Exhibit 1

## TABLE 1: PROJECT BUDGET

**INSTRUCTIONS: All estimates for 1.a.-d., 2.a.-j., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. (DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)**

### A. Use of Funds

1. Capital Costs (if applicable):

| | | | |
|---|---|---|---|
| a. | New Construction | $ | |
| (1) | Building | | |
| (2) | Fixed Equipment (not included in construction) | | |
| (3) | Land Purchase | | |
| (4) | Site Preparation | | |
| (5) | Architect/Engineering Fees | | |
| (6) | Permits, (Building, Utilities, Etc) | | |
| **SUBTOTAL** | | | $ |
| b. | Renovations | | |
| (1) | Building | $ | |
| (2) | Fixed Equipment (not included in construction) | | |
| (3) | Architect/Engineering Fees | | |
| (4) | Permits, (Building, Utilities, Etc.) | | |
| **SUBTOTAL** | | | $ |
| c. | Other Capital Costs | | |
| (1) | Major Movable Equipment | | |
| (2) | Minor Movable Equipment | $27,500[1] | |
| (3) | Contingencies | | |
| (4) | Other (Specify) | | |
| **TOTAL CURRENT CAPITAL COSTS** (a - c) | | | $ 27,500 |
| d. | Non Current Capital Cost | | |
| (1) | Interest (Gross) | $ | |
| (2) | Inflation (state all assumptions, Including time period and rate) | $ | |
| **TOTAL PROPOSED CAPITAL COSTS** (a - d) | | | $ |

2. Financing Cost and Other Cash Requirements:

| | | |
|---|---|---|
| a. | Loan Placement Fees | $ |
| b. | Bond Discount | |
| c. | Legal Fees (CON Related) | $81,000 |
| d. | Legal Fees (Other) | |
| e. | Printing | |
| f. | Consultant Fees | |
| | CON Application Assistance | |
| | Other (Specify) | |
| g. | Liquidation of Existing Debt | |
| h. | Debt Service Reserve Fund | |
| i. | Principal Amortization Reserve Fund | |
| j. | Other (Specify) | |

**TOTAL (a - j)** $__$81,000__

3. Working Capital Startup Costs $__________

**TOTAL USES OF FUNDS (1 - 3)** $___108,500___

**B. Sources of Funds for Project:**

1. Cash __________
2. Pledges: Gross __________, less allowance for uncollectables __________ = Net __________
3. Gifts, bequests __________
4. Interest income (gross) __________
5. Authorized Bonds __________
6. Mortgage __________
7. Working capital loans __________
8. Grants or Appropriation
   (a) Federal __________
   (b) State __________
   (c) Local __________
9. Other (Specify) __________

**TOTAL SOURCES OF FUNDS (1-9)** $__________

Lease Costs:

| | | | | | |
|---|---|---|---|---|---|
| a. Land | $__________ | x | __________ | = | $__________ |
| b. Building | $ _16/sq. ft.__ | x | ___1200___ | = | $19,200 (1Q18 + 2Q18) |
| c. Major Movable Equipment | $__________ | x | __________ | = | $__________ |
| d. Minor Movable Equipment | $_$4,583.33__ | x | _____6____ | = | $__27,500__ |
| e. Other (Specify) | $__________ | x | __________ | = | $__________ |

---

[1] 5 desks at $1,500, 5 laptops at $1,500, 1 copier at $8,000, $2,500 reserve, $2,000 for phone installation.

# TABLE 2b

| | Projected years – ending with first year at full utilization | | | |
|---|---|---|---|---|
| **CY or FY (circle)** | 2018 | 2019 | 2020 | 2021 |
| Admissions | 39 | 167 | 238 | 278 |
| Deaths | 24 | 128 | 186 | 223 |
| Non-death discharges | 5 | 27 | 41 | 49 |
| Patients served | 39 | 177 | 250 | 290 |
| Patient days | 1,755 | 8,346 | 13,099 | 16,692 |
| Average length of stay | 45 | 50 | 55 | 60 |
| Average daily hospice census | 10 | 23 | 36 | 46 |
| **Visits by discipline** | | | | |
| Skilled nursing | 904 | 4,047 | 5,523 | 6,452 |
| Social work | 222 | 992 | 1,354 | 1,581 |
| Hospice aides | 990 | 4,431 | 6,047 | 7,064 |
| Physicians - paid | 18 | 80 | 109 | 128 |
| Physicians - volunteer | N/A | N/A | N/A | N/A |
| Chaplain | 136 | 608 | 830 | 969 |
| Other clinical | 25 | 112 | 153 | 179 |
| **Licensed beds** | | | | |
| Number of licensed GIP beds | N/A | N/A | N/A | N/A |
| Number of licensed Hospice House beds | N/A | N/A | N/A | N/A |
| **Occupancy %** | N/A | N/A | N/A | N/A |
| GIP(inpatient unit) | N/A | N/A | N/A | N/A |
| Hospice House | N/A | N/A | N/A | N/A |

| | | | | |
|---|---|---|---|---|
| Assumptions | 1.50 | 3.21 | 4.58 | 5.35 |

FOR Reference only

| | | AVG Weekly Admits | | |
|---|---|---|---|---|
| | | Year 2 | Year 3 | Year 4 |
| New Admits | | 1.48 | 1.91 | 2.13 |
| New + Readmission | PA | 3.21 | 4.58 | 5.35 |
| New Admits | | 3.62 | 4.1 | 4.1 |
| New + Readmission | VT | 4.6 | 4.89 | 4.6 |
| Average | | 3.21 | 4.58 | 5.35 |

| **Table 4** | **Projected Years (ending with first full year at full utilization)** | | | |
|---|---|---|---|---|
| [✓ CY] or FY (Circle) | **20_18_** | **20_19_** | **20_20_** | **20---_21_** |
| **1. Revenue** | | | | |
| a. Inpatient services | $ 55,926 | $ 239,041 | $ 419,005 | $ 516,726 |
| b. Hospice House services | N/A | N/A | N/A | N/A |
| c. Home care services | $ 310,890 | $ 1,328,808 | $ 2,215,080 | $ 2,711,166 |
| d. Gross Patient Service Revenue | $ 366,816 | $ 1,567,849 | $ 2,634,085 | $ 3,227,892 |
| e. Allowance for Bad Debt[3] | $ - | $ 20,386 | $ 30,460 | $ 37,677 |
| f. Contractual Allowance | $ 7,483 | $ 31,984 | $ 53,999 | $ 66,495 |
| g. Charity Care | $ 77,345 | $ 20,386 | $ 30,460 | $ 37,677 |
| h. Net Patient Services Revenue | $ 281,988 | $ 1,495,093 | $ 2,519,167 | $ 3,086,044 |
| i. Other Operating Revenues (Specify) | $ 104,776 | $ 502,717 | $ 465,902 | $ 606,297 |
| j. Net Operating Revenue | $ 386,764 | $ 1,997,810 | $ 2,985,069 | $ 3,692,340 |
| **2. Expenses** | | | | |
| a. Salaries, Wages, and Professional Fees, (including fringe benefits) | $ 305,057 | $ 811,004 | $ 1,360,559 | $ 1,618,845 |
| b. Contractual Services | $ 155,442 | $ 722,017 | $ 818,108 | $ 1,025,823 |
| c. Interest on Current Debt | $0 | $0 | $0 | $0 |
| d. Interest on Project Debt | $0 | $0 | $0 | $0 |
| e. Current Depreciation | $ 3,500 | $ 5,000 | $ 7,500 | $ 8,000 |
| f. Project Depreciation | N/A | N/A | N/A | N/A |
| g. Current Amortization | N/A | N/A | N/A | N/A |
| h. Project Amortization | N/A | N/A | N/A | N/A |
| i. Supplies | $ 4,176 | $ 17,712 | $ 28,670 | $ 35,964 |
| j. Other Expenses (Specify) | $ 142,031 | $ 450,217 | $ 677,036 | $ 820,527 |
| k. Total Operating Expenses | $ 610,206 | $ 2,005,950 | $ 2,891,872 | $ 3,509,158 |
| **3. Income** | | | | |
| a. Income from Operation | $ (223,442) | $ (8,140) | $ 93,197 | $ 183,182 |
| b. Non-Operating Income | $0 | $0 | $0 | $0 |
| c. Subtotal | ($223,442) | ($8,140) | $93,197 | $183,182 |
| d. Income Taxes | See footnote | See footnote | See footnote | See footnote |
| e. Net Income (Loss) | $ (223,442) | $ (8,140) | $ 93,197 | $ 183,182 |

| **Table 4 Cont.** | **Projected Years (ending with first full year at full utilization)** | | | |
|---|---|---|---|---|
| CY or FY (Circle) | **20_18_** | **20_19_** | **20_20_** | **20---_21_** |
| **4. Patient Mix** | | | | |
| **A. As Percent of Total Revenue** | | | | |
| 1. Medicare | 59.5% | 59.5% | 59.5% | 59.5% |
| 2. Medicaid | 39.5% | 39.5% | 39.5% | 39.5% |
| 3. Blue Cross | | | | |
| 4. Other Commercial Insurance | | | | |
| 6. Other (Specify) **Charity** | 1.0% | 1.0% | 1.0% | 1.0% |
| 7. TOTAL | 100% | 100% | 100% | 100% |
| **B. As Percent of Patient Days/Visits/Procedures (as applicable)** | | | | |
| 1. Medicare | 59.5% | 59.5% | 59.5% | 59.5% |
| 2. Medicaid | 39.5% | 39.5% | 39.5% | 39.5% |
| 3. Blue Cross | | | | |
| 4. Other Commercial Insurance | | | | |
| 5. Self-Pay | | | | |
| 6. Other (Specify) | 1.0% | 1.0% | 1.0% | 1.0% |
| 7. TOTAL | 100% | 100% | 100% | 100% |

*6. Other includes Charity Care

# TABLE 5

| Position Title | Current No. FTEs | Change in FTEs (+/-) | Average Salary | Employee/ Contractual | TOTAL COST |
|---|---|---|---|---|---|
| **Administration** | | | | | |
| Administration | - | 8.13 | $ 60,659 | Employee | $ 492,858 |
| **Direct Care** | | | | | |
| Nursing | - | 6.86 | $ 60,000 | Employee | $ 411,500 |
| Social work/services | - | 1.80 | $ 50,000 | Employee | $ 90,000 |
| Hospice aides | - | 5.13 | $ 26,000 | Employee | $ 133,250 |
| Physicians-paid | - | 0.27 | $ 312,000 | Contractual | $ 84,600 |
| Physicians-volunteer | N/A | N/A | N/A | N/A | |
| Chaplains | - | 1.25 | $ 40,000 | Employee | $ 50,000 |
| Bereavement staff | - | 0.45 | $ 50,000 | Employee | $ 22,500 |
| Other clinical | N/A | 0 | | Contractual | 4500 |
| **Support** | | | | | |
| Other support | N/A | 0 | 0 | Employee | 1500 |
| | | | | Benefits* | $ 328,137 |
| | | | | TOTAL | $ 1,618,845 |

Benefits are calculated based on the sum total of administrative and direct care staff benefits:

- Admin Benefits include: medical insurance, 401k match, other ins benefits, vacation/PTO workers comp, and payroll taxes and are estimated using 2.8% of revenue based on historical expenses for other BAYADA hospice offices in similar markets and sizes.
- Direct Care Staff benefits include medical insurance, 401k match, vacation/PTO, liability insurance, workers comp and payroll taxes and are estimated using 3.7% of revenue based on historical expenses for other BAYADA hospice offices in similar markets and sizes.

- Other support includes dietary
- Other clinical includes PT/OT/ST

Exhibit 2

## Budget Assumptions

Per Diem Rates are based on FY 2017 rates published in the final rule. These rates are carried out throughout from 2018-2021 (revenue generating years through first full year of utilization 2021)

Per Diem Rates are a blended rate based on 60% Medicare and 40% Medicaid from 2018-2021.

Per Diem Routine Rates are based on the following Tier 1/Tier 2 Distributions

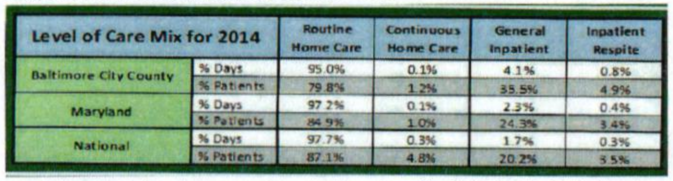
| | |
|---|---|
| **2018** | 75% Tier 1, 25% Tier 2 |
| **2019** | 60% Tier 1, 40% Tier 2 |
| **2020** | 50% Tier 1, 50% Tier 2 |
| **2021** | 50% Tier 1, 50% Tier 2 |

Tier 1 rates are for beneficiaries whose length of stay is 60 days or less; tier 2 rates are for beneficiaries whose length of stay is 61 days and over. Based on our history and length of stay projections (increasing over time, based on 2014 LOS averages for major providers in BC), we believe that we will gradually see a shift from short stay patients to longer stay patients over time. Additionally, it is our belief that our outreach and education efforts will result in earlier admissions to hospice resulting in longer lengths of stay.

Level of Care day distirbutions are based on the 2014 data for Baltimore City as published in the Hospice Data Atlas 2014

This are held constant from 2Q18-4Q21

| | |
|---|---|
| **Routine (All Tiers)** | 95.00% |
| **Respite** | 0.80% |
| **Continuous** | 0.10% |
| **Inpatient** | 4.10% |



| Level of Care Mix for 2014 | | Routine Home Care | Continuous Home Care | General Inpatient | Inpatient Respite |
|---|---|---|---|---|---|
| Baltimore City County | % Days | 95.0% | 0.1% | 4.1% | 0.8% |
| | % Patients | 79.8% | 1.2% | 35.5% | 4.9% |
| Maryland | % Days | 97.2% | 0.1% | 2.3% | 0.4% |
| | % Patients | 84.9% | 1.0% | 24.3% | 3.4% |
| National | % Days | 97.7% | 0.3% | 1.7% | 0.3% |
| | % Patients | 87.1% | 4.8% | 20.2% | 3.5% |

The office is projected to reach breakeven by 3Q19, the fifth quarter of operation. Assuming there was not a charity write off of $77000+ in 4Q18 (due to uncollectable charity care pre licensure), we would have had a ($24212) loss in 4Q18. We are projected to breakeven with about $1500 profit by 3Q19 after five quarters which is consistent with our experience in similar markets.

See Narrative tab for background on Average Daily Census and Admissions projections.

## Table 1 Project Budget

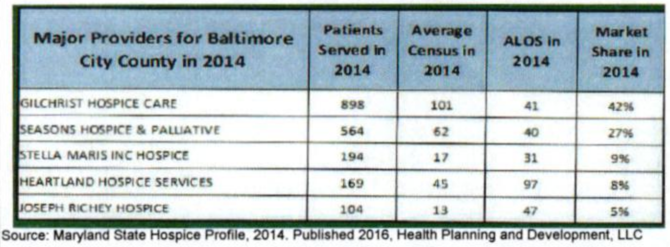
| | |
|---|---|
| **Use of Funds** | |
| **1. Capital Costs** | |
| **1.c.2. Minor Movable Equipment** | Minor movable equipment includes 5 desks at $1500, 5 laptops at $1500, 1 copier at $8000, $2500 cushion, $2000 for phone installation for a total of $27,500 |
| **2. Financing Cost and Other Cash Requirements** | |
| **2.c. Legal Fees (CON Related)** | Includes legal fees from 2016-2017 through approval. |

## Table 2b Statistical Projections

| | |
|---|---|
| **Admissions** | See Table 2b Narrative; Admissions include both new patients and recertified patients; patients served includes current year admissions plus carryover from prior year (determined based on ALOS) |
| **Deaths** | Assume discharges are a factor of ALOS and Admission, with 82% discharges due to death and 18% live discharges (in line with National Standards published by NHPCO in the National Data Set, 2014). |
| **Non-death discharges** | Assume discharges are a factor of ALOS and Admission, with 82% discharges due to death and 18% live discharges (in line with National Standards published by NHPCO in the National Data Set, 2014). |
| **Patients served** | In 2018, this is equal to admissions. In 2019 and beyond, it is equal to prior year admissions less discharges plus current calendar year admissions. |
| **Patient days** | This is the sum of monthly Average Daily Census multipled by the number of days in the month across all calendar months within the calendar year for 2018-2021 for which the hospice is operational. |

**Average length of stay**

Average Length of Stay estimates are based on the median average lenth of stay for the top market shareholders within the county. It is 45 for 2018, 50 for 2019, 55 in 2020 and 60 in 2021. Based on our history and length of stay projections (increasing over time), we believe that we will gradually see a shift from short stay patients to longer stay patients over time. Additionally, it is our belief that our outreach and education efforts will result in earlier admissions to hospice resulting in longer lengths of stay.



| Major Providers for Baltimore City County in 2014 | Patients Served in 2014 | Average Census in 2014 | ALOS in 2014 | Market Share in 2014 |
|---|---|---|---|---|
| GILCHRIST HOSPICE CARE | 898 | 101 | 41 | 42% |
| SEASONS HOSPICE & PALLIATIVE | 564 | 62 | 40 | 27% |
| STELLA MARIS INC HOSPICE | 194 | 17 | 31 | 9% |
| HEARTLAND HOSPICE SERVICES | 169 | 45 | 97 | 8% |
| JOSEPH RICHEY HOSPICE | 104 | 13 | 47 | 5% |

Source: Maryland State Hospice Profile, 2014. Published 2016, Health Planning and Development, LLC

**Average daily hospice census**

See Narrative tab for background on Average Daily Census and Admissions projections.

**Visits by discipline**

| | |
|---|---|
| **Skilled nursing** | Estimates are based off of the National Data Set 2015 published by the National Hospice and Palliative Care Organization which represents average number of visits per discipline per home care admission. BAYADA Hospice's staffing model is premised on both the caseload standards (Average Daily Census/FTE) and visit standards published and endorsed by NHPCO. |
| **Social work** | |
| **Hospice aides** | See Exhibit 48 - NHPCO's Facts and Figures, 2015 Edition - pages 14 and 15 for data |
| **Physicians - paid** | |
| **Physicians - volunteer** | |
| **Chaplain** | |
| **Other clinical** | |

**Table 4 Part 1**

1. Revenue

| | |
|---|---|
| a. Inpatient services | Includes both General Inpatient and Respite Care revenue at 4.1% and 0.8% of patient days respectively |
| b. Hospice House services | BAYADA Hospice does not operate a respite house |
| c. Home care services | Includes both Routine and Continuous Home Care revenue at 95% and 0.10% of patient days respectively |
| d. Gross Patient Service Revenue | |
| e. Allowance for Bad Debt | In 2018, this would be the uncollectable charity care required prior to licensure so this is reflected in Charity Care; in 2019-2021 this would be any uncollected revenue, in line with our historical average of approximately 1% of total revenue (post sequestration). |
| f. Contractual Allowance | Contractual allowance is 2% sequestration |
| g. Charity Care | In 2018, charity care is equivalent to any patient care delivered prior to licensure + 1% total revenue (post sequestration) charity care. In 2019-2021, it is equivalent to 1% of total revenue (post sequestration). |

| | |
|---|---|
| h. Net Patient Services Revenue | |
| i. Other Operating Revenues (Specify) | Includes Medicaid Room and Board and Service Intensity add-on revenue.<br>Medcaid Room and Board revenue is generated when (in some states, MD included), the hospice is required to bill the state Medicaid program on behalf of dual eligible beneficiaries residing in Skilled Nursing Facilities (SNF). When hospice bills the state on behalf of the SNF, the state pays hospice 95% of what it would normally reimburse the SNF. Hospice, in turn, still needs to pass along 100% of the rate billed to the SNF and just ends up absorbing a 5% write-off on each payment.<br>Hospices operating in states where this "pass-through" is mandated, have a negative gross margin on every room and board day billed (since we lose 5%). As a new provider breaking into the market, there will be a big push to grow our census and part of that strategy will include targeting SNFs. Thus, we expect that about 30% of total patient days will be eligible for this Medicaid Room and Board revenue. However, in latter years, as our referral base expands and diversifies with deeper relationships established within the community, we believe that the proportion of total Medicaid Room in Board days relative to total patient days will decrease. So, in 2019, with 30% Room and Board days, we expect about 2504 days. However, in 2020, we expect only 15% Room and Board days on a larger number of patient days which would be about 1,965. In 2021, we would maintain the 15% bringing our total days back up to 2504.<br>Service intensity add-on revenue is revenue that helps offset higher utilization of care in the final week of life. Passed as part of the FY2016 update to the CMS hospice wage index, it pays hospices a rate equivalent to the continuous care unit rate per 15min increment of care provided during the last week of life by an RN. For 2016 YTD, this has been about 1% of total revenue for BAYADA Hospice offices operating in other states.<br>In 2020, we expect this to grow to 2.5% of revenue and in 2021 to 3% of revenue given that visits in the final days of life are part of the Hospice Quality Reporting Program. |
| j. Net Operating Revenue | |
| 2. Expenses | |
| a. Salaries, Wages, and Professional Fees, (including fringe benefits) | This includes Administration and Direct Care Staff payroll and other expenses such as medical insurance, 401k match, vacation/PTO workers comp, payroll taxes, contracted services, vacation, 401K match, liability insurance, payroll taxes, medical insurance, and workers comp insurance. |
| b. Contractual Services | Includes: GIP and Respite Passthrough at 95% contracted rate, Medicaid R&B Passthrough and 5% admin fee for R&B |
| c. Interest on Current Debt | |
| d. Interest on Project Debt | |
| e. Current Depreciation | estimated based on historical depreciation for other BAYADA hospice offices in similar markets and sizes. |
| f. Project Depreciation | |
| g. Current Amortization | Included in depreciation |
| h. Project Amortization | |
| i. Supplies | Includes: Printing/Supplies/Postage and Medical Supplies |
| j. Other Expenses (Specify) | Includes: transporation, onboarding, education, medication and durable medical equipment expenses, advertising, recruiting, equipment, data processing, occupancy, telephone, travel/meals/entertainment, taxes & fees, Miscellaneous, electronic medical record charges, corporate support charges. Ancillary services such as lab, diagnostics, ambulance, etc at estimated 1% revenue |
| k. Total Operating Expenses | |
| 3. Income | |
| a. Income from Operation | |
| b. Non-Operating Income | |
| c. Subtotal | |
| d. Income Taxes | Income taxes are allocated to hospice service offices via a fixed 6% allocation that includes, amongst other things, all of shared corporate services. This is already factored into the item 2j. Other expenses. |
| e. Net Income (Loss) | |

ALOS assumed to be 45 in 2018 and 50 2019 - in line with BC ALOS for top hospices by market share; increases to 60 by 2021 (full utilization) which is slightly below national averages (NDS 2014 median was 65 with mean at 71 days)

**Table 5 Footnotes**

**Average Salary**

We use average admin salaries for 2021; we used contracted rate of $150/hr for medical director, which ends up being $312000 total.

We took the average FTEs for the year and multiplied them by the average salaries to arrive at total costs for 2021 (full utilization)

**Bereavement**

Bereavement expenses are included in Administration via part of the time that the PsychoSocial Manager and Bereavement Coordinator spend supporting the bereaved through telephonic outreach, community support groups, cards, letters, resources, etc.

Direct Care bereavement expenses are calculated using 20% of Social Worker time with the remaining 80% of their time spent on social work activities for hospice patients and their families.

**Starting (Current) FTEs**

0 because we don't have any staff currently

**Physician -Paid**

This is our contracted Medical Director; time is spent partially on administrative activities such as chart reviews, education, IDG, etc.

Baltimore City ADC projections:

**2014 Baseline Year Stats**

| | 2014 Baseline Stats | Notes |
|---|---|---|
| Hospice Deaths | 1,434 | |
| Total Deaths (35+) | 5,707 | |
| Basline Use Rate | 0.251 | per every 1000 deaths for the 35+ population were on hospice<br>Hospice Deaths/Total Deaths |

**2019 Target Year Stats**

| | | |
|---|---|---|
| Total Deaths (35+) | 5,827 | Based on published target year need of 2756 divided by target use rate .473 |
| 2019 Capacity | 1522 | published |
| Target Year 2019 Use Rate based on current use rate and growth | 0.261 | per every 1000 deaths for the 35+ population will be on hospice; 4% increase over 2014 use rate or a difference of 1 point |
| Target Year 2019 Target Use Rate | 0.473 | per 1000 deaths would be hospice; 66.21% increase over 2014 use rate or a difference of 19 points |
| 2019 Need Based on .473 use rate | 2,756 | total hospice deaths projected in 2019 |
| Net Need | 1,234 | |

**2019 Target Year Stats with BAYADA Hospice**

| | | |
|---|---|---|
| Total Deaths (35+) | 5,827 | Based on published target year need of 2756 divided by target use rate .473 |
| 2019 Hospice Death Capacity with BAYADA Hospice | 1650 | |
| Target Year 2019 Use Rate based on BAYADA Hospice's projections | 0.2831 | |
| Additional Hospice Deaths with BAYADA in 2019 | 128 | ties into table 2b |
| Target Year 2019 Target Use Rate | 0.473 | per 1000 deaths would be hospice; 66.21% increase over 2014 use rate or a difference of 19 points |
| 2019 Need Based on .473 use rate | 2,756 | total hospice deaths projected in 2019 |
| Net Need | 1,106 | reduced net need by 128 and increased utilization by 8%, from a .2612 to .2831 use rate |

**Exhibit 3**

# The BAYADA Way®

*Compassion. Excellence. Reliability.*

# A letter from Mark Baiada

As BAYADA approached its 30th anniversary, I realized that our company needed a clearer expression of what is most important about the work we do and the way we should work, in spirit and in action. I felt that our values, when more clearly expressed, would provide us with a powerful shared understanding and commitment to guide our daily work.

Since 1975, we have helped people at home and succeeded by following important, but unspoken, principles. I felt it was time to gather them together so that we as a group could be clearer about what we stood for in our work.

I searched for a way to find and express what is most important. I read about how other successful organizations addressed this need. I spoke with many people within and outside our company, and I thought about the matter a great deal. Then I met Dr. Al Freedman, because we care for his son, Jack. I read his article, "Welcome to Our Home" published in *Caring Magazine*, attended a workshop he led, and realized how close he was to the deepest feelings surrounding our work. I sensed a deep understanding of these issues and asked Dr. Freedman to work with me to find the answers to some important questions:

- What does BAYADA stand for?
- What does the company believe in?
- What are our values?
- What are the special ingredients that make BAYADA such a unique organization?

In answering those questions, we have defined *The BAYADA Way*.

*The BAYADA Way* expresses what is most critical to our work as home health care professionals. *The BAYADA Way* is our philosophy: a set of guideposts and beliefs articulated by the current generation of BAYADA home health care professionals, to be passed down to colleagues who carry on this important work in the future. Our goal is for *The BAYADA Way* to become a lasting legacy, rooted in the highest ideals and standards for the profession of home care.

*The BAYADA Way* is the light that shines within each one of us—a spirit that connects us to each other, a spirit bigger than ourselves. This spirit brings meaning to our lives and to our work, and brings us together for the higher purpose of providing support and care to people in need.

I believe that at the heart of BAYADA Home Health Care are professionals who are motivated, honest, and happy in their work and who demonstrate compassion, excellence, and reliability. At the heart of our organization are professionals who put their clients' needs first. At the heart of our work are people who take the time to listen, make connections, and develop relationships with clients and colleagues. And, perhaps most importantly, at the heart of BAYADA are people who show love.

Thank you for joining me in celebrating *The BAYADA Way*.

J. Mark Baiada

**J. Mark Baiada**
Founder and President

# The BAYADA Way®

## Our Mission

BAYADA Home Health Care has a special purpose—to help people have a safe home life with comfort, independence, and dignity. BAYADA Home Health Care provides nursing, rehabilitative, therapeutic, hospice, and assistive care services to children, adults, and seniors worldwide. We care for our clients 24 hours a day, 7 days a week.

Families coping with significant illness or disability need help and support while caring for a family member. Our goal at BAYADA is to provide the highest quality home health care services available. We believe our clients and their families deserve home health care delivered with **compassion**, **excellence**, and **reliability**, our BAYADA core values.

## Our Vision

With a strong commitment from each of us, BAYADA Home Health Care will make it possible for millions of people worldwide to experience a better quality of life in the comfort of their own homes. We want to build and maintain a lasting legacy as the world's most compassionate and trusted team of home health care professionals.

*We will accomplish our mission and achieve our vision by following our core beliefs and values.*

## Our Beliefs

- We believe our clients come first.
- We believe our employees are our greatest asset.
- We believe that building relationships and working together are critical to our success as a community of compassionate caregivers.
- We believe we must demonstrate honesty and integrity at all times.
- We believe in providing community service where we live and work.
- We believe it is our responsibility to strengthen the organization's financial foundation and to support its growth.

# Our Values

*Our work is guided by our fundamental values of compassion, excellence, and reliability.*

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**Compassion**

*Key result:*

Our clients and their families feel cared for and supported.

*Key actions:*

- Work with a spirit of universal faith, hope, and love.
- Demonstrate exceptional care and kindness to others. Be led by our hearts.
- Be respectful. Treat others the way they wish to be treated.
- Listen closely, show empathy, and respond to the needs of others.
- Be friendly. Let our smiles be seen and felt.

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**Excellence**

*Key result:*

We provide home health care to our clients with the highest professional, ethical, and safety standards.

*Key actions:*

- Consistently demonstrate the highest level of skill, competence, and sound judgment in our work.
- Demonstrate honesty, commitment, and loyalty to our clients and their families, fellow employees, and our organization.
- Strive to provide the very best service to our clients. Set specific goals and work hard and efficiently to achieve them.
- Continuously improve our work through evaluation, education, and training.
- Recognize and reward those who set and maintain the highest standards of excellence.

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**Reliability**

*Key result:*

Our clients and their families can rely on us and are able to live their lives to the fullest, with a sense of well-being, dignity, and trust.

*Key actions:*

- Keep our commitments as promised.
- Consistently deliver expected services.
- Fulfill our clients' needs promptly and thoroughly.
- Be creative, flexible, and determined—get the job done for our clients.
- Communicate clearly and consistently with clients and fellow employees.

# Welcome to Our Home

## An Open Letter to Home Care Professionals
**by Albert Freedman, Ph.D.**

(Reprinted with permission from CARING Magazine, June 2001)

Dear Home Care Professional,

Welcome to our home.

Since you are new to the team of professionals who care for our son, I'd like to share some background with you as a way to begin our journey together.

Six years ago when my wife, Anne, and I decided to become parents, we didn't plan to meet you. Back then, we didn't know anything about pulse oximeters, wheelchairs, bi-pap (two-way positive airway pressure) machines, feeding tubes, nebulizers, or standing frames. We didn't plan for the parade of nurses, social workers, occupational and physical therapists, assistive-technology specialists, medical supply personnel, teachers and case managers who come and go. We didn't anticipate the need for five different doctors to monitor our son's progress at the local children's hospital. And we didn't plan for our child to spend fifty-six nights in the Intensive Care Unit before he reached his third birthday.

*I wish we didn't need you, but we do need you.*

Most of all, when we decided to become parents, we didn't anticipate that very bad day when a doctor told us our six-month-old baby had a year to live.

So I hope you don't take it personally when I say I have mixed feelings about your presence in our lives. Frankly, I wish we didn't need you. I wish our son were going to kindergarten with all the other kids his age, scraping his knees, running around outdoors without his coat on, and spilling Elmer's Glue on his lap. I wish I were spending my weekends watching my son play soccer.

But Jack isn't going to kindergarten, and he isn't playing soccer. He can't sit up, walk, or talk very clearly. He can't move his arms or legs. He can't dress or feed himself. He still uses diapers. He can't eat solid foods. He needs constant supervision and attention. He's medically fragile. His care is physically and emotionally demanding.

I wish we didn't need you, but we do need you.

We need your positive attitude and your confidence. We need your sensitivity and patience. We need your knowledge, experience, and skills. And we need you to help us have hope, for our son and our family.

Al and Jack Freedman

**When you begin your work with our son, please carry yourself with confidence.** You've been trained to take care of medically-fragile children and we haven't. Jack's care requires remembering little things about his needs: what's safe to feed him, how to lift him into his wheelchair, when to remove his secretions, how to set up Jack's arm supports so he can use his computer, which way to turn his head when he lays on his stomach, how often to give him a syringe of formula through his feeding tube. Although none of this is rocket science, the sheer number of details can feel overwhelming to a newcomer. But if you feel overwhelmed, try not to show it. Act confident. Take initiative. Have a positive attitude. Watch us as we demonstrate how Jack's equipment works. Ask us questions. Write things down if it helps you. Enjoy yourself when you're working. But above all, carry yourself with confidence. Jack will feel safe if you feel safe.

**When you begin your work with our son, please be patient with us.** We may insist about certain aspects of Jack's care that don't make perfect sense to you. It may be awhile before we leave you alone with our son even though you're perfectly capable of taking care of him. You may wonder why we ask you about your own health every time you sneeze or cough in our house. We realize we worry about Jack just about all the time. Please understand that we simply can't help it. From the moment the doctor sat us down and told us our baby had an incurable, untreatable disease, things were never quite the same again. We really are doing the best we can.

**When you begin your work with our son, please be sensitive to our family's need for privacy** one minute and our need for your active involvement the next minute. (As a wise home care administrator I know tells each of her new clients, "The good news is…you'll now be getting nursing help in your home. The bad news is….you'll now be getting nursing help in your home.") It's a skill to know when to be involved and when to act invisible. Do your best to fade into the woodwork when Anne or I need to parent our son. But get right in there with Jack's physical therapist if she needs your help. Pretend you're not in the room when I answer the phone and it's a client emergency. But offer to pick up the phone if it's ringing and Anne has her hands full with our baby. If you're not sure which approach to take in a given situation, feel free to ask.

We'll try to be sensitive to the needs of your family, too. Let us know if you need flexibility with your work schedule because your mother is visiting from out of town or you'd like to attend

*And when you show a genuine interest in Jack, he will fall in love with you very quickly.*

your daughter's school play. It feels good to us to help someone else's family once in a while. We'll help you out whenever we can.

**When you begin your work with our son, please take the time to get to know him as a person.** Yes, you're here because of all the things Jack can't do by himself. But there's a lot he can do, too. You'll be surprised the first time you see Jack drive around independently in his power wheelchair. Try to keep up with Jack as he clicks his way through a tricky challenge on the computer. Feel free to join him in the swimming pool while he works hard in the water with his therapist. Listen to him tell jokes using his communication device. Enjoy Jack enjoying the company of his baby sister. Soak up his positive attitude, determination, and his smile. We think he's quite a kid. We hope you will, too. And when you show a genuine interest in Jack, he will fall in love with you very quickly.

**When you begin your work with our son, please teach us what you know about caring for him.** After Jack's diagnosis, one of the first things we heard from medical professionals was, "You will soon be the experts on Spinal Muscular Atrophy (SMA) and caring for Jack." But I didn't want to believe our baby had such a terrible disease, much less become an expert on it. And more importantly, if Jack really did have SMA and would die because he couldn't breathe, how in the world could we become experts on how to help him? After all, isn't that what doctors and nurses are for?

Gradually, we did become experts on SMA because Jack is our son and we had to do whatever we could to help him. But for more than five years now, I feel relieved every time we meet a professional who knows more about caring for a medically-fragile child than we know, or at the very least can teach us something new. As you begin working with our son, tell us what you know, tell us what you've learned, tell us what you've seen. We take care of only one medically-fragile child. You've taken care of many more than one. You can provide us with some perspective. You can give us a reality check when we need one. You can help us take care of Jack when he's sick. We need your expertise. That's why you're here. Please don't hold back.

**Finally, and perhaps most importantly, when you begin your work with our son, please help us to have hope.** When we first learned Jack was affected by Spinal Muscular Atrophy, hope was a scarce commodity in our home. We didn't hear much from the doctors about living with Jack from day to day—they didn't tell us about the good days we would have together as a family. Looking back, I now realize it was Jack's job to teach us these important lessons. After all, doctors at children's hospitals don't spend a lot of time with kids when they are well. Parents do that.

**Jack Freedman**

Our son is intelligent and sensitive; he observes all of our words, actions, and signals. Jack needs us to view his disability and his future with a sense of hope, whether life feels manageable at the time or not. Three years ago, when Jack's bout with Respiratory Syncytialvirus (RSV) led to intubation and a three-week hospitalization, it was very hard for me to be positive and hopeful. But as I looked at my son lying in the Intensive Care Unit, kept alive by a ventilator, his eyes wide open wondering what was happening to him, I believed it was important for Jack to see me smiling and to hear me telling stories as usual, giving him the message that I was hopeful and confident of his ability to recover from his illness.

Somehow, Jack did bounce back from that harrowing illness. And ten days later, after he had been successfully extubated and we were preparing to go home, the head physician in the Intensive Care Unit came by to wish us well. He talked about Jack's remarkable recovery, and he was obviously pleased to be a part of it. But the doctor's focus was not on the treatment plan, the efforts of the hospital staff, or his own good work. He attributed Jack's recovery to the patient himself.

"Jack's a fighter," the doctor told us, quite matter-of-factly.

Indeed, Jack is a fighter. All of the children you care for are fighters. But our children cannot fight without hope, and it is up to us — parents and professionals together — to keep hope alive.

We appreciate everything you do.
Welcome to our home.

Sincerely,
The Freedmans

About the Author: Albert Freedman, Ph.D., is a child, adolescent, and family psychologist in independent practice in West Chester, PA. Dr. Freedman serves as an organizational consultant to BAYADA Home Health Care, and as consulting psychologist at Westtown School in Westtown, PA, and Delaware Valley Friends School in Paoli, PA. Dr. Freedman frequently speaks and writes on the topic of caring for children with special needs. He serves on the National Medical Advisory Council of Families of Spinal Muscular Atrophy and the Family Advisory Council at the A.I. duPont Hospital for Children, Wilmington, DE. Dr. Freedman is the father of Jack (1995) and Cara (2000). He can be contacted via email at freedman@fsma.org.

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THE PHILOSOPHY OF BAYADA HOME HEALTH CARE

Exhibit 4

By Amy S. Kelley, Partha Deb, Qingling Du, Melissa D. Aldridge Carlson, and R. Sean Morrison

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### THE CARE SPAN

# Hospice Enrollment Saves Money For Medicare And Improves Care Quality Across A Number Of Different Lengths-Of-Stay

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ABSTRACT **Despite its demonstrated potential to both improve quality of care and lower costs, the Medicare hospice benefit has been seen as producing savings only for patients enrolled 53–105 days before death. Using data from the Health and Retirement Study, 2002–08, and individual Medicare claims, and overcoming limitations of previous work, we found $2,561 in savings to Medicare for each patient enrolled in hospice 53–105 days before death, compared to a matched, nonhospice control. Even higher savings were seen, however, with more common, shorter enrollment periods: $2,650, $5,040, and $6,430 per patient enrolled 1–7, 8–14, and 15–30 days prior to death, respectively. Within all periods examined, hospice patients also had significantly lower rates of hospital service use and in-hospital death than matched controls. Instead of attempting to limit Medicare hospice participation, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.**

As of 2012, 5 percent of the most seriously ill Americans accounted for more than 50 percent of health care spending, with most costs incurred in the last year of life as a result of hospital-based treatment.[1–3] Despite those high and escalating health care costs, numerous studies demonstrate that seriously ill patients and their families receive suboptimal care, characterized by untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals for care.[4–11]

Hospice has been shown to greatly improve the quality of care for patients and their families near the end of life. Under Medicare Part A, the hospice benefit covers palliative care services delivered by a team of professionals, including physicians, nurses, social workers, chaplains, home health aides, and volunteers, to dying patients—that is, patients with a life expectancy of six months or less—who are willing to forgo curative treatments.[12]

Studies have consistently demonstrated that hospice is associated with reductions in symptom distress, improved outcomes for caregivers, and high patient and family satisfaction.[8,13–15] Recent evidence also indicates that continuous hospice use reduces the use of hospital-based services—including emergency department visits and intensive care unit stays—and the likelihood of death in the hospital.[16]

The number of hospices has increased rapidly over the past twenty years, making hospice programs available to almost all eligible Americans.[17] Medicare hospice spending has risen considerably with the growth and development of new hospice programs, particularly in the for-profit sector, and the resulting rise in the number of patients accessing the hospice benefit.[18,19]

This increase in spending has led the Centers for Medicare and Medicaid Services to explore methods of containing Medicare hospice spending, such as through payment reform or investigation of hospices with long lengths-of-stay.[20] What is not known, however, is how the length of hospice enrollment relates to overall Medicare spending at the end of life—including what periods of enrollment might decrease net Medicare costs as compared to usual care and, if they do, by how much.

The length of hospice enrollment that might achieve the greatest cost savings to Medicare is the subject of considerable debate. Some scholars have argued that beneficiaries must be enrolled in hospice longer than current practice to achieve financial savings under Medicare.[21–23] Others have found that longer hospice length-of-stay is associated with higher Medicare spending—particularly for those with noncancer diagnoses.[24]

In the largest and most rigorous study to date, Donald Taylor and colleagues observed that hospice enrollment 53–105 days before death maximized Medicare savings compared to usual nonhospice care.[23] However, this study has been criticized for its inability to control for factors not present in Medicare claims that are known to be associated with higher costs, such as patients' functional status.[25]

Another criticism cited notable differences between the hospice and control groups: Hospice users had greater costs in the period preceding hospice enrollment compared with their matched controls.[25] Such limitations cast doubt on the validity of the reported findings regarding both the timing of hospice enrollment to maximize savings and the magnitude of those savings.

Health care reform in the past decade has sharpened the focus on increasing the value of health care and on forging effective policy to guide that process. A clearer understanding of the value of existing Medicare programs thus is required. In this study we aimed to better understand the value of Medicare hospice by examining the relationship between length of hospice enrollment and overall Medicare costs.

Specifically, we compared Medicare costs for patients receiving hospice care to those of patients not receiving hospice care across four different periods of hospice enrollment: 1–7, 8–14, and 15–30 days before death, the most common enrollment periods, and 53–105 days before death. In addition, we investigated both the source of hospice-related savings, if any, such as decreased hospital admissions and fewer hospital and intensive care unit days, and the impact of hospice on selected measures of quality of care at the end of life, including thirty-day readmission rates and in-hospital death rates.

We used the rich survey data from the Health and Retirement Study, in combination with individual Medicare claims, and adjusted for previously unmeasured factors known to influence costs, such as functional status and social characteristics. These analyses revealed that net savings to Medicare are not limited to hospice enrollment 53–105 days prior to death but are also observed across the most common enrollment periods: 1–7, 8–14, and 15–30 days before death.

## Study Data And Methods

We examined data from the Health and Retirement Study, a longitudinal survey administered to a nationally representative cohort of adults over age fifty. Serial interviews are conducted every two years and include information on participants' demographic, economic, social, and functional characteristics. Each interview cycle, participants who died since the last interview are identified, and dates of death are drawn from the National Death Index. More than 80 percent of participants provided authorization to merge their survey data with Medicare claims,[26,27] a necessary step in the present analysis.

**SAMPLE** We sampled all survey participants who died during 2002–08. We included those age sixty-five or older who had continuous Medicare Parts A and B coverage for twelve months prior to death, while excluding those enrolled with Medicare managed care (for whom claims data were therefore incomplete). This methodology yielded a final sample of 3,069 people, both enrolled and not enrolled in Medicare hospice prior to death.

For the analyses of each enrollment period, we also excluded those who enrolled in hospice prior to the study outcome period (7, 14, 30, and 105 days, respectively) and those whose final predeath interview took place within the study period.

**MEASURES** We categorized periods of enrollment in Medicare hospice before death based on the number of days prior to death that enrollment occurred, as follows: 53–105 days (the period expected to maximize reduction in Medicare spending),[23] 15–30 days, 8–14 days, and 1–7 days. For each period, the primary outcome was total Medicare spending measured from the beginning of the enrollment period to death.

We adjusted expenditures for inflation (2008 dollars) and for geographic differences in Medicare prices. We also examined six other measures of care utilization: hospital admissions, hospital and intensive care unit days, intensive care unit admission (any or none), thirty-day hospital readmission (any or none), and in-hospital death.

We selected independent variables based on our conceptual framework, "Determinants of Treatment Intensity for Patients with Serious Illness," which postulates that treatment intensity is influenced by both regional and patient or family determinants.[28] We selected variables that could serve as empirical measures of each construct in the conceptual model: age; sex; race or ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity.

Variables were drawn from Health and Retirement Study data, individual Medicare claims, and the *Dartmouth Atlas of Health Care*.[29] Additional details are provided in the online Appendix.[30]

**STATISTICAL ANALYSES** We employed doubly robust methods combining propensity score matching and regression adjustment.[31] We first determined hospice enrollment in relation to date of death from individual Medicare hospice claims. For each enrollment period, we then developed propensity scores for hospice and nonhospice patients to estimate each subject's likelihood of hospice enrollment during the specified period.

We used logistic regression to estimate the likelihood of hospice enrollment using all of the independent variables, described above, that may be associated with treatment intensity. Additionally, we included as a covariate the number of hospital days prior to the target hospice enrollment period up to six months before death, to account for prior utilization as a predictor of subsequent utilization.

We then matched hospice enrollees to one or many nonhospice controls within ±0.02 of the standard deviation of the propensity scores. Unmatched subjects were excluded. This procedure was completed for each enrollment period, resulting in the following sample sizes: 1,801 (1–7 days), 1,506 (8–14 days), 1,749 (15–30 days), and 1,492 (53–105 days).

We examined bivariate comparisons of unadjusted measures of spending and use, as well as patient characteristics, using the matched, weighted samples. We then conducted multivariable regressions for each of the outcome measures, once again adjusting for all independent variables.

Following the estimation of each fully adjusted regression, we examined the adjusted means, including 95 percent confidence intervals, and incremental effects in outcomes between groups of hospice enrollees and matched nonhospice controls. Additional details are provided in the online Appendix.[30] Analyses were conducted using the statistical analysis software Stata, version 11.

**LIMITATIONS** Three study limitations are worth noting. First, the data are retrospective, following back from date of death—that is, we employed a mortality follow-back design. This retrospective approach artificially removed the prognostic uncertainty faced by patients and physicians when making treatment decisions. The mortality follow-back design and our inability to randomly assign patients to treatment groups may therefore have biased the results.

However, by using detailed survey data, propensity score matching procedures, and multivariable regression to adjust the results, we minimized the effect of this bias more than could have been achieved through the use of administrative claims data alone.

Second, we were unable to factor into the analysis direct measures of individual preferences and goals of care. We did, however, adjust for all available characteristics known to be potentially associated with treatment preferences, such as education, race, and debility.

Third, we were not able to fully assess quality of care, which, in combination with cost, determines value. We included among our secondary outcomes two markers of potentially low-quality care: thirty-day hospital readmission and in-hospital death. In addition, many prior studies have demonstrated high quality of and satisfaction with hospice and palliative care.[8,13–15,32–36]

## Study Results

**SUBJECT CHARACTERISTICS** Among the 3,069 subjects, 1,064 (35 percent) were enrolled in hospice prior to death. The mean hospice length-of-stay was 49 days (median 16 days, range 1–362 days). Patient and regional characteristics of subjects are reported in Appendix Exhibit 1.[30] Subjects' mean age at death was eighty-three years. Subjects were predominantly non-Hispanic white (80 percent), female (56 percent), covered by supplemental private insurance (50 percent), and educated through high school or beyond (58 percent). Fifty-eight percent reported needing no assistance with basic activities of daily living leading up to the study period, while 21 percent resided in a nursing home. Twenty-three percent were eligible for both Medicare and Medicaid.

**HOSPICE ENROLLMENT FOR 53–105 DAYS** Eighty-eight (70 percent) subjects enrolled in hospice for 53–105 days prior to death were matched to 1,404 decedents not enrolled in hospice for 53 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 2).[30]

In fully adjusted analyses of outcomes spanning the last 105 days of life, subjects enrolled in hospice for 53–105 days prior to death had significantly lower mean total Medicare expenditures than matched controls ($22,083 versus $24,644, $p < 0.01$) (Exhibit 1). Hospice enrollees during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.01$) compared to nonhospice enrollees. Differences between the groups' total intensive care unit days were not significant in the fully adjusted model ($p = 0.11$). Additional details are provided in Appendix Exhibit 3.[30]

**HOSPICE ENROLLMENT FOR 15–30 DAYS** One hundred thirty-three (80 percent) subjects enrolled in hospice for 15–30 days prior to death were matched to 1,616 decedents not enrolled in hospice for 15 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 4).[30]

In fully adjusted analysis of outcomes spanning the last thirty days of life, subjects enrolled in hospice for fifteen to thirty days prior to death had significantly lower average total Medicare expenditures than matched controls ($10,383 versus $16,814, $p < 0.01$) (Exhibit 1). Those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, thirty-day hospital readmissions, and in-hospital deaths (all $p < 0.05$). Additional details are provided in Appendix Exhibit 5.[30]

**HOSPICE ENROLLMENT FOR 8–14 DAYS** Ninety (70 percent) subjects enrolled in hospice for 8–14 days prior to death were matched to 1,416 decedents not enrolled in hospice for 8 days or more days prior to death. Again, we found no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 6).[30]

In fully adjusted analysis of outcomes spanning the last fourteen days of life, subjects enrolled in hospice for eight to fourteen days prior to death had significantly lower average total Medicare expenditures than matched controls ($5,698 versus $10,738, $p < 0.01$) (Exhibit 1). Once again, we found that those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admission, hospital days, and in-hospital deaths (all $p < 0.01$).

The hospice group had fewer intensive care unit days than the nonhospice group, but this difference did not reach statistical significance ($p = 0.11$). Additional details are provided in Appendix Exhibit 7.[30]

**HOSPICE ENROLLMENT FOR 1–7 DAYS** Three hundred eight (80 percent) subjects enrolled in hospice for 1–7 days prior to death were matched to 1,493 decedents not enrolled in hospice for 7 days or more prior to death. There were no significant differences in patient or regional characteristics between the two groups (Appendix Exhibit 8).[30]

In fully adjusted analysis of outcomes spanning the last seven days of life, subjects enrolled in hospice for one to seven days prior to death had significantly lower average total Medicare expenditures than matched controls ($4,806 versus $7,457, $p < 0.01$) (Exhibit 1). Consistent with those patterns observed in other enrollment periods, those enrolled in hospice during this period also had fewer hospital admissions, intensive care unit admissions, hospital days, intensive care unit days, and in-hospital deaths (all $p < 0.01$).

**COMPARING OUTCOMES ACROSS HOSPICE ENROLLMENT PERIODS** Exhibits 2–4 compare the incremental effects in outcomes between subjects enrolled in hospice and nonhospice matched controls across the study periods. The adjusted savings in total Medicare spending ranged from $2,561 for those enrolled 53–105 days prior to death to $6,430 for those enrolled 15–30 days (Exhibit 2).

The adjusted decrease in total hospital days ranged from 9.0 for those enrolled 53–105 days prior to death to 0.9 for those enrolled 1–7 days, and the decrease in intensive care unit days ranged from 4.9 for those enrolled 53–105 days to 0.5 days for those enrolled 1–7 days (Exhibit 3). The adjusted reduction in in-hospital deaths was similar across groups, and the adjusted reductions in intensive care unit admissions and thirty-day hospital readmissions were largest for those enrolled for 53–105 days (Exhibit 4).

## Discussion

Medicare costs for patients enrolled in hospice were significantly lower than those of nonhospice enrollees across all periods studied: 1–7 days, 8–14 days, and 15–30 days, the most common enrollment periods prior to death, as well as 53–105 days, the period previously shown to maximize Medicare savings.[23]

In addition, reductions in the use of hospital

**EXHIBIT 1**

ealth Care Use At The End Of Life For Subjects Enrolled In Hospice And Matched Nonhospice Controls

| Measure of use | Hospice group, adjusted means | Propensity score matched controls, adjusted means |
|---|---|---|
| **TOTAL MEDICARE EXPENDITURES, 2008 US DOLLARS** | | |
| Last 105 days[a] | 22,083 | 24,644[b] |
| Last 30 days[c] | 10,383 | 16,814[b] |
| Last 14 days[d] | 5,698 | 10,738[b] |
| Last 7 days[e] | 4,806 | 7,457[b] |
| **TOTAL HOSPITAL DAYS** | | |
| Last 105 days[a] | 3.50 | 12.50[b] |
| Last 30 days[c] | 1.60 | 5.70[b] |
| Last 14 days[d] | 0.19 | 4.36[b] |
| Last 7 days[e] | 0.29 | 1.20[b] |
| **TOTAL HOSPITAL ADMISSIONS** | | |
| Last 105 days[a] | 0.58 | 1.22[b] |
| Last 30 days[c] | 0.34 | 0.74[b] |
| Last 14 days[d] | 0.08 | 0.48[b] |
| Last 7 days[e] | 0.12 | 0.35[b] |
| **TOTAL ICU DAYS** | | |
| Last 105 days[a] | 0.71 | 5.65 |
| Last 30 days[c] | 0.31 | 2.91[f] |
| Last 14 days[d] | 0.03 | 1.61 |
| Last 7 days[e] | 0.08 | 0.57[b] |
| **PROPORTION WITH ICU ADMISSION** | | |
| Last 105 days[a] | 0.15 | 0.37[b] |
| Last 30 days[c] | 0.10 | 0.31[b] |
| Last 14 days[d] | 0.02 | 0.23[b] |
| Last 7 days[e] | 0.05 | 0.15[b] |
| **PROPORTION WITH 30-DAY HOSPITAL READMISSION** | | |
| Last 105 days[a] | 0.11 | 0.26[b] |
| Last 30 days[c] | 0.02 | 0.12[b] |
| **PROPORTION DYING IN THE HOSPITAL** | | |
| Last 105 days[a] | 0.02 | 0.42[b] |
| Last 30 days[c] | 0.06 | 0.44[b] |
| Last 14 days[d] | 0.09 | 0.48[b] |
| Last 7 days[e] | 0.15 | 0.53[b] |

**SOURCE** Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Sample sizes vary across periods of enrollment. For enrollment 53–105 days before death: hospice patients, $n = 88$; matched controls, $n = 1,404$. For enrollment 15–30 days before death: hospice patients, $n = 133$; matched controls, $n = 1,616$. For enrollment 8–14 days before death: hospice patients, $n = 90$, matched controls, $n = 1,416$. For enrollment 1–7 days before death: hospice patients, $n = 308$; matched controls, $n = 1,493$. Multivariable regression models adjusted for age; sex; race/ethnicity; education; net worth; marital status; insurance coverage; functional status; residential status; medical conditions; and regional supply of hospital beds, specialist physicians, and local hospital care intensity. 95 percent confidence intervals for all estimates are available in the online Appendix (see Note 30 in text). ICU is intensive care unit. [a] Hospice enrollment 53–105 days before death. [b] Difference between hospice and control groups statistically significant at $p < 0.01$. [c] Hospice enrollment 15–30 days before death. [d] Hospice enrollment 8–14 days before death. [e] Hospice enrollment 1–7 days before death. [f] Difference between hospice and control groups statistically significant at $p < 0.05$.

services at the end of life both contribute to these savings and potentially improve quality of care and patients' quality of life. Specifically, hospice enrollment was associated with significant reductions in hospital and intensive care unit admissions, hospital days, and rates of thirty-day hospital readmission and in-hospital death.

**EVIDENCE OF MEDICARE SAVINGS** Our results not only are consistent with prior studies for Medicare spending, but they also strengthen this evidence by replicating the results within a sample more thoroughly matched for individual health, functional, and social characteristics, as well as regional factors. Finding no difference between the hospice and control groups' preenrollment health care use is evidence of this improved match, as compared to prior work.[23]

Specifically, Taylor and colleagues reported a maximum reduction in Medicare spending among patients enrolled in hospice for 53–105 days prior to death.[23] We found Medicare savings among this group, too, but we also found a similar level of savings among those enrolled for 1–7 days and increased savings among those enrolled for 8–30 days prior to death. Furthermore, we demonstrated parallel reductions in hospital and intensive care unit use, hospital readmissions, and in-hospital death.

**INCREASING VALUE THROUGH MEDICARE HOSPICE** These findings, albeit limited to enrollment up to 105 days, are of particular importance because they suggest that investment in the Medicare hospice benefit translates into savings overall for the Medicare system. For example, if 1,000 additional beneficiaries enrolled in hospice for 15–30 days prior to death, Medicare could save more than $6.4 million, while those beneficiaries would be spared 4,100 hospital days. Alternatively, if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, the overall savings to Medicare would exceed $2.5 million.

Although our findings suggest that hospice enrollment results in savings to the Medicare program across a number of different lengths-of-stay, this work also highlights several areas for future research.

First, because of the limitations of our data set, we were unable to precisely determine the point at which hospice approaches usual care in terms of costs. Future studies will be needed to address this question.

Second, our data were also not able to identify the differential effects of hospice on specific diagnoses. This is of particular importance given the recent growth of for-profit hospices, which typically enroll more patients with noncancer diagnoses (and longer average lengths-of-stay) compared to not-for-profit programs.

We found that net Medicare savings for patients with longer lengths-of-stay are lower because of the per diem cost of hospice services. However, we note that if 1,000 additional beneficiaries enrolled in hospice for 53–105 days before death, these beneficiaries could avoid 9,000 hospital days at the end of life. Indeed, our findings suggest that substantial reduction in hospital days—a primary goal of health care reform—is achieved regardless of the length of hospice enrollment.

Finally, our findings cannot be extrapolated to novel models of health care delivery or reimbursement, such as the integration of hospice programs into accountable care organizations or graded per diem payment systems, higher reimbursement for earlier and later days of enrollment, and lower reimbursement for the middle days.[20,37] The ability of these models to achieve savings while maintaining or improving quality is unclear and must be evaluated.

**BARRIERS TO TIMELY HOSPICE ENROLLMENT** Our results, when taken together with those of prior studies, suggest that hospice increases value by improving quality and reducing costs for Medicare beneficiaries at the end of life. Yet aggressive efforts to curtail Medicare hospice spending, including the Office of Inspector General's investigation of hospices that enroll patients with late-stage diseases but unpredictable prognoses, are ongoing.

