	34,576	34,459	34,343	34,226	34,109	36,029	35,790	35,550	35,311	35,071	34,832	35,790
Thurston	224,951	228,261	231,571	234,880	238,190	240,351	242,356	244,360	246,365	248,369	250,374	242,356
Wahkiakur	2,726	2,669	2,612	2,555	2,498	2,957	2,943	2,930	2,917	2,903	2,890	2,943
Walla Wall	49,893	50,111	50,328	50,546	50,763	50,358	50,364	50,370	50,376	50,382	50,388	50,364
Whatcom	175,840	178,234	180,629	183,023	185,418	184,193	185,493	186,794	188,095	189,395	190,696	185,493
Whitman	42,880	42,965	43,051	43,137	43,222	42,475	42,489	42,503	42,517	42,531	42,545	42,489
Yakima	215,882	217,605	219,328	221,051	222,774	219,274	219,628	219,982	220,336	220,690	221,044	219,628

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
65+ Population Projection

County	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2020-2022 Average Population
Adams	1,773	1,887	2,000	2,114	2,227	2,598	2,605	2,613	2,621	2,629	2,637	2,605
Asotin	5,041	5,233	5,426	5,619	5,812	5,463	5,673	5,884	6,094	6,305	6,515	5,673
Benton	26,328	27,492	28,657	29,821	30,986	32,565	33,826	35,088	36,349	37,611	38,872	33,826
Chelan	13,746	14,279	14,811	15,343	15,876	16,312	16,903	17,494	18,085	18,677	19,268	16,903
Clallam	19,934	20,401	20,867	21,334	21,800	25,061	25,369	25,678	25,986	26,295	26,603	25,369
Clark	64,524	68,044	71,564	75,085	78,605	82,683	86,493	90,303	94,113	97,923	101,733	86,493
Columbia	1,102	1,135	1,169	1,202	1,236	1,140	1,170	1,200	1,229	1,259	1,289	1,170
Cowlitz	18,863	19,684	20,505	21,326	22,148	22,882	23,471	24,060	24,649	25,237	25,826	23,471
Douglas	6,450	6,831	7,213	7,595	7,976	7,683	8,039	8,396	8,752	9,109	9,465	8,039
Ferry	1,876	1,949	2,022	2,095	2,168	1,970	2,058	2,147	2,235	2,323	2,411	2,058
Franklin	7,499	7,921	8,343	8,765	9,188	9,249	9,795	10,341	10,887	11,433	11,979	9,795
Garfield	595	607	620	633	645	716	711	706	700	695	690	711
Grant	12,395	13,011	13,628	14,244	14,861	14,116	14,729	15,343	15,957	16,571	17,185	14,729
Grays Harb	14,005	14,535	15,064	15,594	16,123	17,240	17,700	18,161	18,621	19,082	19,542	17,700
Island	18,086	18,625	19,163	19,701	20,239	23,224	23,676	24,127	24,579	25,030	25,482	23,676
Jefferson	10,244	10,580	10,916	11,252	11,588	12,632	13,029	13,427	13,824	14,221	14,618	13,029
King	254,219	268,307	282,395	296,484	310,572	304,683	316,701	328,719	340,737	352,755	364,773	316,701
Kitsap	45,652	47,697	49,743	51,788	53,833	53,071	55,150	57,228	59,307	61,385	63,464	55,150
Kittitas	6,464	6,760	7,055	7,351	7,647	8,300	8,482	8,664	8,846	9,028	9,210	8,482
Klickitat	4,792	5,051	5,310	5,570	5,829	5,403	5,695	5,987	6,280	6,572	6,864	5,695
Lewis	15,166	15,576	15,987	16,398	16,808	18,545	18,899	19,253	19,608	19,962	20,316	18,899
Lincoln	2,619	2,687	2,755	2,823	2,891	3,062	3,116	3,169	3,223	3,276	3,330	3,116
Mason	13,528	14,123	14,717	15,311	15,905	15,927	16,436	16,945	17,453	17,962	18,471	16,436
Okanogan	8,773	9,198	9,624	10,050	10,475	10,022	10,353	10,685	11,017	11,348	11,680	10,353
Pacific	6,095	6,258	6,421	6,584	6,747	7,784	7,971	8,159	8,347	8,534	8,722	7,971
Pend Oreill	3,195	3,378	3,560	3,742	3,925	3,683	3,845	4,007	4,170	4,332	4,494	3,845
Pierce	108,983	114,409	119,836	125,262	130,688	133,433	139,235	145,038	150,840	156,642	162,444	139,235
San Juan	4,876	5,099	5,322	5,545	5,768	6,091	6,326	6,561	6,796	7,030	7,265	6,326
Skagit	22,735	24,021	25,308	26,595	27,881	29,373	30,250	31,128	32,005	32,882	33,759	30,250
Skamania	2,158	2,286	2,414	2,542	2,670	2,238	2,455	2,673	2,891	3,108	3,326	2,455
Snohomish	95,788	101,674	107,560	113,447	119,333	119,596	125,852	132,107	138,363	144,618	150,874	125,852
Spokane	73,817	77,325	80,834	84,343	87,852	92,886	96,172	99,458	102,744	106,030	109,316	96,172
Stevens	9,454	9,930	10,407	10,884	11,360	10,416	11,029	11,642	12,255	12,868	13,481	11,029
Thurston	42,459	44,534	46,608	48,683	50,757	54,442	56,276	58,110	59,944	61,778	63,612	56,276
Wahkiakur	1,254	1,316	1,379	1,441	1,503	1,465	1,512	1,558	1,604	1,651	1,697	1,512
Walla Wall	10,757	10,819	10,881	10,944	11,006	12,226	12,446	12,666	12,886	13,106	13,326	12,446
Whatcom	33,950	35,688	37,426	39,164	40,902	42,654	44,049	45,443	46,838	48,232	49,627	44,049
Whitman	4,370	4,659	4,948	5,237	5,526	5,498	5,619	5,739	5,860	5,980	6,101	5,619
Yakima	34,088	34,949	35,809	36,670	37,530	37,454	38,467	39,479	40,491	41,504	42,516	38,467

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Adams** **Select from drop down menu*

Adams County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Adams	17,768	17,899	18,029	18,160	18,015	18,199	18,382	18,565	18,748	18,931		18,199

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Adams	1,887	2,000	2,114	2,227	2,598	2,605	2,613	2,621	2,629	2,637		2,605

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		20	23	25					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	23								
Projected patient deaths: 21.09%	3	5								
Average population (OFM)	4	18,199								
Projected population	N/A		18,015	18,199	18,382	18,565	18,748	18,931		
Potential volume	N/A		5	5	5	5	5	5		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		59	92	91					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	81								
Projected patient deaths: 56.80%	3	46								
Average population (OFM)	4	2,605								
Projected population	N/A		2,598	2,605	2,613	2,621	2,629	2,637		
Potential volume	N/A		46	46	46	46	46	46		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		50	51	51	51	51	51		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	44								
Unmet need	5		**6**	**7**	**7**	**7**	**7**	**7**		
Unmet need patient days (statewide ALOS)	6	61.11	392	403	414	426	437	449		
Unmet Average Daily Census (ADC)	7		1	1	1	1	1	1		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Asotin** **Select from drop down menu*

Asotin County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Asotin	16,906	16,842	16,779	16,715	16,822	16,706	16,591	16,475	16,360	16,244		16,706

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Asotin	5,233	5,426	5,619	5,812	5,463	5,673	5,884	6,094	6,305	6,515		5,673

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		56	43	45					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	48								
Projected patient deaths: 21.09%	3	10								
Average population (OFM)	4	16,706								
Projected population	N/A		16,822	16,706	16,591	16,475	16,360	16,244		
Potential volume	N/A		10	10	10	10	10	10		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		186	188	227					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	200								
Projected patient deaths: 56.80%	3	114								
Average population (OFM)	4	5,673								
Projected population	N/A		5,463	5,673	5,884	6,094	6,305	6,515		
Potential volume	N/A		110	114	118	122	126	131		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		120	124	128	132	136	141		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	100								
Unmet need	5		**19**	**24**	**28**	**32**	**36**	**40**		
Unmet need patient days (statewide ALOS)	6	61.11	1,187	1,440	1,694	1,947	2,201	2,455		
Unmet Average Daily Census (ADC)	7		3	4	5	5	6	7		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Benton** **Select from drop down menu*

Benton County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Benton	163,693	165,123	166,554	167,984	174,308	175,851	177,393	178,935	180,477	182,019		175,851

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Benton	27,492	28,657	29,821	30,986	32,565	33,826	35,088	36,349	37,611	38,872		33,826

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		555	536	566				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	552							
Projected patient deaths: 21.09%	3	116							
Average population (OFM)	4	175,851							
Projected population	N/A		174,308	175,851	177,393	178,935	180,477	182,019	
Potential volume	N/A		115	116	117	119	120	121	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		1,522	1,610	1,739				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,624							
Projected patient deaths: 56.80%	3	922							
Average population (OFM)	4	33,826							
Projected population	N/A		32,565	33,826	35,088	36,349	37,611	38,872	
Potential volume	N/A		888	922	957	991	1,025	1,060	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		1,003	1,039	1,074	1,109	1,145	1,180	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	1,057							
Unmet need	5		**(54)**	**(19)**	**17**	**52**	**88**	**123**	
Unmet need patient days (statewide ALOS)	6	61.11	(3,306)	(1,142)	1,022	3,186	5,350	7,514	
Unmet Average Daily Census (ADC)	7		(9)	(3)	3	9	15	21	
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Chelan** **Select from drop down menu*

Chelan County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Chelan	61,520	61,755	61,991	62,227	62,829	62,907	62,984	63,062	63,139	63,217		62,907

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Chelan	14,279	14,811	15,343	15,876	16,312	16,903	17,494	18,085	18,677	19,268		16,903

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		224	256	225					
Average deaths (2020-2022)	2	235								
Projected patient deaths: 21.09%	3	50								
Average population (OFM)	4	62,907								
Projected population	N/A		62,829	62,907	62,984	63,062	63,139	63,217		
Potential volume	N/A		49	50	50	50	50	50		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		785	870	873					
Average deaths (2020-2022)	2	843								
Projected patient deaths: 56.80%	3	479								
Average population (OFM)	4	16,903								
Projected population	N/A		16,312	16,903	17,494	18,085	18,677	19,268		
Potential volume	N/A		462	479	495	512	529	546		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		511	528	545	562	579	595		
Current capacity (DOH survey)	N/A	770								
Unmet need	5		**(258)**	**(242)**	**(225)**	**(208)**	**(191)**	**(174)**		
Unmet need patient days (statewide ALOS)	6	61.11	(15,786)	(14,759)	(13,732)	(12,705)	(11,678)	(10,652)		
Unmet Average Daily Census (ADC)	7		(43)	(40)	(38)	(35)	(32)	(29)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Clallam **Select from drop down menu*

Clallam County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Clallam	52,661	52,605	52,550	52,494	52,094	52,247	52,399	52,552	52,704	52,857		52,247

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Clallam	20,401	20,867	21,334	21,800	25,061	25,369	25,678	25,986	26,295	26,603		25,369

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		195	185	179					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	186								
Projected patient deaths: 21.09%	3	39								
Average population (OFM)	4	52,247								
Projected population	N/A		52,094	52,247	52,399	52,552	52,704	52,857		
Potential volume	N/A		39	39	39	40	40	40		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		777	906	935					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	873								
Projected patient deaths: 56.80%	3	496								
Average population (OFM)	4	25,369								
Projected population	N/A		25,061	25,369	25,678	25,986	26,295	26,603		
Potential volume	N/A		490	496	502	508	514	520		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		529	535	541	547	553	559		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	430								
Unmet need	5		**99**	**105**	**111**	**118**	**124**	**130**		
Unmet need patient days (statewide ALOS)	6	61.11	6,057	6,433	6,808	7,183	7,558	7,934		
Unmet Average Daily Census (ADC)	7		17	18	19	20	21	22		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Clark** **Select from drop down menu*

Clark County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Clark	393,291	399,287	405,282	411,278	420,628	424,857	429,086	433,316	437,545	441,774		424,857

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Clark	68,044	71,564	75,085	78,605	82,683	86,493	90,303	94,113	97,923	101,733		86,493

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		1,043	1,078	1,002					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	1,041								
Projected patient deaths: 21.09%	3	220								
Average population (OFM)	4	424,857								
Projected population	N/A		420,628	424,857	429,086	433,316	437,545	441,774		
Potential volume	N/A		217	220	222	224	226	228		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		3,205	3,705	3,709					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	3,540								
Projected patient deaths: 56.80%	3	2,010								
Average population (OFM)	4	86,493								
Projected population	N/A		82,683	86,493	90,303	94,113	97,923	101,733		
Potential volume	N/A		1,922	2,010	2,099	2,187	2,276	2,365		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		2,139	2,230	2,321	2,411	2,502	2,593		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	2,910								
Unmet need	5		**(771)**	**(680)**	**(589)**	**(498)**	**(408)**	**(317)**		
Unmet need patient days (statewide ALOS)	6	61.11	(47,086)	(41,541)	(35,996)	(30,451)	(24,906)	(19,360)		
Unmet Average Daily Census (ADC)	7		(129)	(114)	(99)	(83)	(68)	(53)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Columbia** **Select from drop down menu*

Columbia County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Columbia	2,947	2,905	2,863	2,822	2,812	2,763	2,713	2,664	2,615	2,566		2,763

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Columbia	1,135	1,169	1,202	1,236	1,140	1,170	1,200	1,229	1,259	1,289		1,170

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		7	11	12					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	10								
Projected patient deaths: 21.09%	3	2								
Average population (OFM)	4	2,763								
Projected population	N/A		2,812	2,763	2,713	2,664	2,615	2,566		
Potential volume	N/A		2	2	2	2	2	2		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		43	43	37					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	41								
Projected patient deaths: 56.80%	3	23								
Average population (OFM)	4	1,170								
Projected population	N/A		1,140	1,170	1,200	1,229	1,259	1,289		
Potential volume	N/A		23	23	24	24	25	26		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		25	25	26	27	27	28		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	36								
Unmet need	5		**(11)**	**(11)**	**(10)**	**(10)**	**(9)**	**(9)**		
Unmet need patient days (statewide ALOS)	6	61.11	(702)	(668)	(635)	(601)	(567)	(533)		
Unmet Average Daily Census (ADC)	7		(2)	(2)	(2)	(2)	(2)	(1)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Cowlitz** **Select from drop down menu*

Cowlitz County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Cowlitz	85,517	85,617	85,717	85,817	87,848	87,937	88,027	88,116	88,206	88,295		87,937

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Cowlitz	19,684	20,505	21,326	22,148	22,882	23,471	24,060	24,649	25,237	25,826		23,471

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		314	401	311					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	342								
Projected patient deaths: 21.09%	3	72								
Average population (OFM)	4	87,937								
Projected population	N/A		87,848	87,937	88,027	88,116	88,206	88,295		
Potential volume	N/A		72	72	72	72	72	72		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		968	1,100	989					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,019								
Projected patient deaths: 56.80%	3	579								
Average population (OFM)	4	23,471								
Projected population	N/A		22,882	23,471	24,060	24,649	25,237	25,826		
Potential volume	N/A		564	579	593	608	622	637		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		636	651	665	680	695	709		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	813								
Unmet need	5		**(177)**	**(162)**	**(148)**	**(133)**	**(119)**	**(104)**		
Unmet need patient days (statewide ALOS)	6	61.11	(10,820)	(9,928)	(9,037)	(8,145)	(7,254)	(6,362)		
Unmet Average Daily Census (ADC)	7		(30)	(27)	(25)	(22)	(20)	(17)		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Douglas **Select from drop down menu*

Douglas County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Douglas	33,938	34,335	34,732	35,130	35,255	35,378	35,501	35,624	35,746	35,869		35,378

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Douglas	6,831	7,213	7,595	7,976	7,683	8,039	8,396	8,752	9,109	9,465		8,039

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		42	45	45					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	44								
Projected patient deaths: 21.09%	3	9								
Average population (OFM)	4	35,378								
Projected population	N/A		35,255	35,378	35,501	35,624	35,746	35,869		
Potential volume	N/A		9	9	9	9	9	9		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		160	174	205					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	180								
Projected patient deaths: 56.80%	3	102								
Average population (OFM)	4	8,039								
Projected population	N/A		7,683	8,039	8,396	8,752	9,109	9,465		
Potential volume	N/A		98	102	107	111	116	120		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		107	111	116	120	125	130		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	566								
Unmet need	5		**(459)**	**(455)**	**(450)**	**(446)**	**(441)**	**(436)**		
Unmet need patient days (statewide ALOS)	6	61.11	(28,064)	(27,785)	(27,507)	(27,229)	(26,950)	(26,672)		
Unmet Average Daily Census (ADC)	7		(77)	(76)	(75)	(75)	(74)	(73)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Ferry** **Select from drop down menu*

Ferry County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Ferry	5,782	5,731	5,680	5,628	5,208	5,127	5,047	4,967	4,886	4,806		5,127
65 +	Ferry	1,949	2,022	2,095	2,168	1,970	2,058	2,147	2,235	2,323	2,411		2,058

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		19	21	22					
Average deaths (2020-2022)	2	21								
Projected patient deaths: 21.09%	3	4								
Average population (OFM)	4	5,127								
Projected population	N/A		5,208	5,127	5,047	4,967	4,886	4,806		
Potential volume	N/A		4	4	4	4	4	4		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		58	63	60					
Average deaths (2020-2022)	2	60								
Projected patient deaths: 56.80%	3	34								
Average population (OFM)	4	2,058								
Projected population	N/A		1,970	2,058	2,147	2,235	2,323	2,411		
Potential volume	N/A		33	34	36	37	39	40		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		37	39	40	41	43	44		
Current capacity (DOH survey)	N/A	36								
Unmet need	5		**1**	**3**	**4**	**5**	**7**	**8**		
Unmet need patient days (statewide ALOS)	6	61.11	75	160	246	331	417	502		
Unmet Average Daily Census (ADC)	7		0	0	1	1	1	1		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Franklin **Select from drop down menu*

Franklin County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Franklin	81,742	83,832	85,922	88,012	87,500	88,772	90,044	91,315	92,587	93,859		88,772
65 +	Franklin	7,921	8,343	8,765	9,188	9,249	9,795	10,341	10,887	11,433	11,979		9,795

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		100	110	79					
Average deaths (2020-2022)	2	96								
Projected patient deaths: 21.09%	3	20								
Average population (OFM)	4	88,772								
Projected population	N/A		87,500	88,772	90,044	91,315	92,587	93,859		
Potential volume	N/A		20	20	21	21	21	21		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		263	261	234					
Average deaths (2020-2022)	2	253								
Projected patient deaths: 56.80%	3	144								
Average population (OFM)	4	9,795								
Projected population	N/A		9,249	9,795	10,341	10,887	11,433	11,979		
Potential volume	N/A		136	144	152	160	167	175		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		156	164	172	180	189	197		
Current capacity (DOH survey)	N/A	191								
Unmet need	5		**(36)**	**(28)**	**(19)**	**(11)**	**(3)**	**6**		
Unmet need patient days (statewide ALOS)	6	61.11	(2,188)	(1,681)	(1,175)	(668)	(162)	345		
Unmet Average Daily Census (ADC)	7		(6)	(5)	(3)	(2)	(0)	1		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Garfield ***Select from drop down menu**