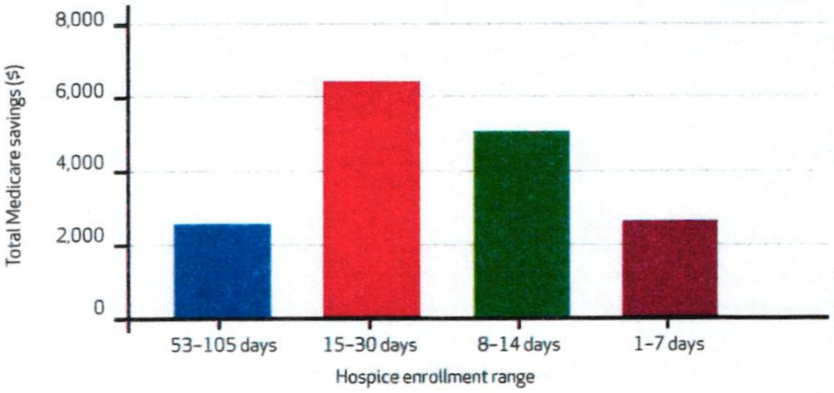
Our findings suggest that these efforts may be misguided. Indeed, this study reveals that savings are present for both cancer patients and noncancer patients and that reductions in the use of hospital services and numbers of hospital days, hospital admissions, and hospital deaths appear to grow as the period of hospice enrollment lengthens within the observed study period (up to 105 days). These outcomes not only are less costly but also have all been associated with higher quality of care and increased concordance with patients' preferences.

Although sample-size limitations prevented us from examining enrollment beyond 105 days, the trend in our data and the projections by Taylor and colleagues support the idea that efforts to curtail hospice enrollment may actually increase use and spending overall. Instead of working to reduce Medicare hospice spending and creating a regulatory environment that discourages continued growth in hospice enrollment, the Centers for Medicare and Medicaid Services should focus on ensuring that patients' preferences are elicited earlier in the course of their diseases and that those who want hospice care receive timely referral.

An additional barrier to timely hospice referral may be limited knowledge or misconceptions regarding hospice and palliative care.[38] In particular, the hospice requirement to forgo curative treatments—even if they might not be beneficial—may be difficult for patients and families to accept or prompt fears of health care rationing. Because some treatments may be used for both curative and palliative purposes, this regulation and the variability with which hospice providers interpret it may also cause clinicians to be uncertain about hospice eligibility.[39]

**EXHIBIT 2**

**Incremental Savings In Medicare Expenditures, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls**

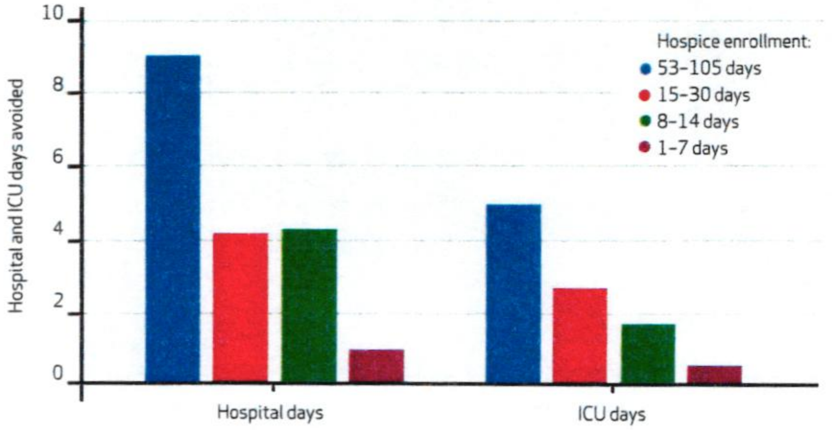


**SOURCE** Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Total savings to Medicare denote the incremental difference in Medicare spending between hospice and nonhospice groups.

Several recent state and federal policy initiatives are designed to promote patient-centered care, specifically by increasing palliative care education among all health professionals and requiring that clinicians apprise patients of palliative treatment options early in the course of a serious illness.[40–42] Such efforts to elucidate patients' preferences and values early may increase timely referral to hospice.

**EXHIBIT 3**

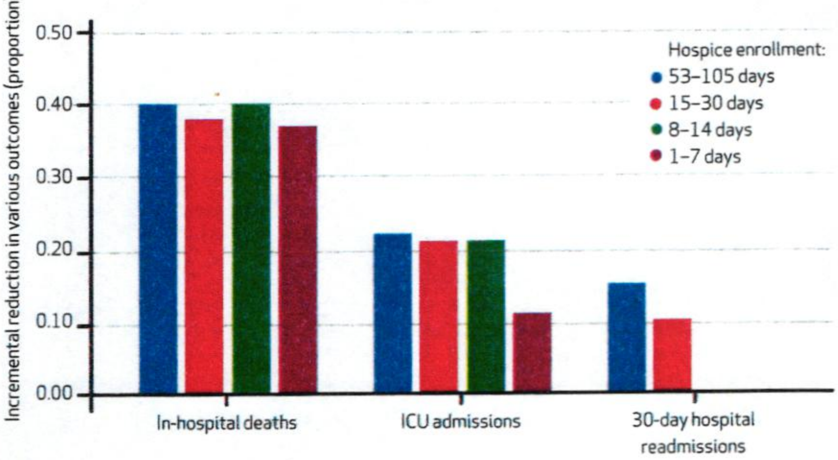
**Incremental Reductions In Hospital Days And Intensive Care Unit Days, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls**



**SOURCE** Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTE** Hospital and intensive care unit (ICU) days avoided is expressed as the incremental effect in days between hospice and nonhospice groups.

**EXHIBIT 4**

**cremental Reductions In Hospital Deaths, Intensive Care Unit Admissions, And Thirty-Day Readmissions, By Various Lengths Of Hospice Enrollment Before Death With Matched Nonhospice Controls**



**SOURCE** Authors' analysis of Health and Retirement Study data linked to Medicare claims. **NOTES** Incremental reduction in various outcomes (in-hospital deaths, ICU admissions, and thirty-day hospital readmissions) is expressed as the incremental effect in proportion between hospice and nonhospice groups. ICU is intensive care unit.

Finally, highly specialized and fragmented care may also present a barrier to hospice access, particularly for patients with the most complex and highest-cost illnesses: those 5 percent of patients, many in their last year of life, who account for nearly half of the nation's health care spending.[1–3] Not only is care for this group characterized by costly hospital-based treatment, but it is also often highly fragmented and of poor quality, particularly among those who are dually eligible for Medicare and Medicaid.[43] Although many demonstration projects seek to address this concern,[43] few target this population's need for assistance in identifying individualized goals of care and developing comprehensive treatment plans to achieve those goals.

One such comprehensive treatment approach might be the enhancement of formal partnerships between hospital palliative care teams and hospice. Evidence from existing models that incorporate hospital palliative care services demonstrates improvement in quality indicators, heightened patient and family satisfaction, reduced hospital use, and increased rates of hospice referral.[44] These benefits may be even more substantial if formal relationships between established palliative care teams and community hospice programs were developed in order to offer a bridge to timely hospice enrollment.

## Conclusion

Hospice enrollment during the longer period of 53–105 days prior to death and the most common period within 30 days prior to death lowers Medicare expenditures, rates of hospital and intensive care unit use, 30-day hospital readmissions, and in-hospital death. Building upon prior studies of hospice and palliative care that have demonstrated higher quality and improved patient and family satisfaction,[8,13–15,32–36] this finding suggests that hospice and palliative care are critical components in achieving greater value through health care reform: namely, improved quality and reduced costs.

Medicare should thus seek to expand access to hospice services so that hospice can contribute to its full potential to the overall value of care. To do so, substantial barriers to timely hospice enrollment must be overcome. The Centers for Medicare and Medicaid Services should abandon efforts to reduce Medicare hospice spending and delay hospice enrollment and should instead focus on ensuring that people who want hospice care receive timely referral.

Within the current Medicare hospice benefit, several approaches may expand access and increase appropriate and timely referral to hospice. These approaches include formalized partnerships between hospital palliative care programs and community hospice programs and the promotion of patient-centered care by educating patients, families, and physicians about the availability and benefits of hospice and palliative care services.

Finally, ongoing demonstration projects and novel models of health care delivery and reimbursement should place a high priority on the rigorous evaluation of hospice service use and its impact on the value of care. ■

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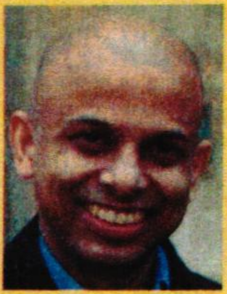
## ABOUT THE AUTHORS: AMY S. KELLEY, PARTHA DEB, QINGLING DU, MELISSA D. ALDRIDGE CARLSON & R. SEAN MORRISON

**Amy S. Kelley** is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

In this month's *Health Affairs*, Amy Kelley and coauthors report on their study examining Medicare costs for hospice patients enrolled for different lengths-of-stay, ranging from 1 day to 105 days. Using data from the Health and Retirement Study and individual Medicare claims, they found savings for Medicare across all lengths-of-stay examined. Hospice patients also had less hospital use than matched controls, and thus a higher quality of life. The authors argue that instead of attempting to limit Medicare hospice participation for fear of not seeing savings, the Centers for Medicare and Medicaid Services should focus on ensuring the timely enrollment of qualified patients who desire the benefit.

Kelley is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai, and is a board-certified physician in internal medicine, geriatric medicine, and palliative medicine. Her research focuses on improving the quality of care for older adults with serious medical illness. She is particularly interested in regional practice variations and the relationship between patient characteristics and treatment intensity.

In 2012 Kelley was selected for the Paul B. Beeson Career Development Award in Aging Research from the National Institute on Aging and won the American Geriatrics Society's best paper award in geriatrics research. Kelley earned a master's degree in health services from the University of California, Los Angeles, and a medical degree from Cornell University.



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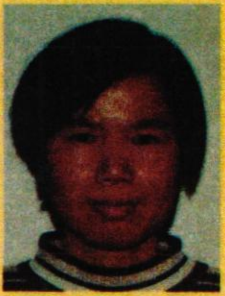
Partha Deb is a professor and director of graduate studies in the Department of Economics at Hunter College and a professor at the Graduate Center, City University of New York. He is also an adjunct professor at the School of Public Health, Hunter College; a senior adviser at the Center for Medicare and Medicaid Innovation, Department of Health and Human Services; a research associate at the National Bureau of Economic Research; and a faculty fellow at the Brookdale Center for Healthy Aging and Longevity, Hunter College. Deb also serves on the editorial board of *Health Services Research*. He earned a master's degree and a doctorate in economics from Rutgers University.



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**Melissa D. Aldridge Carlson** is an assistant professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

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**R. Sean Morrison** is a tenured professor in the Brookdale Department of Geriatrics and Palliative Medicine, Icahn School of Medicine at Mount Sinai.

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# Exhibit 5

# MISSION STATEMENT

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# Exhibit 6

# Are Regional Variations in End-of-Life Care Intensity Explained by Patient Preferences?

## *A Study of the US Medicare Population*

*Amber E. Barnato, MD, MPH, MS,* M. Brooke Herndon, MD,† Denise L. Anthony, PhD,‡ Patricia M. Gallagher, PhD,§ Jonathan S. Skinner, PhD,¶ Julie P. W. Bynum, MD, MS,¶ and Elliott S. Fisher, MD, MPH¶‖*

**Objective:** We sought to test whether variations across regions in end-of-life (EOL) treatment intensity are associated with regional differences in patient preferences for EOL care.

**Research Design:** Dual-language (English/Spanish) survey conducted March to October 2005, either by mail or computer-assisted telephone questionnaire, among a probability sample of 3480 Medicare part A and/or B eligible beneficiaries in the 20% denominator file, age 65 or older on July 1, 2003. Data collected included demographics, health status, and general preferences for medical care in the event the respondent had a serious illness and less than 1 year to live. EOL concerns and preferences were regressed on hospital referral region EOL spending, a validated measure of treatment intensity.

**Results:** A total of 2515 Medicare beneficiaries completed the survey (65% response rate). In analyses adjusted for age, sex, race/ethnicity, education, financial strain, and health status, there were no differences by spending in concern about getting too little treatment (39.6% in lowest spending quintile, Q1; 41.2% in highest, Q5; *P* value for trend, 0.637) or too much treatment (44.2% Q1, 45.1% Q5; $P = 0.797$) at the end of life, preference for spending their last days in a hospital (8.4% Q1, 8.5% Q5; $P = 0.965$), for potentially life-prolonging drugs that made them feel worse all the time (14.4% Q1, 16.5% Q5; $P = 0.326$), for palliative drugs, even if they might be life-shortening (77.7% Q1, 73.4% Q5; $P = 0.138$), for mechanical ventilation if it would extend their life by 1 month (21% Q1, 21.4% Q5; $P = 0.870$) or by 1 week (12.1% Q1, 11.7%; $P = 0.875$).

**Conclusions:** Medicare beneficiaries generally prefer treatment focused on palliation rather than life-extension. Differences in preferences are unlikely to explain regional variations in EOL spending.

**Key Words:** Medicare, health care costs, physician's practice patterns, terminal care, patient satisfaction

(*Med Care* 2007;45: 386–393)

There are wide variations in health care expenditures across regions in the United States.[1] For example, Medicare expenditures in the last 6 months of life vary dramatically across hospital referral regions in the United States, ranging from a low of $8,366 per beneficiary in Grand Junction, Colorado, to a high of $21,123 in McAllen, Texas. Variations in end-of-life (EOL) spending reflect markedly different patterns of resource use at the end of life and not health differences among this group of very ill patients near death. In 2003, the mean number of days in the intensive care unit (ICU) in the last 6 months of life in Grand Junction was 1 day, compared with 5.6 days in McAllen, and 16.7% of Grand Junction beneficiaries died in an acute care hospital, compared with 45.1% in McAllen.[1]

Previous studies have shown that regions with greater overall EOL spending do not have better outcomes; mortality, quality of care, and patient satisfaction among cohorts of patients with common serious conditions are sometimes worse,[2,3] as are perceptions of the quality of EOL care among bereaved family members.[4] In contrast, higher spending regions do have a greater regional supply of specialists,[5] hospital and ICU beds,[6–9] and other technologies.[10,11] Physicians who practice in high-intensity regions have a greater tendency to recommend tests, referrals, and treatments for patients described in structured vignettes and are less likely to refer to hospice.[12,13] It is unknown whether these differences in supply and physician practice style reflect differences in preferences for treatment among patients who reside in these high-spending regions. Yet, the policy prescriptions for addressing these regional variations depend critically on

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whether they are the consequence of differences across regions in patient preferences, the consequence of physician "enthusiasm" or "supplier-induced demand," or other factors related to the supply of health care capacity.[14–16]

We sought to determine whether EOL treatment preferences vary across regions with differing levels of EOL treatment intensity. We used a cross-sectional survey of Medicare beneficiaries to ascertain preferences and average Medicare spending for patients in their last 6 months of life living in the respondents' hospital referral region of residence as the measure of intensity. The central hypothesis of our study was that preferences for greater intensity of medical treatment in the event of a terminal illness would be positively associated with higher levels of regional intensity. Under the null hypothesis, in which regional preferences do not vary by regional intensity, there will be no relationship between individual beneficiaries' preferences and the EOL spending of the region in which they reside.

## METHODS

### Study Population

The sampling frame was all Medicare beneficiaries in the Centers for Medicare and Medicaid 20% denominator file who were age 65 or older on July 1, 2003, alive, and entitled to part A, part B, or both, between July 1, 2003, and June 30, 2004, and residents of a US hospital referral region in 2003 and 2004 (N = 6,384,199). We drew a simple random sample of 4000 from this frame, obtained names and addresses from the Centers for Medicare and Medicaid Services (CMS), and identified telephone numbers from an electronic telephone matching service and directory assistance for a dual-mode survey (telephone administration followed by mailing a questionnaire to all for whom we could not obtain a telephone number or who had not responded by telephone). Exclusion criteria upon contact included those who were deceased or institutionalized.

### Survey

#### Development

We designed the survey instrument to assess beneficiaries' preferences for tests, treatments, and referrals for common health care conditions and their general concerns, goals, and preferences for care in the event of a terminal illness, in addition to sociodemographics, health status, social networks, perceptions of health care quality, and access to and use of health services in the previous 12 months. A nearly final version of the instrument was cognitively tested with 15 seniors in intensive one-on-one interviews to test construct validity and to make sure we were asking questions that people consistently can understand and can answer. The computer-assisted telephone interview (CATI) then underwent pilot testing with 20 seniors. We audiotaped and behavior-coded the pilot interviews for interviewer-respondent interaction to identify questions that were difficult to administer in a standardized format or that were difficulut for respondents to understand and revised the survey accordingly.

#### Administration

This dual-language, mixed-mode survey was fielded between March and October 2005. Bilingual (English/Spanish) telephone interviewers were available for those who preferred to be interviewed in Spanish. If we could not contact the beneficiary by phone after a minimum of 6 call attempts to administer the CATI, we mailed a dual-language, Canadian-style questionnaire that paralleled the telephone interview, along with a 5-dollar cash incentive. A thank you/reminder postcard was mailed 2 weeks later and mail nonrespondents were sent a replacement questionnaire packet (without a cash incentive) about 4 weeks after the initial mailing.

### Measures

#### Local Health Care Intensity

We used a previously derived Medicare spending measure, the End-of-Life Expenditure Index, as our measure of local intensity. This measure is calculated as average per capita spending (as determined by standardized national prices) on hospital and physician services provided to Medicare fee-for-service beneficiaries age 65 and older during their last 6 months of life, adjusted for age, sex, and race. It reflects the component of local Medicare spending that is attributable to the overall quantity of medical services provided, not to local differences in illness or price.[2,3] For the remainder of the article, we will refer to this measure as "EOL spending." We assigned each respondent to 1 of 306 hospital referral regions based upon their zip code of residence. We then used each hospital referral region's 2000–2003 EOL spending to assign the respondent to 1 of 5 quintiles: Q1: \$8,366–\$12,350, Q2: \$12,351–\$13,682, Q3: \$13,683–\$14,686, Q4: \$14,687–\$16,280, and Q5: \$16,281–\$21,123. We report EOL spending, last 6 month hospital days, ICU days, proportion of decedents seeing more than 10 different doctors, and proportion who died in an acute care hospital in each of these 5 quintiles in Table 1.

**TABLE 1.** Differences in 2000 Medicare Spending and Resource Use, by Quintile of EOL Spending*

| | Quintile of EOL Spending | | | | |
|---|---|---|---|---|---|
| | 1 (Lowest) | 2 | 3 | 4 | 5 (Highest) |
| Per-capita EOL spending† | \$11,337 | \$13,155 | \$14,175 | \$15,449 | \$17,772 |
| Service use, last 6 mo of life | | | | | |
| Inpatient days | 7.7 | 9.9 | 10.6 | 11.3 | 14.4 |
| ICU days | 2.0 | 2.7 | 3.0 | 3.5 | 4.9 |
| Physician visits | 18.6 | 24.2 | 26.3 | 31.0 | 43.4 |
| >10 different MDs, % | 18.9 | 24.5 | 26.8 | 30.5 | 42.0 |
| Died in hospital, % | 25.4 | 29.8 | 31.1 | 30.9 | 34.4 |

*Data from the Dartmouth Atlas.

†Age-sex-race and price-adjusted mean Medicare spending on hospital and physician services among beneficiaries in their last 6 mo of life, also known as the End-of-Life Expenditure Index (EOL-EI).

**TABLE 2.** Survey Questions, Response Options, and Associated Study Outcome Variable

**Introduction:**

The next set of questions is about care a patient may receive during the last months of life. Remember, you can skip any questions you don't want to answer. Suppose that you had a very serious illness. Imagine that no one knew exactly how long you would live, but your doctors said you almost certainly would live less than 1 yr.

| **Survey Question and Response Options** | **Outcome Variable** |
|---|---|
| Q E9. In that situation, would you be more concerned that you would receive too little medical treatment or too much medical treatment? [too little,* too much, not concerned, don't know†] | Too little |
| Q E9. In that situation, would you be more concerned that you would receive too little medical treatment or too much medical treatment? [too little, too much,* not concerned, don't know†] | Too much |
| Q E10. If that illness got worse, where would you like to spend your last days—in a hospital, a nursing home, or at home? [hospital†, nursing home, home, don't know‡] | Hospital |
| Q E11. To deal with that illness, do you think you would want drugs that would make you feel worse all the time but might prolong your life? [yes†, no, don't know‡] | Prolong |
| Q E12. If you reached the point at which you were feeling bad all the time, would you want drugs that would make you feel better, even if they might shorten your life? [yes,* no, don't know†] | Palliate |
| Q E13. If you needed a respirator to stay alive, and it would extend your life for a week, would you want to be put on a respirator? [yes,* no, don't know†] | Mechanical Ventilation (MV) 1 wk |
| *Respondents who answered no to Q E13, above, were asked:* Q E14. If it would extend your life for a month, would you want to be put on a ventilator? [yes,* no, don't know‡] | Mechanical Ventilation (MV) 1 mo |

*The underlined option indicates the option used to create the outcome variable.

†"Not concerned" and "don't know" responses were treated as missing data for regression models.

## Medicare Beneficiaries' EOL Concerns, Goals, and Preferences

We used responses to 6 survey questions to create 7 dichotomous outcome variables for the current study (Table 2). When dichotomizing responses, we treated answers other than "yes" or "no" (eg, "not concerned" or "I don't know") as missing data. Outcomes included concern about receiving too little medical treatment in the last year of life or receiving too much medical treatment, preference for dying in an acute care hospital, for life-prolonging drugs with side-effects, for palliative drugs with potential for life-shortening, and for mechanical ventilation. Item nonresponse was less than 1% among eligible respondents for each outcome measure.

## Covariates

In addition to questions about EOL concerns and preferences, the survey collected extensive information about beneficiary attributes. Covariates in our analyses included the respondent's age, sex, race/ethnicity, education, whether the beneficiary reported financial strain, and 3 self-reported health status measures.

## Statistical Analysis

We display results according to quintile of intensity; however, all reported tests for trend are based on logisitic regression in which the independent variable is the EOL spending in the beneficiary's hospital referral region of residence (expressed as a continuous variable, the mean per capita EOL spending dollar value in the hospital referral region) and the dependent variable is the beneficiary's (dichotomized) response. Although our primary hypothesis is related to measuring whether patient preferences help to determine regional differences in EOL treatment intensity (spending), our statistical analysis includes EOL spending as the independent variable because it is measured accurately. Patient preferences (measured at the patient level) are the dependent variables. Thus, our statistical tests reflect an association between EOL spending and patient preferences, rather than the causal effect of patient preferences on EOL spending.

We performed multivariable logistic regression for each of the 7 outcomes, with EOL spending in the beneficiary's hospital referral region of residence as the exposure (expressed as a continuous variable), adjusting for age, sex, race/ethnicity, education, financial strain, and health status. We also used an ordered logistic regression for the first survey question (Table 2) with a 3-level dependent variable: too little, not concerned, too much. We created an index of responses to each survey question (worry about too little medical treatment, preference for hospital death, life prolonging drugs, avoiding life-shortening palliative drugs, and wanting mechanical ventilation for 1 week and 1 month's life extension) where a desire for the more intensive option increased the index by one. We then used linear regression to explore the relationship between EOL spending and the summed index, adjusting for age, sex, race/ethnicity, education, financial strain, and health status.

All multivariable regressions use the Huber/White/sandwich estimator of variance to adjust standard errors for clustering of respondents within hospital referral regions. We performed all statistical analyses using STATA 9.1 (StataCorp, College Station, TX).

## Human Subjects and Role of the Funding Sources

The study was approved by the the Committee for the Protection of Human Subjects at Dartmouth Medical School and the Institutional Review Board (IRB) of the University of Massachusetts Boston and deemed exempt from the requirement for written informed consent. The data analysis plan was similarly considered exempt by the University of Pittsburgh IRB. This study was reviewed by the CMS to ensure protection of beneficiary confidentiality. The authors had full independence from the funding agency, the National Institute on Aging, and CMS in the design, conduct, analysis, and reporting and all authors had full access to the primary data.

## RESULTS

### Sample Characteristics

We attempted to contact 4000 beneficiaries, 160 of whom were discovered to be ineligible (dead or institutionalized). Of the eligible 3840, a total of 2515 responded for a 65% response rate (completed interviews divided by the number of eligible sample members, including refusals and all cases of unknown eligibility). Of those, 1384 (55%) responded by telephone (mean completion time, 22 minutes) and 1130 (45%) by mail (1 responded in a mixed format). Approximately 6% of the sample (n = 222) actively refused participation. Other reasons for nonresponse included those who were unable to complete the interview because of cognitive or physical debility (n = 59), language barrier (n = 3), and those who could not be contacted by phone and did not respond to 2 waves of mailings (n = 1041).

The oldest old (85+), nonwhites, and those with no doctor visits in the preceding year were the least likely to respond by telephone. With the addition of the mail mode, the final group of respondents looked more like the total sample than the group of respondents that would have resulted based on telephone alone.

The mean age of respondents was 75.6 (SD 6.6), 42.2% were men, 85.0% non-Hispanic white, 6.3% black, 4.6% Hispanic, 4.2% other race, 20.8% had not completed high school, 29.8% reported financial issues were very important in deciding whether to obtain medical care, 28.0% were in fair or poor health, 14.0% in fair or poor mental/emotional health, and 56.3% reported having physical or medical conditions that often cause pain or discomfort (Table 3). Compared with the group of beneficiaries from which our simple random sample of 4000 was selected, the respondents had a similar distribution of sex and education (using zip code-level Census imputation), but fewer persons age 85+ (9.7% vs. 14.7%) and blacks (6.3% vs. 8.1%); Hispanic ethnicity data from the enrollment file is not strictly comparable to our survey self-report data.

Survey respondents included beneficiaries from 290 of the 306 US hospital referral regions (Fig. 1). Roughly 20% of beneficiaries were drawn from hospital referral regions (HRRs) in each of the EOL spending quintiles (Table 4). Across these quintiles, the distribution of age, sex, financial strain, and health status were similar. In contrast, black race, Hispanic ethnicity, and lower educational achievement were not uniformly distributed; there was a greater prevalence of these characteristics in some of the higher intensity regions.

### EOL Concerns and Preferences

Faced with a hypothetical terminal illness, the respondents were almost evenly split between those who were concerned about getting too little treatment (40.4%) and those who were concerned about too much treatment (45.0%); the remainder were unconcerned (6.3%) or did not know (8.3%). Most preferred to spend their last days at home (86.0%) rather than in a hospital (9.1%) or nursing home (4.9%). Most did not want potentially life-prolonging drugs that made them feel worse all the time (83.9%), although a significant minority did (16.1%). Most wanted palliative drugs, even if they might be life-shortening (71.7%); 24.3% did not and 4.0% did not know. Most (87.4%) would not want to be put on a ventilator to gain 1 week's life extension, but even if the gain were 1 month, 77.4% would still not want mechanical ventilation.

**TABLE 3.** Sample Characteristics

| Characteristic | Sample n/N (%)[*] |
|---|---|
| Age 65–69 | 526/2471 (21.3) |
| Age 70–74 | 671/2471 (27.2) |
| Age 75–79 | 588/2471 (23.8) |
| Age 80–84 | 443/2471 (17.9) |
| Age 85 or older | 243/2471 (9.8) |
| Male | 1048/2483 (42.2) |
| Non-Hispanic white[†] | 2105/2478 (85.0) |
| Black[†] | 157/2478 (6.3) |
| Hispanic[†] | 113/2478 (4.6) |
| Other race/ethnicity[†] | 103/2478 (4.2) |
| No high school diploma | 511/2461 (20.8) |
| Financial strain[‡] | 736/2473 (29.8) |
| Fair or poor general health | 691/2465 (28.0) |
| Fair or poor mental/emotional health | 347/2476 (14.0) |
| Pain or discomfort often | 1385/2462 (56.3) |

[*] Nonmissing responses from the overall sample of 2515.

[†] We categorized self-reported race and ethnicity into mutually exclusive groups of non-Hispanic white, black, Hispanic, or "other," assigning multi-racial or ethic respondents using the hierarchy: black > Hispanic > other (Asian, Native Hawaiian or Pacific Islander, American Indian/Alaskan Indian/Alaskan Native, or Other) > non-Hispanic white. If respondents endorsed a racial category but had missing data for Hispanic ethnicity, we assumed they were non-Hispanic; this included 28 blacks, 100 whites, and 14 "others."

[‡] We categorized respondents as having financial strain if they indicated that financial issues were "very important" in deciding whether to obtain medical care.

### EOL Concerns and Preferences by EOL Spending

In crude analyses, there were no difference in respondents' EOL treatment concerns and preferences by EOL spending with 1 exception: respondents in the lower quinitles of regional intensity were more likely to want palliative drugs that might be life-shortening (Q1 = 79.9%, Q2 = 75.5%, Q3 = 75%, Q4 = 68%, Q5 = 74.5%, *P* = 0.012; Fig. 2, left panel). In multivariable analyses adjusted for age, sex, race/ethnicity, education, financial strain, self-reported overall health, mental/emotional health, and frequent pain/discomfort, this difference was no longer statistically significant (Q1 = 77.7%, Q2 = 76.5%, Q3 = 75.9%, Q4 = 75.0%, Q5 = 73.4%, *P* = 0.138; Fig. 2, right panel).

Findings were unchanged when respondents' answers to the survey question about worry regarding the amount of medical care they would receive in the last year of life was modeled as a three-level ordinal variable: too little, not concerned, too much (crude *P* = 0.381, adjusted *P* = 0.911).

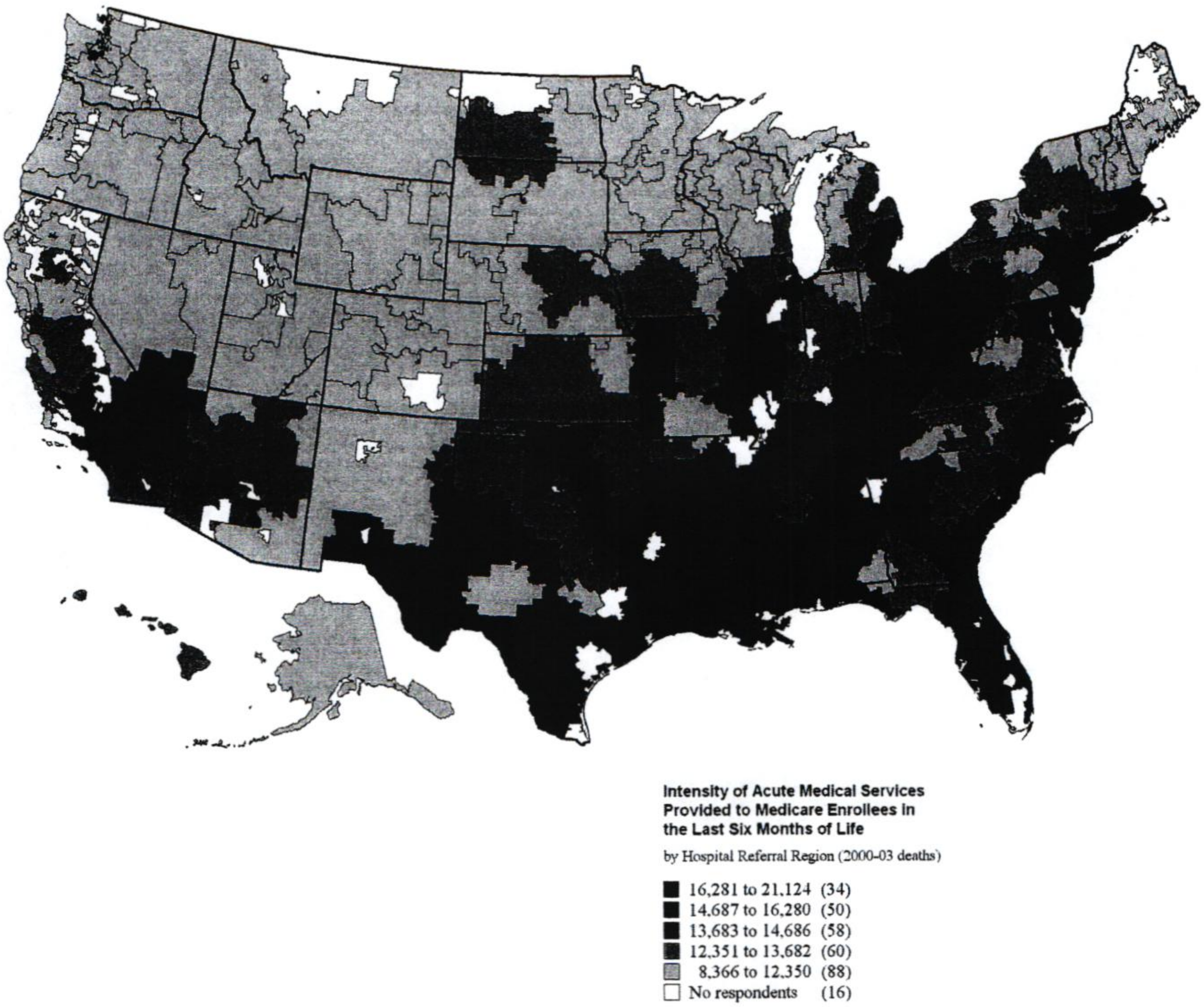

**FIGURE 1.** Intensity of acute medical services provided to Medicare enrollees in the last 6 months of life, by hospital referral region (2000–2003). HRRs are color-coded by the mean per-capita Medicare spending in dollars on hospital and physician services among fee-for-service beneficiaries in their last 6 months of life who reside in the HRR. Thirty-four HRRs contributed to the highest qunitile of spending (depicted in black) and 88 HRRs contributed to the lowest quintile (depicted in lightest gray). There were no study respondents from 16 of 306 total HRRs (depicted in white).

Among the 1595 respondents with no missing data for all 6 survey questions, the mean number of endorsements of the more intensive response was 1.31 (SD = 1.08, range, 0–5), and EOL spending in the respondent's hospital referral region of residence was not associated with number of endorsed items (crude $P = 0.094$, adjusted $P = 0.451$).

## DISCUSSION

Among a national sample of Medicare beneficiaries older than the age of 65, most prefer treatment focused on palliation rather than life-extension. We did not find a pattern of greater concern about receiving too little medical treatment, less concern about receiving too much medical treatment, preference for spending one's last days in a hospital, for life-prolonging drugs despite side-effects, and for mechanical ventilation to achieve 1 week's and 1 month's life extension across respondents living in regions with progressively greater EOL spending. The observed relationship between respondents' preferences for avoiding potentially life-shortening palliative drugs and greater spending regions was explained by the confounding effect of race/ethnicity. Taken together, the lack of cross-sectional association between preferences and spending in our study is unsupportive of the hypothesis that differences in preferences explain regional variations in EOL spending.

It is perhaps unsurprising that we did not find a relationship between individual patient preferences and local practice patterns, since the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT) demonstrated that preferences are seldom cor-

**TABLE 4.** Characteristics of Respondents by EOL Spending Quintile

| | Quintile of End-of-Life Spending* | | | | | |
|---|---|---|---|---|---|---|
| **Characteristic** | **1 (Lowest) (n = 542)** | **2 (n = 474)** | **3 (n = 468)** | **4 (n = 492)** | **5 (Highest) (n = 539)** | **$\chi^2$ *P*** |
| Age 85 or older, % | 10.5 | 9.9 | 8.0 | 8.7 | 11.7 | 0.326 |
| Male, % | 44.3 | 41.4 | 42.6 | 42.9 | 39.9 | 0.656 |
| Non-Hispanic white, % | 91.4 | 86.7 | 83.8 | 86.0 | 77.0 | <0.0001 |
| Black, % | 1.1 | 4.5 | 8.4 | 7.2 | 10.6 | <0.0001 |
| Hispanic, % | 3.4 | 3.6 | 4.3 | 3.7 | 7.5 | 0.006 |
| Other, % | 4.1 | 5.1 | 3.5 | 3.1 | 4.9 | 0.414 |
| No high school diploma, % | 15.9 | 21.9 | 22.3 | 23.1 | 21.1 | 0.036 |
| Financial strain, % | 29.7 | 29.5 | 30.3 | 29.6 | 29.8 | 0.999 |
| Fair or poor general health, % | 26.4 | 31.3 | 26.3 | 29.0 | 27.5 | 0.386 |
| Fair or poor mental/emotional health, % | 12.4 | 16.6 | 16.0 | 13.2 | 12.4 | 0.163 |
| Pain or discomfort often | 56.4 | 57.5 | 56.8 | 56.7 | 54.1 | 0.846 |

*Respondents resided in 1 of 290 (of 306 possible) US HRRs. The number of respondents in each of these HRRs ranged from 1 to 61. Each respondent's HRR of residence was categorized into 1 of 5 quintiles of EOL spending based upon 2000-2003 per-capita Medicare spending on hospital and physician services among beneficiaries in their last 6 months in that HRR. Spending ranges, by quartile are: Q1 (lowest): $8,366–$12,350, Q2: $12,351–$13,682, Q3: $13,683–$14,686, Q4: $14,687–$16,280, and Q5 (highest): $16,281–$21,123.

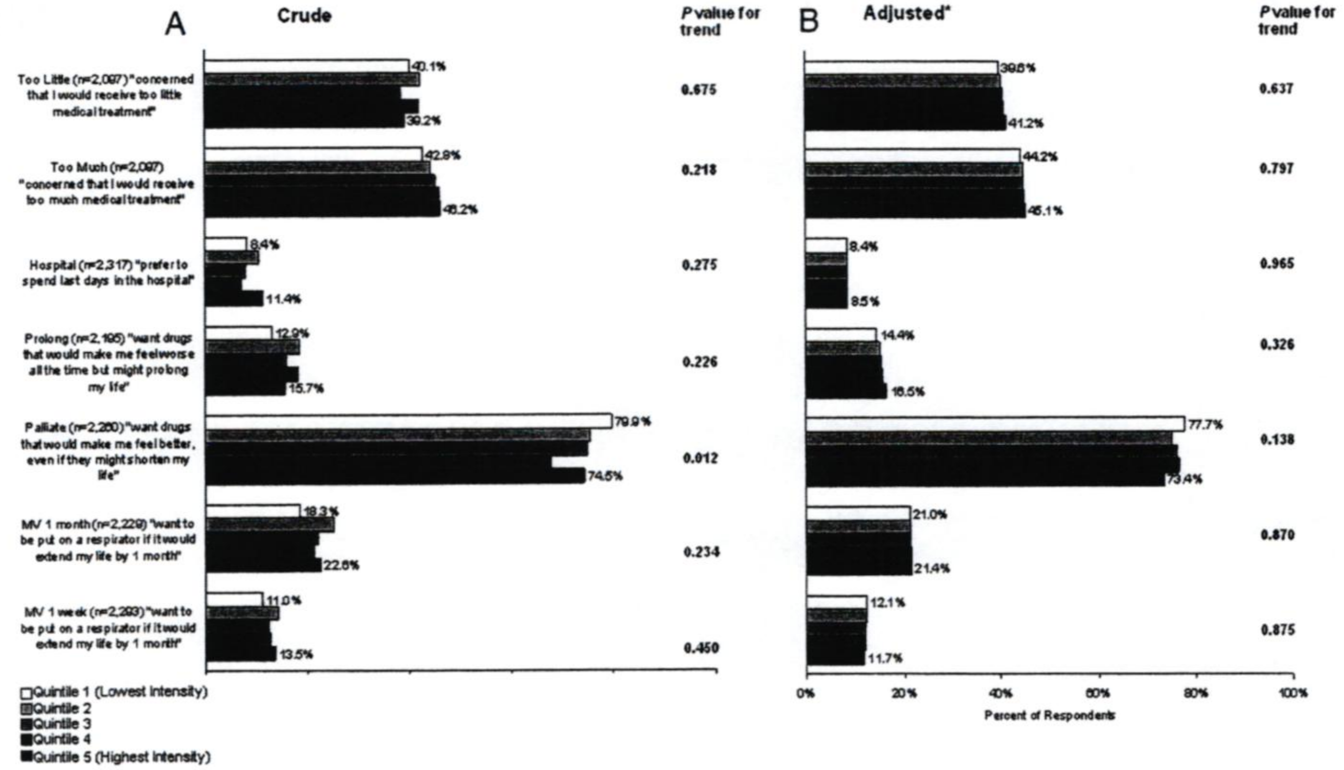

**FIGURE 2.** Proportion of beneficiaries living in regions with differing levels of EOL spending reporting particular EOL treatment concerns and preferences. Crude (left panel) and adjusted (right panel) results are presented. Responses are summarized by quintile of EOL spending, but *P* values are drawn from models with hospital referral region-level EOL spending entered as a continuous dollar figure, not a categorical variable. *Adjusted for age, sex, race/ethnicity, education, financial strain, and health status. MV indicates mechanical ventilation.

rectly ascertained,[17] let alone heeded.[6] However, unlike SUPPORT, we did not correlate actual treatment received with stated preferences. Our findings of lack of cross-sectional association using regional aggregate spending does not refute causality, and further, are potentially subject to the ecological fallacy. That is, although there is an association in aggregate, this association may not exist at the individual level.

Another limitation is the reliance upon a hypothetical scenario. Both the certainty of the prognosis and physicians' willingness to articulate it may be unrealistic. Furthermore, we ascertained stated, not revealed preferences. It is possible that in the event of an actual life-threatening illness, individuals in higher intensity regions might behave differently than they indicated in response to the hypothetical scenario. Younger, healthier Medicare beneficiaries may not have sufficient experience with EOL decision making to reliably predict their preferences; to address this concern, we restricted the analysis only to respondents 75 or older, and our findings were unchanged. Furthermore, we adjusted all analyses for 3 health status measures, none of which were statistically significant predictors of any of the outcomes in our full models. Nonetheless, these remain important concerns because preferences are not entirely stable over time,[18] particularly for those in declining health.[19]

The particular survey items were intentionally oversimplified to gain insight into broad concerns, goals, and preferences, rather than to anticipate particular treatment choices, and, as such were not as nuanced as required for advance care planning.[20] With regard to the question about mechanical ventilation, we did not specify to the respondents the circumstances of their 1 week or 1 month's life extension; some may have anticipated the reprieve to be lived in good health, while others may have understood the extension to be while still on the ventilator.

There was statistically significant pairwise correlation (with Bonferroni correction) for 10 of 21 outcome pairs. Not surprisingly, similar questions were highly correlated, for example between mechanical ventilation for 1 week and mechanical ventilation for 1 month ($r = 0.75$, $P < 0.001$), whereas others were less closely correlated, for example, between between mechanical ventilation for 1 week and worry about "too little" medical treatment ($r = -0.11$, $P < 0.001$). We sought a pattern of differences across all 7 outcomes, and indeed found neither a pattern nor significant differences on any single outcome. Some might argue that the lack of a difference on the responses to the questions regarding worry about getting too much or too little treatment indicates that respondents actually are getting just the kind of treatment they want across regions with differing spending levels. (Otherwise they'd be worried about getting too much in the higher spending regions.) Such an inference, however, would be inconsistent with the responses to the questions about specific services, which suggested that preferences and values for EOL care differ little across regions. Perhaps respondents are similar across regions in their values and preferences, but they observe only the intensity of care in their own region, and thus have little basis for judging what is "too much" or "too little."

The EOL spending measure is based upon hospital and physician services only. It is possible systematic bias exists because of the exclusion of spending from other Medicare benefit cateories, such as hospice, home health, skilled nursing, and long-term acute care, if there is a greater likelihood of substitution of these services for acute care services in lower spending regions. Indeed, as shown by Pritchard and by Virnig, nursing home bed and hospice availability and use are inversely correlated with hospital as the place of death. On the other hand, nursing home bed availability is positively correlated with hospital bed availability and use more generally.[8] Ultimately, this systematic bias is unlikely given the high correlation between hospital referral region-level EOL spending and hospital referral region-level overall spending (year 2000 $r = 0.82$, $P < 0.0001$). Indeed, during the last 2 decades, the substitution of these services has displaced the use of hospital acute care services at the end of life, but has not decreased the growth of total EOL Medicare expenditures.[21,22]

Finally, there was a 35% nonresponse rate to our survey. Although there was not a greater rate of nonresponse in the higher quintiles, it is still theoretically possible that selection bias produced the observed null result. For this to have occurred, beneficiaries preferring more intensive care would have had to be systematically more likely to be nonresponders in the higher intensity regions than in the lower intensity regions, which seems unlikely.

In summary, the results of this survey do not support the hypothesis that observed regional variations in EOL spending are attributable to differences in goals and preferences for care among residents of those regions. Longitudinal study of patients, their preferences, and their health care utilization is a natural next step in disconfirming this hypothesis.

## ACKNOWLEDGMENTS

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# Exhibit 7

Closing the gap for residents to obtain needed dental care is essential. Information on the importance of oral health and the adoption of good oral hygiene coupled with effective preventive measures can reduce disparities in accessing dental treatment services.

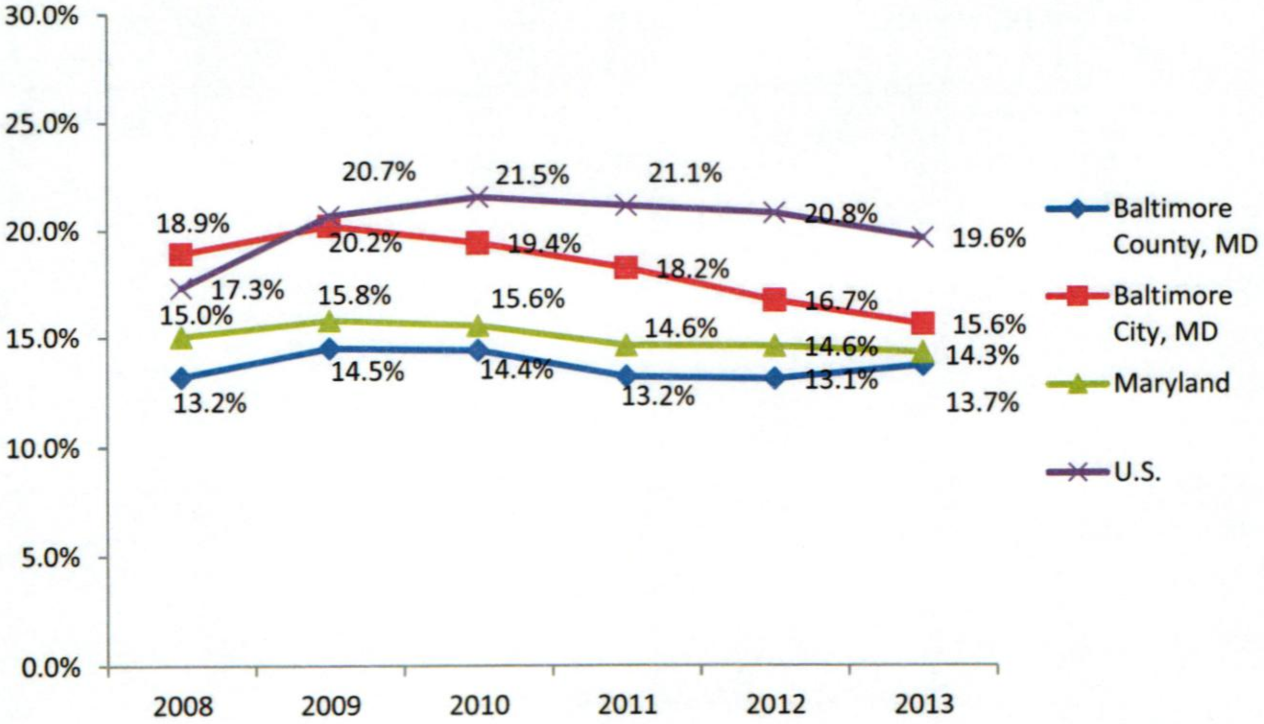
### *Uninsured*

Availability of health care insurance is one of the most important pieces in obtaining primary health care access; however, for many Americans, there is a great need to make it more available. The limitations in health care coverage readily affect the vulnerable, underserved and low-income populations. Many factors contribute to the availability of health insurance, such as economic factors, language, knowledge, citizenship and ease of accessibility.

Since the enactment of the PPACA, access to health insurance has become a basic right and necessity for all. This Act provides Americans with better health security by putting in place comprehensive health insurance reforms that expand coverage, holds insurance companies accountable, lowers health care costs, guarantees more choice and enhances the quality of care for all Americans. Although this legislation introduced historical reform, millions of Americans still find themselves unable to afford health insurance. Often choosing to meet basic needs versus paying health insurance premiums, Americans will go without health insurance coverage, increasing the risk of injury and illnesses, as well as deterring a healthy lifestyle.

The availability and ease of use for insurance have increased with the passage of the PPACA. In 2014, the U.S. Census Bureau cited that 7.9 percent of Marylanders, compared to 10.4 percent of the U.S. population, lives without any type of health care insurance. These numbers are a good indication of progress made, as 2013 levels were significantly higher with 10.2 percent of Marylanders and 13.3 percent of the U.S. population living without insurance coverage. In 2013, the U.S. Census Bureau reported Baltimore City and Baltimore County fell below the nation's rate of 19.6 percent for the uninsured population for those aged 18 to 64 years–with 15.6 percent and 13.7 percent, respectively (See Chart 13). While the coverage of community residents in Baltimore City is above the national rate, the uninsured population still remains vulnerable to the inability of obtaining health care services. Data also revealed that more than one-third of Baltimore City residents (34.2 percent) compared to 14.2 percent in Baltimore County reported Medicaid as their health care insurance provider.

Chart 13: Uninsured Population Aged 18-64 years



Source: U.S. Census Bureau, Small Area Health Insurance Estimates 2010

The County Health Rankings database provided a snapshot and benchmark data on how each county ranks in comparison to one another on multiple measures. Maryland has 24 counties; thus, each county is ranked one through 24.

Exploring clinical care rankings, Baltimore County had increased their clinical care score in 2012 from a five to a ranking of eight in 2015; this represents a negative change in the clinical care ranking score. Baltimore City increased ranking scores from a 15 to a 19 between 2012 and 2015, which indicated that a specific measurement affected the ranking negatively. The increased ranking scores indicated that specific health care issues such as the uninsured, primary care physicians, dentists, mental health providers, preventable hospital stays, diabetic monitoring and mammography screening rates have been impacted; thus, altering the overall ranking outcome (See Table 12). It is recommended to examine and explore what specifically affected the higher ranking scores as a community group.

Table 12: County Health Rankings; Clinical Care

| | Clinical Care Rankings |
|---|---|
| Baltimore City | |
| 2012 | 15 |
| 2015 | 19 |
| Baltimore County | |
| 2012 | 5 |
| 2015 | 8 |

Source: County Health Rankings and Roadmaps 2015 and 2012

The CNI insurance rankings for the CBSA shows ZIP codes 21202, 21205, 21213 and 21218 had a score of 5, which indicates that community residents in these specific neighborhoods have additional insurance access issues when compared to the remaining neighborhoods.

In reviewing information from Table 13, CNI data revealed neighborhoods 21205 (26.34 percent), 21213 (21.26 percent), 21202 (15.72 percent) and 21218 (14.69 percent) had higher percentages of unemployment when compared to the remaining ZIP codes in the CBSA. CNI calculates the percentage of the unemployed population in the labor force, aged 16 and older, and the percentage of the population without health insurance when calculating the insurance barriers.

Additionally, the CNI measures income barriers based on:

a. Percentage of households below poverty line, with head of household age 65 or more

b. Percentage of families with children under 18 below poverty line

c. Percentage of single female-headed families with children under 18 below poverty line

Therefore, even though zip code 21231 had the highest average income within the CBSA (as shown previously in Chart 2), Table 13 shows a calculated CNI income score of 5, indicating significant barriers. This is due to the high percentages for seniors in poverty at 29%, children in poverty at 47%, and single households who have children in poverty at 69%.

There are several socioeconomic issues community residents face when the inability to obtain employment is a factor. Higher unemployment rates add greater accessibility issues to health, social and daily living factors.

Table 13: CBSA CNI ZIP Codes and Scores: Specific Data and Measures

| Zip | 2015 Population | Poverty 65+ | Poverty Children | Poverty Single w/kids | Limited English | Minority | No H/S Diploma | Unemployed | Uninsured | Rent | House | Income | Culture | Education | Insurance Rank | Housing | 2015 CNI Score |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 21202 | 23,812 | 33.00% | 47.07% | 57.42% | 1.13% | 70.41% | 23.04% | 15.72% | 18.18% | 78.29% | 5 | 5 | 5 | 5 | 5 | 5 | 5.0 |
| 21205 | 16,300 | 30.63% | 46.69% | 55.48% | 3.88% | 83.52% | 36.55% | 26.34% | 17.85% | 60.52% | 5 | 5 | 5 | 5 | 5 | 5 | 5.0 |
| 21206 | 50,347 | 12.66% | 20.19% | 28.69% | 1.60% | 77.37% | 15.23% | 12.98% | 9.26% | 39.80% | 5 | 2 | 5 | 4 | 4 | 5 | 4.0 |
| 21213 | 32,146 | 23.72% | 30.38% | 42.37% | 1.08% | 93.94% | 23.55% | 21.26% | 14.10% | 43.05% | 5 | 4 | 5 | 5 | 5 | 5 | 4.8 |
| 21218 | 48,890 | 22.22% | 23.90% | 36.41% | 0.72% | 72.89% | 17.43% | 14.69% | 13.40% | 55.22% | 5 | 3 | 5 | 4 | 5 | 5 | 4.4 |
| 21219 | 9,743 | 8.67% | 13.01% | 24.48% | 0.54% | 7.64% | 17.19% | 10.62% | 6.46% | 18.64% | 2 | 2 | 2 | 4 | 3 | 2 | 2.6 |
| 21222 | 56,953 | 11.38% | 20.30% | 30.65% | 1.69% | 23.65% | 19.13% | 12.99% | 6.93% | 33.58% | 4 | 2 | 4 | 4 | 3 | 4 | 3.4 |
| 21224 | 50,053 | 13.67% | 30.85% | 49.26% | 9.79% | 42.81% | 25.12% | 10.76% | 9.23% | 42.36% | 5 | 4 | 5 | 5 | 4 | 5 | 4.6 |
| 21231 | 16,032 | 28.51% | 46.54% | 69.38% | 4.66% | 47.11% | 16.73% | 11.08% | 11.73% | 63.48% | 5 | 5 | 5 | 4 | 4 | 5 | 4.6 |

Source: Truven Health Analytics 2015

While hand survey results reported that a majority of community residents had insurance, for the percentage of residents who did not have health insurance the most common reasons were: cost (29.6 percent) and the belief that that they did not qualify (25.4 percent).

Community leaders believe there are a number of factors that affect insurance status within the community. Fear and a lack of trust were two consistent points that surfaced during community leader discussions.

Input from focus group sessions found that many residents do not have health insurance because they do not know how to obtain it and do not have access to affordable health services. There was belief that the process is difficult and that 'Obamacare' does not provide adequate coverage. Some stated that they avoid seeking health services because they are not eligible, nor can they afford health insurance premiums or the costs associated with uninsured medical care. For those aware of existing health resources, there was a claim for needed information to come from trusted organizations. Overall, the cost of care, insurance and lack of community awareness are barriers to receiving health care. Many feel that payment for health care services is expensive, which includes out-of-pocket costs, prescription medications and high deductibles.

Disparities and gaps in services plague communities and neighborhoods. Primary and secondary data figures collected provide in-depth information to address and pinpoint areas of concern for improvement.

### *Chronic Diseases*

Heart disease, cancer, diabetes and stroke, which are chronic diseases, are a few leading causes of death and disability among citizens. Chronic diseases are responsible for seven of 10 deaths each year, and treating people with chronic diseases accounts for 86 percent of our nation's health care costs according to the CDC.

Obesity, a nationally growing concern, has affected many communities and neighborhoods and shows no signs of waning. Communities are seeing children as young as two years old diagnosed as being overweight and/or obese. According to The State of Obesity, Maryland has the 26th highest adult obesity rate in the nation. Maryland's adult obesity rate is currently 29.6 percent, up from 19.6 percent in 2000 and from 10.8 percent in 1990. Specifically examining the BMI of adults, the CDC reported that there were more Baltimore City (34.1 percent) residents aged 18 and older with a BMI greater than 30 (which indicates that they are obese) when compared to residents in Baltimore County (27.9 percent) and the state (28 percent) in 2012.

The toll and the overall health care costs associated with chronic diseases are staggering. The CDC reports, 86 percent of all health care spending in 2010 was for people with one or more chronic medical condition. Costs of heart disease and stroke in 2010 were estimated to be $315.4 billion. Of this amount, $193.4 billion was for direct medical costs, not including costs of nursing home care. Medical costs linked to obesity were estimated to be $147 billion in 2008.

Although common, many of the chronic diseases diagnosed in community members are preventable. Living a healthy lifestyle by incorporating exercise, eating healthy and avoiding tobacco and alcohol can assist community residents from developing certain diseases.

Maryland State Health Improvement Process reported that Marylanders and Baltimore County residents have roughly the same life expectancy (79.6 years of age and 79.4 years of age respectively); while dramatically lower, Baltimore City residents have a life expectancy of 73.9 years of age.

Data obtained from Neighborhood Health Profile identify the top leading causes of death in Baltimore City as heart disease, cancer and stroke. These top three leading causes of death mimic those of the overall state of Maryland (See Table 14).

Additional causes of death such as HIV/AIDS, homicide, drug-induced deaths of undetermined manner and injury were not reported in Maryland's overall top leading causes of death. Identifying causes of death can assist health systems, organizations, community groups and community resources in allocating and assisting in the direction where funding can be properly assigned for maximum impact. For example, education and health literacy regarding HIV/AIDS can assist community residents who are unaware of how the disease is transmitted, how to avoid contracting the disease and how to seek treatment options, potentially avoiding death.