Garfield County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Garfield	1,644	1,623	1,602	1,581	1,570	1,570	1,570	1,569	1,569	1,569		1,570
65 +	Garfield	607	620	633	645	716	711	706	700	695	690		711

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	3,647	21.09%
	Total deaths	16,663	18,015	17201	17,293	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	28,225	56.80%
	Total deaths	46,367	50,717	52,002	49,695	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		5	4	2					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	4								
Projected patient deaths: 21.09%	3	1								
Average population (OFM)	4	1,570								
Projected population	N/A		1,570	1,570	1,570	1,569	1,569	1,569		
Potential volume	N/A		1	1	1	1	1	1		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		11	24	24					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	20								
Projected patient deaths: 56.80%	3	11								
Average population (OFM)	4	711								
Projected population	N/A		716	711	706	700	695	690		
Potential volume	N/A		11	11	11	11	11	11		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		12	12	12	12	12	12		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	9								
Unmet need	5		3	3	3	2	2	2		
Unmet need patient days (statewide ALOS)	6	61.11	164	159	154	149	144	139		
Unmet Average Daily Census (ADC)	7		0	0	0	0	0	0		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Grant **Select from drop down menu*

Grant County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Grant	82,660	83,784	84,909	86,033	85,007	85,596	86,185	86,774	87,363	87,952		85,596
65 +	Grant	13,011	13,628	14,244	14,861	14,116	14,729	15,343	15,957	16,571	17,185		14,729

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		186	208	190					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	195								
Projected patient deaths: 21.09%	3	41								
Average population (OFM)	4	85,596								
Projected population	N/A		85,007	85,596	86,185	86,774	87,363	87,952		
Potential volume	N/A		41	41	41	42	42	42		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		455	523	533					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	504								
Projected patient deaths: 56.80%	3	286								
Average population (OFM)	4	14,729								
Projected population	N/A		14,116	14,729	15,343	15,957	16,571	17,185		
Potential volume	N/A		274	286	298	310	322	334		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		315	327	339	352	364	376		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	270								
Unmet need	5		**45**	**57**	**69**	**81**	**93**	**106**		
Unmet need patient days (statewide ALOS)	6	61.11	2,724	3,470	4,215	4,961	5,707	6,453		
Unmet Average Daily Census (ADC)	7		7	9	12	14	16	18		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Grays Harbor **Select from drop down menu*

Grays Harbor County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Grays Harbor	58,675	58,246	57,817	57,387	58,396	58,092	57,788	57,484	57,179	56,875		58,092
65 +	Grays Harbor	14,535	15,064	15,594	16,123	17,240	17,700	18,161	18,621	19,082	19,542		17,700

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		209	236	223					
Average deaths (2020-2022)	2	223								
Projected patient deaths: 21.09%	3	47								
Average population (OFM)	4	58,092								
Projected population	N/A		58,396	58,092	57,788	57,484	57,179	56,875		
Potential volume	N/A		47	47	47	46	46	46		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		558	590	683					
Average deaths (2020-2022)	2	610								
Projected patient deaths: 56.80%	3	347								
Average population (OFM)	4	17,700								
Projected population	N/A		17,240	17,700	18,161	18,621	19,082	19,542		
Potential volume	N/A		338	347	356	365	374	383		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		385	394	402	411	420	429		
Current capacity (DOH survey)	N/A	352								
Unmet need	5		**33**	**42**	**50**	**59**	**68**	**77**		
Unmet need patient days (statewide ALOS)	6	61.11	2,006	2,542	3,078	3,614	4,150	4,686		
Unmet Average Daily Census (ADC)	7		5	7	8	10	11	13		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Island** ***Select from drop down menu**

Island County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Island	62,664	62,814	62,964	63,114	63,633	63,840	64,048	64,256	64,464	64,672		63,840
65 +	Island	18,625	19,163	19,701	20,239	23,224	23,676	24,127	24,579	25,030	25,482		23,676

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		110	116	117					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	114								
Projected patient deaths: 21.09%	3	24								
Average population (OFM)	4	63,840								
Projected population	N/A		63,633	63,840	64,048	64,256	64,464	64,672		
Potential volume	N/A		24	24	24	24	24	24		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		505	504	548					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	519								
Projected patient deaths: 56.80%	3	295								
Average population (OFM)	4	23,676								
Projected population	N/A		23,224	23,676	24,127	24,579	25,030	25,482		
Potential volume	N/A		289	295	300	306	312	317		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		313	319	325	330	336	342		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	469								
Unmet need	5		**(156)**	**(150)**	**(144)**	**(139)**	**(133)**	**(127)**		
Unmet need patient days (statewide ALOS)	6	61.11	(9,522)	(9,174)	(8,826)	(8,477)	(8,129)	(7,781)		
Unmet Average Daily Census (ADC)	7		(26)	(25)	(24)	(23)	(22)	(21)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Jefferson **Select from drop down menu*

Jefferson County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Jefferson	20,653	20,670	20,688	20,705	20,345	20,269	20,192	20,116	20,040	19,964		20,269

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Jefferson	10,580	10,916	11,252	11,588	12,632	13,029	13,427	13,824	14,221	14,618		13,029

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		68	54	59					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	60								
Projected patient deaths: 21.09%	3	13								
Average population (OFM)	4	20,269								
Projected population	N/A		20,345	20,269	20,192	20,116	20,040	19,964		
Potential volume	N/A		13	13	13	13	13	13		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		273	295	298					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	289								
Projected patient deaths: 56.80%	3	164								
Average population (OFM)	4	13,029								
Projected population	N/A		12,632	13,029	13,427	13,824	14,221	14,618		
Potential volume	N/A		159	164	169	174	179	184		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		172	177	182	187	192	196		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	133								
Unmet need	5		**39**	**44**	**49**	**54**	**59**	**64**		
Unmet need patient days (statewide ALOS)	6	61.11	2,387	2,689	2,992	3,294	3,597	3,899		
Unmet Average Daily Census (ADC)	7		7	7	8	9	10	11		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: King *Select from drop down menu

King County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	King	1,820,215	1,841,848	1,863,482	1,885,115	1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962		1,974,586

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	King	268,307	282,395	296,484	310,572	304,683	316,701	328,719	340,737	352,755	364,773		316,701

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		4,456	4,892	4,902					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	4,750								
Projected patient deaths: 21.09%	3	1,002								
Average population (OFM)	4	1,974,586								
Projected population	N/A		1,964,992	1,974,586	1,984,180	1,993,774	2,003,368	2,012,962		
Potential volume	N/A		997	1002	1007	1011	1016	1021		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		11,186	11,896	12,448					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	11,843								
Projected patient deaths: 56.80%	3	6,726								
Average population (OFM)	4	316,701								
Projected population	N/A		304,683	316,701	328,719	340,737	352,755	364,773		
Potential volume	N/A		6,471	6,726	6,982	7,237	7,492	7,747		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		7,468	7,728	7,988	8,248	8,508	8,769		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	8,625								
Unmet need	5		**(1,157)**	**(897)**	**(636)**	**(376)**	**(116)**	**144**		
Unmet need patient days (statewide ALOS)	6	61.11	(70,683)	(54,788)	(38,892)	(22,996)	(7,100)	8,796		
Unmet Average Daily Census (ADC)	7		(194)	(150)	(107)	(63)	(19)	24		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kitsap** **Select from drop down menu*

Kitsap County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Kitsap	214,045	215,543	217,040	218,538	222,540	222,587	222,634	222,681	222,729	222,776		222,587

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Kitsap	47,697	49,743	51,788	53,833	53,071	55,150	57,228	59,307	61,385	63,464		55,150

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		454	489	462					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	468								
Projected patient deaths: 21.09%	3	99								
Average population (OFM)	4	222,587								
Projected population	N/A		222,540	222,587	222,634	222,681	222,729	222,776		
Potential volume	N/A		99	99	99	99	99	99		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		1,714	1,832	1,895					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,814								
Projected patient deaths: 56.80%	3	1,030								
Average population (OFM)	4	55,150								
Projected population	N/A		53,071	55,150	57,228	59,307	61,385	63,464		
Potential volume	N/A		991	1,030	1,069	1,108	1,147	1,185		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		1,090	1,129	1,168	1,207	1,245	1,284		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	1,141								
Unmet need	5		**(51)**	**(12)**	**27**	**66**	**104**	**143**		
Unmet need patient days (statewide ALOS)	6	61.11	(3,117)	(743)	1,631	4,004	6,378	8,752		
Unmet Average Daily Census (ADC)	7		(9)	(2)	4	11	17	24		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Kittitas** **Select from drop down menu*

Kittitas County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Kittitas	36,768	37,330	37,892	38,453	38,168	38,539	38,910	39,282	39,653	40,024		38,539

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Kittitas	6,760	7,055	7,351	7,647	8,300	8,482	8,664	8,846	9,028	9,210		8,482

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		78	88	78					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	81								
Projected patient deaths: 21.09%	3	17								
Average population (OFM)	4	38,539								
Projected population	N/A		38,168	38,539	38,910	39,282	39,653	40,024		
Potential volume	N/A		17	17	17	17	18	18		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		241	241	261					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	248								
Projected patient deaths: 56.80%	3	141								
Average population (OFM)	4	8,482								
Projected population	N/A		8,300	8,482	8,664	8,846	9,028	9,210		
Potential volume	N/A		138	141	144	147	150	153		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		155	158	161	164	167	171		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	152								
Unmet need	5		**3**	**6**	**9**	**13**	**16**	**19**		
Unmet need patient days (statewide ALOS)	6	61.11	181	376	570	765	959	1,154		
Unmet Average Daily Census (ADC)	7		0	1	2	2	3	3		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Klickitat** **Select from drop down menu*

Klickitat County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Klickitat	16,082	15,955	15,828	15,702	17,332	17,217	17,103	16,988	16,874	16,759		17,217

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Klickitat	5,051	5,310	5,570	5,829	5,403	5,695	5,987	6,280	6,572	6,864		5,695

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	3,647	21.09%
	Total deaths	16,663	18,015	17201	17,293	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	28,225	56.80%
	Total deaths	46,367	50,717	52,002	49,695	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		42	50	50					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	47								
Projected patient deaths: 21.09%	3	10								
Average population (OFM)	4	17,217								
Projected population	N/A		17,332	17,217	17,103	16,988	16,874	16,759		
Potential volume	N/A		10	10	10	10	10	10		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		113	164	130					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	136								
Projected patient deaths: 56.80%	3	77								
Average population (OFM)	4	5,695								
Projected population	N/A		5,403	5,695	5,987	6,280	6,572	6,864		
Potential volume	N/A		73	77	81	85	89	93		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		83	87	91	95	99	103		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	99								
Unmet need	5		(16)	(12)	(8)	(4)	(0)	4		
Unmet need patient days (statewide ALOS)	6	61.11	(969)	(731)	(494)	(256)	(19)	219		
Unmet Average Daily Census (ADC)	7		(3)	(2)	(1)	(1)	(0)	1		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lewis** **Select from drop down menu*

Lewis County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Lewis	61,796	62,097	62,398	62,700	63,604	63,811	64,018	64,225	64,432	64,639		63,811

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Lewis	15,576	15,987	16,398	16,808	18,545	18,899	19,253	19,608	19,962	20,316		18,899

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		205	186	191					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	194								
Projected patient deaths: 21.09%	3	41								
Average population (OFM)	4	63,811								
Projected population	N/A		63,604	63,811	64,018	64,225	64,432	64,639		
Potential volume	N/A		41	41	41	41	41	41		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		653	723	753					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	710								
Projected patient deaths: 56.80%	3	403								
Average population (OFM)	4	18,899								
Projected population	N/A		18,545	18,899	19,253	19,608	19,962	20,316		
Potential volume	N/A		396	403	411	418	426	433		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		436	444	452	459	467	475		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	454								
Unmet need	5		**(17)**	**(10)**	**(2)**	**6**	**13**	**21**		
Unmet need patient days (statewide ALOS)	6	61.11	(1,062)	(593)	(123)	347	817	1,286		
Unmet Average Daily Census (ADC)	7		(3)	(2)	(0)	1	2	4		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Lincoln** **Select from drop down menu*

Lincoln County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Lincoln	8,042	7,982	7,923	7,864	7,814	7,804	7,794	7,785	7,775	7,765		7,804

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Lincoln	2,687	2,755	2,823	2,891	3,062	3,116	3,169	3,223	3,276	3,330		3,116

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		15	24	24					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	21								
Projected patient deaths: 21.09%	3	4								
Average population (OFM)	4	7,804								
Projected population	N/A		7,814	7,804	7,794	7,785	7,775	7,765		
Potential volume	N/A		4	4	4	4	4	4		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		75	76	67					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	73								
Projected patient deaths: 56.80%	3	41								
Average population (OFM)	4	3,116								
Projected population	N/A		3,062	3,116	3,169	3,223	3,276	3,330		
Potential volume	N/A		41	41	42	43	43	44		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		45	46	46	47	48	49		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	21								
Unmet need	5		**24**	**25**	**25**	**26**	**27**	**28**		
Unmet need patient days (statewide ALOS)	6	61.11	1,466	1,509	1,552	1,595	1,639	1,682		
Unmet Average Daily Census (ADC)	7		4	4	4	4	4	5		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Mason** **Select from drop down menu*

Mason County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Mason	49,162	49,652	50,142	50,632	49,799	49,998	50,196	50,395	50,594	50,793		49,998

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Mason	14,123	14,717	15,311	15,905	15,927	16,436	16,945	17,453	17,962	18,471		16,436

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		143	168	152					
Average deaths (2020-2022)	2	154								
Projected patient deaths: 21.09%	3	33								
Average population (OFM)	4	49,998								
Projected population	N/A		49,799	49,998	50,196	50,395	50,594	50,793		
Potential volume	N/A		32	33	33	33	33	33		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		408	461	414					
Average deaths (2020-2022)	2	428								
Projected patient deaths: 56.80%	3	243								
Average population (OFM)	4	16,436								
Projected population	N/A		15,927	16,436	16,945	17,453	17,962	18,471		
Potential volume	N/A		235	243	250	258	265	273		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		268	275	283	291	298	306		
Current capacity (DOH survey)	N/A	525								
Unmet need	5		**(257)**	**(249)**	**(242)**	**(234)**	**(226)**	**(219)**		
Unmet need patient days (statewide ALOS)	6	61.11	(15,698)	(15,230)	(14,763)	(14,296)	(13,828)	(13,361)		
Unmet Average Daily Census (ADC)	7		(43)	(42)	(40)	(39)	(38)	(37)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Okanogan **Select from drop down menu*

Okanogan County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Okanogan	32,906	32,726	32,545	32,364	32,082	31,910	31,737	31,564	31,392	31,219		31,910

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Okanogan	9,198	9,624	10,050	10,475	10,022	10,353	10,685	11,017	11,348	11,680		10,353

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		88	92	106					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	95								
Projected patient deaths: 21.09%	3	20								
Average population (OFM)	4	31,910								
Projected population	N/A		32,082	31,910	31,737	31,564	31,392	31,219		
Potential volume	N/A		20	20	20	20	20	20		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		277	324	341					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	314								
Projected patient deaths: 56.80%	3	178								
Average population (OFM)	4	10,353								
Projected population	N/A		10,022	10,353	10,685	11,017	11,348	11,680		
Potential volume	N/A		173	178	184	190	195	201		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		193	198	204	210	215	221		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	183								
Unmet need	5		**10**	**15**	**21**	**27**	**32**	**38**		
Unmet need patient days (statewide ALOS)	6	61.11	601	944	1,286	1,629	1,971	2,313		
Unmet Average Daily Census (ADC)	7		2	3	4	4	5	6		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pacific** **Select from drop down menu*

Pacific County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Pacific	14,972	14,830	14,688	14,545	15,581	15,523	15,464	15,405	15,346	15,287		15,523

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Pacific	6,258	6,421	6,584	6,747	7,784	7,971	8,159	8,347	8,534	8,722		7,971

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		55	59	69					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	61								
Projected patient deaths: 21.09%	3	13								
Average population (OFM)	4	15,523								
Projected population	N/A		15,581	15,523	15,464	15,405	15,346	15,287		
Potential volume	N/A		13	13	13	13	13	13		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		177	239	235					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	217								
Projected patient deaths: 56.80%	3	123								
Average population (OFM)	4	7,971								
Projected population	N/A		7,784	7,971	8,159	8,347	8,534	8,722		
Potential volume	N/A		120	123	126	129	132	135		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		133	136	139	142	145	148		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	65								
Unmet need	5		**68**	**71**	**74**	**76**	**79**	**82**		
Unmet need patient days (statewide ALOS)	6	61.11	4,151	4,325	4,499	4,674	4,848	5,023		
Unmet Average Daily Census (ADC)	7		11	12	12	13	13	14		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pend Oreille** **Select from drop down menu*

Pend Oreille County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Pend Oreille	9,998	9,952	9,905	9,859	9,718	9,660	9,602	9,543	9,485	9,427		9,660

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Pend Oreille	3,378	3,560	3,742	3,925	3,683	3,845	4,007	4,170	4,332	4,494		3,845

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		41	55	44					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	47								
Projected patient deaths: 21.09%	3	10								
Average population (OFM)	4	9,660								
Projected population	N/A		9,718	9,660	9,602	9,543	9,485	9,427		
Potential volume	N/A		10	10	10	10	10	10		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		101	119	127					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	116								
Projected patient deaths: 56.80%	3	66								
Average population (OFM)	4	3,845								
Projected population	N/A		3,683	3,845	4,007	4,170	4,332	4,494		
Potential volume	N/A		63	66	68	71	74	77		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		73	76	78	81	84	86		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	65								
Unmet need	5		**7**	**10**	**13**	**16**	**18**	**21**		
Unmet need patient days (statewide ALOS)	6	61.11	458	623	789	955	1,121	1,286		
Unmet Average Daily Census (ADC)	7		1	2	2	3	3	4		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Pierce** **Select from drop down menu*

Pierce County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Pierce	729,937	738,738	747,538	756,339	786,960	790,591	794,221	797,852	801,483	805,114		790,591

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Pierce	114,409	119,836	125,262	130,688	133,433	139,235	145,038	150,840	156,642	162,444		139,235

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		2,364	2,574	2,518					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	2,485								
Projected patient deaths: 21.09%	3	524								
Average population (OFM)	4	790,591								
Projected population	N/A		786,960	790,591	794,221	797,852	801,483	805,114		
Potential volume	N/A		522	524	527	529	531	534		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		5,608	6,264	6,412					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	6,095								
Projected patient deaths: 56.80%	3	3,461								
Average population (OFM)	4	139,235								
Projected population	N/A		133,433	139,235	145,038	150,840	156,642	162,444		
Potential volume	N/A		3,317	3,461	3,606	3,750	3,894	4,038		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		3,839	3,986	4,132	4,279	4,426	4,572		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	4,244								
Unmet need	5		**(405)**	**(259)**	**(112)**	**35**	**181**	**328**		
Unmet need patient days (statewide ALOS)	6	61.11	(24,774)	(15,812)	(6,850)	2,112	11,074	20,036		
Unmet Average Daily Census (ADC)	7		(68)	(43)	(19)	6	30	55		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**1**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **San Juan** **Select from drop down menu*

San Juan County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	San Juan	11,194	11,084	10,974	10,863	11,697	11,682	11,668	11,654	11,640	11,626		11,682

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	San Juan	5,099	5,322	5,545	5,768	6,091	6,326	6,561	6,796	7,030	7,265		6,326

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		18	24	12					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	18								
Projected patient deaths: 21.09%	3	4								
Average population (OFM)	4	11,682								
Projected population	N/A		11,697	11,682	11,668	11,654	11,640	11,626		
Potential volume	N/A		4	4	4	4	4	4		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		94	91	78					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	88								
Projected patient deaths: 56.80%	3	50								
Average population (OFM)	4	6,326								
Projected population	N/A		6,091	6,326	6,561	6,796	7,030	7,265		
Potential volume	N/A		48	50	52	53	55	57		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		52	54	55	57	59	61		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	99								
Unmet need	5		**(47)**	**(45)**	**(44)**	**(42)**	**(40)**	**(38)**		
Unmet need patient days (statewide ALOS)	6	61.11	(2,888)	(2,775)	(2,663)	(2,550)	(2,437)	(2,325)		
Unmet Average Daily Census (ADC)	7		(8)	(8)	(7)	(7)	(7)	(6)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Skagit** **Select from drop down menu*

Skagit County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Skagit	98,616	99,346	100,076	100,807	100,150	100,574	100,998	101,422	101,846	102,270		100,574

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Skagit	24,021	25,308	26,595	27,881	29,373	30,250	31,128	32,005	32,882	33,759		30,250

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		269	334	258					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	287								
Projected patient deaths: 21.09%	3	61								
Average population (OFM)	4	100,574								
Projected population	N/A		100,150	100,574	100,998	101,422	101,846	102,270		
Potential volume	N/A		60	61	61	61	61	62		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		1,068	1,190	1,215					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,158								
Projected patient deaths: 56.80%	3	658								
Average population (OFM)	4	30,250								
Projected population	N/A		29,373	30,250	31,128	32,005	32,882	33,759		
Potential volume	N/A		638	658	677	696	715	734		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		699	718	737	757	776	795		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	791								
Unmet need	5		**(93)**	**(73)**	**(54)**	**(35)**	**(15)**	**4**		
Unmet need patient days (statewide ALOS)	6	61.11	(5,661)	(4,480)	(3,299)	(2,119)	(938)	243		
Unmet Average Daily Census (ADC)	7		(16)	(12)	(9)	(6)	(3)	1		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Skamania** **Select from drop down menu*

Skamania County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Skamania	9,266	9,260	9,254	9,248	9,366	9,243	9,121	8,998	8,875	8,752		9,243

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Skamania	2,286	2,414	2,542	2,670	2,238	2,455	2,673	2,891	3,108	3,326		2,455

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		26	25	20					
Average deaths (2020-2022)	2	24								
Projected patient deaths: 21.09%	3	5								
Average population (OFM)	4	9,243								
Projected population	N/A		9,366	9,243	9,121	8,998	8,875	8,752		
Potential volume	N/A		5	5	5	5	5	5		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		47	56	60					
Average deaths (2020-2022)	2	54								
Projected patient deaths: 56.80%	3	31								
Average population (OFM)	4	2,455								
Projected population	N/A		2,238	2,455	2,673	2,891	3,108	3,326		
Potential volume	N/A		28	31	34	36	39	42		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		33	36	39	41	44	47		
Current capacity (DOH survey)	N/A	42								
Unmet need	5		**(8)**	**(6)**	**(3)**	**(0)**	**2**	**5**		
Unmet need patient days (statewide ALOS)	6	61.11	(519)	(355)	(192)	(29)	134	297		
Unmet Average Daily Census (ADC)	7		(1)	(1)	(1)	(0)	0	1		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Snohomish** ***Select from drop down menu**

Snohomish County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Snohomish	672,806	683,800	694,793	705,787	708,361	712,731	717,100	721,470	725,839	730,209		712,731

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Snohomish	101,674	107,560	113,447	119,333	119,596	125,852	132,107	138,363	144,618	150,874		125,852

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		1,587	1,563	1,468					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	1,539								
Projected patient deaths: 21.09%	3	325								
Average population (OFM)	4	712,731								
Projected population	N/A		708,361	712,731	717,100	721,470	725,839	730,209		
Potential volume	N/A		323	325	327	329	331	333		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		4,278	4,478	4,833					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	4,530								
Projected patient deaths: 56.80%	3	2,573								
Average population (OFM)	4	125,852								
Projected population	N/A		119,596	125,852	132,107	138,363	144,618	150,874		
Potential volume	N/A		2,445	2,573	2,701	2,828	2,956	3,084		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		2,767	2,897	3,027	3,157	3,287	3,417		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	4,217								
Unmet need	5		**(1,450)**	**(1,320)**	**(1,190)**	**(1,060)**	**(930)**	**(800)**		
Unmet need patient days (statewide ALOS)	6	61.11	(88,586)	(80,650)	(72,714)	(64,778)	(56,842)	(48,905)		
Unmet Average Daily Census (ADC)	7		(243)	(220)	(199)	(177)	(156)	(134)		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Spokane** **Select from drop down menu*

Spokane County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Spokane	416,684	418,875	421,066	423,256	446,453	447,909	449,365	450,821	452,277	453,733		447,909

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Spokane	77,325	80,834	84,343	87,852	92,886	96,172	99,458	102,744	106,030	109,316		96,172

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		1,634	1,842	1,603					
Average deaths (2020-2022)	2	1,693								
Projected patient deaths: 21.09%	3	357								
Average population (OFM)	4	447,909								
Projected population	N/A		446,453	447,909	449,365	450,821	452,277	453,733		
Potential volume	N/A		356	357	358	359	360	362		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		4,322	4,810	4,603					
Average deaths (2020-2022)	2	4,578								
Projected patient deaths: 56.80%	3	2,600								
Average population (OFM)	4	96,172								
Projected population	N/A		92,886	96,172	99,458	102,744	106,030	109,316		
Potential volume	N/A		2,511	2,600	2,689	2,778	2,867	2,956		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		2,867	2,957	3,047	3,137	3,227	3,317		
Current capacity (DOH survey)	N/A	3,196								
Unmet need	5		**(328)**	**(238)**	**(148)**	**(58)**	**32**	**122**		
Unmet need patient days (statewide ALOS)	6	61.11	(20,067)	(14,567)	(9,067)	(3,566)	1,934	7,435		
Unmet Average Daily Census (ADC)	7		(55)	(40)	(25)	(10)	5	20		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Stevens** **Select from drop down menu*

Stevens County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Stevens	34,459	34,343	34,226	34,109	36,029	35,790	35,550	35,311	35,071	34,832		35,790
65 +	Stevens	9,930	10,407	10,884	11,360	10,416	11,029	11,642	12,255	12,868	13,481		11,029

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		86	114	107					
Average deaths (2020-2022)	2	102								
Projected patient deaths: 21.09%	3	22								
Average population (OFM)	4	35,790								
Projected population	N/A		36,029	35,790	35,550	35,311	35,071	34,832		
Potential volume	N/A		22	22	21	21	21	21		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		248	304	336					
Average deaths (2020-2022)	2	296								
Projected patient deaths: 56.80%	3	168								
Average population (OFM)	4	11,029								
Projected population	N/A		10,416	11,029	11,642	12,255	12,868	13,481		
Potential volume	N/A		159	168	177	187	196	205		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		180	190	199	208	217	226		
Current capacity (DOH survey)	N/A	148								
Unmet need	5		**32**	**41**	**51**	**60**	**69**	**78**		
Unmet need patient days (statewide ALOS)	6	61.11	1,965	2,528	3,090	3,652	4,214	4,777		
Unmet Average Daily Census (ADC)	7		5	7	8	10	12	13		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Thurston** **Select from drop down menu*

Thurston County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Thurston	228,261	231,571	234,880	238,190	240,351	242,356	244,360	246,365	248,369	250,374		242,356
65 +	Thurston	44,534	46,608	48,683	50,757	54,442	56,276	58,110	59,944	61,778	63,612		56,276

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025	
Planning area historical resident deaths (OFM)	2		628	763	709				Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	700							
Projected patient deaths: 21.09%	3	148							
Average population (OFM)	4	242,356							
Projected population	N/A		240,351	242,356	244,360	246,365	248,369	250,374	
Potential volume	N/A		146	148	149	150	151	152	

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025	
PA historical resident deaths (OFM)	2		2,007	2,285	2,419				Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	2,237							
Projected patient deaths: 56.80%	3	1,271							
Average population (OFM)	4	56,276							
Projected population	N/A		54,442	56,276	58,110	59,944	61,778	63,612	
Potential volume	N/A		1,229	1,271	1,312	1,353	1,395	1,436	

All Ages	Step	Result	2020	2021	2022	2023	2024	2025	
Combined age cohorts	5		1,375	1,418	1,461	1,503	1,546	1,589	All Ages Steps 5-8
Current capacity (DOH survey)	N/A	1,766							
Unmet need	5		**(391)**	**(348)**	**(306)**	**(263)**	**(220)**	**(178)**	
Unmet need patient days (statewide ALOS)	6	61.11	(23,884)	(21,279)	(18,674)	(16,069)	(13,464)	(10,859)	
Unmet Average Daily Census (ADC)	7		(65)	(58)	(51)	(44)	(37)	(30)	
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Wahkiakum** ***Select from drop down menu**

Wahkiakum County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Wahkiakum	2,669	2,612	2,555	2,498	2,957	2,943	2,930	2,917	2,903	2,890		2,943

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
65 +	Wahkiakum	1,316	1,379	1,441	1,503	1,465	1,512	1,558	1,604	1,651	1,697		1,512

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		10	7	9					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	9								
Projected patient deaths: 21.09%	3	2								
Average population (OFM)	4	2,943								
Projected population	N/A		2,957	2,943	2,930	2,917	2,903	2,890		
Potential volume	N/A		2	2	2	2	2	2		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		18	25	24					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	22								
Projected patient deaths: 56.80%	3	13								
Average population (OFM)	4	1,512								
Projected population	N/A		1,465	1,512	1,558	1,604	1,651	1,697		
Potential volume	N/A		12	13	13	13	14	14		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		14	15	15	15	16	16		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	14								
Unmet need	5		**(0)**	**0**	**1**	**1**	**1**	**2**		
Unmet need patient days (statewide ALOS)	6	61.11	(12)	11	34	57	81	104		
Unmet Average Daily Census (ADC)	7		(0)	0	0	0	0	0		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Walla Walla **Select from drop down menu*

Walla Walla County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Walla Walla	50,111	50,328	50,546	50,763	50,358	50,364	50,370	50,376	50,382	50,388		50,364
65 +	Walla Walla	10,819	10,881	10,944	11,006	12,226	12,446	12,666	12,886	13,106	13,326		12,446

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		150	138	157					
Average deaths (2020-2022)	2	148								
Projected patient deaths: 21.09%	3	31								
Average population (OFM)	4	50,364								
Projected population	N/A		50,358	50,364	50,370	50,376	50,382	50,388		
Potential volume	N/A		31	31	31	31	31	31		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		522	595	598					
Average deaths (2020-2022)	2	572								
Projected patient deaths: 56.80%	3	325								
Average population (OFM)	4	12,446								
Projected population	N/A		12,226	12,446	12,666	12,886	13,106	13,326		
Potential volume	N/A		319	325	330	336	342	348		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		350	356	362	367	373	379		
Current capacity (DOH survey)	N/A	280								
Unmet need	5		**70**	**76**	**81**	**87**	**93**	**99**		
Unmet need patient days (statewide ALOS)	6	61.11	4,271	4,622	4,972	5,323	5,674	6,025		
Unmet Average Daily Census (ADC)	7		12	13	14	15	16	16		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Whatcom *Select from drop down menu

Whatcom County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Whatcom	178,234	180,629	183,023	185,418	184,193	185,493	186,794	188,095	189,395	190,696		185,493
65 +	Whatcom	35,688	37,426	39,164	40,902	42,654	44,049	45,443	46,838	48,232	49,627		44,049

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		457	443	467					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	456								
Projected patient deaths: 21.09%	3	96								
Average population (OFM)	4	185,493								
Projected population	N/A		184,193	185,493	186,794	188,095	189,395	190,696		
Potential volume	N/A		95	96	97	97	98	99		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		1,481	1,674	1,653					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,603								
Projected patient deaths: 56.80%	3	910								
Average population (OFM)	4	44,049								
Projected population	N/A		42,654	44,049	45,443	46,838	48,232	49,627		
Potential volume	N/A		881	910	939	968	997	1,026		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		977	1,006	1,036	1,065	1,095	1,124		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	1,718								
Unmet need	5		**(741)**	**(712)**	**(683)**	**(653)**	**(624)**	**(594)**		
Unmet need patient days (statewide ALOS)	6	61.11	(45,313)	(43,511)	(41,708)	(39,906)	(38,104)	(36,302)		
Unmet Average Daily Census (ADC)	7		(124)	(119)	(114)	(109)	(104)	(99)		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: Whitman **Select from drop down menu*

Whitman County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Whitman	42,965	43,051	43,137	43,222	42,475	42,489	42,503	42,517	42,531	42,545		42,489
65 +	Whitman	4,659	4,948	5,237	5,526	5,498	5,619	5,739	5,860	5,980	6,101		5,619

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		Ages 0 - 64 Steps 2-4
Planning area historical resident deaths (OFM)	2		51	59	65					
Average deaths (2020-2022)	2	58								
Projected patient deaths: 21.09%	3	12								
Average population (OFM)	4	42,489								
Projected population	N/A		42,475	42,489	42,503	42,517	42,531	42,545		
Potential volume	N/A		12	12	12	12	12	12		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		Ages 65+ Steps 2-4
PA historical resident deaths (OFM)	2		226	278	233					
Average deaths (2020-2022)	2	246								
Projected patient deaths: 56.80%	3	140								
Average population (OFM)	4	5,619								
Projected population	N/A		5,498	5,619	5,739	5,860	5,980	6,101		
Potential volume	N/A		137	140	143	146	149	151		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		All Ages Steps 5-8
Combined age cohorts	5		149	152	155	158	161	164		
Current capacity (DOH survey)	N/A	113								
Unmet need	5		**36**	**39**	**42**	**45**	**48**	**51**		
Unmet need patient days (statewide ALOS)	6	61.11	2,210	2,393	2,576	2,759	2,943	3,126		
Unmet Average Daily Census (ADC)	7		6	7	7	8	8	9		
Agency needed (ADC > 35)	8	35	FALSE	FALSE	FALSE	FALSE	FALSE	FALSE		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Department of Health
2023-2024 Hospice Numeric Need Methodology
Methodology By County

COUNTY: **Yakima** **Select from drop down menu*

Yakima County Only

Population information (OFM)

Ages	County	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025		2020-2022 Avgerage
0 - 64	Yakima	217,605	219,328	221,051	222,774	219,274	219,628	219,982	220,336	220,690	221,044		219,628
65 +	Yakima	34,949	35,809	36,670	37,530	37,454	38,467	39,479	40,491	41,504	42,516		38,467

WAC 246-310-290(8)(a) Step 1:

		2020	2021	2022	Average	Use Rate
Ages 0 - 64	Hospice unduplicated admissions	3,680	3,883	3,377	**3,647**	**21.09%**
	Total deaths	16,663	18,015	17201	**17,293**	

		2020	2021	2022	Average	Use Rate
Ages 65 +	Hospice unduplicated admissions	27,957	27,885	28,832	**28,225**	**56.80%**
	Total deaths	46,367	50,717	52,002	**49,695**	

WAC 246-310-290(8)(a) Steps 2-8:

Ages 0-64	Step	Result	2020	2021	2022	2023	2024	2025		
Planning area historical resident deaths (OFM)	2		653	699	628					Ages 0 - 64 Steps 2-4
Average deaths (2020-2022)	2	660								
Projected patient deaths: 21.09%	3	139								
Average population (OFM)	4	219,628								
Projected population	N/A		219,274	219,628	219,982	220,336	220,690	221,044		
Potential volume	N/A		139	139	139	140	140	140		

Ages 65+	Step	Result	2020	2021	2022	2023	2024	2025		
PA historical resident deaths (OFM)	2		1,675	1,644	1,682					Ages 65+ Steps 2-4
Average deaths (2020-2022)	2	1,667								
Projected patient deaths: 56.80%	3	947								
Average population (OFM)	4	38,467								
Projected population	N/A		37,454	38,467	39,479	40,491	41,504	42,516		
Potential volume	N/A		922	947	972	997	1,022	1,046		

All Ages	Step	Result	2020	2021	2022	2023	2024	2025		
Combined age cohorts	5		1,061	1,086	1,111	1,136	1,161	1,187		All Ages Steps 5-8
Current capacity (DOH survey)	N/A	1,088								
Unmet need	5		**(27)**	**(2)**	**23**	**49**	**74**	**99**		
Unmet need patient days (statewide ALOS)	6	61.11	(1,641)	(104)	1,432	2,968	4,505	6,041		
Unmet Average Daily Census (ADC)	7		(4)	(0)	4	8	12	17		
Agency needed (ADC > 35)	8	35	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**	**FALSE**		

Sources:
Self-Report Provider Utilization Surveys for Years 2020-2022
Vital Statistics Death Data for Years 2020-2022
Prepared by DOH Program Staff

Exhibit 4
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

#1

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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 ***viddui***. 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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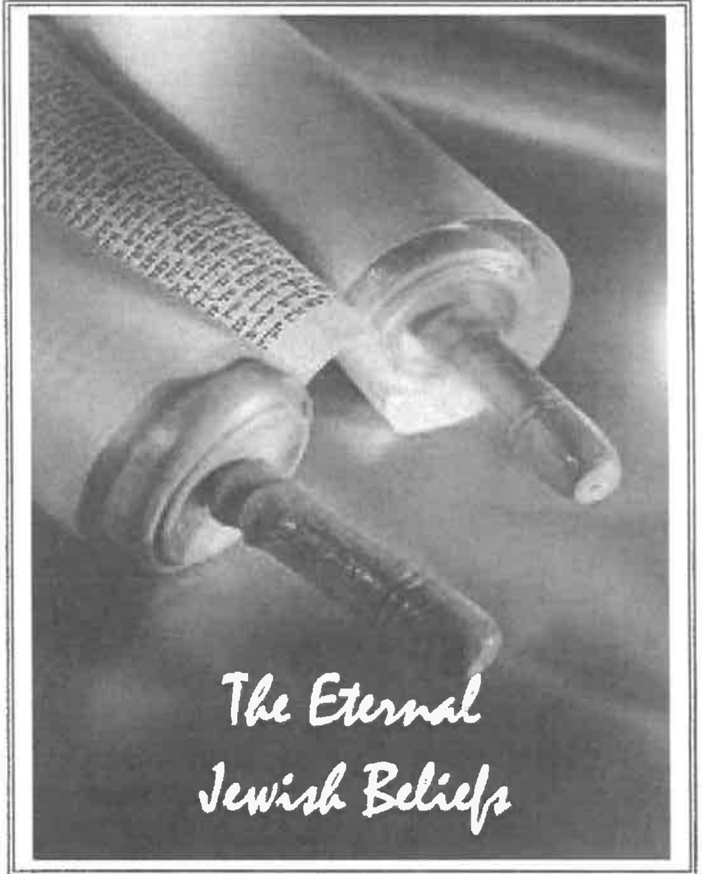