HIV/AIDS, homicide, drug-induced deaths of an undetermined manner and injury are leadings causes of death found in Baltimore City. Primary data collected from the CHNA echo the secondary data findings.

Table 14: Top 10 Causes of Death in Baltimore City

| | Rate (per 100,000) | Percent of Total Deaths | Percent of YPLL[6] |
|---|---|---|---|
| 1. Heart Disease | 28.4 | 25.8 | 15.4 |
| 2. Cancer | 23.1 | 20.8 | 14.8 |
| 3. Stroke | 5.2 | 4.7 | 2.6 |
| 4. HIV/AIDS | 3.9 | 3.5 | 7.6 |
| 5. Chronic lower respiratory disease | 3.9 | 3.5 | 1.6 |
| 6. Homicide | 3.5 | 3.4 | 12.5 |
| 7. Diabetes | 3.5 | 3.2 | 2.0 |
| 8. Septicemia | 3.5 | 3.1 | 2.1 |
| 9. Drug-induced deaths of undetermined manner | 3.2 | 2.8 | 6.9 |
| 10. Injury | 2.8 | 2.5 | 4.8 |

Source: Neighborhood Health Profiles 2011

In 2013, the ten leading causes of death in Maryland were diseases of the heart (25 percent), malignant neoplasms (23 percent), cerebrovascular diseases (5 percent), chronic lower respiratory diseases (4 percent), accidents (4 percent), diabetes mellitus (3 percent), septicemia (2 percent), nephritis (2 percent), influenza and pneumonia (2 percent) and Alzheimer's disease (2 percent) (See Table 15).

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[6] Years of Potential Life Lost

Table 15: Leading Causes of Death in Maryland

| 2013 | Percent |
|---|---|
| 1. Diseases of heart | 25.0 |
| 2. Malignant Neoplasms | 23.0 |
| 3. Cerebrovascular disease | 5.0 |
| 4. Chronic lower respiratory diseases | 4.0 |
| 5. Accidents | 4.0 |
| 6. Diabetes Mellitus | 3.0 |
| 7. Septicemia | 2.0 |
| 8. Nephritis | 2.0 |
| 9. Influenza and Pneumonia | 2.0 |
| 10. Alzheimer's disease | 2.0 |

Source: Maryland Department of Health and Mental Hygiene Vital Statistics 2013

The mortality breakdown reveals that 72.5 deaths per 10,000 population occur between the ages of 15 and 44 (See Table 16). Within this age group, it is likely or plausible that a percentage of these deaths may be preventable. Further analysis to determine the causes of death among this population could provide additional insight regarding how to best disseminate, distribute and promote health education/information, prevention efforts and awareness on diseases, which could assist those who are vulnerable.

Table 16: Mortality by Age

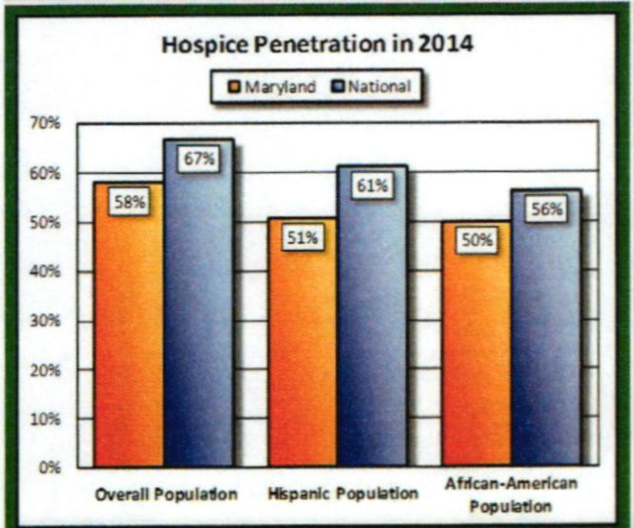
| Age Group | Baltimore City (per 10,000) |
|---|---|
| Less than 1 year old | 12.1 |
| 1-14 years old | 1.8 |
| 15-24 years old | 28.9 |
| 25-44 years old | 43.6 |
| 45-64 years old | 115.0 |
| 65-84 years old | 489.9 |
| 85 years and up | 1,333.3 |

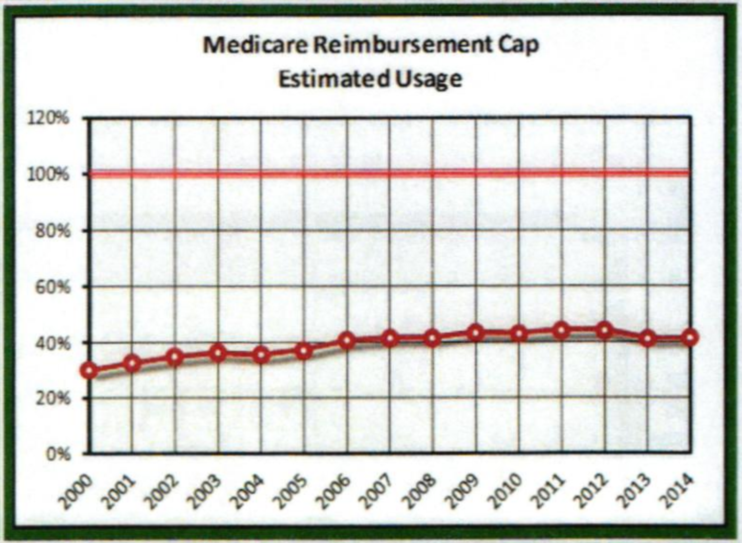
Source: Neighborhood Health Profiles 2011

The Centers for Medicare and Medicaid Services reported that there were more residents aged 18 years and older with coronary heart disease or angina who are on Medicare in Baltimore County (30.4 percent) than residents who have the same condition in Baltimore City (28.6 percent), the state (28.5 percent) and the nation (28.6 percent). There were more Baltimore County (62.3 percent) and Baltimore

# Exhibit 8

# Maryland

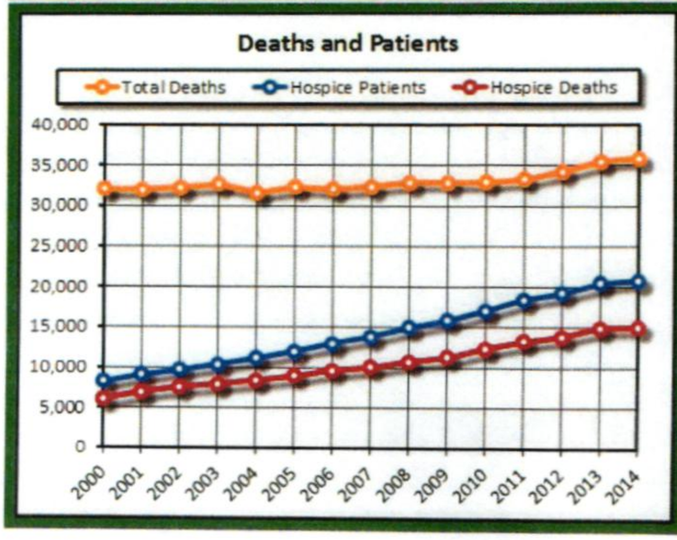

Hospice Penetration in 2014


Medicare Reimbursement Cap Estimated Usage

| Major Providers in 2014 | Patients Served in 2014 | Average Census in 2014 | ALOS in 2014 | % GIP Days in 2014 |
|---|---|---|---|---|
| GILCHRIST HOSPICE CARE | 4,323 | 486 | 41 | 4.8% |
| SEASONS HOSPICE & PALLIATIVE CARE | 2,437 | 384 | 57 | 2.7% |
| HOSPICE OF THE CHESAPEAKE | 2,323 | 326 | 51 | 2.4% |
| MONTGOMERY HOSPICE INC | 1,647 | 289 | 64 | 2.1% |
| HOSPICE OF WASHINGTON COUNTY, INC | 1,138 | 243 | 78 | 0.6% |
| COASTAL HOSPICE INC | 941 | 122 | 47 | 2.8% |
| STELLA MARIS INC HOSPICE CARE | 812 | 68 | 31 | 4.8% |
| HOSPICE OF FREDERICK COUNTY | 751 | 77 | 37 | 2.7% |
| AMEDISYS HOSPICE OF GREATER CHESAPE | 751 | 114 | 55 | 0.3% |

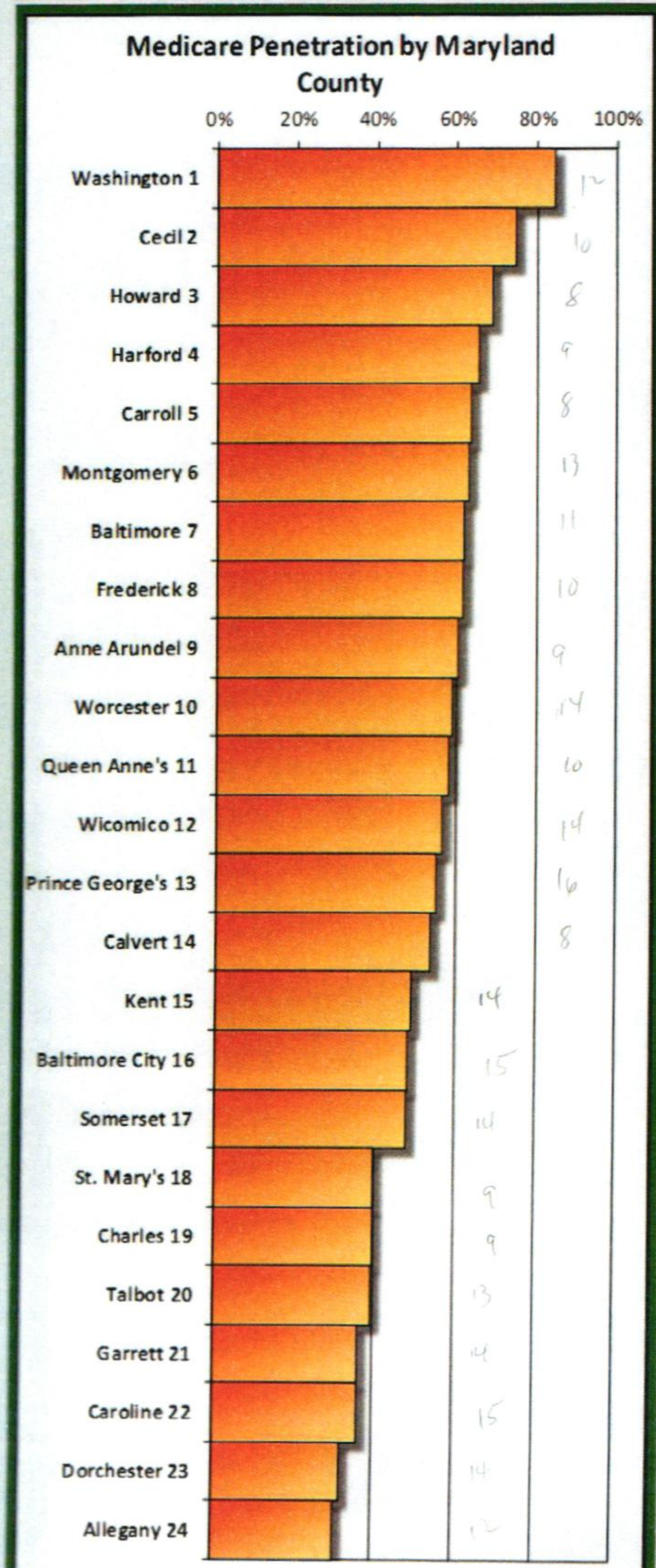
| Level of Care Mix for 2014 | | Routine Home Care | Continuous Home Care | General Inpatient | Inpatient Respite |
|---|---|---|---|---|---|
| Maryland | % Days | 97.2% | 0.1% | 2.3% | 0.4% |
| | % Patients | 84.9% | 1.0% | 24.3% | 3.4% |
| National | % Days | 97.7% | 0.3% | 1.7% | 0.3% |
| | % Patients | 87.1% | 4.8% | 20.2% | 3.5% |

| Distribution of Hospice Census in Maryland for 2014 | |
|---|---|
| Home | 54% |
| Nursing Home | 22% |
| Assisted Living Facility | 20% |
| Hospital | 0% |
| Hospice Facility | 3% |
| Other | 0% |
| Total | 100% |

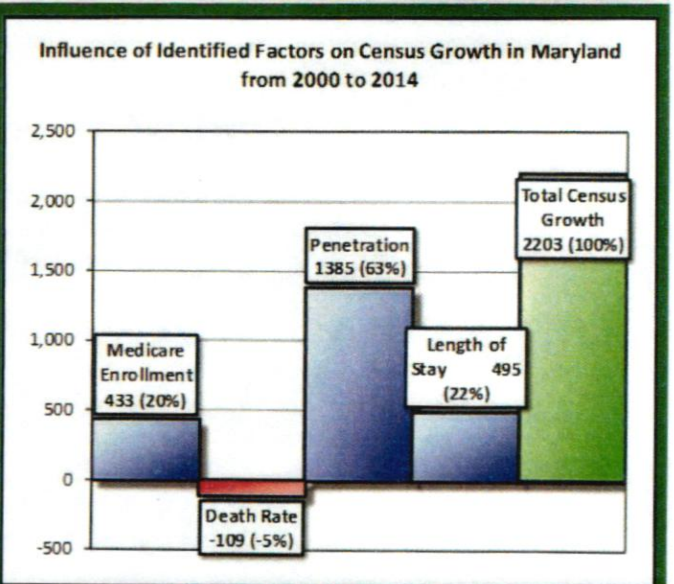

Deaths and Patients


Average & Median Length of Stay (LOS)

# Maryland


Medicare Penetration by Maryland County

| Year | Enrollment | Death Rate per 1000 | Deaths | Penetration Rate | Hospice Patients |
|---|---|---|---|---|---|
| 2000 | 678,655 | 47 | 32,003 | 26% | 8,181 |
| 2001 | 687,346 | 46 | 31,955 | 28% | 9,051 |
| 2002 | 697,493 | 46 | 32,211 | 30% | 9,684 |
| 2003 | 708,186 | 46 | 32,669 | 32% | 10,366 |
| 2004 | 717,994 | 44 | 31,563 | 35% | 11,156 |
| 2005 | 730,352 | 44 | 32,296 | 37% | 12,006 |
| 2006 | 743,867 | 43 | 32,033 | 40% | 12,971 |
| 2007 | 762,513 | 42 | 32,347 | 43% | 13,841 |
| 2008 | 782,757 | 42 | 32,847 | 46% | 15,036 |
| 2009 | 802,602 | 41 | 32,813 | 48% | 15,874 |
| 2010 | 823,496 | 40 | 32,916 | 52% | 17,051 |
| 2011 | 853,658 | 39 | 33,270 | 55% | 18,411 |
| 2012 | 889,688 | 38 | 34,187 | 56% | 19,266 |
| 2013 | 921,600 | 38 | 35,462 | 58% | 20,511 |
| 2014 | 948,875 | 38 | 35,784 | 58% | 20,795 |


Influence of Identified Factors on Census Growth in Maryland from 2000 to 2014

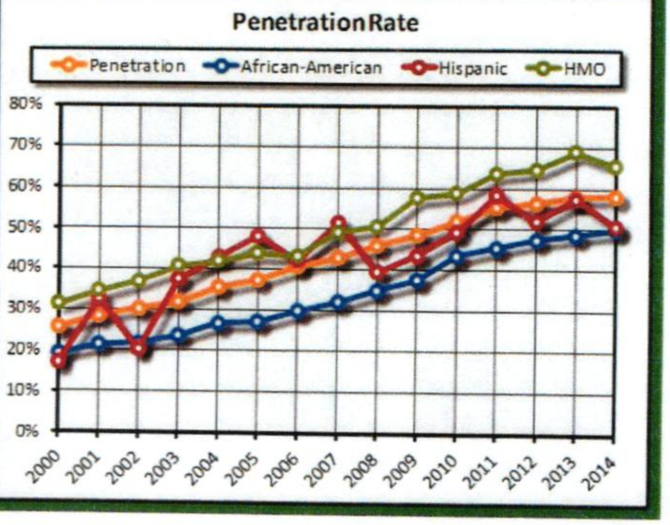

Penetration Rate

**Exhibit 9**

advance for
NURSES

# Home Health Company Founder Chooses Mission over Money

J. Mark Baiada will donate one of the nation's largest home healthcare organizations to a newly created charitable foundation

**By Sarah Sutherland**

**BAYADA HOME HEALTH CARE** has certainly grown over the 40-plus years since its inception. In 1975, J. Mark Baiada opened his first office in Philadelphia with a vision that "everyone should be entitled to a safe home life, with comfort, independence and dignity."[1] Now based in Moorestown, N.J., the organization employs over 23,000 home healthcare professionals in more than 22 states at more than 300 offices.[2] In 2015, Bayada served 150,000 patients and earned $1.1 billion in annual revenue,[3] making it the nation's 10th-largest Medicare-certified home health agency.[4] Since its inception, the agency has also grown to offer services to patients of all ages requiring all levels of care. These include home health, adult nursing, assistive care, pediatrics, hospice, rehabilitation, and primary care.

### A Lasting Legacy

J. Mark Baiada knew that he couldn't always stay with the agency - but he also knew that he didn't want Bayada to stop with him. So on June 28, Bayada Home Health Care announced in a press release that it would restructure its ownership and governance through an initiative known as the "Lasting Legacy Plan." According to this plan, over the next three to five years, J. Mark Baiada and his family will gift the company to a newly-created non-profit foundation.

"The dream of helping millions of people is far more important to me than money," Baiada wrote in an open letter. "Bayada, owned by a foundation solely dedicated to The Bayada Way, has the best chance of achieving our 100-year vision and at the same time fulfilling our daily mission of helping people to live with comfort, independence, and dignity in their homes by providing them with compassionate, excellent and reliable care."

While the donation of a company that could potentially be sold for over $1 billion may seem shocking, Baiada knew that it was the best option for the agency. "I've been of the public service mindset since I started," he told ADVANCE.

### 100 Years Is the Goal

Despite his goal - and ultimate decision - to donate the company, because Bayada is such a large company that serves so many people, Baiada and his family were sure to weigh all of the options before making a final choice. "I have five children and four of them either currently work here or have in the past. They're all committed to the mission," Baiada said. "We studied different organizations with hereditary-based systems, and they really don't last beyond two, maybe three generations. We'd be good for 30 more years, but we're looking for 100."

Baiada hopes the agency will continue to expand in the future in both size and range. Ideally, Bayada will grow to serve millions of people worldwide, and it's already on its way: In 2014, the agency invested $10 million in an Indian home healthcare provider, the agency's first investment overseas.[5]

With a goal of Bayada continuing to be a mission-centered company years into the future, selling the company was also out of the question for Baiada. "The new owners may not be committed to The Bayada Way," he explained, referencing the agency's mission statement that focuses on compassion, excellence, and reliability. "We're not driven by money. We're driven by mission."

### Putting the Mission Over Money

While the agency will be majority-owned by a non-profit foundation, it will still remain a private company. "We want to be a hybrid," Baiada said of the decision. "We want to put mission over money and preserve a long-term commitment to our values, but we also want to have the energy and motivation of a business. We need to capture both for the good of our clients."

The donation of Bayada will serve not only the agency's clients, but also its staff. "Their jobs will be secure," Baiada said. "They won't need to worry about a buyer who's only interested in money. Giving them that security will allow them to concentrate on helping the families that depend on them."

Although Baiada will officially step down as the agency's president on August 17, 2017, he will still be part of Bayada as the chairman of the board of the foundation. His son David Baiada, currently the chief operating officer of home health, hospice, and quality, will be named company president, playing an important role in the day-to-day operations of the organization - and ensuring that it always follows The Bayada Way. ■

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3. Brubaker, H. "Founder to donate Bayada Home Health to charity." The Philadelphia Inquirer. 2016.
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5. Gerace, A. "Bayada Invests $10 Million More into India Home Health Expansion." Home Health Care News. 2014.

**Sarah Sutherland** *is on staff at ADVANCE.*
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# Exhibit 10

# 0-4567 ADMISSION CRITERIA AND PROCEDURE - HOSPICE SERVICES

*This policy was adopted on Feb. 1, 2010 and last revised May. 26, 2015.*

***Our Policy:***

BAYADA Hospice admits clients based on the reasonable expectation that their physical, social, psychological, and spiritual needs can adequately be met throughout the continuum of hospice services, and provides these services in compliance with the Medicare Conditions of Participation. Hospice clients must meet the admission criteria and Medicare Hospice Conditions of Participation eligibility requirements.

***Our Procedure:***

1.0 BAYADA does not discriminate against any person in admission, treatment, participation in programs or services, on the grounds of race, age, color, national origin, or disability, whether carried out by BAYADA directly or through a contractor or any other entity with which BAYADA arranges to carry out its programs and activities.

2.0 Clients who meet admission criteria are admitted regardless of race, color, national origin, sexual preference, age, handicap, sex, communicable disease or religion.

3.0 Client/family, Medical Director, attending physician and hospice Interdisciplinary Group (IDG) participate in determining the appropriateness to begin hospice based on fiscal intermediary Local Coverage Determinations (LCD). The LCD guidelines are used when considering any client's eligibility for Hospice services. Failure to meet LCD guidelines does not disqualify a client for admission. Additional documentation by the Medical Director, physician designee or attending physician is required.

4.0 Additional admission criteria:

a. The client resides in the geographic area served by the hospice program;
b. The client understands and accepts the palliative nature of hospice care and no longer seeks aggressive treatment;
c. There is a capable primary caregiver living in the home or, if no

caregiver is available, the client agrees to assist the hospice in developing a plan of care to meet his or her future needs;

d. The hospice has adequate resources and staffing to meet the needs of the client; and
e. The client and/or caregiver wish to receive hospice services.

5.0 Eligibility for the Medicare hospice benefit. See [policy 0-4551]
To be eligible to elect the Medicare hospice benefit, the client must:

a. Be entitled to Medicare Part A; and
b. Have written certification by the client's attending physician (if there is one) and BAYADA's Medical Director or physician designee that the client has a prognosis of 6 months or less if the disease follows its normal course. See [policy 0-4563].

6.0 When admission criteria are met a member of the hospice IDG obtains a signature by the client or legal representative on [policy 0-4589]. The IDG member informs the office of the admission, and the client is registered for pharmacy, equipment and other services as needed. A RN case manager is assigned, IDG members and On-call nurse are notified.

7.0 Copies of the BAYADA Mission Statement and fact sheet are given to all clients. These documents detail the services provided directly or through contractual arrangements, the hours services are available, a description of the off-hours system for reaching appropriate staff, and other information regarding BAYADA's philosophy and scope of services.

8.0 Prior to the initiation of care, BAYADA notifies the client verbally and in writing of their financial liability. The client's understanding of this is again evidenced by their signature on the [policy 0-4589], completed at the time of admission. We will also assist clients with private medical insurance by calling their provider to verify coverage for needed hospice services.

9.0 During the initial visit, if the client is appropriate for services, the IDG member will perform all of the admission procedures. This admission process includes, but is not limited to, discussion with the client and/or caregiver of the contents of the [policy 0-4588]. The contents include:

9.1 **The Client Agreement Form for Hospice Services** which addresses the following items and is signed by the client or client's representative:

- a. Election of the Medicare Hospice Benefit.
- b. Consent to Services and Release of Information.
- c. Receipt of Privacy Notice.
- d. Client Rights and Responsibilities.
- e. Advance Directive Verification.
- f. Medicare information including completion of Medicare Secondary Payor's Questionnaire and receipt of Product Waiver.
- g. Payment for Services Rendered: Types of Services and payment method including client responsibility.
- h. Assignment of Insurance Benefits.

9.2 The office-specific Client Comment Form is signed by the client and a copy is left in the home.

9.3 Information on medication safety and proper disposal of prescription drugs.

9.4 Any additional documents required by state regulations.

10.0 A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the client. The initial assessment must be completed either within 48 hours after the [policy 0-4589] is signed, unless the physician, client or representative requests that the initial assessment be completed in less than 48 hours.

11.0 Following the initial assessment, the RN gives a report to the client's attending physician from the client's home and obtains appropriate orders. The RN then reports to the office the outcome of the initial assessment and all orders received from the physician and the appropriate office employee:

11.1 Schedules needed IDG members to complete the [policy 0-4606].

11.2 Communicates any new orders to the pharmacy, equipment or other service provider as appropriate.

12.0 Admission to BAYADA may occur 24 hours per day, seven days a week.

13.0 Each client admitted to service must receive a client specific, comprehensive assessment that accurately reflects the client's current health status and includes information that may be used to demonstrate the client's progress toward goals. See [policy 0-4568].

14.0 If a potential client does not meet Admission Criteria, the referring individual or organization and the client's attending physician is notified. This notification is documented in a Referral Log. Efforts are made for referral to appropriate health care providers or community resources, if applicable, and a plan for follow-up contact is developed and recorded in the referral log.

15.0 A file of initial client intake forms is maintained for all clients who do not meet admission criteria; each form includes a brief explanation of why service was not initiated, and referrals for services elsewhere are documented.

16.0 BAYADA periodically evaluates eligibility requirements and limitations with the goal to increase access to hospice care in the community.

17.0 BAYADA collects data regarding the appropriateness and timeliness of admissions that is utilized in the Quality Assurance and Performance Improvement Program.

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0-4567 - ADMISSION CRITERIA AND PROCEDURE - HOSPICE SERVICES

| | |
|---|---|
| Version: | 19.0 ( 9728 ) |
| Author(s): | KRISTIN BARNUM, JOY STOVER (2009); JOY STOVER (2015) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | COP 42 CFR 418.106 (e2A); 418.25, 418.52, 418.102 (b); CHAP Standard HII.4, HII.1; CMS Manual CR 8877 August 22, 2014. |
| Revisions: | May. 26, 2015; May. 26, 2015; Apr. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Sep. 29, 2011; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Sep. 29, 2011; Feb. 01, 2010; |
| Comments: | |

# Exhibit 11

BAYADA
Hospice

# 0-4566 PHYSICIAN SERVICES - HOSPICE

*This policy was adopted on Feb. 1, 2010 and last revised May. 11, 2011.*

### *Our Policy:*

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

### *Our Procedure:*

## 1.0 PHYSICIAN SERVICES.

1.1 All physician employees and those under contract, function under the supervision of the hospice Medical Director.

1.2 All physician employees and those under contract provide services directly or coordinate client care with the client's attending physician.

1.3 If the attending physician is unavailable, the Medical Director, a BAYADA physician employee, and/or contracted physician are responsible for meeting the medical needs of the client.

## 2.0 HOSPICE MEDICAL DIRECTOR.

The Medical Director is a licensed physician (a Doctor of Medicine or Osteopathy) who organizes and assumes overall responsibility for the medical component of BAYADA's client care program including multiple locations, if applicable. When the Medical Director is not available, a physician designated by the hospice assumes the same responsibilities as the Medical Director.

2.1 The Medical Director is Board Certified in a related specialty and:

2.1.1 Has expertise in the medical care of terminally ill individuals.

2.1.2 Is employed full-time or part-time by the hospice or has a contractual agreement that provides for comprehensive medical direction of hospice.

2.2 The Hospice Medical Director provides oversight of physician services:

2.2.1 Complements attending physician care.

2.2.2 Supervises all hospice physician employees and contract hospice physicians.

2.2.3 Acts as medical resource person to Interdisciplinary Group (IDG).

2.2.4 Assures overall continuity of the hospice medical services.

2.2.5 Assures that the client receives appropriate measures to control uncomfortable symptoms.

2.3 The Medical Director or physician designee is responsible for:

2.3.1 Collaborating with the IDG to ensure that the medical needs of the client are met and providing oversight of the plan of care.

2.3.2 Certifying that client meets the medical criteria for hospice admission based upon available diagnosis and prognostic indicators, related diagnosis(es) if any, current subjective and objective medical findings, current medical and treatment orders, information about the medical management of any of the client's conditions unrelated to the terminal illness.

2.3.3 Collaborating with the client's attending physician to develop and update the client's plan of care, to identify needs not met by the attending physician, and to ensure pain and symptom management and control.

2.3.4 Recertifying clients, as appropriate, for continuation of Medicare Hospice Benefit at appropriate levels of care.

2.3.5 Serving as a medical resource to hospice staff, clients, families, and attending physicians regarding pain and symptom control management.

2.3.6 Ensuring the provision of direct medical services to clients either directly or through arrangements, as appropriate, in the absence of the client's attending physician.

2.3.7 Working in a team approach with the IDG and attending IDG conferences.

2.3.8 Participating in plan of care development and managing oversight of medications and treatment.

2.3.9 Documenting care provided in the client's clinical record providing evidence of progression of the end-stage-disease process.

2.3.10 Maintaining current knowledge of the latest research and trends in hospice care and pain/symptom management.

2.3.11 Participating in performance improvement programs, as indicated.

2.3.12 Providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care.

2.3.13 Reviewing and developing protocols for treatment and proposing the most current options for interventions.

2.3.14 Demonstrating knowledge and communications and counseling client/family in dealing with end-of-life issues.

2.3.15 Participating in resolution of interpersonal conflict and issues of clinical and ethical concern.

2.3.16 Participating in the development and updating of client care policies and emergency procedures.

2.3.17 Acting as a liaison to physicians in the community.

## 3.0 **ATTENDING PHYSICIAN.**

At the time of admission to hospice care, the client or his/her representative is encouraged to designate an attending physician who will have the most significant role in the determination and delivery of the client's medical care.

3.1 The attending physician must be a doctor of medicine or osteopathy licensed to practice in the State in which services are provided.

3.2 The attending physician may be a nurse practitioner who is a registered nurse if permitted by State laws and regulations to perform the duties of an attending physician. The certification of terminal illness may not be signed by nurse practitioners functioning as attending physicians.

3.3 The client may designate the hospice's Medical Director as his/her attending physician if the client is unable or unwilling to designate a previous physician.

3.4 The client's attending physician (if any) is responsible for:

3.4.1 Management of the client's medical care, particularly those areas not related to the terminal illness;

3.4.2 Signing the initial certification of terminal illness form stating the client has a prognosis of 6 months or less if the illness follows its normal course;

3.4.3 Consulting with the IDG regarding the completion of the comprehensive assessment within 5 days of the client electing hospice care and subsequent updates to the comprehensive assessment as appropriate;

3.4.4 Participating in the development and review of the client's plan of care;

3.4.5 Providing verbal and signed orders within time frames required by laws and regulations;

3.4.6 Sharing information as needed to facilitate the continuity of care.

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## 0-4566 - PHYSICIAN SERVICES - HOSPICE

Version: 7.0 ( 3584 )

Author(s): KRISTIN BARNUM (2009); JOY STOVER (2011)

Owner:

Manual, Section: HOSPICE MANUAL , POLICIES

References: NHPCO Standards: WE 12,12.1,12.2,13,13.1,13.4,13.5,13.6; CMS Program Memorandum A-03-053 (CR 2750); Sec 408(a) MMA of 2003 (Pub.L. 108-173); COP 42 CFR 418.52(c)(4), 418.54(b), 418.54(d), 418.56(b); 418.56(d), 418.64(a), 418.102; CHAP HII.2r; HII.1a (f); HII.2a (3); HII.2b (1,a) HII.2q; HII.4b; HII.5b.

Revisions: May. 11, 2011; May. 11, 2011; May. 11, 2011; Feb. 01, 2010; May. 11, 2011; May. 11, 2011; Feb. 01, 2010;

Comments:

# Exhibit 12

BAYADA
Hospice

# 0-5825 COMPETENCY ASSESSMENTS- HHA, HMKR, COMPANION, CHORE SERVICE WORKER- HOSPICE SERVICES

*This policy was adopted on Oct. 24, 2011 and last revised Feb. 29, 2016.*

***Our Policy:***

The BAYADA Hospice Competency Assessment Program supports the mission, goals and philosophy of BAYADA and enables staff to comply with agency policy and procedures. Data from self-assessment checklists, staff feedback and annual performance evaluations determines staff learning needs and assist in educational program for staff development and in-services.

***Our Procedure:***

This discipline specific policy is to be used in conjunction with [policy 0-5821]

## 1.0 HOSPICE AIDE.

1.1 **The procedures and forms** used to assess and document competency are:

a. [policy 0-994]
b. [policy 0-416]
c. [policy 0-232]
d. [policy 0-2261]
e. [policy 0-226]
f. [policy 0-225] and [policy 0-3245]
g. [policy 0-906]
h. [policy 0-6061] and [policy 0-3238]
i. [policy 0-510]
j. [policy 0-3538]

1.2 Formal classroom training is not required by BAYADA Hospice, except in cases where state regulation requires it. However, in order for any Hospice Aide to provide personal care to clients, he/she must pass every section of the written BAYADA's [policy 0-232] or [policy 0-2261].

1.3 **Scoring written exams**. The Hospice Aide is expected to achieve a passing score of 70% independently, followed by verbal demonstration of 100% mastery of knowledge and skills expected to be performed. Areas that are answered or performed incorrectly will be reviewed with the Hospice Aide by the Clinical Manager or RN designee to confirm and document mastery.

1.4 **Skills Demonstration**. Hospice Aides must be tested on each of the skills listed on [policy 0-225] directly by a BAYADA Hospice RN who possess a minimum of 2 years nursing experience at least 1 year of which must be in home health or under arrangement with and outside evaluator as part of a BAYADA Hospice approved training program. Requirements for initial skill testing in the home or lab setting are as follows:

a. The following must be evaluated by observing an aide's performance of the task with a client:
    a. Communication skills, including the ability to read, write, and verbally report clinical information to patients care givers and other hospice staff.
    b. Reading and recording temperature, pulse and respiration.
    c. Appropriate safe techniques in performing personal hygiene and grooming tasks, including:
        i. Bed Bath
        ii. Sponge, tub, and shower bath.
        iii. Hair shampoo (sink, tub, and bed)
        iv. Nail and skin care
        v. Oral hygiene
        vi. Toileting and elimination
    d. Safe transfer techniques and ambulation
    e. Normal range of motion and positioning.

b. The following may be evaluated through written examination, oral examination, or observation with a patient:
    a. Observation, reporting, and documentation of patient status and the care or service furnished

b. Basic infection control procedures
c. Basic elements of body functioning and changes that must be reported to an aides supervisor
d. Maintenance of a clean, safe, and healthy environment
e. Recognizing emergencies and the knowledge of emergency procedures
f. The physical, emotional and developmental needs of and ways to work with the populations served by hospice, including the need for respect for the patient, his or her privacy, and his or her property.
g. Adequate nutrition and fluid intake for the dying

1.5 Should an employee hired to provide personal care services fail any section of the Competency Evaluation, (written or skills demonstration), he/she can be tutored by the Clinical Manager and retested. Documentation will be included in the employee file. [policy 0-3245] If the hospice aide is not competent or needs review in one area, the aide can be considered competent, but cannot perform the activity needing review until evaluated as passed.

1.6 **Annual Performance Evaluations** are completed for all Hospice Aides. This includes at least one on-site observation in a client's home during the year.

1.7 **Annual skills competency evaluation**: All skills expected to be performed by the Hospice Aide must be successfully performed under observation at least once during the year in the home or lab setting. Skills observed in the home throughout the year are documented on the [policy 37-57] and either entered into the BEARS skills tracking system or transferred to a [policy 0-225] to ensure that all skills have been observed. Annual lab demonstrations are documented on the [policy 0-225]. All skills competency documentation is maintained in the employee file or central competency file.

1.8 **Additional Competency Requirement for Medication Assistance.** Hospice Aides must meet the following additional requirement before assisting adult clients with medication as described in [policy 0-

1907]:

a. Complete the Home Health Aide Medication Assistance In-service and take the HHA Medication Assistance Questionnaire with review to 100% mastery by the Clinical Manager.

## 2.0 **HOMEMAKER/COMPANION/CHORE SERVICE WORKER.**

Note: The competency assessment procedures outlined below are only applicable to employees who do not provide direct personal care.

2.1 Homemaker/Companion/Chore Service Workers must complete a minimum of 8 hours of training related to environmental support services including instruction on:

a. Overall responsibilities
b. Communication Techniques
c. Standards of supervision
d. Ethics, confidentiality of patient care and patient rights
e. Safety in the home and how to respond to emergencies
f. Incidental household functions
g. Procedures for maintaining a clean and healthful environment
h. Infection control procedures related to food preparation, laundry and handling waste
i. Shopping
j. Participation as a member of the interdisciplinary team
k. Documentation of care

Personnel who have received their training outside the organization, whether employed or under contract must provide proof of training. Proof of training documentation is maintained in the employee file or central competency file.

The procedures and forms used to assess and document competency are:

a. [policy 0-297] or [policy 0-2466]

b. [policy 0-4028].

2.2 **Scoring written exams**. The HMKR/COMP/CHORE worker is expected to achieve a passing score of 70% independently, followed by demonstration of 100% mastery of knowledge and skills expected to be performed. Areas that are answered or performed incorrectly will be reviewed with the employee by the Clinical Manager or RN designee to confirm and document mastery.

2.3 **Skill evaluation:** Each Homemaker/Companion/Chore Service Worker must complete the [policy 0-4028] and provide a self-assessment of experience with home environmental/support tasks. If the employee indicates a need for training or review of a particular task, education will be provided prior to the employee's independent performance of the task in the home.

2.4 **Performance Evaluations** are completed for all Homemaker/Companions/Chore Service Workers, including at least one observation during the year in a client's home while services are being performed. The observed skills are documented on a [policy 37-57] with a copy to the employee file as evidence of annual competency.

## 3.0 **VOLUNTEERS.**

3.1 Volunteers will be required to meet all initial and annual competency requirements for the level of service they provide.

3.2 **Performance Evaluations** are completed annually for all active volunteers.

4.0 Refer to [policy 0-5775], [policy 0-5774], [policy 0-5777], and [policy 0-5778] as needed.

Owner:
Manual, Section: HOSPICE MANUAL , POLICIES
References:
Revisions: Feb. 29, 2016; Feb. 29, 2016; Feb. 29, 2016; Oct. 24, 2011;
Comments:

Exhibit 13

# 0-4562 SPIRITUAL CARE SERVICES

*This policy was adopted on Feb. 1, 2010.*

***Our Policy:***

Qualified counselors are available to BAYADA Hospice clients, family, hospice staff and volunteers, as needed, to assess and address the spiritual/pastoral, bereavement and/or additional individual/group counseling needs.

***Our Procedure:***

1.0 BAYADA ensures there are an adequate number of qualified spiritual counselors available to meet the needs of clients and their families, and offers clients and/or caregivers spiritual care from spiritual counselors employed by BAYADA or from clergy in the community.

2.0 At the client's request, BAYADA's spiritual counselor will make reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community.

3.0 A spiritual counselor is assigned to each client and/or caregiver and participates as a member of the BAYADA Interdisciplinary Group (IDG) in the development and implementation of the client's plan of care.

4.0 The [policy 0-4606] of the client includes a spiritual assessment to evaluate the client and/or caregiver's spiritual needs and identify appropriate spiritual problems, interventions and goals for the client's plan of care. Additionally, when indicated, [policy 0-4627] is used to further assess the spiritual needs of the client/caregiver/family.

5.0 The spiritual counselor provides services to the client and/or caregiver in accordance with the plan of care. Visit frequencies, specified in the plan of care, are determined based on the individualized, assessed needs of the client and/or caregiver.

6.0 Interventions and services provided by the spiritual counselor may include, but are not limited to:

6.1 Assessing the pastoral care needs of clients and/or caregivers;

6.2 Facilitating visits by local clergy, pastoral counselors, or others who can support the client and/or caregiver's spiritual needs;

6.3 Providing counseling to address the spiritual needs of the client and/or caregiver in accordance with their acceptance of the services and in a manner consistent with their beliefs and desires;

6.4 Administering requested sacraments or contacting local clergy to do so;

6.5 Providing inspirational literature or music as requested;

6.6 Praying with the client and/or caregiver as appropriate and if requested;

6.7 Assisting with the planning or conducting of memorial or funeral services;

6.8 Participates in the development of client's bereavement plan of care;

6.9 Serving as a spiritual resource to members of the IDG and members of the community at large as requested;

6.10 Participating in development of approaches to meet staff counseling needs.

7.0 With the IDG, the spiritual needs of the client and/or caregiver are reassessed at a minimum of every 15 days. Changes are reflected in the client's updated plan of care.

8.0 The spiritual counselor documents all care provided in the client's clinical record using [policy 0-4628] in accordance with [policy 0-4816].

9.0 If the client and/or caregiver refuses spiritual care services, no visits are required and the refusal is documented in the client chart. The assigned spiritual counselor continues to offer support to the IDG in its care of the client and to monitor the client and/or caregiver's evolving spiritual needs.

BAYADA
Hospice

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# 0-4562 - SPIRITUAL CARE SERVICES

| | |
|---|---|
| Version: | 4.0 ( 2048 ) |
| Author(s): | KRISTIN BARNUM (2009) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | NHPCO Standards WE17; 1E 17.1; PFC 9; PFC 9.1; PFC 9.2. COP 418.64d(3). CHAP Standard HII.2e (11)(12); HII.2s; HII.4f; HII.5d |
| Revisions: | Feb. 01, 2010; |
| Comments: | |

Exhibit 14

# POSITION DESCRIPTION AND QUALIFICATIONS

BAYADA Hospice
A specialty of BAYADA Home Health Care

POSITION TITLE: **HOSPICE ON-CALL TRIAGE NURSE**

POSITION SUMMARY:

To manage all contact made to the hospice service office from clients, clients' families, referral sources and prospective employees after regular business hours; to triage all client care issues; to coordinate service delivery to hospice clients by on-call field staff; and to maintain record of all "after hours" communication in client's electronic medical record.

SUPERVISED BY: DIRECTOR OR AREA DIRECTOR

MINIMUM QUALIFICATIONS:

1. Exemplifies characteristics of *The BAYADA Way*: compassion, excellence and reliability.
2. Holds a current license in good standing as a Registered Nurse in the state(s) of practice.
3. Graduate of an accredited and approved nursing program as indicated by school transcript or diploma, BSN preferred, and required based on state regulations.
4. Have a minimum of two (2) years of recent, verifiable, related clinical experience, with at least one (1) year in hospice, palliative or home care.
5. Demonstrated record of strong interpersonal skills.
6. Achieves a passing score on the appropriate Nursing exam and all competency tests required for the Hospice Clinical Manager.
7. Completed criminal background and federal/state program exclusions checks.
8. Competence in basic PC skills required to perform job functions.
9. Wonderlic score greater than or equal to twenty four (24).
10. Acceptable results on Profile XT.
11. Ability to read, write and effectively communicate in English.

For exceptions see Office Employee Recruitment and Selection Process, 0-307.

TRAINING AND CERTIFICATIONS:

Within the first three (3) months of employment,

1. Completion of *The BAYADA Way* In-service.
2. Completion of *Welcome to Our New Employees* Training.
3. Completion of in-office Clinical Manager Training.
4. Completion of in-office Client Services Manager Training.
5. Completion of Certified Recruitment Intake Specialist (CRIS) Certification.
6. Completion of Certified Intake Specialist (CIS) Certification.

PRIMARY RESPONSIBILITIES:

1. Demonstrate and communicate the core values of BAYADA Home Health Care and *The BAYADA Way*.
2. Respond to all calls promptly and with outstanding customer service. Professionally represent BAYADA Hospice to all callers.
3. Knowledgeably and successfully handle incoming service inquiries and care coordination calls.
4. Arrange and initiate services for new and readmitted clients.
5. Provide clinical guidance and judgment to field staff to promote understanding of and response to client's needs.
6. Accept incoming telephone calls, or other electronic communication, from patients, family members, caregivers, referral sources or facility staff.
7. Assess any information provided and recommend appropriate nursing interventions.
8. Consult with interdisciplinary team members indicated to determine appropriate interventions and make recommendations.
9. Effectively make staffing changes and replace field staff that cannot make their scheduled hours.
10. Handle complaints and incidents with discretion and good judgment and document accordingly.
11. Deal effectively with emergencies and document accordingly.
12. Answer prospect inquiries and qualify prospects for employment.
13. Maintain long term trusting relationships with clients and staff.
14. Effectively communicate with all parties – client, family, staff, referral source, facility, as appropriate.
15. Document all calls and on-call activity accurately and properly.
16. Complete HCHB workflow as assigned.
17. Accurately report all information to the office staff at the designated time.

18. Contact on-call field staff when a situation requires nursing intervention/visit.
19. Coordinate services specific for hospice (e.g. when client dies, medications, DME, etc)
20. Provide complete, accurate, and timely clinical documentation of on-call activity in the client's electronic medical record; effectively communicate all on-call activity to office staff per the standardized process; provide outstanding customer service to office staff.
21. Demonstrate solid performance or exceed performance standards in key job dimensions/attributes as defined on the Performance Appraisal for Office Staff, 0-3240.
22. Perform related duties, or as required or requested by supervisor.

OTHER RESPONSIBILITIES:

________________________________________

________________________________________

________________________________________

FAIR LABOR STANDARDS ACT STATUS: Exempt from overtime. Employees working in this position must be paid a weekly salary and perform the responsibilities listed above to be exempt from overtime payments.

____________________________ ______________

EMPLOYEE SIGNATURE (optional) DATE

Exhibit 15

BAYADA
Hospice

# 0-4554 LEVELS OF HOSPICE CARE

*This policy was adopted on Feb. 1, 2010.*

***Our Policy:***

BAYADA Hospice offers four levels of care, as provided for by the Medicare Hospice Benefit, to meet the needs of our clients/caregivers.

***Our Procedure:***

## 1.0 **ROUTINE HOME CARE.**

Routine Home Care is provided in the client's residence which may include a skilled nursing facility, assisted living facility or another setting considered the client's home.

## 2.0 **CONTINUOUS CARE.**

Continuous Care is provided during a period of crisis to achieve palliation or management of acute medical symptoms in order to maintain a client at home, and provided on a short term basis.

2.1 A minimum of eight hours during a 24-hour period is provided and includes:

2.1.1 Nursing;

2.1.2 Home Health Aide;

2.1.3 Homemaker; and

2.1.4 Volunteer services.

2.2 One half of the total hours of care provided during each 24-hour period is provided by an RN or LPN.

## 3.0 **INPATIENT RESPITE CARE.**

Inpatient Respite Care is provided in a contracted Medicare/Medicaid-certified hospital or a skilled nursing facility when necessary to provide relief from demands of interventions required for end-of-life care for family members or others caring for the client. This level of care is limited to no more than five consecutive days for each respite stay per benefit period.

24-hour nursing services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care.

## 4.0 <u>GENERAL INPATIENT CARE.</u>

General Inpatient Care is provided under contract in a Medicare/Medicaid Certified hospital or a skilled nursing facility when a client's need for pain or acute or chronic symptom management cannot be managed in other settings and ensures:

4.1 24-hour RN services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care.

4.2 Each client receives all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

4.3 Client areas are designed to preserve the dignity, comfort, and privacy of clients.

4.4 The opportunity for clients to receive visitors at any hour, including infants and small children.

4.5 Criteria for General Inpatient Level of Care:

4.5.1 Pain evaluation to adjust medications and/or determine appropriate treatments;

4.5.2 Intractable or protracted nausea incompatible with management in a home setting;

4.5.3 Respiratory distress unmanageable in a home setting;

4.5.4 Open lesion(s) not responsive to home plan or exacerbating symptoms;

4.5.5 Rapid decline related to varied factors such as bleeding, inconsistent with home management;

4.5.6 Death is imminent and family is unable to cope;

4.5.7 Psychosis, severe confusion, delirium and/or combativeness secondary to end-stage disease process.

4.6 Inpatient Care Limitations: The total number of inpatient days used in a 12-month period by Medicare beneficiaries who elected hospice coverage may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.

5.0 BAYADA utilizes all levels of care and the IDG determines the appropriate level of care for each client based on his or her evolving needs.

6.0 When a client's condition changes and requires a change in level of care, the RN Case Manager notifies the attending physician to obtain an order for the change in level of care and revises the client's plan of care accordingly.

7.0 Members of the IDG providing care to the client are advised of any changes to the client's level of care and documentation is entered into the client chart to ensure continuity of care.

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0-4554 - LEVELS OF HOSPICE CARE

| | |
|---|---|
| Version: | 3.0 ( 1536 ) |
| Author(s): | WEATHERBEE RESOURCES (2009) JOY STOVER, KRISTIN BARNUM (2010) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | CHAP Hospice Standard HII.2a; Medicare Hospice COP 42 CFR 418.108 |

Revisions: Feb. 01, 2010;

Comments:

# Exhibit 16

BAYADA
Hospice

# 0-4568 CLIENT ASSESSMENT - HOSPICE SERVICES

*This policy was adopted on Feb. 1, 2010.*

## *Our Policy:*

BAYADA Hospice Interdisciplinary Group (IDG) conducts and documents a client-specific comprehensive assessment that identified the client's need for hospice care and services, and the client's need for physical, psychosocial, emotional and spiritual care.

## *Our Procedure:*

1.0 An [policy 0-4621] is completed by a hospice Registered Nurse within 48 hours of election of hospice care, unless the physician, client or client representative requests the initial assessment be completed in less than 48 hours. The assessment includes:

   1.1 A description of the client's symptoms;

   1.2 Pertinent medical history, medication and allergy history;

   1.3 Common co-morbid conditions;

   1.4 Pain assessment;

   1.5 Initial Psychosocial/Bereavement assessment.

2.0 A [policy 0-4606] by the IDG in consultation with the client and client's attending physician (if any) must be completed no later than 5 calendar days after the election form is signed.

3.0 The comprehensive assessment includes identification of client/family/caregiver needs related to the terminal illness:

   a. Physical
   b. Psychosocial
   c. Emotional
   d. Cognitive
   e. Spiritual

    f. Nutritional
    g. Functional
    h. Educational
    i. Support and/or counseling

4.0 The comprehensive assessment includes consideration of:

  4.1 Nature and condition causing admission.

  4.2 Complications and risk factors affecting care planning.

  4.3 Functional status, including ability to understand and participate in care and fall risk.

  4.4 Imminence of death.

  4.5 Severity of symptoms.

  4.6 Drug profile, including prescriptions, over-the-counter medications, herbal remedies and alternative treatments which includes identification of:

    4.6.1 Effectiveness of drug therapy.

    4.6.2 Drug side effects.

    4.6.3 Actual/potential drug interactions.

    4.6.4 Duplicate drug therapy.

    4.6.5 Drug therapy related to laboratory monitoring.

  4.7 Initial bereavement assessment of client family's needs focusing on social, spiritual and cultural factors impacting ability to cope with client's death.

  4.8 Need for referrals and further health professional evaluations.

4.9 Ability of client/family/caregiver to self-administer drugs and biologicals in home.

5.0 The [policy 0-4606] includes discipline specific tools that include data elements that allow for measurement of client outcomes.

6.0 The IDG uses information from the comprehensive assessment tools to develop an effective, individualized plan of care with interventions that address identified needs of the client, family and caregivers. See [policy 0-4556]. These additional tools may include, as appropriate:

a. [policy 0-4622]
b. [policy 0-4627]
c. [policy 803]
d. [policy 806]
e. [policy 804]
f. [policy 0-606]

7.0 The hospice IDG reassesses the client's response to care as often as required by the client's condition but no less than every 15 days. Ongoing assessments are documented on discipline specific notes (see [policy 0-4816]) and are discussed at IDG care planning meetings.

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## 0-4568 - CLIENT ASSESSMENT - HOSPICE SERVICES

Version: 3.0 ( 1536 )
Author(s): KRISTIN BARNUM (2009)
Owner:
Manual, Section: HOSPICE MANUAL , POLICIES
References: COP CFR 42 418.54, 418.64c; CHAP Standard HII.2d(1), HII.2f,h; HHII.4.
Revisions: Feb. 01, 2010;
Comments:

Exhibit 17

# 0-4542 BEREAVEMENT CARE PLANNING AND SERVICES

*This policy was adopted on Feb. 1, 2010.*

***Our Policy:***

BAYADA Hospice has an organized program of bereavement services available to the hospice client's family members, caregivers, significant others and to the community at large.

***Our Procedure:***

1.0 BAYADA's bereavement program is under the supervision of a qualified professional with experience or education in grief or loss counseling.

2.0 BAYADA provides bereavement services to the family, caregivers and/or significant others of deceased hospice clients for at least one year following the client's death.

    2.1 These services extend to residents of a Skilled Nursing Facility (SNF)/Nursing Facility (NF) or Intermediate Care Facility for the Mentally Retarded (ICF/MR) when appropriate or identified on the Bereavement Plan of Care.

3.0 Bereavement services are based on the assessed needs of the client's survivors and are in accordance with a Bereavement Plan of Care.

4.0 As part of the [policy 0-4606] of the client, an initial bereavement assessment is conducted to determine the cultural, social and spiritual factors that may impact the ability of family, caregivers and significant others to cope with the client's death.

5.0 The [policy 0-4605] is developed based on the initial bereavement assessment of the patient/family at the time of admission and updated by ongoing assessments of the IDG during provision of care and when the client dies and includes:

    5.1 Client/family grief and/or loss issues;

5.2 Survivor needs;

5.3 Social, spiritual, and cultural issues;

5.4 Services to be provided;

5.5 Referrals to be made;

5.6 Grief risk factors;

5.7 Potential for pathological grief reactions;

5.8 Individual counseling, support groups, letters and cards;

5.9 Frequency of services.

6.0 If the needs of the bereaved are beyond the scope of service provided by BAYADA, referrals are made to appropriate community resources or practitioners.

7.0 Family members, caregivers and significant others of the BAYADA client have the right to refuse bereavement services at any time.

8.0 The initial bereavement assessment, any updates/reassessments, the [policy 0-4542] and [policy 0-4604] are entered into the client chart.

9.0 Evaluation of bereavement services is part of the annual evaluation.

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0-4542 - BEREAVEMENT CARE PLANNING AND SERVICES

| | |
|---|---|
| Version: | 3.0 ( 1536 ) |
| Author(s): | WEATHERBEE CONSULTANTS (2009); JOY STOVER, KRISTIN BARNUM (2009) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | Hospice COP 418.54(c)7; 418.64(d)i; CHAP Standard HII.2s; |

HII.2u; HII.4c(2)l; HII.5d

Revisions: Feb. 01, 2010;

Comments:

# Exhibit 18

# 0-4559 DURABLE MEDICAL EQUIPMENT AND SUPPLIES - HOSPICE SERVICES

*This policy was adopted on Feb. 1, 2010.*

***Our Policy:***

Durable Medical Equipment (DME) and medical supplies needed for the palliation and management of terminal illness and related conditions are provided to BAYADA Hospice clients.

***Our Procedure:***

1.0 All DME and medical supplies are approved by the Interdisciplinary Group (IDG), included in the client's plan of care, and ordered by the client's attending physician when appropriate.

2.0 BAYADA ensures that access to DME and medical supplies is available 24 hours per day, 7 days per week.

3.0 BAYADA educates client, caregivers and families in safe and effective use of DME and supplies.

4.0 The client, family and/or caregiver must demonstrate the appropriate use of DME to the satisfaction of BAYADA staff.

5.0 BAYADA ensures that DME and supplies provided are safe, function as intended and maintained and repaired according to manufacturer or other guidelines. See also [policy 0-1570].

6.0 All equipment hazards, defects and recalls are appropriately addressed and in accordance with [policy 0-744].

7.0 BAYADA will only contract with a medical equipment supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR 424.57. See also [policy 0-664].

SERVICES

Version: 3.0 ( 1536 )

Author(s): WEATHERBEE RESOURCES (2009) JOY STOVER, KRISTIN BARNUM (2009)

Owner:

Manual, Section: HOSPICE MANUAL , POLICIES

References: COP 42 CFR 418.106; CHAP Standard HII.5j; HIII.2e; HIII.2f

Revisions: Feb. 01, 2010;

Comments:

Exhibit 19

# 0-4601 VOLUNTEER SERVICES - HOSPICE

*This policy was adopted on Feb. 1, 2010 and last revised May. 26, 2014.*

***Our Policy:***

BAYADA Hospice uses volunteers in defined roles to support ancillary, administrative and/or client care services. Volunteers are respected, valued, and expected to perform in accordance with relevant BAYADA practices, comparable to its employees.

***Our Procedure:***

## 1.0 ROLE OF THE VOLUNTEER.

See also section 2.6 of [policy 0-4547].

1.1 Qualified volunteers who provide professional services for the hospice must meet all state requirements associated with their specialty area.

1.2 BAYADA volunteers provide assistance in ancillary and office activities as well as direct client care services and/or assistance to clients and families. Volunteer services may include:

a. Providing emotional support to clients/families;
b. Providing personal care to clients;
c. Providing relief to family caregivers;
d. Assisting families with household chores, shopping, and transportation;
e. Companionship;
f. Attending IDG conferences, as appropriate;
g. Reporting response of client/family to BAYADA staff.

## 2.0 VOLUNTEER SELECTION PROCESS.

2.1 When there is an opening for a volunteer position in any of the BAYADA Hospice offices, a standardized procedure is followed.

a. Qualified volunteer applicants are identified through placement of ads in newspapers, the internet, search firms, etc.
b. All volunteer applicants, either by telephone or mailed resumes, are

considered, and all potential volunteers are brought in for an appointment.

c. All volunteer applicants must complete [policy 0-6181] which includes the Agreement of Standards for volunteers
d. No individual will be selected for a volunteer position without having had at least one personal interview.
e. When appropriate, the necessary licensure, registration and/or certification is verified, i.e. nursing licenses, etc.
f. Before any final volunteer selection decision is reached, references are checked, the results of which are documented in the personnel file if selected.
g. If the references are positive and the applicant is selected, he/she will be offered the volunteer position.