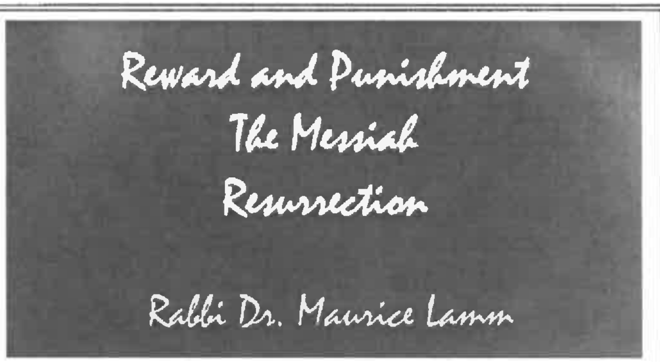

#7

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

#3

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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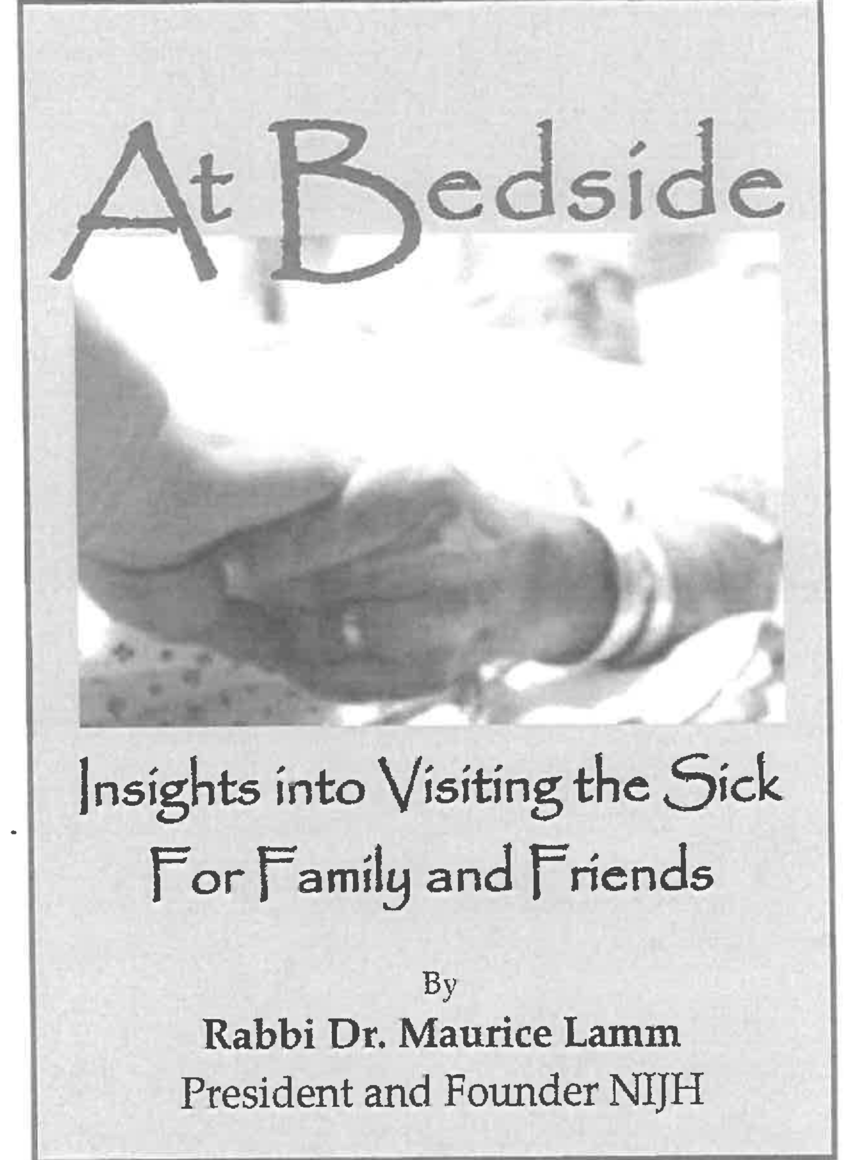

#4

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.

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.

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.

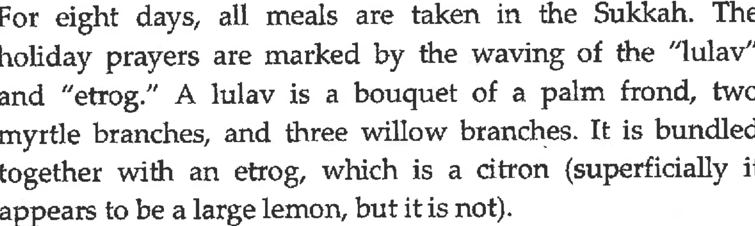
IV. Sukkot and Simchat Torah

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.

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

Dates

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.

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.

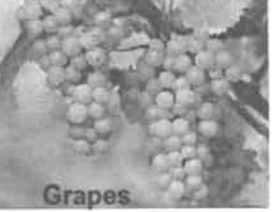
Pomegranates

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.

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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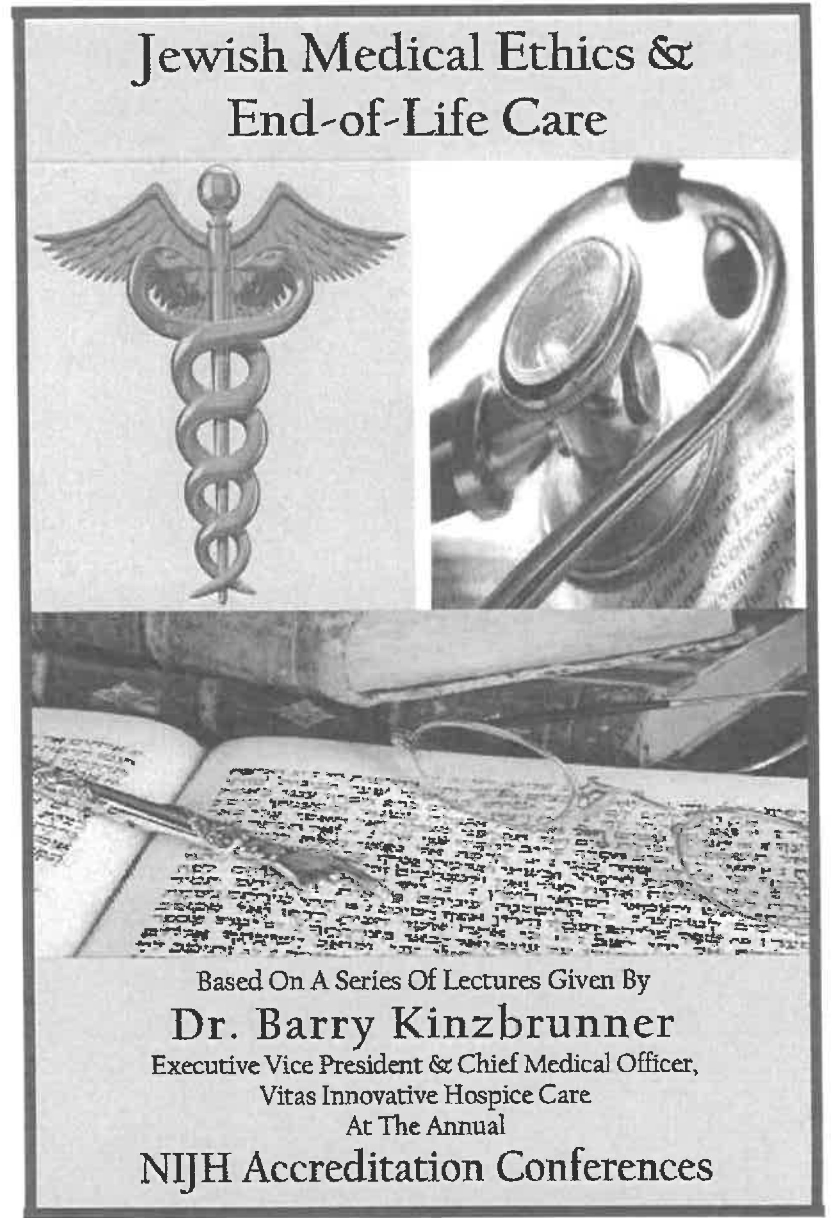

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#5

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Dedicates this Booklet to

Dr. Barry Kinzbrunner

Executive Vice President &
Chief Medical Officer,
Vitas Innovative Hospice Care

For His Dedication and Commitment To
Jewish Hospice and For His Illuminating Lectures
Each Year

At The Annual

NIJH Accreditation Conference

Rabbi Dr. Maurice Lamm
President and Founder, NIJH

Shirley Lamm
Executive Director, NIJH

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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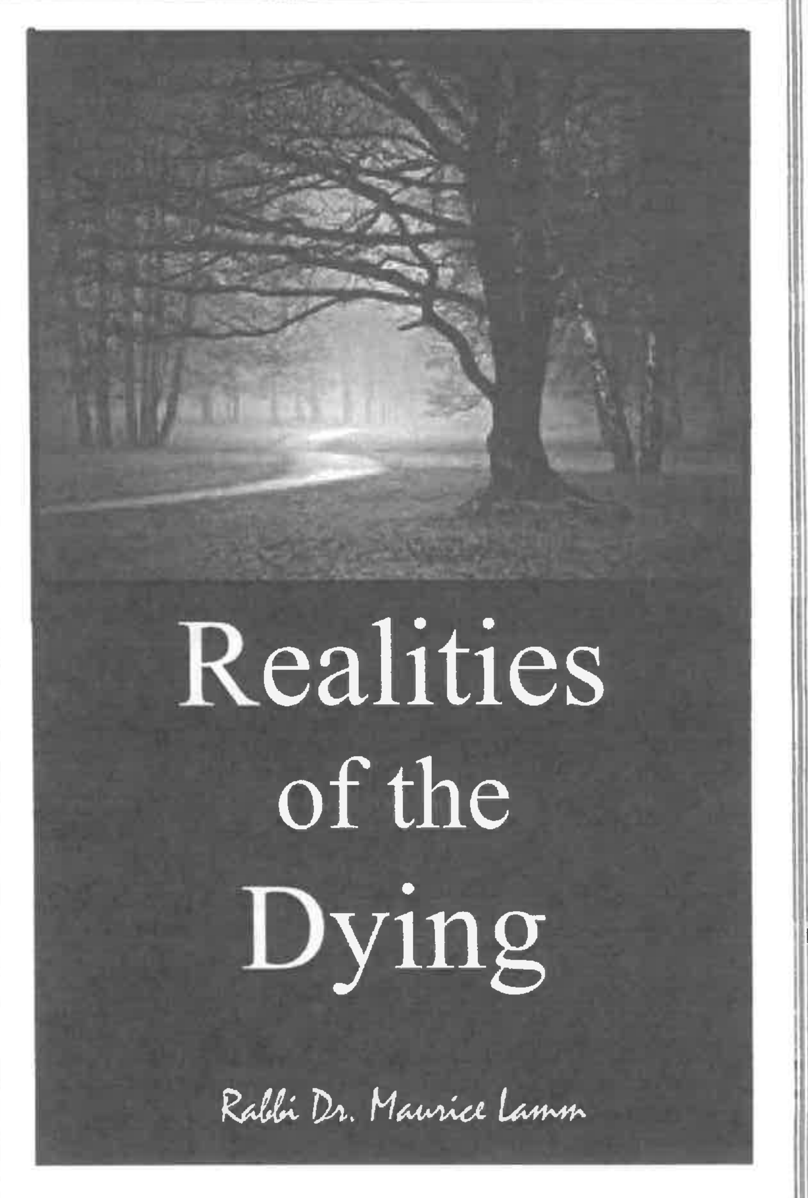

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NIJH In Your Will

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
1-800-446-4448 www.nijh.org

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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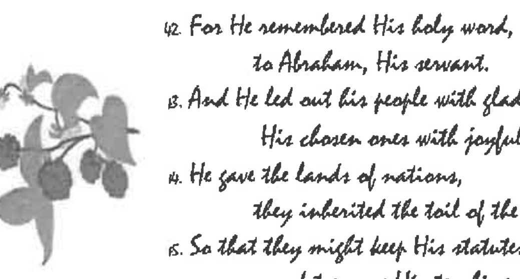
Singing Breaks The Spiritual Deadlock

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,
Halelujah!

"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 Cannan,
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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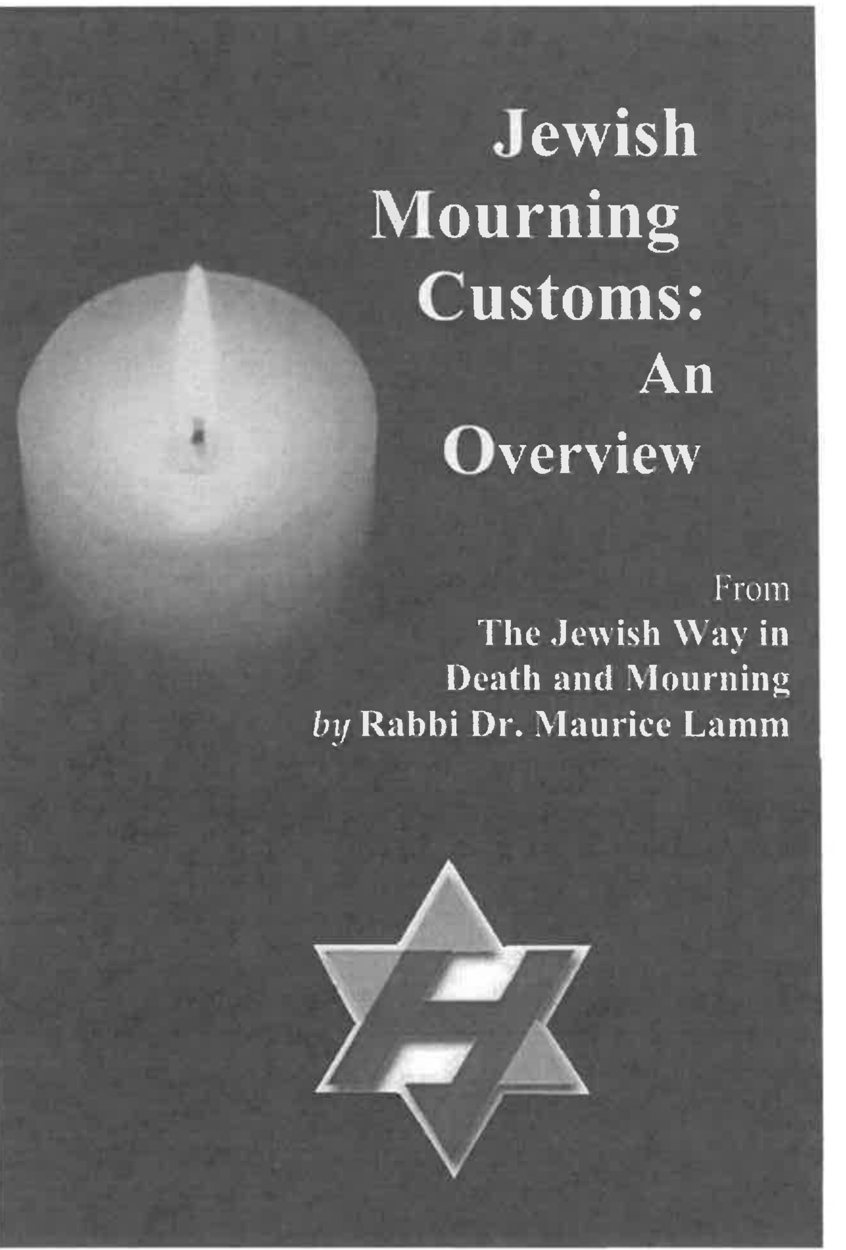

Jewish Mourning Customs: An Overview

From
The Jewish Way in Death and Mourning
by Rabbi Dr. Maurice Lamm

The National Institute for Jewish Hospice
1-800-446-4448 www.nijh.org

#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.

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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
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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
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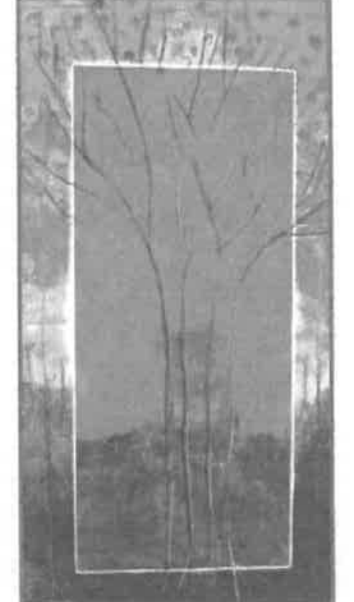

MAURICE LAMM

Author of *The Jewish Way in Death and Mourning*

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

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.

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

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 internment is completed, every aspect, including the eulogy, must be directed to the deceased, the center of concern. But after the internment, 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 5
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	

Attachment 5 Charity Care Criteria

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 6
Financial Pro Forma and Assumptions

Hospice ProForma Profit and Loss
Shalom Hospice Kitsap County

	2025	2026	2027	2028
Admissions	68	121	185	245
ALOS	32.15	61.11	61.11	61.11
Average Daily Census	12.0	20.3	31.0	41.0
Total Days (rounded)	2,186	7,394	11,305	14,972
General Inpatient Care	8	27	41	54
Inpatient Respite Care	-	1	2	3
Routine Home Care	2,178	7,366	11,262	14,915
Continuous Home Care	-	-	-	-
Total Days by LOC	2,186	7,394	11,305	14,972
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	485,136	1,641,249	2,509,238	3,322,957
Medicaid	21,280	71,974	110,042	145,734
Commercial	31,947	108,051	165,197	218,776
Self Pay & Other	8,571	28,986	44,317	58,692
Gross Revenue	546,934	1,850,260	2,828,794	3,746,159
Contractual Adjustments	(19,143)	(64,759)	(99,008)	(131,116)
Operating Revenue	527,791	1,785,501	2,729,786	3,615,043
Avg. Daily Rate	$ 241.44	$ 241.48	$ 241.47	$ 241.45
Deductions from Revenue				
Charity Care	(8,571)	(28,986)	(44,317)	(58,692)
Provision for Bad Debts	(10,384)	(35,130)	(53,709)	(71,127)
Deductions from Revenue	(18,955)	(64,116)	(98,026)	(129,819)
TOTAL REVENUE	**508,836**	**1,721,385**	**2,631,760**	**3,485,224**
Patient Care Costs				
Salaries and Benefits				
Hospice Employees	165,200	559,434	855,107	1,132,035
Payroll Taxes and Benefits	34,692	117,481	179,572	237,727
Total Salaries and Benefits	199,892	676,915	1,034,679	1,369,762
Contracted Services	131	444	678	898
Pharmacy - Medications & IV Supplies & Lab	14,646	49,540	75,744	100,312
DME Costs (Equipment, oxygen)	19,455	65,807	100,615	133,251
Medical Supplies	9,881	33,421	51,099	67,673
Other Direct Costs	366	1,240	1,893	2,504
General Inpatient Costs	8,760	29,565	44,895	59,130
Inpatient Respite Costs	-	603	1,207	1,810
5% R&B Expense	1,101	6,204	9,485	17,587
Mileage	5,866	19,846	30,307	40,083
Total Patient Care Costs	260,098	883,585	1,350,602	1,793,010

** 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 (Continued)
Shalom Hospice Kitsap County

		2025	2026	2027	2028
Administrative and Facility Costs					
Salaries					
Administrative Employees		425,000	690,000	762,500	832,500
Payroll Taxes and Benefits		89,250	144,900	160,125	174,825
Total Salaries and Benefits		514,250	834,900	922,625	1,007,325
Advertising		1,562	5,286	8,072	10,676
Auto (cars, gas, parking, tolls) + Admin Mileage		1,519	5,140	7,849	10,381
Amortization		2,639	5,278	5,278	5,278
Bank svc charges		6	22	33	44
Payroll svcs & Recruiting		6,955	23,532	35,935	47,527
Background Screening/Pre Emp Health		1,678	5,678	8,671	11,469
Business Licenses and Permits		477	1,613	2,463	3,257
Computer and internet		274	928	1,417	1,875
Dues & Subs		349	1,181	1,804	2,386
Insurance		5,283	17,873	27,294	36,098
Legal & Prof fees		36,725	3,016	4,605	6,091
Meals and Entertainment		454	1,535	2,344	3,100
Office exp and supplies		4,518	15,286	23,343	30,873
Other Cost					
Rent & Operating Costs		34,605	35,869	38,398	38,398
Repairs/Maintenance/Janitorial		2,608	2,627	2,641	2,654
Software		1,344	4,549	6,946	9,187
Taxes (Includes B&O and Permits)		9,845	33,305	50,918	67,431
Phone		3,733	12,631	19,288	25,510
Travel		528	1,788	2,730	3,611
Uniforms		166	560	856	1,132
Allocated Regional Office		60,500	42,500	42,500	42,500
Miscellaneous		1,153	1,777	2,509	3,170
Total Other Admin Costs		176,921	221,974	295,894	362,648
Total Administrative Costs		691,171	1,056,874	1,218,519	1,369,973
Total Costs		951,269	1,940,459	2,569,121	3,162,983
Income (Loss) from Operations.		(442,433)	(219,074)	62,639	322,241

** Please note that there is rounding to the nearest whole number which may impact summaries though are immaterial for accounting purposes

Hospice ProForma Balance Sheet
Shalom Hospice Kitsap County

	2025	2026	2027	2028
Assets				
Current Assets				
Cash	302,376	13,216	36,977	323,575
Accounts Receivable	104,735	177,159	270,852	358,688
Allowance for Doubtful Accounts	(2,095)	(3,543)	(5,417)	(7,174)
Prepaid Rent				
Total Current Assets	405,016	186,832	302,412	675,089
Leasehold Improvements	35,807	35,807	35,807	35,807
Furniture & Equipment	43,359	43,359	43,359	43,359
Accumulated Depreciation/Amortization	(2,639)	(7,917)	(13,195)	(18,473)
Total Property & Equipment	76,527	71,249	65,971	60,693
Other Assets				
Security Deposit	5,000	5,000	5,000	5,000
TOTAL ASSETS	486,543	263,081	373,383	740,782
Liabilities				
Current Liabilities				
Accounts Payable	79,042	71,441	101,970	130,983
Payroll Liabilites	54,934	58,147	75,281	91,426
Credit Cards Payable	45,000	45,000	45,000	45,000
Total Current Liabilities	178,976	174,588	222,251	267,409
TOTAL LIABILITIES	178,976	174,588	222,251	267,409
Equity				
Members' Contributions	750,000	750,000	750,000	750,000
Members' Distributions				
Net Income	(442,433)	(219,074)	62,639	322,241
Retained Earnings	(442,433)	(661,507)	(598,868)	(276,627)
TOTAL EQUITY	307,567	88,493	151,132	473,373
TOTAL LIABILITIES & EQUITY	486,543	263,081	373,383	740,782

** Please note that there is rounding to the nearest whole number which may impact summaries though are immaterial for accounting purposes

Shalom Hospice Financial Assumptions

Revenue Rates:

Level of Care	2025 Estimated Medicare Rates	2025 Estimated Medicaid Rates
1-60 days	$262.34	$262.34
61+	$207.09	$207.09
Cont HC (per hour)	$78.64	$78.64
Respite	$603.45	$603.45
GIP	$1,368.74	$1,368.74
R&B Rate	$336.90	
Service Intensity Add On	$78.64	

*** R&B Rate is based on the Average Medicaid Rate for Kitsap County SNF Rates**
*** SIA Amounts in Financials are assumed to be .013% of Routine Medicare Revenue Only**
*** Estimates used 2024 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).
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 $1,094.99 PPD. Due to the census rounding, even a 0.5 patient day difference equates to about $548 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 2025, 5% for 2026 & 2027, and 7% for 2028. Room and Board rate assumed to be $336.90 and is based on the State of Washington, DSHS/Aging and Disability Services Administration Current Rate Report Run Date: November 1, 2023, using Kitsap 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 2025, 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 Exhibit 8.
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
Allocated Regional Office	Includes .1 FTE allocation for each of several key administrative staff (COO, Chief Compliance Officer, CFO, Triage) for half of 2025. In years 2026 - 2028, 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 $6,000.

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, overages on utilities, increases in or new taxes and licensing fees, meals/snacks, seminars, etc.

Exhibit 7
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 PUGET SOUND 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 ___________________
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(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

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

Exhibit 8
Lease

19352 VIKING AVE
COMMERCIAL LEASE AGREEMENT

EXHIBITS AND ADDENDA. Any exhibit or addendum attached to this Lease is incorporated as a part of this lease for all purposes. Any term not specifically defined in the Addenda shall have the same meaning given to it in the body of this Lease. To the extent any provisions in the body of this Lease conflict with the Addenda, the Addenda shall control.

Exhibit A	Floor Plan
Exhibit B	Site Plan
Addendum A	Rules and Regulations
Addendum B	Base Rent Payment Schedule

IN CONSIDERATION of the terms, provisions and agreements contained in this Lease, the parties agree as follows:

ARTICLE ONE
DEFINED TERMS

As used in this Commercial Lease Agreement (the "Lease"), the terms set forth in this Article One have the following respective meanings:

1.01. **Effective Date**: The last date beneath the signatures of Landlord and Tenant below.

1.02.	**Landlord**:	Liberty Bay L.L.C.
	Mailing Address:	P.O. Box 2874 Santa Rosa, CA 95405
	Business Address:	19352 Viking Ave NW Poulsbo, WA 98370
	Telephone:	707-494-5215
	E-mail:	leuzingerfamilyllc@gmail.com
1.03.	**Tenant**:	Shalom Hospice of Puget Sound LLC
	Mailing Address:	14240 Interurban Ave S Ste 212 Tukwila WA 98168-4660
	Business Address:	14240 Interurban Ave S Ste 212 Tukwila WA 98168-4660
	Attention:	Samuel Stern
	Telephone:	(510) 499-9977
	E-mail:	sstern@affinityhealthmanagement.com

1.04. **Demised Premises**: 19352 VIKING AVE NW, Suites C & D

A. Floor Plan: Being a floor area of approximately 2107 square feet and being more particularly shown in outline form on Exhibit A, FLOOR PLAN.

1.05. Property. The building, parking area and common areas associated with 19352 Viking Ave NW, Poulso, WA 98370, including office areas on the ground floor and residential units on the second and third floors.

A. Street address: 19352 Viking Ave NW
Poulsbo, WA 98370
Kitsap County, Washington.

B. Legal description: The property on which the Demised Premises is situated (the "Property") is shown in outline form in Exhibit B, SITE PLAN.

1.06. Lease Term. The lease term shall be thirty-six (36) months from the Commencement Date, plus the number of days necessary to make the Lease Term end at the end of the month (the "Lease Expiration Date"). The Lease Term may be extended per section 2.04.

1.07. Commencement Date. The Lease shall commence on October 1, 2024, irrespective of if Tenant occupies Premises on this date.

1.08. Condition Precedent. Notwithstanding anything in this lease to the contrary, Tenant's obligation to accept Landlord's tender of the Premises under this Lease is specifically contingent on Tenant receiving a Certificate of Need by the Washington State Department of Health for Tenant's intended use of the Premises ("Governmental Approvals"). Tenant shall apply for all Governmental Approvals and diligently pursue the issuance of the same. If, following the application of Governmental Approvals, Tenant does not obtain all such Governmental Approvals, Tenant may, upon written notice to Landlord, terminate this lease and, upon such termination, neither party shall have any liability hereunder except to the extent otherwise expressly provided in this Lease. Tenant shall be solely responsible for obtaining all Governmental Approvals at its sole cost.

1.09. Rent. The initial Base Rent shall be $2528.40/month. At the beginning of each calendar year (January of a new year) the Base Rent shall increase by $105.35 per month. A Rent Payment Schedule is attached as Addendum B.

1.10. Utilities Charge. In addition to the Base Rent, Tenant shall pay $250/month to cover water and sewage utility charges.

1.11. Security Deposit. $5000. (See Sections 3.02 and 3.04.)

1.12. Permitted Use. Office use or uses compatible with the Building approved by the City of Poulsbo, WA, and the Landlord (See Section 6.01.)

1.13. Rent Payment Address: Tenant shall deliver payments under this Lease to Landlord at the mailing address shown in Section 1.02. Landlord may designate in writing the party authorized to act on behalf of Landlord to accept payments and otherwise enforce this Lease, which may include, without limitation, a property management company. Any such authorization will remain in effect until it is revoked by Landlord in writing.

ARTICLE TWO
LEASE AND LEASE TERM

2.01. Lease of Demised Premises for Lease Term. Landlord leases the Demised Premises to Tenant and Tenant leases the Demised Premises from Landlord for the Lease Term stated in Section 1.06. The Commencement Date is the date specified in Section 1.06, unless advanced or delayed under any provision of this Lease.

2.02. Delay in Commencement. Landlord shall not be liable to Tenant if Landlord does not deliver possession of the Demised Premises to Tenant on the Commencement Date specified in Section 1.07 above. Landlord's non-delivery of possession of the Demised Premises to Tenant on the Commencement Date will not affect this Lease or the obligations of Tenant under this Lease. However, the Commencement Date shall be delayed until possession of the Demised Premises is delivered to Tenant. The Lease Term shall be extended for a period equal to the delay in delivery of possession of the Demised Premises to Tenant, plus the number of days necessary for the Lease Term to expire on the last day of a month.
If delivery of possession of the Demised Premises to Tenant is delayed, Landlord and Tenant shall, upon such delivery, execute an amendment to this Lease setting forth the revised Commencement Date and Expiration Date of the Lease Term.

2.03. Early Occupancy. Tenant will be permitted to occupy the Premises fourteen (14) days prior to the Commencement Date in order to move in equipment, inventory, furniture, etc., provided Tenant uses commercially reasonable efforts to minimize interference with or delay of Landlord's completion of necessary work, if any. If Tenant occupies the Demised Premises prior to the Commencement Date, Tenant's occupancy of the Demised Premises shall be subject to all of the provisions of this Lease. Early occupancy of the Demised Premises shall not advance the Expiration Date. Tenant shall not pay any Rent during early occupancy. If Tenant desires to occupy Premises more than fourteen (14) days prior to the Commencement Date an addendum to this Lease shall be generated.

2.04. Lease Term Options. Tenant shall have and is hereby granted the option to extend the Lease Term hereof ("Option") for two (1) additional periods of twelve (12) months (the "Extension Period"), provided (i) Tenant shall give written, irrevocable notice to Landlord of Tenant's election to exercise such Option no earlier than twelve (12) and no later than six (6) months prior to the Lease Expiration Date; (ii) an event of default does not exist under this Lease on the date that is six (6) months prior to the expiration of the Lease Term, beyond any applicable notice and cure period; (iii) Tenant has not assigned its interest in this Lease or sublet any portion of the Demised Premises other than to a Permitted Transferee (defined below); (iv) Tenant has never been in arrears in any amounts due and owing more than one (1) month over the last twelve (12) months and Tenant is current on all payments at the time of exercising the Option; and (v) there has not been a history of reasonable complaints by other tenants of the Property nor unaddressed regulatory issues by Tenant. If Tenant fails to timely give the foregoing-described notice, then the Option shall be deemed automatically and irrevocably declined. Time is of the essence with respect to the exercise of the Option. Upon proper exercise of an Option, the Lease Expiration Date shall be deemed to include the Extension Period. All terms and conditions of this Lease shall remain in full force and effect during the Extension Period. Landlord shall not be obligated to make any improvements or alterations in or to the Demised Premises, with Tenant accepting the Demised Premises in their "as is" condition.

Base Rent shall increase by $105.35 per month on the January after an Option takes effect.

2.05. Holding Over. Should Tenant, without Landlord's written consent, hold over after the termination of this Lease, Tenant shall be deemed a tenant at will. During such holdover period, if Tenant continues to hold over for a period of thirty (30) days following written notice from Landlord that a continued holdover will result in damages to Landlord, Tenant shall be liable for all such damages incurred by Landlord directly as a result of Tenant's withholding of the Demised Premises. Should Tenant holdover after the termination of this Lease, with Landlord's consent, Tenant shall become a tenant from month to month only upon each and all of the terms herein provided as may be applicable to such month-to-month tenancy and any such holding over shall not constitute an extension of this Lease. During such holding over, Tenant shall pay monthly rent equal to one hundred fifty percent (150%) of the last monthly rental rate. Such tenancy shall continue until terminated by Landlord, as provided by law, or until Tenant shall have given to Landlord at least thirty (30) days written notice prior to the last day of the calendar month intended as the date of termination of such month-to-month tenancy.

ARTICLE THREE
RENT AND SECURITY DEPOSIT

3.01. Time of Payment. The first month's Rent and Security Deposit, totaling $7528.40, shall be due within 30 days of execution of this Lease. Subsequent Rent payments shall be due the first day of each month of the Lease Term thereafter. Tenant shall ensure payments are properly mailed or otherwise delivered so as to be actually received by the party identified in 1.10 above on or before the due date (and not merely deposited in the mail). If the Lease Term commences or ends on a day other than the first or last day of a calendar month, the rent for any fractional calendar month following the Commencement Date or preceding the end of the Lease Term shall be prorated by days.

3.02. Manner of Payment. All sums payable under this Lease by Tenant (the "Rent") shall be made to the Landlord at the mailing address designated in Section 1.02, or by electronic funds transfer or ACH to Landlord's bank, unless another person is designated in Section 1.13, or to any other party or address as Landlord may designate in writing. Any and all payments made to a designated third party for the account of the Landlord shall be deemed made to Landlord when received by the designated third party. The Rent is the minimum rent for the Demised Premises and is subject to the terms and conditions contained in this Lease, together with the attached Addenda, if any.

3.03. Late Charges. Payments due to Landlord under this Lease are not an extension of credit. Therefore, if any payment under the Lease is not received on or before the due date or within ten (10) days of the due date (and not merely deposited in the mail), Landlord may, at Landlord's option and to the extent allowed by applicable law, impose a Late Charge on any late payments in an amount equal to five percent (5.0%) of the amount of the past due payment (the "Late Charge"). Any Late Charge will be in addition to Landlord's other remedies for nonpayment of rent. If any check tendered to Landlord by Tenant under this Lease is dishonored for any reason, Tenant shall pay to the party receiving payments under this Lease a fee of One Hundred dollars ($100.00), plus a Late Charge as provided above. The parties agree that any Late Charge and dishonored check fee represent a fair and reasonable estimate of the costs Landlord will incur by reason of the late payment or dishonored check. Payments received from Tenant shall be applied first to any Base Rent, second to Late Charges, and last to other unpaid charges or reimbursements due to Landlord. In addition to the Late Charge described herein, any payment not made when due shall incur interest thereon at the rate of ten percent (10%) per annum from the date due until paid.

3.04. Security Deposit. Upon execution of this Lease, Tenant shall deposit with Landlord a cash Security Deposit in the amount stated in Section 1.10. Landlord may apply all or part of the Security Deposit to any unpaid Rent or other charges due from Tenant or to cure any other defaults of Tenant. If Landlord uses any part of the Security Deposit, Tenant shall restore the Security Deposit to its full amount within thirty (30) days after Landlord's written demand. Tenant's failure to restore the full amount of the Security Deposit within the time specified shall be a default under this Lease. No interest will be paid on the Security Deposit, Landlord will not be required to keep the Security Deposit separate from its other accounts and no trust relationship is created with respect to the Security Deposit. Upon any termination of this Lease not resulting from Tenant's default, and after Tenant has vacated the Property and cleaned and restored the Demised Premises in the manner required by this Lease, Landlord shall refund the unused portion of the Security Deposit to Tenant within sixty (60) days after the Termination Date or sixty (60) days after Tenant fully complies with the conditions of termination as required in Section 7.05, whichever is later.

3.05. Good Funds Payments. If, for any reason whatsoever, any two or more payments by check from Tenant to Landlord for Rent are dishonored and returned unpaid, thereafter Landlord may, at Landlord's sole option, upon written notice to Tenant, require that all future payments of Rent for the remaining term of the Lease must be made by certified check, cashier's check, or money order ("Good Funds") and that the delivery of Tenant's personal or corporate check will no longer constitute payment of Rent under this Lease. Any acceptance by Landlord of a payment for Rent by Tenant's personal or corporate check thereafter shall not be construed as a waiver of Landlord's right to insist upon payment by Good Funds as set forth herein.

3.06. Forfeit of First Month's Rent and Security Deposit. Should Tenant not receive a Certificate of Need by the Washington State Department of Health and consequently terminate this Lease per the Condition Precedent of Section 1.08, the first month's Rent and Security Deposit paid per Section 3.01, shall be forfeit.

ARTICLE FOUR
TAXES

4.01. Payment by Landlord. Landlord shall pay the real estate taxes on the Demised Premises during the Lease Term.

4.02. Personal Property Taxes. Tenant shall pay all taxes assessed against trade fixtures, furnishings, equipment, inventory, products, or any other personal property belonging to Tenant. Tenant shall use reasonable efforts to have Tenant's property taxed separately from the Demised Premises. If any of Tenant's property is taxes with the Demised Premises, Tenant shall pay the taxes for its property to Landlord within thirty (30) days after Tenant received a written statement form Landlord for the property taxes.

ARTICLE FIVE
INSURANCE AND INDEMNITY

5.01. Casualty Insurance. During the Lease Term, Landlord shall maintain policies of insurance covering loss of or damage to the Demised Premises. The policies shall provide protection against all perils included within the classification of fire and extended coverage and any other perils which Landlord deems necessary. Tenant shall at Tenant's expense, maintain insurance on its fixtures, equipment and building improvements as Tenant deems necessary to protect Tenant's interest.

Tenant shall not do or permit to be done anything which invalidates any insurance policies required to be maintained by Landlord under this Section 5.01. Any casualty insurance carried by Landlord or Tenant shall be for the sole benefit of the party carrying the insurance and under its sole control.

5.02. Increase in Premiums. Tenant shall not permit any operation or activity to be conducted, or storage or use of any volatile or any other materials, on or about the Demised Premises that would cause suspension or cancellation of any fire and extended coverage insurance policy carried by Landlord, or increase the premiums therefore, without the prior written consent of Landlord. If Tenant's use and occupancy of the Demised Premise causes an increase in the premiums for any fire and extended coverage insurance policy carried by Landlord, Tenant shall pay to Landlord, as additional rental, the amount for the increase within thirty (30) days after demand and presentation by Landlord of written evidence of the increase.