### 2.2 References/ Experience Requirements- Field Based Volunteers.

Field based volunteers who provide personal care or skilled services must have at least one year of related work experience and must be able to provide a minimum of two positive, verifiable references (obtained in writing or by phone). A positive reference is defined as follows and attempts should be made to obtain references in the order below:

a. A prior or current work /volunteer reference that confirms dates of employment and indicates satisfactory performance, or, if unobtainable,
b. A prior or current work /volunteer reference that confirms dates of employment and affirms the volunteer is still employed or is eligible for rehire, or if unobtainable,
c. A prior or current work/ volunteer reference verifying dates of employment only AND a personal reference from a non-relative that affirms the prospect's ability to perform home care services, A reference provided by a co-worker is considered a personal reference and must be accompanied by a work reference that includes at a minimum, verification of employment dates.

### 2.3 References/ Experience Requirements- Office Based Volunteers and Home Visitors.

Office based volunteers or home visitors must meet the references/ experience requirements. They must be able to provide a minimum of two positive, verifiable references (obtained in writing or by phone).

a. A prior or current work reference that confirms dates of employment and indicates satisfactory performance, or, if unobtainable,
b. A prior or current work reference that confirms dates of employment and

affirms the volunteer is still employed or is eligible for rehire.

c. If prior work/volunteer references are unobtainable, two personal references are acceptable.

## 3.0 <u>INITIAL PAPERWORK.</u>

### 3.1 Forms to Fill Out.

Before the interview, every volunteer applicant must complete the following documents, which can be found in the Forms manual and in the application packet:

a. Volunteer Application, [policy 0-6181]
b. Skills Checklist (as required for the level of service they provide. See [policy 0-4598])
c. Volunteer Integrity Insurance Coverage Application

### 3.2 Additional Information for Applicant.

Every volunteer applicant also receives the following information to read and retain:

a. BAYADA's mission statement.
b. A statement about BAYADA's standards of service.

## 4.0 <u>INTERVIEW.</u>

Once the initial paperwork is completed, every qualified volunteer applicant has a personal interview with a Volunteer Coordinator, Client Services Manager, Recruiter, Associate or Director. The interviewer:

a. Concentrates on the volunteer applicant's prior work experience and education character, skill and interests
b. Gives information about BAYADA and the volunteer position available
c. Asks the volunteer applicant for schedule and location preferences.
d. Answers any questions the volunteer applicant may have.

## 5.0 <u>WRITTEN EXAMS/SKILL REVIEWS- FIELD BASED VOLUNTEERS.</u>

Prior to providing care independently in the home every volunteer prospect/field volunteer must pass the written examinations for his/her discipline, and as required, undergo review of skills/prior experience and successfully complete all appropriate skills demonstrations. Basic testing (listed below in Table A), may be completed at any point in the volunteer selection process to determine and ensure that the prospect is both qualified for the position and appropriately assigned. Volunteer Nurses and/or Therapist may also be tested for specific competencies (listed below in Table- Section B) during the course of volunteerism, but must qualify meeting specific experiential and educational/training requirements.

5.1 **Written Examinations.**

All testing must be conducted under BAYADA's or designee's supervision with the volunteer prospect achieving the required passing score as noted below. Any missed answers must be reviewed with test taker until 100% mastery of the information is verbally demonstrated. In addition, any learning needs identified through written exams or skills demonstration (s) must be met before the employee is assigned to perform related care or procedure independently. The required exams are:

| **A. BASIC EXAM REQUIRED** | **VOLUNTEER** |
|---|---|
| **All field based volunteer applicants must take and pass the appropriate exam listed in this section with a score of 70% (unless otherwise specified). (*) indicates skills demonstration is also required. See [policy 0-558].** | |
| HHA Written Competency Exam (0-232) | Home Health Aides* |
| Pediatric HHA Competency Exam (0-906) | Pediatric Home Health Aides* |
| Homemaker Quiz (0-297) | Homemakers/Companions who do not provide personal care. |
| Nursing Quiz (3-2085) | All RNs and LPNs to work with adults. |
| Pediatric Nursing Competency Exam (0-1991) ***Passing Score - 80%*** | All RNs and LPNs to work with pediatric clients.* |
| Infant Care Nursing Competency Exam (0-5245 ) ***Passing Score - 80%*** | All RNs and LPNs to work with infants (age birth to 18 months)* |
| MSW Initial Competency Exam (0-911) | All MSWs |
| Registered Dietician Competency Exam (0-935) | All RDs |
| OT Initial Competency Exam (0-901) | All OTs and COTAs |
| PT Initial Competency Exam (0-899) | All PTs and PTAs |
| ST Initial Competency Exam (0-903) | All STs |
| **B. SPECIFIC COMPETENCY EXAMS** | **VOLUNTEER** |
| **Volunteer Nurses and Therapists must meet specific experiential and educational/training requirements to qualify for these exams. See [policy 0-558]. Passing scores that exceed 70% are noted. Specific skills i.e. PT/INR, Glucometer etc. required to care for a client will be assessed prior to being performed in the home by the volunteer.** | |
| Psychiatric Nurse Competency Exam (0-5427) ***Passing Score - 80%*** | All RNs qualified to provide Psychiatric Nursing Services. |
| IV Therapy Test (0-1941) | All RNs and LPNs to work with IVs (including pediatric nurses) |

| | |
|---|---|
| ***Passing Score - 84%***<br>***Passing Score (Chemo) - 100%***<br>***Passing Score (PICC Removal) - 100%*** | |
| Blood Glucose Testing Initial Comp (3-2085) or (0-1991) ***100% Mastery Required*** | All RNs and LPNs who perform these procedures for purposes other than teaching or specimen collection.* (Initial skills testing is required) |
| Blood Glucose and PT/INR Annual Competency Exam (0-3198) ***100% Mastery required*** | All RNs and LPNs who perform these procedures for purposes other than teaching or specimen collection. |
| PT/INR Initial Competency Exam (3-2085) ***100% Mastery required*** | All RNs and LPNs who perform these procedures for purposes other than teaching or specimen collection.* (Initial skills testing is required) |
| Adult Trach Certification Exam (0-2230) ***Passing Score - 85%*** | All RNs and LPNs WITHOUT verified experience to provide care to adult clients with a tracheostomy.* |
| Adult Trach Certification Exam - Short Test (0-2426) ***Passing Score - 85%*** | All RNs and LPNs WITH verified experience to provide care to adult clients with a tracheostomy.* |
| Adult Vent Certification Exam (0-2226) ***Passing Score - 85%*** | All RNs and LPNs WITHOUT verified experience to provide care to adult clients with a mechanical ventilator.* |
| Adult Vent Certification Exam - Short Test (0-2423) ***Passing Score - 85%*** | All RNs and LPNs WITH verified experience to provide care to adult clients with a mechanical ventilator.* |
| Pediatric Trach Certification Exam (0-2232) ***Passing Score - 85%*** | RNs and LPNs WITHOUT verified experience to work with pediatric or infant clients with a tracheostomy.* |
| Pediatric Trach Certification Exam-Short test (0-2432) ***Passing Score - 85%*** | RNs and LPNs WITH verified experience to work with pediatric or infant clients with a tracheostomy.* |
| Pediatric Vent Certification Exam (0-2228) ***Passing Score - 85%*** | RNs and LPNs WITHOUT verified experience to care for pediatric or infant clients with a mechanical ventilator.* |
| Pediatric Vent Certification Exam - Short test (0-2429) ***Passing Score - 85%*** | RNs and LPNs WITH verified experience to care for pediatric or infant clients with a mechanical ventilator.* |
| Tracheostomy Care Exam - Combined for Nurses with Adult and Pediatric Experience (0-3133) ***Passing Score - 85%*** | All RNs and LPNs WITH verified, combined experience to care for both adult and pediatric/infant clients with a tracheostomy.* |
| Ventilator Care Exam - Combined for Nurses with Adult and Pediatric Experience (0-3136) ***Passing Score - 85%*** | All RNs and LPNs WITH verified, combined experience to care for both adult and pediatric/infant clients with a mechanical ventilator.* |

## 6.0 **CONDITIONAL OFFER FOR VOLUNTEER POSITION.**

If the interviewer positively evaluates the volunteer applicant, he/she is given a conditional volunteering offer.

6.1 **Required paperwork.**
The individual is then asked to complete the following forms:

a. Job Placement Medical Questionnaire (as appropriate).
b. Work History Investigation Forms (references, as applicable).
c. RN/LPN Experience Verification Form (as applicable).
d. Agreement of Standards- Volunteers.
e. Criminal Background Check (as applicable per state regulation).
f. Child Abuse Screening (only required if volunteer work is with clients under 18 years old is anticipated and in states where it is applicable).

## 7.0 <u>FINAL EVALUATION / APPROVAL .</u>

An overall evaluation and final approval of the volunteer prospect is made by the Director* to ensure that all qualifications are met. This may be done in collaboration with the volunteer coordinator, Clinical manager, clinical Instructor, and/or Client Services Manager, as needed. The Director reviews the complete application packet including interview write-up, test scores, skills checklist, learning needs, reference responses, and health information. if all requirements are met and the prospect is found to be the most qualified for the position, the Director signs and dates the application as approved. Work is offered to the volunteer, as available. If application was not approved, the prospect is notified either by phone, mail or email.
* Only in the event of the Director's absence, may he/she choose to designate a qualified staff member to conduct the final approval and sign off on the application. However, it is recommended that the Director follow-up and review all volunteer selections made in his/her absence.

## 8.0 <u>VOLUNTEER PERSONNEL RECORD.</u>

There is a volunteer personnel file maintained for every Hospice Volunteer. Included in this are at least the following:

a. [policy 0-6181].
b. Resume (as requested).
c. Documentation of verified references.
d. Honesty and Confidentiality Agreement.
e. Criminal Background Check (if applicable per state regulation).
f. Performance evaluations.
g. Copies of necessary licensure, only when appropriate.

h. Volunteer orientation checklist.
i. Signed Hep B Consent/Declination Form (if appropriate).
j. Miscellaneous materials, i.e. inservice attendance notifications, letters or documentation involving the employee, etc.

## 9.0 **ORIENTATION AND TRAINING.**

Volunteer orientation and training is consistent with the specific tasks that volunteers perform. There is a specific orientation to each case assignment which is completed before a volunteer begins a case assignment.

### 9.1 **Orientation.**

The Orientation process addresses:

a. The goals, services and philosophy of BAYADA and The BAYADA Way;
b. Their duties and responsibilities;
c. The person(s) to whom they report;
d. Who to contact if they need assistance and instructions regarding their duties and responsibilities during office hours and on-call procedures;
e. Confidentiality and protection of client and family rights;
f. Knowledge of advance directive and powers of attorney;
g. Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death and bereavement;
h. Procedures to be followed in an emergency or following the death of the client;
i. Guidance related specifically to individual responsibilities.

### 9.2 **Competency.**

Volunteers will be required to meet the competency requirements for the level of service they provide, i.e. professional/licensed services, personal care services, homemaker services, office/administrative help, etc. See [policy 0-4598].

### 9.3 **Ongoing Training and Continuing Education.**

Training/Continuing Education is provided to BAYADA volunteers and in addition to material covered in 1.1 includes:

a. Knowledge of advance directives and powers of attorney;
b. Communication and documentation skills;
c. Interdisciplinary Group (IDG) approach to care with RN as care coordinator;
d. Physiological, psychosocial and spiritual aspects of terminal care;

e. Protocols to deal with grievances and issues of ethical concern;
f. Respect for cultural diversity and special communication needs;
g. Bereavement care;
h. Family dynamics and crisis management;
i. Concepts of palliative versus curative care;
j. Safety policies and procedures;
k. Establishment of boundaries with client/family/caregiver;
l. Areas of potential conflict of interest;
m. Staff request not to participate in aspects of care when faced with conflicting cultural, ethical or religious beliefs.

## 10.0 <u>ASSIGNMENT AND SUPERVISION OF VOLUNTEERS.</u>

### 10.1 Case Assignment.

Case assignments are based on the field volunteer's qualifications and physical capability to provide care safely to the client, and to respond in an emergency.

10.1.1 The duties of volunteers used in direct client care services or helping clients and families must be reflected in the [policy 0-4616] and [policy 0-4630].

10.1.2 Volunteer activities are documented on [policy 0-4629] to reflect services and time worked.

### 10.2 Supervision of Volunteers.

Volunteers are regularly supervised and services coordinated by a qualified and experienced professional hospice employee.

10.2.1 Supervisory encounters are documented in the clinical record on [policy 0-4620].

10.2.2 Active volunteers receive an annual performance evaluation.

## 11.0 <u>USE OF TEEN VOLUNTEERS.</u>

Refer to state-specific regulations for engaging volunteers under age 18.

### 11.1 Teen Volunteer Requirements.

Teen volunteers must be 14 years of age and entering 9th grade (freshman) to

18 years of age.

11.2 **Initial Paperwork.**
In addition to the initial paperwork listed in section 3.0 above, the teen volunteer must have a parent and/or guardian complete the parental consent section of the [policy 0-6181].

11.3 **Orientation and Training.**
Parent and/or guardian of the teen volunteer must attend Honesty and Confidentiality orientation and training.

11.4 **Assignment and Supervision.**
Teen volunteers providing homemaker/companion services in the client's home must be accompanied by a hospice field clinician and/or an experienced hospice volunteer.

## 12.0 USE OF VOLUNTEERS REDUCES HOSPICE COSTS.

BAYADA documents and maintains a volunteer staff sufficient to provide administrative or direct client care in an amount that, at a minimum, equals 5% of the total client care hours of all paid hospice employees and contract staff. The volume of care provided by volunteers may fluctuate after the required 5% minimum is met.

12.1 Documentation of the cost savings through the use of volunteers includes:

a. Identification of necessary positions which are occupied by volunteers;
b. The work time spent by volunteers occupying those positions;
c. Estimates of the dollar costs which BAYADA would have incurred if paid employees occupied the positions identified in 3.1a above for the amount of time specified in 3.1b above.

## 13.0 RECRUITMENT AND RETENTION OF VOLUNTEERS.

BAYADA has procedures and programs in place for the recruitment and retention of employees and volunteers.

13.1 **Recruitment.**
Hospice Volunteers are recruited in accordance with [policy 37-2388] and [policy 37-2389], with the use of tools and supporting documents available in the Resource Center Recruiting Toolbox.

13.1.1 Surviving family members are encouraged to wait a minimum of one year following a client's death to serve as a direct care volunteer or in public relations activities.

13.2 **Retention.**

Each office will establish a yearly Volunteer Recognition Program. In addition, offices will utilize established retention programs including Years of Service, Employee Newsletters and Token of Appreciation.

13.2.1

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0-4601 - VOLUNTEER SERVICES - HOSPICE

| | |
|---|---|
| Version: | 28.0 ( 14336 ) |
| Author(s): | JOY STOVER, KRISTIN BARNUM (2009); JOY STOVER (2011); SHARON VOGEL, SUZANN TEDROW (2014) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | CHAP HIII.1(m,n), HHIII.1(j); Medicare COP 418.78 (a,b,c,d,e) |
| Revisions: | May. 26, 2014; May. 26, 2014; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Mar. 16, 2011; Mar. 16, 2011; Mar. 16, 2011; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Aug. 13, 2012; Mar. 16, 2011; Mar. 16, 2011; Mar. 16, 2011; Feb. 01, 2010; |
| Comments: | |

# Exhibit 20

# 0-561 CLIENT AND CAREGIVER TEACHING AND EDUCATION

*This policy was adopted on Mar. 1, 1995 and last revised Nov. 24, 2014.*

***Our Standard:***

*We believe our clients come first.*

***Our Policy:***

BAYADA Home Health Care provides client and caregiver teaching to promote adaptation, maintain or improve function, or manage disease progression; whenever appropriate, the educational process is interdisciplinary.

***Our Procedure:***

1.0 The initial and ongoing assessments of the client/caregiver include the collection and analysis of data related to learning needs, preferences, abilities and readiness. The needs of the client and his/her caregiver are identified and prioritized.

2.0 Assessment of client/caregiver teaching needs should include, if appropriate:

  2.1 Cultural or religious practices.
  2.2 Emotional barriers.
  2.3 Desire and motivation to learn.
  2.4 Physical and cognitive limitations.
  2.5 Language barriers. See [policy 37-83].

3.0 After the needs are identified, the licensed clinician provides the client/caregiver with the appropriate instruction. As appropriate, the home care record will contain documentation of client education at the beginning of care, during the course of care, and at the time of discharge. Documentation should include:

  3.1 Education provided to improve the client/caregiver current knowledge.
  3.2 Performance of procedures and education on new information and skills.
  3.3 Completion of applicable teaching checklist.
  3.4 Response to teaching.
  3.5 Follow-up needed.

4.0 **<u>EDUCATIONAL RESOURCES.</u>**

Resources include:

4.1 a. **Clinical Policies and Procedures -** these are easily retrievable from the computer in every office. Clinical Managers/Clinical Rehab Managers/ other clinicians print copies of all relevant materials and bring them to the client's home to help instruct the client, caregiver, and field employees providing care.

b. **Educational and resource materials** - these are maintained at each service office, including information on community resources, referral and social service agencies, support groups, and others as appropriate.

c. **BAYADA' Education Manual** - this can be accessed on line in the web policy file. ***Example: The Client Education Manual*** : *It includes information related to common diagnoses i.e. CHF, COPD, Diabetes and stroke.*

d. The **Basic Home Safety Guide -** this is provided to all clients upon admission. It is designed to educate the client and caregiver on safety in the home environment. The Clinical Manager/Case Manager/Admitting Clinician addresses safety issues particular to the client's home and care needs during admission in conjunction with discussion of this guide.

e. The **Nursing Office Library** - where extensive information on medications, disease processes, treatments and other care issues can be obtained. One example of the resources is: ***Pritchett & Hull's -The Teaching Book,*** a resource that addresses many diseases and the management of them. These client specific teaching tools can be requested for distribution to clients/caregivers.

f. **Inter-office networking -** this can be extremely valuable. Consult with the Nursing Office (NUR) and the Visit Clinical Leadership (VCL) office for names and specialties of clinicians throughout the company for consultation.

g. **Advisory Board members and consultants -** these individuals/groups working with the company are additional resources.

h. **Telehealth-** The BAYADA's Telehealth Manual. See [policy 0-3850].

5.0 Client/caregiver knowledge, learning needs, capabilities, and readiness should be monitored and reassessed at intervals relative to the care and the education provided, as appropriate.

6.0 Any instructions provided to the client/caregiver needs to be accurate, reflective of sound Best Practices, in accordance with doctor's orders, where applicable and any relevant regulatory/accreditation standards.

7.0 The early warning tool [policy 0-6929] is provided to all clients in the Home Health practice at start of care. The disease-specific or system tools may be provided (if applicable) at start of care or whenever appropriate during the episode. A hardcopy of the relevant tool(s) is left in the client's home with a picture of the tool(s) entered into the client's electronic record.

a. [policy 0-5092]

b. [policy 0-5093].

c. [policy 0-5094].
d. [policy 0-5721].

e. [policy 0-5720] must be used in conjunction with [policy 0-5723].

f. [policy 0-5095].

g. [policy 0-5291].
h. [policy 0-5722].
i. [policy 0-5096].
j. [policy 0-6887]
k. [policy 0-6889]
l. [policy 0-6930].

The zone tools linked above are also available in Spanish.

8.0 Instructions that may be presented to the client, as appropriate, include but are not limited to:

8.1 The safe and effective use of medical and if participating in the Telehealth Program, Telemonitoring equipment and/or supplies.
8.2 Potential drug-food interactions and counseling on nutrition intervention and/or modified diets.
8.3 Rehabilitation techniques to facilitate adaptation to and/or functional independence in the environment.
8.4 Basic home safety.
8.5 The storage, handling, and access to medication, supplies and medical gases as appropriate to services provided.
8.6 The identification, handling, and disposal of hazardous materials and wastes in a safe and sanitary manner and in accordance with law and regulations.
8.7 Standard precautions to be taken to prevent and/or control infection.
8.8 Access to available community resources.
8.9 Resources available to meet the client's identified needs.
8.10 An Evacuation Plan and procedures to follow in the event of a natural

disaster or emergency,

8.11 Safeguarding of valuables.

8.12 Pain management and/or symptom management needs (i.e., pain, nausea or dyspnea).

8.13 Signs and symptoms of approaching death, disease process and palliation of symptoms for hospice clients.

8.14 How to respond to symptoms and/or a potential, pending or actual medical emergency.

9.0 The licensed clinician must document in the client chart:

a). assessment of learning needs
b). instruction provided
c). the client/caregiver response to teaching and
d). the completed teaching checklist, as applicable.

10.0 For pediatric offices, see [policy 0-453] regarding use of zone tools.

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0-561 - CLIENT AND CAREGIVER TEACHING AND EDUCATION

Version: 24.0 ( 12288 )

Author(s): SHERRI PILLET (1995); ANNE JOHNSON (2004); JOAN MCDANIEL (2006); BARB COLIN (2008); SANDY FRAGLEASSO (2008); JOAN MCDANIEL (2008); DEB PERIAN (2010); JOAN MCDANIEL (2011); KATHLEEN PFEIFFER (2011); BARBARA COLIN (2011); DEB PERIAN (2014); POL (2014)

Owner:

Manual, Section: ADMINISTRATIVE , GOVERNANCE AND MANAGEMENT

References: Community Health Accreditation Program (CHAP). Home Health Standards. HHI. 5e. 2004 Edition.

Revisions: Nov. 24, 2014; Nov. 24, 2014; Nov. 24, 2014; May. 26, 2014; May. 26, 2014; Feb. 27, 2012; Feb. 27, 2012; Nov. 28, 2011; Nov. 21, 2010; Feb. 01, 2010; Feb. 16, 2009; Feb. 09, 2009; Aug. 14, 2006; Aug. 14, 2006; Jan. 01, 2004; Mar. 01, 1995; Aug. 18, 1997; Aug. 20, 1998; Feb. 22, 1999; Nov. 13, 2000; Jan. 1, 2004

Comments: Conversion

Exhibit 21

# MARYLAND HOSPICE NEED PROJECTIONS FOR TARGET YEAR 2019

| Region | Jurisdiction | Hospice Deaths 2014 | Population Deaths Age 35+ 2014 | Baseline Use Rate 2014 | Compound Annual Growth Rate in Hospice Deaths 2010-2014 | Target Year Capacity 2019 | Gross Need 2019 @ Target Use Rate of 0.473 | Net Need 2019 | Need Recognized Based on Volume Threshold of 359 |
|---|---|---|---|---|---|---|---|---|---|
| Western Maryland | Allegany | 195 | 886 | 0.22 | 0.03 | 231 | 427 | 196 | No |
| | Carroll | 730 | 1,470 | 0.50 | 0.02 | 805 | 722 | (83) | No |
| | Frederick | 735 | 1,611 | 0.46 | 0.11 | 1,259 | 817 | (442) | No |
| | Garrett | 63 | 275 | 0.23 | -0.05 | 48 | 133 | 85 | No |
| | Washington | 817 | 1,441 | 0.57 | 0.16 | 1,727 | 719 | (1,008) | No |
| Central Maryland | Anne Arundel | 1,926 | 3,922 | 0.49 | 0.04 | 2,365 | 1,947 | (418) | No |
| | Baltimore City | 1,434 | 5,707 | 0.25 | 0.01 | 1,522 | 2,756 | 1,233 | Yes |
| | Baltimore Co. | 4,321 | 7,706 | 0.56 | 0.05 | 5,429 | 3,752 | (1,677) | No |
| | Harford | 966 | 1,900 | 0.51 | 0.07 | 1,385 | 935 | (450) | No |
| | Howard | 766 | 1,548 | 0.49 | 0.08 | 1,116 | 791 | (324) | No |
| Montgomery | Montgomery | 2,601 | 5,505 | 0.47 | 0.03 | 2,945 | 2,745 | (200) | No |
| Southern Maryland | Calvert | 223 | 609 | 0.37 | 0.02 | 248 | 304 | 56 | No |
| | Charles | 265 | 914 | 0.29 | 0.02 | 286 | 479 | 192 | No |
| | Prince George's | 1,430 | 5,025 | 0.28 | 0.05 | 1,812 | 2,474 | 662 | Yes |
| | St. Mary's | 338 | 718 | 0.47 | 0.06 | 458 | 378 | (80) | No |
| Eastern Shore | Caroline | 89 | 329 | 0.27 | 0.04 | 108 | 167 | 59 | No |
| | Cecil | 379 | 817 | 0.46 | 0.00 | 374 | 408 | 34 | No |
| | Dorchester | 75 | 381 | 0.20 | 0.05 | 95 | 189 | 94 | No |
| | Kent | 111 | 240 | 0.46 | 0.09 | 173 | 121 | (52) | No |
| | Queen Anne's | 200 | 412 | 0.49 | 0.08 | 291 | 210 | (81) | No |
| | Somerset | 66 | 260 | 0.25 | -0.02 | 59 | 126 | 67 | No |
| | Talbot | 167 | 453 | 0.37 | 0.02 | 188 | 226 | 38 | No |
| | Wicomico | 422 | 914 | 0.46 | 0.06 | 553 | 457 | (96) | No |
| | Worcester | 235 | 588 | 0.40 | 0.03 | 275 | 296 | 20 | No |
| State of Maryland | | 18,554 | 43,631 | 0.43 | 0.05 | 23,199 | 21,640 | (1,560) | |

Sources:
Methodology: COMAR 10.24.13.06
Hospice Deaths: MHCC Annual Hospice Survey
Population Deaths: Maryland Vital Statistics Administration
Target Year Use Rate: MedPAC (2013 Medicare use rate published March 2015)
Household Population Projections: Maryland Department of Planning, January, 2015 series

[16-11-29]

# Exhibit 22

| | 2019 Impact Based on No Change in Utilization Take Market Share from Other Providers | | | | | | 2019 Impact Based on Change in Utilization Increase Market Size | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Patients Served in 2014 | Market Share in 2014 | Market Share in 2019 (with BAYADA) | 2019 Patient Deaths (utilization .261) | Net Vol Growth 2014-2019 | | Patients Served in 2014 | Market Share in 2019 (with BAYADA) | 2019 Patient Deaths with BAYADA's impact on utilization (.2831) | Projected Market Share Impact from BAYADA's Penetration | Net Vol Growth 2014-2019 |
| **Gilchrist Hospice** | 602 | 42.00% | 38% | 586 | (17) | **Gilchrist Hospice** | 602 | 42.00% | 693 | -54 | 37 |
| **Seasons Hospice and Palliative** | 387 | 27.00% | 25% | 376 | (11) | **Seasons Hospice and Palliative** | 387 | 27.00% | 445 | -34 | 24 |
| **Stella Maris Inc Hospice** | 129 | 9.00% | 8% | 125 | (4) | **Stella Maris Inc Hospice** | 129 | 9.00% | 148 | -11 | 8 |
| **Heartland Hospice** | 115 | 8.00% | 7% | 112 | (3) | **Heartland Hospice** | 115 | 8.00% | 132 | -10 | 7 |
| **Joseph Richey** | 72 | 5.00% | 5% | 70 | (2) | **Joseph Richey** | 72 | 5.00% | 82 | -6 | 4 |
| **BAYADA Hospice** | N/A | N/A | 8% | 128 | 128 | **BAYADA Hospice** | N/A | 7.75% | 128 | 0 | 0 |
| **Other** | 129 | 9.00% | 8% | 125 | (4) | **Other** | 129 | 9.00% | 148 | -11 | 8 |
| **Total** | 1434 | 100.00% | 100% | 1,522 | 88 | **Total** | 1434 | 108% | 1650 | | 216 |

# Exhibit 23

# 0-8407 CHARITY CARE - MARYLAND HOSPICE

*This policy was adopted on Oct. 4, 2016.*

***Our Standard:***

*We believe our clients come first.*

***Our Policy:***

BAYADA Hospice provides uncompensated, charity care to our clients with financial hardship and in accordance with Maryland regulation.

***Our Procedure:***

1.0 This policy is in furtherance of [policy 0-3682]. BAYADA Hospice ensures access to hospice services regardless of an individual's ability to pay.

2.0 Upon receiving a request for charity care, BAYADA will make an initial determination of probable eligibility within two business days.

3.0 For clients that do not qualify for full charity care, a sliding fee scale and time payment plans are made available.

4.0 The provision of charity care is tracked in order to demonstrate commitment to achieving a planned annual level of charity care.

5.0 Public notice is disseminated annually regarding BAYADA Hospice's charity care, and notice of the charity care policy is posted in the BAYADA Hospice office and on the website.

---

0-8407 - CHARITY CARE - MARYLAND HOSPICE

| | |
|---|---|
| Version: | Draft ( 0 ) |
| Author(s): | JOY STOVER (2016) |
| Owner: | |
| Manual, Section: | MARYLAND , MEDICARE CERTIFIED POLICIES |
| References: | MD Hospice CON Application requirement for Charity Care. |
| Revisions: | |
| Comments: | |

# Exhibit 24

BAYADA®
Foundation

# The BAYADA Foundation
# Handbook

# The BAYADA Foundation Handbook

## Table of Contents

## Disclaimer

Employment decisions at BAYADA Home Health Care are never impacted by an employee's involvement with The BAYADA Foundation, whether as a donor, fund recipient, or board member.

In order to adhere to IRS guidelines for charitable giving, household financial information must be collected from applicants to determine eligibility for assistance through The BAYADA Foundation. Please make sure to complete the financial section of The BAYADA Foundation Application. The BAYADA Foundation will not approve grant requests for situations not qualifying as an unforeseen hardship in a grant category.

The BAYADA Foundation considers all information regarding financial assistance grants personal and highly confidential. Personal information is sent directly to The Foundation and is never shared outside of The BAYADA Foundation. The grant application process is protected and considered confidential information.

The BAYADA Foundation strives to ensure there are adequate funds available to help employees and clients who may experience hardships. To maintain adequate reserves, total grant amounts may be limited based on the criteria below:

| | **Fund Balance < $10,000** | **Fund Balance between $10,000 -$20,000** | **Fund Balance >$20,000** |
|---|---|---|---|
| **The Client and Employee Emergency Fund** | $250 | $500 | $1,000 |
| **The Hospice Fund** | $250 | $500 | $1,000 |

Certain hospice grants have limits that are less than this and The Foundation will honor those limits accordingly; see individual grants for further details.

Financial assistance through The BAYADA Foundation has a lifetime limit of $1,000.

# Mission

The BAYADA Foundation (The Foundation) is a 501(c)(3) approved non-profit, charitable organization with a purpose to improve the lives of individuals by providing financial assistance during times of a financial hardship. The Foundation will also work to advance education and research that supports care of vulnerable populations. The BAYADA Foundation's Board of Directors (The Board) oversees the organization's operation, reviews all assistance requests and accepts donations on behalf of The Foundation.

The Foundation supports its mission by providing financial assistance through two funds:

### The Employee and Client Emergency Fund (The Emergency Fund)

The Emergency Fund recognizes that all of us experience unforeseen hardships during our life. Any BAYADA employee, client and/or family who has experienced an unexpected, severe hardship(s) may apply for financial assistance through The Emergency Fund.

### The Hospice Fund

The Hospice Fund provides financial assistance for hospice patients and their families who are experiencing financial distress and need help due to the circumstances of their terminal diagnosis. The Hospice Fund awards financial assistance through several grants:

- Individual and Family Assistance Grant
- Funeral and Burial Assistance Grant
- Memorial Service Grant
- Bereavement Activity Grant
- Wish Fulfillment Grant
- Caregiver Transition Grant
- Educational Activity Grant

## Glossary of Key Terms

### BAYADA employees, clients, and families

A BAYADA Employee is defined as an individual currently employed by BAYADA, either per diem, part-time or full-time, in either a service office or support office. To be considered for the grant, the employee must have worked for BAYADA for at least one year. A BAYADA client is a current, active client who is receiving services from at least one BAYADA specialty practice. BAYADA families are the family members of either current BAYADA employees or BAYADA clients.

### The BAYADA Foundation application

The application is used to request financial assistance through either The Emergency Fund or The Hospice Fund.

### Hospice patients/families

A patient who has a terminal diagnosis may or may not be enrolled in BAYADA Hospice. If the applicant is not a patient of a hospice agency (BAYADA or other), the application for assistance must include a letter from the applicant's physician indicating that the applicant has a terminal diagnosis.

### Needy and distressed

An individual who is needy and distressed is temporarily unable to be self-sufficient as a result of an event/occurrence. For The Hospice Fund, financial need must be related to the patient's terminal diagnosis.

### Non-qualifying hardship

A non-qualifying hardship is an event or occurrence that is ineligible for financial assistance through The BAYADA Foundation due to the nature of the event or occurrence.

### Qualifying hardship

A qualifying hardship is an event or occurrence that qualifies an individual to receive assistance from either The Emergency Fund of The Hospice Fund. Qualifying hardships for these funds differ and are outlined as part of the specific fund/grant criteria.

### Unforeseen hardship

An unforeseen hardship is an unexpected, temporary reduction in household income or increase in household expenses due to an explainable event/occurrence that has had a significant impact on the livelihood or well-being of the grant requestor.

## The Emergency Fund

The Emergency Fund provides financial assistance to aid BAYADA employees, clients, and family members who have experienced an unforeseen hardship.

### General criteria

BAYADA employees who submit an application for assistance through The Emergency Fund must be active, current employees of BAYADA Home Health Care. To be considered for the grant, the employee must have worked for BAYADA for at least one year.

BAYADA employees, clients, and family members will be considered for financial assistance grants on a case-by-case basis.

The applicant may request financial assistance only for a qualifying hardship; non-qualifying hardships will not be approved for financial assistance through The Emergency Fund.

| Qualifying Hardship | Non-Qualifying Hardship |
|---|---|
| • Loss or damage to home due to fires, floods, or natural disasters<br>• Medical emergencies/sudden illness<br>• Sudden job loss of household income earner | • Routine home maintenance and auto repairs<br>• Personal or education loans<br>• Credit card payments<br>• Reduction in work hours |

The applicant must exhaust all other community resources prior to seeking funds from The Emergency Fund (see Resources Section of this guide).

Application guidelines

BAYADA employees, clients, and family members may apply for assistance individually or have the application completed on their behalf by a family member or BAYADA employee. Due to federal and state regulations, each fund has separate criteria for the application and acceptance of requests for funding.

The BAYADA Foundation Application should be filled out completely and supporting documentation such as bills should be attached to the submitted application. Examples of additional supporting documentation that may be requested by The Foundation include:

- Bank statements
- Copies of bills
- Proof of income

Note on supporting documentation: If The Foundation receives a submission without supporting documentation, the requestor will be contacted asking for such documentation. Failure to submit required documentation may result in the request being withdrawn from consideration. If the requestor is able to acquire the supporting documentation after it has been withdrawn and wishes to re-submit the request with the required documentation, he/she may do so.

## The Hospice Fund

The Hospice Fund provides financial assistance for terminally ill patients and their families who are "needy and distressed" as defined by the IRS and need help due to the circumstances of their terminal diagnosis.

The Hospice Fund awards financial assistance through seven primary grants: Individual and Family Assistance Grant; Funeral and Burial Assistance Grant; Memorial Service Grant; Bereavement Activity Grant; Wish Fulfillment Grant; Caregiver Transition Grant; and Educational Activity Grant. Each grant has its own specific criteria and maximum allowable assistance amounts.

Since financial assistance is limited to patients and families who are needy and distressed, the application should clearly describe the circumstances around the request and why the family/patient/caregiver is eligible for assistance through The Hospice Fund.

### General criteria

Only a patient who has a terminal diagnosis, regardless of care provider, can apply for assistance through The Hospice Fund. If the applicant is not a patient of a hospice agency, The BAYADA Foundation application must include a letter from the applicant's physician indicating that the applicant has a terminal diagnosis. The Hospice Fund will not cover any expenses related to the terminal illness that are otherwise covered by the hospice benefit for any applicant enrolled in hospice.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund (see Resources Section of this guide).

**Note:** If an application is submitted and the patient dies prior to The Foundation's review, the grant will be declined. If the caregiver is experiencing financial distress related to the terminal diagnosis and death of the patient, an application can be resubmitted with their income and expense information for a Caregiver Transition Grant.

# Individual and Family Assistance Grant

Individual or family assistance grants can be awarded to eligible individuals for qualifying expenses.

### Grant Criteria

General criteria for The Hospice Fund must be met to qualify for this grant.

The maximum allowable assistance through The Hospice Fund for the Individual and Family Assistance Grant is $1,000 or up to three months of household bills, whichever is less. The Foundation reserves the right to award less based on the current balance in the account, as disclosed in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Individual and Family Assistance Grant (see Resources Section of this guide).

### Application guidelines

Since financial assistance is limited to patients and families who are needy and distressed, the application should clearly describe the circumstances around the request and why the family/patient/caregiver is eligible for assistance through The Hospice Fund.

If the hospice or terminally ill patient is residing in a medical facility, grant payments will not be made to the patient or family, but to the facility or appropriate vendor.

Grant checks cannot be made payable to a Power of Attorney (POA) unless complete financial information is provided by the POA, and the applicant meets the IRS' definition of "needy and distressed."

The applicant may request financial assistance only for a qualifying hardship; non-qualifying hardships will not be approved for financial assistance through the fund.

| Qualifying Hardship | Non-Qualifying Hardship |
|---|---|
| ☐ Loss of income due to caregiver responsibilities<br>☐ Increased expenses not otherwise covered due to the patient's terminal illness | ☐ Credit card payments/fees<br>☐ Personal/education loans<br>☐ Medical expenses<br>☐ Insurance premiums<br>☐ Taxes<br>☐ Legal fees |

## Funeral and Burial Assistance Grant

The Funeral and Burial Assistance Grant is available to eligible individuals to assist with funeral and/or burial arrangements for a terminally ill patient.

### Grant criteria

General criteria for The Hospice Fund must be met to qualify for this grant.

The maximum allowable assistance through The Hospice Fund for funeral, burial and/or cremation assistance is $1,000. The Foundation reserves the right to award less based on the current balance in the account as disclosed in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Funeral and Burial Assistance Grant (see Resources Section of this guide).

### Application guidelines

Since financial assistance is limited to patients and families who are needy and distressed, the application should clearly describe the circumstances around the request and why the family/patient/caregiver is eligible for assistance through The Hospice Fund

Grant checks cannot be made payable to a Power of Attorney (POA) unless complete financial information is provided by the POA, and the applicant meets the IRS' definition of "needy and distressed."

## Memorial Service Grants

The Hospice Fund can also be used to support community memorial services. A memorial service is a service remembering the life of someone who has passed and may include activities such as music, prayer, readings, poetry, eulogy honoring the life of the deceased, and a sermon.

### Grant criteria

To be eligible for a Memorial Service Grant from The Hospice Fund, the memorial service must be:

- Distinctly separate from the annual memorial service included in the 13-month bereavement program generally provided by hospice. That is, an individual may not apply for the Memorial Service Grant to help subsidize a hospice-organized, annual community memorial service.
- Open to the general public (and not limited to individuals affiliated with a particular hospice provider)
  —Documentation of a Community Event and Activity Worksheet (page 2 of Foundation application) demonstrating this level of access must be submitted with the grant application.
- Planned and carried out in compliance with applicable laws and regulations

Financial need of the requestor (individual or organization) must be demonstrated and submitted along with the application. Grant requests for memorial services must be submitted at least 45 days prior to the event along with a complete budget with reasonable expenses. This helps to ensure that there is time for any questions or clarifications about the application and provides the applicant with adequate time to secure an alternate source of funding if needed.

The maximum allowable assistance through The Hospice Fund for a Memorial Service Grant is $500. The Foundation reserves the right to award less based on the current balance in the account as outlined in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Memorial Service Grant (see Resources Section of this guide).

### Application guidelines

Applicants must complete The BAYADA Foundation Application and supplemental Community Event and Activity Worksheet.

## Bereavement Activity Grants

The Hospice Fund supports a variety of bereavement activities. Bereavement Activity Grant includes a range of activities related to coping with grief and bereavement following the death of a loved one. Specific examples of bereavement activities include grief support groups, grief support group materials, grief and bereavement books, art and craft therapy activities and supplies, and specialized holiday grief and bereavement activities.

### Grant criteria

To be eligible for a Bereavement Activity Grant from The Hospice Fund, bereavement activities must be:

- Distinctly separate from the bereavement activities included in the 13-month bereavement program generally provided by hospice. That is, an individual may not apply for the Bereavement Activity Grant to help subsidize a hospice-organized, bereavement service or activity.
- Available to the general public (and not limited to individuals affiliated with a particular hospice provider)
  —Documentation of a Community Event and Activity Worksheet (page 2 of Foundation application) demonstrating this level of access must be submitted with the grant application.
- Planned and carried out in compliance with applicable laws and regulations

Financial need of the requestor (individual or organization) must be demonstrated and submitted along with the application. Grant requests for bereavement activities must be submitted at least 45 days prior to the event along with a complete budget with reasonable expenses. This helps to ensure that there is time for any questions or clarifications about the application and provides the applicant with adequate time to secure an alternate source of funding if needed.

The maximum allowable assistance through The Hospice Fund for a Bereavement Activity Grant is $500. The Foundation reserves the right to award less based on the current balance in the account as outlined in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Bereavement Activity Grant (see Resources Section of this guide).

### Application guidelines

Applicants must complete The BAYADA Foundation Application and supplemental Community Event and Activity Worksheet.

## Wish Fulfillment Grant

This grant provides financial aid for terminally ill individuals who are seeking closure through a final wish, but are unable to accomplish that wish due to financial hardship related to the diagnosis.

### Grant Criteria

To be eligible for a Wish Fulfillment Grant from the Hospice Fund, the following criteria must be in place:

- The event must be planned and carried out in compliance with applicable laws and regulations.
- Financial need of the requestor (individual or organization) must be demonstrated and submitted along with the application.

The maximum allowable assistance through The Hospice Fund for a Wish Fulfillment Grant is $1,000. The Foundation reserves the right to award less based on the current balance in the account as outlined in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Wish Fulfillment Grant (see Resources Section of this guide).

### Application guidelines

Applicants must complete The BAYADA Foundation Application and supplemental Community Event and Activity Worksheet.

## Caregiver Transition Grant

This grant provides financial assistance after the death of a patient for individuals who provided care for and/or resided with the patient during the course of the patient's terminal illness and death, and who are experiencing financial distress and are unable to be self-sufficient due to the death of the patient.

### Grant Criteria:

To be eligible for a Caregiver Transition Grant from the Hospice Fund, the following criteria must be in place:

- The hospice patient must be deceased for a caregiver to apply for a Caregiver Transition Grant.
- There must be evidence that funding from The Hospice Fund will provide a financial bridge to financial stability for the grant applicant.
- Caregiver Transition Grant checks cannot be made to the power of attorney unless complete financial information is provided by the power of attorney, and the applicant he/she is determined to be financially needy.

Applicants may request assistance for:
— Household bills
— Personal necessities
— Relocation
— Travel

Grant requests for caregiver transition expenses must be submitted at least 45 days prior to the transition. This helps to ensure that there is time for any questions or clarifications about the application and provides the applicant with adequate time to secure an alternate source of funding if needed.

The maximum allowable assistance through The Hospice Fund for a Caregiver Transition Grant is $500. The Foundation reserves the right to award less based on the current balance in the account as outlined in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Caregiver Transition Grant. (See Resources Section of this guide).

### Application guidelines

Applicants must complete The BAYADA Foundation Application.

## Educational Activity Grant

The Hospice Fund supports educational events that bring increased awareness about hospice services, end-of-life, and caregiving to the community.

### Grant Criteria:

To be eligible for an Educational Activity Grant from The Hospice Fund, educational activities:

- Must be distinctly separate from the general education provided by hospices as part of their marketing or community liaisons' activities. That is, an individual may not apply for the Educational Activity Grant to help subsidize a hospice-organized educational event that will specifically help further the business interests of the hospice.
- Must be open to the general public (and not limited to individuals affiliated with a particular hospice provider)
  —Documentation of a Community Event and Activity Worksheet (page 2 of Foundation application) demonstrating this level of access must be submitted with the grant application.
  —Documentation of a communications plan demonstrating this level of access must be submitted with the grant application.
- Must be planned and carried out in compliance with applicable laws and regulations

Financial need of the requestor (individual or organization) must be demonstrated and submitted along with the application. Grant requests for educational activities must be submitted at least 45 days prior to the event along with a complete budget with reasonable expenses. This helps to ensure that there is time for any questions or clarifications about the application and provides the applicant with adequate time to secure an alternate source of funding if needed.

The maximum allowable assistance through The Hospice Fund for a Bereavement Activity Grant is $500. The Foundation reserves the right to award less based on the current balance in the account as outlined in the disclaimer section of this handbook.

The applicant must exhaust all other community resources prior to seeking funds from The Hospice Fund's Bereavement Activity Grant (see Resources Section of this guide).

### Application guidelines

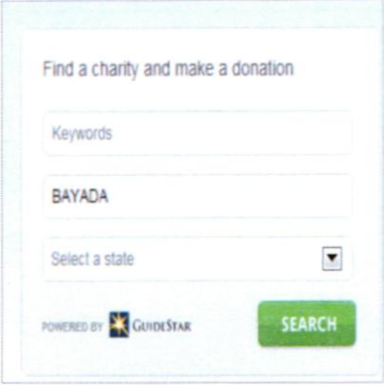
Applicants must complete The BAYADA Foundation Application and supplemental Community Event and Activity Worksheet.

# Donations

The BAYADA Foundation's ability to help those in need is made possible by the generous contributions of our internal BAYADA family of employees and externally by those who have been touched by our hospice services.

There are two primary ways for individuals to make a tax-deductible contribution to The Foundation:

1. **Network for Good:** Potential donors can go to the Network for Good website at www.networkforgood.org and search for BAYADA. This will take them to The BAYADA Foundation's landing page where they can make a donation.



Find a charity and make a donation

Keywords

BAYADA

Select a state

**DONATE**

**Add to Giving Cart**

**I want to contribute:**
$ .00 USD to
($10 USD minimum)

BAYADA FOUNDATION
**1050 Mantua Pike 601 Office Plaza**
**Wenonah NJ**
**08090**
View Full Report on this organization

**Donation Preferences**
● This is a one time donation
○ I would like to make this a recurring donation deducted Monthly

**Please share with this charity:**
● My full contact information
○ My name and email address only
○ None of my personal information (anonymous)

**Designation (Optional)**
To designate your donation for a specific fund or purpose, please enter a description of how you'd like your donation to be used

**Dedication or Gift (Optional)**
To make a donation on behalf of or in memory of another person, please enter the person's name. You will have a chance to send an eCard to this person at the end of making a donation

2. **Personal checks:** Potential donors can also make a personal check out to "The BAYADA Employee Fund" or "The BAYADA Hospice Fund." These checks can be handed in to the service or support office, which should then forward the check immediately to Paul Lindenmuth in the Finance office at:

   BAYADA Home Health Care
   Attn: Paul Lindenmuth
   101 Executive Drive
   Moorestown, NJ 08057

**Note:** due to IRS regulations, any donations made to The BAYADA Foundation through hospice may be used only for hospice grants.

## Acknowledging donations

There are three components for acknowledging a donation:

1. IRS Charitable Contribution tax form
    a. Any donations made through the Network for Good website site will automatically generate an official receipt that can be used for claiming the tax-deductible charitable contribution for the donor.
    b. Donors who make their donations through personal check will receive an official receipt from BAYADA's Finance office via mail using the template included below under "Additional Resources." This will be mailed out within two weeks of the check being received in the FIN office.
2. "Thank You For Your Donation" acknowledgment card
    a. Any donations received either through Network for Good or personal check to The Employee Fund or to The Hospice Fund should be acknowledged by the service office. It is appropriate to send a hand-written card using The BAYADA Foundation Donor Acknowledgement Cards that can be ordered through BAYADA's web store. Offices should mail the thank you out within two weeks of receiving the check.
3. Donation update to hospice families
    a. At times, it may be appropriate to notify the families of former hospice patients that donations have been made on behalf of their loved ones. Under these circumstances, it is appropriate to send a personalized letter informing the family of the donation. Requests for total amounts donated "in memory of" can be sent to Paul Lindenmuth, who can access information from Network for Good and personal checks.
    b. It is not customary to disclose the names of donors who have donated on behalf of hospice patient. If you are ever asked for this information, you can only disclose it if you have received explicit consent from the donor.

## Application and Approval Process

### General process for grant requests

- Applicants must complete The BAYADA Foundation Application.
- Upon receipt of a completed grant application, the applicant will receive notification of the status of the grant application within seven business days.
- The Foundation's Grant Selection Committee will approve or deny grant applications. Committee decisions will be made only by individual(s) not in a position of authority to exert substantial influence over the affairs of BAYADA or the applicant.
- Grant payments are processed once per week with an approved grant application and all necessary documentation.
- Time-sensitive, urgent grant applications will be reviewed on an as-needed basis during regular business hours. All emergency requests will be responded to within a 24-hour period during regular business hours following submission of a complete grant application. Grants will be made payable to the prospective receiver (ie, BAYADA employee, client, family member, hospice patient, funeral home vendor, and any other identified vendor).
- Grant payment will be mailed to the requesting office contact for distribution to the family if not directly mailed.
- Upon receipt of the grant payment, a representative from the office will deliver the grant payment to the grant recipient. A Grant Receipt Form will be included with the grant payment check. When the grant check is received, the grant recipient should sign the form and return it to the BAYADA Foundation. Please note that subsequent grants cannot be made to a grant recipient who has not returned the Grant Receipt Form.
- If the grant payment is made directly to a vendor, receipts or invoices should be submitted for payment as soon as the office receives them.
- Approved grants awaiting payment request information will be held at the Foundation office for up to three months following the grant approval date. If no request for payment has been received within three months, the grant will be closed and the payment will be cancelled.

### Notes about The Emergency Fund

- All grant-related correspondence will be sent to the office director's mail address.
- If a grant application is incomplete, it will be returned to the office director's email with a request for further information. The grant request will be considered "on hold" until the additional information is received. After two months, the grant will be automatically cancelled. Once resubmitted with additional information, the applicant will receive notification of the status of the grant application within seven business days.
- If there is a request is for an emergency grant, the requesting office should complete the grant application for an emergency grant request. However, the office should also call The BAYADA Foundation secretary to alert the Board of Directors of the emergency grant submission.

### Approval process

The Grant Selection Committee will review all requests and submit funding decisions directly to the individual who completed the application.

Grant applications must receive the appropriate approvals prior to submission for grant distribution. The grant approval should be made orally or in writing by the appropriate BAYADA Foundation member. Grant approvals should be recorded in the specified area of the grant application. The grant approvals required are as follows:

Hospice patient physician approval – All grant applications requesting personal care assistance and/or equipment must obtain a letter from the patient's physician stating that the grant request is not related to the hospice diagnosis.

### Application instructions

1. The online application can be found on The BAYADA Foundation website: xxxxx@bayada.com
2. After reviewing the grant guidelines, if you have any questions about the appropriateness of your grant request, please contact our office at xxx-xxx-xxxx or foundation@bayada.com to discuss your potential grant request.
3. You will need to provide a detailed explanation regarding the circumstances causing financial need.
4. You must complete all sections of the grant application and submit the application for it to be received and processed. Incomplete applications will not be considered.

## The BAYADA Foundation Application

See separate attachment

# Community Resources

## Suggested alternate financial resources for funeral and/or burial assistance:

### Federal resources:

- Social Security Office – SSI benefit for surviving spouse and/or dependent
- Veteran's Administration – Individual must have been a U.S. veteran to be eligible for this benefit

### State resources:

- Medicaid/Medical Assistance Program
- State Department of Human Services
- Family Independence Agency (F.I.A.)
- State Anatomy Board

### Local, city, and county resources:

- Local trustee
- Indigent assistance program
- County coroner's office
- County morgue
- Medical anatomy donation programs (through major universities)
- Department of Public Health
- Catholic Charities

## Additional Resources

### Grant Request Fax Cover Sheet

# FAX COVER SHEET

| | |
|---|---|
| To: **BAYADA Foundation** | From: |
| Fax: [Enter BAYADA Foundation fax Number] | Phone: |
| Pages: | Date: |
| Office Loc.: | Office No.: |
| Grant Type Request: | Grant Amount: |

Comments:

Please note that The BAYADA Foundation needs to receive requests no later than Thursday at 12 pm, EST to be processed for a Friday consideration.

## General Donor Acknowledgement/Tax Record

Date

Family Contact Name
Family Contact Address
Family Contact City, State, Zip

On behalf of The BAYADA Foundation, we would like to thank you for your generous gift of [amount donated]. Your commitment to helping those who receive financial assistance from The BAYADA Foundation is sincerely appreciated.

Gifts to The BAYADA Foundation help support a wide variety of community-based services, education, and services to assist individuals and families in time of need.

Please keep this written acknowledgement of your donation for your tax records. Thanks again for your generous support of our efforts.

Cordially,

[Adam or Paul]

## Hospice Donation Acknowledgement for Donors

(sample message for personalized letters)

Date

Family contact name
Address
City, State, Zip

Dear ______ :

On behalf of The BAYADA Foundation, I would like to thank you for your generous gift of $___ in memory of ____. .

We sincerely appreciate your commitment to helping The BAYADA Foundation provide assistance to those who need it. Gifts like yours to The BAYADA Foundation support a wide variety of community-based services and education to help individuals and their families.

Please keep this written acknowledgement of your donation for your tax records.

Thank you again for your generous support of The Foundation's efforts.

Cordially,

Adam C. Groff, MD
President
The BAYADA Foundation

## Hospice Donation Acknowledgement Letter for Families

(sample message for personalized letters)

Date

Family contact name
Address
City, State, Zip

Dear ______ :

The BAYADA Foundation has received a donation of $_____ in memory of ______.

These gifts to The BAYADA Foundation's Hospice Fund support a wide variety of community-based services and education to help terminally ill people and their families.

Thank you for designating The BAYADA Foundation to be the benefactor of these memorials.

Cordially,

Adam C. Groff, MD
President
The BAYADA Foundation

Name
Director
BAYADA Hospice (office)

## Contact Information

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# Exhibit 25

CHAP
MMUNITY HEALTH ACCREDITATION PROGRAM
1275 K Street, NW • Suite 800 • Washington, DC 20005 • tel: 202.862.3413 • fax: 202.862.3419 • www.chapinc.org

October 17, 2014

Ms. Joy Stover
Associate Director, Policy and Accreditation Support
BAYADA Home Health Care, Inc
1555 Bustard Road, Suite 200
Lansdale, PA 19446

RE: Accreditation for: **CORE**
**Home Health**
**Hospice**
**Private Duty**

Location and/or Site(s) Accredited:
BAYADA Home Health Care, Inc
290 Chester Avenue
Moorestown, NJ 08057

**Site Visit Dates:** **September 8, 2014 — September 11, 2014**
**Accreditation Visit Type:** **Renewal**
**Accreditation Decision:** **Accreditation Without Required Action**
**Plan of Correction Accepted Date:** **N/A**
**Accreditation Dates:** **October 10, 2014 — October 9, 2017**

Dear Ms. Stover:

I am pleased to inform you that based on the findings of the site visit conducted at the location (s) and for the service referenced above, your organization is in compliance with the CHAP Standards of Excellence. The CHAP Board of Review has granted Accreditation to your organization for the term of three (3) years.

The continuation in good standing of this Accreditation is dependent upon the organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement. The Accreditation Services Agreement will be renewed every three (3) years.

Please note that CHAP may conduct surveys less than every three years depending upon CMS regulations and/or the level of deficiencies.

As a CHAP accredited agency, you are required to provide our toll free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accrediting organization! Please contact me at 202-862-3413 if you have any questions.

Sincerely,

Taniesha Wise
Customer Relations Representative

# Certificate of Licensure

INPATIENT BEDS #:0

LICENSE #: 17411601

**TO OPERATE A HEALTH CARE FACILITY**

**This is to certify that**

BAYADA HOME HEALTH CARE, INC. D/B/A BAYADA HOSPICE

Is hereby granted this license to conduct and maintain a health facility conducted as a Hospice at One Media Plaza Suite 302, 1023 E Baltimore Pike, Media, PA. This license shall be effective from June 1, 2016 until May 31, 2017 in accordance with law.

Christine C. Filipovich, MSN, RN

*Christine C. Filipovich, MSN, RN*
*Deputy Secretary For Quality Assurance*

Karen M. Murphy, PhD, RN

*Karen M. Murphy, PhD, RN*
*Secretary of Health*

pennsylvania
DEPARTMENT OF HEALTH

**NOTE: This license must be posted in a conspicuous place on the premises.**

**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**Centers for Medicare & Medicaid Services**
Suite 216, The Public Ledger Building
150 S. Independence Mall, West
Philadelphia, PA 19106-3413

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

**Northeast Consortium/ Division of Survey & Certification**

November 28, 2011

Linda Trout, Administrator
Bayada Hospice
One Media Plaza, Suite 302
1023 East Baltimore Pike
Media, PA 19063

Dear Administrator:

CMS Certification Number: 391741

We have received notice of your accreditation by the Community Health Accreditation Program (CHAP) and your application for participation under the Health Insurance for the Aged Program (Title XVIII of the Social Security Act). Based upon your accreditation by CHAP, your agency is deemed to meet the Medicare requirements for participation as a hospice, and your request for participation has been approved. Your effective date of participation is September 7, 2011. Enclosed is one copy of the completed agreement (CMS-1561) for your records.

You have been assigned the CMS certification number shown above. When you make general inquiries to your Medicare Administrative Contractor (MAC), you will be prompted to give either your provider transaction access number (PTAN) or CCN. These identification numbers are used as authentication elements when inquiring about beneficiary and claim specific information. When prompted for your PTAN, give your CCN.

CGS will serve as your MAC. They will contact you shortly regarding billing procedures.

Please note that the addition of satellite offices must be approved by both the State survey agency and your MAC prior to receiving approval from CMS. Please contact both your State survey agency and your MAC regarding any proposed satellite offices, or the deletion or relocation of any existing satellite offices.

Your participation in the Federal Health Insurance Program is contingent upon compliance with federal civil rights requirements as determined by the Office for Civil Rights (OCR). If OCR determines that your facility does not comply with these requirements, your Medicare agreement would be invalidated, and Medicare reimbursement dating from your initial date of certification could be recouped.

We welcome your participation and look forward to working with you on a continuing basis in the administration of the Medicare Program.

Sincerely,

Timothy J. Hock, Manager
Certification and Enforcement Branch

Exhibit 26

# 2016 BAYADA Hospice Division Quality Assurance and Performance Improvement Plan

BAYADA Hospice is dedicated to supporting patients with terminal illness as well as their families. Our mission is to preserve each patient's dignity and to alleviate the fear associated with dying through pain control, comfort care and symptom management. To help fulfill this mission each BAYADA Hospice conducts an ongoing, comprehensive, integrated, self-assessment of quality and the appropriateness of care provided, as well as evaluating management systems and the identification of best practices. Special attention is given to the evaluation of the ability of the hospice to deal with symptom management, pain control, stress management, continuity of care and inpatient care. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary. Our Quality Assurance and Performance Improvement (QAPI) Program is based on current quality improvement practice and the quality assurance guidelines published by the Centers for Medicare and Medical (CMS) for Quality Assurance and Performance Improvement (QAPI). The program consists of quality and performance improvement activities that are designed to maintain and improve the quality of care and management while meeting licensing and regulatory requirements, e.g. state hospice licensure regulations, OSHA regulations and Medicare Conditions of Participation.

## The overall goals of the QAPI Program are:

I. Program Scope § 418.58(a) (1-2)
- Measure, Analyze, and Track Operations
- Measurably improve palliative outcomes and EOL support

II. Program Data § 418.58(b) (1-3)
- Drive QAPI with data
- Monitor and ID opportunities for improvement
- Timing and detail determined by governing body

III. QAPI: Program activities § 418.58(c) (1-3)
- Focus on high risk, high volume, problem prone areas
- Consider incidence, prevalence, severity
- Address & prevent adverse events
- Improve & monitor over time

IV. Performance Improvement Projects § 418.58(d) (1-2)
- Reflect scope and complexity of hospice
- Document what, why and how successful

V. Executive responsibilities § 418.58(e) (1-3)

- Define, implement, and maintain QAPI
- Address quality and patient safety…

## Assignment of Responsibility

The Governing Body representatives of the BAYADA Hospice Practice have oversight responsibility for the quality and effectiveness of the services provided by each Hospice.

The Hospice Director/Associate Director has the responsibility for the administration of the Quality Assurance and Performance Improvement Program including the following activities:

1. Appoint the QA and Performance Improvement Committee chair.
2. Oversee the timely performance of the activities listed in the QA and Performance Improvement Plan.
3. Perform additional or more frequent QA and Performance Improvement activities depending on the needs of the Hospice.
4. Develop, implement and oversee the systems necessary to improve or maintain quality patient care and effective management processes.
5. Submit QAPI meeting minutes monthly to the Division Director or designee.

The QA and Performance Improvement Committee works under the authority of the Hospice Practice Leader and has the responsibility to follow the QA and Performance Improvement Plan, analyze data generated through executing the QAPI plan and develop plans of action.

The Division Director of Clinical Operations and the Practice Quality Committee review data from each hospice for comparison and assists in analyzing trends and identifying best practices.

## QA and Performance Improvement Approach

This organization collects data on important processes or outcomes related to patient care, patient/client satisfaction, risk areas and management functions. Important processes are measured on a continuing basis. BAYADA Hospice employs a two-stage ongoing quality improvement approach to evaluate this data and implement plans for remediation and/or improvement.

### Stage I - Outcome Analysis

Data collection, analysis and trending for an indicator or target outcome. Data is collected according to specific indicator guides and tracked based on the frequency outlined in the BAYADA Quality Assurance and Performance Improvement Calendar.

### Stage II – Outcome Enhancement

Implementation of a performance improvement plan aimed at correcting substandard results or reinforcing exemplary practices. The plan of action is developed through interpreting outcomes and results, selecting target outcomes for follow up, determining which key processes or practices influence these target outcomes, developing a plan and implementing that plan. The second stage feeds back to Stage I the next time the indicator is monitored or an outcome report is received.

***Our QAPI Plan considers five functional areas:***

- People
- Service
- Quality
- Growth
- Finance

## Target Areas Monitored Under Each Domain

(Responsibility for tracking TBD either Divisional or local, frequency of reporting for each domain will also be determined-annual, quarterly, monthly)

**People:**

- Human Resource Practices
- Staff Retention
- Employee Satisfaction Surveys
- Home Office field retention
- On boarding Practices
- Management of Injured
- Employee Staff Education

**Service:**

- Client Satisfaction Surveys
- Patient Incident & Complaints/Events
- Compliance Program
- HIS
- Cahps

**Quality: (10% monthly review of clinical record)**

- Symptom Management
- Pain Control
- Continuity of Care
- Levels of Care
- Coordination of Care with Nursing Facilities
- Comprehensive Assessment

- Care Planning/Coordination
- Documentation Processes
- Clinical Oversight
- Staff Education
- Staff Competency
- Infection Control
- OSHA/Safety Education
- Internal clinical audit

**Growth:**
- Year over Year Revenue
- Year over Year Admission Growth
- Live Discharge/Revocation
- Referral management
- Length of Stay

**Finance:**
- Gross Profit percentage
- Operating Income percentage
- Billing and AR Processes
- AP Management
- Pay practice
- ADR and Pre pay probe processes
- Expense Management
- Budget development and Management
- Internal Operations audit

## Identification of Indicators and Other Issues for Monitoring

Each year a Practice wide Master QAPI Calendar containing scheduled indicators is developed in consultation with the Practice Leader, Directors, Clinical Managers and Hospice staff and distributed by the Division Director of Clinical Operations.

The Corporate QAPI Committee will review the calendar quarterly to make necessary adjustments to meet organizational needs. The Hospice may choose to perform more frequent or additional Performance Improvement activities/projects. The data collection process utilizes available reports and tools and analyzes data using systematic and appropriate statistical techniques. The indicators and monitoring issues are represented by one of the five domains and one of the target areas listed that domain.

## Development of Appropriate Indicators and Thresholds

After an important aspect of practice or area of risk is identified, indicators are developed to assist in the monitoring and evaluation of that practice or risk area. Indicators are either structural, process or outcome in nature. For each indicator developed, a threshold or performance target will be established to assist in the identification of potential problems and promotion of best practices.

## (Branch)Quality Assurance and Performance Improvement Committee

The QAPI Committee is responsible to review and / or gather, analyze data and formulates and implements remediation and maintenance plans in accordance with the BAYADA Quality Assurance Performance Improvement Plan. The QAPI plan is reflective of the local hospice data.

1. The QAPI committee is led by a chairperson and composed of members from clinical, management, marketing and support staff.
2. Clinical staff and contractors are expected to participate on the committee or in the QAPI activities.
3. Quality Assurance and Performance Improvement committee findings and minutes are prepared and presented to the Hospice's Quality Assurance and Performance Improvement Committee and stored in the Hospice's Quality Assurance and Performance Improvement Manual.
4. The committee chair or is responsible for appointing a performance improvement team, hold meetings, maintaining the Quality Assurance and Performance Improvement Manual, preparing and completing minutes that ensure that indicators are monitored and analyzed according to plan.

    - QAPI meetings will be scheduled monthly (third week of each month) at the local level at least quarterly with the Medical Director attending.
    - Will report quarterly or per individual state requirement to the Governing Body.

5. The committee utilizes Performance improvement teams to further analyze, identified problems and to ensure they are brought to acceptable threshold / resolution.
6. Reports will be forwarded to the Practice level QAPI committee by the last week of the month.

## Practice Quality Assurance and Performance Improvement Committee

The Practice QAPI Committee is responsible to review and / or gather, analyze data and formulate and implement remediation and maintenance plans in accordance with the BAYADA Quality Assurance Performance Improvement Plan.

1. The QAPI committee is led by the Division Director of Clinical Operations and composed of member's management, Support and medical staff, contractor appointees may also be appointed as determined by the committee.
2. Quality Assurance and Performance Improvement committee findings and minutes are prepared and presented to the Practice Leader of BAYADA Hospice and stored in the Hospice's Quality Assurance and Performance Improvement Manual.

3. The committee chair is responsible for appointing a performance improvement team, holding meetings, maintaining the Quality Assurance and Performance Improvement Manual, preparing and completing minutes that ensure that indicators are monitored and analyzed according to plan.
4. QAPI meetings will be scheduled the last week of each month and will review the local hospice QAPI reports, as well as the practice level plan
5. Will report quarterly to Hospice Practice leader and Governing Body
6. The committee utilizes Performance improvement teams to further analyze, identified problems and to ensure they are brought to acceptable threshold / resolution.
7. The Practice Leader will be responsible for the communication reporting, obtaining feedback and acceptance of the plan from the Governing Body.

## Staff and Contractor's Responsibility

All staff of BAYADA Hospice (full and part time) as well as all contracted individuals performing services on behalf of BAYADA are expected to participate in QAPI activities carried out by the Hospice. Moreover, staff and contracted individuals will be invited to participate in various QAPI activities.

## Outcome Analysis and Enhancement

When the data collected for an indicator is not consistent with an established threshold, an evaluation of the data is conducted using the process outlined below or other advanced problem solving methodology.

The Director and/or the QAPI Committee may establish or act as an action team to address specific services or areas of focus following this process.

1. **Select** a Target Outcome
2. **Conduct** a Process Investigation to examine and analyze the processes that produced the target outcome results.
3. **Document** a Problem or Strength Statement that simply states the specific problem or exemplary care/management issue to be addressed by the Plan of Action. The issue must be within the hospice's control. Avoid focusing patient care issues primarily on documentation.
4. **Formulate and Implement a written Plan of Action for remediation or reinforcement** that includes the intervention or actions that are needed to guide the staff in best practice, to implement change and/or learn a new skill or process. The action statements include the start/finish times for each specific intervention and the person(s) responsible for seeing that the specific activity is carried out.
5. **Monitor Outcomes (Implement 4dx principles)** to determine if the staff is following best practices, implementing the changes presented or has learned the presented

material. It is critical that monitoring approaches begin shortly after implementation of the intervention (e.g., within two to four weeks) and include plans to inform the staff. Monitoring may involve interview, observation or focused review. Document the effectiveness of actions in the Quality Assurance and Performance Improvement Committee Minutes

## Resolution of Identified Critical Thresholds

When QA data identifies an unsatisfactory aspect of care/service that the QAPI committee deems critical, the Director is immediately notified. The Director may call an ad hoc QAPI meeting or implement other action to address the issue. Follow up evaluation will be conducted to ensure effective resolution and will be presented at the next regularly scheduled Quality Assurance and Performance Improvement Committee meeting.

## Annual Appraisal of the BAYADA Plan and System

Annually the Hospice's Quality Assurance and Performance Improvement Plan is assessed for effectiveness and consistency. The results of the review including problems identified and actions taken are documented in an annual evaluation and reported to the Governing Body Representatives. The Annual plan will be completed prior to the second quarter of the following year.

## Confidentiality

The information related to Quality Assurance and Performance Improvement activities is collected and analyzed in a manner consistent with existing policy and Health Insurance Portability and Accountability Act (HIPAA) regulations. Since all patient identifiable information contained in the clinical record is considered confidential, the identity of the patient is protected by use of an MR number or other system to safeguard the information. In addition information generated through Quality Assurance and Performance Improvement activities is stored in areas outside of public access or view.

# Exhibit 27

BAYADA
Hospice

# 0-4538 INTERDISCIPLINARY GROUP

*This policy was adopted on Feb. 1, 2010 and last revised Mar. 16, 2011.*

## *Our Policy:*

The Governing Body of BAYADA Hospice designates an Interdisciplinary Group (IDG) composed of qualified individuals who assess, plan, coordinate, provide and evaluate the care and services provided to hospice clients/caregivers.

## *Our Procedure:*

### 1.0 INTERDISCIPLINARY GROUP MEMBERSHIP.

1.1 The IDG membership includes employees who are qualified and competent to practice in the following professional roles:

a. Doctor of Medicine or Osteopathy (may be contract)
b. Registered Nurse
c. Social Worker
d. Pastoral or other counselor
e. Bereavement Coordinator/Specialist

1.2 Additional members of the IDG may include:

a. Physical Therapist
b. Occupational Therapist
c. Speech Language Therapist/Audiologist
d. Dietitian
e. Pharmacist
f. Licensed Practical Nurse
g. Home Health Aide/Homemaker
h. Volunteer
i. Representative from a contracted facility

### 2.0 RESPONSIBILITIES OF THE INTERDISCIPLINARY GROUP.

2.1 Establishing, implementing, reviewing and revising the client's plan of care.

2.2 Directing, coordinating and supervising hospice care and services.

3.0 A registered nurse member of the IDG is designated to manage care for each client/caregiver. The RN under physician orders and in coordination with all members of the IDG is responsible for coordinating the care and services provided and implementing the interdisciplinary plan of care.

## 4.0 INTERDISCIPLINARY GROUP CONFERENCE.

The focus of the IDG conference is to plan and coordinate the care and services provided to BAYADA clients and their caregivers.

4.1 The IDG reviews each client's plan of care at least every 15 days, or more frequently as needed, in order to continually monitor the care and services provided to the client and the client's continued eligibility for hospice care.

4.2 The IDG reviews and updates the client's plan of care and changes are communicated to the client's attending physician with requests for new orders when needed.

4.3 The IDG conferences include:

a. Review new referrals
b. Identify obstacles to and solutions for access of care issues
c. Review new admissions
d. Determine appropriate level of services required, evaluate current level of service effectiveness
e. Develop/review/modify individual plans of care including: Change in status, special needs of patient/family
f. Plan of care oversight by Medical Director or Physician designee
g. Evaluate re-certification based on local LCD policy
h. Evaluate level of care and plan for change in level planning
i. Evaluate progress toward achievement of expected outcomes, revising goals as needed
j. Evaluate pharmacotherapeutic effectiveness of symptom management outcomes including pharmacodynamics,

pharmacokinetics and pharmacotherapies

k. Integrate alternative therapies into medical regime as appropriate
l. Ongoing bereavement plan of care development including risk changes for pathological grief
m. Review pending discharges other than death
n. Review deaths to address bereavement need
o. Assess grievances and issues of ethical concerns
p. Assist with transfer and/or revocation of benefit

4.4 Minutes of each IDG conference are kept, and any update or revision to a client's plan of care is entered into the client chart.

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0-4538 - INTERDISCIPLINARY GROUP

| | |
|---|---|
| Version: | 9.0 ( 4608 ) |
| Author(s): | WEATHERBEE RESOURCES (2009); KRISTIN BARNUM; JOY STOVER (2010) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | Hospice COP 42 CFR 418.68; CHAP Hospice Standard HI.2f,g,h |
| Revisions: | Mar. 16, 2011; Mar. 16, 2011; Feb. 01, 2011; Feb. 01, 2010; Mar. 16, 2011; Mar. 16, 2011; Feb. 01, 2011; Feb. 01, 2010; Feb. 01, 2010; |
| Comments: | |

Exhibit 28

# 0-4816 CHART DATA REQUIREMENTS AND FORMAT - HOSPICE

*This policy was adopted on Feb. 1, 2010 and last revised Jan. 1, 2011.*

### *Our Standard:*

*We provide home health care to our clients with the highest professional, ethical, and safety standards.*

### *Our Policy:*

BAYADA Hospice maintains a complete client chart for every client receiving hospice services.

### *Our Procedure:*

## 1.0 CHART ENTRY PROCEDURES.

1.1 All chart contents must be entered into the client's office chart or electronic record within at least 15 days of receipt by the service office.

1.2 Chart contents should be filed in date order with the most recent note/form on top.

1.3 Each entry is signed, including title and credential, by the person providing the care/services. Electronic Signatures are permitted when applicable.

1.4 Each client record will contain the content and information found in the forms listed below, either in paper form as listed below or in comparable entry fields in the electronic system.

## 2.0 ADMINISTRATIVE.

2.1 [policy 0-5449] will be completed in the service office at the time of referral and entered into the chart along with **additional information from the referral source** and including:

- a. Name, address and phone number of contact person for emergencies and/or notification of death.
- b. Pertinent medical history.

c. Family/caregiver demographics.
d. Bereavement contact information.
e. Funeral Home Contact Information

2.2 The [policy 0-4589] which includes:

a. Consent to Services
b. Verification of notification of Client Rights, Complaint Procedure Process, and receipt of information regarding Advance Directive, Emergency Planning, Home Safety and Drug Disposal.
c. Notification of Financial Liability
d. Financial Agreement
e. Election of Medicare Hospice Benefit

2.3 [policy 0-4592] and [policy 0-4602] when applicable.

2.4 A copy of [policy 0-4823] signed by the client.

2.5 [policy 37-141]

2.6 [policy 0-3195]

2.7 [policy 0-4618]

2.8 [policy 0-4580]

2.9 **State-specific Regulatory Forms**

2.10 **Insurance Verification**

## 3.0 PHYSICIAN ORDERS.

3.1 The [policy 0-927] is our physician's orders and the documentation of the hospice care plan process for the care and services to be provided. It includes but is not limited to, the following information:

a. Name of client.
b. Name of client's attending physician.
c. The terminal and secondary diagnoses at admission.
d. Client history relevant to services provided and presenting problems.

e. Description of functional limitations and activity restrictions to be taken into consideration in providing care.
f. Client allergies.
g. Medications-drug name, dosage, frequency, route, and indication for use for "PRN" orders.
h. Treatment orders including: type, frequency, medications, supplies, equipment, relevant pressure settings, special instructions related to equipment set-up, if applicable.
i. Telemonitoring services.
j. Level, frequency and duration of services to be provided.
k. Diet and dietary restrictions.
l. Do-not-resuscitate orders, if any, documented and signed by the client's physician in accordance with applicable law and regulation.
m. Safety measures.
n. Client goals related to the problem list.
o. Discharge plans.

3.2 [policy 0-300] include at least the following information:

a. Client name and number.
b. Physician name and phone number.
c. Dated order, including diagnosis.
d. For any new problems, you must include the problem and goal pertaining to current order.
e. Nurse's signature.
f. Physician's signature.
g. All medication orders must be updated on the medication profile.

## 4.0 **HOSPICE SERVICES.**

4.1 [policy 0-4621]

4.2 When applicable to a specific client, the following will be included in the chart:

a. [policy 0-4622]
b. [policy 0-4606]
c. [policy 803]
d. [policy 806]
e. [policy 804]
f. [policy 0-4627]

## 4.3 **INTERDISCIPLINARY GROUP (IDG).**

a. [policy 0-4616]
b. [policy 0-4623]

## 4.4 **MEDICAL DIRECTOR.**

[policy 0-4866]

## 4.5 **NURSING.**

[policy 0-4620] or [policy 0-919] and [policy 786] are found in the Hospice Services Chart. [policy 0-921] will also be filed here in date order. Nursing documentation should include the following information:

a. Physical and psychosocial signs and symptoms.
b. The care and services provided and/or PRN medications administered. (PRN medications must also be documented on the Medication Record (form #755).
c. Any new service or treatment initiated.
d. Response to services and medications.
e. Ongoing documentation of identified problems and any changes in client's status.
f. Documentation of client and caregiver education.
g. Referrals to internal or external care providers and to community services, such as Meals On Wheels. Referrals may also be documented on a [policy 786]
h. Progress towards goals.
i. Date services were provided and signature with title.

## 4.6 **THERAPY.**

[policy 0-3168], [policy 0-3139], [policy 0-3167], with [policy 786] as applicable to discipline of service provided.

## 4.7 **PSYCHOSOCIAL.**

a. [policy 0-5242].
b. [policy 0-5243].

## 4.8 **HOSPICE AIDE.**

[policy 126] for adult clients or [policy 0-483] for pediatric clients is found in the client chart. It will include, but is not limited to, the following:

a. Client identification information.
b. Instructions for plan of care given by Clinical Manager.
c. Level, frequency, and duration of services.
d. Evidence of client/caregiver participation in planning.
e. Goals.
f. Emergency contact numbers.
g. Safety Instruction.
h. Infection Control Instruction.
i. Priority Level

[policy 0-930] for adult clients or [policy 0-468] for pediatric clients includes, but is not limited to:

a. Tasks or treatments performed by the home health aide per day, per week as directed by the RN on the Home Health Aide Care Plan.
b. Observations made by the employee of changes regarding client's condition, progress, and response to treatments.
c. Date and signature of home health aide.
d. Signature(s) or client/caregiver

### 4.9 **VOLUNTEER.**

[policy 0-4630]
[policy 0-4629]

### 4.10 **DISCHARGE.**

a. [policy 0-4609].
b. [policy 0-4625].
c. [policy 0-4607].

a. Live Discharge per [policy 0-2003].

## 5.0 **MEDICATIONS.**

5.1 [policy 0-4619] is used when we are assessing, monitoring and teaching medications in the home. (If the nurse is administering medications on a visit, administration of the medication is documented in the clinical note.) It provides a medication history to the field nurse, as well, and includes the following information:

a. Notation of medications (prescribed and over-the- counter) currently used by the client, including dose, frequency, and route.
b. Start Date - the date the client began taking the medication, or if unknown the client may estimate the date. If neither is possible, the date the client is admitted for services may be used.
c. Known allergies.
d. Drug Classification.
e. Initials.
f. Clients must have an accurate and up-to-date medication list in the home chart.

5.1.1

5.2 [policy 0-2141] is used in conjunction with the Medication Profile. It is to be used by the Nurse to identify the class, side effects, and contraindications/interactions of the medications. It can also be used as a reference tool for client teaching. A copy should be kept in the office and home/travel chart.

## 6.0 <u>OTHER.</u>

a. Documentation of services, coordination of services and communication with respective vendors, labs, etc.
b. Special reports.
c. Supply order forms.

## 7.0 <u>BEREAVEMENT.</u>

7.1 [policy 0-4605]
[policy 0-4604]

## 8.0 <u>STATE/PRACTICE SPECIFIC AMENDMENT.</u>

### 8.1 NJ Hospice.

8.1.1 Client progress notes must be written, signed, and dated by field staff providing care, within 48 hours of the provision of care. This is accomplished by synching the Homecare Homebase point of care device.

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## 0-4816 - CHART DATA REQUIREMENTS AND FORMAT - HOSPICE

Version: 8.0 ( 4096 )

Author(s): JOY STOVER; KRISTIN BARNUM (2010)

Owner:

Manual, Section: HOSPICE MANUAL , POLICIES

References: CHAP HII.6; COP 418.22, 418.104; NJAC 8:42C - 6.3 (a)(9).

Revisions: Jan. 01, 2011; Jan. 01, 2011; Jan. 01, 2011; Jan. 01, 2011; Jan. 01, 2011; Jan. 01, 2011; Jan. 01, 2011; Feb. 01, 2010;

Comments:

Exhibit 29

BAYADA
Hospice

# 0-5450 CHART FORMAT AND CHECKLIST - HOSPICE

*This policy was adopted on Jan. 1, 2011.*

## *Our Policy:*

A standardized format is used in the office client chart for documenting care and service provided to clients.

## *Our Procedure:*

1.0 All chart contents must be entered into the client's office chart within at least 15 days of receipt in the service office.

2.0 Office client chart will be divided into the following sections:

2.1 **Administrative.**

_____Hospice Discharge Summary
_____Hospice Transfer/Level of Care Change/Live Discharge
_____Client Facesheet
_____Referral Intake Form
_____Admission Checklist
_____Client Agreement Form - Hospice Services
_____Physician Certification of Terminal Illness for Medicare Hospice Benefit
_____Re-certification of Terminal Illness for Medicare Hospice Benefit
_____Client Comment Form - Hospice
_____Medicare Payor Questionnaire
_____Insurance Information/Notification of Client's Financial Liability
_____Advance Directive Verification Form and materials (client 18 years and older)

2.2 **Physician Orders.**

_____Hospice Attending Physician Certification and Plan of Care
_____ Addendum to Plan of Care (0-300)

2.3 **Hospice Services.**

_____Initial Hospice Assessment
_____Initial Psychosocial Assessment

____Physical Therapy Assessment and Care Plan
____Occupational Therapy Assessment and Care Plan
____Speech Therapy Assessment and Care Plan
____Spiritual Assessment
____Physician Clinical Visit Note, if applicable
____Nursing/Social Work/Spiritual
Counseling/HHA/Volunteer/Miscellaneous documentation should follow the various Initial
Assessments listed above.

2.4 **Medication.**
____Hospice Medication Profile
____Enclara Medication Profile
____Drug Classification Form (*If Med Profile/Treatment Rec. used)

2.5 **Care Plan.**
____HHA Care Plan

2.6 **Other.**
____Death Note
____Pharmacy, DME, Lab and Special Reports (i.e. Wilcox orders, Enclara orders, etc.)
____Hospice Interdisciplinary Team (IDG) Meeting Notes (date order, most recent IDG note on top)
____Billing Invoices (Keene, Wilcox, McKesson, etc.)
____Correspondence and documents from medical provider (i.e. History and Physical from DHMC, VA)
____Discharge Summary

2.7 **Bereavement.**
____Bereavement correspondence/follow-up/plan of care

3.0 The sections listed above, in the order they appear, are required. The order of the items included in each is suggested, but not mandatory.

4.0 As the Nurse's Note and/or Clinical Notes section of any chart grows too large to be maintained in the basic chart, this section can be separated out for filing convenience. However, it must be easily accessible for review and kept in chronological order.

5.0 The client charts will be maintained in alphabetical order in file cabinets.

The active charts will be separated from the discharged charts.

6.0 The charts of clients with the same first and last name will be labeled to alert office staff before making entries into the chart. For example, if an office has two clients named William Smith, a label that reads, "There are multiple clients with same name," will be placed on the front of the chart. In addition, the client's entire name should be documented with a middle initial or title, such as Jr. or Sr.

7.0 Every client account is accessible through the computer system by client name or client number.

Please note: Coordination of Services Note should be filed in the section appropriate for the information.

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0-5450 - CHART FORMAT AND CHECKLIST - HOSPICE

| | |
|---|---|
| Version: | 3.0 ( 1536 ) |
| Author(s): | JESSICA DEGRECHIE (2010) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | |
| Revisions: | Jan. 01, 2011; |
| Comments: | |

Exhibit 30

BAYADA
Hospice

# 0-5625 HOSPICE MULTIPLE LOCATIONS

*This policy was adopted on May. 11, 2011.*

## *Our Policy:*

BAYADA Hospice assures the operation of multiple locations is in accordance with regulation.

## *Our Procedure:*

When BAYADA seeks to open additional locations under an existing certification number, the following requirements are met:

1.0 Prior to provision of hospice care and services to Medicare clients, all multiple locations must be approved by Medicare.

2.0 The multiple location must share administration, supervision and services with the hospice issued the certification number (parent office).

    2.1 The parent and multiple location offices communicate weekly, and as needed, to review office operations, client status, any pending issues to service delivery, regulatory changes, and human resource issues.

    2.2 Minutes of the parent-multiple location meetings are recorded.

    2.3 On a quarterly basis, per [policy 0-403], a summary of all QA activities is reported to the President, Division Director, and Directors. In addition, the parent will report any issues with office operations, service delivery, and/or human resources to the Division Director.

3.0 Lines of authority and professional and administrative control are clearly delineated in the organizational structure and in practice, and are traced to the parent office.

4.0 The parent office continually monitors and manages all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each client and family receives the necessary care and services outlined in the plan of care and in accordance with regulation.

4.1 To ensure that all care and services are responsive to the needs of the client/family at all times, client records will be routinely reviewed by the parent.

4.2 The parent office will receive copies of QA survey reports, client satisfaction results, incident reports, complaint reports, and infection reports relative to each multiple location. Any trends are collaboratively addressed with one PI plan instituted by all locations under the certification number.

4.3 Each location provides the same full range of services that is required of the parent office.

4.4 Each client is assigned to a specific IDG for ongoing assessment, planning, monitoring, coordination and provision of care per [policy 0-4538].

5.0 The medical director assumes overall responsibility for the medical component of the hospice's patient care program, which extends to all hospice multiple locations. All other hospice physicians function under the supervision of the medical director, see [policy 0-4566].

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0-5625 - HOSPICE MULTIPLE LOCATIONS

| | |
|---|---|
| Version: | 6.0 ( 3072 ) |
| Author(s): | JOY STOVER (2011); HOSPICE TEAM (2011); POLICY IDG (2011) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | CHAP HI.2d; COP 418.100(f) |
| Revisions: | May. 11, 2011; |
| Comments: | |

Exhibit 31

# 0-7035 COMPLETION AND SUBMISSION OF THE HOSPICE ITEM SET (HIS)

*This policy was adopted on Nov. 24, 2014.*

***Our Standard:***

*Continuously improve our work through evaluation, education and training.*

***Our Policy:***

BAYADA Home Health Care Hospice offices submit a HIS-Admission and HIS-Discharge record for each patient admitted on or after July 1, 2014 as part of the Hospice Quality Report Program (HQRP) requirements.

***Our Procedure:***

## 1.0 DEFINITIONS.

1.1 **Completion Date:** The actual date on which all required information has been collected and recorded in the HIS and completeness of the record has been verified and recorded. This is the actual date on which the hospice completes the HIS record. This is also the "lock by" date.

1.2 **Completion Deadline:** The latest possible date on which a provider should complete the HIS record. The completion deadline for admissions is the Admission Date + 14 calendar days. The completion deadline for discharges is within seven (7) days of discharge.

1.3 **Hospice Item Set (HIS):** A standardized data collection instrument. It is a series of questions embedded within the Start-of-Care assessment and discharge visit intended to gather 64 patient-level data elements including demographic and patient assessment data, both at admission and discharge. All admissions and discharges - regardless of age, payer, or location- are required to have these data elements gathered and submitted to the Centers for Medicare and Medicaid Services (CMS) via their QIES ASAP website.

1.4 **Hospice Quality Reporting Program (HQRP):** The primary mission of the HQRP is to promote the delivery of high quality hospice services through the required reporting of quality and satisfaction outcome measures. Measures will be adopted that support and promote efficient and safe care, and must be endorsed by the National Quality Forum (NQF), except in unusual circumstances. The HQRP was created in 2010 by the Affordable Care Act and is under the jurisdiction of CMS.

1.5 **Item Set:** a standardized mechanism for abstracting data from a medical record.

## 2.0 QUALITY MEASURES.

2.1 Effective July 1, 2014 CMS requires hospices to report on the following seven NQF endorsed measures:

a. NQF #1617 Patients Treated with an Opioid who are Given a Bowel Regimen
b. NQF #1634 Pain Screening
c. NQF #1637 Pain Assessment
d. NQF #1638 Dyspnea Treatment
e. NQF #1639 Dyspnea Screening
f. NQF #1641 Treatment Preferences
g. NQF #1647 Beliefs/Values Addressed (if desired by the client)

## 3.0 HIS DATA COLLECTION.

HIS Data collection consists of abstracting data from clients' clinical records to complete HIS Items. An HIS Admission Record is completed for each client and an HIS Discharge Record is completed upon client discharge from service.

3.1 Questions intended to capture the information required by CMS are embedded in Homecare Homebase and occur at admission and discharge.

### 3.1.1 HIS-Admission.

Most of the items in the HIS-Admission relate to care processes that align with the initial assessment or the comprehensive assessment period, as required by the Medicare Hospice Conditions of Participation. Completing the HIS-Admission sometime after the comprehensive assessment period ends and before the Completion Deadline meets the intent of the HIS.

3.1.2 The HIS-Admission Completion Deadline is the client's admission date + 14 calendar days.

3.1.3 **HIS-Discharge.**
The HIS Discharge completion deadline is the client's discharge date + 7 calendar days.

## 4.0 HIS DATA REVIEW.

4.1 Each hospice office has designated clinical managers who will review the HIS data for completeness and accuracy. Once verified the information is sent to the HIS Coordinator (staffed by the Hospice Support (HOS) office).

4.2 The HIS Coordinator within the HOS office will review the HIS data for completeness and accuracy before it is submitted to CMS. Any edits that are required will be communicated to the clinical managers via a HIS Request Coordination Note. Clinical managers are required to respond to these requests within 24 hours in order to ensure timely completion of the HIS record.

## 5.0 HIS DATA SUBMISSION.

5.1 The HIS Coordinator within the HOS office is responsible for the submission of HIS data files onto the QIES ASAP website.

5.2 HIS Admission and Discharge records are required to be submitted within 30 days of start-of-care/discharge date respectively.

BAYADA
Hospice

Owner:

Manual, Section: HOSPICE MANUAL , POLICIES

References: Hospice Quality Reporting Program (HQRP) Fiscal Year 2016 Requirements

Revisions: Nov. 24, 2014;

Comments:

**Exhibit 32**

# POSITION DESCRIPTION AND QUALIFICATIONS

BAYADA Hospice
A specialty of BAYADA Home Health Car

POSITION TITLE: **Community Liaison - Hospice**

POSITION SUMMARY:

Develop and manage relationships with referral sources and community members to educate and promote BAYADA Hospice services and represent the hospice program within the community.

SUPERVISED BY: DIRECTOR, AREA DIRECTOR OR DIVISION DIRECTOR

MINIMUM QUALIFICATIONS:

1. Exemplifies characteristics of the BAYADA Way: compassion, excellence and reliability.
2. Four (4) year college degree*.
3. A minimum of two (2) years experience in home care and/or marketing.
4. Demonstrated record of strong interpersonal skills.
5. Demonstrated record of goal achievement.
6. Demonstrated record of successfully taking on more responsibility with positive results.
7. Wonderlic score greater than or equal to twenty-four (24)*.
8. Acceptable results on Profile XT.
9. Ability to read, write and effectively communicate in English.
10. Competence in basic PC skills required to perform job functions.

*For exceptions to education and testing qualifications, see Recruiting and Hiring Procedures for Supervisory and Recruiter Staff, 0-3288.

TRAINING AND CERTIFICATIONS:

Within the first three (3) months of employment:
1. Completion of the BAYADA Way In-service.
2. Completion of the general company Welcome to New Employees training at director's discretion.
3. Must pass PC Competency basic skills test.

PRIMARY RESPONSIBILITIES:

1. Demonstrate and communicate the core values of BAYADA Hospice and The BAYADA Way.
2. Develop relationships, in accordance with the BAYADA Way, with new and existing referral sources, physicians, other healthcare professionals as well as other community organizations serving elders and the disabled.
3. Demonstrate mastery of clinical and regulatory hospice eligibility criteria.
4. Maintain and promote BAYADA's presence in the community.
   a. Build relationships with community agencies, professional and civic organizations and business-related networking groups.
   b. Participate in, plan and carry out community events (health fairs, job fairs).
   c. Stay current on community events and opportunities to promote BAYADA's services.
   d. Promote BAYADA as the Hospice Provider and Employer of Choice.
5. Educate referral sources on BAYADA services by clearly articulating the features and benefits of Hospice.
6. Maintain and increase knowledge of Hospice Services, customers and referral sources; identify obstacles of the hospice program to interface with customer satisfaction; assist in development and communication of problem solving systems to achieve enhanced services.
7. Develop community outreach goals, strategy and plan in conjunction with the Director and review regularly.
8. Utilize COM, Marketing toolbox, other BAYADA staff, and other external resources to generate community outreach ideas.
9. Maintain communication with Client Services Managers and BAYADA office staff to stay aware of new referral sources and potential referral sources.
10. Work with Director and Client Services Manager to maintain a system to track all outreach and community education activity and contact information.
11. Monitor and evaluate referral outcomes for outreach effectiveness.
    a. Measure results (# of service inquiries, new clients).
    b. Identify where referrals are being generated from.
12. Maintains the standards of excellence in accordance with the principles set forth by the state, accrediting organization, and agency policies and procedures.

# POSITION DESCRIPTION AND QUALIFICATIONS

13. Cross train with other BAYADA office staff to cover their functions, as needed.

14. Demonstrate solid performance or exceed performance standards in key job dimensions/attributes as defined on the Performance Appraisal for Office Staff, 0-3240.
15. Perform related duties, or as required or requested by Director

OTHER RESPONSIBILITIES:

FAIR LABOR STANDARDS ACT STATUS: Exempt from overtime. Employees working in this position must be paid a weekly salary and perform the responsibilities listed above to be exempt from overtime payments.

EMPLOYEE SIGNATURE (optional)

DATE

# Exhibit 33

# 0-4554 LEVELS OF HOSPICE CARE

*This policy was adopted on Feb. 1, 2010.*

***Our Policy:***

BAYADA Hospice offers four levels of care, as provided for by the Medicare Hospice Benefit, to meet the needs of our clients/caregivers.

***Our Procedure:***

## 1.0 ROUTINE HOME CARE.

Routine Home Care is provided in the client's residence which may include a skilled nursing facility, assisted living facility or another setting considered the client's home.

## 2.0 CONTINUOUS CARE.

Continuous Care is provided during a period of crisis to achieve palliation or management of acute medical symptoms in order to maintain a client at home, and provided on a short term basis.

2.1 A minimum of eight hours during a 24-hour period is provided and includes:

2.1.1 Nursing;

2.1.2 Home Health Aide;

2.1.3 Homemaker; and

2.1.4 Volunteer services.

2.2 One half of the total hours of care provided during each 24-hour period is provided by an RN or LPN.

## 3.0 INPATIENT RESPITE CARE.

Inpatient Respite Care is provided in a contracted Medicare/Medicaid-certified hospital or a skilled nursing facility when necessary to provide relief from demands of interventions required for end-of-life care for family members or others caring for the client. This level of care is limited to no more than five consecutive days for each respite stay per benefit period.

24-hour nursing services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care.

## 4.0 **GENERAL INPATIENT CARE.**

General Inpatient Care is provided under contract in a Medicare/Medicaid Certified hospital or a skilled nursing facility when a client's need for pain or acute or chronic symptom management cannot be managed in other settings and ensures:

4.1 24-hour RN services that meet the nursing needs of all clients and are furnished in accordance with each client's plan of care.

4.2 Each client receives all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

4.3 Client areas are designed to preserve the dignity, comfort, and privacy of clients.

4.4 The opportunity for clients to receive visitors at any hour, including infants and small children.

4.5 Criteria for General Inpatient Level of Care:

4.5.1 Pain evaluation to adjust medications and/or determine appropriate treatments;

4.5.2 Intractable or protracted nausea incompatible with management in a home setting;

4.5.3 Respiratory distress unmanageable in a home setting;

4.5.4 Open lesion(s) not responsive to home plan or exacerbating symptoms;

4.5.5 Rapid decline related to varied factors such as bleeding, inconsistent with home management;

4.5.6 Death is imminent and family is unable to cope;

4.5.7 Psychosis, severe confusion, delirium and/or combativeness secondary to end-stage disease process.

4.6 Inpatient Care Limitations: The total number of inpatient days used in a 12-month period by Medicare beneficiaries who elected hospice coverage may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.

5.0 BAYADA utilizes all levels of care and the IDG determines the appropriate level of care for each client based on his or her evolving needs.

6.0 When a client's condition changes and requires a change in level of care, the RN Case Manager notifies the attending physician to obtain an order for the change in level of care and revises the client's plan of care accordingly.

7.0 Members of the IDG providing care to the client are advised of any changes to the client's level of care and documentation is entered into the client chart to ensure continuity of care.

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0-4554 - LEVELS OF HOSPICE CARE

| | |
|---|---|
| Version: | 3.0 ( 1536 ) |
| Author(s): | WEATHERBEE RESOURCES (2009) JOY STOVER, KRISTIN BARNUM (2010) |
| Owner: | |
| Manual, Section: | HOSPICE MANUAL , POLICIES |
| References: | CHAP Hospice Standard HII.2a; Medicare Hospice COP 42 CFR 418.108 |
| Revisions: | Feb. 01, 2010; |
| Comments: | |

# Exhibit 34

BAYADA

# 0-5604 COMMUNITY OUTREACH LIBRARY POLICY

This policy was adopted on Aug. 16, 2011 and last revised Aug. 16, 2011.

Our Policy:

BAYADA maintains and supports a central repository of education and wellness programs used for community outreach activities.

Our Procedure:

## 1.0 BACKGROUND AND GENERAL INFORMATION.

The Community Outreach Library provides a repository for programs and presentations that can be used by marketing managers, community liaisons, clinical liaisons and directors to support marketing activities and relationship building. The library eliminates duplication in program development, assures the highest quality content and materials, provides program resources appropriate for a variety of audiences. It includes program topics that best represent BAYADA in the community.

1.1 Programs available through the Community Outreach Library are not accredited or intended to be offered to licensed professionals for continuing education credits.

1.2 Programs in the Community Outreach Library are written and intended for presentation with non-professional external audiences. The library is distinct from BAYADA University, which is intended for internal audiences only.

1.3 Presenters are encouraged to use educational materials that are endorsed and included in the Community Outreach Library. However, at the present time and while the library is developed, this policy does not restrict or limit the delivery of educational programs to only those currently included.

## 2.0 DEFINITION OF ACCEPTABLE TERMS.

a. **Community Outreach Library** - a collection of program resources intended to support efforts to build relationships with clients, prospective clients, family members, and provide educational programs for consumers on a variety of clinical and non-clinical topics.

b. **Community Education** - one of two program categories in the library. These programs are intended for non-professional audiences such as residents in assisted living facilities, life care communities, community and civic organizations, etc. These programs do not include a clinical component or require a clinician as presenter. These programs are not for licensed medical professionals nor are they approved continuing education programs. See CONTINUING EDUCATION PROGRAM, #0-4531.

c. **Community Wellness** - one of two program categories in the library, these programs are intended for non-professional audiences such as residents in assisted living facilities, life care communities, community and civic organizations, etc. These programs include a clinical component and must be presented by, or in collaboration with a clinician. These programs are not for licensed medical professionals nor are they approved continuing education programs. See CONTINUING EDUCATION PROGRAM, #0-4531.

d. **BAYADA University** - a proprietary on-line learning site intended exclusively for employees of BAYADA Home Health Care. The term BAYADA University is not to be used to describe or promote community outreach programs targeted to external audiences.

e. **Library Review Committee** - provides oversight on selection of topics for the library and monitors content development. Members may include representatives from the Nursing Office, Visit Clinical Leadership, Pediatric Practice, Communications, Home Care Services, and Visit Sales and Marketing as well as content experts from within the company.

## 3.0 STANDARDS AND PROCEDURES FOR COMMUNITY OUTREACH PROGRAM DEVELOPMENT.

### 3.1 Evaluation and Selection Criteria.

The Library Review Committee evaluates and selects program topics to be included in the library based on the following criteria:

a. Support the mission, vision, values, and beliefs expressed in The BAYADA Way,
b. Relevance and appropriateness to home health care and the services provided by BAYADA,
c. Appropriateness for a variety of audiences and all service lines,
d. Reflect the current body of knowledge and best practices with referenced sources identified,
e. Clinical content is presented in accordance with evidence-based best practices in the industry and conforms with professional standards for clinical practice,
f. Developed with style, format and materials consistent with the BAYADA brand,
g. Include direction for participants attending community education and wellness programs presented by BAYADA to refer to their physician for medical follow-up, as appropriate.

### 3.2 Submitting Developed Programs for Consideration..

Programs may be submitted to the Library Review Committee for consideration at communitylibrary@bayada.com.

3.2.1

Program content submitted for review should include PowerPoint presentations and notes pages where appropriate, flyers, handouts and support materials.

3.2.2 The committee will respond within two weeks with topic approval and will provide a timeframe for development/refinement of program materials and posting in the library.

3.3 Submitting Requests or Recommendations for Programs.
Programs topics may be recommended or requested for development via communitylibrary@bayada.com. All submissions are monitored by the Marketing Manager (COM) and disseminated for evaluation and development.

3.3.1 Recommendations/requests for programs should identify the topic, a brief description of intended audience and purpose of the program. See COMMUNITY OUTREACH LIBRARY PROGRAM REQUEST FORM, #0-5606.

3.3.2 The committee will work with the requester to explore available resources, including content experts and other published programs to fulfill the program need.

3.3.3 The committee will provide a timeframe for development and completion of the program.

3.4 Publication Procedures.
Each program posted in the Community Outreach Library will provide:

a. Overview/abstract of program content,
b. Cover page detailing the purpose of the program, intended audience, suggested handouts and giveaways
c. Qualifications necessary for presenter (clinical vs. non-clinical),
d. PowerPoint presentation with notes pages.
e. Template for invitation flyer,
f. Masters and/or templates for resource materials and handouts.

3.5 Responsibilities of the Library Review Committee.

3.5.1 The committee will select relevant program topics to be included in the library.

3.5.2 The committee is responsible to review, approve, finalize, and prepare content for posting in the library.

3.5.3 The committee will respond to requests for program review and development within two weeks and provide a timeline for completion and posting in the library. Please see COMMUNITY OUTREACH LIBRARY PROGRAM REQUEST FORM, #0-5606.

3.5.4

The committee will seek out content experts to review and approve content as appropriate.

3.5.5 The committee will use the resources of the Communications Office to prepare PowerPoint slides, templates, handouts, flyers, and other resource materials to maintain consistency among all programs posted in the library.

3.5.6 As a member of the Review Committee, the Communications Office (COM) representative will coordinate and insure that programs are posted appropriately in the Marketing Toolbox in Resource Center.

3.6 Responsibilities of the Program Presenter.

3.6.1 When using programs/topics included in the Community Outreach Library, the endorsed program outline and accompanying materials must be used.

3.6.2 If the program focuses on educating the public audience on clinical content (for example, a disease, disease process, symptom management, etc.), the program must be presented by, or in collaboration with, a clinician knowledgeable about the topic.

3.6.3 If the program focuses on BAYADA services—why we can assist a client with a particular diagnosis and what each discipline does in the home environment, or other non-clinical topics, the presenter is not required to be a clinician.

3.6.4 The presenter promotes the program through appropriate distribution of flyer/invitation.

3.6.5 The presenter identifies and selects non-clinical and clinical presenters as required by the program content, including content experts as needed.

3.6.6 The presenter follows all guidelines to prepare for presenting the community program including ordering all hand-outs, materials and giveaways.

## 4.0 PRESENTATIONS TO REFERRAL SOURCE STAFF MEMBERS OR LICENSED CLINICIANS.

For guidance on laws and regulations for presentations to staff members of referral sources or other facilities, contact Associate Counsel, SVS or Legal Services (LS). When presenting programs to licensed clinicians, refer to CONTINUING EDUCATION PROGRAM #0-4531.

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0-5604 - COMMUNITY OUTREACH LIBRARY POLICY

Version: 2.0 (1024)

BAYADA

| | |
|---|---|
| Author(s): | BONNIE LONG, ALLISON STERNER, LAUREL H. TRICE, KELLI MARANS (2011) |
| Owner: | |
| Manual, Section: | ADMINISTRATIVE, GOVERNANCE AND MANAGEMENT |
| References: | |
| Revisions: | Aug. 16, 2011, Aug. 16, 2011, |
| Comments: | |

# Exhibit 35

# CULTURAL COMPETENCE

## 1. Purpose

To provide the home health care employee with information about cultural differences, and how these differences may affect the delivery of health care services.

## 2. Background

Demographic and cultural changes in the U.S. are affecting the health care profession, government agencies, and private sector businesses alike, resulting in a multicultural and multilingual society.

Because of the patient-centered orientation of home care, clinical staff need to adapt their methods of providing care in various cultural contexts. How is this done?

By continually acquiring and adapting to new bodies of cultural knowledge and cross cultural skills.

As world affairs change, there has been an influx of immigrants from diverse cultures. There have been 12 million arrivals in the last decade alone, exceeding the largest previous wave of immigrants (10 million) which occurred from 1905 - 1914.

National health statistics show that culturally inappropriate care and inattention to cultural differences may negatively affect health outcomes. It can also create barriers to accessing health care by:

-Creating logistic obstacles in the form of appointment procedures.
-Difficult public transportation connections.
-Formidable and intimidating buildings.
-Directional signs written in an unfamiliar language.

There has been much under-utilization of health services by immigrants due to many barriers, such as:

-Cost
-Language
-Cultural practices.
-Fear of apprehension by immigration authorities (Illegal Immigrants).
-Lack of education.
-Difficulty obtaining transportation to clinics.
-Lack of sufficient medical personnel.

## 3. Defining Cultural Competence

Cultural competence is essential in order to provide a high standard of care to culturally diverse populations.

> Definition - "The ability of a system, agency, or individual to respond to the unique needs of populations whose cultures are different from that of the dominant or mainstream society. A culturally competent system of care acknowledges and incorporates the importance of culture on all levels - policy, administration, practitioner and consumer." (Cross, I. AJN, August 1998 98(8), p. 31)

How is this accomplished on the personal level?

a. By connecting with the client, that is, making a conscious effort to listen and really hear what is being said.
b. By asking questions; seeking information and clarification.
c. By being genuine and sincere.
d. By presenting information in a way that the client can understand and find relevant.
e. By respecting the client.

f. By responding to the client on many different levels, such as posture, facial expressions, and other verbal/non-verbal type interactions.
g. By being self-aware. If there is any form of discomfort with a certain culture, get another person to intervene. If language is a barrier, an interpreter should be utilized.

Cultural competence is essential to the ability to perform a transcultural assessment.

Areas in which cultural uniqueness must be assessed are:

a. Communication - Written and oral language, gestures, facial expressions and other forms of body language. All affect the expression of ideas, feelings, comprehension and decision making.
b. Personal space - The area surrounding a person's body is influenced by culture. This is important in determining comfort levels and appropriate physical distances during interactions.
c. Social Organization - Determines patterns of behavior during life events such as beliefs, values and attitudes are related to these events. These would include religious views, traditional healing methods and basic beliefs about the nature of health and disease.
d. Time - Cultural groups have different orientations relating to the past, present or future.
e. Environmental control - Perceptions that a person has about his/her ability to direct factors in his/her environment that can affect him/her as an individual.
f. Biologic Variations - The occurrence and incidence of specific diseases in certain ethnic groups.

Health care providers are being driven to increase cultural competency by two forces:

a. Patient Care Standards - Health care reform is resulting in the establishment of cultural competence guidelines, enforced by state agencies.
b. Market Forces - Health care organizations are improving cultural competence to attract segments of the patient market that are becoming newly insured. It is fast becoming a marketing tool.

4. Factors That Impede the Development of Cultural Competence in Health Care

a. Lack of time - many educational institutions do not want to take the necessary time to share experiences and knowledge in this area.
b. Lack of commitment to the idea of cultural competence.
c. Personal biases and prejudice.
d. The financial aspect of time. Being sincere, thorough and compassionate takes time.

5. Strategies to Enhance Cultural Competence

a. Be able to overcome your own biases and prejudices.
b. Be informed as to global events - especially with regard to wars and skirmishes.
c. Take time and be sincere with clients.
d. Help people learn how to access the American system, not just the health care system.
e. Increase diversity among involved clinicians.

References:

Lester, Nora (1998). "Cultural Competence: A Nursing Dialogue I", AJN, 98(8), pp. 27-33.

Lester, Nora (1998). "Cultural Competence: A Nursing Dialogue II", AJN, 98(9), pp. 36-42.

Exhibit 36

# African American

## OUTREACH GUIDE

Caring Connections

*In collaboration with*

DUKE INSTITUTE ON CARE AT THE END OF LIFE

## Table of Contents

## I. Overview

> *"Hospice offers the best hope not to be alone, to be with family, to have pain controlled, and to be connected to your faith and beliefs.*
> *We are as entitled and deserving as anyone else to have these hopes fulfilled."*
>
> — Richard Payne, MD
> Professor of Medicine and Divinity
> Esther Colliflower Director
> Duke Institute on Care at the End of Life
> Durham, NC

Harlem Renaissance author, poet and playwright, Langston Hughes (1902-1967) once said, *"There is no color line in death."* Mr. Hughes understood that however we reach the end of life, our mortality is universal; there is no color line in death and there should not be one in life either.

With that thought in mind, it is interesting to note that while the African American population accounts for over 12% of the overall U.S. population, fewer than 10% of those entering hospice programs across the country are African American. Conversely, the white/Caucasian population comprises 80.1% of the U.S. population (U.S. Census estimate for 2006)[1] and accounts for more than 80% of hospice admissions.[2]

Within Medicare decedents ages 65 and older, the disparity is even more pronounced. Researchers have found that in the last year of life, black decedents were less likely to use hospice than white decedents (22% vs. 29%, respectively).[3] Hospice utilization has also been shown to be "lower among African-Americans than among white decedents, across all age groups," "across all causes of death except Alzheimer's disease" and "in 31 of 40 states." The researchers theorize "that racial disparities in hospice utilization decrease in areas where hospice utilization is more common" and that "one promising strategy to help reduce white/African American disparity in hospice use appears to be to increase access to hospice care for all eligible individuals".[4]

Given the inequalities described above, the purpose of this Guide is to provide outreach strategies and resources for providers and coalitions to better support African Americans with end-of-life issues.

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[1] *http://quickfacts.census.gov/qfd/states/00000.html*

[2] NHPCO Facts and Figures, 2007. *www.nhpco.org*

[3] Connor SR, Elwert F, Spence C, Christakis NA. Geographic variation in hospice use in the United States in 2002.J Pain Symptom Manage. 2007 Sep; 34(3):277-85.

[4] Connor SR, Elwert F, Spence C, Christakis NA. Racial disparity in hospice use in the United States in 2002.Palliat Med. 2008 Apr; 22(3):205-13.

The Guide specifically provides you with a review of significant end-of-life issues relevant to African American communities, and detailed strategies and tools gathered from hospice programs and experts. The "Resources" section offers many suggestions for continuing your research and outreach efforts. We encourage you to focus on taking time to get to know your community and fostering meaningful relationships, growing together as you reach out. In addition, the Caring Connections team has a wealth of materials that can assist you with virtually all aspects of your outreach, located at www.caringinfo.org/community.

We hope that this Guide will help highlight the importance of improving outreach and access efforts with African Americans in your community, as well as provide practical tools so that ultimately patients and their families will be better served in a culturally competent way, honoring and respecting their traditions.

## A. DEMOGRAPHICS

There are over 300 million Americans living in the U.S. today, 39 million of whom are African American (just over 12 percent of the total population). One out of every four African Americans lives in New York, Florida or Georgia, with the largest concentration in the South (55 percent). The highest proportions are in the District of Columbia (57 percent) and Mississippi (37 percent), and the lowest are in Montana, Idaho and Vermont (less than one percent each). 52 percent of all African Americans live within metropolitan areas, with only 13 percent in nonmetropolitan areas.[5]

Most African Americans are high school graduates, and one in six has a college degree. Median income is about $32,000, one in four live below the poverty level, and about nine percent are unemployed (double the national average). African Americans are less likely to be married than non-Hispanic whites, and a larger proportion of their households are maintained by women. African Americans are more likely to live with and care for grandchildren.

## B. HISTORY

Many African Americans remember the days of segregation, Jim Crowe laws and violence towards their people. And many African Americans are deeply distrustful of the government and the healthcare system, a distrust that is rooted in both historical and present day experiences. For example, while emancipation from slavery was achieved in 1865, many African American families are only three generations removed from slavery. And as recently as 40 years ago, African American men with syphilis were purposely left untreated and studied to determine the long-term effects of the disease; many died in excruciating pain, all unnecessarily. In addition, a survey of African Americans conducted from 2002-2003, reported in the *Journal of Acquired Immune Deficiency Syndrome*, found that nearly half of the respondents believe that the U.S. government created HIV/AIDS, in part, as a plot to exterminate blacks.[7] So when African Americans do seek care for their health, particularly at the end-of-life, it is little wonder that many worry that hospice is just another way to hasten death.

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[5] U.S. Census Bureau. (2004). The American Community – Blacks. www.census.gov/prod/2007pubs/acs-04.pdf.

[6] U.S. Census Bureau. (2004). The American Community – Blacks. www.census.gov/prod/2007pubs/acs-04.pdf.

[7] Bogart, L.M., Thorburn, S. (2005). Are HIV/AIDS conspiracy beliefs a barrier to HIV prevention among African Americans? Journal of Acquired Immune Deficiency Syndrome, 39 (2), 213-218.

*"Black people still don't believe in the political process, because the process has never served us. We've been betrayed by the political process, betrayed by the medical process, betrayed by each and every process in America, and it's all based on racism. That distrust affects our entire personality in a great many ways."*

— AFRICAN AMERICAN FOCUS GROUP MEMBER,
NEW YORK, NEW YORK, 2005
(SEE FOCUS GROUP REPORT IN SECTION II)

## C. HEALTHCARE DISPARITIES

Population-specific differences in the presence of disease, health outcomes and access to healthcare are all part of the healthcare disparities conversation. A 2002 Institute of Medicine (IOM) study found that "a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. Research further indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services."[9] This comprehensive report entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, basically reveals that African Americans are dying from treatable and preventable illnesses with more frequency than other ethnic groups.

**"Among African Americans, non-acceptance of advance directives appears to be part of a much broader pattern of values regarding quality of life, as well as a historical legacy of segregation. [Do Not Resuscitate] DNR orders may be viewed as a way of limiting expensive healthcare or as cutting costs by ceasing care prematurely. Historically, this perspective may stem from a long history of distrust of the white-dominated healthcare system."[8]**

For example, African Americans are more likely to develop cardiovascular disease and HIV/AIDS, and are twice as likely to die from diabetes. Cancer incidence rates are ten percent higher overall, with a 25 percent greater chance of dying from it than whites. African Americans have higher infant mortality rates, and are more likely to live with a cognitive disability. Seven million African Americans do not have health insurance, and life expectancy is nearly ten years less than for whites.[10]

Peer-reviewed medical journals cite countless examples of African American patients experiencing discrimination, from the refusal to administer appropriate medications (most notably opiates), to inferior care. The IOM report specifically found that African Americans are less likely than whites to receive kidney dialysis or transplants, undergo coronary bypass surgery or receive state-of-the-art HIV/AIDS treatments.[11]

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[8] Searight, H. R., Gafford, J. (2005, February 1). Cultural diversity at the end of life: Issues and guidelines for family physicians. *American Family Physician*, 71(3), 515-522.

[9] Institute of Medicine. (2002). Report Brief: What Health Care Providers Need to Know about Racial and Ethnic Disparities in Healthcare. Retrieved from *www.iom.edu/Object.File/Master/4/175/Disparitieshcproviders8pgFINAL.pdf*.