5.03. Tenant Liability Insurance. During the Lease Term, Tenant shall maintain a commercial general liability policy of insurance, at Tenant's expense, insuring Landlord against liability arising out of the ownership, use, occupancy, or maintenance of the Demised Premises. The amounts of the insurance must be at least: $1,000,000 for Each Occurrence, $2,000,000 General Aggregate per policy year, and $100,000 Property Damage for the Demised Premises. However, the amounts of the insurance shall not limit Tenant's liability nor relieve Tenant of any obligation under this Lease. The policies must insure Tenant's performance of the indemnity provisions of Section 5.04. Tenant shall not cancel the policy without giving thirty (30) days prior written notice to Landlord by Tenant. Tenant may discharge Tenant's obligations under this Section by including Landlord and any designated property management company or other agent as an additional insured under a comprehensive policy of commercial general liability insurance maintained by Tenant via a blanket additional insured endorsement and containing the coverage and provisions described in this Section. Tenant shall make a certificate evidencing such insurance available to Landlord prior to the Commencement Date (or prior to Tenant's entry onto the Demised Premises, if earlier) and prior to the expiration of the policy during the Lease Term. If Tenant fails to maintain the policy and does not cure such failure by obtaining such policy within five (5) days' written notice from Landlord, Landlord may elect to maintain the insurance at Tenant's expense. Tenant may, at Tenant's expense, maintain other liability insurance, as Tenant deems necessary.

5.04. Indemnity. Landlord shall not be liable to Tenant or to Tenant's employees, agents, invitees or visitors, or to any other person, for any injury to persons or damage to property on or about the Demised Premises or any adjacent area owned by Landlord caused by the negligence or misconduct of Tenant, Tenant's employees, subtenants, agents, licensees or concessionaires or any other person entering the Demised Premises under express or implied invitation of Tenant, or arising out of the use of the Demised Premises by Tenant and the conduct of Tenant's business, or arising out of any breach or default by Tenant in the performance of Tenant's obligations under this Lease; and Tenant hereby agrees to indemnify, defend and hold Landlord harmless from any loss, expense or claims arising out of such damage or injury. Notwithstanding the foregoing, Tenant shall not be liable for any injury or damage to the extent attributable to or caused, in whole or in part, by the gross negligence or willful misconduct of Landlord, or Landlord's employees or agents. Tenant shall not be liable to Landlord or to Landlord's employees, agents, invitees or visitors, or to any other person, for any injury to persons or damage to property on or about the Demised Premises or any adjacent area owned by Landlord caused by the gross negligence or willful misconduct of Landlord, Landlord's employees, subtenants, agents, licensees or concessionaires or any other person entering the Demised Premises or any adjacent area owned by Landlord under express or implied invitation of Landlord, or arising out of the conduct of Landlord's business, or arising out of any breach or default

by Landlord in the performance of Landlord's obligations under this Lease; and Landlord hereby agrees to indemnify, defend and hold Tenant harmless from any loss, expense or claims arising out of such damage or injury. Notwithstanding the foregoing, Landlord shall not be liable for any injury or damage to the extent attributable to or caused, in whole or in part, by the gross negligence or willful misconduct of Tenant, or Tenant's employees or agents.

5.05. Waiver of Subrogation. Each party to this Lease waives any and every claim which arises or may arise in its favor against the other party during the term of this Lease or any renewal or extension of this Lease for any and all loss of, or damage to, any of its property located within or upon, or constituting a part of, the Demised Premises, which loss or damage is insured against by valid and collectible fire and extended coverage insurance policies (or is required to be), to the extent that such loss or damage is recoverable under such insurance policies. These mutual waivers are applicable to the portion of any damage that is not reimbursed by the damaged party's insurer because of the "deductible" in the damaged party's insurance coverage and this waiver is applicable regardless of whether the negligence of one party caused or contributed to the loss suffered by the other party. These mutual waivers shall be in addition to, and not in limitation or derogation of, any other waiver or release contained in this Lease with respect to any loss of, or damage to, property of the parties. Inasmuch as these mutual waivers will preclude the assignment of any aforesaid claim by way of subrogation or otherwise to an insurance company (or any other person), each party hereby agrees to give immediately to each insurance company (which has issued to such party policies of fire and extended coverage insurance) written notice of the terms of such mutual waivers, and to cause such policies to be properly endorsed to prevent the invalidation of the insurance coverage by reason of these waivers.

ARTICLE SIX
USE OF DEMISED PREMISES

6.01. Permitted Use. Tenant may use the Demised Premises only for the Permitted Use stated in Section 1.12. Tenant acknowledges that Tenant has or will independently investigate and verify to Tenant's satisfaction the extent of any limitations or non-conforming uses of the Demised Premises. Tenant further acknowledges that Tenant is not relying upon any warranties or representations of Landlord concerning the Permitted Use of the Demised Premises, or with respect to any uses of the improvements located on the Demised Premises. Tenant acknowledges that the Tenant finish, which Tenant performs, if any, will conform to all City ordinances.

6.02. Compliance with Law. Tenant shall comply with all governmental laws, ordinances and regulations applicable to the use of the Demised Premises, and shall promptly comply with all governmental orders and directives for the correction, prevention and abatement of nuisances and other activities in or upon or connected with the Demised premises, all at Tenant's sole expense, including any expense or cost resulting from the construction or installation of fixtures and improvements or other accommodations for handicapped or disabled persons required for compliance with governmental laws and regulations, including but not limited to the Americans with Disabilities Act (the "ADA"). To the extent any alterations to the approved plans and specifications to the Demised Premises and the Property outside the Demised Premises, including ADA ramps, are required by the ADA or other applicable laws or regulations as a result of Tenant's alterations, the expense of the alterations shall be made at Tenant's cost, and it shall be Tenant's responsibility to comply with such requirements. Should Tenant initiate any work on the Demised Premises in addition to the work agreed upon per plans and specifications, all expense associated therewith shall be at Tenant's expense, including any ADA required alterations thereto. Notwithstanding anything

to contrary herein, under no circumstances shall the Tenant have responsibility for, or be required to bear the expense of, any modification to the Demised Premises, the building in which the Demised Premises are located, or Property required by any laws, ordinances, orders, rules, and regulations of state, federal, municipal, or other agencies or bodies having jurisdiction over the use, condition or occupancy of the Demised Premises, the building in which the Demised Premises are located, or Property or other compliance expenses to the extent such responsibility or requirement (i) existed on the Commencement Date, or (ii) applies to similar premises in general and not particularly to the Tenant's business at the Demised Premises.

6.03. Signs. Subject to prior written approval of Landlord, Tenant will be allowed to install, at its expense, signage on the Property. It is incumbent on Tenant to ensure any signs installed by Tenant conform with City of Poulsbo regulations, applicable laws and other applicable requirements. Tenant may not place any unauthorized signs, ornaments or other objects upon the Property, or paint or otherwise decorate or deface the Property. Tenant must remove all signs, decorations and ornaments at the expiration or termination of this Lease and must repair any damage and close any holes caused by the removal.

6.04. Utility Services. Landlord agrees to provide, at its cost, water, sewer, gas and electricity service connections to the Demised Premises. Tenant shall pay the cost of all utility services, including but not limited to initial connection charges, all charges for gas, water, sewerage, communications and electricity used on the Demised Premises, and for replacing all electric lights, lamps and tubes. Should utilities for the building not be sub-metered to each Tenant, then Tenant shall be responsible for its pro-rata share of said utilities, plus any extra ordinary consumption specific to Tenant. In the event of any interruption, reduction or discontinuance of utility services, Landlord shall not be liable for damages to persons or property as a result thereof, nor shall the occurrence of any such event in any way be construed as an eviction of Tenant or cause or permit an abatement, reduction or setoff of Rent, or operate to release Tenant from any of Tenant's obligations hereunder, provided that Landlord is using reasonable diligence to restore such services.

6.05. Landlord's Access. Landlord and Landlord's agents shall have the right to, during normal business hours and upon at least twenty-four (24) hours' advance notice (other than during an emergency, for which no notice will be required), and without unreasonably interfering with Tenant's business, enter the Demised Premises: (a) to inspect the general condition and state of repair of the Demised Premises, (b) to make repairs required or permitted under this Lease, (c) to show the Demised Premises or the Property to any prospective purchaser or, during the final one hundred fifty (150) days of the Lease Term, prospective tenant, and (d) for any other reasonable purpose. During the final one hundred fifty (150) days of the Lease Term, Landlord and Landlord's agents may erect and maintain on or about the Demised Premises signs advertising the Demised Premises for lease or for sale.

6.06. Exemptions from Liability. Landlord shall not be liable for any damage or injury to the persons, business (or any loss of income), goods, inventory, furnishing, fixtures, equipment, merchandise or other property of Tenant, Tenant's employees, invitees, customers or any other person in or about the Demised Premises, whether the damage or injury is caused by or results from: (a) fire, steam, electricity, water, gas or wind; (b) the breakage, leakage, obstruction or other defects of pipes, sprinklers, wires, appliances, plumbing, air conditioning or lighting fixtures or any other cause; (c) conditions arising on or about the Demised Premises or upon other portions of any building of which the Demised Premises is a part, or from other sources or places; or (d) any act or omission of any other tenant of any building on the Property. Landlord shall not be liable for any

damage or injury even though the cause of or the means of repairing the damage or injury are not accessible to Tenant.

ARTICLE SEVEN
PROPERTY CONDITIONS, MAINTENANCE, REPAIRS AND ALTERATIONS

7.01. Property Conditions. Tenant acknowledges that Tenant is relying exclusively upon Tenant's own investigations and the express representations of Landlord, if any, with respect to the condition of the Demised Premises. Other than as expressly set forth in this Lease, Landlord represents that on the Commencement Date the building fixtures and equipment, plumbing and plumbing fixtures, electrical and lighting systems, any fire protection sprinkler system, roof, skylights, doors, overhead doors, windows, dock levelers, elevators, and the interior of the Demised Premises in general, which Landlord was responsible for installing, if any, are in good operating condition. Other than as expressly set forth in this Lease, Landlord represents that on the Commencement Date the ventilating and heating system are in good operating condition.

7.02. Acceptance of Demised Premises. Subject to the provisions of Section 7.01, Tenant acknowledges that by taking possession of the Demised Premises, Tenant shall be deemed to have accepted the Demised Premises in its "As-Is, Where-Is" condition as provided hereunder.

7.03. Maintenance and Repair. Except as otherwise provided in this Lease, Landlord shall be under no obligation to perform any repair, maintenance or management service in the Demised Premises or adjacent common areas. Tenant shall be fully responsible, at its expense, for all repair, maintenance and management services other than those which are expressly assumed by Landlord.

A. Landlord's Obligations.

(1) Subject to the provisions of Article Eight (Damage or Destruction) and Article Nine (Condemnation), and except for any damage caused by Tenant or its agents as described in Section 7.03(B)(1) below, Landlord shall keep the roof, foundation, base building systems including heating and ventilation, structural components and the structural portions of floors and exterior walls of the Demised Premises in good order, condition and repair. Landlord shall not be obligated, except as otherwise provided in this Lease, to maintain or repair windows, doors, overhead doors, plate glass or the surfaces of walls. In addition, Landlord shall not be obligated to make any repairs under this Section until a reasonable time after receipt of written notice from Tenant of the need for repairs. If any repairs are required to be made by Landlord, Tenant shall, at Tenant's sole cost and expense, promptly remove Tenant's furnishings, fixtures, inventory, equipment and other property, to the extent required to enable Landlord to make repairs; provided that, in the course of making such repairs, Landlord will use reasonable efforts to minimize interference with Tenant's operations in the Premises. Provided Landlord complies with the terms of this Lease, Landlord's liability under this Section shall be limited to the cost of the repairs to the Demised Premises. Tenant waives the benefit of any present or future law which might give Tenant the right to terminate the Lease because of the conditions.

(2) All repair, maintenance, management and other services to be performed by Landlord or Landlord's agents involve the exercise of professional judgment by service providers, and shall be performed in a good and workmanlike manner in

accordance with industry standards; and Tenant expressly waives any claims for breach of warranty arising from the performance of those services.

B. Tenant's Obligations.

(1) Subject to the provisions of Section 7.01, Section 7.03.A, Article Eight (Damage or Destruction) and Article Nine (Condemnation), Tenant shall, at all times, keep all other portions of the Demised Premises in good order, condition and repair, ordinary wear and tear excepted, including but not limited to maintenance, repairs and all necessary replacements of the windows, plate glass, doors, electrical and lighting systems, fire protection sprinkler system, interior plumbing, the interior of the Demised Premises in general, pest control and extermination. In addition, Tenant shall, at Tenant's expense, repair any damage to the Demised Premises, including the roof, foundation, structural components or exterior walls that is caused by Tenant's gross negligence or willful misconduct. If Tenant fails to maintain and repair the Property as required by this Section, Landlord may, on thirty (30) days prior written notice, and Tenant's failure to cure within such thirty (30) day period, enter the Demised Premises and perform the maintenance or repair on behalf of Tenant, except that no notice is required in case of emergency, and Tenant shall reimburse Landlord within thirty (30) days of demand for all reasonable, documented, out-of-pocket costs incurred in performing the maintenance or repair, plus five percent (15%).

(2) Tenant shall be responsible for its janitorial, security and all other operating expenses associated with its occupancy of the Demised Premises.

7.04. Alterations, Additions and Improvements. Tenant shall not make any alterations, additions or improvements to the Demised Premises without the prior written consent of Landlord. Tenant may erect or install trade fixtures, shelves, bins, heating, ventilating and air conditioning equipment without Landlord consent, provided that Tenant complies with all applicable governmental laws, ordinances, codes, and regulations. At the expiration or termination of this Lease, Tenant shall, subject to the restrictions of Section 7.05 below, have the right to remove items installed by Tenant, provided Tenant is not in default at the time of the removal and provided further that Tenant shall, at the time of removal of the items, repair in a good and workmanlike manner any damage caused by the installation or removal. Tenant shall pay for all costs incurred or arising out of alterations, additions or improvements in or to the Demised Premises and shall not permit any mechanic's or materialman's lien to be filed against the Demised Premises or the Property. Upon request by Landlord, Tenant shall deliver to Landlord proof of payment reasonably satisfactory to Landlord of all costs incurred or arising out of any alterations, additions or improvements.

7.05. Condition upon Termination. Upon the expiration or termination of this Lease, Tenant shall surrender the Demised Premises to Landlord broom clean and in substantially the same condition as received, except for ordinary wear and tear which Tenant is not otherwise obligated to remedy under any provision of this Lease. Tenant shall not be obligated to repair any damage which Landlord is required to repair under Article Seven (Property Condition), Article Eight (Damage or Destruction), or Article Nine (Condemnation). All alterations, additions and improvements which are not removed by Tenant shall become Landlord's property and shall be surrendered to Landlord upon the expiration or termination of this Lease. In no event, however, shall Tenant remove any of the following materials or equipment without Landlord's prior written consent: (i) electrical wiring or power panels; (ii) lighting or lighting fixtures; (iii) wall coverings, drapes, blinds or other window

coverings; (iv) carpets or other floor coverings; (v) heating, ventilating, or air conditioning equipment; (vi) fencing or security gates; or (vii) any other fixtures, equipment or items which, if removed, would affect the operation or the appearance of the Property.

ARTICLE EIGHT
DAMAGE OR DESTRUCTION

8.01. Notice. If the Property is damaged or destroyed by fire, flood, windstorm, tornado or other casualty, Tenant shall promptly give written notice of the damage or destruction to Landlord.

8.02. Damage or Destruction. In the event the Demised Premises are damaged by fire, explosion or any other casualty to the extent which is less than twenty-five percent (25%) of the full replacement cost of the Demised Premises (as conclusively determined by Landlord's architect or general contractor) and none of the events described in the next succeeding sentence of this Section shall have occurred, the damage shall be repaired by Landlord within a reasonable time period thereafter, provided that Landlord shall not be obligated to expend for such repair an amount in excess of the insurance proceeds recovered as a result of such damage (however, in the event Landlord does not fully restore the Demised Premises as a result of a limitation on insurance proceeds, Tenant shall have the right to terminate this Lease) and that in no event shall Landlord be required to repair or replace Tenant's stock in trade, fixtures, furniture, furnishings, floor coverings and equipment and any improvements installed in the Premises by or on behalf of Tenant. In the event of any such damage by fire, explosion or any other casualty, and (a) Landlord is not required to repair as hereinabove provided, or (b) the Demised Premises are damaged to the extent of twenty-five percent (25%) or more of the full replacement cost of the Demised Premises (as determined in the manner contemplated above in this Section), or (c) the Building is damaged to the extent of twenty-five percent (25%) or more of the full replacement cost of the Building (as conclusively determined by Landlord's architect or general contractor and specifically exclusive of any and all improvements of any nature whatsoever, performed by any tenant in the Building pursuant to the terms of its respective lease), Landlord may elect either to (i) repair or rebuild the Demised Premises or the Building respectively, or (ii) terminate this Lease. Landlord shall make such election by giving notice of such election in writing to Tenant within one hundred twenty (120) days after the date of the event causing the damage. If Landlord is required or elects to repair the Demised Premises as herein provided, Tenant shall, at Tenant's expense, repair or replace its stock in trade, fixtures, furniture, furnishings, floor coverings and equipment; and if Tenant has closed, Tenant shall promptly reopen for business. Notwithstanding anything to the contrary contained in this Section, Landlord shall not have any obligation whatsoever to repair, reconstruct or restore the Demised Premises when the damage resulting from any casualty covered under this Section occurs during the last twelve (12) months of the Lease Term or any extension thereof. To the extent the Demised Premises cannot be occupied (in whole or in part) following a casualty as described herein, the Rent payable under this Lease during the period in which the Demised Premises cannot be fully occupied shall be adjusted equitably. Notwithstanding anything to the contrary set forth herein, in the event of damage to the Demised Premises or to the Building which Landlord elects to repair pursuant to this Section 8.02, if Landlord shall not have commenced such repairs within one hundred eighty (180) days of the date of the casualty or, once commenced, should such repairs take longer than three hundred sixty-five (365) days, Tenant may elect to terminate this Lease upon thirty (30) days prior written notice to Landlord.

ARTICLE NINE
CONDEMNATION

If during the Lease Term or any extension thereof, all or a substantial part of the Demised Premises are taken for any public or quasi-public use under any governmental law, ordinance or regulation or by right of eminent domain, or are conveyed to the condemning authority under threat of condemnation, this Lease shall terminate and the monthly installments of Rent shall be abated during the unexpired portion of the Lease Term, effective from the date of the taking. If less than a substantial part of the Demised Premises is taken for public or quasi-public use under any governmental law, ordinance or regulation, or by right of eminent domain, or is conveyed to the condemning authority under threat of condemnation, Landlord or Tenant, at their option, may by written notice terminate this Lease. If Landlord or Tenant do not terminate this Lease, Landlord shall promptly, at Landlord's expense, restore and reconstruct the buildings and improvements (other than leasehold improvements made by Tenant or any assignee, subtenant or other occupant of the Demised Premises) situated on the Demised Premises in order to make the same reasonably tenantable and suitable for the use for which the Demised Premises is leased as defined in Section 6.01. The monthly installments of Rent payable under this Lease during the unexpired portion of the Lease Term shall be adjusted equitably. Landlord and Tenant shall each be entitled to receive and retain such separate awards and portions of lump sum awards as may be allocated to their respective interests in any condemnation proceeding. The termination of this Lease shall not affect the rights of the parties to such awards.

ARTICLE TEN
ASSIGNMENT AND SUBLETTING

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

Any transfer of this Lease by merger, consolidation, redemption or liquidation of Tenant, or any change in the ownership of, or power to vote, which singularly or collectively represents a majority of the beneficial interest in Tenant, shall constitute a Transfer under this Section.

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

ARTICLE ELEVEN
DEFAULT AND REMEDIES

11.01. Default. Each of the following events is an event of default under this Lease:

A. Failure of Tenant to pay any installment of the Rent or other sum payable to Landlord under this Lease on the date that it is due and the continuance of that failure for a period of fourteen (14) business days after Landlord delivers written notice of the failure to Tenant, provided that Landlord shall not be required to deliver notice of failure to pay Rent more than twice in any calendar year. Any subsequent failure to pay amounts due on the date when due during such calendar year shall constitute an immediate default hereunder, without additional notice or opportunity to cure. This clause shall not be construed to permit or allow a delay in paying Rent beyond the due date and shall not affect Landlord's right to impose a Late Charge or interest as permitted in Section 3.03.

B. Failure of Tenant to comply with any term, condition or covenant of this Lease, other than the payment of Rent or other sum of money, and the continuance of that failure for a period of thirty (30) days after Landlord delivers written notice of the failure to Tenant, provided, if the nonperformance reasonably requires more than thirty (30) days to cure, Tenant shall not be in default if the cure is commenced within the thirty (30) day period and is thereafter diligently pursued to completion within an additional ninety (90) day period;

C. An admission in writing of inability to pay its debts or the making of a general assignment for the benefit of creditors;

D. The commencement by Tenant or any guarantor of Tenant's obligations under this Lease of any case, proceeding or other action seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property;

E. The commencement of any case, proceeding or other action against Tenant or any guarantor of Tenant's obligations under this Lease seeking to have an order for relief entered against it as debtor, or seeking reorganization, arrangement, adjustment, liquidation, dissolution or composition of it or its debts under any law relating to bankruptcy, insolvency, reorganization or relief of debtors, or seeking appointment of a receiver, trustee, custodian or other similar official for it or for all or any substantial part of its property, and Tenant or any guarantor; (i) fails to obtain a dismissal of such case, proceeding, or other action within sixty (60) days of its commencement; or (ii) converts the case from one chapter of the Federal Bankruptcy Code to another chapter;

F. Use of the Demised Premises for a purpose other than the purpose leased;

G. Failure by Tenant to maintain insurance as provided in this Lease;

H. Tenant shall abandon or permanently vacate the Demised Premises for thirty (30) consecutive days;

I. Tenant shall fail to obtain a release of any mechanic's lien, as required herein; or

J. Tenant shall violate any of the rules or regulations attached hereto as Addendum A and shall not cease or cure such violation within fourteen (14) business days after notice thereof from Landlord.

11.02. Remedies. Upon the occurrence of any of the events of default listed in Section 11.01, Landlord shall have the option to pursue any one or more of the following remedies without any prior notice or demand.

A. Terminate this Lease, in which event Tenant shall immediately surrender the Demised Premises to Landlord. If Tenant fails to so surrender the Demised Premises, Landlord may, without prejudice to any other remedy which it may have for possession of the Demised Premises or Rent in arrears, enter upon and take possession of the Demised Premises and expel or remove Tenant and any other person who may be occupying the Demised Premises or any part thereof, without being liable for prosecution or any claim for damages. Tenant shall pay to Landlord on demand the amount of all loss and damage which Landlord may suffer by reason of the termination.

B. Enter upon and take possession of the Demised Premises, without terminating this Lease and without being liable for prosecution or for any claim for damages, and expel or remove Tenant and any other person who may be occupying the Demised Premises or any part thereof. Landlord shall use commercially reasonable efforts to re-let the Demised Premises and shall receive the rent therefor. Tenant agrees to pay to Landlord monthly or on demand from time to time any deficiency that may arise by reason of any such re-letting. In determining the amount of the deficiency, the reasonable professional service fees, attorneys' fees, court costs, remodeling expenses and other costs of re-letting shall be subtracted from the amount of rent received under the re-letting; provided that, any costs attributable to the reletting (i.e. remodeling costs, broker fees, etc.) shall be prorated such that Tenant shall only be responsible for a portion of such costs equal to the total amount of such cost multiplied by a fraction having the number of months the term of the new lease overlaps with the unexpired portion of the Term as numerator and having the number of months in the term of the new lease as denominator.

C. Enter upon the Demised Premises, without terminating this Lease and without being liable for prosecution or for any claim for damages, and do whatever Tenant is obligated to do under the terms of this Lease. Tenant agrees to pay Landlord within thirty (30) days of demand for reasonable, documented, out-of-pocket expenses which Landlord may incur in thus effecting compliance with Tenant's obligations under this Lease, together with interest thereon at the rate of ten percent (10%) per annum from the date expended until paid. Landlord shall not be liable for any damages resulting to Tenant from such action, whether caused by negligence of Landlord or otherwise; provided that Landlord will use reasonable care when taking such actions.

D. Accelerate and declare the Rent for the remainder of the Lease Term, and all other amounts due under this Lease, at once due and payable, and proceed by attachment, suit or

otherwise, to collect all amounts in the same manner as if all such amounts due or to become due during the entire Lease Term were payable in advance by the terms of this Lease, except that the measure of damages for the Rent due after the termination of this Lease shall be capped at the present value of the total Rent due for the unexpired portion of the Term less the present value of the fair market rental value of the Demised Premises for the unexpired portion of the term, both being discounted at the prime rate of interest, as reported in the Wall Street Journal. Neither the enforcement or collection by Landlord of such amounts nor the payment by Tenant of such amounts shall constitute a waiver by Landlord of any breach, existing or in the future, of any of the terms or provisions of this Lease by Tenant or a waiver of any rights or remedies which the Landlord may have with respect to any such breach.

E. No re-entry or taking possession of the Demised Premises by Landlord shall be construed as an election to terminate this Lease, unless a written notice of that intention is given to Tenant. Notwithstanding any such re-letting or re-entry or taking possession, Landlord may, at any time thereafter, elect to terminate this Lease for a previous default. Pursuit of any of the foregoing remedies shall not preclude pursuit of any other remedies provided by law, nor shall pursuit of any remedy provided in this Lease constitute a forfeiture or waiver of any monthly installment of Rent due to Landlord under this Lease or of any damages accruing to Landlord by reason of the violation of any of the terms, provisions and covenants contained in this Lease. Failure of Landlord to declare any default immediately upon its occurrence, or failure to enforce one or more of Landlord's remedies, or forbearance by Landlord to enforce one or more of Landlord's remedies upon an event of default shall not be deemed or construed to constitute a waiver of default or waiver of any violation or breach of the terms of this Lease. Pursuit of any one of the above remedies shall not preclude pursuit by Landlord of any of the other remedies provided in this Lease. The loss or damage that Landlord may suffer by reason of termination of this Lease or the deficiency from any re-letting as provided for above shall include the expense of repossession and any repairs undertaken by Landlord following possession. If Landlord terminates this Lease at any time for any default, in addition to other Landlord's remedies, Landlord may recover from Tenant all damages Landlord may incur by reason of the default, including the cost of recovering the Demised Premises.

11.03. Notice of Default. Tenant shall give written notice of any failure by Landlord to perform any of Landlord's obligations under this Lease to Landlord and to any ground lessor, mortgagee or beneficiary under any deed of trust encumbering the Demised Premises whose name and address have been furnished to Tenant in writing. Landlord shall not be in default under this Lease unless Landlord (or such ground lessor, mortgagee or beneficiary) fails to cure the nonperformance within thirty (30) days after receipt of Tenant's notice. However, if the nonperformance reasonably requires more than thirty (30) days to cure, Landlord shall not be in default if the cure is commenced within the 30-day period and is thereafter diligently pursued to completion. If Landlord fails to commence the cure within the 30-day period or fails thereafter to diligently pursue the cure, Tenant may perform such obligations and Landlord shall reimburse Tenant within thirty (30) days after Landlord's receipt of supporting documentation, for the reasonable, out-of-pocket costs incurred by Tenant in connection with performing such obligations. In addition, in case of an emergency (being defined as an imminent threat of injury to persons or damage to Tenant's equipment, inventory or other property at the Demised Premises or any other condition which imminently threatens to materially interfere with Tenant's ability to operate within the Demised Premises), Tenant shall have the right (giving only such notice to Landlord as is practical under the circumstances) to make such temporary,

emergency repairs as may be reasonably necessary to prevent such damage to the equipment, inventory or property of Tenant situated in the Demised Premises, or such injury to persons.

11.04. Limitation of Landlord's Liability. As used in this Lease, the term "Landlord" means only the current owner or owners of the fee title to the Demised Premises or the leasehold estate under a ground lease of the Demised Premises at the time in question. Each Landlord is obligated to perform the obligations of Landlord under this Lease only to the extent such obligations accrue or arise during the time such Landlord owns such interest or title. Any Landlord who transfers its title or interest is relieved of all liability with respect to the obligations of Landlord under this Lease accruing on or after the date of transfer, and Tenant agrees to recognize the transferee as Landlord under this Lease. However, each Landlord shall deliver to its transferee the Security Deposit held by Landlord if such Security Deposit has not then been applied under the terms of this Lease.

11.05. Landlord's Default. Landlord shall be in default hereunder if Landlord fails to perform any of its obligations under this Lease within thirty (30) days after delivery of written notice from Tenant to Landlord specifying such failure (the "Default Notice"); provided however that, with respect to non-monetary obligations of Landlord, if the nature of such failure is such that it cannot reasonably be cured within such thirty (30) day period, then Lessor shall have such additional time as is reasonably required to cure such failure provided Lessor commences to cure such failure within such thirty (30) day period and proceeds to prosecute such cure with diligence and continuity. If Landlord fails to cure within the above referenced period, then Tenant may, at its option, in addition to any other remedies at law or equity, exercise self-help rights in accordance with the terms of this Section. If Tenant exercises its self-help rights in accordance with the terms of this Section, then Landlord shall reimburse Tenant for the actual costs and expenses incurred by Tenant within thirty (30) days after delivery of an invoice to Landlord. If Landlord fails to pay such costs and expenses within thirty (30) days after delivery of the invoice to Landlord, then in addition to all other rights and remedies that Tenant may have against Landlord (but without duplication in recovering the amounts due Tenant), Tenant shall be entitled to offset against Rent obligations the unpaid and overdue amount of such costs and expenses until Tenant has been paid in full.

ARTICLE TWELVE
PROTECTION OF LENDERS

12.01. Subordination and Attornment. Landlord shall have the right to subordinate this Lease to any future ground lease, deed of trust or mortgage encumbering the Demised Premises, and advances made on the security thereof and any renewals, modifications, consolidations, replacements or extensions thereof whenever made or recorded. Landlord's right to obtain such a subordination is subject to Landlord's providing Tenant with a reasonable written Subordination, Non-disturbance and Attornment Agreement from the ground lessor, beneficiary or mortgagee wherein Tenant's right to peaceable possession of the Demised Premises during the Lease Term shall not be disturbed if Tenant pays the Rent and performs all of Tenant's obligations under this Lease and is not otherwise in default in which case Tenant shall attorn to the transferee of or successor to Landlord's interest in the Demised Premises and recognize the transferee or successor as Landlord under this Lease. If any ground lessor, beneficiary or mortgagee elects to have this Lease superior to the lien of its ground lease, deed of trust or mortgage and gives Tenant written notice thereof, this Lease shall be deemed superior to the ground lease, deed of trust or mortgage whether this Lease is dated prior or subsequent to the date of the ground lease, deed of trust or mortgage or the date of recording thereof. Tenant's rights under this Lease, unless specifically modified at the time this Lease is executed, are

subordinated to any existing ground lease, deed of trust or mortgage encumbering the Demised Premises.

12.02. Signing of Documents. Within fourteen (14) business days after Landlord's written request, Tenant shall sign and deliver any reasonable instruments or documents reasonably necessary or appropriate to evidence any attornment or subordination or any agreement to attorn or subordinate, subject to Tenant's rights and interest in this Lease to be recognized such that same shall not be disturbed.

12.03. Estoppel Certificates. On or before fourteen (14) business days after written request by Landlord or Tenant, the other party shall execute and deliver to the requesting party a written statement certifying: (1) whether Tenant is an assignee or subtenant; (2) the expiration date of the Lease; (3) the number of renewal Options under the Lease and the total period of time covered by the renewal Option(s); (4) that none of the terms or provisions of the Lease have been changed since the original execution of the Lease, except as shown on attached amendments or modifications; (5) that, to such party's actual knowledge, no default by Landlord exists under the terms of the Lease (or if Landlord is claimed to be in default, stating why); (6) that, to such party's actual knowledge, the Tenant has no claim against the Landlord under the Lease and has no defense or right of offset against collection of rent or other charges accruing under the Lease; (7) the amount and date of the last payment of Rent; (8) the amount of any security deposits and other deposits, if any, (9) the identity and address of any guarantor of the Lease, and (10) such other information as may be reasonably requested, and in the event such party shall fail or neglect to execute and deliver any such certificate within five (5) business days following a second (2nd) request therefor, the requesting party, in addition to any other rights or remedies, may, as attorney-in-fact, execute and deliver such certificate on behalf of the other party and the other party hereby irrevocably nominates and appoints such party as its proper and legal attorney-in-fact for such purpose. The requesting party may forward any such statement to any prospective purchaser or lender of the Demised Premises. The purchaser or lender may rely conclusively upon the statement as true and correct.

ARTICLE THIRTEEN
ENVIRONMENTAL REPRESENTATIONS AND INDEMNITY

13.01. Tenant's Compliance with Environmental Laws. Tenant, at Tenant's expense, shall comply with all laws, rules, orders, ordinances, directions, regulations and requirements of Federal, State, county and municipal authorities pertaining to Tenant's use of the Property and with the recorded covenants, conditions and restrictions, regardless of when they become effective, including, without limitation, all applicable Federal, State and local laws, regulations or ordinances pertaining to air and water quality, Hazardous Materials (as defined in Section 14.05), waste disposal, air emissions and other environmental matters, all zoning and other land use matters, and with any direction of any public officer or officers, pursuant to law, which impose any duty upon Landlord or Tenant with respect to the use or occupancy of the Property.

13.02. Tenant's Indemnification. Tenant shall not cause or permit any Hazardous Materials to be brought upon, kept or used in or about the Property by Tenant, its agents, employees, contractors or invitees without the prior written consent of Landlord, except Tenant shall be permitted to store at the Demised Premises ordinary and general office supplies, such as copier toner, liquid paper, glue, ink and common household cleaning materials (some or all of which may constitute Hazardous Materials as defined in this Lease), Hazardous Materials used in the Tenant's business operations, consistent with the Permitted Use in their sealed and unopened packaging or containers in the Demised

Premises, thermostats or fluorescent bulbs collected pursuant to the Tenant's participation in industry best practice recycling initiatives in compliance with applicable storage and handling regulatory requirements, and propane and/or electric batteries used to power forklifts. Landlord hereby consents to Tenant's use of propane, so long as it does not violate City and/or State ordinances or laws and the Landlord is not required to do any additional improvements or modifications to the Demised Premises. If Tenant breaches the obligations stated in the preceding Section or sentence, or if the presence of Hazardous Materials on the Property caused or permitted solely by Tenant results in contamination of the Property, or if contamination of the Property or any other property by Hazardous Materials otherwise occurs for which Tenant is legally liable to Landlord for damage resulting therefrom, then Tenant shall indemnify, defend and hold Landlord harmless from any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses (including, without limitation, sums paid in settlement of claims, reasonable attorneys' fees, court costs, consultant fees and expert fees) which arise during or after the Lease Term as a result of the contamination. This indemnification of Landlord by Tenant includes, without limitation, costs incurred in connection with any investigation of site conditions or any clean-up, remedial work, removal or restoration work required by any Federal, State or local government agency because of Hazardous Materials present in the soil or ground water on or under the Property. Without limiting the foregoing, if the presence of any Hazardous Materials on the Property caused or permitted solely by Tenant results in any contamination of the Property, Tenant shall promptly take all actions at Tenant's sole expense as are necessary to return the Property as close as reasonably practicable to the condition existing prior to the introduction of any such Hazardous Materials, provided that Landlord's approval of such actions (in the exercise of Landlord's reasonable discretion) is first obtained. The foregoing indemnity shall survive the expiration or termination of this Lease. Tenant's indemnity shall not be applicable or operational in the event hazardous material is released by Landlord or other tenants or to the extent is present as a result of the negligence or willful misconduct of Landlord or other tenants.

13.03. Landlord's Representations and Warranties. Landlord represents and warrants, to the best of Landlord's actual knowledge, that: (i) any handling, transportation, storage, treatment or usage of Hazardous Materials that has occurred on the Property to date has been in compliance with all applicable Federal, State, and local laws, regulations and ordinances; and (ii) no leak, spill, release, discharge, emission or disposal of Hazardous Materials has occurred on the Property to date and that the soil or groundwater on or under the Property is free of Hazardous Materials as of the Commencement Date, unless expressly disclosed by Landlord to Tenant in writing.

13.04. Landlord's Indemnification. Landlord hereby indemnifies, defends and holds Tenant harmless from any claims, judgments, damages, penalties, fines, costs, liabilities, (including sums paid in settlements of claims) or loss, including, without limitation, reasonable attorneys' fees, court costs, consultant fees, and expert fees, which arise during or after the term of this Lease from or in connection with the presence or suspected presence of Hazardous Materials in the soil or groundwater on or under the Property, unless the Hazardous Material is released by Tenant or is present solely as a result of the negligence or willful misconduct of Tenant. Without limiting the generality of the foregoing, the indemnification provided by this Section 13.04 shall specifically cover costs incurred in connection with any investigation of site conditions or any clean-up, remedial work, removal or restoration work required by any Federal, State or local governmental authority.

13.05. Definition. For purposes of this Lease, the term "Hazardous Materials" means any one or more pollutant, toxic substance, hazardous waste, hazardous material, hazardous substance, solvent or oil as defined in or pursuant to the Resource Conservation and Recovery Act, as amended, the Comprehensive Environmental Response, Compensation and Liability Act, as amended, the Federal

Clean Water Act, as amended, or any other Federal, State or local environmental law, regulation, ordinance, or rule, whether existing as of the date of this Lease or subsequently enacted.

13.06. Survival. The representations and indemnities contained in this Article 14 shall survive the expiration or termination of this Lease.

ARTICLE FOURTEEN
BROKERS

Landlord shall be responsible for any and all expenses and/or commissions associated with Landlord' Broker, should Landlord have a broker. Tenant shall be liable for any and all expenses or commissions associated with Tenant's Broker, should Tenant have a broker. This shall pertain to the exercise of the Lease, Lease Options, lease extensions and lease amendments. Tenant hereby agrees to indemnify and hold the Landlord harmless of and from any and all loss, costs, damages or expenses (including, without limitation, all attorneys' fees and disbursements) by reason of any claim of or liability to any other broker or person claiming through Tenant and arising out of or in connection with the negotiation, execution and delivery of this Lease.