[10] Centers for Disease Control. (2008). National Center for Health Statistics: Health of Black or African American Population. Retrieved from *www.cdc.gov/nchs/fastats/black_health.htm*.

[11] Institute of Medicine. (2005). Addressing Racial and Ethnic Health Care Disparities. Retrieved from *www.iom.edu/Object.File/Master/33/249/BROCHURE_disparities.pdf*.

While the reasons for these disparities are numerous and frequently directly correlated to lower socioeconomic status, African Americans do not seek healthcare as often, and when they do, it is often with a physician they may see only once. The healthcare system in America and its many services have made incredible strides over the years, yet much work is to be done with regard to differences in quality of care and treatment options based on ethnic background.

## D. AFRICAN AMERICAN ORIGINS

For purposes of this Guide, we have limited our focus to US-born African Americans (unless otherwise specified). However, it is important to be aware that eight percent of the total black population is foreign-born, and most came to the U.S. after 1990. The highest percentages live in New York, Massachusetts, Minnesota and Florida, and nearly all were born in Africa or Latin America.[12]

Recent immigrants may present with advanced disease that has gone untreated, either because of lack of care or a preference for alternative (and potentially less effective) treatments. Others may have undergone extreme trauma as part of their immigration experience or in their home countries, including illegal flight, genocide and extreme poverty. Take the time to learn where the family is originally from and ask about specific healthcare traditions that are important to them; then integrate these treatments into the plan of care. Be sensitive to the special customs of these groups, particularly with regard to traditional medicine.

> *"I have seen more young people who are immigrants diagnosed with advanced cancer. It's not that unusual for those from a foreign country to present with illness that is further along. And when the patient is young, they're often hesitant to call back home to tell their parents how very sick they are. I have to encourage and facilitate those calls. What's wonderful, though, is that these are often tight communities that provide a network of support. In many cases groups of strangers from the same country immigrated together in search of employment, so their "community" came with them, and it is built on a shared place of origin, culture and tradition."*
>
> — LYLA CORREOSO, MD,
> ATTENDING PHYSICIAN WITH THE VISITING NURSE SERVICE OF NEW YORK, NY

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[12] U.S. Census Bureau. (2007). The American Community0Blacks. Retrieved from www.census.gov/prod/2007pubs/acs-04.pdf.

## E. RELIGION

Historically, African American slaves in the U.S. were denied religious freedom, and racial segregation led to the development of separate, organized religious denominations. While African Americans practice a number of religions, Protestant Christianity remains the most popular with a nearly 76 percent following, the majority of Baptist and Methodist tradition. Seven percent identify themselves as "Other", six and a half percent are Catholic, less than one percent are Jewish and about ten percent do not identify with any religious group.[13]

Further, a profile of African American religious participation reveals that 70 percent attend religious services at least a few times a month, and 80 percent pray nearly every day. 27 percent read religious books and 21 percent watch or listen to religious programming on television or radio daily. Overall, 80 percent consider themselves to be either very or fairly religious.[14]

In African American faith communities, members seek out everything from spiritual guidance, to relationship counsel, to adult vocational education programs. Each African American religious tradition takes great pride in its ability to hold together its congregation even in the gravest of times. From native Africans initial embracing of Western religions while retaining elements of their own native traditions, the evolution of the Black church into today's modern religious practice remains the backbone of African American communities.

***Note that because of the popularity of Christianity among African Americans, Christian themes and spirituality predominate throughout this Guide, and many of the strategies tie into a Christian faith base. However, we recognize that not all African Americans are involved with a church, nor are all Christian.***

*"[Healthcare] decisions and actions taken are often based on religious traditions, such as fasting, prayer, seeking God (specifically God's will) and even asking a doctor to pray with or for the patient and family."*

— Stacie Pinderhughes, MD,
Chief, Division of Hospice and Palliative Medicine,
North General Hospital, New York, NY

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[13] Religion Newswriters Foundation. (2007). A Guide to African Americans and Religion. Retrieved from www.religionlink.org/tip_070108.php#stats.

[14] Mamiya, L. (2006). *Pulpit & Pew: Research on Pastoral Leadership.* Section II: Profiles and Studies of African American Laity. Durham, N.C.: Duke Divinity School. p. 24.

## Section II. African American Focus Group Findings

In May 2006, NHPCO's Caring Connections conducted two African American end-of-life focus groups in St. Louis, Missouri. Men and women were interviewed separately. Group participants discussed their general feelings and issues regarding end-of-life thinking, talking and planning. Participants were then asked to read and react to topics such as advance care planning, end-of-life caregiving and hospice. Key findings are below.

### A. DEATH, DYING AND ADVANCE CARE PLANNING

Group participants were divided on their comfort level on the topic of death and dying – some seemed at ease, while others felt that it was culturally taboo to even discuss it. Older participants indicated that they talk about it more as they themselves are aging. Generally, there is a conflict between wanting to be informed medically, but being culturally bound to privacy and wanting to turn to and rely on faith first and foremost.

*"It interests me now. There was a time when I used to kind of shy away from that, because... there's just something about it that you just don't want to talk about. You don't want to hear about it. But as you get older, it comes to the forefront of your mind and so it's like you want to go and find out things about it."*

— African American focus group member commenting on death

Most participants were unaware of the true meaning of advance care planning, using it interchangeably with end-of-life care, which they connected with life insurance and funeral planning. Many misinterpreted the materials they were given, and thought that advance care planning referred to an agency or organization where all advance directives are stored. Hospice staff, therefore, should emphasize the role of the family, and that it is possible to name the person who would make decisions on a patient's behalf. There was significant distrust that even if preferences are specified in writing, that the medical professional in charge would not honor them.

*"What I sense that you're leading at is, a person fills out a document and then you get this document notarized or something and this goes to some agency and then when the person is ill then the hospital had the responsibility to contact this agency and see if this person has a document ready and the document says or the person says, 'This person wants to be kept alive by all means possible,' then the doctors are going to be bound by that document. I don't think it's going to happen like that."*

— African American focus group member commenting on Advance Directives

Many said they would not want to be kept alive on life support indefinitely because of a fear of being a burden on their loved ones, but would want a few weeks to be given a chance at recovery. While most feel that advance care planning is a wise idea, concerns were expressed; some even stated that the very idea of writing your wishes down was quite strange, especially "pre-crisis."

## B. CAREGIVING

The African American family structure is usually tightly-knit, extended, matriarchal, and includes many close friends who are considered kin. While families are more dispersed today, it is still expected that family members will find a way to care for loved ones in their own homes. This choice is always preferred to someone coming 'from the outside.' Therefore, caregiving provides the strongest foundation on which to begin a discussion of end-of-life issues. Participants repeatedly stated, "We take care of our own." It is important to stress that hospice supports caregivers; it does not replace family members or preclude them from playing a central caregiving and decision-making role.

> *"I think we talk about mostly caring for each other or our loved one at the end, during the end of their life on earth other than just their dying. Blacks seem to be concerned with taking care of their people."*
>
> — AFRICAN-AMERICAN FOCUS GROUP MEMBER

## C. UNDERSTANDING OF HOSPICE

About half of the participants had heard of hospice care, although there was much confusion over what hospice really is. Some recognize that hospice is for when "they run out of things to do medically; they can't do anything to cure you." Yet many think of it as a place someone is "sent away to" when their family has "abandoned" them, and equate it to nursing homes.

Because nursing facilities are viewed so negatively, it is important to emphasize that hospice care is most often provided in a person's own home. The most frequent concern was the financial aspect, and an inability to believe that Medicaid, Medicare and most private insurance companies cover hospice expenses. Some were still doubtful even after reading NHPCO handouts explaining the Hospice Medicare Benefit.

# Section III. Strategies for Reaching Out to African American Communities

There are many ways to conduct outreach that meets the needs of your organization and your community. By showing yourself as a true partner who wants to give, you engender goodwill and open the doors to all members of your community. The most successful outreach programs have been patient, and have taken time to simply observe and listen. We suggest that you be very creative and pursue opportunities that you wouldn't ordinarily consider. Above all, remember the deeply rooted historical issues for most African Americans, and be sensitive to these in your interactions.

## A. GET ORGANIZED

Before implementing any strategies in your outreach, it is important to critically assess your existing resources, survey your community, formulate a plan and gather support. This foundational analysis is critical to any outreach effort, no matter which community you are targeting. While it is always noble to want to expand and diversify your clientele, you must be prepared to serve them adequately, should your outreach be successful!

- **Evaluate resources.** As you begin, your first step should be an assessment of your existing financial and personnel resources. Will the overall financial health of your organization be able to support the special requests and additional expenses that will arise as you conduct your outreach and your census increases?

  Additionally, do you already have a staff person who is designated as outreach coordinator? Can you afford to hire new staff? Perhaps you have someone who is already engaged in community outreach, but his/her work is focused on a different ethnic population. Conceivably, this person might be able to take on additional duties, or assume a new role. (We will explore this point in more detail in "Find the Right Fit" section of this Guide.)

Visit the Caring Connections Web site at *www.caringinfo.org/community* for resources that can get you started. For instance, "The Golden Rules of Outreach" outlines essential elements of outreach, and "Community Assessment Guide" helps you evaluate the specific end-of-life needs in your community.

- **Survey your community.** Gather local demographics as well as your own organization's current trends. Learn what African Americans in your community already know (or don't know) about hospice and palliative care. Some may be well aware but choose other options, while others may be misinformed and not understand the true benefits.

  The focus group findings summarized previously in this Guide offer some insight, and you might consider conducting your own one-on-one informational interviews or organizing small focus groups to gather data specific to your community. Or, hold a town hall meeting to open a wider dialogue.

The structured conversations in this type of gathering provide opportunities for community members to share their concerns, needs and questions about end-of-life care and services. See Caring Connections "Convening Town Hall Meetings" at *http://www.caringinfo.org/Community/Outreach-StrategiesAndTools.htm* for details.

With the knowledge gained during these groups and/or meetings, you will have targeted, detailed and intimate information that gives you the most personal perspective on how African Americans in your own community truly think and feel about end-of-life care. Your staff will be better educated and your ability to serve the community will be infinitely greater.

- **Gather support and form a planning team.** Be certain that your senior leadership and all levels of staff are on board with your outreach plans. The entire organization should be engaged and share the same vision of inclusiveness and growth. The key element is forming a planning team, which should include staff as well as a wide range of community members. These individuals will ensure that a core working group is in place to support the hard work of your primary outreach liaison, and provide reassurance that he/she is part of a larger team working together to build lasting links between your hospice (or coalition) and African American community members. (More suggestions for team planning and building will be discussed in the "Build Partnerships" section of this Guide).
- **Develop a plan.** As you gather your data and support, decide where you want to start. Discuss short and long-term goals and expectations. Develop a plan of action, one that is linked to any existing marketing strategies for hospice access in your service area (see the "Consider Marketing" section of this Guide). Tap into existing networks, particularly the African American hospice outreach programs operating across the country that are highlighted in this guide.

**Lyla Correoso, MD** has found that there is a great lack of understanding among both the African American as well as the general population regarding end-of-life care options and treatment. She describes some specific examples:

- Encountering many caregivers who simply quit their jobs to take care of a parent, spouse or other loved one, not knowing about the Family and Medical Leave Act (FMLA).
- Little to no understanding of the concept of palliative care. Hospice home care statistics for the organization revealed there were 5,000 patients who could benefit from the palliative care model but were not getting referred accordingly. So it is not only the patients themselves who are un-informed, but many healthcare professionals, as well.
- A suspicion of hospice even among nurses, who in some cases also had very little understanding of advance directives (a particular problem in the state of New York because patients are required to have healthcare proxies). In response to this, a special hospice teaching program was initiated designed specifically for nurses. And to help those nurses who were struggling to find the right words with their patients, the organization developed a card with talking points for use when interacting with patients and families.

- **Train your team.** Make sure your hospice incorporates diversity training into your staff orientation or ongoing in-service education. Train all of your staff, including administrative and clinical personnel, as they are all part of the team. Emphasize the following end-of-life care issues specific to African American communities: healthcare history, healthcare disparities, spiritual aspects of care, and sociological and cultural perspectives on death and dying.

**Cassandra Cotton, CNA, CHPNA,** of Nathan Adelson Hospice, shares the following story that illustrates the need for staff to be culturally sensitive. "You need to start by asking, 'What's in your basin?' This refers to the contents of the personal care kits that patients in her program receive upon admission. Many people don't know that fine-tooth combs are difficult to use and can be damaging to African American hair. And so if you present a welcome packet with items that are not suitable for them, it gives the impression that the organization doesn't really know or care about patients. It also misses an opportunity for deeper understanding and connection. Give your staff the right tools to care for patients, and make sure they know how to use them correctly."

An excellent resource is the Duke Institute on Care at the End of Life's APPEAL (A Progressive Palliative Care Educational Curriculum for the Care of African Americans at Life's End) training. Designed specifically for healthcare providers working with African Americans facing serious illness, the curriculum (accredited CEU's) includes a wide range of topics: spirituality, cultural beliefs, values and traditions of African Americans that may influence end-of-life care, the impact of racial disparities throughout the healthcare continuum, and barriers to quality care for African Americans with serious illness and strategies to improve their care. For more information about APPEAL, visit www.iceol.duke.edu.

## B. FIND THE RIGHT FIT

As you begin your outreach to African American communities, your planning team must be led by the right messenger. This messenger is the one who serves as the primary point of contact and organizer for all African American outreach activities. It is a big job, and hopefully one made more manageable by the support of your entire planning team. In addition, consider the diversity of the team itself. While it is not absolutely necessary and will not guarantee success, if your staff reflects the community you are seeking to serve, your ability to connect may be enhanced.

- **Select a messenger.** As introduced in the "Get Organized" section of this Guide, if you do not already have a point person, perhaps one can be hired, or another position can be adapted to fulfill the role. Alternatively, you might find a current hospice volunteer or another community member who would be willing to take on these responsibilities in a volunteer capacity. If you can make this happen, we suggest that you clarify how this person will serve as an official representative of your hospice and speak on your behalf.

  In filling this position, there are some important skills the person must possess. Personality matters more than anything else. *Is this person open-minded and creative? Is he/she the type of person who can develop and maintain relationships? Is he/she comfortable with public speaking? What about offering prayers?* In many settings at which African Americans will be present, it is expected that a prayer will begin and end a meeting, so he/she must be both comfortable in prayerful environments, as well as saying prayers him/herself. *Is he/she able to engage with diverse groups of people? What level of commitment does he/she bring? Can he/she be patient and commit for the long term? Does he/she have a willingness to work after hours and to attend a variety of functions across town?* Finding the right fit for that individual who will share your primary message with the community is of the utmost importance, so try to make your match carefully and appropriately.

- **If you can, hire diversely.** Making staff diversity a priority is simply smart and forward thinking – it enriches your organization and ensures that you remain vibrant and growing. For the specific purpose of outreach to African Americans, many hospice programs expressed that it can help if some members of the team look like the patients they serve. So if your staff is not already diverse, consider targeted recruitment to build a team that more accurately mirrors the wide range of people represented in your community. As mentioned in the "Get Organized" section of this Guide, be sure to provide diversity training for all of your staff, especially for those engaged in direct patient and family contact.

> *"I don't think necessarily you have to be an African American to provide good care to African Americans, but it you're not, you really need to be aware of the culture and some of the issues in that culture, and really look at how you feel about dealing with people from that culture,"*
>
> — AFRICAN AMERICAN NURSE [15]

## C. EDUCATE, SUPPORT AND LISTEN TO YOUR COMMUNITY

Informing, caring for and genuinely hearing the needs of the African American community are essential elements in your outreach, and enrich the opportunity for positive community-building. Simply meet the community where it is. Try to do more listening than talking in your growing relationships. Yet be sure to focus on education, show your support for the family systems that are already in place caring for loved ones, take your time, ask questions and listen to the answers. We suggest that you leave behind any preconceived ideas and stereotypes and don't make assumptions.

- **Address what hospice is and is not.** Be sure to focus on the "mis-facts," and don't assume that everyone is accurately informed. Learn what misconceptions are prevalent, and address the common misunderstandings. One of the biggest barriers to hospice use among African American communities is that they associate hospice with a "place" as opposed to a concept, and that "place" is where they go to die, so it's definitely not a "place" they want to go. There is also the view that suffering is part of hospice because traditional medicine is no longer allowed, or that pain is actually encouraged based on faith beliefs. Clearly, awareness among caregivers is a key to building true understanding.

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[15] From an interview for the Institute of Medicine's "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care" report, 2002.

So wherever you are, whenever given the opportunity, explain hospice benefits clearly. The ability to pay should not be a deterrent for anyone, and particularly African Americans who are more often uninsured. Explain the Hospice Medicare Benefit, and how re-certification works, if needed. Patients and families, and even some healthcare providers themselves, are often unacquainted with the benefits available should the patient live past six months; they are also sometimes unaware that some patients "graduate" from hospice.

- **Support the caregiver.** Recognize and respect the strong history and tradition in African American communities of "taking care of our own." African Americans have done so for centuries, and so effective outreach activities should not include a "we'll come in and do it for you ... because we can do it better" message. Offer to support current caregivers, explaining how the interdisciplinary team will care for the family, as well as the patient's physical, emotional and spiritual needs. Explain different options for care, from home-based to inpatient facilities.

**Cassandra Cotton, CNA, CHPNA,** of Nathan Adelson Hospice shares this perspective on the need to educate families about pain and suffering. "Education is a huge component – for patients, families and faith leaders. No one should die in pain. Alleviation of pain does not mean that prayers and hope for healing are discontinued. Pain and suffering are not necessary for atonement of life's indiscretions. Yet my own mother viewed her suffering as necessary for past sins. She died believing that if she had had just a little more faith she would have been healed."

- **Take your time and be patient.** Because many African Americans are suspicious of hospice and the entire healthcare system, and prefer to keep their illness to themselves, you must be patient throughout this process. Be prepared to make multiple visits, with many family members present, sometimes even with the pastor involved (see the "Embrace the Faith Community" section of this Guide), acting as a family liaison. This won't be a one-time conversation, and you may not get buy-in the first time. You must be willing to go through many rounds with the family so they know you're committed and that you truly have their best interests at heart.

- **Listen to their story.** As healthcare professionals, you have an incredible wealth of information – both from your clinical training as well as your professional experiences, and the natural inclination is to want to share all of it. Yet many African American families are not going to be interested in hearing from you just yet – they would rather be heard themselves, first. Sometimes it's best to listen. Many patients and families want someone to take the time to hear about their life's journey.

**Gloria Ramsey, RN, JD,** a nationally recognized expert in bioethics, nursing education, and health disparities, as well as a professor with the Uniformed Services University of the Health Sciences in Bethesda, Maryland, shares the following observations about the need to respect privacy and how differently African Americans deal with crisis. "What's of concern, from a deeply rooted cultural belief, is that African Americans are very private about diagnoses. The whole notion of people coming to the house, driving the vehicle with the hospice logo on it – these are difficult things for African Americans to accept. The concept of it being 'my business, and I don't want people in my business' can be a struggle, as well, because in an effort to keep people out of 'my business,' families are keeping out the very people who could be of great help."

You and your team members may need to adjust your approach. Currently, your preferred style for initial consults might be to say, "Here's what *hospice* can do for you." Instead, begin the conversation with, "What can we do for *you*?" A frequent comment made by African Americans under hospice care is that they would actually like to be asked what they think, what they know and how you can help. A common statement is *"If only we had been asked."* So ask the questions and go from there. Eventually, the time will come to share the benefits and support that the hospice team will be able to provide.

## D. FIND YOUR VOICE AND LET YOUR MESSAGE BE HEARD

Whenever and with whomever you engage, do so consistently, with a clear voice that sends the same message every time — we care, and are here to support you in all of your needs. Be mindful of the actual language used in personal conversations, and if appropriate, integrate faith-based language as you are comfortable. Your words and messages are critical as you strive to be heard.

- **Be genuine.** This is a simple, yet profoundly important element in your outreach. Be sincere and transparent. Connect deeply, and seek to genuinely empathize with the range of end-of-life issues your African American community is facing. You and your colleagues must be willing to devote time and energy to making lasting changes that support your outreach. With your staff embracing this intention, it is one that your community will eventually buy into. Anything less is disingenuous and will be quickly dismissed as staged efforts to gather people in without true substance.

- **Use the right words.** Try to use simplified terminology. Palliative sedation, end-of-life care, DNRs, advance care directives, opioids, artificial hydration and nutrition – while these are all used frequently in hospice settings, for someone unfamiliar with the healthcare system and facing crisis, these terms can be very confusing and even frightening. Consider focusing on the term "comfort care," especially in the beginning.

  When simplifying your language, however, be careful to not do so in a patronizing manner. Many healthcare professionals, who use medical jargon in everyday speech, should be reminded that using less technical language is a basic courtesy to patients and families who are just learning how to navigate the system.

  In addition, be sure to recognize the connected role of faith and medicine when having conversations with the African American community (see the "Embrace the Faith Community" section of this Guide.) Steer clear of scientific and medical absolutes as much as possible, and if you're comfortable, include references to faith when you engage African Americans in dialogue.

- **Rely on word of mouth.** Your commitment, your passion and your high standards of care will speak for themselves, and your personal relationships will inspire confidence. Within African American communities, personal testimony and word of mouth are among the most meaningful ways to share trusted information and get your message out. Rely on the good that you do being shared verbally within the various community systems that exist. While this shouldn't preclude some targeted marketing as discussed in the "Get Organized" and "Think About Marketing" sections of this Guide, it is a frequent method of information sharing within the African American community, and one that can be relied on.

- **Remember that it's not just business.** Regardless of how your planning team is structured or who is in charge, it is critical to operate within more of a social work frame, and less from the bottom-line business perspective. While building the numbers will be vital as you seek to maintain support and justify your outreach efforts, it is not the only thing that matters.

**Dr. Bernice Catherine Harper, MSW, MSc.PH, LLD,** one of the original leaders of the African American hospice movement, a former Medical Care Advisor to the Department of Health and Human Services (HHS), founding president of the Foundation for Hospices in Sub-Saharan Africa (FHSSA), and a former Board member of the National Hospice and Palliative Care Organization (NHPCO), emphasizes the importance of recognizing the role that "Dr. Jesus" plays for African American Christians facing serious illness. "Among African Americans, there are those who will be suspicious of anyone who purports to have medical answers that are best left to 'Dr. Jesus.' Be careful with any comments that begin with, 'The doctor said …' or 'The experts all say …' These statements of medical absolutes will not go over well. Instead, consider saying, 'While only God can really know when it's your mother's time, the best medical information tells us that …' or 'We really can't know for sure, but with God's will and what medical science tells us …' This manner of explanation is presented in a culturally appropriate manner and takes in the role of faith, and will be 'heard' best."

## E. LOOK AND THINK BEYOND HOSPICE

There must be a commitment to more than simply introducing African Americans within your community to hospice. It's more than numbers and larger than your organization. It is about social justice and ending healthcare disparities, and helping African Americans recognize that hospice truly helps the living. As you reach out, simply consider the big picture.

- **Consider more than the illness.** Sometimes a patient's illness is just one part of a bigger, highly complex family system. It's one thing to struggle with physical pain, but altogether another to be so overwhelmed by medical expenses that there simply isn't enough money to buy groceries for the family. Ensure that your staff is aware of the community resources available to help with a wide range of issues, some completely removed from the patient's physical needs, and be certain that they share this information in detail with patients and families. Above all, an environment should be created in which a patient or family member feels comfortable enough to bring these kinds of problems to anyone on the team.

**Stacie Pinderhughes, MD,** of North General Hospital, New York, NY, reminds us that, "Blacks and Latinos don't want to 'embrace your dying.' So in communities of color the discussion can't be about the dying, it has to be about the living. Initiatives must answer the question, 'How does this palliative care help my living?'"

- **Recognize disparities and remember history.** In this Guide's overview and focus group summaries, a very brief review is provided of African Americans views and experiences with regard to healthcare and death and dying. Additional research reflects that many African American doctors themselves treat their own patients differently, too, and are often inclined to treat disease more aggressively, and turn to hospice later, rather than sooner. This attitude is driven both by the patients, who prefer the treatments for longer than is necessary or beneficial, and by the doctors, who want to "do right" by their African American brothers and sisters. Be mindful of the realities of treatment differences, healthcare disparities and basic historical experiences.

**Lyla Correoso, MD** explains, "Sometimes death is not the biggest factor. Sometimes staff has to focus on concrete services, such as paying for the electric bill and securing guardianship of children and/or parents before they can deal with issues of death and dying. Many homes are in need of additional support prior to the onset of illness, that is, there was dysfunction before, so there is no reason to expect that these problems will go away when tragedy strikes."

## F. CONSIDER MARKETING

Marketing is just one aspect of outreach and community engagement along with education, public/community relations and sales. If you don't get your message out, who will? Remember that there are many misconceptions about hospice within the African American community. This is an opportunity to dispel those myths and spread the word about what hospice is, and is not!

- **Revise existing collateral or create new materials.** Collaborate with your communications team, and be sure that all of your public relations and marketing materials – brochures, newsletters, annual reports, and training manuals – anything that the public will see – offer an accurate representation of your demographics and a thorough understanding of the population you seek to serve. Images that African Americans will connect with include extended family gathered around the bedside of a loved one, families sitting together and holding hands, and a faith leader praying over a patient with family present.

  Consider revising/re-thinking *all* of your collateral, including everything from the display boards you set up at area events to welcome packets for patients and families. Some hospices include coupons from local restaurants and hand-made quilts –anything that makes a personal connection and expresses warmth and concern. If you don't have the resources or time to create or re-create your own marketing materials, Caring Connections offers a variety of brochures that you might consider utilizing.

- **Work within your systems.** If your hospice is part of a wider healthcare system in which all public relations and marketing are managed by a separate department, communicate well before any advertising is submitted. Don't let anything go out until many eyes have viewed it, especially your own, checking for accuracy of language and appropriateness of images. Since you are the one delivering the message, be sure that the actual materials are ones that are suitable and present the right ideas to draw in the African American community.

**Sally Sharpe, RN,** with Pike's Peak Hospice & Palliative Care in Colorado Springs, CO, serves as palliative liaison for communications and marketing. Revising existing collateral was a key part of her outreach strategy. "We formed a coalition to help look at our existing materials. We found that most only included images of white people, which wasn't an accurate representation of our community at all, and they missed an opportunity to target and address the specific fears and needs of the African American community. So we created a new brochure and video that includes images of African Americans, Hispanics, Asians and Caucasians. Basically, the pictures in the outreach materials have to look like your community, and having a specific handout just for the population you're targeting is critical. It should also include the right buzz words, which, in this case, are: relief of suffering, comfort, family and faith, and overall, less of a focus on death and more on 'transition.'"

## G. BUILD PARTNERSHIPS

The foundation of all outreach is relationships, built over time on deep trust and understanding. Seek them out in both obvious and obscure areas. Commit to fostering meaningful, life-long partnerships with a wide variety of African American groups in your community. Nurture them and continually re-examine them to be sure they are thriving and mutually beneficial. This section lists a number of ways and a wide range of organizations that you can turn to, to get your community-building underway and your partnerships established for vibrant, mutually beneficial, long-term engagement.

**Stacie Pinderhughes, MD,** offers the following suggestion for connecting with area businesses, specifically local restaurants. "Food is very important in African American culture. It is life. It is nurturing. So building a relationship with Sylvia's, a well-known restaurant in our area, has been vital. Sylvia's agreed to provide meals to hospice patients and their families once a week. Having a restaurateur of this caliber come in with food that is familiar, is key. Offering families the opportunity for table fellowship is important. Theologically it is very Eucharistic, and this brings great peace to all who are with us."

- **Engage the entire community.** As discussed in the "Get Organized" section of this Guide, it is imperative to gather support. Your planning team can be comprised of staff and volunteers (with all interdisciplinary team members represented), as well as a wide range of African American community leaders. Don't leave anyone out! Invite local faith leaders, healthcare professionals, business leaders, academics and students to be a part of the team that will guide your outreach. Invite members to attend meetings, and encourage them to consider committing to meeting regularly to provide guidance, suggestions, focus and oversight.

- **Learn about African American organizations.** There are numerous groups, committees, organizations and coalitions within your community geared specifically towards African American interests and needs. Some are nation-wide, and others are based right in your own community and serve the needs of your population. Gather this information by simply asking anyone in a position to know, scouring local media, noting community events, surfing the Internet and checking your local Yellow Pages. When you have a fairly comprehensive list, and have done the necessary research to learn about their priorities and interest, start reaching out. (Suggestions for how to do this may be found in the next two sections, "Embrace the Faith Community" and "Participate in and Host Community Events.")

Some of these groups include:

- ❖ Professional organizations, such as the National Medical Association (www.nmanet.org), National Black Nurses Association (*www.nbna.org*), and the National Association of Black Social Workers (*www.nabsw.org*)
- ❖ Local chapters of the NAACP (*www.naacp.org*), National Urban League (*www.nul.org*) and National Black Chamber of Commerce (*www.nationalbcc.org*)
- ❖ Multi-cultural centers, both within the community and on college campuses
- ❖ Health-related organizations, such as HIV/AIDS, child/maternal health, diabetes, heart disease, and others
- ❖ Sororities and fraternities on college campuses, and their related alumni groups and members through the National Pan-Hellenic Council (a coalition of the nine largest historically African American Greek-letter fraternities and sororities with over 1.5 million members)
- ❖ Men's organizations, like 100 Black Men of America (*www.100blackmen.org*) and the Masons (*www.freemasonry.org*)
- ❖ Women's organizations, including the National Council of Negro Women (*www.ncnw.org*) and Sisterhood Agenda (*www.sisterhoodagenda.com*)

**Cheryl Gilkes,** a professor of sociology and African-American studies states: "Throughout history, black churches have shielded African Americans from the harmful effects of personal and structural racism and their worship services have also functioned as a therapeutic community where people can sing with joy and exuberance or cry out in pain among those who care and understand."[16]

- **Join them.** While you may be asked to attend a specific group meeting as a result of the relationships you build, also be proactive and join them, showing your commitment and passion for their cause. Contact their leadership first, and ask whether they have any topics they would like you to address at one of their upcoming meetings (see the "Participate In and Host Community Events" section of this Guide.) If they don't have something in mind, offer your own presentation ideas, and set aside a singular agenda of promoting your own hospice. Instead, use these opportunities to get to know the members themselves and to learn about their needs. Promoting your program and welcoming new consumers will come in time.

Caring Connections offers a Faith Community Outreach Guide that can serve as a supplement to this section. It provides a very comprehensive review of why reaching out to faith communities is so important and detailed strategies for how to do so. Visit *www.caringinfo.org/Community*, then click on "Faith Outreach" to download the Guide for free.

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[16] Gilkes, C.T. (1980). The Black Church as a therapeutic community: Suggested area for research into the black religious experience. Journal of the Interdenominational Theological Center, 8, 29-44.

- **Link up.** Hospice can be linked to so many causes in your community, presenting perfect partnerships for collaboration. An example is the Balm in Gilead programs, which focus primarily on African American HIV/AIDS awareness and cervical cancer (ISIS Project). Often, their events will be co-sponsored by local churches. (See the "Embrace the Faith Community" section of this Guide.) By pooling resources on projects and events, the benefits can be enormous.

- **Involve and engage young people.** Young adults, teenagers, even 'tweens' have the energy and enthusiasm of youth, and an excitement and passion about causes that can invigorate families, schools and communities. Many are often seeking to fulfill community service hours, either through their school or their church, and will eagerly take on a variety of tasks within your hospice, providing diversity through ethnicity and age! Young people will be eager to help spread the word about you and what you do, especially if they're engaged in a project that excites them. So don't leave this pool of potential participants out when seeking opportunities for partnership-building.

**Gloria Ramsey, RN, JD,** relates, "You want to go into a place where you're building upon existing and already established relationships and infrastructure. You can't build that capacity and do the work, too. There needs to be great give and take between both parties. After you've made your assessment (because you need to know your baseline), let them assess if they want to work with you, too. Build on the knowledge you gather about community, culture and church — all these must go together."

## H. EMBRACE THE FAITH COMMUNITY

Within African American communities, faith can carry more weight than medicine. As discussed in the "Religion" section of this Guide, many African Americans are deeply connected to their faith community and will turn there for support before seeking help from other agencies. The church serves as the bedrock of spiritual activity, a center of social engagement, an indispensible source of information on all topics and a critical foundation of support in times of crisis.

- **Faith is "It."** Studies suggest that African Americans are willing to participate in health education programs such as smoking cessation, blood pressure and cancer screenings when they are held at their churches, mosques, and synagogues. And since the place of worship is often the primary source of information on a wide range of subjects, it offers one of the best ways to reach the widest audience in a safe, trusted environment.

*"If I can't have cure in my body, at least let me have healing in my soul."*

— BISHOP SIMON GORDON,
TRIEDSTONE FULL GOSPEL BAPTIST CHURCH,
CHICAGO, ILLINOIS

- **Find your "In."** Begin by identifying the person who handles health-related issues. This might be a lay leader, member of the Diaconate (deacon or deaconess), parish nurse, the head of the congregational care ministry or a social worker who serves as bereavement coordinator. He/she can be your conduit to the pastor (unless you are able to meet with the pastor from the outset). Set up a time to meet and find out the needs of the congregation. If appropriate at the first meeting, offer to host an advance directive or a hospice session. If the church holds its own health fairs, ask to set up an exhibit.

  Consider attending services regularly. Come early and stay late for personal introductions and to distribute materials if appropriate. Become a presence in the church. In time, congregants will know you as the hospice contact, and may start coming to you with their needs.

  Research shows that there are more than 1,700 church-sponsored outreach programs providing for the spiritual and physical well-being of African Americans. These programs cover basic needs such as food, clothing and shelter; financial aid and counseling for personal problems; health-related concerns such as HIV/AIDS and substance abuse; and recreation and fellowship for youth and families.[17] So within this spectrum of faith-based support, be aware that you may be competing with many requests from other groups and simply emphasize that hospice can also be a part of those conversations.

**Sally Sharpe, RN,** involves pastors as intimately as possible in all familial interactions, particularly in the very beginning. "We ask pastors to be present when the initial meeting takes place with a family, or at a minimum, to call in from their offices while we're meeting with the family. The best strategy is to try to make sure that the pastor is actually there in the home. We have developed a great relationship with our African American community and church. If the pastor is pro-hospice, it makes the process much easier, and infuses it with trust and security."

- **The Pastor's role is a critical one.** Not all clergy and faith leaders have the skills to advise families on end-of-life decisions. Be aware that many families will keep their pastor intimately involved in discussions and decisions about their care. Some families will even ask their pastor to be present for at least the initial meeting with hospice admissions staff. Welcome his/her presence and encourage the family to keep that relationship strong.

  Generally, pastors emphasize the duality of spirituality and proper medical care, and when serious illness is involved, it is important that he/she understands the wide range of hospice services, and how they can support his/her congregants. Be aware that some families see the pastor's job as praying for healing, first and foremost. While the pastor him/herself will acknowledge that he/she cannot work miracles, the mere suggestion of hospice might be of concern to a family who will perceive it as a pastor turning away from faith and more towards medicine.

  Pastors often find themselves negotiating the delicate balance between continuing to pray for hope and healing, but also encouraging the supportive network and resources of hospice.

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[17] Billingsley, A. (1999). Mighty like a river: The Black Church and social reform. New York: Oxford University Press.

- **Celebrate life and living, and the role of faith and hope!** Explain that hospice is not about giving up and ending life prematurely, but instead about celebrating life and making the time remaining as meaningful as possible. Hospice's focus is appropriately on life and living, with the ever-present acknowledgment of the role that faith plays. Because faith and healthcare are inextricably linked within African American communities, your team will be unsuccessful if you avoid spirituality and talk only about medicine. But do emphasize that accepting hospice does not mean the patient must give up faith and hope for healing. Hope is always a part of hospice.

**Dr. Bernice Catherine Harper, MSW, MSc.PH, LLD,** shares this perspective on the need to recognize death and dying and views on hospice within African American communities: "Be aware that African Americans, like most of us, are not into death and dying; they are into life and living! As a general rule, they see death as going home, and going away from a world of discrimination and hardship. So they can't get too excited about hospice. To them, hospice is a white middle class movement, and not one they view as personally applicable. So we need to help them understand it and be aware of it and present it to people of color in the appropriate cultural context. Be prepared to address the underlying concerns of the patient and family who will respond with, 'Where have you been my whole life? When I needed clothes? Or food? Now you come when I'm dying. But I'm going home. I don't need this now.' We need to break those barriers to healthcare and hospice for African Americans."

Check out Caring Connections' *It's About How You LIVE* campaign toolkit and NHPCO's 2008-09 Outreach Guide which uses the theme of Hope, Dignity, Love...It must be hospice. Both resources contain a collection of ideas, suggestions and materials to help you with your outreach efforts.

The Duke Institute on Care at the End of Life, and the Duke Divinity Office of Black Church Studies developed the Proctor Covenant Statement on End-of-Life Care. The covenant serves as an initial pledge signed by faith leaders from across the country to support initiatives to improve end-of-life care in the black church. The Proctor Covenant statement is available to view and download in the Appendix of the Guide and can be used as a theological statement on quality care at the end of life and a defining statement, standard and guide for African American clergy. For more information, visit www.iceol.duke.edu.

## I. PARTICIPATE IN AND HOST COMMUNITY EVENTS

To help make hospice a household word in your community, participate in local community events, especially ones organized by and for African Americans, or ones that target issues of interest to the African American community. Organize events and invite everyone to participate. These can be held in conjunction with existing events or independently. Either way, find the appropriate focus and work collectively to plan successful gatherings that energize and inform and bring your diverse groups together.

As with many other elements of your outreach, the key is to take your time and do your research before rushing into things. Excellent tools and resources are available at www.caringinfo.org/event_planning_toolkit, where you will find checklists for planning your event, sample flyers and posters, even how to publicize your event. While most event planning strategies can be effective regardless of your audience, some will be more successful depending on the specific community you are trying to reach. The following essential elements are geared specifically for participating in and hosting events for African American audiences.

- **Come to my house!** Look for opportunities to invite folks to "your house." Welcome all potential partners and interested parties to an inaugural event to initiate your outreach (see the "Build Partnerships" section of this Guide). Community or prayer breakfasts are often very successful and can be incorporated into a workday. Ask one of the attending faith leaders to offer a blessing before the meal, thereby acknowledging the integral role that spirituality plays from the very beginning.

  Think very creatively about opportunities to gather. For instance, an event scheduled around the birthdays of Charles Drew (the father of the modern blood bank) or Daniel Hale Williams (the physician who performed the first successful open heart surgery) is an excellent way to honor the contributions of prominent African Americans, built around a creative celebration that also focuses on wider healthcare/hospice topics. In conjunction with your coalition or planning team, select a prominent community figure to host the event.

- **Can I come to your house?** As your relationships grow, invitations to "go to them" may come. If you sense reticence, spend more time getting to know one another, and in time, as trust is established, the call may happen. If appropriate, bring copies of your collateral materials to distribute.

- **Make your message relevant.** Don't waste your new partner's time or yours by trying to guess which topics will be of most interest. Ask your contacts which issues are important to them. Combine this with the data from your community surveys. (See the "Get Organized" section of this Guide.) You can serve as a clearinghouse organizer for a variety of topics, all with specified relevance to that community group. Hospice, advance care planning, caring for the caregiver, and how to pay for healthcare may be topics to offer depending on your initial assessment.

- **Team up.** Don't try to do it alone! As mentioned in the "Build Partnerships" section of this guide, there are many other organizations with whom you can partner and host joint events. Hospice can play a role with health prevention groups focusing on HIV/AIDS, diabetes and cancer, or offering bereavement support to families of accident, suicide or homicide/gang-related victims.

  Families affected by homicide or gang violence are a natural outreach for hospice since staff members are experts at loss. Bereavement support to families experiencing loss bridges a gap and shows hospice as an inclusive caring group of experts who seek to help all those who are facing death and dying. However, when referring to what might be perceived as a stigmatizing topic for African American communities, be sure to avoid the suggestion that the issues are solely African American problems; homicide, gang violence and crime are universal societal concerns.

- **Go everywhere, attend everything.** There is rarely a lack of African American-focused community events to attend. Go to as many as you can, and invite staff members with you, particularly if it's to a high profile event, such as a gala or an awards banquet. Include a diverse representation of staff disciplines and ethnicity. And, if appropriate, bring your table-top displays and handout materials.

  **Examples of events include:**

  - Black History Month
  - Martin Luther King, Jr. Day
  - Kwanzaa (usually celebrated by younger families in addition to Christmas)
  - Juneteenth celebration (*www.juneteenth.com*)
  - Women's and men's group meetings and conferences
  - Fashion shows
  - School productions
  - and more ...!

**Toula Wootan,** Director of Community Relations for Community Hospice of Northeast Florida in Jacksonville, turned her outreach into a special initiative on community relations, targeting everyone who might be in need. She says, "It's all about relationship-building, and the overall goal should be one of community building. You must be patient and take time to build trust, particularly around healthcare. You need to show that you care about the health and welfare of the community. Show your sincerity by taking things a step further. For instance, we've partnered with one of our city hospitals for indigent care. We reach out by providing preventative care to local churches. In addition, we have the largest murder rate in the state of Florida. So to address a broad community concern, we launched an initiative called 'Operation Safe Street.' We involved many community groups, particularly African American churches. The focus was on gun control. We're experts in loss and bereavement, but can offer our support in ways other than hospice. We try to show that we care about the community, holistically. Our message is that we're here to care for you, and we're concerned about the same issues that you're facing."

**See the Appendix section of the Guide to download PowerPoint templates for Hospice and Advance Care Planning presentations that you can adapt for your community education needs.**

*"You should always ask to participate in health fairs or other community events, such as Juneteenth celebrations. These events are a part of the community, and you should absolutely be there to help support the event and the occasion itself. Some will be invitation-based, so your goal, as part of relationship-building, is to be the one invited. If you've built the right kind of relationship, one that is focused on more than death and dying, they'll see you as a resource and want to include you. So if you've been the first to reach out and trust has been built, you will be seen as a true partner."*

— SALLY SHARPE, RN
PIKE'S PEAK HOSPICE & PALLIATIVE CARE
COLORADO SPRINGS, CO

## J. CONNECT WITH AFRICAN AMERICAN MEDIA

The opportunities to get your message out are plentiful and consider the media outreach as an extension of your outreach plan. Research your local media, and determine which are targeted to African Americans. There are often daily, weekly or monthly periodicals, published by and for the African American community, as well as radio and television stations (both secular and religious) geared specifically to the same.

- **Research media outlets.** While you may have already done a good amount of market research on your community, as described in the "Get Organized" section of this Guide, do some specific digging to gather all of the information you can on your local media, learning which demographics they target. Turn on your radio and television and tune into their stations. Listen to the advertisements and make lists of popular topics and personalities. This may give you some insight into what's being advertised – by whom and to whom.

  However, because many people not of African descent rely too heavily on the media for research into the African American community, be appropriately cautious of the information you come across. Many African Americans will tell you that their community is much different than even the black media portrays them. A good comparison is the representation of Italian-Americans in literature and film, where an almost fantasy version is concocted with its emphasis on mafia ties. The best way to research real African Americans is to go into their communities and participate in their everyday activities.

- **Make contact.** As you have with all other groups or individuals, make formal and sincere introductions. Explain your intent. But before asking about advertising or articles, get to know key staff members – reporters, publishers, DJs. Invite them to join your advisory group, or come to a specific event. As with all of the strategies, a personal relationship will take you much further than throwing collateral at a media representative and expecting it to lead to a prominent feature.

- **Get your advertisements and articles printed.** Buy advertising space and submit articles - and don't necessarily propose something that solely features your hospice, at first. Instead, help celebrate a traditional African American holiday (see the "Participate in and Host Events" section of this Guide). While "Hospice X honors Topic Y" is getting your name out, it's being done in a more subtle and gracious manner. In time, you might present a specific ad or article on your hospice or coalition – and make sure that it is appropriate to the African American community, featuring images and language that are relevant and fitting.

**Sharon Latson**, Senior Director of Access Initiatives, VITAS Innovative Hospice Care® of Chicagoland, suggests that it's wise to link up with ethnic-specific media, but to be subtle in your advertising with them. "Historically, African American businesses weren't able to advertise or be employed by some local media, so they created their own. This has built a rich pool of African American media specialists who know how to reach their audience. While our objective is to get VITAS' name out, we try to do it in a way that is not just about hospice. We submit ads that convey a message of 'When you may need us the most.' This way, we create a presence and an awareness of VITAS in the community in an understated way."

- **Find your own spokesperson.** There may be an African American celebrity, local or national *(e.g., music industry representative, civic leader, local business owner)* who would be interested in becoming another voice for hospice. If a high-profile personality lives in your own community, or someone you know has a personal contact that could be promising ... pursue it!

**As all of these strategies suggest, one of the most important things that your organization must do when working with any cultural community for the first time is to build trust. Gaining the trust of a community takes time. Developing trust must be your main goal when seeking new partnerships and relationships. In our goal-oriented society, it is all too easy to focus on project goals rather than relationships. However, meaningful relationships are the best path to long term accomplishments. This is the best guarantee to successfully build partnerships and implement outreach activities with the African-American community.**

**For more information and resources on outreach to diverse communities, visit *www.caringinfo.org/community*, and click on 'Diversity Outreach'.**

# IV. Model Outreach Programs and Initiatives

## A. BRIDGING THE HEALTHCARE GAP: A TOUCH OF GRACE HOSPICE, INC., CHICAGO, ILLINOIS

After working in the hospice field for many years, Dr. Jennifer Moore knew she wanted to help decrease healthcare disparities among minorities, and specifically, increase the use of hospice services among African Americans.

Her solution? Founding and directing her own hospice, one that would focus on serving African Americans in the inner city. With a mission of bridging the healthcare gap among minorities and improving the overall quality of care to the local population, A Touch of Grace Hospice, Inc. focuses on the highest standards of care and cultural sensitivity, and provides extensive and ongoing diversity education and training for its staff, serving a census that is comprised of 97% minorities.

Moore understood what the barriers were from the outset – primarily distrust and misunderstanding. She found that increasing minorities' use of hospice must begin with healthcare provider education, and how hospice itself is presented. She advises professionals to stay away from typical "med-speak" and to present information in a culturally appropriate manner. The role of faith must be emphasized, not in a sense of giving false hope, but relating to their fears, and acknowledging the need to pray for hope and healing.

Another large obstacle is re-informing the community on what hospice truly is, and dispelling myths, especially those pervasive among African American communities. So education is a key component – in all of her outreach, with individual patients and families, as well as staff. Moore has found that once the community is well informed, residents become more receptive to the hospice dialogue. And the fact that her staff mirrors the community it is serving (94% are African American) is a particularly beneficial aspect.

**Moore's key outreach strategies include the following:**

- Create and make available culturally sensitive material
- Acknowledge the faith of the community
- Address what hospice is not
- Strive to have healthcare staff that looks like the community you're serving
- Meet with people one-on-one and be genuine
- Rely on word of mouth
- Consider more than end-of-life needs, because for some families, you have to start there before you can even talk about hospice

## B. CONNECTING THOUGH FAITH: NATHAN ADELSON HOSPICE, LAS VEGAS, NEVADA

It's personal for Cassandra Cotton, CNA, CHPNA, Community Relations and Outreach Coordinator at Nathan Adelson Hospice. After making a career switch to hospice after her own mother became ill, Cotton found fewer African Americans being served, and set out to change that. So she turned to her faith community, and with the support of her supervisor and pastor, established *The Caring Touch Ministry* at her church, one the largest congregations in the state. The ministry's goals are to support those who have been diagnosed with a life-limiting illness or are experiencing a debilitating disease, and to provide ongoing education about hospice services and continue the dialogue on end-of-life issues with the wider community.

Cotton says, "The education process begins with identifying the role of both the faith community and hospice. For centuries, faith communities have been the epicenter of caring. Hospice providers must find ways to educate faith communities and engage faith leaders in end-of-life care conversations. The congregation must have an informed, trained leader who has an understanding of the range of hospice services and how these services are delivered."

Cotton's first steps with *The Caring Touch Ministry* were to create a task force that helped spread the word throughout the congregation, and conducting a survey of the congregation to learn what they knew about hospice. She found great misunderstanding about hospice and a reluctance to discuss death and dying. So her strategies focused on hospice education, and training a core team of congregants to serve as members of the hospice ministry. Members now serve as hospice educators, spiritual caregivers and important referral sources.

Her next and ongoing initiative was setting up a workshop as part of a wider church health fair, entitled, "Getting Your House in Order." The focus was on advance care planning, presented in a scripture-based way so that the message of "preparing for your home-going" was one the community would hear. She emphasized the importance of building partnerships for the event, and linked with other churches, local Social Security and Medicare offices, the Nevada Center for Ethics and Policy, elder-law attorneys and notaries, nurses and hospice aides, volunteers, and funeral directors. She made sure that other community partners, such as local eateries and entertainers, would provide in-kind donations, and make the event fun and interactive. "Getting Your House in Order" events provide ongoing education and are well received by the entire community. And *The Caring Touch Ministry* serves as a solid link between its congregation and Nathan Adelson Hospice.

## C. EMPHASIZING COMMUNITY-BUILDING: PIKE'S PEAK HOSPICE & PALLIATIVE CARE, COLORADO SPRINGS, COLORADO

In 2001, One Voice At a Time (OVAT) was begun as an initiative by Pike's Peak Hospice and Palliative Care (PPHPC) to address the under-utilization of hospice services by African Americans in Colorado Springs/El Paso County. Led by Sally Sharpe, a nurse who serves as palliative liaison and director of communications and marketing, OVAT quickly turned into a community-building endeavor as well. Recognized locally and state-wide for its innovative ideas, OVAT has received multiple awards, including the Outstanding Achievement Award from the Colorado Hospice Organization in 2003, and the Urban League Community Outreach Award in 2004.

The OVAT advisory committee was formed with the intention of not simply informing the community of what PPHPC does, but also listening to what the community's needs were. OVAT staff focused on spreading that message. Within a year of its inception, OVAT had reached out to other prominent organizations in the African American community such as the Black Leadership Forum, NAACP and the Urban League. From the initial support a coalition was created, including staff, ministers of local congregations, prominent African American leaders and a wide range of community members simply interested in supporting the cause. Recent events include healthcare conferences and fairs, Urban League Elder gatherings, and an NAACP-sponsored Freedom Fund. And as a part of bereavement outreach, an OVAT committee member suggested "Barber Shop Gatherings," which has turned into a popular way to support local African American men in one of their most comfortable settings.

In 2003, OVAT released new brochures and a video geared directly towards end-of-life care for African Americans and other minorities. PPHPC credits its success to building strong relationships, initiating community gatherings and always making face-to-face contact (as opposed to direct mailings). While promoting OVAT events, it also sought to build the initiative beyond hospice. OVAT has become a community-building and enriching program, and together with the strong ties built with both the African American and other minority communities, continues to spread the message of hospice and palliative care.

## D. FOCUSING ON CHILDREN: HOSPICE AND PALLIATIVE CARE OF GREENSBORO, GREENSBORO, NORTH CAROLINA

Kids Path, a unique children's hospice program developed by Hospice and Palliative Care of Greensboro, is the most diverse program of all those offered by the organization, serving well over fifty percent minorities in both North and South Carolina and West Virginia. Housed in its own facility, it cares for children ages 3 – 18 who are living with serious, progressive medical conditions. In addition, it provides support for children and youth experiencing the grief associated with the illness or death of a loved one.

The goal of Kids Path is to enhance the quality of life for children and those who share their lives while regaining a sense of normalcy. Ursula Robinson, Vice President of Clinical Services, explains that "the program is unique in that it targets all sick children, not only those with a six-month prognosis and eligible for Medicare, but situations where the doctor does not believe they will reach adulthood. It is palliative care in the truest sense." Currently serving 40 children, it also reaches out to grieving children whose parents are in hospice. Kids Path is the only vendor allowed in the Guilford County school system.

While the demographics of the area show a majority of Caucasian residents, Hospice and Palliative Care of Greensboro and Kids Path serves a very high percentage of African Americans in the community, more than the average hospice. Robinson works with families and the wider community, emphasizing education. "For those who are eligible for hospice benefits and services, it is their right to receive them. We find that far too many don't utilize hospice simply because they don't understand what is available and what they are entitled to." For African American families with terminally ill children, Kids Path serves a community need that offers quality care to minorities, while building trust, faith, hope and understanding.

## V. Resources for African American Outreach

### A. PROFESSIONAL ORGANIZATIONS

- **Bureau of Labor Statistics (BLS)**, *www.bls.gov/news.release/empsit.nr0.htm*, is the principal fact-finding agency for the federal government in the field of labor economics and statistics. The BLS is an independent national statistical agency that collects, processes, analyzes and disseminates essential statistical data to the U.S. public, Congress, other federal agencies, state and local governments, and the business and labor sectors.

- **Caring Connections**, *www.caringinfo.org*, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer and community engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation. Caring Connections provides free resources and information that address end-of-life issues such as advance care planning, serious illness, caregiving, grief and more.

- **Duke Institute on Care at the End of Life**, *www.iceol.duke.edu*, is a catalyst for growth and transformation, a global resource to improve care for those at life's end. The mission of the Institute is to create and promote the growth of knowledge and to encourage the application of that knowledge in caring for the whole person at life's end.

- **Institute of Medicine of the National Academies (IOM)**, *www.iom.edu/?id=33252*, provides a vital service by working outside the framework of government to ensure scientifically informed analysis and independent guidance. The IOM's mission is to serve as adviser to the nation to improve health. It provides unbiased, evidence-based and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society and the public at large.

- **National Center for Cultural Competence (NCCC)**, *www11.georgetown.edu/research/gucchd/nccc*, provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental healthcare delivery, administration, education and advocacy.

- **National Center for Health Statistics (NCHS)**, *www.cdc.gov/nchs/fastats/black_health.htm*, is the nation's principal health statistics agency and operates as a part of the Centers for Disease Control and Prevention. The NCHS compiles statistical information to guide actions and policies to improve the health of US citizens. It serves as an excellent public resource for health information and a critical element of public health and health policy.

- **National Hospice and Palliative Care Organization (NHPCO)**, *www.nhpco.org*, is the world's largest and most innovative national membership organization devoted exclusively to promoting access to hospice and palliative care and to maintaining quality care for persons facing the end-of-life and their families.

- **Office of Minority Health (OMH)**, *www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=51*, seeks to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. It advises the federal government on public health program activities affecting American Indians and Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians and other Pacific Islanders.

- **Robert Wood Johnson Foundation**, *www.rwjf.org/reports/grr/046134.htm*, seeks to improve the health and healthcare of all Americans. Its efforts focus on improving both the health of everyone in America and their healthcare – how it's delivered, how it's paid for, and how well it does for patients and their families.

- **U.S. Census Bureau**, *www.census.gov/prod/2007pubs/acs-04.pdf*, serves as the leading source of quality data about the nation's people and economy. This link is to a 2004 report that present a portrait of the African American population in the U.S. It provides a wide range of information on demographic, social, economic and housing characteristics of the population.

## B. EDUCATIONAL TOOLS

- **APPEAL (A Progressive Palliative Care Educational Curriculum for the Care of African Americans at Life's End) Training, Duke Institute on Care at the End of Life,** *www.iceol.duke.edu/events/2008appealtraining.html*, is designed for healthcare professionals working with African American patients and families facing serious illness in hospitals, hospices, outpatient clinics, nursing homes and office-based settings and covers a wide range of issues pertinent to end-of-life care, from cultural issues to healthcare disparities. Participants include physicians, nurses, social workers, medical chaplains and other clergy, psychologists, counselors, hospice and hospital administrators, pharmacists and family caregivers.

- **Key Topics on End-of-Life Care for African Americans**, Duke Institute on Care at the End of Life, *www.iceol.duke.edu/resources/lastmiles/index.html*. Topics covered in this on-line book range from the impact of health disparities on end of life decision-making to spiritual aspects of care at life's end, to sociological and cultural perspectives on death and dying and finally, even to health policy considerations. The information is provided for individuals and organizations interested in increasing their understanding of African American perspectives on end-of-life care that influence important questions such as access to hospice and palliative care, and the quality of care delivered in those settings.

## C. WEB SITES

- **African Americans.com**, *www.africanamericans.com/Demographics.htm*, has over 750 web pages on the African American community. The site covers many topics, including black history, the civil rights movement, slavery, African American art, and black gospel music. It also includes profiles of famous African American historical leaders such as Martin Luther King Jr., Muhammad Ali, Frederick Douglass, as well as current black celebrities, like Tiger Woods, Michael Jordan, Serena Williams, and more.
- **Black Demographics.com**, *www.blackdemographics.com*, provides interesting facts and statistics about the African American population nationwide.