ARTICLE FIFTEEN
MISCELLANEOUS

15.01. Force Majeure. If performance by Landlord or Tenant of any term, condition or covenant in this Lease is delayed or prevented by any Act of God, strike, lockout, shortage of material or labor, restriction by any governmental authority, civil riot, flood, or any other cause not within the control of Landlord or Tenant, the period for performance of the term, condition or covenant shall be extended for a period equal to the period Landlord or Tenant, as applicable, is so delayed or prevented.

15.02. Interpretation. The captions of the Articles or Sections of this Lease are to assist the parties in reading this Lease and are not a part of the terms or provisions of this Lease. Tenant shall be responsible for the conduct, acts and omissions of Tenant's agents, employees, customers, contractors, invitees, agents, successors or others using the Demised Premises with Tenant's express or implied permission, to the extent provided in this Lease. Whenever required by the context of this Lease, the singular shall include the plural and the plural shall include the singular, and the masculine, feminine and neuter genders shall each include the other.

15.03. Waivers. All waivers to provisions of this Lease must be in writing and signed by the waiving party. Landlord's delay or failure to enforce any provisions of this Lease or its acceptance of late installments of Rent shall not be a waiver and shall not prevent Landlord from enforcing that provision or any other provision of this Lease in the future. No statement on a payment check from Tenant or in a letter accompanying a payment check shall be binding on Landlord. Landlord may, with or without notice to Tenant, negotiate, cash, or endorse the check without being bound to the conditions of any such statement.

15.04. Severability. A determination by a court of competent jurisdiction that any provision of this Lease is invalid or unenforceable shall not cancel or invalidate the remainder of that provision or this Lease, which shall remain in full force and effect.

15.05. Joint and Several Liability. All parties signing this Lease as Tenant shall be jointly and severally liable for all obligations of Tenant.

15.06. Amendments or Modifications. This Lease is the only agreement between the parties pertaining to the lease of the Demised Premises and no other agreements are effective unless made a part of this Lease. All amendments to this Lease must be in writing and signed by all parties. Any other attempted amendment shall be void.

15.07. Notices. All notices and other communications required or permitted under this Lease must be in writing and shall be deemed delivered, whether actually received or not, on the earlier of: (i) actual receipt if delivered in person or by messenger with evidence of delivery; or (ii) receipt of an electronic facsimile transmission ("Fax") with confirmation of delivery; or (iii) upon to 3rd business day after deposit in the United States Mail as required below. Notices may be transmitted by Fax to the Fax telephone numbers specified in Article One on the first page of this Lease, if any. Notices delivered by mail must be deposited in the U.S. Postal Service, first class postage prepaid, and properly addressed to the intended recipient as set forth in Article One. Any party may change its address for notice by delivering written notice of its new address to all other parties in the manner set forth above.

15.08. Attorneys' Fees. If on account of any breach or default by any party to this Lease in its obligations to any other party to this Lease, it becomes necessary for a party to employ an attorney to enforce or defend any of its rights or remedies under this Lease, the non-prevailing party agrees to pay the prevailing party its reasonable attorneys' fees and court costs, if any, whether or not suit is instituted in connection with the enforcement or defense.

15.09. Governing Law; WAIVER OF JURY TRIAL. All obligations under this Lease shall be performed and payable in the county in which the Property is located. The laws of the State of Washington shall govern this Lease. LANDLORD AND TENANT AGREE THAT ANY ACTION OR PROCEEDING ARISING OUT OF THIS LEASE SHALL BE HEARD BY A COURT SITTING WITHOUT A JURY AND THUS HEREBY WAIVE ALL RIGHTS TO A TRIAL BY JURY.

15.10. Survival. All obligations of any party to this Lease which are not fulfilled at the expiration or the termination of this Lease shall survive such expiration or termination as continuing obligations of the party, provided that any surviving obligations will automatically terminate on the second anniversary of the expiration or termination of this Lease.

15.11. Binding Effect. This Lease shall inure to the benefit of, and be binding upon, each of the parties to this Lease and their respective heirs, representatives, successors and assigns. However, Landlord shall not have any obligation to Tenant's successors or assigns unless the rights or interests of the successors or assigns are acquired in accordance with the terms of this Lease.

ARTICLE SIXTEEN
ADDITIONAL PROVISIONS

16.01. Common Areas. Except as otherwise specifically provided herein, all access roads, courtyards and other areas, facilities or improvements furnished by Landlord are for the general and nonexclusive use in common of all tenants and occupants of the Building and the Property, and those persons invited or permitted upon the land upon which the Building is situated and shall be subject to

the exclusive control and management of Landlord as authorized pursuant to the Covenants, and Landlord shall have the right, without obligation, to establish, modify and enforce such rules and regulations, which Landlord may deem reasonable and/or necessary; provided, however, in no event shall Landlord's actions materially and adversely affect Tenant's rights hereunder or its ability to operate its business in the Demised Premises. Unless as otherwise provided, Tenant's use of the parking spaces, as set forth above, shall be in common with other tenants of the Building and any other parties permitted to use the Property.

16.02. Confidentiality. The terms of this Agreement shall remain confidential to Landlord, Tenant and their respective Agents; and said parties shall not disclose any of the terms herein, without the prior written consent of Landlord and/or Tenant. However, it is agreed and understood that Landlord and Tenant shall have the right to disclose the terms of this transaction with their lenders, attorneys and prospective purchasers (should a sale of the business and/or property become an issue).

[Signatures follow]

IN WITNESS WHEREOF, the parties hereto have executed this Lease as of the effective as of the Effective Date.

LANDLORD:

Liberty Bay, L.L.C.,
a Washington limited liability company

By: [signature]
Name: R. Andrew Leuzinger
Its: Co-Manager

Date of Execution: 1/30/2024

TENANT:

Shalom Hospice of Puget Sound LLC,
a Limited Liability Company

By: [signature]
Name: Samuel Stern
Its: CEO

Date of Execution: 1/30/24

EXHIBIT "A"
FLOOR PLAN

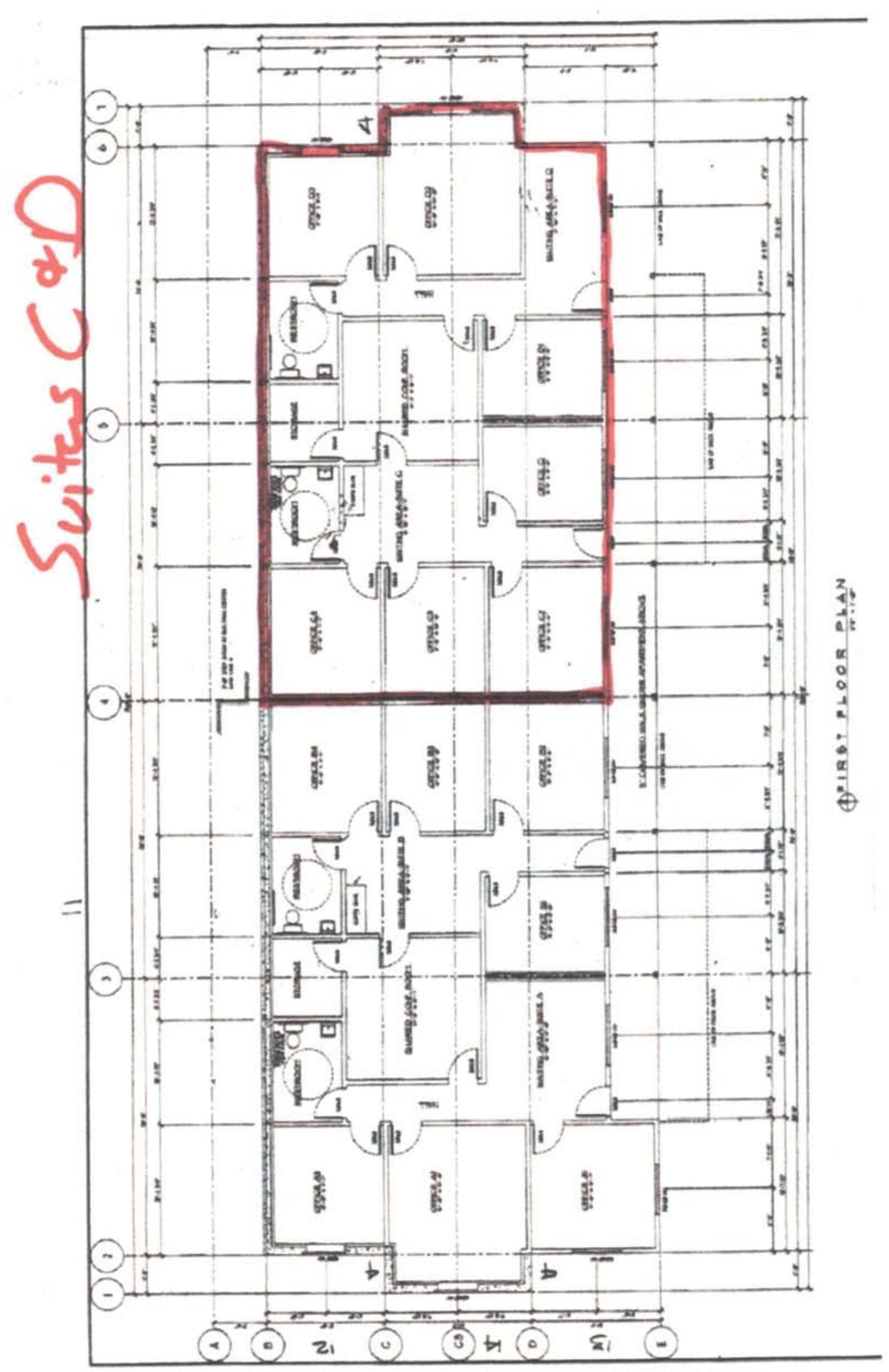
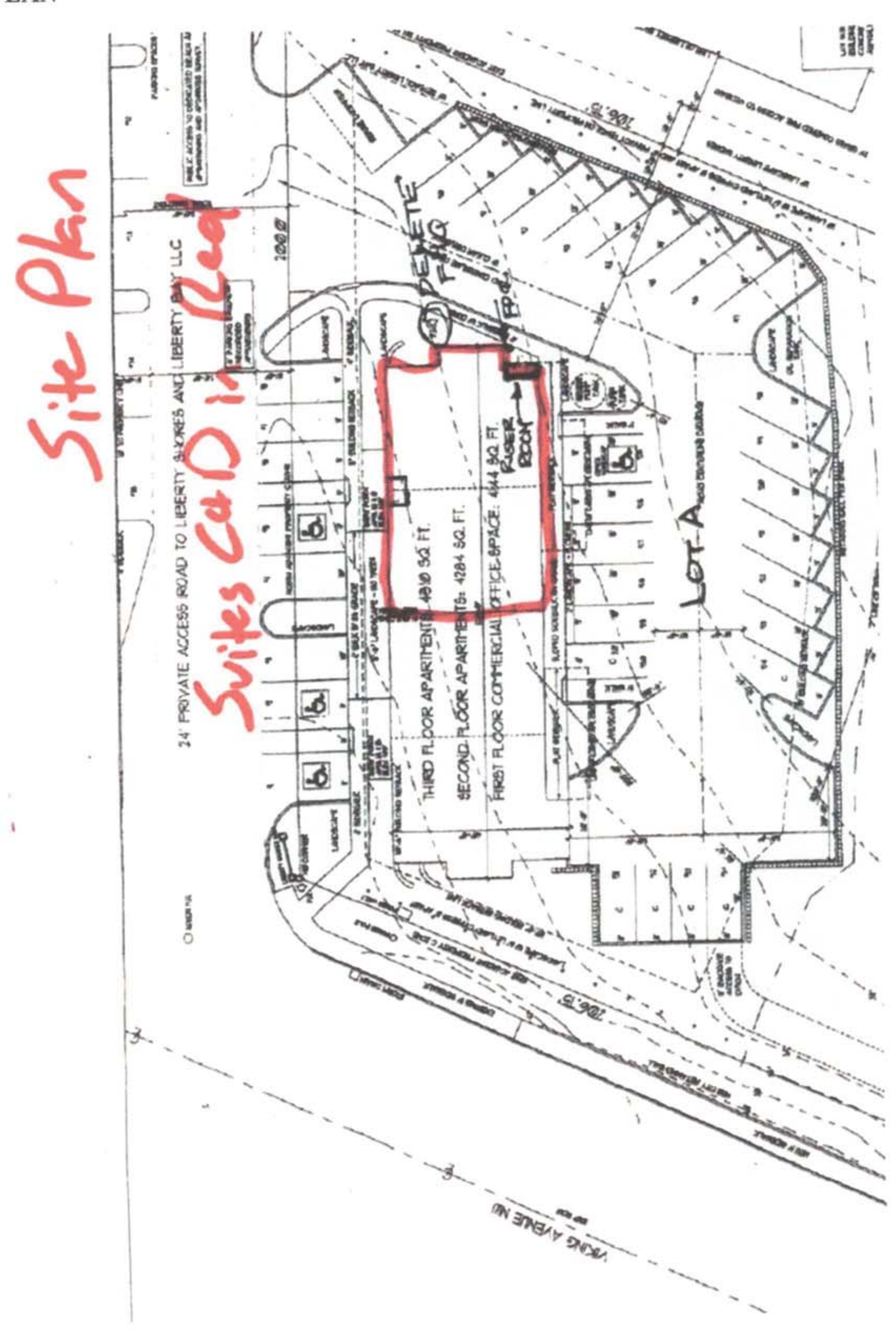


EXHIBIT "B"
SITE PLAN



ADDENDUM "A" TO THE LEASE

RULES AND REGULATIONS

A. **Application**. The following standards shall affect and shall be observed by Tenant, Tenant's employees and invitees, for the mutual safety, cleanliness, care, protection, comfort and convenience of all tenants and occupants of the Property, and shall be applicable to the building(s), to the parking garages, if any, to the common areas, driveways, parking lots, and to the Demised Premises, including the land situated beneath and any appurtenances thereto.

B. **Consent Required**. Any exception to these Rules and Regulations must first be approved in writing by Landlord. For purposes of these Rules and Regulations, the term "Landlord" includes the building manager, the building manager's employees and any other agent or designee authorized by Landlord to manage or operate the Property.

C. **Rules and Regulations**:

1. Tenant may not conduct any auction, "flea market" or "garage sale" on the Demised Premises nor store any goods or merchandise on the Property except for Tenant's own business use. Food may not be prepared in the Demised Premises except in small amounts for consumption by Tenant. The Demised Premises may not be used or occupied as sleeping quarters or for lodging purposes. Animals may not be kept in or about the Property.
2. Tenant shall not obstruct sidewalks, driveways, loading areas, parking areas, corridors, hallways, vestibules, stairs and other similar areas designated for the collective use of tenants, or use such areas for Tenant's storage, temporary or otherwise, or for any purpose other than ingress or egress to and from the Demised Premises. Tenant shall comply with parking rules and guidelines as may be posted on the Property from time to time.
3. Tenant shall not make any loud noises, unusual vibrations, unpleasant odors, objectionable or illegal activities on the Property. Tenant shall not permit the operation of any equipment in the Demised Premises that could unreasonably annoy other occupants of the Property. Tenant shall not interfere with the possession of other tenants of the Property.
4. Tenant may not bring any flammable, explosive, toxic, noxious, dangerous or hazardous materials onto the Property, except for propane as discussed in Section 13.02.
5. Installation of security systems, telephone, television and other communication cables, fixtures and equipment must comply with Section 7.04 of the Lease, except that routine installation and construction of normal communication devices which do not require any holes in the roof or exterior walls of the Property do not require the written approval of Landlord.
6. Movement into or out of the building which require use of a hand truck, dolly or pallet jack to carry freight, furniture, office equipment, supplies and other large or heavy material, must be done at times and in a manner so as not to unduly inconvenience other occupants of the Property. All wheels for such use must have rubber tires and edge guards to prevent damage to the building. Tenants shall be responsible for and shall pay all costs to repair damages to the building caused by the movement of materials by Tenant.
7. Requests by Tenant for building services, maintenance and repair must be made in writing to the building manager designated by Landlord or the Landlord and must be dated. Tenant shall give prompt written notice to Landlord of any significant damage to or defects in the

Demised Premises or the Property, especially including plumbing, electrical and mechanical systems, heating, ventilating and air conditioning systems, roofs, windows, doors, foundation and structural components, regardless of whose responsibility it is to repair such damage.

8. Tenant shall not change locks or install additional locks on doors without the prior written consent of Landlord, except Tenant shall have the right to install a card reader system. If Tenant changes locks or installs additional locks on the Property, Tenant shall within five (5) days thereafter provide Landlord with a copy of each separate key to each lock. Upon termination of Tenant's occupancy of the Demised Premises, Tenant must surrender all keys to the Demised Premises and to the Property to Landlord.
9. Harmful liquids, toxic wastes, bulky objects, insoluble substances and other materials which may cause clogging, stains or damage to plumbing fixtures or systems must not be placed in the lavatories, water closets, sinks, or drains. Tenant must pay the costs to repair and replace drains, plumbing fixtures and piping which is required because of damage caused by Tenant.
10. Tenant shall cooperate with Landlord and other occupants of the Property in keeping the Property and the Demised Premises neat and clean. Nothing may be swept, thrown or left in the outdoor walkways, parking lots or any other common areas on the Property. All trash and debris must be properly placed in receptacles provided therefore.
11. Except as stipulated in Section 6.03, no advertisement, sign, notice handbill, poster or banner may be exhibited, distributed, painted or affixed upon the Property. No directory of tenants is allowed on the Property other than that provided by Landlord.
12. Tenant agrees to cooperate with and assist Landlord in the prevention of peddling, canvassing and soliciting on the Property.
13. Tenant accepts any and all liability for damages and injuries to persons and property resulting from the serving and sales of alcoholic beverages on or from the Property.

D. **Revisions**. Landlord reserves the right to revise and/or rescind any of these Rules and Regulations and to make additional rules, which Landlord may reasonably determine are necessary from time to time for the safety, care, cleanliness, protection, comfort and convenience of the tenants and occupants of the Property and for the care, protection and cleanliness of the building. Revisions and additions will be binding upon the Tenant upon receipt of a written copy of such revisions and additions and as if they had been originally prescribed herein when furnished in writing by Landlord to Tenant, provided the additions and revisions apply equally to all tenants occupying the Property; further provided that such additions or revisions do not alter or interfere with Tenant's operations or the Demised Premises pursuant to its Permitted Use; and further provided that such revisions and additions do not materially deprive Tenant of its rights under this Lease or impose material, additional obligations on Tenant. In all cases of conflict between this Lease and the Rules and Regulations, this Lease shall control.

E. **Enforcement**. Any failure or delay by Landlord in enforcing these Rules and Regulations will not prevent Landlord from enforcing these Rules and Regulations in the future. If any of these Rules and Regulations is determined to be unenforceable, it shall be severed from this Lease without affecting the remainder of these Rules and Regulations.

ADDENDUM "B" TO THE LEASE
BASE RENT PAYMENT SCHEDULE

Year / Months	Base Rent/RSF	Monthly Base Rent	Total Rent by Year
2024 / October – December	$1.20	$2528.40	$7585.20
2025 / January – December	$1.25	$2633.75	$31,605.00
2026 / January – December	$1.30	$2739.10	$32,869.20
2027 / January – September	$1.35	$2844.45	$25,600.05
Approx. Rental Square Footage	2107 ft^2		
Annual Rent Increase	$105.35 per month		

Exhibit 9
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