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# VII. Appendix

Click on links below to view and download the documents. All documents may be accessed at

www.caringinfo.org/community

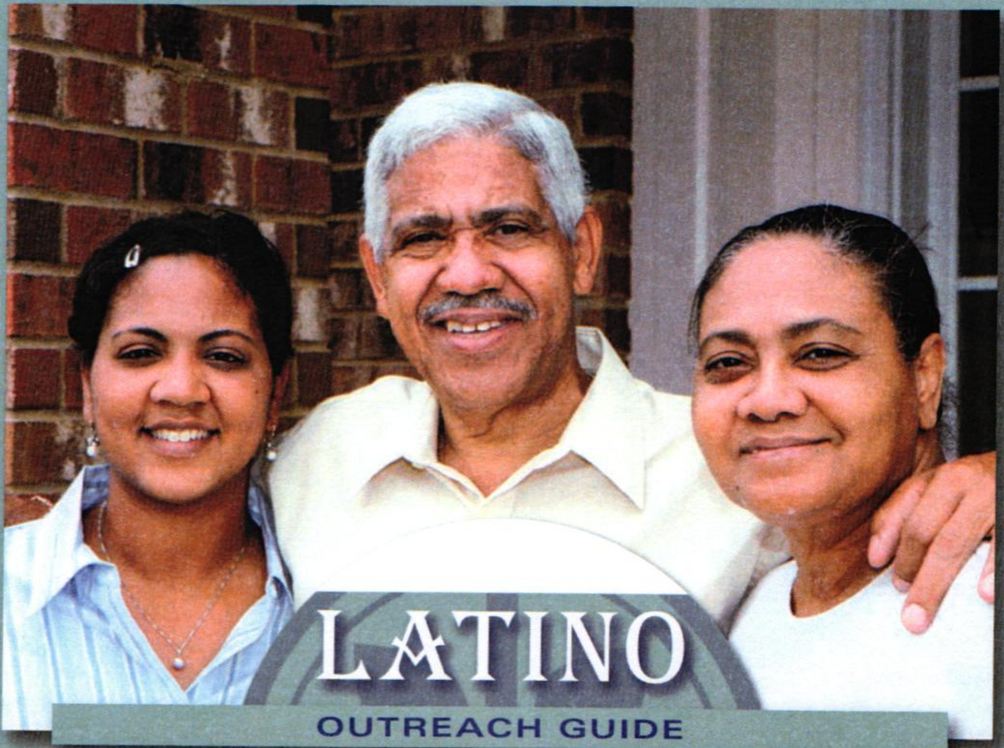
then clicking on "Diversity Outreach".

*Proctor Covenant Statement on End-of-Life Care (pdf)*

*Advance Directives and End-of-Life Decisions (ppt)*

*Understanding Hospice, Palliative Care and End-of-Life Issues (ppt)*

Exhibit 37



# LATINO

## OUTREACH GUIDE

Caring Connections
a program of the
National Hospice and Palliative Care Organization

## Table of Contents

**See the Appendix section of this Guide to download PowerPoint® templates for presentations that you can adapt for your community education needs.**

# I. Overview

As the number of Latinos living in the United States continues to increase, it is vitally important for hospices and end-of-life coalitions to expand outreach and programmatic efforts to ensure Latinos receive quality end-of-life care. NHPCO's Caring Connections has created a Latino Outreach Guide to provide you with ideas and resources to guide your outreach efforts. We have included resources that are in English and Spanish to help you reach out to Spanish-speaking individuals and communities.

In 2005, Hospice Caring Project of Scotts Valley, CA, formed a Latino community partnership called "Mensajeros de Confianza" ("Trusted Advisors") to engage local health and human service professionals in a conversation about end-of-life care for the Latino population. The Latino Outreach Guide highlights this partnership as a model for hospices and coalitions who would like to expand their community outreach to the Latino population.

Please refer to the 'Key Terms for Latino Outreach' document which includes phrases or words you may encounter when interacting with the Latino population. While the Latino community in this country is composed of many different cultures and nations, most Latinos in the United States have Mexican roots. Therefore, we have emphasized Mexican culture and heritage in these materials, while recognizing that there will be variations in many communities. As with all successful outreach efforts, the characteristics of the community or region should always be taken into account.

As you begin to implement your outreach activities, please feel free to adapt the resources included in the Outreach Guide to serve your specific needs, however, we ask that you credit Caring Connections. You can contact us at *caringinfo@nhpco.org* and we will provide you with the text for your credits since our materials are copyrighted.

## II. Caring Connections Latino Focus Groups: Key Findings

In May of 2006, Lake Research Partners (LRP) conducted four focus groups with Latinos for Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO). These focus groups were part of a broader study aimed at informing NHPCO's outreach and communication efforts to diverse racial and ethnic communities. Since the goal of community outreach is to engage people in end-of-life discussions before they are faced with a crisis, the focus groups were conducted with middle-aged Latinos who had not lost a loved-one in the recent past and had never had a life-threatening illness or injury. Two groups were conducted in Spanish in Houston, and two were conducted in English in Los Angeles.

**The following are some preliminary recommendations from the focus groups conducted in May 2006.**

### ADVANCE CARE PLANNING

Although the majority of Latinos are unfamiliar with the concept of advance care planning, the subject resonated with the Latino community and participants felt basic education materials would be helpful. Latinos, more than other Americans, are more likely to have planned for what will happen after death. They may have made funeral plans, purchased life insurance, or written a will. Participants discussed the importance for family members to come to consensus about the care of loved ones.

A majority of focus group participants said they personally would not want to be kept alive on life support, but are more divided about withholding life support from a loved one. Brief, descriptive resources on end-of-life topics including artificial nutrition and hydration are needed.

### END-OF-LIFE CAREGIVING

A better understanding of the term "caregiver" is needed within the Latino community. For many Latinos the term "caregiver" implies a professional role such as that of a nurse or home-health-aid. Family caregivers may not identify themselves as such since caring for family members at home is part of their culture and tradition.

### HOSPICE

It is important to emphasize to Latinos the importance of family in hospice care. Some Latinos have not heard of hospice, and many who have do not know much about it. Some equate hospice with nursing homes. Nursing homes have negative connotations in Latino families because they go against the cultural tradition of the family providing care for the sick and elderly. It was with this focus group that the term "compassionate care" was found to be more effective than "hospice."

## III. Hospice Caring Project's "Mensajeros de Confianza" Community Partnership Profile

**Hospice Caring Project (HCP), a hospice provider that serves the Santa Cruz area in California, raised $170,000 from three funders for an 18-month "Challenge of Change" initiative to:**

- Learn about preferences involving terminal illness, death, and bereavement for the local Latino community, and
- Develop a plan for lessening barriers to hospice that will enable HCP to successfully deliver end-of-life care to this community.

It took a significant amount of time for HCP to gather information from the local community, create and expand community partnerships, and build awareness about end-of-life issues in the local Latino community. **From their experience, HCP found that:**

- It is imperative that culturally-relevant practices and procedures are integrated into all services.
- A strong internal committee and a strong external advisory committee must support the project.
- To best identify service barriers and develop the means to remedy them, the target community must be involved in your organization as a partner.

There were several structural changes that HCP made in order to achieve their objectives. **Specifically, HCP:**

- Hired bilingual/bicultural clinicians and staff when possible.
- Created a new bilingual/bicultural Latino Community Liaison position to coordinate outreach. *A high school educated Latina woman was hired who brought her ties to the community (15 years working at a local clinic) and the right personal traits (an outgoing personality, compassion, and strong communication skills) to the position.*
- Actively recruited Latino leaders to serve on HCP board.
- Provided cultural competency training sessions for all HCP staff.
- Incorporated goals and objectives for serving the Latino community into their strategic plan ensuring a level of accountability to the Board of Directors and the management team.
- Integrated knowledge from research conducted with the Latino community and gained from community partners into day-to-day operations to ensure that all HCP staff work together to provide compassionate end-of-life care to Latinos.

## COMMUNITY PARTNERSHIPS

HCP recruited three key partners (a non-profit community health clinic, an umbrella group for Catholic charities, and an organization that supports women with a cancer diagnosis) as their primary collaborators. HCP established a 'Memorandum of Understanding' with these agencies, agreeing to share knowledge, resources, and provide HCP with referrals to Latino families in need of hospice and bereavement services.

## MENSAJEROS DE CONFIANZA ("TRUSTED ADVISORS") ADVISORY COMMITTEE

The three original partnership organizations served as founding members of the Mensajeros de Confianza, an advisory committee that grew to include 28 organizations of diverse size and purpose who serve the local Latino community; a majority of members are Latino. Establishing the three initial partnerships gave credibility and importance to the development of Mensajeros de Confianza, and their commitment encouraged others to attend, as did familiarity with HCP's Latino Community Liaison from her previous affiliation with the local health clinic.

Through its monthly meetings, Mensajeros de Confianza, has become an important resource for HCP to engage the larger community of local health and human service professionals in a conversation about end-of-life education for the Latino population. Importantly, Mensajeros de Confianza evolved into a community forum for addressing a wide range of Latino service barriers affecting various health and social service disciplines. A diverse group of organizations, from the media, business, and political communities, as well as traditional service providers, are fully engaged in supporting each other, educating each other in their respective community roles, and discussing how they can work together to ensure that all community members are equally served.

## FAMILY INTERVIEWS

To begin their focus on Latino families, the Latino Community Liaison at HCP and an experienced bilingual counselor conducted 8 interviews with Latinos whose family members had previously used HCP's services. Through the interviews, HCP gained information about end-of-life beliefs, concerns, and traditions.

Interviewees made it clear that bilingual and bicultural staff made a significant contribution to their hospice experience. They described cultural nuances such as the importance of family unity, and family members visiting from their home country at the end of life, in which case travel and immigration assistance is very important. All interviewees discussed the importance of the El Novenario ritual, common in many Latin American countries, where the body of the deceased is held in the home for a minimum of 24 hours.

Lastly, interviewees felt that an important way to reach the Latino community is through Spanish language television, radio, and diverse print media.

## INTERNAL WORKGROUP

In order to ensure that HCP incorporated outreach to Latinos throughout its structure, an internal workgroup was formed, composed of the Executive Director, Director of Clinical Services, Director of Volunteer Services, Latino Community Liaison, bilingual/bicultural nurses, home health aides, and a bilingual social worker who met monthly to discuss systems issues related to serving Latinos.

The presence of bilingual/bicultural employees was very important because they are the first to know if an approach that HCP uses is being received well or should be reconsidered. The Internal Workgroup also addressed many of the issues that arose at the Mensajeros de Confianza Advisory Committee meetings and contributed to the development of community outreach materials. In addition, the internal workgroup discussed how to best serve Latino families using HCP services.

## CULTURALLY-RELEVANT BILINGUAL MATERIALS

Another important component of the outreach HCP has done has been retaining a part-time Spanish language consultant for the purpose of translating HCP admittance forms and other appropriate documentation, translating recruitment information targeting bilingual/bicultural personnel and developing a Spanish-language HCP brochure and accompanying outreach materials. This consultant worked closely with the Latino Community Liaison and the other members of the internal committee geared towards Latino initiatives.

Community research and family interviews revealed that materials describing HCP services could not just be translated; they needed to be "transcreated" (translated to ensure that they make sense both literally and culturally) to address the concerns and end-of-life traditions of the Latino community. Members of the Mensajeros de Confianza advisory committee contributed to a review and adaptation of the materials, drawing upon their own agencies' experiences and their bicultural backgrounds. HCP created two brochures, one in English and one in Spanish, to introduce hospice care and the ways in which HCP can help at the end of life. Additionally, the internal translation group created a "fotonovella" for low-literacy Latinos, describing hospice services through photographs and simple text.

## BUILDING AWARENESS

Awareness about end-of-life choices is building in the Latino community that HCP serves. The ongoing support of the Mensajeros de Confianza advisory committee and the presence of bilingual, bicultural staff members at community events have gradually raised the profile of HCP and end-of-life care in the community. The experience of HCP emphasizes that change is gradual and building trust with a Latino community takes time. The ongoing, consistent efforts of HCP have made community partnerships flourish and a vital discussion regarding service barriers facing the Latino population has ensued.

At the conclusion of the eighteen month project HCP is witnessing a new direction in their Latino community— there is greater awareness, collaboration and interest in end-of-life education. HCP is being invited to conduct in-service presentations, participate in community events and present their expertise in community forums previously unreceptive or unknown to them.

For example, in April 2006, HCP hosted a representative from the Mexican Consulate at the Mensajeros de Confianza meeting. The rich discussion focused on end-of-life issues including the transportation of bodies back to Mexico and the challenges of bringing family members from Mexico to be with their loved ones at the time of death. Members of the Mensajeros de Confianza have expressed interest in inviting the INS (Immigration and Naturalization Service) to attend a future meeting to help build awareness and relationships that can benefit the community.

## LATINO OUTREACH PLAN

Using the findings from the family surveys and the Mensajeros de Confianza, HCP developed and implemented a written 'Latino Outreach and Educational Plan' designed to meet specific goals, objectives, and outcomes (which is located at the end of this section).

Over 250 Latinos have received information directly about HCP services through speaking engagements and interactions with HCP staff and volunteers at community events and an advance directive workshop. Community events where HCP has had a presence include a Mexican Independence Day celebration, a local woman of the year award, and Latino business association meetings.

## LESSONS LEARNED

HCP feels that even with the significant internal changes they adopted to serve the Latino community and the comprehensive approach they have taken towards community outreach with Latinos, the targeted community must be ready to learn about end-of-life issues to truly improve access to care. It is important to build trust as well as awareness in a community and this process often happens one family at a time. HCP has acknowledged past weaknesses in serving the Latino community and made a commitment to learning.

Through this initiative, HCP has brought awareness to the fact that many Latinos do experience the benefits of hospice care. By fostering a continual and compelling conversation about the end of life with the Mensajeros de Confianza, HCP has broadened and effectively increased their visibility with community agencies, leaders, health and human service professionals and organizations serving the Latino community. Through these meetings, HCP has begun to develop a safety net of community resources that will encourage Latino families to seek hospice, and also help our larger community of service providers enhance their methods of service within the community.

**For more information contact:** Hospice of Santa Cruz *(formerly called Hospice Caring Project)*
831.430.3000 ♦ *www.hospicesantacruz.org*

## Hospice Caring Project's Latino Outreach and Educational Plan

**The following plan highlights Hospice Caring Project's planned outreach services to the Latino community.**

A three-year agency strategic plan, adopted in August 2005 guides the daily operations of HCP services to the Latino community. The following measurable objectives and outcomes of the plan are reviewed and reported to the board on a monthly basis. Additionally, methods for increasing Latino share of census and outreach are reviewed quarterly at a quality assessment and improvement (QAandI) meeting of management and key staff.

- Increase Latino share of census by 10% per year to 30% in 2008.
- Increase the number of Latino volunteers 800% by 2008.
- Increase bilingual personnel to meet the needs of the Latino patients.

### Public Events

***Informational Tables:*** Latino Community Liaison, Health Educator and volunteers to attend events and create awareness of HCP and end-of-life services.

- Cinco de Mayo – May 5th (annual) – All Day Event
- Mexican Independence Day – September 16th (annual) – All Day Event
- Hospice Foundation teleconference – April (once a year) – All Day Event
- Cabrillo College Wellness Outreach at Watsonville Campus – (twice a year during Fall and Spring semesters) – All Day Event"
- National Hospice Month (November) – Display at Watsonville Hospital
- Watsonville Farmers Market (twice a year) – Half Day Event

***Major Public Event***: Day of the Dead – November 1st. Event will be held in collaboration with the Mensajeros De Confianza.

## Educational Presentations

In-service presentations to professional staff conducted annually

***Clinics:***

- Salud Para La Gente (Staff and MD's)
- La Plazita Medical Clinic (All Staff)
- Clinica del Mar (All Staff)
- Clinica Familiar Costa Central (All Staff)

***Hospitals:***

- Watsonville Community Hospital
- Santa Cruz Dominican Hospital
- Salinas Valley Memorial

***Agencies:***

- WomenCARE
- Catholic Charities

***Community:***

- Migrant Regional Parent Meeting
- Latino Business Association (Local Business and service agencies)
- St. Patrick's Church
- Assumption Church
- Our Lady of Christians

***Media:***

- Educational Presentations bi-annually
- TV (Channel 67)
- Radio (Telefutura)
- Ads and press releases as needed relating to events:
- Santa Cruz Sentinel
- Registered Pajaronian
- La Ganga

## Networking and Collaborative Organizations

- Mensajeros de Confianza Advisory Group (six per year)
- Pajaro Valley Chamber of Commerce
- Latino Business Association Meetings (monthly)
- Mixers (three per year)

## IV. Tips for Building Partnerships with the Latino Community

### BUILD TRUST

One of the most important things that any organization must do when working with a cultural community for the first time is to build trust. Gaining the trust of a community takes time. Building trust needs to be your main goal in building partnerships. Below are suggestions that can help your organization or coalition to build trust with the Latino Community.

### RECRUIT A LIAISON TO THE COMMUNITY

One of the cornerstones of your outreach needs to include the involvement of a bilingual, bicultural person already well connected to the local Latino community. Think broadly about who might be the best person for your outreach—focus on the person and his or her qualities and skills, such as his or her ease of working with people, rather than only on traditional qualifications, such as education level. It is important to assess his/her credibility with and access to the people you are trying to reach. Be sure the person you select is respected in the community.

### GET FEEDBACK

Seek input from your local Latino community and interview families who have received hospice services and learn about their experiences. In order to successfully provide services to Latinos, it is essential for the members of your Latino community to describe their experiences with hospice and voice their desires and concerns about end-of-life care.

***Below is a sample of questions that Hospice Caring Project used for their family interviews:***

- *How did you learn about Hospice Caring Project? From someone at the hospital, a friend or family member?*
- *What did you think when you first heard about hospice?*
- *How did the people from hospice help?*
- *What did you and your family most need when your loved one was in the last stage of her/his life? Personally, practically, spiritually? And afterward?*
- *What are the main traditions in Mexico when someone dies?*
- *Which of these traditions do you consider that hospice should be aware of to better serve your family?*
- *What are some ways to take the message of hospice into Mexicano/Latino communities?*
- *Would you be willing to speak of your experience with hospice to help us tell others about our services?*

## ESTABLISH CLEAR GOALS

After you have gathered information from your community, develop clear goals for your outreach. Once you have collected feedback from the Latino community, goals should be formulated and clearly stated to serve as a guide for your outreach process. Incorporate your goals for engaging the Latino community to the strategic plan of your organization or coalition. This guarantees a long term commitment to cultivating relationships with and serving the Latino community. Having the goals in the strategic plan can help to ensure adequate time and attention is given for program development and funding.

## CREATE AN ADVISORY COMMITTEE

Create formal relationships with a few key service providers to build bridges to the people who need your services. In order to do Latino outreach, form an Advisory Committee composed of community stakeholders who will assist you in the development of culturally competent services. To initiate this process, focus first on a few key service providers who will be most important to your work.

Since most service providers, especially the ones that would be most influential and therefore the best partners, are very busy and their time is valuable, consider drawing up a formal 'Memorandum of Understanding' and setting aside a certain amount of money for each organization for their services if possible. *(See sample located at the end of this section.)* A formal relationship can be the key factor to ensure your Advisory Committee has a strong start, as these organizations will be your initial Advisory Committee members.

### Recruit community stakeholders:

Invite organizations and influential individuals to also join the Advisory Committee after you have initial members in place. Do your homework to learn who is influential in the community and then meet with potential members to explain what you are trying to accomplish. Individuals who may be influential in the Latino community include clergy, those who work with migrant farm workers, union organizers, and local Latino businesses. Other stakeholders include health and human service organizations, the political community (local town and county representatives) and possibly a local foreign consulate (example: Consul of Mexico).

### Make meetings meaningful:

The function of the Advisory Committee includes encouraging and accepting their advice for your outreach, reciprocal learning among committee members and enabling the members to collaborate to better serve the community as whole. Advisory Committee meetings need to be a time to gather input from committee members and to welcome advice that they have for various aspects of your outreach activities which can include questions about terminology to the best venues for outreach activities. It is important to report back to the committee about ways in which their advice and input has been used to shape different aspects of the community outreach your hospice is doing.

Meetings are also an excellent time for committee members to learn from each other, and to have time to discuss their own organization. It may be the case that bringing people together around end-of-life issues serves a larger community purpose, if there has not already been a way for service providers for the Latino community to collaborate and create a better network. The more that the attendees are gaining from the meeting, the stronger their commitment to the Advisory Committee will be. Therefore, looking at the wider community picture should benefit the Committee and your organization or coalition. *(See 'Initial Meeting Agenda' located at the end of this section.)*

***The following are suggestions from Hospice Caring Project on how to conduct a successful advisory committee meeting:***

- *Provide food.*
- *Provide a convenient meeting time and place. Ask the group to decide on frequency of meetings.*
- *Meetings need to be participatory as well as educational.*
- *Have 1 or 2 service providers give a brief presentation about their organization during each meeting. If participants are comfortable doing this, ask them to give a quick update of what is currently a focus in their organization at the beginning of every meeting.*
- *Leave time for networking amongst attendees.*
- *Always have at least one subject that you want advice on. Follow-up on past issues where advice has been given and then let them know what you have done that incorporates their input.*
- *Convey as often as possible to the Committee that their expertise and participation is a valuable asset to your organization or coalition.*
- *Send out minutes to those who attended and those who could not attend.*

### Stay connected:

Email can be a very effective means of communicating and staying connected with Advisory Committee members between meetings. Asking advice on the use of a Spanish term, or letting members know that your organization had a successful experience at an outreach event can demonstrate the commitment that you have to using the Advisory Committee and learning from its members. Careful use of an email listserv can help to reinforce your organization's commitment and serve as another way of building trust.

## FOCUS ON RELATIONSHIPS, NOT PROJECTS

In our goal-oriented society, it is all too easy to focus on project goals. One of the gifts that the Latino culture provides to us is the reminder to focus on relationships. Meaningful relationships always provide the best results. So when you are getting too stressed about your all work-related projects, sit back and enjoy your new friends from a different culture. This is the best guarantee to successfully build partnerships and implement outreach activities with the Latino community.

## Challenge of Change Initiative

### MEMORANDUM OF UNDERSTANDING BETWEEN HOSPICE CARING PROJECT AND [PARTNER]

Hospice Caring Project is developing relationships with Mensajeros de Confianza (trusted messengers within the Latino community) to help reach our goal of creating culturally-relevant end-of-life information and services to the Latino community. [Partner] agrees to enter into a collaborative agreement with Hospice Caring Project (HCP) by providing the following services for the Challenge of Change Initiative.

- Follow-up counseling as needed for focus group participants: HCP is conducting focus group meetings with up to twelve families who have received HPC services. Family members may experience feelings of grief as a result of these meetings and will be encouraged to call the HCP program coordinator if needed. If the coordinator assesses that counseling is needed, she will make a referral to [Partner]. [Partner] will provide up to three counseling sessions at no charge to the client.
- Review of translated materials: [Partner] will review translated materials (postcards, brochures, letters), consulting on cultural relevance of materials presented to the community.
- HCP and [Partner] will partner to present in-service training on end-of-life care once during the year.
- A system will be developed and documented for referring appropriate [Partner] families to HCP when appropriate.

FUNDING:

Hospice Caring Project will allocate $__________ for services provided during the initial year of the grant cycle, and an additional $__________ during the second year.

Ann Carney Pomper, Executive Director
Hospice Caring Project Santa Cruz
Date:

[Representative/Partner]
Date:

## Mensajeros de Confianza Advisory Group
## Hospice Caring Project Challenge of Change Program

### INITIAL MEETING AGENDA

I. **Welcoming by Ann Pomper, Executive Director (3 minutes)**

II. **Goals and Objectives of meeting - Lupe Mendoza, Latino Community Liaison (2 minutes**

III. **Self Introductions – Everyone (15 minutes)**

IV. **Hospice Caring Project Services- Salima Cobb, Professional Liaison (10 minutes)**

V. **Challenge of Change Program - Lupita Mock, Registered Nurse/Lupe Mendoza, Latino Community Liaison (15 minutes)**

   a. How did Challenge of Change Program Start and Why?
   b. Roles and Responsibilities of External /Internal Groups - Mensajeros de Confianza/Hospice Staff
   c. Goals/Objectives/Accomplishments of Program

VI. **Update on Latino Family Interviews – Cathy Conway – Development Director (10 minutes)**

VII. **Mensajeros de Confianza Advisory Group - Everyone (45 minutes)**

   a. What has worked in your community?
   b. What can we learn from you?
   c. How do you want to be involved in helping Hospice Caring Project build their capacity to serve the Latino Community?

VIII. **Develop Meeting Calendar for Mensajeros de Confianza Advisory Group (3 minutes)**

IX. **Closing Remarks – Ann Pomper/Lupe Mendoza, Latino Community Liaison (2 minutes)**

# V. Outreach Strategies and Activities to Engage the Latino Community

The following are examples of outreach strategies and activities that were used by Hospice Caring Project (HCP) and others to engage with the Latino community around end-of-life issues.

## FOTONOVELLA (ALSO CALLED "PHOTONOVELA")

Create a fotonovela to promote hospice, advance care planning or other topics. A fotonovela is a small booklet in picture story form with narration which can be used to carry a message or educational information. A fotonovela uses photos rather than drawings to illustrate a story. In Mexico, the fotonovela is a popular way to convey information about things like social norms and health messages, and is an easy way to communicate with people who have limited literacy skills.

*Hospice Caring Project created a fotonovela that demonstrates hospice services in action and provides information about how to refer someone to hospice care. The story begins outside the church after mass, where two women friends are talking. One woman asks her friend, the wife of a very sick man, "How are you doing?" The woman tells her story and her husband's, and then her friend reacts by explaining what hospice is. The wife of the sick man later calls a hospice. The fotonovela illustrates the process of becoming a hospice patient, receiving services, the experience of the family and the support hospice offers following the death of the family member. Most of this is conveyed in pictures and there are also a few sidebars with information.*

## ENGLISH AS SECOND LANGUAGE (ESL) CLASSES

Make connections with local ESL programs. They often have guest speakers who come to explain a particular community organization. Many students in ESL programs have recently arrived from another country, are a range of ages and have a variety of experiences. Many stories are told during a class and therefore it is a great time to spark a discussion about community resources regarding family caregiving, hospice, advance care planning and grief support.

The presentations are done in English but since students are not yet fluent in English some things are explained in Spanish to ensure that the class completely understands the information. ESL instructors want to encourage students to practice their English skills and further their comprehension, but also want to make sure the presentations are worthwhile for all.

Students are learning English in order to get jobs, and many have a special interest in healthcare jobs. They will go on to work in radiology, dentistry, hospitals, and skilled nursing facilities. These new healthcare workers often become resources for their families when they need knowledge on health related issues. By speaking to people soon after their arrival in America, you can plant seeds about hospice—educating them about a service available in their new country, and potentially interesting them in working in end-of-life care.

## MIGRANT WORKERS

Many Latinos in the United States are migrant workers, especially in rural areas. Often migrant workers speak only Spanish and have sub-standard access to health care and education. Usually, you will be able to find local social service programs that have been developed to assist them. By partnering with these established programs you will be associated with a trusted entity and therefore have an easier time educating the workers about end-of-life care. Many migrant workers are young and have school-aged children. Some school systems have designated teachers or administrators who work with migrant parents who are new to a school system and may require special attention as they enroll their children. In the experience of Hospice Caring Project, meetings of migrant parents organized by the school are especially well attended, and are a good place to reach people with informal presentations and literature.

## SPANISH-LANGUAGE NEWSPAPERS AND RADIO

Many Latinos receive information about local services through Spanish-language newspapers. Many Spanish-language newspapers are not daily papers—they may only be weekly, biweekly or monthly. Contact Latino service providers in your area to discover which publications might provide a free or reduced-rate advertisement on end-of-life issues. Because of the extensive healthcare needs of the Latino community, some newspaper publishers may have a policy of allowing health organizations or non-profit groups to advertise for free.

Radio is another good way to reach the Spanish-speaking population. Even if your area does not have a regular radio station for Spanish-speakers, you may find that there are one or more low wattage radio stations in your area that are important to the Latino community. A public service announcement could be an excellent way of reaching this audience, and again, it is likely that the stations welcome PSAs from health organizations since many Latinos do not have access to good healthcare.

## HISPANIC PR WIRE

Hispanic PR Wire, Inc. (HPRW) is a Miami-based news distribution service reaching U.S. Hispanic media, organizations and opinion leaders nationwide. HPRW features a complete menu of Hispanic media circuits that includes the options of national, state and U.S.-based Pan Regional Latin America distributions. In addition, Hispanic PR Wire offers specialized distribution targeting Latino organizations as well as Hispanic elected officials and opinion leaders.

On their Web site, *www.hispanicprwire.com*, go to "Top Latino Links" to link to popular media outlets all over the United States. HPRW offers a free monthly newsletter via email, the Hispanic PR Monitor. Sign up is available on their Web site or, send an email with your full contact information to *hispanicprmonitor@yahoo.com*.

## LOCAL FARMER'S MARKET

Farmer's markets tend to be popular with many Latinos, especially recent immigrants, because fresh vegetables are very important to them and families always cook and eat at home.

*Hospice Caring Project found that the local farmer's market has a booth paid for by the County Health and Human Services that signs up local organizations to provide information. At their booth, Hospice Caring Project displays a photo board they created that illustrates the hospice circle of care with photos of a local family as well as the Latino staff of HCP. Often the HCP booth has as many as 40 direct contacts each time they attend the farmer's market, giving staff the opportunity to answer people's questions and distribute written materials.*

## PHARMACIES

Pharmacies and drugstores are a good source of health information for many people and many Latinos rely upon their services. Speak with your local pharmacy to see if they would be willing to have Spanish-language materials available on end-of-life issues to distribute.

## HEALTH CLINICS

Local health clinics can be another excellent way of reaching the Latino population. Find out which clinics in your area serve the Latino community and ask to distribute Spanish-language information or make a display for their patients.

## FUNERAL DIRECTORS

In the Latino focus groups conducted for Caring Connections, it was revealed that many younger Latinos make funeral arrangements in advance. Talk to local funeral directors in your area about their experience with the Latino community and see if they have done outreach to the Latino community. You may be able to partner with them to provide other end-of-life information.

**For more consumer and outreach resources, see Section VII and visit *www.caringinfo.org* (under "Community").**

## VI. Key Terms for Latino Outreach

### BICULTURAL

A person who is bicultural is part of two distinct cultures, such as Mexican and American cultures. A bilingual/ bicultural Latino staff person will be able to relate more effectively to Latino families while doing outreach than someone who is just bilingual. Bicultural staff are much more adept at building trust with Latino communities than people who are solely bilingual.

### BILINGUAL

A person who is bilingual is able to comfortably speak two languages, with equal or near equal fluency.

### CURANDERISMO

Curaderismo is a form of folk healing which includes various techniques such as prayer, herbal medicine, healing rituals, spiritualism, massage, and psychic healing. It is a system of beliefs that is common throughout Latin America. Like other forms of alternative medicine, there are reports that these practices can improve symptoms, alleviate pain, and relieve stress. Hospice patients may desire to have curanderismo included in their care. Some curaderismo practices are well known by lay people and are done at home, but sometimes the advice or practice of a specially trained healer, a curandero/curandera, is sought.

### DAY OF THE DEAD (DÍA DE LOS MUERTOS)

The Day of the Dead is an important Mexican holiday and social ritual that recognizes the cycle of life and death. This is a festival that has roots in Aztec culture yet it has Christian overtones. Each year on November 1st and 2nd, families welcome the dead back into their homes and visit the graves of their loved ones. In general, people from urban areas in Mexico are not as likely to celebrate this holiday, but it retains great importance in rural communities. The traditions surrounding the Day of the Dead may serve as an avenue for discussing end-of-life issues.

### FAMILISMO (FAMILY)

Latinos place a great deal of importance on the family as the primary source of support and information. Help and advice are usually sought from the family, and important decisions are made as a group. Medical conditions and treatment are considered a family matter.

## FATALISMO (FATALISM)

Traditionally, many Latinos view an illness as either "natural" (caused by God's will or fate) or "unnatural" (caused by evil done to one by another.) In either case, a person feels that control over the illness has an external influence, and is out of his or her hands. This concept of illness has led to a fatalistic view of life and death—resulting in a person feeling that they have little to do with the success or failure of an illness. It is suspected that belief in fatalism may be in part a reason that Latinos have higher rates of advanced disease at the time of diagnosis.

## HISPANIC

While "Hispanic" is a widely accepted term and often used interchangeably with "Latino," "Hispanic" accurately refers only to people from Spanish-speaking countries. "Hispanic" is the term currently used by the US government to define citizens of any race whose family is originally from a Spanish-speaking nation. In contrast, in Latin America, the term "Hispano" (Hispanic) often refers only to people who trace their ancestry to Spain, and does not include those of indigenous or African heritage. Because of these complexities, "Latino" (defined below) generally seems to be the more flexible and accurate term. Listen to the people in your own community and refer to their group with a term that people feel is accurate and respectful.

## HOSPICIO

While "hospicio" has been adopted by the hospice movement in many Spanish-speaking countries as well as by US hospices doing outreach in Latino communities, it is important to note that the term "hospicio" can have negative connotations for Latinos. People unfamiliar with the concept of hospice care may assume that "hospicio" is a bad place that is of no interest to them.

Throughout Latin America, the term "hospicio" has historically been associated with institutions for the mentally ill, the mentally retarded, and the poor or homeless. A well known mental hospital in Ecuador, "Hospital Psiquiátrico San Lázaro," is known locally as "el Hospicio." In Mexico, the term "hospicio para ninos" was traditionally the term for an orphanage while "hospicio de pobres" (literally, hospice of poor men) was the term for the poor house.

Some hospices in the United States have chosen to use the English word "hospice" in Spanish language documents to distinguish it from the negative history of "hospicio."

## LATINO

This term is used to describe anyone from a Latin American country, whether the person speaks Spanish, Portuguese, or an indigenous language. The term Latino is more accurate than the term "Hispanic" which refers only to people who speak Spanish. While both of these terms are widely accepted, many Latinos are uncomfortable being treated as one large group, since Latin America is a continent with many nations and varied cultural traditions.

Therefore, while it is useful to use this term to refer to a large subset of people in the United States, it is important to listen to the people in your own community and refer to their group with a term that people feel is accurate and respectful.

### EL NOVENARIO/ LA NOVENA

This term is a spiritual mourning ritual that traditionally lasts nine days. Traditionally, in Latin American countries the body of the deceased was held in the home for nine days and family members prayed around it. Today, it is still common for the body to be held at home for at least twenty-four hours so that the family can pray and mourn. This practice is still important to Latinos in the United States, especially in immigrant communities. After the body is removed, the bereaved family attends mass and prays for nine days following the death of the loved one. When serving Latino hospice patients, it is important to understand what the families' expectations and needs will be directly following the death of the patient.[1]

### TRANSCREATE

The concept of "transcreation" is that documents should not just be translated word for word, but must be translated to ensure that they make sense both literally and culturally. Misunderstandings can often occur if materials are not translated in a culturally appropriate way. Latino culture is not monolithic—Mexican, Cuban, and Guatemalan people all have different dialects and expressions, and therefore, it is important to be familiar with your local Latino community when translating materials.

### TRANSLATE

Translation of documents often means translating something word for word. Without someone who is bicultural doing the translation, it is common for literal translations to be confusing or wrong for the target audience.

### EL VELORIO

This refers to the all night vigil following the death of a loved one. It is common for families to eat and drink with each other during this ritual, but the tone is still somber, one of mourning. In Latin American urban areas, el velorio may be conducted at a funeral home, but in the United States, it usually has to be done at home.[2]

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[1] Falcon and C. Yoder Falcon: *Salsa: A Taste of Hispanic Culture*, Westport, CT: Prager, 1998.
[2] Ibid.

# VII. Resources

## CARING CONNECTIONS HELPLINES

HelpLine: **800.658.8898**
Multilingual HelpLine: **877.658.8896**

**Trained HelpLine staff are available to help people find information including:**

- Locating a hospice, palliative care program, or other end-of-life care organization
- Free state-specific advance directives
- Brochures
- Information about state and community end-of-life coalitions
- Identifying local, state and national resources

## CARING CONNECTIONS – BROCHURES AVAILABLE IN SPANISH

Caring Connections has educational brochures on a variety of end-of-life care topics available in Spanish to view at *www.caringinfo.org* or purchase at *www.nhpco.org/marketplace*. See list of topics below.

### Bilingual End-of-Life Care Topics in Spanish/English

- Mis deseos a la atencion de mi Salud: Medicas o Directivas Anticipadas – *Advance Directives: My Wishes for Medical Attention* in Spanish/English
- Cuidado Paliativo o Cuidado de Hospice – *Hospice and Palliative Care* in Spanish/English
- Apoyo para el cuidador – *How to Support Someone Caring for Another* in Spanish/English
- Las etapas en los finales de la vida – *Phases at the End of Life* in Spanish/English
- Afliccion por una perdida – *Grief and Loss* in Spanish/English

### Bilingual Pediatric Topics in Spanish/English

- Cuando Su Hijo Tiene Dolor – *When Your Child is in Pain* in Spanish/English
- Hablando Co Su Hijo Sobre Su Enfermedad – *Talking With Your Child About His or Her Illness* in Spanish/English
- Hablando Con el Medico Sobre Su Hijo: Cuando Su Nino Tiene Una Enfermedad Seria – *Talking to Your Child's Doctor: When Your Child Has a Serious Illness* in Spanish/English
- Cuando Muere un Nino: Un Guia Para Familia y Amigos – *When a Child Dies: A Guide for Family and Friends* in Spanish/English
- Como Ayudar a los Ninos a Afrontar la Muerte de un ser Querido – *Helping Children Cope with the Death of a Loved One* in Spanish

## QUALITY OF LIFE PUBLISHING CO. – PHOTONOVELA

Quality of Life Publishing Co. provides a 12 page photonovela called *A Hospice Caring Story* that summarizes hospice services and staff available for end-of-life care. The story, using black and white photos, is translated in both English and Spanish languages. For view the entire booklet online or to purchase, visit ***www.qolpublishing.com*** (or call 1.877.513.0099).

## PARTNERSHIP FOR PARENTS

***www.partnershipforparents.org***
***www.padrescompadres.org***

An online support program, available in English and Spanish, for parents caring for children diagnosed with a serious illness that was developed by the Children's Hospice & Palliative Care Coalition.

# VIII. Acknowledgements

Authors:

**Ashley Hammarth, MPH**
**Gwynn Sullivan RN, MSN**
National Hospice and Palliative Care Organization
Alexandria, VA

**Salima Cobb**
**Ann Pomper**
Hospice of Santa Cruz
*(formerly called Hospice Caring Project)*
Scotts Valley, CA

NHPCO Staff:

**Melanie Abijauoude**
**Kathy Brandt, MS**
**Helen Ennis**
**Coco Regas**

Funding support for this resource was provided by a grant from The Robert Wood Johnson Foundation, Princeton, New Jersey.

## IX: Appendix

**Click on links below to view and download the documents. All documents may be accessed at**

www.caringinfo.org/community

then clicking on "Diversity Outreach".

Community PowerPoint presentations — with speaker notes *(Spanish and English versions)*

A. *Making End-of-Life Decisions (English ppt)*

B. *Making End-of-Life Decision (Spanish ppt)*

C. *Hospice Can Help You and Your Family (English ppt)*

D. *Hospice Can Help You and Your Family (Spanish ppt)*

## NOTES

## NOTES

Caring Connections
a program of the
National Hospice and Palliative Care Organization

1731 King Street • Suite 100
Alexandria, Virginia 22314
703/837-1500
***www.caringinfo.org***

**Item No. 821397**

For additional copies of this and other NHPCO products, order online
at ***www.nhpco.org/marketplace***
or toll-free at 800/646-6460 • 703/837-1233 (fax)

# Exhibit 38

# CLIENT RIGHTS SUPPLEMENT- MARYLAND

BAYADA®
Home Health Care

Each client receiving care from BAYADA Home Health Care shall have the following rights:

1. To be fully informed of these rights and of all rules and regulations governing client conduct as evidenced by the client's written acknowledgement prior to or at the time of admission.
2. To be fully informed orally and in writing at the time of admission, of services available in Agency and of any changes for services not covered under Titles XVIII or XIX of the Social Security Act. To be fully informed of the extent to which payment may be expected from Medicare, Medicaid or any other payor known to the Agency; of charges that will not be covered by Medicare, and of any charges for which the client may be liable. To be informed of any changes in the above information within 30 calendar days of the date the Agency becomes aware of any changes. Upon request, the client may receive a written statement of services offered, including frequency of services and unit charge per service. Upon request, the client may receive a fully itemized billing statement, including dates of services rendered and unit charge per service. Private clients of BAYADA will be given a contract specifying the rate for the requested services.
3. To receive the Agency's written policy on uncompensated care.
4. Be given appropriate and professional quality home health care services without discrimination against your race, creed, color, religion, sex, national origin, sexual preference, handicap, or age.
5. To be fully informed by a physician or his/her medical condition including diagnosis and prognosis unless medically contraindicated, and to be afforded the opportunity to participate in experimental research.
6. To participate in the development of your home health care plan which meets your unique health care needs and be given updated assessment of this health care plan.
7. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal. The client may refuse any portion of planned treatment without relinquishing other portions of the treatment plan, unless partial treatment is medically contraindicated.
8. To be assured confidential treatment of personal and medical records and to approve or refuse their release to any individual outside the Agency, except in the case of transfer to another health facility or as required by law of third party payment contract. Governmental and other Regulatory agencies have the authority to review clinical documentation without client authorization.
9. To be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care for personal needs.
10. Be free from physical and mental abuse and/or neglect.
11. To be informed by the Agency of procedure for registering complaints confidentially.
12. To be assured the client and his/her family will be taught about the illness so that the client can help him/herself and the family can understand and help the client.
13. To be assured the personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
14. Be given proper identification by name and title of everyone who provides home health care services to you. Upon request, the client may receive information as to the identity of other health care providers with which the Agency has contractual relationships, insofar as the client's home health care is concerned.
15. To expect reasonable continuity of care.
16. Review your clinical record at your request.

All activities must be conducted with an overriding concern for the client, and, above all, the recognition of his dignity as a human being. Success in achieving this recognition assures success in the defense of the rights of the client.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION:

1. You have the right to request restrictions on the uses of and disclosures of health information.
2. You have the right to request to receive confidential communications.
3. You have the right to inspect and copy your health information.
4. You have the right to request to amend protected health care information.
5. You have the right to receive paper copy of the Agency's notice of Privacy Practices.
6. You have the right to request an account of disclosures of health information.

Client Signature: ______________________________ Date: ______________

# Exhibit 39

BAYADA
Hospice

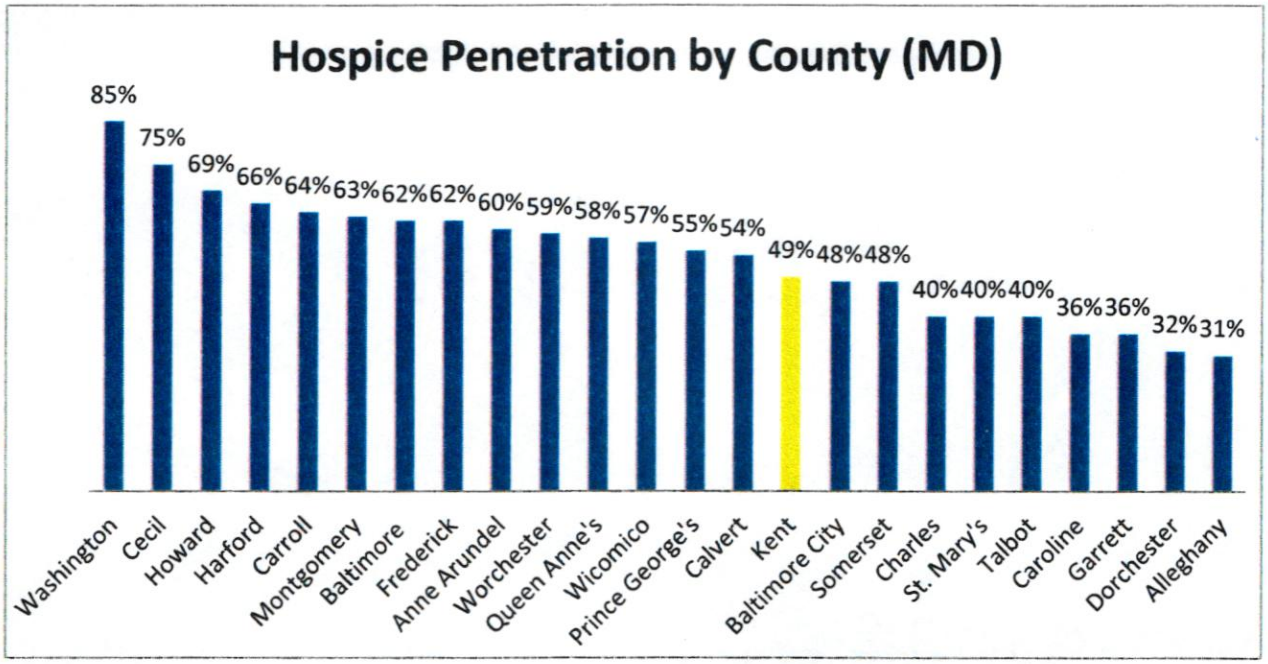
## ADDENDUM TO CLIENT RIGHTS SUPPLEMENT – MARYLAND

Each patient receiving care from BAYADA Home Health Care's Hospice Program shall have the following rights:

1. Be treated with consideration and respect for individual dignity;
2. Confidentiality in all aspects of service or treatment;
3. Privacy;
4. Be free from physical or mental abuse;
5. Participate in the planning of the patient's hospice care;
6. Formulate advance directives as provided under State law;
7. Have all personal property treated with respect;
8. Refuse care and services, including continued participation in the hospice care program;
9. Be informed of short-term inpatient care options available for pain control, management, and respite;
10. Be informed of the hospice care program's discharge policy;
11. Make complaints or grievances to the hospice care program, government agencies, or other persons without threat or fear of retaliation; and
12. Be informed orally and in writing, before care is initiated, of the extent to which payment may be expected from the patient, third-party payers, and any other source of funding known to the hospice care program.

Client Signature: ______________________________ Date: ________________

Exhibit 40



Source: Hospice National Profile, Maryland. 2015, Health Planning & Development, LLC

**Exhibit 41**

CHAP

MMUNITY HEALTH ACCREDITATION PROGRAM

1275 K Street, NW • Suite 800 • Washington, DC 20005 • tel: 202.862.3413 • fax: 202.862.3419 • www.chapinc.org

October 17, 2014

Ms. Joy Stover
Associate Director, Policy and Accreditation Support
BAYADA Home Health Care, Inc
1555 Bustard Road, Suite 200
Lansdale, PA 19446

RE: Accreditation for:

**CORE**
**Home Health**
**Hospice**
**Private Duty**

Location and/or Site(s) Accredited:
BAYADA Home Health Care, Inc
290 Chester Avenue
Moorestown, NJ 08057

| | |
|---|---|
| **Site Visit Dates:** | **September 8, 2014 — September 11, 2014** |
| **Accreditation Visit Type:** | **Renewal** |
| **Accreditation Decision:** | **Accreditation Without Required Action** |
| **Plan of Correction Accepted Date:** | **N/A** |
| **Accreditation Dates:** | **October 10, 2014 — October 9, 2017** |

Dear Ms. Stover:

I am pleased to inform you that based on the findings of the site visit conducted at the location (s) and for the service referenced above, your organization is in compliance with the CHAP Standards of Excellence. The CHAP Board of Review has granted Accreditation to your organization for the term of three (3) years.

The continuation in good standing of this Accreditation is dependent upon the organization paying any and all accreditation and site visit fees in accordance with the terms and conditions of the Accreditation Services Agreement. The Accreditation Services Agreement will be renewed every three (3) years.

Please note that CHAP may conduct surveys less than every three years depending upon CMS regulations and/or the level of deficiencies.

As a CHAP accredited agency, you are required to provide our toll free CHAP Hotline telephone number to all of your clients. This hotline receives consumer complaints and questions about CHAP accredited organizations 24 hours a day, seven days a week. **The CHAP Hotline is 1-800-656-9656.**

Thank you for choosing CHAP as your national accrediting organization! Please contact me at 202-862-3413 if you have any questions.

Sincerely,

Taniesha Wise
Customer Relations Representative

| | **CCN 217101** (Includes ACV, BSF, BV, BVF, BWV, and HFV) | **CCN 217158** (Includes MMV and MMF) |
|---|---|---|
| Number of Surveys Completed | 2,238 | 136 |
| Response Rate | 28% | 18% |
| HHCAHPS Summary Star Rating (MD Average = 3.5) | 4 | 3 |
| HHCAHPS Star Rating for Health Team Gave Care in a Professional Way (MD Average = 3.7) | 4 | 3 |
| HHCAHPS Star Rating for Health Team Communicated Well (MD Average = 3.8) | 4 | 4 |
| HHCAHPS Star Rating for Team Discussed Medicines, Pain, and Home Safety (MD Average = 2.8) | 3 | 2 |
| HHCAHPS Star Rating for How Patients Rated Overall Care from Agency (MD Average = 3.0) | 3 | 3 |
| Percent of Patients Who Gave Their Home Health Agency a Rating of 9 or 10 on a Scale from 0 (Lowest) to 10 (Highest) (MD Average = 83%) | 86% | 80% |
| Percent of Patients Who Reported YES, They Would Definitely Recommend the Home Health Agency to Friends and Family (MD Average = 77%) | 80% | 73% |

Data comes from Home Health Compare for the date range 1/1/2015 to 12/31/2015 (the current data on Home Health Compare).

Exhibit 42

Hospicelink
better business. better care.

September 23, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. BAYADA is one of the largest private home health and hospice organizations in the country, and has extensive experience providing high quality hospice services. With existing home health operations in Maryland and a vast network of partner organizations, BAYADA is well positioned to bring high quality hospice care to underserved areas in the state.

BAYADA is unique in being a national, mission driven, community-based health care organization that is converting from family to not-for-profit ownership and control. People at BAYADA are guided daily by our unique mission, vision, values and long-term orientation as is expressed in the *The BAYADA Way*, which is our commitment to bring compassion, excellence and reliability to every client and every community interaction throughout the organization.

Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Chad Trull
President & CEO

2145 Highland Ave S. • Suite 110 • Birmingham, AL 35205 • 205.440.4459 • hospicelink.com

September ____, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

MAXWELL T. VERGO, MD

Genesis™

September 28, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. BAYADA is the largest private home health and hospice organization in the country, and has extensive experience providing high quality hospice services. We here at Burlington Health and Rehabilitation have had wonderful experiences when teaming up with BAYADA to provide hospice services for our residents. Both residents, families and staff have felt that the added services, their expertise in pain management, support by social work, bereavement, nursing and spiritual providers have made the end of life experience peaceful and positive. They are skilled and very timely to respond to referrals, evaluate and communicate with the center's team, families and physicians. Recently we had a resident on hospice with BAYADA and I received a letter from his wife in an effort to show her appreciation of the partnership with our center and BAYADA during the care that was provided to both of them at such a challenging time for them both. This resident's daughter was getting married over 2 hours away from the center and BAYADA was just as committed to ensuring his attendance at this important event, there were many hours spent arranging nursing and respiratory services, transportation and family support. This effort was well beyond anything required but true to their mission.

I believe that the staff at BAYADA are mission driven and the leadership in our local offices led by example. BAYADA is unique in being a national, mission driven, community-based health care organization that is converting from family to not-for-profit ownership and

Genesis HealthCare • Burlington Health and Rehabilitation Center • 300 Pearl Street • Burlington, VT 05401 • **genesishcc.com**
802-658-4200 Tel • 802-863-8016 Fax

control. People at BAYADA are guided daily their our unique mission, vision, values and long-term orientation as is expressed in the *The BAYADA Way*, which is their commitment to bring compassion, excellence and reliability to every client and every community interaction throughout the organization.

Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Meagan Buckley
Executive Director

September 29, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Kevin:

I hope this letter finds you well since our days of working together in Bennington. I have made career transitions as well since we last crossed paths, and, among other things, provide predominantly hospice and palliative care services for the communities in Southwestern Vermont. I am very fortunate to be working with our local BAYADA Hospice team since 2012.

I understand that BAYADA Home Health Care is seeking a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland. I would like to offer support for this application with my first hand experience with this organization, as well as offer my perspective as a physician practicing in the field of Hospice and Palliative Medicine.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. It is a service that is tremendously underutilized in our country. Since the establishment of Hospice and Palliative Care as a subspecialty in 2006, there has been increasing education and awareness regarding hospice services with a growing demand for trained providers, as well as access to high quality hospice programs.

BAYADA is the largest private home health and hospice organization in the country, and has extensive experience providing high quality hospice services. With existing home health operations in Maryland, BAYADA is well positioned to bring high quality hospice care to underserved areas in the state.

BAYADA is unique in being a national, mission driven, community-based health care organization that is converting from family to not-for-profit ownership and control. People at BAYADA are guided daily by a unique mission, vision, values and long-term orientation as is expressed in the *The BAYADA Way*, which is their commitment to bring compassion, excellence and reliability to every client and every community interaction throughout the organization.

It is my first hand experience as a physician working with the BAYADA team and as a referring provider that *The BAYADA Way* is not just a phrase, it is a way of caring for patients that is truly superior to any other home program with which I have worked. I am certain that the addition of BAYADA hospice services will improve access and quality of hospice care for the residents in Maryland as it has done for those in Vermont. I am hopeful that you will grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Nancy Schuster, MD
Internal Medicine
Hospice and Palliative Medicine
Bennington, VT

Genesis

September 29, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Ms. Judy Morton
Senior Executive Director
Genesis HealthCare/Mountain View Center
9 Haywood Avenue
Rutland, Vermont 05701

Re: Letter of Support for BAYADA Home Health Care Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. BAYADA is the largest private home health and hospice organization in the country, and has extensive experience providing high quality hospice services. With existing home health operations in Maryland, BAYADA is well positioned to bring high quality hospice care to underserved areas in the state.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

JM
Judy Morton

Genesis HealthCare • Mountain View Center • 9 Haywood Avenue • Rutland, VT 05701-4832 • genesishcc.com
802-775-0007 Tel • 802-775-3241 Fax

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Ravi Passi, MD, FACP, CMD
Weihan Wang, M.D.
Patricia Gomez, MD. FACP
Ranjit Yelamanchi, M.D.
Jacinta Elder-Arrington, M D

DOCTOR OF
PHYSICAL MEDICINE
& REHABILITATION
ACUPUNCTURE

Candice Peters, M.D.
Nina Rajaei, M D

DOCTORS OF
INFECTIOUS DISEASE

Rosemary C.Iwunze,M.D., M.P.H

NURSE PRACTITIONERS

Babette Pennay, C.R.N.P
Lemoll Johny, C.R.N.P
Vera Reublinger, C.R.N.P
Chinyere Okeagu, C.R.N.P
Cherie O'Neil,C.R N.P
Trinh Nguyen,C.R.N.P

September 30, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. BAYADA is the largest private home health and hospice organization in the country, and has extensive experience providing high quality hospice services. With existing home health operations in Maryland, BAYADA is well positioned to bring high quality hospice care to underserved areas in the state.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Ravi Passi,MD,FACP,CMD

Tel (301) 527 1650
15245 Shady Grove Road | Suite 130. North Lobby | Rockville | Maryland 20850

Genesis

October 05, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Melissa Greenfield

Genesis HealthCare • Rutland Healthcare and Rehabilitation Center • 46 Nichols Street • Rutland, VT 05701 • genesishcc.com
802-775-2941 Tel • 802-773-2196 Fax

October 5, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing patient-centered, cost-effective, and compassionate care for people facing a life-limiting illness or injury. BAYADA is the largest private home health and hospice organization in the country, and has extensive experience providing high quality hospice services. With existing home health operations in Maryland, BAYADA is well positioned to bring high quality hospice care to underserved areas in the state.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Eileen Adams

Eileen Adams
Regional Director of Operations
Brightview Senior Living

October 5th, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of BAYADA Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

LNHA
Cumberland Manor.

**40TH SENATORIAL DISTRICT**
**MONROE & NORTHAMPTON COUNTIES**

ROOM 168 MAIN CAPITOL
P.O. BOX 203040
HARRISBURG, PA 17120
PHONE: 717-787-6123
FAX: 717-772-3695

2989 ROUTE 611
DEPUE PLAZA, SUITE 103
TANNERSVILLE, PA 18372
PHONE: 570-620-4326
FAX: 570-620-4379

2 NORTH ROBINSON AVENUE
PEN ARGYL, PA 18072
PHONE: 610-863-1200
FAX: 610-863-1214

MSCAVELLO@PASEN.GOV
MARIOSCAVELLO.COM

Senate of Pennsylvania
**MARIO M. SCAVELLO**
STATE SENATOR

**COMMITTEES**

GAME & FISHERIES, CHAIR
CONSUMER PROTECTION & PROFESSIONAL LICENSURE, VICE CHAIR
APPROPRIATIONS
LABOR & INDUSTRY
URBAN AFFAIRS & HOUSING

MAJORITY POLICY

October 5, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Letter of Support for Bayada Home Health Care Certificate of Need

Dear Mr. McDonald:

I am writing this letter in support of Bayada Home Health Care receiving a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

Hospice is the best model for providing quality, cost-effective, holistic, team-oriented, and compassionate care for people facing a life-limiting illness or injury. As a national home health provider, with home health operations in the State of Maryland, Bayada has extensive experience providing high quality hospice services. Bayada is uniquely positioned to bring this high quality hospice care to underserved areas in Maryland.

Bayada is a family-owned, mission driven, community-based health care provider in the areas of home health and hospice. Bayada is guided daily by its unique mission, vision, values and beliefs as expressed in the *The Bayada Way*. *The Bayada Way* is a commitment to bring compassion, excellence and reliability to every client and every community interaction companywide.

Please grant Bayada the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Mario M. Scavello

Mario M. Scavello
State Senator
40th Senatorial District

ManorCare
Health Services

**Kelly Knorr, MSN, RN**
Director of Nursing

kelly.knorr@hcr-manorcare.com
heartland-manorcare.com
facebook.com/hcrmanorcare

550 Jessup Road
West Deptford, NJ 08066
856.848.9551
856.848.1817 fax

October10, 2016

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Letter of Support for BAYADA Home Health Care
Certificate of Need Application

Dear Mr. McDonald:

I am writing this letter in support of Bayada Home Health Care as it seeks a certificate of need to become a licensed general hospice care program in certain jurisdictions in the State of Maryland.

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Please grant BAYADA the opportunity to provide compassionate and high quality hospice care to the people of the State of Maryland.

Sincerely,

Kelly Knorr, RN,DON

Exhibit 43

HBK®
CPAs & Consultants

**October 7, 2016**

**Jonathan Montgomery**
**Gordon Feinblatt LLC**
**233 East Redwood Street**
**Baltimore, Maryland 21202**

**Re: BAYADA Home Health Care, Inc.**

**Dear Mr. Montgomery:**

**I am the independent certified public accountant for BAYADA Home Health Care, Inc.**

**This is to confirm that BAYADA Home Health Care, Inc. has adequate financial resources to fund its proposed hospice project through breakeven as described in its October 7, 2016 application for a certificate of need to operate a licensed general hospice care program in Prince George's County.**

**Please feel free to call me with any questions.**

**Very truly yours,**

**Enrico J. Ballezzi, CPA, Sr. Director**

HILL, BARTH & KING LLC | 2564 BRUNSWICK PIKE LAWRENCEVILLE, NJ 08648 | TEL 609-883-9000 FAX 609-883-9008 | HBKCPA.COM

# Exhibit 44

BAYADA Home Health Care
Actual YTD Versus Annual Plan
Pennsylvania Boyertown Hospice - 465

|  | 01/04/15<br>2014<br>$ | %<br>of Revenue | 01/03/16<br>2015<br>$ | %<br>of Revenue | $ Increase /<br>(Decrease) |
|---|---|---|---|---|---|
| **Revenue:** |  |  |  |  |  |
| Hospice Revenue | 1,641,485 | 100.00% | 2,871,958 | 100.00% | 1,230,472 |
| **Total Revenue** | **1,641,485** | **100.00%** | **2,871,958** | **100.00%** | **1,230,472** |
| **Cost of Services:** |  |  |  |  |  |
| Payroll | 442,833 | 26.98% | 720,246 | 25.08% | 277,413 |
| OT Pay | 2,149 | 0.13% | 8,379 | 0.29% | 6,230 |
| Transportation | 83,160 | 5.07% | 111,132 | 3.87% | 27,972 |
| Contracted Services | 1,004 | 0.06% | 635 | 0.02% | (369) |
| **Total Paid** | **529,146** | **32.24%** | **840,392** | **29.26%** | **311,246** |
| **Gross Margin Before PTO** | **1,112,339** | **67.76%** | **2,031,565** | **70.74%** | **919,226** |
| Vacation (PTO) Earned | 21,615 | 1.32% | 43,987 | 1.53% | 22,372 |
| **Gross Margin** | **1,090,724** | **66.45%** | **1,987,578** | **69.21%** | **896,854** |
| 401K Match | 0 | 0.00% | 219 | 0.01% | 219 |
| Liability Insurance | 4,450 | 0.27% | 7,286 | 0.25% | 2,836 |
| Payroll Taxes | 42,904 | 2.61% | 66,866 | 2.33% | 23,962 |
| Medical Insurance | 22,227 | 1.35% | 33,957 | 1.18% | 11,730 |
| Workers Comp Insurance | 18,664 | 1.14% | 30,904 | 1.08% | 12,241 |
| Workers Comp Insurance-PY | (398) | -0.02% | (4,053) | -0.14% | (3,656) |
| Medical Supplies-Billable | 150,530 | 9.17% | 319,168 | 11.11% | 168,638 |
| Other Field Employee Expenses | 835 | 0.05% | 2,978 | 0.10% | 2,144 |
| **Total Cost of Services** | **789,972** | **48.13%** | **1,341,705** | **46.72%** | **551,733** |
| **Gross Profit** | **851,513** | **51.87%** | **1,530,253** | **53.28%** | **678,739** |
| **G&A Expenses:** | **682,903** | **41.60%** | **1,055,746** | **36.76%** | **372,843** |
| **Operating Income Before P/S** | **168,610** | **10.27%** | **474,506** | **16.52%** | **305,897** |
| Other Income & Expenses: |  |  |  |  |  |
| Profit Sharing | 21,454 | 1.31% | 40,905 | 1.42% | 19,450 |
|  | 21,454 | 1.31% | 40,905 | 1.42% | 19,450 |
| Net Income | 147,156 | 8.96% | 433,602 | 15.10% | 286,446 |

BAYADA Home Health Care
Actual YTD Versus Annual Plan
Pennsylvania Boyertown Hospice - 465

| | 01/04/15<br>2014<br>$ | %<br>of Revenue | 01/03/16<br>2015<br>$ | %<br>of Revenue | $ Increase /<br>(Decrease) |
|---|---|---|---|---|---|
| **General and Adminstrative Expenses** | | | | | |
| **Office Personnel Expenses:** | | | | | |
| Directors | 75,808 | 4.62% | 111,698 | 3.89% | 35,890 |
| Clinical Staff | 74,572 | 4.54% | 98,835 | 3.44% | 24,263 |
| Client Services Staff | 57,884 | 3.53% | 80,939 | 2.82% | 23,055 |
| Marketing Staff | 70,434 | 4.29% | 167,587 | 5.84% | 97,153 |
| Administrative Staff | 35,580 | 2.17% | 32,378 | 1.13% | (3,203) |
| Office Billable | (22,922) | -1.40% | (35,476) | -1.24% | (12,554) |
| Vacation (PTO) Accrued | 6,511 | 0.40% | 12,771 | 0.44% | 6,260 |
| Contracted Services | 16,893 | 1.03% | 8,889 | 0.31% | (8,004) |
| Wokers Compensation | 6,211 | 0.38% | 9,871 | 0.34% | 3,659 |
| Workers Compensation-PY | (473) | -0.03% | (1,871) | -0.07% | (1,398) |
| Payroll Taxes | 26,518 | 1.62% | 40,883 | 1.42% | 14,365 |
| 401K Match | 208 | 0.01% | 983 | 0.03% | 775 |
| Medical Insurance | 29,050 | 1.77% | 35,164 | 1.22% | 6,115 |
| Other Insurance Benefits | 1,156 | 0.07% | 2,750 | 0.10% | 1,594 |
| Other Office Employee Exp. | 378 | 0.02% | 719 | 0.03% | 341 |
| **Total Office Personnel** | **377,808** | **23.02%** | **566,120** | **19.71%** | **188,311** |
| **Other General & Administrative Expenses:** | | | | | |
| **Advertising** | | | | | |
| Display Ads | 2,793 | 0.17% | 949 | 0.03% | (1,844) |
| Other-Advertising | 1,907 | 0.12% | 1,644 | 0.06% | (263) |
| Marketing | 882 | 0.05% | 3,060 | 0.11% | 2,177 |
| Digital Marketing | 0 | 0.00% | 301 | 0.01% | 301 |
| **Total Advertising** | **5,582** | **0.34%** | **5,954** | **0.21%** | **372** |
| **Recruiting** | | | | | |
| Recruiting | 21 | 0.00% | 179 | 0.01% | 159 |
| Help Wanted Ads | 1,710 | 0.10% | 3,645 | 0.13% | 1,935 |
| Events and Job Fairs | 220 | 0.01% | 1,036 | 0.04% | 816 |
| **Total Recruiting** | **1,951** | **0.12%** | **4,860** | **0.17%** | **2,909** |
| **On-Boarding** | | | | | |
| Pre-Employement Screening | 308 | 0.02% | 705 | 0.02% | 397 |
| **Total On-Boarding** | **308** | **0.02%** | **705** | **0.02%** | **397** |
| Printing, Supplies & Postage | | | | | |
| Stationery and Printing | 3,497 | 0.21% | 5,620 | 0.20% | 2,124 |
| Office Supplies | 379 | 0.02% | 1,173 | 0.04% | 794 |
| Office Fixtures | 677 | 0.04% | 11,724 | 0.41% | 11,047 |
| Medical Supplies-Consumable | 5,498 | 0.33% | 2,073 | 0.07% | (3,426) |
| Postage | 819 | 0.05% | 1,502 | 0.05% | 683 |
| Delivery Services | 1,573 | 0.10% | 1,822 | 0.06% | 248 |
| Total Print, Supp & Postage | 12,443 | 0.76% | 23,914 | 0.83% | 11,471 |

BAYADA Home Health Care
Actual YTD Versus Annual Plan
Pennsylvania Boyertown Hospice - 465

| | 01/04/15<br>2014<br>$ | %<br>of Revenue | 01/03/16<br>2015<br>$ | %<br>of Revenue | $ Increase /<br>(Decrease) |
|---|---|---|---|---|---|
| Equipment Expenses | | | | | |
| Depreciation | 9,896 | 0.60% | 9,521 | 0.33% | (375) |
| Repairs and Maintenance | 122 | 0.01% | 702 | 0.02% | 580 |
| Equipment Rental | 12 | 0.00% | 150 | 0.01% | 138 |
| Total Equipment Expenses | 10,029 | 0.61% | 10,373 | 0.36% | 343 |
| | | | | | |
| Occupancy Expenses | | | | | |
| Office Space | 18,537 | 1.13% | 32,372 | 1.13% | 13,835 |
| Training Space | 160 | 0.01% | 160 | 0.01% | 0 |
| Utilities | 1,560 | 0.10% | 2,159 | 0.08% | 598 |
| Other Occupancy Expense | 547 | 0.03% | 2,678 | 0.09% | 2,131 |
| Office Expenses | 850 | 0.05% | 2,302 | 0.08% | 1,452 |
| Total Occupancy Expenses | 21,654 | 1.32% | 39,671 | 1.38% | 18,017 |
| | | | | | |
| Telephone Expenses | | | | | |
| Voice | 5,348 | 0.33% | 5,217 | 0.18% | (131) |
| Data | 2,518 | 0.15% | 3,457 | 0.12% | 939 |
| Mobile and On Call | 2,702 | 0.16% | 3,372 | 0.12% | 670 |
| Answering Services | 190 | 0.01% | 0 | 0.00% | (190) |
| Total Telephone | 10,758 | 0.66% | 12,046 | 0.42% | 1,288 |
| | | | | | |
| Data Processing | | | | | |
| Data Processing Supplies | 2,038 | 0.12% | 1,991 | 0.07% | (48) |
| Off Site Storage | 0 | 0.00% | 150 | 0.01% | 150 |
| Software Maintenance | 0 | 0.00% | 50 | 0.00% | 50 |
| On-Line Services | 57 | 0.00% | 155 | 0.01% | 98 |
| Total Data Processing | 2,095 | 0.13% | 2,346 | 0.08% | 251 |
| | | | | | |
| Education | | | | | |
| Education | 0 | 0.00% | 2,280 | 0.08% | 2,280 |
| Training | 439 | 0.03% | 95 | 0.00% | (344) |
| Conferences and Conventions | 150 | 0.01% | 2,435 | 0.08% | 2,285 |
| Total Education | 589 | 0.04% | 4,810 | 0.17% | 4,221 |
| | | | | | |
| Travel, Meals and Entertainment | | | | | |
| Travel | 12,520 | 0.76% | 21,469 | 0.75% | 8,950 |
| Meals | 774 | 0.05% | 398 | 0.01% | (376) |
| Entertainment | 191 | 0.01% | 163 | 0.01% | (28) |
| Total Travel, Meals, Entertain | 13,484 | 0.82% | 22,030 | 0.77% | 8,546 |

BAYADA Home Health Care
Actual YTD Versus Annual Plan
Pennsylvania Boyertown Hospice - 465

| | 01/04/15<br>2014<br>$ | %<br>of Revenue | 01/03/16<br>2015<br>$ | %<br>of Revenue | $ Increase /<br>(Decrease) |
|---|---|---|---|---|---|
| Taxes and Fees | | | | | |
| Professional Fees | 1,350 | 0.08% | 1,280 | 0.04% | (70) |
| Taxes | 886 | 0.05% | 1,151 | 0.04% | 265 |
| Licenses and Permits | 275 | 0.02% | 125 | 0.00% | (150) |
| Total Taxes and Fees | 2,511 | 0.15% | 2,556 | 0.09% | 45 |
| Miscellaneous Expenses | | | | | |
| Employee Appreciation | 3,265 | 0.20% | 4,205 | 0.15% | 940 |
| Client Expenses | 356 | 0.02% | 165 | 0.01% | (191) |
| Dues & Subscriptions | 1,108 | 0.07% | 3,607 | 0.13% | 2,499 |
| Contributions | 283 | 0.02% | 550 | 0.02% | 267 |
| Miscellaneous Expenses | 2 | 0.00% | 1 | 0.00% | (0) |
| Credit Card Charges | 0 | 0.00% | 9,757 | 0.34% | 9,757 |
| Total Miscellaneous Expense | 5,013 | 0.31% | 18,285 | 0.64% | 13,272 |
| Bad Debt and Collection | | | | | |
| Inc/(Dec) in Reserve > 6 Mos. | 26,865 | 1.64% | (15,165) | -0.53% | (42,030) |
| Write Offs/Ons | 645 | 0.04% | 16,047 | 0.56% | 15,402 |
| Total Bad Debt and Collections | 27,510 | 1.68% | 882 | 0.03% | (26,628) |
| Homecare Homebase | | | | | |
| HCHB Maintenance & Ongoing Charges | 8,159 | 0.50% | 14,846 | 0.52% | 6,687 |
| HCHB Technology Devices | 803 | 0.05% | 901 | 0.03% | 98 |
| HCHB Data Plans | 4,695 | 0.29% | 8,093 | 0.28% | 3,398 |
| Total Homecare Homebase | 13,657 | 0.83% | 23,840 | 0.83% | 10,183 |
| Shared Expenses | | | | | |
| Annual Training | 444 | 0.03% | 0 | 0.00% | (444) |
| Total Shared Expenses | 444 | 0.03% | 0 | 0.00% | (444) |
| Allocated Expenses | | | | | |
| Core Services | | | | | |
| General Allocation (6%) | 98,496 | 6.00% | 172,316 | 6.00% | 73,819 |
| Direct Charges | | | | | |
| Government Affairs | 164 | 0.01% | 428 | 0.01% | 264 |
| Information Services | 89 | 0.01% | 592 | 0.02% | 503 |
| Insurance Confirmation | 420 | 0.03% | 675 | 0.02% | 255 |
| Learning Management | 500 | 0.03% | 1,155 | 0.04% | 655 |
| Managed Care | 1,135 | 0.07% | 4,036 | 0.14% | 2,901 |
| Total Direct Charges | 2,308 | 0.14% | 6,886 | 0.24% | 4,578 |
| Total Core Services | 100,805 | 6.14% | 179,202 | 6.24% | 78,397 |
| Consultative Work | | | | | |
| Total Central Support Services | 100,805 | 6.14% | 179,202 | 6.24% | 78,397 |
| Division | 22,081 | 1.35% | 37,953 | 1.32% | 15,872 |
| Practice Support | 54,179 | 3.30% | 100,200 | 3.49% | 46,020 |
| Total Division and Practice Support | 76,261 | 4.65% | 138,153 | 4.81% | 61,893 |
| Total Allocated Expenses | 177,065 | 10.79% | 317,355 | 11.05% | 140,290 |
| Total G&A Expenses | 682,903 | 41.60% | 1,055,746 | 36.76% | 372,843 |

Exhibit 45

## FY2017 Hospice Wage Index Final Rates

Wage Index values posted on CMS Website - July 29, 2016
FY2017 Hospice Wage Index Final Rule published in Federal Register, August 5, 2016
**FINAL FY2017 Rates -- All rates calculated for October 1, 2016 through September 30, 2017**
Charts developed by the National Hospice and Palliative Care Organization based on rates published in the Final Rule

**MARYLAND**

| County Name | CBSA | CBSA or Statewide Rural Name | Urban/Rural | FINAL FY 2017 Wage Index | FY2017 FINAL Routine Home Care Rate 1-60 days October 1, 2016 - September 30, 2017 | FY2017 FINAL Routine Home Care Rate 61 + days October 1, 2016 - September 30, 2017 | FY2017 FINAL Service Intensity Add-On (SIA) October 1, 2016 - September 30, 2017 | FY2017 FINAL Continuous Care - 24 hours Rate | FY2017 FINAL Inpatient Respite Rate | FY2017 FINAL General Inpatient Rate |
|---|---|---|---|---|---|---|---|---|---|---|
| Baltimore City, Maryland | 12580 | Baltimore-Columbia-Towson, MD | Urban | 0.9725 | $ 186.95 | $ 146.99 | $ 39.43 | $ 946.40 | $ 168.42 | $ 722.00 |

Rate Calculations completed by NHPCO, August 5, 2016

Exhibit 46

BAYADA Clinical Manager Beatrice Lewis, RN, uses her wealth of nursing experience to support her care team and help them provide exceptional care to their clients

# ASPIRE
# Talent Development and Mentoring Program

At BAYADA Home Health Care, going home means going places. Through our ASPIRE Talent Development and Mentoring Program, you can apply your skills and expand them in any of the following areas:

**Clinical specialization**

Become an expert in a clinical specialty, such as pediatrics, geriatrics, high-tech care, or rehabilitation, and share your expertise to benefit client care and employee training.

*"My opinion is valued and I truly make a difference at BAYADA. Hired as a CNA, BAYADA provided me with the flexibility and support to earn my RN degree. I started as a field nurse, became a clinical manager, and now, I'm a clinical support specialist."*

—**Tyke Crawford**,
RN, BSN, CRRN,
Clinical Support Specialist

**Clinical leadership**

Help lead clinical excellence by developing standards, supporting QA, identifying and developing resources, and mentoring other clinical leaders.

*"While attending nursing school, I joined BAYADA as a home health aide. They provided me with the flexibility and support to try a variety of roles and helped me find the career path that best suited me. I found a home at BAYADA."*

—**Marie Blessington**,
RN, Director of Clinical Leadership Development

**Field leadership**

Mentor and assist peers in the field while providing one-on-one clinical excellence to your clients.

*"I enjoy the respect of both clients and peers alike. By moving from a field nurse with high-tech skills to a clinical manager, I've dramatically increased the number of lives I touch. BAYADA supported my goals and made it happen."*

—**Latresha Jackson**,
RN, BSN, Clinical Manager

**Business leadership**

Develop your entrepreneurial skills to eventually lead a service office or division of offices.

*"When I started with BAYADA as a field nurse, I would never have imagined that I would have the opportunity to oversee multiple service offices in a matter of years. They provided me with the tools, coaching, and development I needed to achieve my dream."*

—**Virginia Steelman**,
RN, BSN, Division Director

*BAYADA Home Health Care specialty practices include Home Health Care, Pediatrics, and Hospice. BAYADA provides nursing, rehabilitative, therapeutic, hospice, and assistive care services to children, adults, and seniors in the comfort of their homes.*

**888-4-BAYADA** (422-9232)
**www.bayada.com**

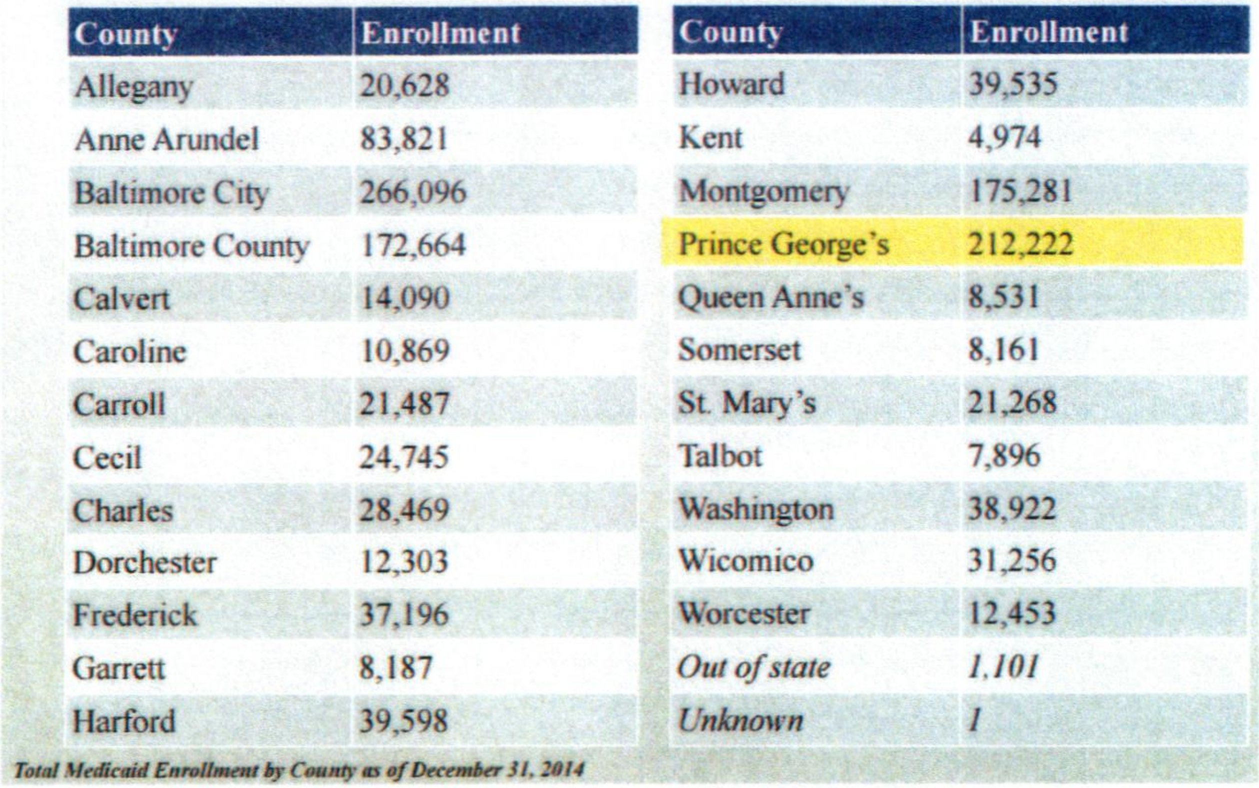
11-1000-2518

BAYADA®
Home Health Care

*Compassion. Excellence. Reliability.*

Exhibit 47

**Medicaid utilization by county in Maryland**



| County | Enrollment | County | Enrollment |
|---|---|---|---|
| Allegany | 20,628 | Howard | 39,535 |
| Anne Arundel | 83,821 | Kent | 4,974 |
| Baltimore City | 266,096 | Montgomery | 175,281 |
| Baltimore County | 172,664 | Prince George's | 212,222 |
| Calvert | 14,090 | Queen Anne's | 8,531 |
| Caroline | 10,869 | Somerset | 8,161 |
| Carroll | 21,487 | St. Mary's | 21,268 |
| Cecil | 24,745 | Talbot | 7,896 |
| Charles | 28,469 | Washington | 38,922 |
| Dorchester | 12,303 | Wicomico | 31,256 |
| Frederick | 37,196 | Worcester | 12,453 |
| Garrett | 8,187 | *Out of state* | *1,101* |
| Harford | 39,598 | *Unknown* | *1* |

***Total Medicaid Enrollment by County as of December 31, 2014***

Exhibit 48

NATIONAL HOSPICE AND PALLIATIVE CARE ORGANIZATION

# NHPCO's Facts and Figures
## *Hospice Care in America*

*2015 Edition*

2015

**National Hospice and Palliative Care Organization**

## Table of Contents

## Introduction

### About this Report

*NHPCO Facts and Figures: Hospice Care in America* provides an annual overview of important trends in the growth, delivery and quality of hospice care across the country. This overview provides specific information on:

- Hospice patient characteristics (e.g., gender, age, ethnicity, race, primary diagnosis, and length of service)
- Hospice provider characteristics (e.g., total patients served, organizational type, size, and tax status)
- Location and level of care
- Role of paid and volunteer staff

Please refer to "Data Sources" (page 16) and to the footnotes for the source information and methodologies used to derive this information. Additional resources for NHPCO members are also provided on page 14.

### What is hospice care?

Considered the model for quality compassionate care for people facing a life-limiting illness, hospice provides expert medical care, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes. Support is provided to the patient's loved ones as well.

Hospice focuses on caring, not curing. In most cases, care is provided in the patient's home but may also be provided in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. Hospice services are available to patients with any terminal illness or of any age, religion, or race.

### How is hospice care delivered?

Typically, a family member serves as the primary caregiver and, when appropriate, helps make decisions for the terminally ill individual. Members of the hospice staff make regular visits to assess the patient and provide additional care or other services. Hospice staff is on-call 24 hours a day, seven days a week.

The hospice team develops a care plan that meets each patient's individual needs for pain management and symptom control. This interdisciplinary team, as illustrated in Figure 1 below, usually consists of the patient's personal physician, hospice physician or medical director, nurses, hospice aides, social workers, bereavement counselors, clergy or other spiritual counselors, trained volunteers, and speech, physical, and occupational therapists, if needed.

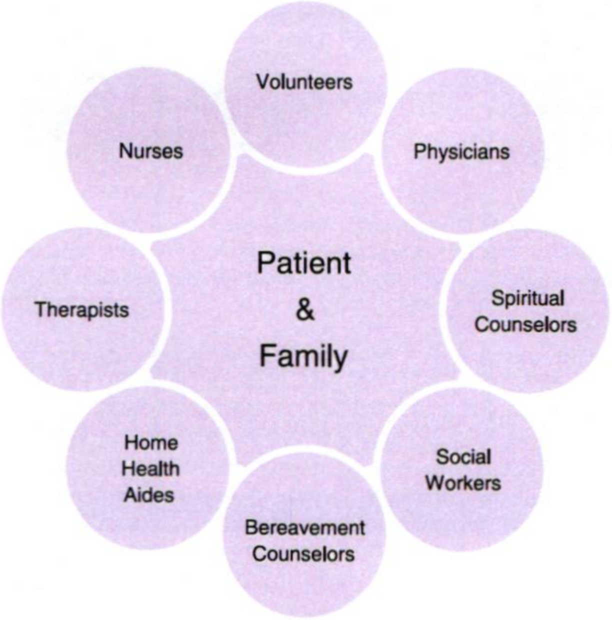


*Figure 1. Interdisciplinary team*

# Who Receives Hospice Care?

## How many patients receive care each year?

In 2014, an estimated 1.6 to 1.7* million patients received services from hospice (Figure 2). This estimate includes:

- patients who died while receiving hospice care
- patients who received care in 2013 and who continued to receive care into 2014 (known as "carryovers")
- patients who left hospice care alive in 2014 for various reasons including extended prognosis, desire for curative treatment, and other reasons (known as "live discharges")

As shown in Figure 2, the number of patients and families served by hospice has steadily increased over the past several years.

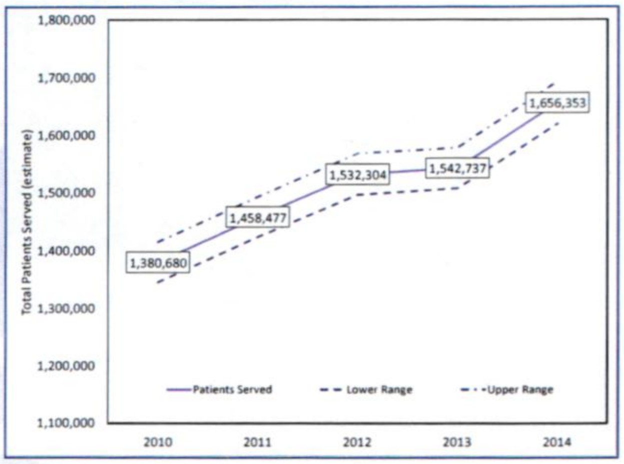


*Figure 2. Total Hospice Patients Served by Year*[1]

NHPCO continually examines, and when appropriate, revises the methodology employed in its data analysis. In 2013 NHPCO revised the statistical model used to generate the estimate of patients served. The revised model is derived from a combination of NHPCO and CMS data and produces a range of possible values for the patients served estimate rather than a single number. Each year additional data points are added to the model and, as a result, prior year estimates are more refined and may differ slightly from previous estimates.

## What proportion of U.S. deaths is served by hospice?

The percent of U.S. deaths served by hospice is calculated by dividing the number of deaths in hospice (as estimated by NHPCO) by the total number of deaths in the U.S. as reported by the Centers for Disease Control and Prevention. NHPCO estimates that approximately 1,200,000 deaths occurred in the U.S. while under the care of hospice. However, as of the publication date of this document, CDC data on the number of U.S. deaths in 2014 is not available. Therefore, NHPCO is not able to report on the estimated percentage of all deaths while under the care of hospice.

## Hospice Use by Medicare Decedents

Over the past decade, the hospice community has been marked by substantial growth in the number of hospice programs and patients served. In an independent analysis of Medicare claims data, Dr. Joan Teno found similar growth in the proportionate use of the Medicare hospice benefit. Of all Medicare decedents in the year 2001, 18.8% accessed hospice for three or more days. By 2007 the proportion of Medicare decedents accessing three or more days of hospice services had increased to 30.1%.

Examination of the number of Medicare decedents with a cancer diagnosis found that 36.6% accessed three or more days of hospice care in 2001. The percentage grew to 43.3% in 2007 for Medicare decedents who received

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* 2014 estimate derived from a combination of data from Medicare and the NHPCO National Data Set.

three or more days of hospice. A similar growth in hospice use was noted for decedents with advanced cognitive impairment and severe functional limitations (dementia). In 2001, only 14.4% of Medicare decedents with a dementia diagnosis received three or more days of hospice care. By the year 2007, that proportion had grown to 33.6%. This trend in hospice use for Medicare decedents from 2001 to 2007 is illustrated in Figure 3.

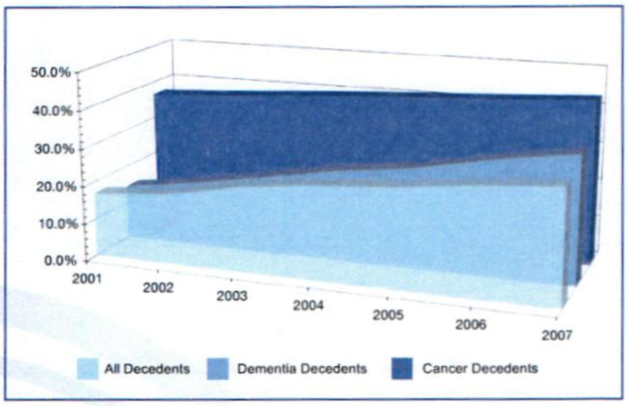

*Figure 3. Proportion of Medicare Decedents Accessing Three or More Days of Hospice Care*

## How long do most patients receive care?

The total number of days that a hospice patient receives care is referred to as the length of service (or length of stay)**. Length of service can be influenced by a number of factors including disease course, timing of referral, and access to care.

The median (50th percentile) length of service in 2014 was 17.4[1] days, a decrease from 18.5[1] days in 2013. This means that about half of hospice patients received care for fewer than 17 days and half received care for more than 17 days[1]. The average length of service decreased from 72.6 days[1] in 2013 to 71.3[1] days in 2014 (Figure 4).

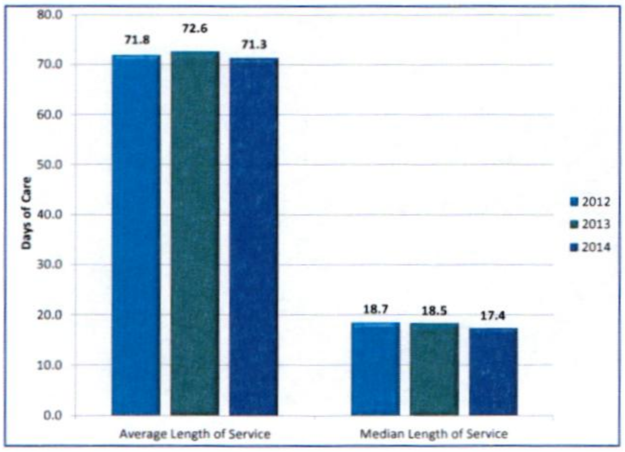

*Figure 4. Length of Service by Year [1]*

## Short and Long Lengths of Service

In 2014, a larger proportion of hospice patients (approximately 35.5%[1]) died or were discharged within seven days of admission when compared to 2013 (34.5%[1]). Likewise, a larger proportion of patients died or were discharged within 14 days of admission in 2014 when compared to 2013 (50.3%[1] and 48.8%[1] respectively). A smaller proportion of patients remained under hospice for longer than 180 days (10.3%[1] in 2014 compared to 11.5%[1] in 2013).

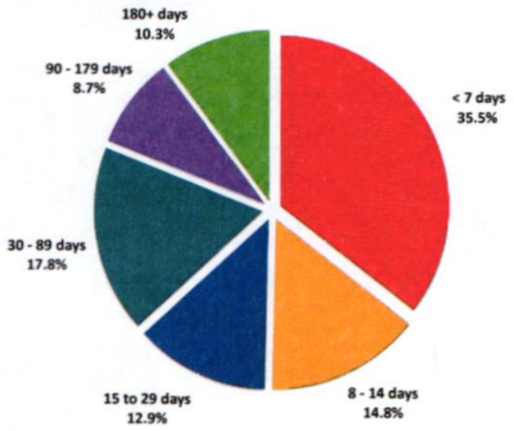

*Figure 5. Proportion of Patients by Length of Service in 2014 [1]*

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** Length of service can be reported as both an average and a median. The median, however, is considered a more meaningful measure for understanding the experience of the typical patient since it is not influenced by outliers (extreme values).

## Where do most hospice patients receive care?

The majority of patient care is provided in the place the patient calls "home" (Table 1). In addition to private residences, this includes nursing homes and residential facilities. In 2014, 58.9%[1] of patients received care at home. The percentage of hospice patients receiving care in a hospice inpatient facility increased from 26.4%[1] to 31.8%[1].

*Table 1. Location of Hospice Patients at Death*[1]

| Location of Death | 2014 | 2013 |
|---|---|---|
| Patient's Place of Residence | 58.9% | 66.6% |
| Private Residence | 35.7% | 41.7% |
| Nursing Home | 14.5% | 17.9% |
| Residential Facility | 8.7% | 7.0% |
| Hospice Inpatient Facility | 31.8% | 26.4% |
| Acute Care Hospital | 9.3% | 7.0% |

## Inpatient Facilities and Residences

In addition to providing home hospice care, about one in three hospice agencies also operate a dedicated inpatient unit or facility[1]. Most of these facilities are either freestanding or located on a hospital campus and may provide a mix of general inpatient and residential care. Short-term inpatient care can be made available when pain or symptoms become too difficult to manage at home, or the caregiver needs respite.

## Hospice in the Nursing Home

As the average life span in the United States has increased, so has the number of individuals who die of chronic progressive diseases that require longer and more sustained care. An increasing number of these individuals reside in nursing homes prior to their death. This rise has been mirrored by growth in the number of hospice patients who reside in nursing homes.

A 2010 study by Miller et al., examined the growth of Medicare-certified hospices providing hospice in the nursing home from 1999 to 2006. Using Medicare's minimum data set (MDS), the study found that the proportion of nursing home decedents who received hospice care rose from 14.0% in 1999 to 33.1% in 2006; a growth rate that closely paralleled the increase in Medicare-certified hospice programs. The demographic characteristics of hospice patients in the nursing home changed little during that time and are very similar to the overall characteristics of hospice patients. Most nursing home hospice decedents were female (67%), white (90%), and were older than 85 years (55%)[5].

## What are the characteristics of the hospice patient population?

### Patient Gender

More than half of hospice patients were female (Table 2).

*Table 2. Percentage of Hospice Patients by Gender*[1]

| Patient Gender | 2014 | 2013 |
|---|---|---|
| Female | 53.7% | 54.7% |
| Male | 46.3% | 45.3% |

### Patient Age

In 2014, approximately 84%[1] of hospice patients were 65 years of age or older—with 41.1%[1] being 85 or older (Table 3). The pediatric and young adult population accounted for less than 1%[1] of hospice admissions.

*Table 3. Percentage of Hospice Patients by Age*[1]

| Patient Age Category | 2014 | 2013 |
|---|---|---|
| Less than 24 years | 0.5% | 0.4% |
| 25 - 34 years | 0.3% | 0.4% |
| 35 - 64 years | 15.3% | 15.3% |
| 65 - 74 years | 16.8% | 16.6% |
| 75 - 84 years | 26.0% | 26.1% |
| 85+ years | 41.1% | 41.2% |

## Patient Ethnicity and Race

Following U.S. Census guidelines, NHPCO reports Hispanic ethnicity as different from race. In 2014, more than 7%[1] of patients were identified as being of Hispanic or Latino origin (Table 4).

*Table 4. Percentage of Hospice Patients by Ethnicity [1]*

| Patient Ethnicity | 2014 | 2013 |
|---|---|---|
| Non-Hispanic or Latino origin | 92.9% | 93.2% |
| Hispanic or Latino origin | 7.1% | 6.8% |

Patients of minority (non-Caucasian) race accounted for about one quarter of hospice patients in 2014 (Table 5)[1].

*Table 5. Percentage of Hospice Patients by Race [1]*

| Patient Race | 2014 | 2013 |
|---|---|---|
| White/Caucasian | 76.0% | 80.9% |
| Multiracial or Other Race | 13.1% | 7.5% |
| Black/African American | 7.6% | 8.4% |
| Asian, Hawaiian, Other Pacific Islander | 3.1% | 2.9% |
| American Indian or Alaskan Native | 0.3% | 0.3% |

## Primary Diagnosis

When hospice care in the United States was established in the 1970s, cancer patients made up the largest percentage of hospice admissions. Today, cancer diagnoses account for less than half of all hospice admissions (36.6%[1]) (Table 6). Currently, less than 25% of all U.S. deaths are now caused by cancer, with the majority of deaths due to other terminal diseases.[4]

The top four non-cancer primary diagnoses for patients admitted to hospice in 2014 were dementia (14.8%[1]), heart disease (14.7%[1]), lung disease (9.3%[1]), and stroke or coma (6.4%[1]).

*Table 6. Percentage of Hospice Admissions by Primary Diagnosis [1]*

| Primary Diagnosis | 2014 | 2013 |
|---|---|---|
| **Cancer** | 36.6% | 36.5% |
| **Non-Cancer Diagnoses** | 63.4% | 63.5% |
| Dementia | 14.8% | 15.2% |
| Heart Disease | 14.7% | 13.4% |
| Lung Disease | 9.3% | 9.9% |
| Other | 8.3% | 6.9% |
| Stroke or Coma | 6.4% | 5.2% |
| Kidney Disease (ESRD) | 3.0% | 3.0% |
| Liver Disease | 2.3% | 2.1% |
| Non-ALS Motor Neuron | 2.1% | 1.8% |
| Debility Unspecified | 1.9% | 5.4% |
| Amyotrophic Lateral Sclerosis (ALS) | 0.4% | 0.4% |
| HIV / AIDS | 0.2% | 0.2% |

## Who Provides Care?

### How many hospices were in operation in 2014?

The number of hospice programs nationwide continues to increase — from the first program that opened in 1974 to approximately 6,100 programs today (Figure 6). This estimate includes both primary locations and satellite offices. Hospices are located in all 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

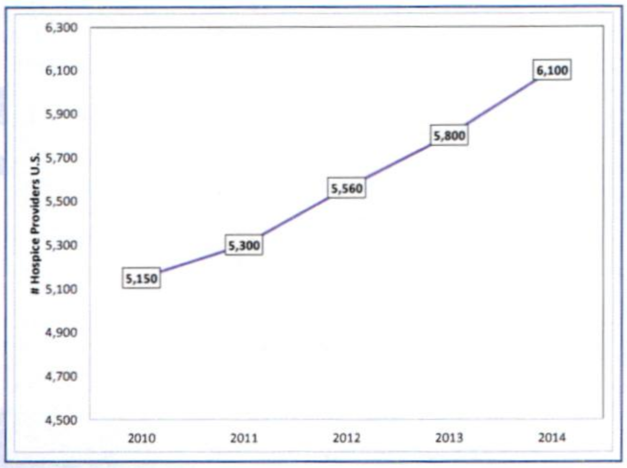

*Figure 6. Total Hospice Agencies by Year* [1]

### Agency Type

The majority of hospices are independent, freestanding agencies (Table 7). The remaining agencies are either part of a hospital system, home health agency, or nursing home.

*Table 7. Agency Type* [1]

| Agency Type | 2014 | 2013 |
|---|---|---|
| Free Standing/Independent Hospice | 59.1% | 58.3% |
| Part of a Hospital System | 19.6% | 19.8% |
| Part of a Home Health Agency | 16.3% | 16.7% |
| Part of a Nursing Home | 5.0% | 5.1% |

### Agency Size

Hospices range in size from small all-volunteer agencies that care for fewer than 50 patients per year to large, national corporate chains that care for thousands of patients each day.

One measure of agency size is total admissions over the course of a year. In 2014, 78.9%[1] of hospices had 500 or fewer total admissions (Table 8).

*Table 8. Total Patient Admissions* [1]

| Total Patient Admissions | 2014 | 2013 |
|---|---|---|
| 1 to 49 | 16.6% | 16.1% |
| 50 to 150 | 28.3% | 29.5% |
| 151 to 500 | 34.0% | 33.1% |
| 501 to 1,500 | 16.5% | 16.4% |
| > 1,500 | 4.7% | 4.9% |

Another indicator of agency size is daily census, which is the number of patients cared for by a hospice program on a given day. In 2014, the mean average daily census was 138.9[1] patients and the median (50th percentile) average daily census was 79.0[1] patients. About 46%[1] of providers routinely care for more than 100 patients per day (Figure 7).

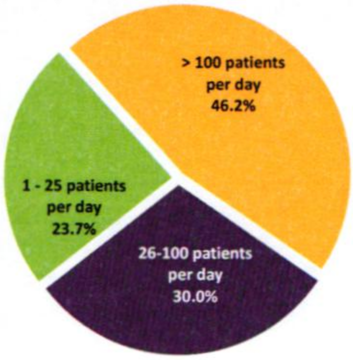

*Figure 7. Average Daily Census* [1]

## Organizational Tax Status

Hospice agencies are organized into three tax status categories:

1. Not-for-profit [charitable organization subject to 501(c)3 tax provisions]
2. For-profit (privately owned or publicly held entities)
3. Government (owned and operated by federal, state, or local municipality).

Based on analysis of CMS's Provider of Service (POS) file, 28%[2] of active Medicare Provider Numbers are assigned to providers that held not-for-profit tax status and 68%[2] held for-profit status in 2014. Government-owned programs comprise the smallest percentage of hospice providers (about 4%[2] in 2014).

The number of for-profit Medicare-certified hospice providers has been steadily increasing over the past several years (Figure 8). In contrast, the number of Medicare-certified not-for-profit or government providers has declined over the same period.

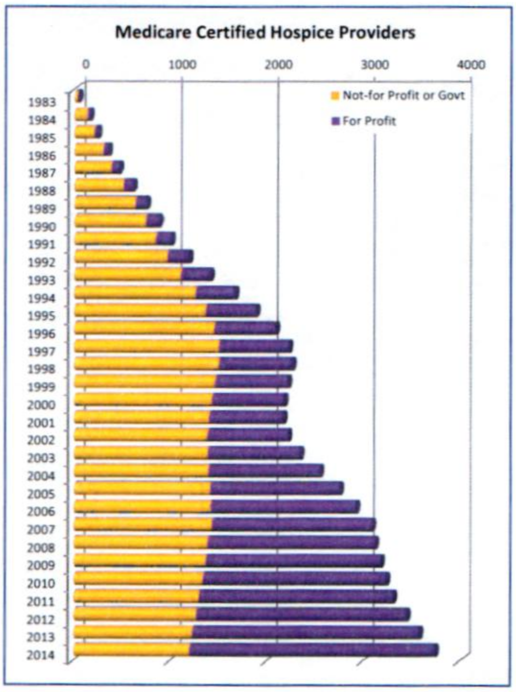

*Figure 8. Growth in Medicare-Certified Hospice Providers*[2]

## Who Pays for Care?

Financial concerns can be a major burden for many patients and families facing a terminal illness. Hospice care is covered under Medicare, Medicaid, and most private insurance plans, and patients receive hospice care regardless of ability to pay.

### Hospice Participation in Medicare

The Medicare hospice benefit, enacted by Congress in 1982, is the predominate source of payment for hospice care. The percentage of hospice patients covered by the Medicare hospice benefit versus other payment sources was 85.5%[1] in 2014 (Table 9). The percentage of patient days covered by the Medicare hospice benefit versus other sources was 90.3%[1] (Table 10).

*Table 9. Percentage of Patients Served by Payer*[1]

| Payer | 2014 | 2013 |
|---|---|---|
| Medicare Hospice Benefit | 85.5% | 87.2% |
| Managed Care or Private Insurance | 6.9% | 6.2% |
| Medicaid Hospice Benefit | 5.0% | 3.8% |
| Uncompensated or Charity Care | 0.7% | 0.9% |
| Self Pay | 0.8% | 0.8% |
| Other Payment Source | 1.2% | 1.2% |

*Table 10. Percentage of Patient Care Days by Payer*[1]

| Payer | 2014 | 2013 |
|---|---|---|
| Medicare Hospice Benefit | 90.3% | 91.2% |
| Managed Care or Private Insurance | 4.0% | 4.0% |
| Medicaid Hospice Benefit | 4.3% | 3.1% |
| Uncompensated or Charity Care | 0.4% | 0.6% |
| Self Pay | 0.4% | 0.5% |
| Other Payment Source | 0.7% | 0.6% |

Most hospice agencies (92.8%[1]) have been certified by the Centers for Medicare and Medicaid Services (CMS) to provide services under the Medicare hospice benefit. In 2014, there were more than 4,100[2] certified hospice agencies. Figure 9 shows the distribution of Medicare-certified hospice providers by state.

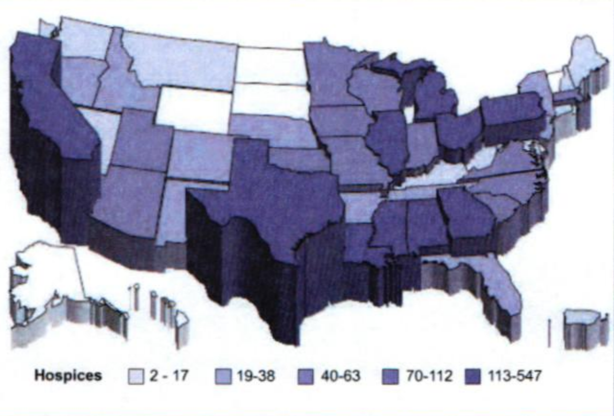

*Figure 9. Medicare-Certified Hospices by State*[2]

Non-certified providers fall into two categories:

1. Provider seeking Medicare certification (e.g., a new hospice);
2. Provider not seeking certification. This group includes providers that (1) may have been formerly certified by Medicare and voluntarily dropped certification, or (2) have never been certified. The provider may have an arrangement with a home health agency to provide skilled medical services, or it may be an all-volunteer program that covers patient care and staffing expenses through donations and the use of volunteer staff.

## How Much Care is Received?

### What services are provided to patients and families?

Among its major responsibilities, the interdisciplinary hospice team:

- Manages the patient's pain and symptoms
- Assists the patient with the emotional, psychosocial and spiritual aspects of dying
- Provides needed drugs, medical supplies, and equipment
- Instructs the family on how to care for the patient
- Delivers special services like speech and physical therapy when needed
- Makes short-term inpatient care available when pain or symptoms become too difficult to treat at home, or the caregiver needs respite
- Provides bereavement care and counseling to surviving family and friends.

### What level of care do most hospice patients receive?

There are four general levels of hospice care:

**Home-based Care**

1. Routine Home Care: Patient receives hospice care at the place he/she resides.
2. Continuous Home Care: Patient receives hospice care consisting predominantly of licensed nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

**Inpatient Care**

3. General Inpatient Care: Patient receives general inpatient care in an inpatient facility for pain control or acute or complex symptom management which cannot be managed in other settings.
4. Inpatient Respite Care: Patient receives care in an approved facility on a short-term basis in order to provide respite for the caregiver.

In 2014, routine home care comprised the vast majority of hospice patient care days (Table 11).

*Table 11. Percentage of Patient Care Days by Level of Care* [1]

| Level of Care | 2014 | 2013 |
|---|---|---|
| Routine Home Care | 93.8% | 94.1% |
| General Inpatient Care | 4.8% | 4.8% |
| Continuous Care | 1.0% | 0.8% |
| Respite Care | 0.4% | 0.3% |

### Staffing Management and Service Delivery

Hospice team members generally provide service in one or more of the following areas:

- Clinical care, including patient care delivery, visits, charting, team meetings, travel, and the arrangement or coordination of care
- Non-clinical care, including administrative functions
- Bereavement services.

Hospice staff time centers on direct care for the patient and family: 70.3%[1] of home hospice full-time equivalent employees (FTEs) were designated for direct patient care or bereavement support in 2014.

The number of patients that a clinical staff member is typically responsible for varies by discipline. In 2014, the average patient caseload for a hospice aide was 10.8[1] patients, 11.2[1] patients for a nurse case manager, and 24.3[1] patients for a social worker.

## Volunteer Commitment

The U.S. hospice movement was founded by volunteers and there is continued commitment to volunteer service. In fact, hospice is unique in that it is the only provider whose Medicare Conditions of Participation requires volunteers to provide at least 5% of total patient care hours.

NHPCO estimates that in 2014, 430,000[1] hospice volunteers provided 19 million[1] hours of service.

Hospice volunteers provide service in three general areas:

- Spending time with patients and families ("direct support")
- Providing clerical and other services that support patient care and clinical services ("clinical support")
- Engaging in a variety of activities such as fundraising, outreach and education, and serving on a board of directors (general support).

In 2014, most volunteers were assisting with direct support (60.8%[1]), 20.2%[1] provided clinical care support, and 19.1%[1] provided general support.

In 2014, 5.2%[1] of all clinical staff hours were provided by volunteers. The typical hospice volunteer devoted 46.3[1] hours of service over the course of the year and patient care volunteers made an average of 20[1] visits to hospice patients.

## Bereavement Support

There is continued commitment to bereavement services for both family members of hospice patients and for the community at large. For a minimum of one year following their loved one's death, grieving families of hospice patients can access bereavement education and support.

In 2014, for each patient death, an average of 2[1] family members received bereavement support from their hospice. This support included follow-up phone calls, visits and mailings throughout the post-death year.

Most agencies (91.6%[1]) also offer some level of bereavement services to the community; community members account for about 12.3%[1] of those served by hospice bereavement programs.

## Additional Statistics for NHPCO Members

### National Summary of Hospice Care

Active hospice and palliative care provider members of the National Hospice and Palliative Care Organization may access additional statistics in NHPCO's ***National Summary of Hospice Care***. This annual report includes comprehensive statistics on provider demographics, patient demographics, service delivery, inpatient services, and cost of care. It is provided exclusively to NHPCO members at no cost, and it can be downloaded from the National Data Set survey webpage at www.nhpco.org/nds.[i]

A partial list of summary tables includes:

- Inpatient facility statistics
  - Level of care
  - Length of service
  - Staffing
- Length of service by
  - Agency size
  - Agency type
  - Primary diagnosis
- Palliative care services
  - Percent providing palliative consult services
  - Percent providing palliative care services at home or in an inpatient facility
  - Percent of physician hours devoted to palliative clinical care
- Patient visits
  - Visits per home care admission
  - Visits per day
  - Visits per week
- Payer mix by
  - Agency tax status
  - Agency type
- Revenue and expenses

### NHPCO Performance Measure Reports

NHPCO members also have access to national-level summary statistics for the following NHPCO performance measurement tools:

1. Patient Outcomes and Measures (POM) (www.nhpco.org/outcomemeasures)
   - Pain relief within 48 hours of admission (NQF 0209)
   - Avoiding unwanted hospitalization
   - Avoiding unwanted CPR
2. Family Evaluation of Bereavement Services (FEBS) (www.nhpco.org/febs)[ii]
3. Survey of Team Attitudes and Relationships (STAR)[iii] (www.nhpco.org/star)
   - Job satisfaction (hospice-specific)
   - Salary ranges
   - Provider-level results

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[i] A valid NHPCO member ID and password are required to access the NHPCO National Summary of Hospice Care report. This report is only available to current hospice and palliative care members of NHPCO.

[ii] Participating agencies receive provider-level reports comparing their hospice's results to national estimates.

[iii] The STAR national summary report is available for purchase by both NHPCO members and non-members through NHPCO's Marketplace.

## Appendix 1: Data Sources

1. 2014, NHPCO National Data Set and/or NHPCO Member Database.
2. 1st Quarter 2015, Centers for Medicare and Medicaid Services (CMS) Provider of Service File (POS).
3. Hoyert DL, Xu J,. *Deaths: Preliminary Data for 2011*, National Vital Statistics Reports, vol 61 no 6. National Center for Health Statistics, CDC, available online at: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.
4. Murphy SL, Xu J, Kochanek KD. *Final Data for 2010*, National Vital Statistics Reports, vol 61 no 4. National Center for Health Statistics, 2013.
5. Miller SC, Lima J, Gozalo PL, Mor V. *The Growth of Hospice Care in U.S. Nursing Homes*. JAGS. 2010 58:1481-88.

## Appendix 2: How Accurate are the NHPCO Estimates?

Estimation, especially when performed on a national level, is a challenging undertaking. NHPCO is continuously working to improve and validate the estimates that are provided to members and the greater hospice community. However, many of the national estimates rely on a less-than-optimal convenience sample of hospices voluntarily submitting data to the NHPCO National Data Set (NDS).

In the fall of 2010, NHPCO performed a comparative analysis with data obtained through a probabilistic sampling methodology – considered the gold standard sampling method – performed by the National Center for Health Statistics (NCHS). Earlier that year, the NCHS released data from its 2007 National Home and Hospice Care Survey (NHHCS). NHPCO first performed a complete analysis of hospice data from the 2007 NHHCS and then compared the results to estimates from the 2007 National Summary of Hospice Care.

The findings of the comparison provide strong corroborating evidence in support of NHPCO's national estimates. Analysis of similar data between the two data sets describes program and patient characteristics of very similar distributions. For statistical comparison, 95% confidence intervals (95% CI) were included in the estimates generated from the NHHCS data. When comparing results, most point estimates generated from the NDS data fell within the 95% CI of the NHHCS results. All such results are considered to be not appreciably different. Even those point estimates landing outside the 95% CI were often very close and also likely not to be statistically significantly different. However, statistical significance testing is needed to confirm that results are, in fact, not statistically significantly different.

An example of the representativeness of the NDS is the distribution of hospices by size, as measured by total unique patient admissions during a year. Table 1 shows the side-by-side comparison of estimates of the distribution of hospice sizes by total admissions generated from NHHCS and NDS data. In all cases, the NDS-based point estimates of the proportion of hospices in each size category were within the 95% CI of the estimate generated from the probabilistic-based NHHCS data. Comparison of results for the distribution of agencies by ownership type [freestanding NHHCS 56.3 (48.4 – 64.2) vs NDS 58.3 | non freestanding NHHCS 41.1 (33.6 – 48.7) vs. NDS 41.8] shows that differences between the two estimates are not appreciably different. Comparable variables were not available for other agency-level characteristics.

***Table 1. Distribution of Hospice Size by Total Patient Admissions (2006)***

| Total Patient Admissions | NHHCS Percent (95% CI) | NDS Percent |
|---|---|---|
| 0 to 49 | 15.9% (10.5 – 21.2) | 17.9% |
| 50 to 150 | 31.7% (23.7 – 39.7) | 29% |
| 151 to 500 | 30.9% (23.3 – 38.5) | 34.1% |
| 501 to 1,499 | 11.1% (7.2 – 15.1) | 14.5% |
| 1,500 or more | 4.2% (2.5 – 5.9) | 4.5% |

Results for estimates of patient characteristics were also comparable between NDS and NHHCS data. Tables 2 through 4 show estimates of the distribution of patient characteristics. In all cases, the point estimates generated from NDS data fall within the 95% CI of estimates generated from NHHCS data. These again are a strong corroborative indication that the characteristics of patients represented in the NDS are representative of patients on a national level.

*Table 2. Percent of Non-Death Discharges*

| NHHCS Percent (95% CI) | NDS Percent |
|---|---|
| 15.6%<br>(13.8 - 17.4) | 15.9% |

*Table 3. Patient Demographics*

| Gender | NHHCS Percent (95% CI) | NDS Percent |
|---|---|---|
| Male | 44.9%<br>(42.4 - 47.4) | 46.1% |
| Female | 55.1%<br>(52.6 - 57.6) | 53.9% |
| **Age (yrs)** | | |
| 0 - 24 | 0.27%<br>(0.03 - 0.52) | 0.5% |
| 25 - 34 | 0.29%<br>(0.02 - 0.57) | 0.4% |
| 35 - 64 | 16.4%<br>(14.5 - 18.2) | 16.5% |
| 65 - 74 | 15.4%<br>(13.6 - 17.2) | 16.2% |
| 75 - 84 | 29.5%<br>(27.2 - 31.7) | 30% |
| ≥ 85 | 38.2%<br>(35.7 - 40.7) | 36.6% |

Not all comparisons were as closely matched as the examples above. In some cases, point estimates generated from NDS were outside the 95% CI of estimates from NHHCS data on one or more characteristics. Table 4 illustrates one such example. The NDS-based estimates for the proportion of patients whose primary payment source was either Medicare, Medicaid, Self-pay, or Other were all outside of the 95% CI of the estimates based on NHHCS data. In this example, it cannot be assumed that the proportion estimates are the same (not statistically significantly different); however, the NDS-based estimates were so close to the 95% CI that it is likely they are still not statistically significantly different. The result of the comparison of estimates of primary payment source is therefore inconclusive.

*Table 4. Percent of Patients by Primary Payment Source*

| Payment Source | NHHCS Percent (95% CI) | NDS Percent |
|---|---|---|
| Medicare | 79.3%<br>(77.2 – 81.4) | 83.6% |
| Medicaid | 3.82%<br>(2.9 – 4.8) | 5.0% |
| Managed Care/ Private Insurance | 9.2%<br>(7.7 – 10.7) | 8.5% |
| Self Pay | 0.79%<br>(0.32 – 1.26) | 0.9% |
| Uncompensated/ Charity | 0.61%<br>(0.23 – 0.98) | 1.3% |
| Other | 2.1%<br>(1.4 – 2.7) | 0.7% |

The tables provided are a sample of the total analysis performed by NHPCO. Overall, the estimates generated from NDS data are very similar to those generated from NHHCS data. These results provide evidence that, although derived from a convenience sample of data, the estimates NHPCO generates in its National Summary of Hospice Care and distributed in this Facts and Figures report are reliable and accurate.

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**Questions may be directed to:**

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